WHO Consolidated Guideline on Self-Care Interventions for Health

Sexual and Reproductive Health and Rights

EXECUTIVE SUMMARY

World Health Organization

human reproduction programme hrp
research for impact
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EXECUTIVE SUMMARY

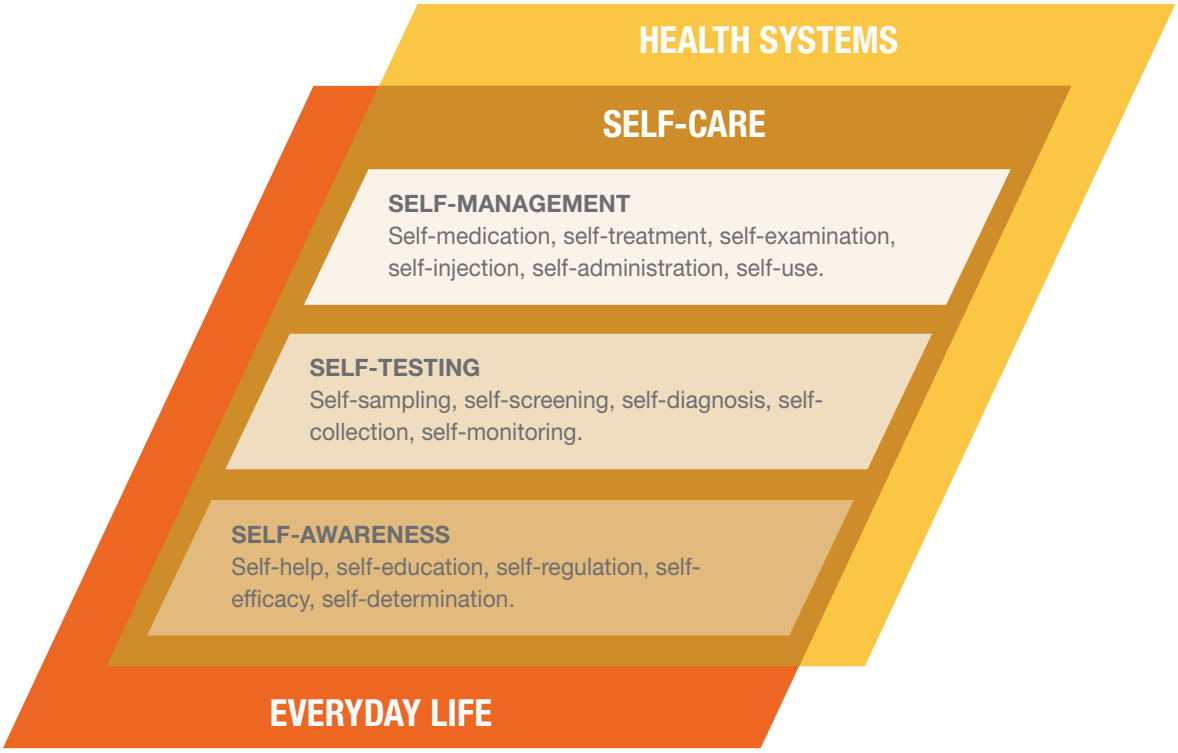
BACKGROUND

Self-care interventions are among the most promising and exciting new approaches to improve health and well-being, both from a health systems perspective and for people who use these interventions. The World Health Organization (WHO) uses the following working definition of self-care: Self-care is the ability of individuals, families and communities to promote health, prevent disease, maintain health, and cope with illness and disability with or without the support of a health-care provider. The scope of self-care as described in this definition includes health promotion; disease prevention and control; self-medication; providing care to dependent persons; seeking hospital/specialist/primary care if necessary; and rehabilitation, including palliative care. It includes a range of self-care modes and approaches. While this is a broad definition that includes many activities, it is important for health policy to recognize the importance of self-care, especially where it intersects with health systems and health professionals (Figure 1).

Worldwide, an estimated shortage of 18 million health workers is anticipated by 2030, a record 130 million people are currently in need of humanitarian assistance, and disease outbreaks are a constant global threat. At least 400 million people worldwide lack access to the most essential health services, and every year 100 million people are plunged into poverty because they have to pay for health care out of their own pockets. There is an urgent need to find innovative strategies that go beyond the conventional health sector response.

