THE REPUBLIC OF UGANDA
MINISTRY OF HEALTH

STATUS REPORT

DOCUMENTATION OF THE UGANDA SELF-CARE IMPLEMENTATION; THE JOURNEY AND ACHIEVEMENTS FOR THE PAST 3 YEARS

APRIL 2024

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ABBREVIATIONS

ACHS	Assistant Commissioner for Health Services
ACP	AIDS Control Program
AGYW	Adolescent Girls and Young Women
ANC	Antenatal care
CEHURD	Center for Health, Human Rights and Development
CHAI	Clinton Health Access Initiative
CHEWS	Community Health Extension Workers
CHWs	Community health workers
CIFF	Children's Investment Fund Foundation
CME	Continued medical education
COF	Catalytic Opportunity Fund
CSOs	Civil Society Organizations
DLG	District Local Government
DHT	District Health Team
DMPA-SC	Subcutaneous Depot medroxyprogesterone acetate
FP	Family Planning
HCD	Human-centered design
HIVSTHIVST	Human Immune deficiency Virus self-testing
HMIS	Health Management Information System
iCCM	Integrated community case management
IPs	Implementing partners
IRC	International Rescue Committee
IT	Information technology
MOU	Memorandum of understanding
NAs	Nursing Assistants
NCDs	Non-communicable diseases
PAC	Post-abortion care
PA	Provider-Assisted
PNC	Postnatal care
PPG	Planned Parenthood Global

PSI	Population Services International
RAHU	Reach a Hand Uganda
SC	Selfcare
SCEG	Selfcare Expert Group
SCTG	Selfcare Trailblazers Group
SI	Self-injection
SOPs	Standard Operating Procedures
UFPA	Uganda Family Planning Activity
UNFPA	United Nations Population Fund
WHO	World Health Organization

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The self-care fraternity is most of all indebted to Dr. -Olaro, Director for Health Services, and the Ministry of Health, for demonstrating their complete dedication through exemplary leadership, institutionalization and continuous coordination of the SCEG; fast-tracking policies under which SC has been incorporated.

We would like to acknowledge the commitment of members of the SCEG and Mukono District Local Government (DLG) for successfully piloting the SC guideline and the 18 health facilities in Mukono district which were instrumental in identifying and supporting self-carers in their catchment areas.
Scaling up self-care in other districts for example the commemoration of SC Day in Dokolo district demonstrated commitment by MOH and readiness to not only scale up the intervention but to also raise the status of importance that stakeholders attach to SC.

Agencies sincerely acknowledged for supporting interventions in Mukono that handled engagement of the cultural and religious leaders in Mukono, Radio talk shows and other knowledge products include WHO, and Planned Parenthood Global (PPG).

Furthermore, we would like to sincerely appreciate Dr Jennifer Wanyana a technical resource and consultant who led the documentation of this piece of work. Finally, special thanks to the CEHURD technical working team which has led and made contributions towards the implementation and documentation of Uganda's journey for selfcare. These include: Ms.Fatia Kiyange, Mr. Frank Ategeka, Mr. Peter Eceru and Ms. Annah Kukundakwe.

EXECUTIVE SUMMARY

In 2019, the MOH through the Self-Care Expert Group developed the draft National Guideline on Self-Care Interventions for SRHR to institutionalize self-care in Uganda. The specific objectives of the guideline included; 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 (multi-stakeholder coordination, referrals, product, information), to facilitate the integration of self-care in the healthcare system (VHTs, IPCs, health promotion) and strengthen monitoring, evaluation, accountability and learning for self-care.

The Self-Care Guideline was successfully piloted in Mukono district and created awareness on the need to institutionalize self-care in the country as one of the means to achieve Universal Health Coverage. Additionally, through the strategic leadership of the Ministry of Health and the technical expertise of the members of the Self-care expert group, Uganda has registered significant policy reforms byincorporating Self-care into Health policies and strategies among other achievements. Uganda being one of the model countries for self-care, has had notable milestones, challenges and lessons that are worth documenting for the other countries to benchmark on for their own institutionalization.

The purpose of this report is to document and highlight the journey of self-care from inception, progress made, best practices, lessons and challenges attained in the implementation of self-care interventions in Uganda.

Approaches used in this process included; collection of quantitative and qualitative data, encompassing literature and records review, national and district level key stakeholder informant interviews, SC stakeholders' consultative meeting, and self-carers' focus group discussion. Various national policies, strategies, plans, guidelines and implementing partner activity reports, were reviewed. Relevant SC data was retrieved from the DHIS2 database and implementing partner activity reports. Stakeholders interviewed were from 13 agencies, 1 district, and 1 health center. The respondents either had membership in the selfcare expert group (SCEG) or were active in the implementation of SC projects or activities. This data was analyzed, incorporated into the SC journey documentation report, and also used to populate the National SC dashboard for the period July – December 2023. The report and the dashboard were presented in a SC stakeholders' meeting for validation for their endorsement and inputs.

According to the findings, the two predominant self-care interventions in Uganda are self-injection (SI) using Subcutaneous Depot Medroxyprogesterone Acetate (DMPA-SC) for contraception and HIV self-testing (HIVST). Uganda's SC journey commenced in 2015, with operational research on self-injection (SI) for contraception among women in reproductive age using of DMPA-SC. The positive pilot results ended into SI with DMPA-SC approved for scale-up. In 2017, the National Drug Authority (NDA) approved use of DMPA-SC for contraception in Uganda, and in the same year, DMPA-SC was incorporated into the Uganda essential medicines list. In 2021, MOH approved a policy for drug shops to dispense DMPA-SC. The proportion of districts implementing SI increased from 3% in the year 2021 to 89% in 2023.

The journey for HIV self-testing (HIVST), started later, with an HIVST pilot in key populations in ANC targeting male partners in 2017, followed by Deprivine virginal ring being approved as an SC method in the year 2019, and by the year 2020, HIVST had been rolled out in 21 districts based on pilot results. A Pilot to promote awareness and uptake of HIVST in the private sector was carried out in 2020. By the end of 2022, there were trained service providers in 80% of HC IIIs, 100% of HC IVS, and 100% of hospitals providing HIVST in 22 districts.

Government response following onset of the Covid epidemic in 2020 in Uganda, was characterized by surveillance, contact tracing, and isolation and lockdown in the affected districts. The districts affected further experienced limitations in access to health care (preventive, clinical, rehabilitative) owing to related fear of COVID-19 infection, travel restrictions nationally and by district, surveillance measures of quarantine for confirmed cases and their contacts. The most plausible and feasible remedy was to promote selfcare, for covid illness, other illnesses, diagnostics and public health measures (family planning).

Development of the National Consolidated SC guideline took place from 2019 to 2023 and this was informed by release of the 'Consolidated Guideline on Self-Care Interventions for Health: Sexual and Reproductive Health and Rights' by the WHO. The WHO guideline provides people-centered, evidence based normative guidance to support individuals, communities and countries with quality health services and self-care interventions. Self-care Expert Group through engagement of a consultant, successfully piloted the Self-Care Guidelines in Mukono district and created awareness on the need to institutionalize self-care in the country as one of the means to achieve Universal Health Coverage. Stakeholders on SC have also contributed to implementation of SC through streamlining SC into relevant policies, strategies and guidelines, applicable regulatory processes, supporting service delivery, obtaining political commitment and mobilizing funding.

As per the national SC dashboard, most of the SC indicators for the reporting period were on track and some had been achieved such as the SC guideline development and incorporation of SC into the national policies, strategies and related guidelines. There are several best practices and lessons learnt captured in this report, that SC stakeholders can still apply to ensure successful implementation of SC. However, health systems gaps for example, SC product stockouts, data management gaps, quality assurance gaps), exit. It is recommended that these gaps are addressed in order to have optimal results from self-care.

SECTION 1: **INTRODUCTION**

1.1 BACKGROUND

According to the WHO, self-care is the ability of individuals, families and communities to promote and maintain health, prevent disease, and cope with illness and disability with or without the support of a healthcare provider. Self-care encompasses all individual activities which contribute to physical and mental health and overall wellbeing. It includes daily behaviours and activities across the spectrum of self-management of minor ailments, including: self-directed use of medications, informed use of digital health technologies, through to co-management of complex conditions under professional health supervision. From the WHO definition above, self-care includes health promotion; disease prevention; self-directed medication; providing care to dependent persons; seeking hospital/specialist/primary care if necessary. Individuals choose self-care interventions for a range of reasons including convenience, confidentiality, and cost. People can also choose self-care interventions to avoid health systems if they anticipate that they may face stigma and discrimination Recent advances in medical and digital technology combined with changing consumer expectations provides an opportunity to refocus attention on this important and evolving approach. Self-care interventions, particularly in the realm of Sexual and Reproductive Health and Rights (SRHR), have transformative potential to increase individuals' autonomy in making decisions about their own care, strengthen countries' health systems, and ultimately pave the way towards Universal Health Coverage (UHC). Selfcare offers particular promise for helping to reach vulnerable populations, including the 270 million women and girls in the developing world who have an unmet need for contraception, the 7.1 million individuals living with HIV who are unaware of their status, the 84% of cervical cancer cases that reside in the developing world, and including those living in humanitarian contexts.

Uganda through the relevant Ministry of Health opted for a two-pronged approach of contextualizing the WHO's Consolidated Guideline on Self-Care Interventions for Health so as to develop the National Guideline for Self-Care Interventions for SRHR. Uganda is one of those countries that has progressed in adopting of the WHO guidelines and contextualizing these to our context. These approaches under taken by the Ministry included the Guideline Development Stage – This involved formation of the Self-Care Expert Group (SCEG) and draft national self-care guidelines and Implementation Stage also known as the pilot which was aimed at implementing the guideline within the existing healthcare system, collate learnings and update and finalize guideline for approval and launch. The guideline is awaiting to be presented before Senior Top Management for final approval.

