AUDIT INTO THE EFFECTIVENESS OF SELF-HELP GROUPS

Roanna Mitford

Roanna is a fourth-year medical student spending a year in Lancaster, having completed her first three years in Liverpool. This audit was carried out as part of her elective visit to South Nepal in the summer of 2008 (at the hospital's request). This has stimulated her interest in tropical medicine and she hopes to intercalate in topical biology next year.

INTRODUCTION

Self-help groups

Self-help groups (SHGs) are organisations *'which provide an environment encouraging social interactions through group activities or individual relationships especially for the purpose of rehabilitating or supporting patients, individuals with common health problems, or the elderly.'*[1]

SHGs are attended worldwide for nearly every major disease listed by the World Health Organisation.[2] There are currently about 2,000 SHGs in the UK alone, probably the most well known being Alcoholics Anonymous, and more are being set up all the time.[2] A recent study looking at the effectiveness of SHGs in HIV-infected patients concluded that they significantly improved self-care.[3] They are usually self-governed and free to members, which is important if attendance is over long periods.[2]

Lalgadh Leprosy Services Centre (LLSC) in South Nepal has recently set up SHGs to reduce the longterm disabilities which leprosy can cause. The purpose of this article is to discover if SHGs increase compliance of the patient with self-care. The results of this audit, however, could be applied to any SHG around the world. Specific recommendations for the UK are made at the end of the article.

Leprosy and SHGs

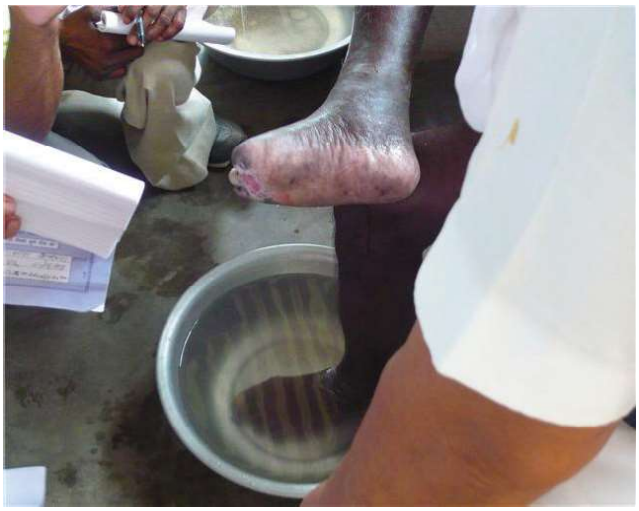
Leprosy has been a much-feared disease since biblical times, and sufferers, in addition to sometimes severe disabilities, are frequently outcast from their communities.

However, one month after starting multi-drug therapy (MDT), leprosy is no longer contagious.[4] Patients can continue normal daily lives, without infecting others. SHGs are therefore an ideal way of maintaining contact with patients, ensuring they get the support they need without having to attend hospital. Self-care in leprosy includes prevention of ulcers by checking, soaking, scraping and oiling feet daily, and exercising clawed fingers to improve straightening.

SHGs can also address the social isolation and stigma associated with leprosy. By providing literacy classes and instruction in income generation, patients can be self-supporting where previously they had no income. The social implications of leprosy can be harder to deal with than the medical ones.[5] One patient, for instance, was given 15 days to leave her village. Without material and psychological support, her future in a country without social services would be very bleak if an SHG was unable to provide this.

Lalgadh Hospital and SHGs

Lalgadh Hospital was built in 1991, began to receive patients from 1993 and now has over 30,000 patients visiting each year. Patients affected by leprosy receive free treatment including medication, surgery and physiotherapy. Patients with other conditions are asked to contribute to the cost if they are able. The centre and its community projects are funded by the Nepal Leprosy Trust.[6]



Foot affected by leprosy being soaked

Lalgadh Hospital

Lalgadh Hospital has a community department helping hundreds of people affected by leprosy in Nepal by integrating them back into society. Pilot SHGs were set up seven years ago and have since continued to grow. There are now 36 SHGs in four districts, providing self-care support and also income generation, education and loans. There are also self-care cells (SCCs), which are primarily focused on teaching self-care but will later develop into SHGs. Most SHGs started less than two years ago but many now have over 20 members.

As the project expanded, the LLSC felt the effectiveness of the SHGs needed to be established, hence this audit.

METHODS

As a measure of SHG effectiveness the criteria selected for investigation were:

- number of outpatient clinics attended before and after joining an SHG
- number of inpatient admissions before and after joining an SHG
- aspects of SHGs which patients found most helpful
- areas in which SHGs could be improved.

This was carried out by interview and reviewing patient records. After patients were interviewed, their records were examined to determine the number of attendances and admissions over the years.

Initially, the audit included patients on the register of the wound care unit. However, as there were some discrepancies with the records of the community department, only patients who had been interviewed were included.

RESULTS

Table 1 shows a reduction in both outpatient attendance and inpatient admission after attending an SHG in a random sample of 35 patients. The reduction in each case may be small, but when multiplied by total number of patients in SHGs (currently over 600), this represents significant savings in time and resources in a small hospital of 50 beds.