While "self-care" is not a new term or concept, self-care interventions 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. In humanitarian settings, for example, due to lack of or limited health infrastructure and medical services in the crisis-affected areas, self-care could play an important role to improve health-related outcomes. Self-care also builds upon existing movements, such as task sharing and task shifting, which are powerful strategies to support health systems.

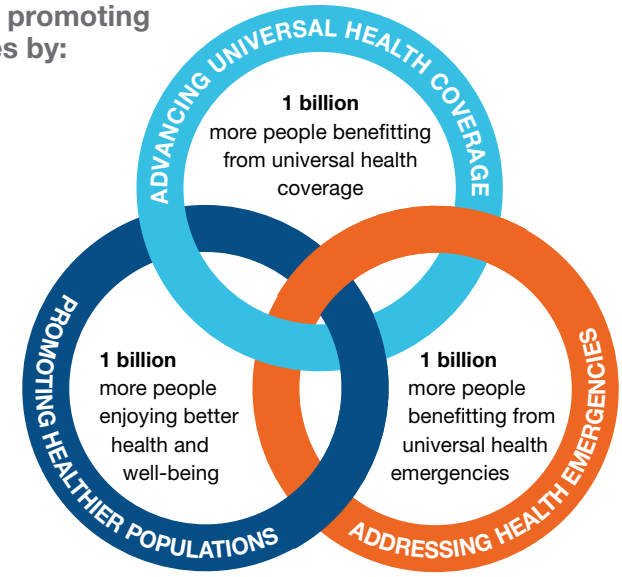
FIGURE 1: SELF-CARE IN THE CONTEXT OF INTERVENTIONS LINKED TO HEALTH SYSTEMS



Source: adapted from Narasimhan M, Allotey P, Hardon A. Self-care interventions to advance health and well-being: a conceptual framework to inform normative guidance. BMJ. 2019;365:l688. doi:10.1136/bmj.l688.

FIGURE 2: WHO STRATEGIC PRIORITIES AND "TRIPLE BILLION" GOALS FROM THE 13TH GENERAL PROGRAMME OF WORK (GPW13)

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



Source: Director-General of the World Health Organization. Thirteenth general programme of work 2019–2023 (Draft 5 April). Seventy-first World Health Assembly. Geneva: World Health Organization; 2018 (A71/4).

Self-care interventions represent a significant push towards new and greater self-efficacy, autonomy and engagement in health for self-carers and caregivers. At the same time, a key consideration in the development of health policy and guidance is that the availability of self-care interventions should not lead to care being disconnected from health services. Therefore, while risk and benefit calculations may be different in different settings and for different populations, with appropriate normative guidance and a safe and supportive enabling environment, self-care interventions offer strategies that promote active participation of individuals in their health and an exciting way forward to reach a range of improved outcomes, including:

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

Self-care has the potential to contribute to all aspects of WHO's strategic priorities and "triple billion" goals (Figure 2) and is increasingly being acknowledged in global initiatives, including for advancing primary health care (PHC) with the new Declaration of Astana, to advance the health and well-being of people most effectively, equitably, efficiently and sustainably through PHC. The new Declaration calls for the mobilization of all stakeholders – health professionals, academia, patients, civil society, local and international partners, agencies and funds, the private sector, faith-based organizations – to include a focus of efforts around empowering individuals, families and communities to optimize their health as advocates for policies that promote and protect health and well-being, as co-developers of health and social services and as self-carers and caregivers.

PURPOSE AND OBJECTIVES OF THE GUIDELINE

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, based on PHC strategies, comprehensive essential service packages and people-centredness.

The specific objectives of this guideline are to provide:

- evidence-based **recommendations** on key public health self-care interventions, including for advancing sexual and reproductive health and rights (SRHR), with a focus on vulnerable populations and settings with limited capacity and resources in the health system; and

- **good practice statements** on key programmatic, operational and service-delivery issues that need to be addressed to promote and increase safe and equitable access, uptake and use of self-care interventions, including for advancing SRHR.