The Ministry of Health in collaboration with the Self Care Expert Group members successfully piloted the Self-Care Guidelines in Mukono district and created awareness on the need to institutionalize self-care in the country as one of the means to achieve Universal Health Coverage. Additionally, through the strategic leadership of the Ministry of Health and the technical expertise of the members of the Self-care Expert Group (SCEG), Uganda has registered significant policy reforms through incorporating Self-care into Health policies and strategies among other achievements. Uganda being one of the model countries for self-care, has had notable milestones, challenges and lessons that are worth documenting for the other countries to bench mark from for their own institutionalization.

1.2 OBJECTIVES

- To document the journey of self-care from inception, progress made, results, best practices, lessons and challenges attained in the implementation of self-care interventions in Uganda.
- To populate the self-care Country Monitoring Dashboard for the implementation period July 2023-December 2023.

1.3 METHODOLOGY

Approach used in documentation was collection of quantitative and qualitative data, encompassing literature and records review, national and district level key stakeholder informant interviews and self-carers' focus group discussion.

The desk review entailed review of the national policies, strategic plans, relevant guidelines (RH, HIV, SC), and DHIS2 database records review. Key informant interviews were held with the Chairperson of the Uganda SCEG, MOH programs (Reproductive Health, AIDS Control Program), CEHURD, Makerere School of Public Health, Population Services International (PSI Uganda), International Rescue Committee (IRC), PATH, Samasha, Reach A Hand Uganda (RAHU), Marie Stopes (MSU), FHI360, SC national technical officer, Mukono District Local Government, and Kyabazaala HC III. One Focus Group Discussion was held in Mukono district (the SC pilot district).

The data gathered was analyzed and a report compiled. Data for this report indicates the milestones registered by Uganda for the last 3 years since the inception of the institutionalization of selfcare. This report was presented in a SC stakeholders' consultative meeting intended to gather more inputs for the Uganda SC journey especially from stakeholders who had not participated in the individual KIIs. Their

inputs were utilized to further beef up the report and update the dashboard. Another SC stakeholders' meeting was held with the major intention of validating the consultant's report and dashboard. After presenting the documentation report and the dashboard, what had been presented was endorsed without any modification.

SECTION 2: **UGANDA'S SELF-CARE JOURNEY**

This section covers the historical perspectives of self-care implementation; depicts where we have been; with key milestones from the perspective of SC stakeholders, highlighting specific timelines and key achievements since inception of the core SC interventions.

Pre-covid period

Implementation of selfcare in Uganda started at household level with support from pharmacies and drug shops, in the nineteen hundreds, way before the covid epidemic. At household level, individuals were accessing over the counter SC medicines, health supplies, diagnostics, such as various brands of male condoms, a variety of oral contraceptives, emergency contraceptive pills, pregnancy test kits, urine sugar and protein test kits and a few brands of uterotonics. In the 2010s, Implementing Partners piloted then rolled out the DMPA-SC (Sayana press) projects involving self-injection, in a bid to improve access to Family Planning services and to support the women in reducing the need for repeated visits to a health facility. The Ministry of Health HIV/ AIDS national program joined the band wagon by introducing the HIV self-test kits. At that time, the Ministry of Health did not have guidelines or clear mechanisms for regulating selfcare.

Covid and post-covid period

Onset of the Covid epidemic in 2020 in Uganda, was characterized by a limitation in access to health care (preventive, clinical, rehabilitative) owing to related fear of covid infection, travel restrictions nationally and by district, surveillance measures of quarantine for confirmed cases and their contacts. Other challenges that the communities were facing included bottlenecks in having re-fills for the persons living with HIV (PLWHIV) together with problems in accessing services for contraception either for initiating or continuation by the women in reproductive age (WRA). The most

plausible and feasible remedy was to promote selfcare interventions, in order to be able to not only manage covid illness, but to also manage other illnesses, and carry out selected diagnostic procedures and public health measures (such as family planning). World Health Organization (WHO), Children's Investment Fund Foundation (CIFF), Selfcare Trailblazers Group (SCTG) and other organizations came on board then, to ensure quality of selfcare by developing and supporting countries to develop country-specific guidelines on implementation of selfcare.

The Table 1 below depicts highlights on key milestones and of self-care past achievements.

Table 1: National level Key self-care milestones on past achievements

Year	Milestone
2014 2014	Contraceptive self-injection was approved by regulatory authorities in more than 25 countries, including the European Union.
	Contraceptive self-injection was registered in Uganda.
2015 2015	WHO recommendation for contraceptive self-injection.
	First phase of research was conducted on SI which was on acceptability and feasibility. Findings: Over 90% acceptability rate.
2016	Sayana press was integrated in Uganda's Essential Medicines List.
	Sayana press Included in the clinical guidelines for provider and VHT administration.
2017 2017	Sayana press was approved for self-injection by National Drug Authority (NDA.
	Implemented a pilot on HIVST in key populations in ANC under which they were targeting male partners.
2018	Second phase of research conducted on effectiveness measured by continuation rates of self-injectors compared to provider administered clients. Findings: 85% for SI vs 64% for provider-assisted (PA) Sayana, continue to use FP after 1 year of follow-up.
	Sayana press for self-injection was integrated into the Health Management Information System (HMIS).
	PEPFAR started funding HIVST and kept scaling up; then Global Fund in 2020. Thereafter, funding was from PEPFAR, Global Fund and Government of Uganda (GoU).

2019	Self-injection was approved to be included in the clinical guidelines and roll out.
	Self-injection with Sayana press was integrated in self-care guidance.
	Uganda approved use of Deprivine virginal ring as a self-care method which is a major step in the prevention of transmission of HIV among the most at-risk populations such as female sex workers.
	Roll out of HIV self-test in 21 districts basing on what worked well in the pilot.
	Before the consolidated guideline was developed there are interventions that were ongoing (e.g. HIVST, Policies in place, eHealth policy for releasing health information online for people to access products, e.g. Jumia that was augmenting delivery of SC products online. These helped to inform the institutionalization of SC that is now ongoing.
2019 - 2022	Started training in 2019 with 22 districts and 79 facilities. Have trained all the HFs providing HIVST (80% of HC IIIs, 100% of HC IVS, and of hospitals). The scale-up was gradual, with an increase each year in facilities and districts covered, until they reached the above coverage. In 2022 integrated the training into the rolled-out consolidated guidelines.
2020	Third phase of research on operational considerations for scale. Findings: SI is feasible and scalable outside research settings; results informed the policy for approval of scale up SI in Uganda.
	National scale-up rolled out for self-injection using Sayana press.
2020/2021	Formation of the SCEG for having a direction to SC and coordinate the formulation of the Uganda self-care Guideline on SRHR
	Formed the SC six technical task teams (Quality of Care, MEA&L, Social Behavior Change, Finance, Human Resources, Medicines and Supplies) have been formulated with Terms of reference (ToRs), to advise on health system preparedness, adoptability and develop standard operating procedures (SoPs) for integrating self-Care within the existing health system
	Development by MOH and SCEG, of the National Consolidated SC Guideline for SRHR as informed by the Mukono SC pilot.

2020 - ongoing	Global engagements/ meetings were talking about SC. Director Health Services (DHS) picked it up as a good intervention. The DHS mobilized and coordinated stakeholders to form the Selfcare Expert Group (SCEG) comprising (a) Secretariat for SCEG (Focal point); (b) advocates for SC (c) the academia; (d) Implementing Partners for SC (e) research agencies and humanitarian agencies, (f) UN agencies responsible for buying SC commodities and provide updates on SC commodities; (g) UN agencies who provide technical guidance (h) NGOs key in Community based implementation for SC; (i) NGOs supporting service delivery and capacity building of VHTs; (j) Regulatory organizations; (k) policy makers and decision makers; (l) Professional associations; (m) Media; (o) HMIS focal person Information on SC and HIV self-testing: (p) HIV and RH program managers: (q) Mukono District Local Government: District SC pilot; (r) SC National Technical Advisor in MOH, to institutionalize SC into other programs of MOH; (x) young people.
2020 – Oct 2023	Commenced implementation of a SC project on HIV self-testing (HIVST) in Kampala with promotion of awareness and uptake of HIV-ST kits in the private sector. The project is being piloted in Uganda, Nigeria, Kenya; funded by CIFF. Had cross learnings.
2020 to-date	Implementing a CIFF-funded "Delivering Innovations in SC" (DISC) whose goal is to promote SC starting with the SI contraceptive. The project started off with consumer and provider research using the Human centered approach that enabled it to uncover the current needs and opportunities for integrating SC into the health system. Research highlights showed that there were gaps in awareness on SI (e.g. not knowing that SI exists, SC products exist, where to access products from; insights on willingness to pay). Trained 20 providers in private sector using the curriculum for private sector providers. Achievements: (a) DISC was the secretariat for the drug shop task force in 2021. Successfully advocated for a policy change for drug shops to dispense injectable contraceptives. Now drugs shops can give contraceptives by SI.
2021	Developed the SOP or guideline to operationalize the SC Consolidated Guideline.
	Did a legal and policy analysis on SC.

