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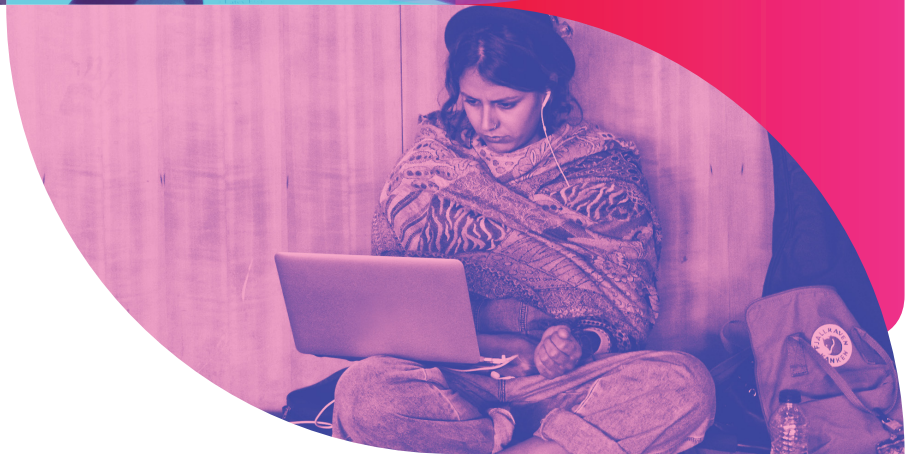
FOR SEXUAL & REPRODUCTIVE HEALTH & RIGHTS

AN ADVOCACY TOOLKIT

CIVIL SOCIETY LED SELF-CARE INITIATIVES IN ASIA AND THE PACIFIC

LESSONS FROM THE COVID-19 PANDEMIC



Civil Society Led Self-Care Initiatives in Asia and The Pacific
Lessons from the COVID-19 Pandemic

An Advocacy Toolkit

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ACRONYMS

ARV – Antiretroviral
CS – Civil Society
CSE – Comprehensive Sexuality Education
CSO – Civil Society Organization
GBV – Gender Based Violence
IPV – Intimate Partner Violence
HIV – Human Immunodeficiency Virus
PPE – Personal Protective Equipment
PLHIV – People living with HIV
PreP – Post Exposure Prophylaxis
PWD – People with Disabilities
RH – Reproductive Health
SGBV – Sexual and Gender Based Violence
SRH – Sexual Reproductive Health
SRHR – Sexual Reproductive Health and Rights
STI – Sexual Transmitted Infection
UHC – Universal Health Care
WHO – World Health Organization

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LESSONS FROM THE COVID-19 PANDEMIC

AN ADVOCACY TOOLKIT

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INTRODUCTION

The global Covid-19 pandemic has disrupted daily life and placed a strain on health services worldwide. While each country has faced the pandemic in its own way, government-imposed restrictions, such as restrictions in movement and increased policing, together with the increased burden on health facilities, have made it more difficult for many people to access sexual reproductive health (SRH) services. In Asia Pacific in 2020, 60% of women faced barriers to seeing a medical professional.[1] The Lancet predicts that disruptions in quality prenatal care could result in up to 39% more women dying of pregnancy and childbirth-related issues every month.[2] Rates of gender-based violence and violence against marginalized groups have also surged, increasing the need for SRH and response services for those affected. In this context, civil society (CS) has been stepping in to address this shortfall and ensure people's SRH needs and rights are met.

Civil society organizations (CSOs) have been piloting self-care interventions in recent years, and the pandemic has brought these interventions to the fore. Self-care interventions provide an important alternative to facility-based or health worker-provided services. CS solutions have become increasingly important to achieving universal health coverage (UHC), and for governments to achieve commitments to Agenda 2030, the Political Declaration on UHC, and International Conference on Population and Development (ICPD) Programme of Action, amongst others.

Yet CSOs have also faced increased scrutiny and restrictions from national governments during the lockdowns. While the world is adapting to the new status quo, it is important to identify and document exemplary CS-led self-care initiatives to address sexual and reproductive health and rights (SRHR), including linkages with HIV. This provides the opportunity to share successes in the region, and to advocate towards global and national policy makers for increased accountability to users of health systems and the empowerment of marginalized communities to make decisions over their own bodies and health.

This advocacy toolkit explores good practices of CS-led SRHR self-care initiatives from the Asia Pacific region in order to highlight the potential of self-care as a contributor to strong health systems. This brief seeks to:

- **Identify how Covid-19 has affected access to SRHR/HIV services and information in the Asia Pacific region.**
- **Highlight case studies of effective self-care initiatives adopted by CS to fill the gap in SRHR/HIV services during the Covid-19 pandemic in the Asia Pacific region.**
- **Present advocacy messages that can be used in (joint) advocacy efforts of APA members and other civil society actors.**

This brief can be used by civil society, health care practitioners, researchers, and others as a shared agenda to promote and advocate for CS-led SRHR self-care initiatives. The results present opportunities for national, regional and international advocacy strategies related to Covid-19 and human rights fulfilments.

KEY ADVOCACY MESSAGES

- Prioritize SRHR during epidemics and/or pandemics such as COVID-19. Emergency preparedness plans must guarantee access to essential SRHR services, including CSE provision and SGBV services and prevention.

- Ensure that the most marginalized groups have access to health services, including SRHR. Governments should work with CS and recognize innovative approaches that empower marginalized communities to take informed decisions over their own health, such as self-care protocols and the use of telemedicine for the SRHR, including access to medical abortion and post abortion care.

- Governments should review and adapt existing or adopt new national SRHR policies and strategies to include self-care interventions.

- Governments should collaborate with non-government service providers to integrate self-care into existing health systems, for example in the provision of accompanied self-testing and self-medication.