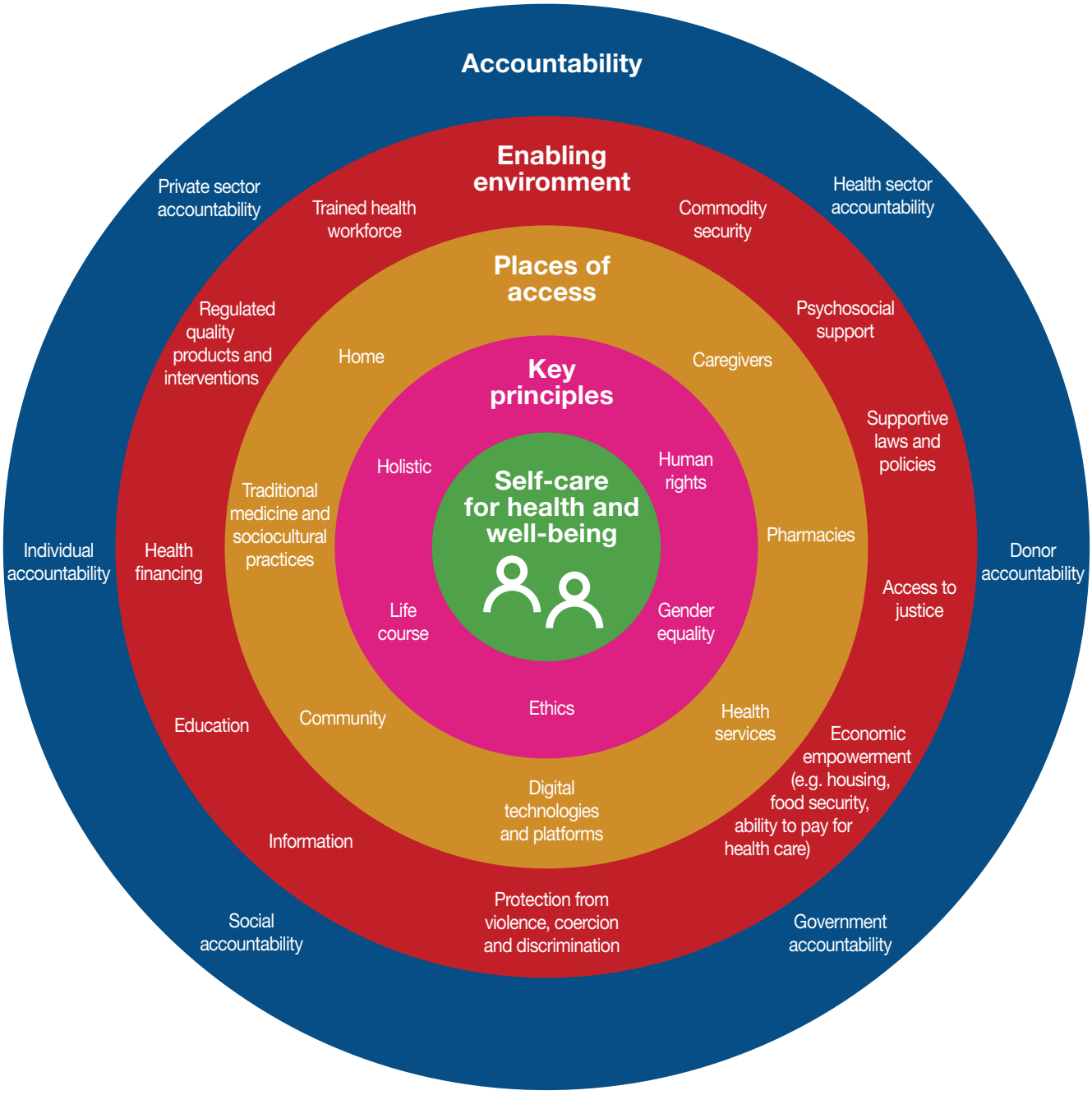
CONCEPTUAL FRAMEWORK FOR SELF-CARE INTERVENTIONS

The conceptual framework provides a starting point for tackling the evolving field of self-care and for identifying self-care interventions for future updates. The conceptual framework illustrates core elements from both the "people-centred" and "health systems" approaches, which can support introduction, uptake and scale-up of self-care interventions. The people-centred approach to health and well-being lies at the core of this framework and is underpinned by "key principles", as shown in Figure 3.

APPROACH AND KEY PRINCIPLES

This guideline is grounded in and advocates for a strengthened, comprehensive, people-centred approach to health and well-being, including for SRHR. This approach is underpinned by the key principles of human rights, ethics and gender equality. People-centredness requires taking a holistic approach to the care of each person, taking account of their individual circumstances, needs and desires across their whole life course, as well as the environment within which they live.

FIGURE 3: CONCEPTUAL FRAMEWORK FOR SELF-CARE INTERVENTIONS



Source: adapted from Narasimhan M, Allotey P, Hardon A. Self-care interventions to advance health and well-being: a conceptual framework to inform normative guidance. BMJ. 2019;365:l688. doi:10.1136/bmj.l688.

