



SELF CARE

A Cost Effective Solution
for Maternal, Newborn &
Child Health for All

A WHITE RIBBON ALLIANCE
POLICY BRIEF

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Self-Care: A Cost Effective Solution for Maternal, Newborn & Child Health for All

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Every action to achieve well-being—whether taken by a medical provider or individual—is a healthcare activity.

Introduction

As a means to meet global maternal, newborn and child health (MNCH) targets, self-care has enormous potential. When promoted throughout the lifecycle and as an essential part of MNCH, self-care empowers women and their families with the knowledge, skills and confidence to proactively maintain healthy pregnancies, prevent complications, protect children’s health, defend their rights and identify emergencies, particularly at the community level. Despite its proven potential, donors, advocates, policy-makers and practitioners often overlook self-care in favor of clinical interventions and disease-specific, top-down approaches to MNCH.

MNCH self-care includes such life-saving activities as taking iron supplements during pregnancy, reacting appropriately to warning signs of obstetric emergencies, breastfeeding and treating diarrhea correctly at home. As an organization that advocates for a world where every woman around the world — no matter her means or status — is safe and healthy before, during and after childbirth, White Ribbon Alliance understands the power of self-care to achieve this goal. Yet, as a pathway to gains in global MNCH, self-care needs a shared vision amongst the many stakeholders in this dynamic field, and now is the time to elevate self-care to its rightful position within global, national and district-level policymakers.

This policy brief is based on a review of literature and interviews with community health, quality-of-care, self-care and MNCH experts.¹ It explores the possibilities and advantages of a paradigm shift in MNCH that would make self-care a central operating premise. We also hope it serves as a call to action for all those in a position to ensure that the very women and children we are trying to help have the support to realize most basic of desires: to care for themselves.

¹ For a list of stakeholders, see Appendix A



Photo by Heather Mason.

Self-Care: The Foundation of Health

Although the concept of self-care as applied to global health has existed for decades, it has received relatively little attention and investment. The World Health Organization provided likely the first definition in 1983:

Self-Care in health refers to the activities individuals, families and communities undertake with the intention of enhancing health, preventing disease, limiting illness and restoring health. These activities are derived from knowledge and skills from the pool of both professional and lay experience. They are undertaken by lay people on their own behalf, either separately or in participative collaboration with professionals.²

More recent definitions have also included the care given by individuals to family or community members. For example, the UK Department of Health definition notes that “Self-care is a part of daily living. It is the care taken by individuals toward their own health and well-being, and includes the care extended to their children, family, friends and

others in neighborhoods and local communities.”³ Women are the primary providers of self-care for their families, caring for sick children, elderly and chronically ill family members, and making decisions about family nutrition and hygiene.

Based on this comprehensive understanding it is clear that self-care comprises the vast majority of health activities for nearly every person in the world. By the definition established in 1978 at the International Conference on Primary Health Care and the Alma-Ata Declaration, health is a “complete state of physical, mental and social well-being.” Every action to achieve well-being — whether taken by a medical provider or individual — is a healthcare activity. Because people spend very little time in the direct care of a medical provider, the largest proportion of every person’s health care is comprised of self-care activities (see the health “tree” in Fig. 1). As WHO South-East Asia points out, studies show self-care “is the most dominant form of primary care in both developed and in developing countries.”⁴

2 WHO. Health Education in Self-Care: Possibilities and Limitations. Report of a Scientific Consultation. Geneva, Switzerland: World Health Organization. November 21-25, 1983.

3 UK Department of Health. “Self-Care—A Real Choice.” 2005.

4 WHO South-East Asia. “Self-Care in the Context of Primary Health Care. Report of the Regional Consultation.” Bangkok, Thailand. January 7–9, 2009.

Self-Care: The Root of Health Care

Tertiary Care

Highly specialized medical care involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities.

Secondary Care

Medical care provided by a specialist or facility upon referral by a primary care physician.

Primary Care

Health care provided by a medical professional (as a general practitioner, pediatrician, or nurse) with whom a patient has initial contact and by whom the patient may be referred to a specialist.

Self-Care

Activities taken by individuals, families and communities to enhance and restore health, prevent disease and limit illness. Such activities are dependent on having appropriate knowledge and skills to make the best health care decisions.

Yet because self-care involves minimal interaction with medical providers, the necessary components to support self-care are often overlooked, or reduced to periodic behavior change campaigns. Investments and interventions focus almost exclusively on curative medical care, the equivalent of only watering a tree's leaves, but not the roots. These investments are certainly important, but do not generally target the majority of health activities. As global health conversations and protocols increasingly emphasize "people-centered" care, it is vital to understand and support the preponderance of health-related actions people take, and as illustrated below, that self-care is at the center of health.

