WHO Self-care Interventions for Health

Sexual and reproductive health and rights*

WEB ANNEX: Global Values and Preferences Survey report

World Health Organization

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* Full guideline available at: www.who.int/reproductivehealth/publications/self-care-interventions/en/

WHO self-care interventions for health: sexual and reproductive health and rights Web Annex: Global Values and Preferences Survey report

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ABOUT THIS DOCUMENT

This document presents results from the Global Values and Preferences Survey (GVPS)[1] and focus group discussions which were held to inform the development of the normative guidance. This document accompanies the *WHO consolidated guideline on self-care interventions for health: sexual and reproductive health and rights.*

About the GVPS and focus group discussions

In the development of the Guideline, specific attention was given to the enabling environment needed for implementation of the interventions, and to the implications for human rights. To investigate these factors, a Global Values and Preferences Survey (GVPS) was conducted among health-care providers and potential end-users on their values and preferences around self-care interventions for sexual and reproductive health and rights (SRHR). The survey was available online in English, French and Spanish and ran for seven weeks from mid-September to mid-November 2018. A total of 825 respondents from 112 countries participated, making this the largest survey to date on self-care interventions for SRHR. The survey responses were taken into account in developing the new recommendations, as well as in assessing the strength of the recommendations. The full results of the GVPS are presented in this document.

Focus group discussions were also held within vulnerable communities and with health-care providers to engage these groups in discussions about their knowledge, use and uptake of self-care interventions. Participants were also asked to identify any key issues that they experienced or expected in accessing or using the interventions. These workshops took place in several countries including Canada, India, Kenya, Mexico, Morocco and the United Kingdom of Great Britain and Northern Ireland. The groups also participated in creating artworks about their interpretation of self-care in the context of their everyday lives and their communities. Selected case study summaries and drawings from the workshops are presented in this document.

Why is this GVPS report important?

This GVPS report is a supplement to the Guideline that presents in greater detail the data used to inform the values and preferences component of the Guideline. It presents both the evidence and the people-centred approach that were central to the development of the Guideline. The results from the survey showed that the values and preferences of the potential end-users were variable and were closely tied to the individuals' circumstances, needs and desires across the life course, and the environment in which they live. This report showcases this diversity and also reveals gaps in the knowledge and uptake of self-care interventions for SRHR.

How is this document structured?

The first three chapters present responses from health-care providers and layperson respondents side by side. The fourth chapter focuses on the perspectives of health-care providers only. The chapters include a blend of qualitative and quantitative data, depending on the question being addressed. The qualitative sections include written responses from the respondents presented as quotes, and the quantitative sections include visualizations of the response data sets. Some visualizations cover responses across 17 self-care interventions and span several pages. To use this document effectively, the reader should read the introductory text for each section, followed by the survey question that was addressed before exploring the data visualizations.

Throughout this document are one-page highlights from discussions with health-care workers and vulnerable population groups.

Accompanying these are artworks created by the respective communities, representing their perspectives on self-care interventions.

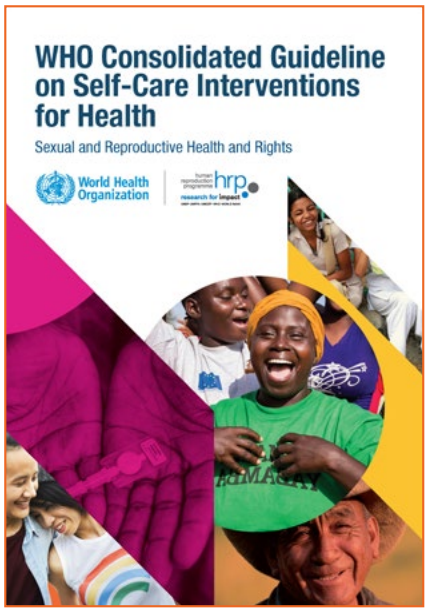
[1] The full guideline document and other supplementary material can be found at: https://www.who.int/reproductivehealth/publications/self-care-interventions/en/

What is self-care?

The World Health Organization (WHO) definition of self-care is:

> **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.**

The concept covers a variety of themes, including health promotion, disease prevention and control, self-medication, providing care to dependent persons, seeking hospital or specialist care if necessary, and rehabilitation including palliative care. Self-care interventions are among the most promising and exciting new approaches to improve health and well-being. These interventions represent a significant push towards new and greater self-efficacy, autonomy and engagement in health for self-carers and caregivers. They have the potential to increase choice when they are accessible and affordable, and they can also provide more opportunities for individuals to make informed decisions regarding their health and health care.



Download the Guideline at https://www.who.int/reproductivehealth/publications/self-care-interventions/en/

What is the WHO consolidated guideline on self-care SRHR interventions?

The Guideline is a consolidation of existing and new recommendations to support the access to, uptake of and use of self-care interventions, especially for SRHR. It also contains good practice statements on key issues that need to be addressed to promote and increase safe and equitable access to and use of the interventions. The purpose of this guidance is to develop a people-centred, evidence-based normative guideline that will support individuals, communities and countries with quality health services and self-care interventions. The primary target audience includes national and international bodies responsible for making decisions or advising on delivery or promotion of self-care interventions. The Guideline is also directed toward product developers and people affected by the recommendations: those who are taking care of themselves, and caregivers.

How was the Guideline developed?

The development of the Guideline involved high-quality systematic reviews of all relevant evidence around the interventions, which involved three working groups performing specific guideline development functions. The process broadly involved developing the scope of the Guideline, identifying priority PICO questions (population, intervention, comparator, outcome), screening WHO guidance documents for existing self-care-related recommendations and good practice statements, and drafting and reviewing the guideline document. The working groups also identified topic areas where new recommendations and good practice statements needed to be developed for the Guideline. The quality and strength of the new recommendations was then assessed using a WHO-approved grading system.

ACKNOWLEDGEMENTS

This document is intended a web annex to the 2019 *WHO consolidated guideline on self-care interventions for health: sexual and reproductive health and rights*. We acknowledge all those who supported work leading up to the development of the Guideline and this web annex.

Sincere thanks in particular to Carmen Logie and her team Heather Abela and Alice Gauntley (Factor-Inwentash Faculty of Social Work, University of Toronto, Toronto, Canada) for administering the online survey and analysing the results. We are also grateful to Ash Pachauri (Center for Human Progress, New Delhi, India) for managing the focus group discussions. We thank all the participants of the survey and focus group discussions for their time and valuable feedback.

This document has been prepared by Manjulaa Narasimhan of the Department of Reproductive Health and Research at the World Health Organization.

ACRONYMS AND ABBREVIATIONS

GVPS	Global Values and Preferences Survey
PEP	post-exposure prophylaxis
PrEP	pre-exposure prophylaxis
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infection
WHO	World Health Organization

1

BACKGROUND, VALUES AND PREFERENCES FOR SELF-CARE SRHR INTERVENTIONS

Chapter summary

This first chapter begins with a summary of respondents' sociodemographic characteristics, followed by descriptive statistics regarding perceptions of self-care sexual and reproductive health and rights (SRHR) interventions. The results are presented for two separate respondent groups: the health-care provider respondents and all layperson respondents. Most of the health-care provider respondents were from the Region of the Americas, the African Region and the European Region. The majority of health-care provider respondents reported being cisgender women, while just under a third were cisgender men. The average age of these respondents was 38.0. The majority identified their sexual orientation as heterosexual while a minority identified as lesbian, gay, bisexual, transgender, queer, intersex or other (sexual and gender minorities). Most health-care provider respondents reported having a postgraduate degree and working in full-time paid employment.

Most of the layperson respondents were from the European Region, the Region of the Americas and the African Region. Most of these respondents reported being cisgender women, while a minority were cisgender men. The average age of these respondents was 31.9. Most reported their sexual orientation as heterosexual, while a minority were from sexual and gender minorities. Most of these respondents reported having a university bachelor's degree or a postgraduate degree. Nearly half reported their employment status as a current student.

The respondents' perspectives on self-care SRHR interventions collected from qualitative responses were thematically analysed. The themes on current and future challenges that emerged in both respondent groups were: lack of accessibility, stigma and discrimination, risk of misuse, lack of expertise or knowledge, affordability, impact of beliefs, lack of confidentiality, and legitimacy of products. The potential benefits and ideal conditions for self-care interventions were also identified from the qualitative responses. Additionally, information was collected from respondents pertaining to sources of SRHR knowledge and preferred types of online resources. For both health-care providers and layperson respondents, the most commonly identified sources of SRHR knowledge included: the Internet, school and doctors. The preferred types of online resources included trustworthy websites, online web search and mobile phone applications (apps).

> "Only if we keep ourselves healthy will we be able to live a better life. If we deal with issues in our daily life, it won't be possible for us to fulfil our wishes and ultimately live the way we want to."
>
> – Participant from self-care SRHR intervention workshop with men who have sex with men

1.1 BACKGROUND AND SOCIODEMOGRAPHIC PROFILE OF PARTICIPANTS

In total, the questionnaire received 837 responses originating from a total of 112 countries (see Annexes A and B for the list of countries). The results have been separated into two categories: those who reported being health-care providers (43%, n=360) and those who did not (layperson respondents; 57%, n=477). This section will report the background and sociodemographic characteristics of both respondent groups.

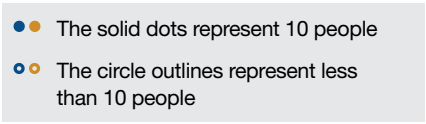
TABLE 1: SOCIODEMOGRAPHIC BACKGROUND OF RESPONDENTS

Total health-care providers

360

Layperson respondents

465



Gender	Women (cisgender)	Men (cisgender)	Transgender	Prefer not to say
Health-care providers n=360	68.9%, n=248	30.8%, n=111	0.3%, n=1	0%, n=0
Layperson respondents[a] n=465	68.0%, n=316	30.1%, n=140	1.3%, n=6	0.6%, n=3

Age	18–29	30–39	40–49	50–59	60–69	70+
Health-care providers n=358	32.7%, n=117	27.4%, n=98	20.1%, n=72	12.3%, n=44	4.7%, n=17	2.8%, n=10
Layperson respondents[a] n=464	56.5%, n=262	19.6%, n=91	11.9%, n=55	7.1%, n=33	3.9%, n=18	1.1%, n=5

WHO region	African Region	Region of the Americas	South-East Asia Region	European Region	Eastern Mediterranean Region	Western Pacific Region
Health-care providers n=360	28.3%, n=102	34.7%, n=125	6.1%, n=22	23.3%, n=84	4.7%, n=17	2.8%, n=10
Layperson respondents[a] n=465	19.1%, n=89	23.4%, n=109	4.3%, n=20	33.8%, n=157	8.0%, n=37	11.4%, n=53

Sexual orientation	Heterosexual/straight	Sexual and gender minorities[b]	Prefer not to say
Health-care providers n=358	84.9%, n=304	13.4%, n=48	1.7%, n=6
Layperson respondents[a] n=464	75.6%, n=351	22.2%, n=103	2.2%, n=10

HOW TO READ THIS TABLE
For example, 9 health-care providers and 16 layperson respondents self-identify as having a disability

Self-identify as having a disability	Yes	No
Health-care providers n=360	2.5%, n=9	97.5%, n=351
Layperson respondents[a] n=466	3.4%, n=16	96.6%, n=450

Engaged in sex work	Yes	No
Health-care providers n=359	5.0%, n=18	95.0%, n=341
Layperson respondents[a] n=465	2.8%, n=13	97.2%, n=452

Size of city/town	A large city (>1 million inhabitants)	A medium city (300 000 – 1 million inhabitants)	A small city (100 000 – 300 000 inhabitants)	Large town (20 000 – 100 000 inhabitants)	Medium town 1000 – 20 000 inhabitants)	Small town or hamlet (< 1000 inhabitants)
Health-care providers n=357	49.6%, n=177	18.5%, n=66	10.9%, n=39	11.2%, n=40	7.0%, n=25	2.8%, n=10
Layperson respondents[a] n=167	49.7%, n=83	19.2%, n=32	8.4%, n=14	9.0%, n=15	9.6%, n=16	4.2%, n=7

Highest level of education	Completed high school	A university bachelor's degree	A graduate degree	Other
Health-care providers n=358	6.7%, n=24	27.1%, n=97	65.6%, n=235	0.6%, n=2
Layperson respondents[a] n=178	27.5%, n=49	36.5%, n=65	35.4%, n=63	0.6%, n=1

Employment status (choose all that apply)	Full-time paid employment	Part-time paid employment	Self employed	Unemployed	Currently a student	Casual labour
Health-care providers n=357	62.7%, n=224	12.3%, n=44	8.1%, n=29	3.1%, n=11	18.2%, n=65	0.8%, n=3
Layperson respondents[a] n=166	40.4%, n=67	6.6%, n=11	5.4%, n=9	3.0%, n=5	48.8%, n=81	1.2%, n=2

[a] Respondents who did not report being health-care providers.
[b] Lesbian, gay, bisexual, transgender, queer, intersex or other.

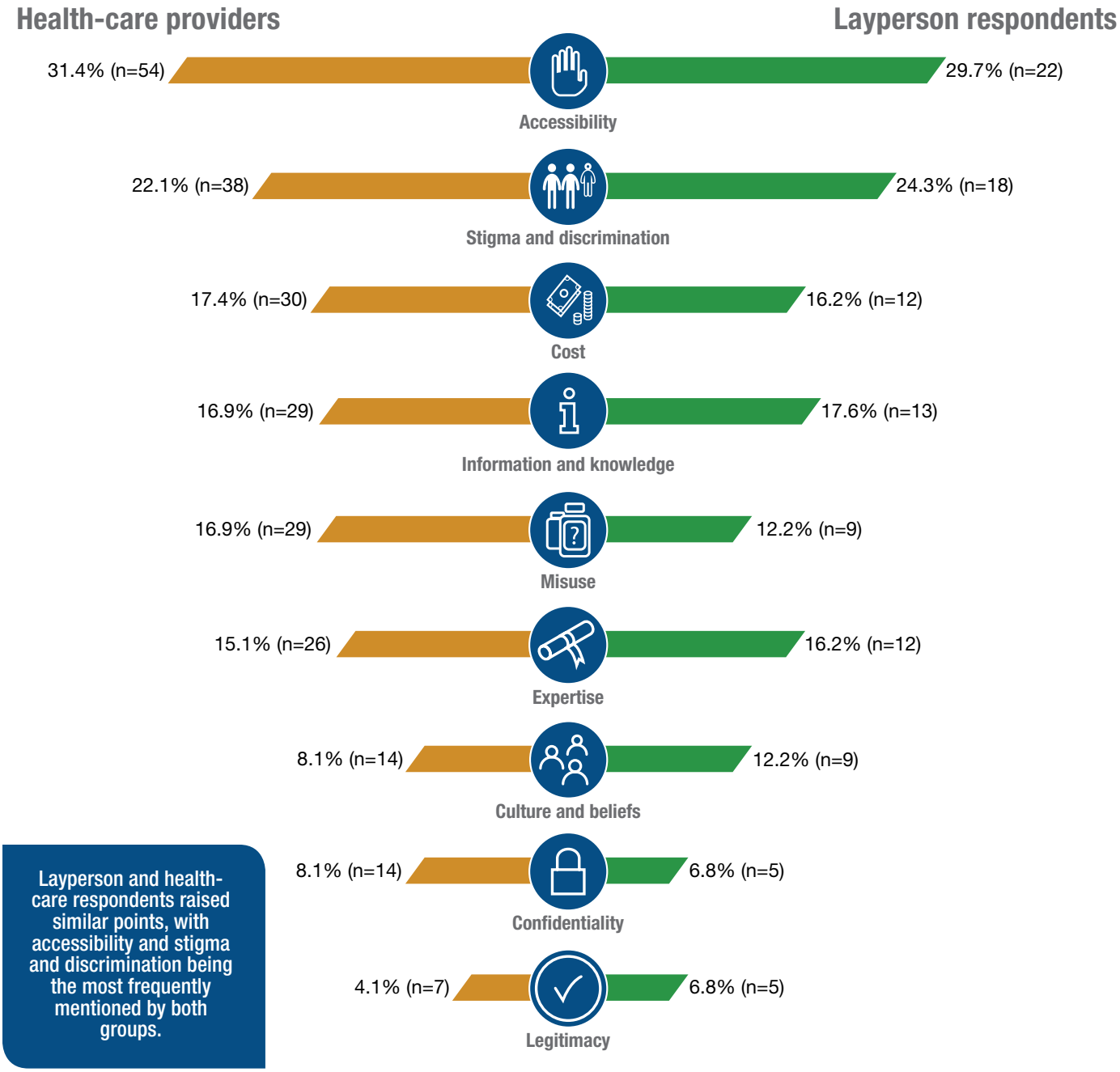
1.2 VALUES AND PREFERENCES FOR SELF-CARE SRHR INTERVENTIONS: Qualitative findings

The survey respondents were asked to share their thoughts on self-care SRHR interventions by writing their responses in the boxes provided. These qualitative responses were coded thematically based on the topics discussed in respondents' comments. This section will report the most common themes that were present in the qualitative responses from both health-care respondents and all layperson respondents.

The topics discussed in the responses were primarily related to at least one of four broader categories relating to self-care SRHR interventions:
- current concerns
- potential benefits
- preferred conditions and
- future issues for consideration.

The most prominent topics raised by the respondents are presented in Figure 1.

