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Shodhini: Insights & Issues

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The Shodhini experience has been able to draw upon a range of disciplines in an attempt to develop a woman-centered health care alternative. In the process, it has drawn upon a critique of patriarchy, our understanding of feminism and gender, ecology and class, knowledge of plants through botany and phytochemistry and knowledge of gynaecology, naturopathy and Ayurveda. These and other disciplinary strands, especially local women's knowledge systems, have helped us arrive at an understanding of class- and gender-sensitive indigenous health care. A first reading of this book may lead our readers to think that we have glossed simplistically over very complicated issues. However, our focus was clear: to try and create a workable model, which the average woman could use to understand and to address her own basic health needs. Eight years of experience in this work has brought forth several issues, which need to be discussed and resolved to some level of satisfaction. This chapter discusses some of these issues, and points to further action.

Issues Arising From The Self-help Experience

Self-help in the Indian Context

Right from the start, Shodhini members nursed certain doubts and fears about the self-help methodology. A commonly heard criticism was, 'Self-help is a western feminist concept unsuitable in our cultural context'. Discussion and experience has convinced us that self-help is not necessarily bound by specificities of the culture of its supposed origin. In fact, self-help tends to be resisted initially by women the world over because it challenges them to confront age-old taboos. Women have been alienated from their bodies. They have been socialised into thinking of their bodies and bodily processes as dirty and shameful. This is a global phenomenon. Women have also been conditioned into believing that their bodies are instruments through which the males of their families can be served.

Self-help as a Participatory Training and Research Method

Women's self-help groups are good examples of participatory training and research. The group members start with their own needs, learn on their own bodies and minds, and try out alternatives in healing methods for their own problems. Training or research is not being done on 'others out there'. Several elements in the philosophies of both self-help and participatory training and research are the same: attempts at equal distribution of power, no hierarchy, and control by the masses over knowledge and information. The added character in this mode of participatory research is its feminist project, something totally missing from the texts of even radical advocates of participatory research.

Training Methodologies

An important feature of training through self-help is to allow the group to take its own time to go through its dynamics and processes. The facilitator has to be sensitive enough to know when to push and when to wait and watch. Self-help with non-literate women poses a special challenge for trainers when it comes to transferring both information and skills. Nothing should be taken for granted and each task has to be broken into small, manageable components. For example, our self-help groups went through systematic exercises in how to wear gloves, how to open and close a speculum and how to use the pictorial case sheets.

In developing the interpersonal skills of interviewing or counselling, accepted cultural modes of expression and local idioms were used. In each field area, role-plays formed the backbone of training. Songs were useful for memorising diagnostic protocols and treatment regimens. And, of course, there was a great deal of emphasis on the practical aspects of preparing medicines and doing examinations.

Aroga sakhi, ame arogya sakhi

Beno ne maate ame arogya sakhi

Safed pani ni beno dava che ghani

Jangli dava ni vaat tame lo jaani

Dahi jeva pani ni dava che sasti

Limda ni potli muki karo ne masti

Jo jaye lal ane bhuru paani

Doctor paase tapas karavi lo jaldi

Health workers, we are health workers

We are health workers for women

O Sisters, there are many medicines for discharge -

Let us tell you about the herbal ones

Curd-like discharge can be treated inexpensively

Insert a neem tampon and enjoy life

If the discharge is red or brown

Consult a doctor in the town a song created at **SARTHI**

Self-help Philosophy and Women's Empowerment

Within eighteen months of starting the self-help groups, the members were not just addressing themselves to each other's physical health problems, but were also providing support to each other at deeper, psychological levels. They were responding genuinely to each other's needs.

The groups used the resources of each member for training. Some in the group were excellent at massage-they led the session on these. Some of the women health workers (WHWs) were eager to learn and practise in the field; they moved faster than others and soon assumed positions of resource persons in the group. Within six months, the hierarchies in the groups melted and the participants moved towards a situation of greater equality.

The self-help groups also provided members with a greater choice of alternatives to allopathic solutions for treatment: from traditional medicines, massage, relaxation and imagery exercises to meditation and appropriate nutrition. Complementarily of multiple treatments was stressed rather than any single approach.

Above all, the self-help group was instrumental in radically changing participants' perceptions of themselves and their relationships to their bodies. As a woman at one of Sarojini's workshops observed:

I felt extremely uncomfortable touching myself there. I was afraid of what I would find, I could not stand the thought of having some infection and people blaming me for it. My husband had no symptoms. I had been suffering from infections for the last one-year. I went to the doctor. I was treated with antibiotics, which brought me temporary relief. I was made to feel unclean because of my infection. Never was the issue resolved as to what was causing this. Never were my sexual partner or practices mentioned. Only through our self-help workshop did I come to know the cause of infection.

