STATE OF SELF-CARE REPORT

2025

SELF-CARE IN A CHANGING WORLD

SELF-CARE
TRAILBLAZER
GROUP

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Most of all, thank you to all the self-care champions, those working tirelessly every day in communities, clinics, coalitions, and capitals to expand choice and agency in how people achieve health and well-being through access to self-care as part of the health system.

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ACRONYMS AND ABBREVIATIONS

AC	Access Collaborative
AGYW	Adolescent girls and young women
ALP	Association of Lady Pharmacists
ANC	Antenatal care
ART	Antiretroviral therapy
ASHA	Accredited social health activists
CEI	Client exit interviews
CHV	Community health volunteers
CHW	Community health worker
CIFF	Children's Investment Fund Foundation
CIP	Costed Implementation Plan
CPR	Contraceptive prevalence rate
DCE	Discrete choice experiment
DISC	Delivering Innovation in Self-Care
DMPA	Depot medroxyprogesterone acetate
DPP	Dual prevention pill
EC	Emergency contraceptive
EFA	Exploratory factor analysis
FP	Family planning
HIP	High Impact Practices
HIVST	HIV self-testing
IDI	In-depth interviews
KII	Key informant interviews
LARC	Long-acting reversible contraceptives
LCA	Latent class analysis
LHW	Lady Health Workers
LMIC	Low- and middle-income country
MA	Medication abortion
MOH	Ministry of Health
MWAN	Medical Women's Association of Nigeria
NACHPN	National Association of Community Health Practitioners of Nigeria
NIPS	National Institute of Population Studies
OCP	Oral contraceptive pill
PEP	Post-exposure prophylaxis
PMA	Performance Monitoring for Action
PrEP	Pre-exposure prophylaxis
PSI	Population Services International
PWD	Population welfare department
RCT	Randomized controlled trial
RHNK	Reproductive Health Network in Kenya
SCARU	Self-Care Academic Research Unit
SCCG	Self-Care Core Group
SCTG	Self-Care Trailblazer Group
SEA	Southeast Asia
SES	Socioeconomic status
SI	Self-injection
SMA	Self-managed abortion
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
SRMH	Sexual, reproductive, and maternal health
STI	Sexually transmitted infections
UHC	Universal Health Coverage
USAID	US Agency for International Development
WHO	World Health Organization

FOREWORD

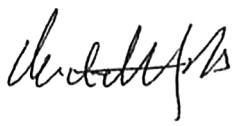
The global health system is experiencing an increasing amount of stress. Despite decades of progress, billions of people continue to be denied access to critical health services. Many others are held back by barriers such as stigma, cost, distance, and insufficient resources. As donor priorities shift and development assistance for health stagnates, numerous low- and middle-income countries face mounting risks of funding gaps for essential health services, including vaccines, HIV treatment, contraception, and maternal health services.

The stakes could not be higher. When external funding contracts, the swift unraveling of hard-won advancements in disease control and survival can occur with alarming speed. Simultaneously, the increasing burdens of noncommunicable diseases, persistent infectious diseases, and emerging health threats demand new approaches to delivering care. Without innovation, the repercussions are not limited to the deterioration of health outcomes but eroded public trust, widening inequities, and weakened resilience in the face of future crises.

Against this backdrop, self-care has emerged as a powerful complementary strategy to resolve these gaps. Self-care is defined by WHO as the ability of individuals, families and communities to promote health, prevent disease, maintain well-being, and manage illness and disability with or without the support of a health worker. Self-care empowers individuals to monitor chronic conditions, manage fertility, prevent infections, and support mental well-being. Self-care is improved by innovations such as HIV self-tests, self-administered contraception, human papillomavirus (HPV) self-sampling, and digital health applications, which have a particularly positive impact on the privacy, autonomy, and convenience of women, youth, and individuals in hard-to-reach or crisis settings.

Building on the 2023 report, this 2025 State of Self-Care report charts this next phase of progress. It captures the lessons learned from policy to implementation. It outlines the policy, regulatory and financing changes necessary to mainstream self-care into the health system. This edition goes further than the previous report by emphasizing the significance of incorporating self-care into national health systems, ensuring safety, regulation, and equitable digital access. It aligns with global commitments to Universal Health Coverage (UHC) and the Sustainable Development Goals, and with other global and regional strategies, such as the UN's 2023 Political Declaration on Universal Health Coverage and WHO's self-care guidance. It reinforces a central truth: self-care is not a replacement for provider-led healthcare, but rather a critical and complementary component of resilient, people-centered systems.

Looking to the future, the path is clear. It is imperative that we take decisive actions to advocate for governments, partners, and communities to prioritize domestic investment, strengthen digital infrastructure, assure regulatory oversight, and support local manufacturing of self-care commodities. These measures will enable us to expand the availability of safe, affordable, and accessible self-care interventions that augment and extend formal healthcare systems. We urge all stakeholders, including policymakers, health providers, development partners, and communities, to prioritize self-care as a critical component of strengthening health systems. Self-care can be established as a fundamental component of UHC and a means to enhance the health and well-being of all individuals by utilizing collective action, innovation, and tradition.



Michael Holscher

President
Population Services International

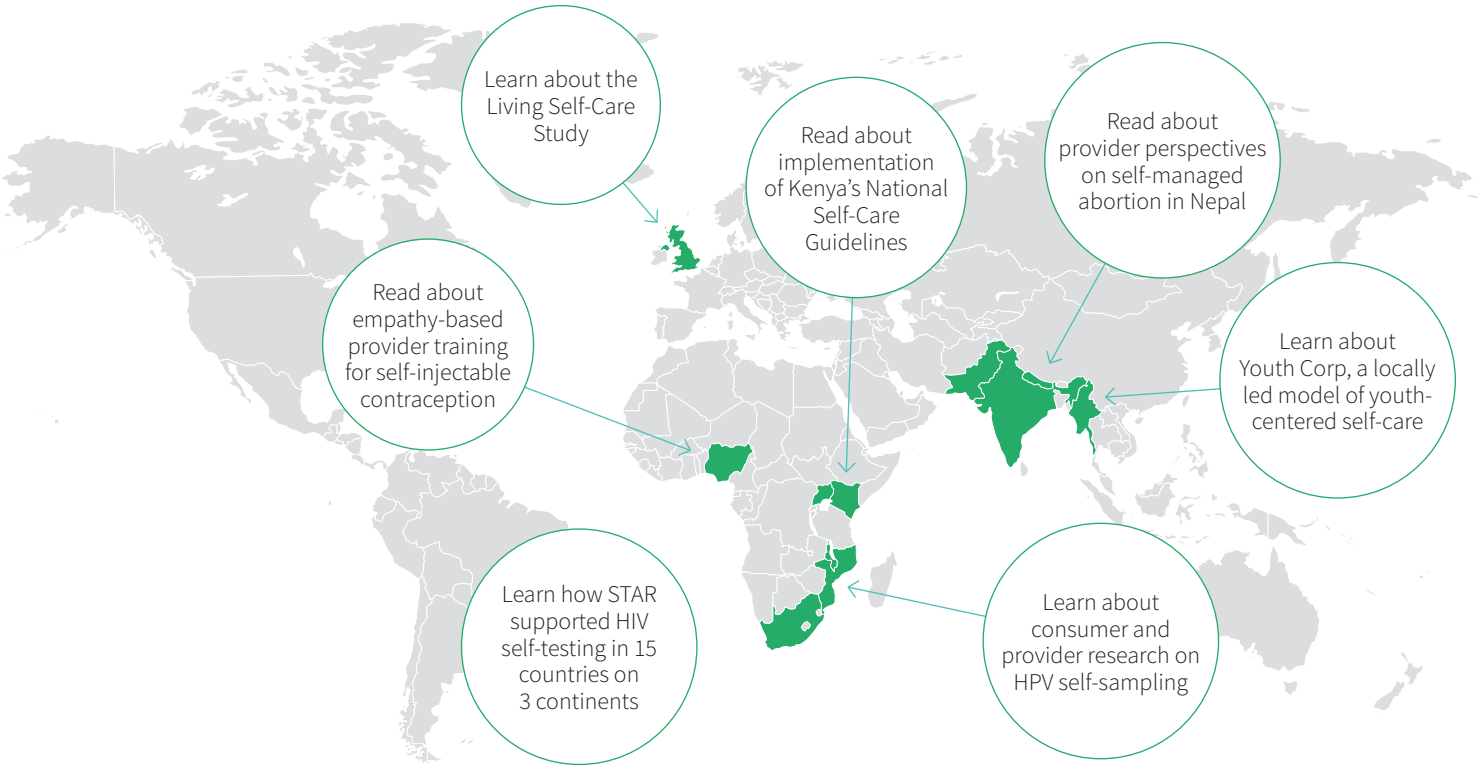
EXECUTIVE SUMMARY

Self-care is the ability of individuals, families and communities to promote health, prevent disease, maintain health, and cope with illness and disability with or without the support of a healthcare provider. In the global health context it encompasses a broad spectrum of actions including daily lifestyle choices, such as a healthy diet and exercise, self-administration of medicines, and self-managed use of diagnostic tools and digital technologies.[1] The evolving global health context and shifting priorities in sexual and reproductive health (SRH) and rights make self-care a particularly timely response to current circumstances. The COVID-19 pandemic catalyzed innovation, demonstrating that health systems can rapidly adapt to new models of care.

Policy support for self-care has also accelerated. By 2023, 48 countries had adopted national self-care guidelines,[2] and by 2024, 107 countries had policies permitting HIV self-testing, reflecting growing political commitment.[3]

This report provides an update on the state of SRH self-care policy, practice, and evidence that can be used as a resource to strengthen self-care implementation and advocacy. In alignment with the focus of the Self-Care Trailblazer Group, this report focuses on self-care as it pertains to SRH and rights, inclusive of HIV, sexually transmitted infections, and maternal health and largely focuses on examples and experiences that are applicable to low- and middle-income countries (LMICs).

Map of case study highlights and locations



At the core of the report are 23 case studies and 3 spotlights on research and data that give voice to self-care practitioners, researchers, and advocates across the world (see map). Additional content was informed by desk reviews of recent research literature, policy documents, and other grey literature describing recent advances and innovations in self-care. As this report serves as an update to the 2023 State of Self-Care Report, we focus on new developments in self-care from 2023 through 2025.

DEVELOPMENTS IN SELF-CARE GUIDANCE AND PRODUCT INNOVATIONS

Since publication of the 2023 State of Self-Care Report, several key developments in global guidance related to self-care have occurred, including WHO's Self-care competency framework for healthcare workers and Implementation of self-care interventions for health and well-being: guidance for health systems. Recent developments also signal an increasing focus on generating evidence while also moving toward pragmatic applications of evidence through implementation, demonstrating progress in advancing along the evidence-to-practice continuum.

From 2023 onward, numerous self-care products have received new or expanded regulatory approval or WHO prequalification. These products include the following:

- Blood-, saliva-, and urine-based HIV self-tests.
- Multiple HPV self-sampling devices.
- Self-tests for syphilis, chlamydia, gonorrhea, and trichomoniasis.
- A generic self-injectable contraceptive method (DMPA-SC).

UPDATES ON SELF-CARE POLICIES

- **Broad national policies on SRH self-care** are becoming increasingly common, including in LMICs. According to 2023 data, 42% of the 115 WHO member states reported a national policy or guideline on self-care interventions for SRH; most of these policies or guidelines included self-use of contraceptive methods; over-the-counter SRH products, devices, and diagnostics; and self-collection of samples for sexually transmitted infections and HIV screening.[2]
- The past several years have seen remarkable progress in national **HIV self-testing policy** and routine implementation. According to WHO tracking, as of 2024, 107 countries had supportive HIV self-testing policies, a nearly three-fold increase since 2019—another 25 countries are in the process of developing HIV self-testing policies.[3] Of countries with policies in place, 71 reported routine implementation of HIV self-testing, a five-fold increase since 2019.[3]
- **HPV self-sampling** is still a developing area for self-care policy, particularly in LMICs. A 2022 publication identified only 17 countries that included HPV self-sampling in their national screening programs, of which 11 are LMICs.[4] About half of these countries recommend self-sampling only for under-screened populations. Eight more countries are piloting HPV self-sampling to inform decisions about incorporating it into national screening guidelines.

REFLECTIONS ON THE EVIDENCE

The case studies included in this report and other recently published research indicate that what works in self-care depends on local and regional contexts, from community social norms that affect acceptability and uptake all the way up to the structure of national health systems, regulatory frameworks, and national political pressures.

PEOPLE AND COMMUNITIES

- Case studies in a variety of settings address the need to understand why and when people use

SRH self-care, including research on preferences for new contraceptive methods in multiple African countries and new data from the United Kingdom from the Living Self-Care Study.
- Digital self-care interventions and approaches are expected to become increasingly important in the SRH self-care landscape. Though a key learning priority, evidence related to their acceptability, uptake, and effectiveness in LMICs remains scarce.
- Robust evidence on self-care acceptability and uptake by specific populations is critical to ensure equity and optimal use of resources.

HEALTHCARE PROFESSIONALS AND SERVICE PROVIDERS

- Understanding how to make self-care more acceptable to providers has been identified as a key learning need[5] to facilitate self-care advocacy efforts and uptake in professional practice. A case study in Nigeria describes efforts to engage professional associations to better understand their concerns about self-care and engage them with self-care advocacy efforts.
- Ensuring long-term effectiveness and retention of knowledge and skills for provider-based interventions to promote self-care has been identified as an evidence need for DMPA-SC trainings.[6] New evidence from an evaluation of the Delivering Innovation in Self-Care project provides evidence for an approach that included supportive supervision in the maintenance phase of the intervention to train providers on self-injectable contraception.

SELF-CARE POLICY AND IMPLEMENTATION

- Given the scarcity of general self-care policies in LMICs and the recency of many national policies related to individual self-care interventions, evidence on policy implementation and effectiveness is limited.
- Evidence needs on cost-effectiveness and optimal delivery models have been identified across SRH self-care products and approaches in the research literature[7-11] and by self-care stakeholders.[5] In this report we highlight two key contributions to this evidence area related to HIV self-testing and self-injectable contraception, yet more research is needed to demonstrate costs at both the individual and health system levels under various financing strategies.
- Finally, recent research has called for more evidence on effectiveness of self-care.[12-14] As self-care is introduced and scaled up, investing in rigorous research to track and understand self-care outcomes will be critical.

CONCLUSION

The coming years will continue to test the resilience of national health systems as public budgets contract and donors shift their priorities. Climate- and disease-related shocks bring added challenges. In this challenging context, self-care can expand choice and agency if integrated strategically and accompanied by deliberate investment, robust regulation, and thoughtful community engagement. Leveraging promising innovations and drawing on the substantial progress in policy, implementation, and evidence in recent years, countries and coalitions can advance self-care in ways that enhance equity, enable sustainability, and open new paths to achieving universal health coverage and – ultimately – better health.

INTRODUCTION

WHAT IS SELF-CARE?

Simply put, self-care is the ability of individuals, families and communities to promote health, prevent disease, maintain health, and cope with illness and disability with or without the support of a healthcare provider.[1] In the global health context, self-care encompasses a broad spectrum of actions ranging from daily lifestyle choices, such as a healthy diet and exercise, to self-administration of medicines and self-managed use of diagnostic tools and digital technologies.[1] Self-care interventions are tools that support self-care—including drugs, devices, diagnostics and digital interventions—that can be provided fully or partially outside formal health services and be used with or without a health worker.[1]

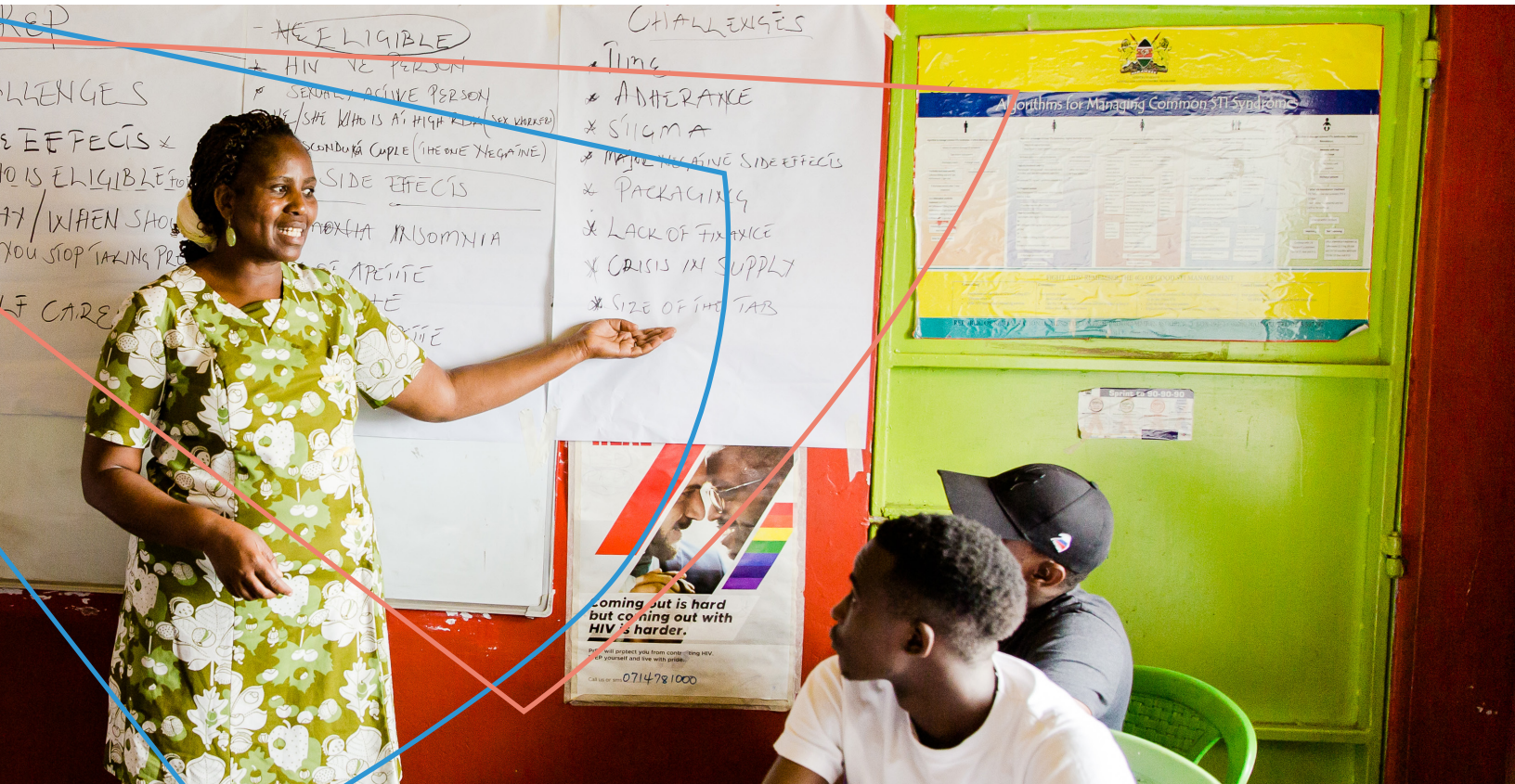
Self-care delivered in accordance with WHO guidelines is **not** a replacement for services delivered by the health system; rather it is an extension of the health system that expands access to care and options for when, how, and where to access healthcare. When integrated into national health systems and supported by regulatory oversight, self-care can drive progress toward universal health coverage (UHC) by expanding the reach of services. It can also be particularly relevant for populations who face barriers, whether physical, economic, social, or cultural, to accessing facility-based services.

GLOBAL CONTEXT FOR SELF CARE

The evolving global health context and shifting priorities in sexual and reproductive health and rights (SRHR) make self-care a particularly timely response to current circumstances.

PANDEMIC IMPACTS AND ADAPTATIONS

The COVID-19 pandemic fundamentally altered health-seeking behaviors and accelerated the adoption of



self-care practices.[15] Lockdowns, travel restrictions, and fear of infection prompted people to seek care outside of clinical settings. Pharmacies, community health workers (CHWs), and digital platforms became vital sources of information, products, and services. For example, self-injectable contraception and HIV self-testing (HIVST) kits allowed people to diagnose and manage multiple aspects of sexual and reproductive health (SRH) while reducing or eliminating clinic visits entirely.[16] Pharmacists and CHWs provided drive-through service delivery, teleconsultations, and community- or mail-based delivery of medications, illustrating how health systems adapted to ensure continuity of care.[17] Digital health innovations, including mobile apps, telemedicine platforms, chatbots, and remote monitoring devices, expanded rapidly. These technologies enabled self-care by connecting users to accurate information, decision support tools, virtual counseling, and remote diagnosis. Five years after the pandemic began, many of these adaptations have been integrated into routine care and continue to expand access to care.

MAJOR SHIFTS IN FOREIGN ASSISTANCE

Changing donor priorities in recent years have resulted in a dwindling of global health assistance. The dismantling of the US Agency for International Development (USAID), which had previously provided 40% of global assistance for family planning;[18] the termination of many US-supported HIV/AIDS projects;[19] and reductions in bilateral aid from European donors, including the governments of Belgium, France, Germany, the Netherlands, and Sweden,[20] are leading to intensified competition for already limited resources for health programs. Kenya, for example, relies on donors for more than half of its immunization, tuberculosis, and HIV funding;[21] as donors transition out, domestic budgets must stretch to fill the gap. Also, as lower-income countries graduate to middle-income status, donors expect them to assume more responsibility for health financing, creating a "donor transition" that can be abrupt and destabilizing.[21]

GROWING EMPHASIS ON AUTONOMY AND AGENCY RIGHTS

There have been growing calls in the field of SRHR to prioritize care that centers individuals' values, needs, and preferences, and that elevates individual autonomy and agency.[22] The World Health Organization (WHO) has developed guidelines and standards that go beyond measuring service availability to assessing whether care is respectful, non-discriminatory, and responsive to individual needs and preferences.[23] There is also growing recognition that marginalized groups, such as adolescents, people with disabilities, LGBTQ+ individuals, ethnic minorities, and those living in poverty, face compounded barriers to SRHR services, alongside a growing emphasis on identifying and addressing these intersecting forms of discrimination and exclusion.[24]

OPPORTUNITIES IN A CHANGING WORLD

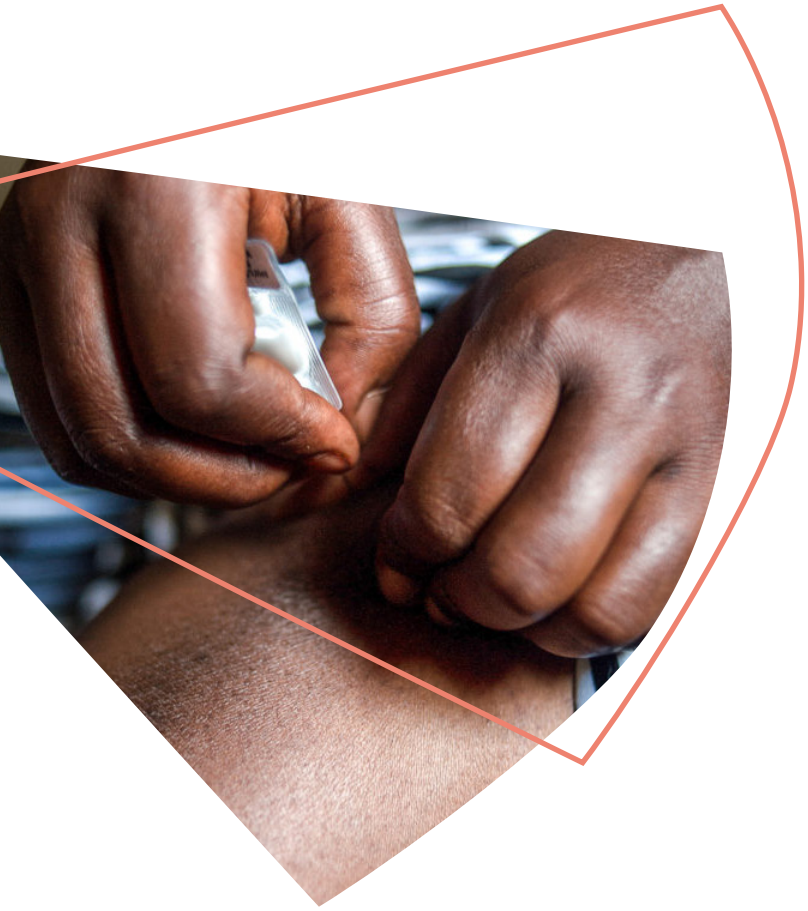
Against this backdrop, self-care should be seen as a priority area for investment in health systems—one that can significantly expand the reach of programs while offering cost efficiencies and expanding the agency of users.

Self-care interventions can expand the reach of programs and coverage of underserved populations who might otherwise avoid facility-based services, as has been shown with tools such as HIVST[25] and HPV self-sampling. Task shifting policies in countries such as Kenya, Nigeria, Senegal, and Uganda allow CHWs and pharmacists to provide self-care services, helping to reach underserved communities.[16] Self-care interventions can also increase the reach of programs in fragile and humanitarian settings that face shortages in trained health workers and weak health infrastructures.[26, 27]

It is also possible that clients who are already empowered and those who are not marginalized will be more likely to take advantage of self-care programs. This can nevertheless serve to reduce burdens on the health

system, and free up resources for delivering in-person care to patients with more complex needs or those who are not equipped to use self-care.

Self-care interventions can reduce costs and increase efficiencies. By shifting simple tasks, such as administering contraception or testing for infections, into the hands of users, health systems may be able to reallocate scarce personnel to more complex care. Self-care products and approaches can also reduce costs to users, even in systems where care is free in the public sector, by reducing or eliminating costs of traveling to facilities and opportunity costs related to lost productivity and income. Efficiency can also be gained in cost savings to the system and to users by encouraging primary and secondary prevention through self-care and avoiding higher long-term costs of treating more advanced conditions or morbidities. Integrating self-care into health insurance schemes and national budgets can help ensure that costs are not shifted onto individuals and ensure that self-care complements rather than substitutes publicly financed health services.[16]



Further, self-care interventions can enhance individual agency. Self-injectable contraception, for example, facilitates private, self-directed use. For example, both HIVST and self-injectable contraception allow people to use the product privately, at their preferred location, and on their own timelines. Self-managed abortion, when offered in alignment with WHO guidelines,[28] can allow users to overcome care-seeking barriers, which can be particularly salient for stigmatized health services or conditions. Self-care can also lead to an increased sense of empowerment,[29] which can have broader positive effects on health and well-being.

But these benefits are not automatically realized through self-care programs. For example, digital self-care innovations have the potential to democratize access to health information and services, but they also risk widening digital divides. Affordable internet connection, literacy, easy-to-use technology, and privacy safeguards are essential to maximizing benefits of digital self-care products and approaches. Careful attention to who can access self-care and at what cost are imperative to ensure that self-care improves health for all, particularly those with the greatest needs, and not just for those who are already privileged within the healthcare system.

LEVERAGING MOMENTUM

The current moment offers unprecedented opportunities to leverage self-care for global health. The COVID-19 pandemic catalyzed innovation, demonstrating that health systems can rapidly adapt to new models of care. Policy support for self-care has also accelerated. By 2023, 48 countries had adopted national self-care guidelines,[2] and by 2024, 107 countries had policies permitting HIV self-testing, reflecting growing political commitment.[3]

Membership in the Self-Care Trailblazer Group (SCTG) has grown substantially in recent years, with nearly 1,070 individuals across 485 organizations, of whom 62 percent were members from the Global South.[30] This network expansion has come with increased

opportunities for advocacy, learning, and resource mobilization. The SCTG and partners have developed global goods such as a Self-Care Social Behavior Change framework, a Self-Care Policy Mapping tool, and a Self-Care Costing and Financing framework that can guide national action.[30] These tools can help countries institutionalize self-care, align with UHC and gender equality commitments, and mobilize diverse funding sources, including domestic budgets, private sector investment, and philanthropic contributions.

Private sector interest is also rising, with pharmaceutical companies and digital health start-ups investing in self-care products and services, from over-the-counter medicines to smartphone applications that support fertility tracking, mental health management, and chronic disease management and monitoring. Governments are increasingly integrating self-care into national strategies and insurance schemes. The Global Self-Care Federation projects that scaling self-care will enhance health outcomes and deliver substantial economic and productivity gains, as people are more able to manage minor conditions without taking time away from work.[31] Looking ahead, self-care can support climate resilience by reducing travel to health facilities; contributing to pandemic preparedness; and advancing UHC and One Health agendas. Harnessing these opportunities requires continued investment in research, digital infrastructure, regulation, and community engagement. Self-care can transform health systems and empower individuals in a rapidly changing world by centering equity and rights, building supportive policies, and ensuring sustainable financing.

AIM AND SCOPE OF THIS REPORT

The aim of the report is to provide an update on the state of SRH self-care policy, practice, and evidence that can be used as a resource to strengthen self-care implementation and advocacy. This report serves as an update to State of Self-Care Report published in 2023 by the SCTG.[32] In alignment with the focus of the SCTG, this report focuses on self-care as it pertains to SRHR, inclusive of HIV, sexually transmitted infections (STIs), and maternal health and largely focuses on examples and experiences that are applicable to low- and middle-income countries (LMICs).

METHODOLOGY

At the core of this report are case studies, data spotlights, and research spotlights that give voice to self-care practitioners, researchers, and advocates across the world, within and beyond SCTG's coalition. Additional content was informed by desk reviews of recent research literature, analysis using global data sets, policy documents, and other grey literature describing recent advances and innovations in self-care. As this report serves as an update to the 2023 State of Self-Care Report, we focus on new publications and other updates from 2023 through 2025.

The development of this report was guided by a steering committee comprising members of the SCTG's Evidence and Learning Working Group. Committee members provided guidance throughout the conceptualization and content development and review of the report and are listed in the acknowledgements section of this report.

Structured desk reviews were conducted to identify SRH self-care research related to service provision and self-care policy from 2023 onward, as these were identified as two emerging research areas. References for the desk reviews were identified through searches in PubMed and targeted searches using Google Scholar and Perplexity, an AI-powered search tool that is particularly useful for identifying grey literature sources. All references were read and interpreted without the assistance of AI tools.

Case studies describing research, program learnings, advocacy experiences, and testimonials from self-care users and providers were solicited through targeted outreach to the self-care community of practice.

Case studies were peer-reviewed by members of the steering committee. Data and research spotlights were also developed for the report to provide snapshots of various dimensions of the state of self-care where data are available.

The report is structured to provide updates on different aspects of the state of self-care, with case studies and data or research spotlights included at the end of each chapter when relevant. First, we provide an update on recent developments in global self-care guidance and regulatory updates. The next three chapters examine self-care from different perspectives: keeping people and communities at the center of self-care, understanding perspectives of healthcare professionals and service providers, and advancing self-care through policy and system-level change. Finally, we provide reflections on the evidence base and conclude by looking ahead at what comes next for self-care in the context of constrained resources for health.