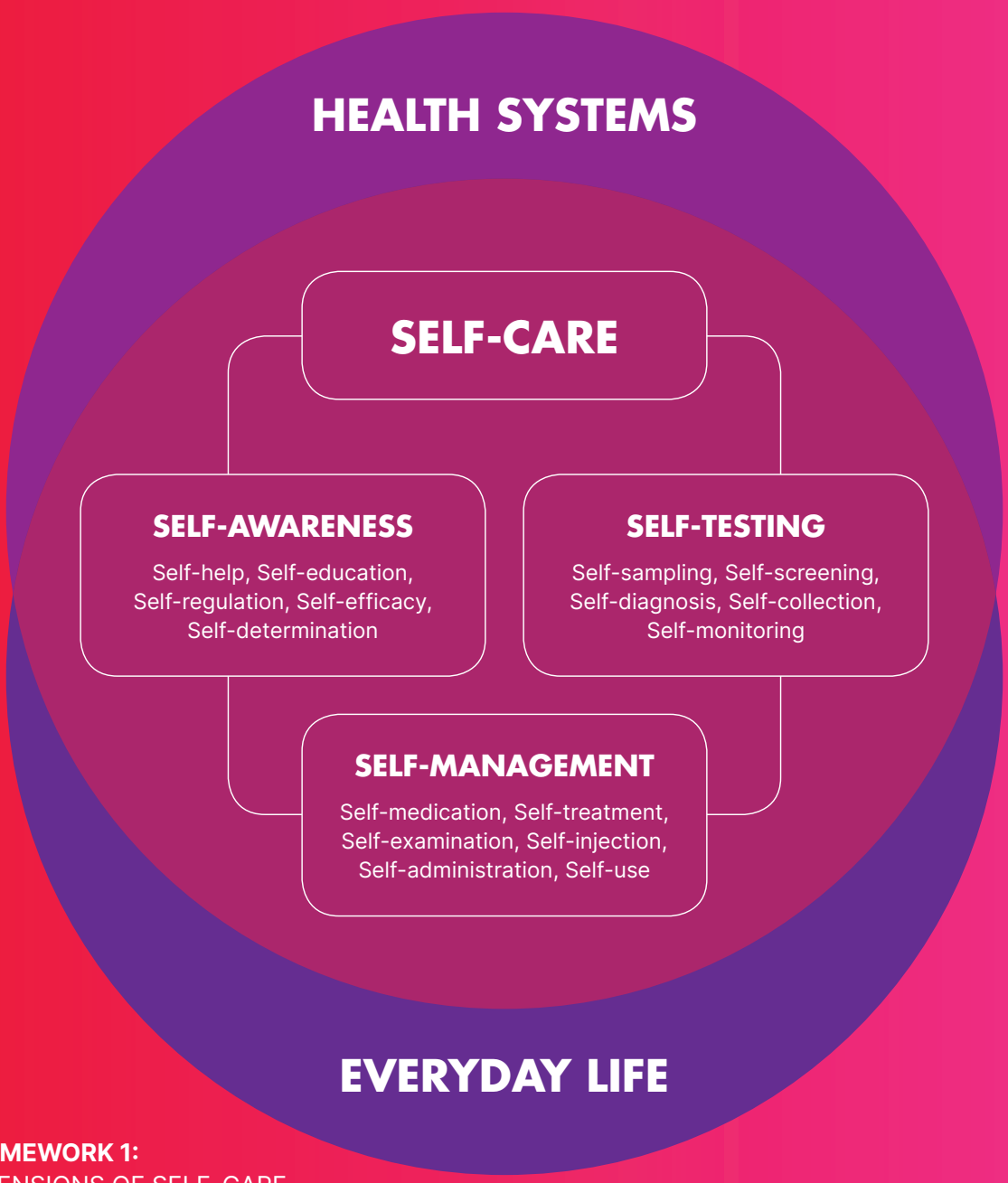
- Ensure the needs of women and marginalized groups—lesbian, gay, bisexual, transgender, queer intersex plus (LGBTQI+), people with disabilities (PWD), people living with HIV (PLHIV), migrants, sex workers, amongst others—are included the design of policies and self-care services, through consultative process.

- Governments should make STI self-tests and self-administered injectable contraceptives and medical abortion pills available to complement the basket of choice to deliver contraception for individuals of reproductive age, this includes putting self-tests and self-injectable contraceptives and medical abortion pills on the Essential Medicines or Devices List (as relevant), work on procurement, and allow them to be sold/distributed through pharmacies.

- Governments, NGOs and private sector service providers should train health workers on counselling for self-care, self-testing, self-injectables contraceptives and self-managed abortion e.g. on how to manage visits from self-injecting clients who return for re-supply.

- Governments, NGOs and private sector service providers should train health workers and helpline staff on how to provide counselling and referrals remotely.

THREE DIMENSIONS OF SELF-CARE



FRAMEWORK 1:
DIMENSIONS OF SELF-CARE
(Source: Remme, et al. 2019)

DATA COLLECTION

The findings presented in this section are the result of a research commissioned by the Asia Pacific Alliance for sexual and reproductive health and rights (APA). Between February and April 2021, a desk review, 11 expert interviews and a survey (n=27) were performed by the authors of the brief. Findings of the interview and survey were discussed in a validation workshop with members of the APA network, along with advocacy messaging.

THE CONCEPT OF SELF-CARE

The concept of self-care is building momentum as a promising and exciting approach to improve health and well-being. Self-care interventions provide an important alternative to facility-based or health worker-provided services. Self-care can be 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."[3] For SRHR services, the WHO recommends inclusion of information about SRH issues as well as ways in which individuals can obtain drugs, devices, diagnostics and/or digital products fully or partially outside of formal health services, and that can be used with or without the direct supervision of a health worker. This might include, for example, self-administered contraception, pregnancy and HIV self-tests, or digital consultations.

Self-care can help mitigate the challenges posed by Covid-19 and other epidemics as it allows for physical distancing measures to be upheld and removes barriers posed by travel/distance to facilities, while ensuring essential SRH services remain available.

New opportunities for self-care have arisen with rapid advances in digital technologies and legislation of over-the-counter SRH commodities, and a multitude of self-care interventions are currently being developed and tested, with promising results.

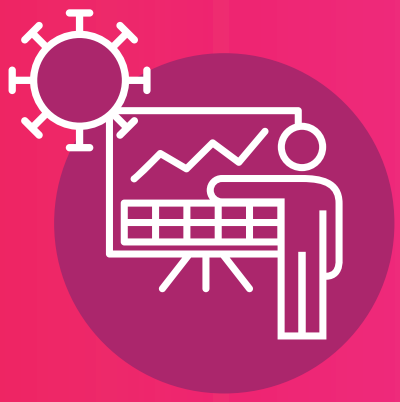
Self-care interventions have the potential to increase choice, accessibility, and affordability, as well as opportunities for individuals to make informed decisions regarding their SRH.

From a health system perspective, self-care is increasingly recognized as having the potential to reduce costs, increase efficiencies, and install patient-centered care. Furthermore, self-care fits in the UHC agenda since UHC includes a people-centered approach to health that views people as active decision-makers in their own health.