During the self-help workshops, women shed their inhibitions and shared genuine problems of sexuality and sexual practices they faced which they could never express in any other forum. Often, these sexual problems and socio-cultural pressures are responsible for infections. In Sarojini's opinion, counselling women on these problems during and after the workshops is as important as the medical aspects of self-examination. Some of us middle-class women broke a myth of a different kind: we had thought that rural women would have dirty, smelly genitalia because of lack of adequate water (and lack of privacy in the villages) to keep themselves clean. We were surprised, and ashamed at our own sense of superiority, to find that they had bodies as clean, if not cleaner, than ours.

A Shodhini network member, Philomena, evaluates her experience with the self-help approach:

It has broken for me the myth that illness has to be treated only by a doctor; it has given me the confidence to know, to feel and understand my own body, its rhythm, its healing powers. A knowledge of the value of herbs has helped me take charge of myself and not be fully dependent on external expertise only.

It has helped me learn how to deal with most common women's complaints ranging from white discharge, excessive bleeding, back or stomach pain to infections of the vagina. Also I was surprised to learn at the end of our three-year action research, that 90 percent of women's health problems are linked to nutrition, self-acceptance and personal care and, most of the time, do not need the intervention of a gynaecologist.

It has given me personal, experiential understanding of the holistic approach and the value of working towards better health and well- being and not just towards cures for women's diseases.

It has provided an excellent opportunity and a system to help develop ordinary, non-literate women healers into barefoot gynaecologists. This offers an exciting

alternative to the expensive and ineffective health care now available through the allopathic system, and its use of drugs for every complaint and illness.

It has enabled me to understand and work with the physical component in women's empowerment, namely better awareness of the body and the capacity to accept it as a resource and a friend; and it has helped me break out of the patriarchal stereotypes imposed on a woman's body such as the attitude of shame and fear related to one's reproductive system, and towards sexuality in particular.

It has affirmed my ability to work with other women more freely and joyously in the task of empowerment and social justice.

Dhuliben and the DHO: a Story of Empowerment

In early December 1993 we at SARTHI, received a letter from the District Health Officer (DHO), stating that he had been informed that we were teaching gynaecology to illiterate women who were now doing speculum examinations in the villages. He would come to SARTHI the following week to carry out an 'enquiry'.

On the appointed day, at the stroke of the appointed hour, he arrived with his assistant. His tone at the start of his visit was brusque. He had been asked by the Deputy Director at Gandhinagar to find out what SARTHI was up to. The Deputy Director in turn, had been asked by the Secretary, Government of India, to enquire into this matter after she had read an article on SARTHI's women's health programme. He wanted to see our training curriculum, and the teaching aids and kits that we had given our health workers. He also wanted to meet the health workers and 'take their statements'. Our attempts to provide a context for our work, to explain our philosophy, were all rejected. He only wished to know who had trained the health workers, how many hours of training had we given and where the training material was that we had used.

After about half hour of this kind of discussion we asked three of our Arogya Sakhis to come in to talk to the DHO-Dhuliben, Shantaben and Rukhiben. The DHO asked them what work they did and what tools they used for this work. Dhuliben stated that she looked after women's health in her village and that she used the 'peculum', moza (gloves) and kaanch (mirror) among other things. We had taken out a speculum for the DHO to inspect; he took it and asked Dhuliben to show him how she used it. Deftly and correctly, Dhuliben demonstrated all the manoeuvres, accompanying her actions with verbal explanations. He asked her, 'what do you examine the women for?' "For soja (inflammation), lalash (redness), phodli (boils or erruptions), pani nu colour ane vaas (colour and odour

of the discharge)," replied Dhuliben. The DHO allowed himself to be impressed. His next few questions were about the treatment that the Arogya Sakhis provided and about their relationship with the government Auxiliary Nursing Midwives (ANMs). We showed him a sheaf of completed case sheets. I think he was relieved that we followed herbal and not allopathic treatments: this absolved him of responsibility. He also seemed reassured that the ANMs and the Arogya Sakhis worked closely together for care of pregnant women and in the immunisation programme.

By the end of his visit, Dhuliben and others had succeeded in unbending the DHO. He went back, promising to help.