	Conducted a legal and policy mapping and analysis to identify laws and policies that recognized self-care as a key health intervention and identify advocacy opportunities that can be exploited to bridge the gap. A number of laws, policies and strategies were found to be blind to self-care (e.g. Uganda Clinical Guidelines, Essential Medicines and Health Supplies List for Uganda, etc). In 2022, SCEG members met to ensure that Self Care is incorporated into these policy documents.
	Held an inception meeting (Oct – Nov) with the District Health Team (DHT) on how to start the SC project and taking on Mukono as a pilot district, with an urban and rural setting. This meeting gave birth to the Selfcare Expert Group (SCEG) a stakeholders' forum which had technical, political and Implementing Partner (IP) representation. The SCEG then engaged the political leadership of Mukono district to get their buy-in; the IPs to discuss the reporting tools and mechanisms for getting in the data; the health facility in-charges to obtain their buy-in and secure their consent because some of them look at SC as taking away their role.
	Conducted a stakeholder mapping aimed at identifying which partners were implementing self-care, and where they were implementing and building a resilient SC movement in Uganda. This mapping was followed by stakeholders defining the advocacy journey through development of a national advocacy strategy for SC which has continued to be a guiding framework for the advocacy interventions the country has implemented to date.
	Conducted a Legal and Policy analysis and mapping aimed identifying the strengths, weaknesses, opportunities and threats (SWOT) to achieving self-care in SRHRs in Uganda. From this analysis a policy brief with recommendations towards legal and policy change that the country needed to adopt and this became a pinpoint on which all the policy reviews that recognized self-care as a key health intervention have been hinged
2021 to-date	Expansion of implementation of SI from 4 (3%) to over 120 districts (89%) out of 135 districts supported by IPs. These efforts have led to a cumulative total to date, of SI 223,083 self-injectors, with 15,000 CHWs trained; 20,993 providers trained in the public sector; 622 providers trained in the private sector.
2022	Held orientation meeting on SC with village health teams (VHTs) and Health Assistants to sensitize them on the community arm of SC (existence of SC and empowering the community to know about SC).

	Engagement with cultural, religious, opinion leaders and the youth to orient them on their role regarding spreading the message to the congregation about existence of SC.
	Held a youth and religious leaders' dialogue meeting to orient the youth and empower them on SC.
	Radio talk show held to discuss SC with the general populations.
	TV talk shows on maternal child health including SC especially FP.
	Developed a Monitoring and Evaluation framework for SC.
	Adapted and finalized the SC Quality-of-Care framework.
	Technical support supervision by national (School of Public Health) and sub-national teams on SC
2022	Process of development of SC guidelines commenced through establishment of the SCEG and hiring the national SC Consultant to facilitate the SCEG in development of the guidelines and its pilot in the learning district. Carried out an extensive SC assessment which guided the SCEG to select the areas of focus for the guideline (intervention areas). Through several consultations, validation meetings, there was consensus on the areas which led to finalization of the guideline.
2022/2023	Integrated selfcare including SI into seven national strategic documents/ guidelines, such as FP2030 commitments, Family Planning Costed Implementation Plan (FP-CIP II) 2021 - 2025, Sharpened Plan on RMNCAH, the Uganda Clinical Guidelines and the National Essential Medicines list the National in-service FP training manual; HMIS. Others are ongoing (e.g. Adolescent Health Policy).
2022/2023	National scaleup plan for SI for DMPA-SC was developed.
2022/2023	Integrated selfcare including HIVST into the national strategic documents, such as the National Consolidated SC guidelines, HMIS. Others are ongoing (e.g. Adolescent Health Policy).
2022/2023	Integrated SC into other existing MOH guidelines, e.g. HIV testing guidelines.
	Integrated selfcare into some national strategic documents, such as the RMNCAH Sharpened Plan, Consolidated SC guidelines, HMIS. Others are ongoing (e.g. Adolescent Health Policy).

<table>
<tr><td rowspan="5">2022/2023</td><td>Integration of SC into the thematic areas (i.e. laws, legislation and policies; regulatory approvals; service delivery practices; current practice in community including, advocacy awareness creation across the board; Political commitment including financing for self- care.</td></tr>
<tr><td>Integrated SC into other existing MOH guidelines, e.g. HIV testing guidelines; the national FP training manual.</td></tr>
<tr><td>The SCEG piloted SC implementation in Mukono district. Learnings from this pilot informed development of the National SC guideline on SRHR</td></tr>
<tr><td>Developed IEC materials on SC including media sensitization of the public.</td></tr>
<tr><td>Community strategy on SC developed and launched.</td></tr>
<tr><td>February 2022</td><td>District SC pilot: Training of Trainers on SC was done. Participants were drawn from Mukono District Local Government (DLG) and MOH.</td></tr>
<tr><td>March – April 2022</td><td>District SC pilot: The first set of 10 health facilities were identified and trained on SC.</td></tr>
<tr><td>May 2022</td><td>Mukono pilot project on SC commenced implementation in 10 Government health facilities and kept expanding until September 2022 when they reached 18 facilities comprising private for profit (PFP), private not for profit (PNFP) and Government facilities.

Numbers reached:
doses contraceptive self-injectors: # doses SI Outreach 1173; # doses SI CBDs 225; # doses SI Pharmacy 362; # doses SI Unit 2446.
<table>
<tr><td>HSTHIVST kits distributed - Unassisted</td><td>3,651</td></tr>
<tr><td>(+)ve HSTHIVST</td><td>657</td></tr>
<tr><td>Confirmed (+)ve</td><td>519</td></tr>
<tr><td>% confirmed (+)ve</td><td>79%</td></tr>
</table></td></tr>
<tr><td>2022 – May 2023</td><td>Regulatory process: Have managed to reduce the registration time of HIV self-test products from 6 months to less than 3 months.</td></tr>
<tr><td>Dec 2023</td><td>Revised the National HIV Testing Kits Optimization Plan for 2023. Intended to optimize all approaches including HIVST.</td></tr>
<tr><td>2023 - ongoing</td><td>Implementation of Government to Government (G2G) project in seven regional referral hospitals with a component on HIVST for eligible population including the adolescent girls and young women (AGYW), partners of the pregnant and lactating women.</td></tr>
</table>

2023	Research done: A multi-regional study was conducted to assess the feasibility of FP-HIV service provision using a Self-care approach, if the service is integrated into the Differentiated ART Service Delivery Models DSDMs (SC-DSDMs) that are pick-up points for HIV clients for easing access to ART. It was found that these pick-up points can be leveraged to improve access to self-care-oriented FP services (through integrated FP-HIV services) among 64% of PLHIV getting care through SC-DSDMs .
2023	Criteria was developed for an implementation district and guidelines (for district entry); developed a district supervision tool, national level supervision tool and training materials (for capacity building), thereby culminating in commencement of implementation around March/ April 2023, and thereafter finalization of the SC guideline. Submitted the final guideline in October/ November 2023.
2023	Started Implementing a SC project sub-nationally and nationally in refugee settlements.
	CSOs met with Members of Parliamentary Health Committee, to update them on Uganda's Journey in Institutionalizing self-care and the understanding of the concept of self-care in Uganda. MPs acknowledged that Self-care interventions as among the most revolutionary approaches to improve health and well-being. Meeting outcome was unanimous adoption of the second Consensus document highlighting priority areas that the committee will focus on during the remaining years of their tenure of office; among these priority areas indicated for Government to allocate financial resources was the finalization, launch and implementation of the National Guideline for Self-Care for SRH which in turn is expected to be a catalyst to Uganda's efforts to eliminate HIV/AIDS by 2030.
	Held a multi-sectoral coordination and collaborative efforts cross government Ministries, departments and agencies meeting to urgently improve the state of Sexual Reproductive Health and institutionalization of self-care. The inter-ministerial meeting which was intended to strengthen coordination/ collaboration across ministries, was also for to updating and orienting them on self-care and the journey Uganda has traversed since 2020 including achievements, challenges, lessons and the piloting of the National Self-care Guideline in Mukono district.
	The inclusion of a SC data element within the addendum to the HMIS to capture data on SI.

SECTION 3: EXTRACT OF ACHIEVEMENTS FOR THE REPORTING PERIOD (JULY – DECEMBER 2023) AS PER THE FINDINGS FROM THE COUNTRY MONITORING DASHBOARD

3.1 WHERE ARE WE TODAY?

This section illustrates performance for the current reporting period, July to December 2023 commencing with the achievements from the perspective of the self-care indicators that Uganda has been assigned under each self-care thematic area, notably, Laws, legislation and policies; Regulation approvals; Service delivery; and Political commitment and financing for self-care. For each indicator, status of attainment is portrayed by a colour code; green for the respective activities "Completed"; amber for "Ongoing but off track"; Orange for "Ongoing and on track"; Red for "Not started".

3.1.1 Achievements on the uganda-specific selfcare indicators by thematic area

Laws /Legislation & Policies

INDICATOR	ACHIEVEMENTS	STATUS (HEALTH AREAS)
5.1.1. Two national policies/ frameworks/ implementation guidelines for SC for SRHR finalized and launched by MOH annually	ADH and SRH policies were merged into the National Health Policy and SC was incorporated; the new policy is yet to be signed.	On going, on track (FP, PAC, ANC/PNC, Other SRH, ADH)
5.1.2.SC policies, frameworks, guidelines, and strategies institutionalized at national and sub national levels.	(a) Integrated SC into some national strategies, finalized; and launched them at the National Safe motherhood day commemoration e.g. Clinical Guidelines; Essential Medicine's list; Family Planning Costed Implementation Plan (FP-CIP II); Reproductive, Maternal, Newborn, Child, Adolescent and Healthy Aging Sharpened Plan II 2022/23 – 2026/27 (previously approved) inclusive of SC; (b) MOH leadership was oriented on SC integration and institutionalization in all Directorates in MOH.	On going, on track (FP, ANC/ PNC, Other SRH, ADH)

5.1.3. Self-care is incorporated into at least 6 sub national implementation plans; increasing by 6 plans annually	Officials and community actors in 9 districts of Greater North, made commitments on how to mainstream SC in the district work-plans during the SC commemoration month in Dokolo district.	On going, on track (FP, ANC/PNC, HIV, Other SRH, ADH)
5.1.4. Temporary or permanent structure with authority, resources, and information to coordinate scale-up	SCEG meets at least once every 6 months to discuss SC implementation updates and coordinate scaleup.	Completed (All health areas)

Regulatory approvals

INDICATOR	ACHIEVEMENTS	STATUS (HEALTH AREAS)
5.2.1National regulatory frameworks that increase access to self-care (OTC, task sharing protocols authorizing private sector/ pharmacists, CHWs to initiate SC) developed and approved.	(a) Awaiting approval of provision of contraceptives for SI through pharmacies by Top management of MOH. (b) Commencing development of standard operating procedures (SOPs) for online channels for dispensing DMPA-SC for SI. (c) Did mapping of drug shops in refugee settlements and host communities in 2 districts to prepare for SI. Most drug shops were not certified with NDA, hence the national committee on FP will do verification of all drugs shops. (d) Ongoing mentorship under the drug shop initiative intended to increase SI through drug shops (targeted will be done during supervision).	On going, on track