SCOPE OF SELF-CARE INTERVENTIONS

While self-care is important in all aspects of health, it is particularly important – and particularly challenging to manage – for populations negatively affected by gender, political, cultural and power dynamics and for vulnerable persons (e.g. people with disabilities and mental impairment). This is true for self-care interventions for SRHR, since many people are unable to exercise autonomy over their bodies and are unable to make decisions around sexuality and reproduction.

The use and uptake of self-care interventions is organic and the shift in responsibility – between full responsibility of the user and full responsibility of the health-care provider (or somewhere along that continuum) – can also change over time for each intervention and for different population groups. In addition, not all people require the same level of support, and vulnerable populations in particular may require additional information and/or support to make informed decisions about their uptake and use of self-care interventions. Safe linkage between independent self-care and access to quality health care for vulnerable individuals is critically important to avoid harm. Where self-care is not a positive choice but is prompted by fear or lack of alternatives, it can increase vulnerabilities.

TARGET AUDIENCE

The primary target audience for this guideline is national and international policy-makers, researchers, programme managers, health workers (including pharmacists), donors and civil society organizations responsible for making decisions or advising on delivery or promotion of self-care interventions. The secondary target audience is product developers. This new guideline is also expected to support persons affected by the recommendations: those who are taking care of themselves, and caregivers.

Health services and programmes in low-resource settings will benefit most from the guidance presented here, as they face the greatest challenges in providing services tailored to the needs and rights of vulnerable populations. However, this guideline is relevant for all settings and should, therefore, be considered as global guidance. In implementing these globally relevant recommendations, WHO regions and countries can adapt them to the local context, taking into account the economic conditions and the existing health services and health-care facilities.

AN ENABLING ENVIRONMENT FOR SELF-CARE

Self-care interventions, if situated in an environment that is safe and supportive, constitute an opportunity to help increase people's active participation in their own health, including patient engagement.

A safe and supportive enabling environment is essential to facilitate access to and uptake of products and interventions that can improve the health and well-being of vulnerable and marginalized populations (Figure 4). Assessing and ensuring an enabling environment in which self-care interventions can be made available in safe and appropriate ways must be a key initial piece of any strategy to introduce or scale-up these interventions. This should be informed by the profile of potential users, the services on offer to them, and the broader legal and policy environment and structural supports and barriers.

GUIDELINE DEVELOPMENT METHODS

The WHO Department of Reproductive Health and Research led the development of this consolidated guideline, following procedures in the *WHO handbook for guideline development*. The Department set up three working groups to perform specific guideline development functions: the WHO Guideline Steering Group (SG), the Guideline Development Group (GDG) and the External Review Group (ERG). Members of the groups were selected to ensure a range of expertise and experience, including appropriate representation in terms of geography and gender.

The SG led the guideline development process. They drafted the initial scope of the guideline; identified and drafted the priority questions in PICO (population, intervention, comparator, outcome) format; and recruited the guideline methodologist and members of the systematic review teams, the GDG and the ERG. The SG oversaw the process of screening WHO guidance documents and identifying existing self-care-related recommendations and good practice statements for sexual and reproductive health. The SG also finalized and published the guideline document, will oversee dissemination of the guideline and be involved in the development of implementation tools. The GDG members were involved in reviewing and finalizing key PICO questions and reviewing evidence summaries from the commissioned systematic reviews. They were also responsible for formulating new WHO recommendations and good practice statements at the GDG meeting in January 2019, as well as for achieving consensus on the final content of the guideline

FIGURE 4: CHARACTERISTICS OF THE ENABLING ENVIRONMENT TO SHAPE ACCESS TO AND USE OF SELF-CARE INTERVENTIONS

document. The ERG members were asked to review the draft of the guideline to provide technical feedback, identify factual errors, comment on the clarity of the language, and provide input on considerations related to implementation, adaptation and contextual issues. The Group ensured that the guideline decision-making processes had considered and incorporated the contextual values and preferences of persons affected by the recommendations. It was not within the ERG's remit to change the recommendations that had been formulated by the GDG.