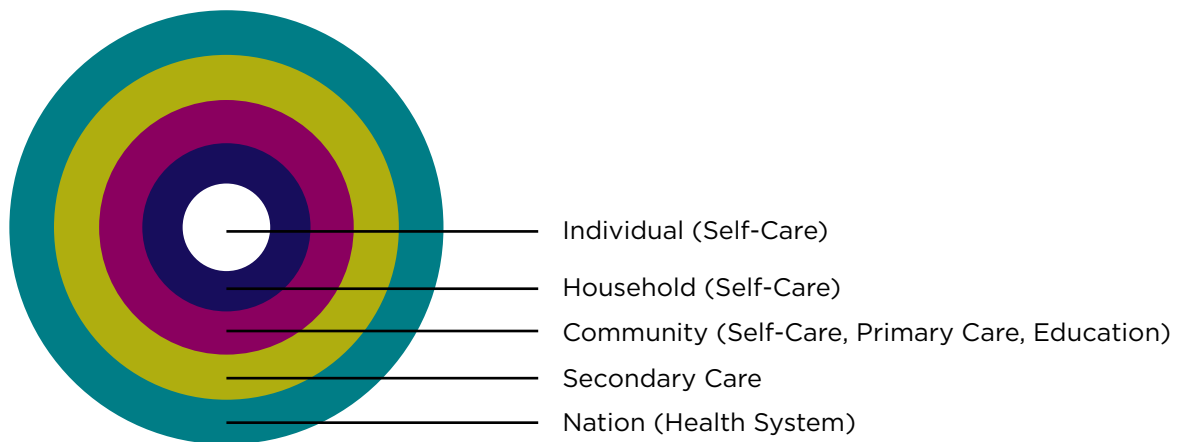
In the Global North self-care is often misconstrued as a luxury — only relevant to those who have the time and resources for yoga classes or massage to alleviate stress, or the power to negotiate leave from work to prevent burnout. This kind of framing ignores the vast majority of individual and community efforts to promote and maintain health that happen externally to an interaction with a health provider. A survey conducted by the World Self-Medication Industry found "no fundamental difference between developed and developing countries in people's aspirations to participate, to their level of ability and preference, in [self-care]

activities that affect their lives."⁵ All individuals and communities engage in some type of self-care, grounded in their own wisdom and traditions. Global leaders have the opportunity to position self-care as a right and an essential intervention, not an add-on. By doing so, leaders can harness and catalyze constructive community responses to the most urgent global health crises and support a sustainable solution for generations, as opposed to short-term measures focused on acute health crises.

Support for self-care, however, cannot represent an abdication of government responsibility for protecting and promoting health, nor a shift of the burden of health costs onto individuals. As will be discussed further in this paper, barriers to effective self-care practices must be seen as primarily structural, stemming from systemic failures to create the conditions necessary for self-care. Otherwise, self-care may become just one more thing that individuals, especially women, are pressured to engage in — and judged if they do not — without having access to adequate resources.

⁵ Bayer. "Self-Care for Better Individual Health and More Sustainable Healthcare: A Global Policy Blueprint." July 2015. To be published.

Self-Care: At the Center of Health



Self-Care: A Person-Centered Ecological Model

The ecological model of self-care's position within the broader health care context helps illustrate its centrality to healthcare, particularly to primary care. Individuals acting to promote their own and their families' health make decisions to prevent, treat or recover from illness, either self-managed at home or in consultation with a community-based pharmacist or health provider. The information these individuals provide to health workers is critical to identifying

In turn, regional and national environments must support communities in strengthening self-care. Such support includes policies and standards that equip providers with counseling skills and hold them accountable to people-centered care. It also includes policies and resources to support the necessary infrastructure for self-care including health literacy programs and grassroots, community-based organizations. This underscores the cross-sectoral nature of self-care, requiring

Primary care providers and community health workers must support individuals and households as informed decision makers about their health, which includes supportive counseling and health education.

the right prevention method, diagnosis or treatment; the feedback they provide identifies quality-of-care issues; and the actions they take in response to provider advice help determine prevention and treatment outcomes. In short, the success of primary health care is dependent in large part on the success of self-care.

To optimize self-care the community must provide an enabling environment through feedback to individuals and households. For example, primary care providers and community health workers must support individuals and households as informed decision makers about their health, which includes supportive counseling and health education. Schools must integrate health literacy to bolster knowledge about how to prevent and respond to illness. Community norms must support equal access to health resources for all races, economic classes and genders. Infrastructure in the community must facilitate hygiene and health through safe water sources, sanitation services and engaging recreational sites. Community organizations are also instrumental in supporting self-care.

coordinated efforts from the public and private sectors in health, education, water and sanitation, and social services.

MNCH Self-Care

Leaders of the International Self-Care Foundation have defined seven main "pillars" of self-care.⁶ The table on the following page classifies common MNCH self-care behaviors according to each of these pillars. The second pillar includes agency and self-efficacy to capture the power that individuals require to advocate for quality health care for themselves and their families, to seek care when they need it, to empower themselves with knowledge, and to make informed self-care decisions. This pillar can be particularly constrained for women and children because of gender norms and power differentials.

Specific examples within each pillar vary based on geographical and cultural context.

⁶ David Webber et al. "Self-Care in Health: We Can Define It, But Should We Also Measure It?" International Self-Care Foundation. Hong Kong, 2013.

Pillars of MNCH Self-Care

Pillar	Example of MNCH Self-Care
Health literacy	Understanding basic health information such as the menstrual cycle, fertility, basic reproductive anatomy, signs of pregnancy complications, symptoms of serious illness in children.
Mental well-being, self-awareness & agency	Awareness of postpartum depression, HIV status and other key conditions enough to advocate for oneself. Understanding, internalizing, and speaking up for right to respectful maternity care; having freedom to seek health care when one chooses; having freedom to use a contraceptive method; asking questions or expressing preferences in antenatal care visits, during labor, and during child health visits; providing feedback on MNCH quality-of-care.
Physical activity	Engaging in moderate exercise, limiting heavy lifting during pregnancy, resting during postpartum period.
Healthy eating	Consuming diverse, nutrient-dense foods; breastfeeding.
Risk avoidance or mitigation	Using bed nets for malaria prevention, spacing births, visiting health provider for antenatal care, using condoms to prevent HIV transmission, developing a birth plan, arranging for a skilled birth attendant, using safe drinking water, keeping sick children away from newborns.
Good hygiene	Washing food and hands using safe water source, using menstrual hygiene products.
Rational and responsible use of products, services, diagnostics and medicines	Properly using iron supplements, oral rehydration salts, zinc; awareness of contraindications of over-the-counter medicines.