Issues Emerging from Other Aspects of Method

Interfacing of Plural Frameworks

The Shodhini experience brought together at least three different systems with their different frameworks of knowledge and reality: popular practice of herbal medicines ('folk' medicine); knowledge acquired and handed through practitioners of Ayurveda, Siddha, Unani and related systems (classical, traditional systems); and some suitably demystified practices and precepts of modern (or 'western') medicine.

At a first level of inquiry, we would try to find out whether the herbal medicines used by 'folk' or popular practitioners had any Ayurvedic references. We would then call these medicines by the somewhat loaded term 'valid' or suitable for further 'shodh' or inquiry. At another level, we would teach healers to diagnose women's gynaecological problems based on the modern, western system of health care and treat these problems with the 'valid' remedies. Interfacing these three levels was a very complex process. Decision-making criteria had to be included so that we could recognise the contradictions and complexities and yet move forward. For instance, suppose the local women's belief system dictates that certain health practices are harmful (say, consuming milk and curds in pregnancy), what would our action be?

The approach in dealing with beliefs was to help women look carefully and critically at them in order to avoid what is harmful and preserve what is best in them. The idea was to emphasise what is valuable in local tradition and to explore ways that build on old traditions rather than ignore or reject them. At best this kind of exercise involves a politics and philosophy of perception, trying to be aware, at a deep level, of how most of what we see, good or bad, is socially constructed. Both modern science and medicine are a -kind of politics and 'modern scientific' explanations are but attempts to make statements that are

consistent with the belief system of modern science. Aware of such dynamics, we tried our best not to be heavy-handed and dominating in our participatory dialogues.

Most of the beliefs fell into the grey area of being neither harmful nor particularly health protecting. These beliefs were left unchallenged or unaddressed, although we made a mental note of them for future reference. Some of the beliefs were analysed in the light of (modern) scientific information available to us. Some were analysed in the light of progressive feminist theories- the ones that fell into this category related to pollution rites and taboos. The feminist world-view that pollution taboos were a means to dis-empower women was a very novel theory to local women. In dealing with local women's beliefs, it was recognised that beliefs have a role in healing. Healing can take place much faster if interventions are compatible with the belief systems of the patient.

On reflection, it is very clear that the bottom line of the decision-making criteria was empowerment of the women concerned. In the process of creating a synthesis of the so-called folk, scholarly and western systems, some elements of each were being taken in and some were being weeded out. Which or whose knowledge and moral system decided what is good and what is bad? Initially, as facilitators, we used the 'modern' paradigm and the feminist perspective to evolve yardsticks for good and bad. But when all of our women participants evolved the decision-making criteria, the only common criteria was what was empowering according to the subjective experiences of the women involved.

We understood empowerment both as a goal and as a process. Empowerment would enable greater control for women (and men) over sources of power in society. In practice this would mean that women would be more assertive in their daily lives, not buckle under oppressive conditions and, in general, be relatively free and autonomous.

Empowerment in the context of women's health can be seen as a continuum. At an intra-personal level, empowerment begins with individual women having a changed perception of them- selves. They now come to accept and own what they earlier thought was dirty and a cause of 'sharam' (shame, embarrassment). The physical and emotional problems, which earlier went undiscussed start to come out of the shroud. At the inter-personal level, women begin to negotiate these relationships. For instance, a small group of women may decide to accompany a friend to the health centre to make sure that she gets the service she requires. And finally it tile community level, women organise lobbies to pressurise the state to have their health rights met, or to draw attention to issues which directly affect their bodies and health, issues like rape and violence.

The Concept of 'Normality'

At every stage of our work we were confronted with the question 'what is normal'? For instance, in many of the field areas where Shodhini work was going on, the local women believe that it is `normal' for pregnant women not to be able to see in the dark. With our knowledge of modern science and medicine, we knew that this phenomenon was a sign of vitamin A deficiency and could be treated. The flip side of women's beliefs about what is 'normal' is modern medicine's norms of 'normality'. For instance, pain at the time of menstruation, or vomiting in early stages of pregnancy is considered 'normal'. The questions before us were: If this is normal, should we just leave it as such and tell the women that this happens and it will pass? Or do we treat it? Should we do something to alleviate these symptoms? Because of our commitment to woman-centred health care, we resolved the confusion around this issue of 'normality' by defining our benchmark: anything which causes discomfort to a woman has to be treated whether it is 'normal' or not. For instance, dysmenorrhoea has to be treated with Mimosa pudica or with chaturbeej chooran. Vomiting in early pregnancy has to be treated with jethimadh (Glycyrrhiza glabra) or lemon juice or with a preparation from mango bark or leaves. At the same time, we must educate women about that which they consider 'normal' (like night blindness in pregnancy) but which can be treated in the viewpoint of modern medicine.

