Self-Care for Sexual and Reproductive Health in Humanitarian and Fragile Settings

Barriers, Opportunities & Lessons Learned

IAWG Inter–Agency Working Group on **Reproductive Health in Crises**

INTERNATIONAL **RESCUE** COMMITTEE

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Acronyms

CHW	Community Health Worker
COVID-19	Coronavirus Disease 2019
DRC	Democratic Republic of the Congo
FP	Family Planning
GBV	Gender-Based Violence
iCCM	Integrated Community Case Management
ICFP	International Conference on Family Planning
IAWG	Inter-Agency Working Group on Reproductive Health in Crises
IRC	International Rescue Committee (NGO)
MOH	Ministry of Health
MIHR	Momentum-Integrated Health Resilience
MISP	Minimum Initial Service Package for Sexual and Reproductive Health in Crisis Situations
MNH	Maternal and Newborn Health
MSI	MSI Reproductive Choices (NGO)
NCD	Non-Communicable Diseases
PPE	Personal Protective Equipment
PPH	Postpartum Hemorrhage
PPMV	Patent and Proprietary Medicine Vendors
PSI	Population Services International (NGO)
SAC	Safe Abortion Care
SCTG	Self-Care Trailblazer Group
SDG	Sustainable Development Goals
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
WHO	World Health Organization

Background

Self-care, defined by the World Health Organization (WHO), is

"the ability of individuals, families and communities to promote health, prevent disease, maintain health and cope with illness and disability with or without the support of a health worker." [i]

Self-care can be instrumental for people coping with non-communicable diseases (NCD) (e.g., managing high blood pressure and diabetes), malnutrition, and across sexual and reproductive health (SRH) areas like sexual health, menstruation, pregnancy, childbirth and post-partum care.

Self-care allows for choice, agency and autonomy for individuals to manage their own healthcare while engaging health providers as needed. The delivery of self-care operates as part of the healthcare system, alongside community-based and facility-based service delivery. The purpose of self-care is to expand health care access by offering options for users to safely self-manage particular health needs, while maintaining close linkages to community-based and facility-based care. Self-care contributes to universal health coverage and achieving the Sustainable Development Goals (SDG) on health, gender equality, women's empowerment and reducing inequalities[ii]. It offers improved outcomes including increased coverage and accessibility, reduces health disparities, increases quality services and can improve overall health and reduce costs to users and health systems[iii]. Self-care interventions are

"tools which support self-care. Self-care interventions include evidence-based, quality drugs, devices, diagnostics and/or digital technologies which can be provided fully or partially outside of formal health services and can be used with or without the support of a health worker." [iv]

While self-care is not a new practice in SRH, it is especially critical in humanitarian and fragile settings. The 2019 coronavirus (COVID-19) pandemic highlighted that no country is immune to health crises. In 2023, 339 million people will need humanitarian assistance compared to 274 million people in 2022[v] and the majority of people who are refugees or internally displaced either come from, or are hosted in fragile settings[vi]. Countries face growing health worker shortages[vii] and increasing climate-related crises[viii]. Self-care is thus emerging as a crucial strategy in response to these crises. It can ensure continuous healthcare access especially in humanitarian and fragile settings when health systems are disrupted.

Appreciating the importance of self-care, WHO recently published the **WHO Consolidated Guideline on Self-Care Interventions for Health: Sexual and Reproductive Health and Rights** (2019) and the **WHO guideline on self-care interventions for health and well-being, 2022 revision**. This included identifying self-care interventions in humanitarian settings as a good practice.[ix]

Leveraging the WHO guideline, 23 countries are now in the process of developing national self-care guidelines. Nearly half of these countries rank within the top 20 most fragile states in the world and/or host significantly large populations of refugees or internally displaced persons. However, guideline implementation plans have yet to include, consider or reach populations within their countries affected by crisis - for example, crisis-affected Borno State in Nigeria and refugee hosting districts of Uganda.

Most self-care SRH efforts continue to be implemented in predominantly stable settings. Despite the formal acceptance of the **Minimum Initial Service Package for Sexual and Reproductive Health in Crisis Situations (MISP)** for sexual and reproductive health in crisis situations as a critical component of humanitarian response to reduce mortality and morbidity,[x] self-care for SRH in humanitarian and fragile settings is nascent (Figure 1). Recognizing self-care for SRH operates across the humanitarian-development-peace nexus in many countries - and that self-care for SRH in humanitarian and fragile settings is a crucial opportunity for enabling health access - the Self-Care Trailblazer's Group (SCTG) and the Inter-Agency Working Group on Reproductive Health in Crisis (IAWG) Self-Care Task Team are exploring ways to advance SRH self-care in humanitarian and fragile settings. However, hesitations among stakeholders persist about how best to advance self-care for SRH in humanitarian and fragile settings including concerns on operational feasibility of self-care interventions in these settings.

Self-care interventions aligned with the Minimum Initial Service Package (MISP) for SRH in Crisis Settings

The MISP, developed by IAWG, is a series of crucial, lifesaving activities required to respond to the SRH needs of affected populations at the onset of a humanitarian crisis. Below is each MISP objective (1-6) with a detailed list of the self-care interventions that align with the corresponding objective.