FIGURE 1: MAIN TOPICS RAISED AROUND SELF-CARE SRHR INTERVENTIONS



Layperson and health-care respondents raised similar points, with accessibility and stigma and discrimination being the most frequently mentioned by both groups.

1.2.1 Current concerns about self-care SRHR interventions

The survey respondents expressed their concerns about self-care SRHR interventions as qualitative written answers. The responses are presented below are grouped within the main themes raised by health-care providers and layperson respondents.

HEALTH-CARE PROVIDERS

Health-care provider respondents expressed their concerns about self-care SRHR interventions.

Stigma and discrimination

Health-care providers frequently raised their concerns around stigma and discrimination.

> *"Stigma and discrimination in traditional communities by health-care providers and pharmacy employees creates a barrier to accessing any STI [sexually transmitted infections] self-treatment methods."*
>
> Male, 27, Thailand

Similarly, facing negative judgement when accessing health care is a concern that was expressed by some participants.

> *"Non-judgemental and quality care and service is the paramount consideration when one decides [to use] self-initiated or health service provider assisted SRH [sexual and reproductive health] service."*
>
> Male, 30, Philippines

Culture and beliefs

According to the respondents, facing stigma and poor treatment when accessing services was connected to culture and beliefs. One respondent explained the phenomenon in his local context:

> *"Especially in Turkey, people are very strict about sexual relationships. They have some rules like two young people cannot have sex before marriage… When they go to the doctor ... young people are exposed to ill treatment by the doctor."*
>
> Male, 22, Turkey

The issue was identified as a barrier to accessing SRHR services.

> *"In health centres many times they do not give information with what they do not agree with, or they are not within the P.O.S. [point of service]."*
>
> Female, 45, Colombia

Lack of accessibility

Lack of accessibility was a major concern expressed by the health-care respondents.

> *"High costs and difficulty of access are important issues for some methods."*
>
> Male, 60, Brazil

This issue was connected to medical professionals controlling access to self-care SRHR interventions.

> *"Doctors, pharmacists or any other health-care staff should not be gate keepers."*
>
> Female, 47, United States of America

Overreliance on medical professionals was identified as a barrier to self-care interventions.

> *"The field is too medicalized. Patients have been taught to go to the doctor for everything. It will take time and effort for people to fight for and access some of these interventions without the use of a health-care provider."*
>
> Female, 31, United States

LAYPERSON RESPONDENTS

All the layperson respondents discussed concerns regarding self-care SRHR interventions. The respondents discussed existing barriers to accessing self-care interventions for SRHR.

Poor accessibility

One respondent expressed how the lack of affordable interventions leads to poor access:

> *"Cost is indeed a big barrier to some."*
>
> Female, 45, Canada

Other factors make it difficult to access specific self-care SRHR interventions.

> *"In Poland, to get emergency contraception you first have to go to the doctor and not all of them want to prescribe it. Some pharmacies also do not want to sell it."*
>
> Female, 21, Poland

Stigma and discrimination

Stigma was recognized by respondents as being a major concern in relation to self-care SRHR interventions.

> *"The principal concern is stigma related to the use of sexual and reproductive health products."*
>
> Female, 25, Colombia

> *"When teenagers and young women visit the hospital for obstetrics and gynaecology for many reasons, consulting on ovulation pain, irregular ovulation, STI test, etc., there is a social stigma from older women and relevant people and [they are] regarded as not moral person. This social stigma blocks many young women to access and take care of their health."*
>
> Female, 27, Republic of Korea

Culture and beliefs

Lastly, culture and beliefs, particularly relating to traditional or conservative beliefs, were perceived by respondents as being a significant concern when it came to self-care SRHR interventions.

> *"Voluntary abortion is illegal in my country and there is a lot of religious (Christian) stigma when expressing wanting it."*
>
> Female, 26, Panama

> *"I would like religion groups to stay away from [influencing] laws and directives about contraception. They mess up a lot of things."*
>
> Female, 29, Croatia

1.2.2 Potential benefits of self-care SRHR interventions

Respondents were also asked to share their thoughts around the potential benefits of self-care SRHR interventions. The qualitative responses of health-care providers and layperson respondents are presented below.

HEALTH-CARE PROVIDERS

Health-care provider respondents discussed the potential benefits of self-care SRHR interventions. The most common responses were that it helps address barriers to access, such as those related to stigma and discrimination, cost and confidentiality. All of those factors help make self-care SRHR interventions more accessible.

Stigma and discrimination

One of the benefits raised was that self-care SRHR interventions could reduce the stigma and discrimination that prevents people from accessing health-care services.

> *"I think that having these interventions easily accessible and without stigmatization or shame would make these interventions easier, more pleasant and safer."*
>
> Female, 21, Poland

> *"I believe self-initiated interventions can play a huge role in reducing barriers to accessing services due to stigma associated around it, especially in sub-Saharan Africa."*
>
> Female, 26, Uganda

> *"Access would be the most important. While I don't have concerns visiting a doctor or health centre as I am out and comfortable with my sexuality, those who are not out would be unlikely to access a health service and disclose their sexuality to a doctor."*
>
> Male, 38, Thailand

Cost

Health-care provider respondents suggested that the affordability of self-care interventions was a potential benefit.

> *"[There is] less cost because there is no service fee for the health provider."*
>
> Male, 38, Malawi

> *"[Self-care interventions are a] good idea, [they] will save cost and time."*
>
> Male, 70, United Kingdom

Confidentiality

A final major benefit that was discussed by the health-care provider respondents was the increased confidentiality associated with self-care interventions.

> *"Confidentiality will be maintained."*
>
> Male, 32, Nigeria

> *"[Benefits include] greater respect and privacy."*
>
> Male, 32, Argentina

> *"Needless to say, my confidentiality will be better safeguarded."*
>
> Female, 26, Kenya

LAYPERSON RESPONDENTS

The most common themes discussed by layperson respondents were decreased barriers to access and reduced stigma and discrimination.

Accessibility

Increasing accessibility is a major benefit of the interventions, as identified by layperson respondents.

> *"I think it's really important to have self-initiated interventions available over the counter at pharmacies at a low cost so that people can access them without having to visit a health-care provider, which adds an additional cost in both monetary value and lost time. Oftentimes going to a health-care provider to access some of these self-initiated options makes women feel shameful and some health-care providers don't do a great job of making it a safe, empowering space for women to choose the method that is right for them. It would be amazing to have more options available, more easily accessible to women in the United States."*
>
> Female, 29, United States

> *"Going to a health-care provider can be a major barrier for women to access RH [reproductive health] services. Putting care directly into the hands of women to manage is an important way to overcome this barrier."*
>
> Female, 31, United States

Stigma and discrimination

Another potential benefit recognized by respondents was how it could reduce stigma and discrimination.

> *"I think an option for self-initiated interventions is good to reduce stigma and discrimination."*
>
> Male, 41, Uganda

It was specified that online sources for SRHR information would be particularly helpful for youth.

> *"Majority of the public are not informed well enough about them, due to stigma surrounding these interventions. A reliable, up-to-date and simple-to-use online, mobile source of information would be highly beneficial, especially to younger population."*
>
> Female, 25, Croatia

1.2.3 Preferred conditions for implementation of self-care SRHR interventions

Respondents were also asked to share their perceptions around what the preferred conditions would be for implementing self-care SRHR interventions. Their qualitative responses are shared below.

HEALTH-CARE PROVIDERS

The health-care provider respondents elaborated on the preferred conditions for implementing self-care SRHR interventions. The major relevant themes discussed were: ease of access; information, knowledge and education; and confidentiality and privacy.

Accessibility

Preference for self-care interventions that are easily accessible and available was discussed in the responses.

> *"The interventions should be readily available and at minimal cost."*
>
> Male, 30, Kenya

> *"Access, and cost should be minimized for these – ideally non-prescription, over the counter, with an ability to seek additional guidance."*
>
> Female, 37, United States

Information and knowledge

Health-care provider respondents recognized the need for better information, increased knowledge and more education for self-care interventions.

> *"Self-initiated interventions require awareness, good educational background and community participation."*
>
> Male, 70, India

> *"Availability of information for users is important and also how to interface with health system after use."*
>
> Male, 40, Uganda

Confidentiality

Better confidentiality and privacy were discussed by health-care respondents as important features for self-care SRHR intervention implementation.

> *"Privacy and confidentiality are key for self-initiated SRH interventions."*
>
> Female, 40, United States

> *"Stigma in Nigeria is still a huge issue. I'd like for more discreet means of accessing SIIs [self-initiated interventions] in such countries."*
>
> Female, 25, Nigeria

LAYPERSON RESPONDENTS

The major themes raised by layperson respondents on their preferred conditions for implementing self-care SRHR interventions were: accessibility and availability; information and knowledge; cost; and confidentiality.

Accessibility

Having self-care interventions accessible and available as an option for SRHR services was viewed as ideal by these respondents.

> *"Self-initiated interventions are somewhat rare in the US – I wish they were more common."*
>
> Female, 32, United States

This was noted as being especially important for certain marginalized or higher-risk populations and in particular contexts.

> *"As a gay man who has regular safe sex with other men, I would like to have PrEP [pre-exposure prophylaxis] and PEP [post-exposure prophylaxis] accessible and affordable in my country."*
>
> Male, 33, Macedonia

Access for rural communities and for youth were suggested as priorities for implementation.

> *"Access to birth control pills should be made available even in the remote areas."*
>
> Female, 20, Kenya

> *"Mobile application for SRH is very important currently for young people since everyone at least has a smartphone."*
>
> Respondent, 37, Uganda

Knowledge and information

Being better informed and educated was discussed as a preferred condition for implementation of self-care SRHR interventions. This was expressed as essential for making informed decisions on SRHR.

> *"I just want to be well informed of the interventions and choices I have, and then I want to choose by myself without needing a doctor."*
>
> Female, 23, Portugal

> *"People must be more informed about all of these self-initiated interventions."*
>
> Female, 20, Portugal

This was also discussed as being particularly important in certain regional contexts.

> *"I would like that in Argentina there would be more sexual education."*
>
> Female, 21, Argentina

Cost

The next major theme in the qualitative responses that discussed preferred conditions for self-care SRHR interventions was cost. Respondents emphasized the importance of affordable self-care interventions, with suggestions on how that would work. One respondent explained:

> *"Cost is an issue. I would want interventions to be covered by insurance or provided for free or on a sliding scale based on income."*
>
> Female, 58, United States

> *"It would be useful if they were presented in a variety of pharmacies with different price ranges."*
>
> Female, 21, Panama

Having self-care interventions that are affordable was discussed as important for decreasing STI rates in the population.

> *"I think that the cost of any sexual health product needs to be the lowest or free. That could help decrease the amount of people infected with any kind of sexual disease."*
>
> Male, 20, Portugal

Confidentiality

The final major theme for preferred conditions in the qualitative responses was confidentiality. Accessing self-care SRHR interventions while ensuring that privacy and confidentiality are protected was discussed as an ideal condition for implementation.

> *"Stocking them not behind the counter without an ID is important, there can be just as much judgement from a pharmacist, especially in conservative places."*
>
> Female, 34, Mexico

> *"I think anonymity is still very important for SRH, and often it is forgotten in services and that's why many people don't access care through health-care providers."*
>
> Female, 26, Sweden

HIGHLIGHTS FROM COMMUNITY WORKSHOPS

Truck drivers in India

All the participants in this workshop were male truck drivers working in the Indian state of Tamil Nadu. Though their education levels varied from primary school through university level, many were illiterate. Body mapping was used as a tool to facilitate this workshop on general and sexual health care and self-care.

The key issues raised by the participants included:

1. Participants typically have a family doctor in their hometown, whose advice they trust and follow.
2. When on long-distance truck routes, they carry previously issued prescriptions prepared by their family doctor and reuse them to buy medicines from pharmacies.
3. Under the state AIDS control programme, they are tested for STIs and HIV every six months and provided treatment if needed.
4. While the truck drivers found it convenient to access self-testing kits, many of them were anxious about using these products because they could not read or follow the directions for use.
5. Fellow drivers are an important source of health information. They also generally trust most health-related information received via social media. Not all drivers have mobile phones and they do not regularly watch television.
6. It is generally very difficult to access proper medical care while travelling long distances due to language barriers, so they rely on old prescriptions from pharmacies back home.

"We are anxious about using self-testing products as we are illiterate and we cannot read the instructions. In some cases, it would be good if the instructions are written in our own language."

Artwork from this workshop community

Benefits and barriers to self-care interventions

- ✔ STI and HIV self-testing and self-treatment products can be used at the individuals' discretion while on the road.
- ✔ Self-care products would help overcome the stigma faced in clinics.
- ✖ There is fear of complications due to inappropriate use of self-care products.
- ✖ There is difficulty understanding which products or services to use and how, given low literacy levels.

1.2.4 Future issues for consideration around self-care SRHR interventions

Respondents were also asked to share their thoughts on any future issues that should be considered around self-care SRHR interventions. Their qualitative responses are presented below, clustered by topic.

HEALTH-CARE PROVIDERS

Health-care provider respondents discussed potential issues for consideration. The major topics discussed were: the importance of expertise, the legitimacy of interventions and the potential for misuse, starting with the most frequently mentioned.

Expertise

Many of these respondents discussed the lack of expertise held by the average user of self-care interventions, and the importance of accessing health-care providers for any SRHR interventions.

> *"Self-initiated interventions need to be avoided as far as possible. Always consult doctor when there arises [a] problem."*
>
> Male, 65, India

> *"There should be very strong counselling communication on the need to consult a doctor or other health-care worker should the patient not be happy with results or if they should develop complications."*
>
> Female, 58, Congo

Legitimacy

A potential issue that was brought up in the qualitative responses was the risk and danger of illegitimate interventions.

> *"Private drug shops [and] clinics need to be well regulated and could be sources of more burden and challenges."*
>
> Male, 46, Uganda

> *"I would want to make sure they are trusted, not counterfeit, if I buy them online."*
>
> Female, 35, United States

Misuse

Another future issue for consideration with self-care interventions is the potential for misuse of the interventions, which can have serious consequences.

> *"There is a risk for the general public of abuse, of misuse due to lack of knowledge. There is a lot of misinformation out there so there must be safeguards and some control."*
>
> Female, 56, Italy

Those risks can impact one's health, and some respondents expressed preference for consulting with a medical professional due to such risks.

> *"An intervention led by a doctor or health-care provider is safer and maintains safer reproductive health."*
>
> Female, 63, Pakistan

LAYPERSON RESPONDENTS

The layperson respondents discussed potential future issues to consider for self-care SRHR interventions. The major relevant themes that emerged in the qualitative responses were (in order of the frequency mentioned): the risk of misuse, the importance of expertise, and the need to ensure legitimacy.

Misuse

The potential for misuse of self-care SRHR interventions with negative consequences was an issue discussed by respondents.

> *"Just make sure there's risk management."*
>
> Female, 20, Indonesia

In particular, this was noted as an issue for certain interventions more so than others. One respondent elaborated on the interventions in which this would be a problem:

> *"Simple interventions can be self-initiated, like birth control or morning after pills or self-testing. But abortion pills, HIV medication, pre- and post-exposure, STI medication should be through a health provider because of complications arising from the condition or from the medication taken."*
>
> Female, 48, Kenya

This was also discussed as being a particularly important issue for individuals with lower educational attainment.

> *"Self-initiated interventions are only good for literates (health, reading, writing, digital, etc.) I feel they might be misused by illiterates."*
>
> Male, 32, Uganda

Expertise

Many respondents emphasized the importance of medical experts when it came to SRHR interventions.

> *"[There should be a] warning [that] only your medical team has the knowledge [necessary for using SRHR interventions]. [People should] avoid self-treatment [because] conditions and drug response are very personal [i.e. depend on individual patients]."*
>
> Male, 67, Mexico

> *"I just hope they don't eliminate the need of a health-care provider because really, anything could go wrong."*
>
> Female, 22, Kenya

This was discussed as being particularly important for specific services.

> *"Some interventions need counselling before they are used, how will that happen in self-initiated interventions?"*
>
> Female, 44, Uganda

Legitimacy

The final major theme in the qualitative responses regarding potential future issues to consider for self-care SRHR interventions was concern regarding the legitimacy of interventions. Respondents discussed the importance that the intervention services and products be of high quality.
One respondent explained that important issues include:

> *"Availability of full information and quality of the products."*
>
> Male, 40, Pakistan

This was noted as a particular concern for online sources for interventions.

> *"Simple STI tests, pregnancy tests and the like should be more readily available because going online also puts people at risk for illegal medication/tests and the like."*
>
> Female, 26, Sweden

It was also discussed that certain populations were especially vulnerable to SRHR products that lack legitimacy or are low quality.

> *"Some girls may need emergency contraception after unprotected sex, but they may buy it online due to other's attitudes and the drugs online are not really safe."*
>
> Male, 19, China

1.3 SOURCES OF KNOWLEDGE AND PREFERENCES FOR SRHR SERVICES

As presented in this section, respondents were asked where they had learned about SRHR services and what types of online resources they would like to use to learn more about SRHR services. Health-care providers and all layperson respondents reported their sources for learning about SRHR services from a list of 14 options, with the ability to choose all that apply (Figure 2; see Annexes E and G for details). Respondents were also asked what types of online resources they would prefer to use to learn more about SRHR from a list of 12 resources, with the option to choose all that apply (Figure 3; see Annexes F and H for details).

