

WHO meeting on Ethical, legal, human rights and social accountability implications of self-care interventions for sexual and reproductive health

12–14 March 2018, Brocher Foundation, Hermance, Switzerland

Summary report



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Acronyms and abbreviations

CIFF	Children's Investment Fund Foundation
CSO	civil society organization
HPV	human papillomavirus
HRP	UNDP-UNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction
mHealth	mobile health, use of mobile devices for health
SDG	Sustainable Development Goal
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infection
UHC	universal health coverage
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WHO	World Health Organization

1 Background

In 2015, the world agreed to a bold set of Sustainable Development Goals (SDGs) (1). The foundation of WHO's work is SDG 3: Ensuring healthy lives and promoting well-being for all at all ages. In its 13th General Programme of Work, 2019–2023 (2), WHO pledged to monitor the world's progress and the WHO Secretariat's own contribution towards health for all in the SDGs with three ambitious SDG-based "triple billion" goals as shown in Box 1.

Historically, health-care providers delivered health care within primary, secondary or tertiary facilities. A well functioning health system that is staffed with trained and motivated health workers, supported by a well maintained infrastructure and a reliable supply of medicines and technologies, backed by adequate funding, strong health plans and evidence-based policies, is a reality in very few countries. In addition, the estimated shortage of 12.9 million health workers which is anticipated by 2035, the expected reduction in international funding for health, and the estimated 1 in 5 of the world's population now affected by humanitarian crises, points to the urgent need to find innovative strategies that go beyond a conventional health sector response.

Among the most promising and exciting new approaches are self-care interventions. When accessible and affordable, these interventions have the potential to increase choice, as well as opportunities for individuals to make informed decisions regarding their health and health care. Approaches that facilitate user autonomy and peer support have the potential to advance health through

strategies that promote participation of individuals in their own health care. Such approaches recognize the strengths of individuals as active agents in their own health care, and not merely passive recipients of health services.

Supporting self-care interventions also has the potential to: strengthen national institutions to maximize efficient use of domestic resources for health; create health sector innovations, including by catalysing digital and mHealth approaches (mobile health; use of mobile devices for health); and improve access to medicines and interventions through optimal interfacing between health systems and sites of health-care delivery.

1.1 What do we mean by self-care interventions for sexual and reproductive health and rights (SRHR)?

i. SRHR

The comprehensive approach to SRHR endorsed by WHO Member States in the 2004 Global Reproductive Health Strategy covers five key areas – maternal and perinatal health; family planning, infertility; abortion; sexually transmitted infections (STIs), including HIV; reproductive system cancers, gynaecological morbidities; and sexual health – as well as several cross-cutting areas such as gender-based violence (3).

Within the framework of WHO's definition of health, as a state of complete physical, mental and social well-being, and not merely the absence of disease

Box 1: WHO's "triple billion" goals

WHO's Strategic Priorities (and goals)

Ensuring healthy lives and promoting well-being for all at all ages, by:

- Advancing universal health coverage (UHC) – 1 billion more people benefitting from UHC
- Addressing health emergencies – 1 billion more people better protected from health emergencies
- Promoting healthier populations – 1 billion more people enjoying better health and well-being

or infirmity, sexual and reproductive health (SRH) addresses sexuality and sexual relationships as well as the reproductive processes, functions and system at all stages of life. Ensuring the full implementation of human-rights-based laws and policies through SRH programmes is fundamental to health and rights. Implicit in this are a wide range of human rights relating to SRH including: the rights of men and women to have pleasurable and safe sexual experiences, free of coercion, discrimination and violence; the right to be informed of and have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice; and the right of access to appropriate health services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.¹

ii. Self-care

WHO defines self-care as “the ability of individuals, families and communities to promote health, prevent disease, maintain health, and to cope with illness and disability with or without the support of a health-care provider” (5). The scope of self-care as described in this definition includes: health promotion; disease prevention and control; self-medication; providing care to dependent persons; seeking hospital/specialist care if necessary; and rehabilitation, including palliative care (6). Inherent in the concept is the recognition that whatever factors and processes may determine behaviour, and whether or not self-care is effective and interfaces appropriately with professional care, it is the individual person who acts (or does not act) to preserve health or respond to symptoms.

iii. Examples of self-care for SRHR

The definitions outlined above provide a useful foundation that could be adapted for the development of normative guidance around self-care interventions for SRHR:

- health promotion activities (e.g. voluntary family planning; self-testing for HIV, other STIs or pregnancy; or seeking advice and information through mHealth);
- disease prevention and control activities (e.g. practising safe sex when condoms are consistently and correctly used to prevent unintended pregnancy and STIs, including HIV); and

- self-treatment and medication (e.g. contraception; self-management of abortion by taking oral misoprostol; or self-administered antibiotics made available without prescription through pharmacies to treat STIs).

Alongside these examples of services, supportive approaches to ensuring equity and quality of self-care are critical, including consideration of the following examples:

- providing care to dependents, such as taking care of differently abled people and infants or young children who are not able to access or use the intervention themselves (e.g. providing self-injection of depot medroxyprogesterone acetate [DMPA] to adult women with disabilities);
- seeking medical assistance, such as going to a health centre (e.g. to seek professional advice, counselling and treatment if the result of a self-sampling for human papillomavirus [HPV] is positive; or for confirmatory testing after HIV-positive self-test results); and
- rehabilitation (e.g. helping elderly people regain or maintain their intrinsic physical and mental abilities).

iv. WHO's interest in self-care for SRHR

WHO periodically and systematically reviews evidence on clinical and service-delivery interventions to produce normative guidance for countries. The WHO Department of Reproductive Health and Research recognizes the importance of self-care within health systems, and the rapid advances being made in relation to self-care interventions including services, behaviours and information that can be initiated by individuals. This area is also an exciting and innovative approach that can help to accelerate attainment of universal health coverage (UHC; SDG Target 3.8) and all other SDGs.

Furthermore, as with the SDGs, self-care interventions are integrated, interdependent, complex and reach beyond SRH. An example of an SRHR intervention that extends to another health sector can be seen in use of antibiotics for STIs; when an antibiotic is not appropriately prescribed or is taken incorrectly this could increase the risk of antimicrobial resistance (AMR) in the individual and in the wider community.

1 For a more complete list of relevant rights, see the following pages on the WHO website: “Defining sexual health” (http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/); “Reproductive health” (http://www.who.int/topics/reproductive_health/en/). See also the 2015 WHO publication, *Sexual health, human rights and the law* (4).

The WHO Constitution states that: “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition” (7). In order to ensure that WHO normative guidelines support the realization of the right to health of all, it is fundamental to their development that equity, human rights, gender and the social determinants of health are taken into consideration. In the case of self-care interventions, it is therefore essential to place particular emphasis on the needs of populations who may neither be aware of their right to health nor able to access the services they need. These include vulnerable, marginalized and socioeconomically underprivileged populations who have the poorest health outcomes globally.

1.2 What do we mean by vulnerability and who are vulnerable populations?

Vulnerability depends on the context, and can be experienced across diverse populations including, but not limited to, individuals who: are lesbian, gay, bisexual, transgender or intersex; use or have used drugs; are or have been involved in sex work; are single, married, in stable relationships, separated, divorced or widowed; are and are not sexually active; have undergone female genital mutilation (FGM); are living with HIV, tuberculosis (TB), malaria, hepatitis B or C, and/or other infections; are currently or have previously been incarcerated, detained or homeless; are economic or political migrants; are indigenous; are living with disabilities, including learning disabilities; are from minority ethnic groups; are elderly with reduced intrinsic capacity and/or are adolescents.