This toolkit identifies three key dimensions of self-care (see figure 1). This conceptual framework is used to explore initiatives which have arisen in the Asia Pacific region during the pandemic. The dimensions are:

- Self-awareness (self-help, -education, -regulation, -efficacy, -determination). This includes, for example, online SRHR education, pharmacy databases, decision-making to seek services etc.
- Self-testing (self-sampling, -screening, -diagnosis, -collection, -monitoring). This includes, for example, self-testing for pregnancy, STIs, HIV, and Antenatal Care (ANC) monitoring, etc.
- Self-management (self-medication, -treatment, -examination, -injection, -administration and -use). This includes, for example, self-administered contraceptives, self-administered Antiretroviral medication (ARVs), self-managed medical abortion etc.

EFFECTS OF COVID-19 ON ACCESS TO SRHR/HIV SERVICES AND INFORMATION IN ASIA PACIFIC



GOVERNMENT RESPONSES TO THE COVID-19 PANDEMIC

As the Covid-19 pandemic spread around the world in March 2020, governments throughout the Asia Pacific region imposed lockdown orders, restrictions on travel and physical meetings and gatherings, stay-at-home and/or work-from-home orders, and curfews. The duration and intensity of the lockdowns differed per country but in most countries disruptions in normal life took several weeks to months. In many countries, schools and universities were closed. In 2021, countries across the region are experiencing second and third waves of the virus that are even more virulent than the first, with lockdowns and other restrictions being put in place again.

The socio-economic effects of the lockdown and restrictions are tremendous. Few countries have been able to provide the financial support to their populations that such measures necessitated. In India, the lockdown led to nationwide migration with seasonal workers losing their income and forcing them to return to their home villages for food and shelter. In Thailand, refugees and migrants lost their livelihoods and required food and relief packages, most of which were provided by non-governmental organizations (NGOs). In the Philippines, the government responded with aid packages in the early stages of the lockdown, however this was stopped early due to high costs, leaving many people vulnerable. And the army and police forces were deployed to reinforce the rules in certain countries, leading to increased violence in some places.

THE EFFECTS OF COVID-19 ON SRHR/HIV SERVICES AND INFORMATION PROVISION

Across the region of Asia and the Pacific, SRH services have been significantly disrupted by the Covid-19 pandemic. Few governments initially classified SRH services as essential services, making access extremely difficult. The closure of hospitals for non-essential services, travel restrictions, overburdened health providers, limited hospital beds and delays in reproductive health (RH) medicine supplies caused severe damage to the quality and continuity of SRH services in the region. Throughout the region, resources, such as equipment and staff involved in the provision of SRH services were diverted to tend to Covid-19 cases. In Pakistan, health clinics and pharmacies were closed, or were asked to suspend SRH services that were not classified as essential, such as abortion care. In Indonesia, Nepal and Thailand, the government only continued essential services, which excluded SRH. And even if services were ongoing, people were unable to take public transport or were reluctant to go for SRH services out of fear of transmission. Police and army barricades further discouraged people from travel, especially if they needed to state the reason for their journey. IPPF saw a 25% decline in demand for SRH services in their clinics across the Asia Pacific region.

The supply chain for contraceptive commodities and other RH medicines was also affected due to factory closures and travel disruptions.[4] Most condoms and contraceptives in the world are manufactured in Asia. During the outbreak, factories in China and India were closed, and factory workers were asked to stay home or work reduced hours. Many contraceptive suppliers are not yet back to full capacity which has global implications for the SRH commodity supply. In addition, delays in shipping and supply chain disruptions are still visible. Although cargo flights picked up quickly after the initial outbreak, the lack of passenger air travel means that the costs of shipping by cargo planes have increased significantly. In South Korea, supplies of SRH commodities, including medical abortion pills, were affected because international planes could not land.

Most community based initiatives and outreach services were cancelled. As such, CSOs were unable to provide information and SRH services in the communities face-to-face. Community based initiatives are an effective method to reach rural and more underserved communities. Gender Based Violence (GBV) support is often given in the form of face-to-face meetings and many shelter homes for survivors of violence, or refugees, remained closed. As such, reaching already underserved groups became even harder during the period of government restrictions. This was further hampered by the lack of Personal Protective Equipment (PPE) for health and social workers to protect themselves.

EFFECTS ON MARGINALIZED COMMUNITIES

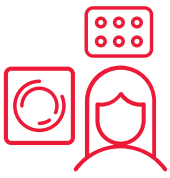
The effects of the lockdown and disruptions in SRH services on the health and wellbeing of marginalized communities has been severe and widespread. Although everyone is affected by the disruptions, women, young people, people living with HIV, people with disabilities, refugees, migrants, sex workers, and people who identify as LGTBQI+ are even more disadvantaged. Multiple and intersecting forms of discrimination increase vulnerability and amplify the experience of exclusion and disadvantage that individual's experience. Systemic racism and historical injustices act as barriers to SRHR services and information, and have been further intensified by the disruptions in care.

60% OF WOMEN IN ASIA PACIFIC FACED BARRIERS TO SEEING A MEDICAL PROFESSIONAL, ACCORDING TO UN WOMEN.

The first estimations of the effects of the Covid-19 pandemic and lockdowns show the unprecedented impact on the sexual health and wellbeing of women and marginalized groups around the world. 60% of women in Asia Pacific faced barriers to seeing a medical professional, according to UN Women. IPAS estimates that 1.85 million women worldwide experienced restricted access to abortion services in 2020, which could result in an additional 3.3 million unsafe abortion across Low- and Middle-Income Countries.[5] According to Guttmacher Institute even a modest decline of 10% in maternal care can result in an additional 1.7 million women who give birth and 2.6 million with major complications.[6]

Across the Asia Pacific region, CSOs mentioned a rise in fertility and a large unmet need for family planning services. For adolescents the pandemic aggravates their already high unmet need for SRH services and logistical challenges to accessing care. The lockdowns increase their barriers to safe and confidential SRHR services and information at a location and time that is accessible for them. Adolescents are also more vulnerable to violence, and young girls may be confronted with early, child and forced marriage due to their families' economic hardships related to the loss of work. In Indonesia, on remote islands family planning services are performed by midwives during outreach visits. However, the midwives were not able to travel regularly during the lockdown which led to a high unmet need for contraceptives. Since women in Indonesia prefer IUDs or injectable contraceptives due to a strong belief in side-effects of other methods, self-care options such as oral contraceptive pills were not an option for them. As such, the Indonesian Government observed an increase in pregnancies and is anticipating a baby boom. The increased fertility rate is also a result of a lack of safe abortion services. In Nepal, for example, abortion services are legal but were not classified as essential meaning services were disrupted.

FOR ADOLESCENTS THE PANDEMIC AGGRAVATES THEIR ALREADY HIGH UNMET NEED FOR SRH SERVICES AND LOGISTICAL CHALLENGES TO ACCESSING CARE.