UPDATES ON GLOBAL SELF-CARE GUIDANCE AND PRODUCTS

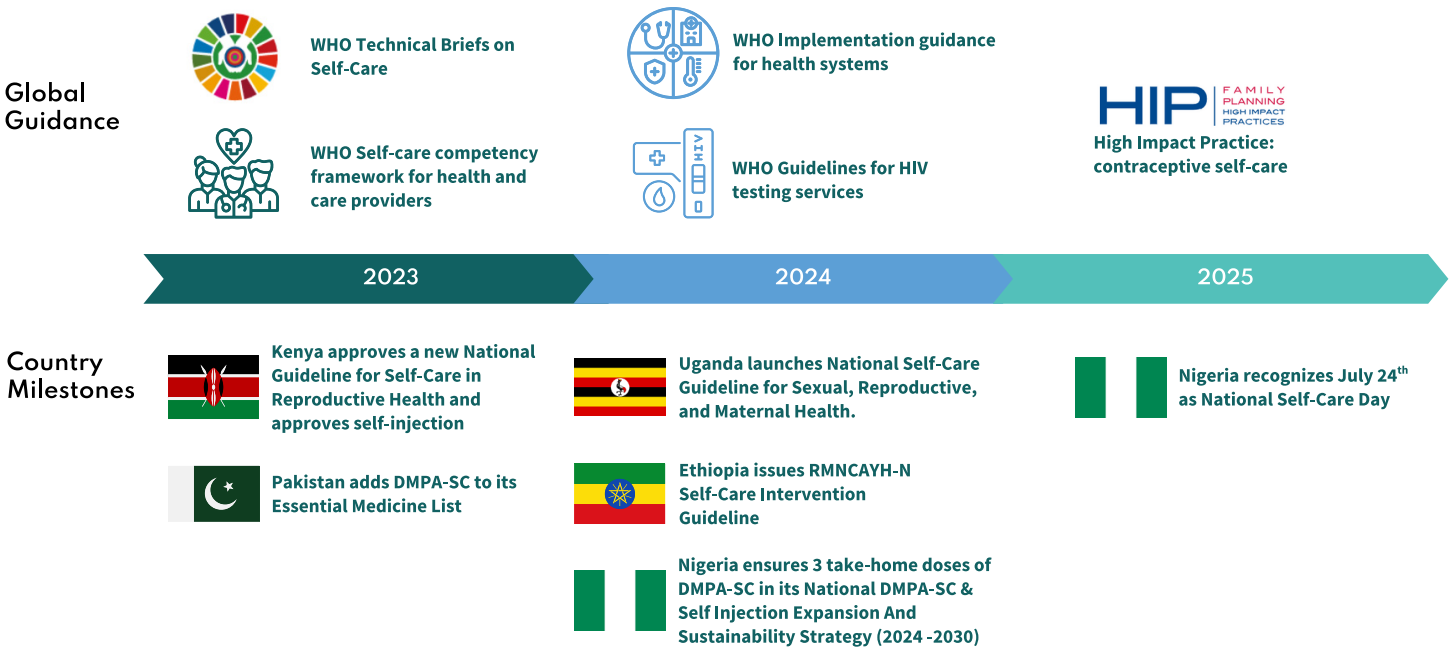
Since publication of the 2023 State of Self-Care Report, several key developments have emerged in guidance that applies broadly across SRH self-care. These new and updated resources expand guidance to cover a broader range of interventions. They also support the development of programmatic and policy-relevant tools that uphold quality and competency standards, ensuring that self-care is supported by the formal health system rather than practiced outside of its bounds. Recent developments signal two trends: a growing evidence base and meaningful progress in bridging research and implementation. Recent developments also signal an increasing focus on generating evidence while also moving toward pragmatic applications of evidence through implementation, demonstrating progress in advancing along the evidence-to-practice continuum (see timeline).

SELF-CARE GUIDANCE FROM THE WORLD HEALTH ORGANIZATION

Since the publication of the 2022 revision of its guideline on *self-care interventions for health and well-being*, WHO has continued to produce and disseminate guidance documents and technical resources related to self-care to support upwards of 50 countries that are working to adopt the guideline. A 2025 *communications toolkit* for self-care interventions for health and well-being conveniently summarizes WHO's technical and communication resources related to dissemination of the self-care guideline. Key guidance documents published from 2023 onward are summarized below.

Technical briefs from the 2022 guideline revision provide an accessible summary of individual self-care recommendations. Briefs on *HPV self-sampling*, *over-the counter emergency contraception*, and *availability of*

Updates on global guidance and country-level milestones for SRH self-care, 2023-2025



lubricants during sexual activity were published in 2023 and join those published in 2022 on *self-administration of injectable contraception*, *self-management of medical abortion*, and *self-collection of samples for sexually transmitted infections*.

Also published in 2023, WHO's three-volume self-care competency framework for healthcare workers to support people's self-care includes *global competency standards*, a *knowledge guide*, and a *curriculum guide*. This publication sets ten standards for supporting self-care in professional practice. The curriculum guide serves as an actionable resource to guide the development of competency-based training for healthcare workers.

In 2024, WHO published a guidance document for health systems on *implementation of self-care interventions for health and well-being* to support countries working to adopt the self-care guideline. It provides guidance on implementation considerations across the health workforce, service delivery, leadership and governance, medical products and technologies, and financing. It also addresses the need for accompanying self-care scale-up with implementation research and a robust monitoring and evaluation framework.

GUIDANCE AND REGULATORY UPDATES FOR SELF-CARE PRODUCTS

REGULATORY APPROVALS AND WHO PREQUALIFICATIONS

From 2023 onward, a variety of self-care products have advanced in the product development pipeline, including STI self-tests, HPV self-sampling devices, new contraceptive methods, and more.

Selected regulatory updates for self-care products from the US Food and Drug Administration and other regulatory authorities from 2023-2025

Year	Regulatory authority	Product/intervention	Regulatory update
2023	US FDA	Medication abortion	REMS modification removes in-person dispensing requirement for mifepristone
2023	US FDA	Daily progestin-only contraceptive pill (Opill)	Approved for use without a prescription (over-the-counter)
2023	US FDA	Chlamydia and gonorrhea self-sampling (Simple 2 Test)	Approved for use at home
2023	Australia TGA	Medication abortion	Eliminated requirement for doctors and pharmacists to be certified/registered to prescribe MA drugs
2024	US FDA	Reusable menstrual cup with applicator (Sunny Cup and Applicator)	Approved
2024	US FDA	HIV self-test (OraQuick)	Approval expanded to include ages 14-17
2024	US FDA	HPV self-sampling (Onclarity HPV and cobas HPV)	Approved for use in healthcare settings
2024	US FDA	Syphilis self-test (First To Know Syphilis Test)	Approved for use at home
2025	US FDA	HPV self-sampling (Teal Wand)	Approved for use at home
2025	US FDA	Self-test for chlamydia, gonorrhea, and trichomoniasis (Visby Medical Women's Sexual Health Test)	Approved for use at home
2025	US FDA	Rapid HIV self-test (INSTI HIV Self Test)	Approved

REMS: Risk Evaluation and Mitigation Strategies; TGA: Australian Therapeutic Goods Administration; MA: Medication abortion.

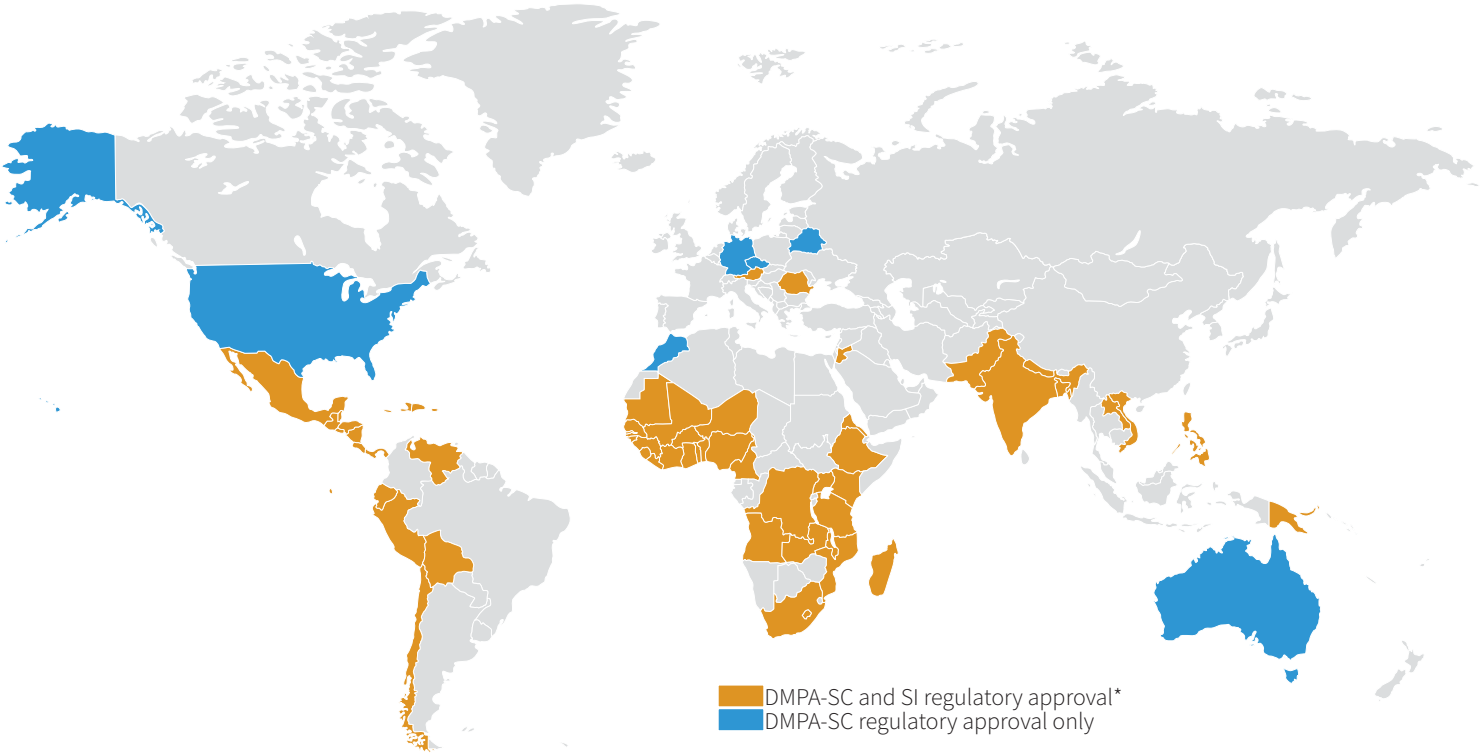
Selected WHO prequalified self-care diagnostics from 2023-2025

Year	Product	Regulatory update
2024	Cobas HPV (Roche)	HPV test compatible with self-collected vaginal samples
2025	Advanced Quality HIV Self-Test (InTec Products)	Blood-based HIV self-test
2025	HIV Self-test by urine (Wantai BioPharm)	Urine-based HIV self-test
2025	Medogen SubQ (Incepta Pharmaceuticals)	Generic DMPA-SC

CONTRACEPTIVE METHODS

Recent studies and clinical trials have investigated several potential contraceptive self-care products that are not yet on the market. These products include a non-hormonal monthly intravaginal device (Ovaprene) that is currently undergoing Phase 3 clinical trials,[33] pericoital oral contraceptive pills (*see case study on page 15*), and a dual prevention pill for pregnancy prevention and HIV pre-exposure prophylaxis (PrEP) (*see case study on page 18*).

DMPA-SC and self-injection registration status



*Includes countries where registration is not required that have placed an order since Jan 2024

Implementation and availability of self-injectable contraception have steadily expanded in recent years, with several key recent developments. In 2025, a generic subcutaneous injectable contraceptive product (manufactured by Incepta) was added to UNFPA's procurement catalogue[34] and to WHO's prequalified list,[35] marking the first available generic self-injectable contraceptive method and opening up possibilities for expanding access to the method, potentially at lower price points.

Oral contraceptive pills are available over the counter in more than 100 countries, largely in LMICs.[36] In 2023, the United States joined this list of countries, with the FDA approving use of a daily progestin-only contraceptive pill (Opill) without a prescription. After more than a year of availability in United States retailers, questions remain regarding access, affordability, and uptake,[37] as well as implications in countries outside of the United States. Although this latest approval expands access only to a single oral contraceptive pill (OCP) method in the United States, and not the broader range of combined oral contraceptive pills that are more widely used, it marks a major symbolic milestone in advancing toward over-the-counter access to oral contraceptive pills in alignment with the WHO self-care recommendation.

The Family Planning High Impact Practices (HIPs) partnership developed and published a brief on contraceptive self-care in 2025.[38] The HIP briefs provide programmatic and policy guidance based on reviews of research literature and expert input.[39] The contraceptive self-care HIP enhancement brief presents a contraceptive self-care theory of change, summarizes the evidence on how self-care supports family planning, and shares learnings from implementation experiences.

HIV SELF-TESTING

Several HIVSTs passed key regulatory milestones. In 2024, the United States FDA expanded approval of the OraQuick self-test for use among people ages 14-17 from the previous approval for people ages 18 and older and in 2025, the FDA granted premarket approval to the INSTI HIV Self Test, which provides results instantly.[40] New WHO prequalifications in 2025 included a blood-based HIVST (Advanced Quality HIV self-test) and the first urine-based HIVST (Wantai HIV self-test by urine).[41, 42]

In 2024, WHO released a new version of its *Consolidated guidelines on differentiated HIV testing services*, making a specific effort to integrate the latest version of the 2022 self-care guideline.[1] As such, several key updates pertain to HIV self-testing and syphilis self-testing. The guidelines expand the recommendation for routine use of HIV self-testing within healthcare facilities, including for initiation and continuation of PrEP.

In 2025, WHO and Population Services International (PSI) released the *Facility based HIV Self-testing Implementation Toolkit and Training Modules*. Facility-based HIVST—the provision of HIVST within healthcare settings—has emerged as an effective strategy to expand testing uptake and improve access, particularly in resource-constrained environments and facilities with limited human resources. By enabling individuals to conduct the test themselves, facility-based HIVST enhances convenience, reduces stigma-related barriers, and supports more person-centered service delivery. The training modules provide a practical and adaptable toolkit to support the orientation and training of health workers in implementing and scaling up facility-based HIVST across diverse healthcare settings.

HPV SELF-SAMPLING

Though HPV self-sampling has been piloted and implemented at a national level in at least 17 countries over the past decade,[4] a major recent development in HPV self-sampling was the first approval by the United States FDA of HPV self-sampling devices. In 2024, the FDA approved two HPV self-sampling devices (Onclarity HPV and cobas HPV) for use in healthcare settings. HPV self-sampling options expanded in 2025, with FDA approval of a self-sampling device (Teal Wand) for home-based use.

Following the 2024 FDA approval of HPV testing of clinic-based self-collected samples, the US-based Enduring Consensus Cervical Cancer Screening and Management Guidelines Committee published *recommendations* in 2025 for HPV testing using self-collected samples.[43] These recommendations advise limiting use only to assays and collection devices that have been FDA-approved, and they recommend use only among people who are average-risk and asymptomatic.

The WHO guideline for cervical cancer screening and treatment, published in 2021, recommends HPV DNA testing as a preferred method for screening and endorses the use of self-sampling both in the general population and among people with HIV.[44] The WHO guideline also notes the higher burden of cervical cancer among people with HIV, a particular concern given that the 2025 Enduring Guidelines do not recommend self-collection for people with HIV because of insufficient data and in line with guidelines from the US Centers for Disease Control and Prevention (CDC) that people with HIV should undergo screening with cytology.[43,45] As noted in the 2025 review, however, optimal cervical cancer screening protocols for high-income countries, including that proposed by the Enduring Guidelines, may differ from those most effective in LMIC settings.[46]

As of 2022, LMICs that officially recommend HPV self-sampling included three in Africa (Kenya, Rwanda, and Uganda), five in the Americas (Argentina, Ecuador, Guatemala, Peru, and Honduras), and two in Asia (Malaysia and Myanmar).[4] More recent research has laid the groundwork for scale-up of HPV self-sampling and potential introduction of self-testing in Mozambique (*see research spotlight on page 11*) and could serve as a model for other countries.

SELF-TESTING FOR SEXUALLY TRANSMITTED INFECTIONS

Progress in bringing self-care diagnostics for STIs to market has been substantial. In 2023, a mail-in self-sampling kit for chlamydia and gonorrhea (Simple 2 Test) was approved by the US FDA, marking the first approval of a home-based diagnostic for an STI other than HIV.[47] The following year, a home-based self-test for syphilis (First to Know) was approved,[48] followed by 2025 approval of a single self-test for chlamydia, gonorrhea, and trichomoniasis (Visby Medical Women's Sexual Health Test).[49] Updates to the WHO's 2024 *Consolidated guidelines on differentiated HIV testing services* included a new recommendations for syphilis self-testing, including dual HIV/syphilis self-tests, as an option for syphilis testing. No STI self-tests have been prequalified by the WHO, aside from HIV self-tests.[42, 50] Although self-tests and self-sampling options for STIs other than HIV are not generally available in LMICs, lessons learned from the scale-up of HIVST along with experiences with developing and deploying COVID-19 self-tests are expected to facilitate implementation of STI self-testing in the coming years.[13]

SPOTLIGHT: END USER AND PROVIDER RESEARCH TO INFORM PERSON-CENTERED HPV SELF-SAMPLING AND RAPID SELF-TESTING KIT DESIGN AND SERVICE DELIVERY IN MOZAMBIQUE

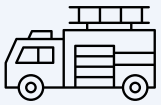
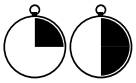
Author: Kristen Little
Affiliation: Population Services International

Cervical cancer screening and treatment are an important component of women's SRH. Though cervical cancer is a prominent cause of cancer and cancer-related deaths among women globally, the burden is highest in LMIC settings. In Mozambique, cervical cancer is the leading cause of cancer-related death among women. Limited access to HPV vaccination, cervical cancer screening, and treatment means that women are often diagnosed at late stages of disease (if they are diagnosed at all) and experience worse outcomes. Expanding access to screening is essential to reducing the burden of cervical cancer in Mozambique and other LMICs. New approaches and technologies such as lower cost HPV testing platforms, the option to self-sample (rather than have provider collection during a pelvic exam), and potentially HPV self-test kits (which, if developed, could allow women to both self-collect their sample and perform the rapid HPV test themselves, with or without the support of a healthcare provider), may help increase access, expand coverage, and improve outcomes. However, design and implementation of new cervical cancer screening interventions and service delivery models should be informed by end-user perspectives and preferences.

To date, limited data are available on women's preferences for cervical cancer screening service delivery features, including the option to self-collect, in LMIC settings. To address these knowledge gaps, PSI and our partners designed end user and provider research to inform person-centered HPV self-sampling and rapid self-testing kit design and service delivery in Mozambique. This study aimed to identify end user and provider preferences for HPV self-sampling and self-testing service delivery and experiential features, to better understand barriers/motivators to uptake, and to estimate willingness to pay among target end users. We also wanted to explore heterogeneity in preferences across different end-user segments, including differences by geography, age, marital status, and socioeconomic status (SES). The mixed-methods research included qualitative in-depth interviews (IDIs) with cervical cancer screening eligible adult women (ages 25-49) and key informant interviews (KIIs) with stakeholders and healthcare providers engaged in SRH service delivery, across in two provinces in Mozambique (Gaza and Maputo). We also conducted a quantitative survey with women eligible for screening who were receiving SRH services from participating health facilities, who completed a survey and discrete choice experiment about their screening, self-sampling, and HPV self-testing preferences.

Between October–November 2023, we recruited 606 women (Maputo n=304; Gaza n=302) for quantitative surveys, 40 women for IDIs, and 32 providers and 9 stakeholders for KIIs. Most quantitative survey respondents (96%) had heard of cervical cancer, though awareness was significantly higher in Maputo vs. Gaza (99.7% vs. 91.4%, $p < 0.001$), and substantially fewer women had previously heard of HPV (37%) or HPV testing (33%). The proportion of women who had ever undergone cervical cancer screening was relatively high in our survey sample (62%), and increased with age, from 42% among 25–29-year-olds to 82% among 45–49-year-olds ($p < 0.001$).

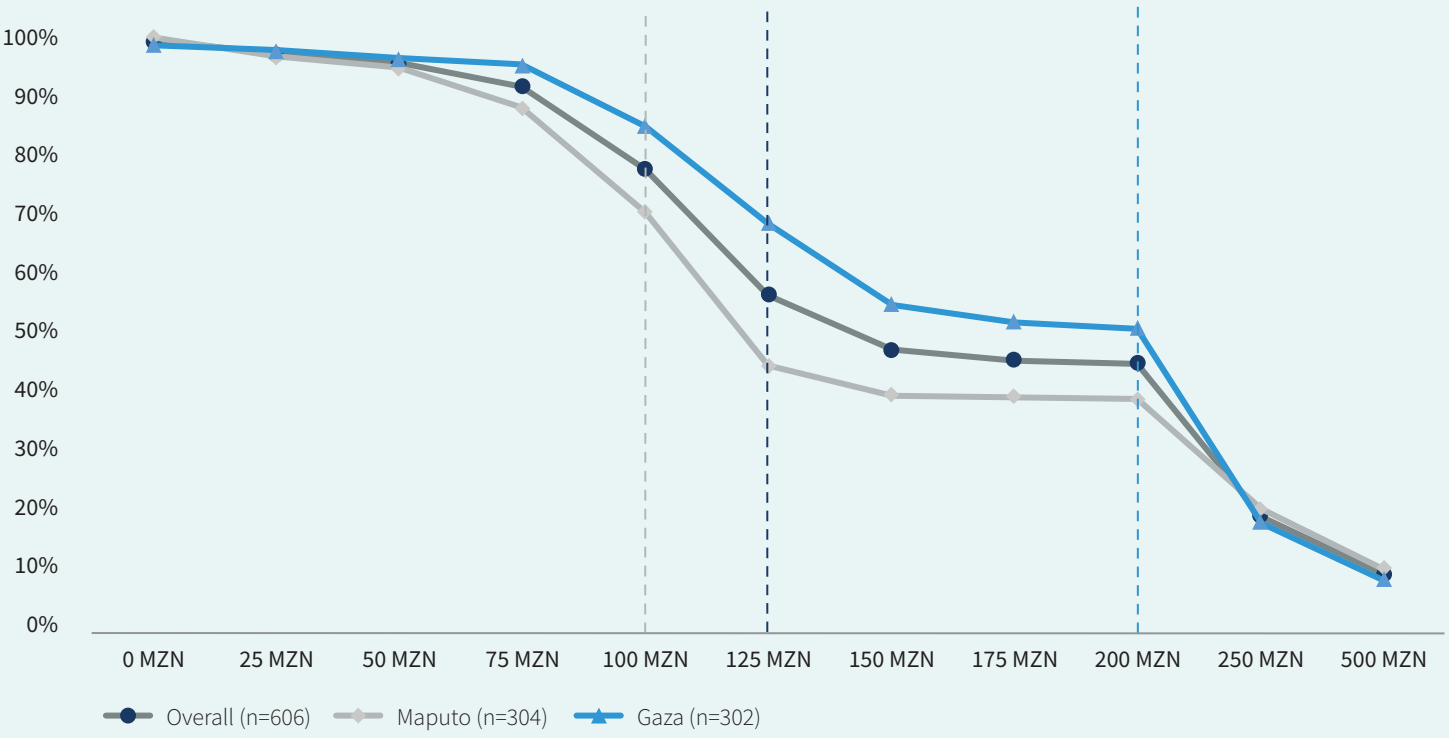
Attributes and Levels Tested During the Discrete Choice Experiment

Attribute	Level 1	Level 2	Level 3	Level 4
Where you get the test kit	Public sector health facility 	Private sector clinic/ pharmacy 	Delivery to home by community health worker (CHW) 	Mobile brigade 
How much the kit costs	Free	50 Meticals 	150 Meticals 	
Test kit instructions	One-on-one in-person session with healthcare provider 	Sent via WhatsApp (text/ images/video) 	In-person group session with CHWs 	
How long you have to wait for your results	15-30 min 	1-2 days 	3-4 days 	1 week 

Among screened women, only 18% of surveyed women reported disliking something about their experience, primarily feeling uncomfortable (78%) or a lack of privacy (15%). We found similar results during our IDIs, where women who had previously undergone screening described generally positive experiences, reporting that services were "easy," "fast," and "efficient." Providers mentioned Visual screening with Acetic Acid (VIA) as the primary screening tool in Mozambique. Providers and stakeholders identified several barriers to cervical cancer screening coverage included lack of equipment, staff, and materials. Other barriers included lack of awareness about the importance of screening among women, client fear, and limited privacy.

If HPV self-tests were made available in Mozambique, 96% of our survey respondents said they would be "likely" or "very likely" to use them. Significant predictors of product preference included location where the kit would be obtained (public facility vs. CHW utility ratio [UR]: 4.55, 95%CI: 3.82 5.42), cost (free vs. 150MZN UR: 1.91, 95%CI: 1.67 2.18), instructions (WhatsApp vs. a group session with CHW UR: 1.30; 95%CI: 1.15 1.46), and wait time (15-30 minutes to results vs. 3+ days UR: 1.45; 95%CI: 1.28 1.64). Compared to women in Maputo, respondents from Gaza had significantly stronger preferences for lower priced kits. When asked about preferences for a hypothetical HPV self-test kit, women in our IDIs said they would prefer the most efficient route to testing that would deliver their results as soon as possible, free of cost, with in-person support if HPV positive.

Demand for HPV Self-Test Kits at a Range of Potential Price Points, by Province



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During the KIIs, providers supported the distribution of HPV self-sampling and testing products contingent on the system, process, and campaigns that would be involved. KIs were enthusiastic about HPV self-testing but felt the public health system would need significant support from partners to roll out programming. If HPV self-testing products were to become available in Mozambique, providers would prefer a product that is

available in both the public and private sectors, for free or low cost, with community-based distribution to make it equitably accessible. Most importantly, they would prefer information about HPV and results be shared with women at the health centers. The most reported barriers to scaling self-sampling among women in our IDIs included low awareness among women about HPV, misperceptions about the severity of cervical cancer, and fears around performing self-sampling and learning the results. To overcome these barriers, respondents recommended community-level sensitization, demand creation campaigns along with mobile brigades, and other local outreach efforts.

"I would choose to do it the same way [self-sampling] … Explain it to me, I take it myself, do it in person, just hand it in, wait for the result. Nobody touched me, I did my own thing. And it's very good. It's very good." (Woman, Maputo City).

Despite high awareness, only 60% of our quantitative sample had ever screened for cervical cancer, which is below global targets for cervical cancer elimination. Though women in both our quantitative and qualitative samples were largely satisfied with their screening experience, many women reported disliking the pelvic exam and experiencing feelings of discomfort or a lack of privacy. New options such as self-sampling (and in the future, self-testing) may address these factors and encourage uptake of screening, and were widely appealing to women, healthcare providers, and stakeholders.

"There are many benefits [to introducing self-testing]… we can reach more women and then we can diagnose these women early. It will change the landscape of HPV infection a lot." (Provider, Maputo City).

When self-sampling is offered as an alternative to provider sampling in facility-based screening programs in Mozambique and elsewhere it has shown a high acceptability in research contexts. Reflecting a wider interest in self-care options, interest in self-testing was substantial among all participants in this study, with significant preferences for kits obtained through the public sector for free/low cost, and for which results would be rapidly available. Support for follow-on care, greater awareness of cervical cancer, and demand creation efforts were identified by participants as key to self-sampling scale-up in Mozambique. Introduction of person-centered cervical cancer self-care options, including self-sampling options, quality home-based sampling kits and even rapid HPV self-tests, could expand screening coverage in Mozambique. These findings will be used to design cervical cancer screening options that move care closer to women in LMIC settings, expanding opportunities for screening and giving women more control over their SRH.

CASE STUDY: POTENTIAL PREFERENCES FOR NEW CONTRACEPTIVE METHODS AMONG WOMEN AND ADOLESCENT GIRLS IN MALAWI: PERSPECTIVES ON EMERGENCY AND PERICOITAL ORAL CONTRACEPTIVE PILLS

Authors: Kristen Little,[a] Eden Demise,[a] Jennifer Wheeler,[a] Erica Felker-Kator,[a] & Philip Mkandawire[b]
Affiliations: [a]Population Services International, [b]Family Health Services Malawi

Background

New contraceptive options are critical to support choice and close the gap in unmet need for modern contraceptives. Pericoital OCPs are one promising new contraceptive option and are intended to be taken pericoitally (just before or after sex), only as needed. Clinical trials are currently being planned to explore the effectiveness of potential pericoital OCP formulations, including options containing levonorgestrel. As clinical trials are launched, market research with target end users in LMICs is critical to ensuring pericoital OCP products meet the actual needs and desires of women and girls in these settings. To inform ongoing product development, this study sought to understand Malawian women's and girls' values and preferences for potential pericoital OCPs, as well as their experiences with existing emergency contraceptive pill (EC) options. We hypothesized that pericoital OCPs would be appealing to women and girls in Malawi, especially those who were not current family planning (FP) users and who reported having infrequent or unpredictable sex. This study also explored differences in potential preferences by demographic factors, including SES, sexual frequency, marital status, and geographic location.

Methodology

We conducted a representative household survey among women (adolescent girls 15-17, young women 18-24, and adult women 25-39) in rural and urban settings in Machinga and Lilongwe districts, Malawi. In the absence of an up-to-date sampling frame, households were identified for the study using a spatial sampling approach. Consenting participants completed a quantitative survey and discrete choice experiment (DCE) focused on potential pericoital OCP attributes (e.g. times taken per month, effectiveness, bleeding changes, pack size, when taken). A DCE is a stated preference method used to quantify the utility of product attributes in the context of constraints or trade-offs. Adolescent participants provided informed assent and had parental consent to participate. Given the hypothesized importance of these products among young, unmarried women and girls and those not using other forms of family planning, sexual activity and use of contraception were not required for study eligibility. Socioeconomic status was measured using the EquityTool. We aimed to recruit 450 respondents, divided evenly across study geographies and study age groups. Data were analyzed without weighting using Stata 15.0. We conducted conditional logistic regression on our DCE preference data and conducted a latent class analysis to explore potential preference heterogeneity.

Results

Between March–May 2024, we recruited 449 respondents, including 151 adolescent girls, 145 young women, and 153 adult women. Participants tended to belong to national wealth quintiles 3 (24%), 4 (32%), or 5 (31%). Most respondents were married (43%) and sexually active (79%). Among sexually active respondents, 86% (304/355) had ever used contraception. EC awareness ranged from 32% among adolescent girls to 56% among young women ($P < 0.001$). Just 10% of respondents had ever used EC (48/218), though users had reported taking EC an average of 3.3 times. Acceptability of pericoital OCPs was high, with most respondents (78%) saying they would be "likely" (38%) or

"very likely" (40%) to try them if available. Acceptability was higher among sexually active respondents (83% vs. 60%, P < 0.001), though this did not differ by sexual frequency or use of contraceptives. Participants were most interested in pericoital OCPs because they seemed private or discrete (35%) and convenient (27%), could be used only when having unprotected sex (30%), and would be useful if having infrequent sex (22%). In the DCE, women expressed the strongest preferences for a pericoital OCP with the highest effectiveness against unplanned pregnancy (log odds ratio [logOR]: 1.43, 95% CI: 1.29-1.57), and single dose pack sizes (logOR: 0.63, 95% CI: 0.45-0.82 relative to a pack of 6). Side effects that included spotting (logOR: 0.23, 95% CI: 0.08-0.38) or irregular bleeding (logOR: 0.29; 95% CI: 0.15-0.43) were preferred over delayed menstruation. When analyzing potential preferences by age group, bleeding changes were a more significant driver of product choice for young women than either adolescent girls or adult women.

Knowledge Contribution

Our study found a high level of interest in a pericoital OCP product among Malawian women and girls, who valued the discrete nature of the product and the ability to take it only as needed. Despite the hypothesis that pericoital OCPs would be particularly appealing among adolescents and those having infrequent sex, we found the highest levels of interest in using this product among adult, sexually active women, and a similar acceptability of the product by sexual frequency and previous experience with other contraceptive products, including EC. In terms of preferred product attributes, women and girls expressed strong potential preferences for the most effective products and those with smaller pack sizes. Smaller pack size was especially important to lower SES women. These insights will be used to inform ongoing research and development for on-demand contraceptives, as well as additional research in other LMIC settings. Additional qualitative research to understand how the product might be framed for target users and how demand might be created for on-demand contraceptive products (once available) should also be explored. Consideration of end user preferences at the design stage for new contraceptive technologies has the potential to better address barriers to contraceptive uptake and reasons for contraceptive non-use or discontinuation.

