Implementation of self-care interventions for health and well-being

Guidance for health systems

World Health Organization
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Foreword

Every year, 100 million people are plunged into poverty due to out-of-pocket expenditure for health. Self-care interventions are among the most innovative strategies that go beyond a conventional health sector response to address this challenge in accessing quality and affordable health care.

As an extension of the health system, self-care interventions can help reduce health inequities in society and across the life course. It is essential for driving improvements in health and well-being in every country as part of a primary health care approach towards universal health coverage. The World Health Organization's (WHO's) conceptual framework on self-care interventions is underpinned by the key principles of human rights and gender equality.

The COVID-19 pandemic showed that effective self-care interventions, and practising self-care, are essential for enabling societies to meet basic health needs when access to health services is restricted and health systems are under pressure. Beyond the COVID-19 pandemic, half the world's population still lacks access to essential health services. In addition, communities continue to face challenges arising from conflicts, climate change and health emergencies, which result in major disruptions to national health systems.

Self-care is essential to achieving the overarching goal of WHO's Fourteenth General Programme of Work (2025–2028) – promoting, providing and protecting health and well-being for everyone, everywhere.

Successful self-care hinges on adequately supporting individuals, communities and health systems alike. It is about facilitating true choices for people – both in terms of the available self-care interventions they use and how they interact with health and care workers and services in the process. In addition to strengthening health systems, self-care also expands both the autonomy of individuals and their direct engagement in the pursuit of health for all.

Bruce Aylward
Assistant Director-General, Universal Health Coverage, Life Course

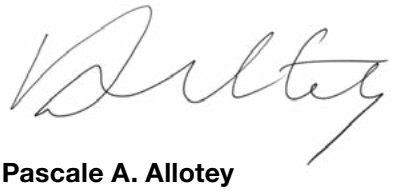
Preface

With billions of people lacking access to essential health services and a global shortage of health and care workers, self-care interventions have the potential to revolutionize how people worldwide manage their health and well-being, as an integral part of primary health care and universal health coverage. The World Health Organization (WHO) recommends making self-care interventions available in every country and economic setting to enhance access to services and to empower individuals to proactively take charge of their health more independently and privately, if and when they choose to do so.

In just five years since WHO published its landmark 2019 guideline on self-care interventions for health, which focused on sexual and reproductive health and rights (SRHR), over 47 countries have taken the vital step of amending national policies on SRHR to include self-care options as additional choices complementing facility-based health care. This guidance for health systems builds on that momentum, providing a springboard to implement WHO's evidence-based self-care recommendations and practices equitably and sustainably.

This document charts the path forward, presenting key considerations and offering guidance to advance the introduction and scale-up of self-care interventions in countries the world over. It is intended to be useful to policy-makers, legislators, regulators, programme managers, health and care workers and community members – all those responsible for shaping how self-care interventions complement health system engagement, to ultimately improve efficiency, equity, health outcomes and financial protection.

When implementing the global guideline, WHO regions and countries can adapt the recommendations to the local context, considering economic conditions, existing health services and health facilities, and the needs and rights of underserved populations. This implementation guidance will help accelerate realization of the full potential of self-care interventions for all.



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Abbreviations

CHW	community health worker
CSE	comprehensive sexuality education
DHI	WHO Department of Digital Health and Innovation
HRP	UNDP-UNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction
HWF	WHO Health Workforce Department
IEC	information, education and communication
PHC	primary health care
SDG	Sustainable Development Goal
SRHR	sexual and reproductive health and rights
SRH	sexual and reproductive health (also used to refer to the WHO Department of Sexual and Reproductive Health and Research)
STI	sexually transmitted infection
UHC	universal health coverage
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Trinidad and Tobago. Credit: WHO/Alasdair Bell

Introduction

Background

In 2021, an estimated four and a half billion people were not fully covered by essential health services *(1)*. Approximately 100 million people were plunged into poverty in 2017 because they had to pay for health care out of their own pockets *(2)*. Additionally, the United Nations has predicted that nearly 300 million people will need humanitarian assistance and protection during 2024, due to conflicts, climate emergencies and other drivers *(3)*, and thus would be lacking essential health services. Furthermore, a shortage of 10 million health workers is anticipated globally by 2030 *(4, 5)*.

There is, therefore, an urgent need to find innovative health-care strategies that go beyond the conventional health sector response. Self-care interventions represent a significant push towards greater self-determination, self-efficacy, autonomy and engagement among people caring for their own health and people in the role of caregiver. These interventions include many medicines, diagnostics, devices and other technologies for people to use themselves, and they are shifting the way health care is perceived, understood and accessed.

Self-care interventions are among the most promising and exciting new approaches to improving health and well-being, both from a health systems perspective and for the users of these interventions. Self-care interventions should be an adjunct to, rather than a replacement for, direct interaction with the health system. These interventions are increasingly being acknowledged in global initiatives, including to advance primary health care (PHC) and universal health coverage (UHC), to support the Sustainable Development Goals (SDGs). When they are accessible, available, acceptable and affordable, self-care interventions hold the promise of advancing the attainment of UHC.

Building upon the latest normative recommendations and good practice statements from the World Health Organization (WHO), this guidance includes key considerations to support the introduction and scale-up of self-care interventions in countries, at the national or subnational level. In implementing the global recommendations on self-care interventions for health and well-being, countries will need to adapt them to the local context, considering the economic conditions and the existing health services and facilities. This guidance is intended to assist with that process. This guidance is relevant for all settings and should, therefore, be considered as global guidance.

Target audience

The primary target audience for this guidance is national and international policy-makers, legislators, regulators, programme managers, health and care workers and their professional organizations, and community members who are responsible for making decisions or advising on the delivery and promotion of self-care interventions.

Objectives of the guidance and its roll-out in every country

- To help end-users operationalize relevant WHO recommendations and good practice statements.
  - This includes recommendations and good practice statements from existing WHO guidelines, including those presented in the *WHO guideline on self-care interventions for health and well-being (6)*.
- To support the goals of PHC and UHC more generally.

Structure of the implementation guidance

Implementing self-care interventions requires interaction with all six of the WHO health systems building blocks to ultimately improve national health systems in terms of efficiency, responsiveness, more equitable health outcomes, and social and financial risk protection. After this introduction, the guidance is therefore structured to reflect implementation considerations as they pertain to the six WHO health systems building blocks, as outlined below (Chapters 1–6), with an additional final chapter.

Chapter 1. Information. An overview of the terminology and classification of self-care interventions, the relationship between self-care and the health systems building blocks, the role of self-care in advancing PHC, UHC and well-being generally, and the WHO conceptual framework for self-care interventions, which supports implementation.

Chapter 2. Health workforce. Background on the self-care competency standards and training curricula for health and care workers, and how family physicians, pharmacists, community health workers and caregivers can support the implementation of self-care interventions, including their vital role in providing instructions, information and education, as well as outreach efforts.

Chapter 3. Service delivery. Presentation of models and channels of delivery for self-care interventions, from task sharing to traditional medicine, the role of peer support and digital health interventions, and service delivery in fragile and humanitarian settings.

Chapter 4. Leadership and governance. The policy and legal, environmental, and strategic planning considerations pertinent to implementing self-care interventions, with examples and case study information from many different settings.

Chapter 5. Medical products and technologies. Regulatory considerations for access to quality products, and for ensuring people-centred access to quality, regulated products, and medical commodities.

Chapter 6. Financing. Economic and financial considerations that can support equitable access to cost-effective self-care options.

Chapter 7. Implementation of research, monitoring and evaluation
A description of the relevant components of implementation research, and how to identify, measure and monitor key outcomes.

A set of selected technical resources is also provided at the end of each chapter to support the guidance. A glossary is included at the end of the document. The methods for the development and compilation of this guidance are summarized in Annex 1, while Annex 2 provides additional relevant information about the WHO self-care framework, and Annex 3 presents information about indicators for monitoring and reporting.

Chapter 1. Information

Lao People's Democratic Republic. Credit: WHO/Enric Catala

It is important to ground the information available to all stakeholders in WHO's global evidence-based recommendations and good practice statements *(6)*. This will ensure that quality self-care interventions can provide more opportunities to strengthen health systems and for individuals to actively participate in their own health care and well-being and make informed health-related decisions.

This chapter of the implementation guidance is intended to provide up-to-date information regarding the basis of WHO's global self-care guideline, including terminology, the conceptual framework supporting implementation, and strategic approaches to advance universal health coverage (UHC) and primary health care (PHC), in order to better support communication efforts relating to the roll-out of self-care interventions.

Good practice statement

All self-care interventions for health must be accompanied by accurate, understandable and actionable information, in accessible formats and languages, about the intervention itself and how to link to relevant community- or facility-based health-care services, and the opportunity to interact with a health or care worker or a trained peer supporter to support decisions around, and the use of, the intervention.

Source: adapted from WHO, 2022 *(6)*.

1.1 Definitions and concepts

Health

State of complete physical, mental and social well-being, and not merely the absence of disease or infirmity *(7)*.

Well-being

Well-being is a multidimensional construct aimed at capturing a positive life experience, frequently equated to quality of life and life satisfaction. Measures of well-being typically focus on patient-reported outcomes covering a wide range of domains, such as happiness, positive emotion, engagement, meaning, purpose, vitality and calmness *(7)*.

Similar to health, well-being is a resource for daily life and is determined by social, economic and environmental conditions. Furthermore, the positive state and the concept of "well-being" applies not only to individuals but also societies. Well-being encompasses quality of life and the ability of people and societies to contribute to the world with a sense of meaning and purpose. Focusing on well-being supports the tracking of the equitable distribution of resources, overall thriving and sustainability.

A society's well-being can be determined by the extent to which it is resilient, builds capacity for action, and is prepared to transcend challenges *(8)*.

Individual well-being can be interpreted as "hedonic" – a feel-good subjective experience – and also as eudemonic – involving a person's ability to live in alignment with and act upon their own sense of meaning and purpose *(9)*. An individual's perception of their own well-being, referred to as subjective well-being (SWB) *(10)*, is experienced dynamically, is impacted by life events, and typically returns to a consistent equilibrium state for each person *(11)*. Supporting a person's well-being can promote resilience by ensuring that they have the resources (including social conditions) needed to cope with challenges as they arise.

Societal well-being is measured at the population level *(12)*. While individual SWB is a critical component, societal well-being is not the mere sum of individual well-being. The orientation that draws these initiatives and concepts together is a holistic notion of human progress that considers psychological, physical, social, economic and environmental dimensions of well-being *(11)*.

Self-care

Self-care is the ability of individuals, families and communities to promote health, prevent disease, maintain health and cope with illness with or without the support of a health or care worker *(13)*.

The scope of self-care includes health promotion, disease prevention and control, self-medication, providing care to dependent people, seeking primary, secondary or tertiary care if needed, and rehabilitation, including palliative care *(14)*.

Self-care interventions

Self-care interventions are tools that support self-care and actions to improve the care for oneself. Self-care interventions include evidence-based, high-quality medicines, devices, diagnostics and/or digital interventions that can be provided fully or partially outside formal health services and can be used with or without the support of health or care workers. Self-care actions include practices, habits and lifestyle choices.

Some people may have good knowledge of some self-care interventions and feel comfortable using them independently from the outset, but others may need more counselling and support before they can accept and use them independently. Self-care interventions that need initiation by a health or care worker, or additional health or care worker support (e.g. to follow up on a positive test result), must be linked to the health system and supported by it in order to be safe and effective.

1.2 Classification of self-care interventions, to support collaboration and implementation

WHO's *Classification of self-care interventions for health* (2021) provides a structure with the objective of promoting accessible and bridging language for researchers, policy-makers, donors and health programme planners to use to discuss and advance the implementation of self-care interventions. The classification categorizes the different ways in which self-care is used to support people's health needs and to address health system challenges *(15)* through:

i. self-care interventions for self-carers and caregivers;
ii. enabling actions by health and care workers;
iii. enabling actions by health programme managers; and
iv. enabling actions by health policy-makers, legislators and regulators.

Box 1.1 puts the spotlight on a new WHO tool that uses these concepts of shared terminology and clear classification to help unlock the potential of self-care at the community level.

Box 1.1 **The Self-Care Wheel**

The Self-Care Wheel is a combined paper and digital information tool that illustrates the evidence-based recommendations in the 2022 *WHO guideline on self-care interventions for health and well-being* in an easy-to-understand way. It promotes a shared language on self-care for health and care workers and clients, and helps to strengthen links with the health system by using a simple colour-coded traffic light system to show which interventions can be accessed without the support of a health and care worker and those that would need their support. The tool is still undergoing extensive testing *(16)*.

1.3 The role of self-care interventions in strengthening health systems

Self-care is inextricably embedded in the provision of health care. For instance, self-care can be the result of many direct interactions with primary care. Self-care interventions are therefore an adjunct to, rather than a replacement for, direct interaction with the health system. As users' experiences of self-care interventions are shaped, in part, by the health system, accountability across the health system is needed to ensure ethical and appropriate implementation *(17)*. Self-care interventions should not cause health system fragmentation but should rather be linked to the health system and supported by it where appropriate *(17)*. In this way, the health system remains accountable and can determine how to appropriately interact with and support the implementation of self-care interventions *(17)*. To be safe and effective and to reach individuals who may not be able to access health facilities, successful implementation of self-care interventions may need more – not less – support from the health system *(18)*.

Implementing self-care interventions requires interaction with all six of the WHO health systems building blocks (see Fig. 1.1) *(19)* to ultimately improve national health systems in terms of efficiency, responsiveness, more equitable

health outcomes, and social and financial risk protection. This guidance also addresses additional considerations to support both health systems strengthening and people-centred care. This includes a special focus on communication, community-led initiatives, end-user input and cross-cutting considerations, such as environmental issues and the constraints of fragile and humanitarian settings.

Fig. 1.1 Self-care in relation to the WHO health systems building blocks

Source: adapted for the self-care context from original information in WHO, 2010 *(20)*.

1.4 The role of self-care interventions in advancing primary health care and universal health coverage

1.4.1 Primary health care (PHC)

Implementation of self-care interventions supports the following key principles of the Astana Declaration on PHC *(21, 22)*:

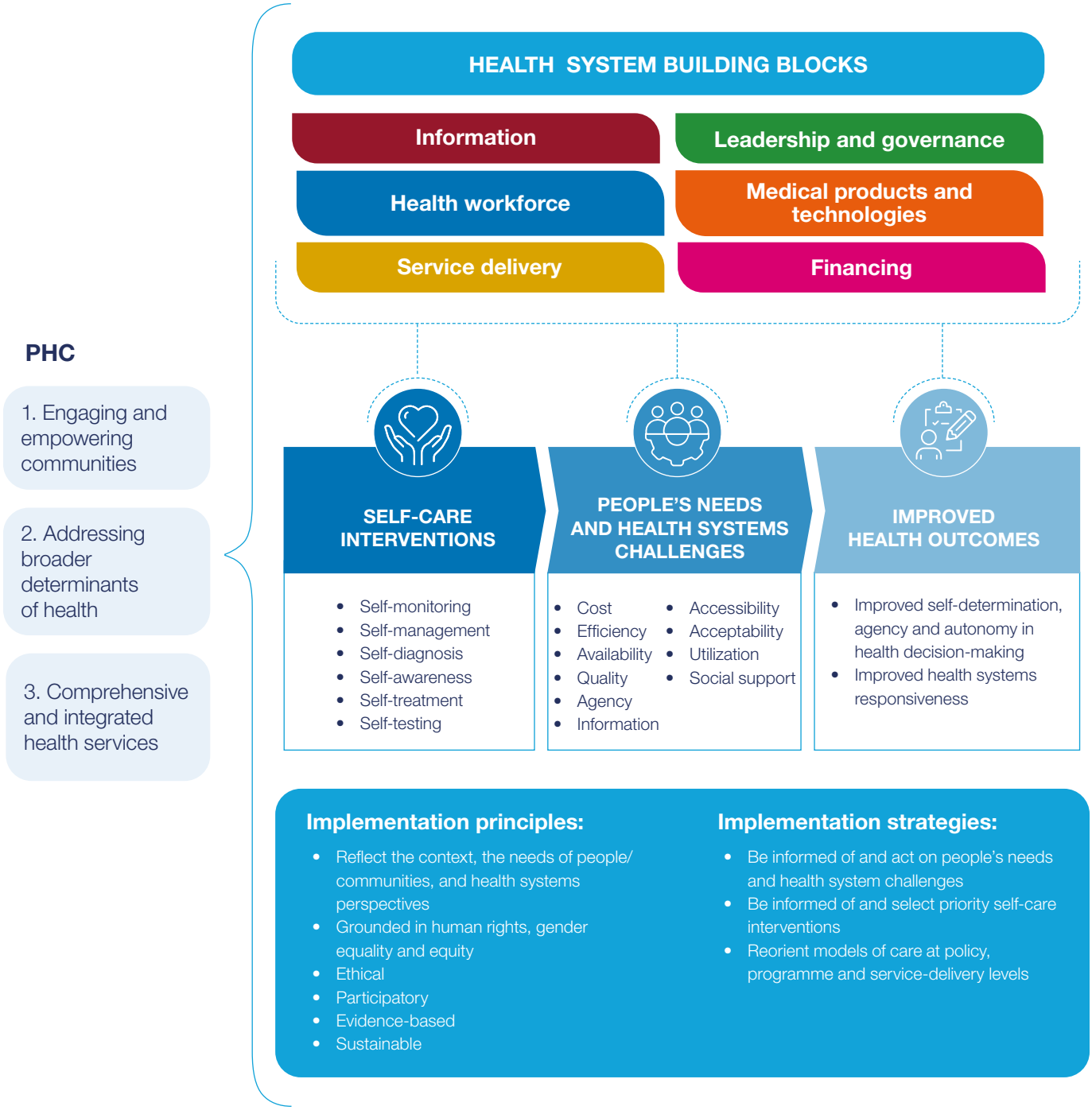
i. meeting people's needs through comprehensive and integrated health services (including promotive, protective, preventive, curative, rehabilitative and palliative) throughout the entire life course, prioritizing primary care and essential public health functions;
ii. systematically addressing the broader determinants of health (including social, economic and environmental factors, and individual characteristics and behaviours) through evidence-informed policies and actions across all sectors; and
iii. empowering individuals, families and communities to optimize their health – as advocates of policies that promote and protect health and well-being, as co-developers of health and social services, and as self-carers and caregivers.

1.4.2 Universal health coverage (UHC)

PHC is a fundamental component that is necessary for the achievement of UHC. Self-care interventions can contribute substantially to making a paradigm shift in health service delivery to improve PHC in support of UHC. Sustainable Development Goal 3 (SDG 3) is "to ensure healthy lives and promote well-being for all at all ages" and target 3.8 for this goal is – in short – to achieve UHC *(23)*. WHO developed the UHC Compendium – a website and database of health services and intersectoral interventions – to assist countries in making progress towards UHC. The UHC Compendium provides a strategic way to organize and present information and creates a framework for thinking about health services and health interventions *(24)*. The database spans the full spectrum of promotive, preventive, resuscitative, curative, rehabilitative and palliative services, plus a full complement of intersectoral interventions, including self-care.

Figure 1.2 illustrates and explains further how PHC and UHC connect and link self-care with WHO's six health systems building blocks, around which this guidance is structured.