In India, reports from the first lockdown reveal that safe abortion care was severely impacted; private clinics are often preferred for abortion services, however, these clinics were closed. At the time of writing, India is experiencing a second and more severe wave, and further impediments are expected.

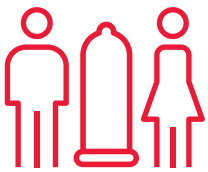
CSOs ACROSS ASIA PACIFIC REPORTED AN INCREASE IN SGBV AND INTIMATE PARTNER VIOLENCE (IPV).

CSOs across Asia Pacific reported an increase in SGBV and intimate partner violence (IPV). Lockdowns and quarantine measures have meant that millions of women are confined with their abusers, with limited options for seeking help and support. Different forms of SGBV have been shown to escalate due to heightened tensions in the household. Hotlines for victims of domestic violence in Malaysia have reported a 57% increase in calls. In Singapore, the women's helpline saw a 33% increase over calls received compared to the previous year (2019).[7] In China, an anti-domestic violence organization in the Hubei Province reported that IPV nearly doubled since cities were put under lockdown. In the whole Asia Pacific region, schools were closed or moved online. Past health outbreaks have shown that disruptions in education are extremely harmful to young women, not only in terms of lost earnings and education, but also increased vulnerability to sexual and gender-based violence and unintended pregnancy.[8]

School closures disrupt comprehensive sexuality education (CSE) and prevent students from visiting school-based health centers that offer vital SRH services and social support. CSOs mentioned that teachers are trying to switch to online platforms to deliver CSE, however many of them do not have adequate skills to deliver online CSE limiting the scope and depth of the content. Furthermore, in many countries, such as Nepal, Pakistan, the Philippines, South Korea and Thailand, violence, stigma and discrimination against the LGBTQI community increased, including violence related to curfews and cases of rape. Due to meeting restrictions, SGBV survivor support groups could not take place thereby damaging the carefully constructed social support networks.

The lockdown also affected sex workers, for example in Nepal and Thailand, it was shared that negotiation power (for condom use or price) went down due to their poor economic status. In Bangkok, bars and entertainment establishments were closed down; sex workers employed here had to sleep in the bars were they worked since many did not have a safe place to return to. The impact of the pandemic on tourism also severely affected sex workers' income opportunities, yet, as their work was not regarded as official labor, they were not eligible to receive government support.

THE IMPACT OF THE PANDEMIC ON TOURISM ALSO SEVERELY AFFECTED SEX WORKERS' INCOME OPPORTUNITIES.



PEOPLE IDENTIFYING AS LGTBQI WERE TARGETED AND SCAPEGOATED FOR SPREADING THE VIRUS, AS THEY WERE NOT SEEN AS COMPLYING WITH SOCIETAL RULES.

The LGBTQI community was particularly affected by the lockdown and restrictions. Transgender people experienced increased difficulties accessing hormones and gender-affirmative health care. It was mentioned that transgender women were afraid to go the hospital out of fear of contracting the virus, while their medication and hormone supplies were running low. Although social isolation is not unknown to transgender people, since many have been rejected and excluded from their families and communities, before the COVID pandemic they were able seek social and emotional support from peers and trans rights organizations. Physical distancing measures and lockdowns now prevent trans and gender diverse communities from accessing these vital resources to sustain their mental health. In addition, people identifying as LGTBQI were targeted and scapegoated for spreading the virus, as they were not seen as complying with societal rules. This has resulted in increased violence against the LGTBQI community. Some people identifying as LGBTI saw no other option than to move into commercial sex work due to a lack of income.

Migrants and refugees were severely impacted by the socio-economic effects of the lockdown. In Thailand, document checks at the health centers made it difficult for non-documented workers and migrants to receive care. Migrant workers across the region faced a double burden; due to their dependency on seasonal work, they saw their income decrease while at the same time stigma increased. In Thailand, refugees and migrants were thought to have brought the virus into the country. Yet when it came to the provision of information about Covid-19 and the pandemic, governments failed to provide accessible resources for migrants in their native languages. Many migrants and refugees became dependent on food and relief packages. NGOs often had to fill this gap; even in cases where governments provided financial support to the population, migrants were usually excluded from receiving this support.

MIGRANTS AND REFUGEES WERE SEVERELY IMPACTED BY THE SOCIO-ECONOMIC EFFECTS OF THE LOCKDOWN.

PWD IN THE ASIA PACIFIC HAVE BEEN SEVERELY IMPACTED BY THE COVID-19 PANDEMIC DUE TO THEIR SOCIALLY MARGINALIZED POSITION.

People with Disabilities (PWD) in the Asia Pacific have been severely impacted by the Covid-19 pandemic due to their socially marginalized position. PWD's access to SRH services is around 2-3 times lower, and information, including reliable information about Covid-19, is often not available to them in accessible format, e.g. sign language or braille. Many PWD rely on community-based or specialized services to meet basic daily needs, such as meals and hygiene services; many of which have been disrupted due to travel restrictions. In addition, CSOs report that the lockdown triggered previous trauma of being isolated and restricted in the freedom to move.

People living with HIV, especially women and young people, face increased vulnerabilities due to the lockdown and service disruptions. In China, CSOs found that 33% of PLHIV risked running out of ARVs and 49% did not know where to collect their next supply.[9] In Thailand, clinics sent ARVs to patients, however this caused privacy issues since some PLHIV did not wish to disclose their status to their families or neighbors. In addition, when a CSO representing young key populations in the Asia Pacific region asked their constituency about their experience during the pandemic, they heard about delays and disruptions in HIV services across the region, as well as a lack of clean needles, PreP and HIV tests. Moreover, 70% of their constituents expressed having mental health issues and being more anxious.

PEOPLE LIVING WITH HIV, ESPECIALLY WOMEN AND YOUNG PEOPLE, FACE INCREASED VULNERABILITIES DUE TO THE LOCKDOWN AND SERVICE DISRUPTIONS.

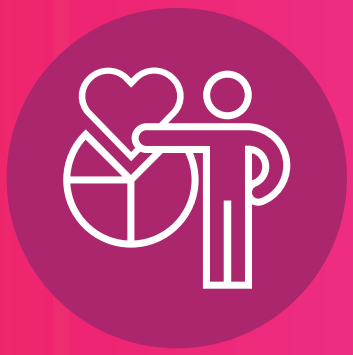
SHRINKING CIVIL SOCIETY SPACE

Changes in civic space were visible in many countries in the region. The strict lockdowns and surveillance imposed additional barriers for many CSOs to perform their work. Many governments have taken emergency measures restricting human rights and freedom of movement. Even though these measures are legitimate given the severity of the crisis, governments need to ensure that the measures are proportionate and time-limited. Although in some countries there are examples of collaborations between CSOs and government, for example in the Philippines where the government asked CSOs to support the provision of essential SRHR services which they were unable to provide, in most countries governments became more hostile towards activism and SRHR movements, taking the pandemic as an opportunity to curtail their freedoms.