5.2.2 Regulatory policies are modified to expand access to marginalized, vulnerable, and hard to reach populations	(a) Incorporated into the National SC Guidelines, SC for adolescent girls and young women (AGYW) in refugee settlements and their host communities. (b) Commenced SC project in refugee settlements. (c) Did research in refugee settlements resulting in an innovative SC card for SI. (d) Did mapping of drug shops in refugee settlements and host communities in Lamwo and Yumbe districts (focusing on the Parabek and Bidibidi settlements) to prepare for SI through certified drug shops. All drug shops will be verified in the refugee settlements by the national committee on Family Planning.	On going, on track
5.2.3 Community based providers are allowed to train, initiate/or stock/ provide self-care commodities	Not yet done	Not started

Service delivery practices: programme strategies and guidelines

INDICATOR	ACHIEVEMENTS	STATUS (HEALTH AREAS)
5.3.1 National self-care guidelines for SRHR finalized, launched, and disseminated to key stakeholders	Following more priority areas being added globally to SC, the National Consolidated SC Guideline has been updated and finalized to incorporate additions of NCDs, mental health for older persons, and adolescent health. It is awaiting signature.	On going, on track (all health areas)

5.3.2 Consolidated self-care guidance for national health priorities developed and incorporated into national strategies.	(a) Developed SC criteria and tools for district entry; a district supervision tool, national level supervision tool and training materials. (b) Incorporated SI and HIVST indicators into HMIS through an addendum. (c) The health register has been updated to include a column where all self-care interventions can be reported. This is yet to be finalized and printed for usage. (d) Rolled out Echis system throughout the district which also reports about SC services.	Completed (all health areas)
5.3.3 Self-care guidance integrated into new or revised SRHR related strategies and frameworks	(a) Designed, field-tested and finalized SC knowledge management tools. (b) HIV strategies and policies were revised to cater for SC. Examples are: the National HIV Testing Kits Optimization Plan for 2023 covering optimizing all testing approaches including HIVST; the HIV testing services policy & Implementation guidelines; Guidelines for HIV prevention, care & treatment.	Completed (all health areas)
5.3.4 Implementation of self-care Scale-up - No of districts providing comprehensive SRHR self-care programme	Data on this indicator is described under the section "Available self-care data". All in all, the number of districts implementing SC is gradually increasing.	On going, on track
5.3.5 Self-care integrated into the pre-service and in-service training curricula for HWs	a) National Comprehensive Family Planning clinical skills curriculum for in-service training, has SC content. (b) The "moment of truth" training curriculum that enables providers to support women overcome barriers in uptake of SI, has been integrated into the in-service national FP training curriculum. (c) In-service FP and HIV curriculum have SI & HIVST incorporated. (d) Have adapted the National HIVST curriculum for private sector.	On going, on track

5.3.6Increased access to SRHR self-care services at community level	During the reporting period, there were 93,471 self-injectors from 63 districts . Total of 278,620 HST kits were distributed, out of which, 2933 (1.1%) tested positive with the HST. Out of the kits distributed, 1480 (0.5%) were confirmed positive. The truly positive self-tests, 1480, translated into 50.5% of those that had tested positive with the HST. With 16 days of activism held targeting young persons (aged 15 to 30 years) due to increasing prevalence of HIV, prior to the World AIDS day, in 3 districts (Mbarara, Isingiro, Rwampara) The national AIDS day was commemorated in Kabarole, Rwampara, and Isingiro districts. hosted by Tooro kingdom. An inter-generational campaign and dialogue on HIV/ AIDS prevention were run, integrated with HIVST messages; HIVST kits were distributed; and outreaches were held.	Ongoing, off track
5.3.7Partnerships developed with key stakeholders (e.g. ob/gyn, midwives, nursing, pharmacists' associations) to increase awareness of self-care to mitigate opposition	(a) Have set up an IT tracking system of SC stakeholders, showing their SC areas of priority and their geographical areas of operation. (b) Oriented 57% (4 out of the 7) of the targeted professional associations & training institutions on SC, (Pharmaceutical Society, Uganda Medical Association, Midwifery and Nurses Association, Training Institution for Midwives-Makerere). All committed to add SC. Memorandum of understanding (MOUs) with them have not yet been signed. (b) Inter-ministerial engagements were held with non-health Ministries to orient them on how they can move SC forward. (c) AIDS Control Program embraced SC	On going, on track

Political commitment including financing for self- care		
INDICATOR	**HEALTH AREAS**	**STATUS (HEALTH AREAS)**
5.4.1 Political awareness and support for self-care increases among target decision makers	(a) MOH held a district leaders' orientation on SC in 7% of districts, during which they formed champions for SC and commitment to support SC in their districts. (b) Uganda has set aside, June – July, as the SC commemoration month. The month was commemorated in Dokolo district.	On going, on track (All health areas)
5.4.2 Self-care policies and financing are instituted at national level paving way for institutionalization at various healthcare levels	(a) SC has been included in the MOH strategic Plan (b)In a bid to solicit for domestic financing of SC, Civil society organizations (CSOs), in their' budget frame work paper for F/Y 2024/25 recommended that the budgetary allocation for Procurement of self-care commodities that is currently among the unfunded priorities, be increased; and subsequently presented it to the Parliamentary health committee for further discussion and consolidation. Awaiting feedback after it is forwarded to Ministry of Finance for endorsement.	On going, on track (All health areas)
5.4.3 Costed Implementation Plan for implementation of self-care interventions developed - national and sub national	SC stakeholders held a meeting to plan for 2024 and beyond but also reviewed and updated the key indicators for the Country SC Monitoring Dashboard.	On going, on track (All health areas)

5.4.4 MOH allocates annual budget for implementation of National Self-Care Guidelines	(a) ACP (MOH) allocated funds from Global fund to HIVST. ACP is also funded on HIVST by PEPFAR and Global Fund. (b) CIFF is funding institutionalization of SC at MOH; funding FHI360 for research on SC; funding PSI; funding PATH on SI training, supervision, mentorships. (c) Bill and Melinda Gates is funding PATH on SI training, supervision, mentorships. (d) Hewlett and Packard are funding IRC on SC in refugee settlements & host populations. (e) TOT of providers to integrate SC into implementation was funded by WHO and UNFPA.	On going, on track (FP, HIV)
5.4.5 Dedicated technical lead for self-care in MOH	(a) MoH has a SC desk officer (National SC technical lead). (b) A global SC Advisory Board was established and the MOH SC technical specialist is the representative of Uganda on the board. (c) SCEG is an advocacy platform that meets quarterly on SC matters. (d) SCEG formed small committees to functionalize SC.	Completed (All health areas)
5.4.6 Demand and accountability for self-care increases among the target communities and constituencies	(a) Commemorated the first SC awareness month (June-July) was held in Dokolo district. During the SC awareness week, pre-events symposium was held during which district officials and community actors made commitments on how to mainstream SC in the district work-plans. (b) Had media orientation on SC to ensure positive media reporting. (c) Conducted radio and TV talk shows on SC. (d) Oriented 29 health journalists on SC for informed reporting. (e) National SC status report compiled every 6 months.	On going, on track

Current practice in community

Even though the thematic area of “Current community practice” does not feature among the SC indicators to be reported on, this section has been added in order to note the respective achievements.

PLANNED ACTIVITY AS PER REPORT FOR JAN – JUNE 2023)	ACHIEVEMENTS	STATUS
Media fellowship with an aim of onboarding journalists to positively report and amplify self-care in Uganda	26 media personnel were oriented on SC	Completed
Amplify country wins at the September 2023 women Deliver conference, cross learn from other countries and share best practices.	Selfcare amplified at a Global conference, created visibility for Uganda's interventions on sel care and successfully intersection to gender equality and bodily autonomy created	Not started
Coordinate and implement a self-care workshop as part of the planned 2023 national conference on health, human rights and Development. (UHCD)	This was successfully conducted, and scaling up of self-care interventions and solidifying the institutionalization of Self-care was among the commitments and outcomes of the UHCD outcome document known as the Kampala on Declaration Health and Human Rights	Completed
Contribute to growth of the SC movement with more individuals, health professionals, stakeholders and policy makers expressing interest to advocate for SC, created national buy in for SC, and solicit commitments from policy makers.	During 2023 Safe motherhood conference, SC was amplified in a panel discussion and on social media. Altogether, during the reporting period, the engagements held had a reach of 15,503,619.	Completed

3.1.2 FURTHER EVIDENCE OF POLITICAL COMMITMENT TO SC

What has facilitated political support for selfcare? The response to this question was highlighted to be "Nonpolitical affiliation" and "Engaging political arms in major consultations".

What has facilitated responsiveness to selfcare from MOH? The response was "Partner involvement".

Other examples of political commitment included:

- Have engaged members of Parliament to solicit political will, allyship and appreciation for SC in achieving Universal Health Coverage (UHC). of Parliamentary Health committee Chairperson committed to use his position to advocate for inclusion among the priorities for Government funding, SC given that it has a potential to contribute to the reduction in HIV prevalence.
- Members of parliament engaged in the previous reporting cycles have continued to demonstrate good will to champion self-care in spaces like the safe motherhood conference.
- Development partners like WHO and policy makers from the Ministry of Health and Education also have continued to publicly declare their belief and allyship to self-care.