FIGURE 2: SOURCES FOR LEARNING ABOUT SRHR SERVICES

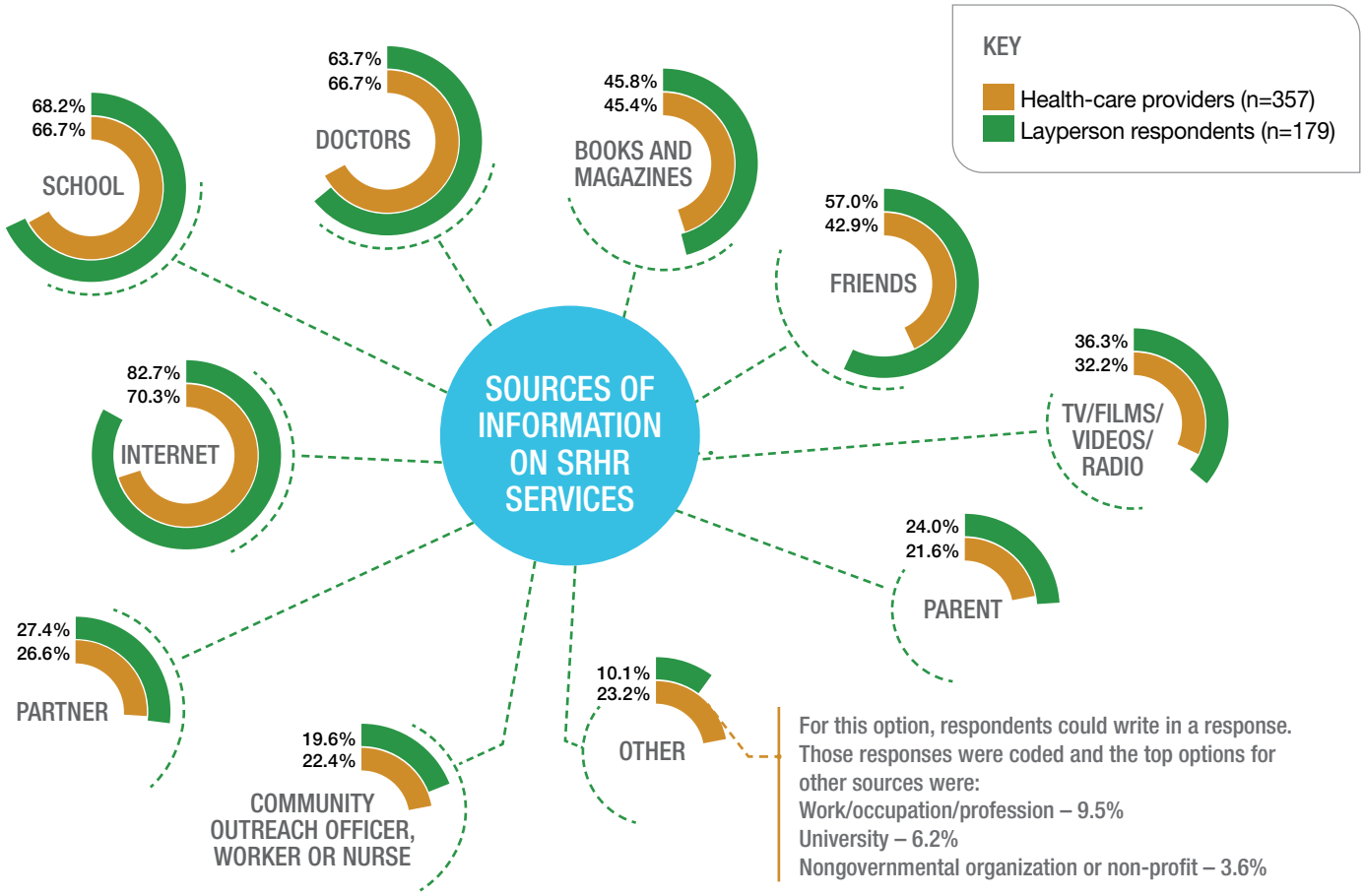
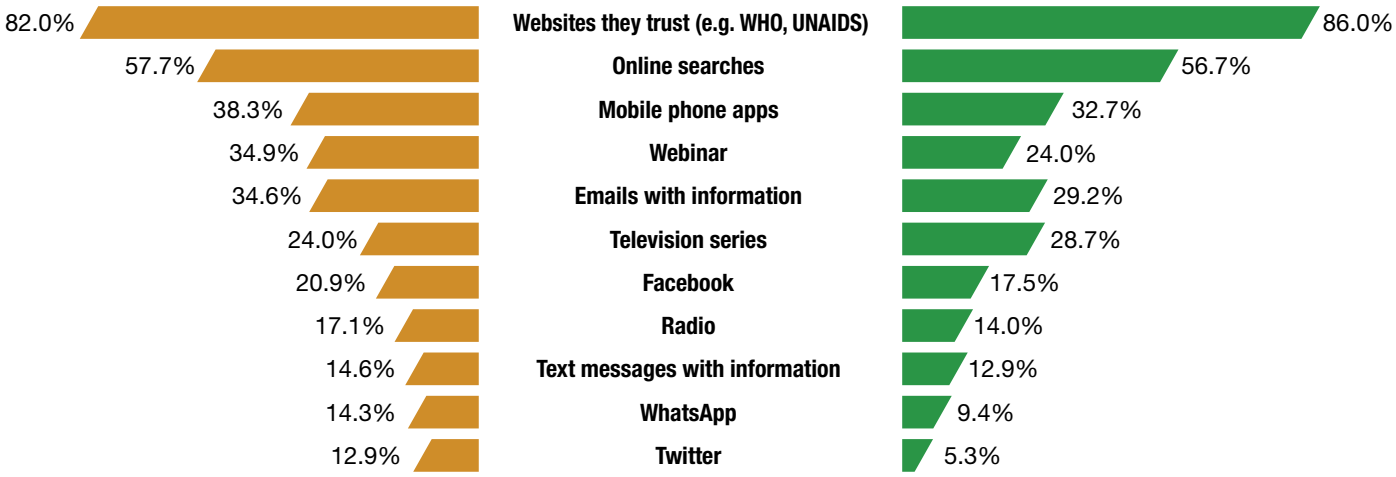


FIGURE 3: PREFERRED ONLINE SOURCES OF SRHR KNOWLEDGE



HIGHLIGHTS FROM COMMUNITY WORKSHOPS

Drug-using juvenile girls in conflict with the law

This workshop was held in New Delhi, India and involved female participants, the majority of whom were minors. The youngest was 10 years old. Education levels varied, but many were illiterate and came from poor backgrounds. All were accessed via a drug rehabilitation centre. Resource mapping and graffiti were used as tools to promote dialogue during the session.

The key issues raised by the participants included:

1. The girls described numerous common physical ailments such as blurred vision, dizziness and sleeplessness, as well as complications resulting from gonorrhoea and the use of unclean needles.
2. Common ailments are often treated at home, after reaching out to family members.
3. The participants had used alcohol, marijuana, adhesive solutions, pain killers, cough syrups, heroin, cocaine and other drugs.
4. They reported frequently visiting pharmacists for medication, with or without prescriptions. Several have also visited "voodoo" practitioners.
5. Participants were largely uneducated about health issues and health care, including having no knowledge of HIV or HIV risk reduction strategies prior to enrolment in the rehabilitation centre.
6. At the centre, they obtained information, testing and treatment for drug- and HIV-related issues and accessed counsellors and doctors.
7. They also reported gathering information about health issues from TV, radio, billboards and newspaper ads and through books.

There were two people living with HIV in this group. This group were at risk of HIV and hepatitis C, through shared use of infected needles and sexual transmission (several of the participants were sexually abused, raped or married as minors.)

"We come from very poor, uneducated backgrounds and we cannot read or write. So we don't practise self-care as we don't know anything about it."

Artwork from this workshop community

Benefits and barriers to self-care interventions

- ✔ Ease of access was a perceived benefit, although the participants did not report use of many self-care products.
- ✖ Being unable to read or write restricts access to self-care products.
- ✖ Those from a poor, uneducated background do not have access to self-care products or even knowledge about health issues and how to address them.

2

AWARENESS AND USAGE OF SELF-CARE INTERVENTIONS

Chapter summary

This chapter focuses on respondents' awareness of self-care SRHR interventions. The respondent groups, health-care providers and layperson respondents, are presented seperately. The self-care interventions are listed on the right. In addition to exploring knowledge of, and access to, each of these interventions, we also examined whether participants themselves, or their partners, had used each of these interventions. Finally, we examined factors (e.g. privacy or confidentiality, feelings of non-judgement, empowerment, convenience and access) that respondents rated as the most important in deciding whether to use each of these interventions.

"I use condoms. My peers were the ones who told me to use it. When I first came here, they asked me to take an HIV test and I refused, but they made me understand that this was for my own benefit."

– Commercial sex worker

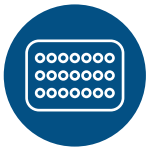
LIST OF THE SELF-CARE INTERVENTIONS

- Oral contraceptives
- Emergency contraception
- Contraceptive patch
- Vaginal ring
- Self-injectable long-acting contraceptives
- Diaphragm or cervical cap
- Abortion self-management
- Self-testing for sexually transmitted infections
- HIV self-testing
- Post-exposure prophylaxis (PEP)
- Pre-exposure prophylaxis (PrEP)
- Sexual health information found online
- Reproductive health information found online
- HIV treatment (antiretroviral therapy)
- STI treatment
- Sexual health mobile phone application (app)
- Reproductive health mobile phone app

2.1 AWARENESS, USAGE AND PERSPECTIVES ON SELF-CARE SRHR INTERVENTIONS

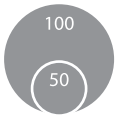
KEY
Health-care providers
Layperson respondents

100
50
% respondents



	ORAL CONTRACEPTIVES		EMERGENCY CONTRACEPTION		CONTRACEPTIVE PATCH	
AWARENESS	n=360	n=423	n=359	n=421	n=356	n=420
Aware of intervention and where to access it (%)	98.1	93.4	92.8	85.3	74.4	66.0
Aware of intervention but not where to access it (%)	1.1	5.7	4.7	8.8	16.6	17.9
Not aware of intervention (%)	0.8	0.9	2.5	5.9	9.0	16.2
USAGE	n=354	n=366	n=346	n=361	n=346	n=361
Have used intervention (%)	48.6	38.8	36.4	29.6	5.5	5.0
Have used intervention in past three months (%)	6.2	7.4	4.0	3.6	0.0	0.8
Have not used intervention (%)	26.6	26.5	35.0	31.0	71.7	60.4
Not relevant (%)	18.6	27.3	24.6	35.7	22.8	33.8
PERSPECTIVES Top factors for deciding to use intervention:	n=320	n=193	n=292	n=175	n=267	n=155
Privacy and confidentiality (%)	48.4	43.0	55.8	51.4	41.2	36.1
Lack of judgement (%)	25.3	22.3	32.9	28.6	23.6	20.0
Empowerment (%)	31.3	24.9	27.1	20.6	27.3	25.2
Convenience (%)	56.6	56.0	49.3	41.7	53.6	45.8
Accessibility (%)	52.8	64.2	51.7	52.6	44.9	54.2

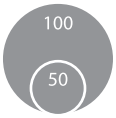
This section describes participants' awareness and usage of self-care SRHR interventions and their perspectives on important related factors. Participants were asked whether they knew of each intervention and where to access it. Participants' perspectives on important factors that help them decide whether or not to use an intervention are also reported. In that question, participants could choose one, some or all that applied from a list of options. The results are presented in the chart below.



% respondents

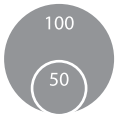
	VAGINAL RING		SELF-INJECTABLE LONG-ACTING CONTRACEPTIVES		DIAPHRAGM OR CERVICAL CAP	
AWARENESS	n=357	n=420	n=356	n=418	n=353	n=417
Aware of intervention and where to access it (%)	69.2	61.0	69.1	57.4	73.4	63.3
Aware of intervention but not where to access it (%)	24.4	26.9	16.6	21.1	21.0	24.7
Not aware of intervention (%)	6.4	12.1	14.3	21.5	5.7	12.0
USAGE	n=343	n=362	n=345	n=360	n=344	n=363
Have used intervention (%)	4.1	5.8	4.3	4.4	6.1	5.0
Have used intervention in past three months (%)	0.9	0.8	0.6	0.8	0.0	0.8
Have not used intervention (%)	70.3	57.7	71.0	58.9	70.6	59.2
Not relevant (%)	24.8	35.6	24.1	35.8	23.3	35.0
PERSPECTIVES Top factors for deciding to use intervention:	n=264	n=156	n=268	n=152	n=254	n=148
Privacy and confidentiality (%)	43.9	36.5	41.0	39.5	42.1	34.5
Lack of judgement (%)	23.9	23.1	23.9	23.0	22.4	23.0
Empowerment (%)	24.2	23.7	23.5	27.0	22.8	24.3
Convenience (%)	50.4	46.8	55.2	46.1	49.2	45.3
Accessibility (%)	44.3	51.9	44.4	53.3	44.9	54.1

KEY
Health-care providers
Layperson respondents



% respondents

	ABORTION SELF-MANAGEMENT		SELF-TESTING FOR SEXUALLY TRANSMITTED INFECTIONS		HIV SELF-TESTING	
AWARENESS	n=357	n=420	n=356	n=419	n=357	n=417
Aware of intervention and where to access it (%)	65.3	57.1	48.9	44.4	56.9	48.9
Aware of intervention but not where to access it (%)	28.0	33.6	36.2	36.0	33.9	34.8
Not aware of intervention (%)	6.7	9.3	14.9	19.6	9.2	16.3
USAGE	n=345	n=361	n=346	n=362	n=346	n=360
Have used intervention (%)	5.5	6.9	9.2	7.2	13.3	7,5
Have used intervention in past three months (%)	0.6	0.6	3.2	2.8	2.3	3.6
Have not used intervention (%)	67.5	53.2	69.7	63.8	65.3	65.0
Not relevant (%)	26.4	39.3	17.9	26.2	19.1	23.9
PERSPECTIVES Top factors for deciding to use intervention:	n=261	n=144	n=280	n=157	n=278	n=156
Privacy and confidentiality (%)	65.5	59.0	61.4	65,6	64.4	64.1
Lack of judgement (%)	38.3	41.0	34.6	38.9	35.3	39.1
Empowerment (%)	31.8	27.8	26.1	30.6	24.8	27.6
Convenience (%)	43.7	32.6	47.9	40.8	46.8	39.7
Accessibility (%)	43.3	47.2	43.2	49.0	41.7	50.0



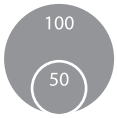
% respondents

	POST-EXPOSURE PROPHYLAXIS (PEP)		PRE-EXPOSURE PROPHYLAXIS (PREP)		HIV TREATMENT (ANTI-RETROVIRAL THERAPY)	
AWARENESS	n=356	n=416	n=355	n=412	n=356	n=419
Aware of intervention and where to access it (%)	69.7	51.7	64.5	48.5	89.9	72.8
Aware of intervention but not where to access it (%)	21.1	23.6	25.4	25.5	7.3	20.0
Not aware of intervention (%)	9.3	24.8	10.1	26.0	2.8	7.2
USAGE	n=344	n=359	n=343	n=361	n=338	n=361
Have used intervention (%)	3.8	2.5	2.0	1.7	4.7	3.9
Have used intervention in past three months (%)	0.6	0.6	1.7	1.4	0.6	1.1
Have not used intervention (%)	66.3	64.3	66.2	64.8	56.5	55.4
Not relevant (%)	29.4	32.6	30.0	32.1	38.2	39.6
PERSPECTIVES Top factors for deciding to use intervention:	n=266	n=149	n=262	n=148	n=262	n=150
Privacy and confidentiality (%)	57.9	57.7	56.5	54.1	59.2	57.3
Lack of judgement (%)	32.0	29.5	33.6	30.4	29.0	34.0
Empowerment (%)	24.8	26.8	26.3	28.4	23.7	26.0
Convenience (%)	42.5	36.2	41.2	36.5	40.5	36.7
Accessibility (%)	45.5	49.0	43.1	48.6	42.0	51.3

KEY
Health-care providers
Layperson respondents

100
50
% respondents

	STI TREATMENT		SEXUAL HEALTH INFORMATION FOUND ONLINE		REPRODUCTIVE HEALTH INFORMATION FOUND ONLINE	
AWARENESS	n=353	n=415	n=355	n=420	n=356	n=420
Aware of intervention and where to access it (%)	87.3	71.6	89.6	87.1	91.0	87.9
Aware of intervention but not where to access it (%)	7.9	16.4	6.5	8.3	5.6	7.4
Not aware of intervention (%)	4.8	12.0	3.9	4.5	3.4	4.8
USAGE	n=345	n=356	n=347	n=364	n=347	n=365
Have used intervention (%)	15.4	11.2	53.3	46.4	54.8	45.5
Have used intervention in past three months (%)	1.2	2.5	10.7	10.2	11.2	10.1
Have not used intervention (%)	52.5	50.0	24.8	25.5	22.2	24.1
Not relevant (%)	31.0	36.2	11.2	17.9	11.8	20.3
PERSPECTIVES Top factors for deciding to use intervention:	n=268	n=156	n=276	n=155	n=276	n=156
Privacy and confidentiality (%)	60.1	60.3	46.4	40.6	44.2	41.0
Lack of judgement (%)	32.1	35.3	25.0	24.5	24.6	24.4
Empowerment (%)	22.8	23.1	31.5	23.9	31.2	24.4
Convenience (%)	41.0	39.1	46.4	45.8	47.5	45.5
Accessibility (%)	43.3	54.5	54.3	58.7	54.7	58.3



% respondents

	SEXUAL HEALTH MOBILE PHONE APP		REPRODUCTIVE HEALTH MOBILE PHONE APP	
AWARENESS	n=357	n=422	n=355	n=420
Aware of intervention and where to access it (%)	47.3	41.7	56.1	53.8
Aware of intervention but not where to access it (%)	29.4	27.7	26.8	22.9
Not aware of intervention (%)	23.2	30.6	17.2	23.3
USAGE	n=344	n=363	n=341	n=362
Have used intervention (%)	12.2	12.7	17.6	20.4
Have used intervention in past three months (%)	3.5	2.8	7.0	2.8
Have not used intervention (%)	66.0	60.3	57.2	51.1
Not relevant (%)	18.3	24.2	18.2	25.7
PERSPECTIVES Top factors for deciding to use intervention:	n=268	n=154	n=267	n=153
Privacy and confidentiality (%)	41.0	42.2	40.8	42.5
Lack of judgement (%)	22.8	19.5	21.7	19.0
Empowerment (%)	29.1	24.0	31.1	24.8
Convenience (%)	50.0	46.1	50.6	45.8
Accessibility (%)	50.0	53.9	50.2	54.2

HIGHLIGHTS FROM COMMUNITY WORKSHOPS

African and Caribbean women service providers

The participants at this workshop were young women of African or Caribbean descent living in Toronto, Canada. All of the participants work in the community or public health sector and have at least a high school education. Two thirds of the group actively shared and participated in the discussion.