CASE STUDY: EXPLORING THE PERICOITAL ORAL CONTRACEPTIVE PILL VALUE PROPOSITION: PERSPECTIVES FROM WOMEN IN KENYA AND UGANDA

Authors: Andrew Secor, Eden Demise, Doreen Nakimuli, Julius Njogu, and Kristen Little
Affiliation: Population Services International

Background

An estimated 230 million women in LMICs still face unmet needs for modern contraception. Supply-side issues are not the sole constraint; demand-side barriers, such as infrequent sex, also disincentivize modern contraceptive method use for many women. For other women, the hormonal profile, side effects, and dosing schedules of many contraceptives available on the market make

these methods less attractive. Pericoital OCPs, defined as products taken only as needed either right before or soon after sex, are an emerging option that could respond to these needs and preferences. One such pericoital OCP option is a levonorgestrel (LNG1.5) pill, similar to the EC currently available but indicated to be used repeatedly as a primary contraceptive method. Clinical trials are currently being planned for a pericoital OCP. The pill ultimately tested in clinical trials may contain LNG with or without another active ingredient. However, there is limited data on the potential value proposition of a pericoital OCP alternative or demand for and perceptions of this product among women of reproductive age in Kenya and Uganda. This study aimed to understand these perspectives to inform clinical trial pathway decisions, product positioning, and new product introduction efforts.

The objective of the study was to understand perspectives on pericoital OCPs to inform clinical trial pathway decisions and product positioning There were two primary research questions:

1. What are current EC use patterns and motivators for use among women of reproductive age in Kenya and Uganda?
2. What are the perceived benefits and disadvantages and demand for pericoital OCPs among women of reproductive age in Kenya and Uganda?

Methodology

This study employed a mixed-methods approach, utilizing semi-structured IDIs and quantitative online surveys. IDI participants were recruited from pharmacies and private health facilities affiliated with Maisha Meds, a health and technology organization, in two urban sites (Nairobi & Nakuru) and a rural/peri-urban site (Kilifi) in Kenya and in one urban site (Kampala) and two peri-urban sites (Mbarara and Jinja) in Uganda. Facilities were purposively chosen based on EC sales volumes during the previous year ("high" or "low/moderate" relative to country averages) to ensure representation across EC volume settings. Survey participants were recruited nationally through PSI's existing social media accounts as well as social media advertisements. Participants were eligible if they were female, of reproductive age (18 to 45 years old), were not currently or intending to become pregnant, were not currently using a long-acting modern contraceptive method and had been sexually active in the prior year. Survey participants additionally had to have used EC pills within the prior year. All participants were 18 years or older. Quantitative data were analyzed using descriptive statistics and qualitative data using thematic analysis. In total, 95 participants completed IDIs and 457 completed the e-survey.

Results

EC use: Survey participants reported a median of four lifetime uses of ECs (IQR=2,8) and two uses in the last year (IQR=1,4). Most (77%) respondents said ECs are the main way they prevent pregnancy, with most saying that compared to other methods ECs are easier to obtain (64%), more discrete (69%), and less stigmatizing to purchase (60%).

Pericoital OCP: Most survey respondents said they would be very likely (59%) or somewhat likely (30%) to try the proposed pericoital OCP product, with most (84%) agreeing that they would prefer a method they could use only when needed. Motivations for wanting to try pericoital OCPs included reduced exposure to hormones and associated side effects; flexibility in timing (before or after sex); and discreetness of use. Perceived disadvantages included the limited window for use (within 24 hours before/after sex), forgetting to take the pill, and potential availability issues when needed. Median willingness to pay was $1.17 USD (IQR $0.78, $1.56) per unit.

"…it will help women, especially those who have been taking daily. You can choose to take on this method and the burden of taking a pill every day will be no more"
Kampala

Knowledge contribution

Our study provides valuable insights into the acceptability and potential demand for pericoital OCPs in Kenya and Uganda. The ability to take a contraceptive only when needed was a key motivator for the strong interest in pericoital OCPs among study participants – particularly in relation to infrequent sexual activity, concerns about hormonal side effects, and method discreteness – reinforcing the importance of expanding options beyond traditional daily or long-acting methods. This study also highlights critical considerations for potential introduction efforts for pericoital OCPs, with access, side effect profile, efficacy, dosing schedule and window of use, and cost the primary areas of concern for potential users. These findings will help inform clinical trial pathway decisions and product positioning, including decisions on new pericoital OCP product registration versus a relabeling of existing LNG1.5 EC products to explicitly allow for regular/routine use. Overall, these findings contribute to the broader discourse on contraceptive innovation in LMICs, providing actionable insights for policymakers, health providers, and pharmaceutical developers aiming to expand contraceptive choices. By addressing concerns and needs unmet by the current contraceptive mix, this study supports efforts to enhance reproductive autonomy and contraceptive equity.

CASE STUDY: COMMUNITY-CENTERED PERSPECTIVES ON THE DUAL PREVENTION PILL AS A SELF-CARE PRODUCT

Authors: Natasha Mwila,[a] Kate Segal,[a] Blossom Makhubalo,[b] Nombeko Mpongo,[c] Lonjezo Injesi,[d] Amandah Chido Soza,[e] Wawira Nyagah[a]
Affiliations: [a]AVAC, [b]The Aurum Institute, [c]Desmond Tutu Health Foundation, [d]Malawi Girl Guides Association, [e]University of Zimbabwe-Clinical Trials Research Centre (UZ-CTRC)

Background

Women continue to face overlapping SRH challenges, including vulnerability to HIV, other STIs, and unintended pregnancies.[1] HIV infection rates remain high, particularly in the African Region, where women accounted for 62% of new infections in 2023.[1] Despite progress, women still have unmet needs with available products, as they may fail to address multiple risks, be difficult to access, or whose usage is hindered by women's limited negotiation power.

The dual prevention pill (DPP) combines HIV prevention and contraception into a single, daily oral pill. While most multipurpose prevention technologies are in early development, the DPP could reach markets in 2026, pending WHO prequalification and regulatory approval.[2] The DPP should be offered to women as an option, along with other family planning and HIV prevention products, particularly for those who prefer the flexibility of short-acting, immediately reversible, user-controlled contraceptives and for whom daily pill-taking is not a barrier.[3]

Women need accessible, user-controlled solutions to take charge of their SRH. By meeting these needs, the DPP is a promising and potentially groundbreaking self-care product. To ensure the final product effectively promotes self-care initiation, it is also critical to engage with and solicit feedback from end users throughout the process. This case study highlights how community

engagement keeps communities and end users—especially women and adolescent girls—at the center of design and decision-making and transforms the DPP from a biomedical innovation into a self-care product with the potential to advance rights, equity, and choice.

Approach

AVAC, through the DPP Civil Society Advisory Group (CSAG), conducted consultations between April and July 2025 with healthcare workers (HCWs) and potential end users in Malawi, South Africa, and Zimbabwe to gather feedback on the DPP. These consultations aimed to assess perceptions, acceptability, and health systems factors shaping potential access to the DPP.

Sixteen community focus group discussions with potential end users—women and adolescent girls—and five consultative meetings with HCWs were conducted. In Malawi, consultations were held with HCWs from Ndirande, Bangwe, Chileka, and Zingwangwa health facilities and potential end users from Blantyre. In South Africa, HCWs participated from clinics under the Mitchells Plain Health Forum and community members participated from Gugulethu, Nyanga, Khayelitsha, Strand, Philippi, and Jouberton. In Zimbabwe, consultations with potential end users were conducted in Harare. These consultations helped uncover the unique needs, motivations, and self-care practices of different population segments, including adolescent girls and young women (AGYW) and HCWs, to inform a user-centered introduction of the DPP.

The data from these discussions and meetings were analyzed to extract key qualitative insights. Themes focused on participants' perceptions and the acceptability of the DPP as a self-care product.

Results

The DPP was viewed positively by AGYW as a self-care product due to its potential for valued dual protection, reduced pill burden, and discreet empowerment over their SRH. One female participant from South Africa noted, "life gets busy—the DPP is easy and convenient. One pill a day and I can go on with my life without worrying about HIV and pregnancy." Other participants highlighted that the colorful, distinct packaging reduced stigma and made the product approachable. Many AGYW expressed a preference for pill-based methods over injectables, valuing the greater choice and the opportunity to combine HIV prevention with family planning services. Participants emphasized the importance of peer support in building supportive networks that foster confidence, autonomy, and greater acceptability of self-care practices. Flexibility to access the DPP through community centers, private clinics, NGOs, pharmacies, and mobile services was seen as a major advantage that would make the DPP a practical, accessible, and appealing self-care option for AGYW.

HCWs recognized the promise of the DPP as a self-care product and identified several opportunities to increase health-seeking behavior and enhance uptake. Although awareness and understanding of the DPP was limited, HCWs highlighted that integrating services, expanding youth corner availability, and addressing misconceptions that link PrEP to promiscuity or other stigmatized behaviors could improve acceptability. Age of consent requirements were also noted as a barrier that needs careful consideration to ensure adolescents can access the product. HCWs further emphasized the need to strengthen health system touchpoints for self-care, such as integrating DPP counseling into family planning/HIV services and equipping providers to support use. Engaging local leaders, conducting targeted awareness campaigns at antenatal and family planning service delivery points, and hosting youth-friendly sessions were seen as effective strategies to empower communities with information on and access to the DPP. Addressing stigma and fertility concerns through education and dialogue were recommended to build confidence and facilitate uptake.

Conclusion

Planning for introduction of the DPP demonstrates the critical role of community-centered approaches in transforming biomedical innovations into effective self-care products before they are rolled out. Feedback

from the consultations underscores the potential of the DPP to empower users through discreet, user-controlled dual protection. Its appealing packaging, pill-based format, and likely accessibility through diverse delivery channels should enhance acceptability and reinforce autonomy, confidence, and peer support networks. While challenges such as limited awareness, stigma, and service integration remain, these can be addressed through targeted education, community engagement, and health systems strengthening. Notably, many of these findings align with learnings from acceptability studies conducted on the DPP in South Africa[4] and Zimbabwe.[5] Another study in Kenya and South Africa among women aged 18–30 found that participants "overwhelmingly" preferred a combined HIV and pregnancy prevention product over separate products, with many willing to forgo their preferred single-indication product in favor of a dual protection option.[6]

The DPP consultations highlight that self-care can only deliver on its promise when communities remain at the center, and health systems support diverse user needs. This approach sets a precedent for future self-care innovations, emphasizing that meaningful community engagement is essential to plan for acceptable introduction of new products.

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4. Tenza, S., Mampuru, L., Moji, M. et al. (2024), "Killing two birds with one stone" – a qualitative study on women's perspectives on the dual prevention pill in Johannesburg, South Africa. *BMC Women's Health* 24, 462. *doi.org/10.1186/s12905-024-03269-8*
5. Dandadzi A, Mathur S, Musara P, et al. (2025) "…this could be a noble idea and a game changer." The potential of a dual prevention pill for HIV and pregnancy prevention among adolescent girls and young women in Zimbabwe. *PLOS Glob Public Health*.;5(8):e0005071. doi:10.1371/journal.pgph.0005071
6. RTI International. (2020). Listening to Young Women in Kenya and South Africa to Inform Multipurpose "2-in-1" *Products for HIV and Pregnancy Prevention*. *www.prepwatch.org/resource/listening-young-women-mpt*

CASE STUDY: SELF-MANAGED ABORTION CARE: GLOBAL EVIDENCE, POLICY INSIGHTS, AND LESSONS FOR SOUTHEAST ASIA

Authors: Samina Parveen and Sushanta Kumar Banerjee
Affiliation: Ipas Development Foundation

Background

The landscape of abortion care is rapidly evolving, with self-managed abortion (SMA) becoming an increasingly preferred option, particularly in settings where access to facility-based services is constrained. Evidence indicates that when supported by accurate information, quality-assured medications (misoprostol or misoprostol and mifepristone taken together), and appropriate health system linkages, SMA is a safe and effective approach. According to WHO, ensuring person-centered, equitable, and accessible abortion care optimizes resource use and enables individuals to make decisions aligned with their values, preferences, and circumstances. Achieving this requires well-functioning health systems, widespread availability of accurate information, and a legal and policy environment that upholds human rights. As

SMA continues to reshape abortion access globally, synthesizing existing evidence is critical for informing policies and enhancing user experiences. This study presents a structured synthesis of global evidence on SMA, with a specific focus on Southeast Asia—a region where emerging SMA pathways remain underexplored. By offering a nuanced understanding of how individuals access and experience SMA, the review highlights critical evidence gaps and informs future research priorities. It also provides actionable insights for the development of rights-based, context-sensitive program strategies that promote safety, autonomy, and equitable access for all abortion seekers.

This study seeks to comprehensively review existing global evidence on SMA, with a special focus on Southeast Asia (SEA), particularly India, Nepal, and Bangladesh, with the following research questions:

- What does the current evidence reveal about access, acceptability, safety, support systems, and quality of SMA globally and in SEA countries, namely India, Nepal, and Bangladesh?
- How can key insights from this evidence be synthesized to inform the design of programs that enhance the safety, accessibility, and effectiveness of self-managed abortion?

Legal and Ethical Considerations

This review approaches SMA as a recognized component of the global spectrum of abortion care, consistent with WHO guidance on self-care interventions. It synthesizes existing evidence to understand the safety, accessibility, provider viewpoints, and lived experiences associated with SMA in various forms across diverse contexts. While acknowledging that legal and regulatory frameworks vary across countries, this study does not advocate for actions that contravene national laws. Instead, it seeks to inform strategies that enhance safety where SMA occurs and identify evidence gaps.

Methodology

We conducted a comprehensive literature search across PubMed, Cochrane Library, Google Scholar, the Ipas Library, the IDF Abortion Research Compendium, and websites such as IPPF, Ibis Reproductive Health, MSI Reproductive Services, Women on Web, DKT International, and the Guttmacher Institute. The search terms included "self-managed abortion," "medical abortion," "abortion pills," "mifepristone," "misoprostol," "post-abortion contraception," and region-specific terms such as "Southeast Asia," "India," "Nepal," and "Bangladesh."

Studies were included if they were peer-reviewed articles, reports, or briefs published between 2014 and July 2024, focusing on SMA domains such as safety, efficacy, decision-making, access, affordability, abortion experience, support systems, sources of information, provider perspectives, and postabortion contraception. Studies not in English, editorial pieces, book reviews, or those focused solely on provider-supported medical abortion were excluded.

Key details extracted included author, title, year, country, study design, participant type, and key insights. Findings were categorized into 15 SMA domains across four access pathways: SMA through pharmacies or unsupported sources, partial SMA with clinic support, SMA supported by NGOs/accompaniment groups, and SMA via telemedicine. Insights from the review provide a structured understanding of SMA trends and access models with a focus on SEA.

Results

This review analyzed 162 studies from databases (135), websites (5), and previous syntheses (22), with 47 studies focused on Southeast Asia—India (31), Nepal (12), and Bangladesh (4). Most studies report over 90% SMA completion, except one Indian hospital-based study (11.8%). Globally and in SEA, SMA is highly accepted and satisfactory. However, evidence on telemedicine and NGO/accompaniment support is largely from high-income countries and Latin America.

In India, Nepal, and Bangladesh, SMA access is primarily through informal vendors and pharmacies, similar to Colombia and Mexico, while parts of Europe rely more on online platforms and formal channels. Informal sources offer lower costs, making SMA more affordable in South Asia. The quality remains a concern due to poor storage, handling, and non-compliance with standards. Women often rely on partners, family, and online resources for SMA. Southeast Asian studies highlight emotional distress due to inadequate information and limited support, while global evidence emphasizes NGOs and digital tools in reducing anxiety. Barriers include a lack of information, inconsistent pharmacist guidance, abortion stigma, and transportation costs. Legal restrictions and opposition from anti-abortion groups are less pronounced in SEA.

Evidence gaps persist on barriers in telemedicine, clinic support, and NGO/accompaniment models. Provider acceptance varies—Bangladesh shows low support for SMA via pharmacies, while Nepal supports home administration within partial SMA. We found limited evidence on provider attitudes from India or Nepal on SMA. Pharmacies frequently provide inconsistent medication abortion guidance, affecting safe and effective use.

Knowledge Contribution

This study provides a structured synthesis of global evidence on SMA, with a focused lens on SEA. By categorizing SMA into four access pathways, it moves beyond broad discussions to offer a nuanced understanding of access, safety, and support mechanisms. The study also identifies critical evidence gaps, particularly regarding SMA through telemedicine, clinic support, and NGO/accompaniment models, as well as provider perspectives and access among unmarried individuals and other vulnerable groups in SEA. Unlike high-income countries and Latin America, where structured support systems are more established, South Asia lacks sufficient research on these emerging SMA pathways. By highlighting these gaps, this review informs future research priorities and policy recommendations aimed at strengthening safe and equitable SMA access. By integrating insights from both the Global North and Global South, this study provides a comprehensive evidence base for policymakers and practitioners. It underscores the need for inclusive, rights-based approaches that prioritize safety, autonomy, and accessibility, ensuring that SMA pathways are responsive to the diverse needs and lived realities of those seeking abortion care. Additionally, it identifies evidence gaps related to telemedicine, provider attitudes, and accompaniment models in low-resource settings, underscoring the need for context-specific program strategies that address both structural and interpersonal barriers to safe SMA.

CASE STUDY: FROM SKEPTICISM TO SUPPORT: A CLINICIAN'S JOURNEY PROVIDING A SELF-ADMINISTERED CONTRACEPTIVE VAGINAL RING IN KENYA'S LARGEST INFORMAL SETTLEMENT

Author: Serah Gitome
Affiliation: Kenya Medical Research Institute (KEMRI)

Annovera, a self-care contraceptive vaginal ring developed by the Population Council, provides a full year of pregnancy prevention. There is currently an ongoing study sponsored by the Population Council's Center for Biomedical Research and supported by the Gates Foundation that explores the acceptability of Annovera based on actual ring use compared to pills and injectables. As vaginal rings are under development for multiple reproductive health indications, this work can fill key knowledge gaps to inform future investments for this important self-care option.

In one arm of the trial, women aged 18-45 attending family planning (FP) services at Kibera D.O Health Centre in Nairobi, Kenya, are enrolled in the study after selecting either Annovera or another method for use over one year. In the testimonial below, a clinician at the center shares her experience providing Annovera to clients. She describes her own perspective change from skepticism of a self-administered method to support after gaining experience counseling and providing the method to clients.

Names have been changed to protect privacy

Nancy had been working as an FP counselor at Nairobi's Kibera D.O Health Centre, a public health facility in the largest informal settlement in Kenya, for over 10 years when she first heard about the Annovera contraceptive vaginal ring study. As the head of the health facility, she was very familiar with the challenges that such women faced in managing their fertility. Although there is a fairly wide range of contraceptives available at the health center, women still needed to visit the health facility multiple times in a year to receive a resupply of their method, encountering barriers such as travel costs, long hospital queues, and inadequate counseling time. Thus, when she first learned of Annovera, she had mixed feelings – on the one hand, it sounded like a game changer as women did not have to come to the clinic often, but on the other hand, she wondered about all the things that could go wrong as women inserted and removed the ring by themselves.

"You know, I only learned about contraceptive rings during my nursing training. I have never seen one," Nancy said as she settled in the chair in her office. She had her doubts as to whether women would be interested in using the ring for a whole year. Natasha, another FP nurse, seated in the small counseling room, expressed similar skepticism, remarking that she had never seen a contraceptive ring. The walls in the FP counseling room displayed reproductive health informational materials, including various contraceptive methods, but none showed vaginal rings. Natasha asked if there were placebo rings that the nurses could practice with to gain experiential knowledge when counseling women, a suggestion that was supported by another FP nurse, Fifi.

Nancy and her colleagues' initial skepticism reflected common concerns among healthcare providers and unconscious biases about their clients' ability to use self-administered methods correctly. They were used to providing methods like intramuscular depot medroxyprogesterone acetate (DMPA) injections where they were in charge of the administration and the schedule. The idea of putting more control in the women's hands felt… uncertain.

The Annovera study training process was eye-opening. The FP nurses and study clinician, Juliet, learned that despite being a "new" delivery method only offered in the context of clinical research, the Annovera ring contained the same hormones found in OCPs that had been in use in Kenya for decades. In addition, the Annovera ring was already approved for use in the United States and women there were using it. This was reassuring to the FP nurses because they could tell women that while the ring might look different, the hormones inside were familiar and well-studied.

But the real transformation came when the FP nurses and the study clinician began counseling women on Annovera. Kezia, one of the first clients that Natasha counseled, wanted to change the method she was using due to side effects. After initial FP counseling by Natasha, she thought that Annovera had a more favorable safety profile, and she liked that she could use the ring on her own for a year before needing to come back to the clinic. Thus, Natasha referred her to Juliet for potential enrollment into the study as an Annovera user. However, when Juliet showed her a sample ring, her face changed. She looked worried, almost scared. Kezia's concerns were typical of what Juliet would hear repeatedly: *Would insertion be painful? Could the ring get lost inside her body? Would it affect her relationship with her husband?* These fears required Juliet to develop new counseling skills as she learned how to really listen and address much deeper concerns about women's bodies and relationships than what was required with pills or injections.

The visual demonstrations became crucial. Juliet would show women exactly how to insert and remove the ring using anatomical models, then guide them through practicing the technique. Doing this made all the difference. Once women practiced insertion in a safe, private environment, their confidence grew tremendously. After inserting the ring on her own under Juliet's observation, Kezia beamed with confidence as she described how unbelievably easy she found it and the fact that she could not feel the ring once it was in place. But Kezia's story also highlighted the ongoing support needs that Juliet had not anticipated. During her first ring-free week, Kezia called the clinic in a panic, convinced she was not protected from pregnancy. Although this had been covered during counseling, experiencing it was different. Juliet realized she would need to provide ongoing emotional support as needed, beyond the initial technical instruction.

Other women in the community began asking about *"that ring method"* after hearing positive experiences from the initial users who had enrolled in the study. As Natasha said, *"word spreads quickly in Kibera."* When women heard that their friends were successfully using the new Annovera ring, their interest in the method grew.

Juliet's and Natasha's experiences with Annovera counseling and provision have convinced them that contraceptive vaginal rings have an important place in Kenya's method mix, but successful integration requires intentional effort. Juliet pointed out that providers need comprehensive training that addresses not just the clinical aspects, but also their biases and assumptions. They need clear service delivery guidelines such as which healthcare cadres can train women on ring insertion and removal. Most importantly, they need to trust women with their own contraceptive decisions.

Looking toward the future, Juliet is optimistic about the potential for vaginal rings to transform FP services. Every day, she sees women in this community juggling incredible responsibilities—running businesses, caring for families, managing household finances. She is convinced that if they can do all that, they can certainly manage their own contraception journeys. She feels that her job is to give them the tools and support they need.

KEEPING PEOPLE AND COMMUNITIES AT THE CENTER: DELIVERING ON RIGHTS, EQUITY AND CHOICE

UPDATES TO THE EVIDENCE ON SELF-CARE AWARENESS, PREFERENCES, AND PRACTICES

Several reviews published since 2023 summarize evidence on self-care acceptability, preferences, and practices for specific products. Two systematic reviews on HIVST among adolescents and young adults synthesize the evidence base on HIVST acceptability, finding high acceptability in these subpopulations. A global review reported a pooled estimate that 79% of adolescents and young adults completed an HIV or syphilis self-test among those who were offered one[51] and a review of studies conducted in sub-Saharan Africa reported a range in acceptability of HIVST from 49% to 100% among adolescents and young adults across studies.[52] A scoping review of research on HPV self-sampling in sub-Saharan Africa reported a range of self-sampling acceptability from 32% to 99% across studies.[53] New research on acceptability, preferences, and practices related to self-care also includes advances in understanding self-care as a unified category beyond individual products. The Living Self-Care Study, for example, includes data from 3,255 adults in the UK and provides insights on how people understand and practice self-care (*see case study on page 32*).

Additional research focuses on informing product introduction and scale-up by understanding people's preferences. For example, research conducted in Mozambique elicited preferences about preferred product characteristics for HPV self-sampling and self-testing to inform national self-care scale-up (*see research spotlight on page 11*). Another study conducted in Mongolia explored acceptability and preferences related to HPV self-sampling, also to inform national strategy.[54]

Methodological advances include the development of a metric for client experience with self-injectable contraception that may also inform metric development for other self-care products or approaches. (*see case study on page 29*). A novel measure of self-injectable contraception self-efficacy was also developed and validated in Uganda.[55] The measure was specifically designed to be applicable regardless of self-injection (SI) use or training, making it attractive as a rights-based alternative to program outcomes measures such as SI uptake.

PERSON-CENTERED AND COMMUNITY-BASED APPROACHES

Recent advances in research and programs show how self-care can meet the needs of populations that face particular challenges in accessing health services, including in fragile and humanitarian settings.[56] In Nigeria, a program reached women displaced by conflict through trusted community-based providers who were trained as referral agents to provide contraceptive self-care information and services (*see case study on page 26*). Self-care can also be a powerful approach for adolescents and young adults. Alongside the newly compiled evidence on acceptability of HIVST from recent systematic reviews,[51, 52] additional youth-focused initiatives that are underway include a Youth Corps in Myanmar to conduct research and co-design contraceptive self-care and mental health solutions for adolescents (*see case study on page 31*).

Digital solutions have long been part of self-care but are increasingly visible and can play a powerful role in extending care to reach underserved populations. For example, a pilot study in rural Bangladesh evaluated a digital intervention for doorstep self-care primary health services in which CHWs used a smart health kit that allows them to conduct AI-based risk assessment and use a clinical decision support system (see below).

Repeated cross-sectional study evaluating an AI-driven community health worker digital intervention in rural Bangladesh: Findings from the CMED model on doorstep self-care for primary health services.

A digital health intervention in rural Bangladesh shows how AI-enabled self-care tools can extend SRH services within primary care.[1] The program equipped CHWs with smart health kits and mobile apps to provide monthly doorstep health education, screenings, and digital referrals. Over 18 months, they served 32,581 people, 64% under 35, and nearly 60% women. By pairing community-led counseling with real-time decision support, the model improved early detection of noncommunicable disease risks. It empowered women and adolescents to monitor their health, including reproductive health, at home. Participants reported improvements in body mass index and blood-pressure profiles and appreciated the convenience of digital referrals. The low cost of the tool, about US $1 per family per month, combined with its potential to integrate SRH information into routine household visits, makes it a scalable example of digital self-care. The authors recommend scaling through public–private partnerships to support UHC.

1. Zaman M, Hridhee RA, Bhuiyan RA, Gomes CA, Rahman MM, Islam SM, et al. Efficacy of using a digital health intervention model using community health workers for primary health services in Bangladesh: a repeated cross-sectional observational study. BMC Public Health. 2025;25:1833.

Community-based strategies are increasingly leveraged as person-centered approaches to reaching people with self-care. Substantial research has been conducted regarding acceptability, effectiveness, and costs of secondary distribution and community-based distribution models for HIVST, largely through the Self-Testing in Africa Initiative (STAR)[57] (*see case study on page 57*). This evidence can be leveraged to support introduction and scale-up of different self-care

CASE STUDY: SELF-CARE ACCESS VIA FAMILIAR ENTRY POINTS: LEVERAGING TRUSTED COMMUNITY PROVIDERS TO EXPAND CONTRACEPTIVE ACCESS IN DISPLACEMENT

Authors: Aisha Jaafar Abubakar, Jummai Umar, Francis Junior Ojemu, Meru Vashisht, Caitlin Mannering, Nathaly Spilotros
Affiliation: International Rescue Committee

Background

Northeast Nigeria has low contraceptive prevalence rates (17.5% in Adamawa and 9.5% in Borno) and high unmet need for FP (24.5% and 26.3%), particularly among displaced populations.[1] More than 2 million people remain internally displaced in northeast Nigeria, following 15 years of conflict with Boko Haram and other armed groups, and risks related to childbirth and maternal mortality are elevated for displaced women and girls.[2] Barriers to contraceptive uptake include limited mobility, partner opposition, low contraceptive awareness, and social stigma, contributing to

unsafe abortions, morbidity and socioeconomic disadvantages.[3]

In 2024, the International Rescue Committee conducted human-centered design research in humanitarian settings in northeast Nigeria to understand behaviors, preferences, and social norms influencing contraceptive uptake among displaced women and girls including self-managed contraceptives. Findings identified trusted community actors – such as Kayan Mata (aphrodisiac) sellers and henna artists – who routinely engage women on sexual wellness and beauty as a self-care practice. Though outside the formal health system, these providers have earned women's trust, have home access, and offer a culturally resonant self-care platform for FP engagement.

Additionally, given the protracted conflict, community health volunteers (CHVs) and nutrition services, including in-patient and mobile clinics providing stabilization care and Ready-to-Use Therapeutic Food, are critical components of the health system in northeast Nigeria. However, evidence on integrated models for nutrition and FP programming is limited despite the promising potential they have to address significant malnutrition in under-five children and improve SRH.

Grounding FP within trusted self-care entry points has the potential to illustrate how even in fragile, displacement-affected contexts, innovative approaches can expand choice and autonomy where formal systems are strained.

Program Description

From October 2024 to May 2025, the International Rescue Committee piloted an FP program model in Maiduguri Metropolitan Council and Gwoza Local Government Area in Borno State. The model trained referral agents—including Kayan Mata sellers, henna artists, CHVs, and nutrition officers—to integrate FP discussions into routine interactions using visual job aids and referral cards. Agents discussed self-managed FP methods, birth spacing, FP reversibility, and myth-busting, and referred clients to nearby health facilities.

Community Health Extension Workers, midwives at Comprehensive Women's Centers and public Primary Healthcare Centers, and Patent and Proprietary Medicine Vendors were trained to receive referrals, conduct contraceptive medical eligibility screening, and dispense commodities. To integrate self-care best practices, clients were provided with up to three months of combined OCPs or up to nine months (three take-home doses) of DMPA-SC for self-injection, in line with national guidelines. Visual stickers were added to commodities to guide clients on when to take additional doses, allowing women to safely self-manage without needing another clinic visit.

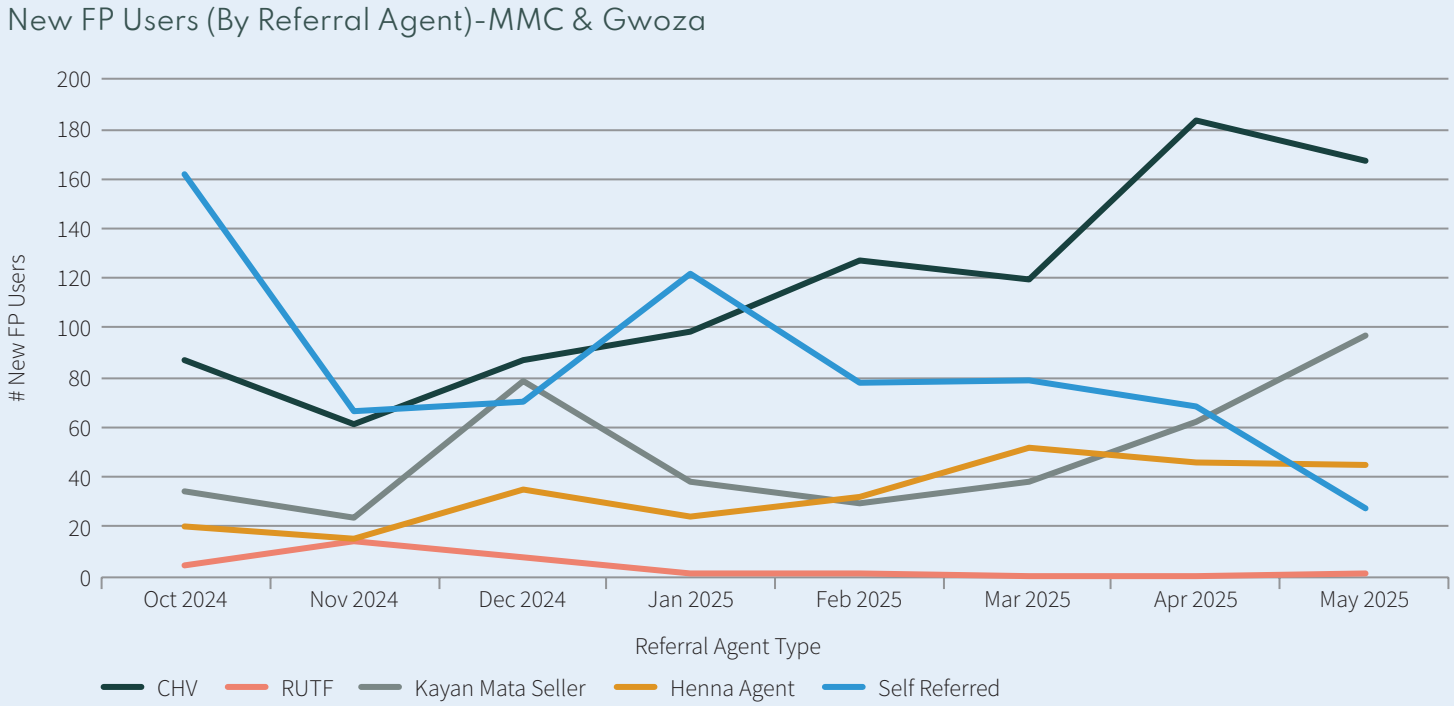
To evaluate this program, monitoring included FP registers, monthly summary sheets with referral codes, and a 29-metric tracking template capturing first-time FP users, referral outcomes, and commodity use. Monthly review meetings, on the job coaching and supportive supervision gathered qualitative insights from agents and stakeholders, informing program adaptations.

