REPUBLIC OF UGANDA
MINISTRY OF HEALTH

National Guideline on Self-care Interventions for Health and Well-being

October, 2024

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FOREWORD

One's ability to promote health, prevent disease, maintain health, and cope with illness and disability with or without the support of a health-care provider is termed as self-care. This guideline is adapted based on recommendations of the WHO Guideline on self-care interventions for health and well-being. However, it will further be expanded in the future to incorporate tested and proven self-care practices in other health areas.

The important role self-care plays was amplified and exemplified during the COVID-19 pandemic where physical distancing, good respiratory hygiene, and hand washing were important Self-care examples one could practice every day to protect against COVID-19, and there are many other areas in which self-care can make a difference to your health and well-being.

Uganda continues to experience a high population growth rate (due to high fertility) that has outstripped the growth of the health sector infrastructure, health workforce, health financing and diagnostics. The resultant impact of the above is the high Out-of-Pocket (OOP) expenditure and long waiting times that individuals experience at the health facilities. As the Ministry of Health (MOH) continues to strengthen the community provision of SRHR services, self-care will play an important role in addressing the increasing inequitable access to SRHR services through increasing health literacy. The Ministry of Health's comprehensive approach, coupled with citizen engagement in lifestyle changes, aims to not only combat the current challenges posed by NCDs but also to create a healthier future for the nation.

I would like to thank Dr. Olaro Charles for providing stewardship of the Self-Care Expert Group (SCEG) that has guided the development of the National guideline on Self-Care interventions for Health and Well-being, supported by Roselline Achola, the Technical Specialist for SRHR and Self-care for the job well.

Implementation of the guideline will require active involvement and collaboration at multi-sectoral levels to realize its intention and objectives. The MOH commits to put in place a favorable enabling policy environment, infrastructure, and resources to operationalize the self-care innovation. In addition, through the Public-Private Partnership for Health platform (PPPH), support will be accorded to the private sector to take on self-care with quality assurance as a guiding principle.

Dr. Henry G Mwebesa
Director General, Health Services
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PREFACE

The National guideline on Self-care interventions for health and well-being takes both a *people-centered* and *health systems* approach. The guideline also emphasizes equity in self-care: i.e. ensuring all people, including the most vulnerable, have access to support from health workers, high-quality informational materials, and reliable access to supplies in both public and private sector health outlets.

The COVID-19 pandemic further stretched the Uganda healthcare system that experiences a low growth in the health workforce and infrastructure. Self-care is not new in Uganda. It has been practiced in areas of non-communicable diseases, Traditional and complementary medicine, cancer prevention and treatment, mental health, and other health areas. For more than 8 years, Uganda has piloted and scaled up self-care interventions in the area of SRHR that include the provision of DMPA SC, HIV self-testing, and self-sampling for HPV to mention but a few.

The importance of introducing the National guideline on self-care interventions for health and well-being cannot be overlooked. The guideline encompasses combined efforts to (i) improving antenatal, intrapartum and postnatal care; (ii) providing high-quality services for family planning, including infertility services; (iii) eliminating unsafe abortion; (iv) combating sexually transmitted infections (including HIV), reproductive tract infections, cervical cancer and other gynecological morbidities; (v) promoting sexual health; and (vi) addressing noncommunicable diseases, including cardiovascular disease and diabetes.

Universal access to SRHR and non-communicable diseases prevention is essential for Uganda to achieve its Sustainable Development Goals (SDGs) country targets. SRHR and non-communicable diseases prevention is fundamental to individuals, couples, and families, and to the social and economic development of communities in Uganda. Commitment to the implementation of self-care interventions by all stakeholders may offer 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;
- Reduced cost and more efficient use of health care resources and services.

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I would like to acknowledge the following partners and members of the SCEG who provided technical assistance, indirect investments such as human resources, additional self-care research, and support to various guideline development activities: MoH (Reproductive and infant health division, Adolescent and school health division under the leadership of Dr Mugahi Richard, the Commissioner RCH, AIDS control division, public health laboratory division, community health department, Health Promotion and Disease Prevention, supply chain, and logistics division), UNFPA, USAID, PATH, CEHURD, Makerere School of Public Health, FHI360, Samasha, Living Goods, Marie Stopes Uganda, RHU, CHAI, Mild May, RAHU, Public Health Ambassadors Uganda, IRC, TEGEM, ERIC Cancer Initiative Uganda, UYAFPAH and Mukono District Local Government.

Particular mention goes to Children Investment Fund Foundation, Hewlett, the Self-Care Trailblazers Group, PSI, WHO, and Planned Parenthood Global who funded the development of the Self-care guideline

Now that the guideline has been launched, let us all work together for the sustainable health of our country, Uganda.

Dr. Olaro Charles

Director Health Services (Curative services) and chair of the Self-Care Expert Group

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List of Abbreviations

Acronym	
MOH	Ministry of Health
NDA	National Drug Authority
PNFP	Private Not for Profit
PFP	Private For Profit
CSO	Civil Society Organization
FP/RHCS WG	Family Planning/Reproductive Health Commodity Security Working Group
MCH TWG	Maternal Child Health Technical Working Group
RH	Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
DMPA SC	Depo-Medroxyprogesterone Acetate Sub-Cutaneous
HIVST	HIV Self-Testing
HTS	HIV Testing and Counseling Services
HPV	Human Papilloma Virus
STI	Sexually Transmitted Infections
WHO	World Health Organizations
NPC	National Population Council
OPK	Ovulation Predictor Kit
RDT	Rapid Diagnostic Kit
RBS	Random Blood Sugar
SCEG	Self-Care Expert Group
CIFF	Children's Investment Fund Foundation
PHC	Primary Health Care
UHC	Universal Health Coverage
REC	Recommendation
GPS	Good Practice Statement
TCM	Traditional and Complimentary Medicine
NCDs	Non-Communicable Diseases
PSI	Population Services International
PAC	Post Abortion Care
HC	Health Centre
CPHL	Central Public Health Laboratory
BSE	Breast Self-Examination

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CHAPTER 1: INTRODUCTION

1.1 Background

Uganda's health care system is overstretched to meet the needs of its growing population. Uganda's population is estimated at 45.07 million people (2022 UBOS population estimates) and projected to reach 100 million by 2050. The high fertility rate (5.4) and annual population growth rate (3.1%) will continue to place significant demands on provision of health and social services, as well as on families, who must spend scarce resources on ill health. Uganda has 6,937 public and private health facilities (National Health Facility Master List 2018). With the current annual population growth rate, it is estimated that Uganda will require 9,320 health facilities by 2037 (NPC 2018).

The population growth has outstripped the rate of development of skilled health workforce. The overall density of skilled health workforce (1.64 per 1,000 population) is below 2.3 per 1,000 (2006 WHO recommended) and 4.5 per 1,000 for 50% attainment of Universal Health Coverage and Sustainable Development Goals attainment threshold (2016 WHO recommendation). The increasing population coupled with limited skilled health workforce has resulted into increased client load at health facilities.

NCDs have surpassed infectious diseases as the leading cause of premature deaths (death below 70 years) in Uganda. Currently the NCDs contribute about 30% of all the annual hospital-based mortalities (MOH Report 2018). This proportion increases to 40% with inclusion of road traffic accidents and mental health conditions. A recent survey utilizing the WHO STEPS tool across Uganda demonstrated a 26.4% prevalence for hypertension (HTN), particularly in central Uganda at 28.5%[1]. A similar survey concerning type 2 Diabetes Mellitus (DM) demonstrated a prevalence of 1.4% [2]. Prevalence of self-reported Hypertension and Diabetes Mellitus in Nakaseke district was 6.3% and 1.1% respectively[3]. There is an urgent need to improve education and diagnostic capabilities among rural communities of Uganda and elsewhere for the prevention, early diagnosis, and effective management of NCDs.

According to the 2014 Uganda national NCD risk factors survey prevalence's of key NCD risk factors and diseases, 24.3% of adult Ugandans had raised blood pressure that needed

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[1] UN supporting Uganda to halt the rise of non-communicable diseases, 23 sept 2019: https://www.who.int/news-room/feature-stories/detail/un-supporting-uganda-to-halt-the-rise-of-non-communicable-diseases

[2] Bahendeka S, Wesonga R, Mutungi G, Muwonge J, Neema S, Guwatudde D. Prevalence and correlates of diabetes mellitus in Uganda: a population-based national survey. Tropical Med Int Health. 2016;21(3):405–16. https://doi.org/10.1111/tmi.12663.tyoe

[3] World Health Organization (WHO). *Uganda: Noncommunicable Diseases (NCD) Country Profiles, 2018*. WHO; 2018. Accessed February 28, 2021. https://www.who.int/nmh/countries/uga_en.pdf

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treatment yet 76.1% of these did not know that they had high blood pressure. 1.4% of adult Ugandans were diabetic, the proportion goes up to 3% urban areas. NCDs are difficult to treat and often lead to fatal complications like heart disease, stroke, kidney failure and liver failure.

Rational for Self-Care

According to WHO guideline on self-care interventions for health and well-being, 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 worker. Self-Care includes a broad set of interventions and approaches, such as 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.

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. Self-care builds on existing movements, such as task sharing and task shifting, and has the potential to contribute to all aspects of Uganda health systems strategic plan and WHO's strategic priorities and triple billion targets. As such, Self-care is increasingly being acknowledged in global initiatives, including advancing Primary Health Care (PHC) with the new Declaration of Astana (2018) through effective, equitable, efficient and sustainable means.

While self-care is not a new term or concept, rapid advancement in medical and digital technologies is accelerating the range of interventions that were previously delivered by health workers but can now be acquired and managed more directly by individuals.
Self-care interventions have the potential to increase choice, where they are accessible and affordable, and they can also provide more opportunities for individuals to make informed decisions regarding their health and health care. Consequently, self-care interventions represent a significant push towards new and greater individual self-efficacy, autonomy, and engagement in health for self-carers and caregivers.

Self-Care will not replace the health care system but will reduce client load for the available limited health workforce and pull down the out-of-pocket expenditure on health by individuals and families.

1.2 Health system organization

Uganda operates a decentralized health care system for the delivery of essential health services that also ensures referral linkages. The health care system is structured into

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national and regional referral hospitals, general hospital, Health Centre (HC) IVs, HC IIIs, HC IIs and Village Health Teams (HC I's). The health sector structure follows the local government administrative structure as indicated in the table 1 below.

Table 1: Health sector structure

Health unit	Physical structure	Location	Population covered
Health Centre I	None	Village	1,000
Health Centre II	Outpatient services only	Parish	5,000
Health Centre III	Outpatient services, maternity, General Ward and laboratory	Sub-county	20,000
Health Centre IV	Outpatients, Wards, Theatre, Laboratory and blood transfusion	County	100,000
General Hospital	Hospital, laboratory and X- ray	District	500,000
Regional Referral Hospital	Specialists' services	Regional	3,000,000
National Referral Hospital	Advanced Tertiary Care	National	10,000,000

Source- Uganda health sector strategic plan 2010-2015

1.3 Global context and overview of WHO Consolidated Guideline on Self-care interventions for Health and Well-being

On 24th June 2019, the WHO released the '*Consolidated Guideline on Self-Care Interventions for Health: Sexual and Reproductive Health and Rights*' that was revised in 2022 to the *WHO guideline on Self-care interventions for health and Well-being.* The guideline provides a people-centered, evidence-based normative guidance to support individuals, communities and countries with quality health services and self-care interventions. The guideline includes:

- ***37 Evidence-based recommendations*** on key public health self-care interventions, with a focus on vulnerable populations and settings with limited capacity and resources in the health system. That includes interventions for improving antenatal care, intra-partum and postpartum: providing high-quality services for family planning, including infertility services; Eliminating unsafe abortion; and combating STIs, (including HIV), Reproductive Health (RH) tract infections, cervical cancer, and other gynecological morbidities; Promoting sexual and reproductive health; Non-Communicable Diseases (NCDs) that include cardiovascular disease and Diabetes among others NCDs.

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- ***18 Good Practice Statements (GPS)*** on key programmatic, operational and service-delivery issues that need to be addressed to promote an increase in safe and equitable access, uptake and use of self-care interventions, including advancing SRHR. These statements address; financing and economic considerations; training needs of health-care workers; rational delegation of tasks and task sharing; competence-based training of health workers, life course approach, implementation considerations of underserved and marginalized populations, Digital health interventions, and environmental considerations

Globally, at least half of the world's population still lacks access to basic health services[4], due in part to overstretched health systems with shortage of health worker force, which were further strained by the COVID-19 pandemic. Every year, 100 million people are pushed into poverty due to unaffordable care[5]. Innovative strategies that go beyond traditional health sector responses are therefore urgently needed to contribute to Universal Health Coverage (UHC).

With appropriate normative guidance and a safe and supportive enabling environment, self-care interventions may offer 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.

Living Guideline Approach

Self-care is a quickly evolving field. Therefore, the *WHO guideline on Self-care interventions for health and Well-being (2022 revision)* will be updated as new areas of self-care emerge and/or additional self-care interventions are prioritized. That approach will allow for continuous review of the Uganda guideline to inform further versions; it is a "living" document that will gradually include a broader set of self-care interventions in future.

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4 AHSPR 2018/19

5 World Health Organization. (2017). *Tracking universal health coverage: 2017 global monitoring report.* https://apps.who.int/iris/bitstream/handle/10665/259817/9789241513555-eng.pdf?sequence=1

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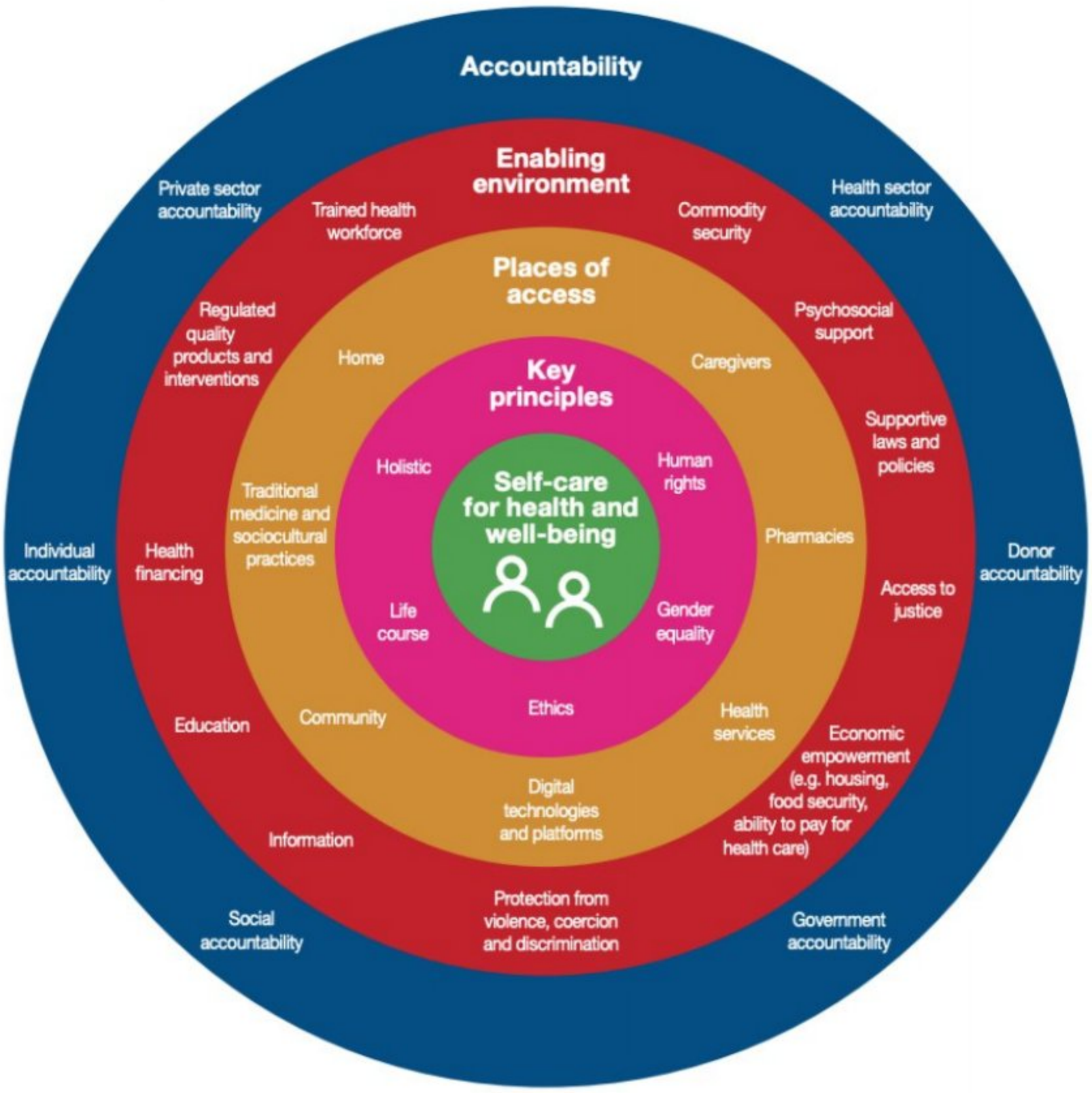
Conceptual Framework for Self-Care

People-Centered approach lies at the core of this conceptual framework for self-care (green circle) and is underpinned by "key principles" (pink ring). With this as a foundation, the framework then shows key places of access for self-care interventions (mustard ring), and then the key elements of a safe and supportive enabling environment (red ring). The outer blue ring highlights accountability at different levels.

Figure 1: 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.

Enabling environment for self-care

A safe and supportive enabling environment is essential to facilitate access to and uptake of self-care products and interventions. Creating an enabling environment for self-care requires systematic attention to all aspects of the health system as well as the broader

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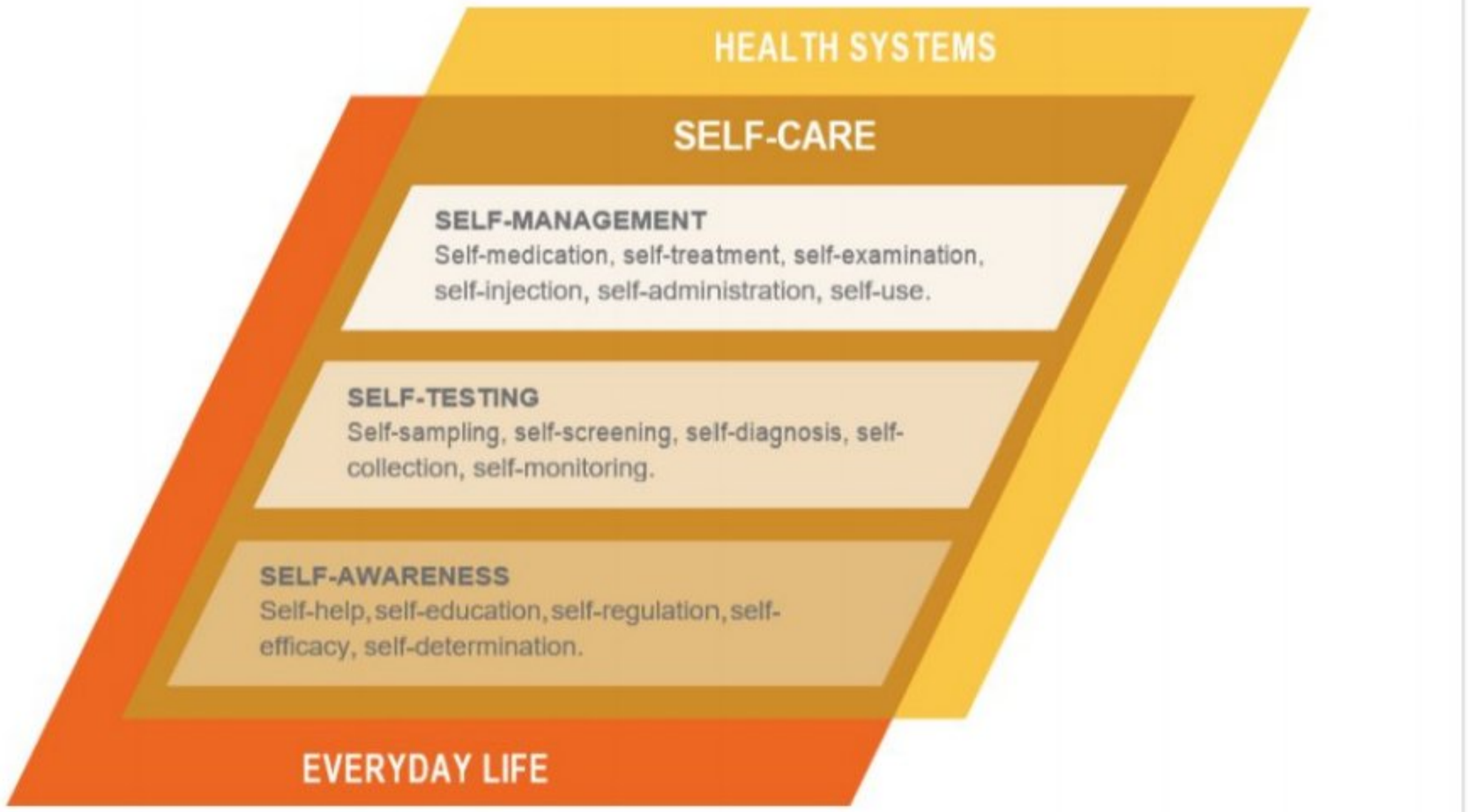
environment within which self-care interventions are delivered. Building partnerships between user-led/community-led platforms and health systems around self-care interventions are a promising approach to ensure correct and accelerated implementation of effective and safe health-care interventions.

