

# Considerations for social accountability in the expansion of self-care for sexual and reproductive health and rights

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## Introduction

Self-care's integral role in health systems and in delivering rights-based sexual and reproductive health and rights (SRHR) has, at long last, been accepted and endorsed with the launch of the World Health Organization (WHO)'s consolidated guideline on self-care interventions for SRHR.<sup>1,2</sup> With major disruptions to sexual and reproductive health (SRH) services brought about by the COVID-19 pandemic,<sup>3</sup> self-care has gained traction as an important alternative in cases where the usual health facility- or health worker-based services are no longer accessible or safe. Self-care has now been recognised as an essential part of the SRH service package when physical distancing measures make it difficult for people to access essential information and services.<sup>4</sup> Yet this is happening in a context where COVID-19-related measures have severely limited the health systems' and local authorities' ability to ensure access as a result of restrictive emergency laws and protocols that limited movement, disrupted supply chains and affected clinic access.<sup>3</sup> In this commentary, we outline some emerging considerations for social accountability for SRHR in the rapid shift towards self-care.

## Background

Strengthening accountability is critical to improving health services coverage and quality.<sup>5</sup> Accountability encompasses both answerability and enforceability for discharging legally

obligated services and responsibilities between citizens and public sector duty-bearers that are central to ensuring human rights.<sup>6,7</sup> Accountability in the health system encompasses many inter-related accountability relationships, particularly those between citizens and the state and those within the state.<sup>7</sup> Many such accountability relationships have been noted in SRHR.<sup>8,9</sup>

There is growing interest in social accountability as part of efforts to strengthen health governance. Social accountability initiatives are described as citizens' collective efforts to engage public institutions for accountability in the provision of public goods.<sup>10</sup> Social accountability goes beyond participatory community approaches that focus on sharing health information and generating demand for services, to encourage those health users to collectively demand state obligated services and provoke answerability by those responsible. Social accountability initiatives have shown much promise in locating and addressing inefficiencies and corruption and improving resource allocation, the cost-effectiveness of interventions, how the public sector fulfils its obligations, improved healthcare provider behaviour and reduced inequity in accessing health services.<sup>7,11,12</sup> There is increasing evidence of the impact of social accountability on service-related outcomes, including improved service provision (such as availability of supplies), healthcare provider behaviour, funding disbursements, and health knowledge.<sup>13–15</sup> Governance, empowerment, participation, and the responsiveness of healthcare providers and officials are also notable outcomes related to human rights protection and gender considerations.<sup>16–18</sup>

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Yet ensuring accountability, particularly social accountability, has been curtailed during the COVID-19 pandemic. Schaaf et al<sup>3</sup> found that many of the critical elements for fostering accountability have been compromised during the COVID-19 pandemic. For instance, there are “practical limitations on the freedom of association and collective action, making it more difficult for citizens to demand accountability” which can be further compromised by changing standards of care to which people are entitled. Schaaf et al<sup>3</sup> argue that “Promoting accountability is even more urgent, as SRHR health and rights concerns grow more acute in crisis circumstances, and modes of governance and oversight practices are relaxed in the name of emergency response.”

Within this context, self-care has been widely endorsed and rolled out as a response to the pandemic.<sup>19</sup> Self-care is defined 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 healthcare provider”.<sup>20</sup> This includes self-management, self-testing, and self-awareness.<sup>20</sup> Some examples of self-care interventions for SRHR include self-administration of contraceptive injection of subcutaneous depot medroxyprogesterone acetate self-test (DMPA-SC), emergency contraception, home pregnancy testing and self-managed medical abortion.<sup>21</sup>

Like other fields of health, SRH care has traditionally been delivered through trained staff at primary, secondary and tertiary facilities and outreach services. Constraints within the health system, such as shortages of health workers and medical supplies, have highlighted the need for diversifying health care delivery through expanding task-sharing and self-care to improve service coverage. Self-care, it is argued, can lead to “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 healthcare resources and services”.<sup>22</sup>

Self-care is not new and has existed since time immemorial, but self-care interventions only recently gained increased legitimacy as part of the health system.<sup>23</sup> In June 2019, WHO launched a consolidated guideline on self-care interventions for SRHR. The purpose of the guideline is to support individuals, communities and countries with quality health services and self-care interventions as part of primary health care

and essential service packages.<sup>22</sup> As a formal part of the health system, self-care interventions are acknowledged as a human right and therefore the State is obligated to ensure their safety, efficacy, effectiveness and availability just like other health interventions.<sup>24</sup>

### ***Thinking through the implications of self-care for social accountability for SRHR***

According to the WHO,<sup>22</sup> self-care interventions are among the most promising approaches to improve health and well-being, both from a health systems perspective and for people who might use these interventions. The COVID-19 pandemic has accelerated the widespread acceptance of self-care as part of universal health care. Self-care has been central to promoting and fulfilling the right to health by tackling discrimination and systems failures.<sup>20</sup> Self-care itself aims to address limitations, such as health worker shortages, long waiting times, lack of privacy and discriminatory practices, which alone or together reduce access to SRHR. In addition to addressing system-related constraints, self-care can help users circumvent power asymmetries and discrimination in sexual and reproductive health care due to providers’ bias, or third-party involvement. Self-care also supports users’ autonomy and agency, particularly in unfavourable legal and policy environments (for example, self-managed medical abortion in highly restrictive contexts where abortion is criminalised). If health systems recognise self-care as part of their remit, then they must be held accountable for it. Therefore, we urge coordinated thought and action to ensure that accountability relationships central to the human rights approach around self-care for SRHR are further elaborated.

