STATE OF SELF-CARE REPORT

PROGRESS AND POTENTIAL OF SELF-CARE: TAKING STOCK AND LOOKING AHEAD
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ACKNOWLEDGEMENTS

This report represents the contributions of many advocates and implementers of self-care at the country level and globally.

We would like to sincerely thank all the individuals and institutions who have contributed to the development of this report in various ways, including by providing case examples of their work and by reviewing drafts of the report. The names of contributing authors and institutions, many of whom are members of the Self-Care Trailblazer Group (SCTG), are listed by their specific contributions.

We greatly appreciate the thoughtful advice and guidance provided by the SCTG Secretariat and members of the report’s Sub-Working Group, including, Aissatou Thiolye (FHI360), Claire Watt Rothschild (PSI), Dinesh Kumar (Dr RP Government Medical College, Himachal Pradesh, India), Elesha Kingshott (GAC consultant), Kimberly Whipkey (WRA), Pritha Biswas (Pathfinder), and Sandy Garçon (PSI). We thank them for their active engagement and their review of the outline and key sections of the report. We also acknowledge the contribution of Austen El-Osta (SCARU/Imperial College London), Patricia Mechael (HealthEnabled), Eva Lathrop (PSI) and Heather Hancock (JHU) for reviewing the section on Self-Care frameworks.

We are thankful to Ryan Brown for copy editing and proofreading of the report, and to PSI’s External Communications for the design and layout of the report. We gratefully acknowledge the financial and technical contribution of the Children’s Investment Fund Foundation (CIFF) and the William and Flora Hewlett Foundation, whose support has made this work possible.

Overall coordination, curation, and preparation of the report was provided by Dr Sarah Onyango, Project Lead and Secretariat Director, SCTG, and Martha Brady, Senior Consultant in Women’s Health and Self-Care.
### ACRONYMS AND ABBREVIATIONS

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<tr>
<td>ANC</td>
<td>Ante-Natal Care</td>
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<tr>
<td>CSE</td>
<td>Comprehensive Sexuality Education</td>
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<td>DISC</td>
<td>Delivering Innovation in Self-Care</td>
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<tr>
<td>DMPA</td>
<td>Depot Medroxyprogesterone Acetate</td>
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<td>DMPA-IM</td>
<td>DMPA in its Intramuscular Form</td>
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<td>DMPA-SC</td>
<td>DMPA in its Subcutaneous Form</td>
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<tr>
<td>EC</td>
<td>Emergency Contraception</td>
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<td>ELWG</td>
<td>Evidence and Learning Working Group</td>
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<td>EML</td>
<td>Essential Medicines List</td>
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<td>HIVST</td>
<td>HIV Self-Testing</td>
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<td>HCD</td>
<td>Human-Centered Design</td>
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<td>HMIS</td>
<td>Health Management Information System</td>
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<td>HSS</td>
<td>Health System Strengthening</td>
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<td>ICEC</td>
<td>International Consortium for Emergency Contraception</td>
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<td>JSI</td>
<td>John Snow Inc</td>
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<td>LMIC</td>
<td>Low- and Middle-Income Countries</td>
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<td>LMIS</td>
<td>Logistics Management Information Systems</td>
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<td>OCP</td>
<td>Oral Contraceptive Pill</td>
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<td>OTC</td>
<td>Over the Counter</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>PSI</td>
<td>Population Services International</td>
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<td>MA</td>
<td>Medical Abortion</td>
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<td>NSN</td>
<td>National Self-Care Network</td>
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<td>SCTG</td>
<td>Self-Care Trailblazer Group</td>
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<td>SDG</td>
<td>Sustainable Development Goal</td>
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<td>SMA</td>
<td>Self-Managed Abortion</td>
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<tr>
<td>SRA</td>
<td>Stringent Regulatory Authority</td>
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<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<td>SRHR</td>
<td>Sexual and Reproductive Health and Rights</td>
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<td>STAR</td>
<td>Self-Testing Africa Initiative</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>UHC</td>
<td>Universal Health Coverage</td>
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<td>WHO</td>
<td>World Health Organization</td>
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People have always practiced sexual and reproductive health self-care. Using a condom is self-care. So is taking a home pregnancy test, tracking your menstrual cycle, or searching online for information on family planning.

Particularly for those with inadequate access to formal health services – for example, displaced populations, people with disabilities, adolescent girls and young women, and many others – self-care interventions can be life-changing. Self-care acknowledges and fortifies the capacity of individuals and communities to take charge of their own sexual and reproductive health. It can help people maintain privacy and avoid the stigma and discrimination that continues to surround many SRH concerns. Access to SRH information and tools also supports people to make independent decisions and exert greater control over their own bodies.

In 2019, the World Health Organization (WHO) issued guidelines that set out important recommendations for self-care in family planning and fertility management, antenatal and postpartum care, medical abortion, self-testing for sexually transmitted infections including HIV, and sexual health. In 2022, these guidelines were expanded into a broader set of “living” guidelines, including but not limited to SRH interventions, that situate self-care as a core strategy for advancing a wide range of primary healthcare goals.

WHO’s recommendations make clear that self-care is not simply an individual lifestyle choice. In fact, self-care is an essential dimension of the healthcare infrastructure that must be guided, regulated, and supported by governments as part of achieving Universal Health Coverage (UHC). In turn, when properly implemented and supported, self-care approaches have great potential to promote the achievement of UHC by enabling more people to access health services while often reducing burden on health systems. When it comes to family planning, we know that the most effective system is one that covers the broadest range of contraceptive choices – including self-care options. And by preventing unintended pregnancies, expanding access to family planning services tends to lower healthcare costs overall – which can allow national health systems to provide more care for more people.

Practical evidence from self-care interventions is now beginning to emerge from across the globe. These experiences should play a role in global efforts to achieve UHC and will be important to consider as part of the consultations leading up to the 2023 High Level Meeting to assess progress toward global UHC targets.

We must not lose sight of what happens when a country accelerates family planning access – where conditions are set to realize the transformative power of family planning. Improved access to family planning sets a country on a different path in achieving gender equality, economic progress and in achieving many sustainable development goals. Selfcare options offer countries that possibility. At this important stock-taking moment, the following pages offer essential lessons and insights into how self-care interventions can help advance rights-based, equitable access to SRH care for all.

Dr. Samukeliso Dube
Executive Director, FP2030
EXECUTIVE SUMMARY

Self-care interventions are among the most promising and exciting new approaches to improve health and well-being, placing people at the center of care and allowing individuals to be agents of their own health. Self-care has the potential to reshape the way health care is delivered, and the ways in which individuals seek care. Moreover, self-care holds the potential to make healthcare more accessible, affordable, convenient, and equitable. This is especially important for vulnerable populations who are often out of reach of, or underserved by, conventional health services.

The World Health Organization (WHO) estimates that at least 400 million people worldwide lack access to the most essential health services and anticipates a global shortage of health workers. In 2016, the Global Strategy on Human Resources for Health: Workforce 2030 projected a global shortage of 18 million health workers by 2030. Although this estimate has been revised downwards, it remains unacceptable high. This, coupled with dramatic and sudden surges in health care needs – as demonstrated by the COVID-19 pandemic and climate shocks – calls for innovation in the way sexual and reproductive health care is delivered. This is precisely where self-care can play a critical role.

The momentum around self-care is building, spurred on, in large part, by the publication of the WHO Consolidated Guideline on Self-Care Interventions for Health in 2019 and the release of the WHO Abortion Care Guideline in 2022, which explicitly mentions self-managed approaches, including self-management of medical abortion and self-management of post-abortion contraception. Many countries around the globe have developed and are now piloting or implementing national self-care guidelines. The field is witnessing an exciting and dynamic time for self-care seen through a burgeoning array of self-care practices, policies, and interventions globally.

This report aims to take stock of the sexual and reproductive health (SRH) self-care field and document its progress since the publication of the WHO Guideline.
It is intended to provide a resource for global and national advocacy, to inform implementation of self-care guidelines, and to link the reader to evidence and learning exchanges.

The report is organized in four sections:

- **Section One: Self-Care Basics** provides definitions, terminology, and frameworks currently in use in the self-care field and connects the reader to a self-care glossary and resources.

- **Section Two: Where Self-Care Policy, Enabling Environment, Practice, and Program Strategies Meet** highlights lessons from a selection of SRH self-care interventions, including contraceptive self-injection, self-managed abortion, HIV self-testing, and self-administration of emergency contraceptive pills. Case examples are drawn from across a variety of settings, including fragile contexts. The report illustrates the powerful role that advocacy plays in building support for self-care at the individual, community, and national levels.

- **Section Three: Measuring and Monitoring Self-Care Practices** argues for innovation in the measurement and monitoring of self-care practices, and for increased attention to the development and refinement of key indicators and data collection approaches. Furthermore, the report notes the importance of research to continue building the evidence base around self-care implementation.

- **Section Four: Looking Ahead** outlines areas of ongoing interest and offers practical suggestions of how readers can engage in shaping the next generation of programing and thought leadership in self-care.

**OVERARCHING MESSAGES**

- Although the practice of self-care is long-standing and universal, it is not yet formally integrated into health systems in most settings.

- Self-care can contribute to progress towards universal health coverage (UHC) by making health systems more equitable and efficient. It is the foundation of primary health care.

- Self-care – with person-centered care at its core – is an essential component of strong, robust, and resilient health systems.

- There is a need to institutionalize self-care within donor funding as a practice integral to primary health care and attaining UHC.

- The diversity of self-care interventions is notable. Different population segments with varying health conditions can be addressed through self-care approaches, in a broad range of contexts.

- The powerful role self-care can play in humanitarian and climate emergencies has not been fully realized.

- Self-care enables individuals to exercise choice, autonomy, power, and control over their health, and in so doing, improve their health and well-being.

- The evidence around the cost and cost-effectiveness of self-care interventions is limited. Where evidence does exist, as in the case of the DMPA-SC self-injection, self-care approaches have been shown to be cost saving and effective as compared to provider-administered options.

- Investments are needed to ensure that self-care interventions, including health literacy, are supported, and integrated into health systems, and that self-care’s contributions to health outcomes are appropriately measured.

- A robust learning agenda is needed to deepen the understanding of the complexities and challenges of self-care, as well as its potential.

- Engaging the private sector more deliberately and strategically is needed. Harnessing the power of digital technology to expand access to and use of health products and services, and ultimately, to improve health outcomes, is a key strategy to move self-care forward.
Moving a country-led self-care agenda forward requires leadership from the local Ministry of Health, and engagement of rights holders and community advocates, as well as health professionals and technical experts working together to define and implement a plan of action.

Stakeholder engagement in the process of adaptation and adoption of self-care guidelines is a multi-step process that requires robust stewardship.

National Self-Care technical working groups comprising a range of health cadres, consumer groups, and professional associations play an important role in the adoption and implementation of national guidelines.

Development of multi-sectoral National Self-Care Networks (NSN) to advance self-care policy and programming at country level is a promising approach.

Global and country advocacy is critical and plays a key role in socializing the concepts of self-care, and in creating an enabling policy and legal environment.

Continuous learning and evidence generation as countries design, implement, and scale self-care approaches is critical.

Engaging youth advocates and existing community groups in self-care is both feasible and desirable.

Ensuring the availability and affordability of SRH supplies remains a challenge, both within the context of self-care and beyond.

Financing of self-care interventions is fragmented and insufficient.

Streamlining monitoring, evaluation, research, and learning (MERL) on self-care is critical.

A deeper understanding of the socio-behavioral dimensions of self-care is needed.