Fig. 1.2 Linking self-care interventions to health systems building blocks, PHC and UHC



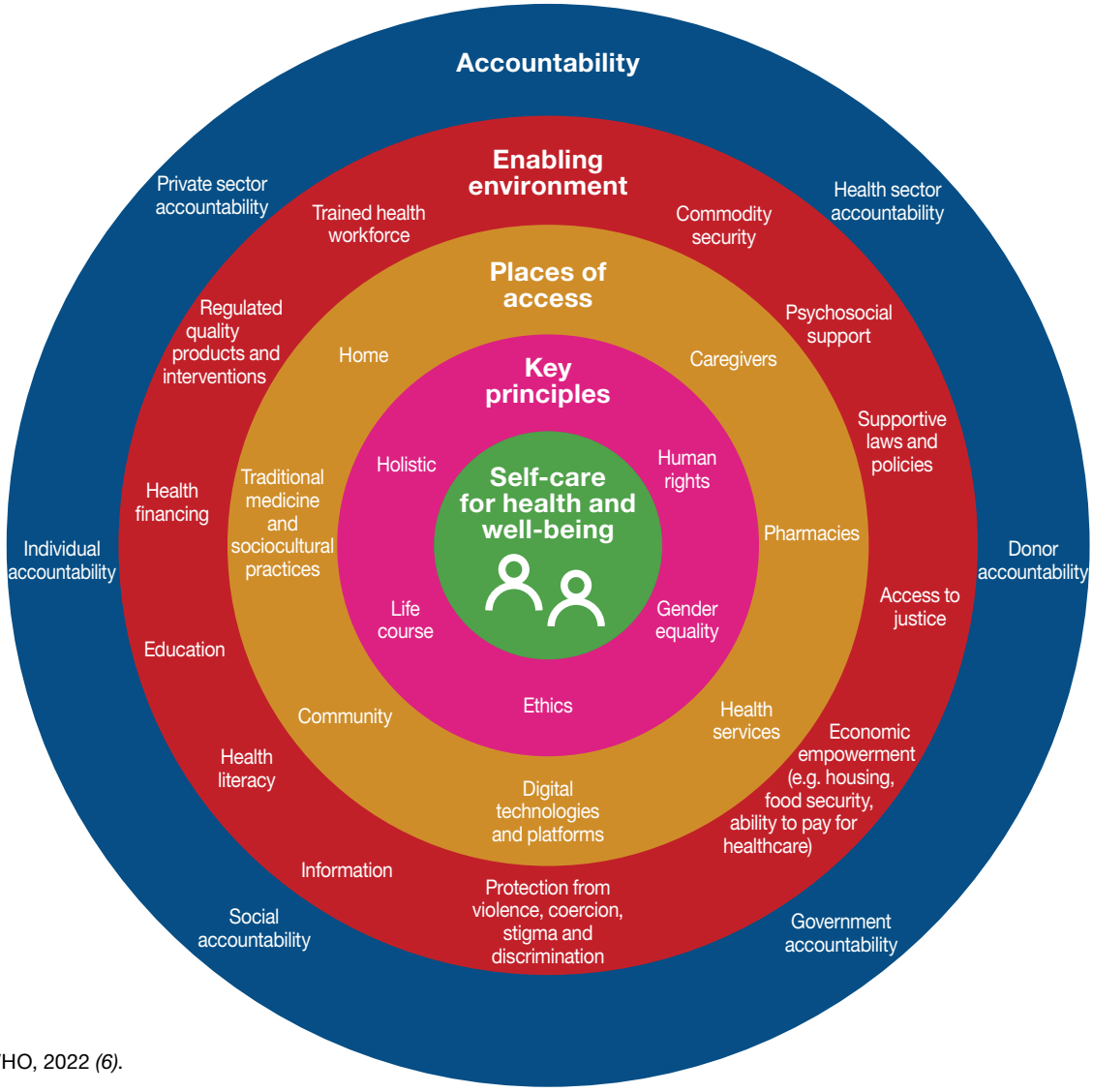
Source: adapted from Narasimhan et al., 2023 *(25)*.

1.5 The WHO framework for self-care interventions

The conceptual framework informing this guidance was designed to focus on and draw attention to the key areas for creating and maintaining an enabling environment for self-care, and to ensure that self-care interventions reach users with all the necessary checks and balances in place to support their rights and needs. Ensuring that the environment in which self-care interventions are made available is safe and appropriate must be key to any strategy for introducing and/or scaling up these interventions. These strategies in each country or setting should be informed by the profile of potential users, the services on offer to them, the broader legal and policy environment, and the relevant structural supports and barriers.

The conceptual framework for self-care interventions, shown in Fig. 1.3, illustrates core elements – from both people-centred and health systems approaches – to support their introduction, access, uptake and scale-up *(26)*. The people-centred approach to health and well-being lies at the core of this framework (green circle) and is underpinned by key principles (pink ring). The framework then shows key places of access to, and delivery of, self-care interventions (mustard ring), the key elements of a safe and supportive enabling environment (red ring), and accountability at different levels (blue ring). Elements of each layer are further described in Annex 1.

Fig. 1.3 Conceptual framework for self-care interventions



Source: WHO, 2022 *(6)*.

To ensure the safe, effective and efficient provision of self-care interventions, mechanisms must be put into place to overcome any barriers to service uptake and use, and any barriers to continued engagement with the health system. These barriers occur at the individual, interpersonal, community and societal levels. They may include challenges such as social exclusion and marginalization, criminalization, stigma, and discrimination based on gender, age, disability, sexual orientation, religion, ethnicity and other factors that usually interact with each other and which, therefore, need to be addressed from an intersectoral perspective. If these barriers are left unaddressed, they could undermine health, even where self-care interventions are available; removing these barriers is a critical part of creating an enabling environment for self-care interventions. Box 1.2 provides an example of preparing the enabling environment for self-care interventions in Uganda.

Box 1.2 Increasing public understanding of self-care in Uganda

Information, education and communication (IEC) materials are key to increasing understanding among members of the public, health and care workers, and policy-makers about self-care interventions. In Uganda, the Ministry of Health requested the development of self-care messaging for seven areas in response to recommendations in the 2022 *WHO guideline on self-care interventions for health and well-being* and national public health priorities as part of the life-course approach: (i) antenatal care, (ii) family planning, (iii) sexually transmitted infections (STIs) including HIV, (iv) post-abortion care, (v) noncommunicable diseases (hypertension, diabetes, mental health), (vi) adolescents and young people's health and (vii) older people's health. The Ministry of Health has led the development of the materials with technical support from the WHO Uganda Country Office, which kicked off the process by convening a team of stakeholders – including programme managers and representatives from partner organizations (Population Services International, the International Rescue Committee and the Centre for Health and Human Rights), professional associations and the Makerere School of Public Health – for consultations that were held over five days during a workshop in Entebbe, followed by three days of input from key experts in self-care.

The IEC messaging materials will be field-tested in collaboration with key stakeholders, including Ministry of Health technical units and health workers at health facilities in two districts (Buikwe and Kayunga), and disseminated in 2024. WHO Uganda and the Ministry of Health will share the IEC materials with selected health facilities, and staff will be trained to monitor and track the uptake of self-care interventions. The Ministry of Health communications team intends to monitor community understanding of self-care through surveys, health facility data and data sourced from the community. It is envisaged that the dissemination and use of the IEC materials on self-care will not only increase awareness of what self-care is (and what it is not) among the general population but will also help targeted groups and their families and communities to implement known self-care interventions to improve their health and well-being. To further strengthen communication around self-care, the Ministry of Health and WHO Uganda have also been working closely with the national media to raise awareness and understanding of self-care interventions.

Source: WHO, 2024 *(27)*. This is from a 2023 case study in Uganda on self-care interventions for SRHR.

Box 1.3 provides an example of home-based records that people can keep in their households for a range of health issues.

Box 1.3 Home-based records

A home-based record is a health document used to record the history of health services received by an individual. It is kept in the household, in either paper or electronic format, by the individual or their caregiver, and is intended to be integrated into the health information system and complement records maintained by health facilities. Home-based records can be used for a range of health issues. They were initially used to record proof of smallpox vaccinations; more recently they have been used to record maternal and newborn/child vaccinations and child nutrition. The information collected in home-based records can be used by programme managers for routine health information reporting, monitoring and planning purposes *(28)*.

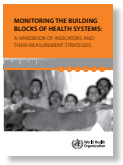
In WHO's 2022 self-care guideline, a recommendation was issued on home-based records and specifically women-held case notes to improve the utilization and quality of antenatal care:

> **Recommendation:** WHO recommends that each pregnant woman carries their own case notes during pregnancy to improve the continuity and quality of care and their pregnancy experience *(6)*.

For women, caregivers of children and family members, home-based records can facilitate learning and awareness of health problems; promote detection of risks and timely action; encourage continuity of care and positive health behaviours during pregnancy; and improve maternal, newborn and child health-care practices in the home.

Resources

WHO guideline on self-care interventions for health and well-being, 2022 revision (WHO, 2022), available at: https://www.who.int/publications/i/item/9789240052192



Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies (WHO, 2010), available at: https://iris.who.int/handle/10665/258734

UHC Compendium: health interventions for universal health coverage (WHO, 2024) (website and database), available at: https://www.who.int/universal-health-coverage/compendium

Continuity and coordination of care: a practice brief to support implementation of the WHO Framework on integrated people-centred health services (WHO, 2018), available at: https://www.who.int/publications/i/item/9789241514033

Operational framework for primary health care: transforming vision into action (WHO and UNICEF, 2020), available at: https://www.who.int/publications/i/item/9789240017832

Chapter 2. Health workforce

Kyrgyzstan. Credit: WHO/Mihail Grigorev

Culturally sensitive, inclusive, respectful and compassionate care is needed in the provision of self-care interventions across the health workforce. In this chapter, education and training are discussed, followed by sections on implementation of self-care interventions by different groups of health and care workers.

2.1 Education and training: self-care competency standards and training curricula

Good practice statements

- Health and care workers should receive appropriate recurrent education to ensure that they have the competencies, underpinned by the required knowledge, skills and attitudes, to provide self-care interventions based on the right to health, confidentiality and non-discrimination.
- Countries should adopt a systematic approach to harmonized, standardized and competency-based training that is needs-driven and accredited so that health and care workers are equipped with the appropriate competencies for:
  - engaging in and supporting self-care practices that promote emotional resilience, health and well-being;
  - determining the extent to which an individual wishes to, and is able to, self-monitor and self-manage health care;
  - promoting access to and the correct use and uptake of self-care interventions; and
  - educating individuals for preparing and self-administering medications or therapeutics.

Source: adapted from WHO, 2022 *(6)*.

WHO's *Self-care competency framework* encompasses the key considerations that will enable health and care workers to develop the competencies necessary for supporting individuals, families and communities in making evidence-based decisions and taking action to manage their own health and the health of those they care for. Service delivery, use and uptake that promotes user-led approaches and autonomy will require pre- and in-service training and on-the-job supervision and accountability.

2.1.1 The self-care competency standards

Implementation of self-care interventions by health and care workers should be based on the competency standards for health and care workers to support people's self-care and other information presented in WHO's *Self-care competency framework*, which comprises three separate but interlinked volumes, based on the conceptual framework for self-care interventions (see section 1.5/Fig. 1.3 of this document, and the 2022 self-care guideline *[6]*).

Volume 1 of the Self-care competency framework is the *Global competency standards for health and care workers to support people's self-care*; it defines 10 competency standards for providing self-care, which are designed to outline the minimum behaviour standards and evidence-based clinical standards to support people's ability to undertake self-care *(29)*. The competency standards are organized within six domains that align with the structure of WHO's *Global competency framework for universal health coverage (30)*, as shown in Table 2.1.

Table 2.1 Ten competency standards for health and care workers to support people's self care

No.	Self-care ompetency standard	Global competency framework domain
1	Promotes self-care by individuals, caregivers, families and their communities	1. People-centredness
2	Provides people-centred support for self-care by individuals, caregivers and families	
3	Takes an adaptive and collaborative approach to decision-making about self-care by individuals	2. Decision-making
4	Communicates effectively with individuals, caregivers and families	3. Communication
5	Collaborates with other health and care workers and community workers to support self-care	4. Collaboration
6	Promotes trust, agency and collaboration among individuals, caregivers and families with regard to self-care	
7	Supports evidence-informed self-care practice by individuals, caregivers and families	5. Evidence-based practice
8	Demonstrates high standards of ethical conduct	6. Personal conduct
9	Undertakes reflective learning and practice about self-care	
10	Manages own health and well-being	

While the behaviours associated with each competency standard, as described in Volume 1, are designed to be sufficiently broad to be applied across different health systems and countries, there is scope for behaviours to be tailored to specific settings.

2.1.2 Training curricula to support the competency standards

The other two volumes of the *Self-care competency framework* are both central to the education and training of health and care workers.

The knowledge guide (Volume 2) describes how to apply the competency standards in practice *(31)* and the curriculum guide (Volume 3) is a resource for educational institutions and curriculum developers to develop competency-based education and training programmes *(32)*.

The behaviours linked to each of the 10 competency standards are the observable, measurable components of performance, encompassing knowledge, skills and attitudes (KSA). The presence or absence of KSA can be inferred from the presence or absence of the behaviours associated with the competency and the tasks. The KSA can be customized for different groups of health and care workers, taking into consideration their training or area of responsibility, the local setting and the health system.

The curriculum guide introduces the relationships between capacity-development for better health-care systems (including self-care) and the

competency standards, proposing a five-step approach to developing customized curriculum materials using the competency standards:

1. Analyse the training setting and learner needs in relation to the competency standards.
2. Identify knowledge, skills and attitudes using the knowledge guide.
3. Develop relevant learning outcomes.
4. Create relevant learning activities.
5. Assess the development of the competency.

In applying the contents of the curriculum guide, educational designers are encouraged to consider the cadre of health or care worker and their level of experience, the type of self-care activity and the health context.

Box 2.1

Online programmes for health and care workers to promote self-care interventions – example of an e-learning programme on pharmacy access to contraceptives, available at the WHO Academy

The WHO Academy's open-source Learning Experience Platform (LXP) is a dynamic digital platform that serves as the central hub for hosting and delivering a comprehensive range of learning resources, including online learning programmes with multilingual capabilities. It is designed to empower learners through self-paced, engaging and interactive experiences. The Academy's LXP ensures flexibility and accessibility as learners can conveniently access the resources through any mobile device.

WHO Academy LXP e-learning programme on counselling and prescribing contraception in pharmacies

Summary of content of this openly available self-paced e-learning programme:

- Learning strategies: Problem-based activities, case studies, learning activities, e.g. multiple-choice questions, reflective learning
- Assessment strategies: Multiple-choice question bank, reflective learning
- Modules:
  1. Being prepared
  2. Contraceptive pills (emergency contraceptive pills, combined oral contraceptive pills, progestin-only oral contraceptive pills)
  3. External (male) condoms and internal (female) condoms
  4. Progestin-only self-injectable contraceptives
  5. Follow-up and support.

Source: Borg et al., 2022 *(33)*.

2.2 Family physicians

Family physicians have long recognized the importance of being equipped with the necessary skills and knowledge to effectively support patients in managing their own health, to achieve improved health outcomes and patient satisfaction. The World Organization of Family Doctors (WONCA) has publicly endorsed WHO efforts in support of this aim as well as WHO efforts to establish the best evidence as a basis for training family physicians to support self-care *(34)*.

The previously sparse evidence on the association between training of family physicians in patient self-care and measured health outcomes has gradually been strengthened, particularly since the inclusion of self-care in the WONCA Europe definition of general practice *(35)*. The most recent systematic review, including a broad range of educational interventions, has been instrumental in illuminating how education and training of family physicians can enhance patient self-care and improve outcomes for those with chronic diseases *(36)*.

Effective training of family doctors in supporting self-care requires a multifaceted approach that involves several key components: enhancing communication skills, promoting patient-centred care, utilizing evidence-based tools, incorporating technology, and follow-up. Multi-component interventions that are embedded in continuous professional training programmes are more likely to be successful. Barriers and challenges in the adoption and implementation of such interventions include physician workload and treatment fidelity.

Patient-centred care, including individualized care plans and lifestyle goal-setting, has emerged as a critical factor for successful interventions, aligning with the broader principles of effective self-management support *(37)*. Ongoing patient follow-up, feedback and booster training are important for sustaining improvements in self-management and health outcomes.

2.3 Pharmacists and pharmacy workers

Community pharmacists play an essential role, assisting individuals on their path to improved health. The pharmacy team serves as a crucial link for patients seeking advice and support in maintaining their health and wellness. Due to their proximity and accessibility to individuals and communities, pharmacists are uniquely positioned to provide medicines, education and health services to support people to manage their minor ailments and embrace self-care for disease prevention. Pharmacists provide patient-centred assistance with care coordination, medication management, communication, education and coaching, as well as encouraging timely follow-up by a clinician *(38)*.

During the COVID-19 pandemic, the role of the pharmacist/pharmacy team was amplified as pharmacies were, in some places, the only health facilities that remained open. The subsequent realization that pharmacists are under-utilized in many settings highlighted the clear need to equip pharmacists with the appropriate knowledge, skills and enhanced sensitivity to better enable them to serve patients and populations, including assisting with self-care.

Although pharmacists are pivotal in offering over-the-counter counselling and services to clients and patients, several obstacles hinder their capacity to

provide enhanced support for people's self-care, including *(38, 39)*:

- lack of knowledge and skills about self-care and how to provide support;
- the need for education and workforce development (continuous professional development/education/training and tools adapted to community needs);
- structural and regulatory barriers (time and scope limitations, regulatory restrictions);
- perceptions and attitudes (lack of confidence, resistance to change);
- the impact of the COVID-19 pandemic (isolation measures, need for digital solutions);
- inadequate client health literacy (as a basis for making informed decisions regarding health and well-being);
- workload pressures (capacity, management, supply chain, remuneration);
- lack of appropriate remuneration models (no remuneration for pharmacists providing health education and disease prevention services);
- the need for better inter-professional teamwork (pharmacists need to be included/represented in decision-making and policy-making);
- lack of time to educate patients about health technologies and digital self-care tools;
- limited access to patient records; and
- inequitable access to evidence-based digital self-care tools and health-care technologies used by patients.

These barriers are often compounded with chronic underinvestment in community pharmacy.

Pharmacists can improve health literacy levels as well as assist and empower individuals in understanding key aspects relevant to their health and well-being *(38)*. Methods that pharmacists can use for this include:

- identifying patients' abilities and level of engagement in health-related discussions, and adjust how information is delivered;
- creating a shame-free environment in which individuals can ask questions and express concerns, such as by using consultation rooms at community pharmacies;
- giving non-judgemental answers and encouragement;
- using the teach-back technique, i.e. asking individuals to repeat in their own words what has been previously discussed (this may also be accompanied by the use of drawings or diagrams);
- using a participatory teaching approach when educating patients, such as allowing an individual to count their tablets as the pharmacist explains the medicine, or asking the patient to demonstrate the use of a blood glucose monitoring device; and
- using patient-friendly language and avoiding health-care jargon and complicated, elaborate explanations.

Pharmacists play a vital role in improving medication adherence by identifying at-risk patients and educating them about the benefits of taking medications correctly. Medication adherence and therapeutic stability can improve patient motivation to explore self-care conditions and solutions for their minor ailments.

2.4 Community health workers

A growing body of evidence supports the effectiveness of community health workers (CHWs) for a range of promotive, preventive and curative health services, including self-care interventions, contributing to reducing inequities in access to care. CHW integration in health systems and communities varies and evidence-based policy adoption regarding CHW engagement is uneven. However, the *WHO guideline on health policy and system support to optimize community health worker programmes* offers opportunities to harness the potential of CHWs to strengthen primary health care and expand equitable access to priority health services for all *(40)*. The reorientation of the health workforce will require health and care workers to "approach patients, clients and communities differently, be more open to working in teams (particularly inter-professional teams), use data more effectively in their work and be willing to innovate in their practice" *(41)*. It is important that all health and

care workers see CHWs as respected colleagues who can help share the workload and promote health system and community goals.

WHO recommendations support several key aspects of CHW training and their engagement in promoting and supporting the introduction, use and uptake of self-care interventions, including:

- **Community engagement:**
  - community participation in CHW selection;
  - selection and priority-settiing of CHW activities;
  - support to community-based structures; and
  - involvement of community representatives in decision-making, problem-solving, planning and budgeting processes.
- **Community resource mobilization:**
  - identifying priority health and social problems and developing and implementing corresponding action plans with the communities;
  - mobilizing and helping to coordinate relevant local resources representing different stakeholders, sectors and civil society organizations to address priority health problems; and
  - strengthening linkages between the community and health facilities.
- **Competencies required for CHW pre-service education:**
  - competencies required to ensure high-quality service delivery;
  - pre-existing knowledge and skills (whether acquired through prior training or relevant experience); and
  - the social, economic and geographical circumstances of trainees *(40)*.

Application of WHO recommendations relating to CHWs should be tailored for use in each local context, with country-specific policies for CHWs and efforts to align with broader health system policies and community structures.

Box 2.2 highlights the contributions of both pharmacists and CHWs to self-care in Bangladesh.

Box 2.2 Health workforce support for self-care interventions in Bangladesh

Primary health care (PHC) is a foundational strategy for tackling sexual and reproductive health and rights (SRHR) issues in relevant policies in Bangladesh. The Government of Bangladesh is also committed to achieving universal health coverage (UHC) by focusing on PHC and has pledged to move quickly – doubling down on its mission to provide health care to all by the year 2030 by boosting service delivery, increasing funding and enhancing effectiveness. Bangladesh's National Health Policy 2011 emphasizes this need to provide health care to all, and to deliver quality health services to all at a low cost, with a focus on preventive care in all national and international development policy and planning.

Local pharmacies and medicine sellers were reported to play a crucial role in meeting communities' PHC needs, in both urban and rural areas, being the preferred option for both men and women. Women and adolescent girls rely on them to obtain contraceptives without the need for a prescription (injectables and oral contraceptive pills are most popular, along with condoms and emergency contraceptive pills), and sanitary napkins, which are preferred over cloth napkins. Some pharmacists and medicine sellers have received training to administer injectable contraceptives.