Figure 2: Self-care interventions linked to the health system



e: adapted from Narasimhan et al., 2019 *(12)*

The Self-Care Trailblazer Group's Evidence and Learning Working Group seeks to generate and synthesize high-quality evidence to support evidence-based self-care. This community of practice of over 500 members (65% representing the global south) produced a series of global goods and tools to advance self-care policy and practice. These tools include:

- ***Digital self-care framework:*** It provides a practical guidance for effectively designed, implemented and researched digital health in support of self-care. (https://www.psi.org/project/self-care/digital-self-care/)
- ***Quality of care framework for self-care:*** It provides the elements of WHO framework critical for Quality of Care in self-care (https://www.psi.org/project/self-care/quality-of-care-framework-for-self-care/)
- ***Policy mapping*** which involves assessing implementation of the WHO consolidated guideline on self-care interventions (https://www.psi.org/project/self-care/policy-mapping-assessing-implementation-of-the-who-consolidate-guideline-on-self-care-interventions/)
- ***Social & behavior change self-care framework***: It articulates how SBC can support sexual and reproductive self-care initiatives and contribute to improved health

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outcomes (https://www.psi.org/project/self-care/social-and-behavior-change-self-care-framework/)

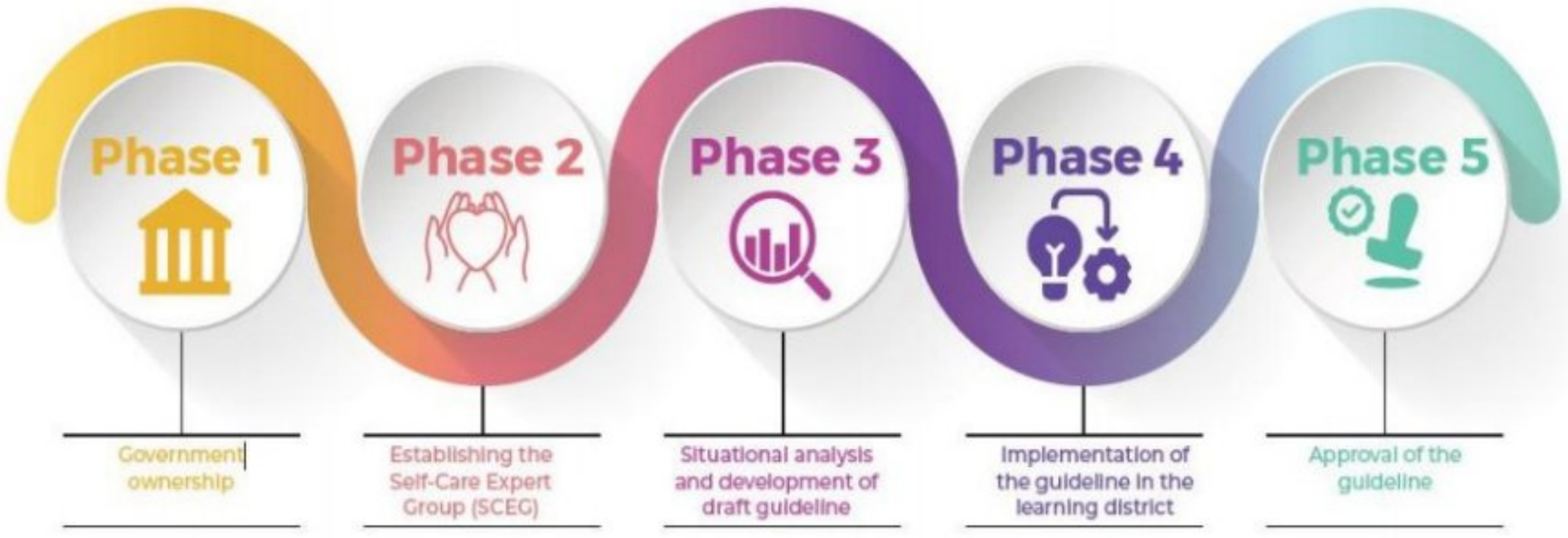
- ***Sexual & reproductive health self-care measurement tool:*** This is a practical, adaptable resource for self-care stakeholders engaged in monitoring and evaluating SRH self-care programs. (https://www.psi.org/project/self-care/sexual-reproductive-health-self-care-measurement-tool/)
- ***Priority indicators for sexual and reproductive health self-care***: recommendations from an expert working group. (https://srh.bmj.com/content/familyplanning/early/2023/06/09/bmjsrh-2023-201909.full.pdf)

1.4 Process of Development of the National Guideline on self-care interventions for health and well-being

The Ministry of Health (MOH) constituted the Self-Care Expert Group (SCEG) to coordinate the process of development of the National guideline on self-care interventions for SRHR which were later updated to National guideline for self-care interventions for health and well-being. The SCEG is composed of government officials, development partners and Civil Society Organizations (CSOs). The purpose of the SCEG was to accelerate the adoption of the 2019 WHO *Consolidated Guideline on Self-Care Interventions for Health: Sexual and Reproductive Health and Rights*' that was later revised in 2022 to the *WHO guideline on Self-care interventions for health and Well-being.*

The specific objectives of the SCEG were to bring together SRHR experts to advise the MOH on SRHR self-care adaptation, guide the development of the guideline and implementation plan, coordinate stakeholders in the implementation of SRHR self-care, promote SRHR self-care policy change and mobilize resources for implementation of SRHR self-care[6]. Following the 2022 revision, stakeholders with expertise in NCDs were also onboarded as members of the SCEG.

The process of development of the guideline was implemented in phased manner as shown below:



[6] Detailed SCEG TORs can be found in Annex B

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Phase 1-Government ownership: Though self-care has existed over many years, the self-care concept still remains new in some circles within government. Through advocacy by development partners and CSOs, the self-care concept as defined by the WHO was introduced to the MOH leadership with clear justification for its formal introduction into the health care system. The MOH adopted the concept and permitted a phased approach to its adaptation initially focusing on SRHR but later incorporated NCDs. The Ministry of Health management designated the Director Health Services (curative services) to provide stewardship to the self-care adaptation process.

Phase 2- Establishing the Self-Care Expert Group (SCEG): The SCEG was established by the MoH headed by the Director Health Services (Curative Services) and co-chaired by Assistant commissioner Adolescent and Child Health, with clear Terms of Reference (TOR)[7] to support and guide the introduction and scale-up of self-care interventions in the country. A consultant was hired to facilitate the process of development of the guideline under the guidance of the SCEG and stewardship of the MOH with support from the SCEG secretariat-Population Services International-Uganda (PSI-U).

Phase 3- Situational analysis and development of draft guideline: The consultant developed a draft National guideline using an all-inclusive consultative and evidence based participatory process. The process involved sensitizing key stakeholders on self-care concept in order to socialize the self-care concept and get a uniform understanding of Self-care. The consultant carried out desk review and key informant interviews in order to determine the enablers and hindrances of self-care practice in Uganda. The results of the assessment (refer to 1.5) were presented to the SCEG that resulted into consensus on the four SRHR priority areas to be addressed by the guideline.

A draft guideline was developed and disseminated/validated by the different stakeholders whose input was incorporated and approved by SCEG for implementation in a learning district. The SCEG offered the "over-arch" to the Consultant throughout the whole process of Guideline- development.

However, with the release of the 2022 WHO guideline on self-care interventions for Health and well-being, the national consultant was engaged to incorporate the component of non-communicable diseases which necessitated a rapid situational analysis focusing on non-communicable diseases. The summary analysis was added to the situational analysis section of the updated guideline.

Phase 4-Implementation of the guideline in the learning district: To enable testing the guideline in a real-life environment, the SCEG used the "sand-boxing" method and implemented the guideline in a learning district (Mukono District). The lessons learned

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[7] Annex B

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from the learning district were incorporated into the final guideline. The learning district experience provided input into the scale up implementation plan to other Districts (Refer to 1.6. Approach, and lessons learnt from the learning district). Non-communicable diseases where not part of the pilot intervention.

Phase 5-Approval of the guideline: The updated guideline was presented for validation and approval to the various MOH approval levels, namely: Family Planning/Reproductive Health Commodity Security Working Group (FP/RHCS), Maternal and child Health Working Group (MCH WG) and Medicines Procurement and Management Working Group (MPM WG) and Senior Management Team (SMT) and final approval granted for dissemination of the guideline and scale-up of Self-care.

1.5 Self-Care situational Analysis

The situational analysis focused on the Self-care Interventions prioritized by the Uganda SCEG. A desk review of the selected self-care interventions was conducted. This involved literature review of lessons learned from current and past self-care interventions implemented in Uganda as well as existing national policies, guidelines, SOPs, laws, and global evidence including the WHO consolidated guideline on self-care interventions for SRHR was done. In 2024, another situational analysis was done with a focus on NCDs. Key informant interviews were conducted to give qualitative enrichment to the desk review findings. The summary findings from the situational analysis are given below.

Human immune-deficient Virus self-testing (HIVST). The consolidated guideline for the prevention and treatment of HIV and AIDS in Uganda (2022 version) permit HIVST when using approved HIV self-testing kits that can be accessed freely through the public sector or sold over the counter at private pharmacies and drug shop. The HIV Self-test kits that are currently being used in Uganda include Insti, SureCheck and OraQuick.

The Adolescent Health Policy and Service Standards (2012) stipulate that HIV testing will involve counseling of adolescents before (pre) and after (post) the test. Results shall be communicated to all those who have been tested. Privacy and confidentiality will be ensured for the adolescents. Adolescents shall have access to HIV prevention methods and technologies. These shall include (ABC) Abstinence, Being Faithful, and correct and consistent use of Condoms, Medical male circumcision, and any other approved prevention interventions by MOH. If an institution is unable to offer any of the ABC components, appropriate information and/or referrals shall be made (e.g., institutions may not provide condoms but they shall refer). The policy encourages adolescents to involve their parents if they so choose.

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Self-Care provision of contraceptives (Self-Injection, oral contraceptive pills). The National Drugs policy and Authority act (1993) classifies Oral and Injectable contraceptives as Class B drugs or controlled drugs, meaning that the two can only be supplied in retail only on the prescription of a duly qualified medical practitioner for medical purposes. In early 2017, National Drugs Authority (NDA) approved DMPA SC Self -injection scale-up (WHO Self-Care REC 10 – New) through an administrative announcement. There is need for a formal process to approve amendment of the NDA act of 1993 so as to permit the product to be accessible as per the DMPA SC Implementation guideline.

The National SRHR policy guideline (2012) stipulates that no verbal or written consent is required from a parent, guardian or spouse for a client to receive family planning information and services except in cases of incapacitation (intellectual disability). This opens a window of opportunity for self-care with regard to REC 10 (DMPA-SC) and REC 11 (Oral Contraceptive Pills Over the Counter). The Uganda Essential Medicines and Health Supplies list 2016 (EMHS) permits DMPA SC for use/distribution starting at health Centre II (HC II).

Self-care management of Post Abortion Care (PAC): PAC is a high impact practice for reduction of maternal mortality. The National SRHR Policy guideline (2012) permit PAC and hence opens a window for PAC self-care WHO REC18 (self-assessing completion of abortion) and self-administration of Injectable contraceptives post abortion (WHO REC 19).

The National SRHR policy guideline defines Post Abortion Care (PAC) as health care provided to a woman or a couple seeking advice and services either for legal termination of a pregnancy or managing complications arising from an abortion. The people who can get services for legal termination of pregnancy include those with severe maternal illnesses threatening the health of a pregnant woman e.g., severe cardiac disease, renal disease, severe pre-eclampsia and eclampsia; Severe fetal abnormalities which are not compatible with extra-uterine life e.g. molar pregnancy, anencephaly; Women with cervical cancer; HIV-positive women requesting for termination.

Self-collection of Samples (Self-swabbing): The Uganda National Health Laboratory Hub and Sample Transport Network guideline 2017 (page 19) provide for specimen collection, handling, packaging and transportation by trained healthcare workers according to the standard operating procedures following universal infection and prevention measures. This guideline states that in situations where the patient is to collect the sample, clear

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instructions for proper specimen collection shall be given by the Central Public Health Laboratory (CPHL). The instructions are yet to be developed.

HPV Self-Sampling: The Cervical cancer Information, Education and Communication Booklet for Health Workers 2017(pg 11) stipulates that for HPV DNA test procedure, the sample can be taken by the provider or by the woman herself, stored in a container with appropriate preservative solution and sent to the laboratory (or processed immediately on-site if a new test is used). The MOH adopted the WHO guideline for HPV detection tests and sample collection techniques for HPV testing accompanied by a training manual.

Non-Communicable diseases policy environment: Uganda has demonstrated high level political commitment to tackle NCDs through creation of the department of non-communicable diseases at the Ministry of Health comprised of the Mental and substance abuse division and lifestyles diseases division, all headed by assistant commissioners. The department provided stewardship in development of the NCD strategy

Because of the increasing burden of non-communicable disease in Uganda, a number of networks and coalitions have been formed like the Uganda Parliamentary forum for NCDs formed in 2011, The Uganda NCD alliance (UNCD) which consists of Uganda Heart-Research Foundation, Uganda Cancer Society and Uganda Diabetes Association. It was founded in 2010 as a response to the global NCD epidemic which especially is striking hard in low-income countries. The UNCD developed The Uganda NCD Alliance Strategic Plan DRAFT 2016-2019 and this was followed by the Ministry of health drafted the National Multisectoral strategic plan for prevention and control of non-communicable diseases (2018-2023) now at draft two status.

Self-measurement to monitor blood pressure: A community based cross sectional survey among people≥15 years in Buikwe and Mukono districts of Uganda was conducted[8]. The findings of the study were that more than a quarter of the adult population had hypertension but awareness and control was very low. The study recommended that measures were needed to enhance control, awareness and prevention of hypertension. Having patients measure their own blood pressure at home can improve awareness and diagnosis of hypertension, and for those patients who have it, can help get their hypertension under control.

An Acceptability and feasibility of a mobile health application for blood pressure monitoring in rural Uganda was conducted. Blood pressure monitoring at community

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[8] Prevalence, Awareness and Control of Hypertension in Uganda; Geofrey Musinguzi , Fred Nuwaha

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level was found to be acceptable and feasible in rural Uganda. The study concluded that Patients with hypertension in rural Uganda embraced the Positive Links mobile application and had improved medication adherence, social support, and blood pressure control[9].

Self-monitoring of blood glucose:

In a cross-sectional study conducted a Regional Referral Hospital in Mbarara city**,** Diabetes self-care practices were assessed based on domains, namely: foot care; dietary practices; physical activity, blood glucose testing, and taking medications. Overall, the proportion of participants with adequate self-care practices in the previous week was very low (35%). This finding highlights the prevailing risk for the development of diabetes related complications that are usually associated with inadequate self-care practices. Blood glucose testing was also assessed in the previous month based on the fact that most rural participants rarely tested within a week. This is because they didn't have glucometers and testing from other facilities was expensive for them. They could only test blood glucose on clinic visit days which was also at a cost. This is a great concern noted because blood glucose levels guide almost other interventions to diabetic control. For example; when blood glucose is high, one would reduce the insulin doses, or oral medications, adjust diet and other self-care activities. People with diabetes need to be supported by the health care team to enhance their overall self-care practice, guiding them to identify self- management challenges and develop strategies to solve them, including setting self-selected behavioural goals noting that it takes time (about 2–8 months) to change a habit or apply behaviour[10].

1.6. Lessons Learned from the Learning District

The goal of implementation of the guideline in a learning district was to test a coordinated, holistic approach to promoting and scaling-up self-care interventions in the learning District, focusing on the selected SRHR self-care interventions. The guideline implementation was guided by objectives, implementation pathway, Theory of Change and indicators to measure success as shown in the table and figures below:

Table 2: Objectives and Learning questions for the learning district

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[9] Acceptability and feasibility of a mobile health application for blood pressure monitoring in rural Uganda; Beatrice Mugabirwe, Tabor Flickinger, Lauren Cox, Pius Ariho, Rebecca Dillingham, and Samson Okello

[10] Knowledge and Practices of Self-Care among People with Diabetes in South Western Uganda: A Cross-Sectional Study at a Regional Referral Hospital in Mbarara City. Gladys Nakiddea, Ronald Kamogac, Eve Katushabea, Rachel Luwagaa, Mercy M. Mwanja

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No	Objective	Learning Question
1	To promote awareness on self-care concept	• What is the stakeholders understanding of self-care concept? • What is the effectiveness of the awareness creation activities?
2	To implement the draft national self-care guideline for SRHR in selected learning district	• Which stakeholders (providers, consumers, policy makers etc.) were reached (directly or indirectly) with the draft national Self-care guideline?
3	To monitor and evaluate integration of the draft national guideline for self-care interventions for SRHR within the health care system	• What is the acceptability, willingness and practice of integration of self-care guidelines into the health care system? • How can self-care guideline be integrated in the health care system? • What are the considerations for using Self-care guideline for special groups? • What are the barriers and enablers to promoting the self-care guideline