The Hon. Minister of Health in another one her speeches, further emphasized that:

> *"given the health systems indicators such as human resource gaps in low-income settings; HIV prevalence among adults (15-49 years) of 6% but higher in females (7.5%) in comparison to males (4.3%); as well as among adolescent females (1.8%) compared to male counter parts (0.5%); low uptake of PNC; the limited access to health care and inequitable service provision; it is imperative that stakeholders continue to embrace Self-care in aspects of health, remembering that Self-care is with or without support of the health provider".*

- The Minister of Health (political head of MOH) also demonstrated in her speech during the Uganda conference on Health, Human Rights and Development, her commitment and passion for SC by stating:

> *"We look forward to innovative approaches such as self-care interventions: enhancing primary health care; contributing to Universal Health Coverage."*
> *"Such Self-care interventions can empower individuals and communities to manage their health and well-being; strengthen national institutions with efficient use of domestic resources for health; Improve primary healthcare (PHC) and contribute to achieving UHC "*

- Participation of the core SC program in various stakeholder forums has opened doors for wider stakeholder engagement and potential funding for SC. The AIDS Control Program, for instance, through their HIVST intervention, fully embraced SC through rigorous engagement at various forums; this was the time when HIV

was finalizing the HIV grant through the Global Fund; as a result, a significant chunk of funds for Global fund has been allocated for HIVST. It is anticipated that around May 2024, HE the President launch a campaign called “Check now”, to mobilize the population to come and self-test for HIVs.

3.1.3 SELF-CARE FROM THE PERSPECTIVE OF THE DISTRICT SELF-CARE FOCAL POINT AND THE DISTRICT HEALTH OFFICER (Mukono SC pilot)

The District Health Team perspective on negative factors that may impede SC (Mukono SC pilot), were described to be:

- “Data capture: Since people are self-caring, it is sometimes hard to document the SC products that have been utilized.
- There exist scenarios whereby the client may intentionally or unintentionally give a telephone that is not valid, rendering it difficult to follow them up especially in regard to HIV self-testing.
- Poor storage of SC products (e.g. Oraquick) and HCG. These are sensitive to exposure to sunshine which renders them non-functional, and sometimes give false negatives or false positives. This affects quality of care.
- Poor time management by clients while conducting self-tests, thereby not abiding by the Standard Operating Procedures (SOPs), also leads to false positives or negatives. This affects quality of care.
- MADARAJA an NGO is promoting SI with Sayana and they commenced with 8 private clinics in August following an inception meeting with the DHT and training of service providers; and plan to expand to 20 private clinics by the end of 2024.”

3.1.4 HEALTH FACILITY PERSPECTIVE ON SC (Mukono SC pilot)

The SC focal person at the HC III define selfcare as:

> *“The way anyone should conduct themselves on how to look after themselves without the support of a health worker in their home and community.”*

SC activities that were described to be taking place at the health facility included:

- Laboratory supplies like Oraquick, HCG which all help to reduce the work load.
- SRH: Post-abortion care (FP e.g. SI with Sayana;)
- Educating mothers on how STIs are spread, what symptoms to look out for before

coming to the HC;
- Condoms and lubricants
- In ANC: Educate women on SC, hygiene, breast examination and care.
- HIV, STI: Self-testing: What is used for HIV self-test is Oraquick (is oral) and INSTI (for pricking) and Sure check for pricking.

Views of the service provider responsible for supervising self-carers were,

> *"Women now have the confidence to administer SI following orientation by the providers. The oral contraceptives are rarely used. They commonly use the injectables because most don't want their husbands to know."*

Benefits of SC benefits to of implementing SC in the community from the perspective of the service provider:
- Reduces work load
- Improves nurse-patient relationship due to being in close contact with the nurse
- Improves communication between the nurse, patient and the community
- Reduces ignorance on health
- Helps to reduce wastage of medicines and health product
- Reduces occurrence of diseases mainly STIs – reduction in client load
- Reduces unplanned pregnancies
- Selfcare per se empowers an individual to be able to care for herself, maintain their health (for example for Diabetes mellitus patients), and prompts the client to seek care early enough (as seen in the case of HPV); and ascertains faster management (e.g. Rapid Test kits for malaria)
- The SC intervention has helped to improve health for the adolescent girl and young women (AGYW). The approach has further led to an improvement in health seeking behavior in this age bracket.

3.1.5 IMPACT OF SC AT COMMUNITY LEVEL (Mukono pilot)

Perspective of the self-carers regarding SC

FOCUS GROUP DISCUSSION: Self-carers interviewed were 20, with more females (80%) than males (20%. Representation was 35% for under-20 years, 35% for those 20 to under-24 years, 30% for those 24 years and above. The profile of respondents reflected presence of adolescent mothers being among the Self-carers. They had all come to the health facility to get their babies vaccinated. This reflects that teenage pregnancy exists in the community served by the health facility of assessment. Hence it is crucial that adolescent health is incorporated into the SC program.

From the self-carers' perspective, the following factors featured:

- The commonly used methods for selfcare in the past 6 months were reported to be SI (45%), and Oraquick (15%).
- They reported that the health facility where they access self-care services was from the Government health center (55%) and through the pharmacy (15%).
- Their friends or neighbours or neighbours were reportedly using SI (25%), Oraquick (25%), pregnancy tests (45%).
- Before they started using selfcare in preventing pregnancy, they or other women were relying on contraceptive pills (20%), herbs (5%), to prevent pregnancy.
- They reported that the benefits they or their friends and neighbours, experienced when they use selfcare methods, were as follows:
  - Child spacing and affording to pay school fees.
  - To know the HIV status.
  - Readily available SI.
  - Child spacing
  - Know when to commence treatment.
  - Reduction in funds spent on transport to hospital
  - Easy to use.

- They reported that the bad effects that using selfcare products had in their households or in the community were:
  - Side effects (such as dizziness) requiring to return to the health facility.
  - Running out of supplies.

- Their suggestions for improvement of these challenges/ recommendations to address these challenges were:
  - Avail the relevant supplies to their door step.
  - Outreaches should be integrated with re-supply for SC.
  - More sensitization for some of the community members who don't believe in SC.
  - Prefer oral tests not injectable for HIV.
  - Need sanitizer for the community.

- They reported that their methods for disposal of injection materials from the SC products were:
  - In the toilet.
  - By burning them
  - Are taken back to the health facility.

3.1.6 AVAILABLE SELF-CARE DATA (NATIONAL AND DISTRICT)

SELF-INJECTION WITH DMPA-SC

Table 2: Number of SI clients by sub-region, January 2022 to December 2023

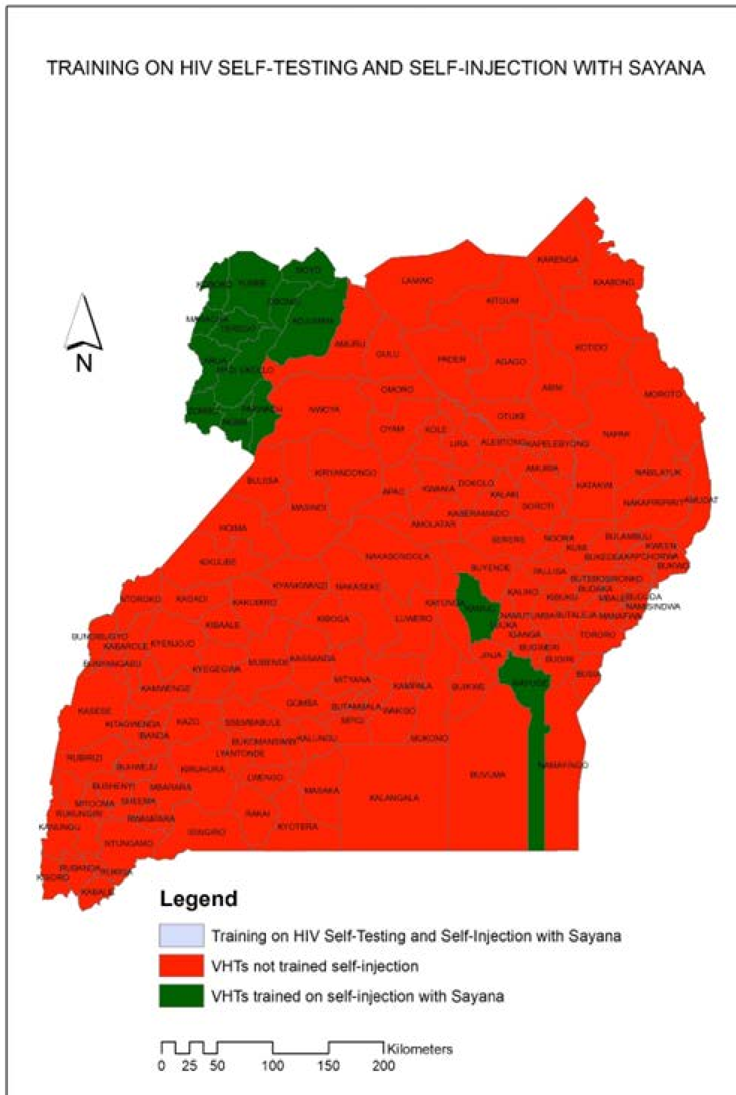
Sub-region	July 2022 - June 2023	Sub-region	July 2023 - Dec 2023
Tooro	13,983	Tooro	23,397
North Central	3,874	North Central	21,822
Bunyoro	3,293	Busoga	17,892
Kampala	1,989	Bunyoro	7,892
Kigezi	1,620	Kampala	7,631
Busoga	1,505	South Central	6,443
South Central	1,133	Lango	5,891
West Nile	914	Kigezi	1,103
Lango	350	Bukedi	463
Ankole	329	West Nile	459
Bukedi	126	Ankole	239
Teso	71	Bugisu	128
Acholi	0	Teso	69
Bugisu	0	Acholi	30
Karamoja	0	Karamoja	12
TOTAL	**29,187**		**93,471**

The Table 2 above indicates that Tooro sub-region has had the highest number of DPMA-SC self-injections in the current and last reporting period, followed by the North Central sub-region. Total reported SI for the period July – December in 2023 was 93,471, from 63 districts.