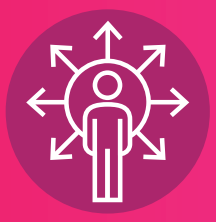
Civic space for SRHR in the Asia Pacific region was already shrinking before the pandemic and Covid-19 accelerated the process. Lockdowns, restricted offline spaces and gatherings hamper the freedom of expression and social support networks.

In Thailand, the strict measures further hampered civil society's ability to fulfil their mandate. The government closed spaces such as shelters and banned public meetings. The Thai parliament is discussing further restrictions in external funding for NGOs. In Nepal, the government introduced a new social media bill that states that criticism towards the government is a criminal offense. Also, in India, human rights activists were being charged under anti-terrorism laws. In several countries, such as India, Bangladesh and Nepal CSOs experienced delays in approval of their programmes funded with international grants, especially SRHR and advocacy projects. Next to this, it was mentioned that the government in Pakistan used Covid-19 as an excuse to not talk about family planning and other taboo subjects. There was also mention of police raids in abortion clinics and law enforcers increasing surveillance and arrests on trans people.

CSO-LED SELF-CARE INITIATIVES IN THE ASIA PACIFIC REGION



Across the Asia Pacific region, CSOs have stepped in to support their communities. Many CSOs had to pivot their way of working to cater to the 'the new normal'. Almost all CSOs surveyed have deployed creative and innovative methods to improve access to SRH information and services. CSOs self-care initiatives ranged from self-awareness interventions using chatbots and social media channels, to support with self-testing and self-management of HIV. A variety of CSO-led self-care initiatives are presented below, including case studies from across the region.



SELF-AWARENESS

CSOs adopted strategies to support their communities and increase self-awareness about SRHR. Social media was the most popular, especially compared to more traditional outlets such as TV and radio channels. Social media platforms such as Facebook, WhatsApp and zoom were used for interventions such as online information meetings and webinars using platforms, while other strategies included the roll out and development of mobile applications, setting up mobile helplines, digital consultations and telehealth, distribution of information about the location of pharmacies and supporter care for SGBV survivors, and online and social media campaigns. These channels were used to distribute accurate information about SRHR and SRHR services, comprehensive sexuality education, as well as about how to protect oneself against the coronavirus.

Reproductive and Family Health Association of Fiji used Facebook and TikTok to reach out to young people during the pandemic. This initiative is run by young people, for young people. Facebook was used to share key messages, and they are there to answer any questions related to SRHR, such as on contraception and STIs. If needed, clients are advised to go to a mobile clinic for treatment, or a home visit can be arranged. This initiative has been successful in reaching a diverse audience of youth including LGBTIQ, young people with disabilities and young sex workers.

Online spaces were seen as a safe space to discuss any issues without shame or prejudice. One CSO in Pakistan established an 'Emergency Response Cell' that focused on coordination of advocacy efforts for the availability of ARVs. The response cell coordinated with clinics and PLHIV to ensure they could receive the right information. And in Indonesia, an innovative chatbot called Tanya Malo was used; young people can ask all their SRHR related questions to the chatbot via their mobile phones or internet browser.

Although these strategies were successful in reaching many people, challenges with digital literacy and access to mobile phones were present, which further disadvantaged marginalized groups. Furthermore, most information is presented as text, which leaves out people with a visual impairment. Next to this, it was mentioned that some platforms display inaccurate information that is not in line with medical guidelines, or not vetted by a health professional.

ONLINE DATABASE OF HELPLINES/SERVICES

Y-PEER ASIA PACIFIC

Young people have been particularly hard hit by the pandemic. In 2020, Y-Peer Asia Pacific found much of their work had to stop and they were left unable to reach the young people they work to support. Furthermore, many key services, such as abortion clinics and youth friendly services, were closed as they were not considered essential services. This left many young people uncertain about where to go to access the services they needed. As much of their work had moved online, they decided to set up a database of helplines and online services. The Asia-Pacific Adolescents and Youth-Friendly Service is a platform for young people, operated by young people. This platform is supported by the Y-PEER Asia Pacific Center, Youth Friendly Health Services Asia and UNFPA and the Robert Carr Foundation, with support of youth advocates and Y-PEER members across the Asia-Pacific region.

SELF-TESTING

While many CSOs have strategies to support their communities to increase self-awareness about SRHR, significantly fewer CSO's in the survey mentioned facilitating or providing access to SRHR self-testing and monitoring. Pregnancy, HIV and Hepatitis B self-tests were most commonly mentioned, with only one mention of combining pregnancy self-test with the provision of medical abortion. Furthermore, some CSOs reported self-tests for several combinations of STIs, most frequently including HIV self-tests (see the case of Bandhu below).

One of the reasons for the lower response on self-testing could be explained by a lack of awareness. One of the challenges for self-testing is the need for a relatively high level of awareness and (health) education to be able to know about and conduct self-tests. This was brought up in an expert interview and validated by CSOs.

The capacity and confidence to properly do self-test following the instructions, as well as to correctly read and interpret test results, is often (perceived to be) low and not always built by health professionals. This was also referred to as sensitivities and taboo around self-testing and diagnoses in some cultures. An expert previously attached to WHO referred to similarities with the "task shifting" discussion in health care, in which shifting tasks to lower level health workers led to resistance of the higher level health workers let alone to patients themselves. This resistance is sometimes also related to economic factors as explained in another expert interview. For instance midwives would miss out on income from their services when pregnancy self-tests are more widely available and used. Besides, the Bandhu case below touches on the right to non-disclosure. Self-testing can provide increased privacy, a right which is not yet fully accepted in many Asia Pacific countries.

SELF-TESTING FOR HIV
BANDHU

Bandhu provides health services for HIV, STIs and general health services through service centers throughout Bangladesh. Normally a medical assistant is responsible for taking out the HIV/STI tests and treatments. At community level, field teams and voluntary peer educators work closely with gender diverse key populations to screen and test beneficiaries.