Artwork from this workshop community

The key issues that emerged include:

1. In Canada, African and Caribbean Black women face high levels of stigma, racism and judgement that deter them from accessing health care and services.
2. Health-care centres are not easily accessible to these communities because distance and clinic hours are inconvenient.
3. Community Health Ambassadors can potentially overcome many of the cultural barriers to health care by speaking the same language and being present in the communities they serve.
4. The community lacks trust in doctors and the health-care system. This lack of trust is embedded in their culture with roots in the exploitative history lived by African communities.
5. Women feel they are expected to uphold the image of a "strong Black female" – always putting their family's needs before their own. While they value self-reliance, which could serve as a springboard for self-care, it is uncommon in their cultures to talk openly about health or mental health.
6. Intimate partner violence is prevalent but many women do not realize that their relationship is violent and lack positive examples of healthy relationships.

Benefits and barriers to self-care interventions

- ✔ People can avoid judgement and stigma through the more confidential and anonymous nature of self-care products and services.
- ✔ Access is needed to wide community networks and peers who speak their language.
- ✖ Literacy poses a barrier to reading and following directions for medication.
- ✖ Lack of knowledge and awareness about self-care products and services poses a barrier.

HIGHLIGHTS FROM COMMUNITY WORKSHOPS

Transgender people, male and transgender sex workers, and men who have sex with men

Resource mapping and graffiti tools were used to support dialogue and gather information at this workshop in India, which had 15 participants.

The key issues raised by the participants included:

1. The community often visits unqualified practitioners and gurus (i.e. community leaders) for treatment, health-care advice and sex reassignment surgery (SRS). Those who are literate rely on social media and the Internet for information.
2. They also self-medicate, re-use and exchange prescriptions for treatment of STIs and common ailments.
3. This community is largely faceless, voiceless and highly marginalized by society.
4. Debt is ubiquitous among the participants because of the high cost of care and SRS, forcing them into sex work and putting them at greater risk of HIV and STIs.
5. Outward beauty and appearance is often emphasized over health.
6. The community strongly feels the need for reliable transgender resources (health, legal and others) and the need to sensitize health-care providers.
7. The community wants access to safe HIV and STI testing facilities.
8. The government health system is not trusted due to stigma, discrimination and the fear of breach of confidentiality. Government hospitals are often the last resort for help.
9. The National AIDS Control Organization and the governmental AIDS programmes do not encourage self-testing as they are concerned that the community may not access treatment if needed. Therefore, the community is not aware that HIV self-testing and other self-testing kits exist.

Artwork from this workshop community

Benefits and barriers to self-care interventions

- ✔ Educated men who have sex with men, male sex workers and transgender people access health-care information online, allowing them to manage interventions on their own and guide their peers.
- ✔ There is no stigma or fear of disclosure in accessing self-care products.
- ✖ There is no support system to guide the community in case of failure or complications as a result of using self-care products.
- ✖ Since many of the services the community accesses are illegal, there is no recourse or remedial measure available when self-care products fail.

3

HEALTH-CARE ENGAGEMENT AND SELF-CARE SRHR INTERVENTIONS

Chapter summary

This chapter focuses on respondents' experiences and preferences for engagement with health-care providers in relation to self-care SRHR interventions. Of the layperson respondents, 57.0% had engaged with health-care providers in relation to self-care SRHR interventions. This chapter also presents data on where respondents go to access self-care SRHR interventions by specific intervention, as well as where they access information on these interventions. Generally, across self-care SRHR interventions in this study, respondents reported a doctor or health clinic, and a pharmacy as the top two places where they go to access each one, and the Internet and a doctor or health-care provider as the top two places where they access information on individual interventions. With respect to their perspectives on engaging with health-care providers for access to self-care SRHR interventions, most respondents, both health-care provider respondents and all others, reported that it is important for them to be able to access these interventions without going to a health-care provider. That said, when asked if they prefer to access self-care SRHR interventions on their own or with a health-care provider, most respondents reported that it would depend on the type of self-care SRHR intervention they were seeking to use. Additionally, 60.6% of health-care provider respondents and 58.0% of all layperson respondents reported that it was "very important" for them to have a health-care provider to access after having used one of the interventions. The chapter concludes with a summary of access to health care and online information with 94.7% of health-care provider respondents and 96.6% of all layperson respondents reporting that they have access to a health-care provider when they need one. The majority reported that it is "very easy" for them to access online information or a mobile phone app confidentially.

"When home or Internet-based information regarding remedies are not an option, we heavily depend on pharmacies. It's always paracetamol for basic conditions, if you ask for 20, they don't refuse to give you 20. No prescriptions required. We go to doctors only when nothing else works out."

– A youth from the Dalit community, India

3.1 ENGAGEMENT WITH HEALTH-CARE PROVIDERS FOR SELF-CARE SRHR INTERVENTIONS

This section reviews respondents' engagement and experiences with health-care providers in relation to self-care SRHR interventions. In Chapter 2 of this report, respondents indicated their personal, or their partner's, usage of self-care SRHR interventions; they were given a list of specific interventions and asked to report whether they had used them. As a follow-up to that question, if they reported usage of any of the listed interventions, they were then asked whether they had engaged with health-care providers when using, or as a result of using, that intervention. In addition, they were asked if anyone had forced or pressured them to use the aforementioned self-care SRHR interventions.

QUESTION: Did you engage with a health-care provider when using, or as a result of using, that intervention?

FOR HEALTH-CARE PROVIDER RESPONDENTS

Among 326 respondents, the majority at 69.3% (n=226) engaged with health-care providers when they used, or as a result of using, the self-care SRHR interventions listed. Around one third, at 30.7% (n=100) did not engage with health-care providers.

Among 304 respondents, only a small minority at 4.9% (n=15) reported ever feeling forced or pressured to use the self-care SRHR interventions. Most, at 95.1% (n=289) did not feel forced or pressured.

FOR LAYPERSON RESPONDENTS

Among 300 respondents, the majority reported engaging with health-care providers when using or as a result of using the interventions: 57.7% (n=173) reported they did engage, while 42.3% (n=127) did not.

Among 280 respondents, a small number reported ever feeling forced or pressured to use the interventions at 6.4% (n=18), while the majority reported they had not experienced that (93.6%, n=262).

Current state of SRHR self-care training for health professionals

The training of health professionals needs to address the growing access to, and delivery and uptake of, self-care interventions for health care. Recognizing the importance of such training, the WHO Department of Reproductive Health and Research convened the first consultation of early-career health professionals from the fields of midwifery, nursing, pharmacy, public health and medicine.

This case study summarizes key gaps and challenges of SRHR self-care training for these professionals, including:

- Curricula focus on technical and scientific content rather than communication skills, decision-making and comprehensive problem-solving.
- Biased training from biased teachers creates biased providers, institutionalizing stigmatization of present and future patients.
- Lack of integrated approaches is due to lack of funding, as well as institutional and specialty siloes.
- There is a lack of training to build trust and work with health professionals across sectors in interdisciplinary and inter-professional teams.
- In the training, there is a lack of sensitivity to social, cultural and religious context.
- Training on patient management and how to establish healthy client–provider relationships is insufficient, including retaining those young people, adolescents and vulnerable populations who may need longer-term care.
- Training in gender equality, human rights and ethics is inadequate.
- Institutional glass ceilings hinder women's advancement to leadership positions in many health careers, although women now constitute the majority of the incoming health workforce.

To address these issues, there is a need for more interactive ways of teaching, to help students integrate their knowledge, skills and attitudes for improved real-world patient care. Curricula should also be person-centred and emphasize specific training on SRHR issues and work to strengthen understanding of social, cultural and religious contexts that affect SRHR.

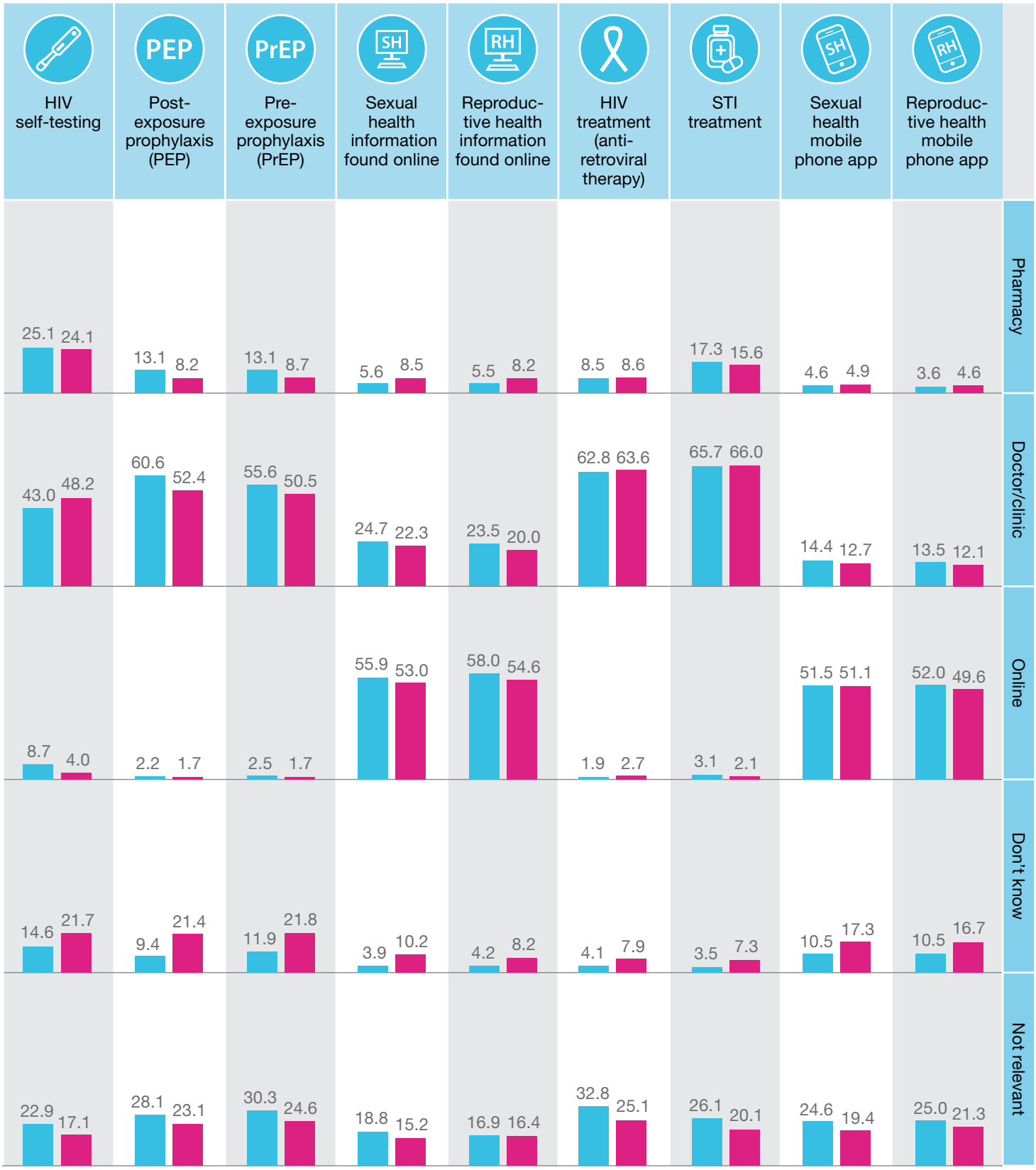
Artwork from this workshop community

3.2 ACCESSING SELF-CARE SRHR INTERVENTIONS AND RELEVANT INFORMATION

This section reports the findings on where participants access self-care SRHR interventions and how they access information about them. Respondents were asked about where they access or would access the interventions, with the option to choose all that apply. The results for this question are presented in Figure 4 below.

FIGURE 4: WHERE RESPONDENTS GO TO ACCESS SELF-CARE SRHR INTERVENTIONS

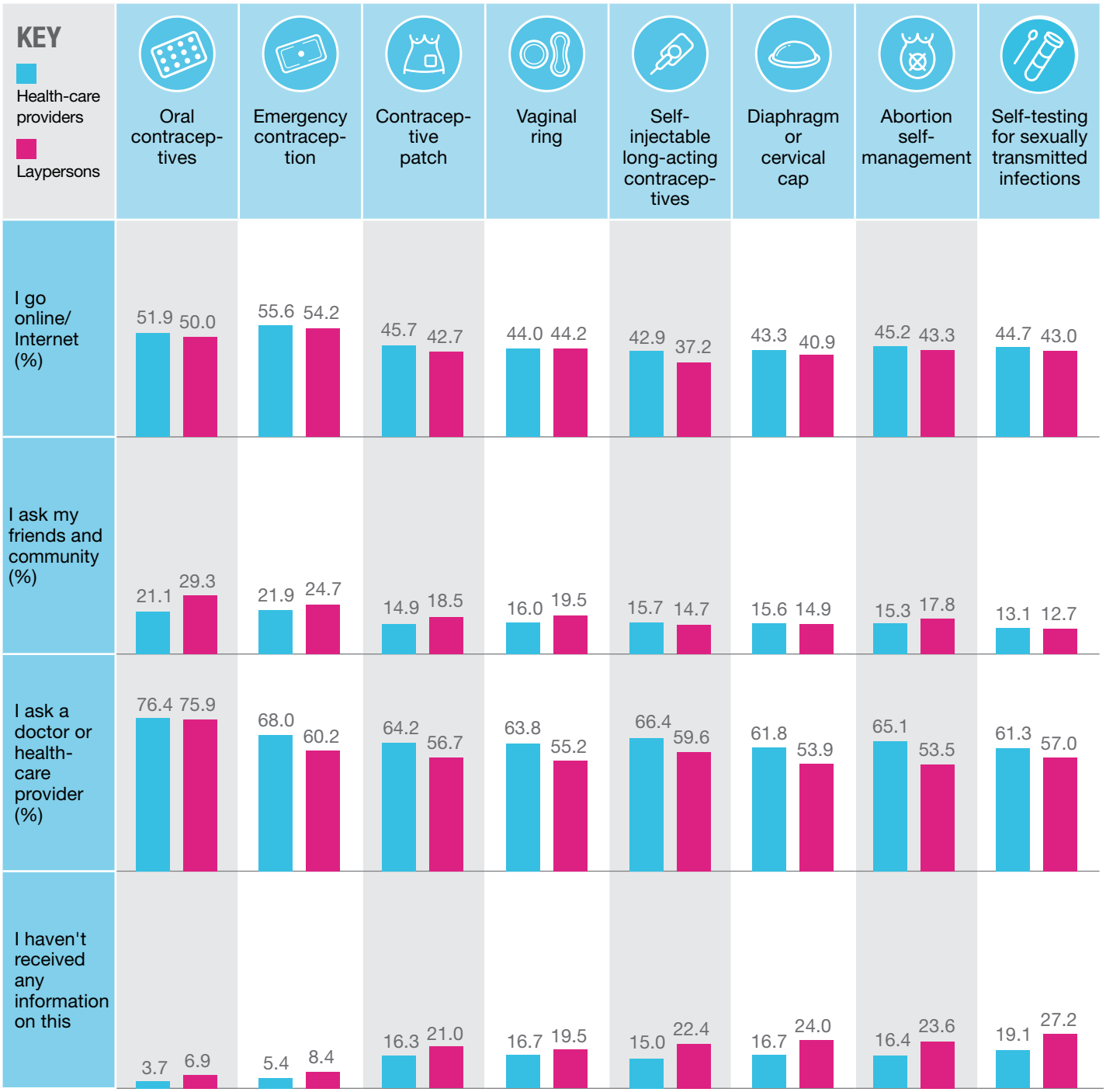
HOW TO READ THIS TABLE
Looking at the first cell of this page, 25.1% of health-care providers, and 24.1% of layperson respondents report accessing HIV self-testing products from a pharmacy