OBJ. 1 COORDINATION:
Ensure the health sector/cluster identifies an organization to lead the implementation of the MISP

- Not applicable. However, the implementation of self-care interventions should be the fruit of concerted policy and programmatic efforts at all levels

OBJ. 2 GENDER-BASED VIOLENCE:
Prevent sexual violence and respond to the needs of survivors

- Care of injuries
- Over the counter oral contraceptive pills
- Emergency contraception
- HIV post-exposure prophylaxis
- STI presumptive treatment
- Positive coping methods

OBJ. 3 HIV/STI:
Prevent the transmission and reduce morbidity and mortality due to HIV and other STIs

- Condom use
- HIV post-exposure prophylaxis for survivors of sexual violence
- ART treatment, for people already enrolled including pregnant and postpartum women
- Cotrimoxazole prophylaxis

OBJ. 4 MATERNAL & NEWBORN HEALTH:
Prevent excess maternal and newborn morbidity and mortality

- Misoprostol for prevention of PPH
- Chlorhexidine for neonatal care
- Other components essential newborn care (thermal care, breastfeeding, etc.)

OBJ. 5 CONTRACEPTION:
Prevent unintended pregnancies

- Self-administration of injectable contraception
- Over the counter oral contraceptive pills including emergency contraception
- Up to 1-year supply oral contraceptive pills
- Condom use
- Post-abortion hormonal contraception initiative
- Postpartum contraception initiation
- Lactational amenorrhea method
- Fertility awareness-based / standard day methods / traditional methods (e.g. withdrawal)

OBJ. 6 TRANSITION TO COMPREHENSIVE SRH:
Plan for comprehensive SRH services, integrated into primary care as soon as possible

- HIV self-testing
- ART programming for new enrollees
- HIV pre-exposure prophylaxis (oral PrEP)
- Self-collection of samples for STI testing
- Self-administered interventions for common physiological symptoms of pregnancy
- Non-clinical interventions to reduce unnecessary cesearean sections
- Cancer: Self-sampling for HPV testing, breast cancer self-exam, testicular self-exam
- Fertility: Home-based ovulation predictor kits, home-based pregnancy tests, menstrual health management
- Sexual health: Sexuality education
- Mental health: Positive coping, self-help

OTHER PRIORITY: SAFE ABORTION CARE.
Ensure safe abortion care is available in health centers and hospitals, to the full extent of the law.

- Self-management of medical abortion process in the first trimester
- Post-abortion hormonal contraception initiation

This visualization is based on *Sexual and reproductive health self-care in humanitarian and fragile settings: where should we start?* by Nguyen Toan Tran, Hannah Tappis, Pierre Moon, Megan Christofield and Angela Dawson. Originally published in Conflict and Health (2021) 15:22. Access by scanning QR code.

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Figure 1: MISP objectives with detailed list of self-care interventions that align with corresponding objective.

The International Rescue Committee (IRC) commissioned this global assessment in collaboration with the IAWG Self-Care Task Team to better understand the barriers and opportunities for advancing self-care for SRH in humanitarian and fragile settings and to share lessons learned from existing SRH self-care efforts.

The audience for this report includes program implementers (across the humanitarian-development-peace nexus inclusive of IAWG and SCTG); policymakers and advocates; researchers and donors who are interested or actively engaged in humanitarian and fragile settings.

Purpose

The purpose of this assessment was to:

- Identify barriers to and opportunities for self-care for SRH in humanitarian and fragile settings across advocacy and policy, implementation, research and investment

- Share lessons learned from current SRH self-care interventions in humanitarian and fragile settings and relevant lessons from stable settings

Methodology

Qualitative interviews were held with key informants working on SRH self-care in humanitarian, fragile and stable settings. In total, 25 virtual interviews were conducted among 36 people from 20 organizations using Zoom. Key informants were selected in consultation with members of the IAWG Self-Care Task Team and IRC colleagues. Participants included representatives from donor organizations and agencies, advocacy organizations and coalitions, national and international implementing organizations, and international research organizations. Participants represented two

national organizations, three donors and 15 international organizations and global coalitions. Six organizations worked in predominantly stable settings, 9 organizations worked in humanitarian and fragile settings, and 5 organizations worked across the humanitarian-development-peace nexus. In addition to the interviews, qualitative insights were also drawn from a technical consultation at the International Conference on Family Planning (ICFP) on SRH self-care in humanitarian and fragile settings.[1] Interviews were audio recorded and transcribed and data from all sources were coded and analyzed using Dedoose software.

Limitations

Participants did not provide information related to acute emergency response or self-care programming outside of one type of self-care method. Most key informants spoke to their work on safe abortion care, self-injectable contraceptives or prevention of post-partum hemorrhage (PPH) in stable, fragile or protracted humanitarian settings. Therefore, the findings do not reflect other SRH health areas or perspective or lessons from acute emergency response.

Findings

The findings are categorized under advocacy/ policy, implementation, measurement and research and investment.

Advocacy & Policy

Barriers

to advocate for or develop policies to improve self-care for SRH in humanitarian and fragile settings

- *There are ongoing debates within the global self-care community on how to define and conceptualize self-care.* These debates include how to distinguish self-care interventions from telehealth or community-based distribution interventions where users administer their own self-care.

Findings in Stable Settings:
There is a broad misperception that self-care programming in humanitarian and fragile settings is significantly different than programming in stable settings. In reality, one of our major takeaways is there are many commonalities across contexts. From the advocacy space to program implementation to research to investment, many barriers and opportunities are universal. While this report focuses primarily on fragile and humanitarian settings, an exclamation point icon has been used to indicate the finding is also reflected in stable settings.

Other questions include how to ensure self-care is understood by stakeholders to mean safe self-care (e.g., self-care for *safe* and supported self-management of medical abortion versus self-management of an unsafe abortion) or whether an intervention qualifies as self-care when there are no other choices for care.[2] These debates and lack of consensus can hinder progress in advocating for self-care in humanitarian and fragile settings.