Community health workers (CHWs) employed by the health and family planning units of local government and nongovernmental organizations are an important bridge between community members and the health system. CHWs facilitate and provide self-care interventions, as well as services such as contraceptive counselling, home visits for antenatal/postnatal care, and skilled assistance with home births. The lack of male CHWs means that men and boys do not have that "bridge" and instead they rely on other community members or elders for guidance on matters related to sexual health. Many men in both rural and urban areas also commonly seek the assistance of traditional medicine practitioners.

Source: WHO, 2024 *(42)*. These are findings from a 2023 WHO scoping study (involving policy analysis and consultations with key stakeholders in Bangladesh) on existing self-care practices, interventions, gaps, challenges and opportunities.

2.5 Caregivers

The United Nations International Labour Organization (ILO) estimated that unpaid caregiving would account for as much as 9% of global GDP (or US$ 11 trillion per year) if carers had been paid hourly at minimum wage *(43)*. The same report estimated that 76.2% of unpaid care work is undertaken by women globally *(43)*. Caregiving is a role that lies at the intersection of many challenges, including gender roles, duties and expectations; cultural norms and power dynamics; physical labour; mental health and mental labour; emotional labour; time pressure; poverty; learning and using new skills and tools; tension between one's identity and the role of being a caregiver; the need to take time for self-care without feeling guilty or selfish.

Compassion, both for others and oneself, is crucial when giving care. Compassionate caring is a skill that can be learned, requiring practise and the right environment. The responsibility on family members for caregiving can be high and tends to be filled most often by women. Multiple phenomena can impact the mental health of caregivers. Caregiving is often invisible, unrecognized and underappreciated. Lack of role models and feelings of tiredness and guilt, for example, can cause caregivers to neglect their own self-care. They may experience caregiver burnout. Effective self-care in this situation requires a specific mindset, involving reflexivity, self-awareness, and understanding of one's purpose.

2.6 Instructions, information, education and outreach efforts to promote effective self-care

The provision of accurate and tailored information about specific self-care interventions and technologies is important to promote safe and effective self-care. To this end, information is needed to:

- facilitate access and informed choice (e.g. with details of potential sources/access points);
- promote the appropriate use of an intervention/technology, through comprehensible (step-by-step) instructions;
- inform end-users about their right to bodily autonomy and agency;
- inform potential users about the possible physical and emotional ramifications and the potential side-effects and contraindications; and
- advise potential users about the circumstances under which they should seek care, and how to do so.

A vast range of self-management support applications (apps), online resources and printed or web-based toolkits are designed to assist health and care workers in having conversations with and supporting individuals at home to continue towards their health and self-care goals. Many of the resources include basic information to be discussed with individuals, and practical tips to help them find further details about their condition or access support for its management.

Resources

Self-care competency framework (WHO, 2023):

Volume 1: Global competency standards for health and care workers to support people's self-care

Volume 2: Knowledge guide for health and care workers to support people's self-care

Volume 3: Curriculum guide for health and care workers to support people's self-care

Available at: https://www.who.int/publications/i/item/9789240077423

Online learning programmes:

WHO Academy – Learning Experience Platform (LXP) (WHO, 2024), available at: https://web-staging.lxp.academy.who.int/ (login required)

Guidance for family physicians:

External resources on self-management support (Agency for Healthcare Research and Quality, 2024), available at: https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/education/continuing-ed/moc_smsresources.pdf

Guidance for pharmacies and pharmacists from the International Pharmaceutical Federation (FIP):

Empowering self-care: a handbook for pharmacists (FIP, 2022), available at: https://www.fip.org/file/5111

Community pharmacy insights: supporting the need for self-care (FIP, 2023), available at: https://www.fip.org/file/5710

Guidance for community health workers:

WHO guideline on health policy and system support to optimize community-based health worker programmes (WHO, 2018), available at: https://www.who.int/publications/i/item/9789241550369

Supporting community-based health workers (CHWs) (WHO website, 2024), available at: https://www.who.int/activities/supporting-community-based-health-workers

Guidance for caregivers:

WHO eLearning Caregiver Skills Training for Families of Children with Developmental Delays or Disabilities (OpenWHO, 2024), available at: https://openwho.org/courses/caregiver-skills-training

Evidence profile: caregiver support – integrated care for older people: guidelines on community-level interventions to manage declines in intrinsic capacity (WHO, 2017), available at: https://www.who.int/publications/i/item/WHO-MCA-17.06.01

Chapter 3. Service delivery

Uganda. Credit: WHO/Badru Katumba

People might choose self-care interventions for convenience, cost, empowerment or a better fit with values or daily lifestyles, or because the intervention may provide the desired options and choice. People might also opt for self-care interventions to avoid contact with the health system (e.g. as a result of discrimination from health and care workers), or because of a lack of quality services or lack of access to them (e.g. in humanitarian settings). While not ideal, in these situations self-care interventions may fulfil a particularly important role, as the alternative might be that people have no access to health care at all.

Good practice statement

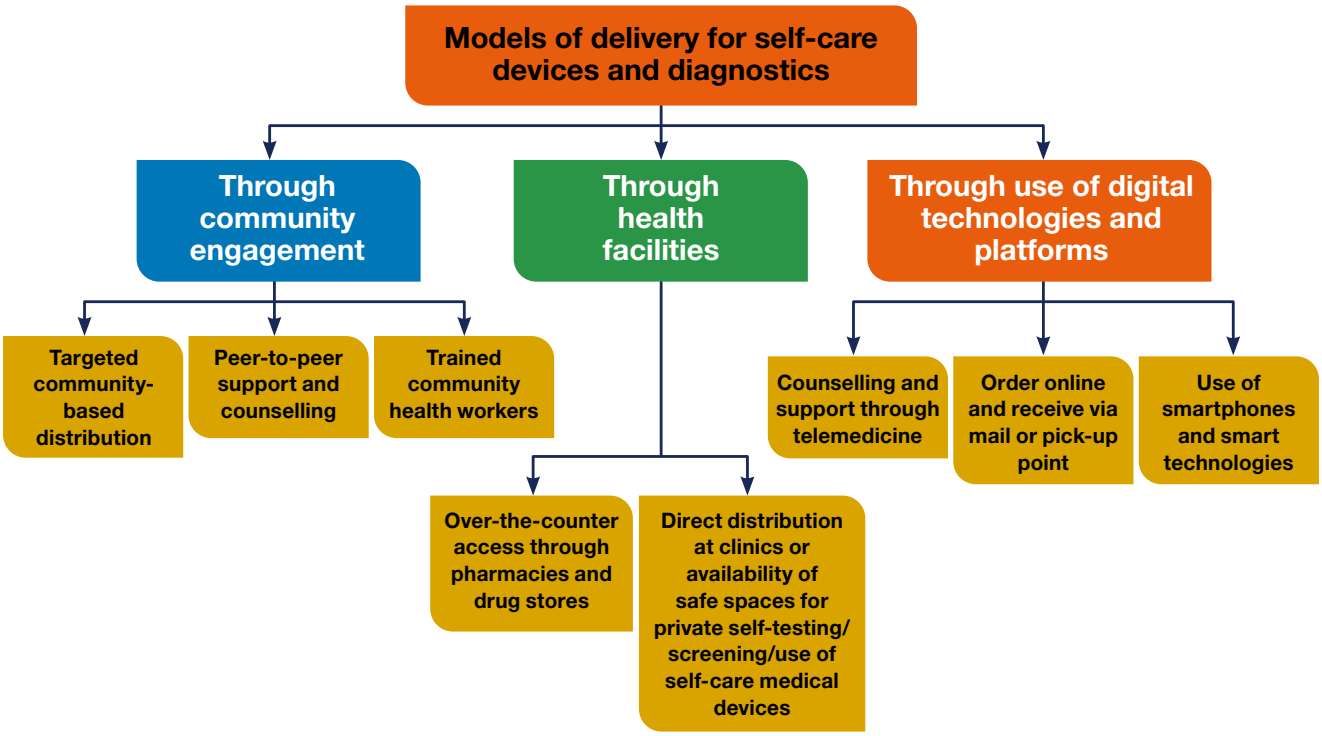
The provision of self-care interventions for health should increase clients' options about when and how they seek health care, including offering flexibility in the choice of interventions and in the degree and manner of the engagement with health services.

Source: WHO, 2022 *(6)*.

3.1 Models of delivery for self-care interventions

The best ways to deliver and access self-care interventions depend on the specific context. They can be distributed through various models and delivery channels including through health facilities, communities and peer-support networks, over-the-counter access at pharmacies, and through digital health technologies (Fig. 3.1).

Fig. 3.1 Examples of distribution models for self-care interventions



Self-care interventions support a continuum of care, as shown in Fig. 3.2; implementation of self-care interventions requires meeting people's needs with adequate support from the community and the health and care workforce. Box 3.1 discusses issues around implementation of HIV self-testing, as an example.

Fig. 3.2 Continuum of care for self-care

Personal determinants

- Knowledge, skills, attitudes and competencies
- Health literacy
- Daily choices (hygiene, safe sex, risk avoidance, nutrition/diet, work–life balance, adherence to treatment)

Situational, economic, emotional and social determinants

- Peer-to-peer actions
- Support
- Counselling
- Engagement in health decisions

Health systems determinants

- Identify opportunities to promote self-care
- Provide written or visual materials
- Support development of action/calendar/ follow-up plan with increased severity of health condition
- Promote tools, interventions, information for improved autonomy
- Support caregivers

Source: adapted from WHO, 2022 *(6)*.

Box 3.1 Implementation of HIV self-testing

Despite the established clinical efficacy and effectiveness of HIV self-testing (HIVST) kits, individuals' access to and uptake of HIVST are limited by client-level and structural-level challenges *(44)*. Policies can work to alleviate these burdens by facilitating the introduction and scale-up of HIVST. Nagai et al. asked policy-makers in Ghana for their views on challenges they believe will impact a policy directive on this topic *(44)*. The greatest challenge they identified on the client level was poor linkage to care and treatment *(44)*, and indeed good linkage to care has been identified in numerous studies as a determinant of successful implementation *(44–48)*. Clients were lacking the appropriate pre-test counselling and confirmatory testing that would have better enabled them to understand their results and seek follow-up care when necessary *(44)*. Policy-makers can address this challenge by requiring the inclusion of instructions and counselling messages within the test kits and creating "wrap-around" entry-to-care systems that are linked with support services *(46)*.

On a structural level, studies show that lack of national policy and implementation guidelines, as well as inefficient supply chains *(44)*, management of commodities, and data monitoring and reporting are barriers to successful implementation of HIVST roll-out. Policies can lay the foundations upon which countries and organizations can develop an operational framework for the roll-out of interventions *(44, 49)*.

Ghana developed HIVST guidelines, which were added to its 2021–2025 National Strategic Plan *(44)*. This addition allowed HIVST kits to be distributed and managed by the country's medical product supply chain *(44)*. It also allowed for improved testing rates among key populations, and adolescent girls and young women *(44)*.

Consistency is required across policies that seek to implement HIV self-testing. Support aids such as guidelines, training, and adequate monitoring and regulation systems can address these concerns. Policy-makers can employ measures like those undertaken in implementing HIVST kits globally to introduce other self-care kits.

3.2 Task sharing: delegating tasks to people without formal health training

WHO's definition of the rational delegation of tasks among health teams supports the redistribution of specific tasks, where appropriate, from highly qualified health workers to health and care workers with shorter training and fewer qualifications – such as community health workers (CHWs) – to make more efficient and cost-effective use of the available human resources for health *(50)*. The principles of people-centred care include that individuals, caregivers and communities are seen as active participants in managing their own health, and as members of the health team.

The reassignment or sharing of tasks and roles need not be a permanent delegation of tasks and is not an abrogation of the responsibility or accountability of health workers. Task sharing or delegation of tasks to carers and self-carers should be seen as an opportunity where appropriate, and as a way of enhancing and acknowledging the important roles that individuals, families and communities play in managing their health. It is appropriate when:

- self-care interventions can be managed with little or no support from a health or care worker; and/or
- individuals can acquire and apply certain skills to help them manage their health, including gathering information, managing medication, managing symptoms, managing psychological consequences, adjusting their lifestyle, using social support and communicating effectively.

Good practice statements

- Countries, in collaboration with relevant stakeholders, including patient groups and the community, should consider implementing and/or extending and strengthening the rational delegation of tasks to individuals, carers and communities, as members of the health and care team, in effective ways that lead to equitable health outcomes.

- Self-carers and caregivers who are not trained health or care workers can be empowered to manage certain aspects of health care under the responsibility of a health or care worker, particularly in relation to self-care and the use of self-care interventions, where appropriate and within the context of safe, supportive health systems.

Source: adapted from WHO, 2022 *(6)*.

This delegation of tasks to individuals, carers and communities is shaped by context, sociocultural factors and political factors. It is being implemented to various degrees in many countries and is acknowledged in national guidance documents and strategies. In each country considering the roll-out of a range of self-care interventions, national dialogue is needed to determine whether:

- health and care worker availability at different levels contributes to the accessibility and use of self-care interventions;
- policy-makers, programme managers and health and care workers are willing to consider the rational delegation of tasks to lay people;
- health and care workers are supported by other interrelated health-system components to promote self-care interventions; and
- self-care interventions are considered in the context of improving overall health-care delivery, to enable holistic integrated care.

The delegation of tasks within the health and care team(s) is more likely to succeed when the

stakeholders involved are convinced that the consequences will be positive. Redistributing or delegating tasks requires stakeholder dialogue to understand and address the expectations and fears of the people who will be affected, including the individuals, their carers and communities, as well as health and care workers and managers. This means that delegation should not be seen as a cost-saving measure. When tasks are delegated to individuals and their carers, the goals, expectations and capacities of those adopting new roles regarding self-care should be recognized, ensuring they are empowered to engage fully with health and care workers to plan and manage their health care, and with the ongoing monitoring and evaluation needed to ensure improved health outcomes.

3.3 Traditional medicine

Traditional medicine is well established in many parts of the world, where it plays an important role in the culture, health and well-being of communities. For some people, traditional medicine is either the only available source or the preferred source of health care *(51)*. Of WHO's 194 Member States, 170 have reported on the use of herbal medicines, acupuncture, yoga, Indigenous therapies and other forms of traditional medicines. Many Member States also recognize traditional medicine as a valuable source of health care and have taken steps to integrate traditional medicine practices, products and practitioners into their national systems *(52)*.

WHO is working with countries on developing standards and benchmarks for the training and practise of different systems of traditional medicine, and for their evidence-based integration into the WHO International Classification of Diseases (ICD).

The *WHO traditional medicine strategy: 2014–2023* focused on developing norms, standards and technical documents based on reliable information and data to support Member States in:

- providing safe, qualified and effective traditional and complementary medicine services;
- integrating these services in an appropriate way into their health systems; and
- developing proactive policies and implementing action plans that will strengthen the role traditional and complementary medicine play in keeping populations healthy *(53)*.

To rise to the challenge of integrating traditional medicine into their health systems, Member States should do the following.

i. Build the knowledge and evidence base that will allow traditional and complementary medicine to be managed actively through appropriate national policies that understand and recognize the role and potential of traditional and complimentary medicine.
ii. Strengthen the quality assurance, safety, proper use and effectiveness of traditional and complementary medicine by regulating products, practices and practitioners through traditional and complementary medicine education and training, skills development, services and therapies.
iii. Integrate traditional and complementary medicine services into health-service delivery and self-care by capitalizing on their potential positive contributions to health services and health outcomes, and by ensuring users are able to make informed choices about self-care for health and well-being.

Box 3.2 highlights some relevant points agreed at the first WHO Traditional Medicine Global Summit, which took place in Gujarat, India, in August 2023. Box 3.3 describes the establishment and operations of India's newly created Ministry of Ayush.

Box 3.2 Self-care at the WHO Traditional Medicine Global Summit: the Gujarat Declaration

The following self-care considerations emerged from this Summit:

"Prioritize well-being for societies and economies aligned with the time-tested wisdom and values of Indigenous knowledges and [traditional, complementary and integrative medicine] TCIM systems, and as also recommended in the WHO global framework for achieving well-being *(54)* and by the WHO Council on Economics of Health for All, shifting political and economic models beyond profits to promote health and well-being, equity of access, shared benefits, and financial protection, and incentivising adoption of evidence-informed TCIM approaches, making this a driving force in achieving the health-related SDGs towards health and well-being for all."

"Support countries to redefine, where appropriate, laws, policies and health services to enable people to make holistic, relevant, evidence-informed choices for their health and well-being, encompassing disease prevention, health maintenance and primary care and planetary health, and including support for the recognition and appropriate regulation of TCIM products, practices and practitioners to ensure safety, accessibility and efficacy of TCIM interventions."

Source: WHO, 2023 *(55)*.

Box 3.3 Traditional health practices and the Ministry of Ayush in India

In India in 2022, there were an estimated 812 591 traditional, complementary and integrative medicine (TCIM) practitioners and 1 300 290 biomedical practitioners *(56)*. Building on 5000 years of Indigenous knowledge systems, traditional practices and understanding of health and well-being, the Government of India created the Ministry of Ayurveda, Yoga, Naturopathy, Unani, Siddha, Sowa-Rigpa and Homoeopathy – known as the Ministry of Ayush – in 2014. The Ministry of Ayush is dedicated to promoting health and well-being through education and the provision of services in alignment with ancient traditions. These practices – based heavily on respect for the planet and the seasons, as well as monthly and daily rhythms – provide a holistic approach to wellness that encompasses spiritual, physical, mental and social well-being, not only of individuals but of whole communities and the larger nation *(8)*.

The Ministry of Ayush has ensured progress and improvement in TCIM research, product development and professional standards, and has promoted a national vision for holistic health care to support a healthy nation *(57, 58)*. National commissions have been established to control the quality of higher education for AYUSH professionals (undergraduates receive instruction in biomedical subjects) and maintain central registers of practitioners who have achieved minimum educational and competency standards. Combined across all regulated professions, in 2020–2021, approximately 753 universities, institutions and private bodies were offering degrees and training in various related professions. The Ministry collaborates through states, provinces and rural communities to provide education and clinical services. Through partnerships engaging with young children to university-level programmes, the promotion of yoga and other ancient practices are embedded in daily self-care routines and in related curricula *(8)*.

3.4 Peer support and counselling

In many settings, people lack access to quality health services that respond to their needs and respect their rights and dignity *(59)*. Peer support is particularly valuable when formal health systems are inaccessible or hostile, including denial of services or lack of confidentiality. The power of peer support – whether it is one-to-one or in formal or informal groups, in person or over the telephone or internet – lies in connecting people with shared experiences in a safe, encouraging space. To be successful, peer support depends on building relationships based on mutual respect and understanding.

Peer support develops people's knowledge, skills and confidence, enabling them to take steps to live as well as possible, and it can in turn help to reduce pressure on the health system. A study in the United Kingdom of Great Britain and Northern Ireland found that people who have the knowledge, skills and confidence to self-manage their health conditions had 38% fewer emergency admissions, 32% fewer emergency department attendances and 18% fewer primary care appointments than those lacking the skills and confidence to manage their health *(60)*.

By facilitating access to peer support and the skills and knowledge of people with shared lived experience, health systems can empower people to make more informed choices in managing their health. Box 3.4 provides an example of the power of peer support.

Box 3.4

Transgender and gender diverse individuals: equitable access to self-care interventions for sexual and reproductive health and rights

Participants in two online dialogues with transgender and gender diverse individuals defined self-care as seeking to positively manage illness and other health needs outside of formal health systems. They stated that they access informal care through the internet, the queer community, sex worker communities, and other peer groups. These resources enable them to access care when needed, provide affirming spaces, and support improved self-determination and mental health through connections with other people undergoing similar experiences. The lack of an enabling environment hindered their access to and uptake of self-care interventions. Informal support resources and groups may not be accessible to all who need them, and that the quality of care can vary. Many trans people do not have the confidence to raise the subjects of sexuality and sexual health with health workers in clinical settings due to the fear of stigma, discrimination and harassment.

To facilitate better access to self-care interventions for transgender and nonbinary people, the discussion participants called for policies that require training so that health and care workers can offer appropriate care to trans people. Reducing barriers to care is also important. Advocacy work and campaigning can encourage governments to support self-care interventions that are inclusive of trans and gender-diverse individuals.

Source: Adapted from the transcripts of two online group discussions on this topic on 11 July 2023 organized by WHO (unpublished report).