Also, there is over-medicalisation by the medical establishment in its approach to the treatment of routine physiological changes, e.g., menopause. Instead of appropriate counselling, most doctors suggest Hormone Replacement Therapy. What is completely missed by the medical establishment is that treatment appropriate for the woman should be given, rather than resorting to technological fixes.

`Validity', Field Testing and The Shodhini Approach

How do we judge the 'validity' of traditional medicines? That is, how do we know a particular herbal remedy works? Modern medicine is very categorical about the procedure for judging the validity: it usually involves some combination of double-blind clinical trials, in-vitro, in-vivo testing and community-based epidemiological studies. Application of these methods to test the efficacy of traditional medicines has been discussed in medical- literature and usually means standardisation of plant remedies and extraction of the so-called active principle in each plant. However, almost all traditional system practitioners feel that the full therapeutic effect of a plant is decreased and can even vanish completely if extraction and fractionation is carried out. Apart from the difficulty in isolating the active principle of the plant, standardisation of the parts of the plant to be used and quantities to used will also be difficult. This is

particularly so because the same plant can have a varying alkaloid content depending on environment and climate, geographical location, and even the time and the year of plant collection. Also there is the factor of variability and complexity in standardisation due to different herbal plants that may have to be used at the same time to have a full therapeutic effect, and sometimes in the presence of two or more facilitating and activating substances, like honey or black pepper.

Therefore, as a methodology, modern clinical trials do not lend themselves to testing the validity of traditional medicines. Double-blind trials, in addition, have both procedural and ethical problems. How do we 'disguise' a plant (as the equivalent of the dummy) during a double blind clinical trial when the entire plant or substantive parts of it are supposed to be used? Even if we could disguise the plant, why should a feminist research group seeking humane alternatives resort to deceiving the patient? Also, when we are attempting to do a cooperative inquiry, why should we use a placebo and 'blind' the patient? Using a dummy substitute and 'blinding' the patient in practice means that the patient does not have a choice and is not supposed to know whether she is getting the dummy substitute or the real thing. Who then is interested in clinical trials?

Neither traditional medicine practitioners nor patients who have always used traditional medicine are interested to find out whether an herbal remedy acts. The practitioner feels that the plants act and the patient believes that the plant medicine being administered to him works. Neither will be impressed if, after years of research, they are informed that a plant substance used for a thousand years and being used at this moment of time, perhaps, is effective. Both the patient and the traditional medicine practitioner know, and have always believed, that the plant is effective. If, again, after years of research it is shown that a plant or a plant substance is not effective, this will hardly have any effect and both the practitioner and the patient will continue to use the plant. It is, therefore, the allopathic practitioner and perhaps the health administrator who are anxious to know whether the plants used are effective. They are keen to know this because, if the plant is effective, this could be added on to the armamentarium of drugs already available to treat a particular disease. (Roy Chowdhury 1991)

However the above observation is only part of the reality. Traditional medicine practitioners, and advocates of traditional medicine like us, do not want to throw the baby out with the bathwater. We realise that other paradigms of inquiry, with all their limitations, have their uses in the realm of traditional medicines. These other paradigms can possibly add to the utility of traditional medicines in the long run. However in the short run, modern pharmacological research, aided by drug companies, tends to exploit traditional knowledge of plant-based

medicines through a free market economy. Also, at the level of sociopolitical relationships, such 'validation' by modern medicine adds to the bargaining power and status of those who practise and advocate traditional medicines.

It was thus encouraging for us to discover that several of the plants that we are working with and consider valuable are also undergoing scientific trials and experimentation elsewhere. For instance, Tinospora cordifolia which gave us promising results for heavy bleeding appears to be a particular focus of research in more than one medical establishment for carcinoma of the cervix.

Dahanukar and Thatte (1989) describe their studies on the `rasayana' concept (or rejuvenating drugs). In animal studies they found that Tinospora cordifolia and Asparagus racemosus protected animals against different types of infections. The experiments proved that both the plants, were potent immunostimulants.