HIV self-testing was officially introduced in Bandhu's service centres in February 2021, and was rolled-out in all service centers in April 2021, during the Covid-19 pandemic. Oraquic, the HIV self-testing method used, follows HIV self-test guidelines. Beneficiaries collect the test kit from the service center where the medical assistant gives them counselling regarding the testing method, after which beneficiaries need to give their consent. The beneficiary collects his or her own specimen (oral fluid or blood), performs the HIV test and interprets the result. The self-test is done in a service center, either alone or with someone the beneficiary trusts. Positive self-test cases are followed-up with three blood tests as prescribed by WHO.

HIV self-tests are permitted by the Directorate General of Health Services in Bangladesh under the Ministry of Health and Family Welfare, according to the National HIV Testing Services (HTS) Guideline. As this particular self-testing method has just been launched, it is still too soon to evaluate. There is a concern that if someone were to take this method by themselves, alone and it came out positive, they could hide their HIV status. To mitigate this challenge, Bandhu has come up with a "hybrid" model of accompanied self-testing, and continued technical support to field staff.

This example raises interesting questions about the need for disclosure. While organizations may want clients to disclose the test results, according to a rights-based approach, clients should maintain the right to non-disclosure in health care.

SELF-TESTING FOR HIV
APCOM

TestBKK is a community-led initiative of APCOM to encourage gay men, men who have sex with men to get tested and access HIV services through online and social media in Thailand. TestBKK provides information on sexual health, living with HIV, accessing prevention and treatment services, distribution of prevention packages, as well as topical information for the community to make the most informed choices. TestBKK has also launched specific harm reduction resource for men who have sex with men in Thailand. Resources include:

- "Safer Hi-Fun" Guidance, which provides Q&A-formatted advice to avoid and reduce health risks when engaging in a chemsex.
- Alcohol and Drugs Information Hub, which contains facts and figures on 15 different substances known to be used among Thai people.

TestBKK also sends out prevention packages to those that are planning group fun, which they can order online. It includes a leaflet containing a QR code for them to access harm reduction resources on the TestBKK website and to promote the use of PrEP.

SELF-MANAGEMENT

The pandemic severely limited access to essential SRH services and commodities for multiple reasons. There was widespread concern about access to contraceptives and safe abortion during the initial stages of the pandemic, not only because women were unable to access health facilities, but also due to the rising rates of SGBV and unwanted pregnancies. Self-management options have the potential to provide a lifeline to many women and girls and the Covid-19 pandemic presents a unique opportunity to expand self-care services related to self-management.

While a growing number of self-management options are available—such as self-injectable contraceptives and safe and effective medical abortion medication—legislative and regulatory barriers, together with norms and attitudes related to the SRHR of women and marginalized groups, and their autonomy over their own bodies, prevent the wider application of self-management options. In general, they are less widely known among CSOs, and the rate was much lower than for self-awareness and self-testing.

Self-administered contraceptives were the most commonly mentioned by CSOs using self-management initiatives. Self-administered contraceptives can mean a number of things; many commonly used contraceptives, like the contraceptive pill, fall into this category. Innovative self-administered methods are becoming more widespread, yet these remain uncommon in Asia Pacific.

To date, self-injectable contraceptives have largely been piloted in Sub-Saharan Africa and uptake in the Asia Pacific region has lagged behind. One CSO in Fiji saw the opportunity to change this, advocating with the government to include the self-injectable contraceptive 'Sayana Press' on the Essential Medicines List. In the meantime, they provided women with a 3-month supply of the contraceptive pill to reduce their need to visit the health center.

In Japan, in April 2020, regulations around online appointment with physicians were relaxed. Prescriptions for the morning-after-pill was included as part of these services and made more widely available. The morning-after pill was available at pharmacies, and staff was trained to specifically sell the pills. Pharmacists had to follow training designated by the Ministry of Health Labour and Welfare.

But the relaxed online appointment was a temporary measure during the pandemic. The medication remains expensive, is not covered by insurance, and has to be taken in front of the pharmacist to avoid illegal sales. Furthermore, the women were obliged to take a face to face appointment with a gynecologist after 3 weeks to confirm the pregnancy was terminated. CSOs are currently advocating to make the morning after pill available as over-the-counter medicine.

In Australia, much has been learnt about using telemedicine to provide safe access to self-managed medical abortion due to the large territory and remote areas. These services continued in line with current legislation. Other CSOs took up the call to advocate for the available of self-managed medical abortion as an option for women seeking to terminate pregnancies. The Safe Abortion Advocacy Initiative – A Global South Engagement (SAIGE) and the South Asia Reproductive Justice and Accountability Initiative (SARJAI) launched a call on 4 September 2020 to ensure access to medical abortion in global south countries.

SRH TELEMEDICINE
FAMILY PLANNING NSW

Family Planning NSW is the leading provider of SRH services in New South Wales, Australia. Across Australia, at the start of the COVID-19 pandemic, the government introduced funded access to telehealth (digital consultations), enabling vital sexual and reproductive health continuity of care. Funded telehealth made it possible for people who have difficulty accessing mainstream health services to receive sexual and reproductive healthcare, sometimes for the first time. During the six-month period that Family Planning NSW was able to provide funded telehealth alongside clinic appointments, more than 1,500 clients accessed their telehealth services in 1,900 consultations. More than 95% of clients were women who accessed contraception, gynecological and pregnancy management services. Telehealth proved itself an essential strategy to address unmet need, evidenced by the high uptake rates when funding became available. Unfortunately, due to changes to funding eligibility in July 2020, patients who had not visited a doctor in the past 12 months were excluded from accessing telehealth services.

Following this move, Family Planning NSW continually advocated to health colleagues and the government for the reintroduction of funded telehealth for all clients seeking sexual and reproductive healthcare. After ongoing advocacy, in May 2021, the government announced access to telehealth would be extended for all clients seeking sexual and reproductive healthcare under the 2021/2022 Federal Budget. The reinstatement of telehealth ensures equity of access to high quality, essential care for more Australians.

The call highlighted the lived realities and unique vulnerabilities that women from global south face in accessing safe abortion services and demanded a intersectional, reproductive justice approach by the governments in promoting and protecting women's right to safe abortion.

HOME DELIVERY OF ARVS
APLHIV, PAKISTAN

When the pandemic broke out, there was widespread concern about the risks for People Living with HIV (PLHIV). Multiple factors were of concern; not least because little was known about the risk the Covid-19 virus posed to people living with HIV, but also, because lockdown restrictions on movement and public transport, and the immense burden on health services, would impact access to, availability and supply of ARVs, contraceptives, counselling and other health services. Disruptions in their ARV regimen could compromise the health of PLHIV. The Association of People Living with HIV/AIDS, Pakistan knew it was important to act quickly to ensure that PLHIV were supported in this constantly evolving situation. The Association established an Emergency Response Cell [ERC] to coordinate support, which included close coordination and advocacy with the National and Provincial AIDS Control.