Table 3: Guideline implementation pathway in the learning district

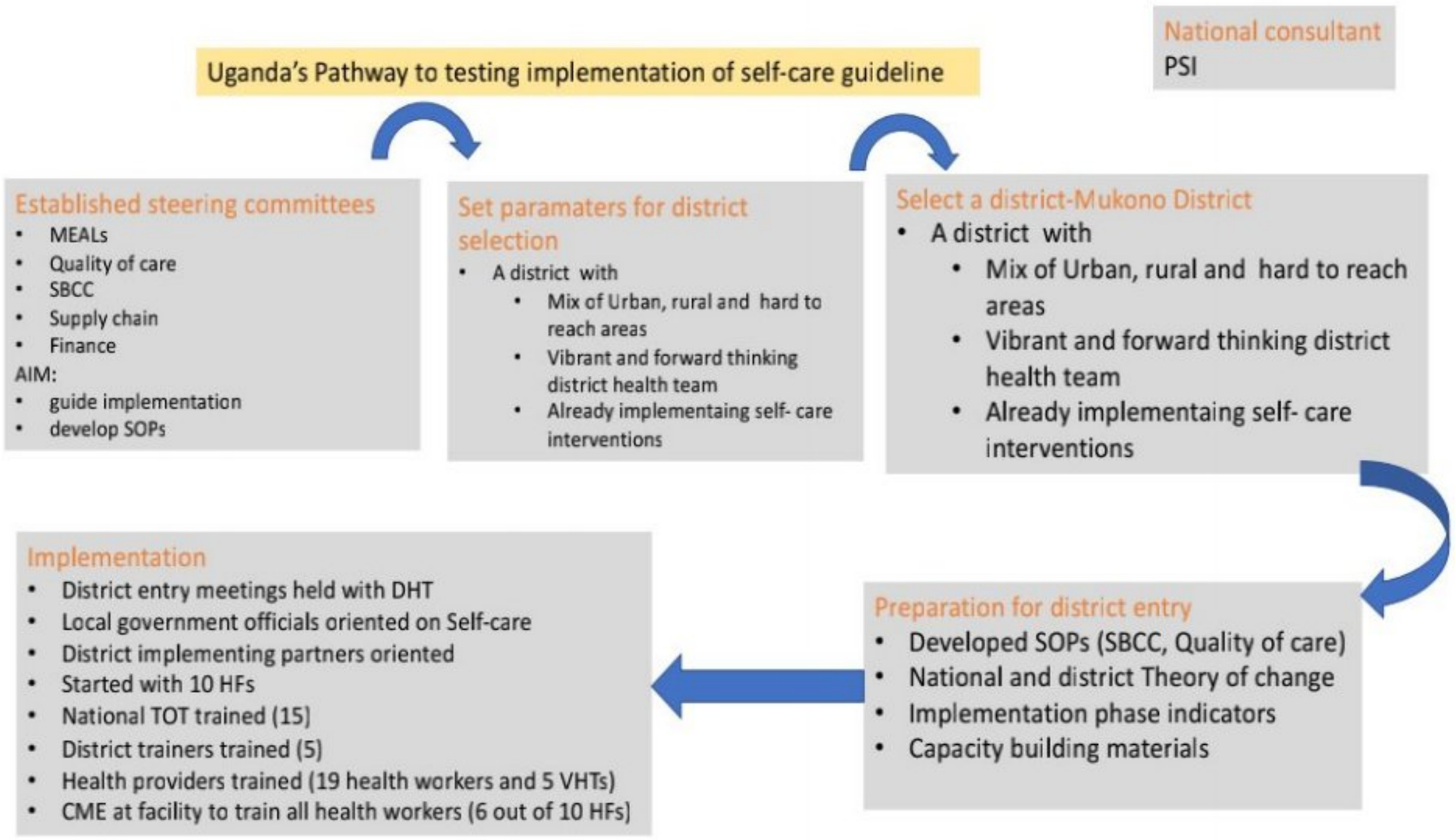

Table 4: Guideline implementation Theory of Change

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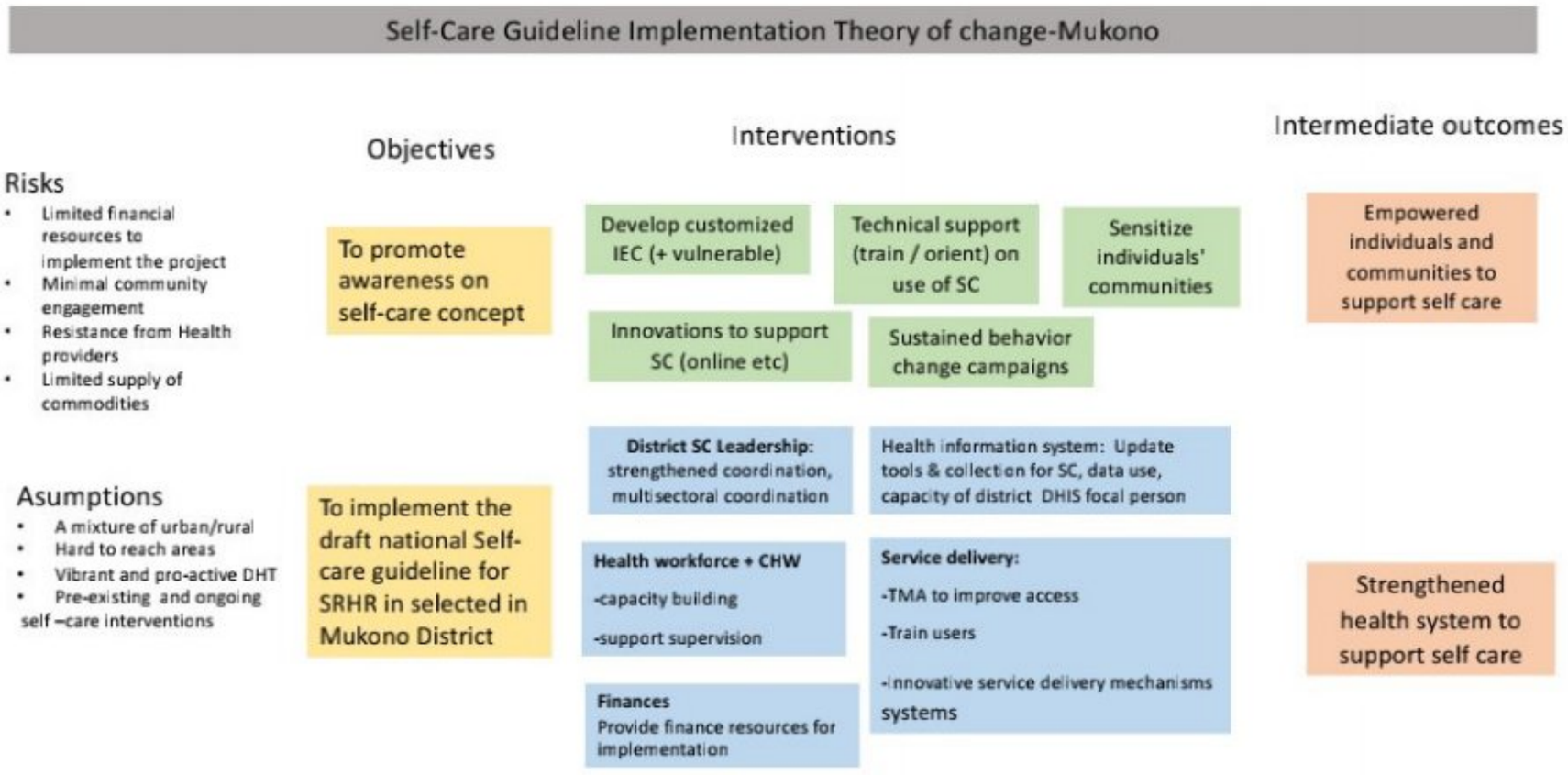

Table 5: Guideline Implementation indicators

MEALs Facilitated Consensus Meeting: Implementation Phase Indicators

Intermediate outcome 1
Empowered individuals and communities to support self care

Indicators-Individual empowerement
- Level of knowledge including disposal
- Level of skill in self-care
- Autonomy-Who Makes the decision
- Health literacy rate
- Level of Self-care practice

Indicators-Commumnity
- Level of social support
- Percieved social norms
- Social action eg community access

Intermedate Outcome 2
Stregnthened health systems to support self-care

Indicators- Self-care intergration into health systems
- Willingness to support self-care by health providers (public and Private
- A functional Self-care Client data capture system established
- Level of compliance/buy-in to the SC guidelines and policies (Provider, district leaders and individuals)

Mukono District was selected as a learning District because of its location with a mixture of urban, rural and hard to reach areas, various (past and current) self-care implementing partners and the District Health Teams' readiness and a responsiveness to undertake this exercise. The district has the third largest population in the country with an estimated population of 757,500 (UBOS 2023 population projections), high urbanization level of 27% compared to national average of 18%. The estimated total number of women of reproductive age group is 193,270 with a modern Contraceptive Prevalence Rate of 42%

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and unmet need of 24%. The district experiences a high population of young persons aged 10-24 at 31% (estimated population of 234,825). Mukono district has a total of 113 health facilities including 40 Government facilities, 51 Private for Profit (PFP) health facilities and 22 private Not for Profit health facilities. In addition, it also has 100 pharmacies and 93 drugs shops as registered by National Drugs Authority (NDA).

Implementation focused on women of reproductive age group (15-49 years) and men. There were exceptions for adolescent girls between age 10 and 14 who are sexually active, are pregnant, child mothers and /or already in marriage. The main Implementation actors included self-carers, health workers, district local government, SRHR implementing partners including faith-based organizations, Ministry of Health, religious, cultural and political leadership in the district. All actors were trained and/or oriented on Self-care concept while the different task teams at national level gave guidance on district entry, standard operating procedures and learning.

Table 6: Stakeholder training and orientation on the self-care concept

Activity	Participants
1. Orientation of District leaders and partners implementing SRH projects in the district	27 District leaders 5 Implementing partners
2. Orientation of in-charges of health facilities in the district	29 Health facilities in charges
3. Training National TOT on Self-Care	15 National and District trainers of trainees
4. Training health care providers in public health facilities in Mukono District	21 health workers from 10 facilities: 5 VHTs, 3 trainers
5. Training health care providers in Private Health Facilities Mukono District	11 health workers from 8 facilities 4 trainers
6. Training of VHT and Health assistants	28 Trainees

**Two districts neighbouring Mukono (Buikwe and Kayunga) were identified and oriented on the concept of self-care and the guideline with support from WHO. However, these were not the primary test implementation districts, and such, no data or learnings were collated from these districts.

Lessons learned from the implementation district

Leadership and governance

- The leadership of the MoH in the advancement of self-care was very important and it significantly contributed to the successful development and test implementation of the national self-care guideline.
- The Mukono district leadership and the District Health Team provided a conducive environment for the test implementation of the national self-care guideline.

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- Self-care advancement requires multi-sectoral engagement with critical players from different sectors including academia, development partners, health workforce, local government, and young people for synergies.
- The health facilities led by lower cadres (clinical officers, nurses, and midwives etc) performed better than the health facilities led by higher cadres(doctors). This could be because at lower-level facilities, implementers were the facility in charges among others as opposed to higher level facilities where the implementers were the junior staff who didn't get much support from their supervisors.
- The directors /owners of the private facilities were hesitant to implement self-care because they perceived it as something that would reduce their clientele and the health workers implementing self-care in those facilities were at risk of losing their jobs.

Service delivery

- Quality of care: Adoption of robust follow-up mechanisms will enable the health providers support self-carers better
- The integration of self-care in health education at triage points enabled the clients to choose the self-care options available, which resulted in reduction of time spent at the health facility.

Health workforce

- The health providers remain the most trusted source of information and support for self-care, making.
- The VHTs played a critical role in facilitating the practice of self-care at the community level through integrating self-care in community health education sessions, distributing and supporting correct use and disposal of self-testing and self-sampling kits, and referring the self-carers to health facilities for continuity of care.

Medical products

- The availability of self-care products significantly determines the practice of self-care among individuals.

Health information systems

- Whereas innovative ways of capturing self-care data were adopted at various health facilities, its critical to nationalize self-care data capturing and management.

Client side

- Self-carers felt empowered to manage their own health.
- Self-carers appreciated self-care as they spent less time at the health facilities.

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- Some self-carers were afraid of self-care products that required pricking. For instance, self-carers testing for HIV preferred OraQuick which is a mouth swab compared Insti and Sure-Check which require pricking to collect samples.
- Some self-carers were not confident about their self-testing results, requiring continuous health education and counselling.

Challenges

- The test implementation of the self-care guideline revealed that nurturing acceptability in a business-oriented service provision setting is challenging.
- The support supervisions were inadequate which impacted continuous mentorship and collation of self-care data within the selected facilities.
- The client supports and feedback loops were not robust enough to ensure effective practice of self-care, management of side effects and linkage to further care.

On implementing the draft guideline, there was generally sceptism from stakeholders especially the health workers who feared that the guideline was aimed to take away their jobs. However, after being trained on the Self-care concept, the attitude generally changed and they embraced Self-care.

During the implementation in the learning district, Self-care supported Self-carers to be responsible for their own health as they took charge of their health to some extent, there was improved health worker-client relationship, Improved prevention of illness in the community, Reduced workload of health workers and Reduced overcrowding at different entry points at the health facilities.

The health workers (2 per health facility) who received a three days residential training on self-care facilitated session on Self-care to their respective health facility staff through Continuing Medical Education (CMEs). This proved to be a cost-effective way to cascade the trainings and creating more awareness on Self-care amongst the health workers in a more sustainable manner within the health system.

Self-care scale-up can optimize existing HMIS tools and registers to record Self-carers and integrate client health education in the triage talks at the facility as well as during outreaches e.g. immunization outreaches

Generally, Self-carers (especially the youth) in the learning District preferred OraQuick because the test is done orally and it does not involve pricking to get a blood sample unlike the rest of the tests

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CHAPTER 2: THE GUIDELINE ON SELF-CARE INTERVENTIONS FOR HEALTH AND WELL-BEING

2.1 Purpose

To guide the introduction and scale up of self-care in Uganda

2.2 Objectives

- To guide the introduction of new self-care interventions.
- To guide the scale up of self-care interventions.
- To establish and operationalize a coordination mechanism for self-care.
- To facilitate integration of self-care in the healthcare system.
- To strengthen monitoring, evaluation, accountability and learning for self-care.

2.3 Guiding Principles

- Shall be an adjunct to, rather than a replacement for direct interaction with the health system.
- Shall not be a cost-shifting mechanism from the government or existing health care financing structure to Self-carers.
- Shall be safe, effective and able to reach individuals who may not have access to health care.

2.4 Target Audience

- Policy makers (government departments, Ministries, Agencies, district, political leaders at all levels)
- Implementing partners
- Advocacy and accountability focused CSO's
- Self-carers (special groups including young people)

2.5 How to Use the Guideline

The guide will be used by policy makers, implementing partners, Self-carers, health workers and general public as guidance on what is permitted and what is not permitted under self-care. Further, the guideline will guide innovators on introduction of new Self-care technologies in Uganda.

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2.6 Coordination of Self-Care for health and well-being

Coordination of implementation of the approved National guideline on self-care interventions for Health and Well-being will be steered by the MOH through the technical working groups that focus on the selected priority areas. In case of expansion to address other health areas, the respective health area Working Groups will be actively engaged in updating the guideline. A multi-sectoral committee that will include the Ministry of Education and Sports, Ministry of Gender and Labour, Prime Minister's Office and departments (curriculum development center, National Drugs Authority, Health Service Commission, Allied Health Professional Council, Medical and Dental Practitioners' Council, Pharmacy Board) will be constituted to ensure wider representation and engagement of the various stakeholders at different levels.

The health of individuals and their capacity to maintain and improve their health through self-care does not exist in a vacuum. They are influenced by and are the product of social, economic and environmental factors that lie beyond traditional health policies and services. The WHO has endorsed a Health in All Policies (HiAP) approach as a strategy to reduce and prevent health disparities and preventable disease. The International Self-Care Foundation has also called for self-care to be included in HiAP strategies.

The inequality gap between communities in Uganda has widened over recent years. Factors such as employment, housing, education, exposure to violence, access to medical care and socioeconomic status strongly influence health outcomes, with low socioeconomic status being a major risk factor for poor health and premature death. Health and the capacity to self-care are influenced by these social and environmental factors and by public policies that reach beyond access to and utilization of health care. Implementation of a cross government 'health in all policies' (HiAP) approach enables interdependent and intersectoral strategies to promote and support individual self-care and a healthy population by addressing the social and economic risk factors that drive poor health.

For multi-sectoral collaborative care to be enabled and effective, health professionals and service providers need to be familiar with a range of support services and strategies. Health professionals should be aware of the breadth of community resources outside the formal health sector that may effectively encourage self-care (e.g., Men's Sheds, cultural groups, etc.). The development of inter-professional skills and multidisciplinary perspectives is also essential to provide consumers with best practice self-care support. Establishing core competencies in self-care practice and support for all relevant health

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professional and workforce roles would enable self-care to become a core component of all care throughout the healthcare continuum.

The HiAP approaches should include:

- A clear mandate for joined-up government policies and actions;
- Systemic processes that take account of interactions across sectors;
- Shared accountability, transparency and integrated data;
- Engagement of private and community stakeholders with public sector stakeholders;
- Practical cross-sector initiatives that build partnership and trust;
- Enabling collaborative approaches that encourage innovation and resource sharing;
- Embedding of responsibilities into public sector strategies, goals and targets; and
- Establishing agreed and comprehensive feedback and mediation mechanisms for all relevant stakeholders.

At district level, there will be a District focal person for self-care who will coordinate capacity building activities, resource mobilization through inclusion of self-care activities in the district health work-plan, District FP Costed Implementation Plans (DCIPs) and in galvanizing partners around self-care. Members of the District Health Team will be trained on Self-care and these will in-turn train the health workers at health facilities. Each health facility will have a self-care focal person that will guide the implementation of self-care at health facility, coordinating and building the Village health teams' capacity for self-care and making sure that Self-care is fully integrated in the health system.

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2.7 Graduated Assistance in Self-Care Provision

Graduated assistance is the progression of an individual from being directly assisted by a health worker to being unassisted to undertake a self-care intervention. Self- care is not only limited to an individual undertaking Self-awareness, Self-testing or Self-management; it also accommodates individuals that are interested in self-care but do not have prerequisite skills for self-care or based on their individual preferences and right to health care. Some individuals need to first be assisted in order to learn or feel comfortable with self-testing, self-administering, etc. Self-care among adolescents (10-19 years) remains a special area of concern and particularly the young adolescents (10-14 years). In addition, another group of concern is the age group 15-17 years who by the Uganda laws are still dependents. However, the Uganda HIV and AIDS Act (2014), having recognized the early sexual debut among 15-17-year-olds permitted this age group to access HIV self-testing without parental/guardian consent. For this guideline, this same principle has been applied to adolescent (15-17 years) seeking self-care services to not require consent from the guardian for the same reasons they do not seek consent for HIV testing. General guidance for graduated assistance in self-care provision is summarized in the table below. This table is meant to provide overall guidance, particularly for young populations, to ensure they are provided with the right level of assistance to ensure quality and safety. If in doubt, refer to intervention specific guidance for the level of assistance required for different age groups and profiles.

Definitions:

Directly Assisted self-testing: An individual who is self-testing receives an in-person demonstration from a trained provider or peer before or during self-testing, with instructions on how to perform the self-test and how to interpret the self-test result. This assistance is provided in addition to the manufacturer-supplied instructions for use and other materials found inside self-test kit.

Unassisted Self-Testing: Individuals self-test using guidance from the manufacturer provided instructions. As with all self-testing, users may be provided with links or contact details to access additional support, such as telephone hotlines or instructional videos. No in person demonstration from a trained provider or peer is

Table 7: Graduated assistance for self-carer

Age in Years	Self-Carer User profile	Directly Assisted	Directly assisted by Provider until they can perform the skill on their own	Unassisted
10-14	No caregiver (regardless of whether the adolescent can read and understand instructions)			

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	Caregiver cannot understand or read instructions			
	Care giver can read and understands instructions with or without access to visual/audial instructions			
15-19	Cannot read and has no access to visual and audio instructions			
	Cannot Read but has access to visual and audio instructions			
	Can read and understands instructions with or without access to visual/audial instructions			
20 and Above	Cannot read and has no access to visual and audio instructions			
	Cannot Read but has access to visual and audio instructions			
	Can read and understands instructions with or without access to visual/audial instructions			
All	People with different abilities			
Self-carers below 10 years should always be directly assisted.				

2.8. Summary of Uganda's Self-Care Interventions for Health and Well-being

In 2019, WHO published the consolidated guideline on Self-Care interventions for health focusing on SRHR. The Uganda Self-Care Expert Group having reviewed all the 24 recommendations and based on findings of the situational analysis and learnings from the implementation District, selected the Self-care Interventions of focus. In 2022, WHO increased the recommendations from 24 to 37. The Self-care Expert Group then decided to engage the consultant to perform an analysis of the new interventions and adapt those that suite Uganda. The table below summarizes the selected self-care interventions. More Self-care interventions will likely be added based on with new evidence and experience.