The WHO Standards for Maternal and Neonatal Care emphasize health education and community understanding of these self-care practices.⁷ The health of women and children depends largely on their ability to navigate these key areas of self-care, given that these activities are part of daily life and visits to health providers are relatively rare. In each community, specific MNCH self-care practices are shaped by community norms, traditions, wisdom, and conditions. Support for MNCH self-care does not mean replacing the wisdom that exists or attempting to impose new norms, but engaging communities in reflective processes to examine traditions and affirm those that have positive outcomes.

Grounded in the communities where it takes place, MNCH self-care happens whether the health system promotes it or not. If the health system is not involved in supporting or providing information to support self-care decisions, traditional community practices tend to dominate. This is not necessarily negative for health. For example, evidence now shows that birthing in upright positions, as is traditional in many cultures, has distinct advantages over the lithotomy position. Some traditional practices surrounding pregnancy and childbirth, however, add to risks for women or their children, such as denying meat to pregnant women, discrimination in the care and feeding of female infants or bathing newborns in salt water.

Health care providers at the community level can play an important role in affirming positive traditional practices while educating communities about the impact of negative practices. WHO South-East Asia comments, “The family functions as a basic health care unit with an elaborate system of beliefs and procedures, many of which are rooted in the local culture. All levels of professional primary care are thus only supportive to self-care and modest facilitation of it has the potential to improve the health and socioeconomic status of the whole

population. [emphasis added]”⁸

Yet it is important to note that evidence-based self-care activities are not simply choices all women can make for themselves and their children. This helps explain why behavior change interventions on their own have limited power to support self-care. At the individual, family and community levels, the ability to engage in effective self-care depends heavily on gender dynamics, education level, income, place of residence and social status. Policy and programming at the local, national and global levels must confront these structural barriers.

Structural Obstacles to MNCH Self-Care

While self-care is most of what people do to stay healthy or recover their health, there are large gaps in who is able to engage in self-care activities that are effective and appropriate. It is essential to understand that these obstacles are embedded in structures. The responsibility for confronting these barriers must not rest on the individual and self-care must not be approached as a means of shirking government responsibility for respecting, protecting and fulfilling a right to health.

Individual and Household Obstacles

Individual obstacles to self-care do not stem from a lack of desire to engage in self-care. A recent policy paper released by Bayer points out, “...if people cannot access, process and understand basic health information, they will not be able to look after themselves well or make sound health-related decisions.”⁹

Disparities in effective self-care stem from systemic failures in supporting the pillars of self-care — most importantly health literacy — across diverse populations. As with basic literacy, those excluded from health literacy — including women and poor, rural, and minority populations — tend to experience discrimination in access to education and resources.

7 WHO. “Provision of effective antenatal care.” Standards for Maternal and Neonatal Care. 2006

8 WHO South-East Asia 2009

9 Bayer. “Self-Care for Better Individual Health and More Sustainable Healthcare: A Global Policy Blueprint.” July 2015. Data on file. To be published.



According to the Women’s Health and Education Center, women, rural residents and immigrants “experience significantly worse health outcomes such as higher rates of morbidity and mortality due to lack of health literacy...”¹⁰ Women often have disparately low access to key health literacy tools, such as mobile phones and other technologies.

sive sexual education is extremely rare. As Rima Jolivet of Maternal Health Task Force noted, “Even though a woman has critical knowledge of what is going on in her own body, she may not make sense of information in the same terms as those used by the health care system.” Moreover, a Women’s Health Education Center study found that those

The health of women and children depends largely on their ability to navigate these key areas of self-care, given that these activities are part of daily life and visits to health providers are relatively rare.

Health literacy is particularly relevant for MNCH as improvements in women’s understanding of basic reproductive anatomy and its functioning helps optimize pregnancy outcomes. Yet even the most rudimentary information on this topic is stigmatized in many parts of the world, leaving women unable to appropriately assess symptoms or take action for themselves to avoid risks before, during and after childbirth. The vast majority of the world’s schools spend little to no time on self-care and comprehen-

with low health literacy are likely to be ashamed of their lack of knowledge, suggesting that they may feign understanding when communicating with health providers, thus making it difficult for providers to identify critical knowledge gaps.¹¹

Gender dynamics are a significant barrier to women’s ability to engage in self-care, even when they are health literate. Many women lack the confidence or power to act on the information they have because others in their household or community control their movements or resources. For example, a woman who identifies signs that something is going wrong in childbirth may not be able to access care if her

10 Women’s Health and Education Center (WHEC). “Health Literacy, e-Health and Sustainable Development: WHEC Practice Bulletin and Clinical Management Guidelines for healthcare providers.” Accessed at <http://www.womenshealthsection.com/content/print.php3?title=heal017&cat=5&lng=english>

11 WHEC

husband or mother-in-law deny her permission to leave the home. Cultural norms based on gender also can prevent women from providing information or asking questions in interactions with providers. In some cultures, women have limited mobility outside the home, so they may not have the freedom to seek care for themselves or their children, especially when the provider is male. Several stakeholders mentioned that women are also conditioned to have low expectations for quality of care. Marion McNabb, senior technical advisor at Pathfinder International, commented that women may not know what kind of care they should receive and how they should be treated.

