Home Based Self-Care in West Bengal- Name of the best practice

The best practice has been in implementation since January 2019. It is a best practice related to Self-care a service at Community and Primary levels. the best practice was implemented at different levels: Urban, Peri-urban/semi-urban, Urban slums, Rural, Tribal. The persons affected by leprosy living in their homes constitute the target population

Which problem did this best practice address?

1. In the health system regular services for leprosy disable patients are not available.
2. Government DPMR camps are organised in blocks once a year. Due to distance, cost of travelling, loss of wage, and other frustrations, there was less attendance or participation by the persons with disabilities (PWD) due to leprosy in the camps.
3. There was irregularity in providing self-care materials, MCR foot ware and other necessary needs of those patients.
4. There were no records or documents to trace the patients and do follow up of the patients.

Who was most impacted by the problem?

The persons with disabilities due to leprosy were most impacted by this problem.

How did the problem impact the target population?

Because of the above problems as mentioned in section C1, only 15 to 20% patients attended the DPMR camps. This led to deprivation of services which further deteriorated the conditions of the affected persons. To add to this, there was no monitoring mechanism of the health system to follow up with the disabled patients to know whether they were practicing self-care or not. As a result, the leprosy disabled patients suffered the most and were found to be the most vulnerable group.

Which NLEP goals, targets, indicators, objectives, or priorities were getting impacted due to this problem?

Target/Goal:

Zero Disability, Zero Exclusion

Indicators:

Proportion of patients practicing self-care

Proportion of patient showing improvement

Objective:

To Established a sustainable service delivery mechanism for disabled leprosy patient within the government health system.

Summary of the best practice - 19,000 persons with disability due to leprosy live in West Bengal. Government DPMR camps are organised in blocks once a year where only 15 to 20% patients attend. During these camps patients are trained to take care of their disability, and footwear are supplied. Even if training is given, it was not possible to know

if the affected persons were practicing self-care regularly. NLR India had advocated with the government of West Bengal for the home-based self-care (HBSC). This has brought significant change in the condition of disabled persons.

Goal(s) of best practice - Provide regular services to the leprosy disable patients at their doorsteps, and improve their conditions through practice of regular self-care

Objectives (primary & specific) of best practice

1. Improve the physical conditions of persons with disabilities due to leprosy by promoting regular self-care
2. Capacity building of Govt. health staff and infrastructure to promote self-care
3. Develop a monitoring system for tracking this practice
4. Establish a service delivery system from the sub-centres with proper documentation

Main activities of best practice

1. Advocacy and sharing of a plan with the West Bengal government to include HBSC into health care system
2. Capacity building of government health staff
3. Regular follow up with the leprosy disabled person by ASHAs in their respective villages and the reporting to their ANMs
4. ASHAs deliver self-care materials to patients every month (gauze, bandage, antiseptic lotion etc)
5. Also, a tumbler, and one pumice stone in a year to patients with insensitive foot/hand.
6. A pair of protective shoes for every 6 months and a pair of glasses to patients with eye problems

This initiative was taken up in the year 2019, across the state

What factors were considered while designing / implementing this practice? (endemicity, local norms, culture, etc.,)"

It was felt that there was a need to improve the service delivery system so that the most vulnerable get home-based services that are sustainable. ASHAs were considered to be the best drivers of this change. They regularly visit the households for different health services. The approach had a potential to address community stigma and discrimination.

Who were the key implementers & collaborators?

Name: ASHA and ANMs, ANM supervisors, leprosy disable patients, NLR India.

Type: The collaborators were from the government, affected persons and the NGO (NLR India)

Role: While the government provided training and self-care materials to patients every month, NLR India facilitated the model by training and monitoring

Tentative cost of implementing the best practice? How much does it cost (men, money, material) to implement this practice? Can it produce results with reasonable level of resources?
A plan was submitted with a zero cost to the government. However, a minimum cost was required for giving training to GHCs staff on regular intervals with monitoring and supervision by the supervisors.

As a cost of Government: Logistics support, Dressing Materials, Infrastructure support.

As a cost from NLR India: Manpower for advocacy, Training & Monitoring.

Yes, it can produce immense result with proper utilization of Health infrastructure with reasonable resources.

The benefits that the best practice had on the target population?

1. More or less all the disabled patients are receiving regular services.
2. Regular visits by the FLWs to the house of the patient has helped to reduce the stigma and improve the psychological support.
3. Improvement in physical condition of the disabled leprosy patients.

Internal evaluation was taken up in the first quarter of 2021

1. Reach to disabled leprosy patients increased more than 10 times.
2. The number of self-care kit (materials) and protective footwear supplied and users also increased many folds.
3. 67% of the patients expressed happiness as someone was reaching their homes every month.
4. 54% of patients with ulcer on foot showed improvement, either healed or decrease in recurrence.
5. Improvement in skin condition like softening was noticed in 68% of patients.
6. As the service delivery system is done at the doorstep within the community by the health worker, this practice itself reduces stigma from the community.

External evaluation is being currently done under the guidance of technical committee chaired by the DDG, Central Leprosy Department, GoI

What worked well? What facilitated this?

Involvement of front-line health workers like ASHA and ANMs. Regular follow up of ulcer and leprosy disable patient. Regular training and capacity building of GHC staff was also a contributor. The ASHAs are also able to deliver the self-care services in the leprosy colonies.

What did not work? Why? Lack of regular supply of self-care materials in all areas.

The best practice can be implemented all across the country. Can be replicated in other count also where health system has frontline health workers. Filariasis programmes that can consider replicating your best practice.

What recommendations can be made for those intending to adopt this best practice?

A policy decision to use Front line workers (FLWs) for promotion of self-care

Capacity building of health staff & development of monitoring system and supply of logistics.

Figure 1: ASHA guiding self-care of leprosy ulcer at home

Figure 2: Self-care being demonstrated by ASHA in leprosy colony