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Table 8: Scope of self-care priority areas

	Self-care priority areas				
	Antenatal Care (ANC)	**Family Planning (FP)**	**HIV/Sexually Transmitted Infections (STIs)**	**Post Abortion Care (PAC)**	**Non-communicable diseases (NCDs)**
Self-awareness	○ Specific health information per age group (10-19 and 20+) ○ Post-Partum Family Planning (PPFP) ○ Post Abortion Family Planning (PAFP) ○ Gender-specific considerations ○ eMTCT medicines ○ Birth preparedness plan ○ Danger signs ○ Exercise and Nutrition ○ ITN Use ○ HIV Prevention and PrEP ○ Breastfeeding	○ Specific health information for Women of Reproductive Age group including males ○ Menstrual health ○ Facts about FP methods including side effects ○ Fertility awareness ○ The individual Reproductive health system ○ Use of digital platforms and hotlines to access SRH information services and products	○ Specific health information by age group (10-19yrs; 20yrs and above (STI, s, HIV)) ○ Mode of transmission ○ HPV Vaccination ○ Hepatitis B vaccination ○ Preventive Measures (e.g., ABC, Circumcision PrEP, PEP, eMTCT, counseling, and information) ○ HIV testing and management (adherence, appointment keeping, self-referral etc.) ○ Information on Sexual and Gender-Based Violence (SGBV) collection of forensic evidence	○ Specific health information for women of reproductive age group that is gender specific including males ○ Causes, risks and prevention, ○ Access to services and referral ○ Link post abortion care to FP ○ Return to fertility ○ Triggers for self-referral	○ specific information on causes, symptoms, effects and warning signs of NCDs ○ counselling and reinforcement/mentorship ○ Access to services and referral ○ Information on triggers for self-referral

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Self-Testing	○ Blood pressure measurement ○ Weight and height measurement ○ Urine HCG (Pregnancy testing) ○ Human Immunodeficiency Virus (HIV) self-testing for both Men and Women ○ Breast self-examination (Screening testing)	○ Urine HCG (pregnancy test) ○ Weight and height measurement ○ Home Based Ovulation Predictor Kit	○ Human Immunodeficiency Virus (HIV) self-testing oral HIV testing (Screening test) ○ Human papilloma Virus (HPV) Self-sampling ○ Neisseria Gonorrhea and Chlamydia trachomatis self-sampling ○ Treponema Pallidum (Syphilis) and Trichomonas for women Vaginalis self-sampling and for men first catch urine		• Self-Monitoring of blood pressure during pregnancy • Self- testing of proteinuria • Self-monitoring of blood glucose • Self-Monitoring of blood coagulation
Self-management	○ Folic (pre-conception care and the 1st trimester) ○ Iron (Fe)/Folic (in 2nd & 3rd trimester of Pregnancy) ○ Expanded clean delivery kit ○ Magnesium trisilicate ○ Treated Mosquito nets ○ HIV Prophylaxis (For exposed newborn)	○ Self-Injection (DMPA SC) ○ Oral Contraceptive Pills over the counter up to 3 months' supply ○ Emergency Contraceptive Pills ○ Self-referral for management of side effects ○ Use of condoms both male and female ○ Cycle Beads	○ Correct and consistent use of condoms both male and female ○ Adherence to ART treatment including PrEP, PEP and Nutrition ○ Appointment keeping and self-referral ○ Dapivirine vaginal ring	○ Post Abortion Family Planning (PAFP) ○ Self-referral ○ Adherence to treatment	• Adherence to treatment and nutrition • Mental health • Healthy aging

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CHAPTER 3.0: GENERAL HEALTH CARE SYSTEM PREPAREDNESS FOR SELF CARE (PUBLIC SECTOR, PRIVATE NOT FOR PROFIT - PNFP, SOCIAL MARKETING AND COMMERCIAL SECTOR)

There are five supportive pillars that universally improve self-care; Health literacy, Healthcare professionals, Healthcare systems, Technology, and Products/Medication. To implement self-care, it's important to;

- Create an enabling policy environment
- Improve Health Literacy for all
- Build Self-Care into Health care practice
- Enable Self-carers to be active partners in healthcare
- Assure Quality and accessibility of digital health information
- Access Self-care commodities and health supplies

3.1 Create an enabling policy environment

Currently there is good will for introduction and scale up of self-care in Uganda from the MOH and sister departments/ agencies including NDA, NMS, and NPC and Health Service Commission. The high level support for self-care needs to be accompanied by concrete policy adjustments that include formally declaring oral contraceptive pills and injectable contraceptives as non-prescription drugs, including self-care in the pre and in-service training curriculum for all health workers and allied health professionals, developing detailed guideline for self-sampling (self-swabbing) for gonorrhea, syphilis, HPV, candida infections, NCDs and creating understanding of self-care concept among policy makers, health workers and implementing partners.

Systems are required to ensure health sector accountability for quality-self-care. Key measures to include are the following, adapted from the Self-Care Quality of Care Framework[11].

- Services or support is provided by licensed and registered health professionals who are authorized to perform the procedures by national laws.
- A supportive supervision system assesses Self-carers and/or health provider/worker's skills, documents quality gaps and progress towards rectifying identified quality gaps.

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[11] https://www.psi.org/project/self-care/a-new-quality-of-care-framework-to-measure-and-respond-to-peoples-experience-with-self-care/

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- National protocols or guideline that support self-care exist and are updated to reflect international guideline and best practice for self-care.
- A mechanism to assess if a client can access comprehensive information that is responsive to their expressed needs and includes information regarding benefits, risks and side effects. A review of progress towards improving the client's experience occurs on a consistent basis and results in an action plan.
- A mechanism to assess whether a client's experience of care is empathetic, respectful, non-judgmental, and facilitates choice and agency. A review of progress towards improving the client experience occurs on a consistent basis and results in an action plan
- Mechanisms exists so that Self-carers and health providers / workers can report complications and adverse events.
- Mechanisms exist to verify that referrals and follow-up systems are functioning.
- A mechanism for review/update of the national HMIS to be responsive to self-care data/reporting needs.

3.2 Improve Health Literacy for all

KEY DEFINITIONS:
Personal health literacy is the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others
Organizational health literacy is the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

Data and /or studies on Uganda health literacy are limited or largely non-existent. However, overall health literacy in sub-Sahara Africa of individuals between 15-49 years is just over a third, 35.7% (34.08% females and 39.17 Males)[12].Low health literacy is linked to poor health across the life course, reduced capacity to engage in self-care to maintain or improve one's health, and increased healthcare costs. Investment in strategies that build personal and organizational health literacy is critical for disease prevention, management and improved population health, as well as health protection during public health emergencies such as COVID-19 pandemic. Development of a national health literacy strategy would contribute to prevention, more effective management of health issues, and improved health status for all.

[12] Constructing a measure of health literacy in Sub-Saharan African countries. *Health Promotion International*, Volume 35, Issue 5, October 2020, Pages 907–915, https://doi.org/10.1093/heapro/daz078

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Primary health care is the universal entrance to health care for all. Strengthening support for health literacy at the primary health care level, particularly for at risk vulnerable populations, can contribute to reducing health inequities across the population. System level changes to health and social settings are required to build health literacy and facilitate self-care. Several countries now have health literacy policies, and some have established health literacy as a priority within broader health strategies ranging from structured guideline, such as accreditation standards, to more programmatic approaches and these policies commonly promote a universal approach (targeting all patients and /or communities) with some also emphasizing high priority or at-risk groups.
The following four approaches are recommended for improving health literacy at all levels

Use Plain Language→ An important strategy is to use plain language in both verbal and written communications. According to www.plainlanguage.gov/guidelines (an official website of the United States Government), plain language should ensure that users can find what they need, understand what they find, and use what they find to meet their needs.
Key elements of plain language include:

- Organizing information so that the most important points come first
- Breaking complex information into understandable chunks
- Using simple language and defining technical or medical terms
- Using the active voice

Use Visual Aids→ Visual aids, such as simple illustrations, images, informational graphics and videos, can help patients better understand health information. They can be excellent tools for reinforcing written or verbal health communication. This is especially important since health information that is provided in a stressful or unfamiliar situation is less likely to be retained. It is important to choose meaningful visuals that are culturally sensitive, linguistically appropriate, are clearly labeled and captioned, and support your message.

Recommend and Use Technology→ Making use of available technologies, such as patient portals, telemedicine solutions, and mobile applications can help you connect more effectively with your community members and may ultimately contribute to improved health literacy levels:

- Patient portals can give access critical health information, such as test results and treatment instructions.
- Telemedicine can be used to assess and treat underserved patient populations, such as those with limited mobility or who live in rural areas.

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- Mobile applications offer patients multiple options for learning about or managing health issues. Smartphone applications can collect personal health data to be shared with health workers, provide general health information, and assist with preventive lifestyle strategies.

Use Effective Teaching Methods→The Institute for Healthcare Improvement suggests several teaching methods health workers can use to improve communication and better understand health information. These include:

- Ask open-ended questions to assess an individual's understanding of written materials, including prescription labels.
- Use the Teach Back communication method to determine if an individual has understood your instructions and can repeat the information in their own words.
- Use "Show Back" when teaching an individual to use a device or perform a task, to demonstrate correct use.
- Speak more slowly when providing instructions, with an emphasis on being respectful and clear without being patronizing.

Guidance to improve health literacy in Uganda in advancement of self-care

National Level: Develop the national health literacy strategy and implementation plan, develop health literacy materials (audio, visual, technology applications), make health literacy a priority within the health sector). In addition, the Ministry of health should work with radio and TV stations to allocate at least 50% of the free time for health education.

District level: Develop district specific health literacy costed plans in support of self-care. In addition, the district should include a budget for health literacy in the district work plan and ensure that its costed and allocated funds. Specifically, the budget allocation should focus on facilitating health workers' expenses incurred to attend talk shows. A core team of health educators could be formed and trained to champion and advance health literacy on various communication channels within the district.

Health facility: Conduct health literacy during the education sessions with clientele during ANC visits, Immunization days, adolescent and youth days etc.

Community (including CBOs and CSOs): Build community health literacy capacities through recruiting and training local leaders/opinion leaders /social influencers to pass on accurate information to the community, hold community dialogues and have presenters (radio, TV, blogs) focusing on health literacy for self-care in local languages.

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3.3 Build Self-Care into Health care practice

Establishing core competencies and defining roles for optimized self-care support by relevant health professional bodies and other health worker roles will enhance the capabilities of health professionals and support staff and enable greater health workforce flexibility for service providers to support self-care by all health consumers. Health workforce self-care competencies should include:

- Understanding professional roles and responsibilities in supporting self-care practice
- Understanding and demonstrating skills in collaborative, multidisciplinary and ongoing team-based care with an explicit focus on shared decision-making;
- Relevant health literacy competencies and skills mentioned in 3.2;
- Communication skills that engage and motivate consumers.
- Skills to assess and identify individual self-care capability across a diverse range of healthcare consumers and to tailor interventions accordingly.

Self-care support is not well defined and is not explicitly considered an essential component of healthcare practice by health professional councils and service providers. Self-care and self-management are conceptualized differently by health professionals, support staff and consumers, which may explain mixed evidence of effectiveness of self-care and self-management interventions. Insufficient numbers of health professionals and other health workers that are appropriately and explicitly trained to enable self-care or self-management has been identified as a barrier to the provision of best practice self-care support by health services. A narrow focus on practitioner-led models of care is also a barrier to effective self-care support in primary care settings.

Support staff and community health worker roles have considerable potential to support self-care. Effective self-care by healthcare consumers is reliant on the ability of healthcare workers to initiate and support consumer engagement in health care planning, decision-making and interventions, otherwise referred to as collaborative care. Appropriate education and training of healthcare workers is essential, particularly for primary health care providers, to facilitate collaborative care and improve self-care support.

There is need to invest in the development of cross disciplinary self-care core competencies for all relevant health professionals and other health workers. These include the need for health professionals and other health workers to:

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- Be trained in motivational interviewing – a counseling philosophy and technique to enhance patient engagement in a range of self-care behaviors;
- Support consumers with SRHR and NCD issues to engage in self-care and behavior change techniques and concepts including self-efficacy, motivation and goal setting;
- Understand and implement shared health care planning and decision-making with all consumers;
- Be skilled in strategies such as health coaching, care planning and peer-led groups to improve health literacy, self-care capability and self-care activity, for which there is an emerging evidence base;
- Understand the social determinants of health and identify social support structures and resources that can effectively improve self-care.

Self-care interventions, particularly for individuals and in communities affected by socio-economic disadvantage, are most likely to be effective when multiple strategies, including social and other supports, are employed.

Ensuring quality of care for health provider's capacities should include the following adopted from the QOC framework for self-care[13].

- Health provider/worker or digital application exhibits the appropriate level of knowledge and clinical skills needed to effectively transmit information and skills to a client so that they can safely and effectively self-manage their case.
- Health provider/worker or digital application effectively assesses if a client can safely self-manage their care which includes properly screening Self-carers for medical eligibility according to national service delivery protocols.
- Health provider/worker or digital application elicits input from the client and provides counseling/ consultation that responds to the client's expressed needs and preferences.
- Health provider/worker or digital application gives information regarding benefits, risks and side effects of a chosen service prior to receipt.
- Health provider/worker or digital application provides information or care in a respectful, empathetic, non- judgmental way that is free from coercion and facilitates the client's agency.

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[13] [13] https://www.psi.org/project/self-care/a-new-quality-of-care-framework-to-measure-and-respond-to-peoples-experience-with-self-care/

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- Health provider/ or digital application gives information on follow-up care, including circumstances under which a client should seek care and where to seek care.
- Health provider/worker recognizes, manages and reports complications and adverse events according to program or national guideline.

3.4 Enable Self-carers to be active partners in health care

Recognition of the value of engaging Self-carers in decisions about treatment and care options for their health needs has grown in recent decades. However, despite a range of policies and strategies that place the Self-carer at the center of health care, their lived experience and capacity to self-care continues to be overshadowed by professional expertise. Involvement of Self-carers in decision-making about their health care needs, in partnership with health professionals, is recognized as contributing to better health outcomes. The ability to choose and have some control over self-care options can also increase the capacity of individuals to engage in informed self-care, such as self-management of established health conditions. Self-management programs have been shown to achieve better care, better outcomes and lower costs. A comprehensive national health consumer engagement framework is required to:

- Provide guidance and resources for health services and health professionals to actively support and encourage shared health care planning and decision-making;
- Facilitate consumer participation and engagement at all levels of the health system, from peer-led health interventions and co-designed health services right through to system evaluation and policy development processes.

Ensuring quality of care for self-care for consumer capacities adopted from the Quality-of-Care framework should include the following[14]

- Consumer demonstrates the knowledge and skills needed to competently self-managed care (e.g., through self-screening, self-testing, self-referral, etc.).
- Consumer understands how to safely use the product and can adequately assess if they are medically eligible to use the product to self-manage their care.
- Consumer can comply with waste disposal standards as per national protocols.
- Consumer can accurately determine if they are experiencing a side effect or complication.

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[14] [14] https://www.psi.org/project/self-care/a-new-quality-of-care-framework-to-measure-and-respond-to-peoples-experience-with-self-care/

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- Consumer can access comprehensible information that responds to their expressed needs and preferences and includes a range of options.
- Consumer can access information regarding benefits, risks and side effects of a chosen self-care product prior to receipt.
- Consumer's experience of care during all self-care interactions is dignified, empathetic, and respectful.
- Consumer accesses care in a setting where visual and audio privacy is assured.
- Consumer accesses care or information that does not vary in quality because of their personal characteristics such as age, marital status, gender, disability, ethnicity, geographic location, and socioeconomic status.
- Consumer exercises choice, is not pressured or coerced, and gives consent to use a self-care product intervention.
- Consumer can accurately determine if they are experiencing a side effect, complication, or an adverse event.
- Consumer knows how to access or where to go for support/ follow-up care with questions, concerns or after experiencing a complication or adverse event.
- Consumer has the ability to access follow-up support or care if they have questions, concerns or in the event of an emergency

3.5 Assure Quality and accessibility to digital health information

Uganda's Internet penetration now stands at 46% with over 18.9 million Internet subscriptions. Tele-density stands at 61% of the population, 24 million people own smartphones, which is over 50%[15], and Ugandans have rapidly adopted digital health technologies and online information sources, including web-based resources and mobile applications for health advice and support. The vast volume of available applications and online health focused resources is both an opportunity and a barrier to effective uptake by both consumers and health professionals because of need for evidence based digital health interventions.

The major barriers to digital application prescription by health professionals include insufficient knowledge of effective applications and the lack of a trustworthy source to access them. Critical thinking and appraisal skills are now considered essential to enable health consumers to effectively search for and utilize appropriate and evidence-based online health information. There is need to establish a national digital health information and resource library and national quality assurance framework to assess the quality and

[15] Uganda Communications Report (FY 2020 Quarter 2 report)

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credibility of web-based health resources and mobile health applications. The benefits of digital health technologies – such as personalization, interactivity and mobility – enhance both the accessibility and impact of health information and support the delivery of self-care interventions.

The WHO acknowledges the significant role of digital health in improving health outcomes through increased access to health care and health information. The WHO identifies the potential for digital health information and interventions to improve health literacy, promote positive health behavior change and support disease self-management. This is why the WHO developed an application called medical eligibility criteria for contraceptive use that has guidance on the best family planning options for an individual considering their medical history, current disease, current medication and individual preferences.

Ensuring quality of care for consumer communication tools (adopted from the QOC framework for self-care[16]) includes;

- Consumer communication tools effectively instruct the consumer how to self-manage their care.
- Communication tools are medically accurate, contain information on correct dosage and side effect management, and are in line with national, international/WHO guideline
- Communication tools are accurate, comprehensible, and available in an accessible/ local language
- Consumer communication is respectful, empathetic, non- judgmental, and free from coercion.
- Consumer communication tools give accurate information on follow-up care, including circumstances under which a client should seek follow-up care and where to seek care.
- Consumer communication tools provide information that supports adherence, including through the use of reminders.

Ensuring quality of care for Health provider/worker communication tools (adopted from the QOC framework for self-care)

- Communication tools effectively build the skills needed to instruct a consumer in how to self- manage their care.

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[16] https://www.psi.org/project/self-care/a-new-quality-of-care-framework-to-measure-and-respond-to-peoples-experience-with-self-care/

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- Communication tools are medically accurate, contain information on correct dosage and side effect management, and are in line with national and international/WHO guideline
- Communication tools support health providers/workers to elicit input from the consumer and provide accurate, comprehensible information in support of self-care.
- Communication tools support the health provider/ worker to interact with the consumer in a way that is empathetic, non-judgmental and respects their choice and agency.
- Communication tools support the health provider/worker to properly inform a consumer about follow-up care options and the recognition of side effects or danger signs

3.6 Access to Self-care commodities and health supplies

Access to self-care commodities in Uganda is through the public sector (free), Private Not for Profit (known as The Alternative Distribution System-ADS), social marketing and social franchising and commercial sector pharmacies, clinics and drug shops. Currently, there is no provision for self-care commodities in public sector apart from accessing condoms that are placed in condom dispensers at health facilities. Contraceptives are received after the customer has presented a prescription from a health provider to the dispenser.

There is need for Standard Operating Procedures (SOPs) for self-care within public sector facilities so that a customer does not have to first line up to see a health provider before going to the dispensary. Self-carers should be able to walk straight to the dispenser and request for commodities and supplies. Mechanisms should be created to ensure that consumer details are collected at the dispensing unit. For oral contraceptive pills, it is recommended that 3-month supply be dispensed to customers. All the self-care commodities should be included on the list of commodities for Private Not for Profit (PNFP) for ease of access. The PNFP sector should be sensitized on support for self-care.

Ensuring quality of care for self-care regulated quality products and interventions (adopted from the QOC framework for self-care)

- Products are registered in- country and are WHO or stringent regulatory authority (SRA) approved.
- Products are non-expired and stored according to manufacturer requirements.
- Product is available and accessible including if the client desires continued use

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CHAPTER 4: GUIDANCE ON INTRODUCTION AND SCALE UP OF DIGITAL SELF-CARE

Digital health is the systematic application of information and communications technologies, computer science, and data to support informed decision-making by individuals, the health workforce, and health systems, to strengthen resilience to disease and improve health and wellness for all. Digital health enables self-care in several ways. The first is as a stand-alone self-care intervention. For example, mobile applications for better home-based care and risk assessment during pregnancy. The second is using digital technology in combination with self-care commodities such as instructional videos for more effective use of HIV self-testing kits. Third, at a health systems level, digital health offers the opportunity for better continuity of care through the use of shared health records accessible to patients and health professionals.

4.1. Relevance of Digital Self-Care

Value added from digital health care interventions include increased access to health services, increased anonymity and autonomy, linkages to healthcare support system as needed, continuous monitoring of quality and safety and Increased ability to monitor and evaluate self-care interventions

4.2. Guidance on Digital Self-care

The guidance for development and introduction of the new digital self-care tool in Uganda is adopted from the Digital Self-Care Framework[17] as follows:

Step 1: The developer will present the digital self-care tool to the MOH or approval for piloting. The parameters that will be used to assess the digital self-care tool will focus on four domains of digital self-care adopted from the digital self-care framework developed by the self-care trailblazers' group (2020) that include accountability and responsibility, user experience, quality assurance, privacy and confidentiality. It is recommended that all digital self-care interventions conform to the checklist below during the design, implementation and evaluation.