Based on this experimental evidence we propose that the rasayana of Ayurveda harmonize the functions of the body by modulating the neuroendocrine immune mechanism. They strengthen the host's general resistance by stimulating the immune function, a concept similar to 'prohost' therapy of modern medicine. The role of stress and emotion on immunological dysfunction is well known, so is the role of stress in pathogenesis of many diseases. Therefore it seems feasible that increased immuno-competence improves quality of tissues so that they sustain effects or external and internal stress better. The role of rasayana in delaying ageing and causing rejuvenation can also be explained by their effects on the immune system.

Likewise, Satyavati's study (1988) on the action of guggulipid, and Sharma's study on the role of fenugreek seeds in diabetes mellitus, show that with the use of modern experimental tools some of the assertions and findings of traditional medicines can be corroborated in a modern, scientific paradigm.

In not privileging modern scientific medicine and related modes of inquiry, and in adopting a more tentative, workable criteria for the efficacy of traditional remedies (see the discussion below), Shodhini has probably attempted to define a new paradigm in traditional medicine research.

Choice of Plants for Research

Any research in traditional medicine is confronted with the problem of where to begin. How and where do we focus in the vast reservoir of traditional medical practice?

For the purpose of our experiment through Shodhini, we defined three levels of inquiry that the traditional remedies would have to pass before being considered worthwhile or 'valid' for further action research. Firstly, a plant should be traditionally used in more than one field area of our study for the same symptoms. That is, our data should tell us that women in more than one geographical area have been traditionally using it for the same symptoms. Secondly, we would compare the traditional use of the plant with phytochemical knowledge and with Ayurvedic knowledge. If the botanist and the Ayurvedic vaidya in the Shodhini team could verify that the plant had the properties that it was being used for, we would consider it having passed through the second stage of inquiry.

The third level of inquiry was akin to confirming whether the use of a plant on women with similar symptoms within a community, resulted in relief from the symptoms (see below for a discussion of this confirmation/verification process). Only when such confirmation was available for a numerically significant number of cases would we consider the plant 'valid', that is it 'really works' for the complaint as claimed.

Why did we adopt this three-stage inquiry process? There are at least three reasons. Firstly, as we have already pointed out, in the realm of traditional medicines we have a problem of choice from the many plants available. We have to start somewhere. Our primary deciding criteria for choosing a particular plant was that it should have been reported to be useful in popular practice and been of relevance to women's health problems. We narrowed it further by stipulating that it should be cited for use and efficacy in the multiple geographical areas where our group members were working. This meant two things: that it would ensure some commonality of research tools in the different research locations and that it would point out that the plant behaviour was not an isolated occurrence. (In effect, some kind of field trial has been carried out of a remedy that has survived across time and space). We further narrowed our choice by trying to seek sanction of the literature of more sanctified sciences by asking for a reference to Ayurveda. This was to ensure that we were broadly on the right track. Also we were concerned for the safety of the women who would be using the plants: we would need to know whether a plant was contra-indicated for a particular condition, or considered toxic, or otherwise shunned in Ayurvedic literature.

In the field testing we asked the women diagnosed of particular complaints to use the plants and report the results. At this point a sceptic attuned to double-blind methodology can ask: How do we know the patient is not fooling herself? How do you know all those involved in Shodhini are not deceiving themselves? How do we know that the natural course of the disease could not have come to

play a part and how do we know whether the particular plant indeed was a causative agent or was merely a placebo? The answer is that we have no way of knowing for an absolute fact. Absolute facts do not have much meaning when the experience of getting well is a subjective-objective reality. Of more relevance is that most of the women were suffering from particular chronic complaints and had tried almost everything else they thought could alleviate their condition before they 'crossed over' to the plant.

There could be one valid question however: the symptoms may have disappeared, the women may report that they are well but what about the root cause of the disease and latent problems? This is an area for further research. Even modern medicine has practical problems in detecting and controlling latent manifestations of disease.

Confirmation of Remedies

What works or does not work can be judged only if the data can be verified or confirmed. In this we were as minimally positivist as we could be. Attempts were made to introduce checks and balances in field trials of the traditional remedies e.g., the women health workers (WHWs) were trained to differentiate between various types of white discharge and to record these differences with accuracy. The case sheets included diagrams on which the WHWs were supposed to locate the various symptoms of their clients. Secondly, the treatments and dosages were standardised to the best of our ability. Using finger and hand measurements, the amount of the bark, root or stem of the plants to be taken were standardised. The method of preparation of the medicines, for example, tinctures, powders or decoctions, were also standardised. In some field areas these attempts at building uniformity and standards succeeded, albeit with much effort, while in others it was just not possible to ensure that the standards were followed. The culture and practice of traditional medicine is just not compatible with 'rigorous', uniform standards.