We hope this report will stimulate ideas and innovation in self-care and serve as a useful resource for the field. By highlighting several effective and innovative self-care interventions, we hope this report will inspire new lines of inquiry, testing of new models, and increased investment. Through examining the current state of self-care, we can envision a future state, and accelerate efforts to make it a reality.
INTRODUCTION

ABOUT THIS REPORT

Many achievements have been made since the publication of the *WHO Consolidated Guideline on Self-Care Interventions for Health* in 2019. This report aims to take stock of these achievements and share examples of country-level and global initiatives. It is intended to provide a resource for global and national advocacy, to inform implementation of self-care guidelines, as well as to disseminate and link the reader to evidence and learning exchanges.

In this report we provide a snapshot of self-care interventions underway in diverse settings and highlight progress to date. It is not intended to be an exhaustive review of self-care policies and programming, nor is it intended to capture all self-care efforts underway globally. We recognize that there are any number of self-care projects, initiatives, and activities currently underway. We have attempted to capture a reasonable number that offer insights and lessons for the sexual and reproductive health (SRH) self-care field. By highlighting effective and innovative self-care interventions, we hope this report will inspire new ideas, testing of new models, continuous innovation, and increased investment in self-care. Through examining the current state, we can imagine a future state and begin charting a course for the next generation of self-care.

This report relies on literature and document reviews, and a scanning of self-care tools, websites, and resources developed by the Self-Care Trailblazer Group (SCTG) and a variety of organizations. We include both peer-reviewed papers as well as gray literature, blogs, and personal communication. Case studies and country examples were written by a diverse group of individuals and institutions, working across a range of SRH self-care interventions. We view this as a living document, which we will update periodically as new programs and data emerge.

A WORD ABOUT EVIDENCE

Existing evidence suggests that self-care has the potential to increase access to, and affordability, convenience, equity, and choice of a range of SRH interventions, depending on how well they are designed, implemented, and financed. And while this report is not intended to be an evidence review, or an evidence gap-mapping exercise (those processes are underway elsewhere), there are several important points we can make about the state of evidence. For example, there is good evidence around the safety and efficacy of several self-care interventions that have been reviewed and vetted through a rigorous process undertaken by the WHO Self-Care Guidelines Development Group (GDG). Based on the recommendations of this group, the *WHO Consolidated Guideline on Self-Care Interventions for Health* was issued in 2019 and updated in 2022 to include additional self-care interventions beyond SRH.

And while the evidence is promising, data around programmatic aspects of self-care is lacking. A fundamental difficulty in the measurement of SRH self-care interventions is that the very feature that
defines self-care is also what makes it hard to track and measure. Codified national and global SRH self-care guidelines are still nascent, as are effective strategies for monitoring and evaluating these programs. As the self-care field evolves, it will be important to continue to collect data around the feasibility, acceptably, cost, and effectiveness of implementing diverse self-care interventions at scale.

THE SELF-CARE TRAILBLAZER GROUP

Although self-care has been in existence for generations, several factors – including lack of awareness, supportive laws, policies, and financing, and negative health care provider attitudes towards self-care, among others – continue to limit access to self-care products and services.

To address these challenges, the Children’s Investment Fund Foundation (CIFF) and the William and Flora Hewlett Foundation funded the formation of the Self-Care Trailblazer Group (SCTG) in 2018, with Population Services International (PSI) as the Secretariat, to incubate a global self-care movement.

The SCTG has established itself as a global, multi-stakeholder coalition of partners dedicated to expanding the safe and effective practice of self-care so that individuals can better manage their own health, health outcomes can be improved, and health systems can become better equipped to achieve universal health coverage (UHC). By improving the enabling environment for self-care, particularly through policy development, the SCTG aims for self-care to be institutionalized into policy and integrated into national health systems. It also seeks to increase the demand, use, and accountability for self-care among target communities and constituencies.

This report highlights some of the efforts of the SCTG and its members to advance self-care globally.
SECTION 1
SELF-CARE BASICS
For centuries, women and girls have managed the physiological life events of menstruation, contraception, pregnancy, and childbirth, in addition to combating illness for themselves and their families. What is new is the context in which self-care is being practiced to address barriers and promote the health and well-being of families. Exciting developments and an expanded array of user-centered sexual and reproductive health (SRH) products and practices are being introduced and scaled, enabling individuals to participate in their health care more actively and safely. A greater recognition of women’s agency and rights, coupled with the increasing availability of improved tools, are maximizing women’s ability to safely apply self-care tools and practices. Self-care has evolved from a vague notion to a formalized concept, practice, and strategy designed to serve the health care needs of all.

DEFINITIONS AND TERMINOLOGY

Self-care is defined by the World Health Organization (WHO) as “the ability of individuals, families, and communities to promote health, prevent disease, and cope with illness with or without the support of health care providers.” Self-care interventions include “medicines, counseling, diagnostics, and/or digital technologies” which can be accessed fully or partially outside of formal health services. Depending on the intervention, they can be used with or without the direct supervision of health workers.

Self-care practices have existed for millennia, but only recently has self-care been recognized in global and national health policy as an evidence-based and effective way of improving health. A major landmark was the development of the WHO Consolidated Guideline on Self-Care Interventions for Health: Sexual and Reproductive Health and Rights in 2019. Subsequently, in 2020, the SCTG was established to provide a global forum and community of practice for countries and individuals developing, advocating for, and implementing self-care programs and policies, with a focus on sexual and reproductive health. Since then, there has been rapid development, with several countries developing their own national self-care guidelines in alignment with the WHO. The WHO Guideline on Self-Care Interventions for Health and Well-Being, which expanded the recommendations of the 2019 guideline, was published in 2022.

The SCTG has developed a comprehensive glossary of Common Self-Care Terms to ensure that self-care champions have a common set of terms and a shared language about self-care. The definitions focus on how people practice self-care and are aligned with the WHO Consolidated Guideline on Self-Care Interventions for Health.

SELF-CARE FRAMEWORKS

Interest in the concept and practice of self-care as a means to improve the health and wellbeing of individuals, and as a strategy to mitigate the growing demands on health systems, continues to grow. Therefore, it is instructive to have conceptual frameworks to help guide program implementers. Several frameworks have been developed to contextualize self-care, chief among them are those highlighted below.

WHO (2019) CONCEPTUAL FRAMEWORK FOR SELF-CARE INTERVENTIONS

The WHO Consolidated Guideline on Self-Care Interventions for Health’s Conceptual Framework for Self-Care Interventions provides a solid basis for health practitioners to consider the important elements in introducing and scaling up self-care practices. It uses a people-centered approach together with a health systems’ focus, incorporating places of access and the enabling environment to encourage individuals to practice self-care.
Conceptual Framework for Self-Care Interventions

Self-Care in the Context of Interventions Linked to Health Systems

FRAMEWORKS DEVELOPED BY SCTG’S EVIDENCE AND LEARNING WORKING GROUP MEMBERS

The following frameworks have been developed by the SCTG’s Evidence and Learning Working Group (ELWG), to support the implementation of self-care.

Source: adapted from Narasimhan et al. (doi:10.1136/bmj.l688)
Breakthrough Action (2021) Supporting Sexual and Reproductive Self-Care through Social and Behavior Change: A Conceptual Framework to Encourage Self-Care Practice

The Social and Behavior Change (SBC) Self-Care Framework explores self-care through a social and behavioral lens and demonstrates the importance of incorporating SBC approaches in SRH. Social and behavioral determinants such as knowledge, attitudes, policies, motivations, social norms, and individual agency can positively or negatively influence people’s demand for and use of self-care products and behaviors. SBC approaches can help users define and achieve their reproductive intentions by addressing these social norms and other determinants that facilitate or prevent people from making and acting on decisions related to self-care.

Source: breakthroughactionandresearch.org/supporting-sexual-and-reproductive-self-care-through-sbc
Population Services International (2020)  
**Quality of Care Framework for Clients and Providers in the Delivery of Self-Care**

The *Quality of Care (QoC) Framework for Clients and Providers in the Delivery of Self-Care* was developed by PSI and a consortium of partners through the SCTG Working Group, and builds on other well-established quality frameworks and the WHO Consolidated Guideline on Self-Care Interventions for Health. And while all elements in the Conceptual Framework for Self-Care Interventions – for example, psychosocial support and economic empowerment – are critical for the ecosystem that enables self-care, the selected elements for this Quality of Care Framework are specifically valuable for monitoring and supporting quality when clients are engaging with self-care on their own, or in partnership with a health care provider. This framework is accompanied by a set of self-care quality of care standards meant to be used by implementers, ministries of health and policy makers who wish to ensure quality of care in self-care across an intervention or the whole health system.


The Self-Care Matrix (SCM) is a unifying framework for self-care based on an analysis of 32 existing models and frameworks. SCM was developed by Imperial College London’s Self-Care Academic Research Unit (SCARU) to help conceptualize and frame the totality of self-care and its various interconnected elements. The mid-level descriptions and the SCM visual schema illustrate the inter-relationships between each of the four cardinal dimensions of self-care and render this model easily accessible to a wide audience. In this conception, the totality of self-care can be described using four cardinal dimensions:

1. Self-care activities, which represent the person-centered set of activities that constitute self-care
2. Self-care behaviors and how to sustain them
3. Self-care context and individual dependence on external support and resources
4. Self-care environment, including wider determinants of health and the built environment.

The SCM is intended for use by stakeholders who are interested in the study, development, commissioning, and evaluation of self-care initiatives.

The Digital Self-Care Framework was developed by HealthEnabled under the leadership and guidance of the SCTG to provide practical guidance for effective research, design, and implementation of digital health in support of self-care. The framework draws on a broad range of self-care and digital health guidelines and standards and serves as a living document to guide designers, implementers, researchers, and policy makers as they embark on the digital transformation of self-care.

These frameworks have different dimensions and focus. Each has its own purpose. Policy makers and program implementors will need to determine the framework that is best fit for their purpose based on their specific needs and context.

PRINCIPLES FOR DIGITALLY-ENHANCED SELF-CARE DEVELOPMENT

- Quality Assurance
- Privacy and Confidentiality
- Value added from digital self-care interventions
- Increased access to health services
- Increased anonymity and autonomy
- Linkages to healthcare support system as needed
- Continuous monitoring of quality and safety
- Increased ability to monitor and evaluate self-care interventions
SECTION 2
WHERE SELF-CARE POLICY, ENABLING ENVIRONMENT, PRACTICE, AND PROGRAM STRATEGIES MEET
This section provides an overview of select sexual and reproductive health (SRH) self-care interventions and topics, and highlight insights and lessons learned through a collection of country case examples. The section begins with attention to the national self-care guidelines development process and progress, followed by specific self-care interventions and topics.

**ENABLING ENVIRONMENT: FORMULATING GUIDELINES AND PREPAREDNESS - INSIGHTS FROM TRAILBLAZING COUNTRIES**

Spurred on by the 2022 WHO Consolidated Guideline, self-care is gaining traction at the national level as a key strategy for improving equity of health systems and advancing universal health coverage (UHC). Countries are at different stages in the process of developing national self-care guidelines in alignment with the WHO’s Consolidated Guideline. While each country will have unique challenges and considerations when developing and implementing their self-care guidelines, there are some commonalities across countries with respect to process.

This report draws from the pioneering work of exemplar countries that are far along in the self-care codification and policy development process. In these front-leading countries, including Kenya, Nigeria, Senegal, and Uganda, technical working groups/teams and National Self-Care Networks (NSN) have been established. The technical working teams review and consider country level data around key self-care interventions to determine research and program gaps and priorities. The role of National Self-Care Networks has been to develop and lead civil society and grassroots self-care advocacy efforts. NSN leads continue to refine and implement their national advocacy strategies, engage grassroots networks and communities in increasing demand, and strengthen social accountability for self-care policies and programs in their countries (For more detail, see National Self-Care Networks). Below are country examples of integration of self-care policy into practice.
Uganda: Advancing Self-Care as an Integral Part of the Health System

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Background and Context

The Uganda Ministry of Health through the Self-Care Expert Group (SCEG), with support from PSI and other partners, adopted a three-phased approach to developing a national sexual and reproductive health and rights (SRHR) self-care guideline to promote the delivery of SRHR self-care programs with equity and inclusion. The phases included:

- Inception Phase (March-May 2021) – to generate buy-in from decision-making stakeholders.
- Development Phase (June-November 2021) – to organize, draft, and revise the guideline and seek its approval; and
- Implementation Phase (December 2021-June 2022) – to coordinate guideline test implementation at sub-national levels with feedback loops for learning and guideline update.