All individuals are susceptible to injury, harm and dependency over the life-course and the inevitability of vulnerability means that there is no absolute position of invulnerability; only the opportunity for resilience along with the provision of appropriate support and care. Creating an enabling environment that promotes self-efficacy and resilience should therefore be an important goal of health systems.

Self-care interventions will not in themselves empower individuals. However, by ensuring safety, quality, acceptability and informed decision-making in the provision, access and use of these interventions

and technologies, it will be possible to create the social change needed to reduce vulnerabilities. For instance, when medical abortion (abortion pills) first became available, many from the women’s health movement believed that this would be an empowering tool for women, who could now access safe and low-cost abortion as an outpatient at a local health clinic without having to necessarily inform their partners unless they chose to. This was expected to help women in abusive situations to have access to safe abortion services. At that time, non-consensual sex was an important reason why many women sought abortions, and two studies carried out 10 years apart in the same setting showed that the reasons for seeking abortion had not changed, but there had been improvement in the availability of safe abortion services because of the availability of medical abortion. In another example, an acceptability study of female condom use among women sex workers in Zimbabwe demonstrated that it was not the women’s ability to negotiate condom use with their clients that had improved, but rather that it was acceptable because their male clients preferred it.

1.3 Objectives of the meeting

The WHO Department of Reproductive Health and Research convened an expert consultation to discuss, debate and synthesize emerging evidence on ethical, human rights, legal and social accountability considerations related to self-care interventions for SRHR. The Department serves as the Secretariat for the UNDP-UNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP).² Following the recommendation by HRP’s Gender and Rights Advisory Panel (GAP) and Scientific and Technical Advisory Group (STAG), this meeting focused on exploring how self-care interventions might improve agency and autonomy among vulnerable populations, as well as factors that may inadvertently add to an individual’s burden or imply the abdication of responsibility from the health sector to provide high-quality services.

The meeting summary provided in the remainder of the report captures some of the key points from the main areas of discussion during the two-and-a-half-day meeting. The meeting agenda is provided as Annex B.

² More information is available at the “About HRP” webpage at WHO’s Department of Reproductive Health and Research/HRP website: <http://www.who.int/reproductivehealth/hrp/en/>

2 Terminology and typology

2.1 Background

The WHO Department of Reproductive Health and Research is also leading the development of normative guidance on digital health and digital transformation of health. A classification of digital health interventions (DHIs) has been developed which categorizes the different ways in which digital and mobile technologies are being used to support health system needs, including those in reproductive health (8). Targeted primarily at public health audiences, this classification framework aims to promote an accessible and bridging language between technologists and health professionals, to facilitate discussions and ways of articulating needs, as well as to describe the functionalities in digital health systems.

Self-care interventions are both a continuation of existing movements and a significant push towards new and greater self-efficacy and engagement in health. Take-away points from the digital health arena included a focus on standardized terminology, qualities and approaches that digital health enables, as opposed to specific interventions, and attention to change management regarding promoting self-care interventions within organizations.

The term “self-care” and related concepts such as self-awareness, self-testing, self-screening, self-diagnosis, self-management, self-monitoring, self-medication, self-injection, self-treatment and self-efficacy, are not new in the field of health. In SRH, self-management of medical abortion is an intervention that can take place without direct supervision of a health-care provider; in this situation, the woman herself can be considered a health-care provider. “Provider-initiated” and “client-initiated” are not new terms either. In HIV, WHO guidelines on provider-initiated testing and counselling (PITC) describe an approach whereby health-care providers can specifically recommend an HIV test as an intervention to patients attending health-care facilities.

Developing a common understanding of terminology and typology will therefore be an important first step towards developing a conceptual framework for self-care interventions for health, including SRHR.

2.2 Who is the “self”?

The “users” of interventions are individual people, located within families, couples and communities, but they also include caregivers for dependent persons. With reference to dependent persons, there are existing contexts of unequal power, and WHO guidelines need to recognize that in some contexts there is the potential for coercion or harm. Individuals have both rights and responsibilities, such that users of an intervention accept an element of responsibility with regard to the decision they have made. Individuals might choose self-care interventions for positive reasons, which may include convenience, cost, empowerment, a better fit with values or daily lifestyles, or the intervention may provide the desired options and choice. However, individuals might also opt for self-care interventions to avoid the health system due to lack of quality (e.g. stigma from providers) or lack of access (e.g. in humanitarian settings). Self-care interventions fulfil a particularly important role in these situations, as the alternative might be that people don't access health services at all.

A supportive and safe enabling environment for the introduction of self-care interventions is essential. These interventions should be implemented in the context of:

- a supportive legal and policy environment, and access to justice;
- a strong, accountable, person-centred health system;
- integrated and accessible services of good quality;
- protection from violence and coercion;
- social inclusion and acceptance (non-discrimination, social support, etc.); and
- access to knowledge and information, appropriately tailored to different needs.

There are also implementation considerations, such as training needs for providers (both pre- and post-service) and sustainability, and these implementation considerations will vary across settings and contexts.

2.3 Where do users access self-care?

Increasingly, people are accessing information, products and interventions outside of traditional health-care facilities. Much of health care is done at home, and products and information are increasingly accessed through stores, pharmacies or the internet. There is a need to identify and map places where health-care interventions are accessed and used to better understand the patterns of and reasons for use of self-care interventions. In addition, some interventions have been on the market for several years, including pregnancy tests, condoms or lubricants, even though they are not always accessible in all contexts where they are needed. In each instance, the role of the health professionals, lay providers or social workers, and the risk of increased vulnerabilities for some populations, need to be considered in the context of power dynamics between the individual and the health system or health-care providers.

The focus of the guidelines on self-care interventions will be mainly around new interventions that can be considered to be in transition – i.e. those interventions for which there is current debate about whether they should be provided by health-care providers or individuals themselves, and for which the health sector needs to determine an appropriate role to support individuals' SRHR. However, it is anticipated that this will be a consolidated guideline that will also include existing WHO guidance relating to other interventions such as male and female condoms.

What is considered a self-care intervention may therefore change over time, and the risks and benefits of interventions, or the role of the health system (appropriate support) may also change. Many of these interventions may also complement, supplement or substitute for facility-based, health-care provider-delivered interventions.

Importantly, self-care interventions are still part of the health system and considerations for the development of normative guidance might include points of interaction or linkages with the health system for



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accessing information, the intervention itself, or linkages to care. The self-care interventions should not be stand-alone products or cause further health system fragmentation, but should rather be linked to the health system and supported by it. This would ensure that the health system remains accountable and can determine how to appropriately interact with and support implementation of self-care interventions. This is important given that many of these interventions are in various stages of development and availability, and will require varying degrees and frequency of contact with different levels of the health system.

2.4 Conceptualization of self-care interventions for SRHR

Not all self-care interventions are situated in the same space between users and health-care providers. Health-care interventions range from being the full responsibility of the individual (user) to being the full responsibility of the health-care provider, or somewhere in between; and this can also change over time. There are interventions that users can have good knowledge of and feel comfortable using independently from the outset, while other interventions need to be provided with more guidance and support before they can be accepted and independently utilized (see Figure 1).