These gender dynamics exacerbate a fundamental provider-client power imbalance. Healthcare providers—particularly doctors—are seen in most countries as those uniquely endowed with knowledge and decision-making power about health. In its history of self-care, the World Self-Medication Industry notes,

The role model of the patient as a largely passive recipient of public services was complemented by the mystique of the expert healing physician. At the low point of self-care—around the 1960s in the West—self-care and self-medication were regarded as unnecessary and potentially even unhealthy practices. This paternalistic approach to medicine, supported by health systems designed to treat sickness (rather than to prevent disease) remains a familiar aspect of healthcare in many countries to this day.¹²

The legacy of this over-dependence on physicians continues to undermine individuals' assertion and sense of urgency in understanding and taking action on their health, while contributing to massively

12 World Self-Medication Industry. "The Story of Self-Care and Self-Medication; 40 Years of Progress, 1970-2010." Accessed at http://www.wsmi.org/wp-content/data/pdf/storyofselfcare_brochure.pdf.

overburdened health systems. Behavior change interventions can inadvertently reinforce this dynamic by using judgmental messaging, or by highlighting health professionals' knowledge and downplaying individuals' and communities' experiences and perspectives. In communities of poor, indigenous or minority populations, the power disparity between providers and those they treat is frequently even greater. Young women and adolescents are at a particular power disadvantage, no matter the gender of the provider.¹³ Sanjathi Velu, JCAP's team lead for Asia, cautioned that women must be equipped with the skills to assess care and negotiate their treatment, while providers must learn to expect these self-care behaviors from women.

Financial constraints also limit people's ability to care for themselves. Many of the most expensive elements of self-care have limited availability from the public sector, or are too costly for many from the private sector. Insurance, where available, often does not cover self-care because it is designed to alleviate costs of illness, not prevent illness. Pharmaceuticals are often an out-of-pocket expense. Care-seeking behavior can also be affected by transportation costs to the nearest health clinic. As mobile phones are increasingly used to disseminate health information and engage people in self-care, it will be important to ensure that those who cannot afford a phone are not left behind. Financial constraints disproportionately affect women as laws, gender norms and household dynamics can restrict their access to financial resources.

13 Veloshnee Govender and Loveday Penn-Kekana. "Gender biases and discrimination: a review of health care interpersonal interactions." Background paper prepared for the Women and Gender Equity Knowledge Network of the WHO Commission on Social Determinants of Health. June 2007.



Obstacles to Self-Care

Individual and Household Obstacles	Community Obstacles	District-Level Obstacles	National Obstacles
<p>Gender discrimination and stigma</p> <p>Passive attitude toward providers</p> <p>Health illiteracy</p> <p>Financial constraints</p>	<p>Provider resistance</p> <p>Lack of health education</p> <p>Primary health does not support self-care</p> <p>Lack of community civil society organizations engaged in self-care</p>	<p>Provider training does not support self-care</p> <p>Concentration of decision making power</p>	<p>Policies and funding focuses on reaction, not prevention</p> <p>Policies and funding are disease specific</p> <p>Policies assume passive recipients of care</p>

Provider Obstacles

Health providers also face constraints in supporting self-care. The language providers use to describe medical conditions often discourages self-care because many are not trained to speak to people's level of understanding. According to WHEC, "Many adopt the 'culture of medicine' and the language of their specialty as a result of their training and work environment. This can affect how health professionals communicate with the public."¹⁴

Suzanne Stalls of the American College of Nurse Midwives pointed to a lack of attention in providers' clinical training to "soft skills," leaving them without clear expectations of how they are to speak to and interact with clients. Those interviewed noted that even providers who support the idea of involving women in care may not have the counseling skills to be able to convey information effectively.

Many stakeholders interviewed for this brief pointed out that primary healthcare at the community level in most cases does not lend itself to improving self-care. Counseling women about actions they can take to promote a healthy pregnancy may save the health system time and resources in the future, but according to these stakeholders, providers currently do not have the appropriate financial incentives to see it that way. Given a primary care provider's daily patient load, providing time and space to support one woman's MNCH self-care would result in unacceptable tradeoffs, either because the provider would work too many hours to ensure quality, or because the provider would be forced to curtail time with other patients.

Health System Obstacles

To an increasing extent health funding targeted at the community level is disease-specific, which undermines holistic approaches to self-care. Donors generally seek movement on specific metrics—in MNCH these include percentage of women who have skilled attendants in childbirth, number of oral rehydration solutions and zinc treatments delivered and family planning coverage. While community

education may be a component of projects targeting specific issues or diseases, this education is narrowly constrained to topics relevant to reaching project metrics. For example, a vaccination campaign may not include health education elements when targets are focused on vaccination rates instead of on community understanding of disease prevention.

Trends in global health have also increased the burden on Community Health Workers (CHWs) to address the shortage in degreed professionals. While shifting the emphasis to the community makes sense, CHWs have limited power in a system that keeps putting more work on their shoulders. They may have the desire but not the freedom to engage in community mobilization, especially when engaged in disease-specific campaigns. The African Union Commission notes, "CHWs represent the 'front line' of the health system, and should be critical agents in community mobilization, health promotion and referral. In some instances, CHWs are not being utilized efficiently."¹⁵ Moreover, a pure service-delivery model at the community level can keep people in a passive mindset, continuing to see the provider, in this case the CHW, as the sole source of knowledge.