Test Implementation of the National Guideline on Self-Care Interventions for SRHR: This phase aimed to assess the real-life application of the self-care guideline in SRHR service delivery and access in both the public and private health sectors, as well as in the community. It sought to identify barriers and enablers to the integration of the guideline, to assess the impact of holistic delivery of self-care for SRHR on both health system components and the clients, and to answer questions on maintaining Quality of Care (QoC).

The SCEG selected one implementation district, Mukono, in central Uganda, due to a) its heterogeneous population composition, which includes the vulnerable and the hard to reach; b) supportive district health team (DHT); and c) ongoing SRHR self-care interventions.

Methodology: The test implementation entailed a series of activities conducted at the national level (led by SCEG) and sub-national level (led by the district team). These included:

- National Level: a) developing training curriculum for self-care; b) training of 15 national and sub-national trainers selected by the MOH and DHT, with consideration of their roles within the health facility or the MOH; and c) conducting inception meeting with DHT.
- Sub-National Level: a) orienting 32 members of the DHT, political leaders and gatekeepers, 30 public health facility in-charges, and drug shop and pharmacy representatives on the concept of self-care for SRHR; b) selecting 10 public and eight private health facilities; c) training 32 health care providers (21 from public health facilities and 11 from private health facilities) and 11 Village Health Teams (VHTs) on self-care, the guideline, and its application; d) conducting a series of radio talk shows on the benefits of self-care targeting stakeholders and communities; and e) adopting specific evaluation mechanisms for knowledge retention, application of the guideline, and client experience.

Learning Questions: The test implementation was intended to answer the following learning question: What is the best approach for integrating self-care for SRHR into the existing health system? Specifically: a) what is the existing level of self-care acceptability for both public and private sector healthcare providers and their clients?; b) how will adding self-care in the existing health system affect client experience and reduce health care provider workload and waiting time at the health facilities?; c) how can providers best be involved to ensure safety and to strengthen linkages to care among individuals practicing self-care?; and d) how can health care providers in public and private sector health facilities be engaged in improving knowledge and practice of SRHR self-care?
**Data Collection:** Data was collected through routine assessments; qualitative interviews with health care providers, Village Health Teams (VHTs), self-carers and key informants; and service delivery and performance data tracked through health facility tools such as client registers.

**Data Collection Plan**

1. Tools included assessments and surveys for both qualitative and quantitative data.
2. Data sources included health facility client records, stock cards, self-carers, other clients, and health care providers.
3. Data collection happened in three rounds. The first round was in June 2022, during the joint support supervision, the second round was in August 2022 during the health facility assessment, and the last round of data collection was in October 2022. The self-care study led by MaKSPH was conducted in August, and data analysis is still ongoing.
4. Data collection methods included client register review, self-carers, and client and health care providers interviews.

**Preliminary Findings and Observations**

1. *Acceptability Among Health Providers:* Findings from routine assessments showed positive perception and openness towards self-care among trained healthcare providers, especially those in public sector facilities, as they noted that it was solving the challenge of long queues, overcrowding, and the burden of attending to one client at a time. On the other hand, healthcare providers in private facilities felt that while self-care was a good initiative, it was reducing their client load, which translated to reduced income generated from consultation fees.
2. *Awareness and Perception of Self-Care among Individuals:* The interviewed self-carers (eight out of ten) understood self-care as having health information and using it to make decisions regarding their own health and wellbeing. Further interactions with randomly selected clients at the health facility revealed that awareness of self-care was not widespread, with only two out of 10 clients able to clearly explain what self-care was with examples of interventions. Self-carers felt that utilizing self-care interventions such as the self-injectable contraceptives and HIVST kits saved time and money that would have been spent on transport to the health facilities. They were confident in practicing self-care since they got the information, instructions, and products from their healthcare providers, though some expressed disappointment as they were turned away from the facility with their self-collected samples.
3. *Continuity of Care:* Health care providers, especially in public sector facilities, indicated that client follow up was not robust. Although the self-carers sometimes returned to the health facility for further assistance – for instance when they tested positive for HIV or pregnancy or were experiencing side effects of using a self-injectable contraceptive – the numbers were low. Some self-carers expressed fear of attaining wrong results, especially for HIV self-testing, and stated that they would appreciate additional support from a healthcare provider.
4. *Uptake of Self-Care Interventions:* The most popular self-care intervention is HIVST using the OraQuick® kits, followed by DMPA-SC self-injection. However, the number of self-carers who took on the self-injectable contraceptives was lower than anticipated, due to notable stock-outs and the self-carers’ fear of self-pricking. The clients’ service data also showed more self-carers in public health facilities, especially in the health center IIIs, compared to private sector facilities, where some facilities had no self-carers at all. This was partly due to poor reporting, as private health facilities had poor data and records management practices. Further investigations may be required to ascertain the reason for the low numbers.
5. **Data Management and Reporting:** Public sector facilities improvised the recording of self-care data, by indicating “SC” for “self-carer” in the regular health data management tools. The private sector facilities had poor data management, with most of them not capturing client data.

**Challenges:** The structured introduction, scale-up, and delivery of self-care interventions for SRHR (categorized as: ante-natal care (ANC), delivery, and post-natal care (PNC); family planning; post-abortion care; and HIV / STIs; across the pillars of self-awareness, testing and management) in Uganda’s health system is a novel concept, necessitating empirical evidence to facilitate the adoption of an operable guideline, suited to the local context. Therefore, the third phase of the guideline development process is critical, as it is enabling iteration and learning of the feasibility, acceptability, and applicability of self-care practice within the existing health system.

**Looking Forward:** With support from partners within the SCEG, the MOH will complete the final round of data collection and utilize the observations and learnings to refine the National Guideline on Self-Care Interventions for SRHR, which includes a suite of operational tools for training, monitoring, evaluation, and learning, and for quality assurance, as well as a costed implementation plan and a customized SCTG SBC framework, among others.

**Nigeria: New Demand Generation Strategy Paves the Way for Increased Uptake of Self-Care**

**Authors:** White Ribbon Alliance, Country Advocacy Working Group lead

As more countries worldwide develop, adapt, and adopt WHO’s 2022 Guideline on Self-Care Interventions for Health and Well-Being, Nigeria continues to be a frontrunner. Following the launch of its National Self-Care Guideline, the Nigeria Federal Ministry of Health (FMOH) developed a National Demand Generation Strategy for Self-Care that helped transform policy into practice and offered key approaches to institutionalize self-care at the community level. In partnership with the FMOH, members of the Nigeria Self-Care Network – including Society for Family Health, John Snow Inc. (JSI), Pathfinder International and White Ribbon Alliance Nigeria – organized a workshop in November 2021 to begin shaping the demand generation strategy. During the workshop, misconceptions around self-care quickly became evident, including that self-care approaches are mainly about family planning, as well as concerns about misuse of products.

Recognizing a need for greater sensitization about the scope of self-care and the importance of health literacy, the FMOH led a second workshop to shape the strategy,
inviting its network of community organizations to contribute to the strategy development. Attended by 25 local and international reproductive and maternal health organizations, the workshop played a valuable role in energizing the self-care movement and increasing understanding of and knowledge around the applications of self-care. Inspired by the potential of self-care, all organizations in attendance – including the Health Promotion Unit of the FMOH – became members of the Nigeria Self-Care Network, growing the coalition from a few organizations to 25.

Drawing on the strength of multi-sectoral participation and viewpoints, the strategy outlines key actions for states to generate demand within their areas, approaches to reach diverse audiences, and best practices to monitor self-care activities. The strategy targets women, girls, religious and community leaders, and health care providers as priority populations to sensitize with information on self-care to generate demand for products and services. Key activities include focus group discussions, town halls, and facility- and community-based trainings to sensitize community members, leaders, and health care providers on self-care, as well as placement of information, education, and communication (IEC) materials in highly visible locations such as healthcare centers.

After the Health Promotion Unit pre-tested the IEC materials with target audiences like youth and healthcare workers in central Abuja, the Minister of Health approved the Demand Generation Strategy in June 2022. JSI has since led country-wide training on the Strategy, targeting healthcare providers to bring self-care back to their communities and become champions. As the National Self-Care Guideline on Self-Care for Sexual, Reproductive and Maternal Health (2020) rolls out nationwide, the Demand Generation Strategy has proven to be a key companion by fostering the socialization of self-care among a wider group of stakeholders and promoting successful uptake of self-care at the community level.

**ENABLING ENVIRONMENT: THE ROLE OF AWARENESS AND ADVOCACY IN ADVANCING SELF-CARE**

Strong and effective advocacy can play a powerful role in influencing and shaping policy at the global and country level. We highlight two recent examples illustrating how robust country advocacy efforts have led to policy change.

**Health Literacy: A critical, yet under-invested Enabler for Self-Care**

*Authors:* Angela Nguku,1 Christy Asala1 (1 White Ribbon Alliance)

"Health is wealth and knowledge is power."

These adages are not just clichés – knowledge builds agency to make informed decisions about our lives and health literacy is key. At its most basic, health literacy refers to the ability of an individual to understand information given to them by healthcare professionals. However, this information can be confusing and complex, and is not always designed for a non-clinical audience. Yet, at some point in our lives we need to be able to research, understand, and use health information and services for our personal well-being and that of our families.

The WHO defines health literacy as “the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways to promote and maintain good health.” Health literacy includes reading, writing, communication, and the use of digital technology to access health information, make informed choices, and successfully navigate the health system. People with strong health literacy skills enjoy better health
and well-being, while those with weaker skills tend to engage in riskier behavior and have poorer health.

Health literacy is critical for self-care. It helps individuals make informed decisions to prevent health issues and protect their health. With 3.6 billion people – half of the world – lacking access to essential services, the WHO recommends self-care interventions for every country and economic setting as a critical path to reach universal health coverage (UHC), promote health, keep the world safe, and serve the vulnerable. Self-care recognizes individuals as active agents in managing their own health care in areas including health promotion, disease prevention and control, providing care to dependent persons, and rehabilitation, including palliative care. But can individuals practice self-care independent of health literacy? The practical answer is no.

Despite its foundational role in self-care, health literacy is often lacking in budgeting and programming – even amid the current conversations around universal health coverage. While many players have begun to promote self-care in the context of sexual and reproductive health, most of these conversations are around the “what” and not the “how” – i.e., health literacy. Even within the self-care community, stakeholders are quick to focus on new technologies and digital tools as the solutions, overlooking the fact that technologies are not used in a vacuum. People, especially women and girls, need the knowledge, skills, and agency to be able to negotiate, use, and apply self-care approaches and technologies.

Among young people, the need for health literacy is greater than ever when it comes to sexual and reproductive health so that they can practice safe health care choices, which will ultimately lead to better health outcomes. Excluding health literacy from programs and funding has left many young people with hard choices to make while lacking adequate information to do so, forcing them to frequently rely on misinformation. White Ribbon Alliance (WRA) and grassroots partners believe we can change this narrative by asking, listening, and acting on what people – especially young people – want for their SRH needs. We can improve planning efforts by prioritizing health literacy through greater investments in health education and initiatives to increase agency and bodily autonomy at the household, community, and policy levels.