Peer support is useful at moments of change across the life course, including for instance, starting a new relationship, planning a family, or going through the menopause. Among people living with HIV, peer support can be helpful when it comes to coping with diagnosis, starting treatment, adhering to treatment, dealing with stigma and sharing one's HIV status with others. Effective oversight, management and support are critical for implementation of quality peer support.

Recommendations

- Following an HIV diagnosis, a package of support interventions should be offered to ensure timely linkage to care for all people living with HIV (*strong recommendation, moderate-certainty evidence*).
  - Note: Peer support (including peer counselling) has demonstrated benefits in improving linkage to care following an HIV diagnosis.

Source: WHO, 2021 *(61, 62).*

- Adherence support interventions should be provided to people on antiretroviral therapy (*strong recommendation, moderate-certainty evidence*).
  - Note: Interventions (including peer counsellors, text messages and reminder devices) have demonstrated effectiveness in improving adherence and virological suppression.

- Programmes should provide community support for people living with HIV to improve retention in HIV care (*strong recommendation, low-certainty evidence*).
  - Note: Community-level interventions (including peer support) have demonstrated benefit in improving retention in care.

Source: WHO, 2021 *(61).*

Steps for scale-up of peer support include:

- consultation with stakeholders;
- costing to determine operational costs for training, delivery and support;
- clear peer-support model;
- clear scope of work, outline of duties and training (including pre-service);
- planning for recruitment, standards, terms of service, supervision and reporting lines;
- in-service support, including mental health support for the supporters; and
- monitoring.

Box 3.5 highlights how young people value the inclusion of trusted and understanding local people and the availability of safe spaces for discussion, and how this supports their sense of personal agency.

Box 3.5

Young adults: equitable access to self-care interventions for sexual and reproductive health and rights

The inclusion of parents, community members and health and care workers in understanding the needs and perspectives of youth was viewed as important, by young adults (18–24 years) and people who work professionally with young adults, to address issues of accessibility and stigma. The participants believed that the creation or identification of local safe spaces for discussions around sexual and reproductive health and rights (SRHR) can increase their sense of personal agency and enable them to initiate self-care. In a community setting, awareness of health and self-care necessities, and information about modes of access and the cost of self-care interventions should be widely disseminated, especially in low-resource settings. Trusted community leaders and mentors within the society can serve as good SRHR advocates in community outreach initiatives.

Source: Adapted from the transcript of two online group discussions on this topic on 11 July 2023 organized by WHO (unpublished report).

Recommendations

- For women living with HIV, interventions on self-efficacy and empowerment around sexual and reproductive health and rights should be provided to maximize their health and fulfil their rights (*strong recommendation; low-certainty evidence*).

Source: WHO, 2022 *(6)*.

- Brief sexuality-related communication (BSC) is recommended for prevention of sexually transmitted infections among adults and adolescents in primary health services (*strong recommendation; low- to moderate-quality evidence*).

Source: WHO, 2015 *(63)*.

Good practice statement

Psychosocial support interventions, such as support groups and peer support, provided by, with and for women living with HIV, should be included in HIV care.

Source: WHO, 2017 *(64)*.

3.5 Digital health interventions

Digital health technologies offer potential conduits for information beyond the more traditional information sources, such as leaflets/brochures, posters, face-to-face counselling sessions, information posted on websites or shared by email attachments. Digital health technologies encompass a variety of approaches to information provision, including targeted communications between health and care workers and their clients (e.g. via text messages or apps), client-to-client or peer network communications (e.g. online discussion forums) and on-demand information services (e.g. information found on the internet) *(65)*.

Telehealth enables transmission of information across a distance and can therefore transform access, providing substantial support to self-care (self-management, self-testing, self-awareness), and allowing for improved remote monitoring and support for task sharing among health and care workers.

Good practice statements

- Digital health interventions offer opportunities to promote, offer information about and provide discussion forums for self-care interventions.
- Client-to-provider telemedicine to support self-care interventions can be offered to complement face-to-face health services.
- Digital targeted client communication by health and care workers on the use of self-care interventions can help to implement, monitor and evaluate health outcomes.

Source: adapted from WHO, 2022 *(6)*.

Box 3.6 describes WHO's newly launched AI health assistant, S.A.R.A.H – an example of a digital health technology that can support self-care.

Box 3.6 WHO's S.A.R.A.H. – a Smart AI Resource Assistant for Health

In 2024, WHO launched S.A.R.A.H. – a Smart AI Resource Assistant for Health. S.A.R.A.H. represents an evolution of AI-powered health information avatars, using new language models and cutting-edge technology. She is powered by generative AI and designed to help people access health information by engaging in conversations that more accurately mirror human interactions, enabling realistic emotional responses and dynamic conversations. S.A.R.A.H.'s advanced machine learning enables her to adapt to user questions and interests in real-time. She can engage users 24 hours a day in eight languages on multiple health topics, on any device. Previous iterations of S.A.R.A.H. (under the name Florence) were used during the COVID-19 pandemic to disseminate critical public health messages on the virus, vaccines, tobacco use, healthy eating and physical activity.

Source: WHO, 2024 *(66)*.

The COVID-19 pandemic served as a global proof of concept for telemedicine, since it enabled the remote provision of health-related assistance, without the risk of spreading the virus. There was a major increase in uptake of telehealth during the pandemic. For example, there was a 766% increase in telehealth contacts (from 0.3% to 23.6% of interactions) during the first three months of the pandemic in a large United States insured cohort of over 36 million *(67)*, telephone consultations in the NHS in England almost tripled from 2.2 million in February 2020 to 6.2 million in August 2021 *(68)*, and by May 2020, there had already been 100 million downloads of a contact-tracing app in India *(69)*.

Telehealth or remote engagement with health care remains significant post-pandemic, although some countries have dismantled some of the mechanisms or ended some of the legislation they put in place during the pandemic. Telehealth has also been valuable in response to other events that cause instability in the delivery of health services, such as natural disasters, wars and civil strife. In the USA, the use of telehealth post-pandemic is 38 times as high as it was pre-pandemic *(70)*.

It is important to acknowledge that persons with different profiles encounter different barriers in using digital technologies *(71)*. With the sudden increase in adoption of telehealth during the COVID-19

pandemic, certain challenges, including disparities in access, were highlighted or magnified, based on income level and rural versus urban location. Lessons learned show that the effectiveness of telemedicine approaches depend on access to devices, power and connectivity *(72, 73)*; acceptability of the delivery channel(s); relevance of the information for different groups; perceived security/confidentiality *(74)*; and levels of population literacy, including digital and health literacy. Box 3.7 provides information about the views of people with disabilities regarding access to self-care, and digital health technologies in particular.

Box 3.7 **People with disabilities: equitable access to self-care interventions**

During the online community dialogue with people with disabilities, participants mentioned common concerns around how information reaches people. While most people these days rely on the internet and digital devices to get information, people with disabilities are often left behind in terms of technology and therefore do not receive clear information about health issues. Others may not fully understand or lack insight into their disability. Participants emphasized that the relevant guidelines and other sources of information should be presented in accessible formats and disseminated widely by the government among disability communities. Designers of self-care tools or processes should also consider accessible options to enable people with disabilities to learn, choose, adopt and use.

Participants wanted to note that women with disabilities generally experience multiple, intersectional burdens or barriers. In Kenya, where there is high mobile phone access and availability among the population, women with disabilities are left at a disadvantage because technology is unaffordable, and they may have to negotiate access within a patriarchal society.

To facilitate access to self-care for people with disabilities, among whom there is much heterogeneity, the participants suggested making health education and information available in various accessible formats, as well as raising awareness and confidence in the community, and also emphasized that consulting them on the best way to provide information and interventions is crucial. Different formats of information and methods of dissemination may need to be designed to meet the needs of people with different disabilities. One participant specifically suggested a free landline or call centre set up by the government through which people with disabilities can ask for information.

Source: Adapted from the transcript of an online group discussion on this topic on 11 July 2023 organized by WHO (unpublished report).

3.6 Self-care interventions in fragile and humanitarian settings

In conflict and crisis-affected settings, health systems can quickly become overstretched creating unprecedented demand on individuals and communities to manage their own health. Strategic adaptations in health-care delivery during epidemics/pandemics and other humanitarian crises should be made in accordance with ethical principles, such as equity in the allocation of and access to resources, and self-determination, non-abandonment, and respect for dignity and human rights *(75)*. The implementation of self-care interventions for SRHR in fragile and humanitarian settings is challenging due to disruption to the local or national health system and supply chains, and prevalent stigma towards sexual and reproductive health (SRH) services in some regions, among other factors. However, as depicted in the conceptual framework (Fig. 1.3), the use of self-care interventions with a people-centred approach can link individuals to the health system,

which can ultimately help to reshape disrupted health systems as they stabilize again, to become increasingly supportive of self-care interventions as well as actively promoting SRH and well-being.

The COVID-19 pandemic, for instance, has clearly shown that programmatic approaches that link to existing national responses are insufficient in estimating health workforce needs, given the overlapping social, financial and human costs. Self-care measures such as physical distancing, wearing masks and good hygiene have been recommended and practised globally as an essential part of the response.

However, there is evidence that existing gender and social inequalities were exacerbated by COVID-19 pandemic contexts, which impacted girls and women in different ways than boys and men, and gender-diverse individuals. Overall, the failure to protect underserved and marginalized groups puts them at a higher risk and undermines the broader response to an epidemic/pandemic or other crisis.

Box 3.8 presents country case-study information about the use of self-care in post-conflict Ethiopia.

Recommendations

- WHO recommends prioritizing digital health services, self-care interventions, task sharing and outreach to ensure access to medicines, diagnostics, devices, information and counselling when facility-based provision of sexual and reproductive health services is disrupted.
- WHO recommends maximizing occupational health and staff safety measures, including providing mental health care and psychosocial support and promoting self-care strategies.

Source: WHO, 2022 *(6)*.

Box 3.8 **Self-care in post-conflict Ethiopia**

Conflict in northern Ethiopia and the effects of severe and unprecedented drought situations in Borena zone of Oromia have hampered access to and delivery of comprehensive sexual and reproductive health (SRH) services for women, newborns, children, adolescents and youth in affected parts of Ethiopia. The WHO Ethiopia Country Office has been supporting the Ethiopian Government's efforts to restore essential health services in conflict-affected areas, and self-care interventions were identified as a key method to support the delivery of comprehensive SRH services. Working closely with the Ministry of Health and other stakeholders, WHO Ethiopia has been making efforts to increase uptake and use of self-care interventions for SRH since 2021. Over-the-counter contraceptive pills, emergency contraception and self-care interventions as part of antenatal care have all been rolled out in seven health centres in four regions of Ethiopia, and monitoring of uptake is under way. The WHO Ethiopia Country Office also supported the adaptation of the *National reproductive, maternal, newborn, child, adolescent and youth health and nutrition (RMNCAYH-N) self-care guideline*, published in 2023, followed by orientation of health and care workers and health facility managers on its use. In November 2023, some 43 participants from Afar, Amhara and Oromia regional health bureaus, zonal health bureaus, health facilities and the Ethiopian Midwives Association participated in a three-day orientation workshop on RMNCAYH-N self-care interventions in conflict-affected regions, organized by the Ministry of Health and WHO Ethiopia. The workshop involved presentation of RMNCAYH-N self-care interventions, a SWOT (strengths, weaknesses, opportunities and threats) analysis, and group work on indicators to monitor implementation. The next step will be for WHO, the Ministry of Health and the regional health bureaus to jointly monitor the implementation of RMNCAYH-N self-care interventions in conflict-affected areas to ensure the continued delivery of health services during crises.

Source: WHO, 2024 *(76)*. This is from a 2023 case study in Ethiopia on self-care interventions for SRHR.

Box 3.9 provides the perspectives of migrants and refugees on access to self-care interventions.

Box 3.9 Migrants and refugees: equitable access to self-care interventions

An online group dialogue among members of migrant and refugee communities around the globe focused on the precarious nature of life lived as a refugee or migrant and how it impacts one's health. Refugees have been forced to leave their countries and are often residing in risk zones. They generally have limited access to health centres and health or care workers, and they may have to wait in long queues for services or commodities and still find that what they need is out of stock. This often demotivates people from seeking health care. For example, in the refugee settlement of Bidi Bidi in Uganda, health centres are located in different zones such that people have to walk long distances, sometimes in extreme weather conditions, for the services they need, only to discover that some health centres are not equipped to handle the patient load.

The adverse circumstances in refugee settlements or camps means that it is vital for people to have access to self-care measures to maintain and improve their health. When asked, "What kind of self-care interventions are you aware of?", participants mentioned HIV self-testing kits, pre-exposure prophylaxis (PrEP) self-management, emergency contraceptives, pregnancy tests, and information packages/booklets.

Participants noted various factors that can hinder the uptake of self-care by migrants and refugees. Social stigma and lack of confidentiality play a significant role. For example, the majority of the population in Nepal follow orthodox religious practices and contraceptive use cannot be openly discussed. In such societies, support is needed to enhance access to self-care interventions. Similarly, people often avoid attending health centres that may be labelled or known as "HIV clinics" because of the stigma of receiving antiretroviral drugs, even though this may not be the reason for their visit. Limited access and skewed gender norms were also noted as concerns. Legality can also be a barrier; for example, in Uganda, in rape cases without police involvement it is difficult for victims to access morning-after pills or medical abortion. Lack of information and knowledge was also mentioned as a substantial barrier; for example, in Bidi Bidi many people were not aware of post-exposure prophylaxis (PEP) and did not know that it could be accessed for free.

To improve access to self-care among refugees, the discussion participants highlighted the importance of raising awareness. For example, people may not be aware that self-test kits are available in camps, and condoms may be distributed without instructions on how to use them. Training health and care workers is essential so that care is given effectively and efficiently. Stigma also needs to be reduced to improve access to care (e.g. through the use of peer educators and graphic illustrations/comic books).

When asked what they would like to see included in self-care kits, participants requested the following: contraceptives, pregnancy tests, HIV tests, sanitary pads, basic medicines, infographics/brochures on self-care in local languages, and envelopes in which the kits can be supplied and then disposed of privately. Emphasis was put on the fact that self-care kits should include the contact information for the person or clinic that provided the kit, since otherwise people may not know how to replenish the items in their kit when they run out. These kits should be made available at health facilities and at social service centres in or near refugee camps, in public restrooms and via community health workers and community-based health teams or units.

Source: Adapted from the transcript of an online group discussion on this topic on 11 July 2023 organized by WHO (unpublished report).

Resources

Task sharing:

Task shifting: global recommendations and guidelines (WHO, 2007), available at: https://www.who.int/healthsystems/TTR-TaskShifting.pdf

Traditional medicine:

Achieving well-being: a global framework for integrating well-being into public health utilizing a health promotion approach (WHO, 2023), available at: https://iris.who.int/handle/10665/376200

The role of pharmacists in relation to natural health products. Report from an international insight board (FIP, 2023), available at: https://www.fip.org/file/5649

Peer support:

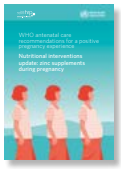
Peer support mental health services: promoting person-centred and rights-based approaches (WHO, 2021), available at: https://www.who.int/publications/i/item/9789240025783

Digital or mobile health:

WHO–ITU global standard for accessibility of telehealth services (WHO, 2022), available at: https://www.who.int/publications/i/item/9789240050464

ICT infrastructure business planning toolkit (International Telecommunication Union, 2019), available at: http://handle.itu.int/11.1002/pub/813e6d7f-en

Recommendations on digital interventions for health system strengthening (WHO, 2019), available at: https://www.who.int/publications/i/item/9789241550505



Digital adaptation kit for family planning: operational requirements for implementing WHO recommendations in digital systems (WHO, 2021), available at: https://www.who.int/publications/i/item/9789240029743

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Chapter 4. Leadership and governance

Pakistan. Credit: WHO/Noor/Sebastian Liste

4.1 Policy and legal considerations

Policies and laws can either create barriers or promote access to health services, including self-care interventions for health. Changes in laws and policy can improve health outcomes by bridging the gap between services and user access. Policy changes can also promote equitable access to quality self-care interventions by considering the needs of vulnerable populations within a specific context *(17)*. Examples include: broadening access to abortion care; decriminalizing various aspects of sexual orientation, gender identity and sex work; and expanding eligibility criteria for services and products.

Eliminating the requirement for third-party authorization to facilitate better access to services and self-care interventions involves revisiting policies on the age of consent, spousal consent and insurance, which all act as barriers in different situations. Strengthening health literacy at the local level can be achieved with an emphasis on comprehensive sexuality education (CSE) in schools or community programming as part of the broader strategy, which requires supportive policies and advocacy. Additionally, policies should be crafted that will help connect clients with the care and treatment services they need. For instance, policies on task sharing can be developed to expand access beyond traditional health facilities.

By addressing these issues at various levels, a more inclusive and enabling environment can be created for the implementation of self-care and to serve the diverse needs of populations in each country.

Good practice statement

Countries should review and, where necessary, revise laws, policies and regulations to ensure that quality self-care interventions are made widely available in the community, that they are accessible to all without discrimination, through public, private and community-based health and care workers, and that they are acceptable to users.

Source: adapted from WHO, 2022 *(6)*.

Boxes 4.1–4.5 provide examples from Nigeria, Burkina Faso, Morocco, Thailand and Bhutan, where policy changes have improved coverage and equitable access to different aspects of self-care interventions for health and well-being.

Box 4.1 **Shifting the self-care paradigm in Nigeria**

In 2020, the Federal Ministry of Health in Nigeria, with the support of the WHO Nigeria Country Office, led the adaptation of the 2019 edition of the *WHO guideline on self-care interventions* to develop Nigeria's national guideline on self-care for sexual, reproductive and maternal health. This was done through a consultative process by engaging advocacy groups, nongovernmental organizations, policy-makers, the private sector, professional associations and regulatory bodies to include their input. The national guideline was officially launched in March 2022, providing strategic direction on integrating and implementing sexual and reproductive health (SRH) self-care interventions into the Nigerian health system. By adapting and contextualizing the conceptual framework and good practice statements from WHO's global guideline, the Government and national stakeholders could strategically roll out and implement the new national guideline. As of 2023, some 21 states in Nigeria had committed to implementing the national guideline and expanding access to self-care interventions for SRH – from building awareness of healthy behaviours to increasing the availability of self-administered injectable contraception, HIV self-testing, and

human papillomavirus (HPV) self-sampling for increased cervical cancer screening. In collaboration with the Government and other partners, the WHO Nigeria Country Office is taking steps to ensure the roll-out of self-care interventions at the state and community level through state-level dissemination and engagement with key stakeholders, including the media and community representatives. So far, dissemination has taken place in 19 of the 36 states in Nigeria. Strengthening partnerships for the implementation of self-care interventions is a key area of work in Nigeria. As more partners include self-care options in their intervention packages, self-care interventions can reach more communities.

Source: WHO, 2024 *(77)*. This is from a 2023 case study in Nigeria on self-care interventions for SRHR.

Box 4.2 A new roadmap for self-care in Burkina Faso

Using the 2019 edition of the *WHO guideline on self-care interventions* as a springboard, in 2020, Burkina Faso developed national guidelines on self-management of reproductive, maternal, newborn, child and adolescent health (RMNCAH) and an operational guide to support implementation. In 2021, a multisectoral policy dialogue on self-care was established and a workshop held to determine different methods of integrating self-care within the implementation of national community health policies and strategies. This initiative led the Ministry of Health and Public Hygiene, with technical support from the WHO Burkina Faso Country Office, to develop a roadmap to integrate self-care into the National Community Health Strategy in June 2021. The roadmap lists types of RMNCAH self-care interventions, along with recommendations, approaches and priority actions for their effective integration and implementation.

To implement the roadmap, the Ministry of Health and Public Hygiene is:

- using community health consultation frameworks to regularly assess self-management issues at all levels, including community health clubs and adherence clubs;
- integrating self-management information into major community health interventions;
- considering self-care in the fight against malaria, tuberculosis and HIV/AIDS;
- using national events as opportunities to integrate self-care, e.g. Women's Day, World Cancer Day, World Population Day, Family Planning Week and Self-Care Month;
- considering self-care in Ministry of Health and Public Hygiene planning guidelines; and
- integrating self-care into education for family life.

Educational fact sheets on self-care have also been developed and disseminated in three districts. To accelerate the introduction of self-care into the national health system, in 2023 a task delegation policy was developed by the Ministry of Health and Public Hygiene with support from the WHO Burkina Faso Country Office, based on the *WHO self-care competency framework (29)* and adapted to the current national context. Now that the national guidelines on self-management of RMNCAH have been updated to align with the 2022 edition of the *WHO guideline on self-care interventions (6)*, and the national self-care package has been defined, WHO Burkina Faso aims to support the Ministry of Health and Public Hygiene to implement and scale up self-care interventions. Self-care interventions were highlighted by the Ministry of Health and Public Hygiene as particularly important in improving the health of the most vulnerable populations, especially in the current context of humanitarian and health emergencies in Burkina Faso.