Results

Across both sites, 2,680 new FP users were reached (2,052 in Maiduguri and 628 in Gwoza). The three program sites in Maiduguri, all mobile clinics, had offered FP services several months before the start of the program but had stopped due to funding cuts and had not previously offered self-managed FP prior to this program. In Gwoza, security access issues and low staffing levels affected initial program rollout in the two Comprehensive Women's Centers. In January, the US government stop work orders did not enable programming to continue in these two sites which were entirely US government funded.

Of the new FP users, 1,641 (61%) were directly referred by trained agents. CHVs contributed the largest share (40%), followed by *Kayan Mata* sellers (17%), henna artists (12%), and nutrition providers (2%). Despite the stop work orders from the US government, the program saw steadily increasing referral numbers for CHVs and Kayan Mata sellers for the remainder of the program. Nearly one-third (29%) of clients sought services without a referral.

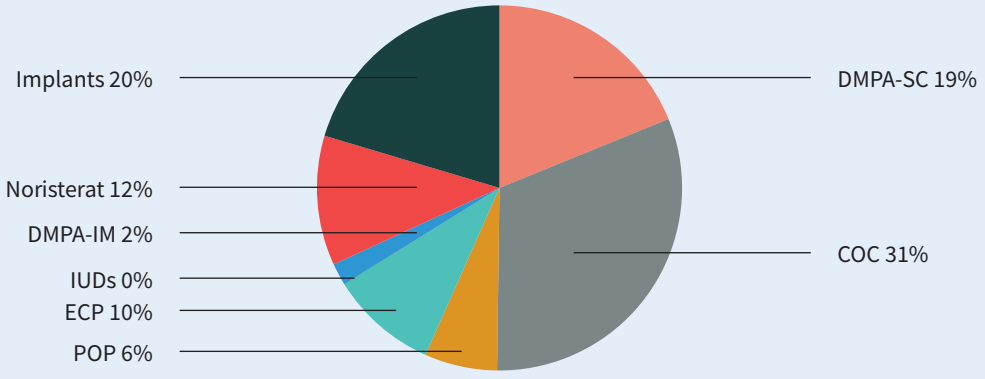
Figure 1. Number of New FP Users in Maiduguri Metropolitan Council (MMC) and Gwoza Disaggregated by Referral Agent Type from October 2024 through May 2025.



Method mix reflected facility staffing and commodity availability. Combined oral contraceptives (31%) and implants (20%) were most used, while DMPA-SC for self-injection—newly introduced at pilot sites—was adopted but constrained by reoccurring stockouts at the state level. Facilities without midwives—such as the mobile clinics—could not offer long-acting methods, skewing uptake toward short-term options.

Demographically, most DMPA-SC self-injection users and new FP users were over 19 and had multiple pregnancies.

Figure 2. Method Mix among new FP users in MMC and Gwoza from October 2024 through May 2025.



According to a program evaluation, referral agents regularly engaged women who had never previously considered FP, integrating conversations into everyday settings such as markets, henna sessions, and home visits. The most persuasive FP engagements with clients used job aids and referral cards outlining both provider and self-administered contraception that also combined biological explanations, emotional reassurance, and logistical clarity.

Lessons learned

- Trusted entry points matter: Familiar, culturally resonant providers who successfully promote other forms of self-care can also become effective advocates for self-managed FP even during health system shocks.
- Community integration expands reach: Agents' accessibility on weekends, absence of queues, and proximity to women lowered barriers and made FP and self-managed FP feel approachable.
- Program challenges revealed humanitarian system challenges: Stockouts (particularly of DMPA-SC), facility closures, and lack of dedicated program management staff in Gwoza limited uptake, underscoring the importance of reliable supply chains and sustained program management during protracted crises.

Implications

This pilot demonstrates that self-care FP can be effectively introduced in displacement settings by leveraging everyday interactions with trusted community providers. As with all self-care models, the aim is not to replace the existing health system but rather to expand its reach into the community, normalize FP discussions, and create new pathways for uptake and continuation. With proper training, supervision, and supply chain support, community-based referral agents can play a critical role in expanding access to self-managed contraception for women and girls in humanitarian contexts. Experiences in northeast Nigeria show the promise of this model: that even amidst protracted crisis, trusted community entry points can safeguard and expand women's reproductive autonomy — offering a scalable pathway for self-care in humanitarian settings.

1. dhsprogram.com/pubs/pdf/PR157/PR157.pdf
2. United Nations Office for the Coordination of Humanitarian Affairs (OCHA)
3. Azuka, E. Unmet needs for contraception in African Women. DateLineHealthAfrica July 6, 2024. Addressing Unmet Need for Contraception in Africa: Challenges and Solutions

CASE STUDY: DEVELOPMENT OF A CLIENT EXPERIENCE OF CARE METRIC FOR SELF-INJECTABLE CONTRACEPTIVES IN LILONGWE, MALAWI

Authors: Erica Felker-Kantor,[a] Eden Demise,[a] Philip Mkandawire,[a] Benjamin Kaneka,[b] Jesman Chintsanya,[b] Kristen Little[a]
Affiliations: [a]Population Services International, [b]Department of Sociology and Population Studies, School of Humanities and Social Sciences, University of Malawi.

Background

In the past decade, the field of FP has seen a growth in the availability of self-care interventions, including self-administered subcutaneous depo medroxyprogesterone acetate (DMPA-SC) injectable contraceptives. Self-injectable contraception has the potential to reduce

access-related barriers while also providing women with increased reproductive autonomy and choice. Given that self-injection is a relatively new yet growing practice, continuous monitoring of client experiences of care is essential to ensure delivery of high-quality self-injection services. While several validated and standardized measures to assess person-centered care for FP exist, to our knowledge, there is no validated measure specific to client experience of care for self-care service delivery with a focus on injectable contraceptives. Providers need a practical and validated metric that captures the most important aspects of patient-centered care for women using self-administered DMPA-SC.

This research aimed to answer the following questions: How do we develop and validate a person-centered metric for self-injectable contraceptives? Are there differences in women's experiences of care between self-injectors and provider-administered clients in Lilongwe, Malawi?

Methodology

This was a mixed-method study in rural and urban Lilongwe from Sept 2023-Jan 2024. Domains and items for a client experience of care metric for injectable contraceptives were identified from literature reviews and IDIs (N=20). Client exit interviews (CEIs) were administered to 400 Malawian women who used DMPA-SC by self-inject (n=198) or provider-inject (n=202) within the past year. Women were recruited from 20 private and public health facilities across rural (n=9) and urban (n=11) Lilongwe. Women were randomly assigned to complete the exit interview in-person as they left the facility or by phone seven days later. The CEI tool was validated using cognitive interviews (n=20) prior to administration.

Qualitative data were analyzed using Dedoose. Quantitative data were analyzed in Stata using descriptive statistics and iterative exploratory factor analysis (EFA) with a polychoric correlation matrix. Cronbach's alpha was used to assess reliability. Bivariate linear regression was used to assess criterion validity and to test for mean differences in client experience of care by self-inject or provider-administered. We also explored differences in client experience of care by age, rural/urban, and survey administration mode (in-person or phone).

Results

Average age was 27 years, 94% of participants were married, and nearly 40% had secondary education. 70% of study participants belonged to the upper three wealth quintiles. Most women visited a government-owned public facility (82%) for DMPA-SC, followed by faith-based organizations (22%).

A total of 57 items were included in the fielded CEIs. 45% (n=25) were dropped due to missingness/low variability. 32 items were included in the EFA which yielded a 2-factor solution with 18 items, identifying a unifying scale for client experience of care (8 items) and a sub-scale for empowerment (10 items). The client experience of care scale included items on choice, agency, trust, communication, and respect. It had high construct validity, high criterion validity, and moderate reliability. The empowerment scale included items from an already validated and tested metric (Contraceptive Self-Efficacy among women in sub-Saharan Africa).

There was no statistically significant difference in empowerment scores by injection method (Coefficient= 0.017; p-value=0.411; 95% CI: -0.024 to 0.059). In adjusted models, statistically significant differences in client experience of care were detected by injection method (Coefficient=0.086; p-value= 0.001; 95%CI: 0.033-0.1377), with self-inject clients reporting better experience of care compared to provider-administered clients.

Knowledge Contribution

This study used EFA to produce an 18-item metric that can be rolled out widely to measure client experience of care with DMPA-SC to inform Malawian private and public health systems as they continue to expand the FP method mix. The validated scale can also be used for service quality improvement at the provider and facility level. This study also provided insights into Malawian

women's experience of care with DMPA-SC. Findings suggest there was little difference in empowerment scores by injection method, which could mean that the choice of self- or provider-administered DMPA-SC is empowering. We also found that those who self-injected had better overall client experience of care, which could be due to an increased sense of choice, agency, or trust.

This client experience of care metric includes items across a variety of domains that are clients' priority areas for assessing their experience of care. The metric and the approaches used to create them can serve as a global good for countries that want to adapt the validated measurement to their country context across a range of FP self-care products.

CASE STUDY: YOUTH-LED SELF-CARE FOR ADOLESCENT MENTAL HEALTH AND SRH IN MYANMAR

Authors: Zay Yar Swe,[a] Elissa Kennedy,[b] Stephen Bell[b]
Affiliations: [a]Burnet Institute, Myanmar. [b]Burnet Institute, Australia.

Background

Adolescents in Myanmar face significant challenges in accessing SRH and mental health (SRH/MH) services. Stigma, lack of privacy, and ongoing political instability have disrupted public health systems, leaving young people with high unmet need for health services and limited safe avenues for support. The WHO recommends self-care as a strategy to improve access and equity, particularly for marginalized populations, however there is limited evidence of feasibility and acceptability among young people, including in fragile and conflict-affected settings.

Program Overview

Building on over a decade of community-based projects to improve adolescent health, this program aims to develop a sustainable, locally led model of youth-centered self-care to improve SRH, mental health and well-being of youth aged 15-24 years in underserved peri-urban and rural communities in Myanmar (Yangon and Magway). The model of self-care will focus primarily on a package of youth-led interventions and commodities to prevent poor SRH (particularly unintended pregnancy and STIs/HIV) and mental health, promote psychosocial well-being, and strengthen community referral systems. The program also aims to generate new knowledge about the feasibility and acceptability of youth self-care, and implementation guidance relevant to other conflict-affected settings.

Approach

The primary approach is to establish, train, and support a community-based Youth Corp in each location. The Youth Corp will comprise young people from each community who will co-lead the design of the program and implement project activities. The program is also supported by a project governance group and community leadership groups to ensure local leadership and sustainability.

In year one, formative research will be conducted, co-led with the Youth Corp members, using participatory qualitative methods to explore young people's self-care practices and preferences, and the attitudes and perceptions of health providers and adult community stakeholders. Co-design workshops will then be conducted with young people and community stakeholders to develop a sustainable Youth Corp model, define the self-care interventions and mode of delivery, and co-

create tools and resources to support implementation. Community referral systems are also being mapped and strengthened to link the Youth Corp and communities with facility-based health services where needed and establish peer-supported referral mechanisms.

Early Learning and Anticipated Outcomes

The program is currently in the early stages of year one. While full implementation is planned after co-design, early engagement suggests strong community and youth interest. Lessons from preliminary work highlight that:

- Youth leadership is central: Adolescents value peer-to-peer learning and mentorship as less stigmatizing and more acceptable than formal health services. However, to sustain these approaches, there is a clear need for capacity building and ongoing support ensuring that youth leaders/youth corps have the efficient skills, resources, and guidance to continue providing safe, effective, and trusted support to their peers.
- Safe environments are essential: Physical venues are needed to support young people's privacy, trust, and participation.
- Integration with community systems matter: Partnerships with community members, families, and service providers enhance acceptance and sustainability.

A mixed-methods process and outcome evaluation planned for year four will assess feasibility, acceptability, and effectiveness, with findings expected to inform adaptation, scaling, and replication in other fragile settings.

Conclusion

This initiative is one of the first in Myanmar to pilot a youth-led model of self-care that integrates SRH and mental health in a conflict-affected context. By placing adolescents and communities at the center, it seeks to generate new evidence and practical approaches for advancing equity and choice in self-care.

CASE STUDY: SELF-CARE IN FOCUS: VOICES FROM THE COMMUNITY AND THE CLINIC

Authors: Austen El-Osta[a] and Pete Smith[b]
Affiliations: [a]Self-Care Academic Research Unit (SCARU), Imperial College London.[b]Self-Care Forum UK.

When health systems strain under the combined pressures of rising demand, limited resources and growing inequities, self-care emerges as both a practical necessity and a human right. Yet despite policy endorsements and the proliferation of new products and digital tools, surprisingly little is known about how people themselves perceive, understand and practice self-care.

Two complementary studies by the *Self-Care Academic Research Unit (SCARU)* at Imperial College London and the *Self-Care Forum* set out to change that by listening to the voices of thousands of community members across the United Kingdom. Findings from the Living Self-Care survey exposed the gaps between aspiration and reality and suggest a new way forward for embedding self-care into health systems.

The challenge: moving beyond rhetoric

Self-care is widely recognized as a cornerstone of sustainable health. It encompasses preventive practices,

management of common conditions and informed decision-making about when professional help is needed. But rhetoric alone is insufficient. For self-care to be meaningful, policymakers, health professionals and industry need to understand what people know, how they feel and what they actually do in their daily lives. Without that insight, programs risk being designed in a vacuum, disconnected from the communities they are meant to serve.

Listening at scale

To generate that evidence, researchers designed and launched one of the largest survey-based research studies ever conducted on self-care in the UK. More than 3,255 adults participated, representing diverse ages, genders, ethnicities and backgrounds. The surveys explored knowledge, attitudes, perceptions and behaviors across the seven internationally recognized "pillars of self-care," which range from health literacy and healthy eating to risk avoidance and responsible use of medicines. The design drew on established behavioral science frameworks, while analysis captured both descriptive trends and predictors of behavior.

By asking simple yet revealing questions, such as whether people understood the term "self-care," how confident they felt about making health decisions, or what barriers prevented them from engaging in healthy practices, the study brought the lived realities of ordinary people into sharper focus.

What the public told us

The responses from the first arm of the Living Self-Care Survey Study have been published in a preprint[1] and convey the sobering perspective of self-carers. Many participants associated self-care only with crisis-driven actions, such as taking over-the-counter medicines when sick, rather than a proactive and holistic approach to health. Large knowledge gaps emerged, particularly around nutrition, digital health and preventive behaviors. While most respondents expressed positive attitudes towards taking more responsibility for their health, they also cited barriers including cost, lack of trustworthy information and time pressures from work or caring responsibilities. Equity concerns were also striking. Younger adults and those from minority ethnic groups were more likely to report difficulties accessing information they trusted. People living with chronic conditions often felt abandoned once outside formal care settings, highlighting the need for stronger integration between professional services and self-care support.

Healthcare professionals in the picture

A second arm of the research from the Living Self-Care Survey Study focused on healthcare professionals themselves. Also published as a preprint,[2] doctors, pharmacists and nurses were asked about their attitudes to self-care and the extent to which they promoted it in their daily practice. The results highlighted both enthusiasm and hesitation. While many recognized the potential of self-care to reduce unnecessary consultations and empower patients, several concerns were identified. Would promoting self-care shift too much responsibility onto individuals? Could patients misinterpret advice or misuse products without supervision?

These findings mirror the results of *another study by the Imperial SCARU research team* that looked at healthcare professionals' attitudes regarding self-care in people with multiple health conditions. In both instances, there was a recognition that healthcare professionals appeared to often lack structured training, guidelines or incentives to integrate self-care into routine practice. This disconnect between policy aspirations and frontline realities highlights the importance of system-level change.

Lessons from the data

Several key insights emerged from bringing the perspectives of communities and professionals together. First, there is a mismatch between how experts define self-care and how the public understands it. Bridging that gap requires clear, consistent communication that frames self-care as a continuum of everyday practices rather than an emergency fallback. Second, self-care cannot be

divorced from social determinants. Income, education and cultural context shape whether individuals can act on the advice they receive. Without addressing affordability and access, calls for self-care risk deepening inequities. Third, healthcare professionals are willing but not yet fully enabled to champion self-care. Investment in training, supportive policies and system integration is needed to align professional practice with the self-care agenda.

Why it matters globally

There have been many attempts to capture people's perspectives about self-care, but these were in the realm of market research, and not bona fide research studies with ethical approvals. The Living Self-Care Survey Study is the first and largest study of its kind that addresses this gap. Efforts are underway to translate the survey into other languages and to work with partners to recruit respondents from other countries including low-resource settings.

Although the Living Self-Care Study was conducted in the UK, its implications resonate far beyond. Many countries are grappling with similar challenges including overstretched health systems, growing burdens of chronic disease and uneven public understanding of self-care. By demonstrating how large-scale data collection can illuminate both opportunities and barriers, this research offers a model for other nations seeking to advance self-care in ways that are evidence-based, equitable, and system-ready. The approach also aligns with international priorities. Global strategies increasingly call for strengthening primary healthcare, enhancing health literacy, and expanding people-centered services. Self-care, when grounded in evidence, directly contributes to these aims.

From evidence to action

The Living Self-Care Survey Study does not stop at identifying gaps. The findings also point towards solutions. Educational campaigns tailored to diverse audiences could help demystify self-care and expand its meaning beyond crisis response. Digital platforms, if designed inclusively, offer promise for providing reliable information at scale. Community pharmacies and primary care providers could serve as trusted touchpoints, offering both products and guidance to people from all walks of life and in different settings.

At the policy level, embedding self-care into guidelines, financing mechanisms, and professional training would help ensure it is not treated as an optional extra but as a foundational component of health systems. Measuring self-care capability through validated tools can also help track progress over time and identify which groups require additional support.

A vision for the future

The ultimate lesson from this case study is that self-care is not merely about individual choice; it is about creating environments where healthy choices are possible, supported, and valued. Evidence from thousands of community members and hundreds of professionals demonstrates both the appetite for and the barriers to achieving that vision. If taken seriously, the insights can catalyze a shift from rhetoric to reality. Self-care can move away from being a slogan to a lived practice embedded across society—one that advances equity, strengthens systems and upholds the right of every person to play an active role in their health.

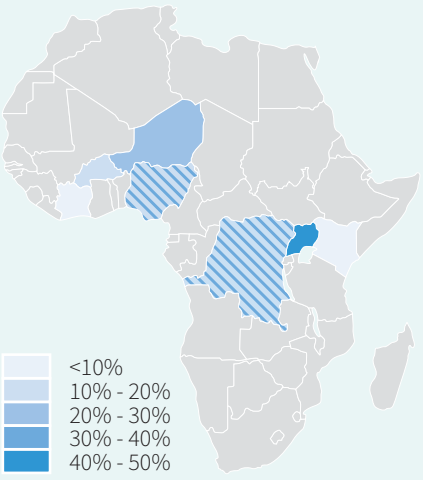
1. El-Osta A, Altalib S, Al Ammouri M, Smith P. Understanding Demographic Disparities and Personal Barriers to Self-Care in the UK: Findings from the Living Self-Care Survey Study. *medrXiv*. Preprint posted online June 3, 2025. doi: 10.1101/2025.06.01.25328757
2. Smith P, Altalib S, Al Ammouri M, El-Osta A. Self-Care Confidence, Professional Support and Health Literacy in the UK: Findings from the Living Self-Care Survey Study. *medrXiv*. Preprint posted online June 3, 2025. doi: 10.1101/2025.06.01.25328745

SPOTLIGHT: PERFORMANCE MONITORING FOR ACTION DATA ON DMPA-SC

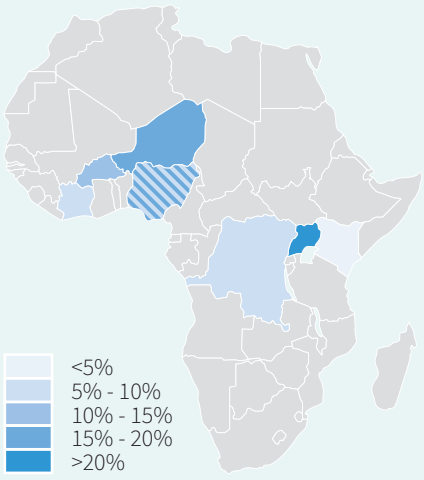
Author: Phil Anglewicz and Guy Bai
Affiliation: William H. Gates Sr. Institute for Population and Reproductive Health, Johns Hopkins Bloomberg School of Public Health

Since 2019, the Performance Monitoring for Action (PMA) surveys have captured standardized indicators on self-injectable contraceptive awareness, use, and intended use among women of reproductive age across eight sub-Saharan African countries. PMA data are collected with support from the Gates Foundation, Children's Investment Fund Foundation (CIFF), and many other donors. For more details on the PMA survey methodology, see the *PMA website* and a published cohort profile.[1] These figures present the most recent available data on self-injectable contraception awareness and use. Across all countries, awareness of injectable contraception is high – ranging from 80.7% in Niger to 94.4% of women of reproductive age reporting having ever heard of injectables (data not shown). Among women aware of injectable contraception, awareness of self-injectable contraception varies, with relatively low prevalence in Cote d'Ivoire (20%) and Burkina Faso (22.9%) to higher prevalence in Nigeria – Lagos (41.6%) and Uganda (50.1%). Among all married women, prevalence of self-injectable contraceptive use was lower than 10% in all sampled countries: prevalence of use among married women was highest in Uganda at 9.5%, but only 3% or less in all other settings. Among married women using modern contraception, self-injectable contraception use accounted for between 3.9% (Nigeria – Lagos) to 23% (Uganda) of all modern contraceptive use.

Have you heard that there is a type of injectable that you can inject yourself? (2021-2024)



Prevalence of DMPA-SC among married women contraceptive users (2021-2024)



Prevalence of DMPA-SC among married women (2021-2024)

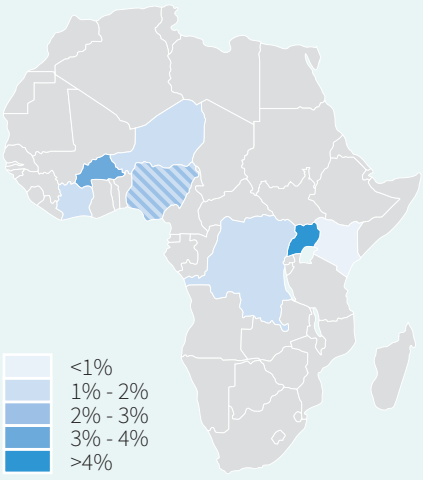


Figure note: In two countries data were collected from two subnational sites, Kinshasa and Longo Central in DRC and Lagos and Kano states in Nigeria. Estimates represent 2024 data for all countries except for DRC – Kongo Central and Kenya. The most recent estimates for DRC – Kongo Central were collected in 2022, while the most recent estimates available for Kenya are from 2021.

1. Siewe A et al. 2024. Cohort Profile: The Performance Monitoring for Action (PMA) panel surveys. *Int J Epidemiol*, 54.

PERSPECTIVES FROM HEALTHCARE PROFESSIONALS AND SERVICE PROVIDERS ON SELF-CARE

Updated self-care guidance and a new tool for providers Alongside WHO's 2023 self-care competency framework for healthcare workers to support people's self-care, the WHO also developed a Self-Care Wheel. The Self-Care Wheel has both digital and paper versions and is designed to summarize the WHO self-care recommendations in an accessible format for healthcare professionals and the public. The wheel was co-developed by a team from the WHO India Office and WHO Headquarters and is being tested in India, Morocco, and Nigeria.[58]

PROVIDER PERSPECTIVES ON ACCEPTABILITY AND BENEFITS OF SELF-CARE

Over the past decade, research conducted in diverse settings across self-care products and approaches, including HIVST, self-injectable contraception, and HPV self-sampling, has suggested that many healthcare professionals and service providers find it highly acceptable and they recognize the benefits that it conveys to people in their communities.[59-67] New evidence published since 2023 confirms these findings across SRH self-care broadly,[68] HIV and STI self-testing,[69] self-injectable contraception,[70] HPV self-sampling,[71] home pregnancy testing,[72] and self-managed abortion (*see case study on page 38*). Across self-care areas, healthcare professionals recognize that self-care increases convenience and accessibility of healthcare services.[9, 71, 73, 74] They also note that self-care has the potential to be empowering to their clients[69, 71] and can alleviate concerns about privacy when accessing potentially stigmatized services.[71, 74] In some cases, evidence suggests that self-care can make providers' work easier by reducing workload.[68, 73, 75] Additionally, some providers have noted that self-care has actually increased their engagement with clients or communities, as in the case of CHVs distributing home pregnancy tests in a study conducted in Kenya,[72] as well as among FP providers in Nigeria delivering training on DMPA-SC self-injection to their clients (*see case study on page 47*).[76]

> *"Teaching your client [self-injection] has taken the relationship to another level. The rapport is more cordial and a bit informal because of the teaching that comes in between."— Primary Health Care Provider in Nigeria* *(see case study on page 47)*

PROVIDERS' CONCERNS AND BARRIERS TO IMPLEMENTING SELF-CARE

Some concerns among providers about self-care, particularly HIVST, have been documented over the past decade and include concerns about clients' ability to correctly use self-care products,[63-65, 67] inadequate linkage to care or follow-up after use of a self-care product,[66] and potential threats to their own business.[77]

In research published since 2023 many of these same concerns were raised, including lack of confidence in clients' health literacy and ability to correctly use self-care products[9, 68, 71, 73, 74] and concerns about challenges linking to the health system after using a self-care product, including linking to treatment, receiving test results, and accessing care for side effects or complications.[9, 69, 72, 74, 75]

Other issues described in recent research include concerns about adequate reimbursement and financial motivations for providers to engage with self-care services and concerns about sustainable financing.[71, 73, 74] Some also expressed that introducing self-care into their practice could add to their workload and increase demand for certain services in a way that might exceed their capacity.[69, 71, 73] Other barriers to providers engaging with self-care that were mentioned across multiple recent studies included a lack of knowledge about self-care

products or approaches[9, 74] and the perception that self-care was not their responsibility.[73, 78]

Several of these concerns emerged in self-care case studies. In the United Kingdom healthcare professionals expressed concerns about whether people might misuse self-care products (*see case study on page 32*), and in Nepal private sector providers worried that self-managed abortion could decrease their workload and threaten their livelihoods (*see case study on page 38*).

APPROACHES FOR ENGAGING HEALTHCARE PROVIDERS

Recently published evidence and case studies included in this report show how providers can be effectively engaged in providing self-care. Healthcare professionals and other service providers engage with self-care in a variety of ways including through community-based promotion of self-care; individual-level counseling, training, and provision of self-care products; and participation in linkage to care and follow-up services (*see case study on page 43*).[71] Across self-care products, in recent research healthcare professionals note that they need additional training to effectively deliver and support self-care.[9, 72, 79] Several studies on training interventions with healthcare providers have shown promising results.

New research has engaged CHWs to participate in community-based distribution of self-care products.

- In Uganda, village health teams have been trained to provide DMPA-SC for self-injection. A study conducted across eight districts of the country found that village health teams provided counseling and training for self-injection that was of similar or greater quality than that provided by a higher-level cadre of clinic-based healthcare professionals (*see case study on page 45*).
- A pilot study conducted in Sikkim, India, trained accredited social health activists (ASHAs) to facilitate home-based HPV self-sampling in their communities. Women reported positive experiences with this approach, as nearly all said they were not embarrassed and did not have problems with self-collection.[71]

Two evaluations provide new evidence on approaches to training clinic-based providers on DMPA-SC for self-injection.

- Research from an empathy-based provider training on DMPA-SC SI in Nigeria indicates that the intervention was associated with a significant increase in DMPA-SC service provision and overall increases in FP service delivery, along with provider reports of increased confidence and capacity to provide self-injectable contraception. (*see case study on page 47*)
- An evaluation of an eLearning approach to DMPA-SC SI training in Uganda and Senegal found similar posttest scores among eLearning and in-person trainees, yet the authors emphasize that eLearning should be seen as a complementary approach rather than as a replacement for face-to-face learning.[6]

CASE STUDY: PROVIDER PERSPECTIVES ON SELF-MANAGED MEDICATION ABORTION IN NEPAL: MIXED-METHODS RESEARCH WITH PUBLIC, PRIVATE SECTOR, AND COMMUNITY-BASED PROVIDERS IN NEPAL

Authors: Kristen Little, Eden Demise, Jennifer Wheeler, Jyotsna Tamang, and Mahesh Paudel
Affiliation: Population Services International

Background

While policy in Nepal related to medication abortion is generally well aligned with WHO recommendations, there are opportunities to expand access through self-managed MA models. WHO guidelines state that a person can safely self-manage an abortion during the first trimester if they have accurate information about the process, access to a trained provider if support is needed or desired, and access to quality MA drugs. However, more evidence is needed to support policy changes to scale self-managed MA with stakeholders in Nepal. Regardless of whether part or all of the MA process is managed by a woman herself or a healthcare provider, providers play critical roles in raising awareness, supporting and advising women, and ensuring high-quality back-up care is available. Our study was intended to provide insights into provider perspectives on MA, including feasibility and acceptability, perceived ability of their clients to safely and confidently self-manage abortions, and provider willingness to support MA self-management.

We recruited public and private sector health providers and female CHVs (FCHVs) in Nepal to answer two primary research objectives: **1)** To describe healthcare providers' knowledge, attitudes, perceptions of family planning and SRH (FP/SRH) and safe abortion self-care, and their willingness to support self-care service delivery in Nepal; and **2)** To understand provider preferences for SRH self-care products and service delivery options, with a special focus on self-managed MA. We explored preferences around training opportunities, client support models, products/services, monitoring and implementation approaches, and client support strategies.

Methodology

We conducted mixed-methods research with providers from the public and private sectors as well as FCHVs. Providers were recruited from Bagmati and Madhesh Provinces in Nepal. We conducted semi-structured IDIs with 20 mid-level providers (from both the public and private sectors), 10 FCHVs, and 10 specialist providers (gynecologists, specialists, etc.). Interviews were conducted using a semi-structured interview guide administered by trained staff. Interviews included general questions as well as specific sections on self-care topics including self-managed MA, self-injectable contraceptive, and self-sampling for HPV testing. We also conducted a quantitative survey with 600 providers, including 200 mid-level public sector providers, 200 mid-level private sector providers, and 200 FCHVs. The survey included questions about self-care knowledge, awareness, and training, and had specific sections dedicated to self-managed MA, self-injectable contraception, and HPV self-sampling. Providers were recruited from sites identified via listings of healthcare facilities and facility catchment areas maintained by the public sector and PSI. Quantitative data were analyzed descriptively in Stata, and we conducted a latent class analysis (LCA). Qualitative data were analyzed deductively in NVivo using a thematic approach and a pre-developed codebook.