As part of the What Women Want campaign, more than 120,000 women and girls from Kenya shared their top priorities for quality maternal and reproductive health care services. About 24% of the responses came from women under the age of 18, whose top request was SRH information. This encompassed demands such as “information that can make sense” or “introduction of online guidance and counseling programs for women”. This also resonated with young women and girls across eight other countries in Africa and Asia where the campaign took place, pointing strongly towards gaps in health system organization and delivery. Their demands provided evidence that the systems are not equitable, are very much health care provider-driven, and do not necessarily respond to the self-articulated needs of those that they are meant to serve. Given its ability to bridge gaps in health care delivery, self-care can be especially transformative in SRH for young people, where stigma abounds, privacy is critical, and access to health care providers is often a challenge.

To achieve UHC with self-care as a driver, more innovative and contextualized ways of building health literacy must be employed. Over the years, WRA has developed innovative and inclusive community engagement methodologies, such as listening sessions, town hall meetings, and door-to-door sensitization sessions. Based on our unique experience listening deeply to women and girls, we have deployed key tools that put community voices in the driver’s seat to steer health programming and rally communities to self-organize. These strategies build women’s and girls’ individual and collective power and agency to make positive decisions about their health by educating them, listening to their concerns, and working with them to devise local solutions to their challenges.
For better health outcomes, societies need to embrace and practice self-care. However, self-care cannot be optimally practiced without access to the right information. To build health literacy, we must apply social and behavior change frameworks and develop tailored, contextualized messages using mechanisms people can relate to. This includes:

- Working with policy makers to create an enabling policy environment to practice self-care and access information.
- Working with community leaders and champions to disseminate the right information in the right methods and format.
- Empowering individuals with the right information and channels to make informed choices.

For this to happen, there must be a total shift in the way we devise and design our policies and programs, and how we prioritize what populations want and need for their health care. Governments must ensure the bodily autonomy and integrity of women and girls by removing restrictions that hinder their ability to exercise their rights to the full spectrum of SRH and self-care. Finally, and most importantly, we need to change how health care literacy is financed. Governments and health stakeholders must shift their approach and adopt one that starts with asking what people need, listening to these needs, and acting on them. This way, they will make self-care investments that will lead to tangible positive outcomes in the long run. The time to start is now.
**Senegal Self-Care Pioneers Group: A Closer Look at Guidelines Development**

**Author:** PATH/Senegal

The Senegalese Ministry of Health and Social Action made a strong commitment to self-care by establishing the Self-Care Pioneers Group in 2020. Senegal has become a pioneer in French-speaking Africa, through a combination of a strong commitment, an impactful partnership of diverse stakeholders, and a co-creation process following the WHO Consolidated Guideline. The idea behind developing the self-care guidelines was simple – by bringing together experts and civil society we could take advantage of Senegal’s experience in self-care and translate that into benefits for both the health system and users of health services.

The recommendations and good practices that are described in the WHO Consolidated Guideline served as the basis for identifying a set of priority interventions and related products within the self-care conceptual framework. Criteria used to select the interventions included the prevalence of the disease and the need for long-term or lifelong treatment (e.g., hypertension, diabetes, chronic respiratory diseases, etc.), as well as how the disease affects the individual’s longevity, biological functions, and social life (e.g., cervical cancer, HIV).

A key lesson from the Senegal guideline development process was the importance of prioritizing interventions and focusing on those that are feasible and acceptable in both a short- and medium-term timeframe. The Self-Care Pioneers Group has seized every opportunity to advocate for the inclusion of self-care in country priorities moving forward.

**Senegal: Pioneers Group Elevates Self-Care in Global Family Planning Commitment**

**Authors:** White Ribbon Alliance, PATH

For women and girls in Senegal, prioritization of, and access to, family planning options are expanding, including in emergency situations. The Self-Care Pioneers Group – a multi-sectoral coalition led by PATH Senegal and housed within the Ministry of Health and Social Action – successfully advocated for the incorporation of key self-care strategies into Senegal’s FP2030 commitment, creating impetus to weave self-care approaches into the government’s efforts to expand access to voluntary, rights-based contraception.

The successful establishment of the Self-Care Pioneers Group in 2020 helped catapult self-care into the national spotlight in Senegal. The group worked quickly to identify entry points to embed self-care in government commitments and policies, including the opportunity to influence Senegal’s commitment to FP2030 – a global partnership to advance equitable access to contraception worldwide. Government commitments to FP2030 signal family planning as a key priority, can catalyze local efforts, and serve as a key tool to hold governments accountable.

At the official FP2030 workshops organized by the Maternal and Child Health Unit of the Ministry of Health and Social Action, decision-makers and Self-Care Pioneers Group members alike brought self-care into the discussions on commitment formulation. The strong presence of Self-Care Pioneers Group members – including the Family Planning Unit of the Ministry of Health and Social Action, National Alliance of Youth, Young Ambassadors of Family Planning, Young Women for Action Senegal, ACDEV, and Population Council – coupled with buy-in from multisectoral decision-makers, influenced the final commitment to include two objectives that advance self-care.
Specifically, the commitment calls for increased availability of self-care products, including self-administered injectable contraceptives and pregnancy and HIV self-tests, as a key strategy to enhance sexual and reproductive health and increase contraceptive prevalence among married women. Spurred by COVID-19 and civil unrest, the commitment also includes measures to strengthen and protect availability of family planning in emergency contexts, by reinforcing self-care communication and expanding dispensing options to allow women to obtain nine-to-12-month supplies of contraceptives for use in their homes.

The FP2030 commitment is now shaping the development of Senegal’s National Self-Care Guideline, the government’s larger strategy for advancing self-care across a wide range of health areas. The guideline is expected to be finalized by the end of 2022 and piloted in 2023. Additionally, as of September 2022, the Ministry of Health and Social Action is developing an implementation strategy to put the guideline into practice. This example shows not only how a well-placed coalition can make self-care a national priority, but also how high-level government commitments can propel policy development and implementation, ultimately putting self-care within greater reach for the populace.

Kenya: Using Legal and Provider Advocacy to Increase Access to Self-Managed Abortion

Authors: White Ribbon Alliance, Reproductive Health Network Kenya

Although more than a decade has passed since abortion in life-threatening situations was legalized in Kenya, political opposition, community reporting, and police harassment at healthcare clinics have threatened women’s access to safe abortion services and had a chilling effect on self-managed abortions. In March 2022, when a young woman seeking emergency medical treatment following a spontaneous abortion (miscarriage) was arrested, the Reproductive Health Network Kenya (RHNK) joined forces with the Center for Reproductive Rights (CRR) to bring the case to the Malindi High Court. The court ruled in favor of the young woman, reaffirming that abortion care is a fundamental right protected by the constitution and determining that the arbitrary arrest and persecution of women seeking abortion care is illegal. The ruling has since increased access to safe abortion services, including self-managed abortion.

RHNK – Kenya’s SCTG National Self-Care Network lead – employed several tactics to generate necessary pressure on decision-makers to ensure the ruling’s outcome and increase access to services. One key strategy to influence decision-makers was to train intergenerational spokespersons including journalists, young people, and religious and community leaders on how to engage with different stakeholders. Participants were trained on effective communication methods, media engagement skills, and evidence-based advocacy to speak out about abortion and contraception rights as well as comprehensive sexual and reproductive health education. The trainings motivated participants to hold community dialogues and pen progressive articles in local media to educate their communities and highlight cases where girls were hospitalized or died after receiving care from unskilled providers.

Following the ruling, RHNK turned its focus to expanding access to safe abortion services, with a particular emphasis on sensitizing providers to support self-care, including self-managed abortion. For many providers reluctant to support self-care, concerns of losing business were top of their mind, particularly for those operating small facilities. Through various platforms including WhatsApp, Facebook, meetings, and webinars, RHNK educated providers on how self-managed abortion services can complement their work. The trainings taught providers how self-care can reduce the burden on the
health system and decrease crowding at facilities by using innovative approaches such as the RHNK’s abortion hotline service. Community members call the toll-free hotline where they receive SRH counselling services from a trained health care provider who then provides an option of self-management (medical abortion and self-injectable contraception) or referral to a nearby trained healthcare provider. Of the 8,500 women who have called the hotline, more than 40% are managing their own care.

By creating strong self-care networks and communities using synergistic approaches to self-care advocacy and service provision, RHNK has rapidly created support for self-care, facilitating easier access to health care and paving the way for more supportive government policies.

Kenya: The Power of Learning Exchanges - Lessons from Uganda

Author: Reproductive Health Network Kenya

The Reproductive Health Network Kenya (RHNK) is a network of health professionals in private and public facilities, committed to comprehensive sexual and reproductive health and rights (SRHR) advocacy and service provision. The network was formed in 2010 to provide evidence-based information and quality SRHR services in Kenya. RHNK is a dynamic national organization that provides technical assistance on reproductive health policy, legislation, advocacy, training, and service delivery. Beginning in January 2022, RHNK has supported a National Self-Care Task Force to expand safe and effective use of self-care so that individuals can better manage their own health, and domesticate the WHO Consolidated Guideline on Self-Care Interventions for Health in Kenya under the auspices of the Self-Care Trailblazer Group. Kenya’s policy and legislative arm is anchored in the 2010 Constitution and provides a platform for access to fundamental health rights, including safe abortion and contraception (Chapter four article 26(4) and 43(1)).

To initiate the project, RHNK conducted a learning exchange visit to the Center for Health, Human Rights and Development (CEHURD) in Uganda to learn about the approaches used in Uganda to domesticate the WHO Consolidated Guideline. Kenya and Uganda have similar governance systems, and political goodwill and the government’s manifesto are key the determinants of SRHR priorities and intervention plans. The Ministries of Health in both countries have a robust national technical working group that provides technical expertise in policy formulation, review, and domestication. Uganda’s Self Care Technical Working Group is led by a national consultant, who reports to the Ministry of Health and leads the coordination of the MOH and partners. Documented experience from Uganda shows
that resistance among healthcare providers, existing extreme religious and socio-cultural barriers, and limited SRHR awareness and information – including for self-care – have affected the implementation of self-care and SRH in the country.

Learning from this exchange, the RHNK initiated programming for self-care by conducting a national stakeholder and policy mapping, convening country self-care implementers and innovators, and identifying priority areas for monitoring through an adopted tracking dashboard. RHNK also used digital and community-led campaigns, and written articles to create awareness on self-care. RHNK participated in the MOH-led Family Planning Self-Care Guidelines review and validation workshop that preceded the development of the national self-care guidelines. Some of the key learnings from the exchange and initial implementation include the following:

- Noteworthy progress in the implementation of self-care using a hotline, web applications, and telehealth in Kenya.
- Some of the key challenges to implementing self-care guidelines include ensuring a sustained commodity supply and accurate reporting of self-care services through the national HIS.
- There is overall goodwill from the MOH, partners and, rights holders to adapt the WHO Consolidated Guideline in Kenya.
- Effective stakeholder participation will yield Kenya’s most progressive domesticated self-care guidelines. This includes involving medical professional bodies e.g., in the self-care TWG.
- Centering youth advocates in the implementation of self-care provides a platform for adolescents and youth to access self-care information and services.

**PRACTICE AND PROGRAM: IMPLEMENTING SELF-CARE INTERVENTIONS**

The range and type of self-care interventions for health which are detailed in the WHO Consolidated Guideline are many and varied. This section of the report focuses on key SRH self-care interventions that are currently being implemented and scaled-up, namely: DMPA-SC self-injection (SI), emergency contraception (EC), HIV self-testing (HIVST), and self-managed abortion (SMA).

**DMPA-SC SELF-INJECTION**

**A Brief Overview**

Traditionally, DMPA has been injected into a muscle with intramuscular DMPA (DMPA-IM). Subcutaneous DMPA (DMPA-SC) combines a lower dose of DMPA and a shorter needle into a single device that is injected into the fat underneath the skin rather than the muscle. DMPA-SC is small, light, and easy to use, allowing for any trained person to administer it, including community health workers, pharmacists, and women themselves through self-injection.