The SG identified the following topic areas where new recommendations needed to be developed for this guideline: self-administration of injectable contraception; over-the-counter (OTC) provision of oral contraceptive pills (OCPs); use of home-based ovulation predictor kits (OPKs) for fertility management; HPV self-sampling (HPVSS) for cervical cancer screening; and self-collection of samples (SCS) for sexually transmitted infection (STI) testing. In addition, they identified the following areas where new good practice statements were needed: safe and sustainable management of health-care waste; environmentally preferable purchasing (EPP); economic considerations for access, uptake and equity; the life-course approach to SRHR; the use of digital health interventions to support the use of self-care interventions; and support for self-care interventions in humanitarian settings.

In accordance with the WHO guideline development process, when formulating the recommendations, the GDG members' deliberations were informed by the quality and certainty of the available evidence. WHO has adopted the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach to recommendation development.

For this guideline, specific attention was also focused on the need for an enabling environment for implementation of interventions (see Chapter 2), and the GDG was asked to consider the implications for human rights (both positive and negative) for each recommendation. A Global Values and Preferences Survey (GVPS) was also conducted on self-care interventions for SRHR (relevant GVPS findings are presented in Chapter 4). The values and preferences of the end-users and health-care providers, as well as consideration of the relevant feasibility, resource use and equity issues, all contribute to determining the strength of a recommendation.

This guideline presents new WHO recommendations that have been published for the first time in this guideline in 2019 (indicated by the label of "NEW"; see Table 1) and existing recommendations that have been previously published in other WHO guidelines that applied the GRADE approach, as well as new, adapted and existing good practice statements (again the former are labelled as "NEW"; see Table 2).

DEVELOPING THE RESEARCH AGENDA

Future research in self-care can be conceptualized under two broad areas: (i) *development* of self-care interventions and (ii) *delivery* of self-care interventions.

Underpinning the focus of research on efficacy, effectiveness, safety, implementation and delivery will be the perspectives of individuals, collectives, communities and providers, or systems perspectives. As such, attention needs to be given to matching the selection of outcomes to be measured with the relevant perspective. The same is true for studies of costs and cost–effectiveness.

The increasing adoption of digital health and digital therapeutics in the self-care space offers new opportunities to generate real-world evidence in real time. However, it demands that privacy, security and identity management are integral to the conduct of ethical self-care research. Transparency, a culture of trust, and mutual benefit between those who participate in research and those who conduct research are paramount to creating a sustainable research environment.

During the guideline development process and in-person GDG meeting, the GDG identified important knowledge gaps that need to be addressed through further primary research. Chapter 6 of the guideline discusses the limitations of the existing evidence base, presents illustrative research questions relevant to the enabling environment for self-care for SRHR, lists questions to address the identified research gaps related to the new recommendations in this guideline, as well as illustrative research questions on self-care interventions relevant to several outcome domains for measuring human rights and equity.

IMPLEMENTATION, APPLICABILITY, AND MONITORING AND EVALUATION OF THE GUIDELINE

Effective implementation of the recommendations and good practice statements in this guideline will likely require reorganization of care and redistribution of health-care resources, particularly in low- and middle-income countries. The potential barriers are reviewed in Chapter 7. Various strategies will be applied to ensure that the people-centred approach and key principles that underpin this guideline are operationalized, and to address these barriers and facilitate implementation.

The implementation and impact of these recommendations will be monitored at the health-service, regional and country levels, based on existing indicators. However, given the private space in which self-care is practised, alternative ways to assess the impact of the interventions need to be developed. Emphasis on use and uptake by vulnerable populations means that there will need to be meaningful engagement of affected communities.

UPDATING OF THE GUIDELINE

The concept for the format of this guideline is a “living guideline”. In a fast-moving field, this approach will allow for continual review of new evidence to inform further versions of the “living” document. The recommendations presented in this publication represent a subset of prioritized self-care interventions for SRHR, and this guideline aims to gradually include a broader set of self-care interventions over subsequent versions, as well as updating the recommendations as new evidence becomes available.

This guideline will therefore be updated as new evidence becomes available. An update to this guideline will likely be required within 18–24 months of dissemination of the present version, to accommodate either new evidence on existing recommendations or to develop new recommendations based on emerging evidence, including on new SRHR self-care interventions that may not have been available or identified during the discussions for the current version.

WHO aims to develop further guidance for SRHR and other health areas that would be likely to promote equity, be feasible to implement, and contribute to improvements in self-care, so that the appropriate recommendations can be included in future versions of this guideline, and can be adopted and implemented by countries and programmes.