■ *Unavailable or unsupportive policy frameworks.*

> Globally most countries do not have national self-care guidelines and many existing SRH legal or policy frameworks do not mention self-care interventions, including task-shifting guidance[3]. In addition, existing SRH policies might pose barriers to self-care if they require prescriptions for self-care commodities (e.g., oral contraceptive pills) or require users to collect or purchase commodities in-person at facilities.

> Countries with national self-care guidelines currently do not integrate considerations for crisis-affected populations or implement guidelines in fragile states. This might be due to a lack of understanding or prioritization of the unique needs of displaced or migratory populations; a perception that self-care implementation is not operationally feasible in these areas due to insecurity and competing priorities; or to a lack of humanitarian programming and advocacy experience among policy makers. Even in countries that are developing self-care guidelines, policymakers might not pilot those guidelines in fragile states within the country. For example, until recently,

Borno, Adamawa and Yobe States in crisis-affected Nigeria were not included as part of the 18 pilots for the self-care guidelines. Adamawa was recently selected and will start the guideline domestication process.

> Refugee camp policies might restrict self-care interventions. Self-care efforts might be restricted in camps for refugees or displaced communities if camp policies mandate receiving SRH care at facilities.

■ *Hesitancy based on misconceptions, bias or fears.* There is hesitancy among government policymakers, health providers, donors, and program staff, including those working in humanitarian and fragile settings, to support self-care. Hesitations stem from misconceptions about what self-care is and is not (e.g., how it differs from wellness activities such as relaxation techniques; or how it differs from types of self-management such as unsafe abortion). Hesitations are also founded on biased beliefs around users self-efficacy to manage their own care. Moreover, hesitations arise from a lack of awareness or confidence in a person's own ability to support SRH self-care within their own role, particularly amongst health providers or program staff. Finally, although self-care is widely accepted to refer to a wide range of self-care interventions across the SRH life-course, for some stakeholders there is a misperception that self-care guidelines and packages always include, focus, or promote self-managed abortion which results in hesitancy or resistance to support self-care efforts. This hesitancy is likely rooted in individuals' own values, attitudes and beliefs around SAC.

> For health providers specifically, there are concerns as to whether self-care threatens their employment, concerns that users would not have enough knowledge or training to administer self-care products, concerns their revenue would be affected and concerns they would not have the time to counsel users on how to administer self-care products. One health official expressed concerns that self-care might weaken national efforts to strengthen accessibility and use of facility-based care.

■ *Some humanitarian or fragile contexts do not have a recognized government* leaving a policymaking gap and limiting options for sustainability.

Opportunities

to advocate for or develop policies to improve self-care for SRH in humanitarian and fragile settings

■ *Share the WHO guidance that supports SRH self-care in humanitarian and fragile settings.* The **WHO consolidated guideline on self-care interventions for health: sexual and reproductive health and rights**, published in 2019 includes a 'good practice statement' for humanitarian settings[4]. And updated in 2022, the **WHO guideline on self-care interventions for health and well-being**, includes two recommendations for pandemic and humanitarian settings.

■ *Seize the growing interest in SRH self-care in humanitarian and fragile settings driven by the acknowledgement of its enormous potential.* This includes increasing interest in ways self-care interventions align with nearly all components of the MISP.

■ *Highlight the increasing number of countries developing self-care guidelines and identify learnings* about how humanitarian and fragile settings could be better considered throughout the policy development process.

■ *Leverage national self-care guidelines and policies to expand self-care in humanitarian and fragile settings.* In countries with national self-care guidelines, pilot and implementation plans, advocate for humanitarian or fragile states to be included.

■ *Build on the increasing collaboration between the SCTG and IAWG* to increase attention and demand for SRH self-care across the humanitarian-development-peace nexus. This will bolster efforts in humanitarian and fragile settings and identify opportunities for collaboration globally and nationally through respective members and national coalitions.

■ *Collaborate with national self-care for SRH groups, networks and advocates who could integrate more humanitarian considerations in their work* and expand their network to humanitarian and fragile settings within their countries. This includes the national affiliates of the SCTG.

Lessons learned

- *Self-care interventions can be implemented by leveraging a supportive MOH or existing SRH policies in the absence of explicit SRH self-care guidance.*

  > In South Sudan where there are no formal self-care policies, the IRC and the MOH referenced an existing family planning (FP) policy when introducing a self-care pilot on self-injectable contraceptives to communities to demonstrate alignment with existing policies, showcasing national endorsement to increase community support for the program.

  > In Niger, although there is not yet a formal self-care guideline or policy that includes the distribution of misoprostol for prevention of PPH, the government is very supportive of this self-care intervention through their National Initiative to Fight against Postpartum Hemorrhage.

- *Health providers can be supportive allies, particularly those practicing at lower-levels in humanitarian or fragile settings and closer to communities.*

  > IRC in South Sudan, when exploring the support of health providers for a self-care intervention in Awiel East, found health providers at lower-level facilities closer to communities were supportive as they recognized the potential of self-care to alleviate their concerns around understaffing and overburdened providers. They recognized the role self-care could provide in bolstering access to SRH while linking back to facility-based care.

  > IRC Nigeria conducted a formative study asking healthcare providers what their role would be in advancing self-care. Respondents saw themselves as creating awareness of self-care and being the go-to person for information and commodities to self-manage SRH needs for women.

- *Self-care as harm reduction messaging.* Ipas, through their work on SAC, found that emphasizing the importance of self-care as a harm reduction strategy may resonate more with some health workers, communities and partners (as compared to human rights framing) because they often bear witness to the harms of unsafe self-care.

- *Learnings can be drawn from stable settings:*

  > Strategies for developing national guidelines:

    – Engage representatives from a range of health areas within and beyond SRH and working in strong collaboration between national, and global technical working groups when developing national self-care guidelines.