[17] https://www.psi.org/wp-content/uploads/2020/10/Digital-Self-Care.pdf

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Table 9: Digital self-care checklist of key characteristics

User Experience	**Data Privacy and Confidentiality**	**Accountability / Responsibility**
• Are users treated with respect and compassion? • Are+-, services accessible, inclusive and usable regardless of gender, race, sexual orientation, ethnicity or ability? • Do providers, implementers and regulatory agencies demonstrate active and ongoing response to user and public perceptions, suggestions and concerns?	• Are the user's identity and personal information protected? • Is valid consent obtained from all users? • Are confidentiality measures clearly communicated?	• Is the implementation and design in accordance with the legal and policy environment or global best practices with regards to quality and safety? • Is there a process in place for continual review and improvement of services? • Is there a system in place for redress and for reporting false information?
Quality Assurance		
Technical Competency: • Do users have the skills necessary to engage in digital self-care activities? • Do the relevant health care providers have the knowledge and skills necessary to support appropriate digital self-care behaviors? • Are the relevant health care providers licensed, registered and trained according to local regulations related to both self-care and digital health? ***Client Safety:*** • Are the supported self-care activities and information safe, accessible, acceptable, and of good quality with built-in safeguards to manage and limit risks? • Is the intervention based on evidence that it can improve intended outcomes for the user? • Is the intervention developed and designed with participation from the target audience to meet user's needs? • Are all information and services accurate and in compliance with national protocols, standards and global best practices?		

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Information Exchange:

- Do the information and services provide a means to have back and forth exchange with health care providers as necessary?
- Interpersonal Connection and Choice:
- Do users receive care, information and support through the digital intervention and from relevant health care providers that is respectful, empathetic and free from judgment or stigma?
- Do users exercise choice; give consent without pressure or coercion to use the digital intervention?

Continuity of Care:

- Does the digital system allow providers to make an adequate assessment of the client's health condition and/or provide appropriate referral to a licensed and trained health professional?
- Continuity of Care: Does the user have a reliable link to a health professional to ask questions, express concerns and receive care?

Step 2: The developer will then present the tool to Ministry of Health Technical Working Groups for consideration for approval.

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CHAPTER 5: SEXUALLY TRANSMITTED INFECTIONS

5.1 Guidance on HPV self-swabbing (Self Sampling)

HPV self-sampling is a process where a woman who wants to know whether she has HPV infection uses a kit to collect a cervical-vaginal sample, which is then sent for analysis by a laboratory. Collection methods include lavage, brush, swab and vaginal patch. While HPV self-sampling cannot provide a diagnosis of cervical (pre-) cancer, it identifies those women at higher risk. The privacy afforded by self-sampling may encourage more people to get tested compared with Pap smears that, especially in Uganda, still have low coverage due to limited population awareness and lack of availability.

HPV DNA-based screening methods are based on the detection of high-risk HPV DNA in vaginal or cervical smears. A sample of cells is collected from the cervix or vagina using a swab or small brush, and placed in a small container with a preservative solution to be sent to nearby laboratory. There they can be tested for HPV infection, which can stimulate changes in the cells covering the cervix. The specimen can be collected by a health care provider or by the woman herself, inserting a swab deep into the vagina.

Justification for HPV self-sampling

It also grants privacy and convenience to women, bypassing common barriers like fear, shame, geographical barriers, time limitations, cultural or religious considerations, and lack of access.[55] Self-sampling has the potential to overcome the practical and personal barriers which may prevent some women from responding to standard cervical cancer screening.

Table 10: Guidance on introduction and scale up of HPV self-sampling (self-swabbing)

Basic Requirement	Guidance
Procedure	Molecular testing for HPV – swab taken by provider or woman Herself and sent to laboratory
Eligible to take self-sample	• Women from 25 years of age. It is highly recommended that menopausal women use HPV test as the primary screening method for cancer cervix
When not to take a sample	• It is best not to take a sample from women who are menstruating. Slight bleeding is acceptable.

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	• HPV testing, if available, is most useful when done in conjunction with a cytological test, in women aged 35 years or older.
Self-swabbing	• Health provider will explain to the woman how to collect her own specimen, as per instructions of the manufacturer of the test kit. • Provide her with swabs and a vessel with preservative solution. • She can collect the specimen in the clinic, if there is a private area, or at home. • If she collects the specimen at home, she should bring it to the clinic within the time specified by the manufacturer of the test kit. • Send the specimen to the special laboratory for examination
Link to Health provider	• When the woman returns, whether the specimen was collected by her or by the provider, give her the test result, explain what it means, and if necessary, advise her on any additional tests or treatment needed. • Current MoH and WHO guidance recommends HPV that those with a positive screen are assessed with Visual Inspection with Acetic Acid (VIA). VIA positives are referred for treatment for precancerous cervix.

5.2 Guidance on Introduction and scale up of self-swabbing for Neisseria Gonorrhoeae, Chlamydia Trachomatis and Trichomonas Vaginalis

Self-collection of samples is one way to facilitate the expansion of STI testing services. Self-collection of samples occurs when individuals take a specimen themselves, either at the clinic or elsewhere, and send it to a laboratory for testing. Follow-up in the case of positive test results requires a linkage with the health system. Self-collection approaches also have the potential to address some common barriers to clinician-dependent and/or clinic-based diagnosis, such as concerns around autonomy, inconvenience, stigma and lack of privacy.

There are numerous types of self-collected samples for different STIs, including: urine (mainly among men, but also women and youth) for NG, CT and TV; vulvovaginal swabs for NG, CT and TV; and pharyngeal and anal-rectal swabs for NG and CT. Rapid dual tests

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for HIV/syphilis have been developed and evaluated, but only one so far has been prequalified by the WHO, though others are in the process.

What is a first catch urine specimen: It is the first part of the urine stream passed. A first catch urine specimen can be collected at any time of the day when testing for Chlamydia trachomatis or Neisseria gonorrhoeae using a NAAT (PCR) Chlamydia trachomatis (CT) and Neisseria gonorrhoeae, Trichomonas vaginalis is a protozoan that is responsible for the most common nonviral sexually transmitted infection (STI) in the world.

The advent of nucleic acid amplification tests (NAATs) has made it possible to screen people in homes with self-collected specimens. Home-based screening, with urine or self-collected vaginal specimens, has been shown to be acceptable and has the potential to reach people who do not get tested otherwise

Table 11: Guidance on introduction and scale up of self-swabbing for Neisseria gonorrhea, chlamydia trachomatis and trichomonas vaginalis:

Basic requirement	Guidance
Eligible	• Chlamydia Trachomatis annual screening of sexually active men and women in Uganda • Neisseria Gonorrhoeae screening will depend on local prevalence and individual risk factors should be considered • People with any of the following risk factors should be tested: ○ Aged 16 to 29 years ○ Recently changed sexual partners or had more than 1 sexual partner in the past 6 months ○ Not using condoms every time, they have sex. ○ Not in a long-term monogamous relationship ○ Sexual partner has had an STI or symptoms of an STI ○ Pregnant women at their booking antenatal visit
Female Sample collection	• Asymptomatic females: self-collected vaginal swab is recommended. • A self-collected vaginal swab is the preferred testing method for chlamydia and gonorrhea in asymptomatic females—first catch urine should only be considered if a self-collected swab cannot be taken. First catch urine is not as sensitive as a self-collected vaginal swab

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	• A specimen can be collected at any time of day as long as it is more than 20 minutes since last urination • Advise the patient not to clean or wipe their genitals before passing urine. • Collect 20ml (approximately) of the first part of the urine stream (the first catch) directly into the specimen jar. When the jar is one-third full, pass the rest of the urine into the toilet. • A midstream urine or early morning specimen is not required.
Male sample collection	For asymptomatic males a first catch urine specimen collected at any time of the day is preferable for chlamydia or gonorrhea testing.
Linkage to the health care system	Linkage to health facilities is recommended

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CHAPTER 6: HIV and AIDS

6.1 Guidance on introduction and scale up of HIV Self Testing (HIVST)

HIV Self Testing (HIVST) has the potential to promote access to HIV testing services, increase autonomy, assures confidentiality, empowers and is convenient. From a program point of view, HIVST could potentially increase knowledge of HIV status and has the public health benefits that may significantly reduce the risk of HIV transmission. With the current optimal uptake of conventional HIV testing in the country, it is important therefore to implement innovative strategies with a view to widen the scope of HIV Testing (HTS) provision in this country.

The development of this HIVST guideline was therefore necessitated by the need to increase the uptake of HIV testing in the country, given that HIV testing is the gateway to prevention, care and treatment. This guideline outlines the programmatic approaches to HIV self-testing, describe the package of support services required under HIVST, describe commodity management system requirements and outline coordination mechanisms for HIVST. They also outline quality assurance strategies, and monitoring and evaluation for HIVST.

HIVST is intended as a HIV screening tool that has the potential to meet the needs and address challenges of increasing access to knowledge of HIV status. It is a complementary strategy to increasing knowledge of HIV status and uptake of prevention, care and treatment services. HIVST has been shown to be acceptable to many diverse population groups in a variety of settings. It is generally accurate when performed with regulated and quality rapid diagnostic tests. When provided in conjunction with adequate instructions for use and post-test support services, self-testing is also effective and is an efficient strategy requiring fewer human resources than other approaches. HIVST can also be convenient and empowering for individuals and support testing for people who do not attend health and other services offering HTS.

Guidance

HIVST can be delivered through two distinct approaches to reach different target populations thus Directly-Assisted HIVST and Unassisted HIVST. Both directly assisted and unassisted HIVST may include additional tools such as telephone helplines, mobile phone text messages, videos, social media and internet-based applications which provide technical support, counseling and referrals for further HIV testing, prevention, care treatment and support services.

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Table 12: Guidance on introduction and scale up of HIV self-testing (HIVST)

Requirement	Guidance
Who qualifies for HIVST	• Young people 18 years to 24 years • Emancipated minors (17 <18 years) i.e., married, have a child. • Men including partners of Pregnant women • Key Populations
Who does not qualify for HIVST	HIVST is NOT recommended for people who are already taking ARV drugs such as PREP, because rapid HIV tests (including HIVST) may give false negative results as antibody levels may be lower when people with HIV are on ART Children under 2 years
Introduction of the test kit for scale up	• WHO pre-qualified • Locally validated • MOH approved
Access points permitted to issue HIVST to Self-carers	• Facility Based (Outpatients, Antenatal Care, Laboratory and diagnostics, ART Clinic, Facility based drop-in center, Adolescent /youth corners/center's, Family Planning/STI clinic) • Community Based (Workplace, Community Health Extension Workers/Village health Teams/ Peers, Community Based Organizations, drop-in centers, Peer to peer, Sexual Partners of pregnant and lactating mothers) • Others (Private pharmacy/outlets/vending Machines, Electronic platforms, community distribution point.
Guiding principles	Consent, confidentiality counseling, correct results, available linkage and referral HIV post-test services based on outcome of the test and other needs
Quality Assurance and control for HIVST	• Quality Assurance (QA) in the context of HIVST refers to adherence to the set standards; conducting quality control and Continuous quality improvement (CQI) to offer quality HIVST. • Quality assurance should be achieved through training, mentorship, data quality assessment and implementation of process control mechanisms. • Routinely collected HIVST data should be used to track performance, identify any gaps and use CQI approaches to improve performance.

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Quality assurance for the Kit	• Self-test kits for national procurement and use MUST attain WHO pre-qualification • All HIVST test kits must be validated, certified and registered by relevant National Drugs Authority (NDA) authorities before being dispatched into the market • All procuring entities must ensure that any new lots of HIVST test kits coming into the country are evaluated to ensure that products delivered meet criteria for quality and performance. Only lots with satisfactory results should be distributed. Quality control should be performed on the test kits using the manufacture's controls • Post-market surveillance will be conducted periodically by the National drug authority in conjunction with MOH to assess the quality and performance of the test kits in use, in compliance with the set standards. • HIVST shall be provided according to the provisions of the addendum to the HIV Testing services policy and implementation guideline Therefore, HTS supervisors and managers should ensure that HIV self- testing providers adhere to the set standards.
Creating self-awareness	• The kit will include instructions in English and other local languages as well as pictorial diagrams to aid ease of use and correct interpretation of results. It is recommended that all HIVST kits distributed must also be accompanied with client education material such as e.g., FAQs. • All distribution points should display illustrations or instructions on HIVST procedures should a tester require further explanation or testing support. • In addition, all outlets must have a separate, private space especially for directly assisted testing. • Community based follow up by trained community health care workers, peer and outreach workers through telephone or SMS. This is especially applicable where HIVST is offered at community level • Vouchers, coupons or rebates – applicable mostly to key populations • Online audio or video counseling services and step-by-step instructions on what to do following a reactive self-test may be provided by internet, computer-based programs and applications (such as WhatsApp, Twitter etc.)

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	• Telephone helpline where users call for pretest and post-test counseling and technical support can still offer linkage to HTS • Bulk mobile phone text message services to provide information, reminders and linkage messages • Through public gathering conducted by local administration and in market places where information on where to find HTS services is given
To create awareness and increase utilization of HIVST	• Emphasize correct usage of the self-test kits, and ensure correct interpretation of results and create awareness of the need for linkage for additional testing, HIV prevention, care and treatment. • These can be enhanced through development of communication strategies
HIVST Results	• Individuals with negative self-test results should re-test as per their risk to HIV infection as outlined in the national HTS guideline retesting recommendations • If the HIVST test result is positive, the individual should seek confirmatory testing from a trained HTS provider, where the approved national HIV testing algorithm will be utilized to conduct the HIV test
Partner Notification and Disclosure	• Self-carers should be informed about the potential health benefits of disclosing their HIV status to significant others prior to receiving their self-testing kits. • This information should be included in the Self-carers' information pack. • Self-carers whose test result is negative should also be encouraged to disclose their status to their sexual partners and encourage their partners to know their HIV status through use of HIVST kits or a visit to an HTS service point. • Health providers should assess for possible social harm and/or violence following disclosure, such as intimate partner violence, and provide guidance and referral as appropriate (assessment tool for social harm) – explore how to handle the private sector
Referral and Linkage	There should be clear guideline to facilitate linkage to HIV prevention, care, treatment and support following HIVST.

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Misuse and Adverse events associated with HIV self-testing	• Misuse and adverse events associated with HIVST should be assessed pre and post-distribution: • Individuals who disclose any form of violence by an intimate partner or social contact should be offered immediate support. • Health care providers should offer first line support when Self-carers disclose violence. • Do not provide HIV self-testing kits for secondary distribution to Self-carers experiencing intimate partner violence. • Partners of individuals experiencing intimate partner violence should be offered alternative HIV testing services. • A person testing negative is advised to re-test as per the national retesting guidelines. • The HIV Self Testing is NOT suitable for users who are taking antiretroviral treatment (ART) • There should be a system (framework) in place to report and document adverse events experienced during the provision of HIVST services. • Providers experiencing adverse events should equally be offered first line support. These events should be appropriately reported and documented using the standardized HMIS tools.

6.2 Guidance on Introduction and Scale-up of the Dapivirine Vaginal Ring for HIV Prevention

The PrEP ring is a long-acting HIV prevention method developed specifically for Self-carers who are unable or do not want to take oral PrEP or when oral PrEP is not available. The ring is made of a flexible silicone material containing 25 mg of an ARV drug called Dapivirine. It is inserted into the vagina and should remain in place for one month. Dapivirine belongs to a class of ARVs called nonnucleoside reverse transcriptase inhibitors (NNRTI) that reduce the ability of HIV to replicate itself inside a healthy cell. The ring delivers the drug directly to the site of potential infection over the course of one month, with low absorption elsewhere in the body, lowering the likelihood of systemic side effects. Self-carers can insert, remove, and replace the ring themselves each month, or with the assistance of a health care provider if desired.

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NB: The PrEP ring does not prevent pregnancies. It may be offered as an additional prevention choice for women at substantial risk of HIV infection as part of combination prevention approaches.

Possible Side Effects of the PrEP Ring

Possible side effects of the ring are typically mild and include urinary tract infections (UTIs vaginal discharge vulvar itching and pelvic and lower abdominal pain). These side effects usually occur during the first month of use and resolve without the need to remove the ring. Ring users should be counseled on possible side effects and to contact their health care provider if they experience any urinary or reproductive tract changes, because these could be a sign of an STI or UTI needing treatment.

PrEP Ring and Other Drug Interactions

There are no known interactions between Dapivirine and contraceptive hormones, hormones used for gender-affirming hormone therapy, alcohol, or recreational drugs. However, if a client or potential client thinks that their use of alcohol or other substances is interfering or may interfere with effective use of the ring, the provider should discuss and support behavior change and offer additional prevention options, including use of condoms and condom-compatible lubricant.

Contraindications for PrEP Ring Use

- The ring should not be provided to people with:
- An HIV-positive test result according to the national HIV testing algorithm
- Known exposure to HIV in the past 72 hours (because such Self-carers may
- derive more benefit from post-exposure prophylaxis (PEP) if the potential for HIV exposure was high)
- Inability to commit to effectively using the ring and attend scheduled follow-up visits
- Allergy or hypersensitivity to active substance or other substances listed in the product information sheet

Inserting the PrEP Ring

Self-carers may need initial guidance and support to learn how to use the ring and, once confident, can continue to use the ring on their own. Some Self-carers are comfortable using the ring on their own with minimal support from their first use. However, for Self-carers who prefer support, a health care provider can help insert the ring or confirm placement. The ring is inserted by hand; there is no need to use a speculum or other tools to insert the ring. Clear visual instructions should be offered with the ring.

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Ring insertion steps for self-carers

1. Get into a position that is comfortable for inserting the ring, such as squatting, one leg lifted, or lying down. If a health care provider is assisting you, you should be in a reclining position.
2. With clean hands, squeeze the ring between the thumb and forefinger, pressing both sides of the ring together so that the ring forms a "figure 8" shape.
3. Use the other hand to open the folds of skin around the vagina.
4. Place the tip of the ring into the vaginal opening and use your fingers to push the folded ring gently up into the vagina.
5. Push the ring as far toward the lower back as possible. If the ring feels uncomfortable, it is probably not inserted far enough into the vagina. Use a finger to push it as far up into the vagina as is comfortable. Ring insertion should be painless. If you have any bleeding or discomfort upon insertion, contact your health care provider.

Removing the Dapivirine Ring

Self-carers can remove the ring without the help of a health care provider. However, for Self-carers who prefer support, a health care provider can help remove the ring. The ring is removed by hand; there is no need to use a speculum or other tools to remove the ring. If a client is being assisted by a health care provider, they should be in a reclining position during removal.

Ring removal steps for Self-carers

1. Get into a position that is comfortable for removing the ring, such as squatting, one leg lifted, or lying down.
2. With clean hands, insert one finger into the vagina and hook it around the edge of the ring.
3. Gently pull the ring out of the vagina. Ring removal should be painless. If you have any bleeding or discomfort upon removal, contact your health care provider.

Table 13: Guidance on introduction and scale up of Dapivirine ring

Basic Requirement	Guidance
Assessing Self-carers	Any HIV-negative sexually active woman who primarily engages in vaginal sex and wants to protect herself from HIV but is unable or unwilling to use oral PrEP • A client should not use the ring if she has tested positive to HIV infection or if she prefers to or is able to use oral PrEP

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	• Self-carers can switch between oral PrEP and the ring without needing a washout period • Simultaneous use of the ring and oral PrEP is likely to be well-tolerated but is not recommended; women should be counseled to choose the method that is best for them and to use their chosen method appropriately
Quality assurance	Product must be approved and registered by National Drug Authority
Access	Service delivery models and product access will be determined once national guideline for the ring are in place. Possible access points include: • Over the counter (pharmacies, drug shops) • Public and private health facilities • Community health workers • Peer ambassadors • Health entrepreneurs • Women and girl's safe spaces Electronic platform for contraceptive
Introduction	Preliminary registration by National Drug Authority Approval by the MOH coordination mechanism and management
Scale up	• Inclusion on the Essential Medicines and health supplies list • Inclusion on the clinical guideline • Approved training curriculum, IEC materials
First self – insertion of the ring	Trained health care providers should counsel and support women during their first ring self-insertion. If requested by the client, the health care provider can assist with the insertion or check for correct placement of the ring inside the vagina. Women who are ready for independent self-insertion should be given information and materials (job aid/video, calendar for future insertion timing, expiry dates etc.)
Product initiation procedures	• Provide risk-reduction and ring adherence counseling: • Provide condoms and education on their use • Initiate ring adherence plan • Counsel client on possible side effects • Discuss ring storage options in case the client is taking more than one ring • Discuss proper waste disposal options

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Follow-up/monitoring procedures	After the initial visit, the client should be given a one-month follow-up appointment and can be given quarterly appointments thereafter as appropriate Perform a pregnancy test if there is history of amenorrhea. Review the Self-carers understanding of PrEP and the ring, any barriers to adherence, tolerance as well as any side effects. Review the patient's risk exposure profile and perform risk-reduction counseling. Evaluate and support PrEP adherence at each clinic visit. Evaluate the patient for any symptoms of STIs at every visit and treat according to current STI treatment Guideline. *Ring side effects are typically mild to moderate genital and urinary tract issues (such as urinary tract infections, vaginal discharge or itching, and pelvic or lower abdominal pain) and are typically transient in most cases and resolve without interrupting ring use. Self-carers should be counseled to contact their health care provider as soon as possible if they experience any genital or urinary tract changes.
Ring storage	Self-carers should be advised to store their rings if more than one is provided at a clinic visit: At room temperature (out of the sun, away from extreme heat/cold), out of reach of children, rodents and animals.
Re-insertion	Self-carers should be taught how to calculate reinsertion dates. Providers should have job aids available to review re-insertion procedures. Additional educational materials on removal and insertion can be sent home with Self-carers as needed.
Waste disposal	Ring disposal processes will be determined once national guideline for the ring are in place and should be discussed during the counseling session. Possible disposal methods include: Dispose of the used ring in a pit latrine Return the used ring to a safety box at either a private, public or community-based provider.