Table 1 presents the new and existing recommendations on self-care for SRHR covering the following topics: (1) Improving antenatal, delivery, postpartum and newborn care; (2) Providing high-quality services for family planning, including infertility services; (3) Eliminating unsafe abortion; and (4) Combating sexually transmitted infections, including HIV, reproductive tract infections, cervical cancer and other gynaecological morbidities. These topics represent four of the five priority areas of sexual and reproductive health that are targeted in the 2004 WHO Global Reproductive Health Strategy. There are no new or existing recommendations on self-care interventions for the fifth area – Promoting sexual health – but relevant existing WHO guidance is provided in this guideline.

Table 2 presents the new and existing good practice statements on self-care interventions, covering the topics of (1) Environmental considerations; (2) Financing and economic considerations; (3) Training needs of health-care providers; and (4) Implementation considerations for vulnerable populations.

TABLE 1: SUMMARY OF NEW AND EXISTING RECOMMENDATIONS (REC) ON SELF-CARE INTERVENTIONS FOR SEXUAL AND REPRODUCTIVE HEALTH (SRHR)[1, 2]

RECOMMENDATION (REC)[a]	STRENGTH OF RECOMMENDATION, CERTAINTY OF EVIDENCE
1. Improving antenatal, delivery, postpartum and newborn care	
Existing recommendations on non-clinical interventions targeted at women to reduce unnecessary caesarean sections	
REC 1: Health education for women is an essential component of antenatal care. The following educational interventions and support programmes are recommended to reduce caesarean births only with targeted monitoring and evaluation.	Context-specific recommendation, low-certainty evidence
REC 1a: Childbirth training workshops (content includes sessions about childbirth fear and pain, pharmacological pain-relief techniques and their effects, non-pharmacological pain-relief methods, advantages and disadvantages of caesarean sections and vaginal delivery, indications and contraindications of caesarean sections, among others).	Low- to moderate-certainty evidence
REC 1b: Nurse-led applied relaxation training programme (content includes group discussion of anxiety and stress-related issues in pregnancy and purpose of applied relaxation, deep breathing techniques, among other relaxation techniques).	
REC 1c: Psychosocial couple-based prevention programme (content includes emotional self-management, conflict management, problem solving, communication and mutual support strategies that foster positive joint parenting of an infant). "Couple" in this recommendation includes couples, people in a primary relationship or other close people.	
REC 1d: Psychoeducation (for women with fear of pain; comprising information about fear and anxiety, fear of childbirth, normalization of individual reactions, stages of labour, hospital routines, birth process, and pain relief [led by a therapist and midwife], among other topics).	
Existing recommendations on antenatal care for a positive pregnancy experience – self-administered interventions for common physiological symptoms	
REC 2: When considering the educational interventions and support programmes, no specific format (e.g. pamphlet, videos, role play education) is recommended as more effective.	Not specified
Interventions for nausea and vomiting	
REC 3: Ginger, chamomile, vitamin B6 and/or acupuncture are recommended for the relief of nausea in early pregnancy, based on a woman's preferences and available options.	Not specified
Interventions for heartburn	
REC 4: Advice on diet and lifestyle is recommended to prevent and relieve heartburn in pregnancy. Antacid preparations can be offered to women with troublesome symptoms that are not relieved by lifestyle modification.	Not specified

[1] Further details on assessment of the quality of the evidence and determination of the strength of recommendation can be found in Chapter 3, sections 3.5.2 and 3.5.3

[2] See a list of existing recommendations for noncommunicable diseases (NCDs) in Annex 2.

TABLE 1 (continued)