Evidence has demonstrated that DMPA-SC is safe, effective, and highly acceptable, and that it can increase access for women in their communities and homes, including through self-injection. Self-injection is an evidence-based practice that is endorsed globally, approved nationally, and is being introduced and scaled-up in a growing number of countries. Data from multiple countries shows that women can self-administer DMPA-SC safely and effectively. DMPA-SC is registered for self-injection in more than 55 countries, and more than 35 countries are offering self-injection.

The PATH-JSI DMPA-SC Access Collaborative (AC) is a global initiative to increase access to DMPA-SC and self-injection (SI) as part of an expanded range of
contraceptive methods through data-driven technical assistance, coordination, resources, and tools. To understand the self-injection policy environment, a mapping exercise has been conducted, and is updated periodically. The figure below illustrates the status of SI policy in 16 countries in which the Access Collaborative operates.

Self-injection policy: Q2 2022 status

14 of 16 included countries offering SI now have at least one alternative channel to public sector facilities (CHW, pharmacy or drug shop) that offers it; the two remaining countries (DRC and Madagascar) are in the process of adding alternative channels.

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<td>Procurement of DMPA-SC integrated into national procurement/supply plans?</td>
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<td>SI materials included in procurement budgets?</td>
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† Kenya and Myanmar are not implementing SI; SI indicators are left blank for these countries.

Malawi:
National Scale-Up of DMPA-SC Self-Injection

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A 2011 study concluded that it takes an average of 17 years for research findings in health to be translated into policy and practice, but in the case of DMPA-SC, Malawi reached this milestone in fewer than three. In May 2018, the Ministry of Health (MOH) in Malawi approved the phased introduction of DMPA-SC (including for self-injection) at the community and facility-level, based on acceptability and feasibility data from a randomized controlled trial completed in 2017. The story of this rapid, efficient introduction is a model of teamwork among a multitude of stakeholders working toward a common goal.

Recognizing that successful introduction and scale-up of DMPA-SC as part of the family planning method mix would require widespread buy-in, intense cooperation, and tangible results, the MOH’s Reproductive Health Directorate created and led a dynamic task force of government agencies, local implementing partners (from
both the public and private sectors), and international nongovernmental organizations, including the Center for Health Agriculture, Development Research and Consulting (CHAD); Youth Net and Counseling (YONECO); FHI 360; Banja La Mtsogolo (BLM); Population Services International (PSI); Clinton Health Access Initiative (CHAI); Management Sciences for Health (MSH); United States Agency for International Development (USAID); and United Nations Population Fund (UNFPA). In meetings that were initially held quarterly and later monthly, the task force completed the following tasks:

- Selected seven phase one districts and identified partners to support the rollout, which started in November 2018
- Updated the service delivery guidelines to include DMPA-SC and SI for the public sector
- Updated training curricula and job aids
- Successfully advocated for DMPA-SC to be available in private franchised clinics and pharmacies.

Task force members also led the revision and printing of the family planning registers, reporting booklets, and self-injection leaflets and supported updates to national electronic and paper reporting forms to include DMPA-SC so that data can be disaggregated into provider–administered and self-injected. In August 2019, provider-administered DMPA-SC was rolled out nationally in response to the national stock-out of DMPA-IM. Self-injection was scaled nationally from February 2020.

Today DMPA-SC, including self-injection, is fully integrated into the national family planning program in Malawi, including the health management information system (HMIS), and 100% of public sector facilities have at least one provider trained. Active involvement of pharmacy and HMIS staff in training and supervision visits, community engagement in demand generation activities, and MOH support of routine review of program data and implementation research has ensured holistic support for the roll out. For example, the MOH supported studies that informed their approach to reaching young people, waste management, and male engagement. This, combined with effective coordination of the national taskforce, has streamlined support, and avoided duplication, resulting in the rapid and successful scale-up of this evidence-based self-care intervention.
Nigeria: Driving Sustainable Scale-up of Contraceptive Self-Care

Authors: Oowo Anita Elabo,¹ Robin Swearingen,¹ Abi Winskell¹ (1 - DISC)

The Delivering Innovation in Self-Care (DISC) project, funded by the Children’s Investment Fund Foundation (CIFF) and active since 2020, is combining demand-generation and provider capacity-building interventions in Nigeria to sustainably scale-up self-injection of DMPA-SC contraception. The core objectives of the project are to increase the prevalence of self-care in family planning and to support women to “discover their power” by adopting a method that places control directly in their hands.

Prior to DISC, awareness of self-injection (SI) was low in Nigeria, despite the popularity of provider-administered injectables. Yet SI has a huge untapped potential. It is more convenient than provider administration, it is discreet and effective, and it can increase the efficiency of the health system by reducing provider workloads.

DISC sought to actualize these benefits by leveraging consumer insights to galvanize demand. Since early 2021, we have been implementing an interactive campaign called #DiscoverYourPower that appeals to birth-spacing mothers and urban youth who can harness SI to fulfill their personal and professional goals. Built on consumer insights, the campaign engages women on- and offline, combining in-person events, community mobilization, radio, and social media.

But consumer demand is only one side of the equation. Even after receiving SI training, many clients have apprehensions about the act of self-injection. To increase the ‘conversion rate’ of trained clients who go on to confidently self-inject, DISC developed a supplemental training module to center on empathy and directly speak to client’s misgivings. The new module also incorporates a hands-on practicum. The updated materials are currently being rolled out across 15 states by state and local governments, alongside partners including MSI, A360, IntegratE, and others.

DISC has prioritized local ownership of the intervention by engaging governments and integrating into their structures and systems. To the fullest extent possible, DISC is using preexisting coordination platforms to drive all aspects of the process, including training, supervision, and data management. Constant engagement with health system leadership has shown that much can be achieved when resources are pooled, and efforts are combined.

Nigeria has seen the proportion of DMPA-SC that is self-injected (as opposed to provider-administered), rise from 7% in March 2021 to 15% in May 2022 (Access Collaborative, 2022). Looking ahead, DISC will continue to leverage our robust partnerships to increase the availability of SI training, thereby making contraceptive self-care a viable option for a greater number of women across Nigeria.
EMERGENCY CONTRACEPTION

A Brief Overview

Emergency contraception (EC) has been known about for several decades, and dedicated products have been on the market for close to 20 years. The most widely distributed emergency contraceptive pills (ECP) contain the hormone levonorgestrel (LNG), while products containing the antiprogestins ulipristal acetate (UPA) or mifepristone are on the market in a smaller number of countries.

Emergency contraception is a unique addition to the range of contraceptive methods, as it is the only method that can be effective after sex has taken place. During the past decade, several positive policies and regulations have been put in place. For instance, emergency contraceptive pills are registered in a majority of countries around the world, listed in many countries’ essential medicines lists (EMLs), included in widely used guidance, and supported by several donors.

A recent articulation of emergency contraception is that of a self-care product that women can use “on demand.” Pericoital, or “on-demand,” contraception can be used by women who want an intermittent method that is taken only when needed (as opposed to a daily pill), under their control, and not detectable by a sexual partner. Across a wide range of countries, studies have found an interest in on-demand options among women who have infrequent sex, many of whom desire its convenience, ease of remembering, the ability to conceal use, and the avoidance of continuous exposure to contraceptive hormones and/or side effects.

Pericoital oral contraception could address a need for women who want the option to use a contraceptive pill before or after sex, as needed. A review of 19 studies in 16 countries found substantial interest among women in a pericoital oral pill that could be taken repeatedly. Research by the WHO supports the safety and efficacy of this use of LNG 1.5 mg pills – the same formulation of many current ECPs – multiple times within a menstrual cycle. The demand for an on-demand oral contraceptive has been underestimated in the past, but likely is widespread. Efforts to accelerate the development of such a method are underway. On-demand contraceptive methods have the potential to become more widely available in the future.
International Consortium for Emergency Contraception: Twenty-Five Years

Authors: ICEC

The International Consortium for Emergency Contraception (ICEC) was formed in 1995. Its early work focused on showing that emergency contraceptives could become a part of mainstream reproductive health care worldwide. Over time ICEC’s mission expanded to focus on access, ensuring safe and locally-appropriate use of emergency contraception (EC) worldwide within the context of family planning and reproductive health programs, with an emphasis on developing countries.

ICEC was instrumental in advocating for the introduction of a dedicated EC product and led the introduction of EC in a number of countries. Today women and girls in over 140 countries can buy emergency contraception pills. ICEC has also helped establish regional consortia that play an important role in increasing access to EC, including the American Society for Emergency Contraception, the Latin American Consortium for Emergency Contraception, ECafrique, and the European Consortium for Emergency Contraception.

For more than 25 years, the ICEC curated research, convened expert working groups, conducted advocacy, and developed policy and clinical guidance through the work of a vibrant and broad coalition of members. ICEC was the go-to agency for up-to-date information on emergency contraception. A rich collection of factsheets, briefs, policy documents, and clinical guidelines were produced by the ICEC and are available in several languages including English, Spanish, French, and Chinese. Representing two-decades’ worth of resources on emergency contraception, this collection recently migrated to the Reproductive Health Supplies Coalition’s online document repository, the Supplies Information Database (SID). RHSC’s Supplies Information Database is dedicated to preserving and sharing the wealth of knowledge on reproductive health supplies. This rich collection of EC resources can be found online and is free to access and download.

HIV SELF-TESTING

A Brief Overview

HIV Self-Testing (HIVST) is a vital tool to help people discover their HIV status. It gives individuals a pathway to start treatment and effective HIV prevention – including Pre-and Post-Exposure Prophylaxis (PrEP/PEP) and Voluntary Medical Male Circumcision (VMMC); links them to sexual and reproductive health services and reduces the HIV burden globally. This is particularly relevant in low- and middle-income countries (LMICs), where concerns around stigma and difficulties in accessing healthcare can put up significant barriers.

Many countries have adopted HIVST as a key strategy in their national HIV testing programs. As HIVST programs roll out globally, it will be important to design, and test differentiated service delivery models to reach diverse populations and continue to build the programmatic evidence base.

HIV Self-Testing: Opportunity for Health Systems Strengthening to reach Universal Health Coverage

Author: Karin Hatzold1 (1 Unitaid/STAR Consortium)

The largest HIV self-testing (HIVST) initiative globally, known as the Self-Testing Africa (STAR) Initiative, has produced strong evidence that the approach is an effective, cost-effective, and accessible way for young people, men, and key and vulnerable population groups to find out their HIV status. It has also provided evidence that self-testers are linking to effective treatment and prevention services. Since the WHO Guidance for HIVST was released in 2016, the number
of countries including HIVST in their national testing programs and plans increased to 98, and over 32 million HIVST kits are in the procurement pipeline (2020-2023).

Adapting services to the specific needs of the individual client who is currently not able or reluctant to take up testing services is crucial. Various HIVST delivery modes have been considered, including community based, facility based, vending machines, over-the-counter sales at pharmacies, online distribution, and secondary distribution (where an HIVST is distributed to one person for use by another through sexual and social networks). There are currently six WHO-prequalified HIV self-test kits – five blood-based and one oral fluid test – contributing to market competition and resulting in substantial price reductions. This makes them affordable for out-of-pocket purchase by individuals in LMICs.

With further reductions in the unit price for HIV self-test kits, integration of HIVST with facility-based testing could help to decongest clinical testing facilities. Clients could then perform HIVST in outpatient settings, allowing health care workers to focus only on those clients who screen positive and ensure that they are linked to confirmative testing and treatment. HIVST could thus replace health care provider-offered HIV screening and significantly reduce costs to the health delivery system.

In the HIV prevention world, there is a growing recognition that differentiated service delivery models can help decentralize prevention services and reach populations not engaged in traditional care models. With the new WHO guidance on differentiated and simplified pre-exposure prophylaxis for HIV prevention, there exists now the opportunity to further differentiate PrEP delivery with HIVST for initiation and monitoring of oral PrEP.