Figure 1: Map showing districts that have had training of health workers on HST and SI

The map above (Figure 1) shows that all districts apart from 3 districts in West Nile sub-region, have had training for health workers on HST and SI in the health facilities providing the services.

Figure 2: Map showing districts that have had training of VHTs on HST and SI



The map above (Figure 2) shows that 2 districts in Eastern parts of the country and all districts in West Nile sub-region, have had training of VHTs on HST and SI.

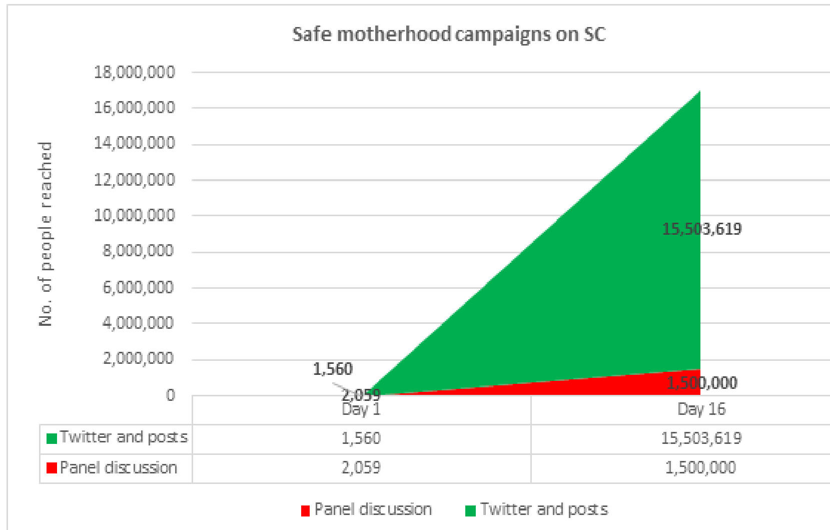
The Table 3 below reflects the SI data as obtained from the IP activity reports. It should be noted that the DHIS2 data (above) may or may not be part of the data reported by the IPs.

Table 3: Impact of media engagement on self-care during 2023 Safe motherhood commemoration

Item	Activity/ indicator	Number
Services	Impact of Safe motherhood messages on SC to the community:	
	# of people reached through panel discussion	2,059
	# of people reached with SC information, through online campaign during the 16 days of activism	1,500,000
	# of people reached with SC information during the Uganda planning workshop on twitter and the posts	1,560
	# of total engagements made during the entire campaign	15,503,619

The data reflected in Table 3 above is also depicted in Figure 3 below.

Figure 3: Impact of media engagement on self-care (Safe motherhood & Uganda planning workshop)



(Data source: IP activity report)

Table 4: SI service provision and training data

Item	Activity/ indicator	Number
Services	Cumulative # of SI clients in 2023 in 5 districts (Mityana, Kakumiro, Kabarole, Kamwenge, Kagadi)	223,083
Services	Targeted young people aged 15 – 30 years in 10 districts (Kasese, Bunyangabo, Hoima, Kagadi, Mbarara, Isingiro, Rwampara, Arua, Madi Okollo, Adjumani):	
	(a) # of young persons (15 - 30 years) reached with information on self-care	23,955
	(b) # of SI clients	8,126
	(c) # of provider-administered SI clients	1,619

Services	16 days of activism were held on HIV/AIDS among young people prior to the World AIDS day in 3 districts (Mbarara, Isingiro, Rwampara)	
Services	# (%) of districts implementing SI in 2021	4 (3%)
Services	# (%) of districts implementing SI in 2023	> 120 (89%)
Services	Self-care services provision among refugees and host populations in 2 districts (Yumbe, Lamwo)	
	# of SI clients using the "She Cares" SC cards in 2023	106 (13%)
	# of clients received the "She Cares" SC card in outreaches in 2 districts in 2023	790
Training	Cumulative # of service providers trained by some IPs on SI by the year 2023 in 5 districts (Mityana, Kakumiro, Kabarole, Kamwenge, Kagadi):	
	# of providers trained in public sector (nurses, midwives, nursing assistants)	20,993
	# of providers trained in private sector (nurses, midwives, nursing assistants)	622
	# of VHTs trained on SI	15,000
Training	Social media influencers trained on promoting SC awareness in Mukono	3
	# of districts with clients trained on SI in the 4 regions	30
	# of districts with providers (biostatisticians, Health Assistants, and HMIS focal persons) trained on reporting SC indicators	30
	# of districts with VHTs trained on Sayana press in West Nile sub-region	14
	# of districts with VHTs trained on Sayana press in Eastern region	2
	# of VHTs from 2 districts (Kamuli, Mayuge) trained on Sayana press	30
	# of districts implementing the “Moment of Truth” curriculum	21

Training	Service providers targeted in providing SC services to young people aged 15 – 30 years in 10 districts (Kasese, Bunyangabo, Hoima, Kagadi, Mbarara, Isingiro, Rwampara, Arua, Madi Okollo, Adjumani):	
	# of VHTs trained to mobilize young people on SI	60
	# of peer providers trained to mobilize young people on SI	120
	# of health workers trained to orient young people on SI	120
	# of health facilities trained to offer SI products to young people	60
	# of health workers in 60 health facilities, trained on data capture using SI addendum that captures the SI clients and doses	120
	# of health workers in 60 health facilities, trained on the electronic management information system (ELMIS) focusing on the customer self service portal (CSSP); to enable them to be able to order for SC commodities	120
Training	% of districts (all districts except Arua, Madi-Okollo, Moyo, Nebbi, Zombo, Yumbe) with HWs at all levels of care, trained on SI.	96%

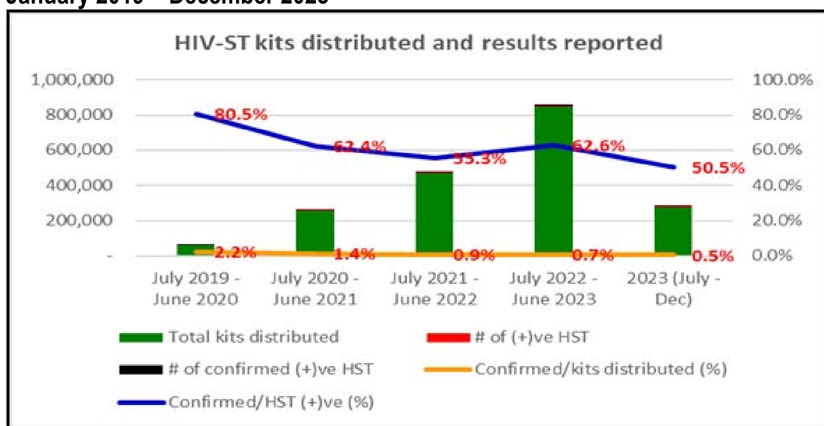
HIV SELF-TESTING

Table 5: HIV self-test laboratory results and HIVST kits distributed, January 2019 – December 2023

Period	Total kits distributed (A)	# of (+) ve HIVST (B)	# of confirmed HIVST (C)	Confirmed (+)ve (%) (C/A)	Confirmed (+)ve (%) (C/B)
2023 (July - Dec)	278,620	2,933	1,480	0.5%	50.5%
July 2022 - June 2023	842,604	9,482	5,940	0.7%	62.6%
July 2021 - June 2022	469,017	7,495	4,148	0.9%	55.3%

July 2020 - June 2021	256,892	5,904	3,682	1.4%	62.4%
July 2019 - June 2020	61,571	1,664	1,340	2.2%	80.5%

Figure 4: HIV self-test laboratory results and HIVST kits distributed nationally, January 2019 – December 2023



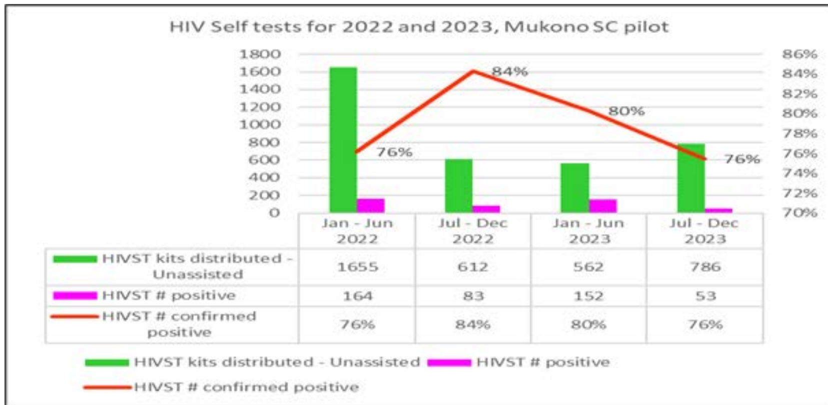
(Data source: DHIS2)

The trend for percentage of reported self-tests out of the total HIV self-test kits distributed is apparently reducing; it stood at 0.5% during the reporting period. Approximately 50.5% of those that tested positive on the self-test, were found to be truly positive. The routine reports from 132 districts as per the DHIS2 showed that out of the 278,620 HIVST kits distributed (assisted and unassisted) during the reporting period, 2933 (1.1%) tested positive on self-test and 1480 (0.53%) were confirmed positive.