RECOMMENDATION (REC)[a]	STRENGTH OF RECOMMENDATION, CERTAINTY OF EVIDENCE
Interventions for leg cramps	
REC 5: Magnesium, calcium or non-pharmacological treatment options can be used for the relief of leg cramps in pregnancy, based on a woman's preferences and available options.	Not specified
Interventions for low back and pelvic pain	
REC 6: Regular exercise throughout pregnancy is recommended to prevent low back and pelvic pain. There are a number of different treatment options that can be used, such as physiotherapy, support belts and acupuncture, based on a woman's preferences and available options.	Not specified
Interventions for constipation	
REC 7: Wheat bran or other fibre supplements can be used to relieve constipation in pregnancy if the condition fails to respond to dietary modification, based on a woman's preferences and available options.	Not specified
Interventions for varicose veins and oedema	
REC 8: Non-pharmacological options, such as compression stockings, leg elevation and water immersion, can be used for the management of varicose veins and oedema in pregnancy, based on a woman's preferences and available options.	Not specified
Existing recommendation on self-administered pain relief for prevention of delay in the first stage of labour	
REC 9: Pain relief for preventing delay and reducing the use of augmentation in labour is not recommended.	Weak recommendation, very low-quality evidence
2. Providing high-quality services for family planning, including infertility services	
New recommendation on self-administration of injectable contraception	
REC 10 (NEW): Self-administered injectable contraception should be made available as an additional approach to deliver injectable contraception for individuals of reproductive age.	Strong recommendation, moderate-certainty evidence
New recommendation on self-management of contraceptive use with over-the-counter oral contraceptive pills (OTC OCPs)	
REC 11 (NEW): Over-the-counter oral contraceptive pills (OCPs) should be made available without a prescription for individuals using OCPs.	Strong recommendation, very low-certainty evidence
New recommendation on self-screening with ovulation predictor kits (OPKs) for fertility regulation	
REC 12 (NEW): Home-based ovulation predictor kits (OPKs) should be made available as an additional approach to fertility management for individuals attempting to become pregnant.	Strong recommendation, low-certainty evidence

TABLE 1 (continued)

RECOMMENDATION (REC)[a]	STRENGTH OF RECOMMENDATION, CERTAINTY OF EVIDENCE
Existing recommendation on condoms	
REC 13: Consistent and correct use of male and female condoms is highly effective in preventing the sexual transmission of HIV; reducing the risk of HIV transmission both from men to women and women to men in serodiscordant couples; reducing the risk of acquiring other STIs and associated conditions, including genital warts and cervical cancer; and preventing unintended pregnancy.	Not specified
REC 14: The correct and consistent use of condoms with condom-compatible lubricants is recommended for all key populations to prevent sexual transmission of HIV and STIs.	Strong recommendation, moderate-quality evidence
Existing recommendations on the number of progestogen-only pill (POP) and combined oral contraceptive (COC) pill packs that should be provided at initial and return visits	
REC 15a: Provide up to one year's supply of pills, depending on the woman's preference and anticipated use.	Not specified
REC 15b: Programmes must balance the desirability of giving women maximum access to pills with concerns regarding contraceptive supply and logistics.	Not specified
REC 15c: The re-supply system should be flexible, so that the woman can obtain pills easily in the amount and at the time she requires them.	Not specified
3. Eliminating unsafe abortion	
Existing recommendations on self-management of the medical abortion process in the first trimester	
REC 16: Self-assessing eligibility [for medical abortion] is recommended in the context of rigorous research.	Not specified
REC 17: Managing the mifepristone and misoprostol medication without direct supervision of a health-care provider is recommended in specific circumstances. We recommend this option in circumstances where women have a source of accurate information and access to a health-care provider should they need or want it at any stage of the process.	Not specified
REC 18: Self-assessing completeness of the abortion process using pregnancy tests and checklists is recommended in specific circumstances. We recommend this option in circumstances where both mifepristone and misoprostol are being used and where women have a source of accurate information and access to a health-care provider should they need or want it at any stage of the process.	Not specified
Existing recommendations on post-abortion hormonal contraception initiation	
REC 19: Self-administering injectable contraceptives is recommended in specific circumstances. We recommend this option in contexts where mechanisms to provide the woman with appropriate information and training exist, referral linkages to a health-care provider are strong, and where monitoring and follow-up can be ensured.	Not specified

TABLE 1 (continued)

RECOMMENDATION (REC)[a]	STRENGTH OF RECOMMENDATION, CERTAINTY OF EVIDENCE
REC 20: For individuals undergoing medical abortion with the combination mifepristone and misoprostol regimen or the misoprostol-only regimen who desire hormonal contraception (oral contraceptive pills, contraceptive patch, contraceptive ring, contraceptive implant or contraceptive injections), we suggest that they be given the option of starting hormonal contraception immediately after the first pill of the medical abortion regimen.	Not specified
4. Combating sexually transmitted infections, including HIV, reproductive tract infections, cervical cancer and other gynaecological morbidities	
New recommendation on HPV self-sampling	
REC 21 (NEW): HPV self-sampling should be made available as an additional approach to sampling in cervical cancer screening services for individuals aged 30–60 years.	Strong recommendation, moderate-certainty evidence
New recommendation on self-collection of samples for STI testing	
REC 22a (NEW): Self-collection of samples for Neisseria gonorrhoeae and Chlamydia trachomatis should be made available as an additional approach to deliver STI testing services for individuals using STI testing services.	Strong recommendation, moderate-certainty evidence
REC 22b (NEW): Self-collection of samples for Treponema pallidum (syphilis) and Trichomonas vaginalis may be considered as an additional approach to deliver STI testing services for individuals using STI testing services.	Conditional recommendation, low-certainty evidence
Existing recommendation on HIV self-testing	
REC 23: HIV self-testing should be offered as an additional approach to HIV testing services.	Strong recommendation, moderate-quality evidence
Existing recommendation on self-efficacy and empowerment for women living with HIV	
REC 24: For women living with HIV, interventions on self-efficacy and empowerment around sexual and reproductive health and rights should be provided to maximize their health and fulfil their rights.	Strong recommendation, low-quality evidence
5. Promoting sexual health	
There are no new or existing recommendations on self-care interventions in this area, but relevant existing WHO guidance is provided in this guideline.	