    – Working from subnational to national to global levels, along the humanitarian-development-peace nexus and across different health areas (like how primary healthcare is approached) has allowed for an integrated and endorsed policy development process.

> National strategies to advance self-care:

▬ Advocate for broad self-care and individual interventions/types of self-care while simultaneously implementing advocacy strategies at the policy level. In addition, implement interventions to build a proof of concept for decision-makers.

▬ Identify champions, particularly health providers, to facilitate more government interest in self-care. For example, in Uganda, the self-care champion is the Director of Curative Services, and they have been critical to work in collaboration with government, national civil society and health providers.

> Talking points to galvanize support among governments and donors:

▬ Use examples from self-care in NCD services (e.g., self-administered insulin and self-care for nutrition) to address bias and demonstrate the stark difference between the higher levels of concern among stakeholders that users cannot self-manage SRH compared to the low levels of concern for users administering self-care for NCD or nutrition. These differences might stem from bias towards users (predominately women and girls) that they do not have the skills or competencies required to self-manage care, and/or biased beliefs that SRH requires unnecessary oversight of what women and girls and other historically marginalized users do for SRH.

▬ Point to how self-care will reduce the burden on healthcare workers leaving them able to invest in care where they can be most impactful.

▬ Reference how self-care is a way to advance gender equality and women's empowerment, advance equitable access to healthcare, particularly for underserved, historically marginalized or hard to reach populations, and further universal healthcare.

▬ Reference the global experience of the COVID-19 pandemic to emphasize the necessity for self-care in emergencies. Highlight that all countries face increasing risk of health system disruptions and emergencies in the face of growing displacement and climate change.

Implementation

🚧 Barriers

to implement self-care interventions for SRH in humanitarian and fragile settings

- *Communities might have less access to mobile phones or internet* leaving them with less access to digital self-care interventions. In addition, women might have more constraints in accessing phones and using them privately without supervision of a male relative or partner.

- *Communities might be mobile,* making referrals and follow-up more difficult for the users.

- *Fragmented coordination between international organizations and governments* can exist, particularly with responses to acute crises. This can hinder opportunities for strong coordination and sustainability of self-care interventions.

- *Difficulties in ensuring privacy and confidentiality for users* in storing, administering, and recovering from self-care commodities at home with often limited household privacy.

- *Fears among users of their own self-efficacy reduces their confidence* in their own ability to safely and effectively administer or use a self-care commodity (i.e., self-injectable contraception).

- *Barriers to implementing safe, equitable and inclusive interventions* if attention is not given to ensuring protection, equity and inclusion.

> If male relatives, partners or community leaders are not engaged in mobilizing for self-care, users may face increased risks of gender-based violence (GBV) if found to be storing or administering self-care products when the partner disapproves. There also may be risks to exploitation by health providers because self-care is a 'discrete service.'

> Inequality can also be exacerbated in self-care interventions if the costs of self-care products fall on the users leaving only those able to afford care with access to care.

> Without adequate attention to inclusion, more historically marginalized groups of communities such as users with disabilities, young users (married and unmarried), users who cannot read and more hidden populations, may not be reached with self-care interventions.

- *There can be less of a private sector presence* in humanitarian or fragile settings, leaving communities with fewer points of access to care and fewer potential implementing partners than in stable settings.

- *Where there is private sector presence, there is difficulty in managing engagement with the private sector* (whether it is pharmacies, private clinics and facilities or e-commerce) including:

  > Determining how best to include the private sector.

  > Mobilizing the private sector providers to offer self-care methods.

> Determining how to regulate quality of medication, counseling and payment schemes that don't exacerbate inequality within the private sector.

■ *Unreliable or low availability of supplies and supply chains.* Limited supply or supply chain disruptions were reported in a range of settings. The implications of this on self-care included the following:

> Women switched to preferring facility-based care after worrying self-care delivery was unreliable.

> Reports of stock expiring during interventions meant shorter durations of self-care programs.

> Sustainability was difficult to achieve especially when the organization supplying commodities for an intervention was not linked to a national supply chain.

> Limited supply or a limited range of commodities can be barriers to offering self-care options that are preferred by users. For example, IRC colleagues in Nigeria found it necessary to first research what commodities were available before asking women and girls what they wanted for self-care interventions.

■ *Underlying barriers to contraception and SAC* can influence perceptions of self-care for contraception and abortion and need to be addressed. There are concerns among stakeholders on whether self-care contraceptive methods or safe abortion care can and should be accessed. These are influenced by cultural and religious beliefs, socio-economic factors, gender norms, education and health literacy

and other context-specific factors, affecting both the users and decision-makers if they are not making the decision.

Opportunities

for self-care interventions for SRH in humanitarian and fragile settings

■ *Leverage existing self-care practices.*

> IRC Nigeria will soon launch a self-care program building on existing community-based practices of self-care such as pregnancy testing and breast cancer self-checks.

> Whether or not there is a program, women will figure out self-care if they decide it is worth it. In Sierra Leone during Ebola, it was seen that women were buying oral contraceptive pills who normally preferred injectables, or buying injectables from pharmacies and paying neighbors who were nurses to inject them.

■ *Leverage digital health options.*

> In Kabul, Afghanistan, Jhpiego and Viamo piloted a program for postpartum women using interactive voice response for six weeks covering breastfeeding, wound care, mental health, baby nutrition and immunization. The women were phoned a few times each week and taken through a menu of options of information.