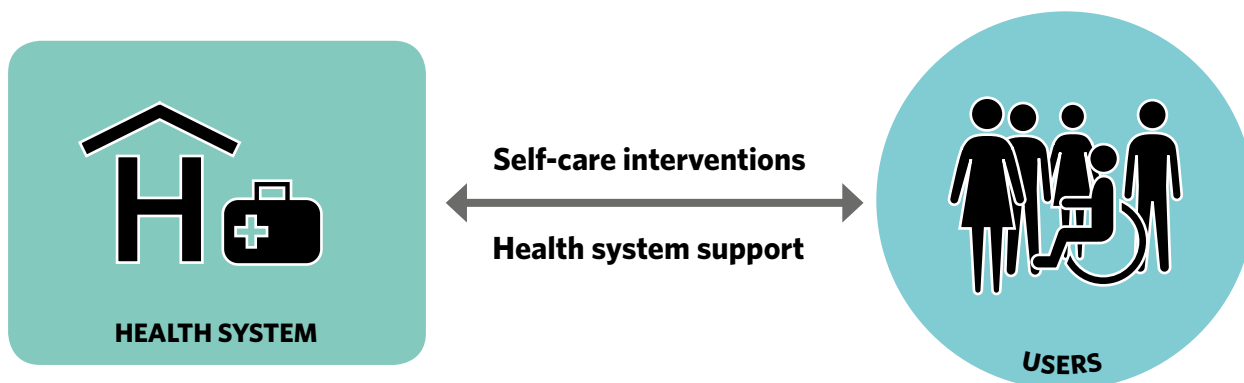
Self-care interventions for health care are applicable much more broadly than just for SRHR; different self-care interventions can be used to manage

noncommunicable diseases (NCDs), infectious diseases, mental health conditions and beyond. A holistic approach to health includes approaches that go beyond access or uptake of biomedical interventions, such as self-tests. In the context of holistic health care, the terms “self-care” and “self-initiated care” encompass an overarching and innovative approach to health systems.

Building upon the current WHO definition of self-care noted previously (see section 1.1), the scope of self-care for health in the context of normative guideline development could be further divided into three categories:

1. self-awareness for health promotion;
2. self-testing, self-screening and self-diagnosis for disease prevention; and
3. self-management, self-medication, self-treatment and self-care for improving health outcomes.

Figure 1: Self-care interventions are often on the continuum between the health system and the user – appropriate support is always required



3 Frameworks to better understand accountability of the health sector and user autonomy

Human rights, legal, ethical and social accountability frameworks can all be used to better understand the responsibilities of the health sector, other sectors within government, the private sector and individuals themselves with regard to access to, uptake and use of SRH interventions.

3.1 Human rights and legal framework

Serious health and human rights consequences arise where people are unable to access SRHR interventions in the full range of service contexts including health-care facilities. To ensure human rights are promoted and protected in the context of self-care interventions for SRHR, users must have information, autonomy and the ability to make decisions about their own lives and health. While this is true for all potential users of self-care interventions, it is particularly relevant for vulnerable groups who may face discrimination and violence in their efforts to secure their health and exercise their rights.

The provision of information and supportive systems around any new technology or product needs to be based upon the principles of: availability, accessibility, acceptability and quality (3AQ). For the user (the rights holder), the ability to utilize self-care interventions that are available, accessible, acceptable and of good quality is a core component of promoting and protecting their right to health. From the perspective of the duty-bearer, ensuring availability, accessibility, acceptability and good quality information, goods and services should form the *raison d'être* of relevant laws, policies and regulations. It is critical to balance the importance of quality and safety against the challenge of not restricting access. In addition, attention is required to: promoting participation of users, non-discrimination, informed decision-making, privacy and confidentiality, and accountability. When human rights considerations are addressed, users' exercise of their rights to health, to information and to autonomous decision-making can significantly improve.

3.2 Ethical framework

An ethical framework emphasizes well-being and not just the absence of disease. The theory of social justice in public health and health policy is the moral foundation of public health and health policy, and therefore social justice is also an integral part of their purpose and obligation. A just system of public health will reduce and ultimately eliminate inequalities in the social basis of well-being, which is defined by sufficiency in the six dimensions of well-being: health, personal security, reasoning, respect, attachment, and self-determination. These dimensions are all relevant to user autonomy in SRH. An ethical framework can help us to better understand how user autonomy could promote or challenge one or more dimensions of well-being. For example, a displaced woman living in a settlement and wanting to access contraception may not be able to afford it or to use it due to her marital relationship dynamics. In another example, a transgender woman in a relationship with a man living with HIV may feel pressured to start pre-exposure prophylaxis for HIV prevention (PrEP), and at the same time may not have appropriate support for her gender transition. These examples show the relevance and usefulness of an ethical framework for holding the health sector accountable for individual and community-level SRH outcomes.

3.3 Social accountability framework

Social accountability is an approach to governance that involves citizens and civil society organizations (CSOs) in the process of assuring accountability. Across definitions, social accountability has three core components that interrelate and interact: information, citizen and collective action, and official response.

As self-care interventions can be seen to disrupt traditional user-provider relationships, social accountability can help broker trust, collaboration, communication and points of engagement. It is

a framework that also allows for parallels and complementarities to improve capacity to deliver services and mobilize for rights-based SRH interventions. It can also provide solutions for the inclusion of vulnerable groups who may feel they are not part of the community or that they cannot participate in citizen-focused redress mechanisms.

Self-care interventions require accountability across several fronts of the health system for their full ethical and appropriate provision. In Uganda, for instance, the availability of misoprostol was blamed for increasing abortion rates, though it is primarily indicated for postpartum haemorrhage. The drug regulatory agency response was to regulate misoprostol procurement as a prescription-only medicine. There is a tendency for blame-shifting in overstretched and weak health systems, and also corruption, such as from unscrupulous sellers of information and technology.

3.4 Opportunities for harnessing agency to improve SRH outcomes, in particular for vulnerable populations

Accountability of the health sector remains a key factor in the provision of self-care interventions. From a human rights perspective, accountability refers to the relationship 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. Agency is at the core of health care, and self-care interventions have the possibility to build agency at the individual and community levels and to promote people's agency to use health systems.



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4

Life-course approach to sexual and reproductive health and rights (SRHR)

Socioeconomic conditions throughout people's lives shape health outcomes, disease risk, health-seeking behaviour and needs, as well as the use and uptake of self-care interventions. A life-course approach stresses the value and importance of all ages and stages of life and acknowledges the intergenerational context within which individuals exist. Individuals can access some self-care interventions during distinct periods of their lives or throughout their lives, depending on their needs. Different populations have specific needs in terms of their ability to exercise their rights, access care and meet their needs. Healthy persons often maintain their health and well-being at home, and engage or re-engage with the health system at discrete stages of their lives. For example, women often access health services during pregnancy or for reproductive health matters.

As each stage in a person's life exerts influence on the next stage, self-care interventions during the neonatal period, early and late childhood and adolescence, youth and adulthood, and older age are all important. Trauma, violence or mental health difficulties experienced early in life may affect risk behaviours and decision-making regarding SRH later in life. A focus on vulnerabilities as being characteristics that anybody may experience under different circumstances or at different stages of their lives, rather than on vulnerable populations, is important for understanding how circumstances and needs change throughout the life of an individual. Key considerations include the importance of consent, autonomy, independence and privacy for different groups, as well as the impact of restrictive legal and policy environments, and poor quality, stigmatizing or absent health services, and the need for tailored, supportive information and services to overcome these challenges. Self-care interventions can improve quality of life, but they are also affected by the nature of the enabling environment in which they are delivered.

One important area is the training provided to health-care workers so that they can enable and

support clients to use self-care interventions. Providing training of health professionals from the start of their career could have the most long-term impact. Young professionals in the medical, pharmacy, nursing, public health and other allied health professional schools can be taught about self-care interventions and accountability of the health sector and health-care providers, including through building competencies in support of human rights, gender equality and ethics. Good training in SRHR in the future health workforce may help with long-standing issues of discrimination, coercion and violence as well as substandard care faced by many vulnerable populations. In the education and training of health professionals, a life-course approach offers the potential to enhance the integration of teaching and intersectoral collaboration, and to prepare students globally, for carrying out their responsibilities in the 21st century.

