Self Help: A Critical Factor in Healthcare for Many People

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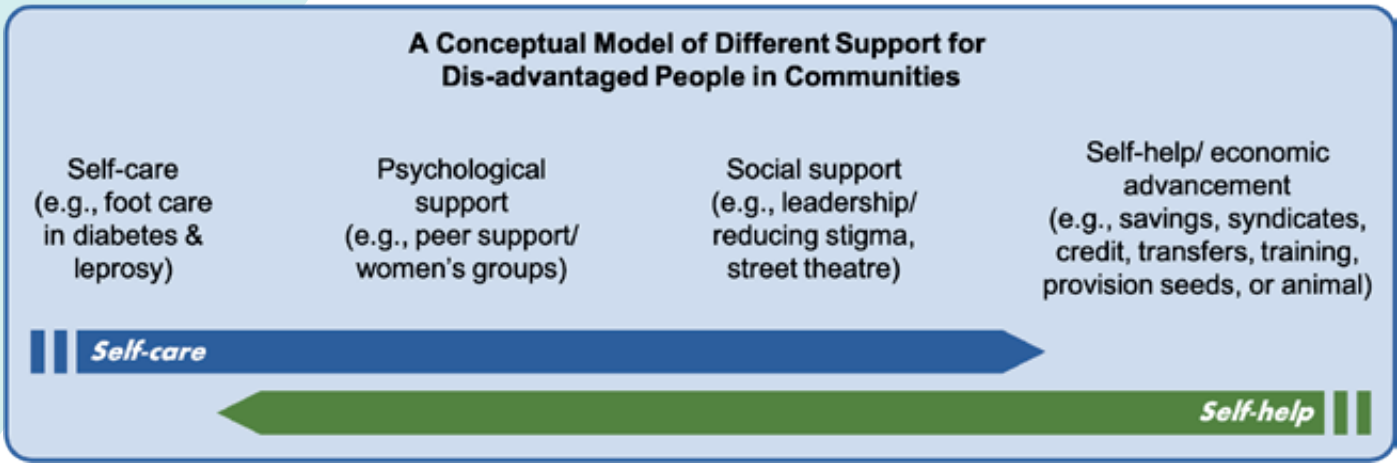
At what point does self-care topple over into self-help? Self-care, narrowly interpreted, relates to a person taking responsibility for their own clinical care. Self-care is very widely used in diabetes where it is often reinforced by peer support. Self-help, by contrast, is interpreted to mean that steps are taken to empower disabled or disadvantaged people. While self-care and self-help might be distinct conceptually, the concepts may elide in practice. First, self-help programmes may include self-care elements. Second, both self-help and self-care programmes may include specific elements to provide psychological and social support. The figure below provides a conceptual map showing how four different elements (promoting self-care, providing psychological support, promoting a supportive social environment, and fostering economic development) can make a spectrum of activities. It is likely that these activities interact in such a way as to reinforce each other.

The global extension of ARC West Midlands is carrying out work on community support for people affected by leprosy. Like ARC WM itself, this work is supported by the NIHR. It is through this route that we became interested in self-help. We are carrying out a prospective evaluation of a self-help intervention in Nepal, along with retrospective evaluations of the sustainability of self-help interventions in Nigeria, India and Nepal.

As part of the above work, we are reviewing self-help programmes more broadly. We have read the systematic review of economic self-help group programmes for woman's empowerment by Brody and colleagues.[1] We have also reviewed work on micro-finance and tried to avail ourselves of the work of the Abdul Latif Jameel Poverty Action Lab.

The financial instruments that may be used within self-help programmes, are made up of one or more of the following three basic methods: *savings groups*, *micro-credit*, and *cash transfers*. Cash transfers may be conditional or unconditional. These financial instruments are often accompanied by some form of training intervention so that people can be more productive. Self-help is based around the formation of self-help groups – groups of people who are disadvantaged in some way are created and mentored by facilitators. Part of the theory is that these self-help groups are psychotropic



– they foster comradery, provide psychological support and enable people to share know-how. The facilitators are usually funded through an NGO, such as The Leprosy Mission, operating with support of local authorities.

Self-help interventions are usually evaluated in terms of economic advancement and psychosocial benefit. Economic advancement can be measured on the basis of income, expenditure and wealth (or some combination of these). Psychosocial effects can be measured at one or more of three levels: personal, community and political. If they are combined with self-care, then health outcomes should be included in the evaluation.

It turns out that micro-finance is less effective economically than generally claimed, and the larger and more rigorous the study, the smaller the effect of the intervention. It may be that the benefits of micro-finance are more psychosocial than strictly economic, avoiding the anxiety of having to take out more expensive loans from 'sharks'.

Self-help groups that we work with in India are women only, while self-help groups in Nepal include both men and women. The jury is still out on whether women only or mixed gender groups are preferable. There is, however, some evidence that self-help does not reach the very poorest of the poor, despite them being the main target group. We have found some evidence that stigma may flow bi-directionally in self-help groups; suffering stigma does not preclude a negative attitude to people with other disabilities.

The self-help industry is vast; over 80 million women in India have taken part in some form of self-help intervention. The 2019 Nobel Prize in Economic Sciences was awarded to economists who have contributed to this science of development economics at grassroots levels, and who co-founded the Abdul Latif Jameel Poverty Action Lab.

Economic self-help groups funded by Leprosy Missions have broadened to include other conditions and very poor and marginalised people. Thus, healthcare and more general socio-economic care have merged. This integration of health and broader welfare is also epitomised in our ARC WM where we have programmes on school mental health, social prescribing, and the health and welfare of the work force. The health economics profession is recognising that a narrow focus on just 'health' is not sound, except perhaps in examining the more technical ends of care. That is why the ICE-CAP (ICEpop CAPability measure) is gaining popularity. In the case of leprosy, self-help and self-care could be particularly synergistic, since most people affected by leprosy are subsistence farmers. Farming is inimical to preventing and recovering from the foot ulcers that are a major feature of the disease. Economic empowerment and providing the skills to pursue sedentary occupations should therefore be of special value to people affected by the long-term neurological sequelae of the disease.

Reference:

1. Brody C, de Hoop T, Vojtkova M, et al. Economic Self-Help group Programs for Improving Women's Empowerment: A Systematic Review. *Campbell Syst Rev*. 2015; **11**(1): 1-182.

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