> Telemedicine and app-based self-care can work well in urban areas and areas widely linked to the internet. For example, the Syrian refugees in Jordan can access FP or SAC support and commodities

through smart phones or internet terminals and obtain commodities via (snail) mail.

> **Women Help Women** and **Women on Web** provide asynchronous telemedicine abortion services globally and **Vitala Global** developed a mobile health application specifically to support Venezuelans who are displaced and or seeking asylum.

■ *Recognize interest for self-care among users in humanitarian and fragile settings*

> In Cox's Bazar, Bangladesh, there was noted demand for misoprostol in the Rohingya refugee camps, it was just a matter of making it available.

■ *Leverage specific aspects of humanitarian and fragile contexts that make self-care a crucial opportunity to expand SRH access*

> Service delivery gaps driven by understaffing and limited health services; displaced and populations on the move and other contextual factors means self-care can be an instrumental strategy for achieving health coverage.

> Populations in these contexts may demonstrate higher levels of self-efficacy out of necessity and as a result of their circumstances.

> Leverage donor-funded self-care interventions in contexts where sustainability is not a priority and urgent care is needed to offer free services that expand access to SRH through self-care.

> In many humanitarian SRH interventions, GBV prevention and response is well integrated, and as such self-care interventions can be implemented in a

manner that reduces risks to gender-based violence and offers self-care services for survivors of GBV.

> Humanitarian agencies and actors are at times perceived to have the potential to be more coordinated and have more robust supply chains depending on the response efforts. When this is true, leverage the supply chain for streamlined and efficient self-care interventions.

Lessons learned

■ *Successful implementation relies on localized and community-centered approaches.*

> Local government and health systems are instrumental to self-care interventions. For example, in South Sudan, IRC found that working in partnership with the MOH at all levels of care was essential to the project's viability. Only with the MOH and subnational health departments introducing the project to the community was community acceptance possible. This assured the community that the project was not to benefit the international organization but to benefit the community and aligned with the government FP policy.

> Local and community-based organizations are crucial to relevant self-care interventions. For example, IRC Nigeria is planning to partner with local organizations in Borno State to frame messages and build on existing self-care efforts, recognizing that local organizations are staffed with trusted community members and their input and guidance to the program is critical to its success.

> Working through community-based interlocutors is key. The crucial role of trusted community-based actors and health workers, such as CHWs and traditional birth attendants (TBA) can not be overemphasized across all types of self-care. Trusted sources are appreciated by communities to enable safe and supportive self-care interventions and through their participation self-care can also be destigmatized.

– For example, for de-medicalized safe abortion self-care, different community interlocutors were identified depending on the context to support SAC access. On the Thailand-Burma border it was counselors and social workers - intentionally people who were not providers but who were trusted. In Pakistan it was with network of female health workers and in Sub-Saharan Africa it has been through partnerships with feminist organizations.

– In DRC, IRC found that CHWs were key to discreetly spreading the word about the availability of safe abortion medication at facilities and pharmacies.[xv]

■ *User preferences depend on context and can be influenced by factors such as costs, privacy and safety.*

> In South Sudan, MIHR has seen more interest among rural women for self-injection than urban areas because self-care reduces transport costs, the time costs of health facility visits, and costs for personal protective equipment (PPE) and women in rural areas do not have access to pharmacies.

> In DRC, IRC reported a larger proportion of users accessing medication abortion at pharmacies than facilities and suggested it was due to perceived barriers among users in accessing facility-based care due to the COVID-19 and Ebola outbreaks, or from preferring self-management instead of facility-based care believing pharmacies were more accessible and supportive.

> Users may determine where to access self-care based on privacy, particularly adolescents. MSI found adolescents were more comfortable going to Patent and Proprietary Medicine Vendors (PPMV) for privacy and discretion in Nigeria whereas IRC found adolescents preferred facilities because of their confidentiality and privacy in DRC, noting there were adolescent health committees linked to program facilities.

> In South Africa, an international organization worked with a sex worker network to increase access to SAC and contraceptives because facility access was too unsafe for the users due to stigma and discrimination.

> In Kenya during the beginning of the COVID-19 pandemic, Kasha, an e-commerce platform that offers contraceptive commodities, boomed and has remained popular, likely due to the discretion, convenience and availability that it offers.

■ *Users can manage self-care regardless of literacy.*

> In South Sudan, the IRC has found that women in rural areas with low levels of literacy remember to take their next self-

injection by keeping track of different locations' market days rather than using traditional calendars. Users were also found to be coordinating self-injections with other users in their community.[xviii]

■ *Continuity of care is possible thanks to community acceptance, partnerships and prioritizing continuity of care.*

> In DRC, the IRC found that 78% of self-managed abortion care users came to the facility for post abortion care and contraception, believed to be stemming from increasing community acceptance of post-abortion care, robust partnerships among IRC, CHWs, health facilities and local health officials throughout the duration of the program, and the prioritization of continuity of care.[xix]

■ *Quality is possible in humanitarian and fragile settings.* The IRC in DRC and South Sudan found that the fundamentals of quality of care do not differ in humanitarian settings when appropriately adapted to the context.

■ *COVID-related modifications* demonstrated the power of self-care in enabling access to healthcare during the pandemic-related lockdowns. In Kenya, at the onset of COVID-19, the Ministry of Health developed guidelines on the continuity of Reproductive, Maternal, Newborn and Family Planning services. In those guidelines, community distribution of contraceptive methods, specifically condoms and oral pills by community health volunteers was recognized as a key pillar for self-care, to relieve pressure on health facilities and minimize client-provider interaction.

■ *Strategies to ready organizations for self-care.* International organizations shared strategies to mobilize organizations and staff to support and administer self-care interventions.