HIVST service provision and training

Item	Statistic	Data
Services	% of health facilities that provide HIVST, trained (nurses, midwives, lab personnel, counsellors and lay testers) on revised HIVST guidelines in 2023.	75%
Training	% of districts (all districts except Arua, Madi-Okollo, Moyo, Nebbi, Zombo, Yumbe) with HWs at all levels of care, trained on HIVST.	96%
Training	% of the health facilities providing SC, that had repeat training of nurses, midwives, lab personnel, counsellors and lay testers, using the revised HIVST guidelines.	75%

Figure 5: Implementation of HIVST in the districts: Mukono SC pilot



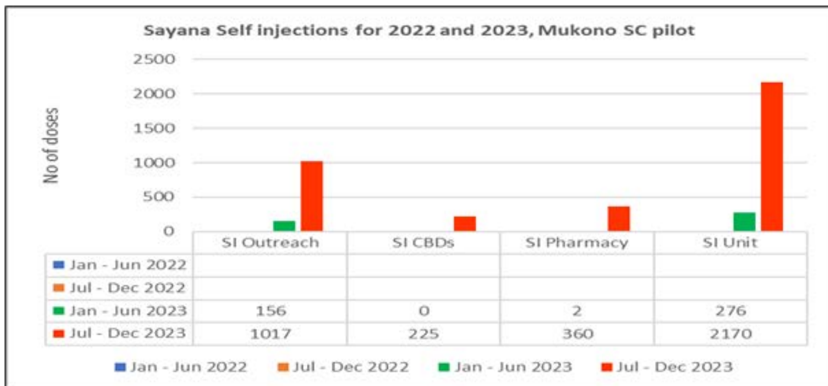
	Jan - Jun 2022	Jul - Dec 2022	Jan - Jun 2023	Jul - Dec 2023
HIVST kits distributed - Unassisted	1655	612	562	786
HIVST # positive	164	83	152	53
HIVST # confirmed positive	76%	84%	80%	76%

(Data source: District DHIS2)

Figure 5(above) shows that Mukono SC pilot has continued to serve the community as far as SC is concerned, with an increase in number of clients self-testing for HIV in 2023 but with a corresponding reduction from 80% (in Jan – June 2023) to 76% (July - Dec 2023) in the percentage of those confirmed positive.

Mukono district SI data for the current reporting period also demonstrates that the number of self-carers is increasing in the district. Refer to Figure 6below.

Figure 6: Sayana press self-injection trend for 2023



	SI Outreach	SI CBDs	SI Pharmacy	SI Unit
Jan - Jun 2022				
Jul - Dec 2022				
Jan - Jun 2023	156	0	2	276
Jul - Dec 2023	1017	225	360	2170

- MOH adapted the National HIV self-testing curriculum to suit the private sector or for use in the private sector. This approach for HIVST integrates marketing and the value proposition for the HIV self-tests basing on outcome of the project implemented on HIV self-testing in Kampala. This project was intended to promote awareness and uptake of HIVST kits in the private sector. It has had cross learnings among Uganda, Nigeria, and Kenya including innovations on how to sell the SC products.
- A fter revising the guidelines on HIVST, MOH repeated training in health facilities providing HIVST. Cadres trained included nurses, midwives, lab personnel, counsellors and lay testers. The lay testers comprise Senior 4 leavers that are recruited to do routine testing and HIV self-testing. They work as volunteers to provide the service of HIVST and the professional testing.
- Project referred to as Delivering Innovations in SC (DISC), has a goal to promote SC starting with the SI contraceptive. DISC started off with consumer and provider research using the Human-centered design (HCD) approach that enabled it to uncover the current needs and opportunities for integrating SC into the health system. Some of the highlights from the research showed that there were gaps in awareness on SI (e.g. not knowing that SI exists, SC products exist, where to access products from; insights on willingness to pay). This curriculum is used to train providers in the private sector.
- Implementation of a self-care project in the Humanitarian settings of Palabek and Bidibidi refugee settlements and the host communities of Lamwo and Yumbe District. The project approach is a human centered design whereby adolescent girls apply solutions based on their personal needs in order to address the barriers to accessing and using self-managed contraception.
- Conducted a SC readiness assessment and promoter Knowledge Attitude and Practice (KAP) survey were conducted in two refugee settlements. As a result of this Knowledge, Attitude and practice KAP survey and readiness assessment, with involvement of the clients, innovative SC cards were developed to promote privacy and confidentiality for the SI clients. The card has signs (pictorials) representing different FP methods. Use of this card helped to promote the use of SI in the refugee camps.
- A mechanism has been set up by MOH to ensure commodity security to continue supplying SC commodities to the districts.
- Integration of HIVST into MCH services, OPD, Key population programming, adolescent health services and school health (the latter has been applied

to extend HIVST to universities (have piloted this in 8 universities in Kampala Metropolitan area).

- Have created demand in the Private sector using digital platform. Products are ordered online. Using Health entrepreneurs who are like VHTs; they apply a subsidized user cost to the product and they deliver the health products at a subsidized cost to customers as a form of public private partnerships.
- Have been able to normalize SC and Self-injection (SI) directly among consumers by conducting direct to consumer demand creation activities which include first digital social media activities using influencers to steer discussion on SI; posting content on Facebook, Whatsup, Twitter. These online events promote awareness and clients are referred to facilities where they can get services.
- Conducted community events which facilitated both awareness and trial. Have been done in all the 21 districts to reach non-digital clients.
- Have compressed the Self-injection messages into an interactive voice response (IVR) in partnership with and NGO called VIAMO. The messages can be found by dialing 161 and following the prompts.

3.2 BEST PRACTICES

Commodity security:

- A group of IPs conducted a landscape analysis to identify the gaps in the supply chain. Found that there were challenges starting from late delivery of schedules, facilities not forecasting and not quantifying well; there were reporting gaps e.g. Some SI commodities were issued but not recorded in the registers; Failure to keep track on available stock. This report was shared with MOH and disseminated with partners; and it led to the designing of a training package to address these challenges. The package has been successfully rolled out in 3 districts (Mayuge, Kabarole, Kamuli). To be able to overcome stockouts, have supported facilities to quantify in public and private sectors.

Community sensitization in Mukono SC pilot:

- Some health facilities (Seeta Nazigo HC III, Kyabazaala HC III) first do a continued medical education (CME) at their facility of the clients on SC as a must before they are treated for a health condition.
- Using continued medical education (CMEs) at the health facilities to train the remaining health workers who did not attend the official training on SC helps to build capacity for SC affordable.
- Use of improvised client registers (adding additional columns to capture SC data) prior to the official development of data management tools helped to cover the

gap in data management.

- Ntunda sub-county is an island located in Mukono district. It is sometimes cut off by flooding from the nearby swamp during heavy rains. This is an ideal population for SC. Some of the VHTs were trained on SC through CMEs at the health facility and on integrated community case management (iCCM), identification of danger signs, when to refer and where to refer clients. In case of a danger sign, the VHT calls the facility to notify them of an incoming patient, then sends the patient with a referral note to the facility. This mechanism has contributed to strengthening of the community-health facility linkage and improvement in access to health care.

Coordination

- Uganda team constituted a Task Force chaired by the Director of Health Services at MOH and co-chaired by an implementing partner, through which stakeholders with various expertise essential for implementing a successful SC activity came together to implement a successful activity. They provided support to each other, using each other's comparative advantage, reducing duplicating of efforts, ensuring aligning to the national scale-up plan; and using data for decision making. The leadership of MOH and coordination of stakeholders has rendered SC a well-coordinated intervention.
- Government leadership and stewardship of the SCEG led to the success in implementing SC. Expert working groups meet to ensure that Uganda is on course by providing direction through them in terms of findings observed.
- Coordination of SC stakeholders and their contribution to programming of SC has been successfully done because of constituting the SCEG right from the commencement of development of the national consolidated SC guidelines. The SCEG is an advocacy platform that continued to popularize SC. SCEG formed small committees to functionalize SC (a) M & E and knowledge management committee plans on how to reach people and how to ensure that knowledge is translated into SC (b) Advocacy committee; (c) Service delivery committee; and caters for conference dissemination (d) Leadership and Governance committee that looks at Policies and Policy briefs; headed by National SC technical lead.

Demand creation

- Have been able to normalize SC and Self-injection (SI) directly among consumers by conducting direct to consumer demand creation activities which include first digital social media activities using influencers to steer discussion on SI; posting content on Facebook, WhatsApp, Twitter. These online events promote awareness and clients are referred to facilities where they can get services.
- Conducted community events which facilitated both awareness and trial. Have been done in all the 21 districts to reach non-digital clients.

- Compressed the SI messages into an interactive voice response (IVR) in partnership with and NGO called VIAMO. The messages can be found by dialing 161 and following the prompts.
- Developed and evaluated training approaches e.g. the e-learning and interactive voice response (IVR) which proved to be good innovations.
- Task sharing: Involving VHTs to build their capacity for SC and engaging a huge number of VHTs

Funding

- Efforts to integrate SC into other programs so that it is not being implemented as a stand-alone has been a good practice because it provides a better chance to be funded. Focused advocacy efforts through continued engagement of stakeholders in various forums by the key SC program focal persons led to commitment of the ACP to allocate a significant chunk of funds for HIVST interventions.

Identification of SC champions

- Identification of SC champions and their engagement in driving the operationalization of SC has helped to expertise e.g. in MOH, the Director for Health Services is a SC champion who was appointed by the global community to sit on the Global forum after being recognized as a SC champion. He requested the incorporation of a desk officer which he pushed for while in a global conference in Pataya in Thailand Nov 2022. This has led to appointment of a dedicated officer that drives everyone after formation of the SC desk. CIFF through PSI made it possible.

IPs perspective

- THE MOMENT OF TRUTH: DISC innovated a training curriculum that enables providers to support women overcome barriers (fear to SI, fear that they won't do it correctly on their own, etc) in uptake of SI. The curriculum is called "The moment of truth" (which encompasses empathy training). This curriculum has been integrated into the national curriculum for FP for in-service training. It has also been implemented in 21 districts (all regions). Has also been adopted by in-country partners; the most recent one being UHA (USAID funded) in 2022 and ongoing, BERGSTROME Foundation partners (are seven: RAHU, RHU, Coherinet, Inclusive Health Bureau, XXX) in 2021, USAID Lango project in 2021, AMREF in 2021 in Eastern region; USAID FP Activity (UFPA) in 2021, the USAID Maternal Neonatal Child Health (MNCH) project with KCCA in Kampala in 2021. Moment of Truth (MOT) has been scaled up in Nigeria and Malawi and as a result they have integrated it into their national curriculums and TOT training, provider and VHT trainings have been conducted by Malawi and Nigeria in 2021. For Malawi, they have had national impact of an increase of the SI conversion rate from 21% prior to the innovation to the current 32%.