HIVST could enable individuals taking PrEP to test routinely, by replacing or complementing existing testing intervals with providers, which could potentially increase access and adherence to PrEP services. Additionally, HIVST could enable greater differentiated service delivery for PrEP initiation and continuation in new settings beyond the bounds of traditional healthcare facilities, such as at private pharmacies or during at-home visits. Countries could consider integrating HIVST into PrEP delivery to potentially increase the resilience of service delivery and patient-centered care during an era of pandemics, and to achieve and maintain global HIV prevention targets.

Lessons learned from the introduction of HIV self-testing can also be applied across self-testing for other health and disease areas. The achievements provide a foundation from which the potential of other self-testing and self-care approaches can now be more readily realized as people-centered options, including for sexually transmitted infections, Hepatitis, and COVID-19.
SELF-MANAGED ABORTION

A Brief Overview

Throughout history women have been self-managing abortion. The need for safe methods for pregnancy termination has been and will continue to be a critical component of comprehensive reproductive healthcare. This includes the ability of individuals to have self-managed abortions, which are performed through self-care interventions or without clinical supervision, particularly early in pregnancy through medication abortion.

The WHO recommends that individuals have the option to self-manage abortion using medication abortion. Further, the WHO recognizes that individuals can safely and effectively self-assess their eligibility for abortion and self-administer abortion medication, demonstrating that self-managed abortion is a critical tool for enabling individuals to safely exercise reproductive freedom.

It is noteworthy that most abortions in the world happen outside of clinical settings. A variety of approaches to provide women access to safe abortion services have been pioneered. For example, there are “accompaniment models” to support women and help them navigate the process, and telehealth and hotlines that provide information to women and refer them to care.

Below we highlight three innovative, feminist, and grassroots-driven approaches to self-managed abortion care.

Understanding the origins and practice of Medication Abortion Accompaniment: A Case Study of two Global Networks

Authors: Mobilizing Activists around Medical Abortion (MAMA) Network; La Red Compañera; Ibis Reproductive Health

Self-managed abortion is commonly defined as “any action a person takes to end a pregnancy without clinical supervision”. Self-managed abortion with medications refers to the use of medications for abortion without clinical supervision.
Around the world, access to safe, quality abortion care is restricted by existing laws, pervasive social stigma, financial and logistical barriers, and a lack of resources. This includes a lack of knowledge about the WHO-recommended medications for abortion, which are either misoprostol alone or in combination with mifepristone. Facility-based abortion care in most of the world, even when legally available, is often difficult to access and can be prohibitively expensive. Across contexts, we see again and again that those who are most marginalized face the greatest barriers to care, a reality that has only been exacerbated in the midst of a global pandemic. Barriers to safe abortion care can lead to delays in seeking abortion, or outright deterrence, and can result in the use of unsafe or ineffective methods, and/or forced childbearing. Both carry significant consequences for health, autonomy, and well-being.

Given the barriers to safe abortion within the formal health sector, people have self-managed their abortions for a range of reasons. For decades, people have relied on safe WHO-recommended medications to terminate unwanted pregnancies on their own, without clinical supervision or support. People who are self-managing may obtain these medications at a pharmacy over the counter, from an informal seller, over the internet, or from a collective or friend. They are often supported in person, or virtually, through their process by someone in their support network who acts as a counselor.

People self-manage their abortions for a variety of different reasons, including personal preference, mistrust of the medical system, desire for privacy, fear of discrimination or stigma, and legal restrictions that make clinic-based abortion unavailable or inaccessible to them.

Over the past two decades, feminist abortion accompaniment networks have emerged as a response to the criminalization of abortion and the pregnant people who have them and as resistance to restrictive abortion laws. They are a form of protest against the abdication of the state’s responsibility for providing access to safe abortions, as well as an avenue of abortion access for those who cannot or do not want to seek care within formal health systems. This includes populations that have experienced trauma, discrimination, or violence in the health system. Feminist abortion accompaniment networks build upon a practice that has occurred throughout history – women accompanying each other during an abortion – to ensure that women and other pregnant people can access safe abortion regardless of the legal context.

The medication abortion accompaniment movement is driven by community-based strategies to de-medicalize abortion provision and ground abortion care in an evidence-based, compassionate approach, while actively working to counter stigma, violence, and judgement. Through the accompaniment process, highly skilled (non-clinically trained) abortion accompaniers provide evidence-based medication abortion counseling as well as emotional and physical support over the phone, through digital platforms, or in person, responding throughout the abortion process to the unique needs of the individuals they accompany. Notably, in the recent update of the WHO Abortion Care Guideline, self-managed abortion is fully recommended as a safe and effective method. Additionally, thanks to rigorous evidence generated by collaborative partnerships between accompaniment groups and researchers, community health workers – such as safe abortion accompaniment groups – are fully recommended as providers of medication abortion care.

Accompaniment groups are far-reaching and operate in more than 50 countries worldwide. Regional networks of abortion accompaniment groups have formed in Latin America (La Red Compañera) and Africa (the MAMA Network) with the shared mission of mobilizing toward improving access to, and information around, medication abortion within their regions using a feminist, grassroots, community-based approach. Collectively, across both regions, La Red Compañera and the MAMA Network are composed of more than 100 organizations, servicing
countries in Central, Eastern, and Western Africa, Latin America, and the Caribbean. La Red Compañera and the MAMA Network share a commitment to feminist, grassroots technical support for member organizations within their respective regions, and both regional networks share a commitment to remaining fluid, open to new ideas, and evolving their models to incorporate social, political, and scientific learnings.

In contexts shaped by the criminalization, stigmatization, and inaccessibility of abortion, member organizations of La Red Compañera and the MAMA Network have risen to the challenge of innovation in providing safe, effective, and empowering support for people self-managing abortions.

La Red Compañera and the MAMA Network have newly formalized a co-created space to enable cross-regional collaboration between the two networks and among member organizations. Collaboration between the two regional networks will facilitate the sharing of best practices, allow for cross-regional learning about advocacy strategies, strengthen relationships between and among members, and support the expanded reach of abortion accompaniment in both regions.

This space is horizontally structured and anchored in human rights and grassroots values that are shared by both networks. It aims to achieve the following goals:

1. Build capacity for scaled-up access to self-managed abortion with accompaniment group support, particularly among historically marginalized and hard-to-reach populations.
2. Share best practices to ensure that all members are supported with the information and resources needed to provide high-quality, person-centered, evidence-based abortion accompaniment that best fits the needs of their communities.
3. Share movement-building strategies aimed at shifting social norms, increasing abortion access, and advancing progressive abortion legislation globally.

Bolivia: Self-Managed Abortion - An option and a right for women

Authors: Delmy Iriondo, Cecilia Terrazas, Leonardo Lira (1 Ipas Bolivia)

In response to the barriers faced by women to access safe and legal abortions, Ipas Bolivia implemented the Community-Based Model for Medical Abortion Self-Use (MASU), centered on comprehensive care and counseling for this practice, following WHO recommendations. This model was implemented with the help of trained community members who work as volunteers (community agents), promoting the provision of reliable information and commodities to reduce the probability of harming women's health. This enabled them to self-manage their abortion safely and at the lowest possible cost.

Between September 2019 and July 2022, as a result of the implementation of the model, 4,640 women received MASU counseling and 3,994 were accompanied during the process of terminating their pregnancies in the departments of Beni, La Paz, Pando, Potosí, and Santa Cruz. A total of 1,903 of them used misoprostol and 2,091 used the combined regime of mifepristone and misoprostol.

To be able to meet the needs of women and adolescent girls, the community agents receive the support of:

- Health care providers (including providers of medications) who treat cases over 12 weeks and provide comprehensive care. This includes post-abortion contraceptive methods through a referral system that includes individuals, pharmacies, and institutions willing to sell the medications at affordable prices, thus ensuring that women and adolescent girls are able to carry out their decision to have a medical abortion on their own.
- A network of attorneys who provide counseling, accompaniment, lawsuits, and follow up and who are prepared for litigation cases.
Experience has shown that the MASU Community-Based Model meets the needs of women and adolescent girls, contributing to reducing maternal mortality, adapting to different situations, and succeeding at upholding the right to abortion, even within an unfavorable national policy context. With respect to users, 100% valued the information and accompaniment provided. We were able to meet their demand for termination of pregnancy with discretion, respect, and accompaniment, and without complication and stigmatization. The challenge now is to achieve sustainability and expand the model to other geographical areas, as well as advance awareness-raising and advocacy with national and local authorities to change the national legal standards in favor of safe abortion.

**Mexico: TeleAborto - Guided Self-Managed Abortion via telemedicine**

**Author:** Gynuity Health Projects

TeleAborto is a direct-to-patient medication abortion telemedicine service. It was introduced in Mexico by Gynuity Health Projects to help address the limited access to abortion care in most of the country.

After a screening consultation and standard abortion counselling by phone or videoconference, individuals are sent – via tracked mail or other reliable means of delivery – packages containing mifepristone, misoprostol, painkillers, and an instruction guide. People who are determined ineligible are offered service alternatives by providers registered with TeleAborto. Pre-abortion tests, such as ultrasound, are done at facilities local to the individual, and the results are evaluated by the provider requesting them. Follow-up contact via phone call or messaging is scheduled seven to 14 days after shipment of the package to ascertain abortion outcome and any need for additional care.

An analysis of this care model by Gynuity Health Projects and partners, published in 2022 in the medical journal Contraception, shows that guided, self-managed abortion is safe, acceptable, and feasible when supportive care is provided from a distance and abortion pills are mailed. Most pregnancies ended successfully with the medications provided and without further intervention. Satisfaction levels were extremely high. Convenience and privacy were cited as the most-valued aspects of the service, which was used by people from all 32 Mexico states. Nearly half of clients reported distances of 500 kilometers or more from their chosen provider, which could translate to at least four hours of bus travel each way.

The findings from this observational study, available in summary form in Spanish and English, add to the mounting evidence globally in support of self-managed abortion via telemedicine, a model endorsed by the WHO. These findings add to the promising landscape for abortion access and rights in Mexico. A growing number of Mexican states are lifting legal restrictions on abortion since a 2021 Supreme Court decision declared it unconstitutional for Coahuila state to criminalize women for having an abortion. The team behind the medication abortion telemedicine service continues to explore ways to reach more vulnerable and remote populations in Mexico.

**SELF-CARE IN HUMANITARIAN AND FRAGILE SETTINGS**

**Realizing the full potential for Self-Care in Humanitarian and Fragile settings**

**Authors:** Caitlin Mannering, Andrea Edman, Erin Wheeler, Roopan Gill, Angel M. Foster, Hannah Tappis (1 - IRC; 2 - Vitala Global; 3 - University of Ottawa; 4 - Jhpiego)

Displacement, extreme poverty, and acute food insecurity are on the rise, driven by the converging crises of the continuing COVID-19 pandemic, climate change,
and armed conflicts. As of September 2022, 313.5 million people globally were in need of humanitarian assistance, a significant increase from the 235 million estimated in 2021, already one of the highest figures in decades. Those living in humanitarian contexts continue to experience glaring gender inequalities, including gaps in SRH services.

All individuals, regardless of their background or current situation, have the right to make their own SRH choices, and access to these essential services should not be lacking or denied. Yet, across the globe, SRH-related conditions remain one of the leading causes of death and ill-health among women and girls of reproductive age. More specifically, an estimated 61% of maternal deaths occur in countries experiencing fragility and crisis.

In these situations, self-care provides a critical opportunity to ensure access to necessary SRH services and is becoming increasingly recognized for its potential to fill critical gaps in disrupted health systems through increased self-management, self-testing, and self-awareness. Some experts argue that self-care may better serve the needs of displaced, marginalized, and underserved populations who may experience stigma and discrimination, and that it may also help increase community and lay health worker capacity and support their role in a sustained humanitarian response.