4.1 Adolescents and young people

Adolescents – young people between the ages of 10 and 19 years – are often thought of as a healthy group, but over 1.2 million adolescents die every year from largely preventable causes. SRHR issues particularly affect adolescent girls and young women. In addition, many practices that impact health later in life, such as sexual practices that elevate the risk of HIV and STI exposure, begin in adolescence and therefore comprehensive sexuality education (CSE), quality services, information and support are needed throughout these formative adolescent years for boys and girls.

Many adolescents and youths now have access to digital technologies and use them to access information on a range of health conditions, symptoms and treatments. Guidance around self-care interventions for this age group is therefore an important measure to promote access to accurate information and to reduce mortality and morbidity.

4.2 Women of reproductive age

Women engage with the health sector for various SRH conditions, including, but not limited to, menstruation, contraception, infertility, pregnancy (including termination of unintended pregnancy) and childbirth. Women's right to manage their own health has been highlighted across several WHO guidelines. Self-management approaches that don't require the direct supervision of a health-care provider are noted as a positive option, when information and quality commodities are available and accessible. Women may also engage with the health sector for management of STIs, such as syphilis, HIV and HPV, and self-testing options may improve their autonomy, choice and support their right to make informed decisions regarding their own bodies.

The promotion of gender equality is central to the achievement of SRHR for all women. This means recognizing and taking into account how unequal power in women's intimate relationships, harmful gender norms and women's lack of access to and control over resources affect their access to and experiences with health services. Gender inequality can constrain access to self-care interventions for certain groups of women, make access particularly valuable for some, and necessitate particular protections for others. For women and girls who have various social, physical and economic vulnerabilities and who experience discrimination, use of self-care products can be challenging. Adult women with learning disabilities face long-standing challenges from the legacy of eugenics, assumed incompetence and assumed asexuality. Barrier methods for contraception are often not recommended for people with intellectual disabilities precisely because they are user-controlled. Within the provision of rehabilitation, including adaptations of the physical environment, it is important that people who are or become disabled have access to the range of self-care interventions available. In the implementation of any self-care intervention, supporting women who have learning disabilities can improve their quality of life.

4.3 Older people

WHO has a strategy and guidance supporting resilience and adaptation and aimed at attaining the highest level of well-being achievable for older populations. This includes addressing changing

SRHR needs over time and across the diversity of experiences. Sexual health in particular extends beyond 49 years when many of the Demographic and Health Surveys (DHS) stop monitoring health indicators. Reproductive health considerations are also relevant, even in postmenopausal women, as older people look to surrogacy, adoption or assisted reproductive technology to have a family.

Sexual health promotion also includes physical changes (age-related thinning and dryness of vaginal tissues, sexual function), and in many regions there is a vibrant market catering to demands for sexual enhancement, including a number of virility products that are not evidence-based and could cause harm.

Health-care providers do not often have the training to provide support, counselling or care to older people on sexual health. There is an assumption of asexuality and low STI and HIV risk among older populations, although evidence shows that STIs and HIV remain high in this group. As adult populations age, they engage more with the health system. Self-care interventions could bridge the gap between self-care and health systems when older clients seek sexual health advice and this could potentially result in positive health outcomes.

Finally, ageing populations have particular challenges affecting their ability to exercise rights, access care and meet their SRH needs. For example, many older people have decreased independence and privacy (e.g. living with their families or with caregivers). Most have left or are leaving the workforce and have decreased access to health care, due to financial constraints or limited access to insurance coverage. Fundamental declines in cognition and shifting information and decision-making needs also characterize this population. These factors need to be considered when developing guidance around self-care interventions to promote health and well-being in older populations.

4.4 Humanitarian settings

The intersectoral nature of SRHR is all the more important in humanitarian and emergency settings. Personnel from sectors such as protection, health, nutrition, education and community services all have important roles in planning and delivering SRH services. In 2015, the United Nations High

Commissioner for Refugees (UNHCR) estimated that the global forcibly displaced population exceeded 65 million for the first time in history. This included over 21 million refugees, 40 million internally displaced persons and more than 3 million asylum seekers. Of those needing humanitarian assistance, approximately 1 in 4 are women and girls of reproductive age. The diversity in populations (refugees, asylum seekers, internally displaced persons), settings (from refugee camps to urban areas) and circumstances (conflict, post-conflict, natural disasters), and varying access to rights (for citizens compared to non-citizens), all add to the complexity of providing quality health care in challenging circumstances.

Events such as armed conflicts, natural disasters, epidemics and famine result in the coping capacity of affected communities being overwhelmed, with the in-country infrastructure disrupted and external assistance required. A minimum initial service package (MISP) for reproductive health in crisis situations exists to support health systems, but this includes neither comprehensive SRHR services nor some of the self-care interventions currently available. However, crises may also exacerbate issues, such as the examples of sexual assault by health-care workers, further impeding the access, uptake and use of a health clinic; such problems may push individuals to use self-care without the support of the health sector.

In crisis situations and among displaced populations, there is a distinct cascade of declining availability, access and use of health services and interventions. Often, these services or interventions are not available or their quality declines, and the affected populations have worse access, use and uptake than other populations. Health systems strengthening during emergencies remains essential to support and facilitate access to self-care interventions for SRHR.

Communities also respond on their own to crises, developing informal yet strong social support systems and an enabling environment. All these entry points to supporting individuals and communities are required to improve health outcomes.

Given the ever-increasing health emergencies in crisis situations and the lack of an evidence base on the use and uptake of self-care interventions in these settings, further research in this area is a priority.

4.5 Changing needs and challenges across the life course

A life-course approach to health places people's current health status in the context of their life-long sociocultural, biological and psychological health and highlights diversity within and across populations. This includes the importance of an intersectional approach that recognizes how individuals fall within multiple identity groups (e.g. intersection of race, class, age, gender). Benefits of considering such an approach include increased delivery efficiency, decreased costs, improved equity in uptake of services, better health literacy and self-care, increased satisfaction with care, improved relationships between patients and their care providers, and an improved ability to respond to health-care crises.

Populations that experience increased vulnerabilities have varying abilities to exercise their rights, access care and meet their SRH and broader health needs. This is particularly relevant in the context of their consent, autonomy, independence and privacy. This once again underlines the need for a strong enabling environment that addresses restrictive legal and policy environments, and absent or low-quality, stigmatizing health services. Tailored and supportive information and services, including self-care approaches, are important to overcome these challenges.