Results

Approximately 72% of public sector providers surveyed had never even heard of self-managed abortion compared to 77% of private sector providers and 90% of FCHVs. After learning about it, providers were generally willing to offer self-managed abortion to clients, shifting their role from direct provision to facilitation/support. While 94% of providers surveyed said they would be willing to be trained to support greater client self-management, almost one in four felt that self-managed abortion should be illegal. Despite this nearly 90% stated that they would be supportive of the government scaling up self-managed MA in Nepal. Self-managed MA was commonly seen as increasing client privacy and confidentiality (66–88%, across cadres), more convenient (64–74%), and more affordable (40–53%). However, providers also saw potential challenges to implementing self-managed abortion, including women's ability to manage side effects and complications (75–87%), to confirm completeness of a self-managed abortion (57–68%), and to fully understand the process/procedure (19–40%). We identified three distinct provider groups using LCA. "Resisters" (25% of providers) were unsupportive of self-managed abortion, felt that it would decrease their work/value, and would be unlikely to recommend this service to clients. Resisters were more likely to be private sector providers (68%). "Concerned supporters" (59%) would support self-managed abortion if the policy in Nepal were changed (with some concerns) and were mostly from the public sector (61%). "Enthusiastic supporters" (16%) were the most supportive of self-managed MA and were split across sectors.

Knowledge Contribution

Awareness of self-managed MA was low among public, private, and community-based providers surveyed in Nepal. While there was a high willingness to be trained to support clients to self-manage MA among providers in our survey, LCA revealed a significant segment, largely in the private sector, who oppose the introduction and scale-up of self-managed abortion, largely based on perceived threats to their livelihoods and work. Given the important role of the private sector in increasing access to safe abortion options, including self-management, social and behavior change campaigns targeting providers (especially those in the private sector) will be critical before self-managed abortion is scaled in Nepal. The largest segment of providers identified using LCA were generally supportive of self-managed abortion, but had concerns around women's ability to safely, confidently, and effectively manage MA on their own. Provider training, along with support materials for women tailored to local contexts and populations, may help to address these concerns and ensure that abortion services are delivered safely and with high quality, whether managed by a woman herself or with the support and supervision of a healthcare professional. More research on client perspectives is still needed, including on feasibility/acceptability and women's perceived ability to safely and confidently self-manage MA. Tailored tools to support abortion self-care, including eligibility and completion checklists (including their safety and usability), are still required. Finally, information is needed on clients' willingness to pay and to address safety, efficacy, and quality concerns providers had related to self-managed MA in Nepal.

CASE STUDY: UNLOCKING THE ROLE OF COMMUNITY PHARMACIES IN EXPANDING HIV PREVENTION

Authors: Austen El-Osta
Affiliation: Self-Care Academic Research Unit (SCARU), Imperial College London

Despite major advances in HIV prevention, access to PrEP remains uneven. In England, PrEP is currently available free of charge through specialist sexual health clinics. Yet these clinics are often few in number, concentrated in central locations and open only during standard hours. For many people, particularly those from minority backgrounds or living in deprived areas, such arrangements create barriers to timely access. Community pharmacies, with their ubiquity, long hours and trusted role in local health, offer a potential game changer.

Taking the pulse of pharmacy teams

To understand whether pharmacies are ready to take on this role, researchers at the SCARU surveyed 110 pharmacy staff across London and carried out ten IDIs.[1] The findings were encouraging but highlighted what work needs to be done to position pharmacies as trusted places where people can access HIV PrEP.

On the positive side, most respondents welcomed the idea of supplying PrEP from pharmacies, seeing it as a logical extension of their public health remit. Nearly 80% agreed that pharmacy-based PrEP would raise awareness and demand, while three-quarters said they would consider offering a commissioned service. Pharmacists emphasized their accessibility, consultation skills and expertise in drug interactions as strengths they could bring to HIV prevention.

However, the research identified significant barriers that needed to be considered. Surprisingly, many pharmacy staff had limited or no awareness of PrEP, with one in three respondents unfamiliar with it entirely. Confidence in discussing sexual health topics varied, and training needs were flagged repeatedly. Staff also worried about workload, time to counsel clients and how such a service would be funded. Interviewees emphasized the sensitivity of sexual health discussions in some cultural contexts, highlighting the need for privacy and public education.

Mapping the opportunity

A second related study by the same team examined the landscape of pharmacies and sexual health clinics across 11 London boroughs spanning two integrated care systems serving a population of 3 million residents.[2] The scoping review identified nearly 700 community pharmacies, more than three-quarters of which already provided some form of sexual health service. Importantly, 95 pharmacies (about 15%) were rated as "Tier 2," meaning they were equipped to deliver enhanced sexual health services such as contraception and STI testing, and could therefore be rapidly scaled to include PrEP provision.

By contrast, specialist PrEP clinics were scarce and unevenly distributed. In some boroughs with high HIV prevalence, such as Brent and Haringey, residents faced a mismatch between need and available services as most of the HIV PrEP and sexual health clinics were located in the central London region. This highlighted a post-code lottery of sorts since residents living outside of central London had to travel far and usually at a significant cost to access these clinics. Pharmacies, often within a 15-minute walk for most Londoners, were far more evenly spread and typically offered extended hours and private consultation rooms.

What this means for policy and practice

Taken together, the two studies tell a coherent story. Pharmacy teams are open to the idea of dispensing PrEP but need accredited training, structured guidelines and system support to do so confidently. Public health campaigns are required to raise awareness and reduce stigma, particularly in communities where HIV remains taboo. At the same time, the geographic reach of pharmacies offers a clear opportunity to plug gaps in service provision, especially for underserved groups who may not engage with specialist clinics.

Embedding PrEP in community pharmacies would align with broader NHS commitments to prevention and equity. It would also follow international precedents: in the United States and parts of Europe, pharmacists already play a frontline role in HIV prevention, including testing, counseling, and PrEP dispensing.

Looking ahead

Pharmacies cannot replace specialist clinics, but they can extend the reach of prevention services in ways clinics alone cannot. By combining accessible mapping data with the lived insights of pharmacy teams, this research offers policymakers a blueprint: invest in training, commission services, and normalize PrEP as part of everyday pharmacy practice.

The prize is significant because easier access to PrEP could help reduce new HIV infections in some of London's most affected communities, while positioning pharmacies as central partners in a broader self-care and public health agenda. The studies together highlight a simple but powerful lesson: to end HIV transmission, we must meet people where they are, and that often means at the pharmacy counter.

1. Alter M, Lakhani S, Alaa A, Karki M, Riboli-Sasco E, El-Osta A. Investigating facilitators and barriers to the routine provision of HIV PrEP in community pharmacies in London. *BMC Health Serv Res*. 2025;25(1):312. doi:10.1186/s12913-025-12336-1
2. Alaa A, Mujong D, Lakhani S, Alter M, El-Osta A. Investigating the potential accessibility to HIV pre-exposure prophylaxis via community pharmacies and sexual health clinics: a scoping review of two integrated care systems in London. *BMC Health Serv Res*. 2025;25(1):878. doi:10.1186/s12913-025-12985-2

CASE STUDY: EMPOWERING USERS OF MEDICAL ABORTION TO IMPROVE UPTAKE AND CONTINUATION OF MODERN CONTRACEPTIVE METHODS

Authors: Garima Mathias, Sushanta Kumar Banerjee and Ram Gopal Shukla
Affiliation: Ipas Development Foundation

Uttar Pradesh is India's most populous state, accounting for 16% of the nation's total population. The state faces significant demographic challenges, with early marriage practices (with a median age of 19.1 years)[1] and limited adoption of modern contraceptive methods contributing to high fertility rates (Total Fertility Rate [TFR] at 2.4)[1] and a notable prevalence of unintended pregnancies (49%).[2] A comprehensive study on abortion incidence in 2015 revealed that an estimated 3.2 million induced abortions take place in Uttar Pradesh. A majority (2.6 million, 83%) of these abortions are carried out by medical abortion (MA) outside the formal health settings.[2]

While MA offers safe and discrete abortion, women seeking MA often encounter a significant gap in access to information, products, and counseling support regarding modern contraceptive methods. This gap can be attributed to several factors, including the extended duration of the completion of the abortion process and limited or no contact with the health facilities after the procedure. It is also important to note that there is either a lack of or limited evidence available on postabortion FP intentions and practices, especially in cases of self-managed medical abortion.

Given this context, there was a pressing need to assess and address the postabortion contraception needs and devise a solution to improve the uptake and sustained use of contraception post-self-managed medical abortion. In line with this objective, operational research was launched to identify and implement effective strategies for reaching women who have undergone self-managed medical abortions and devising sustainable solutions for enhancing postabortion contraceptive care in two districts of Uttar Pradesh – Agra and Lucknow.

Formative research was done to understand women's pathways, experiences, and contraceptive preferences. Findings from the research highlighted that chemists play a critical role in the MA journey, and partners play a key role in access to commodities and in decision-making. Findings also indicated that there is a high risk perception of getting pregnant again during the MA process, which reduces over a period of one month. The formative research was followed by a user-centered design process to design a solution in conjunction with findings and in consultation with the community.

The final intervention had five key stages: **a)** reach – approach the client via chemists; **b)** counsel to seed information about contraception; **c)** facilitate decision-making; **d)** facilitate uptake of contraception; and **e)** follow-up to ensure sustained use. The intervention was branded as Saksham (meaning empowered) and included the following components:

- Chemists were the primary point to reach MA buyers with an information leaflet on contraception, and to promote the helpline. They received incentives to promote the helpline and distribute leaflets.
- A toll-free helpline, staffed with counsellors and a doctor, provided information and counseling about contraception at multiple points, referral support, and follow-up for continued use.
- Community intermediaries were oriented to support home-based counseling and delivery of contraceptives.
- Health facilities, both private and public, were enrolled to provide contraceptive services that require clinical intervention.

The intervention was implemented with 1200 chemists for over 32 months. During this period 95,000 leaflets were distributed by the chemist and the helpline received 14,000 calls from people undertaking self-managed abortion. Of these 14,000 calls:

- 51% of calls were from urban or peri-urban callers
- 12% of calls were from unmarried individuals
- Average age of MA users was 28 years
- 28% of callers were zero-parity married couples
- 41% of the callers were not using any contraceptive method before this pregnancy
- 95% of callers were counseled on contraception
- 51% agreed to follow up by helpline
- Of those who agreed to follow up, 32% adopted a contraceptive method

The insights and findings from the project underscore the multifaceted nature of addressing postabortion contraception challenges. A pivotal revelation is that chemists serve as the primary entry points and initial contacts for those purchasing medical abortion kits, which are typically male partners. The process of establishing contact, both initially and in follow-ups with MA self-users, particularly in bridging the gap between male partners and tele-counselors, poses a significant

challenge as male partners may not necessarily recognize the importance of their involvement in this process. Thus, it becomes imperative to incorporate relatable and actionable points within tele-counseling sessions aimed at partners. It was observed that there is a surge in momentum for contraceptive uptake about a month after an abortion, emphasizing the critical need for support and information provision during the entire period. Addressing questions and concerns related to abortion emerges as a potent catalyst for postabortion contraceptive counseling. It's worth noting that making productive calls often necessitates multiple attempts to establish effective communication. Furthermore, it's important to acknowledge that the adoption of contraception occurs in stages, especially for long-acting reversible contraceptives (LARC). Couples tend to start with short-term methods before making a final decision regarding the adoption of a LARC or permanent contraceptive method.

Globally, there is limited evidence on postabortion contraceptive uptake and its continuation, especially after self-managed medical abortion. Learning from the project has provided an evidence-based solution to improve the contraceptive uptake following self-use of medical abortion.

Legal and Ethical Considerations: This work was done to enhance understanding of postabortion contraception, specifically among MA self-users. This study does not advocate for actions that contravene national laws. Instead, it seeks to inform strategies that enhance postabortion contraception and bridge the evidence gap.

1. NFHS-5
2. *www.guttmacher.org/fact-sheet/abortion-postabortion-care-uttar-pradesh-india*

CASE STUDY: STRENGTHENING HIV POST-EXPOSURE PROPHYLAXIS ACCESS AND ADHERENCE THROUGH HEALTHCARE PROVIDER-LED SELF-CARE SUPPORT IN MOZAMBIQUE

Author: Jhpiego, Mozambique

Objectives

This case study explores healthcare provider perspectives on improving access and adherence to HIV post-exposure prophylaxis (PEP) services in Mozambique. The objective was to identify provider-led strategies used to support self-care among survivors of sexual and intimate partner violence and inform scalable interventions that can be integrated into the health system in Mozambique, taking into account the survivor profiles (young age, fear of reprisal and/or revictimization at home, dependence on others).

Methods

From March to August 2023, semi-structured IDIs were conducted with 20 healthcare providers (17 women, 3 men) from 20 health facilities across seven provinces in Mozambique. Participants included doctors, nurses, psychologists, and medicine technicians with 2 to 15 years of experience in post-violence care. Interviews were conducted in Portuguese, transcribed, and analyzed using inductive and theoretical thematic analysis. Thematic coding focused on provider recommendations for improving PEP access and adherence. Data were managed using MaxQDA software and anonymized to protect

participant confidentiality. This study was conducted under the Violence Umbrella Protocol (Project ID #: 0900f3eb81ac9ed9), reviewed by the Mozambique Ministry of Health Institutional Review Board and the US Centers for Disease Control and Prevention (CDC). The study was deemed not research and was conducted in accordance with applicable US federal law and CDC policy.

Results

The following three key themes emerged as providers' recommendations:

1. **Improve Access through Community Education**: During interviews, ten providers emphasized the importance of community lectures and health talks conducted in public spaces to raise awareness about PEP availability and the critical importance of the 72-hour window for medication initiation. Providers noted that many survivors are unaware about available PEP services and the importance of timely arrival (before 72 hours) for better results in the prevention of HIV acquisition; often, they arrive too late to be eligible for PEP. One provider stated, *"We have to leave our comfort zone and go into the community and educate about PEP advantages and importance of early arrival. If we don't educate clients about PEP literacy, they won't know that the services exist."*
2. **Counseling and Education to Support Adherence**: Thirteen providers recommended enhanced client counseling at the point of care to ensure understanding of the importance of completing the regimen and managing possible side effects. Providers stressed that counseling must build trust and empathy. One provider explained, *"Counseling is not just talking – it's a process of convincing the person on the importance of completing treatment and return for follow-up."*
3. **Follow-Up trough Telephone Calls for Continued Support**: Nine providers advocated for *"chamadas preventivas"* (follow-up calls) within two weeks of the initial visit to check on side effects, reinforce adherence, and remind clients to return for retesting. Providers described these calls as a way to build a supportive bond, even across distances. One provider stated, *"It's possible to create a connection through a call. They feel welcome and supported."* Providers also recommended institutionalization of these calls across facilities that offer post-violence care, similar to what the Mozambique HIV Program does for patients on anti-retroviral therapy. This strategy is currently being considered for national scale-up.

Conclusions

Healthcare providers in Mozambique play a critical role in enabling self-care through education, empathy, counseling, and system-level support. Their recommendations (community outreach, client counseling, and follow-up support) are low-cost, scalable, and adaptable to other sub-Saharan African contexts. These strategies empower survivors to initiate and maintain PEP independently, aligning with global guidance on self-care and HIV prevention.

Mozambique Ministry of Health has begun implementing these recommendations through initiatives such as the "Cada Hora Conta" (Every Hour Counts) campaign, revised standard operating procedures for PEP kit preparation, and expanded training on adherence counseling. These efforts reflect a growing commitment to provider-facilitated self-care support across the country.

CASE STUDY: THE PROMISING ROLE OF COMMUNITY HEALTH WORKERS IN CONTRACEPTIVE SELF-CARE SERVICE DELIVERY: AN EVALUATION OF CONTRACEPTIVE SELF-INJECTION SERVICE DELIVERY IN UGANDA

Authors: Jane Cover,[a] Allen Namagembe,[b] Barbara Kunihira,[b] Andrew Secor,[c] and Fiona Walugembe[b]
Affiliations: [a]PATH, United States.[b]PATH, Uganda.[c]PSI, United States.

Context

Accelerating task sharing for FP and contraceptive self-care can minimize the impact of a projected global shortage of 10 million health care workers by 2030.[1] Upon extensive review of the evidence, the WHO issued recommendations (in 2012 and 2017) that CHWs can safely and effectively offer FP methods, including administration of injectable contraception.[2] Despite this guidance, countries introducing DMPA-SC for self-injection (SI) have usually opted to offer SI service delivery only via clinic providers. Uganda is one of just three countries that have trained a substantial number of volunteer lay CHWs (over 18,000) to counsel women on SI (among 18 countries scaling DMPA-SC for self-injection).[3] Accordingly, the Ugandan country context presents an opportunity to assess the potential of CHWs to expand access to FP, including contraceptive self-care.

A study led by PATH compared the quality of FP counseling and SI training offered by CHWs (called village health teams) relative to services from facility-based providers.[4] The study, which was approved by the Ugandan National Health Laboratory Services Research and Ethics Committee and the Ugandan National Council for Science and Technology, addressed two key research questions:

1. What is the level of quality of FP counseling and SI training as reported by clients?
2. Despite lower levels of training and education, are CHWs able to offer FP and SI services that are of comparable quality to those offered by clinic providers?

Methods

The study employed exit interviews with 240 injectable clients and interviews with 80 of the providers who conducted their counseling from 43 purposively selected public sector clinics across 8 districts of Uganda. Clients were evenly split between those served by CHWs and those served by facility-based providers. Similarly, half of the providers were CHWs offering FP services in the communities surrounding the 43 facilities. The study examined the acceptability and quality of contraceptive service delivery, including SI training for women interested in self-care. A key measure was the Method Information Index plus (MII+), which comprises four questions (see Figure 1) and is expressed as the percent of women who respond affirmatively to all four questions. The study centers client experiences and preferences to inform our understanding of FP and SI service quality and acceptability.

Results

Findings reveal pronounced differences in the quality of care provided by CHWs relative to that provided by clinicians, with CHW clients receiving more comprehensive FP counseling. Figure 1 shows the individual measures that comprise the MII+, as well as indicators on information clarity and solicitation of client questions. As reported by clients, CHWs significantly outperformed their clinic-based colleagues across

all measures (p<.05), in some cases by margins of 20 percentage points or more (told about side effects and how to manage them, clarity of information and the MII+).

In terms of SI training, stakeholders are often reticent to permit CHWs to train clients in self-injection out of concern over insufficient capacity or competence among lay health workers. As shown in Figure 2, a side-by-side comparison of SI training practices, as reported by clients, suggests their concerns may be misplaced. Across most measures that define quality SI training, CHWs outperformed facility providers. CHWs were significantly more likely to conduct individual training or ensure private time with the client (if trained in a group), show the client a job aid, coach while injecting, advise what to do if injection was missed, advise on storage, advise on disposal, and give the client a job aid to take home (p<.05). The small sample size precludes detecting statistically significant differences for the other measures with a gap. Among clients who self-injected at the end of their training, 96% of clients trained by CHWs strongly agreed with the statement: 'I felt confident that I could self-inject on my own at the end of the training' (vs. 81% of the clients trained by clinic providers; difference not significant [not shown]).

Figure 1. Quality of family planning counseling provided by CHWs and clinic providers

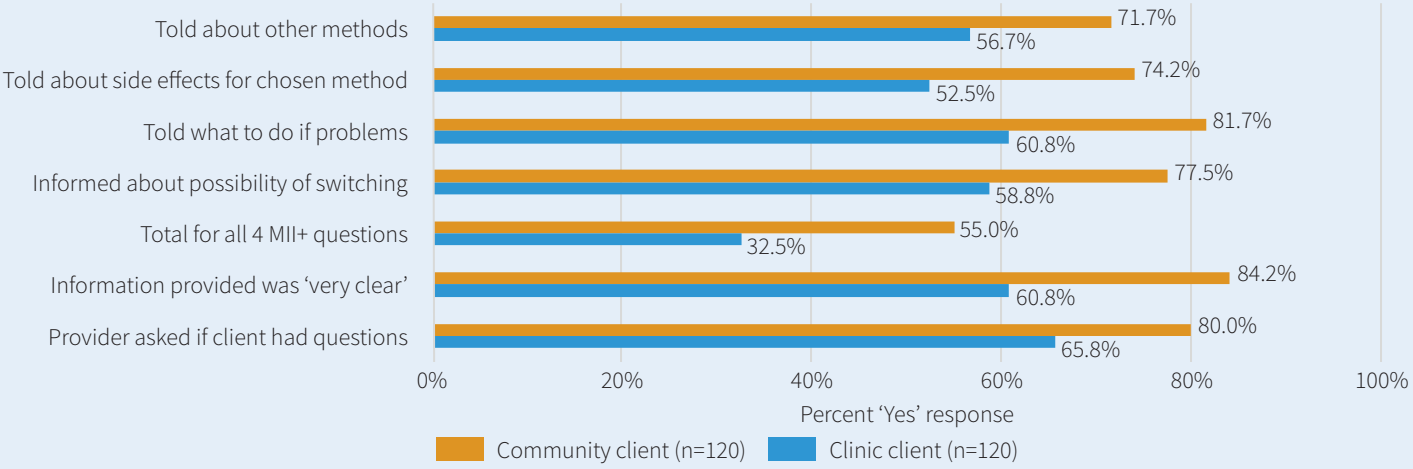
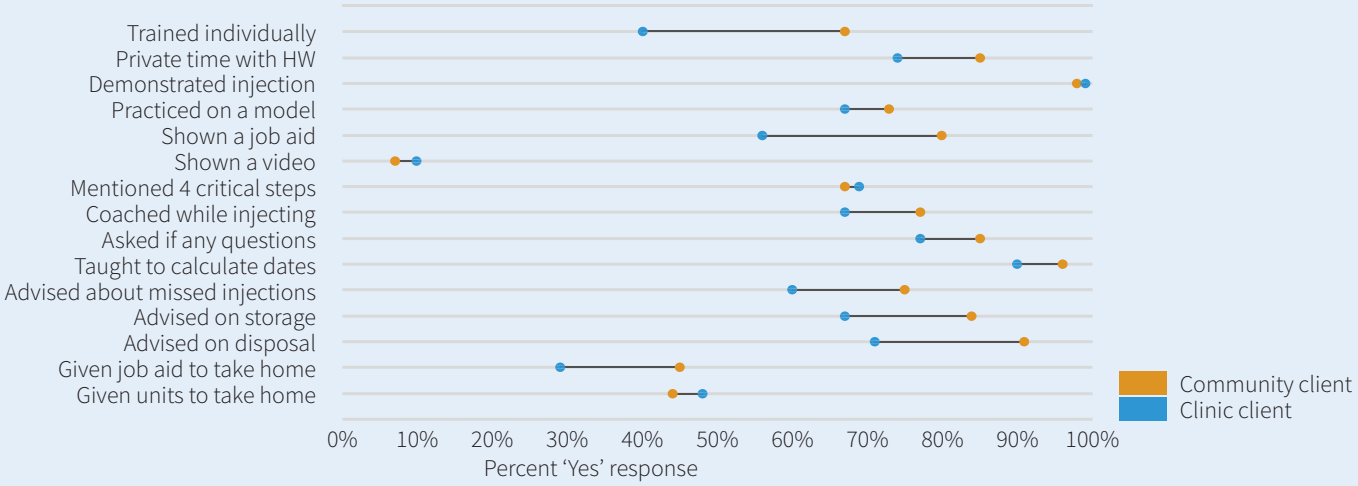


Figure 2: Quality of self-injection training provided by CHWs and clinic providers



Conclusions

The findings from this study should reassure ministry representatives, program managers, and clinicians that, when provided with appropriate, competency-based training and supervision, CHWs can help fill a looming human resource shortfall, reinforcing FP service delivery and increasing access to contraceptive self-care. That said, the promise of effective, high-quality FP services at the community level is best realized when countries implement measures to strengthen systems that support CHWs. Specifically, the WHO guidelines for CHW programs call for supportive supervision, integration into the supply chain and data collection systems, and feedback to monitor performance and measure the CHW contribution to the FP program. In the words of the Community Health Impact Coalition (CHIC), a nonprofit membership group for CHWs and aligned organizations, an effective workforce of CHWs should be "salaried, skilled, supported and supplied."[5]

1. World Health Organization. Health workforce. Accessed August 28, 2025. www.who.int/health-topics/health-workforce
2. *Community Health Worker Programmes in the WHO African Region: Evidence and Options — Policy brief*. Geneva: World Health Organization; 2017. www.afro.who.int/publications/community-health-worker-programmes-who-african-region-policy-brief
3. Injectables Access Collaborative. *Global DMPA-SC Status Report, Q4 2024*. PATH.
4. Cover J, Namagembe A, Kunihira B, Nantume C, Secor A, Walugembe F. DMPA-SC self-injection experiences of clients and providers in Uganda: the role of community health workers in reproductive self-care service delivery. *BMC Womens Health*. 2025;25(Suppl 1):341. doi.org/10.1186/s12905-025-03850-9
5. Community Health Impact Coalition website: joinchic.org

CASE STUDY: ACCEPTABILITY AND EFFECTIVENESS OF EMPATHY-BASED PROVIDER TRAINING AND COMMUNITY MOBILIZATION FOR SELF-INJECTABLE CONTRACEPTION IN NIGERIA: A MIXED-METHODS PROGRAM EVALUATION

Authors: Susan Ontiri,[a,b*] Claire W. Rothschild,[a*] Fauzia Tariq,[a] Oluwaseun Adeleke,[c] Michael Titus,[c] Mopelola Raji,[c] Julius Njogu,[a] Susannah Gibbs,[a] Robin Swearingen,[a] and Fidelis Edet[sc] ***Authors contributed equally**
Affiliations: [a]Population Services International. Current affiliation: [b]International Center for Reproductive Health. [c]Society for Family Health, Nigeria.

A study recently published in BMC Women's Health[1] demonstrates the effectiveness and acceptability of combining supply- and demand-side interventions to increase access to self-injectable contraception in Nigeria.

Background

Discrimination, stigma, and lack of empathetic care are well-documented barriers to SRH care-seeking and utilization. There is ample evidence that healthcare providers can act as gatekeepers of contraceptive services, limiting access by refusing to provide services as chosen, or by creating a health facility environment that is stigmatizing to groups such as adolescents and unmarried women. DMPA-SC is a method of contraception designed to be self-injectable (SI). Lack of provider competency and training, in addition to provider-imposed barriers, may limit access to DMPA-SC. Studies in various settings have found that provider-imposed restrictions on DMPA-SC use are common, particularly for specific groups of women such as adolescents, youth, and women with lower educational attainment. Providers themselves have reported lack of capacity to provide empathetic counseling and coaching to people interested in DMPA-SC SI. Interventions aimed to increase healthcare provider

empathy and capacity to deliver person-centered care have been shown to improve healthcare seeking and health outcomes. In Nigeria, the Delivering Innovation for Self-Care (DISC) project developed and evaluated an empathy-based in-service training and supportive supervision intervention for public sector FP providers, which was implemented in conjunction with community-based sensitization activities.

We conducted a mixed-method quasi-experimental evaluation to assess DISC's complex intervention, which included empathy-based provider in-service training, data strengthening support, community mobilization activities, and ongoing supportive supervision in Lagos, Oyo, and Niger states of Nigeria. Specifically, our study aimed to:

- Evaluate the effectiveness of the intervention in terms of its impact on service delivery of DMPA-SC for self-injection, DMPA-SC overall (including as a provider-administered method), and other contraceptive method service delivery in DISC-supported study facilities.
- Assess the acceptability and self-reported changes in attitudes and practices towards SI after the training from the perspective of participating healthcare providers.

Methodology

We conducted a mixed-method quasi-experimental evaluation of the DISC program in Nigeria. Effectiveness of the intervention was assessed in 36 facilities using a single-group interrupted time series analysis design that leveraged four phases: **1)** pre-intervention; **2)** strengthening of routine data only; **3)** implementation of empathy training and community mobilization; and **4)** supportive supervision/maintenance. Service data were extracted from the Nigerian Health Management Information System and facility-based monitoring tools. Primary outcomes of interest were number of DMPA-SC SI visits; number of DMPA-SC provider-administered visits; and number of total DMPA-SC visits (SI and provider-administered combined). Models were fit using generalized estimating equation models accounting for repeated observations within facility. We used linear models with observations at the facility-month-level, in which coefficients can be interpreted as mean differences in monthly facility-level service visits. To evaluate whether implementation was associated with shifts in overall FP service volumes and in the service delivery method mix, we fit analogous interrupted time series analysis models with secondary outcomes: total FP, LARC, and DMPA-IM visits. In-depth interviews were conducted with 31 trained reproductive health coordinators and providers during the intervention period; transcripts were analyzed using a hybrid deductive-inductive thematic analysis approach.

Results

Mean DMPA-SC service provision increased by 28.[1] visits (95% confidence interval [CI] 18.0-38.3) on average per facility in the first month of implementation. The intervention was associated with an increase in mean facility-level DMPA-SC SI service delivery of 25.9 visits (95% CI 16.3-35.4) in the first month of implementation. The intervention was also associated with significant increases in overall FP service delivery. Trained providers reported substantial increases in client demand for DMPA-SC SI, coupled with increased self-reported provider confidence and capacity to counsel and train clients to self-inject. Providers specifically cited that the training had supported them to adopt effective empathy-based strategies fostering positive client-provider relationships.

> *"…teaching your client [SI] has taken the relationship to another level. The rapport now is more cordial and a bit informal because of the teaching that comes in between. I may give a patient OCP or implant and I may not even remember the patient if we meet on the road. But because I teach, it makes every contact special."*
> *Primary Healthcare Provider*

We observed a decrease in the monthly trend of provider-administered DMPA-SC provision from no monthly change pre-implementation (adjusted β [aβ]: 0.01; 95%CI: -2.23 to 2.25) to a monthly decrease of 3.7 visits on average per facility during implementation (aβ: -3.67 95%CI -6.0 to -1.4). We observed no group-level changes in DMPA-IM or LARC provision associated with the intervention. Increases in DMPA-SC service provision were sustained in the supportive supervision/maintenance period.

Knowledge Contribution

Evidence across a variety of health areas and settings has demonstrated that interventions focused on improving the relationship between health workers and clients can effectively increase provider empathy and confidence and improve healthcare utilization and other outcomes. Yet such approaches have not, to our knowledge, been widely used in settings such as Nigeria to support provider capacity to deliver a newly introduced self-injectable contraceptive method. Our findings demonstrate the effectiveness and acceptability of a project implementing combined supply- and demand-side interventions to increase awareness of and access to self-injectable contraception in Nigeria. Our qualitative findings highlight high acceptability of the DISC empathy training intervention among participating healthcare providers. Providers noted pre-training biases that had previously limited their provision of DMPA-SC SI to more highly educated and urban women. While most providers had received previous "hard skills" training or sensitization on provision of DMPA-SC, including via SI, providers noted that the DISC training provided concrete examples and practice on interpersonal communication that were critical for them to effectively coach women to self-inject; several providers even reported amazement in their ability after the training to effectively establish rapport and to empathetically address clients' questions and concerns. This study provides novel insights into the effectiveness and acceptability of an empathy-focused intervention implemented in Nigeria to expand access to and quality provision of DMPA-SC self-injection. In the context of DISC's programming in Nigeria, an intervention grounded in principles of empathy and person-centered care provides a promising blueprint for expanding access to contraceptive self-care and other FP methods.