> Enlist organizational staff in trainings on self-care to ensure they are supportive of all types of self-care and work to address their fears or hesitations around implementing it.

> Identify self-care as the third point of service along with facility and community-based care and draft standard operating procedures to support it, as undertaken by Pathfinder.

PSI resources that could be useful in humanitarian and fragile settings:

Provider trainings to address self-efficacy with empathy. PSI conducts empathy training with health providers so they can better support users to build their own self-efficacy by coaching users with more empathy while ensuring there is no coercion.

PSI is developing a *playbook to design self-care interventions that are grounded in person-centered principles and offer quality checks* at every stage regardless of type of intervention or context.

Measurement and Research

🚧 Barriers

to measurement and research on self-care for SRH in humanitarian and fragile settings

- Research teams cannot always reach communities due to *security shifts or rains, floods, or other seasonal changes.*

- *Self-care is difficult to measure* due to the nature of self-care often increasing anonymity, confidentiality and self-efficacy among users. This leads to potential difficulties and ethical issues in follow-up with users. Without data it is difficult to measure:

  > How many people end up effectively and safely administering the product.

  > Whether quality is achieved at every stage.

  > How self-care interventions are impacting the health system.

Abortion

Most currently available abortion data related in legally-restricted humanitarian and fragile settings are typically facility-based data collected when users return to a facility for post-abortion care because their abortion was ineffective or unsafe. This biases abortion-related data to mainly highlight instances when abortion care does not work.

- *Difficult to integrate self-care measurement indicators (and inclusive self-care indicators) into the healthcare reporting system* that could allow for more sustainability of self-care models in the national health system.

- *A limited number of published learnings or guidance*, including peer-reviewed studies for self-care, means it is hard to build on learnings.

- *A lack of standardized programmatic tools* such as indicators for health information management systems, checklists for providers, checklists for users and information tools on managing common side effects. The lack of standardized program tools carries the risk of programs reinventing forms and tools.

- *Conflicting research interests among donors.* Donors noted they can sometimes find it easier to fund smaller research interventions to build up to larger ones based on learnings, while others noted their preference to move away from reporting on pilots to focus on larger interventions to collect more robust evidence.

💡 Opportunities

for measurement and research on self-care for SRH in humanitarian and fragile settings

- *Glean learnings on measurement from humanitarian integrated community case management (iCCM) and NCD self-care sectors* which also implement self-care interventions in humanitarian settings and have potentially identified strategies

for measurement that are adequate and acceptable to the health system, governments, donors and communities.

- *Leverage the high interest among donors and implementing partners (national and global) for implementation science research,* including operational research.

  > *Leverage the rising donor interest for research* and learning on what the self-care journey is, how to provide services to the hardest to reach, and identifying which self-care is desired among users in different contexts.

- *Build on forthcoming research publications* on SRH self-care in humanitarian and fragile settings.

Opportunity from stable settings:

The SCTG has recently developed **a Sexual and Reproductive Health Care Measurement Tool** which aims to provide a global standard approach to practical and accurate measurement of SRH self-care interventions, with a focus on three specific interventions:

1) self-injectable hormonal contraception;

2) HIV self-testing; and

3) self-managed abortion.

Lessons learned

There were valuable lessons learned related to measurement and research in humanitarian and fragile contexts which differed across projects.

- *The prioritization of measurement could depend on the phase of emergency.*

  > Measurement might be less prioritized to enable immediate access to self-care for SRH due to the type of crisis. In one example cited for Afghanistan, interventions focused on piloting a response project without prioritizing sustainability and measurement.

  > Measurement might be equally prioritized as in stable settings. In South Sudan, Nigeria, Burkina Faso, DRC, and Niger the measurements and research focused more sustainability and ensuring self-care was a part of health systems strengthening and increasing longer-term access.

- *Prioritize leadership of local research teams.* When outbreaks of insecurity and pandemics have caused international research staff to evacuate, locally led and staffed research teams in South Sudan and in Kenya and Uganda have managed research activities, demonstrating their leadership. This is an opportunity to reimagine the roles of international and local research staff in self-care research (as long as no staff are compromising their own safety and health for the research).

Investment

🚧 Barriers

to investment in self-care for SRH in humanitarian and fragile settings

- *Financing* for self-care in stable settings might come from the private sector and/or health insurance systems which are more likely to be unavailable in humanitarian or fragile settings where often communities rely on free facility-based health services. If the costs fall to users, that can increase inequity of programs leaving those unable to afford care, unable to access care.

- *Some humanitarian donors are restricted in their ability to fund certain enabling factors to self-care*, e.g., policy development or type of product, leaving them restricted overall or restricted to funding one piece of self-care.

- *Resources are difficult to mobilize when self-care is inherently difficult to measure.* Without data on impact, (as outlined above) it is hard to mobilize resources and support among donors, since they cannot monitor their financial support in the same way as other types of healthcare.

- *Donor preferences:*

  - > Donors are sometimes drawn to a particular type of self-care product instead of a package of different self-care products and interventions. This can lead to siloed funding and interventions that focus less on health-system strengthening or care across SRH.

  - > Donors can be hesitant to fund interventions in humanitarian or fragile contexts, concerned that it is difficult to implement effectively in precarious settings.

  - > Donors tend to fund short term projects without much flexibility, rendering interventions siloed from health systems, unable to be adequately contextualized and community-informed, and unable to meaningfully strive for improved outcomes or sustainability. Without longer-term funding, there are limited learnings generated to build on for improved self-care interventions and efforts.

💡 Opportunities

for investment in self-care for SRH in humanitarian and fragile settings

- *Donors can coordinate their support* through the SRH in crisis donor group both to allow for more funds for more comprehensive self-care packages, as well as offering advice or support to one another and coordinating programs or strategies.