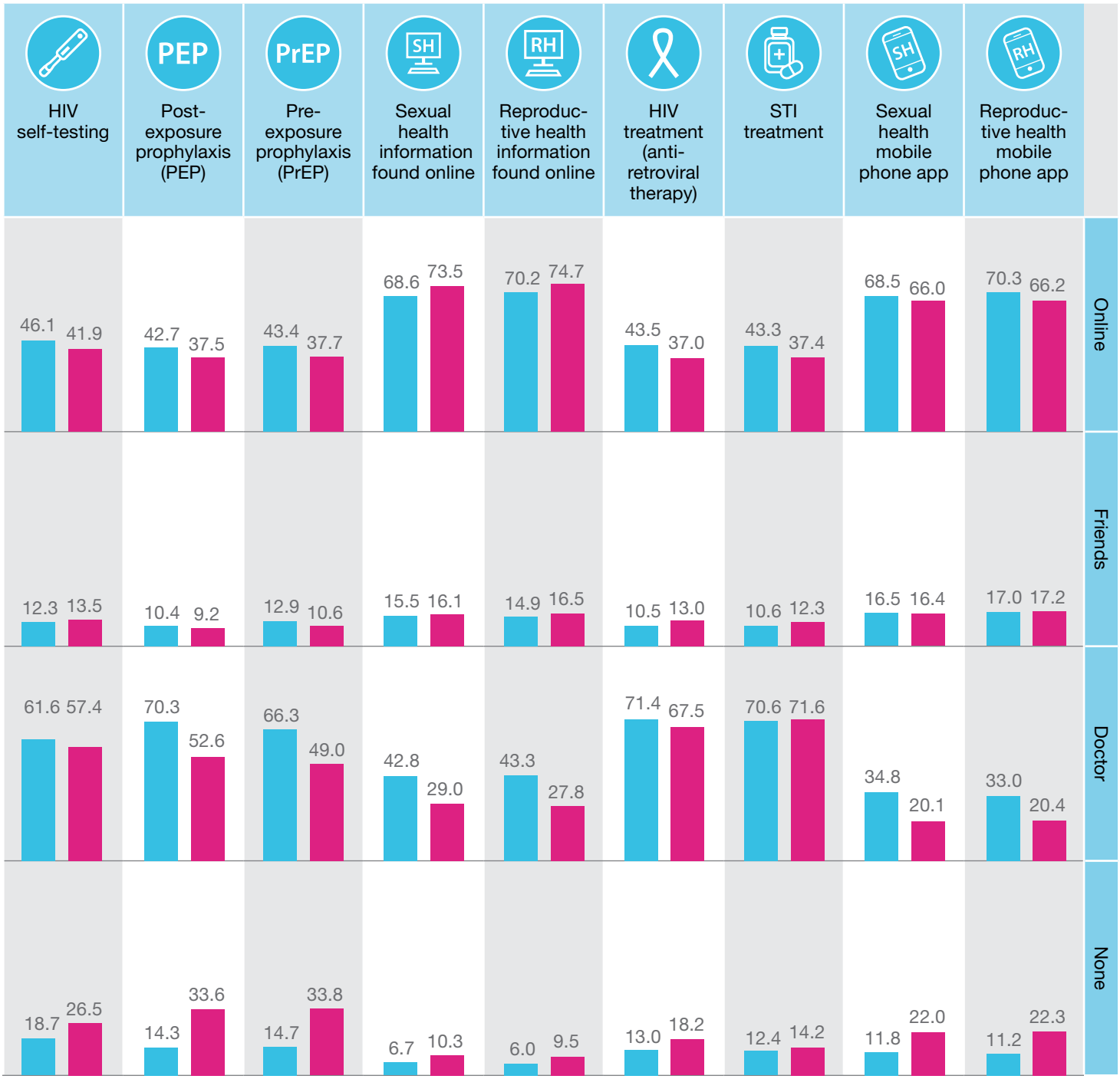


3.2 (continued)

This section continues to report the findings on access to self-care SRHR interventions and information. The survey also asked respondents how they access information about the interventions, again providing a list of options from which they could select all that apply. The results for this question are presented below in Figure 5.

FIGURE 5: HOW RESPONDENTS ACCESS INFORMATION ABOUT SELF-CARE SRHR INTERVENTIONS




HIV self-testing
Post-exposure prophylaxis (PEP)
Pre-exposure prophylaxis (PrEP)
Sexual health information found online
Reproduc-tive health information found online
HIV treatment (anti-retroviral therapy)
STI treatment
Sexual health mobile phone app
Reproduc-tive health mobile phone app
Online
Friends
Doctor
None
46.1 41.9
42.7 37.5
43.4 37.7
68.6 73.5
70.2 74.7
43.5 37.0
43.3 37.4
68.5 66.0
70.3 66.2
12.3 13.5
10.4 9.2
12.9 10.6
15.5 16.1
14.9 16.5
10.5 13.0
10.6 12.3
16.5 16.4
17.0 17.2
61.6 57.4
70.3 52.6
66.3 49.0
42.8 29.0
43.3 27.8
71.4 67.5
70.6 71.6
34.8 20.1
33.0 20.4
18.7 26.5
14.3 33.6
14.7 33.8
6.7 10.3
6.0 9.5
13.0 18.2
12.4 14.2
11.8 22.0
11.2 22.3

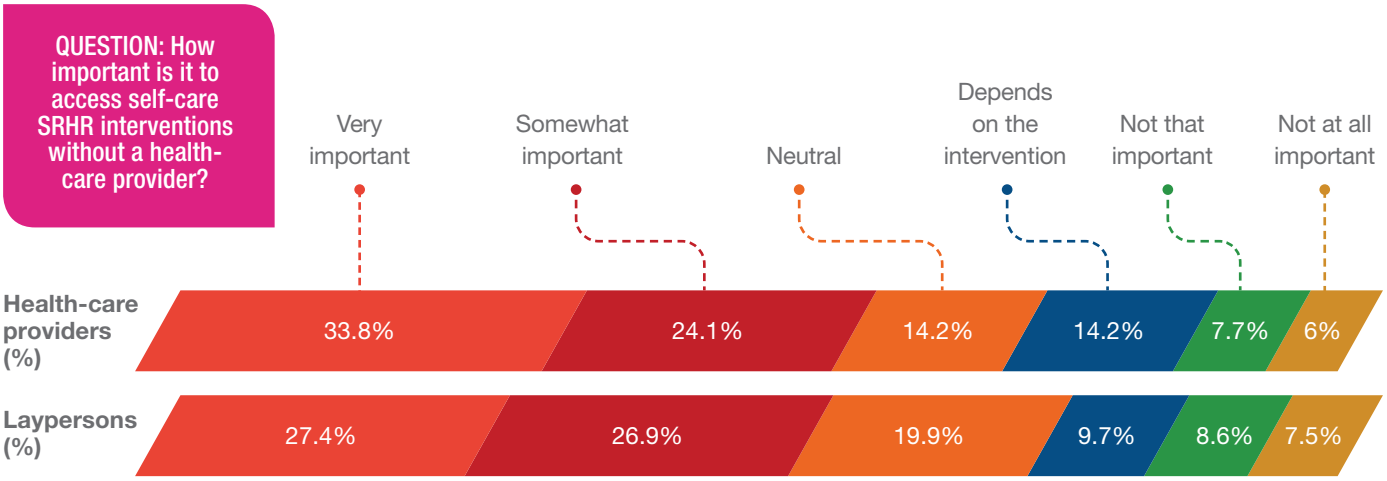
3.3 ENGAGING HEALTH-CARE PROVIDERS WITH SELF-CARE SRHR INTERVENTIONS

This section presents the results of questions about respondents engaging with health-care providers for self-care SRHR interventions. It reports respondents' perceptions of the importance of both accessing interventions without a health-care provider and seeking a health-care provider after using interventions. It reports their preferences on accessing a self-care SRHR intervention on their own or with a health-care provider. Lastly, it reports whether respondents can access health care when they need it and their ease of accessing the Internet or mobile phone confidentially.

3.3.1 Level of importance of accessing interventions without a health-care provider

The majority of health-care provider respondents (n=352) reported that it is important for end-users to access the self-care SRHR interventions without going through a health-care provider. For all layperson respondents (n=186), more than half rated it as important to access the interventions without going through a health-care provider. See the full results for both respondent groups in Figure 6.

FIGURE 6: RESPONDENT RATINGS OF THE IMPORTANCE OF ACCESSING INTERVENTIONS WITHOUT A HEALTH-CARE PROVIDER



For those who responded that it depends on the intervention, an explanation was sometimes provided. Qualitative answers from the health-care providers and other respondents are presented in the following pages.

HEALTH-CARE PROVIDERS

Health-care provider respondents expressed their current concerns about self-care SRHR interventions.

Needing more information

Needing trusted information on interventions from a health-care professional was discussed by some health-care respondents.

> *"For anything more complex I'd like reassurance of a health professional as there is so much information available online, not always very credible."*
>
> Female, 31, United Kingdom

Seeing a health-care provider can ensure that a patient makes independent, well informed decisions:

> *"Because the knowledge that I have may not be comprehensive and I would want to rely on a health-care provider's intervention. It does not mean that I shouldn't decide but I should know everything about the intervention before I give consent or not."*
>
> Female, 24, Turkey

Stigma and discrimination

The stigma, judgement and controversy attached to specific interventions meant that, for some, it is preferable to access without seeing a health-care professional.

> *"The more controversial (emergency contraception, HIV testing/treatment) the more I want access without going through a health-care provider."*
>
> Female, 59, United States

The societal view of that intervention is also a factor for some.

> *"If the intervention is normal and accepted by the society then it's fine. However, if it would lead to people making judgements then I would prefer to do it myself."*
>
> Female, 23, Qatar

Complexity and risk of intervention

Other health-care provider respondents explained that the decision to use the intervention without a health-care provider depends on the complexity of using the intervention and the risk for adverse reactions.

> *"In case of any complications or adverse reactions, unproper use of the intervention, if the risk is minimal and the supervision of the health provider is not required, then let it be."*
>
> Female, 27, Moldova

Some respondents specified the interventions with higher risks. Others discussed the importance of knowing the risks for those interventions in advance:

> *"Some interventions, for example the abortion pill, are somewhat dangerous in the sense that it's a lot of hormones so I feel that those types of interventions should be acquired after having an unbiased consultation just to know the side-effects."*
>
> Female, 18, Macedonia

LAYPERSON RESPONDENTS

Layperson respondents explained that it depends on the nature of the intervention, with complexity and urgency being major concerns.

> *"For example, if I needed antiretroviral therapy I definitely would go to a health-care provider, or if I suffered a STI or if I required injectable medicines."*
>
> Female, 24, Venezuela

Another respondent noted the issue of time-sensitive matters relating to SRHR.

> *"If the intervention needs to be quick and convenient, where time is the matter of urgency, it is important to be able to access the health care provided quickly or to bypass them if necessary. Otherwise, I prefer to have contact with a health-care provider."*
>
> Female, 25, Croatia

Some respondents noted that accessing interventions through a health-care provider may not always be reliable.

> *"It depends if I feel it's something I can get sufficient information on without seeing a doc. But so many are poorly informed on sexual health and, generally, access to the intervention."*
>
> Female, 34, Mexico

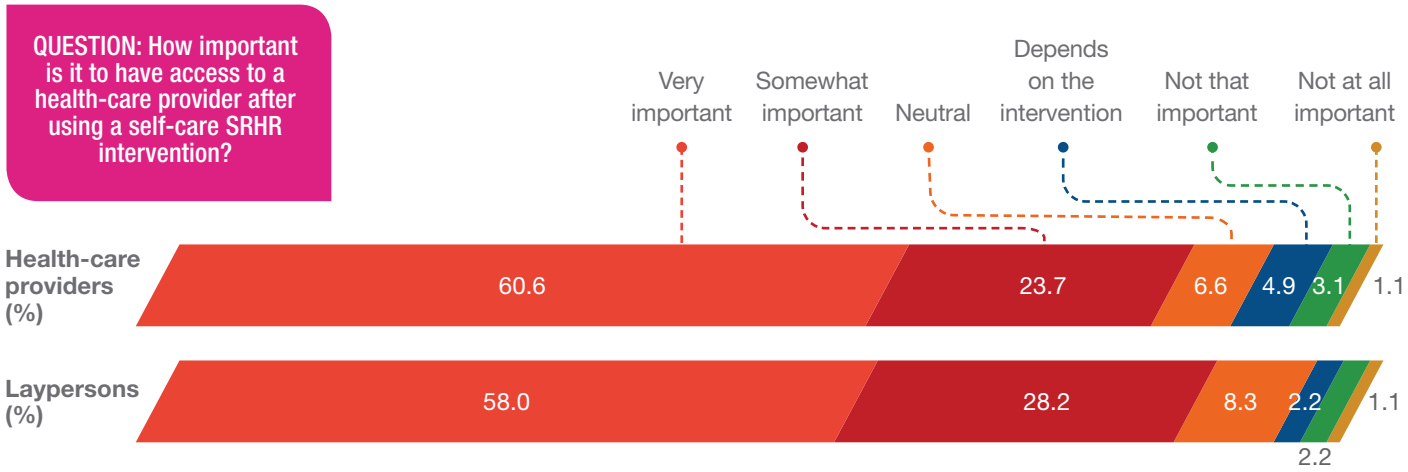
Another respondent noted the advantage of accessing trusted sources for information, particularly for individuals from sexual and gender minorities.

> *"As long as wherever I am getting information is safe, ethical, accessible and queer friendly."*
>
> Female, 25, Australia

3.3.2 Level of importance of accessing health-care providers after using an intervention

Of the health-care providers who responded (n=350), most thought it was very important to have access to a health-care provider after using a self-care SRHR intervention. Layperson respondents (n=181) also mostly rated this as very important. The results from both respondent groups are presented below in Figure 7.

FIGURE 7: RESPONDENT RATINGS OF THE IMPORTANCE OF ACCESSING HEALTH-CARE PROVIDERS AFTER USING AN INTERVENTION



HEALTH-CARE PROVIDERS

For those health-care providers who responded that it depends on the intervention when choosing to access health care after use of an intervention, an explanation was sometimes provided. Some respondents explained that it depends on the result of the intervention and the associated adverse effects.

> *"Yes. For example, after HIV home testing, I would want to have counselling with a provider. On the other hand, after use of EC [emergency contraception], I wouldn't need to talk with anyone in the health profession unless I was experiencing complications."*
>
> Female, 38, United States

Other health-care provider respondents elaborated that while for some interventions accessing a health-care provider after using the intervention is important, it does not have to be in person.

> *"I need to be able to ask questions or go to someone in case of side-effects, etc. If this was telephonic that is fine I would not need to see someone physically."*
>
> Female, 51, South Africa

LAYPERSON RESPONDENTS

The complexity of and risk for adverse reactions to the interventions was a factor reported by other respondents for determining if they would access health care after using an intervention.

> *"For simple intervention not important – but for HIV, abortion, complicated STI very important."*
>
> Female, 48, Kenya

3.3.3 Preferences around accessing interventions with or without health-care providers

Health-care providers (n=351) and other respondents (n=179) were asked about their preferences in relation to accessing a self-care intervention on one's own or with a health-care provider. The majority said that it depends on the intervention: 56.4% (n=198) of health-care providers and 64.2% (n=115) of other respondents.

A quarter of health-care provider respondents (24.5%, n=86) said it was preferable for end-users to access the interventions with a health-care provider, while 19.1% (n=67) said it was preferable to access it on one's own. Among other respondents, about 1 in 10 (11.7%, n=21) stated that they prefer to access the interventions on their own, while around a quarter (24.0%, n=43) reported that they prefer to access the interventions with a health-care provider.

3.3.4 Ease of access to self-care interventions

Health-care providers (n=359) and other respondents (n=174) were asked how easily they could access health care when they needed it. The vast majority of health-care provider respondents reported being able to access health care when they need it, at 94.7% (n=340). Similarly, most of the layperson respondents reported being able to access health care when they needed it, at 96.6% (n=168).

The respondents were also asked how easily they could access the internet or mobile phones confidentially. Most health-care providers reported that it was very easy (81.6%, n=292) or easy (16.5%, n=59). The remaining 2.0% reported that it is not easy (1.1%, n=4) and very difficult (0.8%, n=3). Most of all other respondents also reported that confidential access to the Internet and mobile phones was very easy at 86.1% (n=142) and easy (10.9%; n=18). Only 3% (n=5) reported it as not easy (no participants reported it as very difficult).

4

HEALTH-CARE PROVIDERS' PERSPECTIVES ON SELF-CARE SRHR INTERVENTIONS

Chapter summary

This chapter summarizes health-care provider respondents' perspectives on self-care SRHR interventions. The most common health-care providers in the survey were doctors, pharmacists and other professionals working in a clinic that provides SRH information. In terms of health-care providers' concerns regarding self-care SRHR interventions, misuse of the intervention by the patient, access to care following the intervention if used incorrectly, age restrictions, and spousal consent laws were the most commonly cited concerns. In terms of perceived benefits of self-care SRHR interventions, 27.7% of health-care providers reported that they saw no benefit to these interventions. However, 22.3% saw important intrapersonal benefits, including increased empowerment, self-confidence, and better-informed decision-making, while 13.4% viewed self-care SRHR interventions as promoting increased use of these interventions, and another 13.4% viewed self-care SRHR interventions as increasing the convenience of these interventions. When asked about how to link patients to health care after the use of self-care SRHR interventions, the most common suggestion for how to facilitate this linkage was to provide patients with the contact information of a health-care provider, while 26.4% suggested having a referral system and 22.2% suggested increased education. In terms of health-care providers' needs for training and information about self-care SRHR interventions, 29.8% of respondents reported needing more information on new, common or specific interventions, including HIV self-testing, contraceptives and abortion self-management. Other common responses included instructions and next steps on how to proceed and specific training on topics such as administrating interventions, providing appropriate linkages to care and offering counselling to patients. Finally, this chapter concludes with a breakdown of health-care providers' experience, knowledge and preferences for the various self-care SRHR interventions under study.