5 Developing a research agenda on self-care interventions for SRHR

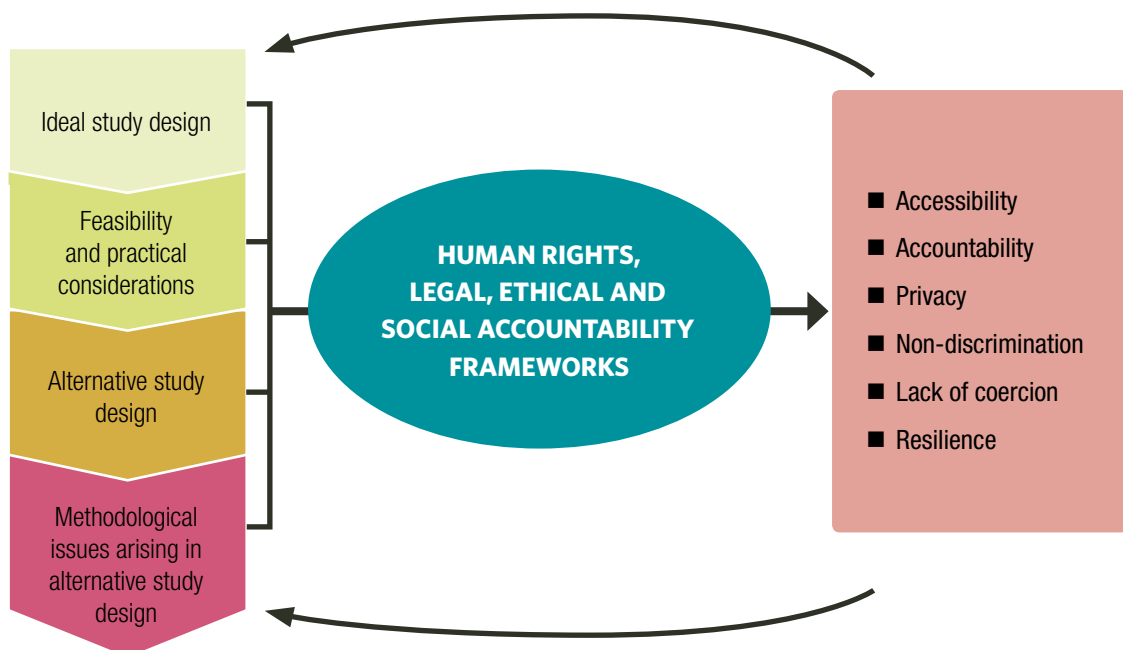
The field of self-care interventions is new, fast-moving and multidisciplinary. As such, the field requires a dynamic and flexible research environment driven by a collaborative ethos. Principal to successful collaboration will be the inclusion and contribution of end-users to shaping the research agenda and promoting user engagement with studies.

There are two broad areas for future research: (i) development of self-care interventions; and (ii) delivery of self-care interventions. Examples of development research questions include: Is stigma and discrimination a driver for the use of self-care interventions within the health system? and, What is the optimal design of a culturally appropriate self-care intervention for displaced populations? Examples of questions around delivery include: Will a specific self-care intervention improve coverage, reduce out-of-pocket expenditure, and be responsive to current and emerging population needs? and, Are health workers supportive or resistant to shifting towards self-care interventions?

The focus of the research will differ between studies, as outcomes, costs and cost-effectiveness may be different when viewed from an individual or collective perspective. With the increasing adoption of digital health and digital therapeutics, privacy, security and identity management are key to the conduct of ethical research.

The research process will need to consider the content (what?), context (where?), the target audience (who?), the modality (how?), the type of evaluation (study design, outcome measurements and indicators) and the evaluator. The research endeavour specific to self-care interventions can be conceptualized as combining conventional health-care epidemiological principles with the lenses of human rights, ethics and the law (as shown in Figure 2). Studies on self-care interventions for SRHR should clearly identify their contribution to advancing knowledge with respect to a holistic approach to health and well-being, reducing disparities, vulnerabilities and power differentials, and advancing UHC.

Figure 2: Research relating to self-care interventions: using human rights, legal, ethical and social accountability frameworks



6 Conclusion

In the development of WHO normative guidance, equity in access to, and uptake of, quality health interventions that are based on human rights, gender equality and social determinants of health is essential. A particular focus on changing vulnerabilities across the life course of individuals, rather than a focus on specific vulnerable or key populations, is also considered important.

In addition, for self-care interventions for health (including SRHR), it is also relevant and important to consider ethics, the law and social accountability, as well as the application of life-course and person-centred approaches.

The enabling environment to support the introduction of self-care interventions must be:³

- **Equitable** – providing care that is accessible and available to all.
- **Continuous** – providing care and services across the life course.
- **Respectful** – of people’s dignity, social circumstances and culture.
- **Endowed with rights and responsibilities** – that all people should expect, exercise and respect.
- **Grounded in gender equality** – so that individuals have equal opportunity to realize their full rights and potential to be healthy, contribute to health development and benefit from the results.
- **Governed through shared accountability** – of care providers to local people for the quality of care and health outcomes.
- **Ethical** – by making sure that care optimizes the risk-benefit ratio in all interventions, respects

individuals’ rights to make autonomous and informed decisions, safeguards privacy, protects the most vulnerable and ensures the fair distribution of resources.

- **Holistic** – focusing on physical, socioeconomic, mental and emotional well-being.

It is essential that there is interaction with the health system and that accountability remains with the health system.

The normative guidance on self-care interventions will support WHO’s role in moving forward with its global plan of work – specifically, advancing UHC for 1 billion people. While risk and benefit calculations may be different in different settings and for different groups, with appropriate guidance and an enabling environment, these interventions offer an exciting way forward to reach a range of improved outcomes. The potential benefits include:

- increased coverage and access;
- reduced health disparities and increased equity;
- increased quality of services;
- improved health, rights and social outcomes; and
- reduced cost, due to more efficient use of health resources and services.

There is already widespread and rapidly growing use of self-care interventions. The development of global, consolidated, normative guidelines, and a focus on research prioritization and monitoring of new interventions can help ensure that these interventions are person-centred and evidence-driven.

3 Adapted from the 2015 WHO global strategy on people-centred and integrated health services (9).

7 Next steps

- Given the complexity and wider-ranging issues and implications of self-care interventions for health, including SRHR, a similar approach to the development of the WHO mHealth guideline⁴ will be taken to define terminology. This will support the development of WHO guidelines on self-care in terms of consolidation, growth of the evidence base, and development of constructive frameworks and tools for design and evaluation.
- Selected conceptual and background papers will be considered for a special supplement in a peer-reviewed journal.
- A community of practice will be established to share resources and strengthen collaboration and partnerships.
- A global community survey and focus group discussion involving members of vulnerable populations will be conducted, in addition to developing a framework that will highlight human rights and gender equality, and take a life-course and person-centred approach. These aspects will serve as the foundation for the values and preferences as well as the key principles for the development of WHO normative guidelines on self-care interventions.



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4 Currently in development.

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Annex A: List of participants

Pascale ALLOTEY

Director, United Nations University International Institute for Global Health (UNU-IIGH)
Kuala Lumpur, MALAYSIA

Pascale Allotey has two decades of experience as a researcher in global health. She has a multidisciplinary background, and experience working across four continents to promote health and well-being.

Batool ALWAHDANI

Vice President for External Affairs
International Federation of Medical Students' Associations (IFMSA), Amman, JORDAN

Batool Alwahdani is a final year medical student studying in Jordan. She leads IFMSA's advocacy work and external representation. IFMSA has 1.3 million medical students from 127 countries. She is also IFMSA's focal point to the United Nations. During her work in IFMSA, she has been very active working on the Sustainable Development Goals, especially SDG 3. Her focus area is universal health coverage (UHC) and human resources for health, and she has represented medical students at many international events and working groups related to UHC. Batool led many refugee-related initiatives in Jordan, including voluntary screening and awareness campaigns. She acted as the President of IFMSA-Jordan, and the Liaison Officer to student organizations in IFMSA where she actively led and worked with the World Health Students' Alliance. She is also IFMSA's President Elect for 2018–2019.