1. Ontiri S, Rothschild CW, Tariq F, et al. Acceptability and effectiveness of empathy-based provider training and community-level awareness activities on self-injectable contraceptive use in Niger, Lagos, and Oyo States, Nigeria: a mixed methods program evaluation. *BMC Womens Health*. 2025;25(Suppl 1):428. doi:10.1186/s12905-025-03992-w

ADVANCING SELF-CARE THROUGH POLICY AND SYSTEM-LEVEL CHANGE

GLOBAL DATA ON SELF-CARE POLICY UPTAKE

Broad national policies on SRH self-care are becoming increasingly common, including in LMICs. According to the WHO's 2023 Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health Policy Survey, 42% of the 115 member states reported a national policy or guideline on self-care interventions for SRH. Most of these policies or guidelines included self-use of contraceptive methods; over-the-counter SRH products, devices, and diagnostics; and self-collection of samples for STI and HIV screening.[2] Many additional national self-care policies focus on individual health areas, products, or approaches, like HIVST, self-injectable contraception, and HPV self-sampling. Other key enabling policies related to self-care include those related to task shifting,[80, 81] complementary and alternative medicine,[7, 8] and national medicines policies.[82]

Multiple LMICs have advanced national self-care policies in recent years. After rigorous consultative processes, Kenya approved its National Guideline on Self-Care for Sexual Reproductive and Maternal Health, following the lead of Nigeria and Senegal, which both advanced self-care policies starting in 2021.[83, 84] Uganda pilot-tested its self-care guideline in 2021–2022 and subsequently incorporated self-care into its clinical standards and list of core medicine.[85] Ethiopia published a comprehensive National RMNCAYH-N self-care intervention guideline in May 2024.[86] Taken as a whole, these policy advances demonstrate national self-care wins and show considerable progress translating evidence-based advocacy to policy to practice at the country level.

HIV SELF-TESTING

The past several years have seen remarkable progress in national HIVST policy and routine implementation. According to WHO tracking, as of 2024, 107 countries had supportive HIVST policies, a nearly three-fold increase since 2019—another 25 countries are in the process of developing HIVST policies.[3] Of countries with policies in place, 71 reported routine implementation of HIVST, a five-fold increase since 2019.[3]

Progress is particularly notable in several LMICs, where efforts have moved beyond pilot stages. Kenya, for example, incorporated HIVST into its 2023 National Guideline for Self-Care in Reproductive Health.[30] Similarly, Uganda's Ministry of Health introduced a national self-care guideline in 2024 that includes HIVST, building on its previous integration into clinical protocols and the essential medicines list in 2023.[30] India has pursued evidence generation for national adoption through the STAR HIVST project (2021–2023), funded by Unitaid.[87] This mixed-methods demonstration covered 50 districts across 14 high-prevalence states, testing five delivery models – community-based, private sector, workplace, network-led by people with HIV, and virtual – and reported that HIVST contributed to reduced stigma and greater convenience. These findings are informing the development of a national HIVST policy.

SELF-INJECTABLE CONTRACEPTION

As of a 2023 publication, the Access Collaborative (AC) reports that DMPA-SC is registered in more than 80 countries and is approved for self-injection in more than 55 countries.[88] The expansion of DMPA-SC and self-injection regulatory approvals and supportive policies has meant meaningful growth in DMPA-SC SI service delivery: As of the 2nd quarter of 2025, the AC reports that nearly 150,000 providers have been trained in SI since 2018 across 18 countries monitored by the AC.[89] Most investments in SI training since 2018 have been in the public sector (87%) and among facility-based providers (57%). Among all providers

trained in SI since 2018, one-third were CHWs, while 5% were drug shop staff or pharmacists. In a subset of 10 of these countries, 42% of all reporting service delivery points were actively offering SI. The share of DMPA-SC visit that were for self-injection is also increasing: service delivery data from 16 sub-Saharan African countries indicates that just under one-third (31%) of all DMPA-SC client visits in the 2nd quarter of 2025 were self-injected – an increase of 10 percentage points over the past year.

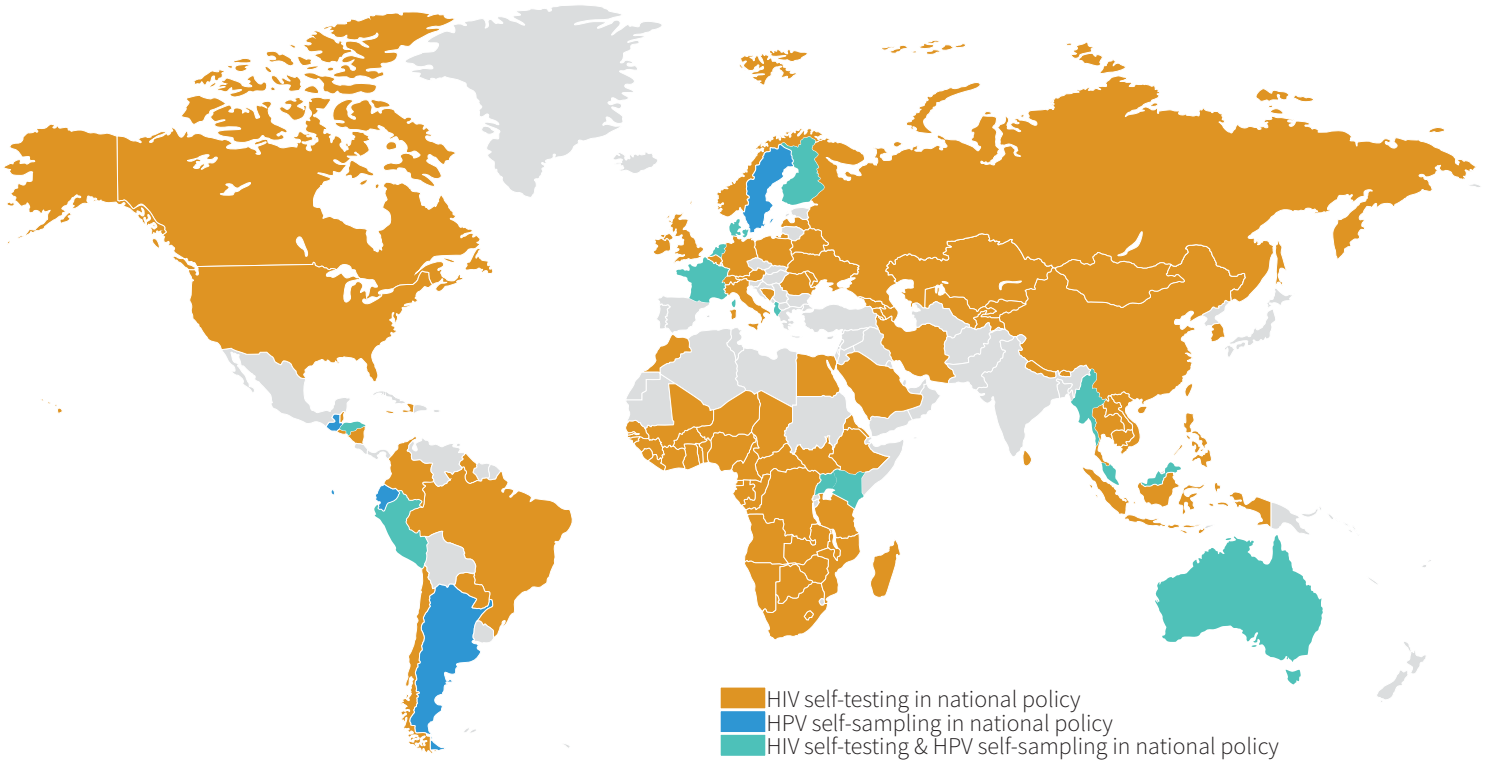
HPV SELF-SAMPLING

HPV self-sampling is still a developing area for self-care policy, particularly in LMICs. A 2022 publication identified only 17 countries that included HPV self-sampling in their national screening programs, of which 11 are LMICs.[4] About half of these countries recommend self-sampling only for under-screened populations. Eight more countries are piloting HPV self-sampling to inform decisions about incorporating it into national screening guidelines.

SELF-MANAGED ABORTION

New in 2024, the Center for Reproductive Rights has developed an interactive report describing the legal landscape for self-managed abortion across 39 countries. The report summarizes the range of restrictive and supportive policy environments, emphasizing the substantial policy barriers, even in more supportive locations.

Self-care diagnostics in national policy, programs, or guidelines



Data sources: Serrano B et al. Worldwide use of HPV self-sampling for cervical cancer screening. *Prev Med*. 2022;154:106900. doi:10.1016/j.ypmed.2021.106900 and UNAIDS Laws and Policies Analytics *lawsandpolicies.unaids.org*

NATIONAL-LEVEL SELF-CARE POLICY ADVOCACY AND IMPLEMENTATION

Given the recency of many self-care policies in LMICs, rigorous evidence on how these policies have been implemented, integrated into national health systems, and scaled up remains scarce. Recent studies have noted a clear need for implementation guidelines across health areas and self-care products,[8, 90, 91] along with workforce development to equip healthcare professionals and other service providers to effectively support self-care.[80, 91, 92]

As an emerging evidence area, case studies included in this chapter provide an exciting window into the leading edge of advocacy and implementation of self-care policy. Though the case studies included in this report largely focus on FP and self-injectable contraception, significant progress has also been made in HIVST and HPV self-sampling, as described above. A case study from Nigeria documents an advocacy initiative that aimed to understand resistance to self-care from professional organizations and engage them in self-care advocacy (*see page 63*). Another case study describes implementation of Kenya's Reproductive Health Self-Care Guidelines (*see page 66*). A case study from Sindh, Pakistan, describes a subnational effort to introduce and scale-up DMPA-SC for self-injection (*see page 60*). A final pair of case studies describe Malawi's approach to institutionalizing DMPA-SC self-injection and includes an analysis showing the costs of DMPA provision across different delivery and administration approaches, a key tool for informing decisions about scaling up method introduction (*see case studies on pages 67 and 69*).

COSTING AND COST-EFFECTIVENESS STUDIES TO INFORM POLICY DECISIONS

Self-care has long been positioned as a strategy with potential cost savings to the health system, and there is a growing evidence base empirically demonstrating the cost-effectiveness of self-care.[93] The SCTG has also invested in this area through a workstream on costing in financing. Through this workstream, the Health Economics and AIDS Research Division at the University of KwaZulu Natal conducted an *evidence review* of costing and financing for self-care in LMICs and developed an *accompanying conceptual framework* for costing and financing self-care interventions in LMICs.

In this report, two case studies on costing and cost-effectiveness of self-care interventions provide examples of action-oriented evidence generation. An analysis showing the costs of DMPA provision across different delivery and administration approaches serves as a key tool for informing decisions about product introduction and scale-up, and cost-effectiveness studies on HIVST provide critical data for policy advocacy (*see case studies on pages 67 and 69*). Additional recently published research includes experimental evidence from Kenya finding that provision of HIVST to long-distance truck drivers was a cost-effective intervention to increase testing uptake relative to a comparison arm that offered provider-administered testing only[94] and recent evidence from the United States supporting cost-effectiveness of HPV self-sampling.[95, 96]

TOOLS FOR SELF-CARE POLICY DEVELOPMENT, CHANGE, AND IMPLEMENTATION

Several tools related to advocacy, policymaking, and implementation that have been developed and documented in recent years may be of particular interest to the self-care community and include the following:

- Self-Care Policy Monitoring Tool (*see page 66*)
- Self-Injectable Policy Cycle Analysis (*see page 54*)
- Leading with Self-Injection Checklist (*see page 67*)
- Health Economics Value Assessment Tool for DMPA-SC and Self-Injection (see below)
- HIV Self-Testing Performance Dashboards (*see spotlight on page 72*)

A TOOL FOR VALUE ASSESSMENT OF SELF-INJECTED DMPA-SC

PATH developed a health economics value assessment tool to facilitate evidence generation for introduction, scale-up, and institutionalization of DMPA-SC and SI. This tool can inform country stakeholders and decision-makers around "value-for-money" pertaining to DMPA-SC and SI for product prioritization as part of the overall method mix. The tool builds on the previous cost-effectiveness analysis in Senegal and Uganda[1,2] and expands the model to include capacity for budget impact analysis within the tool—a response to the key health economic questions facing country decision-makers, as shared during consultations with key stakeholders from Ethiopia, Kenya, Nigeria, and Pakistan.

The health economic tool is flexible, allowing users to input a range of data points and parameters to understand the cost-effectiveness, budget impact, and cost savings potential of both DMPA-SC and SI, as compared to alternative injectable options like DMPA-IM. Pilot testing of the tool using secondary data from published and unpublished sources from each of the four countries, and under reasonable assumptions, align with the previous research, suggesting:

- Women who self-inject have overall better health outcomes compared to those who receive DMPA-IM from a provider.
- Costs from a health systems perspective are higher among women who self-inject compared to those who receive DMPA-IM from a provider.
- Costs from a societal perspective are lower among women who self-inject compared to those who receive DMPA-IM from a provider, representing cost savings for clients.

A useful function of the tool is the ability for users to adjust inputs to analyze the impacts of changes large and small to understand how program and policy changes might make DMPA-SC and SI more or less cost-effective from the health system and/or societal perspectives, ultimately contributing to optimal program design suitable to various settings. Adjustable inputs include product cost, cadre of health worker providing services, length of time spent on service provision, continuation rates, and costs to the client, among others. This resource can be utilized* by global and county stakeholders to generate health economic evidence for informed decision-making.

* The tool can be made available upon request from PATH and may require appropriate technical assistance to ensure proper use. Request can be sent to fpoptions@path.org

1. Di Giorgio L, Mvundura M, Tumusiime J, Morozoff C, Cover J, Drake JK. Is contraceptive self-injection cost-effective compared to contraceptive injections from facility-based health workers? Evidence from Uganda. *Contraception*. 2018;98(5):396-404. doi:10.1016/j.contraception.2018.07.137
2. Mvundura M, Di Giorgio L, Morozoff C, Cover J, Ndour M, Drake JK. Cost-effectiveness of self-injected DMPA-SC compared with health-worker-injected DMPA-IM in Senegal. *Contracept X*. 2019;1:100012. doi:10.1016/j.conx.2019.100012

CASE STUDY: FROM RED TO GREEN: A NOVEL POLICY DATA ANALYSIS APPROACH TO MONITOR AND ACCELERATE INTRODUCTION AND SCALE-UP OF DMPA-SC AND SELF-INJECTION ACROSS 11 AFRICAN COUNTRIES

Authors: Bonnie Keith,[a] Adewole Adefalu,[b] Christina Bernadotte[a] Célestin Compaore,[c] Rajiv Gangadia,[d] Jane Cover[a]
Affiliations: [a]PATH. [b]John Snow, Inc. [c]Jhpiego. [d]Clinton Health Access Initiative.

Background

Expanding the contraceptive method mix by adding new products to the market often requires the establishment or expansion of the enabling environment through creation of and/or adjustments to policies, guidelines, and standards. This has been particularly true with efforts to introduce and bring DMPA-SC and self-injection (SI) to scale, largely due to the practice of self-injection for contraception being a novel service delivery option in many LMICs. A significant amount of implementation research and policy advocacy has been needed to advance access to DMPA-SC and self-injection in LMICs, and the Injectables Access Collaborative (AC) project has created a novel policy data analysis and visualization approach to help decision-makers and influencers understand the enabling environment for DMPA-SC/SI at the country and global level, and identify opportunities for advocacy, improved policy implementation efforts, and alignment within the health system.

Program intervention tested

To facilitate evidence-based decision-making, the AC created a first-of-its-kind analysis of the enabling environment for SI in its 11 focus countries (Benin, DRC, Ghana, Kenya, Madagascar, Malawi, Mozambique, Nigeria, Togo, Uganda, and Zambia). The SI Policy Cycle Analysis visualizes the status of policy implementation across 16 indicators covering national-level policies and commitments, task sharing policies, dispensing policy, and data collection standards. For each country, detailed descriptions of the circumstances informing the assigned policy status help users understand how decisions have been made to date and where opportunities exist to improve the enabling environment.

Methodology

To document the nuances behind the SI enabling environment, AC identified 16 indicators based on the DMPA-SC Institutionalization Tracker and desired policy landscapes. For each country, the indicator data reflect:

1. National commitments to SI and/or self-care.
2. Political support for task sharing DMPA-SC service delivery, SI resupply, and SI initiation training across different health provider channels (i.e., CHWs, pharmacies, drug shops).
3. How many DMPA-SC units a woman can take home for future SI.
4. The inclusion of disaggregated SI data in the country's health information management systems.

For each indicator, countries were assigned a color-coded designation reflecting the current state of policy implementation:

- **Yes/Green**: Policy in place, implementation underway.
- **Yes*/light blue**: Policy in place, but it is incomplete, or implementation is stalled or underway only as a pilot.

- **In Process/Yellow**: Policy drafted and/or decision-maker publicly expressed commitment to advance policy.
- **No/Red**: No policy or public commitments.

A comprehensive narrative was included for each indicator, by country. AC staff assigned and validated the indicator designations, as well as the narratives. Ministry of Health officials in each country also validated the designations and narratives.

Key findings

The *SI Policy Cycle Analysis* provides users with critical insights into the state of the SI enabling environment in AC countries. With data available via a color-coded snapshot view, and in-depth narrative content for each indicator, users receive robust insights into the particulars of policymaking processes at the country level. The analysis enables viewers to understand the steps necessary to see a policy through from the advocacy stage all the way to actual implementation at scale, a process that is detailed, lengthy, and multilayered.

To date, the analysis has been conducted six times (2022 Q4; 2024 Q2; 2024 Q3; 2024 Q4; 2025 Q1; 2025 Q21). In that period, 10 of the 11 countries had secured a more enabling environment for SI, including 16 policy authorizations, 11 advancements from no policy/commitment to in process efforts, and seven progressions of policy from partial to comprehensive implementation. One country experienced a policy setback in the timeframe. The Table shows the most recent (2025 Q2) analysis, with arrows indicating the state of progression for relevant changes.

These developments were documented in each update to the analysis, allowing users to monitor progress or backsliding and key decision points along the way. Alongside successes and challenges, opportunities to strengthen the enabling environment are highlighted based on the detailed narratives accompanying each indicator, allowing for evidence-informed strategic planning as demonstrated in each country's annual work plan. Successful advocacy tactics are also emphasized, offering learning for future strategic planning.

Program and policy implications

The SI Policy Cycle Analysis has become an essential tool for partners providing technical assistance to governments to shape the enabling environment for DMPA-SC/SI. The Analysis informs country action plans and advocacy strategies. In addition to providing key data and background evidence for in-country discussions, it is helpful for countries to see how their enabling environment compares to others', and where they may be able to adopt advocacy strategies and leverage similarities or differences across countries to shape their enabling environments to suit their local context.

At a global level, the Analysis supports program implementation and investment strategies, allowing for rapid insights into the state of policy environments, and where and—critically—why policy implementation faces hurdles.

The Analysis offers a practical model that global- and country-level market stewards can use and adapt for routine monitoring of the comprehensive policy environment for SRH markets. This addresses a critical and previously unmet need in the FP sector, especially as countries continue to introduce and scale new health products and service delivery modalities, including self-care approaches.

1. fpoptions.org/resource/si-policy-analysis

Self-injection policy snapshot (June 2025)

Focal Countries for the Injectables Access Collaborative (AC)

		Benin	DRC	Ghana	Kenya	Mad.	Malawi	Moz.	Nigeria	Togo	Uganda	Zambia
National SI Policy		2020	2021	2019	↑ 2023	2019	2018	2021*	2018	2019	2019	2019
National Self-care Policy		No	No	↑ In Process	↑ 2023	No	↑ 2024*	No	2021	No	2020	↑ 2024
National FP2030 Commitment Includes SI and/or Self-care		No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Community Health Worker (CHW)	Policy to administer DMPA-SC	2020*	2021*	No	2018*	2019	2018	2015	2019	2018	2010	2018
	Policy to resupply SI clients	2020*	2021*	No	↑ 2023*	2019*	2018	2021*	2019	No	2019	↑ 2023
	Policy to initiate SI	2020*	2021*	No	No	2019*	2018	2021*	2019	↑ In Process	2019	↑ 2023
Pharmacy	Policy to administer DMPA-SC	↑ In Process	→ 2022*	In Process	2018	↑ 2025*	2022*	No	2019	↑ In Process	↑ 2024*	2020
	Policy to resupply SI clients	↑ In Process	→ 2022*	In Process	↑ 2023	↑ 2025*	2022*	No	2019	2020	↑ 2024*	2020
	Policy to initiate SI	↑ In Process	2022*	In Process	↑ 2023	↑ 2025*	2022*	No	2019	↑ In Process	↑ 2024*	2020
Drug Shop	Policy to administer DMPA-SC	No	No	No	N/A	No	2022*	N/A	2019	N/A	2021	N/A
	Policy to resupply SI clients	↑ In Process	No	No	N/A	No	2022*	N/A	2019	N/A	2021	N/A
	Policy to initiate SI	No	No	No	N/A	No	2022*	N/A	2022	N/A	2021	N/A
Dispensing protocol ^	# of doses sent home after first SI visit	0	0	2*	0	1*	↑ 3*	2*	3*	0	3*	2*
	# of doses sent home after subsequent SI visits (refill)	2	3	3*	2/4*	1/2*	↑ 3*	2*	3*	2	3*	3*
Date	SI visit data disaggregated from PA visits to HMIS	2020	↑ 2025*	2020	No	2023*	2020	In Process	2021	2020	2022	2023
	LMIS includes DMPA-SC	2020	2018	2019	2021	Pre-2018	2019	-2016	2018	Pre-2020	2018	2013

↑ Indicates increasing policy support ↓ Indicates decreasing policy support → Indicates clarification of policy designation

^ Dispensing protocol designations reflect the state of dispensing policy authorization and implementation, rather than the scope of dispensing latitude, i.e., the quality of the policy.

CASE STUDY: THE HIV SELF-TESTING AFRICA (STAR) EXPERIENCE

Author: Karin Hatzold
Affiliation: Population Services International

Launched in 2015 with support from Unitaid, the HIV Self-Testing Africa Initiative (STAR) united governments, policymakers, regulators, scientists, implementers and communities to catalyze a shift in HIV service delivery. STAR was implemented through three distinct phases across 15 countries on three continents, and generated a robust body of evidence on accuracy, acceptability, client preferences, feasibility, safety, impact, and cost-effectiveness of self-testing. These findings were instrumental in informing global policy development and advocacy. STAR delivered measurable results through distribution of more than 100 million HIVST kits, primarily in Africa, significantly expanding testing coverage and access among underserved populations.

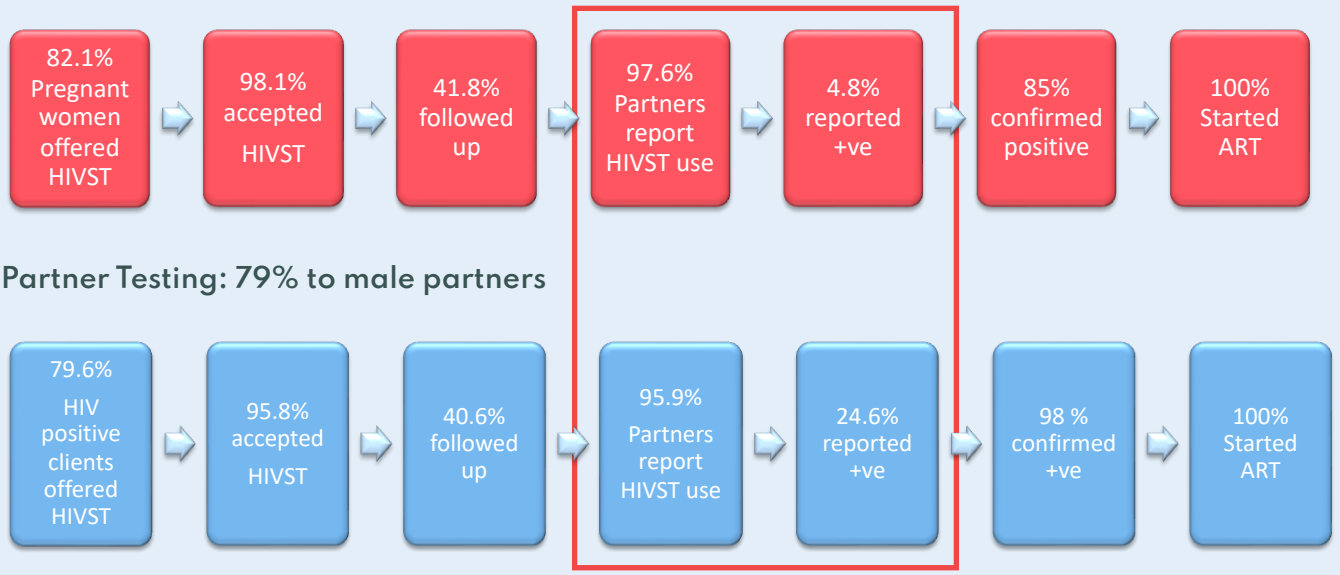
Evidence from STAR directly informed the first WHO self-testing guidelines in 2016,[1] as well as subsequent updates and global market-shaping efforts.[2] This evidence base was instrumental in catalyzing the WHO prequalification of seven HIV self-test products as of May 2025 and driving prices down to nearly $1 per test for LMICs.[3] These advances in self-testing helped sustain HIV testing services during the COVID-19 pandemic amidst widespread service disruptions.

In 2023 the STAR Initiative published a paper outlining the benefits, feasibility, acceptability of partner testing strategies using HIVST.[4] The paper with the title *"Secondary distribution of HIV self-test kits by HIV index and antenatal care clients: implementation and costing results from the STAR Initiative in South Africa"* provided excellent guidance on how secondary distribution of HIVST can be used effectively for case finding.

HIV testing rates among men in sub-Saharan Africa remain low, contributing to late diagnosis and poorer outcomes. HIVST, particularly through partner-delivered or "secondary distribution" models, offers a promising strategy to address these gaps. This study, conducted within STAR in South Africa, assessed the real-world implementation of partner-delivered HIVST kits provided to antenatal care (ANC) attendees and people newly diagnosed with HIV (index clients). Between April 2018 and December 2019, over 14,000 HIVST kits were distributed across 12 clinics in Johannesburg, Tshwane, and Dr. Kenneth Kaunda districts. Of these, 71% were given to ANC clients and 29% to index clients to pass on to their partners. Follow-up showed high uptake: more than 95% of partners offered a kit accepted and used it. Among partners of ANC clients, 4.8% tested reactive, with the majority confirmed HIV-positive and nearly all initiating antiretroviral therapy (ART). Among partners of index clients, the yield was much higher at 24.6% reactive results, again with nearly universal confirmatory testing and ART initiation.

The average cost per kit distributed ranged from US$7.90 to US$14.81 across districts, with human resources as the main cost driver. These findings demonstrate that partner-delivered HIVST is highly acceptable, cost-effective, and capable of reaching men who are often missed by traditional facility-based testing. Particularly when distributed by index clients, HIVST identified a high proportion of undiagnosed individuals and ensured strong linkage to treatment, offering a vital strategy to sustain HIV testing services and close gaps in diagnosis.

High Uptake of HIVST and Post-Test Referral Among partners reached through secondary distribution



Zishiri, V., Conserve, D.F., Haile, Z.T. Majam, M. et al. Secondary distribution of HIV self-test kits by HIV index and antenatal care clients: implementation and costing results from the STAR Initiative in South Africa. *BMC Infect Dis 22* (Suppl 1), 971 (2022)

The STAR Experience: Costing and Cost-effectiveness of HIV Self-testing in Africa

HIVST continues to emerge as one of the most affordable and adaptable ways to expand HIV testing coverage in sub-Saharan Africa, but its value depends on where and how it is deployed, and—crucially—on whether programs convert tests into confirmed diagnoses and rapid treatment starts.

A systematic review conducted by the PSI-led STAR consortium, covering 65 studies (167 cost estimates, 2006–2020) harmonized to 2019 USD found that the incremental cost per person tested is consistently lowest for HIVST (mean ~$12.75; median ~$11.50).5 Facility, home-based, and mobile models cluster higher (roughly $16–$20), while campaign-style approaches are costlier (mean ~$27.6). When reported, the incremental cost per HIV-positive identified also compares favorably for HIVST (mean ~$339) and home-based testing (~$297), relative to mobile (~$357), facility (~$399), and campaign-style (~$413), although these figures vary with underlying prevalence and yield. Importantly, targeted strategies—such as testing male partners in antenatal contexts or secondary/index testing—tend to cost more per person tested (e.g., ANC male partner testing ~$48; secondary/index testing ~$27.5 vs. primary/direct ~$16.6), reflecting the additional effort needed to reach smaller, higher-risk pools. Even so, such strategies can be justified when they close persistent diagnosis gaps among men, partners of people living with HIV, and other under-reached groups.

Two cross-cutting operational signals stand out. First, scale and throughput matter. Programs delivering ≥20,000 tests achieve lower average costs than small pilots, because fixed and semi-fixed inputs are spread over more outputs. Similarly, cost per positive identified is lower in programs that identify 1,000–5,000 positives than in those finding <1,000, an epidemiologic expression of the same scale logic: higher yields reduce unit costs per case found. Second, costing method matters for planning.

Most studies in the review report incremental provider costs; relatively few include full economic costs that count infrastructure and donated inputs. Where both are available, full costs per test are roughly double incremental ones, reminding planners not to over-extrapolate from "add-on" costing when budgeting for scale-up in settings that lack pre-existing platforms. The review also notes frequent gaps against Global Health Cost Consortium standards (e.g., limited uncertainty analyses and weak valuation of donated inputs), and a notable evidence gap on unit costs per positive identified for key populations—precisely the groups where targeted, stigma-sensitive strategies are most needed.

In the STAR-led Eswatini costing study we show how these dynamics play out in practice in a high-prevalence, near-95-95-95 context where remaining undiagnosed cases are harder to find.[6] Over April 2019–March 2020, PSI distributed 19,155 oral fluid HIVST kits to 13,023 individuals (≈1.5 kits per recipient), using community (83% of kits) and workplace (17%) distribution, with both primary and secondary distribution options and onsite/offsite testing. Best-case cascade estimates suggest that 91% of recipients self-tested (17,458), 4% were reactive (633), 96% of reactives received confirmatory testing (606), and 83% of confirmed positives initiated ART (505). From the provider perspective, average incremental costs (2020 USD) were ~$17.23 per kit distributed and ~$18.91 per person self-tested—well within the ranges synthesized by the regional review. Costs rose along the cascade—~$522 per reactive, ~$551 per confirmed positive, and ~$709 per ART start—showing how linkage assumptions dominate perceived cost-effectiveness: when reactivity or linkage dip, unit costs per diagnosis and per ART initiation climb sharply. Sensitivity analysis underscores that personnel and kit prices are the largest levers; scenario analysis shows that lower reactivity rates and weaker linkage are the fastest ways to erode value.

Eswatini's model comparisons add nuance for program design. Workplace clients were less likely to test onsite than community clients (8% vs. 29%), likely reflecting stigma and employment concerns; yet onsite workplace testing yielded a higher reactivity rate (6% vs. 2%), suggesting that well-executed workplace strategies can be efficient for case finding among employed men and shift workers who seldom attend healthcare facilities. More broadly, the program's unit costs align with the review's signal that HIVST is among the cheapest ways to add tests, while reminding us that in "last-mile" conditions—where incidence is lower and many have tested before—cost per ART start will rise unless distribution is tightly targeted and linkage is actively supported (e.g., assisted referrals, hotlines, convenient confirmatory sites, same-day community ART).

Bringing the two strands together, three policy implications are clear:

- First, deploy HIVST as the backbone of a diversified HIV testing services mix, prioritizing channels that combine low per-test costs with higher yields—index/partner delivery, workplace clusters, and focused community hotspots—while maintaining options that men and other underserved groups prefer (privacy, convenience, minimal time costs).
- Second, protect the cascade: pair HIVST with robust, user-friendly linkage (remote support, verification pathways as countries adopt three-test strategies, immediate or community-based ART starts), because small drops in linkage can double downstream unit costs.
- Third, budget with realism: use full economic costs for scale planning where infrastructure is not in place; exploit economies of scale via high-throughput venues; and keep pressure on key cost drivers by leveraging lay distributors, integrating into existing outreach where appropriate, and benefiting from declining kit prices—without compromising intimate partner violence screening, instructions, and quality control.