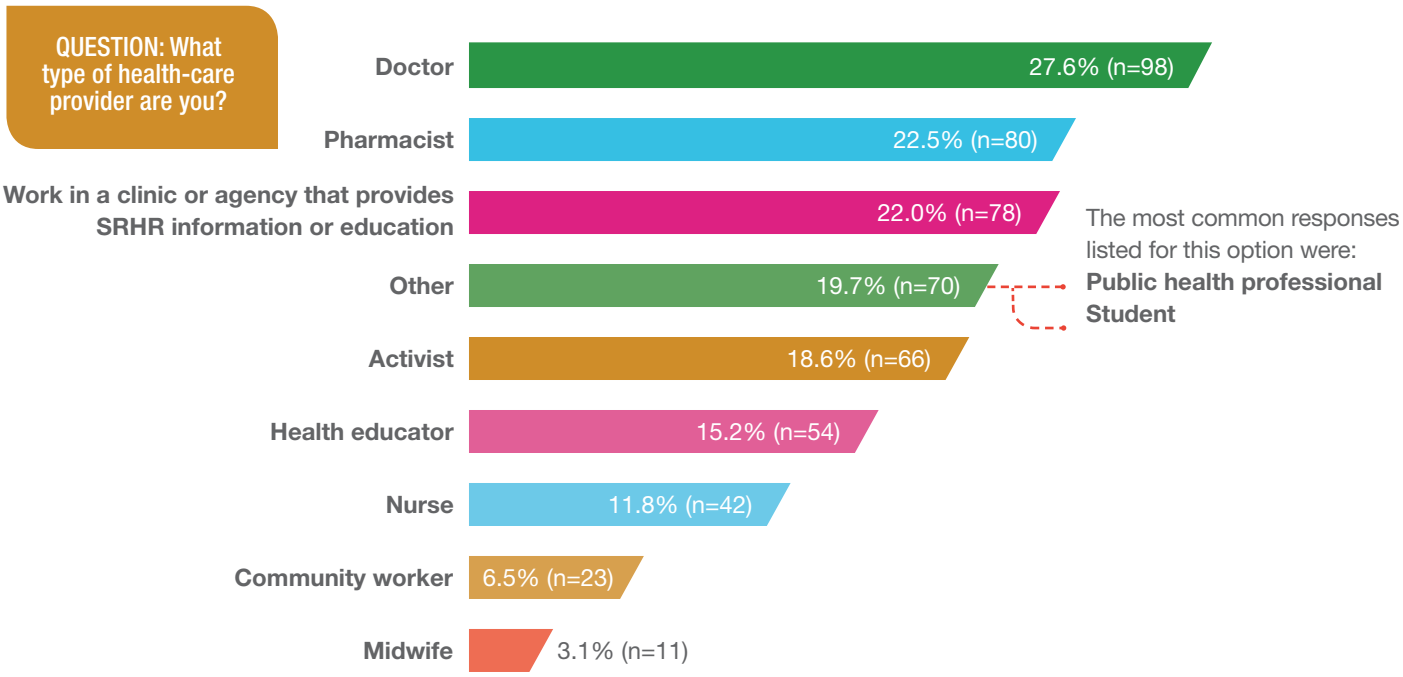
"Only men have easy access to condoms in the pharmacy. Women like us are given judgemental looks and sometimes asked what we need it for! This is the same problem when we try to access self-testing pregnancy kits."

– A female college student

4.1 DEMOGRAPHIC PROFILE OF HEALTH-CARE PROVIDER RESPONDENTS

Respondents were asked if they were health-care providers, educators or researchers. Of those who responded (n=528), 68.2% (n=360) said they were one of those, while 31.8% said they were not. The following section consisted of questions for the health-care respondents only. They were asked what kind of health-care professional they were, with the option to choose all that apply. The top responses for this question are reported in Figure 8.

FIGURE 8: TYPES OF HEALTH-CARE OCCUPATIONS AMONG SURVEY PARTICIPANTS



4.2 HEALTH-CARE PROVIDER VALUES AND PREFERENCES: Qualitative responses

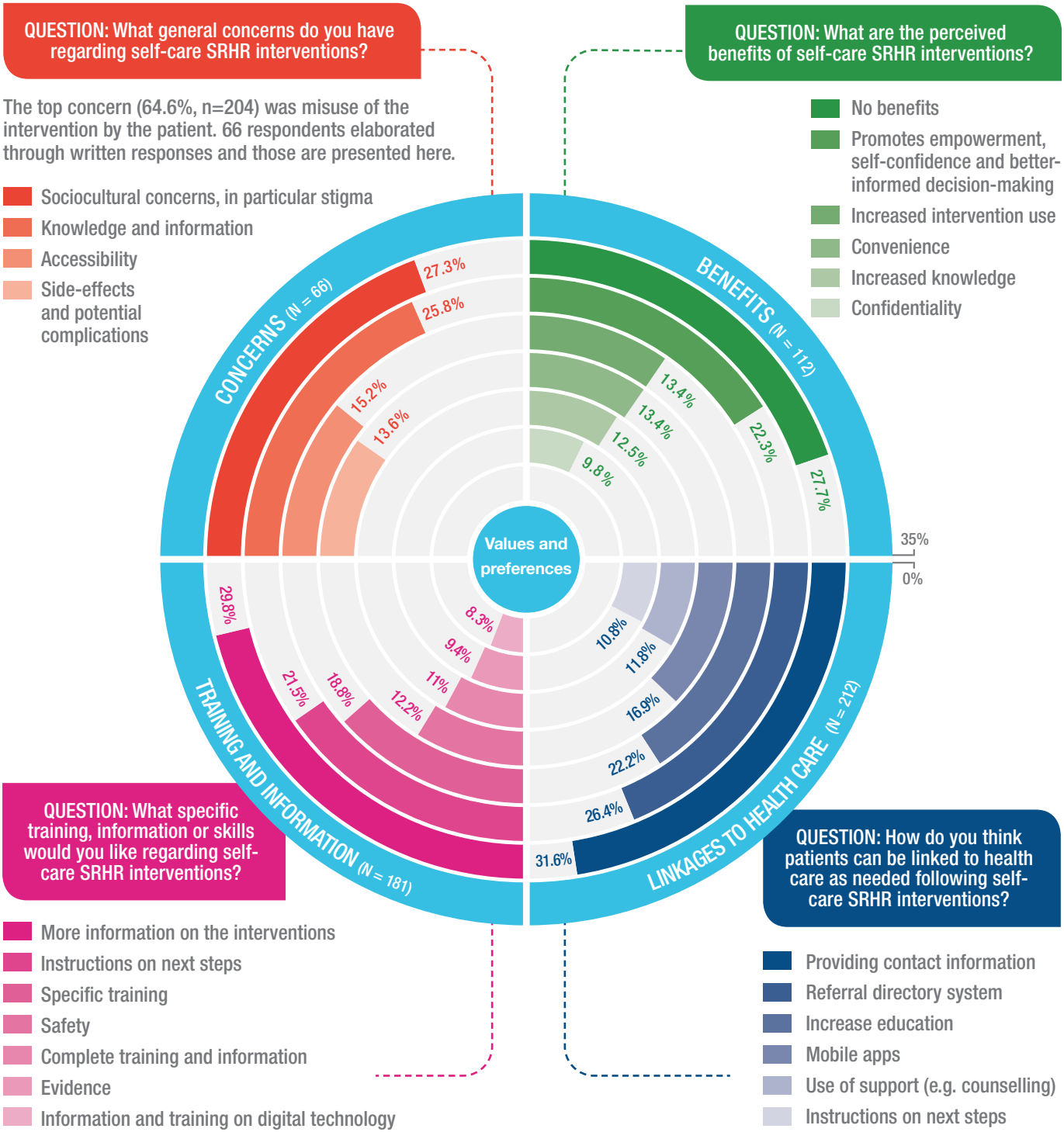
Health-care providers were asked about several topics around the self-care SRHR interventions, including:

- general concerns;
- other general benefits the interventions may present;
- how patients could be linked to health care as needed following the use of interventions; and
- what specific training, information or skills the practitioners would require.

They were given a list of options within these topics where they could choose all that apply, with the option to elaborate on other concerns through a qualitative written response.

The various responses for each of these sections are summarized in Figure 9.

FIGURE 9: SUMMARY OF TOPICS RAISED BY HEALTH-CARE PROVIDERS AROUND INTERVENTIONS



4.2.1 Health-care provider concerns regarding self-care SRHR interventions

Health-care providers expanded upon their responses in the previous section using qualitative answers. In this section, the written responses regarding their concerns around the interventions are presented.

Sociocultural issues and stigma (27.3%; n=18)

Sociocultural issues were described as being present at the individual level through shame, at the community level through stigmatizing norms and at the state level through lack of supportive policies.

> *"Shame accompanying using them, e.g. because of social stereotypes."*
>
> Bisexual female, 21, Poland

There could be challenges in accessing these interventions due to low community acceptance and stigma. This highlighted the need for:

> *"Accessibility to self-care interventions without prejudice."*
>
> Male, 32, Nigeria

Sociocultural issues may exist on the macro level through:

> *"Traditional and discriminatory state policy."*
>
> Female, 33, Cameroon

Knowledge and information (25.8%; n=17)

Another concern raised by health-care providers around the interventions was in relation to knowledge and information.

> *"I think there is a lot of false information out there, and it can be hard to distinguish the credible sources from the ones that aren't."*
>
> Female, 39, United States

The lack of appropriate information can have consequences on one's health-care decisions.

> *"Incomplete information to make a really informed choice."*
>
> Female, 43, Spain

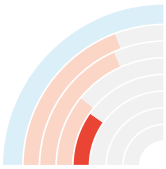
Accessibility (15.2%; n=10)

Respondents also raised concerns around the accessibility of SRHR interventions.

> *"Lack of access to health services when needed, even if they exist, due to many barriers."*
>
> Female, 56, Italy

This was mentioned as a particular issue for certain marginalized populations. One respondent noticed:

> *"Lack of access by disabled people."*
>
> Female, 42, Poland



Side-effects and complications (13.6%; n=9)

Respondents expressed concern regarding how patients should respond in circumstances when interventions cause side-effects. For example, one respondent expressed concern about:

> *"Handling of complications."*
>
> Male, 54, Kenya

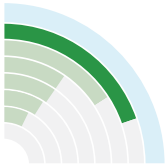
This was explained further by some as having potential harmful consequences.

> *"Side-effects [are a concern] and as a result [users may make the] decision to quit and refuse the self-initiated interventions in the potential future."*
>
> Female, 27, Moldova

> *"Access to and support provided by health services if the patient has used something incorrectly and needs treatment/support to correct that."*
>
> Female, 54, Switzerland

4.2.2 Health-care provider perspectives on the benefits of self-care SRHR interventions

In this section, health-care provider responses are further elaborated on, in regard to the perceived benefits of self-care SRHR interventions.



No benefits (27.7%; n=31)

The most common sentiment was that there are no benefits to self-care interventions as stated by 27.7% of health-care provider respondents.

> *"[No benefits] at all! People should go see a doctor, otherwise all self-initiated interventions are a failure."*
>
> Male, 34, Lebanon

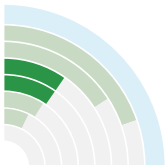
Intrapersonal benefits (22.3%; n=25)

Many noted how the use of self-care interventions promotes empowerment, self-confidence and better-informed decision-making.

> *"[These interventions] increased power to people."*
>
> Female, 54, Switzerland

Some described the personal benefits it would provide to higher-risk populations.

> *"[Self-care interventions] enable [young women] to make informed decision without being pressured by anyone."*
>
> Female, 25, Kenya



Increased use and convenience (13.4%; n=15)

The next most commonly reported benefits were increased intervention use and convenience, both at 13.4%. Those respondents noted how the self-initiated aspect of these interventions could increase their use in the population.

> *"There is greater uptake and adherence of interventions if self-initiated."*
>
> Female, 59, United States

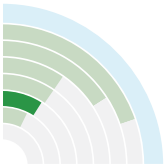
> *"Many [self-care interventions] are excellent for increasing access by youth to RH services as they are often deprived."*
>
> Female, 56, Italy

Convenience was explained in terms of ease of access and time saved.

> *"[These interventions] remove gatekeepers."*
>
> Female, 56, New Zealand

> *"Faster treatment if patients don't have time to wait in health clinics and hospitals."*
>
> Female, 31, Serbia

> *"Better accessibility and quicker process (abortion/ self-testing for STI/HIV)."*
>
> Female, 28, France



Increased knowledge (12.5%; n=14)

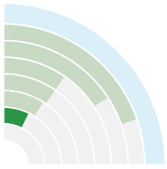
Self-care SRHR interventions were described as having the potential to increase the population's knowledge and information on SRHR, which benefits their health and well-being in multiple ways.

> *"This can lead to improvement of knowledge and confidence."*
>
> Male, 65, Kenya

> *"It helps to know better the functioning of your body. It will have better elements for dialogue with health personnel."*
>
> Female, 58, Peru

Similarly, some health-care respondents identified the advantage of self-care SRHR interventions for improving health.

> *"[These interventions will] encourage health seeking behaviour of the public."*
>
> Male, 30, Philippines



Confidentiality (9.8%; n=11)

One provider describes how this would help those who are marginalized, such as women in abusive relationships:

> *"Privacy [is a benefit], especially for women in abusive situations where husbands may control medical care."*
>
> Female, 40, Canada

4.2.3 Health-care provider perspectives on linkages to health care

Health-care providers were asked how they thought patients could be linked to health care, if needed, following use of self-care SRHR interventions.

Contact information (31.6%; n=67)

Out of 212 respondents for this question, one third suggested providing contact information, for example, telephone numbers, websites or QR codes, with the intervention so patients could seek further care if needed. It was suggested by several respondents that the phone number also include anonymous and confidential text messaging (SMS) services.

Referral directory system (26.4%; n=56)

Having a referral directory system in place was the next most common suggestion. Respondents explained the various ways this could take place. Two suggestions from respondents were:

> *"Involve health workers before commencement to ensure linkages."*
>
> Female, 49, Nigeria

> *"There needs to be a directory of clinics/doctors/ health-care providers that are sensitive and not prejudiced against people who need health-care services for SRH problems. Patients/clients could be matched to the nearest doctor/clinic through a web application."*
>
> Gender non-binary provider, 24, Turkey

Increase education (22.2%; n=47)

The next most common suggestion was to increase education to ensure linkages to care. It was explained that this could be done through raising awareness, knowledge levels and health literacy among the population. Some suggested the use of the media and prominent public figures, while others thought increasing education at the community level would be most effective.

> *"More awareness and more media coverage could help."*
>
> Female, 26, Nepal

> *"[I support] spreading information about that in the community."*
>
> Female, 21, Poland

> *"By educating people, letting them know that if something is not right and they need more information or an intervention from health personnel, they should go, for the good of their health."*
>
> Male, 36, Paraguay

Increasing education was identified as helpful for reducing the negative impact of community beliefs on self-care SRHR interventions.

> *"Education for community leaders [is needed] to mitigate sociological, cultural, religious factors."*
>
> Male, 71, United States

Mobile apps (16.9%; n=36)

The use of mobile apps in this context was described as involving interactive features that attempt to encourage linkages to health care.

> *"In the app, there is a constant reminder for the patient to visit a health-care provider and log the details in the app with follow-ups."*
>
> Female, 30, Kenya

Mobile apps were noted as being especially useful in certain regions of the world. One provider explains the potential for:

> *"Online services, especially considering the growing internet coverage in African countries."*
>
> Male, 30, United Republic of Tanzania

Use of support (11.8%; n=25)

The use of support referenced includes counselling, psychological care and guidance.

> *"A toll-free number that provides quality counselling services should be put on the products used in the interventions so that people can easily talk to someone who will guide them on what to do."*
>
> Female, 24, Uganda

Some respondents described who they perceived would best be able to provide such support.

> *"Patients need assurance of confidentiality and trust in the personnel. Thus, through the use of professional and empathetic community health workers."*
>
> Female, 32, Cameroon

Instructions on next steps (10.8%; n=23)

The next most common response was outlining instructions on next steps to ensure linkages to care. This would be provided with the self-care SRHR intervention and would clearly outline how to proceed following the use of the intervention.

> *"This should be an integral part of all interventions with clear guidance provided on all platforms of how to access services if needed."*
>
> Female, 56, Italy

The instructions could provide clarity on how to proceed following the use of the intervention.

> *"[It would work] by outlining steps to follow after each test result, either negative or positive."*
>
> Female, 32, Nigeria

4.2.4 Health-care provider perspectives regarding training and information needs

Health-care providers had the option to provide a written response on what specific training, information or skills they would like regarding self-care SRHR interventions.

More information (29.8%; n=54)

Out of those providers who responded (n=181), the most common response was more information on new, common or specific interventions. Specific interventions mentioned include HIV self-testing, contraceptives and abortion self-management.