These structural barriers to effective self-care act in concert to limit the impact and sustainability of MNCH interventions. Yet, at both a policy and programmatic level, most current efforts to promote the MNCH self-care behaviors listed in the table above are centered on the health worker as the purveyor of information and not on dismantling the structural obstacles to women's health literacy and self-efficacy that obstruct MNCH self-care.

Benefits of MNCH Self-Care

The obstacles to self-care are formidable but must be overcome to address long-term challenges to global health. Self-care efforts promise substantial benefits in terms of cost-effective use of resources, bolstering quality-of-care and contributing to sustainable community health.

14 WHEC

15 African Union Commission



Efficiency and Cost Savings

Investing in self-care is ultimately a cost-saving strategy and a strategic use of global and national resources. Much of the impetus for self-care, particularly in the Global North, has been the enormous strain that chronic illness places on health systems, along with diminishing resources available to fund healthcare. The same trends driving up health costs in the Global North are beginning to affect the South as well. As a policy

In addition to helping ease or eliminate the chronic diseases that contribute to poor maternal health outcomes self-care holds particular benefit for MNCH health outcomes at low cost. Many of the top causes of maternal mortality and child death are addressed through effective self-care. Delays in care during labor can be addressed by improving women's awareness of danger signs and their confidence and power to seek care. Of the five interventions the March of Dimes recommends to

Of the five interventions the March of Dimes recommends to prevent child deaths due to prematurity, four of them can and should be implemented in the home.

paper by Bayer points out, "In spite of popular perceptions of chronic diseases as a developed world problem, 80 percent of such illnesses occur in low- and middle-income countries."¹⁶ Chronic diseases like diabetes and hypertension increase the risk of complications in childbirth. Countries in the Global North have found self-care to be an effective means of limiting the impact of chronic diseases and reducing the costs that accompany them.

16 Bayer. "Self-Care for Better Individual Health and More Sustainable Healthcare: A Global Policy Blueprint." July 2015. To be published.

prevent child deaths due to prematurity, four of them can and should be implemented in the home.¹⁷

Costs of poor self-care are extremely high for families, communities, and countries. The cost of poor maternal, newborn and child health in terms of human lives is enormous and the economic costs to countries, communities, and families are similarly catastrophic. One in ten women who have a live

17 March of Dimes. Premature Birth. March of Dimes Foundation. 2012. <http://www.marchofdimes.org/materials/born-too-soon-infographic-15-million-babies-every-year.pdf>

birth experience severe complications and disability.¹⁸ A study in Bangladesh found that women who had complications in childbirth spent 10 times the cost of an uncomplicated birth.¹⁹ Premature births are increasing and are the leading cause of death for children under five. Seventy-five percent of premature children require only minimal, low-cost interventions (most based in self-care) to save their lives.²⁰ Because children born too soon are more likely to

overstretched health systems, reduce cost, and increase its effectiveness, all of which facilitate efforts in achieving universal coverage.²³ Advocates note that costs for the individual will also decrease particularly in places like Pakistan where most providers are in the private sector. While individuals bear the up-front costs for self-care, they reduce their out-of-pocket costs over the long term by preventing illness and avoiding complications. WHO South-East Asia

“Self-care related to health promotion can reduce the cost of improving health and disease prevention at personal, family and health care system levels, since self-treatment accounts for a big chunk of the family’s health expenditure.” –WHO SE Asia

suffer ongoing medical problems, prematurity also generates significant costs for health systems, estimated by the Institute of Medicine at \$26 billion annually in the United States alone.²¹

Self-care reduces costs for the health system and individuals. The cost savings to health systems gained by increasing self-care have been lauded by many sources.²² Nand Wadhvani, director of the Mother and Child Health and Education Trust says, “It is clear that every dollar spent on education saves money on disease.” The WHO Southeast Asia Region notes, “self-care will ease the burden of the

argues, “Self-care related to health promotion can reduce the cost of improving health and disease prevention at personal, family and health care system levels, since self-treatment accounts for a big chunk of the family’s health expenditure.”²⁴

Self-care improves efficient use of scarce health system resources. In its policy paper on self-care, Bayer notes, “The wider adoption of self-care practices can also direct resources to the patients with greatest need.” If women can engage in effective self-care during pregnancy and postpartum, their lowered incidence of complications means that health providers will have more time to spend with more difficult cases, improving the survival odds for the mothers and newborns in their care.

Self-care mHealth interventions have an extended reach for limited cost. Mobile phones have become important resources for distributing health information about pregnancy, childbirth, postpartum and child health to wide audiences.

18 USAID. Ending Preventable Maternal Mortality. Maternal Health Vision for Action. <https://www.usaid.gov/sites/default/files/documents/1864/MCHVision.pdf>. 2014.

19 Mohamed Emanul Hoque, et al. “Costs of Maternal Health Related Complications in Bangladesh.” *Journal of Health, Population and Nutrition*. 2012 June. (30:2) 205-212.

20 WHO. Pre-term Birth. Fact Sheet No. 363. Updated November 2015. <http://www.who.int/mediacentre/factsheets/fs363/en/>

21 Institute of Medicine. Committee on Understanding Premature Birth and Assuring Healthy Outcomes. Washington, D.C. National Academies Press. 2007.

22 The British government estimates a self-care spending to benefits ratio of 1.5 to 1. UK Commission Wanless Report 2002.