[a] The recommendations are grouped under the five priority aspects of sexual and reproductive health that are targeted in the 2004 WHO Global Reproductive Health Strategy (available at: https://www.who.int/reproductivehealth/publications/general/RHR_04_8/en/).

TABLE 2: SUMMARY OF NEW AND EXISTING GOOD PRACTICE STATEMENTS (GPS) ON SELF-CARE INTERVENTIONS FOR SRHR

GOOD PRACTICE STATEMENT (GPS)
1. Environmental considerations
Adapted good practice statement on safe and sustainable management of health-care waste
GPS 1 (ADAPTED): Safe and secure disposal of waste from self-care products should be promoted at all levels.
Adapted good practice statement on environmentally preferable purchasing (EPP)
GPS 2 (ADAPTED): Countries, donors and relevant stakeholders should work towards environmentally preferable purchasing (EPP) of self-care products by selecting supplies that are less wasteful, or can be recycled, or that produce less-hazardous waste products, or by using smaller quantities.
2. Financing and economic considerations
Adapted good practice statements on economic considerations for access, uptake and equity
GPS 3 (ADAPTED): Good-quality health services and self-care interventions should be made available, accessible, affordable and acceptable to vulnerable populations, based on: the principles of medical ethics; avoidance of stigma, coercion and violence; non-discrimination; and the right to health.
GPS 4 (ADAPTED): All individuals and communities should receive the health services and self-care interventions they need without suffering financial hardship.
3. Training needs of health-care providers
Existing good practice statement on values and competencies of the health workforce to promote self-care interventions
GPS 5: Health-care workers should receive appropriate recurrent training and sensitization to ensure that they have the skills, knowledge and understanding to provide services for adults and adolescents from key populations based on all persons' right to health, confidentiality and non-discrimination.
4. Implementation considerations for vulnerable populations
New good practice statement on the life-course approach to SRHR
GPS 6 (NEW): Sensitization about self-care interventions, including for SRHR, should be tailored to people's specific needs across the life course, and across different settings and circumstances, and should recognize their right to sexual and reproductive health across the life course.
New good practice statement on the use of digital health interventions to support the use of self-care interventions
GPS 7 (NEW): Digital health interventions offer opportunities to promote, offer information about and provide discussion forums for self-care interventions, including for SRHR.
New good practice statement on support for self-care interventions in humanitarian settings
GPS 8 (NEW): Provision of tailored and timely support for self-care interventions, including for SRHR, in humanitarian settings should be in accordance with international guidance, form part of emergency preparedness plans and be provided as part of ongoing responses.
Adapted and existing good practice statements relevant to implementation of self-care for vulnerable populations
GPS 9 (ADAPTED): People from vulnerable populations should be able to experience full, pleasurable sex lives and have access to a range and choice of reproductive health options.
GPS 10 (ADAPTED): Countries should work towards implementing and enforcing antidiscrimination and protective laws, derived from human rights standards, to eliminate stigma, discrimination and violence against vulnerable populations.
GPS 11: Countries should work towards decriminalization of behaviours such as drug use/injecting, sex work, same-sex activity and nonconforming gender identities, and towards elimination of the unjust application of civil law and regulations against people who use/inject drugs, sex workers, men who have sex with men and transgender people.
GPS 12: Countries are encouraged to examine their current consent policies and consider revising them to reduce age-related barriers to HIV services and to empower providers to act in the best interests of the adolescent.
GPS 13: It is recommended that sexual and reproductive health services, including contraceptive information and services, be provided for adolescents without mandatory parental and guardian authorization/notification.

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