Another way of confirming the efficacy of treatment sought to be done, was a second examination of the clients after at least a month, to ensure that the symptoms had receded. Again, while this was possible in some field areas, in others we could not establish this as a firm practice. The women would say "We have told you that our symptoms have gone away, we won't let you examine us now". In spite of this, after about two years of practice in the field, Shodhini has at least 200 case sheets of women who have been treated successfully, with a physical evaluation and subsequent follow-up to verify the matter contained in the case sheets.

Toxicity

The general impression is that herbal medicines have no adverse side-effects and reactions and that they are non-toxic. In fact this is one of the major reasons why herbal remedies are preferred over allopathic ones. Shodhini tended to treat this assumption lightly. In our list of 411 remedies, we found 14, which could be classified as downright harmful for women. As mentioned earlier, these were categorised as 'C' items. Our definition of toxicity is 'whatever is harmful for a woman in her present condition'. Thus a plant, which is known to be effective for one particular condition, may be harmful in others. A simple example of this is a 'hot' plant given to a woman who is suffering from 'garmi' (heat)-this plant will aggravate her symptoms. Likewise, methi (fenugreek) seeds given to a pregnant woman for constipation may induce abortion.

While the toxicity of some plants is common knowledge, for example dhatura (thornapple) and poppy seed, there is a lack of information about the chemical constituents or the toxic potential of many herbs. Obviously there are gradations of toxicity: there are some plants, which are toxic only in a particular context or situation regarding the patient, or in a particular mode of presentation or preparation. Others are harmful more universally It is important that traditional knowledge of toxicity and contraindications of the use of plants in specific conditions are also documented acid that this is verified against available literature

Patenting of Traditional Medicines

In the nineties, especially, the patenting of traditional medicines has become an issue of concern. Shodhini has been accused of making it easy for drug companies and other commercial operations by publishing the findings of plant-based remedies. We, however, see it in a different light. Firstly, we do not see any resource-efficient way of propagating this traditional knowledge other than by putting it in book form in several languages. Secondly, if we and others like us do not do even this much, whatever useful knowledge in local health traditions exists is likely to go rapidly into extinction. Thirdly, the information we have documented is considered the inherited property of humankind and therefore not patentable. Only chemical modifications of the active principles of plant-based medicines, and their derivatives, can be patented. Therefore what we are doing is providing, or rather reconfirming, hints for research for the modern drug industry and scientific laboratories. Such hints exist by the thousands in traditional pharrnacopocias and Materia Medicas, which are all easily available in printed form. Also, the route to isolating the active principle of a medicinal plant and establishing useful medicines from active principles is long and

difficult. The active chemical constituent often does not work when isolated, as has been the experience of many researchers.

But the entire discussion above bypasses the basic question of agreeing to a patent regime: should those who believe in free use of intellectual properties for the benefit of humankind play the patent game at all? We suspect patenting is an incorrect strategy in the long-term battle against those who believe in collecting royalties for their 'discoveries' and 'inventions'. Organising local communities to protect their traditions and resources is probably a more sustainable strategy.

Limitations of the Study

Shodhini was a complicated experiment involving a number of individuals, organisations and village-level women from ill over India. The pace and time-schedule set by network members was unrealistic as far as village-level processes were concerned. For example, it took healers longer to learn the basics of gynaecology than had been estimated by network members. Also, the time it took healers to win the confidence of rural women and begin to examine them was longer than estimated.

Although Shodhini as an idea has immense political significance, the scale at which it could be tried out was miniscule. Ultimately only three field-based groups participated in the community testing phase of the herbs. The range of symptoms or problems that could be taken up in the three years was extremely limited. In fact, two crucial areas which could not be included in this study were women's traditional contraceptives and abortifacients. In a country like India, where the State has placed such an emphasis on the family planning programme, finding an alternative to the invasive technologies being pushed by western systems becomes imperative.

Another aspect of the limited scale of this experiment that needs to be mentioned is the backward and forward linkages. Reports from all our field areas indicate that the medicinal plants and trees are becoming scarcer. Regeneration of these resources, as a backward linkage, and processing them into simple formulations as a forward linkage, also need to be done. Perhaps the next phase of Shodhini will include these aspects.

The Shodhini experience is most relevant to the primary level of gynaecological health care. At present, we, that is the Shodhini group, do not have any answers in the form of herbal remedies to more complicated problems requiring secondary and tertiary levels of care, but the search continues.