Programmes to ensure that the supply of ARVs was undisrupted, a helpline to provide advice and support to PLHIV on their ARV supply, and home delivery of a multi-month supply of ARVs to PLHIV to ensure they had a steady supply of medication. They also distributed over 6,000 food packages to some of the PLHIV most in need in Pakistan.

There were also initiatives to ensure that people living with HIV had a guaranteed supply of ARVs, for example the Thai government arranged for the home delivery of ARVs, as did one CSO surveyed in Pakistan, and a CSO in the Philippines provided financial assistance to cover courier costs to deliver ARVS to HIV+ migrant workers in remote areas or stranded overseas.

These examples help show how access to self-managed SRH commodities and services can be expanded and can help in advocacy towards governments and other stakeholders. However there are also challenges to adopting self-managed options which should be acknowledged. Firstly, this option is not for everyone. Some users may prefer facility-based care however this is why holistic service provision and a full basket of options should be available so people can make informed choices based on their personal needs. To achieve this, legislative, regulatory and normative barriers which exist due to ideas about the autonomy of women and marginalized groups over their own bodies need to be removed. Furthermore, in contexts such as Indonesia where long-term, reversible contraceptives are favored, and which generate good income from midwives and service providers, there will be additional resistance to overcome towards self-administered methods. This is already seen with the contraceptive pill. The relatively small evidence base for self-injectable contraceptives, particularly in the Asia Pacific region, may discourage governments and health authorities from approving and adopting this method.

EXAMPLES FROM AFRICA

Self-care examples from the African continent can be seen as complementary to the case studies presented above. Due to differences in laws, regulations, and larger government- and donor involvements, self-care for SRHR is developing at a faster pace in some of the countries in Africa.

SAYANA PRESS INJECTABLE CONTRACEPTIVES

Injectable contraceptives are an increasingly popular method, especially in sub-Saharan Africa where 43 percent of women opt for this method. Injectable contraceptives are typically administered by a health care professional. However, self-injectable options are beginning to gain traction. Sayana Press is a three month injectable dose of DMPA-SC that is easy for women to use by themselves.

Since 2017, PATH has been working closely with ministries of health and partners across the continent (such as Ethiopia) and with public and private sectors, to facilitate the introduction and scale-up of the self-injectable contraceptive Sayana Press. Research projects found that women feel comfortable, after a quick demonstration by health workers, to self-inject. Moreover, women value the time and expense saved by self-administration versus travelling to the health facility, and that the product can be used discreetly. Women could report to health workers in case of side-effects.

EXAMPLES FROM AFRICA

SELF-MANAGEMENT OF ABORTION

South Africa experienced two stringent lockdowns during the Covid-19 pandemic. During this time, abortion care was affected in the clinics and women were unable to leave their neighborhood. MSI clinics initiated self-managed abortion services to serve women in need of an abortion.

MSI South Africa applied lessons from MSI Australia's experience to show that telemedicine was safe and effective. Dedicated call centers where consultants counseled women by phone and determined if abortion was viable through a series of questions were set up. If the candidate was suitable (pregnancy of less than nine weeks), the patient was called by a trained nurse to screen for eligibility and exclude risk of ectopic pregnancy, undesirable drug interactions or excessive bleeding. The nurse also explained the procedure and answered any questions the patient had. The woman was given the choice of collecting the medication from an MSI clinic or having it delivered by a courier.

The WHO defines self-managed abortion as a termination of pregnancy that happens outside a medical setting like a hospital or clinic without the direct supervision of a healthcare worker. It involves the use of either a combination regimen of mifepristone and misoprostol or a misoprostol-only regimen.

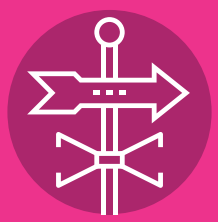
During the pandemic, this use of telemedicine helped ensure over 6,800 women in South Africa were supported to access safe abortion services from the comfort and privacy of their own homes, and access was expanded to those in rural and underserved communities. Although it fits the legal framework in South Africa around termination of pregnancy, self-managed medical abortion is not yet widely available in public clinics. Advocacy is ongoing and the government is positive about integrating medical abortion and telemedicine in guidelines.

RECOMMENDATIONS FOR CSOs TO PROMOTE, ADOPT AND SCALE-UP SELF-CARE INTERVENTIONS

Self-care interventions have been used during the pandemic to provide a vital lifeline to people and ensure people's SRHR are fulfilled. A broad range of self-care strategies have been used by CSOs in the Asia Pacific region during the COVID-19 pandemic, presenting a unique opportunity to learn and gather evidence on the success of self-care interventions. These examples can support CSOs to apply such approaches, and to convince their governments of the need for self-care interventions.

The huge impact of the pandemic on the accessibility and workload of health care facilities has rapidly increased the need for alternative, non-facility based care models such as self-care. With limited opportunities for people to leave their homes or access traditional health services, self-care alternatives which bring SRHR information, testing and management options to people have become more pressing. At the same time, in many countries, the pandemic has brought the introduction, wide distribution and promotion of Covid-19 self-tests; normalizing a self-testing culture in a way that has never been done before. This has the potential to influence attitudes and mindsets towards self-testing, and self-care more broadly.

While self-care interventions are becoming more widespread in Asia Pacific, there are also hesitations and questions. There are clear opportunities to learn from other countries—both within and beyond Asia Pacific—to ensure people's SRHR are fulfilled.



Given how new the concept of SRHR self-care interventions is in the Asia Pacific region, the following recommendations build on the findings of this research in order to support CSOs wishing to adopt or advocate for self-care interventions:

MAPPING

Start mapping who does what in your country and what the laws and policies say on self-care, including availability of products, health system infrastructure and legislation around diagnostics and medication.

Are there any gaps or opportunities for interventions or advocacy on self-care?

What are enablers for the adoption of SRHR self-care approaches?

Learn from others, by looking beyond borders.

What are others doing within your own country, in neighboring countries and other regions, and how could this be applied to your specific context?

Consult your constituency to identify their needs and the barriers they face in regard to access to SRH care.

Do they face any specific barriers to SRHR which could be met through self-care approaches and innovations?

Understand and unpack potential resistance to the adoption of SRHR self-care approaches.

Why are there concerns and hesitations? How could they be overcome?

INVESTING IN EVIDENCE

Generate (community-led) evidence to demonstrate the efficacy of self-care. A strong evidence base showing how self-care interventions can achieve greater impact can be used to strengthen advocacy and call for governments to integrate self-care in the health system.