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CHAPTER 7: FAMILY PLANNING

7.1 Guidance on introduction and scale up of self-care provision of Oral Contraceptives Over the Counter

Definitions

Prescription: Requires a prescription from a licensed prescriber, upon which the drug can be dispensed by a pharmacist or directly from the prescriber

Over the Counter: Available without a prescription at any location with no restrictions

Behind the counter: refers to a subgroup of over-the-counter medication available without a prescription behind the pharmacy counter. Unlike other Over the counter medicines sold in-aisle, these products require the assistance of a pharmacy employee to purchase.

Relevance of self-care provision over the counter (OTC)

Currently, there are three types of oral contraceptive pills: combined estrogen progesterone, progesterone only and the continuous or extended use pill. OTC drugs generally have these characteristics: their benefits outweigh their risks, their potential for misuse and abuse is low, the consumer can use them for self-diagnosed conditions, they can be adequately labeled by the manufacturer, and health practitioners are not needed for safe and effective use. Oral contraceptives are not habit forming and self- diagnosis is a matter of personal choice and prevention rather than a medical diagnosis. Over-the-counter drugs can be purchased from any venue and are not restricted in any way. Barriers to access are one reason for inconsistent or nonuse of contraception. The requirement for a prescription can be an obstacle for some contraceptive users.

Perquisites for OTC

To meet these requirements, patients must be able to read and interpret the package labeling in order to self-diagnose, recognize contraindications, and prevent drug interactions.

Table 14: Guidance on introduction and scale up of self-care provision of oral contraceptives over the counter

Basic Requirement	Guidance
Eligibility for over-the-counter oral contraceptives	• Women of Reproductive age group 15-49 with exception of those with contra indications • Young adolescents 10-14 years
Regulation and quality assurance	The product must be registered by NDA

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Introduction of the product	• Self-carers who can read and comprehend instructions with adequate self-awareness can use product without going through counseling by provider • Self-carers who do not have the required awareness or lack capacity (i.e., cannot read, cannot understand instruction) will provider assisted until they can self-administer on their own
Scale up	The following needs to be done in preparation for scale up • Inclusion on the essential medicines and health supplies list • Inclusion on the clinical guideline • Stock availability in both public and private sector
Safety, screening and counseling	• Use of the Medical eligibility criteria for oral contraceptives • Ability to self-screen for these contraindications
New client	• A new client who can read and understand the medical eligibility criteria should be given contraceptives • A new client who cannot read or understand the medical eligibility criteria should be provided direct assistance
Continuing Self-carers	Should be provided with a refill and incase of any side effects, should be counseled and referred.
Contraceptive supply	Self-carers should be issued contraceptives that will last for 3 months

7.2 Self-Management: Guidance on introduction and scale up of contraceptive Injection

Self-injection of DMPA-SC is an evidence-based practice that is endorsed globally and approved in a growing number of countries. There are strong data that women—including women in low-resource settings— can self-administer DMPA-SC safely and effectively, and that they like doing so. Several countries are already moving forward with scaling up self-injection, including Burkina Faso, the Democratic Republic of the Congo, Madagascar, Malawi, Nigeria, Senegal, Uganda, and Zambia.

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The Updated HMIS tools will have a column where Self-carers who have Self-injected using DMPA SC will be recorded. This will provide invaluable data on the impact of Self-care on the demographic dividend

Table 15: Guidance on introduction and scale up of contraceptive injection

Basic Requirement	Guidance
Who qualifies for DMPA-SC Self Injection	Women of reproductive age (15-49) who want an effective, reversible method can use DMPA-SC safely and effectively. This includes women who: • Have or have not had children • Are married or are not married • Have had an abortion or miscarriage • Smoke cigarettes, regardless of woman's age or number of cigarettes smoked • Are breastfeeding, starting at least 6 weeks after childbirth Are living with HIV and taking antiretroviral medications (ARVs): The time between injections does not need to be shortened for women taking ARVs
Who does not Qualify for Self-injection	A client should typically not use DMPA-SC if she: • Is diagnosed with very high blood pressure (include specific level) • Has unexplained bleeding between monthly menstrual periods or bleeding after sex • Is diagnosed with breast cancer, serious heart or liver disease, or lupus • Has had a heart attack or stroke • Has had diabetes for more than 20 years or if diabetes has caused damage to her arteries, vision, kidneys, or nervous system
Quality assurance	Product must be approved and registered by NDA
Access	Over the counter (pharmacies, drug shops), public and private health facilities, community health workers, peers, health entrepreneurs
Introduction	• Preliminary registration by NDA • Approved protocol by Uganda National Council of Science and Technology – Adopt the protocol developed by PATH

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	for introduction of new products (Safety, acceptability, feasibility and cost-effectiveness) • Approval by the MOH coordination mechanism and management
Scale up	• Inclusion on the Essential Medicines and health supplies list • Inclusion on the clinical guideline • Approved training curriculum, IEC materials
First Self Injection	• Trained provider should supervise women during their first self-injection. • Women who are ready for independent self-injection should be given information and materials (job aid/video, calendar and appointment card for future injection timing, expiry dates etc.)
Storage at Home	Self-carers should be advised to store their take-home DMPA-SC units: •Safely, At room temperature (Out of the sun, away from extreme heat/cold), Out of reach of children, rodents and animals.
Re-Injection	Self-carers should be taught how to calculate reinjection dates. •Self-carers should use a job aid to re-inject
Waste disposal	• Disposal should be addressed during client training. • Self-carers should be advised to place the used uniject in a puncture proof container with a lid. • Self-carers who self-inject at home will be required to give the empty injector to their VHTs or mentor mothers for disposal
Follow -Up	Women need to be given clear guidance up front about how and when to follow-up with a health provider.

7.3: Self-Management: Condoms

Condom self-efficacy refers to an individual's confidence in his/her ability to purchase condoms, negotiate the use of condoms with partners, and use condoms correctly during sexual intercourse. Individuals who have a high sense of condom self-efficacy are likely to

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use condoms, whereas those who have self- doubts about their ability to use condoms are less likely to do so.

Table 16: Introduction and scale up of condom use

Basic requirement	**Guidance**
Eligible to use a condom	All sexually active individuals (males and females)
Quality Assurance	All condoms must be registered by NDA and undergo pre and post shipment testing
Access	Over the counter at public health facilities, Private sector, commercial sector (condom dispensers)
Use	Require counseling and instructions/demonstration if they cannot read or understand the instructions
Self-awareness	• Through digital platforms for those that can read • Through audio and visual platforms for those that cannot read or understand instructions

7.4: Self-Management: Cycle Beads

Cycle Beads, a color-coded string of beads that represents the days of a woman's cycle, helps an individual use the Standard Days Method, by helping her track her cycle days. Starting the first day of her period, she moves a band to the red bead then to a new bead every day.

Table 17: Introduction and scale up of cycle beads

Basic Requirement	**Guidance**
Eligibility	All sexually active women not using any other FP method
Quality assurance	Does Not require NDA approval
Access	Over the counter, public and private health facilities
At Home	• Women who can read and understand instructions can self-manage • Women who cannot read and write require detailed counseling and training by community health worker
Self-awareness	• Through digital platforms for those that can read • Through audio and visual platforms for those that cannot read or understand instructions

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7.5: Self-Management: Calendar method

The rhythm method, also called the calendar method or the calendar rhythm method, is a form of natural family planning. To use the rhythm method, you track your menstrual history to predict when you'll ovulate. This helps you determine when you're most likely to conceive.

Table 18: Introduction and scale up of calendar method

Basic Requirement	Guidance
Eligibility	All sexually active women not using any other FP Method
Quality assurance	Does Not require NDA approval
At Home	Women who can read and understand instructions can self-manage Women who cannot read and write require detailed counseling and training by community health worker
Self-awareness	Through digital platforms for those that can read Through audio and visual platforms for those that cannot read or understand instructions

7.6: Home Based Ovulation Predictor Kit (OPK)

Home-based use of OPKs has the potential to increase autonomy and agency for women in Uganda. Increasing reproductive health awareness by using OPKs could yield greater knowledge concerning ovulation and a woman's fertile window. Use of OPKs through a human rights-based approach could be particularly empowering for women and girls who face barriers to enacting decisions in relation to their sexuality, reproduction, health and wellbeing. OPKs could include both urine-based and serum-based kits and any modality (stick, monitor, digital, electronic slip that connects to a phone and so on).

However, they are currently not available in the public sector and can only be accessed in the private outlets.

Table 19: Introduction and scale up of home based ovulation kit (OPK)

Basic Requirement	Guidance
Eligibility	Women with desire to get pregnant
Quality assurance	The OPK must be approved by NDA
Access	Over the counter, public and private health facilities

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Testing At Home without assistance	• Women who can read and understand instructions • Women who have done the test before
Testing At Home with inability to read or understand instructions	Directly assisted by community health worker until able to follow instructions
Testing At Health Facility without assistance	• Self-test for Women who can read and understand instructions • Self-test for Women who have done the test before
Testing At Health facility with inability to read or understand instructions	Directly assisted
At Private pharmacy and drug shops	• Women who can read instructions can be issued with the kit for self-testing. • Women who cannot read or understand instructions be referred and directly assisted until they are able to independently test
Self-awareness	• Through digital platforms for those that can read • Through audio and visual platforms for those that cannot read or understand instructions

7.7: Pregnancy Test

Pregnancy tests check for the presence of the pregnancy hormone, human chorionic gonadotropin (HCG), in your urine. Your body begins to produce HCG after you conceive. If you get a positive test result on the first day of your missed period, it's probably about 2 weeks since you conceived.

Table 20: Introduction and scale up of rapid pregnancy tests

Basic Requirement	Guidance
Eligibility	All sexually active women who have missed their periods
Quality assurance	The Pregnancy test kit must be approved by NDA
Access	Over the counter, public and private health facilities
Testing At Home without assistance	• Women who can read and understand instructions • Women who have done the test before

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Testing At Home with inability to read or understand instructions	Directly assisted by community health worker until able to follow instructions
Testing At Health Facility without assistance	• Self-test for Women who can read and understand instructions • Self-test for Women who have done the test before
Testing At Health facility with inability to read or understand instructions	Directly assisted
At Private pharmacy and drug shops	• Women who can read instructions can be issued with the kit for self-testing. • Women who cannot read or understand instructions be referred and directly assisted until they are able to independently test
Self-awareness	• Through digital platforms for those that can read • Through audio and visual platforms for those that cannot read or understand instructions

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CHAPTER 8: ANTENATAL CARE, DELIVERY AND POST NATAL CARE

8.1 Breast Self-Examination (BSE)

Breast cancer is an uncontrolled growth of breast cells. According to the World Health Organization (2017), breast cancer is the most common cancer among women worldwide, claiming the lives of hundreds of thousands of women each year and affecting countries at all levels of modernization. It is the second leading cause of cancer death among women in Uganda, after cancer of the cervix. However, the annual rate of increase in the incidence of breast cancer is 3.7 % which more than that of cancer of the cervix (1.8%). Dr. John Schreel, (2014) elaborated on the high levels of mortality in Uganda. He noted that 1 in 2 women with breast cancer will die of the disease, as they are usually diagnosed with breast cancer when it is advanced, and chances of a cure, low.

An effective breast self-examination is one that is conducted at the same time each month, uses the techniques appropriately and covers the whole area of each breast, including the lymph nodes, underarms and upper chest, from the collarbone to below the breasts and from the armpits to the breastbone.
Each area of examination should be covered three times, using light, medium and firm pressure.

How to do a Breast Self-examination:

- Breast self-examination can be done using vertical strip, wedge section, and/or concentric circle detection methods. In all three methods, the woman should use two or three fingers, thumb extended and using the sensitive palmar pads on the flat, inner surfaces of the fingers for a systematic and careful feel of the breast. It is best to use the palmar pads of the finger because fingertips are less sensitive and long nails can impede the movement of the hand.
- The breast should also not be compressed between fingers as it may cause the woman to feel a lump that does not really exist.
- With the vertical strip method, the woman should start in the underarm area of the breast, moving the fingers downward slowly until she reaches the area below the breast. The fingers are then moved slightly towards the middle and the process begins again, this time moving the hand upwards over the breast. This process continues up and down until the whole surface of the breast and underarms is examined. Both breasts should be examined.
- The wedge section technique was developed as some women find the circular movement of the hand easier to use during the breast self-examination. In this method, the breast is divided into wedges, moving the palmar pads of the fingers towards the centre of the breast or the nipple. Both breasts are examined wedge by wedge in this manner until completely covered.

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- Concentric circle: In this method, the woman uses a circular motion starting with a small circle around the nipple area to feel the breast. The circle is widened as the woman moves over the surface of the breast. The breast, upper chest and underarm area are fully examined through this circular motion. As with other methods, both breasts should be fully examined.
- Examination position: Tactile examination of the breast can be done lying down or standing up in the shower, primarily depending on the preference of the woman

Changes to look out for

In examining the breast, the woman should feel for changes in the texture and feel of the breast. Among the things that should be noted and reported to a physician are:

- Any new lump or hard knot found in the breast or armpit;
- Any lump or thickening of the tissue that does not shrink or lessen after her next period;
- Any change in the size, shape or symmetry of her breast;
- A thickening or swelling of the breast;
- Any dimpling, puckering or indention in the breast;
- Dimpling, skin irritation or other change in the breast skin or nipple;
- Redness or scaliness of the nipple or breast skin;
- Discharge from the nipple (fluid coming from the nipples other than breast milk), particularly if the discharge is clear and sticky, dark or occurs without squeezing the nipple;
- Nipple tenderness or pain;
- Nipple retraction (turning or drawing inward or pointing in a new direction);
- Any breast changes that may cause concern.

8.2 Folic Acid (pre-conception care and 1st Trimester)

Folic Acid is very important for the development of a healthy fetus. It can significantly reduce the chance of neural tube defects (NTDs) such as Spina Bifida. If a woman has the right level of folic acid in her body before you getting pregnant and during the 1st trimester, it reduces the risk of the baby developing neural tube defects by up to 70%. Neural tube defects are problems with the brain or spinal cord, including spina bifida. Spina bifida is not common but it can cause a wide range of problems for the baby, including: problems with movement, bladder and bowel problems and learning difficulties. Most women are advised to take a 400mcg supplement every day.

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Table 21: Folic acid during pre-conception and 1st Trimester

Basic Requirement	Guidance
Eligibility	Women planning on getting pregnant and those in the 1st trimester of pregnancy
Quality assurance	Must be approved and registered by NDA
Access	Over the counter, public and private health facilities
Access: Community Health worker, Drug shop, pharmacy, health facility	Women should be provided with folic acid upon Verbal instructions and correct labeling of the carrier envelope

8.3 Iron ferrate (in 2nd & 3rd Trimester of Pregnancy)

It is estimated that more than 40% of pregnant women worldwide are anaemic. At least half of the anemia burden is assumed to be due to iron deficiency. Pregnant women require additional iron and folic acid to meet their own nutritional needs and as well as those of the developing fetus. Deficiencies in iron and folic acid during pregnancy can potentially negatively impact on the mother, her pregnancy, as well as fetal development.

Table 22: Iron ferrate in the antenatal period

Basic Requirement	Guidance
Eligibility	Pregnant Women in their 2nd and 3rd Trimester
Quality assurance	Must be approved and registered by NDA
Access	Over the counter, public and private health facilities
Self-Management	• Verbal instructions upon issuing the tablets and clear and correct labeling on the carrier envelope. • Counseling during ANC session
Self-awareness	• Through digital platforms for those that can read • Through audio and visual platforms for those that cannot read or understand instructions

8.4 Expanded Clean Delivery Kit

Clean delivery Kit known as Maama Kit in Uganda was launched in Uganda in 2003 with support from WHO and funding from The Links Inc. of United States of America in an effort by the MoH to reduce on illness and deaths of mothers associated with poor hygiene and unclean environment at delivery. The initiative had started much earlier in 1997 as a joint WHO/ MoH venture. Since then, many partners have come to support this initiative and these include UNFPA, USAID, UNICEF, Uganda Red Cross Society (URCS), Barclays Bank, MoH, etc. Quite often, mothers are required to buy the basic maternity

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necessities such as gloves, razor blades, cord ligature, syringe and needles, cotton wool, sanitary pads and soap. The absence of these items during delivery increases chances of sepsis or infection to all the baby, mother and midwives.

Table 23: Use of expanded clean delivery kit

Basic Requirement	Guidance
Eligibility	Pregnant Women
Quality assurance	Contents in the kit Must be approved and registered by NDA
Access	Over the counter, public and private health facilities
Access: Community Health worker, Drug shop, pharmacy, health facility	Verbal instructions upon issuing the kit with more focus on when and how to use misoprostol Counseling during ANC session
Self-awareness	Through digital platforms for those that can read Through audio and visual platforms for those that cannot read or understand instructions

8.5 Self-care management of heartburn using Magnesium Trisilicate

Heartburn is a burning feeling in the chest caused by stomach acid travelling up towards the throat (acid reflux**)**. It occurs in 25% -50% of all pregnant women. Heartburn usually begins in the first or second Trimester of pregnancy and continues throughout the remainder of the pregnancy. Heartburn during pregnancy is usually mild and intermittent; it can be severe in some cases. Lifestyle changes that can help relieve heartburn during pregnancy are similar to those women who are not pregnant, for example, raise the head of the bed, lie on the left side at night, avoid trigger foods that aggravate heartburn symptoms, eat frequent small meals and avoid lying down after eating. There are several types of medications used to relieve heartburn in women that include Magnesium Trisilicate.

Table 24: Self-care management of heartburn using magnesium trisilicate

Basic Requirement	Guidance
Eligibility	Pregnant Women
Quality assurance	Must be approved and registered by NDA
Access	Over the counter, public and private health facilities
Access: Drug shop, pharmacy, health facility	Verbal instructions upon issuing the tablets and on the carrier envelope.

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	Counseling on use during ANC session
Self-awareness	Through digital platforms for those that can read Through audio and visual platforms for those that cannot read or understand instructions

8.6 Self-care prevention of malaria in pregnancy using Treated Mosquito Net

Some population groups are at considerably higher risk of contracting malaria, and developing severe disease, than others. These include pregnant women, infants, and children less than 5 years of age and patients with HIV/AIDS, as well as non-immune migrants, mobile populations and travelers. Malaria in pregnancy increases the risk of maternal and fetal anaemia, stillbirth, spontaneous abortion, low birth weight and neonatal death. Infants born to mothers living in endemic areas are vulnerable to malaria from approximately 3 months of age, when immunity acquired from the mother starts to wane. The Intermittent Prophylaxis Treatment of malaria (IPT2) coverage for pregnant women in Uganda declined from 66% in FY 2018/19 to 60% in FY 2019/20.