Victoria BOYDELL

Rights and Accountability Advisor for the Evidence Project
International Planned Parenthood Federation (IPPF),
Geneva, SWITZERLAND

Victoria Boydell is currently conducting implementation research on how policies that respect and protect the human rights of women and girls can be operationalized and how programmes and practices can be held accountable for providing high-quality family planning (FP) and reproductive

health (RH) services. Before joining the Evidence Project, she worked at UN Women's Fund for Gender Equality and has held several positions at IPPF. Her research is focused on examining users' experiences of RH and community engagement and social accountability for more responsive health systems. Vicky received her PhD in anthropology from the London School of Economics and Political Science, where her research focused on contraceptive use dynamics in the United Kingdom.

Elizabeth BUKUSI

Professor, Departments of Global Health and Obstetrics and Gynecology, University of Washington, Seattle, USA
Co-Director, Research Care Training Program, Kenya Medical Research Institute (KEMRI), Nairobi, KENYA

Elizabeth A. Bukusi's primary areas of interest and research include sexually transmitted infections (STIs), RH, and HIV prevention, care and treatment, and she has a keen interest in research and clinical ethics/research regulatory systems. She is a member of the Kenya National AIDS Control Council HIV Prevention Task Force, and a member of the Board of Management of the South African Medical Research Council. She is also a board member of AVAC. She serves on the Advisory Board of the International Centre for Reproductive Health (ICRH), is a trustee for the HIV Trust, and an Elected Fellow of the African Academy of Sciences (AAS).

Joanna ERDMAN

Associate Director, Health Law Institute
Associate Professor/inaugural MacBain Chair in Health Law and Policy
Schulich School of Law, Dalhousie University, Halifax, CANADA

Joanna N. Erdman's research focuses on sexual and reproductive health (SRH) and human rights in a transnational context. Joanna is the co-editor of *Abortion Law in Transnational Perspective* (2014), which was also translated into Spanish (2016). She has acted as an intervener before various courts and international bodies, including the European Court of

Human Rights, and the United Nations Committee on the Elimination of Discrimination against Women. Joanna chairs the Global Health Advisory Committee of the Public Health Program, and serves on the advisory board of the Women's Rights Program, Open Society Foundations. She is a past chair of WHO's Department of Reproductive Health and Research's Gender and Rights Advisory Panel. She holds a JD from the University of Toronto and an LLM from Harvard Law School.

Laura FERGUSON

Associate Director and Assistant Professor, Institute for Global Health

Co-Director, Program on Global Health & Human Rights, Keck School of Medicine
University of Southern California, Los Angeles,
UNITED STATES OF AMERICA (USA)

Laura Ferguson's research focuses on understanding and addressing health system and societal factors affecting the uptake of health services, and developing the evidence base on how attention to human rights can improve health systems, behaviours and outcomes. She uses multidisciplinary approaches to global health research and evaluation. She collaborates with a range of United Nations agencies, foundations, universities and nongovernmental organizations in different countries. She has spent extended periods of time in low-income countries, primarily in sub-Saharan Africa, collaborating with partners, helping to build the capacity of her local colleagues, and designing and managing research and projects to tackle a broad range of issues including SRH, HIV/AIDS and child health. She is also an Associate Editor for the journal *Reproductive Health Matters*.

Patricia GARCÍA

Dean of the School of Public Health
Universidad Peruana Cayetano Heredia, Lima, PERU

Patty García, is the former Minister of Health of Peru and former Chief of the Peruvian National Institute of Health. She is recognized as a leader in global health. She has been a member of the Pan American Health Organization (PAHO) Foundation Technical Advisory Group (FTAG), a board member of the Consortium of Universities in Global Health, and President of the Latin American Association Against STDs (ALACITS).

She is an Affiliate Professor of the Department of Global Health at the University of Washington, Seattle, and of the School of Public Health at Tulane University, New Orleans, USA. She is actively involved in research and training on RH, STI/HIV, global health, HPV and medical informatics.

Charity GIYAVA

Programme Officer, Youth Engage
Member, Adolescent and Youth Constituency
Partnership for Maternal, Newborn and Child Health
(PMNCH), Harare, ZIMBABWE

Charity Giyava is an advocate for SRHR for young people. Charity plays an active role in advocating for access to comprehensive youth-friendly SRH services and access to comprehensive information and meaningful participation of young people in decision-making. She uses her health promotion skills to encourage young people to take responsibility for their own health and to adopt better health seeking behaviours. She is a member of the Youth Engage network and is actively involved in the implementation of the ACT!2030 Phase 4 global project in Zimbabwe focusing on youth data-driven accountability on SRHR and HIV and she is a co-facilitator for SDG advocacy.

Anita HARDON

Co-Director, Institute for Advanced Studies
Professor of Anthropology of Health, Care and the Body, University of Amsterdam, Amsterdam,
NETHERLANDS

Anita Hardon has directed a large volume of studies on users' perspectives on and experiences with fertility regulating technologies, pharmaceuticals and HIV/AIDS technologies. She has provided intensive guidance to young researchers (many from Africa and Asia). She is co-author of *Social Lives of Medicines* (Cambridge Press, 2002), *The Routledge Handbook of Medical Anthropology* (2016), the WHO manual *How to Improve the Use of Medicines by Consumers*, and *Monitoring Family Planning and Reproductive Rights: A Manual for Empowerment*. She publishes regularly in journals in the fields of medical anthropology and SRH. She is a member of the Scientific and Technical Advisory Group of the WHO Department of Reproductive Health and Research.

Caitlin KENNEDY

Director, Social and Behavioral Interventions Program
Associate Chair, Department of International Health
Johns Hopkins Bloomberg School of Public Health,
Baltimore, USA

Caitlin Kennedy is a social and behavioural scientist trained in both qualitative and quantitative methodologies. She applies these methods to the development and evaluation of innovative HIV prevention interventions and strategies to improve the health and well-being of people living in resource-limited settings. Caitlin has particular methodological expertise in systematic reviews and meta-analyses and has published over 30 systematic reviews and meta-analyses in peer-reviewed journals. She has led reviews that have been used as evidence for over a dozen WHO guidelines and helped develop other WHO and inter-agency documents including *Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions* and *PrEP demonstration projects: a framework for country level protocol development*.

Kaveh KHOSHNOOD

Associate Professor of Epidemiology
Director of Undergraduate Studies
Yale Institute for Global Health, New Haven, USA

Kaveh Khoshnood is trained as an infectious disease epidemiologist and has more than two decades of domestic and international experience in HIV prevention research among drug users and other at-risk populations, including ethical aspects. Kaveh is the principal investigator of a pilot study of “Rapid assessment and response to substance use and risk of HIV and other blood-borne infections among Lebanese nationals and displaced populations”, and an investigator on a NIH/NICHHD study: “Addressing disparities in HIV testing and care among displaced men who have sex with men in Lebanon”.

Denis KIBIRA

Executive Director, Coalition for Health Promotion
and Social Development
Regional Coordinator for the Health Systems
Advocacy (HSA) Partnership
Health Action International (HAI), Kampala,
UGANDA

Denis Kibira (MPS) is a pharmacist, researcher and activist, and possesses experience in community work, public health, pharmaceutical policy, research and advocacy. He has coordinated a multistakeholder Medicines Transparency Alliance (MeTA) in Uganda since 2012. Denis has research experience in over 50 studies. Denis is a PhD candidate in Pharmaceutical Policy and Regulation at the WHO Collaborating Centre for Pharmaceutical Policy and Regulation at Utrecht University. He is a graduate of the Advanced Health Management Program at the Yale School of Public Health and the Foundation for Professional Development. He has a Master of Business Administration from Uganda Martyrs University, Uganda, and a Bachelor of Pharmacy from Rajiv Gandhi Technical University, India.