Recognized by the Sphere Handbook as the global standard in humanitarian response, the Minimum Initial Service Package (MISP) for SRH is designed to address priority reproductive health needs in the initial days and weeks of an emergency. The MISP forms the starting point for SRH programming, with the aim being to build upon it with comprehensive health services to meet population health needs in protracted crises and settings recovering from emergency.

Many self-care interventions could align with and build off these well-established humanitarian standards for SRH. Table 1, featured in the Conflict and Health article, “Sexual and reproductive health self-care in humanitarian and fragile settings: where should we start?” maps out the alignment of self-care interventions with MISP objectives and activities. The authors also outline critical policy, program, and research considerations and note that these interventions must be refined according to the local context and implemented within a continuum of care and a whole-system approach.

There is limited evidence on self-care interventions in humanitarian settings, but a recent scoping review of SRH in humanitarian and fragile settings found 25 publications on interventions implemented in these settings and concluded that well-supported self-care interventions have the potential to increase access to quality SRH for displaced populations. A 2021 event hosted as part of the Self Care Trailblazer Group’s Self Care Learning and Discovery Series further highlighted promising examples.
of self-care interventions implemented in South Sudan, the Democratic Republic of Congo, and Venezuela featuring innovative self-managed contraception and abortion models. Despite these advancements, pilots in the published literature were conducted in isolation and not within multipronged programs with access to SRH services. The details of the interventions themselves, study settings, and factors influencing implementation were not fleshed out, and none of the studies have documented barriers to self-care or implementation considerations in humanitarian contexts.

The potential of SRH self-care in humanitarian and fragile contexts has yet to be fully realized. Programmatic models are needed to inform decision-makers around the allocation of resources for safe and effective SRH self-care intervention implementation in areas with severely disrupted health systems. Implementation research is needed and must inform policies and programs through both expanding the use of established self-care interventions into humanitarian contexts and generating evidence on new models of care in these settings. In particular, replication and multi-country studies are needed, along with more robust details on how promotion and support for self-care can be tailored to context-specific population interests and health system considerations. The package of self-care interventions may vary based on fragility typology, acuteness, and local context, and the key stakeholders and target audience may differ.

Digital health is another avenue of exploration for SRH self-care interventions in humanitarian settings. When facility-based care and services are disrupted, the WHO recommends prioritizing digital health services. With rapid acceleration in the use of digital technology in healthcare as a result of the COVID-19 pandemic and growing ownership of mobile phones in humanitarian settings, there is a potential path forward to digitally implementing SRH self-care interventions, provided they ensure privacy, confidentiality, and accessibility. The 2019 WHO recommendations on digital interventions for health system strengthening offer a good starting point for humanitarian and SRH actors to leverage digital health in crises.

To realize its revolutionary potential in humanitarian settings, there is need for investment to increase the evidence base, scale up availability of commodities, and integrate self-care into national, regional, and global guidelines and standards. This must also be inclusive of humanitarian settings as well as stigmatized and frequently sidelined SRH service areas such as safe abortion care.

Advocating for self-care could help to strengthen health resiliency to cope with current and future emergencies. SRH self-care services must be prioritized as both an effective option to increase health coverage in humanitarian settings and as an essential human right. SRH needs do not stop in crisis, and access to these essential, life-saving services must be ensured and maintained.

DIGITAL HEALTH: CONNECTING USERS AND HEALTH SYSTEMS

Self-Care is not Solitary Care: Centering the Health System on Users via Digital Channels

Authors: Ben Bellows, Eric Green (Nivi)

When supporting individuals across diverse cultural, geographic, and socio-economic contexts, non-profit, commercial, and public health organizations face significant challenges in tailoring interventions to provide the information and resources that individuals need to make informed decisions and meet their health objectives. Nearly 4 billion people go without healthcare, and individuals with a low sense of agency are less likely to seek health services or care. Health organizations face greater challenges serving individuals who feel inhibited or lack agency in articulating and acting on their health priorities.
A person-centered approach that supports, motivates, and empowers individuals to initiate care-seeking, often called “self-care,” involves significant repositioning of health system resources. To meet the self-care demand, organizations design and distribute drugs, devices, and diagnostics that people can use with or without the help of healthcare providers. New digital technologies, such as smartphones and wearables – along with expanding internet connectivity and processing advances in artificial intelligence – are creating novel ways for organizations to engage people on their self-care journeys.

Successful self-care interventions rely on understanding an individual’s motivation in order to help them improve the likelihood of acting on health priorities they recognize as their own. Health organizations have struggled to support individuals to articulate their priority motivations and monitor their readiness for self-care interventions. It remains even more difficult to deliver tailored self-care interventions that can modify readiness and increase the likelihood that an individual will move further along their self-care journey.

There are hundreds of chatbot interventions that support self-care health journeys related to mental health, SRH, weight loss, and other topics. However, monitoring and responding to consumers’ levels of readiness using reliable and validated metrics is not done consistently. Without validated and reliable metrics of readiness and a priority to measure them, it becomes impossible to tailor digital interventions to support individuals where they are, thereby providing them with the information they most need, in the format and at the time they most need, as they change their readiness and move their health priorities forward.

Nivi is a digital health marketplace that has served health information, digital counseling, and referrals to more than 1.5 million users in India, Kenya, and Nigeria via more than 20 partnerships to date. Anyone can access the Nivi chatbot experience on WhatsApp.

By targeting information when it is most relevant to the users who are most likely to act on it, Nivi can identify highly motivated (“high readiness”) individuals and support them from initial awareness through to action. To date, most of the interaction has been health education and referral generation.

The next stage of Nivi’s evolution is focused on completing referrals across a wide range of product and service endpoints including ecommerce, pharmacies, teleconsultation, and clinics. Building on a theoretical approach to behavior change, Nivi will deepen its ability to measure reported readiness in order to tailor family planning messages based on readiness level. This greater segmentation on readiness and fostering greater readiness among Nivi users will improve individuals’ reproductive health journeys.
Nigeria: Leveraging Digital Self-Care culture to improve the lives of women of reproductive age

Authors: Ayoposi Ogboye,1 Chiagozie Abiakam,1 Dr Nneka Moissan1 (1 - mDoc Healthcare)

Nigeria’s maternal mortality rate of 512 per 100,000 live births is among the highest in the world. There is a trend in which indirect causes are now increasingly contributing to the maternal mortality and morbidity burden.

mDoc is a digital health social enterprise that employs a range of digital tools to help women of reproductive age with general and personalized guidance on self-care and lifestyle modifications in order to reduce this burden. To support these women, we leveraged an omnichannel four-pronged self-care approach centered on:

• Providing access to coach-led multidisciplinary teams that provide self-care support such as digital nudges, health education, mental health coaching, nutritional advice, virtual exercise classes, and tracking of health metrics such as blood pressure and weight via our digital platform CompleteHealth™.
• Providing a place for members to meet in person with their health coaches at our NudgeHubs™, giving a sense of connection and security.
• Improving the quality of reproductive healthcare by providing strategic guidance to health organizations and Ministries of Health on quality as well as capacity-building opportunities for health care workers and patients both in-person and virtually via the mDoc Quality Network™.
• Guiding members through NaviHealth.ai™, our geo-coded directory of health facilities, services, and providers which also provides a patient feedback system based on the six dimensions of quality.

To date, more than 83,000 women of reproductive age are enrolled on CompleteHealth™. We have seen a 61% increase in their knowledge of risk factors for indirect causes of maternal mortality, and a 46% increase in their knowledge of and engagement in self-care practices. However, we have seen that mobile phone ownership is not a proxy for digital literacy and have had to make significant investments in improving both the digital and health literacy of our members.

By leveraging technology to support and provide the right ecosystem for women to improve their self-efficacy and health literacy, we can positively influence lifestyle changes and lead to improved reproductive and maternal health outcomes.

Next steps include expanding access to our digital platforms via USSD integration and continuing iterations of our tiered payment plans (which were created to ensure that we do not curb access to our services for people who cannot afford to pay). Our goal is to ensure that women in Nigeria can live longer, better, and healthier lives.
SECTION 3
MEASURING AND MONITORING SELF-CARE PRACTICES
Measurement of self-care interventions is important to identify what works and what does not. However, a fundamental difficulty of SRH self-care interventions, is that the very feature that defines self-care - aspects of the users’ journeys - is also what makes it difficult to track and measure. By design, much, if not all, of a user's self-care experiences take place outside of the formal health system, which is where data on health service and outcome indicators are typically collected. Despite self-care practices, codified national and global SRH self-care guidelines are still nascent, as are effective strategies for monitoring and evaluating these programs.

A fundamental challenge to developing and consolidating indicators related to SRH self-care is the lack of consensus on exactly which activities fall under the umbrella of self-care. Even for widely recognized self-care interventions, there is also a lack of consensus on the best indicators or measures for monitoring and evaluating interventions. Moreover, data collection on self-care indicators often happens through parallel systems in the public sector, private sector, and community, as well as through defined programs or studies. Harmonizing indicators and consolidating data from different entities with different purposes is especially challenging. Facility-based indicators related to self-care do not capture self-care that happens outside of the health system, and activities outside of the formal health system are often poorly tracked. Below are case examples of on-going initiatives to measure self-care interventions.

**ELWG Measurement Workstream**

In February 2023, the SCTG’s Evidence and Learning Working Group (ELWG) published a measurement tool that can serve as a practical resource for stakeholders engaged in the self-care movement. The aim of the tool is to provide a “user guide” to inform monitoring, evaluation, and research conducted in the context of the implementation of self-care guidelines. A set of priority indicators has been proposed with the goal of advancing standardized metrics that can be used and compared across diverse programs and settings. As self-care programming continues to expand, improving the comparability and feasibility of measurement of progress, outcomes, and impact of self-care on health outcomes is critical. Access the Sexual and Reproductive Health Self-Care Measurement Tool here.

**Performance Monitoring for Action Project**

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The Performance Monitoring for Action Project (PMA) collects representative longitudinal panel data in eight countries (Nigeria, Kenya, DRC, Burkina Faso, Uganda, Niger, India, and Cote d’Ivoire), which permit us to measure trends in various indicators at the national and/or sub-national level. PMA collects data from women, households, health facilities that provide FP, and client exit interviews; and our surveys focus on contraceptive dynamics, women’s empowerment (sexual, reproductive, and economic), fertility and contraceptive preferences, and self-care.

For self-care measures, PMA has consistently measured self-injection of DMPA-SC since 2019 in all geographies where it was available. In addition to measuring the prevalence of DMPA-SC and self-injection, the project also captures women’s preferences for self-injection (versus provider injection), whether facilities offer training in self-injection (and the content of the training), and if women had been trained in SI at the facility.
Translating Self-Care Data to Action: A Human-Centered Design Approach to Dashboard Development

Author Institutions: The PATH-JSI DMPA-SC Access Collaborative

Translating data into action is a key aspect of global health programs. Understanding your audience and their information needs is a critical first step to designing effective communication. Data for self-care practices require particular attention as these health care practices occur with or without the support of a health care provider and therefore may not be captured in routine data. This issue was particularly salient for the DMPA-SC Access Collaborative (AC), a global initiative to increase access to DMPA-SC and self-injection (SI) as part of an expanded range of contraceptive methods through data-driven technical assistance, coordination, resources, and tools.

There were no existing central repositories of DMPA-SC/SI country data, and many countries did not yet include SI indicators in their national health information systems, resulting in limited visibility into SRHR self-care scale-up, practices, and needs. This data accessibility gap motivated the creation of the AC data dashboard, which serves as a hub for the most up-to-date information and actionable insights around DMPA-SC and SI across select countries, and which is made available to Ministries of Health, technical assistance partners, and global donors. This case study highlights the activities undertaken by the AC to redesign the DMPA-SC/SI dashboard through a human-centered design (HCD) process in order to better address the evolving data needs of stakeholders.