A group of patients receiving treatment

Department	Before attendance	After attendance
Outpatients	19	14
Inpatients	15	9

Table 1 Number of patients presenting before and after attendance at an SHG from a random sample of 35

Figure 1 shows that the single most important factor patients consider SHGs provide is advice on self-care. This is the primary purpose of the groups, but the figure also demonstrates that advice on generating income, reducing the stigma associated with leprosy, social fellowship and support, and education are regarded as just as important by some individuals.

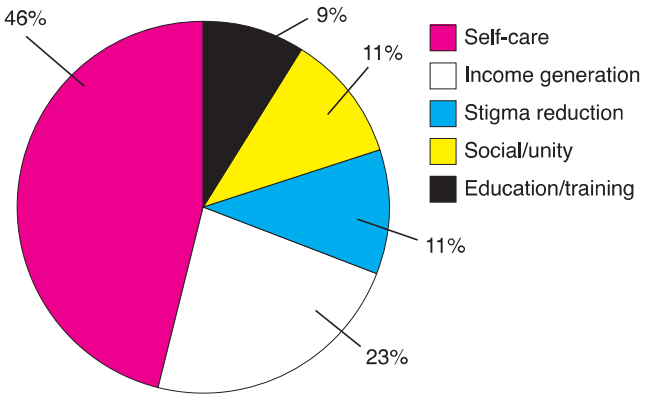


Figure 1 The most helpful aspects of SHGs as identified by a sample of 35 patients.

DISCUSSION

The mean size of SHGs in the sample was 18 members. As there are 36 SHGs, this gives a rough estimate of over 600 (specifically 648) members. This is quite an achievement for LLSC, but emphasises the need for proper records and analysis, and the completion of standard forms. When asked how many members were in their SHG, several patients in the same SHG gave different answers. This reinforces that more formal records need to be kept to facilitate future audits, ensure everyone is attending SHGs who should be, and to maximise use of limited resources.

SHGs at LLSC comprised mainly older males, which possibly reflects the hierarchy within Nepalese culture. Promoting membership of women by having more female facilitators, however, may reduce membership of men of female-led groups. This could be overcome by having female-only groups, but feedback to ensure no-one felt excluded would be needed. Likewise, an effort should be made to recruit younger patients into SHGs. The earlier a patient learns to minimise the effects of the condition, the fewer disabilities and stigma will result.

After self-care, income generation was viewed as a priority by patients and is an area for possible expansion. In addition to financial help making patients self-sufficient, it also demonstrates to people without leprosy that the patients are valued and can have a relatively high standard of living.

As SHGs continue to grow and the suggestions above are implemented, re-auditing will be necessary. The benefits measured by this audit are small but should be greater within two years.

A beading class to help people with anaesthetic fingers earn a living

Facilitators of the SHGs would be able to keep a record of how often people were attending, and the extent of any skin damage. If it appeared patients were attending hospital with more severely infected wounds from particular SHGs, it would alert staff to the fact that those facilitators might need more training. Another aspect of SHGs raised in the interviews was that they can act as a form of follow-up after attendance at outpatient or inpatient departments. Facilitators can refer patients back if there are any problems.

Although SHGs were initiated seven years ago, the programme has expanded rapidly recently and many SHGs are newly formed. Many patients in the sample had attended for less than two years. If their attendance can be sustained for a prolonged period the small improvements demonstrated by this study could equate to large improvements with time.

In summary, I feel in terms of income generation the SHGs at LLSC are successful. However, it will only be after re-audit that the effectiveness of SHGs in reducing attendances and admissions at the hospital can be judged.

APPLICATION TO THE UK

The general principles highlighted by this audit are relevant to the UK. For instance:

- where one sex or age group is under-represented in an SHG, steps should be taken to encourage participation without isolating original members
- formal records should be kept to:
  - check the number in each group and frequency of attendance
  - allow audits to be undertaken to assess effectiveness of each individual group
  - record management of individual progress
  - facilitate the establishment of criteria for the distribution of financial and non-financial resources
- members of SHGs should be asked what aspects of the group they find useful and what other facilities could be provided to maximise potential of the groups
- SHGs should be re-audited periodically to ensure their continual effectiveness
- when re-auditing, ensure health professionals do not ask leading questions which could influence responses

FURTHER INFORMATION

More information about LLSC and the work of the National Leprosy Trust can be found at www.nlt.org.uk

Financial donations are gratefully received, and opportunities exist to work in the hospital at Lalgadh either as an elective or longer term.

REFERENCES

1. 'Self Help Groups' Online medical dictionary. Last revised 12 December 1998. Available at: http://cancerweb.ncl.ac.uk/cgi-bin/omd?query=self+help+groups (accessed 10 August 2008)
2. SHGs in the UK. http://www.patient.co.uk/selfhelp.asp (accessed 6 November 2008)
3. Ngamtrairai N, Phuaram B, Sukkho B, Vechsawan D, Pheungcham P. International Conference on AIDS. The effectiveness of Self-Help Group on self-care behaviours in HIV-infected prisoners, Thailand. Int Conf AIDS 2004;15:11-16
4. World Health Organisation. 'Leprosy' 2007. Available at: http://www.who.int/mediacentre/factsheets/fs101/en/ (accessed 10 August 2008)
5. Thomas M. Challenges in leprosy rehabilitation. Asia Pacific Disability Rehabilitation Journal 2004;15:45-9
6. Nepal Leprosy Trust. www.nlt.org.uk/page.php?nameShort_Term_Opportunities (accessed 23 January 2008)

All photographs courtesy of the author