Source: WHO, 2024 *(78)*. This is from a 2023 case study in Burkina Faso on self-care interventions for SRHR.

Box 4.3 Political commitment for self-care in Morocco

Morocco has high-level political commitment to universal health coverage (UHC). The country aims to guarantee the right to health for all, and its health system has focused on improving primary health care (PHC). Morocco's Health Plan 2025 (launched in 2018) promotes the right to sexual and reproductive health (SRH) and aspires to enhance the well-being of young people, women and couples. The Health Plan embraces innovative approaches to increase access to SRH services and to empower health service users. Therefore, Morocco was well situated to adopt the WHO recommendations on self-care interventions for health and well-being to reduce disparities in access to health care.

Health policy-makers in Morocco played a major role in promoting self-care interventions for SRH and launched a national initiative to introduce and promote self-care interventions, which helped to overcome many cultural, organizational and safety challenges to people's engagement with and uptake of self-care interventions. Strong political commitment facilitated the adoption of self-care interventions in Morocco in 2019. This adoption took place through a partnership between the Ministry of Health and Maroc Organisation PanAfricaine de Lutte pour la Santé (OPALS), and implementation was carried out under the partnership of the Ministry of Health, OPALS, the United Nations Population Fund (UNFPA) and WHO. Examples of self-care interventions adopted in Morocco include: over-the-counter oral contraceptives, self-administration of subcutaneous depot medroxyprogesterone acetate (DMPA-SC), home-based ovulation predictor kits for fertility regulation, self-sampling for HPV testing and self-testing for HIV and other sexually transmitted infections. These five approaches have been incorporated into Morocco's national strategy for SRH covering the period 2021–2030. A dedicated national committee has also been instituted to supervise the implementation of these interventions, and national guidelines for self-care interventions were published in 2023 *(79)*.

Source: WHO, 2024 *(80)*. These are findings from a 2023 scoping study (involving policy analysis and consultations with key stakeholders in Morocco) on existing self-care practices, interventions, gaps, challenges and opportunities.

Box 4.4 Improving access to safe abortion in Thailand

In the early 2000s, self-managed medical abortion was determined to be clinically safe and effective, and in 2022, WHO endorsed this approach when the gestational age is less than 12 weeks *(81)*. Though it has been proven that self-managed medical abortions can be safely conducted within informal spaces, policies in many regions of the world either fully prohibit access to any type of abortion, or limit access to abortions administered by health and care workers. With these limitations to access, the greater burden of health and legal risks falls on marginalized communities. Policy-makers in the field of abortion care should consider decriminalizing comprehensive abortion care and providing pharmacists and others the licence to sell and distribute abortion medicines. Training pharmacists and raising awareness in the general public will also help ensure that people are receiving accurate information and quality care *(81)*.

Policies work to bridge the gap between clients and the health system. Beyond restrictions on abortion, many people lack equitable access to self-care interventions due to existing restrictions based on age, gender, sexuality and other personal characteristics. Criminalization based on sexual orientation and sex work hinders key populations from accessing necessary care, meanwhile decriminalization can increase access and use of services and reduce stigma and discrimination *(82)*. Adolescents are also largely ignored in health policies and programming despite their increased vulnerabilities. In a study, youth aged 14–17 identified that parental or guardian consent is a significant barrier to seeking care. Policy in Thailand permits adolescents (aged 13–18 years) access to HIV and STI testing and treatment without parental consent or approval by an ethics committee *(83)*. Policy to lower the age of consent can create a more enabling environment for young people to access care. Key populations should be included in national policies to increase their engagement with self-care interventions.

Box 4.5

Enhancing well-being by striving to increase Gross National Happiness in Bhutan

One of the most mature examples of a national policy strategy aimed to enhance well-being is Bhutan's Gross National Happiness (GNH) initiative *(84)*. GNH was introduced by the fourth King of Bhutan, Jigme Singye Wangchuck, in 1972. GNH was borne from the recognition that human development cannot be measured by GDP alone and was also driven by an underlying motivation to counteract climate change. GNH centres on nine domains: health, education, living standards, ecological diversity and resilience, cultural diversity and resilience, good governance, community vitality, time use, and psychological well-being *(85)*. Over the years, GNH has unified actors both within Bhutan and in the global community to pursue more encompassing development goals. In 2011, the United Nations General Assembly unanimously adopted *Happiness: towards a holistic approach to development* (Resolution 65/309) and enlisted Bhutan to convene a high-level meeting to design a development strategy on happiness-focused development, which resulted in a publication outlining a variety of approaches to measuring happiness alongside economic development *(86, 87)*. Bhutan's leadership through these efforts helped inform the sustainable development agenda.

Source: WHO, 2021 *(8)*.

4.2 Environmental considerations

Health care accounts for around 4.6% of global net emissions *(88, 89)*. Almost all aspects of health care must be considered to meet national and global goals for decarbonization. To reduce the negative environmental impacts and improve sustainability, changes are needed in the patterns of consumption of health-care products; the methods, materials and locations used for production; supply chain management; and waste management. When procuring commodities and equipment, governments, health-care institutions, manufacturers and suppliers need to take responsibility for developing and using more environmentally friendly commodities and processes. Alternative methods of delivering, receiving and interacting with health care through the uptake of self-care approaches present opportunities for both positive and negative impacts on the environment. Considering the environmental impact throughout the process of design and implementation of self-care approaches is critical to achieving long-term sustainability and the successful deployment of self-care approaches.

Good practice statements

- Safe and secure disposal of waste from self-care products should be promoted at all levels.
- Countries, donors and relevant stakeholders should work towards environmentally preferable purchasing of self-care products by selecting supplies that are less wasteful, can be recycled or produce less-hazardous waste products, or by using smaller quantities.

Source: WHO, 2022 *(6)*.

The growing decentralization of health care, including through primary health care, community-based care and self-care approaches, means that plastic and hazardous chemical waste will often be dispersed into communities rather than at health facilities, requiring different waste management solutions. Reportedly, 600 tonnes of plastic waste will be generated from HIV self-testing alone in 2030 (approximately 20 g of plastic per test multiplied by 2030 demand of 30 million tests) *(90)*.

The effects on nature are concentrated in low- and middle-income countries (LMICs), where many ecosystems are already facing considerable stress and increasing vulnerability to climate hazards, and the capacity for mitigation is more limited. Most upstream activities (e.g. pharmaceutical manufacturing) take place in Asian LMICs where industrial waste management processes tend to be less well-regulated/enforced, which has led to significant discharges of harmful waste products into the natural environment. Downstream activities (e.g. last-mile transportation, product use and disposal) are concentrated in Africa and South and South-Eastern Asia, where LMICs often lack infrastructure or regulatory frameworks to mitigate or prevent the harmful effects of certain products on nature. Mismanaged solid waste can lead to adverse health outcomes in the local population *(90)*.

Some self-care commodities may need refrigeration, and in these instances, more environmentally friendly refrigerators should be procured and made accessible in communities, and access to renewable energy sources should be expanded, including at the household level. With regard to waste management, improper disposal of pharmaceuticals and devices poses a significant threat to public health and ecosystems. “Take-back” programmes (see “Circularity levers” below), public education about proper disposal, and expanded programmes for recycling and safe disposal for used and unused items should be considered.

Circularity levers could help to mitigate the effects of waste in decentralized systems. These levers include improving product design (extended lifetime and increased recyclability), a reverse supply chain approach (collection and return of hazardous waste to a central management point) and improving infrastructure for sorting/decontamination/recycling. Using these levers can decrease the need for raw materials and minimize waste – this could be applied to products like point-of-care (POC) testing kits and self-tests. However, health and safety restrictions limit the adoption of these circularity levers (e.g. instructions to incinerate any products that have come into contact with patients), and furthermore products like POC testing cartridges combine biohazardous, chemically hazardous and plastic waste into one product, which makes them difficult and costly to recycle *(90)*.

Green chemistry principles are increasingly being adopted in manufacturing, to make chemical processes more sustainable, including preventing, reducing or eliminating pollution/hazardous waste. Some products can be redesigned to avoid or reduce the use of high-emission materials (e.g. plastic has higher emissions than paper), to help mitigate impact. One option to reduce the impact on nature is for manufacturers to source more sustainable plastics. For instance, bio-based or carbon-capture-based alternatives to plastic can reduce hazardous waste and water use from the raw-materials stage of plastic-heavy products. Targeted research and development support for green chemistry innovations and investment in new technology and equipment (e.g. when new manufacturing capacity is being installed) could help to improve public health outcomes, particularly in LMICs *(90)*.

As we think ahead in considering implementation and roll-out of existing and new self-care interventions, we have to consider the environment

in terms of local- and national-level action as well as individual behaviour. Following are some suggested options that countries may consider.

- Ensure that national policies on different areas of self-care (e.g. personal protective equipment, menstrual health, self-testing kits) include considerations for environmental sustainability.
- Establish multisectoral partnerships and ensure that increased sustainability of health-care products is on the agenda, including self-care interventions. Consider how to balance the need for cheap, safe, accessible and easy-to-use commodities/interventions against the local and national environmental impact.
- Consider the roles of and mechanisms for composting, recycling or otherwise sustainably disposing of medical and self-care products, within or near to the communities where they are used.
- Ensure there is environmental accountability on the side of those designing, manufacturing or importing self-care products.
- Push stakeholders to pledge to reduce waste, including plastics.

Box 4.6 presents an example of menstrual hygiene products – their impact on the environment and alternatives to disposable products.

Box 4.6

Ethics, environment and ecology: menstrual health and hygiene products as an example

Menstrual products present a major challenge in terms of environmental sustainability. There are many types and brands of tampons and pads, and it is crucial for those who need them to have access to these products and safe/sanitary environments in which to store, use and dispose of them. Most single-use disposable menstrual products contain up to 90% plastic and are often also individually wrapped. After use, they commonly end up in landfills or being incinerated, with some level of energy recovery at these facilities, or polluting the environment directly through flushing. It has been estimated that, respectively, some 49 billion and 19 billion single-use menstrual products are consumed each year in the European Union and USA, and that approximately 87% and 80% of these products end up in landfills *(91)*. Whether in landfill or directly in the environment, the plastic components can take up to 500 years to break down, potentially releasing toxic chemicals and microplastics into the environment, threatening ecosystems *(91)*. Though reusable options (menstrual cups, washable period underwear and pads) are available, they are not widely accessible and can be challenging to use due to the need for access to clean water and space to dry the items, inconvenience of storing/carrying clean and used items while away from home, and persistent stigma/taboos surrounding menstruation and menstrual products. The desire to capitalize on a naturally occurring phenomenon (menstruation) has led to serious regulatory concerns over sanitary products that have a high impact on the environment.

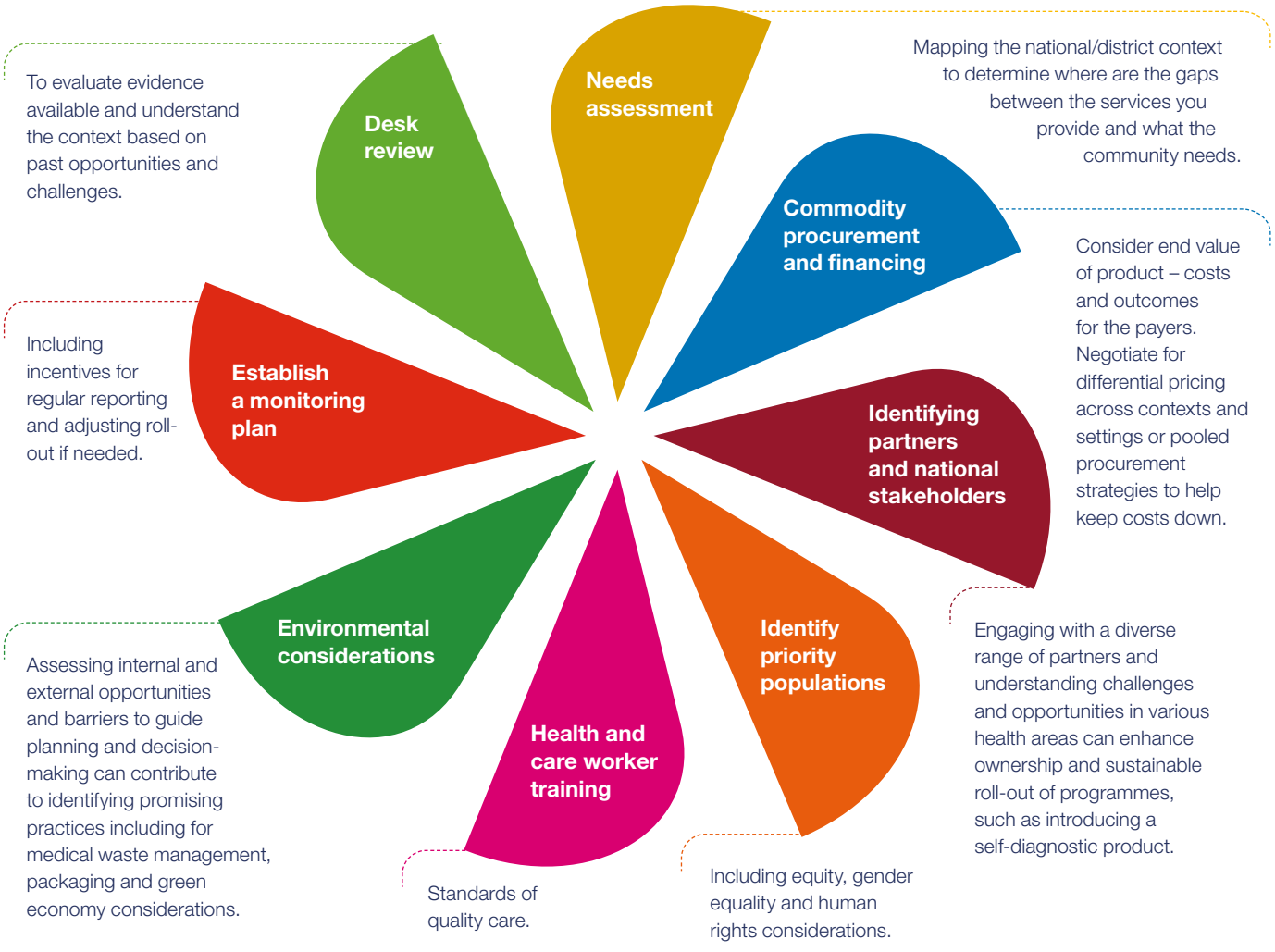
4.3 Strategic planning considerations

Self-care behavioural practices have implications that are broader than the public health context. While self-care has been brought into a medical/health-care model, such as dietary preferences, self-medication, and the use of devices to monitor and treat health conditions, it concerns and interacts with many other aspects of everyday life. Therefore, planning for the introduction or scale-up of self-care interventions requires consideration of factors that shape self-care behaviours and their impact on alternative patterns of care. These factors include:

- the extent to which social policies, the organization of health services, and community decision-making processes either enhance or impede self-care;
- psychological aspects, social networks and cultural factors that determine attitudes and behaviours relating to self-care among individuals and communities;
- policies, laws and regulations that affect understanding, use, uptake and continuation of self-care interventions;
- the types, scope and availability of quality health systems; and
- the levels of contact and modes of interaction with the health systems, including health and care workers.

Several planning tools exist for implementing self-care options *(75, 92, 93)*. Most suggest similar steps for national authorities to consider, depending on national context and the type of self-care interventions being adopted, as shown in Fig. 4.1.

Fig. 4.1 Planning considerations for implementing self-care interventions



Resources

Leadership:

Happiness: towards a holistic approach to development: note by the United Nations Secretary-General (United Nations, 2013), available at: https://digitallibrary.un.org/record/743697?v=pdf

Environmental considerations:

Health-care waste: key facts (WHO, 2018), available at: https://www.who.int/news-room/fact-sheets/detail/health-care-waste

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Global road map for health care decarbonization: a navigational tool for achieving zero emissions with climate resilience and health equity (Health Care Without Harm, Arup, 2021), available at: https://healthcareclimateaction.org/sites/default/files/2021-08/Global%20Road%20Map%20for%20Health%20Care%20Decarbonization.pdf

Chapter 5. Medical products and technologies

Thailand. Credit: WHO/Patrick Brown

5.1 Regulatory considerations for access to quality products

Governments and other bodies have regulatory accountability for providing high-quality self-care products and interventions. Since self-care interventions are part of the overall health system, the health system must remain accountable for these interventions.

The reclassification of drugs, diagnostics and devices from prescription only to over-the-counter (OTC) self-care interventions requires drug regulatory and health authorities to consider which reclassification is appropriate, safe and rational in the interests of public health. The OTC products can include those obtained through pharmacies, community-based distribution, vending machines or ordered through the internet. The regulation of self-care interventions should also be aligned with human rights laws and obligations, and should also be sensitive to the relevant differences among interventions and among users. It should also be applicable to the diversity of locations where these self-care interventions are purchased and used. In contexts where there are legal, political, economic or social barriers to accessing health care and other services, OTC self-care options may be the only options available to people. A harm-reduction approach to guide supportive public health approaches and minimize risks to end-users also remains important.

Drugs with specific pharmacological action, such as non-steroidal anti-inflammatory compounds or nicotine preparations for cessation of smoking, have been successfully reclassified from prescription to non-prescription status. In many countries, access to OTC contraceptives has improved coverage and reduced unintended pregnancies (see further information in Box 5.1). However, in some instances, product status has been reverted back from non-prescription/OTC to prescription-only, based on evidence of new safety concerns.

In order to use an OTC self-care product safely and effectively, the end-user performs a range of actions that might have previously been conducted by a health or care worker. These include recognition of symptoms, setting of therapeutic objectives, selection of a product to be used, and monitoring of effects and side-effects. Regulatory authorities must ensure that labelling of the OTC self-care product, user instructions (including on dosage, dosage strength, dosage schedule), packaging and sources of information about it in the media are correct and coherent, supporting safe and appropriate use of the product.

Regulatory authorities therefore need to monitor OTC products and post-marketing data, and respond promptly and adequately to possibly harmful developments. Some actions to improve, harmonize and standardize regulatory procedures for OTC medicines and to ensure that they are safe and effective include the following *(94)*.

i. Countries could adopt formal, regulatory procedures for reclassifying prescription-only contraceptives (e.g. oral contraceptives, including emergency contraceptives) as OTC products.
ii. Formal regulatory procedures could be standardized across countries, thereby increasing marketing authorization holders' interest in, and adoption of, legal classification changes.
iii. Countries could develop and publish national lists of OTC medicines that are updated periodically.
iv. Countries that do not have a legal classification for OTC medicinal products could introduce this category as a first step.
v. The development of standardized, risk-based criteria for the safety and eligibility of medicinal products would enable countries to adopt a consistent approach to determining whether a medicine should be provided OTC or should be recategorized from being a prescription-only product.

Box 5.1 **Over-the-counter access to contraceptives**

With substantial unmet need for contraception in many countries, having more contraceptive methods available over the counter (OTC; without a prescription) can provide better access, and enable more individuals to make independent decisions to manage their own fertility, with greater anonymity, as long as they are sufficiently well informed to make an accurate self-assessment. The key risk to end-users is higher out-of-pocket costs for contraception.

A review of 30 countries on this subject found that just four of them included contraceptives on their national lists of OTC medicines (and only 11 countries had such lists at all). Thirteen of the countries had formal regulatory procedures in place for changing prescription-only medicines to OTC medicines. This process presents a challenge for national regulatory authorities and manufacturers, involving quality control and reporting of side-effects, as well as other steps for making this switch, which are often poorly defined.