Bottom line: HIVST is consistently among the lowest-cost modalities per person tested, and—when targeted and coupled with dependable linkage—translates that affordability into competitive cost per diagnosis and rapid ART initiation.

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CASE STUDY: SINDH EXPERIENCE OF DMPA-SC, SELF-INJECTION: LEVERAGING FOR ADVOCACY IN OTHER PROVINCES OF PAKISTAN

Authors: Talib Lashari,[a] Roshan Fida,[b] Shabana Saleem,[c] Julie Hansen,[d] and Jane Cover[d]
Affiliations: [a]CIP/PWD. [b]RIZ Consulting. [c]Population Program Wing, Ministry of National Health Services, Regulation and Coordination, Government of Pakistan, [d]PATH

Background

Pakistan is the fifth most populous country in the world with over 240 million people and a high growth rate of 2.5%. Though the government has initiated several interventions at various levels with some success, FP and reproductive health still remain a challenge with a high fertility rate of 3.6 children per woman, unmet need for modern contraception at 17.7%, and a contraceptive prevalence rate (CPR) of only 34%.[1] Furthermore, inequalities persist across rural, peri-urban and underserved areas, where women face limited access to contraception due to both demand- and supply-side issues. Self-injectable DMPA-SC is a key part of contraceptive self-care, allowing women to safely manage their contraceptive needs at home, with the potential of enhancing autonomy and continuity. Contraceptive self-care has become even more critical in Pakistan due to increasing risks of climate change-related emergencies whereby populations face displacement and clinical facilities become inaccessible.

The national family planning priorities of the Government of Pakistan align with the FP2030 agenda and with recommendations from the country's 2018 Council of Common Interest Recommendations on Family Planning, aiming to raise the CPR to 60% by 2030. Following Pakistan's 18th Constitutional Amendment in 2010, the health, population and other social sectors were devolved to provinces while the roles of strategic direction, public health emergencies, international commitments and coordination remained with the federal government. Subsequently, the provincial population welfare departments (PWDs) have taken the lead in province-level FP strategies, financing and implementation.

The Sindh province of Pakistan was the first to introduce DMPA-SC and SI starting in 2018 through concerted efforts around evidence-based policy reforms, system readiness and community engagement. This case study focuses on experiences, results and lessons learned in Sindh and how these learnings were leveraged by development partners to advocate for introduction of DMPA-SC SI in other provinces and Federally Administered Areas.

Approach, Experiences, and Lessons from Sindh

In 2015, DMPA-SC was incorporated into Sindh's Costed Implementation Plan (CIP) for FP under the guidance of the current Minister for Health and Population. In 2017, Sindh authorized community-based Lady Health Workers (LHWs) to administer the first dose of DMPA-SC under supervision. In 2018, a randomized controlled trial (RCT) was conducted, led by FHI360, USAID, Jhpiego, and Aga Khan University in collaboration with CIP/PWD to assess the safety and feasibility of task shifting DMPA-SC. The RCT found that introduction of DMPA-SC is feasible in Sindh.[2]

The Drug Regulatory Authority of Pakistan registered DMPA-SC in 2018, which enabled Sindh to procure DMPA-SC. It was then rolled out across 30 districts through provider-administered services. Initially, UNFPA/FCDO provided a grant in 2019 for the rollout. The PWD in Sindh started procuring it in 2018-19. A self-injection cohort study was then conducted in 2021-22. The findings demonstrated that, with appropriate counseling and follow-up, women can safely self-inject DMPA-SC in privacy. These findings informed evidence-based advocacy, leading to revisions in training curricula and provider capacity, the development of Sindh's Self-Injection Guidelines, and the five-year Self-Injection Rollout and Scale-Up Plan (2022–2027).

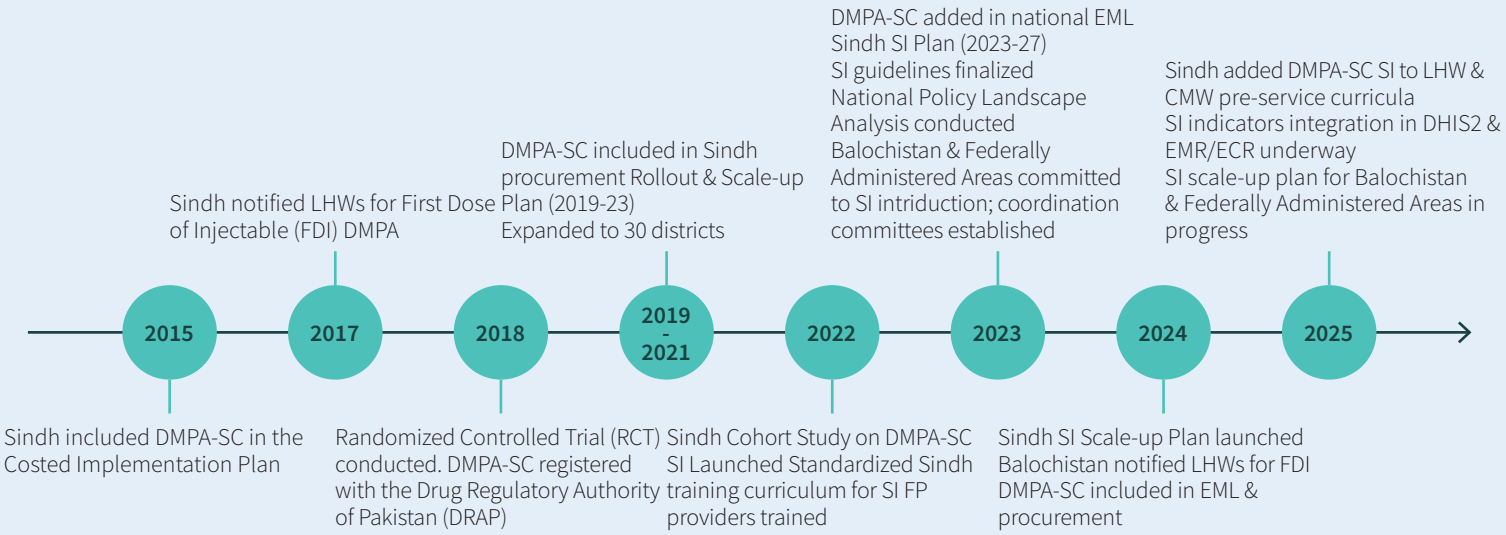
The approach for introduction of DMPA-SC in Sindh through the CIP and PWD has been systematic with support provided by RIZ Consulting. Based on evidence from the RCT and the cohort study, policy reforms were introduced related to the rollout plan, procurement, and task shifting, among others. Additional system readiness milestones included the development of training manuals, SI guidelines, Information education and communication materials, as well as training providers and LHWs. During 2021-25, a total of 2,975 providers were trained by PWD. A third fundamental element in this approach was community engagement through awareness campaigns, peer demonstrations, and involvement of local influencers.

DMPA-SC: Implementation in Sindh and Other Provinces/Regions (2018–2024)

Province / Region	Procurement (2018–2024)	Provider-Administered Clients	Self-Injecting Clients	Capacity Building of Facility-Based Providers & Community Workers
Sindh	1.821 million	1,040,155	2,799	2,975
Balochistan	64,730 (UNFPA Grant)	2,036	1,133	577
Islamabad Capital Territory	24,678 (UNFPA Grant)	1,267	727	114
Azad Jammu & Kashmir (AJK)	16,578 (UNFPA Grant)	561	355	211
Gilgit-Baltistan (GB)	9,486 (UNFPA Grant)	338	283	141
Total	1.921 million	1,044,357	5,297	4,059

Source: cLMIS, PWD Sindh and RIZ Consulting

Timeline of DMPA-SC introduction in Sindh



During the 2018-2025 period 1.82 million units of DMPA-SC were procured by PWD Sindh. The Gates Foundation supported the Government of Sindh through subsidized rates for the procurement. A detailed account of implementation in Sindh and other provinces and regions is provided in table above.

Key Learnings and Concerns

There have been certain lessons learned and concerns related to the implementation in Sindh. Though the number of self-injecting clients is low, all assessments have shown that women find self-injection acceptable and easy to use with minimum side effects irrespective of their demographic background. However, low follow-up; difficulty storing units during high temperatures at home in the wake of frequent electric failures; lack of proper disposal of used units; and difficulties in data gathering are some of the challenges yet to be addressed. Challenges gathering data have been prioritized with the introduction of an Electronic Client Record to improve data accuracy. Relevant indicators are also being integrated into DHIS2. A new empathy-based approach to providing DMPA-SC for self-injection through the DISC project is also being implemented in Sindh by PSI to address demand-related issues.

Advocacy for Replication to other Provinces

Building on Sindh's experience, advocacy efforts were initiated starting in 2023 to introduce DMPA-SC self-injection in other provinces, including Baluchistan and the Federally Administered Areas (Islamabad Capital Territory; Azad Jammu & Kashmir; and Gilgit-Baltistan) with support from RIZ Consulting. As a first step, the Country Engagement Working Group on FP/FP2030, consisting of federal ministry and provincial departments, was engaged to provide buy-in for the advocacy efforts.

Those advocacy efforts included the following:

- **Policy Reforms**: Evidence from Sindh informed updates to FP standards, training curricula, and operational guidance. Key achievements included establishing coordination mechanisms, authorizing LHWs for first dose administration, and integrating DMPA-SC into the national Essential Medicine List and procurement process in Baluchistan.
- **System Readiness**: Sindh's provider training materials for LHWs, facility staff, and master trainers were adopted to equip providers with skills in

counseling, SI techniques, screening, and follow-up. SI indicators are being integrated into provinces' Health Management Information Systems.

- **Community Engagement**: Advocacy and engagement strategies from Sindh (awareness campaigns, peer demonstrations, and involving local influencers) are being replicated to build trust and acceptance.

Lessons Learned and Next Steps

While provinces initially raised cost-effectiveness concerns, Sindh's experience, supported by global evidence, demonstrated that self-injection reduces provider workload, optimizes supply chain, and improves client retention, addressing financial concerns and supporting scale-up. In this process, RIZ Consulting, supported by the Gates Foundation, worked as a catalyst to coordinate across stakeholders.

Next steps include addressing barriers in provinces and regions related to continued supportive supervision, follow-up and refresher trainings, and home-based provision of DMPA-SC units. Documentation of lessons learned relating to these efforts in Baluchistan is currently underway.

Recent advocacy progress in two additional provinces include Khyber Pakhtunkhwa where stakeholders have been engaged for necessary approvals for DMPA-SC introduction and Punjab where a Jhpiego-led study has been conducted to assess the feasibility of self-injection.

At the national level, coordination mechanisms—such as the Country Engagement Working Group and FP2030 Working Groups—have been engaged to share lessons, harmonize guidelines and ensure that provinces remain connected and informed to encourage replication.

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CASE STUDY: ADDRESSING OPPOSITION TO SELF-CARE FOR FAMILY PLANNING THROUGH STRATEGIC ENGAGEMENT AND VALUE CLARIFICATION—A CASE STUDY FROM NIGERIA

Authors: Omolade Ogunlela and Tonte Ibraye
Affiliation: White Ribbon Alliance Nigeria

Background

In Nigeria, while self-care for sexual, reproductive, and maternal health (SRMH) is recognized as a pathway to achieving UHC, significant misconceptions among healthcare professionals impede full integration. Though mCPR increased from 12% to 15% in 2024, FP uptake remains uneven, and health systems remain overstretched. Despite the adoption of WHO guidelines, misconceptions persist around the role of healthcare workers, patient autonomy, and the safety of self-care practices. These barriers and differing views from key stakeholders, particularly evident among professional healthcare associations, which serve as gatekeepers for policy implementation and service delivery, have been a bottleneck to the integration of self-care in advancing FP and SRMH interventions.

In 2025, the White Ribbon Alliance (WRA) Nigeria conducted a perception survey, revealing mixed support, particularly among healthcare workers and community-level providers. The findings underscore the need for targeted, evidence-informed advocacy to align values, correct misinformation, and promote acceptance of self-care for SRMH, thereby fostering an enabling environment for implementation. This abstract presents a data-driven, participatory approach, anchored in addressing oppositions and strengthening policy acceptance for self-care in FP.

Advocacy Intervention Tested

From Q4 2024–Q1 2025, WRA Nigeria led an advocacy intervention targeting professional associations in Abuja, including the Medical Women's Association of Nigeria (MWAN) and the National Association of Community Health Practitioners of Nigeria (NACHPN). The advocacy aimed to address perceptions, barriers, and concerns about self-care for SRMH among professional healthcare associations and sign partnership agreements towards the scale-up of self-care for SRMH. Collaborators included the Federal Ministry of Health and national executives from each association. WRA Nigeria facilitated advocacy meetings and visits, virtual orientation workshops, presentation of perception survey findings, newsletter publications, and the "Voices of Self-Care" podcast, tailored to achieve advocacy objectives.

Methodology

In Q1 2025, WRA Nigeria conducted a perception survey to understand how self-care for FP and SRMH is viewed by healthcare and non-healthcare providers. Using online questionnaires, focus group discussions, and KIIs, the survey reached over 1,200 respondents across all six geopolitical zones. Findings revealed knowledge gaps, concerns about patient safety, and resistance, particularly among healthcare professionals, toward self-care practices.

Informed by these insights, WRA Nigeria organized evidence-driven virtual orientation workshops in March–April 2025 with national executives from MWAN, NACHPN, the Association of Lady Pharmacists (ALPs), and the Society of Gynaecology and Obstetrics of Nigeria (SOGON). Held via Zoom in Abuja, the sessions brought together these professionals for thoughtful discussions, addressed misconceptions, and developed collaborative action plans to support self-care for SRH within their networks.

Primary decision-makers targeted were executives of the professional associations, while the intended beneficiaries included women of reproductive age, community members, and frontline health workers. WRA Nigeria also used newsletters and the "Voices of Self-Care" podcast to extend outreach. These efforts led to signed partnership agreements, strengthened advocacy, and facilitated policy acceptance for self-care in Nigeria.

Results

The perception survey findings revealed both acceptance and resistance toward self-care for SRMH in Nigeria. While 73% of respondents agreed that women should have a degree of self-management for their SRH, 60% expressed discomfort with reduced healthcare provider involvement, and 65% feared patients might bypass essential medical interventions. These concerns highlighted misconceptions about self-care, despite its growing global adoption as an innovative approach for FP.

The orientation workshops effectively addressed these issues. Participants from MWAN, NACHPN, ALPs, and SOGON demonstrated increased understanding of self-care as complementary, and not substitutive to the healthcare provider's role. Discussions clarified responsibilities, challenged beliefs, and promoted equity and practical steps to advance self-care messaging.

Key results were:

- MoUs signed: Each association signed a Memorandum of Understanding with WRA Nigeria,

formalizing collaboration to promote self-care for SRMH. These partnerships support continued advocacy, participation in policy review, and integration into training curricula.
- Policy alignment: All four associations committed to integrating self-care messaging into outreach and webinars, and to supporting subnational advocacy efforts.
- Sustained advocacy: Participants agreed to co-lead sensitization and promote self-care within their networks.
- Digital advocacy: WRA's newsletters on self-care reached over 1,200 recipients, including healthcare professionals, with a 90.7% readership rate.
- Podcast launch: "Voices of Self-Care" is Nigeria's first podcast centered on self-care and has garnered hundreds of views across episodes, reflecting growing audience interest.

These outcomes reflect the success of the advocacy objectives and targeted engagement in shifting perceptions and securing long-term support for self-care.

Implications and Conclusion

This advocacy approach highlights the power of strategic engagement with professional health associations towards advancing self-care for FP and SRMH. By combining perception data, participatory orientation workshops, and multi-platform communication, WRA Nigeria helped shift resistance into an active partnership. The survey findings show that opposition to self-care often stems from misconceptions and challenges that can be addressed through evidence-informed dialogue.

This approach is not only cost-effective but also scalable. The use of virtual workshops removed logistical barriers while still allowing for deep, productive engagement. Signed MoUs and commitments from MWAN, NACHPN, ALPs, and SOGON ensure long-term sustainability of collaborative work with the healthcare professionals on ensuring national and subnational acceptance of self-care policies and guidelines.

Key lessons for other advocates:

- Engaging professional associations directly is essential to reshape narratives and unlock policy acceptance.
- Orientation and value clarification sessions encourage reflective discussions and shared ownership of future advocacy efforts.
- Perception data strengthens the credibility and precision of advocacy strategies.
- Using media tools, like newsletters and podcasts, can extend impact beyond formal, organized meetings and reach national and global audiences.

In the broader context of SRMH and FP, this reflection offers a practical model for integrating self-care into existing health systems through collaborative, equity-driven advocacy. It emphasizes the importance of meeting resistance with understanding and an evidence-informed approach.

Nigeria's experience demonstrates that support from healthcare professionals is not just possible but crucial for scaling self-care and achieving health equity at national and subnational levels.

CASE STUDY: USE OF SELF-CARE POLICY MONITORING TOOL FOR TRACKING RESULTS IN IMPLEMENTATION OF NATIONAL SELF-CARE GUIDELINES IN KENYA

Authors: Pamela Adhiambo, Nelly Munyasia and Edison Omollo
Affiliation: Reproductive Health Network in Kenya (RHNK)

Background

Since 2022, the Reproductive Health Network Kenya (RHNK), in partnership with the SCTG, has supported the development and implementation of Kenya's National Self-Care Guidelines for Reproductive Health. Led by the Ministry of Health through the Self-Care Core Group (SCCG), this initiative has promoted the institutionalization of self-care practices. A key component has been the use of the self-care policy monitoring tool by SCCG members, including RHNK, to track progress, generate insights, and ensure alignment with national priorities. The tool provides a coordinated mechanism for data collection, accountability and cross-sectoral collaboration in advancing self-care in Kenya.

Methods

The SCCG routinely uses the self-care policy monitoring tool to track progress across defined indicators aligned with national self-care guidelines. The process involves quarterly data collection and review sessions with implementing partners. RHNK works with SCCG members to compile the qualitative and quantitative data on activities, policy shifts, program integration, and system-level adoption of self-care practices.

Throughout this process, SCCG identified challenges in usability and data visualization within the original tool structure. In response, SCTG through RHNK led efforts to revise and simplify the tool to ensure improved functionality. These revisions were guided by user feedback and piloted within SCCG review sessions. RHNK also supported convenings where members collectively reviewed progress and identified areas needing support or strategic adjustments.

Results

The experience of using the self-care policy monitoring tool has provided the SCCG members with a structured approach to assess implementation self-care progress, identify gaps, and showcase achievements. The tool has enabled timely tracking of advocacy milestones, partner contributions, and integration of self-care into service delivery across multiple counties. It has also supported evidence generation for quarterly and annual reporting to the SCTG and Ministry of Health. Importantly, the use of the tool has strengthened collaboration within SCCG, enhanced data-driven planning, and strengthened collective ownership of self-care outcomes. Members reported that having a common reporting mechanism improved alignment, strategic focus and the ability to respond to policy shifts and implementation challenges.

Conclusion

The use of the self-care policy monitoring tool has proved to be important in supporting the operationalization of Kenya's national self-care guidelines. Kenya's experience demonstrates that a centralized, participatory monitoring mechanism promotes transparency, cross-learning and accountability. Regular use of the tool has encouraged collaboration among stakeholders and allowed for real-time reflection on self-care progress toward national goals. Continued engagement with the tool is essential to drive sustained self-care integration and to ensure that implementation is guided by data and responsive to local needs. This experience offers lessons for other countries considering similar approaches to self-care monitoring within national health systems.

Key Decisions and Outcomes from Using the Policy Monitoring Tool

Insights from the self-care policy monitoring tool informed key decisions by the SCCG, which have significantly advanced Kenya's self-care agenda. One major decision was to prioritize dissemination of the National Self-Care Guidelines through professional health associations as a fast-tracked strategy to reach healthcare providers nationwide. This approach has enabled wider reach and enhanced credibility and acceptance of self-care among different cadres of health providers. As a result, a series of webinars accredited by Continuing Professional Development have been conducted in collaboration with the National Nurses Association of Kenya, the Midwives Association of Kenya and the Pharmaceutical Society of Kenya, reaching over 5,000 healthcare providers to date and strengthening integration of self-care practices in service delivery.

Additionally, the SCCG resolved to strengthen partner self-care implementation and coordination through the use of the shared self-care monitoring dashboard. This has improved data collection, accountability and joint follow-up on county-level implementation, leading to more structured reporting, evidence-based planning and alignment across partners supporting self-care in Kenya.

CASE STUDY: LEADING WITH SELF-INJECTION: A CASE STUDY OF MALAWI'S INNOVATIVE DMPA-SC INTRODUCTION STRATEGY

Authors: Leigh Wynne,[a] Hannah Kachule,[b] Jessie Salamba Chirwa,[c] Wingston Felix Ng'ambi,[b] Megan M. Lydon,[a] Lily Duboff[a] and Holly M. Burke[a]

Affiliations: [a]FHI 360, Durham, USA, [b]Data Science and Statistical Consulting Center, Lilongwe, Malawi, [c]Reproductive Health Directorate, Malawi Ministry of Health

Background

Malawi is one of the first countries to introduce DMPA-SC self-injection and has one of the highest proportions of DMPA-SC that is self-injected (27%). In 2018, about eight months after a trial conducted by FHI 360 found significantly higher continuation rates among Malawian women who self-injected DMPA-SC compared to those who received provider-administered DMPA-SC, the Ministry of Health (MOH) rapidly scaled up self-injection. Malawi was unique in that when the MOH introduced DMPA-SC, it chose to 'lead with self-injection' by introducing self-injection and provider-administered DMPA-SC at the same time to clients. To date, 59 countries have DMPA-SC and self-injection regulatory approval. Despite its benefits, uptake of self-injection in Malawi and other countries has been lower than expected. We conducted qualitative research to explore Malawi's introduction approach to inform new product introduction in Malawi and elsewhere.

Methods

We conducted KIIs with 24 purposively selected decision-makers who were involved in national or district-level decision-making or implementation of self-injection rollout in Malawi. The interviews were informed by a desk review of DMPA-SC self-injection publications and grey literature, focusing on Malawi and other countries' introduction models, and policy-related documents. The interviews were audio-recorded and transcribed. We summarized the data by themes supported by quotations.

Results

The MOH's process for introducing provider-administered DMPA-SC and self-injection simultaneously resulted in rapid scale-up. Through KIIs and reflected in the DMPA-SC and self-injection introduction timelines and service delivery data from several countries, we observed Malawi reached national scale of self-injection in the public sector relatively quickly and has successfully maintained a high proportion of DMPA-SC visits that are for self-injection, with some exceptions due to stockouts. Although Malawi has had challenges with supply and delays in the private sector introduction of DMPA-SC, the MOH is applying what it has learned to the introduction of other methods. We consolidated the key concepts and recommendations from this study into a checklist.

Conclusions

Applying the concepts and recommendations from this study may help foster a supportive environment for countries looking to lead with self-injection. The checklist can also inform health system introduction plans for other methods and commodities, as well as increase self-injection uptake in countries that have already introduced DMPA-SC.

We recommend that countries interested in introducing self-injection follow Malawi's model to 'lead with self-injection' because it may result in a more rapid uptake of self-injection—resulting in pregnancy prevention that is cost-effective for societies, health systems, and importantly, individual women.

Key Concepts and Recommendations from the Malawi Model on Leading with Self-Injection

MOH Leadership

- ☐ MOH Ownership from the start and continuity of staff and champions at central level.
- ☐ Formation of DMPA-SC Task Force led by MOH RHD with members from public and private sectors.
- ☐ Frequent engagement of MOH SMT by the RHD leadership on the task force.

Policy and Guidelines

- ☐ Addendum to achieve national scale-up rather than formal policy change.
- ☐ Curricula development streamlined to be one training manual for in-service and pre-service training
- ☐ Integration of SI and an expanded method mix into policy related documents such as the self-care guidelines, SRHR Strategy, and FP 2030 goals

Service Delivery

- ☐ Trainings that are inclusive of FP providers, HMIS and LMIS officers, as well as facility pharmacists.
- ☐ Leaflets with SI instructions for clients, printed and distributed with registers to save on costs.
- ☐ Future DMPA-SC trainings should consider using provider-facing empathy-based counseling intervention during DMPA-SC trainings.

Supply Chain Management

- ☐ A healthy supply of DMPA-SC and DMPA-IM are important for successful SI introduction.
- ☐ Intradistrict redistribution by DHMT is a mitigation strategy that is often used.
- ☐ LMIS uses actuals for numbers of units received and dispensed by SI users.

Data Collection and Quality
☐ Electronic systems (HMIS, DHIS) should be updated with DMPA-SC SI and PA prior to introduction.
☐ HMIS should not auto-populate with 4 units per SI user.
☐ Paper-based tools (FP registers, facility reports) should be updated with DMPA-SC SI and PA prior to introduction.
☐ Reporting tools and processes that allow for community-based (HSA, CBDA) contributions to FP to be captured in the DHS and HMIS reporting.

Private Sector Introduction
☐ Private sector included in introduction plan on a small scale.
☐ National level MOH guidelines for private sector.
☐ MOU to establish a private-public partnership signed at district level that standardizes procurement, reporting, and pricing.
☐ Reporting tools and processes that allow for private sector contributions to FP to be captured in the DHIS and HMIS reporting.

MoH: Ministry of Health; RHD: Reproductive Health Directorate; SMT: Senior Management Team; LMIS: Logistics Management Information System; DHMT: District Health Management Team; FHS: Family Health Services; HMIS: Health Management Information System; DHIS: District Health Information System; SI: Self-injection; PA: Provider-administered; HSA: Health Surveillance Assistant; CBDA: Community-Based Distribution Agent.

CASE STUDY: THE CASE FOR INVESTING IN PROVIDER-ADMINISTERED DMPA-SC: A COSTING STUDY

Authors: Holly M. Burke,[a] Wingston Felix Ng'ambi,[b] Rick Homan,[a] Megan M. Lydon,[a] Jessie Salamba Chirwa,[c] Hannah Kachule,[b] Grace Jabu,[c] Mario Chen[a]
Affiliations: [a]FHI 360, Durham, USA, [b]Data Science and Statistical Consulting Center, Lilongwe, Malawi, [c]Reproductive Health Directorate, Malawi Ministry of Health

Significance

Injectable contraceptives are the number one choice of FP method in Malawi. Injectables are available as: **(1)** provider-administered intramuscular injection (PA DMPA-IM); **(2)** provider-administered subcutaneous injection (PA DMPA-SC); and **(3)** subcutaneous DMPA-SC self-injection. Self-injection reduces health facility visits, increasing accessibility and FP continuation. However, the unit price of DMPA-SC is higher than DMPA-IM. Self-injection uptake remains low, undermining its potential cost-effectiveness. As described in a recent BMJ Global Health publication, we conducted research to determine any benefits of provider-administered DMPA-SC that may overcome the higher unit cost.

Main questions

- What is the 'value proposition' of provider-administered DMPA-IM, provider-administered DMPA-SC and DMPA-SC self-injection (i.e., quantifying any benefits related to continuation or health system efficiencies). And does this compensate for the higher unit price of DMPA-SC compared to DMPA-IM?
- What is the 'value proposition' of community-based distribution of DMPA-SC?

Methodology

We enrolled new and continuing injectable (DMPA-IM, provider-administered DMPA-SC, self-injection) users between the ages of 15-49 years into a cohort study. We recruited participants from nine purposively selected public facilities and their surrounding catchment areas in five districts in Central and Southern Malawi. We interviewed participants every three months to compare method continuation, switching, and experiences over a 12-month period. We used Kaplan-Meier probability curves to compare continuation across the three injectable options and transition rates to self-injection.

We compared the resource requirements for each injectable through 23 group discussions involving facility-based providers and CHWs. Providers reported on time spent providing DMPA-IM or DMPA-SC (either provider-administered, supervised self-injection by clients, or supplying DMPA-SC to clients for later self-injection). We identified and valued the supplies and infrastructure required to support service provision by product and location (facility or community). Assuming DMPA-SC cost .20 USD more than DMPA-IM, we used a recursive (quarterly) Markov model to examine patterns of service use and associated costs, over a 12-month period. In addition to the discussions with providers, model inputs came from the cohort study to estimate transition and discontinuation probabilities and databases that compile cost data. We also extracted and tallied monthly injectable service volume data for the facilities.

Results

From April-May 2023, we enrolled 992 women into the cohort study: 393 DMPA-IM, 299 provider-administered DMPA-SC, and 300 self-injection users. While provider-administered DMPA-SC users at enrollment were twice as likely to discontinue their enrollment method than DMPA-IM users (HR=2.01 [1.66-2.43]), more provider-administered DMPA-SC users transitioned to self-injection, and transitioned at a faster rate to self-injection over the course of the study, than DMPA-IM users. The cumulative switching probability estimate for DMPA-IM to self-injection at 12-months was 20.4% (95% CI: 16.0-24.9%) compared to 47.1% (95% CI: 40.1-54.1%) for provider-administered DMPA-SC to SI at 12-months.

The resource requirements models showed the usage patterns, cost for DMPA services, and cost per person-year of use were similar between the provider-administered DMPA-SC and DMPA-IM groups. We found no substantial difference in annual DMPA service cost per person-year of use between DMPA-IM at US$11.01 (95% CI: US$10.57-US$11.44) and provider-administered DMPA-SC at US$11.47 (95% CI: US$10.63-US$12.46).

While the usage patterns did not differ, the annual costs for DMPA services were 27% higher for facility-based services than community-based services. Further, the annual DMPA service cost per person-year of use was 31% lower for community-based services at US$8.07 (US$6.91-US$9.41) than facility-based services at US$11.61 (US$10.70-US$12.54).

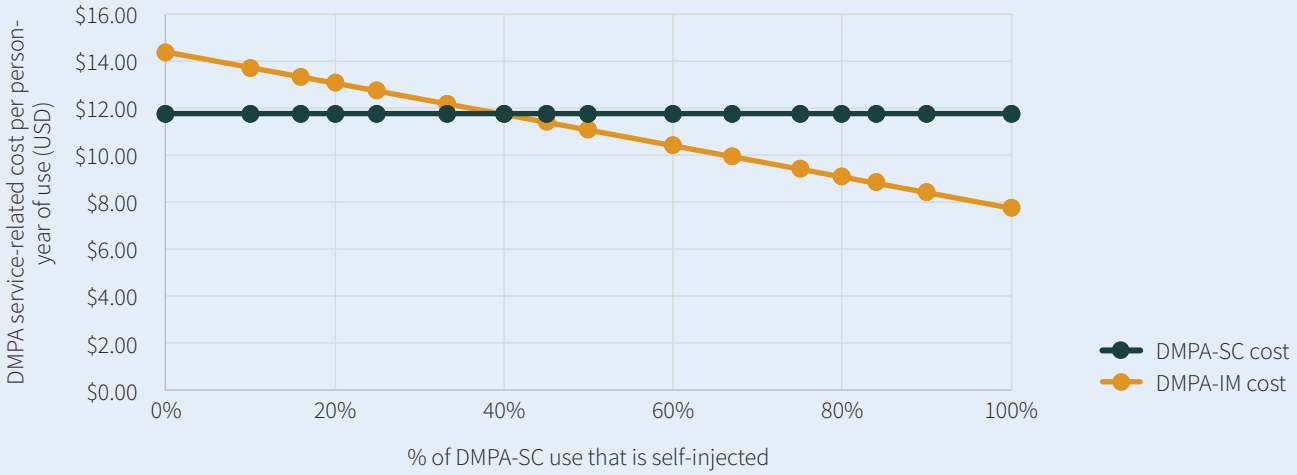
For facility-based services, delivering DMPA-SC is less expensive compared to DMPA-IM when 40% or more of all DMPA-SC visits are for self-injection, whereas for community-based services, only 23% of DMPA-SC visits need to be for self-injection for DMPA-SC to be cost-saving. Routine service delivery data from the study catchment areas demonstrate that these thresholds are achievable.