- *Donors are increasingly recognizing that humanitarian and fragile settings – or the potential for them - exists within all countries*, a critical learning from the COVID-19 pandemic. This allows for more openness among donors to fund across the humanitarian-development-peace nexus, and/or more urgency and acceptance of the need to fund in humanitarian and fragile settings.

- *Increasing interest among donors in priorities that align with self-care*

  > Donors should see self-care aligning with their existing priorities

    − Self-care is a part of healthcare that bolsters the ability of the healthcare system and communities to withstand shocks and be more resilient

    − Self-care is simultaneously working on health system strengthening, emergency preparedness, response and recovery

  > Self-care, when implemented well, advances localization and partnerships among governments, international and national organizations for self-care

  > Donors desire bottom-up, community-informed approaches to self-care based on engagement with users and user-centered design that are foundational to self-care

Lessons learned

- *Donors from politically conservative countries that fund humanitarian and fragile programs can learn from their colleagues (from the same country) working/funding self-care in stable settings.* In particular, they can glean insights into how best to frame and approach funding self-care within a conservative and a funding restrictive government.

- *Flexible and longer-term funding benefits communities and programs* given the high potential for changes or shifts due to insecurity and shocks within humanitarian

and fragile contexts. It also provides a longer runway for communities to change preferences and mindsets, as seen in South Sudan where during formative research women believed they would be comfortable storing injectables in their home, yet once a new pilot program began they reported discomfort in doing so.

- *Self-care benefits communities when sustainability is considered.* In DRC, the IRC had worked to hand over the self-care SAC program to local health departments however funding was unavailable to continue once IRC's program finished, impacting the longevity of the program and its beneficial outcomes. The number of users who purchased abortion medication pills sharply dropped when program's community engagement activities ceased, possibly also influenced by the Ebola outbreak being publicly declared over.

- *Interventions can integrate different donors* who fund specific types of self-care to offer a full package of self-care for SRH to communities.

Discussion

The barriers, opportunities and lessons identified from the key informant interviews and throughout the technical consultation at ICFP 2022 offer insights that can help advance self-care for SRH in humanitarian and fragile settings.

Humanitarian, fragile and stable settings face similar barriers for advancing self-care. There is a broad misperception that self-care programming in humanitarian and fragile settings is significantly different than in stable settings. However, while there are more magnified gaps in care in humanitarian settings, they share more in common with stable settings than originally assumed. Some of the magnified gaps include:

- Hesitancy among health providers, governments and donors in supporting self-care

- Restrictive or lack of enabling policies

- Difficulty ensuring privacy for the user

- Difficulty in financing without a robust healthcare system

- Public-private partnerships or health insurance options

- Siloed programming that is disconnected from health systems and fails to integrate certain SRH health needs related to GBV, HIV/ sexuality transmitted infections (STI) and maternal and newborn health (MNH)

- Difficulties in identifying indicators, following up with users and measuring impact

- Ongoing debates within the self-care community regarding definitions of self-care

- Barriers to implementing safe and inclusive programs

- Barriers in reaching hidden or remote populations

- Uncertainty of how best to engage the private sector

- Challenges with supply chains

Across contexts, barriers are produced by the way self-care efforts have been designed and implemented. Top-down, donor-driven, short term, single product focused, and unsustainable funding weakens the ability for effective self-care interventions. The impact of these barriers is exacerbated in humanitarian and fragile settings.

Humanitarian settings offer particular opportunities for self-care. The barriers in humanitarian settings and development settings might be the same, but the opportunities in humanitarian settings might be more substantial. Opportunities include leveraging:

- Current national self-care guidelines in countries with fragile states or hosting displaced communities

- Supportive health workers faced with constrained realities who may readily see the value of self-care in task sharing and increasing access

- Existing community self-care practices and national self-care movements that exist to fill the specific gaps in care for mobile populations

- Existing prioritization of inclusion and GBV prevention and response in the MISP and SRH in humanitarian or fragile settings

- The potential for users to have high self-efficacy simply due to their existing circumstances and experience navigating disrupted systems and states

- The availability of free health services

- The expansive role and potential for digital technologies, including low-tech, already functioning in humanitarian settings

- The leadership of national and subnational health officials, civil society and researchers

- Widespread interest from organizations and agencies in creating operational research of SRH self-care in humanitarian and fragile settings; any learnings from measuring NCD or iCCM in humanitarian and fragile settings

- Growing interest among donors

- The possibility that robust self-care measurement may not be prioritized due to competing priorities in more acute emergencies

- Available evidence that quality is possible regardless of context, and users identify their own strategies to manage their self-care

- The recent formulation and momentum of the IAWG Self-Care Task Team and increasing collaboration with national and global self-care advocates

Decision-makers need to embrace new ways of working for self-care in humanitarian settings to be relevant, effective, acceptable and accessible.

- *Self-care programs need to be context-specific and user-centered.* They must be co-designed with users, implemented and researched in a process that is grounded in the users' perspectives, context, safety, priorities, and lived realities.

- *Users must be trusted and empowered.* Across all types of initiatives, from policies to programs to research, it must be reinforced that users should be trusted to manage their self-care and can be equipped to do so through access to quality information, training and empathetic support to bolster self-efficacy.

- *Re-centering management and funding towards users.* Self-care inherently offers more anonymity and privacy to users. However, these strategies require many decision-makers to acknowledge inherent biases towards SRH and relinquish some aspects of control as it relates to trust in clients, program scrutiny, and data similar to the respect shown towards other self-care programs such as nutrition and diabetes. This also requires a shift in funding from top down and donor-driven programs to supporting user-centered, context specific programs that build on existing self-care practices, partner with and embolden local organizations, bolster national health systems, and are flexible, long-term and approach SRH self-care as a package.