Dashboard Implementation: Initially launched as a monthly Excel workbook in 2018 with data from six countries, the dashboard was moved online and shifted to a quarterly schedule in 2019 and now contains data from 18 countries - Benin, Burkina Faso, Côte d’Ivoire, DRC, Ghana, Guinea, Kenya, Madagascar, Malawi, Mali, Mauritania, Myanmar, Niger, Nigeria, Senegal, Togo, Uganda, and Zambia. In-country teams and implementing partners liaise with ministry officials and relevant stakeholders to extract data from multiple sources, including national health information systems, country-specific electronic sentinel systems, and program documents. Data is aggregated by AC staff, who then share the data back for validation by country teams. Key AC staff also review the data for accuracy and completeness through regular data review meetings. Routine country-level data review meetings are held to monitor progress, identify gaps, and prioritize strategies to accelerate progress. Quarterly global SI reports and discussion groups promote cross-country learning on barriers and facilitators to SI scale-up efforts.
Dashboard Redesign/Human-Centered Design Process: In response to stakeholder feedback, evolving data needs, and a desire to increase use of the dashboard by stakeholders in the countries contributing data, a major redesign of the dashboard was undertaken in December 2020. To inform the redesign, the AC conducted an HCD study, a participatory process that combines intensive stakeholder research with creative ideation and iterative testing. In total, 40 stakeholders representing 21 organizations across eight countries provided their input through stakeholder interviews, surveys, and partner workshops.

The HCD work revealed four primary ways the dashboard was being used: 1) advocacy (e.g., how evidence can be used to shift policy); 2) operational decision-making (e.g., identifying training gaps); 3) validation and learning (e.g., data accuracy); and 4) evaluation and comparison (e.g., cross-country comparisons). Participants highlighted disconnects between tracked indicators and the data needs of country coordinators and on-the-ground stakeholders (e.g., the need for a greater focus on SI uptake data), as well as insufficient access to and promotion of the dashboard as key barriers to engaging with the dashboard and data. There were additional concerns about data security, data quality, and the lack of contextual data (e.g., the need for more clearly defined and better publicized indicator definitions and data sources). These results guided a rethinking of how the AC aggregated and communicated DMPA-SC and SI data.

Evaluation/Outcome (Learning): Several changes were enacted as a result of the HCD exercise. In response to feedback on evolving data needs, particularly as SI transitioned from initial introduction to scale-up in many countries, the dashboard shifted from a primary focus on process and status-related indicators (e.g., SI policy) to more quantitative monitoring (e.g., provider training and SI uptake). These quantitative indicators were standardized and clearly defined to reduce ambiguity and facilitate cross-country comparisons and learning. The varying data needs of different audiences, made clearer through the HCD exercise, are now being addressed through multiple dissemination channels. These include the dashboard; routine global, national, and sub-national data review meetings; global webinars; and quarterly reports (these reports are comprised of an SI status report – which provides critical contextual information and triangulates data related to SI at both the global and national level – and a donor consortium report, providing higher-level insight into global SI scale-up). To further promote engagement, the AC increased communication around updates to the dashboard and when new data are made available. In response to data quality concerns, the data review process has been streamlined, with additional opportunities for country teams to review and provide feedback on aggregated data.

The HCD exercise also informed development of a monitoring, learning, and evaluation (MLE) toolkit designed to inform and standardize monitoring and evaluation of SI programs. The toolkit includes tools and information to support programs to create dynamic and visually compelling SI program data displays (e.g., dashboards, presentations) that facilitate comprehension and use of SI data for family planning program decision making. While the toolkit was developed with SI in mind, many of the principles could be applied to data visualization needs across self-care practices, and family planning programs and methods.

The dashboard currently aggregates data on DMPA-SC provider-administered (PA) and SI uptake, as well as provider training, policy, stock, and method availability across 18 countries. Our latest analytics show that, since October 2021, almost 100 unique users accessed the dashboard more than 1,000 times. Through Q2 2022, 9,230,050 DMPA-SC visits, 864,265 SI visits, and 97,056 trained providers have been reported via the dashboard. An example of the Uptake & Visits page of the dashboard can be seen below:
Key Lessons: There were key challenges faced while developing and launching the redesigned dashboard. Data availability, particularly levels of data disaggregation (e.g., visits reported by age group), varied widely by country, presenting a challenge in aggregating data across more than a dozen countries under common indicators. Disconnects between data needs and the availability of appropriate data, as well as disparate priorities across countries and stakeholders, further complicated the creation of a universal dashboard. The HCD results helped to identify these priorities as well as meaningful compromises to generate indicators and visualizations that would benefit a wide variety of stakeholders while remaining feasible given data limitations. Balancing access to the data with data security was also a challenge, and HCD participants cited both level of access and trust in the security of the data as key factors when considering sharing data externally. While the dashboard is password protected and access is by invitation only, the use of multiple dissemination channels has allowed the data to be viewed by a wider audience while still respecting data privacy and sharing agreements (e.g., removing confidential information from more widely shared reports).
Advocacy efforts to promote inclusion of SI indicators in national health information systems has also facilitated greater access to national SI data across a number of countries. Presently, nine of 14 countries currently contributing SI uptake data to the dashboard have SI indicators in their health management information systems (HMISs). Ensuring data quality when aggregating data across multiple countries and from multiple sources (e.g., HMISs, sentinel systems, program documents) will always be a challenge. Clearly defined indicators, data collection strategies, and reporting schedules, as well as multiple rounds of data validation, have helped maintain data quality across dashboard indicators.

Earlier iterations of the dashboard were geared towards donors and senior leaders, focusing on high-level policy and operations indicators to inform early SI introduction and scale-up activities. Re-alignment with evolving stakeholder needs and priorities through new indicators, visualizations, and dissemination channels increased the utility of the dashboard for stakeholders in the contributing countries, better informing and supporting on-the-ground operations. Ad hoc visualizations and analyses using dashboard data in response to stakeholder requests have further boosted engagement. These one-off requests help bridge gaps between individual stakeholder priorities and the need for a single dashboard and universal indicators and visualizations across multiple countries and stakeholders.

Key facilitators to a successful dashboard redesign and overall implementation have included: dedicated ministries, implementing partners, AC staff, and other stakeholders; willingness to revise indicators and the dashboard based on evolving stakeholder feedback and needs; use of an HCD approach to understand user needs and perspectives; and transparency around the purpose of the dashboard and process for responding to additional information requests.

**Future Plans:** The dashboard was meant to fill program-specific data gaps to inform scale-up activities and was not intended as a permanent mechanism for aggregating and communicating SI data. More systematic and long-term solutions to SI data availability are being promoted by equipping country staff and stakeholders with information and support, such as through the MLE toolkit and technical assistance to integrate DMPA-SC and SI indicators into national HMISs.

As the self-care field moves forward, there is a need for innovative approaches to measurement and monitoring of self-care practices. Greater attention to the refinement of indicators and data collection approaches, and streamlining monitoring, evaluation, research, and learning (MERL) on self-care would be of great benefit to the field.
SECTION 4
LOOKING AHEAD
With an ever-expanding array of self-care initiatives and interventions underway, it is an opportune moment to create a forward-looking agenda and build the next generation of self-care efforts. As the report title, “Progress and Potential,” suggests, we have made enormous progress over the past few years and have opened up even greater possibilities for self-care in the future.

Several themes have emerged and continue to resonate with stakeholders. These include, but are not limited to:

i. Moving from pilot to scale-up of self-care practices. Many self-care interventions have been small-scale and narrowly focused. More robust scaling-up of effective self-care interventions, in tandem with evidence generation, is a key next step.

ii. Continuing research, collaboration, and learning around self-care is needed to move the self-care field forward with evidence-informed programs and policies.

iii. Establishing knowledge management of lessons, insights, and evidence from the growing body of work on self-care.

iv. Ensuring that self-care is clearly articulated and strategically incorporated into the UHC agenda remains an important task for advocates and policymakers e.g., that self-care is recognized at the UHC High Level Meeting in 2023 and work towards a World Health Assembly Resolution on self-care is accelerated.

v. Linking self-care more intentionally to Health System Strengthening (HSS) efforts.

vi. Highlighting the connections between self-care, bodily autonomy, and sexual and reproductive health and rights.

vii. Building political will and financial commitment to self-care. Continuing to make the investment case for self-care. Financing of self-care should include a diverse range of resources, including national budgets, global commitments, and philanthropic efforts.

viii. Ensuring sustainability of self-care efforts.

ix. Engaging the private sector more intentionally at key stages of the self-care journey.

x. Drawing attention to other self-care interventions such as pericoital contraception, non-communicable diseases (NCD), and other maternal health related self-care.
xi. Watching and learning from the national self-care guidelines development process and roll out in several early adopter countries.

An important next step will be to develop a program, policy, research, and action agenda for the next generation of self-care activities. Through a process of consultation and deliberation with a broad range of constituents and stakeholders, the SRH self-care community can foster the next generation of self-care efforts and move the self-care field forward.

WHAT YOU CAN DO

1. Help build the Next Generation Self-Care Agenda. A consultative process to deliberate and define an agenda for the next iteration of self-care initiatives and actions is proposed.

2. Join the self-care movement. There are many ways to engage in self-care, including by joining the Self-Care Trailblazer Group (SCTG) using the link here, and any of its working groups such as the Evidence and Learning Working Group (ELWG), the Global Advocacy and Communications Working Group (GAC), and the Country Advocacy Working Group (CAWG).

3. Add to this living document. As the self-care “policy to practice” journey evolves, we continue to seek input, experiences, insights, and evidence of self-care efforts. We welcome and value your input as we build the self-care movement. Send your comments and suggestions to secretariat@selfcaretrailblazers.org with the Subject: State of Self-Care Report.

4. Any major events or meetings that we need to plan around? Email the Self-Care Trailblazer Group (SCTG) Secretariat at: secretariat@selfcaretrailblazers.org with the Subject: Events/Meetings.
REFERENCES AND FURTHER READING

WORLD HEALTH ORGANIZATION RESOURCES ON SELF-CARE

4. World Health Organization (2022) How to use the WHO Guideline on self-care interventions for health and well-being. Available at: app.magicapp.org/#/guideline/Lr21gL
6. World Health Organization (2022) Abortion Care Guideline. Available at: apps.who.int/iris/handle/10665/349316

OTHER RESOURCES ON SELF-CARE

State of Self-Care Report  Progress and Potential of Self-Care: Taking Stock and Looking Ahead

9. Self-Care Trailblazer Group (SCTG) (2021) Self-Care Learning and Discovery Series (link to the recordings on PSI’s website) and the corresponding outcome report Insights that Ignite from the Series

RESOURCES ON SPECIFIC SELF-CARE INTERVENTIONS

### Safe Abortion


### DMPA-SC


**Emergency Contraception**


**RESOURCES ON DIGITAL HEALTH INTERVENTIONS**


**RESOURCES ON SELF-CARE IN HUMANITARIAN AND FRAGILE SETTINGS**


2. **Inter-Agency Working Group (IAWG) on Reproductive Health in Crises.** Minimum Initial Service Package (MISP) for SRH in Crisis Situations. Available here: www.unfpa.org/resources/minimum-initial-service-package-misp-srh-crisis-situations


SELF-CARE PROJECTS AND WEBSITES

1. DISC (Delivering Innovation in Self-Care) Project - www.psi.org/project/disc/  https://www.psi.org/project/disc
2. DMPA-SC Resource Library - fpoptions.org
5. Nivi Website - Conversations that create connections - www.nivi.io
6. Research for Scalable Solutions (R4S) - www.fhi360.org/projects/research-scalable-solutions-r4s
8. Self-Care Trailblazer Group (SCTG) - www.psi.org/project/self-care
10. Teleaborto - teleaborto.org
11. The United Nations Digital Solutions Centre (UN DSC) - www.un-dsc.org
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