23 WHO South-East Asia 2009

24 WHO South-East Asia 2009



Although there are still barriers in terms of phone access for women and girls in many cultural contexts, these programs have become very popular because they are cost-effective and use a tool many people already have. Sanjanthi Velu, Team Lead for Asia at JHCCP said there is “huge potential” in mHealth for MNCH. For example, Hesperian — creators of “Where There is No Doctor” — have created a mobile phone app that helps women recognize signs of concern during pregnancy and provides appointment reminders to facilitate antenatal care. Although mHealth interventions are relatively new for MNCH and therefore without an established evidence base, MNCH donors increasingly see mHealth as a promising area for their investments.

Quality-of-Care

Increasing the ability of people, particularly pregnant women and mothers, to engage in appropriate self-care has many direct benefits for MNCH quality-of-care. As Rima Jolivet of Maternal Health Task Force commented, “No one cares more about MNCH quality-of-care than the woman receiving the care, yet most systems make women passive recipients of care, critically undermining quality.” Andre Lelonde of FIGO pointed out that women are pushing back on the poor quality of the care they receive, primarily by not going to facilities where abuses occur.

In arguing for expansion of self-care promotion in the National Health System (NHS), the United

Kingdom Department of Health asserted, “Research shows that supporting self-care can improve health outcomes, increase patient satisfaction and help in deploying the biggest collaborative resource available to the NHS—patients and the public.” In terms of child health, WHO South-East Asia notes, “if self-care knowledge and practice are widely available in the communities; i) the care giver will identify the symptoms earlier ii) the child will be taken at an earlier stage to the health facility (iii) the home treatment will be according to the prescribed standard.”²⁵

Self-care reduces unnecessary visits and preventable complications, reducing provider workloads.

Evidence shows that MNCH self-care reduces negative outcomes for women, newborns and children. Interventions such as iron supplementation and antenatal care reduce the chances of complications, thus reducing the workload for providers. Such a reduction in provider workload is strongly associated with improved quality-of-care.²⁶

Self-care improves provider-patient communication, which affects health outcomes.

Self-care efforts that build health literacy also improve patient-provider communication as clients

²⁵ WHO South-East Asia 2009

²⁶ See for example “Provider workload and quality of care in primary care settings: moderating role of relational climate.” *Med Care*. 2013 Jan 51:1. 108-114.

are more likely to understand what the provider is saying and correctly implement provider instructions. Providers who have been trained to support self-care are more likely to communicate in language that is understandable to the client and respect what clients tell them. This creates a positive feedback loop, as providers will understand their clients “to be more active and more responsible by implementing self-care.”²⁷ Client questions will help providers identify where they can communicate better.

mHealth can place quality-of-care in the hands of individuals. Some quality-of-care programs have employed mobile health applications to gather data about service quality from users. The South African National Department of Health worked with the Praekelt Foundation to reach half a million pregnant women with their mobile website. In addition to providing healthy pregnancy information, the site allows users to report on how they are treated in

understanding of their medical condition, resulting in improved interactions with their provider.²⁸ Increased knowledge and awareness of one’s health contributes to compliance with provider instructions when necessary, which in turn builds provider confidence in the client’s ability to make smart choices. In childbirth, such improvements in the provider-patient relationship lead to better birth outcomes. Veloshnee Govender points out that “there is clear evidence that positive support for women during labor fundamentally improves the experience of childbirth for women both in physical and psychological terms, and results in better clinical outcomes.”²⁹

Community Health

In addition to contributing to MNCH quality-of-care, self-care approaches promise significant advantages for community health. While evidence still must be collected, community-based self-care has the potential to build a sustainable and cost-effective

Increased knowledge and awareness of one’s health contributes to compliance with provider instructions when necessary, which in turn builds provider confidence in the client’s ability to make smart choices.

public sector clinics. By placing accountability tools in the hands of individuals, such initiatives alter the power relationships between providers and those they serve. Other applications give people the ability to communicate directly with providers. For some having a private communications portal helps them to feel more at ease in asking questions or providing information about their condition.

Self-care increases women’s self-efficacy, improving provider-patient interactions. An article in the British Journal of Community Nursing found that self-care builds self-efficacy and greater

approach to preventing disease, treating illness and caring for those who are sick all informed by the needs and perspectives of health seekers. Self-care promotion lays a foundation of health literacy and community responsibility for health, upon which disease-specific interventions can build upon as necessary.

Self-care and community health are interdependent: As several stakeholders argued, community health advocates and self-care

27 Ibid.

28 “Self-Care Management Education Models in Primary Care,” British Journal of Community Nursing, 2013.

29 Buttiens, Marchal et al. 2004 cited in Govender 2007

advocates approach MNCH differently, but with important intersections and interdependencies. While MNCH self-care is about empowering women to trust themselves, know their rights and take actions to improve their health, community health focuses on social norms, group interactions and the resources available and controlled at the community level to support healthy behavior. At the same time, MNCH self-care depends on a supportive community health environment and community MNCH depends on individual women's ability and agency to support their own health.

Self-care can express local knowledge building on community wisdom. At its best, self-care can help community members express mutual support and concern based on local traditions and connections. Tina Gryboski, senior program officer for women and children's health at Project Hope, remarks that embracing culture as a resource is critical to the adoption of new health behaviors. In her experience such an approach can build on embedded traditions that prioritize community health, emphasizing community service and responsibility for one another. She cites the example of traditional birth attendants as one form of community support for women's health, pointing out that innovative approaches have harnessed these cultural resources instead of trying to abolish them.