Source: Ammerdorffer et al., 2022 *(94).*

5.2 People-centred access to quality, regulated medicines

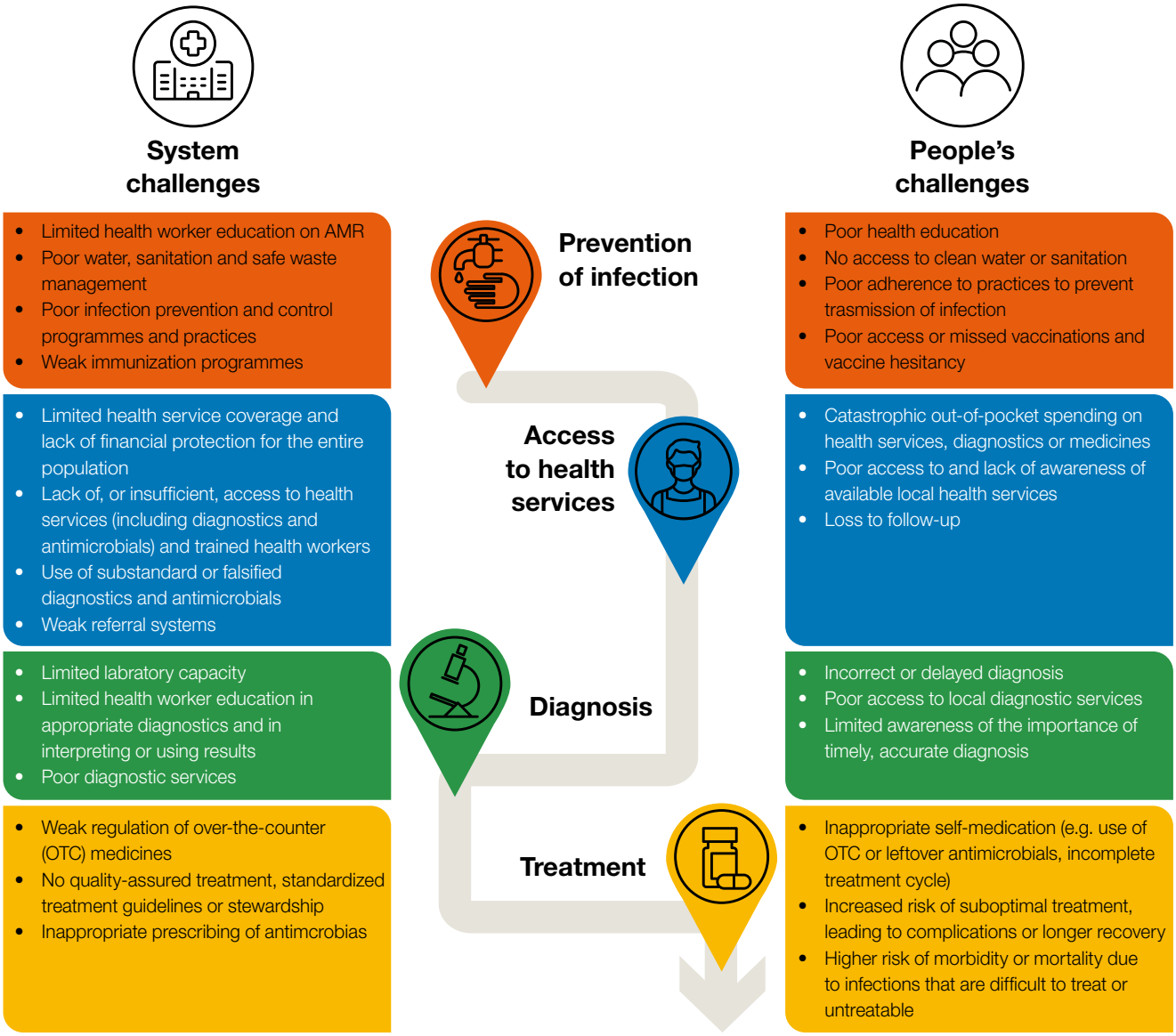
Many people access substandard or unregulated OTC products, which carry risks of increased morbidities and mortality. For instance, the misuse and overuse of antimicrobials in humans can lead to antimicrobial resistance (AMR). It is estimated that bacterial AMR was directly responsible for 1.27 million deaths globally in 2019 and contributed to 4.95 million additional deaths *(95)*.

An approach to care that consciously adopts individuals', carers', families' and communities' perspectives as participants in, and beneficiaries of, trusted health systems that respond to their needs and preferences in humane and holistic ways requires that people have the education and support they need to make decisions and participate in their own care. For the appropriate use of antimicrobials, it is important:

- to prioritize people's needs and values;
- to ensure equitable access in the design and delivery of health services from prevention to diagnosis, treatment and care of infections (including drug-resistant infections); and
- to educate relevant stakeholders on appropriate interventions.

Figure 5.1 presents challenges for health systems and people relevant to AMR.

Fig. 5.1 Challenges faced by health systems and people along the journey that can lead to antimicrobial resistance (AMR)



Source: WHO, 2023 *(96)*.

5.3 Medical commodities

The regulatory requirements needed to initiate the approval process for a new self-care intervention or for an existing product to be used as a self-care option (e.g. through reclassification as an OTC product) at national levels need to be well supported to ensure a smooth procurement process for self-care products. For instance, procurement of self-testing kits for HIV, syphilis, pregnancy or COVID-19, or other self-diagnostics, should be based on the preferences of communities and end-users. Factors to consider when selecting test kits include affordability, ease of use and ease of interpretation.[1]

Several self-care interventions packaged together also have the advantage of being able to address multiple health needs of the end-user. Box 5.2 presents an example of self-care kits in India.

[1] Further information will be available in the forthcoming WHO operational tool for HIVST (in preparation, to be launched in late 2024).

Box 5.2 The self-care kit for primary health care centres in India

In April 2023, India's Ministry of Health and Family Welfare launched "self-care kits" during the second G20 Health Working Group Meeting in Goa. Developed with technical support from the WHO India Country Office, the self-care kits include condoms, emergency contraceptive pills and pregnancy tests, and are dispensed at public health facilities. Furthermore, the kits are QR-code enabled, providing access to evidence-based information through smartphones on how to use selected barrier methods and hormonal contraceptives, and how to use pills for safe medical abortion in early pregnancy.

The self-care kit is a first-of-its-kind effort by the Ministry of Health and Family Welfare and WHO India, putting reproductive options and decisions directly into the hands of people. It is designed to bypass the stigma, people's experiences of fear, and the biases expressed by health and care workers when people try to access sexual and reproductive health (SRH) services – particularly adolescents and young people. The combination of commodities and information will help to improve access, use and uptake of contraception, averting the risk of unwanted pregnancies, increasing early detection of pregnancy, decreasing unsafe abortions, and ultimately reducing maternal deaths and morbidities.

Initially targeting the 150 000 health and wellness centres across India, the self-care kits will eventually be made available at all health facilities nationwide. A policy directive issued by the Ministry of Health and Family Welfare to all states in India provides detailed guidelines on how to make self-care kits available free-of-charge at all public health facilities.

As the kits are rolled out, the Ministry of Health and Family Welfare has focused on high-level advocacy events, such as the G20, Y20 and the national consultation of the partnership for maternal, newborn and child health, to raise awareness. The WHO India team is supporting the Government in developing short informational brochures and videos in local languages, available via the QR-code on the kits, to further accelerate uptake of SRH self-care interventions. The clear design and specifications of the self-care kit make it easy to replicate in other countries seeking to introduce self-care interventions and bring SRH services closer to people and communities.

Source: Narasimhan et al., 2024 *(97)*.

Resources

Self-administration of injectable contraception, 2022 update (WHO, 2022), available at: https://www.who.int/publications/i/item/WHO-SRH-22.2

Self-care interventions: human papillomavirus (HPV) self-sampling as part of cervical cancer screening and treatment, 2022 update (WHO, 2023), available at: https://www.who.int/publications/i/item/WHO-SRH-23.1

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Chapter 6. Financing

Bhutan. Credit: WHO/Sue Price

6.1 Equitable access to cost-effective self-care options

Implementing self-care approaches and technologies could affect (i) how much societies pay for delivering these interventions, (ii) who pays for these interventions, and (iii) who accesses them *(98)*. When allocating budgets and developing financing strategies, health systems should consider the potential savings that may result from earlier diagnosis and treatment due to the use of self-care interventions and include these in the financial equation.

Good practice statement

Good-quality health services and self-care interventions should be made available, accessible, affordable and acceptable to underserved and marginalized populations, based on the principles of medical ethics; the avoidance of stigma, coercion and violence; non-discrimination; and the right to health.

Source: WHO, 2022 *(6)*.

In addition to increasing user autonomy and engagement, self-care interventions present a critical opportunity for health systems to support universal health coverage (UHC), namely equitable access, efficient delivery of quality health interventions, and financial protection. Self-care interventions can enhance the efficiency of health-care delivery, thereby increasing access to essential services. They could also increase the uptake of preventive services and improve adherence to treatment, thereby reducing downstream complications and use of curative or emergency health services *(99)*. Underserved and marginalized populations could be given new routes of access to services that they would otherwise not access through health or care workers due to stigma, discrimination, distance and/or cost.

However, there are also the potential risks of introducing or further exacerbating vulnerabilities through the abrogation of government responsibility for quality health services. Moreover, shifting control to individuals may inadvertently shift the financial burden and increase out-of-pocket expenditures. A critical consideration for equity is that self-care should not be promoted as a means of saving costs for the health system by shifting costs to users. For example, if users have to obtain test kits or other devices or supplies to access an intervention that would otherwise be paid for by the health system when accessed through health services, these costs should, wherever possible, remain with the health system and not be transferred to the user.

6.2 Economic considerations

WHO recommends self-care interventions for all economic contexts. Economic considerations are particularly important for underserved and marginalized populations who do not frequently engage with the health system; it will be critical to assess the value for money of these interventions from a societal perspective that factors in the costs (and potential cost savings) for individuals *(98)*. Benefit packages and risk-pooling mechanisms should be designed to support people accessing self-care interventions in a range of settings and to ensure financial protection. Calculations of the risks and benefits of self-care interventions may differ across settings and populations. Since UHC aims to ensure equitable and sustainable access to an essential package of quality care, there may be scope for differentiated financing models that include a combination of government subsidies, private financing, insurance coverage and partial

out-of-pocket payments, based on the principle of progressive universalism.

Self-care interventions can also help to limit some health system costs, by co-opting users as members of the health team when accessing care outside of health facilities, provided that the interventions largely maintain diagnostic accuracy, uptake and quality. Moreover, for most self-care interventions to remain safe and effective, the involvement of health and care workers is needed along the continuum of care – from the provision of information about self-care interventions, to outreach to promote linkages to care where appropriate – which may attenuate the cost savings that can be generated for the health system, especially in the early stages of adoption of new technologies. Importantly, for these interventions to improve overall access for users, health systems will need to be able to identify those users needing different levels of support. The availability of self-care alongside facility-based health services may even contribute to more efficient health systems with better health outcomes, not least by including self-care as part of an integrated health system, allowing people who can manage their own health care to do so, while focusing health system resources on those who most need help.

6.3 Financial considerations

When considering the financing of these interventions, a distinction should be made between entirely self-initiated/self-administered tools without health or care worker involvement and those that are integrated within health-care provision. Self-care interventions must be promoted as part of a coherent health system and reinforced with health system support where needed. The health system remains accountable for patient outcomes linked to the use of these interventions and should closely monitor the economic and financial implications for households and governments; otherwise, the wide use of self-care interventions may promote fragmented, consumerist approaches to health care and undermine integrated person-centred care *(100)*.

The introduction of self-care interventions within a health system should consider whether a continuum of care is in place to address the health-care needs that may arise after using self-care interventions. Self-diagnosis products, for example, should not be introduced if the health system is not able to provide treatment for people who test positive and need to be linked to care. HPV self-sampling needs the availability of treatment for cervical cancer and pre-cancer lesions, and HIV self-testing needs the availability of reliable supplies of antiretroviral drugs, without stock-outs. Such factors affect the demand for and the uptake of self-care interventions.

Similarly, the delivery infrastructure for many of these products relies on a functioning postal system and a good technological infrastructure for internet-based ordering options and the return of results. Digital platforms and information systems have huge potential to enable greater access to health care, but they may also exacerbate inequities in access, creating a “digital divide”.

As with the integration of any health technology into health systems, it is important to consider the pricing, delivery and procurement strategies for the implementation and adoption of self-care interventions. Interactions between public and private institutions in product innovation, sales and delivery are likely to influence the end value, costs and outcomes for the payers. Negotiations for differential pricing across contexts and settings, or for pooled procurement strategies, may bring prices down.

Box 6.1 presents a case study on the costs and cost–effectiveness of self-injecting contraception.

Box 6.1 Case study on the costs and cost–effectiveness of self-injecting contraception

PATH conducted studies on the costs and cost–effectiveness of self-injecting contraception in Burkina Faso, Senegal and Uganda. The costs of delivering subcutaneous depot medroxyprogesterone acetate (DMPA-SC) were estimated under three strategies: (i) facility-based administration, (ii) community-based administration and (iii) self-injection. Both direct medical costs to health systems (e.g. commodity costs and health and care worker time) and non-medical costs incurred by users (i.e. travel and time costs) were estimated. Depending on the distance from users' homes to the health facility, and after replacing a training booklet with a clinically effective one-page instruction sheet, the total costs were lowest for community-based administration of DMPA-SC in Uganda (US$ 7.69), followed by self-injecting DMPA-SC in Uganda (US$ 7.83) and Senegal (US$ 8.38), and highest for facility-based administration (US$ 9.46 in Senegal and US$ 10.12 in Uganda). In all three countries, the direct non-medical costs were lowest for users who were self-injecting contraceptives, compared with community-based and facility-based delivery *(101)*.

In Uganda, the incremental cost–effectiveness of DMPA-SC was estimated per pregnancy averted and per disability-adjusted life year (DALY) averted. Self-injected DMPA-SC had greater health impacts in terms of preventing unintended pregnancies and maternal DALYs per year, compared with intramuscular DMPA (DMPA-IM) administered by a health or care worker. From a societal perspective, due to savings in user time and travel costs, DMPA-SC could save US$ 1.1 million, or US$ 84 000 per year. From a health system perspective, DMPA-SC could avert more pregnancies but would cost more than DMPA-IM administered by a health or care worker, due to the training needed during a client's first visit. Simplifying the training approach with feasible, clinically effective and less costly training aids would make DMPA-SC more cost-effective than DMPA-IM, at US$ 15 per unintended pregnancy averted and US$ 98 per maternal DALY averted *(102)*.

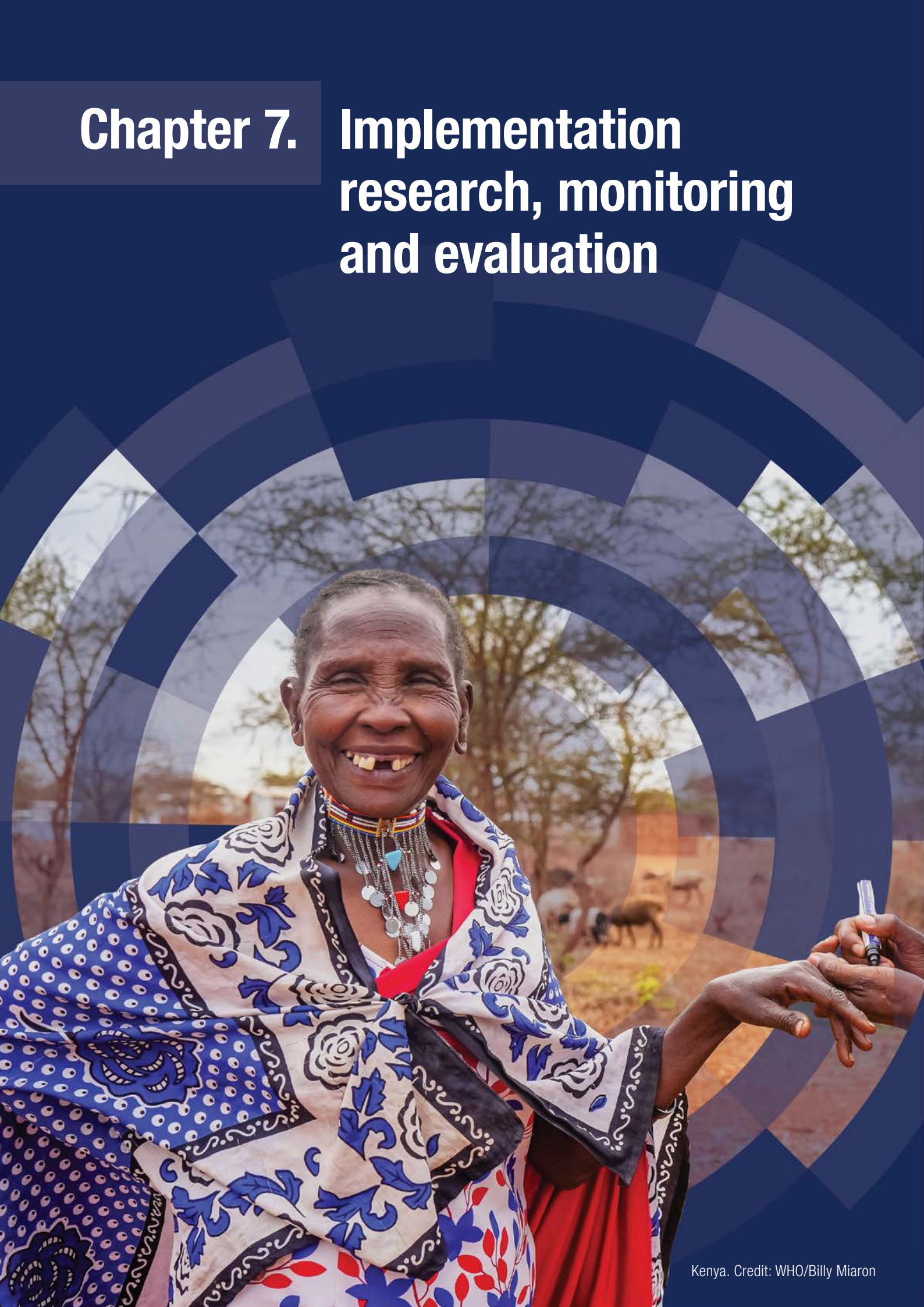
Furthermore, laypersons must often obtain certificates from health workers to legitimize their health condition, allow access to health facilities, medication, workplaces or travel options. These steps should not place additional financial burdens on individuals as well as on the health system. The COVID-19 certificates of vaccination status demonstrate an example of how such information can be made available in all settings at reasonable cost *(103)*.

Resources

Role of strategic purchasing in the integration of sexual and reproductive health services into primary health care: evidence brief (WHO, 2023), available at: https://www.who.int/publications/i/item/9789240087859

Potential for strategic purchasing to promote person-centred provision of sexual and reproductive health services in low- and middle-income countries: evidence brief (WHO, 2023), available at: https://www.who.int/publications/i/item/9789240087835

Chapter 7. Implementation research, monitoring and evaluation



Kenya. Credit: WHO/Billy Miaron

The initiation and ongoing roll-out of implementation of self-care interventions should be accompanied by an **implementation research agenda** and a framework for **monitoring** and **evaluation**.

7.1 Implementation research

The aim of implementation research should be to show not just which self-care interventions work (and which do not), but for whom, how and in what settings, as well as what their potential is for unintended consequences. The report of the findings should also provide guidance on replication and adaptation of successful efforts in different settings. The results of individual studies should be synthesized to strengthen the evidence base for implementation and to inform the ongoing development of the research agenda. The following elements of implementation research practice are suggested to strengthen the overall implementation research agenda for self-care interventions *(104)*.

7.1.1 Complex intervention components

A comprehensive implementation strategy for the roll-out of self-care interventions will have many of the characteristics of a "complex intervention", with several interacting components *(105)*. Successful implementation strategies may require changes of behaviour from multiple stakeholders, including potential beneficiaries/end-users, health and care workers, and actors in the private sector. They may also involve specific activities across the health system, at multiple levels. For example, regulatory or policy change may be needed in addition to simultaneous engagement at the community level. Guidance for developing and evaluating complex interventions from the Medical Research Council (one of nine councils that are part of United Kingdom Research and Innovation) was updated in 2021 *(104, 106, 107)*.

7.1.2 Learning and documentation of implementation approaches across settings

Tools such as the template for intervention description and replication (TIDieR) checklist *(108)* and the Proctor tool for specifying implementation strategies *(109)* encourage formal documentation of all of the key actors involved in the delivery of a particular strategy, the resources they use and the actions they take.

7.1.3 A theory of change or logic model to guide the implementation research

A programme theory or theory of change should be developed that links the inputs and activities of the strategy to its intended outputs, and to the short-, medium- and longer-term intended outcomes. A useful programme theory will usually include a visual representation, such as a logic model or theory of change diagram, but will also be guided by appropriate behavioural and social theory. For example, the COM-B framework articulates that the practice of any health behaviour is a product of the motivation of individuals to undertake that behaviour, their opportunity to do so, and their capabilities to perform the behaviour appropriately *(110)*. A programme theory can be used to guide both implementation and evaluation and may be updated over time to accommodate new learning. Good practice statements suggest that the theory should be developed through consultation with a range of relevant stakeholders.