Knowledge contribution

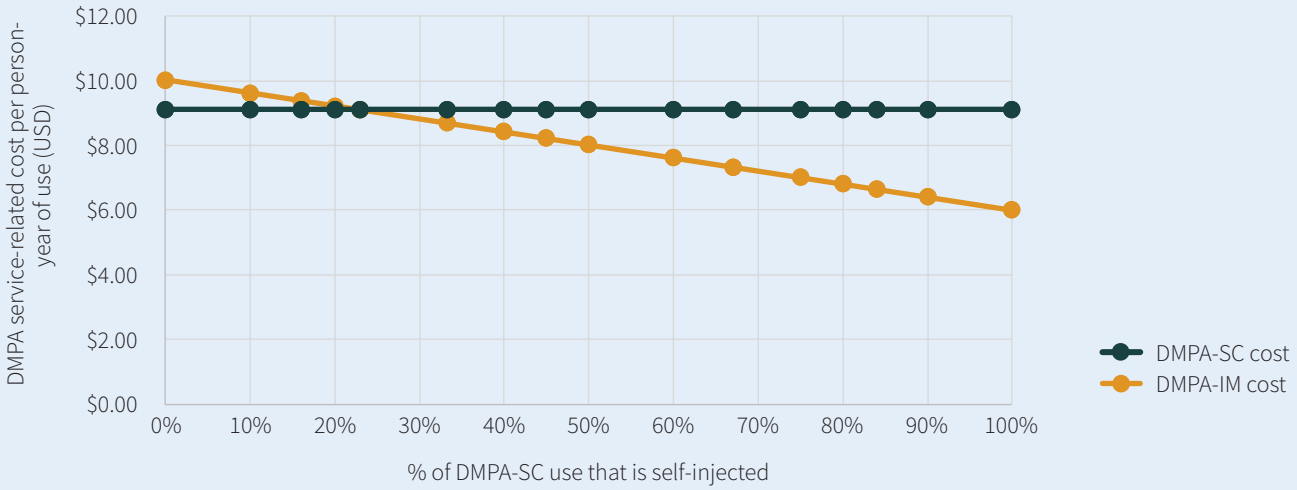
Globally, ministries of health are tasked with strategically allocating resources to maximize population health, including assessing FP method mix needs and making procurement decisions. While the cost-benefits of DMPA-SC self-injection are well known, governments and donors have grown hesitant about continued investment in the more expensive DMPA-SC product if it is provider-administered, as this undermines its cost-effectiveness. Based on our study results, we recommend that country policies allow for the provider-administered DMPA-SC option in both facilities and in

communities, in addition to offering self-injection. This should be supported by robust national FP programs that offer all three injectable options across service delivery sites. This recommendation follows from our results such that we found that **(1)** more provider-administered DMPA-SC users than DMPA-IM users transitioned to self-injection; **(2)** provider-administered DMPA-SC users transitioned to self-injection faster, compared to DMPA-IM users; and **(3)** service costs do not differ substantially between DMPA-IM and provider-administered DMPA-SC. Further, we found that injectables delivered in community settings may result in even more cost savings. Results from this research will be used to inform Malawi's scale-up of DMPA-SC and global best practices for introducing and scaling up DMPA-SC and self-injection.

Break-even of DMPA service-related cost between DMPA-SC and DMPA-IM as a function of % of SC use that is self-injected: Health facility-based services



Break-even of DMPA service-related cost between DMPA-SC and DMPA-IM as a function of % of SC use that is self-injected: Community-based services



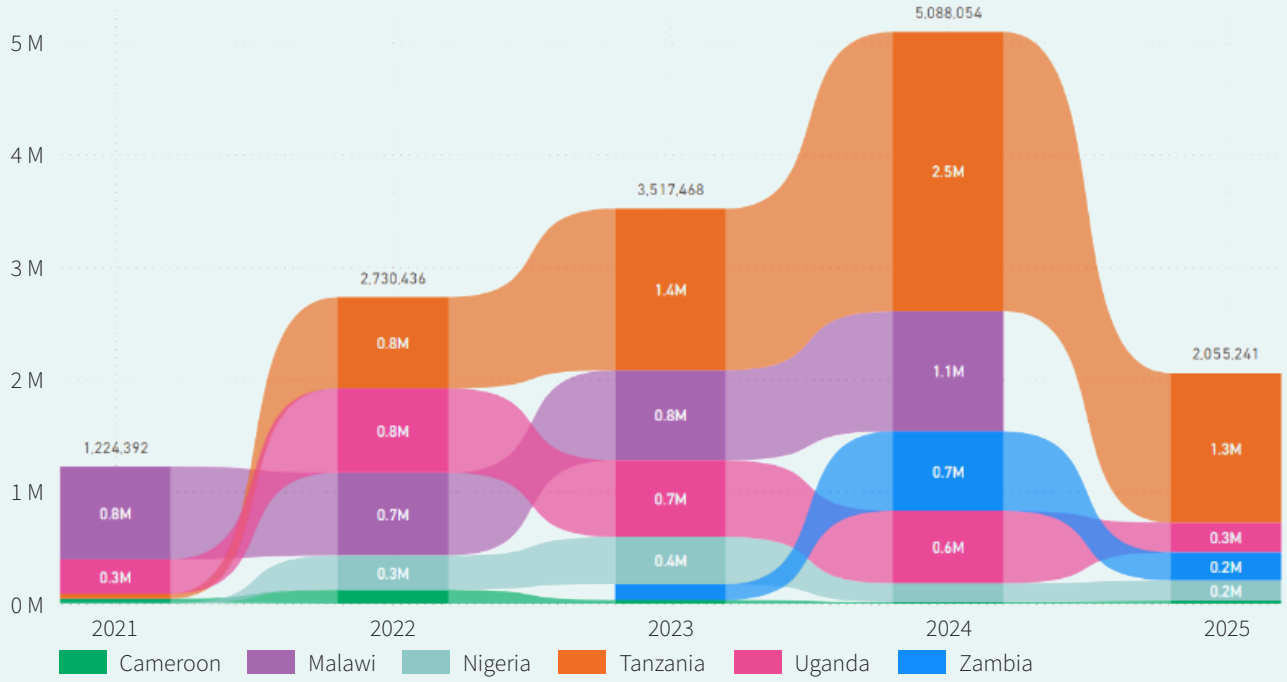
SPOTLIGHT: TECHNICAL ASSISTANCE TO OPTIMIZE HIV SELF-TESTING IMPLEMENTATION THROUGH HIVST MATCHING FUNDS INITIATIVE

Launched in 2020 by the Global Fund in partnership with the CIFF, the HIVST Matching Funds initiative was designed to catalyze scale-up of HIVST as part of broader HIV testing services optimization in priority LMICs. Backed by a US$25 million matching fund, the initiative now supports seven countries—Cameroon, Mozambique, Nigeria, Tanzania, Uganda, Malawi, and Zambia—expanding access to HIVST, increasing diagnostic reach, and strengthening monitoring and evaluation.

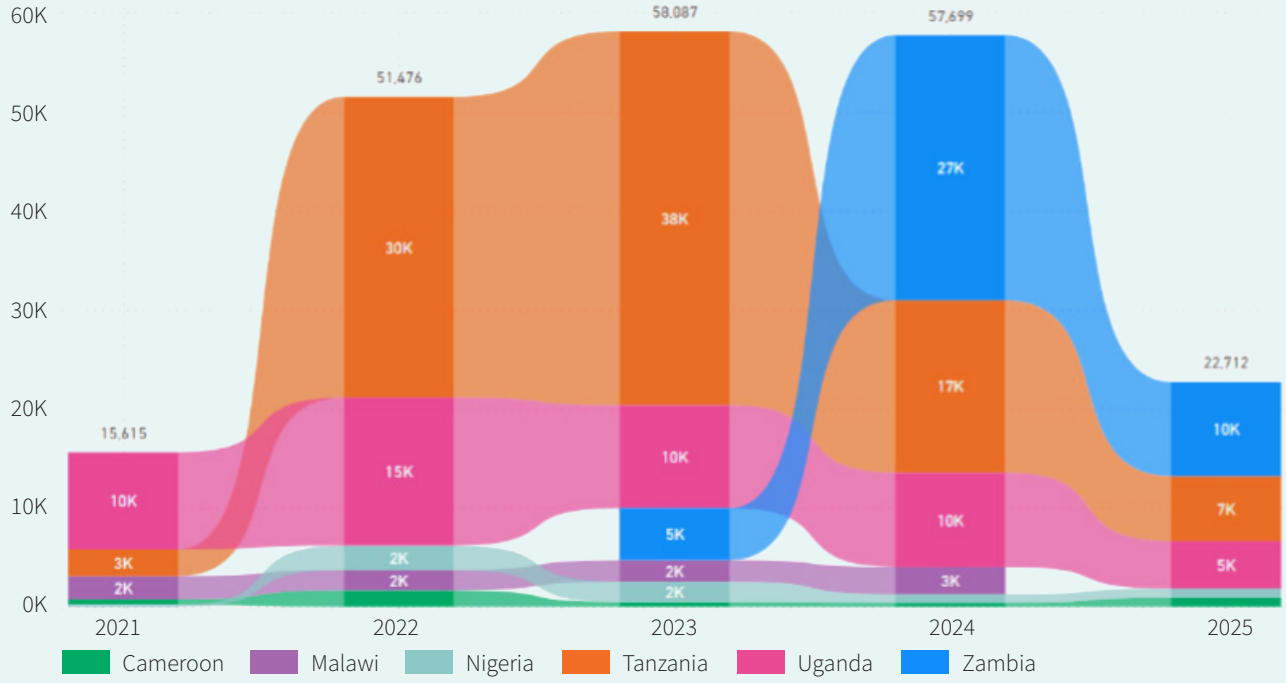
Aligned with WHO recommendations on optimizing HIV testing services, PSI has provided targeted technical assistance to national programs to enable the expanded and effective use of HIVST. Technical assistance has focused on: **(i)** reviewing and revising HIVST data collection tools and systems; **(ii)** defining and integrating HIVST cascade indicators into national DHIS2 platforms; and **(iii)** optimizing implementation through updated HIVST SOPs and HIV testing services guidelines, capacity building for providers and peer cadres, and practical planning for efficient HIVST distribution.

Working with in-country partners—FHI 360 (Nigeria), CIDRZ (Zambia), ACMS (Cameroon), PSI Tanzania, and PSI Uganda—PSI also produces quarterly performance dashboards to support routine review and rapid course correction. Ministries of Health use these dashboards to strengthen data use and optimize HIVST implementation toward the first and second 95 targets (proportion of people living with HIV who know their status, and those diagnosed who are on ART).

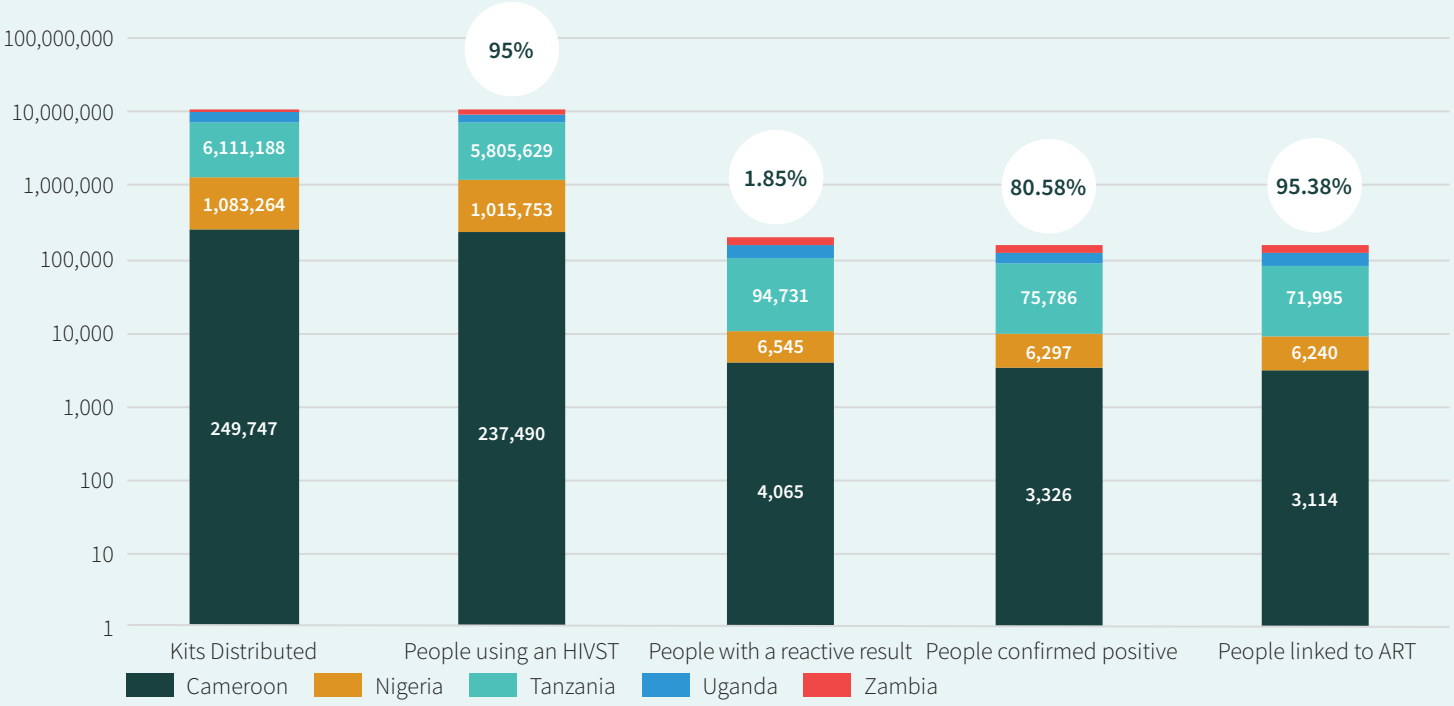
HIVST Kits Distributed, Multiple Countries, 2021-2025



People with Reactive Results, Multiple Countries, 2021-2025



People with Reactive Results, Multiple Countries, 2021-2025



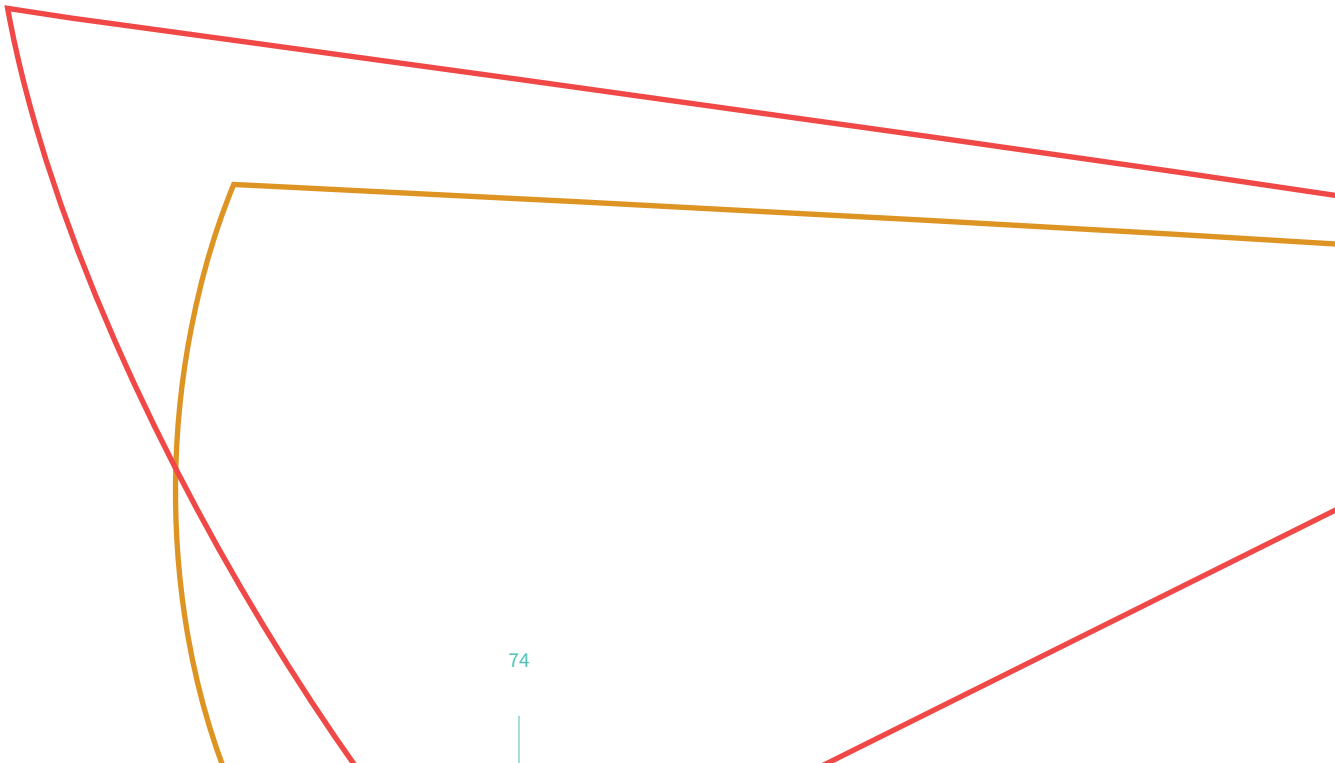
With Global Fund and CIFF financing, and PSI technical assistance, a cumulative 14,615,591 HIV self-test (HIVST) kits were distributed from 2021 through Q2 2025. Country shares were Tanzania 42% (6,111,188); Malawi 23%; Uganda 18%; Zambia 7.5%; Nigeria 7.4%; and Cameroon 1.7%. Kits were delivered through facility-based and community-based models, reaching adult women, adult men, AGYW, ABYM, and key populations (FSW, MSM, PWID). Approximately 95% of distributed kits were reported used, with an overall reactivity (positivity) rate of 1.91%.

Linkage to care was ≥95% across all countries, supported by a standardized package of strategies:

- **Same-day ART initiation**: All clients with reactive self-tests are fast-tracked for confirmatory testing and initiated on ART the same day whenever eligible.
- **Expert client accompaniment**: Each newly diagnosed client is paired with an expert client for intensive follow-up and support over three months.
- **Targeted counselling**: Trained counsellors provide adherence and ART-readiness counselling tailored to client needs.
- **Community-based initiation**: ART initiation is offered at community outreach sites to reduce travel and time costs and minimize loss to follow-up.
- **Peer and family support**: "Buddy" systems and family engagement are promoted to improve linkage and early retention.

Uganda—DSD enhancements: PSI supported differentiated service delivery (DSD) to strengthen client-centered HIV care, including Community Drug Distribution Points (CDDPs) and Community Client-Led ART Delivery (CCLAD). PSI also advanced community engagement by fostering collaboration between traditional and biomedical practitioners, improving acceptability, timely linkage, and continuity of care.

Overall, the program demonstrates that large-scale HIVST distribution, when coupled with robust, community-proximate linkage mechanisms, can maintain high utilization and achieve **near-universal linkage** even at national scale.



REFLECTIONS ON THE EVIDENCE BASE

In 2023, the SCTG supported the development of a learning agenda for SRH self-care based on a survey of more than 50 self-care stakeholders.[5] The evidence and learning presented in this State of Self-Care Report reflect progress across evidence areas in the learning agenda, and many of the persisting evidence gaps echo those identified in the learning agenda.

What works in self-care depends on local and regional contexts, from community social norms that affect acceptability and uptake all the way up to the structure of national health systems, regulatory frameworks, and national political pressures. For some self-care interventions, development and introduction start in high-income countries but lag in LMICs where the need and benefit might be the greatest. Implementation and evidence generation in self-care also varies substantially across regions, as indicated by the predominance of case studies in this report from African countries and the limited number from Asia and Latin America.

PEOPLE AND COMMUNITIES

- Case studies in a variety of settings address the need to better understand why and when people use SRH self-care, including research on preferences for new contraceptive methods in multiple African countries (*see case studies on pages 15 and 16*) and new data from the United Kingdom from the Living Self-Care Study (*see case study on page 32*).
- Data on people's experiences using or practicing self-care remain scarce,[7,97] though a case study on the development of a client experience of care metric for self-injectable contraception marks an important advance in the potential to measure such experiences in a standardized way (*see case study on page 29*). Additional measurement research for other self-care interventions and development of measures that could be used across health areas could provide a valuable advancement to the field.
- Digital self-care interventions and approaches are expected to become increasingly important in the SRH self-care landscape. Though a key learning priority, evidence related to their acceptability, uptake, and effectiveness in LMICs remains scarce, including in the case studies presented in this report. Likewise, more evidence is needed on the equity implications of digital self-care interventions, including careful consideration of which populations they fail to reach due to national and local connectivity, availability of mobile data, device ownership, and delivery mechanisms.
- Robust evidence on self-care acceptability and uptake by specific populations is critical to ensure equity and optimal use of resources. Specific evidence needs have been identified to understand self-testing acceptability and use by gender and age for HIV and other STIs.[51,52] A need for more evidence of acceptability among rural and underserved populations has also been identified for HPV self-sampling.[53] This report's research spotlight on HPV self-sampling and self-testing makes a key contribution to this evidence area, presenting a variety of acceptability and preference data from research with rural and urban populations in Mozambique (*see spotlight on page 11*).

HEALTHCARE PROFESSIONALS AND SERVICE PROVIDERS

- The SRH self-care learning agenda highlights the need to understand how to make self-care more acceptable to providers,[5] which can facilitate self-care advocacy efforts and uptake in professional

practice. A case study from Nigeria addresses this evidence gap, describing efforts to engage professional associations in Nigeria to better understand their concerns about self-care and engage them with self-care advocacy efforts (*see case study on page 63*).

- Ensuring long-term effectiveness and retention of knowledge and skills for provider-based interventions to promote self-care has been identified as an evidence need for DMPA-SC trainings.[6] New evidence from an evaluation of the DISC project (*see case study on page 47*) provides evidence for an approach that included supportive supervision in the maintenance phase of the intervention to train providers on self-injectable contraception.

SELF-CARE POLICY AND IMPLEMENTATION

Given the scarcity of general self-care policies in LMICs and the recency of many national policies related to individual self-care interventions, evidence on policy implementation and effectiveness is limited.

- Evidence needs related to cost-effectiveness and optimal delivery models have been identified across SRH self-care products and approaches in the research literature[7-11] and by self-care stakeholders.[5] In this report we highlight two key contributions to this evidence area, cost-effectiveness research from the HIV Self-Testing Africa Initiative (*see case study on page 57*) and evidence on costs of delivering DMPA through different models in Malawi (*see case study on page 69*). However, additional research is needed to demonstrate costs at both the individual and health systems levels under various financing strategies.
- Finally, multiple recent studies and reviews have called for more robust evidence on effectiveness, including clinical outcomes and mortality, related to use of self-care.[12-14] As self-care is introduced and scaled up, investing in rigorous research to track and understand self-care outcomes will provide key evidence for course correcting when outcomes are suboptimal and advocating for scale-up in other settings when things are working well. In addition to standard disease-focused outcomes, such research would benefit from using broader measures of health, such as measures of sexual and reproductive well-being,[98] to capture a range of holistic health outcomes that self-care may support.

TAKING STOCK AND LOOKING AHEAD: SELF-CARE NOW AND INTO THE FUTURE

In the two years since the SCTG last released its biannual report on the state of SRH self-care, substantial progress has been made in self-care advocacy, programming, and evidence generation. The case studies in this report highlight these advances, while also identifying the unique challenges facing health systems broadly and the self-care movement specifically at this moment in time and prioritizing the most pressing issues that need to be addressed for the self-care movement to gain further traction.

SOLIDIFYING SELF-CARE AS A RECOGNIZED PUBLIC HEALTH FIELD

This report represents an effort to consolidate self-care evidence and measurement gathered across multiple geographies. Research and data spotlights in the report provide multi-country snapshots of progress and challenges in self-care practice areas such as self-managed abortion; contraceptive self-injection policy, knowledge, awareness, and practice; and HIVST kit delivery and linkage to care. Multi-country data on self-care indicators such as these remain rare but can provide important information on the state of self-care globally. In this vein, SCTG has partnered with the BMJ to produce a *Special Collection*, *"Strengthening the evidence for self-care in sexual and reproductive health."* Growing recognition of self-care as a unified public health field – in the same vein as other disciplines like primary healthcare and noncommunicable disease prevention and treatment – is critical for identifying best practices and gaps in the policy-to-practice continuum that transcend a single intervention or disease area.

UNDERSTANDING END-USERS' PREFERENCES IS CRITICAL

Second, the report reflects insights gained from critical stakeholders in self-care—end-users and healthcare providers who support them. Case studies demonstrate nuances of when, where, how, for how much, and for whom self-care is preferred to facility-based care. Several case studies explore user preferences across a variety of self-care delivery models—demonstrating that product delivery is more nuanced than simply the choice of "facility-based" or "self-care." Self-care can and should be recognized as a spectrum, ranging from fully user-independent behaviors to practices that are more closely tied to provider- and facility-based care. Several case studies highlight how understanding users' self-care practices and preferences can inform R&D and guidelines for new self-care products, such as pericoital OCPs and the dual HIV prevention and contraception pill. Moreover, there are measurement challenges and novel metrics are needed that capture person-centeredness, quality of care, and a user's experience of self-care. The accumulation of evidence will help to guide self-care policy, implementation guidance, and delivery models that are aligned to end-user preferences as well as health system realities.

COMMUNITY STRUCTURES CAN SUPPORT SELF-CARE, WITH APPROPRIATE RESOURCING

Self-care is about recognizing that individuals are active agents in their own health. As such, healthcare assets that are available locally within individuals' own communities become central to healthcare. Featured case studies highlight innovative ways to leverage existing community-led structures, such as a community-based "Youth Corp," community pharmacies, and community health workers (CHWs). One case study evaluating the quality of FP counseling comparing facility-based providers to CHWs in Uganda found that CHWs delivered more comprehensive counseling on DMPA-SC for self-injection than facility-based providers—findings that may reassure policymakers about the safety of CHW

task-sharing. But even while highlighting opportunities, the evidence presented in this report also comes with cautions and challenges, including overreliance on underpaid or unpaid CHWs and dependence on the altruism of community-based providers. At the end of the day, self-care cannot address all healthcare needs, nor should governments rely on self-care to fix underfunded health systems. Governments need to invest in strengthening health systems that support both end-users in their health needs and providers in supporting and helping end-users.

THE DIGITAL FRONTIER OF SELF-CARE

Digital innovations, including telemedicine for consultation and follow-up at a distance; apps for educating and supporting SRH-related behaviors including referrals to care, appointment reminders, and provision of health information; and AI-supported CHW programs, have potential for integrating self-care with primary healthcare such that people can be active partners in caring for themselves, accessing behavioral counseling, and consulting with providers in their community or from home.[99] Evidence of the potential for scaling digital health in LMICs reveals that such programs are effective when they prioritize unmet needs, integrate end-users early in the process, train stakeholders, implement simple interoperable technology, and exist within an environment of supportive policy and financing that includes appropriate infrastructure and stable funding.[100] Without appropriate resourcing, digital self-care interventions have the potential to exacerbate health inequalities. Governments must invest in internet connectivity and digital literacy, develop robust regulatory frameworks and financing mechanisms, and ensure that digital self-care complements rather than replaces facility-based health services.[101] Such investments are critical for ensuring that self-care interventions alleviate rather than exacerbate socioeconomic and health inequalities.

FINANCING SELF-CARE AND ENSURING SUSTAINABILITY

Sustainable financing will help ensure that self-care reaches everyone in need. National governments must include self-care products and services in their health budgets and insurance coverage in ways that prevent high out-of-pocket costs to consumers. Dedicated funding lines will be key for facilitating the procurement of self-testing kits, contraceptive methods, and digital technologies, and for training pharmacists, CHWs, and other healthcare professionals and service providers to deliver and support self-care. Innovative domestic financing strategies, such as small taxes on tobacco, alcohol, or sugary drinks, can be leveraged to generate revenue for self-care programs and encourage healthier behaviors. Governments can also support local manufacturing of self-care products, reducing import dependence and increasing supply security. Blended finance models that combine public resources with private investment and donor grants can help scale up self-care markets. Development partners can provide catalytic funding and technical assistance to help countries build procurement systems and regulatory frameworks that ensure quality and affordability. Transition plans should be established at the outset and should incorporate local capacity building throughout implementation so that programs remain sustainable when donors exit.

THE NEED FOR EQUITY

Self-care should never be treated as a replacement for health professionals or facilities. Even when people use self-tests or manage their own treatment, they need accurate information, quality-assured products, and access to follow-up care. Self-care could widen disparities without careful attention. Higher-income urban residents may have greater access to and ability to pay for self-care products in the private sector and retail settings, and those with smartphones may benefit preferentially from digital tools. Governments and partners should monitor self-care equity by collecting data on self-care use and experiences across ages, genders, and income groups.

Policymakers and implementers should present self-care as one of a range of options from which end-users can choose. As self-care advocacy matures, additional attention should be paid to the nuances of integration – not only of self-care with brick-and-mortar health systems but also of self-care options in the public and private sector.

A LOOK AT THE SCTG'S STRATEGIC PRIORITIES FOR EVIDENCE AND LEARNING

Taking stock of the progress and challenges ahead shared in this report, the SCTG is committed to strengthening its global coalition and specialized communities of practice – providing a technical space for advocates, policymakers, implementers, and researchers and monitoring and evaluation specialists to learn, strengthen partnerships, and amplify evidence-based practice. Within this space, the SCTG will double-down on its investments through the following strategies:

- **Amplifying the voices of self-care exemplars**: As self-care policies become more widespread, countries early in the continuum of policy adoption to practice have much to learn from countries with well-established policies and programs. By partnering with and elevating the voices of exemplars, the SCTG aims to better understand and share what works at the country-level so that these countries' experiences can pave the way for others.
- **Strengthening cross-disciplinary national self-care networks (NSNs)**: In its focal countries, the SCTG will continue to support MOH-led national efforts to advance self-care policy and practice, to institutionalize self-care into national health systems and scale up implementation of self-care interventions. The SCTG will continue to facilitate the sharing of learnings within and beyond the NSNs directly supported by the SCTG.
- **The SCTG will continue to create broad platforms for evidence, learning, and exchange**, including through efforts such as the Self-Care Learning and Discovery Series (SCLADS), the SCTG's home-grown self-care conference; the Annual Member Summit; and working group meetings. As self-care grows, such opportunities to build SRH self-care networks and linkages between diverse members are critical.
- **Strengthening partnerships with non-SRH self-care partners**: Recognizing that many of the most critical advances in self-care have been in other health areas, such as NCDs, the SCTG is increasingly expanding its work to join forces with other health areas. Current and future opportunities to learn from and create linkages between SRH and health areas such as mental health are important – not only to avoid reinventing the wheel, but also to advance a holistic approach to healthcare.
- **Building the evidence base for self-care**: Self-care's core value proposition is that it can increase individuals' autonomy by giving them control over their own health. As such, there is a need to continue strengthening the evidence base on the effects of access to and use of self-care on person-centered outcomes, including empowerment, autonomy, self-perceived health status and healthcare access, and wellbeing. Recent advances to define and measure SRH wellbeing[98] provide a blueprint for the type of holistic and person-centered outcomes self-care evaluations can and should be measuring.

CONCLUSION

The coming years will continue to test the resilience of national health systems as public budgets contract and donors shift their priorities. Climate- and disease-related shocks bring added challenges. In this challenging context, self-care can expand choice and agency if integrated strategically and accompanied by deliberate investment, robust regulation, and thoughtful community engagement. Leveraging promising innovations and drawing on the substantial progress in policy, implementation, and evidence in recent years, countries and coalitions can advance self-care in ways that enhance equity, enable sustainability, and open new paths to achieving universal health coverage and – ultimately – better health.

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