Self-care benefits all types of communities: Poor and rural communities can benefit greatly from self-care promotion but urban and middle- and upper-income communities similarly benefit. One advantage of a self-care approach is that it can be adapted to the particular health concerns, resources, education levels and priorities of any given community. Communities, no matter their setting or income level, can be effectively mobilized to prioritize self-care to great benefit. A study conducted in 2005 in urban Thailand on self-care among women in the informal employment sector found that through the collective process of adopting self-care actions the women discovered that their health problems were related to their work. With a common goal and mutual support

they worked together to address the source of their ill health.³⁰

mHealth can be a tool for creating communities based on self-care: Mobile phones and other technologies can be used as a tool to create a virtual community for self-care. Yet, unlike the example from South Africa referenced earlier, most MNCH mHealth programs are conceived and implemented to distribute information in one direction. These uni-directional programs contribute to self-care but lose a critical opportunity to collect information from beneficiaries and share information amongst peers. A community health approach to mHealth, for example, could ask for users' feedback about urgent health needs, medication or medical supply stock-outs, human rights and quality-of-care violations. Such platforms can also integrate social media to serve as safe spaces and virtual communities to share information about side effects, common experiences and healthy behaviors. They could also benefit from information sharing between health providers. Creating these confidential online communities could be of particular benefit for adolescent girls, whose ability to delay pregnancy often depends on negotiating community stigma around their sexual behavior, or overworked midwives as a means of support and knowledge sharing.

Community-based self-care approaches can play an important role in addressing inequality: Self-care efforts grounded in community needs, which are truly representative and participatory, can overcome structural barriers to information. Self-care in general lends itself to innovative and customized approaches that can reach the entire population, not only those who have the status and means to practice effective self-care or seek care through health systems. Proper measurement and evaluation of self-care programs, with data disaggregated by sex, age, and other key factors, is needed to uncover disparities within a given community so that self-care benefits within all segments in society are equally documented and shared.

30 WHO South-East Asia 2009.

Women’s groups can be an important tool for promoting self-care while improving accountability around and ownership over community health:

One of the African Union Commission’s recommendations in its report for the International MNCH Conference was to advance women’s groups for learning and action: “Studies show these groups to be a cost effective way to improve maternal and neonatal survival in rural, low-resource settings, even when the proportion of pregnant women participating is only 30 percent. ...Such groups improve care practices (e.g. hygiene, breastfeeding, bed net use) build social support for mothers,

A holistic community approach to self-care can transform women and CHWs into agents of community mobilization and health promotion. While this approach would require a short-term investment in training and deployment of volunteers and organizers, in the long term it will ultimately reduce costs for the health system. Men’s groups can be mobilized alongside women’s groups to engage constructively in community health. This model leverages the multi-generational wisdom that women have harnessed and shared to keep themselves and their children healthy, ideally in a process that is supported, informed and affirmed by medical professionals.

Community-based self-care requires a shift of both resources and mindsets but it promises to greatly reduce the burdens on the health system in the long run.

improve decision-making for care seeking and help women hold health services accountable.”³¹

Women’s MNCH groups can dismantle gender inequities and promote empowerment: A systematic review of women’s MNCH groups explained the reasoning behind them, asserting that, “where gender inequity constrains improvements in maternal survival, empowered groups could give women the understanding, confidence and support to choose a healthy diet in pregnancy and seek care or advice outside of their homes.” The groups “discussed danger signs, raised community-wide support for maternal health, organized transport for pregnant women and contributed to emergency funds for transport and health-care costs.” The review found significant improvements in women seeking antenatal care and smaller changes in the speed in which they sought that care.³²

In notable cases community health initiatives have engaged meaningful participation of diverse segments of communities in the definition of health problems and the implementation of solutions. Yet too often shifting the locus of health service delivery has not altered the underlying assumptions and structural barriers that keep communities disempowered in terms of their health. Community-based self-care requires a shift of both resources and mindsets but it promises to greatly reduce the burdens on the health system in the long run.

31 African Union Commission 2013.

32 Audrey Prost et al. “Women’s groups practicing participatory learning and action to improve maternal and

newborn health in low-resource settings: a systematic review and meta-analysis.” *Lancet* 2013; 381: 1736-46.

Self-Care as a Solution

Individual and Household Solutions	Community Solutions	District-Level Solutions	National Solutions
<p>Gender equality programs</p> <p>Promotion of self-care as a right</p> <p>Health literacy based in local culture</p>	<p>Community accountability</p> <p>School-based health education</p> <p>Community groups including men's and women's groups</p>	<p>Provider standards that support self-care</p> <p>Decentralization of health policies</p>	<p>UHC Supports prevention, self-care</p> <p>Policy change to person-centered care</p> <p>Policies and funding take holistic approach to health</p>

Recommendations

Self-care encompasses the vast majority of health-promoting activities globally, and individuals and communities engage in self-care regardless of how well they are supported by systems. But to fully optimize global health resources in pursuit of a “complete state of physical, mental and social well-being” for women, newborns, and children, leaders must invest in the tools that support effective MNCH self-care. Global and national bodies can no longer afford to neglect the vast opportunities that sit at the base of the health “tree.”

International Bodies:

- The WHO must move faster toward people-centered care. Their work on patient-centered care and on quality-of-care standards must promote MNCH self-care including strong messaging about women as empowered agents of their own care. WHO’s Global Strategy on Human Resources for Health (Workforce 2030) affirms “integrated, people-centered health services devoid of stigma and discrimination,” yet the policy still focuses provider capabilities

and numbers rather than leveraging the potential of those most committed to health: people.