7.2 Identification, measurement and monitoring of key outcomes

7.2.1 Accurate identification of outcomes

The *WHO guideline on self-care interventions for health and well-being* outlines five potential outcome areas in which self-care interventions might have broader impact, beyond the specific purpose each one is designed for *(6)*. Monitoring and evaluation of the implementation and the impact of country-level efforts to implement self-care interventions will therefore require clarity about, and efforts towards, the accurate measurement of these key outcomes:

- increased coverage and access;
- reduced health disparities/greater health equity;
- increased quality of services;
- improved health, human rights and societal outcomes; and
- reduced cost and more efficient use of health services.

7.2.2 Measurement and monitoring

Measuring and monitoring are context- and intervention-specific, and require careful consideration of how the monitoring of new indicators and outcomes – such as those relating to the roll-out of self-care interventions – can be fully integrated into existing health management information systems (HMIS). This will ensure that the impacts of self-care interventions can be routinely captured despite being provided through different channels, such as digitally or through pharmacies. Given the wide range of entry points to health care associated with self-care interventions, including private sector health providers, measures are needed to concurrently monitor all five of the relevant outcomes listed above. Focusing on achieving success in just one outcome area, such as increased access, will not mean that there will necessarily be gains in terms of the other outcomes – such as increasing the quality of services and improving health and human rights outcomes.

It will be especially important to monitor not just the number of self-care interventions distributed or purchased, but also how many of them were used, and the effectiveness of linkages to care. It is important to know, for example, how many women who test positive on pregnancy self-tests proceed to access antenatal care, and how many people seek confirmatory HIV testing at a health facility after testing positive on an HIV self-test – and how many of them are subsequently linked to treatment and care if they are confirmed to have HIV.

The monitoring system must include disaggregated data based on meaningful subsets of the population, as it is more likely that marginalized and stigmatized groups will be left behind and this will be hidden in national aggregate data. For example, adolescent girls who are pregnant may feel "ashamed" due to societal norms and thus may not visit the health facility, or people who inject drugs may feeling stigmatized and thus avoid accessing health services. The cost implications of providing self-care interventions – both the out-of-pocket expenses for individuals and the costs to the health system as a whole – are also crucial to capture within the monitoring system.

Annex 3 provides summary examples of key indicators that can be measured during different stages of implementing selected self-care interventions. Clarity regarding the intended outcome coupled with cutting-edge measurement efforts will be critical to the advancement and evaluation of self-care interventions.

7.3 Evaluation

The main building blocks of a comprehensive evaluation strategy are process and outcome evaluation. Where possible, outcome and process evaluation should be conducted in an integrated manner, and economic evaluation may also be included.

7.3.1 Process evaluation

Process evaluation has a key role to play in the evaluation of self-care interventions. This is a mixed-methods research endeavour, including both qualitative and quantitative methods, and it can comprise empirical studies in the following three key areas.

i. Research on the implementation processes, focusing on questions such as: What was the fidelity of delivery of the intervention? What was the quality and intensity of coverage achieved? What was the reach and accessibility of the interventions among the target populations? What were the facilitators and barriers to successful implementation?
ii. Analysis of the mechanisms of change set in process by the interventions, focusing on questions such as: How do the intended beneficiaries respond to, or interact with, the interventions? What are the behavioural mediators, at multiple levels, between the implementation process and the intended outcomes – and do they change over time because of the strategy? What are the potential unintended consequences of the interventions?
iii. Documentation of the interaction between context, implementation and mechanisms of change. This documentation can facilitate an understanding of what would be needed to transfer both the implementation and the successful outcomes of a given strategy to new settings.

7.3.2 Outcome evaluation

Impact or outcome evaluation studies will be essential to build the evidence base for self-care interventions. As complex interventions, many implementation strategies for the roll-out of self-care interventions will be most appropriately evaluated using cluster-allocated designs. Where feasible, cluster trials should be attempted. Where randomization is not feasible, a range of non-randomized designs can be considered, and there is published guidance available that seeks to support evaluators in making the best choices. Non-randomized study design options include time series, matching, stepped wedge and synthetic control.

7.3.3 Synthesis of evidence

Building an evidence-based foundation for self-care will further require the synthesis of evidence on the process and outcomes of the implementation of self-care strategies *(111, 112)*. Evidence and synthesis should be part of an evidence cycle, where primary studies are informed by synthesis of the existing evidence, and then the new findings are disseminated and used to update the evidence base, and so on. Since the evaluation agenda for self-care strategies incorporates both qualitative data and evidence from randomized and/or non-randomized study designs, information from this range of evidence types will need to be synthesized. This will require complementing traditional synthesis methodologies with recent developments in realist synthesis for implementation research and for qualitative research on complex interventions.

Resources

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WHO Health Financing Dashboard (WHO, 2024), available at: https://www.who.int/teams/health-systems-governance-and-financing/health-financing/hfpm-background-indicators

Health expenditure tracking (WHO, 2024), available at: https://www.who.int/teams/health-financing-and-economics/health-financing/expenditure-tracking

Sexual and reproductive health and rights: infographic snapshot (WHO, 2022), available at: https://www.who.int/publications/i/item/WHO-SRH-21.21

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Glossary

Age groups (younger to older)	
Child	According to Article 1 of the Convention on the Rights of the Child, "A child means every human being below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier" *(1)*.
Adolescent	For the purposes of this guideline, adolescents are defined as individuals between the ages of 10 and 19 years. Adolescents are not a homogeneous group; physical and emotional maturation comes with age, but its progress varies among individuals of the same age. Also, different social and cultural factors can affect their health, their ability to make important personal decisions and their ability to access services *(2)*.
Young people	People between the ages of 10 and 24 years *(3)*.
Youth	People between the ages of 15 and 24 years *(4)*.
Adult	A person aged 18 years or older *(1)*.
Older person	A person whose age has passed the median life expectancy at birth *(5)*.

Other definitions (alphabetical)	
Acceptability	All provision of health facilities, commodities and services must be acceptable to the people who are their intended beneficiaries. The provision must be in a manner that is respectful of medical ethics and of the culture of individuals, minorities, peoples and communities; sensitive to gender and to life-cycle requirements; and designed to respect confidentiality and improve health status. Countries should place a gender perspective at the centre of all policies, programmes and services affecting sexual and reproductive health, and should involve people in the planning, implementation and monitoring of such policies, programmes and services *(6)*.
Accessibility	Under international human rights law, countries are required to ensure that health facilities, commodities and services are accessible to everyone. This includes physical and economic accessibility, and access to information. Human rights bodies have called on countries to eliminate the barriers people face in accessing health services, such as high fees for services, the requirement for authorization by a spouse, parent/guardian or hospital authorities, distance from health facilities, and the absence of convenient and affordable public transport *(6)*.

Other definitions (alphabetical)	
Accountability	The obligation to report, or give account of, one's actions, for example to a governing authority *(7)*. Countries are accountable for bringing their legal, policy and programmatic frameworks and practices in line with international human rights standards. Further, effective accountability mechanisms are key to ensuring that the agency and choices of individuals are respected, protected and fulfilled, including when seeking and receiving health care. Effective accountability requires that individuals, families and groups, including people from marginalized populations, are made aware of their rights, including with regard to sexual and reproductive health, and are empowered to claim their rights *(6)*.
Autonomy	Autonomy relates to the rights of individuals to self-determination in health (including physical, mental, social, sexual, etc.); rights that need to be recognized by the State and enabled by everyone – from partners and families to global institutions *(8)*.
Availability	Functioning health facilities, goods, services and programmes have to be available in sufficient quantity within the State. The characteristics of the facilities, goods and services will vary depending on numerous factors, including the State's developmental level. Countries must, however, address the underlying determinants of health, such as the provision of safe drinking water, adequate sanitation facilities, health-related education, hospitals, clinics and other health-related buildings, and should ensure that trained medical and professional personnel are receiving domestically competitive salaries. As part of this core obligation, countries should ensure that the commodities listed in national formularies are based on the WHO model list of essential medicines, which guides the procurement and supply of medicines in the public sector *(6)*.
Comprehensive sexuality education (CSE)	A curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with the knowledge, skills, attitudes and values that will empower them to realize their health, well-being and dignity, develop respectful social and sexual relationships, consider how their choices affect their own well-being and that of others, and understand and ensure the protection of their rights throughout their lives *(9)*.
Digital health	The use of digital technologies for health. An overarching term that comprises both eHealth and mHealth, and emerging areas, such as the use of computing sciences in the fields of artificial intelligence, big data and genomics *(10)*.
Digital health intervention	A discrete function of a digital technology to achieve health sector objectives. The classification of digital health interventions follows the different ways in which digital and mobile technologies are being used to support health system needs *(10)*.

Other definitions (alphabetical)	
Digital literacy	The confident and critical use of a full range of digital technologies for information, communication and basic problem-solving in all aspects of life. It is underpinned by basic skills in information and communications technology (ICT): the use of computers to retrieve, assess, store, produce, present and exchange information, and to communicate and participate in collaborative networks via the internet *(11)*.
Disability	Disability is not the same as a health condition or impairment. Disability results from the interaction between health conditions or impairments that a person experiences, such as dementia, blindness or spinal cord injury, and a range of environmental and personal factors including societal attitudes, access to infrastructure, discriminatory policies, age and gender. This understanding of disability is grounded in the WHO International Classification of Functioning, Disability and Health (ICF) *(12)*.
eHealth	The use of ICT in support of health and health-related fields, including health-care services, health surveillance, health literature, and health education, knowledge and research. **mHealth** is a component of eHealth *(10)*.
Enabling environment	Attitudes, actions, policies and practices that stimulate and support the effective and efficient functioning of organizations, individuals and programmes or projects. The enabling environment includes legal, regulatory and policy frameworks, and political, sociocultural, institutional and economic factors *(13)*.
Engagement	The process of involving people and communities in the design, planning and delivery of health services, thereby enabling them to make choices about care and treatment options or to participate in strategic decision-making on how health resources should be spent *(7)*.
Equity in health	The absence of systematic or potentially remediable differences in health status, access to health care and health-enhancing environments, and treatment in one or more aspects of health across populations or population groups defined socially, economically, demographically or geographically within and across countries *(7)*.
Family planning	Family planning allows people to attain their desired number of children and determine the spacing of pregnancies. It is achieved through the use of contraceptive methods and the treatment of infertility *(14)*.
Fertility	The capacity to establish a clinical pregnancy *(15)*.
Fertility awareness	The understanding of reproduction, fecundity, fecundability and the individual risk factors (e.g. advanced age, sexual health factors such as sexually transmitted infections, and lifestyle factors such as smoking and obesity) and non-individual risk factors (e.g. environmental and workplace factors); including the awareness of societal and cultural factors affecting options for reproductive family planning *(15)*.

Other definitions (alphabetical)	
Fertility care	Interventions that include fertility awareness, support and fertility management with the aim of helping individuals and couples to realize their desires associated with reproduction *(15)*.
Gender equality	Equal opportunities for the diversity of groups of women and men to access and control social, economic and political resources, including protection under the law (such as health services, education and voting rights). Also known as equality of opportunity – or formal equality. Often used interchangeably with gender equity, but the two refer to different, complementary strategies that are needed to reduce gender-based health inequities. Under gender equality, different people have equal conditions to realize their full rights and potential to be healthy, contribute to health development and benefit from the results. Achieving gender equality requires specific measures designed to support groups of people with limited access to such goods and resources *(16)*.
Gender equity	Refers to the different needs, preferences and interests of people of different genders. This may mean that different treatment is needed to ensure the equality of opportunity. This is often referred to as substantive equality (or equality of results) and requires considering the realities of people's lives. Often used interchangeably with gender equality, but the two refer to different, complementary strategies that are needed to reduce gender-based health inequalities.
Gender-responsive	A policy or programme that considers gender norms, roles and inequality, and has measures to actively reduce their harmful effects.
Health	State of complete physical, mental and social well-being, and not merely the absence of disease or infirmity *(7)*.
Health intervention	A health intervention is an act performed for, with or on behalf of a person or population to assess, improve, maintain, promote or modify health, functioning or health conditions. Health interventions can be carried out by a broad range of health workers, including laypeople,[3] across the full scope of health systems, and includes diagnosis, medical, surgical, mental health, primary care, allied health, functioning support, rehabilitation, traditional medicine and public health *(17)*.
Health literacy	The ability of individuals to gain access to, understand and use information in ways which promote and maintain good health for themselves, their families and their communities *(18, 19)*.
HIV self-testing	A process in which a person collects their own specimen (oral fluid or blood) and then performs a test and interprets the result, often in a private setting, either alone or with someone they trust *(20)*.
Holistic care	Care that considers the whole person, including psychological, social and environmental factors, rather than just the symptoms of disease or ill-health *(7)*.

[3] This is an adapted definition; the term "laypeople" has been added here and was not part of the definition provided in the cited source).

Other definitions (alphabetical)	
HPV self-sampling	A process where a person who wants to know whether they have HPV infection uses a kit to collect a (cervico-)vaginal sample, which is then sent for analysis by a laboratory. Collection methods include lavage, brush, swab and vaginal patch. While HPV self-sampling cannot provide a diagnosis of cervical (pre-)cancer, it identifies people who are at higher risk *(21)*.
Human rights	Human rights are legal guarantees that are equally applicable to everyone everywhere in the world and enshrined in international human rights documents. Human rights protect against actions that interfere with fundamental freedoms and human dignity, and support the agency of individuals and populations. The promotion of human rights requires governments and others to take active steps to put in place institutions and procedures that enable people to enjoy their guaranteed rights *(22–24)*.
Informed decision-making	Respect for individual dignity and for the physical and mental integrity of every person using a health facility means also providing each person the opportunity to make reproductive choices autonomously. The principle of autonomy, expressed through free, prior, full and informed decision-making, is a central theme in medical ethics, and is embodied in human rights law. In order to make informed decisions about their sexual and reproductive health, comprehensive information, counselling and support should be made accessible for all people without discrimination, including young people, people with disabilities, Indigenous peoples, ethnic minorities, people living with HIV, and transgender and intersex people. People should be able to exercise their choice from across a range of options but also be free to refuse any or all options *(6)*.
Intersectionality	The concept of intersectionality builds on, and extends, the understanding of how gender interacts with other factors including race, ethnicity, age, class, geographic locations, gender identity and sexual orientation. It is understood that unequal gender power relations do not operate in isolation but intersect with other social and economic inequalities to produce health inequities *(25)*.
Intimate partner violence	Behaviour within an intimate relationship that causes physical, psychological or sexual harm, including acts of physical violence, sexual violence, emotional or psychological abuse and controlling behaviours *(20)*.
Key populations	Groups who, due to specific higher-risk behaviours, are at increased risk of HIV irrespective of the epidemic type or local context. These guidelines refer to the following groups as key populations: men who have sex with men, people who inject drugs, people in prisons and other closed settings, sex workers and transgender people *(20)*.
Lay health worker	Any person who performs functions related to health-care delivery and has been trained to deliver these services but has no formal professional or para-professional certification, nor a relevant tertiary education degree *(20)*.

Other definitions (alphabetical)	
Life course approach	An approach suggesting that the health outcomes of individuals and the community depend on the interaction of multiple protective and risk factors throughout people's lives. This approach provides a more comprehensive vision of health and its determinants, which calls for the development of health services more centred on the needs of its users in each stage of their lives *(7)*.
mHealth	Part of eHealth, this is the use of mobile and wireless technologies to support health-sector objectives *(10)*.
Non-discrimination	The human rights principle of non-discrimination obliges states to guarantee that human rights are exercised without discrimination of any kind based on race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status such as disability, marital and family status, health status, place of residence, economic status, social situation, sexual orientation or gender identity. This obligation in connection with the right to health means countries are to ensure the availability, accessibility, acceptability and quality of services without discrimination *(6)*.
Participation	Meaningful participation requires that individuals are entitled to participate in the decisions that directly affect them, including in the design, implementation and monitoring of health interventions. Under international human rights law, countries have an obligation to ensure the active, informed participation of individuals in decision-making that affects them, including on matters related to their health. The International Conference on Population and Development programme of action reaffirms this core principle in relation to sexual and reproductive health, stating that "the full and equal participation of women in civil, cultural, economic, political and social life, at the national, regional and international levels, and the eradication of all forms of discrimination on grounds of sex, are priority objectives of the international community". The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) specifically requires countries to ensure that women have the right to participate fully and to be represented in the formulation of public policy in all sectors and at all levels *(6)*.
Patient engagement	To promote and support active patient and public involvement in health and health care and to strengthen influence on health-care decisions at both the individual and collective levels. Having real patients articulate their experiences and viewpoints helps those taking part in training to appreciate the patient perspective and the importance of preserving trust between clinicians and patients. These core values are essential to care that is compassionate, quality-assured and, above all, safe. Exposure to patient stories during training is valuable and helps to motivate practitioners to improve safety. At an organizational level, patients and families can be engaged in the design or development of patient-centred processes and systems, for example as members of advisory committees *(26)*.

Other definitions (alphabetical)	
Patient experience	Patient experience encompasses the range of interactions that patients have with the health-care system, including their care from health plans, and from doctors, nurses and staff in hospitals, physician practices and other health facilities. As an integral component of health-care quality, patient experience includes several aspects of health-care delivery that patients value highly when they seek and receive care, such as getting timely appointments, easy access to information, and good communication with health workers *(27)*.
Patient safety	Patient safety is the absence of preventable harm to patients during the process of health care and the reduction of risks of unnecessary harms associated with health care, to an acceptable minimum. An acceptable minimum is the collective notion when the current knowledge, resources available and the context in which care is delivered are weighed against the risk of non-treatment or other treatment *(28)*.
People-centred care	An approach to care that consciously adopts the perspectives of individuals, carers, families and communities as participants in, and beneficiaries of, trusted health systems that respond to their needs and preferences in humane and holistic ways. People-centred care also requires that people have the education and support they need to make decisions and participate in their own care *(7)*.
People-centredness	Providing care that is respectful of, and responsive to, individual preferences, needs and values, and ensuring that patient values guide all clinical decisions *(29)*.
Point-of-care test	The key elements of point-of-care tests are that they allow (i) testing to be done with or near the person being tested, (ii) results to be returned to the person being tested during the same visit, and (iii) results of a point-of-care test to be used immediately for patient care and referral *(30)*.
Pregnancy	A state of reproduction beginning with the implantation of an embryo in a uterus and ending with the complete expulsion and/or extraction of all products of implantation *(15)*.
Primary care	A key process in the health system that supports first-contact, accessible, continued, comprehensive and coordinated patient-focused care *(7)*.
Primary health care	A whole-of-society approach to health that aims to maximize the level and distribution of health and well-being through three components: (a) primary care and essential public health functions as the core of integrated health services; (b) multisectoral policy and action; and (c) empowered people and communities *(7)*.

Other definitions (alphabetical)	
Privacy and confidentiality	The right to privacy means that an individual accessing health information and services should not be subjected to interference with their privacy, and that they should enjoy legal protection in this respect. Sexual and reproductive health involves many sensitive issues that are often not widely discussed within families or communities, and health and care workers are often entrusted with very personal information by their patients. Confidentiality – which implies the duty of health and care workers to not disclose, or to keep private, the medical information they receive from patients and to protect an individual's privacy – has an important role to play in sexual and reproductive health *(6)*.
Psychosocial support	The term "psychosocial" refers to the dynamic relationship between the psychological dimension (e.g. internal, emotional, thoughts, feelings, reactions) and the social dimension (e.g. relationships, family, community, social values, cultural practices) of an individual. "Psychosocial support" refers to the actions that address needs in both of these dimensions. It is a process of facilitating resilience within individuals, families and communities, and it can be both preventive (decreasing the risk of developing problems) and curative (helping to recover and overcome problems) *(31)*.
Quality	Quality is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge; as well as the totality of characteristics of an entity that bear on its ability to satisfy stated and implied needs. Fulfilment of human rights requires that health facilities, commodities and services be of good quality, including scientifically and medically appropriate. This requires, among other things, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation *(6)*.
Quality assurance	Part of quality management to give confidence to stakeholders that the requirements for quality will be fulfilled *(20)*.
Quality care	Care that is safe, effective, people centred, timely, efficient, equitable and integrated *(7)*.
Regulation	The imposition of constraints upon the behaviour of an individual or an organization to force a change from preferred or spontaneous behaviour *(7)*.
Self-administration	The process of people administering pharmacological substances or biomedical interventions to themselves.