> *"[I would like] information about the range of self-initiated interventions currently available and their status (i.e. which have been tested in which settings; as well as information about new technologies in the pipeline)."*
>
> Female, 44, Mozambique

Instructions on next steps (21.5%; n=39)

This was explained as training on the specifics of how to implement the interventions, how the interventions are used and guidelines on following up. One provider suggested information on:

> *"Correct usage of these interventions; also standard protocol in following steps."*
>
> Female, 29, China

> *"[More information on] rolling it out."*
>
> Male, 25, Kenya

Specific training (18.8%; n=34)

Specific training for health-care providers was the next most common response. This training includes how to administer the interventions, provide appropriate linkages to care and offer counselling to patients.

> *"[Training on] the power of trust and contact between the health-care provider and the patients."*
>
> Female, 25, Egypt

Some respondents gave specifics on who should do the training.

> *"Creating women health educators' groups within communities who will train trainers."*
>
> Female, 32, Cameroon

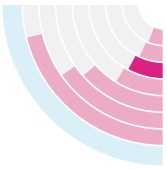
Others went into detail on how the training would be disseminated.

> *"Maybe a webinar or some sort of online course but that could be a barrier for some, I think that empowering pharmacists or those dispensing self-initiated interventions (if they are not bought online) should be trained to give training on them."*
>
> Female, 29, United States

Safety (12.2%; n=22)

The next most common response was regarding safety, particularly regarding additional information on side-effects, adverse reactions, contraindications and risks of using the self-care SRHR intervention.

> *"[Information is needed on] how to identify bad side-effects and where to go to seek medical help."*
>
> Female, 33, United States

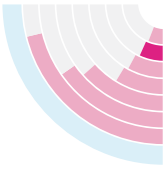


Complete training and information (11%; n=20)

The need for complete training and information was the next most common response. Many respondents described wanting extensive knowledge on all aspects of self-care interventions.

> *"All the necessary knowledge and skills regarding self-initiated interventions."*
>
> Female, 52, Nigeria

> *"[I want] all that is possible at my level of knowledge. This concerns me strongly."*
>
> Male, 20, Tunisia



Evidence (9.4%; n=17)

The respondents described preferred sources of evidence which included reliable online sources that provide accurate and up-to-date information on self-care SRHR interventions.

One provider describes wanting:

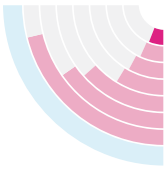
> *"SRHR information on sites that are authentic and registered for the work."*
>
> Female, 63, Pakistan

A few respondents make specific references to sources like WHO, while others describe seeking additional updated evidence more generally.

> *"More research on this field made public and translated in a couple of international languages."*
>
> Female, 27, Moldova

Another respondent mentioned the importance of accurate evidence on specific interventions:

> *"[I want] more information about contraceptives that can be 100% trusted – information about safe abortion and information about access to abortion."*
>
> Female, 21, Poland



Training on digital technology (8.3%; n=15)

Digital technology in this context includes mobile phone applications, webinars and online sources. Two providers highlighted the following needs.

> *"All matters digital. Mobile phone apps, online access confirmation."*
>
> Female, 50, Kenya

> *"Access to online tutorials by health-care providers."*
>
> Male, 44, United Kingdom

4.2.5 Additional comments on self-care SRHR interventions

In the final question of the health-care provider portion of the survey, respondents were asked to provide any additional comments in the form of written responses (n=102). Over half of respondents (52.9%, n=54) wrote that they decline to provide a comment. Following that reply, the top responses were regarding specific issues (15.7%, n=16) and perspectives on what is needed for self-care SRHR interventions (13.7%, n=14). One provider describes the potential for these interventions and what is needed for their success:

> *"Self-testing could revolutionize disease detection within the public health sphere. With the right amount of support channels this could empower people to take ownership of their health. There has been a lot of negative flack around self-testing, but I feel that to empower people is the rationale of thought leadership practices, which could be successful for public health initiatives."*
>
> Female, 28, South Africa

Some mentioned the need for community-level empowerment and awareness.

> *"It is important to empower the community with information about their sexual and reproductive health."*
>
> Male, 58, Kenya

> *"Community-based patient education rather than health facility-based health talks will drive uptake of the self-initiated care better because oftentimes, non-utilization is due to lack of or inadequate awareness or knowledge about them."*
>
> Female, 42, Nigeria

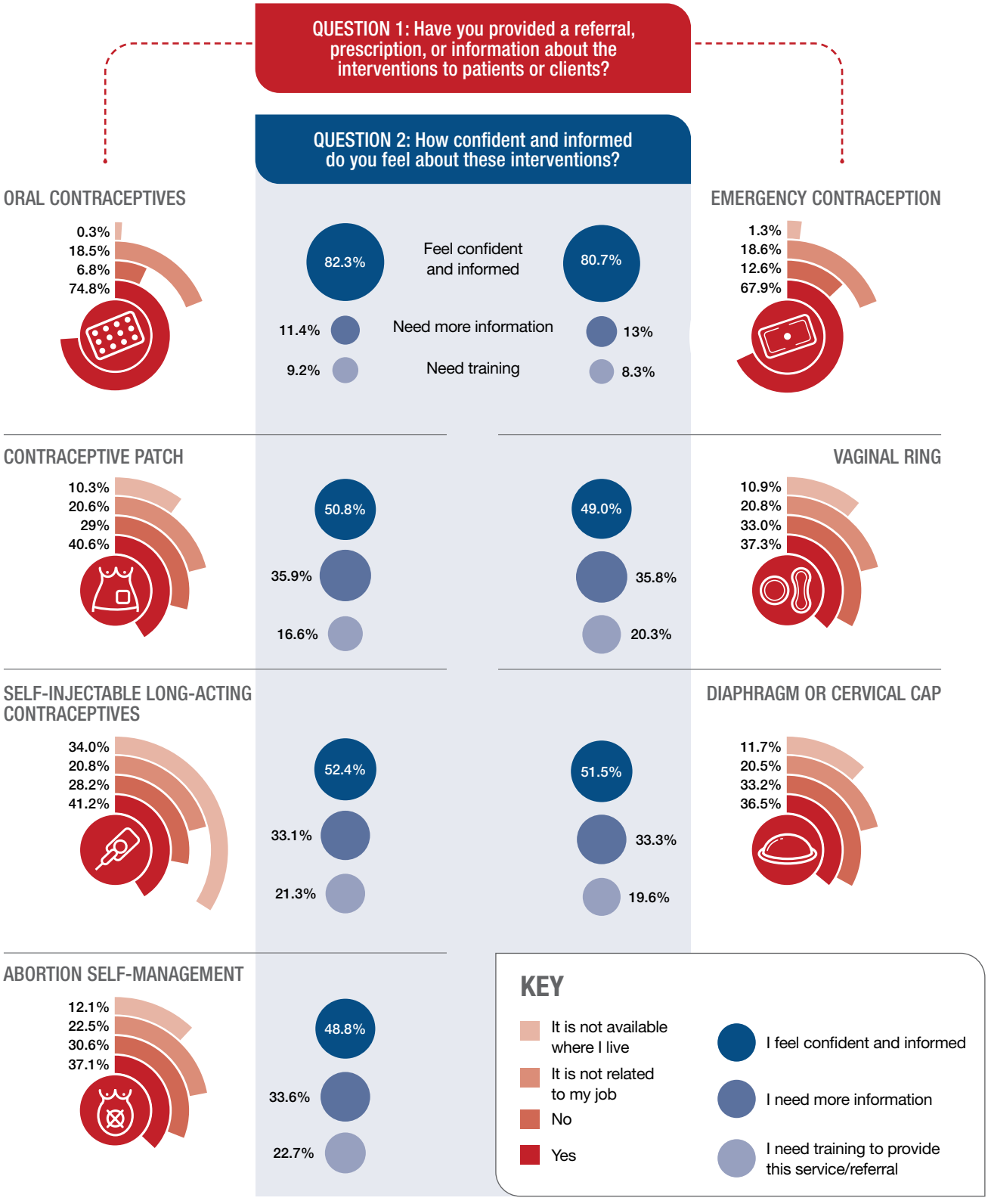
Respondents brought up additional issues relevant to the topic of these interventions.

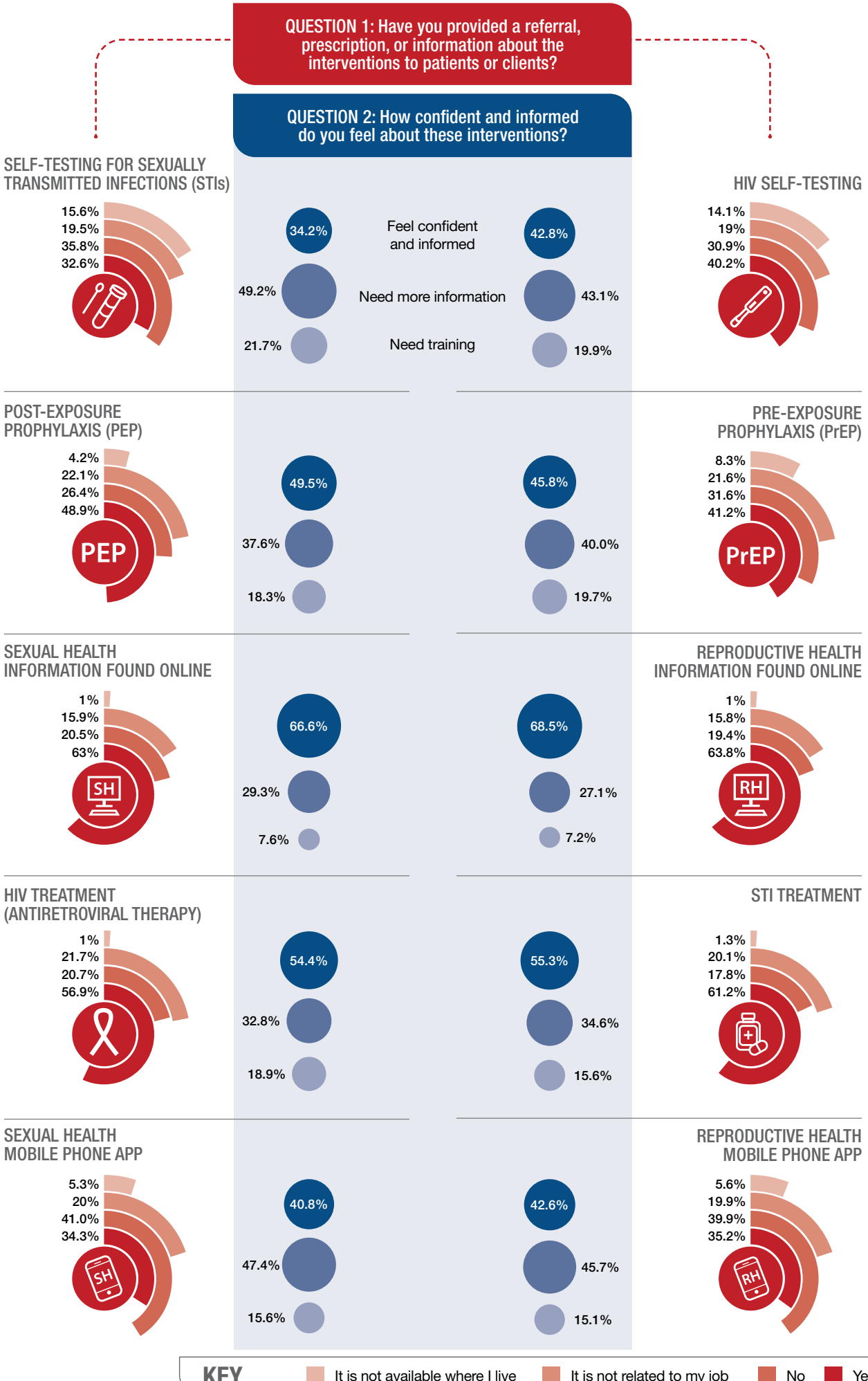
> *"Family planning services are still not widely accepted in many parts of Africa, especially Nigeria. This is as a result of cultural and religious beliefs. There is a lot of emphasis on continuous education of the reproductive age group."*
>
> Female, 32, Nigeria

4.3 HEALTH-CARE PROVIDER EXPERIENCE, KNOWLEDGE AND PREFERENCES FOR SELF-CARE SRHR INTERVENTIONS

In this section the findings from the quantitative questions for health-care providers on self-care SRHR interventions are reported. Respondents were asked about their experiences, their knowledge levels and their preferences for each intervention. First, they were asked if they had ever provided a referral, prescription or information about any of the interventions to their patients or clients. Next, they were asked how confident and informed they felt about each intervention or service. For both questions, participants could select all the answers that applied. The results are shown in Figure 10 below.

FIGURE 10: HEALTH-CARE PROVIDER RESPONSES REGARDING SELF-CARE SRHR INTERVENTIONS




QUESTION 1: Have you provided a referral, prescription, or information about the interventions to patients or clients?
QUESTION 2: How confident and informed do you feel about these interventions?
SELF-TESTING FOR SEXUALLY TRANSMITTED INFECTIONS (STIs)
15.6%
19.5%
35.8%
32.6%
34.2%
49.2%
21.7%
Feel confident and informed
Need more information
Need training
42.8%
43.1%
19.9%
HIV SELF-TESTING
14.1%
19%
30.9%
40.2%
POST-EXPOSURE PROPHYLAXIS (PEP)
4.2%
22.1%
26.4%
48.9%
PEP
49.5%
37.6%
18.3%
45.8%
40.0%
19.7%
PRE-EXPOSURE PROPHYLAXIS (PrEP)
8.3%
21.6%
31.6%
41.2%
PrEP
SEXUAL HEALTH INFORMATION FOUND ONLINE
1%
15.9%
20.5%
63%
SH
66.6%
29.3%
7.6%
68.5%
27.1%
7.2%
REPRODUCTIVE HEALTH INFORMATION FOUND ONLINE
1%
15.8%
19.4%
63.8%
RH
HIV TREATMENT (ANTIRETROVIRAL THERAPY)
1%
21.7%
20.7%
56.9%
54.4%
32.8%
18.9%
55.3%
34.6%
15.6%
STI TREATMENT
1.3%
20.1%
17.8%
61.2%
SEXUAL HEALTH MOBILE PHONE APP
5.3%
20%
41.0%
34.3%
SH
40.8%
47.4%
15.6%
42.6%
45.7%
15.1%
REPRODUCTIVE HEALTH MOBILE PHONE APP
5.6%
19.9%
39.9%
35.2%
RH
KEY
It is not available where I live
It is not related to my job
No
Yes

QUESTION 3: What are your concerns regarding these self-care interventions?

For preferences, respondents were asked in separate questions about potential concerns about and benefits of each intervention, with the option to choose all that apply. The responses to the listed concerns are presented in Figure 11.

FIGURE 11: HEALTH-CARE PROVIDER CONCERNS PER INTERVENTION

Interventions	Safety (e.g. side-effects)	Quality of product	Incorrect use	Access to health care if needed
Oral Contraceptives	53.6%	27.8%	58.6%	31.6%
Emergency contraception	45.7%	26.3%	59.9%	39.3%
Contraceptive patch	28.4%	15.5%	38.9%	37.2%
Vaginal ring	37.7%	23.3%	59.6%	35.0%
Self-injectable long-acting contraceptives	52.0%	21.0%	47.2%	40.2%
Diaphragm or cervical cap	35.2%	22.7%	63.9%	36.1%
Abortion self-management	54.0%	24.9%	51.9%	53.6%
Self-testing for sexually transmitted infections	25.7%	24.3%	53.6%	57.2%
HIV self-testing	24.4%	20.0%	53.3%	58.2%
Post-exposure prophylaxis (PEP)	42.4%	17.9%	52.7%	53.6%
Pre-exposure prophylaxis (PrEP)	40.9%	17.8%	52.9%	54.2%
Sexual health information found online	19.1%	30.1%	45.5%	48.8%
Reproductive health information found online	19.9%	30.3%	46.0%	48.3%
HIV treatment (anti-retroviral therapy)	49.1%	22.6%	52.7%	53.1%
STI treatment	42.6%	23.8%	54.7%	54.3%
Sexual health mobile phone app	16.0%	29.1%	44.2%	48.1%
Reproductive health mobile phone app	15.1%	29.8%	44.9%	46.8%

QUESTION 4: What are the benefits of these self-care interventions?

With regard to the potential benefits, respondents were again given a list of options and were allowed to select all that apply. The results for this section are presented in Figure 12.