- Standards for self-care must be integrated at the highest levels. WHO must include standards for health system and provider quality that include promotion of self-care in its guidelines on MNCH quality-of-care. In its indicators to measure quality-of-care, WHO must encourage community-based accountability and how well health systems and providers support MNCH self-care.
- Self-care research must be funded, prioritized and widely disseminated. Much more remains to be learned about self-care behaviors in MNCH and what supports health activities within a community context. WHO can play a strong role in researching the long-term feasibility of community-based self-care and the impact such a shift would have on MNCH outcomes and healthcare costs. This research should be widely shared to ensure that national governments can replicate and expand what is working to reach everyone.

- Ongoing monitoring and evaluation must broaden in scope so that we fully understand the potential of self-care. The International Self-Care Foundation has proposed developing an index of self-care behaviors to enable measurement of “self-care deficits.”³³ This has important possibilities for application to MNCH, but the index must also measure contextual factors in order to accurately assess what structural determinants affect self-care.
- International bodies must consult with community-based women’s groups and engage them as key partners in promoting MNCH self-care and improving MNCH outcomes.

National Governments:

- Governments must conduct a full inventory of existing community approaches to MNCH self-care in their countries and fully understand what they need to thrive. Such an approach will honor local knowledge while appropriately placing individuals and communities at the center of government policies to promote health.
- Governments must ensure that insurance schemes cover prevention in addition to care and treatment. There are excellent opportunities to do this as more governments move toward Universal Health Coverage.
- Governments must acknowledge, respect and fulfill their citizens’ right to information about self-care. According to the Institute for Information Law and Policy at New York Law School, “health information is an essential component of many identified and established human rights,” and states must “affirmatively take steps to ensure that individuals are provided with health information.”³⁴ Governments have an obligation to fulfill this right by setting and enforcing

health care standards that require providers to give care-seekers relevant information about their health and their care.

- National governments also need to collaborate across ministries to promote self-care. Ministries (such as health, education, nutrition, water, sanitation, social services) must develop strategies and targets to support self-care over the long term. These efforts should support and recognize traditional knowledge and practices that support health and affirm individuals, families and communities in their roles as caregivers. Targets should include national health literacy targets.
- Governments should move away from using community health workers (CHWs) as disease-specific service providers. CHWs should be recognized, employed and compensated adequately as robust community organizers they have the potential to become. The tradition from Latin America of health promoters is based in community empowerment and self-efficacy and provides a good model for governments to adopt.
- National governments must provide robust support for community mobilization and women’s empowerment with a focus on MNCH self-care. Women’s groups have been proven to improve gender dynamics, a major determinant of MNCH self-care and governments have the ability to transform community members into self-care advocates, informed consumers and providers of mutual support. They must embrace this.
- Communities must be involved in policy making. Ministries of health must build community-based self-care over time, beginning with community consultation, health literacy efforts and tackling gender inequality. Over time, governments must move more decision-making to the community level, eventually giving communities full responsibilities and control over health resources.

³³ Webber 2013

³⁴ “Access to Health Information Under International Human Rights Law.” Institute for Information Law and Policy (IILP). New York Law School. May 2012.

- Self-care must be integrated into the education system and begin early. For MNCH self-care, comprehensive sexuality education is extremely important to lay the groundwork for empowered pregnant women and mothers. Governments must immediately begin to train teachers — starting in primary school — to provide comprehensive, evidence-based sex education and work closely with communities to ensure appropriate implementation so that as children grow up, they understand their rights and responsibilities in terms of their own health care.

Professional Associations and Training Institutions:

- Professional associations must recognize and prioritize self-care. By engaging in values clarification training for existing providers, professional associations can help to prioritize self-care and reframe health provision as a partnership with health seekers, with respect for local knowledge and health-positive traditions.
- Professional associations must issue guidelines that support self-care. Many health providers are currently a barrier to self-care because they don't have time to spend on counseling, nor the expectation that their clients will engage in self-care. Training institutions must provide pre-service education that reframes the provider-client role in a way that empowers individual and community action.

Private Sector Partners and MNCH Donors:

- Bilateral, multilateral and private donors must be willing to invest in long-term, self-care capacity building programs. Longer-term, cross-sector projects will help implementers focus efforts on the systemic changes that are needed for effective self-care to take root in a community. The changes in attitudes, health literacy and community empowerment necessary for quality-of-care need sustained support across sectors.
- mHealth projects that provide a robust feedback loop should be prioritized. Bilateral,

multilateral, and private donors must support mHealth maternal health projects that include opportunities for women, health workers and communities to provide information about the barriers they face to self-care, as well as to form online communities for mutual support.

- An empowered and well-resourced civil society can provide a foundation for community-based self-care. The African Union Commission recommends robust funding for advocacy organizations in particular: “A strong advocacy climate is critical to engaging local communities, as community organizations are vital stakeholders in defining and demanding appropriate services, as well as ensuring accountability.”³⁵ Donors must fill this gap by supporting civil society organizations for advocacy and community-based self-care projects.

Conclusion

The shift to a people-centered approach that prioritizes and supports self-care will not occur without concerted effort from global, national and community stakeholders to direct resources, change provider mindsets, develop community organizations and build health literacy. While this shift will require significant effort and resources it offers the opportunity to lay the groundwork for a long-term and fundamental transformation in equipping communities and individuals to promote and preserve their health while realizing their rights.

35 African Union Commission 2013



Appendix A

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