Amy KNOFF

Assistant Professor of Nursing
Indiana University, Indianapolis, USA

Amelia (Amy) Knopf is a doctorally prepared nurse scientist with a primary interest in preventing HIV and other STIs among socially marginalized adolescents. She brings a broad background in nursing and public health, with specific training and expertise in community-engaged research, qualitative research methods, statistics, and social network analysis. She is currently funded by the Adolescent Medicine Trials Network for HIV/AIDS Interventions (ATN); she is the principal investigator of a \$1.145 million applied ethics study of the role of parental consent in minor adolescent enrolment in biomedical HIV prevention trials.

Carmen LOGIE

Assistant Professor, Factor-Inwentash Faculty of
Social Work
Adjunct Scientist, Women’s College Hospital
Ontario Ministry of Research & Innovation Early
Researcher
University of Toronto, Toronto, CANADA

Carmen Logie has been awarded funding from the Canadian Institutes of Health Research, the Social Sciences & Humanities Research Council of Canada, Grand Challenges Canada, and the Canada Foundation for Innovation, to lead global research focused on sexual health and rights. She is particularly interested

in understanding and addressing intersectional stigma and its sexual health impacts. She is currently conducting mixed-methods and intervention sexual health and rights research with: Indigenous Northern adolescents in Northern Canada; African, Caribbean and Black women in Ontario, Canada; and urban refugee and displaced adolescents in Uganda. Her community-based research aims to identify social ecological risk and protective factors associated with SRH outcomes, and provide evidence of effective interventions to improve SRHR.

Olumide MAKANJUOLA

Executive Director, The Initiative for Equal Rights (TIERS), Lagos, NIGERIA

Olumide Makanjuola is a sexual health and rights advocate with over a decade of experience in sexual rights programming for gay men and men who have sex with men in Nigeria. He has wide-ranging experience in capacity development for nascent sexual rights activists and for organizations in Anglophone West African countries. Olumide is engaged in sexual-rights-related issues at the level of national, regional and international human rights platforms.

Michelle MCCARTHY

Reader in Learning Disabilities, University of Kent, Canterbury, UNITED KINGDOM

Michelle McCarthy has worked with people with learning disabilities throughout her career. She worked first in residential care, then trained as a social worker. Her work in the area of relationships began when she was appointed Team Leader for a specialist sex education service. Her academic and practice-based work at the Tizard Centre involves all matters relating to sexuality, but she has a particular interest in working with women with learning disabilities on issues of sexual abuse, sexual and reproductive health and domestic violence. Michelle has published widely in these fields. This includes a number of educational and resource packs, books, academic and professional journals.

Patricia MECHAE

Principal and Policy Lead, HealthEnabled, Washington, DC, USA

Patricia (Patty) Mechael is co-founder and policy lead at HealthEnabled, a South African-based non-profit focused on national-scale integrated digital health systems. With over 20 years of experience working in more than 30 countries, primarily in Africa and Asia, Patty is celebrated for her roles as thought leader, writer, researcher, professor and executive director of the mHealth Alliance. She is a Rockefeller Foundation Bellagio Fellow, Johns Hopkins University Knowledge for the World Distinguished Alumnus Award recipient, British Council UK Education Social Impact Award recipient, editorial board member of the *Journal of Medical Internet Research*, and co-editor of *mHealth in practice: mobile technology for health promotion in the developing world*.

Pierre MOON

Director, Support for International Family Planning Organizations
Population Services International, Washington, DC, USA

Pierre Moon is Director of a global USAID-funded programme focusing on family planning and HIV service delivery. The programme operates in 20 countries and supports several SRHR user-initiated interventions. Prior to moving to Washington, DC, in 2014, Pierre spent a decade delivering national SRH programmes in the Horn, East and Southern Africa. Pierre has led programmes on HIV prevention among key populations in Ethiopia and Angola, social marketing programmes in the United Republic of Tanzania and Angola, and regional programmes on RH supplies in East and West Africa. Pierre has published on social franchising and social marketing and been involved in numerous global and national partnerships, including global initiatives such as ICPD@10 and ICPD@20.

Kevin PEINE

Biomedical Research Advisor
United States Agency for International Development (USAID), Washington, DC, USA

Kevin Peine supports research and development efforts for contraceptive technologies and other priority activities related to RH and broader women's

health initiatives. He began his career in international development as a Science and Technology Policy Fellow with the American Association for the Advancement of Science. He has a PhD in Molecular, Cellular and Developmental Biology from Ohio State University and conducted postdoctoral research in the Division of Molecular Pharmaceutics at the University of North Carolina's Eshelman School of Pharmacy.

The USAID participant did not participate in discussions related to access to abortion.

Sundari RAVINDRAN

Professor, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Thiruvananthapuram, INDIA

Sundari Ravindran is former co-editor of *Reproductive Health Matters*, and is currently a member of its editorial advisory board. She has worked at WHO's headquarters and regional offices in various capacities. Sundari is a founder-member of: Rights Oriented Research and Education in sexual and reproductive health (RORE), an international network; the National Coalition for Maternal-Neonatal Health and Safe Abortion (India); and Rural Women's Social Education Centre (RUWSEC), a grass-roots women's health organization in Tamil Nadu. She has been involved in RUWSEC's activities in various capacities since its inception in 1981 until the present.

Iqbal SHAH

Principal Research Scientist, Department of Global Health and Population (GHP)
Harvard T.H. Chan School of Public Health, Boston, USA

Iqbal H. Shah, was Senior Advisor to the Research, Monitoring and Evaluation Unit of a foundation before joining GHP. From 1985 to 2010, he worked at WHO headquarters initially as Chief of Social Science and Operations Research in the Department of Reproductive Health and Research, and later as the Coordinator of the Department's Maternal and Perinatal Health and Preventing Unsafe Abortion Team. Before 1985, he worked for the World Fertility Survey, run by the International Statistical Institute. Iqbal's research interests and publications cover a range of topics in SRH, including family planning, abortion, pregnancy prevention in the era of HIV, adolescent SRH, and infertility, among other topics.

Nandi SIEGFRIED

Independent Clinical Epidemiologist
Chief Specialist Scientist, Medical Research Council of South Africa
Honorary Associate Professor, Faculty of Health Sciences, University of Cape Town, Cape Town, SOUTH AFRICA

Nandi Siegfried is a South African public health medical specialist working as an independent consultant based in Cape Town. She worked for a decade at senior management level at the South African Medical Research Council, where she was co-director of the South African Cochrane Centre and Deputy Co-coordinating Editor of the Cochrane HIV/AIDS Review Group. Since 2011, as an independent consultant, Nandi provides assistance and guidance, as well as technical support, to international, national, institutional and nongovernmental agencies in the health-care sector, including in her role as chair, technical advisor and/or methodologist to 15 WHO clinical guideline development groups.

Neha SINGH

Associate Professor in Health Systems Research
London School of Hygiene & Tropical Medicine (LSHTM), London, UNITED KINGDOM

Neha Singh is a social scientist with over a decade of experience in quantitative and qualitative research in addition to programme implementation. She organizes the Family Planning Programmes module and teaches on the Conflict and Health module at LSHTM. Neha is currently assessing the effectiveness and utilization of SRH interventions in humanitarian crises, including: an evaluation of interventions delivered across the continuum of care for women and children affected by the Syrian conflict in Lebanon and Syria; developing and applying health system evaluation methods to inform decision-making in humanitarian settings including Lebanon, Uganda and Sierra Leone; revising Afghanistan's Basic Package of Health Services and conducting a subnational-level health system assessment; and evaluations of performance-based financing schemes to improve women's and children's health in Brazil, Mozambique, the United Republic of Tanzania, Zimbabwe and Zambia.