Table 25: Self-care prevention of malaria in pregnancy using treated mosquito nets

Basic Requirement	**Guidance**
Eligibility	Pregnant Women
Quality assurance	Must be approved and registered by NDA
Access	Over the counter, public and private health facilities
Access: Drug shop, pharmacy, health facility	Verbal instructions upon issuing the mosquito net Counseling on use during ANC session
Self-awareness	Through digital platforms for those that can read Through audio and visual platforms for those that cannot read or understand instructions

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CHAPTER 9: POST ABORTION CARE

Post abortion care (PAC) is an integrated service delivery model that includes both maternal health and family planning interventions that are both curative and preventative. Curative interventions respond to the signs of complications that threaten a mother's life: hemorrhage and sepsis. Preventative interventions respond to the unmet need for family planning—a root cause of incomplete abortion—to prevent the next unintended pregnancy that may result in a repeat abortion and possibly maternal death.

Table 26: Self-care management of post abortion care

Basic Requirement	Guidance
Eligibility	Any woman who has had an abortion
Quality assurance	N/A
Pain relief tablets such as paracetamol, or ibuprofen. Please do not take aspirin as it can increase bleeding	Over the counter, public and private health facilities Here are some other things you can do to lessen the pain: • Apply a warm compress • Wear, comfortable loose clothing. • Ensure you're comfortable and relaxed at home.
Contraceptive Use	• Comprehensive FP information on available method options, side effects and how to manage the side effects when they do occur should be done. • Long-Acting Reversible methods of contraception are recommended (LARCS)
Self-awareness	Through digital platforms for those that can read Through audio and visual platforms for those that cannot read or understand instructions

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CHAPTER 10: HEALTHY AGING AND NON-COMMUNICABLE DISEASES

10.1 Self- Monitoring of Blood Glucose (SMBS)

Diabetes is a metabolic disease resulting from insulin insufficiency or ineffectiveness, due to decreased insulin secretion, or peripheral resistance to the action of insulin, or a combination of the two.

Types of diabetes:

- Type 1: decreased insulin production due to autoimmune destruction of the pancreas. Usually starts at a young age
- Type 2: insulin resistance, usually combined with insufficient production of insulin as the disease progresses. Usually starts in adulthood
- Gestational Diabetes - any degree of glucose intolerance with onset or first recognition during pregnancy.
- Secondary diabetes: due to other identifiable causes, e.g Cushing's syndrome, chronic pancreatitis, etc

Blood sugar monitoring is one of the most important and helpful tools for monitoring diabetes-especially for those who take insulin. Diabetes affects everyone differently so regular blood checks can help the patient and their provider customize the treatment plan to the patient's needs.

Why test for Blood sugar

- To track the effect of diabetes medicine on blood sugar levels
- Adjust doses of diabetes with the guidance of your treatment team/provider
- Find out if your blood sugar levels are high or low, then if needed, change treatment to treat high blood sugar or take fast acting carbohydrates to treat low blood sugar
- To track progress in reaching your treatment goals
- Learn how diet and exercise affect blood sugar levels
- Understand how other factors, such as sickness or stress, affect blood sugar levels

Table 27: Random Blood sugar test .

Basic Requirement	Guidance
Eligibility	• Age 10 -18 who are overweight; Once every three years • Age 19 and above; once every three years • Family history in first degree relatives • Delivery of big baby >4kg is a risk for gestational diabetes. • Genetic factors and environmental factors (e.g., some viral infections) for Type 1 • All pre-conception and pregnant women with pre-existing diabetes or gestations diabetes should be offered self-monitoring of blood glucose (SMBG) test kits. • Persons on insulin, persons having difficulty reaching blood glucose targets, persons having frequent low blood sugar episodes, Persons with low blood glucose levels without

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	experiencing the usual warning signs, sick persons, just had surgery
When to check blood sugar	• The health care provider will give suggestions for the best times to check for blood sugar. This will vary from person to person • Check blood sugar when you experience symptoms of low or high blood sugar
Precaution	Check with your health care provider about using a CGM (continuous Glucose monitoring if you are: • Pregnant • On dialysis • Very ill
Recommended blood targets for non-pregnant adults with diabetes	Before meals: 80 to 130 mg/dl One to two hours after beginning of the meal: Less than 180mg/dl
Monitoring Blood sugar and ketones before pregnancy	• Diabetic women planning to get pregnant need to intensify blood glucose lowering therapy and monitor blood glucose more often to include fasting levels and a mixture of pre-meal and post meal levels • Offer blood ketone testing strips and meter to women with type 1 diabetes who are planning to get pregnant and advise them to test for ketonemia if they become unwell • Agree individualized targets for self-monitoring of blood glucose with women who have diabetes and are planning a pregnancy, taking into account the risk of hypoglycemia
When to call/visit a health worker	Experiencing high or low blood sugar levels and /or symptoms frequently whether you have type 1 or type 2 diabetes Have symptoms of diabetes related keto acidosis such as Alterated consciousness/coma , Deep breathing (acidotic), Sweet, acetone smell on the breath (from ketosis), Cardiovascular collapse (hypotension)
What to ask the provider	• What's my target blood sugar range? Why is that the target for me? • How often should I check my blood? • Do you recommend using a glucose meter or a Continuous Glucose Monitor (CGM) for blood sugar monitoring? • What do different sugar level mean? • What changes should we make to my treatment plan ?
Quality assurance	The blood glucose testing kit must be approved by NDA
Access	Over the counter, public and private health facilities
Testing At Home without assistance	• Women and men who can read and understand instructions • Women and men who have done the test before
Testing At Home with inability to read or understand instructions	Directly assisted by community health worker until able to follow instructions

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Testing At Health Facility without assistance	• Women and men who can read and understand instructions • Women and men who have done the test before
Testing At Health facility with inability to read or understand instructions	Directly assisted
At Private pharmacy and drug shops	• Women and men who can read instructions can be issued with the kit for self-testing at home. • Women and men who cannot read or understand instructions be referred to a provider and directly assisted until they are able to independently test
Self-awareness	• Through digital platforms for those that can read • Through audio and visual platforms for those that cannot read or understand instructions

10.2 Self-measured Blood pressure (SMBP).

Hypertension is Persistently high resting blood pressure (>140/90 mmHg for at least two measurements five minutes apart with patient seated) on at least 2 or 3 occasions 1 week apart.

Self-measured Blood Pressure (SMBP) is when you measure your blood pressure outside of the doctor's office or other health care settings. Self-measured BP monitoring is a validated approach to measure out of office BP and is recognized to be part of hypertension diagnosis and treatment. Blood Pressure self-monitoring can either be used to replace BP measurements on the day of a scheduled clinic (i.e. intermittently) or can be done routinely and more frequently (e.g. one to three times per week) in addition to usual care. For women with chronic hypertension, gestational hypertension or pre- eclampsia, more frequent BP monitoring is required, over and above standard antenatal care. Other groups of people may also require increased frequency if they have additional risk factors. The aim of BP self-monitoring is to reduce face to face consultations while maintaining a level of safety.

Table 28: ***Self-measured Blood pressure (SMBP).***

Basic Requirement	Guidance
Eligibility	• 18-39 years. Self-measure BP at least once every three to five years unless they fall into the high-risk category • 40 years and above. Self-measure BP at least once a year unless they fall in the high-risk category • Risk Family history of hypertension, • Obese people • physically inactivity people • people to take excessive of salt and alcohol, • Diabetes patients • Dyslipidemia patients • All normotensive pregnant women as part of standard antenatal care

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	• Normotensive women that have one of the following risk factors of pregnancy hypertension: hypertensive disease during a previous pregnancy • chronic kidney disease • autoimmune disease (e.g. systemic lupus erythematosus or antiphospholipid syndrome) • type 1 or type 2 diabetes Women with two of the following risk factors: • first pregnancy • age 40 years or older • pregnancy interval of more than 10 years • body mass index (BMI) of 35 kg/m2 or more family history of pre-eclampsia • multi-fetal pregnancy
Exclusion criteria	BP self monitoring should not be offered or continued for patients who require admission (e.g. severe hypertension, pre-eclampsia with adverse features)
Support for home blood pressure monitoring at health facility	• Arrange for a patientto attend face to face during hospital visits and check eligibility for self-monitoring of blood pressure. A health provider may choose to make alternative arrangements to provide a blood pressure monitor and information (e.g. by arranging remote pick-up). The patients may already own their own validated monitor (which can be used). • Ensure that patient'ss contact details are up to date on DHIS (home, mobile phone number, email) and update these as necessary. • Provide a patientwith a semi-automated or automated home blood pressure monitor that is validated. and an appropriately sized cuff (check upper arm measurement). Label the blood pressure monitor with name of the health facility, and appropriate contact detailsfor the health facility. Complete a blood pressure monitor form with the patient • Give written instructions on how to take a blood pressure reading (attached document: *How to take your blood pressure at home*). Ask the patientto take her blood pressure twice, at least one minute apart and write the second blood pressure down, or send the second reading via a text message or smart phone app. • Give written instructions on expected frequency of blood pressure monitoring, making it clear whether this will be done in place of usual care (e.g. on the morning of a scheduled telephone/ virtual clinic appointment) or in addition to usual care (e.g. once a week or three times a week). • Give written instructions (rainbow coloured chart) about self-monitoring of blood pressure, and check that the patient understands who to contact with an abnormal reading. • If the patient requires additional investigations (e.g. growth scan, PlGF-based testing), arrange these as indicated. If the patientis asked to self-monitor urine for proteinuria, arrange this.

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Technique and device delivery	• Use upper arm self-measured BP monitoring devices and appropriately sized cuffs • Use devices that store readings or get a log where to input the results Take two measurements 1 min apart in the morning and two measurements 1 minute apart in the evening for seven days.
Follow these steps for an accurate blood pressure measurement	Prepare: • Avoid caffeine, smoking and exercise for 30 minutes before measuring your blood pressure. • Wait at least 30 minutes after a meal. • If you're on blood pressure medication, measure your BP before you take your medication. • Empty your bladder beforehand. • Find a quiet space where you can sit comfortably without distraction Position: • Keep your back supported • Keep feet flat on the floor • Sit with legs uncrossed • Keep arm supported, palm up, with muscles relaxed • Position arm so cuff is at heart level • Put cuff on bare arm, above elbow at mid arm Measure: • Rest for five minutes while in position before starting. • Take two or three measurements, one minute apart, twice daily for seven days. • Keep your body relaxed and in position during measurements. • Sit quietly with no distractions during measurements—avoid conversations, TV, phones and other devices. • Record your measurements when finished. • An average self-measured BP of more than 135/85mm Hg is a threshold that defines high BP which corresponds to mean office BP level of 140/90mm Hg
Quality assurance	• Use an SMBP device and blood pressure cuff that are recommended by your doctor or care team. • If you purchase your own device, ask your care team to check it for accuracy. • Understand the correct way to take a blood pressure reading. • Know when and how you will share your blood pressure readings with your doctor. • Make sure you have instructions from your care team on what to do if your blood pressure is out of the expected range. • Provision of validated blood pressure measuring machine by NDA and validated at the health facility where health facility measured BP is compared to validated machine for the patient.

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Device use self-efficacy	• The health worker should ensure to support the patientto be able to use the device properly and be able to record the blood pressure. • Efforts should be made to check the device self-efficacy of the self carer by the health worker to ensure that the blood pressure measurement protocol is properly followed for valid results

10.3 Self-monitoring of blood coagulation

1. Point of care coagulometers are designed to monitor the clotting tendency of blood in people on long term vitamin K antagonist therapy in the form of International Normalized Ratio (INR).
2. Self-testing refers to the patient doing the INR test themselves and then contacting their healthcare professional with the reading for advice on any change of the dose of the anticoagulant that may be needed. Self- managing refers to the patient doing the test and self-adjusting the dosage of the anticoagulant according to an agreed protocol.
3. The use of coagulometers may reduce the frequency of visits to the clinics for patients and enable them to be monitored more regularly, which may lead to improved health outcomes and avoidance of adverse effects.

The specific blood test used to measure the time it takes for blood to clot is called a prothrombin time test, or protime (PT). The PT is reported as the International Normalized Ratio (INR). The INR is a calculation based on results of a PT test and is used to monitor individuals who are being treated with the anticoagulation medication warfarin.

Careful and routine INR testing helps physicians monitor and, as needed, adjust a patient's warfarin dosage – either up or down – to ensure that a patient is optimally protected from both blood clots and dangerous bleeding. Medication adjustments usually result in additional blood tests to check a patient's INR and ensure effectiveness and safety.

Potential Benefits of INR Self-Testing?

While INR levels can be monitored effectively and safely through traditional in-office testing, there are several advantages associated with INR testing at home. While self-testing may not be suitable for every patient, there are several patients for whom it may be beneficial, including:

Patients who have demonstrated compliance with previous anticoagulation management.

Patients who have the physical ability to perform testing or have a committed caregiver who is willing to assist in testing.

Patients who have a healthcare provider who approves patient use of a POC device.

Patients who agree, with their healthcare providers, upon a method of communication for discussing delivery of results and medication adjustments.

Table 29: Self-monitoring of blood coagulation

Basic Requirement	Guidance
Eligibility	• You are on long-term warfarin anticoagulation therapy.

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	• You have a good line of communication with your doctor or healthcare providers and follow your doctor's instructions and treatment plans successfully. • You have a good personal support network at home. • You may benefit from the convenience of self-testing, because, for example, you presently do not drive, you have to rely on someone else or a caregiver for transportation, you have a schedule that does not easily accommodate routine or frequent travel for blood tests. • You are interested in testing your INR more frequently for an added layer of confidence, because, for example, you have a history of fluctuating INRs, you are starting on another new medication, you have changed your diet recently, or you have another illness. • You enjoy or frequently travel and self-testing will allow for easier travel, especially to other states or countries, where patients may not know what service providers are available to them or where there may be language barriers. • You dislike or are afraid of needles or have a difficult time producing blood from a vein draw. Patient prescribed warfarin must have their blood monitored frequently – at least once a month and sometimes as frequently as twice weekly – to confirm that the dose of warfarin prescribed is in a safe and effective range.
Exclusion criteria	• You have the clotting condition antiphospholipid syndrome, which may interfere with self-testing INR results. • You are anemic, which can disrupt or cause INR test results to fluctuate frequently. • You are not physically able to perform the test at home. For example, a diagnosis of arthritis might make it difficult to hold the test strips and get an accurate reading. • You are apprehensive about self-testing, do not understand how it works, or might not be able to follow through with doctor recommendations and instructions. • You are not able to access the equipment through your insurance provider or you are not able to afford the cost of the equipment. • You have alcohol or recreational drug issues.
Quality assurance	INR values obtained with the finger stick home testing devices typically correlate well and are able to be replicated with INR results that are determined from venous blood draws, making them reliable. It is important to note that POC instruments are unreliable in about one-third of patients who take warfarin and who are also affected by the clotting disorder antiphospholipid antibody syndrome (APLS or APS). In these patients, the POC devices give INR readings that are too high, or the instruments can report an error message. If you have APS, your INR levels should be checked via a vein draw in a laboratory setting and compared with a POC reading from a finger stick. Only if both

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	values correlate, may it be acceptable for APS patients to use a POC device. APS patients should discuss their testing options with their healthcare providers.
Choice of testing device	• The advice or recommendation of your physician or anticoagulation clinic, based on their experience and knowledge • The experience of other patients and their satisfaction with their home monitoring device and the educational and support services provided to them by the manufacturer and/or distributor • The amount of blood needed for the test strip • Ease of use associated with operating the instrument or testing device • Weight of the instrument may matter to you, especially if you travel frequently.

10.4 Self-care for Mental Health

Mental health is a state of mental well-being that enables us to cope with the stresses of life, achieve our capacities, learn, and work well and contribute to our community. It is an essential part of our health and well-being, Mental health also supports our ability to make decisions, establish relationships and participate in decision making about things that matter to use. Mental health includes emotional, psychological, and social well-being

Guidance on how:

Table 30: Mental Health self-care

Basic Requirement	Guidance
Eligibility	• Adolescents and young persons • Adults and elderly • Those with disabilities, with chronic illnesses, grieving, those with economic hardships, SGBV
Create self-awareness on healthy living	• Get regular exercise. • Eat healthy, regular meals and stay hydrated. • Make sleep a priority. • Try a relaxing activity. • Set goals and priorities. • Practice gratitude. • Focus on positivity. • Stay connected.
When to seek professional care	Seek professional help if you are experiencing severe or distressing symptoms that have lasted 2 weeks or more, such as: • Difficulty sleeping • Changes in appetite or unplanned weight changes • Difficulty getting out of bed in the morning because of mood

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	• Difficulty concentrating • Loss of interest in things you usually find enjoyable • Inability to complete usual tasks and activities • Feelings of irritability, frustration, or restlessness
Promoting social and emotional wellbeing	• Coping with stress • Social connectedness • Isolation and older adult health • Promoting healthy schools • Promoting cultural connectedness • Workplace health promotion
Stress reduction/prevention using self-care	• Take control • Prioritize certain tasks that will make a real difference and accept that we cannot do everything. • Try to be positive at the end of each day think about the things we are grateful for. • Accept the things we cannot change: Try to concentrate on the things we do have control over. E.g., if we have a chronic disease that cannot be cured, think of all the things we can do to prevent our disease from getting worse. **Five tips to help reduce our stress:** 1. Connect with other people 2. Be physically active 3. Learn new skills 4. Give to others 5. Pay attention to the present moment (mindfulness).
Self-care can help us cope if we are feeling depressed	• **Keep a daily routine.** When we feel down, we may experience sleep problems. Not having a good sleep routine can also affect our eating. Try to keep to a regular sleep routine and eat regular meals during the day. This will contribute to an increased feeling of wellbeing. • **Face your fears.** Don't avoid the things we find difficult. When we feel low or anxious, we sometimes avoid talking to family and friends. Sometimes we can lose our confidence in going out, driving or travelling. If this starts to happen facing up to these situations will help them become easier to manage. • **Stay in touch.** Don't withdraw from life. Socialising can improve our mood. Keeping in touch with friends and family means we have someone to talk to when we feel low. • **Considering joining a support group.** Sharing our experiences and concerns with other people who suffer with depression can be very helpful. • **Avoid drinking alcohol** for some of us, alcohol can become a problem. We may drink more than usual as a way of coping with or hiding our emotions. But alcohol won't solve our problems and can make us feel more depressed. • **Stay active.** Take up or continue physical exercise. There's evidence that exercise can help lift your mood. If you haven't exercised for a while, start gently

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	by walking for 20 minutes every day. Invite friends or family members to join you.
Guidance on using self-care to help reduce anxiety, fear and panic:	• Find someone we can talk to about our feelings such as a friend, family member, a health care provider or a counsellor. • Set small targets that we can easily achieve. Do not try to do everything at once. • Focus our time and energy on helping ourselves to feel better. Do not focus on the things we cannot change. • Try calming breathing exercise, listening to calming music or practicing meditation. • Do activities that we enjoy and help us relax such as walking, swimming and yoga. • Learn how we can improve our sleep. • Eat a healthy diet. Have meals with friends and family whenever possible. • Consider peer support, meet people experiencing similar issues so that we can provide mutual support to each other. • Seek advice from our health care provider about available services in our area. • Try not to use alcohol, cigarettes, gambling or recreational drugs to reduce our anxiety. They may provide temporary relief but can contribute to poor mental health

10.5 Healthy aging and self-care

Healthy ageing is influenced by ones physical and mental abilities and the environment in which the live, and how these areas of life interact. Many factors influence healthy ageing as shown below. Some factors are beyond one's control such as genetic factors but there are many others such as lifestyle choices that one can have more control over. Maintaining/ adopting and sustaining healthy lifestyle makes an important contribution towards one's health and wellbeing.