Other definitions (alphabetical)	
Self-care	The ability of individuals, families and communities to promote health, prevent disease, maintain health and to cope with illness with or without the support of a health or care worker *(32)*. The scope of self-care within this definition includes health promotion, disease prevention and control, self-medication, providing care to dependent people, seeking hospital/specialist care when needed, and rehabilitation, including palliative care *(33)*. Self-care is a broad concept that also encompasses hygiene (general and personal), nutrition (choices about the type and quality of food eaten), lifestyle (choices of sporting activities, leisure, etc.), environmental factors (living conditions, social habits, etc.), socioeconomic factors (income level, cultural beliefs, etc.), and self-medication *(34)*.
Self-care interventions	Tools that support self-care and actions to improve the care for oneself. These tools include evidence-based, high-quality medicines, devices, diagnostics and/or digital interventions that can be provided fully or partially outside formal health services and can be used with or without the support of health or care workers.
Self-management	Management of or by oneself; the taking of responsibility for one's own behaviour, health and well-being *(35)*.
Self-medication	Self-medication is the selection and use of medicines (including herbal and traditional products) by individuals to treat self-recognized illnesses or symptoms. Self-medication is one element of self-care *(36)*.
Self-monitoring	Self-monitoring is a key aspect of self-management and includes the monitoring of clinical parameters, symptom measures and daily activities *(37)*.
Stigma	Originally derived from a Greek word meaning a mark or stain, stigma is beliefs, attitudes, practices and social processes that label difference, enable discrimination, reduce opportunities and reproduce social inequalities. Stigma manifests in community norms (felt or normative stigma), mistreatment and acts of discrimination (enacted stigma), and can be internalized (self- or internalized stigma) *(3)*.
Task sharing	The rational redistribution of tasks and the increased scope of work among different cadres of health worker, including trained laypeople *(20)*.
Telemedicine	Within the WHO/International Telecommunication Union national eHealth strategy toolkit, telemedicine is defined as supporting “the provision of health care services at a distance” *(38)*.

Other definitions (alphabetical)	
Transgender	An umbrella term for people whose gender identity and expression is not matched by the norms and expectations traditionally associated with the sex assigned to them at birth, including people who are transsexual, transgender or otherwise gender non-conforming. Transgender people may self-identify as transgender, female, male, transwoman or transman, trans-sexual or, in specific cultures, as *hijra* (India), *waria* (Indonesia), *kathoey* (Thailand) or one of many other transgender identities. They may express their genders in a variety of masculine, feminine and/or androgynous ways. Sexual-risk practices may differ among different subgroups within the transgender community. For example, sexual risk may be higher among transgender women (assigned male at birth) or transgender men (assigned female at birth) who have receptive anal intercourse with men than among transgender men or transgender women who have sex only with women *(39)*. Transgender people are often highly vulnerable to stigma, discrimination and violence, and have specific health needs that necessitate a distinct public health response.
Universal health coverage	Ensuring that all people have access to needed promotive, preventive, curative, rehabilitative and palliative health services, of sufficient quality to be effective, while also ensuring that the use of these services does not expose any users to financial hardship *(7)*.
Vulnerable populations	Groups of people who are particularly vulnerable to health conditions in certain situations or contexts, due to socioeconomic factors, disabilities, legal status and/or unequal power dynamics. WHO defines vulnerability as the degree to which a population, individual or organization is unable to anticipate, cope with, resist or recover from the impacts of disasters. Vulnerable populations can include children, pregnant individuals, elderly people, malnourished people and those who are ill or immunocompromised *(40)*.
Waste management	The collection, transportation, disposal or recycling and monitoring of waste.
Well-being	A multidimensional construct aiming at capturing a positive life experience, frequently equated to quality of life and life satisfaction. Measures of well-being typically focus on patient-reported outcomes covering a wide range of domains, such as happiness, positive emotion, engagement, meaning, purpose, vitality and calmness *(7)*.

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Annex 1. Methods for the development and compilation of the guidance

The development of this guidance began during the development of the World Health Organization's (WHO's) global normative guideline on self-care interventions, when implementation considerations were included as part of the discussions within all expert consultations, focus group discussions and end-user engagement. The WHO self-care team has also conducted the following information-gathering initiatives and then drawn upon that information to compile this document.

- Several technical consultations were conducted, including a global meeting for the development of implementation guidance (18–20 September 2023) and a global meeting on advancing the role of self-care interventions for sexual and reproductive health and rights (SRHR) in fragile and humanitarian settings (23–24 March 2023) *(1)*.
- Online community dialogues were held on equitable access to self-care interventions, involving members of nine underserved communities: people living with HIV, racially minoritized communities, transgender and gender diverse individuals, persons with disabilities, older adults (over 50 years), young people (18–24 years), people experiencing homelessness, refugees and migrants, and Indigenous women and girls (July 2023).
- National case examples were prepared about countries that have implemented the *WHO guideline on self-care interventions for health and well-being (2)*. These were prepared (August 2022 to December 2023) by drawing on baseline information that was gathered in preparation for multi-country implementation research and/or through national examples presented during expert consultations. Country examples by WHO region: Burkina Faso, Ethiopia, Kenya, Nigeria, Uganda, Zambia (African Region); Bangladesh, India, Timor-Leste (South-East Asia Region); Lebanon, Morocco, Pakistan, Syrian Arab Republic (Eastern Mediterranean Region); Cambodia, Japan, Philippines, Republic of Korea (Western Pacific Region); Argentina, Canada, Peru, Uruguay, United States of America (USA) (Region of the Americas); Germany, the Kingdom of the Netherlands and the United Kingdom of Great Britain and Northern Ireland (European Region).
- A global policy survey of all Member States was conducted in 2023, about policies relevant to sexual, reproductive, maternal, newborn, child and adolescent health *(3)*.

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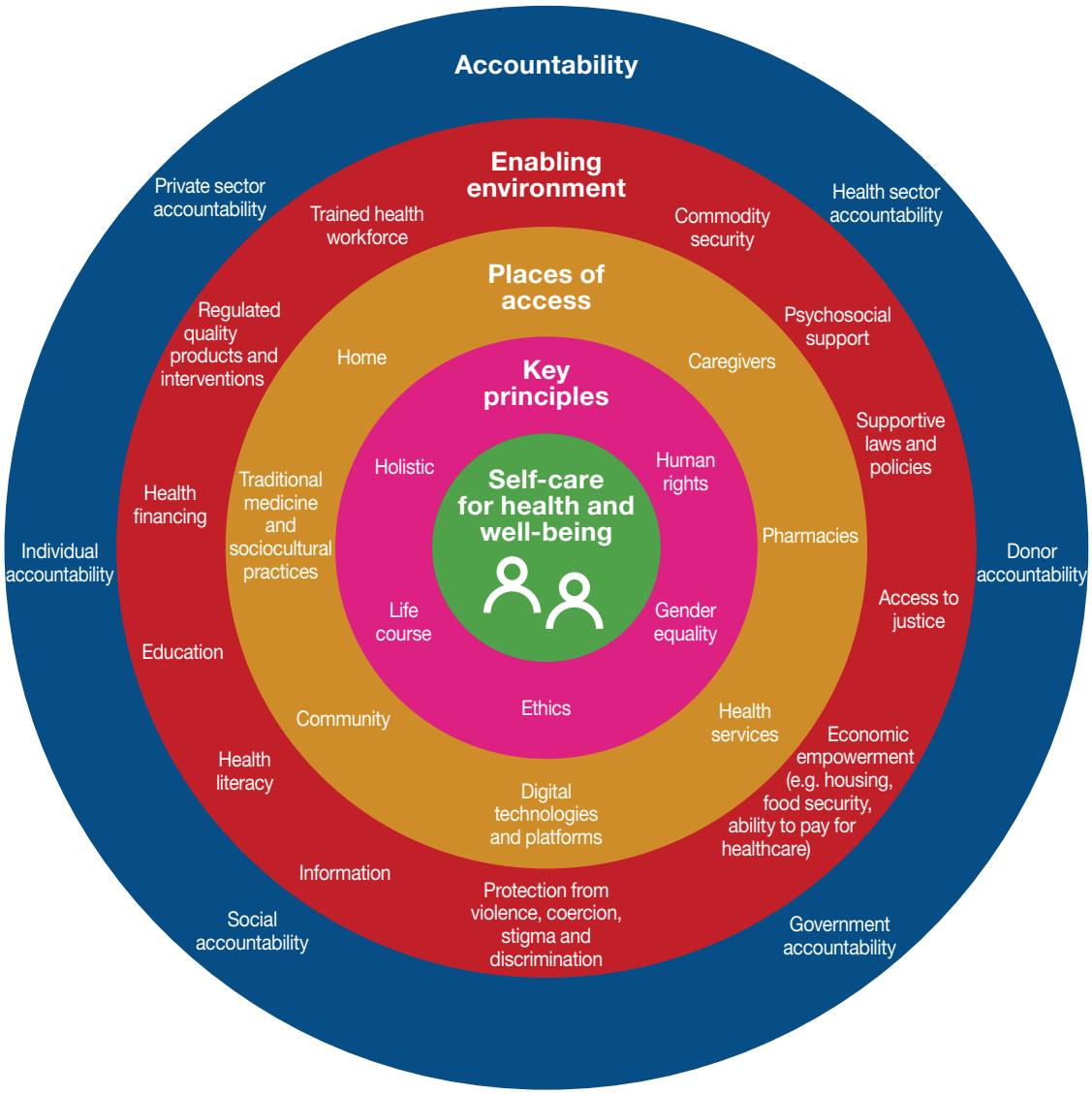
Annex 2. Elements of the WHO self-care framework



The core of the framework: people-centred approach for health and well-being

Implementation of self-care interventions must be grounded in a strengthened, comprehensive, people-centred approach to health and well-being. People-centredness means taking a holistic approach to the care of each person, and taking account of the environment in which they live and their individual circumstances, needs and desires across their whole life course. Health services must be delivered using an approach to health care that consciously adopts the perspectives of individuals, families and communities.

A people-centred approach *(1, 2)*:

- sees individuals as active participants in, as well as beneficiaries of, trusted health systems that respond to their needs, rights and preferences in humane and holistic ways;

- emphasizes the promotion of gender equality as central to the achievement of health for all and promotes gender-transformative health services that examine harmful gender norms and support gender equality;
- ensures that people are empowered – through education and support – to make and enact decisions in all aspects of their lives, including in relation to sexuality and reproduction;
- calls for strategies that promote people's participation in their own health care;
- recognizes the strengths of individuals as active agents in their health and not merely passive recipients of health services; and
- is organized around the health needs and priorities of people themselves rather than disease management and control.

Application of the approach can build robust and resilient health services, which are critical for progress towards universal health coverage (UHC) and fulfilling the Sustainable Development Goals (SDGs) *(1)*.

First circle of the framework: key principles

The following key principles – which are further elaborated in the 2022 guideline *(3)* – should be systematically considered to ensure better health for all in the provision of self-care interventions, in the context of a well functioning health system and a safe and supportive enabling environment.

Holistic approach to health: This means working at multiple levels from the individual, the family and the community, to the broader health system and the overarching enabling environment, to ensure that every aspect of the individual's physical and mental health and of their environment is considered – beyond a specific disease or health condition. A holistic approach to health can better reflect its complex and dynamic elements *(4)*.

Ethical considerations: An ethical approach should inform all decisions about self-care interventions, underpinned by the principles of fairness and equity *(5)*. This includes respect for medical ethics within health services, and ensuring an ethical approach anywhere that self-care interventions are accessed and used outside the health system. Health care must optimize the risk–benefit ratio in all interventions, respect individuals' rights to make autonomous and informed decisions, safeguard privacy, protect the most underserved, and ensure equitable distribution of resources. Other ethical considerations include an emphasis on well-being rather than just the absence of disease, and consideration of the capacity of individuals to make health decisions or to use a self-care intervention *(6)*.

Life-course approach: Self-care interventions are needed at all stages of the life course, so the health needs and priorities of different age groups over time must be taken into account in terms of access to and use of self-care interventions. Healthy people often maintain their health and well-being at home and engage or re-engage with the health system at discrete stages of their lives. Socioeconomic conditions throughout people's lives shape their health outcomes, disease risk, health-seeking behaviour and needs, and influence their use and uptake of self-care interventions *(5)*. Taking a life-course approach will support increased efficiency of service delivery, decreased overall costs, improved equity in the uptake of services, better health literacy and self-care, increased satisfaction with care, improved relationships between individuals and their health and care workers, and an improved ability to respond to health-care crises.

Human-rights and gender-equality approaches: Respect for and protection of human rights and gender equality lies at the heart of ensuring the dignity and well-being of individuals, as well as being central to facilitating access to self-care interventions for all people who might benefit from them. Laws, policies and interventions should address gender inequalities, which exacerbate people's vulnerability, affect their access to and experience of health services, and create barriers that prevent them from fully exercising their health-related rights, including their sexual and reproductive health (SRH)-related rights (see more information in the 2022 guideline).

Second circle of the framework: places of access

Increasingly, people access health information, products and services outside of formal health facilities *(5)*. Self-care interventions can be

accessed through several avenues, giving individuals more choice and improving individual autonomy. Much self-care is done at home, with self-care interventions accessed through pharmacies, digital platforms (such as telehealth or through mobile applications), caregivers/family members or traditional health practitioners. Other places of access include health facilities (such as hospitals, specialized clinics or care homes) and community centres.

Third circle of the framework: enabling environment

Users' experiences of self-care interventions – their access, use and outcomes – are shaped, in part, by the health system and the environment around it. An enabling environment is particularly crucial for self-care interventions, since these are mostly accessed and/or used outside of formal health services. A safe and supportive enabling environment is essential to facilitate access to and uptake of products and interventions that can improve health and well-being, especially for marginalized and underserved populations. The successful introduction and/or scale-up of self-care interventions therefore requires systematic attention to all aspects of the health system, and to the broader environment within which self-care interventions are delivered *(5)*. Drawing on the WHO health system framework, every health system building block needs to be adapted to ensure its adequacy for effective self-care interventions: service-delivery; health workforce; information; medical products, vaccines and technologies; financing; and leadership/governance *(7)*. To be safe and effective and to reach individuals who may not be able to access health care, self-care interventions may need more – not less – support from the health system *(8)*. There will be an increased need to reach out to communities to ensure that people have appropriate information about self-care interventions to make informed choices in using them, and to ensure that they seek support from health and care workers when needed. The characteristics of the enabling environment are summarized below, and although the creation of this enabling environment is beyond the scope of this implementation guide, there is further information throughout this guide that describes implementation of self-care with reference to these characteristics.

Characteristics of the enabling environment

Access to justice: Policies and procedures are needed to ensure that all people, including users of self-care interventions, have access to justice in the form of a functional system through which they can safely report, seek legal redress for, and prevent further rights violations and hold duty-bearers accountable. Facilitating this access to justice must primarily consider safety, confidentiality, and choice and autonomy in terms of whether an individual wants to report a violation. Violations may include discrimination, violations of medical confidentiality, and denial of health services. Various forms of redress and accountability should be made available, as formal legal systems may present too high a barrier for individuals, especially for those who face marginalization and criminalization. Where appropriate, health or care workers can offer to support clients who want to report violations to the police.

Economic empowerment: Livelihood insecurity, poverty and a lack of resources to meet key needs and expenses contribute to greater vulnerability and poor health outcomes. There is a risk that self-care interventions shift the costs of care from the health system to the individual (see section 6.1), which could exacerbate access inequities. Interventions focused on economic empowerment, poverty reduction and access to resources, such as housing and food support, therefore have the potential to improve access to health care and to improve health outcomes for all.

Education: Education, particularly secondary education, is important for empowering people in their health and well-being and has repeatedly been found to be associated with a wide range of better health outcomes as well as improved knowledge of how to maintain good health *(9, 10)*. The central role of comprehensive sexuality education (CSE), for example, in empowering young people to take responsible and informed decisions about their sexuality and relationships is well documented *(11)*. Ensuring access to education, including CSE, for all will support informed decision-making about care-seeking and self-care interventions.

Protection from violence, coercion, stigma and discrimination: Violence can take various forms, including physical, sexual and psychological, and vulnerability to violence can be influenced by laws, policing practices and sociocultural norms *(12, 13)*. Violence (and the psychological impact of that violence) may undermine people's ability to make and enact health-promoting decisions, or to access and use health services, including self-care interventions *(14)*. Therefore, when self-care interventions are promoted and distributed, there must be a multisectoral effort to consider and mitigate the risks of violence that may be affecting people. While appropriate action around violence could help to improve SRHR for everyone, special attention should be paid to people who may be more vulnerable to stigma/discrimination, exclusion and violence. Protecting against such stigma and discrimination is a critical part of the enabling environment for self-care interventions, to ensure equitable access to services for all who need them, without fear of reprisals for seeking information or connecting with health services. This may need intervention at multiple levels, from individuals to communities as well as people working in health facilities and services.

Psychosocial support: Early, adequate and tailored psychosocial support (see the definition in the glossary) helps individuals and communities to heal psychological wounds and rebuild social structures after an emergency or a critical event. It can (i) prevent distress and suffering developing into something more severe, (ii) help people to cope better and become reconciled to everyday life, (iii) help people to resume their regular lives, and (iv) meet community-identified needs *(15)*.

Supportive laws and policies: The legal and policy environment shapes the availability of health services and programmes, and the degree to which they are responsive to individuals' needs and aspirations. Laws and public policies are also key tools with which to positively influence the socioeconomic context *(16)*. The barriers created by, for example, the criminalization of adult same-sex consensual sexual conduct and induced abortion, should be addressed because these barriers impede linkage to health services following the use of self-care interventions. In addition, regulations that support access to safe and good-quality self-care interventions are a critical area for action (see section 5.1).

Health and digital literacy (see definitions in the glossary): Health literacy is essential for people to make the most informed choices regarding their own health and that of people they care for. Improving health literacy in populations also enables citizens to engage successfully with community action for health, and to push governments to meet their responsibilities for health and health equity. A health-literate individual is able to seek out and distinguish correct health information and to interpret and act upon this information, including the instructions for simple and complex self-care interventions. A health-literate person is also able to plan and achieve lifestyle adjustments to improve their health; to make informed, positive health decisions; to know how and when to access health services; and to engage with others in society regarding health issues and health-promoting activities *(3)*. When digital platforms are used for self-care interventions, digital literacy – proficiency in operating digital devices and platforms – needs to be considered since this will affect the uptake of these self-care interventions. Some populations, such as adolescents and youth, may have higher levels of digital literacy, so self-care interventions delivered though digital or mobile devices may be more appealing to them *(17, 18)*.

Fourth circle of the framework: accountability

From a human rights perspective, accountability means ensuring the fulfilment of the obligations of government policy-makers and other duty bearers to the rights holders who are affected by their decisions and actions. From an ethics perspective, accountability is about answerability, liability, and the expectation that blameworthy individuals or organizations will be held accountable for their actions *(5)*. Accountability for self-care interventions is shared among several different sectors and should be considered at all levels – local, national, regional and global. The enabling environment to support self-care interventions must be governed through shared accountability to ensure quality of care and better health outcomes.

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Annex 3. Indicators to consider for routine monitoring and reporting on implementation of self-care interventions

Indicator	Source	Rationale
Enabling environment		
Is there a national strategy or policy on self-care interventions?	WHO Sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) Policy Survey	Indicates whether self-care interventions are being recognized and prioritized by a country
Are there laws or policies that allow HIV self-testing?	Joint United Nations Programme on HIV/AIDS (UNAIDS) Laws and Policies Database	Highlights whether HIV self-testing is legal/ allowed
Are there laws and policies that make oral pre-exposure prophylaxis for HIV (PrEP) available?	UNAIDS Laws and Policies Database	Shows whether the regulatory environment allows oral PrEP to be made available
Health systems		
How many pharmacists are there per 10 000 population?	WHO Global Health Observatory	Pharmacists have an important role to play in self-care as they are the gatekeepers for over-the-counter medication. It is recommended that there should be at least 1 pharmacist per 2300 people (4.35 pharmacists per 10 000 people). If there are significantly fewer than this, the ability for a country to rapidly scale up self-care could be compromised. – Disaggregate by urban and rural areas
Service delivery		
What is the modern contraceptive method mix (used by women aged 15–49)?	United Nations Population Division	The proportion of methods that are self-care methods and the proportion that require a health or care worker to administer them – Disaggregate by age

Indicator	Source	Rationale
How many current oral PrEP users are there?	UNAIDS Global AIDS Monitoring	Number of people currently able to access oral PrEP as a self-care intervention – Disaggregate by age and sex
How many HIV self-tests are conducted?	UNAIDS Global AIDS Monitoring	Number of people currently accessing HIV self-tests as a self-care intervention – Disaggregate by age and sex
Is emergency contraception available for women (within 5 days) in cases of rape or incest?	UNAIDS Laws and Policies Analytics	Ability of a women who has been subject to rape or incest to access emergency contraception as a self-care intervention – Disaggregate by age

Source: Sexual and reproductive health and rights: infographic snapshot. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/WHO-SRH-21.21). Licence: CC BY-NC-SA 3.0 IGO.

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