Teresa YEH

Senior Research Program Coordinator, Department of International Health
Social and Behavioral Interventions Program, Johns Hopkins Bloomberg School of Public Health, Baltimore, USA

Ping Teresa Yeh uses her social science training in qualitative and quantitative methods to develop, describe and evaluate strategies to improve the health and well-being of people living in resource-limited settings. Her current research portfolio primarily comprises systematic reviews and qualitative research related to HIV prevention, care and treatment interventions, and SRHR.

United Nations agencies**Lucinda O'HANLON**

Women's Rights Advisor
Office of the United Nations High Commissioner for Human Rights (OHCHR)
Geneva, SWITZERLAND

Petra TEN HOOPE-BENDER

Technical Adviser Sexual and Reproductive Health
United Nations Population Fund (UNFPA)
Geneva, SWITZERLAND

Kene ESOM

Policy Specialist: Human Rights, Law and Gender
HIV, Health and Development Group
United Nations Development Programme (UNDP)
New York, NY, USA

Luisa CABAL

Human Rights Adviser
Joint United Nations Programme on HIV/AIDS (UNAIDS)
Geneva, SWITZERLAND

**World Health Organization (WHO),
Geneva, SWITZERLAND****Islene ARAUJO DE CARVALHO**

Senior Policy and Strategy Adviser, Department of Ageing and Life Course (ALC)

Ian ASKEW

Director
Department of Reproductive Health and Research (RHR)

Michalina DREJZA

Consultant, RHR, Human Reproduction Team

Mario FESTIN

Medical Officer, RHR, Human Reproduction Team

Bela GANATRA

Scientist, RHR, Maternal and Perinatal Health and Preventing Unsafe Abortion Team

Lianne GONSALVES

Technical Officer, RHR, Adolescents and at-Risk Populations Team

Rajat KHOSLA

Human Rights Advisor, RHR, Director's Office

James KIARIE

Coordinator, RHR, Human Reproduction Team

Hyo Jeong KIM

Technical Officer, Emergency Operations (EMO), Humanitarian Policy and Guidance

Loulou KOBEISSI

Technical Officer, RHR, Adolescents and at-Risk Populations Team

Manjulaa NARASIMHAN

Scientist, RHR, Human Reproduction Team

Tigest TAMRAT

Consultant, RHR, Adolescents and at-Risk Populations Team

Rebekah THOMAS BOSCO

Technical Officer, Family, Women's and Children's Health Cluster (FWC), Gender, Equity and Human Rights Team

Adriana VELAZQUEZ BERUMEN

Senior Adviser, Department of Essential Medicines and Health Products (EMP), Innovation, Access and Use

Annex B: Meeting agenda

TIMING	TOPIC AND ISSUE	PRESENTER(S)
DAY 1: Monday, 12 March 2018		
Co-chairs: Pascale Allotey and Joanna Erdman		
08:30 - 09:30	Welcome and introductions Meeting objectives and expected outcomes	James Kiarie , WHO
09:30 - 10:30	What are self-care interventions for sexual and reproductive health and rights (SRHR)? <i>Group discussion</i>	Manjulaa Narasimhan , WHO
10:30 - 11:00	TEA/COFFEE BREAK	
11:00 - 12:30	Human rights and legal dimensions of self-care interventions for SRH: what we know so far <i>Group discussion</i>	Laura Ferguson , University of Southern California, United States of America (USA) Sundari Ravindran , Sree Chitra Tirunal Institute for Medical Sciences and Technology, India
12:30 - 14:00	LUNCH BREAK	
14:00 - 15:30	User autonomy in SRH: social justice theory as a framework for identifying key ethical considerations <i>Group discussion</i>	Amy Knopf , Indiana University, USA Kaveh Khoshnood , Yale University, USA
15:30 - 16:00	TEA/COFFEE BREAK	
16:00 - 17:30	Social accountability regarding self-care interventions for SRHR <i>Group discussion</i>	Vicky Boydell , Population Council, United Kingdom Denis Kibira , Coalition for Health Promotion and Social Development, Uganda
17:30 - 18:00	<i>Wrap-up and close of Day 1</i>	
18:00 - 19:00	Reception	
Day 2: Tuesday, 13 March 2018		
Co-chairs: Pascale Allotey and Joanna Erdman		
08:30 - 09:30	mHealth as a facilitator for self-initiated SRHR <i>Group discussion</i>	Patricia Mechael , HealthEnabled, USA Olumide Makanjuola , The Initiative for Equal Rights (TIERS), Nigeria
09:30 - 10:30	Self-care interventions for adolescents and young vulnerable populations <i>Group discussion</i>	Charity Giyava , Youth Engage, Zimbabwe Batool Alwahdani , International Federation of Medical Students' Associations (IFMSA), Jordan
10:30 - 11:00	TEA/COFFEE BREAK	
11:00 - 12:00	Self-care for women of reproductive age <i>Group discussion</i>	Elizabeth Bukusi , Kenya Medical Research Institute (KEMRI), Kenya Michelle McCarthy , University of Kent, United Kingdom
12:00 - 13:00	User engagements in sexual and reproductive health care for older populations <i>Group discussion</i>	Anita Hardon , Institute for Advanced Studies, University of Amsterdam, Netherlands Iqbal Shah , Harvard T.H. Chan School of Public Health, USA

TIMING	TOPIC AND ISSUE	PRESENTER(S)
13:00 - 14:00	LUNCH BREAK	
Chair: Pascale Allotey		
14:00 - 15:00	Exploring access and acceptability of self-initiated SRHR services among refugee and displaced populations <i>Group discussion</i>	Neha Singh , London School of Hygiene & Tropical Medicine (LSHTM), United Kingdom Carmen Logie , University of Toronto, Canada
15:00 - 16:00	Understanding the user: how implementers are involving the user in self-care interventions for SRHR <i>Group discussion</i>	Pierre Moon , Population Services International, USA Patricia García , Universidad Peruana Cayetano Heredia, Peru
16:00 - 16:30	TEA/COFFEE BREAK	
Chair: Joanna Erdman		
16:30 - 17:30	Developing a classification scheme and language for self-care interventions <i>Working group discussions</i>	Joanna Erdman , Dalhousie University, Canada
17:30 - 18:00	<i>Reporting back in plenary</i>	
18:00	CLOSE OF DAY 2	
Day 3: Wednesday, 14 March 2018		
Co-chairs: Pascale Allotey and Joanna Erdman		
09:00 - 10:30	Key messages from Days 1 and 2 <i>Group discussion</i>	Caitlin Kennedy , Johns Hopkins Bloomberg School of Public Health, USA Teresa Yeh , Johns Hopkins Bloomberg School of Public Health, USA
10:30 - 11:00	TEA/COFFEE BREAK	
11:00 - 11:20	Establishing a community of practice on self-care interventions for SRHR	Michalina Drejza , Consultant, WHO
11:20 - 11:40	Documenting best practices on self-care interventions for SRHR	Pascale Allotey , United Nations University International Institute for Global Health, Malaysia
11:40 - 12:00	Global values and preferences survey: what are the channels to get feedback?	Carmen Logie , University of Toronto, Canada
12:00 - 12:30	Next steps <i>Discussion and close of the meeting</i>	Manjulaa Narasimhan , WHO
12:30 - 14:00	LUNCH	

For more information, please contact:

**Department of Reproductive Health and Research
World Health Organization
20 Avenue Appia, 1211 Geneva 27
Switzerland
Fax: +41 22 791 4171
Email: reproductivehealth@who.int
Website: www.who.int/reproductivehealth**