FIGURE 12: PERCEIVED BENEFITS BY HEALTH-CARE PROVIDERS PER INTERVENTION

Interventions	It is more convenient for patient/client	It will remove barriers such as stigma	It reduces health-care provider workload	It is empowering	It is cheaper for the client
Oral Contraceptives	75.7%	44.2%	40.4%	49.8%	40.1%
Emergency contraception	73.1%	47.9%	34.3%	49.2%	35.5%
Contraceptive patch	69.6%	35.5%	40.1%	46.5%	27.6%
Vaginal ring	65.0%	36.0%	37.9%	46.7%	25.7%
Self-injectable long-acting contraceptives	68.8%	35.5%	44.6%	48.2%	30.8%
Diaphragm or cervical cap	67.2%	31.4%	37.3%	44.6%	25.5%
Abortion self-management	59.4%	62.2%	41.5%	52.5%	33.2%
Self-testing for sexually transmitted infections	64.1%	61.5%	44.6%	48.5%	30.3%
HIV self-testing	64.4%	63.9%	43.8%	50.6%	29.2%
Post-exposure prophylaxis (PEP)	66.7%	62.0%	37.5%	45.8%	25.9%
Pre-exposure prophylaxis (PrEP)	65.4%	58.9%	42.1%	50.0%	27.1%
Sexual health information found online	68.4%	51.1%	43.6%	58.7%	36.9%
Reproductive health information found online	67.8%	50.2%	44.1%	57.3%	37.9%
HIV treatment (antiretroviral therapy)	62.3%	58.5%	40.1%	50.2%	24.2%
STI treatment	66.5%	60.4%	39.6%	47.2%	25.5%
Sexual health mobile phone app	68.4%	45.3%	37.3%	56.9%	35.1%
Reproductive health mobile phone app	66.4%	44.4%	38.1%	58.3%	36.8%

Transformative training for health professionals on self-care SRHR interventions

New approaches and changes in training and education of health-care providers are needed in order to institutionalize sensitive and effective use of self-care interventions. It is crucial for a revised curriculum to be embedded in principles of human rights, gender equality, and increased user autonomy and health literacy to improve empowerment and support confident decision-making. Recognizing the importance of such training, the WHO Department of Reproductive Health and Research convened the first consultation of early-career health professionals from the fields of midwifery, nursing, pharmacy, public health and medicine. For this session of the meeting, panelists were invited from different WHO departments and United Nations agencies to talk about their experiences and approaches to health education and ending stigma and discrimination in health care. After the discussion, recommendations for the new types of training and transformation to accommodate self-care interventions were made by participants and are listed here.

Artwork from this workshop community

Participant recommendations for transformative training:

- Focus on competency-based curricula, with a special emphasis on communication, compassion and a person-centred approach to care.
- Integrate self-care interventions into the curricula for health professional education and training.
- Support students and young health professionals to take active roles in university governing bodies, societies and academic communities to advocate for appropriate advances and innovations in curricula.
- Provide early training on holistic and integrated health care and sensitization, to institutionalize empathetic attitudes among health professionals that take into account the broader social, psychological, spiritual and religious context of people's lives.
- Emphasize and operationalize inter-professional collaborations and build teamwork skills for more effective integrated service delivery, including mobility and access to opportunities for skills exchange at global, regional and national levels.
- Address issues of power and vulnerability to support increased user autonomy and empowerment.
- Integrate the use of innovative research, technologies, digital and online resources, interactive learning and other innovative forms of training to reinforce comprehensive learning of information and practical skills.
- Facilitate continuous quality improvement through implementation of appropriate accountability and feedback mechanisms.

ANNEXES

ANNEX A: DISTRIBUTION OF HEALTH-CARE PROVIDER RESPONDENTS BY WHO REGION AND COUNTRY (n=360)

REGION AND COUNTRY	No.	%
AFRICA	108	30.0%
Central Africa	4	1.1%
Cameroon	3	0.8%
Congo	1	0.3%
Eastern Africa	69	19.2%
Ethiopia	3	0.8%
Kenya	48	13.3%
Malawi	1	0.3%
Mozambique	1	0.3%
Rwanda	1	0.3%
Uganda	10	2.8%
United Republic of Tanzania	3	0.8%
Zambia	1	0.3%
Zimbabwe	1	0.3%
Northern Africa	7	1.9%
Algeria	1	0.3%
Egypt	2	0.6%
Sudan	1	0.3%
Tunisia	3	0.8%
Southern Africa	7	1.9%
Eswatini	1	0.3%
South Africa	6	1.7%
Western Africa	21	5.8%
Burkina Faso	1	0.3%
Ghana	1	0.3%
Liberia	2	0.6%
Mali	1	0.3%
Nigeria	16	4.4%
ASIA	51	14.2%
Eastern Asia	4	1.1%
China	4	1.1%
South-East Asia	12	3.3%
Malaysia	1	0.3%

REGION AND COUNTRY (HEALTH-CARE PROVIDER RESPONDENTS)	No.	%
Myanmar	1	0.3%
Philippines	3	0.8%
Thailand	6	1.7%
Viet Nam	1	0.3%
Southern Asia	20	5.6%
Afghanistan	1	0.3%
Bhutan	1	0.3%
India	8	2.2%
Iran	3	0.8%
Nepal	3	0.8%
Pakistan	1	0.3%
Sri Lanka	3	0.8%
Western Asia	15	4.2%
Azerbaijan	1	0.3%
Jordan	1	0.3%
Lebanon	2	0.6%
Palestine	1	0.3%
Qatar	1	0.3%
Turkey	8	2.2%
Yemen	1	0.3%
EUROPE	75	20.8%
Eastern Europe	13	3.6%
Bulgaria	2	0.6%
Czech Republic	2	0.6%
Moldova	1	0.3%
Poland	7	1.9%
Romania	1	0.3%
Northern Europe	18	5.0%
Sweden	2	0.6%
United Kingdom	16	4.4%
Southern Europe	30	8.3%
Croatia	4	1.1%
Italy	1	0.3%
Macedonia	2	0.6%
Portugal	20	5.6%
Serbia	1	0.3%
Spain	2	0.6%

REGION AND COUNTRY (HEALTH-CARE PROVIDER RESPONDENTS)	No.	%
Western Europe	14	3.9%
Austria	1	0.3%
Belgium	2	0.6%
France	3	0.8%
Germany	2	0.6%
Netherlands	1	0.3%
Switzerland	5	1.4%
LATIN AMERICA AND THE CARIBBEAN	75	20.8%
Caribbean	4	1.1%
Cuba	1	0.3%
Dominican Republic	1	0.3%
Haiti	2	0.6%
Central America	10	2.8%
Costa Rica	2	0.6%
Guatemala	3	0.8%
Mexico	2	0.6%
Nicaragua	3	0.8%
South America	61	16.9%
Argentina	7	1.9%
Brazil	8	2.2%
Colombia	34	9.4%
Ecuador	1	0.3%
Guyana	2	0.6%
Paraguay	2	0.6%
Peru	5	1.4%
Uruguay	2	0.6%
NORTHERN AMERICA	50	13.9%
Northern America	50	13.9%
Canada	6	1.7%
United States	44	12.2%
OCEANIA	1	0.3%
Australia and New Zealand	1	0.3%
New Zealand	1	0.3%
GRAND TOTAL	**360**	**100.0%**

ANNEX B: DISTRIBUTION OF LAYPERSON RESPONDENTS BY WHO REGION AND COUNTRY (n=465)

REGION AND COUNTRY	No.	%
AFRICA	107	23.0%
Central Africa	3	0.6%
Cameroon	1	0.2%
Democratic Republic of the Congo	2	0.4%
Eastern Africa	56	12.0%
Burundi	1	0.2%
Ethiopia	2	0.4%
Kenya	37	8.0%
Mauritius	1	0.2%
Somalia	1	0.2%
Uganda	12	2.6%
United Republic of Tanzania	1	0.2%
Zimbabwe	1	0.2%
Northern Africa	17	3.7%
Egypt	1	0.2%
Morocco	2	0.4%
Sudan	2	0.4%
Tunisia	12	2.6%
Southern Africa	8	1.7%
Botswana	1	0.2%
Eswatini	1	0.2%
Namibia	1	0.2%
South Africa	5	1.1%
Western Africa	23	4.9%
Gambia	1	0.2%
Ghana	2	0.4%
Mali	1	0.2%
Nigeria	19	4.1%
ASIA		
Central Asia	1	0.2%
Turkmenistan	1	0.2%
Eastern Asia	11	2.4%
China	6	1.3%
Japan	3	0.6%
South-East Asia	42	9.0%
Indonesia	3	0.6%
Malaysia	2	0.4%

REGION AND COUNTRY (LAYPERSON RESPONDENTS)	No.	%
Philippines	2	0.4%
Republic of Korea	2	0.4%
Singapore	31	6.7%
Thailand	3	0.6%
Viet Nam	1	0.2%
Southern Asia	26	5.6%
Afghanistan	1	0.2%
Bangladesh	2	0.4%
India	11	2.4%
Iran	2	0.4%
Pakistan	9	1.9%
Sri Lanka	1	0.2%
Western Asia	14	3.0%
Lebanon	2	0.4%
Oman	2	0.4%
Qatar	2	0.4%
Syrian Arab Republic	1	0.2%
Turkey	7	1.5%
EUROPE	149	32.0%
Eastern Europe	19	4.1%
Belarus	1	0.2%
Poland	17	3.7%
Slovakia	1	0.2%
Northern Europe	27	5.8%
Denmark	1	0.2%
Finland	2	0.4%
Norway	3	0.6%
Sweden	5	1.1%
United Kingdom	16	3.4%
Southern Europe	89	19.1%
Albania	1	0.2%
Bosnia and Herzegovina	1	0.2%
Croatia	8	1.7%
Greece	1	0.2%
Italy	2	0.4%
Macedonia	9	1.9%
Malta	3	0.6%
Portugal	61	13.1%

REGION AND COUNTRY (LAYPERSON RESPONDENTS)	No.	%
Slovenia	1	0.2%
Spain	2	0.4%
Western Europe	14	3.0%
Austria	3	0.6%
Belgium	2	0.4%
France	1	0.2%
Germany	5	1.1%
Switzerland	3	0.6%
LATIN AMERICA AND THE CARIBBEAN	49	10.5%
Caribbean	3	0.6%
Dominican Republic	1	0.2%
Grenada	1	0.2%
Trinidad and Tobago	1	0.2%
Central America	13	2.8%
Costa Rica	2	0.4%
El Salvador	1	0.2%
Guatemala	3	0.6%
Honduras	1	0.2%
Mexico	2	0.4%
Panama	4	0.9%
South America	33	7.1%
Argentina	11	2.4%
Brazil	2	0.4%
Colombia	14	3.0%
Ecuador	1	0.2%
Paraguay	1	0.2%
Peru	2	0.4%
Venezuela	2	0.4%
NORTHERN AMERICA	60	12.9%
Northern America	60	12.9%
Canada	6	1.3%
United States	54	11.6%
OCEANIA	6	1.3%
Australia and New Zealand	6	1.3%
Australia	4	0.9%
New Zealand	2	0.4%
GRAND TOTAL	**465**	**100.0%**

ANNEX C: DISTRIBUTION OF HEALTH-CARE PROVIDER RESPONDENTS BY AGE (n=358)

AGES FOR HEALTH-CARE PROVIDER RESPONDENTS																	
18–29			30–39			40–49			50–59			60–69			70+		
Age	No.	%	Age	No.	%	Age	No.	%	Age	No.	%	Age	No.	%	Age	No.	%
18	1	0.3%	30	10	2.8%	40	12	3.4%	50	2	0.6%	60	2	0.6%	70	4	1.1%
19	3	0.8%	31	11	3.1%	41	7	2.0%	51	6	1.7%	61	2	0.6%	71	1	0.3%
20	11	3.1%	32	7	2.0%	42	11	3.1%	52	4	1.1%	63	2	0.6%	72	1	0.3%
21	8	2.2%	33	10	2.8%	43	5	1.4%	53	3	0.8%	64	3	0.8%	74	2	0.6%
22	15	4.2%	34	8	2.2%	44	7	2.0%	54	8	2.2%	65	3	0.8%	83	1	0.3%
23	16	4.5%	35	16	4.5%	45	6	1.7%	55	3	0.8%	66	1	0.3%	87	1	0.3%
24	9	2.5%	36	9	2.5%	46	5	1.4%	56	6	1.7%	67	2	0.6%	Total	10	2.8%
25	11	3.1%	37	9	2.5%	47	6	1.7%	57	3	0.8%	68	1	0.3%			
26	10	2.8%	38	11	3.1%	48	7	2.0%	58	3	0.8%	69	1	0.3%			
27	12	3.4%	39	7	2.0%	49	6	1.7%	59	6	1.7%	Total	17	4.7%			
28	13	3.6%	Total	98	27.4%	Total	72	20.1%	Total	44	12.3%						
29	8	2.2%															
Total	117	32.7%															

GRAND TOTAL	
No.	358
%	100.0%

ANNEX D: DISTRIBUTION OF LAYPERSON RESPONDENTS BY AGE (n=464)

AGES FOR LAYPERSON RESPONDENTS																	
18–29			30–39			40–49			50–59			60–69			70+		
Age	No.	%	Age	No.	%	Age	No.	%	Age	No.	%	Age	No.	%	Age	No.	%
18	13	2.8%	30	15	3.2%	40	10	2.2%	50	8	1.7%	60	4	0.9%	70	2	0.4%
19	20	4.3%	31	10	2.2%	41	3	0.6%	52	8	1.7%	61	1	0.2%	71	1	0.2%
20	35	7.5%	32	71	1.5%	42	3	0.6%	53	1	0.2%	62	4	0.9%	75	1	0.2%
21	36	7.8%	33	8	1.7%	43	10	2.2%	54	4	0.9%	63	2	0.4%	83	1	0.2%
22	39	8.4%	34	14	3.0%	44	1	0.2%	55	1	0.2%	64	2	0.4%	Total	5	1.1%
23	25	5.4%	35	4	0.9%	45	6	1.3%	57	3	0.6%	65	2	0.4%			
24	19	4.1%	36	9	1.9%	46	5	1.1%	58	3	0.6%	66	1	0.2%			
25	23	5.0%	37	8	1.7%	47	4	0.9%	59	5	1.1%	67	1	0.2%			
26	14	3.0%	38	9	1.9%	48	9	1.9%	Total	33	7.1%	68	1	0.2%			
27	11	2.4%	39	7	1.5%	49	4	0.9%				Total	18	3.9%			
28	12	2.6%	Total	91	19.6%	Total	55	11.9%									
29	15	3.2%															
Total	262	56.5%															

GRAND TOTAL	
No.	464
%	100.0%

ANNEX E: SOURCES OF KNOWLEDGE FOR SEXUAL AND REPRODUCTIVE HEALTH (SRH) SERVICES FOR HEALTH-CARE PROVIDER RESPONDENTS (n=357)

Q88: WHERE HAVE YOU LEARNED ABOUT SRH SERVICES? (CHOOSE ALL THAT APPLY)	COUNT	% (OF TOTAL RESPONDENTS)
School	238	66.7%
Partner	95	26.6%
Parent	77	21.6%
Brother	12	3.4%
Sister	22	6.2%
Other family members	19	5.3%
Friends	153	42.9%
Doctors	238	66.7%
Internet	251	70.3%
Community outreach officer, worker or nurse	80	22.4%
Parent support group	9	2.5%
Books, magazines	162	45.4%
TV, films, videos, radio	115	32.2%
Other – All	83	23.2%
Other – Own work/profession	34	9.5%
Other – University	22	6.2%
Other – Nongovernmental/non-profit organization	13	3.6%
TOTAL RESPONDENTS	**357**	-

ANNEX F: PREFERENCES FOR TYPES OF ONLINE SOURCES TO LEARN ABOUT SRHR SERVICES AMONG HEALTH-CARE PROVIDER RESPONDENTS (n=350)

Q89: WHAT TYPES OF ONLINE OR SOCIAL MEDIA RESOURCES WOULD YOU LIKE TO USE TO LEARN MORE ABOUT SRHR? (CHOOSE ALL THAT APPLY)	COUNT	% (OF TOTAL RESPONDENTS)
Website that I trust (such as WHO, UNAIDS)	287	82.0%
Online web search	202	57.7%
Facebook	73	20.9%
WhatsApp	50	14.3%
Twitter	45	12.9%
Mobile phone app	134	38.3%
Webinar	122	34.9%
Getting text messages with information	51	14.6%
Getting emails with information	121	34.6%
Television series	84	24.0%
Radio	60	17.1%
Other	25	7.1%
TOTAL RESPONDENTS	**350**	-

ANNEX G: SOURCES OF KNOWLEDGE FOR SEXUAL AND REPRODUCTIVE HEALTH (SRH) SERVICES FOR ALL LAYPERSON RESPONDENTS (n=179)

Q88: WHERE HAVE YOU LEARNED ABOUT SRH SERVICES? (CHOOSE ALL THAT APPLY)	COUNT	% (OF TOTAL RESPONDENTS)
School	122	68.2%
Partner	49	27.4%
Parent	43	24.0%
Brother	3	1.7%
Sister	13	7.3%
Other family members	12	6.7%
Friends	102	57.0%
Doctors	114	63.7%
Internet	148	82.7%
Community outreach officer, worker or nurse	35	19.6%
Parent support group	2	1.1%
Books, magazines	82	45.8%
TV, films, videos, radio	65	36.3%
Other – All	18	10.1%
Other – Nongovernmental/non-profit organization	7	3.9%
Other – Own work/profession	6	3.4%
Other – University	3	1.7%
TOTAL RESPONDENTS	**179**	**-**

ANNEX H: PREFERENCES FOR TYPES OF ONLINE SOURCES TO LEARN ABOUT SRHR SERVICES AMONG ALL LAYPERSON RESPONDENTS (n=171)

Q89: WHAT TYPES OF ONLINE OR SOCIAL MEDIA RESOURCES WOULD YOU LIKE TO USE TO LEARN MORE ABOUT SRHR? (CHOOSE ALL THAT APPLY)	COUNT	% (OF TOTAL RESPONDENTS)
Website that I trust (such as WHO, UNAIDS)	147	86.0%
Online web search	97	56.7%
Facebook	30	17.5%
WhatsApp	16	9.4%
Twitter	9	5.3%
Mobile phone app	56	32.7%
Webinar	41	24.0%
Getting text messages with information	22	12.9%
Getting emails with information	50	29.2%
Television series	49	28.7%
Radio	24	14.0%
Other	9	5.3%
TOTAL RESPONDENTS	**171**	-