### **Balancing individual versus structural change**

Self-care can provide opportunities for more autonomy, particularly for people seeking to realise their SRHR in the face of opposition from family members, healthcare providers and broader social expectations and pressures. In such instances, self-care interventions respond to the need for covert and clandestine use of SRH services.<sup>25</sup> Self-care interventions may increase access to some services for individuals under some conditions. Yet, we cannot automatically assume that self-care interventions will be suited to addressing structural discrimination; that

requires seeding change in actors' (users and providers) self-perception and actions and their interactions.<sup>26</sup> Identifying, reflecting, and learning from others who face the same challenges is critical in questioning harmful norms and strengthening personal self-efficacy in health-seeking and personal and collective empowerment.<sup>27,28</sup> Social interactions themselves offer opportunities to address deep-rooted internal stigma and discrimination.<sup>29,30</sup> However, the individual solutions that self-care offers could undermine collective processes that are necessary for social mobilisation and social accountability. Building solidarity among service users is central to collective action and social accountability, which can transform into public pressure to question many of the tacit social norms and determinants that shape discriminatory practices in the provision of SRH services.<sup>29,30</sup> Solidarity building among service users is central to collective action and social accountability.<sup>15,31,32</sup>

We need, therefore, to explore how different people across various socio-economic strata experience self-care interventions to avoid systematic and structural discrimination against particularly vulnerable people that further isolates them from those with shared experiences of discrimination. There is a need to explore whether using self-care interventions may limit people's ability to voice their concerns and individual and community capabilities to ask critical questions about poor care and who is responsible for it.

### **Fostering countervailing power**

With the rise of self-care for SRHR, the traditional patient-provider relationships are altered because a service user's interaction with the health system changes. Reducing service users' direct interaction with the health system to access health care can pose potential challenges for successful social accountability efforts. The fundamental right to health, users' entitlements, the roles and responsibilities of both health users and health service actors remain the same regardless of the shift to self-care. Nevertheless, these are often initially misunderstood, and much of the work in social accountability attempts to address this through empowering communities, creating mutual understanding and joint problem solving between users and service providers.<sup>27,33,34</sup> Some questions that have to be addressed include: without public pressure associated with collective action, would

health system actors feel the same sense of obligation to patients? With self-initiated care, do healthcare providers still have the same sense of responsibility to ensure high-quality care?

We also need to examine whether expanding self-care intervention inadvertently places an additional burden on those already overloaded, particularly women, and would shift the costs to patients. Self-care could increase financial costs for individuals already burdened with high out-of-pocket expenditures for health.<sup>35,36</sup> Self-care expenditure by individuals could make it difficult to hold duty bearers to account for financial commitments made.

It is also important to address the possible counter argument, that inviting the health system to exercise its controls on self-care may compromise the autonomy that makes self-care so attractive to so many. So how do we demand action in a manner that keeps individuals in the driver's seat and does not relinquish power back to the health systems that some users are purposefully trying to circumvent through the use of self-care interventions? How can we heighten the voices of self-carers so they can express what they want (e.g. access to follow-up care)?

### ***Moving ahead***

Self-care interventions change the social dynamics and interactions between citizens and between citizens and health system actors in a way that can have many positive benefits and impact how collective action and accountability are organised. For example, self-care interventions in humanitarian settings may fill the gap left by insufficient health workers and health infrastructure.<sup>37</sup> However, as self-care interventions are developed and implemented, it is critical to consider the surrounding power dimensions and how best to encourage and foster rights, agency, autonomy, and solidarity amongst users, particularly those who experience stigma, discrimination and human rights violations.

We believe there are two starting points. First, it is important to recognise that specific types of self-care interventions for health require different types of engagement with the health system. This nuance is critical for mapping out the implications for social accountability efforts. For instance, self-medication (e.g. self-injectable contraceptives, self-medication abortion, advanced emergency contraception) requires engagement

with health system actors for information provision, screening, prescribing, or training and then possible follow-up or treatment. Self-testing (e.g. for chlamydia and HIV) requires more engagement, from getting the test results and follow-up for longer-term treatment if needed and counselling. In self-monitoring (e.g. fertility apps), there is little or no interaction with the health system required.<sup>20</sup> The diverse points of engagement with the health system may require social accountability efforts on multiple fronts to ensure ethical and appropriate self-care provision (from screening to referral/follow-up). A more explicit systems-thinking approach could help to understand these dynamics better. This extends beyond the service delivery points themselves to challenges resulting from wider health systems failures (e.g. policies, supply chains) that require action by higher-level authorities and additional policy advocacy or legal accountability efforts.

Second, this being said, there are several ways that social accountability processes could be applied to ensure the equitable and high-quality implementation of self-care interventions for SRHR. Efforts to empower and educate service users and providers could help increase awareness of such interventions and people's rights and entitlements, while mobilisation can ensure that provision is happening without discrimination or hidden costs and that users are not excluded from the continuing right to care. Civil society organisations (CSOs), communities and other social networks can play an important role in mobilising, organising and giving a voice to self-care users.<sup>38</sup> Social accountability efforts can

support health service actors to recognise and act on people demanding their right to health by ensuring they are aware of the obligations and responsibilities, and work with communities to address access barriers.

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### Contributors and sources

VB and DK reviewed relevant literature and wrote multiple drafts of the paper. LM and JK reviewed and made substantial contributions to the paper several times. VB and DK integrated comments and coordinated co-authors contributions. All authors read and approved the final manuscript.

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