Table 31: Factors that influence health ageing

Individual factors	Environmental
Age related conditions	Policy implementation
Chronic diseases	Housing
Lifestyle practices	Transport
Genetics	Social connections
	Income insecurity
	Health and care services
	Assertive technology
	Ageism

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Table 32: Self-care guidance on health ageing

Basic Requirement	Guidance
Eligibility for health aging	Right from inception to adulthood. Different behaviors and exposures during conception through adolescent and youth influence quality of aging
Self-care actions that can be taken to achieve a healthy lifestyle	• Stay active, take regular physical activity. • Eat a healthy diet and stay hydrated. • Get a goodnight sleep. • Reduce and manage stress. • Maintain an active brain. • Quit smoking. • Avoid harmful use of alcohol. • Receive an annual health check and be fully vaccinated
Self-monitoring of one's health at home	• Reflect on your current health status. What is going well? What lifestyle practices would benefit from improvement? Use the healthy lifestyle checklist in the section below as a reflection guide. • Select one or two healthy lifestyle choices that are important to you. • Make specific goals e.g., eat a serving of vegetables every day. • It is helpful if you work with a group of peers to improve healthy lifestyle choices. Individuals can encourage and motivate each other. • Identify a friend who can support and encourage you. • Make it a weekly practice to review and share your progress with your self-care support person/s. • Do not become disheartened if you are unable to achieve your goals as fast as we planned. The most important thing is we stay committed to making positive changes and continue to work towards our goals. Celebrate our achievements. • If we do not have a blood pressure measuring machine, weighing scales or other equipment, find out what is available in our community. Community volunteers may be able to help us. • If we have an internet connection and an android phone, we can find free health monitoring apps on Google Play Store. If this is not available to us record our healthy lifestyle plan in a booklet. Add useful numbers for health and care services, contact people etc.
Self-care guidance for addressing ageism (Ageism is having unfair and untrue beliefs about people or discriminating against people based on their age)	• Strengthen intergenerational bonds • Push back on ageist attitudes or actions • Defy the unfair and untrue beliefs about older people • Focus on the positive • Manage stress • Learn how to deal with discrimination at work age

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self-care for bladder and bowel problems	• If we frequently need to get up to the toilet at night try drinking less in the few hours before we go to sleep. • Cut down on tea, coffee and fizzy drink; also, alcoholic drinks or drinks with artificial sweeteners as they may irritate our bladder and make it more active. • Stopping smoking decreases our risk of bladder cancer, and reduces coughing, which can put pressure on our pelvic floor muscles. • Maintain a healthy weight. Being overweight puts pressure on and can weaken our pelvic floor muscles. • Avoid constipation by eating plenty of fibre-rich foods and making sure we are drinking plenty of liquid. • Keeping as active and mobile as we age will help keep our bowel healthy. • Ask our health care provider if any medicines we are taking could be disturbing our bladder.
A healthy diet is self-care	**A healthy diet includes:** • Plenty of fruits and vegetables (protective foods) • A portion of protein foods (muscle building foods) • A portion of carbohydrates (energy foods) • Low in salt (sodium chloride). • Limited amount of unhealthy fatty oils (saturated fats) and Processed fat. • Limit amount of ultra-processed package foods, fast foods and sweetened carbonated drinks. • Limited amounts of free sugars (e.g., sugar, honey added to tea, coffee, or adding sugar to foods we cook). • Low in red meat and pork. Getting enough vitamins and minerals from our diet, remains important as we age. Vitamins and mineral that are especially important as we age. • CALCIUM • Vit D • Potassium In addition, fibre is a vital part of a healthy diet and is very good for us especially as we age. Water is also essential for a healthy digestive system. Tiredness and lack of coordination caused by dehydration can increase our risk for falls and injury. Staying hydrated is very important as we age. Prevent dehydration by drinking more water throughout the day. Generally, we need to have approximately 1.5 litres of fluid per day (8- 10 glasses) throughout the day.

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Table 33: Checklist on life style choices

Use this checklist to reflect on your lifestyle choices					
#	**Healthy behavior**	**Question**	**Response**		**What action will I take?**
			Yes	No	
1	Stay active	Do I take at least 30- 60 minutes of light or moderate exercise a day, or 15- 30 minutes of more vigorous exercise?			
2	Eat well	Do I eat a portion of protein foods at each meal?			
		Do I eat 5 or more servings of vegetables or fruit every day?			
		Do I restrict my daily intake of salt to not more than one teaspoon?			
		Do I restrict my intake of sugar to no more than the equivalent of 6 teaspoons of sugar per day?			
		Do I drink at 6- 8 glasses of water/ other liquids per day?			
		Do I restrict my daily intake of oil to no more than 6 teaspoons of healthy oil in my food?			
3	Sleep well	Do I have a good sleep routine?			
4	Reduce and manage stress	Do I stay in touch with family and friends?			
		Do I make time to do things that I enjoy?			
5	Maintain your brain	Do I continue to try to learn new things?			
		Do I participate in community activities and decisions about issues that matter to me?			
		Do I participate in social group activities?			
6	Quit smoking	Do I smoke?			
		Do I chew tobacco?			
7	Avoid harmful use of alcohol	Do I drink too much alcohol?			
8	Medications	Do I take my medication correctly?			
9	Healthy check/vaccinations'	Did I have an annual health check?			
		Am I up to date on my vaccines?			
Older adults need the same amount of sleep as all adults 7 to 9 hours each night. Getting enough sleep keeps us healthy and alert. Adequate sleep can also help reduce our risk of falls, improve our overall mental well-being, and has many other benefits.					

Table 34: Physical exercise guidelines

Light-moderate exercises (30-60 minutes per day)	**Intense exercises (15-30 minutes per day)**	Plus **Muscle strengthening and balance exercise (at least twice a week)**
Example: Fast walking, Swimming, Gentle cycling, dancing, Yoga	**Example:** Heavy physical work, Jogging/running, jumping rope, fast cycling, running upstairs, all kinds of team sport	**Example:** Push-ups/ squats, standing up from sitting, lifting weights, climbing stairs, heavy gardening, using resistance bands, hill climbing
Tip to assess your level of physical activity.		

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When you're active, try talking:

- If your breathing hard but can still have a conversation easily, its moderate intensity activity
- If you can only say a few words before you need to take a breath, it's vigorous intensity activity

REMEMBER Be sure to drink water if you are doing any activity that makes you sweat. Always keep water close by during exercise

Table 35: Recommended vaccinations for healthy ageing

#	Vaccine Have I received the full course of?	Schedule	Update to date	
			Yes	NO
1	Covid 19 vaccine?	2 primary doses, then a booster dose according to the vaccination guideline in your country. For older people we are included in high priority groups as we are more vulnerable to Covid infection. It is recommended we receive an annual booster dose of vaccine, 12 months after our previous dose. For older people who have a chronic health condition it is recommended to have a booster dose 6 months after the previous dose		
2	Annual flu vaccine	I dose every year		
3	Pneumonia vaccine? Pneumococcal pneumonia	Depends on the type of vaccine given, you may only need to receive one dose or 2 doses with the 2nd dose given 12 months after the 1st dose.		
4	Shingles vaccine	Two doses of vaccine. The 2nd dose given within 2 to 6 months after the 1st dose		

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Annex A: SUMMARY OF WHO RECOMMENDATIONS FOR SELF-CARE INTERVENTIONS.

Interventions	Recommendations and key considerations
Improving antenatal, intrapartum and postnatal care	
Non-clinical interventions targeted at women to reduce caesarean sections	
Recommendation 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)*
Recommendation 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)*
Recommendation 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). *(Low to moderate certainty evidence)*
Recommendation 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. *(Low to moderate certainty evidence)*
Recommendation 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). *(Low to moderate certainty evidence)*
Self-administered interventions for common physiological symptoms	
Recommendation 2	When considering the educational interventions and support programmes, no specific format (e.g. pamphlet, videos, role play education) is recommended as more effective.
Interventions for nausea and vomiting	

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Recommendation 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
Interventions for heartburn	
Recommendation 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.
Interventions for leg cramps	
Recommendation 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.
Interventions for low back and pelvic pain	
Recommendation 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.
Interventions for constipation	
Recommendation 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.
Interventions for varicose veins and oedema	
Recommendation 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
Self-administered pain relief for prevention of delay in the first stage of labour	
Recommendation 9	Pain relief for preventing delay and reducing the use of augmentation in labour is not recommended. *(Conditional recommendation; very low certainty evidence)*
Iron and folic acid supplements	
Recommendation 10a (new)	WHO recommends making the self-management of folic acid supplements available as an additional option to health worker-led provision of folic acid supplements for individuals who are planning pregnancy within the next three months. *(Strong recommendation; very low certainty evidence)*
Recommendation 10b (new)	WHO recommends making the self-management of iron and folic acid supplements available as an additional option to health worker-led provision of folic acid supplements for individuals during pregnancy. *(Strong recommendation; very low certainty evidence)*

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Recommendation 10c (new)	WHO recommends making the self-management of iron and folic acid supplements available as an additional option to health worker-led provision of iron and folic acid supplements for individuals during the postnatal period. *(Strong recommendation; very low certainty evidence)*
Self-monitoring of blood pressure during pregnancy	
Recommendation 11 (new)	WHO suggests making the self-monitoring of blood pressure during pregnancy available as an additional option to clinic blood pressure monitoring by health workers during antenatal contacts only, for individuals with hypertensive disorders of pregnancy. *(Conditional recommendation; very low certainty evidence)*
Self-monitoring of blood glucose during pregnancy	
Recommendation 12 (new)	WHO recommends making self-monitoring of glucose during pregnancy available as an additional option to clinic blood glucose monitoring by health workers during antenatal contacts, for individuals diagnosed with gestational diabetes. *(Strong recommendation; very low certainty evidence)*
Women-held case notes to improve the utilization and quality of antenatal care	
Recommendation 13	WHO recommends that each pregnant woman carries their own case notes during pregnancy to improve the continuity and quality of care and their pregnancy experience
Providing high-quality services for family planning, including infertility services	
Self-administration of injectable contraception	
Recommendation 14	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)*
Recommendation 15	Over-the-counter oral contraceptive pills (OCPs) should be made available without a prescription for individuals using OCPs. *(Strong recommendation; very low certainty evidence)*
Over-the-counter availability of emergency contraception	
Recommendation 16 (new)	WHO recommends making over-the-counter emergency contraceptive pills available without a prescription to individuals who wish to use emergency contraception. *(Strong recommendation; moderate certainty evidence)*
Self-screening with ovulation predictor kits for fertility regulation	

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Recommendation 17	Home-based ovulation predictor kits should be made available as an additional approach to fertility management for individuals attempting to become pregnant. *(Strong recommendation; low certainty evidence)*
Condom use	
Recommendation 18	The 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.
Recommendation 19	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 certainty evidence)*
Recommendation 20a	Provide up to one year's supply of pills, depending on the woman's preference and anticipated use.
Recommendation 20b	Programmes must balance the desirability of giving women maximum access to pills with concerns regarding contraceptive supply and logistics.
Recommendation 20c	The resupply system should be flexible, so that the woman can obtain pills easily in the amount and at the time she requires them.
Pregnancy self-testing	
Recommendation 21 (new)	WHO recommends making self-testing for pregnancy available as an additional option to health worker-led testing for pregnancy, for individuals seeking pregnancy testing. *(Strong recommendation; very low certainty evidence)*
Eliminating unsafe abortion	
Self-management of the medical abortion process in the first trimester	
Recommendation 22	Self-assessing eligibility for medical abortion is recommended within the context of rigorous research.
Recommendation 23	Managing the mifepristone and misoprostol medication without the direct supervision of a health worker is recommended in specific circumstances. We recommend this option in circumstances where women have a source of accurate information and access to a health worker should they need or want it at any

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Recommendation 24	Self-assessing the 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 worker should they need or want it at any stage of the process.
Post-abortion hormonal contraception initiation	
Recommendation 25	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 worker are strong, and where monitoring and follow-up can be ensured.
Recommendation 26	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.
Combating sexually transmitted infections (including HIV), reproductive tract infections, cervical cancer and other gynaecological morbidities	
Human papillomavirus (HPV) self-sampling	
Recommendation 27	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)*
Self-collection of samples for STI testing	
Recommendation 28	Self-collection of samples for *Neisseria gonorrhoeae* and *Chlamydia trachomatis* should be made available as an additional approach to deliver STI testing services. *(Strong recommendation; moderate certainty evidence)*
Recommendation 29	Self-collection of samples for *Treponema pallidum* (syphilis) and *Trichomonas vaginalis* may be considered as an additional approach to deliver STI testing services. *(Conditional recommendation; low certainty evidence)*
HIV self-testing	
Recommendation 30	HIV self-testing should be offered as an additional approach to HIV testing services. *(Strong recommendation; moderate certainty evidence)*
Self-efficacy and empowerment for women living with HIV	

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Recommendation 31	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 certainty evidence)*
Promoting sexual health	
Lubricant use for sexual health	
Recommendation 32 (new)	WHO recommends making lubricants available for optional use during sexual activity, among sexually active individuals. *(Strong recommendation; moderate certainty evidence)*
Noncommunicable diseases, including cardiovascular disease and diabetes	
Cardiovascular disease	
Self-measurement to monitor blood pressure	
Recommendation 33	Self-measurement to monitor blood pressure is recommended for the management of hypertension in appropriate patients where the affordability of the technology has been established. *(Strong recommendation; low certainty evidence)*
Self-monitoring of blood coagulation	
Recommendation 34	Self-monitoring of blood coagulation is recommended for appropriate patients treated with oral anticoagulation agents, where the affordability of the technology has been established. *(Weak recommendation; moderate certainty evidence)*
Recommendation 35	Self-monitoring of blood coagulation and self-augmentation of dosage in patients receiving oral anticoagulation agents is recommended if affordable, and according to an agreed action plan with a health professional. *(Conditional recommendation; moderate certainty evidence)*
Diabetes	
Self-monitoring of blood glucose	
Recommendation 36	The use of self-monitoring of blood glucose in the management of patients with type 2 diabetes not on insulin is not recommended at the present time because there is insufficient evidence to support such a recommendation. *(Conditional recommendation; moderate certainty evidence)*
Recommendation 37	People with type 1 and type 2 diabetes on insulin should be offered self-monitoring of blood glucose based on individual clinical need. *(Conditional recommendation; low certainty evidence)*

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Annex B: Self-Care Expert Group Terms of Reference

TERMS OF REFERENCE FOR THE NATIONAL SELF-CARE EXPERT GROUP (SCEG)

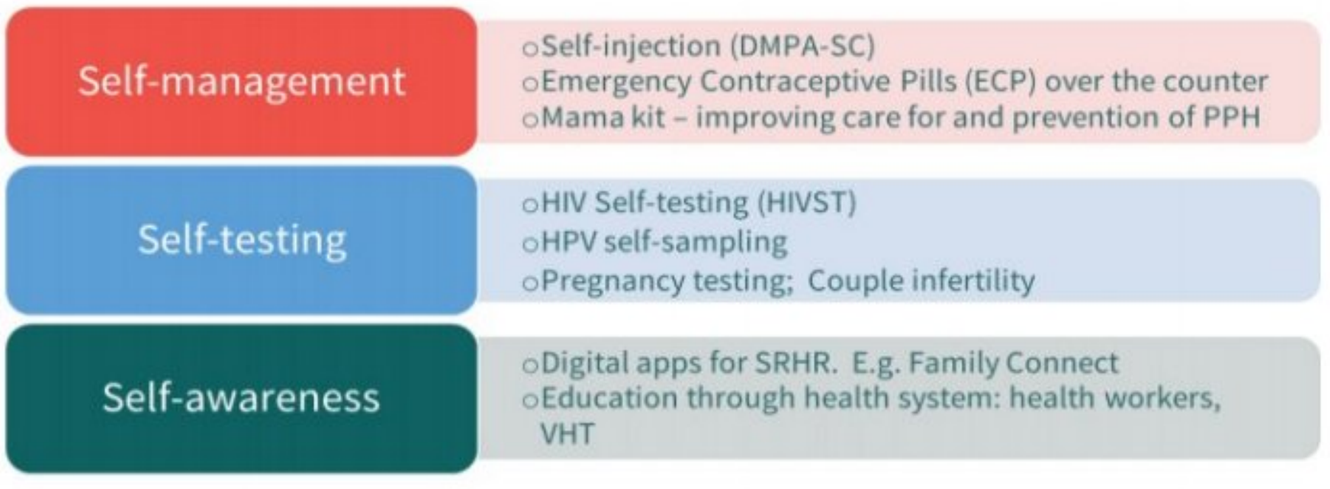
BACKGROUND

Self-care, while not new, is becoming firmly embedded within the larger global health and development agenda with increasing relevance for health systems. Self-care interventions, particularly in the realm of Sexual and Reproductive Health and Rights (SRHR)[18], have transformative potential to increase individuals' autonomy in making decisions about their own care, strengthen countries' health systems, and ultimately pave the way toward universal health coverage (UHC).

The World Health Organisation defines self-care as the ability of individuals, families and communities to promote health, prevent disease, maintain health, and to cope with illness and disability with or without the support of a health-care provider[19]. In 2019, the World Health Organization (WHO) developed and launched the Consolidated Guideline on Self-Care Interventions in Health for Sexual and Reproductive Health and Rights[20], which seeks to facilitate coordination of self-care interventions and call for adoption of national policies to usher in the transformative era.

DEFINING SELF-CARE IN UGANDA

The Ministry of Health and partners in Uganda have successfully rolled out several individual self-care interventions for SRH including; HIV self-testing, oral PrEP for HIV prevention, self-administered injectable and emergency contraception, pregnancy self-testing, condoms and self-awareness.



As more self-care products and technology are introduced in the SRHR space and others scaled up, well guided and coordinated implementation is critical and the operational environment needs to be attuned to facilitate advancement of interventions.

PROCESS AND PROGRESS

The Ministry of Health has embraced the WHO Consolidated Guideline for Self-Care Interventions in Health for Sexual and Reproductive Health and Rights (2019) and is in the process of upscaling the interventions therein. The MOH, WHO, and key development partners have been convening over the past 1 year. The three critical outcomes of the initial discourse included: a) Establishing a national multisectoral self-care expert group (SCEG) April 2020, b) Contracting a Consultant to lead a scoping study on self-care in

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[18] WHO, June 2019. Consolidated Guideline on Self-Care Interventions for Health

[19] WHO, June 2019. Consolidated Guideline on Self-Care Interventions for Health

[20] Consolidated Guideline on Self-Care Interventions in Health for Sexual and Reproductive Health and Rights; World Health Organization, Human Reproduction Program, 2019.

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Uganda with a Costed implementation plan developed by May 2020 (then), and c) WHO was to provide technical support on rolling out and testing the WHO implementation guidance along a Country -specific Self Care Work plan effective June 2020.

ROLES OF THE SCEG

Purpose: Accelerate the adoption of the WHO National guideline on self-care interventions for SRHR with country-specific costed implementation framework for scalable SRHR self-care interventions and innovations.

Objectives of the SCEG

1. To bring together experts to advise the Ministry of Health on SRHR self-care implementation
2. To guide the development of the guideline and costed implementation framework for SRHR self-care
3. To coordinate stakeholders in the implementation of SRHR self-care
4. To promote SRHR self-care policy change
5. To mobilize resources for implementation of SRHR self-care

Convener: The Director Clinical Services, supported by Commissioner Maternal and Child Health and / or the Commissioner Reproductive Health division (*The convener holds the responsibility of mobilizing the SCEG members and providing strategic leadership to ensure achievement of the purpose of the group)*

Co-Chair: Commissioner Reproductive Health division and / or Commissioner Adolescent and School Health or as appointed by the convenor.
(The co-chairs' role is to host the SCEG engagements and guide the discussions during SCEG meetings)

Secretariat: PSI Uganda with support from World Health Organization
(The secretariat provides technical support to the SCEG and May also hold the responsibility to maintaining records of the SCEG engagements

Meeting frequency & Term: Regular monthly meetings (unless otherwise).
Financial and coordination support: Anticipated to be provided by PSI Uganda through DISC/CIFF and interested partners. Support is dependent on receipt of donor funding. Individual *SCEG* members may be asked to assist in guiding specific efforts

Communication: The SCEG will share minutes for actions within the group, within the technical working groups and other stakeholders appropriately.

Membership: The *SCEG* will consist of organizations and where necessary, co-opt members

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Terms of membership: Up to twenty-five (25) members will be nominated to participate in the SCEG for two years, renewable. The *SCEG* will comprise representatives from the following entities;

1. The Ministry of Health (R&I division, ADH&SH division, pharmacy department, Nursing department, DHO and ADHO representatives)
2. H6 Development Partners representation (WHO, UNICEF, UNFPA, USAID)
3. Non-government organizations - PSI, FHI360, PATH, WRA, Planned Parenthood Global, Samasha, Living Goods, Marie Stopes Uganda, Reproductive Health Uganda, USAID FPA, CHAI, Mild May, youth organizations (RAHU, PHAU, UYAFPAH, TEGEM)
4. Academia – Makerere School of Public Health
5. ***Pool of members to be co-opted as may be needed:*** Ministry of Health Planning department, NMS, JMS, NDA, CPHL, ACP
6. Other Government line ministries – Ministry of Gender Labour and Social Development (MoGLSD), Ministry of Education and Sports (MoES), Uniformed Services – Military, Police, Prisons, ICT ministry
7. Religious and cultural leaders

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