What works and how can this be used to convince others?

Invest in evidence to show the cost-benefit of self-care interventions. While some self-care strategies may save costs, others can be more expensive.

What is the cost-benefit analysis of the selected self-care intervention and how can this help you convince others?

RAISING AWARENESS

Raise awareness on self-care to important stakeholders including fellow NGOs/ CSOs. Understanding your audience will help you target your messages.

Which other stakeholders working on SRHR might be in favor of self-care? Who might be against it?

Raise awareness on rights based approaches and social accountability with governments and communities.

What gaps regarding the governments' responsibilities can be leveraged to ensure people's SRHR are fulfilled? How can communities be supported to claim their SRHR through the existing health system?

Utilize media as a platform for sharing messages on self-care, and use people as the medium.

Who do you need to educate on self-care and which channels work best to inform them?

IMPLEMENTING

Use evidence to inform messages within self-care interventions to ensure that accurate information is communicated.

What information do people need and how can you communicate it accurately and correctly?

What are the needs of your constituency? What is their level of knowledge about SRHR and self-care?

Engage health professionals and community members in the design of interventions to increase their buy-in and use global best practice guidelines to understand roll-out.

Who needs to be involved in the roll-out of the self-care intervention and how can you encourage their support?

Advocate with service providers to use a variety of self-care solutions, including help apps to share information from a trusted source, as well as self-testing and self-medication/ management options.

What can service providers do to increase roll-out of SRHR self-care solutions?

ADVOCACY

Advocate with governments to priorities rights-based SRH and SRHR self-care and work on policies, regulations and interventions.

Who and what to advocate/ influence in order to ensure rights-based SRH and SRHR self-care are prioritized?

Utilize international conferences to build support for self-care as a means for increasing rights-based care and recognizing bodily autonomy, such as ICPD, the High Level Political Forum, UHC2030, and Generation Equality Forum action coalition commitments.

What are the relevant advocacy spaces for your organization or network where you can bring messages on self-care?

Leverage human rights obligations and review mechanisms to call for SRHR self-care as a human rights fulfilment.

When is the UPR cycle for your country and are you able to contribute to the stakeholder report?

Join or align with other organizations and groups—such as the Self-Care Trailblazers Group—to strengthen the call for self-care interventions.

Who can you work with to align your messages and amplify your voice?

ADVOCACY MESSAGES

For SRHR self-care options to become widely available in the Asia Pacific region, advocacy will be an important tool for organizations to use to create the conditions for widespread adoption. Furthermore, it is evident that the Covid-19 pandemic has not only challenged access to SRHR services but the entire SRHR agenda. Self-care can be used as a way to keep SRHR on the agenda and vice versa.

These advocacy messages are targeted towards national governments and can be adapted, as relevant, for the national and local level government being targeted. They can be used in international fora such as:

- ICPD, where the focus on SRHR can be used to bring forward arguments for SRHR self-care as an additional approach to ensure rights-based, inclusive and holistic SRHR information and services;
- HLPF where the annual review cycles which focus on relevant SDGs (SDG3, SDG5 and SGD10) can be used to leverage support for SRHR self-care; and
- UHC2030, where SRHR self-care can be brought forward as a necessary dimension under the Universal Health Coverage agenda.
- UPR cycles where the call for SRHR self-care can be brought forward as a human rights fulfilment. This will depend on the timing of the review for each country.[10]
- The Human Rights Council where special procedures in relation to Covid-19 have been launched with the aim of stressing the importance of adopting a human rights-based approach in addressing the crisis. CSOs and individuals can make submissions through the communications procedure regarding rights violations that have occurred in their country during the pandemic.[11]

PRIORITIZING SRHR SELF-CARE

TARGET: GOVERNMENT AND INTERNATIONAL FORA

- Priorities SRHR during epidemics or pandemics such as COVID-19. Neglecting SRHR places women and key populations at risk. Self-care can be an important strategy to:
    - Ensure SRHR access continues during the COVID-19 pandemic—while reducing Covid-19 transmission risks—and future public health emergencies.
    - Improve access to SRHR by reducing the need for patients and health care providers to travel long distances.
    - Provide dignity to users to obtain services in the comfort of their homes, ensuring privacy and anonymity.
    - Potentially save costs and resources in the healthcare system (e.g. digital technology to disperse SRHR information, self-tests and self-medication).

ADOPTING SRHR SELF-CARE

TARGET: GOVERNMENT

GOVERNMENTS SHOULD:

- Review and adapt existing or adopt new national SRHR policies and strategies to include self-care interventions.
    - Review policies and regulations to expand access to telemedicine/ telehealth, self-tests and self-managed abortion, contraceptives and ARVs.
    - Eliminate legal barriers limiting women's access to SRH services and commodities, including misoprostol and mifepristone, in support of self-managed abortion.
- Address structural barriers and eliminate all forms of gender based violence and discrimination to ensure women and adolescents' bodily autonomy and decision making over their SRHR, and enable access to contraception, SRHR self-tests and self-managed abortion.
- Collaborate with non-government service providers to integrate self-care into existing health systems, for example in the provision of accompanied self-testing and self-medication.

IMPLEMENTING SRHR SELF-CARE

TARGET: GOVERNMENTS, NGOs AND PRIVATE SERVICE PROVIDERS

GOVERNMENTS, NGOs AND PRIVATE SERVICE PROVIDERS SHOULD:

- Work together with NGOs and service providers to provide information on, address taboos and ensure access to self-care options, including:
  - SRHR self-tests, including self-tests for STIs.
  - Self-administered (injectable) contraceptives.
  - Self-managed medical abortion to help women make informed decisions and minimize risks to women's health.
- Make STI self-tests and self-administered injectable contraceptives and medical abortion pills available to complement the basket of choice to deliver contraception for individuals of reproductive age, this includes putting self-tests and self-injectable contraceptives and medical abortion pills on the Essential Medicines or Devices List (as relevant), work on procurement, and allow them to be sold/distributed through pharmacies.
- Train health workers on counselling for self-care, self-testing, self-injectable contraceptives and self-managed abortion e.g. on how to manage visits from self-injecting clients who return for re-supply.
- Train health workers and helpline staff on how to remotely provide counselling and referrals.
- Include the needs of women and marginalized groups (LGBTQI+, PWD, PLHIV, migrants, sex workers, amongst others) in the design of policies and self-care services, through consultative process.
- Develop and disseminate communication materials to health service users on the self-care initiative being offered, to ensure their health literacy is sufficient to benefit from the self-care services.

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