- *Ensuring equity and impact.* Attention must be given to inclusivity by promoting equity when designing, implementing and researching self-care programs.

- *Thinking beyond numbers.* Quality can be achieved even if traditional methods of measurement at every stage are not possible. As one international organization representative said, "control doesn't necessarily equate good outcomes and self-care is about [being] patient-centered, being respectful, seeing the community you're working with in solidarity".

There are risks to the success of self-care programs if new strategies and approaches are not embraced. Implementing organizations, governments and donors risk obstructing successful self-care interventions if investment does not allow for:

- Sufficient user-centered design periods which ensure program designs respond to specific needs and lived experiences

- Working in partnership with national and subnational governments, organizations and health systems

- Prioritizing health literacy and self-efficacy of diverse communities through empathy and inclusive strategies

- Enabling flexible and long-term funding with an eye towards sustainability, supporting self-care across the SRH lifespan, and functioning as a service delivery model alongside facility-based care and community-based care

Self-care - as a package of different types of self-care interventions - is increasingly important and complicated. There is increasing acceptance that self-care interventions should be comprehensive across the SRH life-cycle, and yet current interventions are frequently fractured from health systems and implemented for one type of self-care intervention.

■ This often reflects funding opportunities for one type of self-care despite advocates finding it easier to argue for comprehensive care. On top of this, different types of self-care stem from vastly different types of community needs and operate in alignment with - or regardless of - policy context. For example, SAC self-care was borne out of the objective to make an existing practice safer, much like offering misoprostol to prevent PPH in out-of-facility births. SAC is considerably more politically sensitive than other types of self-care, and yet offers critical learnings to the self-care movement because it has had a longer lifespan, despite remaining significantly underfunded and deprioritized within the wider self-care movement.

■ Although there is a recognition that self-care should fall across the SRH lifespan, most attention is given to SAC and self-injections and more attention and coordination is needed with MNH, HIV/STIs and GBV. There has been considerable work on HIV self-testing however often these programs operate siloed from larger SRH programs.

■ Advancing an SRH package will benefit from an incremental process that does not compromise individual interventions or overall health systems and can build on learning from studies on health service integration.[xxiii]

Conclusion

Although self-care is not new, discussions on self-care for SRH in humanitarian and fragile settings are new. This assessment has surfaced some ongoing debates and outstanding questions within the self-care global and humanitarian and fragile settings community that may benefit from joint reflection, collaboration and consensus-building (Table 1).

There are considerable opportunities for self-care for SRH in humanitarian and fragile settings unique to each context. More than half the world's countries are at medium, high or very high risk of crisis.[7] Many stable countries also host crisis-affected or fragile populations and/or sub-regions reinforcing the importance of working across the humanitarian-development-peace nexus. As national self-care guidance and policies continue to be developed, mutually reinforcing and collaborative self-care movements across the nexus will be advantageous for everyone. Self-care offers a promising strategy to overcome challenges when health systems are disrupted, ensuring communities can address SRH needs across their lifespan.

Table 1	Outstanding Questions for Joint Reflection, Collaboration and Consensus Building
Overall	■ How can we better ensure self-care interventions are context specific and user-informed? ■ What implications does this have for advocacy, design, implementation, research and investment?
Advocacy/Policy	■ How can self-care advocacy strategies be more effectively integrated across the nexus? ■ Is there a need for humanitarian/fragile context specific self-care policies and guidelines? ■ Would context specific guidelines enable or hinder progress in humanitarian/fragile settings? ■ How is self-care best defined and managed in relation to existing community-based distribution methods and telehealth?
Implementation	■ Is there such a thing as "good-enough" quality when emergencies often require pivots due to insecurity or access issues and may include a need for remote trainings/supportive supervision for CHWs or local pharmacies to administer quality support for self-care? ■ Should a specific quality of care framework for self-care in humanitarian and fragile settings be developed? ■ What are a minimum set of self-care interventions in emergencies and how can they link to the MISP?
Measurement and research	■ Are traditional methods of measurement necessary in all contexts, or does this desire to measure, particularly impact, stem from a need for control? ■ Are these different expectations, and if so, why, when comparing the expectations of measurement that exist for iCCM and NCD self-care? ■ Is the recent call for new self-care measurement frameworks and innovative models for SRH self-care data collection perpetuating a lack of trust of users?
Investment	■ How might donors become more comfortable with funding more flexible, long-term, context and user-informed self-care programs and research?

Endnotes

[1] The technical consultation had up to 60 participants and included presentations and breakout groups.

[2] Out of concern that "where self-care is not a positive choice but is prompted by fear or lack of alternatives, it can increase vulnerabilities." (WHO Guideline, 2022, p. xvi).

[3] Task shifting refers to the allowance of specific heath cadres who do not normally have competencies for specific tasks to deliver them and thereby increasing levels of medical care access.

[4] "Provision of tailored and timely support for self-care interventions, including for SRHR, in humanitarian settings should be in accordance with international guidance, form part of emergency preparedness plans and be provided as part of ongoing responses." (p. xx)

[6] This included "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" (p. xxiv)

[7] The INFORM risk index has three dimensions: natural and human-made hazards and exposure; socio-economic and other vulnerability; and lack of institutional and infrastructural coping capacity. See: INFORM Risk Facts and Figures. 2023. https://drmkc.jrc.ec.europa.eu/inform-index/INFORM-Risk/Risk-Facts-Figures.

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