Leadership engagement

- Engaging leadership to make them understand what SC is about by seeking a buy-in of the leadership, for instance, the breakfast meetings with Parliament to seek their buy-in as gatekeepers to the communities, have provided a good opportunity for discussion regarding appropriation of domestic funding to SC.

Multi-sectoral engagement

- Multi-sectoral engagement has helped to expedite creation of awareness and knowledge about SC across sectors and further increase uptake of SC interventions including HIVST. As in the case of HIV/ AIDS, it should be emphasized that SC should not be the sole responsibility of the health sector but should be mainstreamed into the non-health sectors as well.

Peer approach

- The peer provider approach: Have had peers who provide information without young people accessing services. More young people were able to take up SI and HIVST by engaging fellow young people to do peer provision of the services and support clients to self-administer – the peer providers take up the VHT role with a focus on young people aged 15 – 30 years.

Reporting

- Advocated for the inclusion of SI reporting into the Family Planning register.

Research

- Research is key in promotion of SC especially in Family Planning because it provides information on the existing strengths and gaps. This is going to guide implementation of SC in the two districts that host refugees and their host communities.
- The research findings will also inform the national programming and Policy development or review for SC.

Service delivery

- A VHT trained a health worker on how to use Sayana press. This shows that skills transfer can come from the lower level upwards.
- Piloting of the National consolidated SC guideline led to a lot of learnings that enriched the guideline. This was coupled with phased development of the consolidated SC guidelines which has rendered it easy to implement, knowing what works and what does not work.
- Pre-service and in-service capacity building: The modules used for the training integrated both pre- and in-service FP training materials. The SCEG has worked with Ministry of Education and Sports to ensure that whoever completes the pre-

service training has already been exposed to SC and is ready to provide the service once deployed.

- Integrating different components of SC service delivery that are experiencing challenges, e.g. supply chain management, empathy counselling and data reporting and management, must be carefully integrated from inception. This ensures continuity of health care.
- Institutionalizing data collection and use.
- Supporting supervision mentorships as part of capacity building efforts for SC.

3.3 KEY LESSONS LEARNT

Medicines and health supplies

For the success of the SC programs, constant availability of SC products is critical in advancing SC. This is achieved by maintaining an adequate stock of the SC product for continuum of care for clients of SC.

Reporting

Investing in data capture and reporting is part and parcel of the success of the SC program. Prior to setting up a data management system for the SC program, ongoing SC interventions could not be gauged. Planning for institutionalization of data reporting on SC services should be done right from inception of the program. This also takes advantage of the routine reviews, timing advocacy, prioritizing indicators for program monitoring and optimizes the use of resources. In addition to the regular data management systems, it was learnt that regular meetings of SC stakeholders provide an opportunity for data sharing and ensures momentum for scale up.

Training

- SC uptake will be higher in communities that have been trained e.g. in Mukono pilot.
- Health facility perspective: With proper training most women can do Self-injection thereby reducing pressure on client load at the health facilities.

Community Health Workers

- Working with CHWs e.g. VHTs who have been engaged on SC at the health facility is very key for the success of SC. Task sharing with CHWs was critical for improving access to SC services and achieving sustainable scale-up.

Peer providers

- Having a successful adolescent health SC program involves peer providers working alongside the VHTs, and the peer providers looking out for the needs of

the young people but providing synergy to the VHTs as they conduct their work.

Service delivery

- Many People especially men and adolescents (male and female) prefer HIVST to the conventional HIV testing owing to the confidentiality.
- The (confirmatory test positivity ÷ resulting HIVST) i.e. yield positivity for HIVST, is comparable to the routine HIV testing. At the beginning it was very low but with time, it has leveled with the one from the routine testing program.
- Stigma: HIVST eliminates the stigma related to HIV testing. Many People especially men and adolescents (male and female) prefer HIVST to the conventional HIV testing.
- Training and engaging mostly female VHTs, promotes community acceptance of SC interventions.

Team work

- Commodity access, reporting, the training and support supervision should be carried out in unison, thereby complementing each other in order to successfully attain the intended goal.
- Working together through the SCEG brings together a range of expertise that has made the process of implementing the SC program, easy and seamless.

Leadership and Coordination

- MOH-led coordination of the SC program ensures credibility and clear decision making. Strong Government leadership at the national and district level, is key in advancing the SC agenda.
- It was the multi-stakeholder engagement process supported by everyone (donors, civil society, etc) that led to the successful development of the guideline.
- Piloting SC requires a lot of resources (financial, human, SC products, time) for successful capacity building and community mobilization.
- In order to attract the attention of political leaders who have a lot of influence in resource allocation and establishing relevant legal frameworks, it is crucial to align self-care to the political aspirations of Uganda like the Vision 2040, which lays out the general development objectives for Uganda over a 30-year period. Vision 2040's goal is to transform Uganda from a predominantly peasant and low-income country to a competitive upper middle income status country . This lesson was picked from the engagements with Ministry officials as they were updating the National Health Policy III. This is important because one of the key requirements for sustainability of SC, is domestic financing.

3.4 CONCLUSION

This documentation gave us an opportunity to appreciate Uganda's thrilling journey of institutionalization and integration of self into various programmes. The integration of self-care into relevant policies and guidelines is a great step to creating a policy enabling environment for self-care. This needs to be hinged on an equally strong legal frameworks hence it's important that the country leverages on existing political will to advance enacting a law on self-care. This report demonstrates that Uganda as a country is on track regarding attainment of many of the key SC indicators, the enabling environment is almost ripe for implementing self-care. Uptake of SI and HIVST is on the increase and training of service providers including VHTs is ongoing. With continued dedication from Government and support from SC stakeholders, application of the best practices, lessons learnt and the consolidated SC guidelines can lay a good foundation for roll out of SC implementation to all the districts.

3.5 CHALLENGES AND RECOMMENDATIONS/ SOLUTIONS

In general, the policies into which SC has been integrated should be translated into strategies so that they are implemented. Under the legislation, the MOH has deliberately incorporated SC in the different developed and updated strategies and the National Health Policy III (which has content on the FP CIP, Manifesto, National Development Plan – NDP IV, RMNCAH Sharpened plan) and the self-care desk is tasked to ensure that strategies and guidelines have SC components.

Challenges	Proposed solutions/ recommendations
Knowledge, attitude and practice	
• Senior cadres at operational level were not much involved in SC e.g. the doctor. The concept was exciting the lower cadres (Mukono pilot). • PFP facilities fear the SC concept because they invested a lot in diagnostics and clinical management of clients, which contravenes SC principles. SC downgrades the importance of a client seeking care at their facility. Should devise an activity to convince the Doctors in private and Govt facilities to embrace the SC concept. • Lack of awareness about SC among DHOs, HWs, health facilities (some exerting resistance). • There are still a lot of ambiguities: SC for pregnant young people, you may want them to use locally available herbs (e.g. ginger, herbal tea, tea which are not harmful)- this raised the issue of promoting herbalists by scientists. • The concept of SC is still not well understood by stakeholders. Some of them think SC is encouraging the community to do self-medication.	• Continued engagement of the leadership to ensure buy-in of the higher cadres. • Dissemination of policies should be improved. This is being handled by the technical advisor and the Direct Curative services at the Ministry of Health. Circular to HWs from MOH on SI was helpful. The guidelines can also render the dissemination easier. • The IEC materials that have not yet been improved should include clear messages on some of these materials with clear amounts that can acceptably be taken by the pregnant women. • The community should be oriented on the benefits of SI to the self-carers. • Orient the VHTs (the newly recruited ones) on iCCM to improve the community component of SC. There is a need to bring the private sector into these conversations since the private sector accounts for over 55% of health delivery points in the country. • There is a need to bring the private sector into these conversations since the private sector accounts for over 55% of health delivery points in the country. • SCEG should bring on board, other SC stakeholders to tackle for “self-awareness”. One IP is intensifying awareness creation on SC and are working through Government structures in the settlements and host populations.

Adolescent health issues:	
• SC for young people if led by health facility, it will not be easily accepted by the young people. It should be driven by young people themselves. • Non functionality of Youth friendly services.	• Engage young people in the provision of support needed by the young users of SC. • Revamping and functionalization of youth friendly services
Access to care	
• In the private sector and private facilities, clients do not readily access free SC products thereby affecting SC product availability with stockouts. • Last mile stockouts including for test kits and commodities may compromise continuity of care. • Sub-optimal linkage to confirmatory testing for individuals who report a positive self-test. This challenge is subjective because there are individuals who confirm their positive status in the private sector. • Lack of capacity to use the newly introduced system (Client Self Service Portal) in accessing medical supplies by the providers in addition to the fact that many providers are multi-tasking (e,g, nurses at HC II). • Accessibility and administration of SC by the differently-abled persons (PWDs). • Poor redistribution mechanisms for medicines and related health supplies.	• Should have in place a community-based distribution system for some of the SC products like is done under malaria. It renders access to these supplies easier.
Funding and geographical coverage:	

• There is in general, lack of partners to support SC as a full package hence this hinders progress in implementing the entire program. Majority of the funders for SC fund piece meal based on specific interests. • Limited financial resource. There is a lot that needs to be implemented. Eg. Lack of BP machines yet mothers are dying from Ecclampsia. • Cost of training is extra enormous. • Duplication on coverage in the districts by IPs hence coverage is not equitably distributed across the districts and sub-regions. • SC for adolescents and SGBV intervention has not yet taken root and are not yet supported. • Limited resources (financial) to implement in a district. This was not done to perfection hence the pilot had challenges. E.g. hosting task teams was a challenge. Were supposed to be cross learnings within the districts which was not properly done.	• The MOH should liaise with IPs to explore application of the innovative low-cost training approaches. • SCEG in liaison with the funding sub-committee should follow-up with members of Parliament on outcome of the discussions held on the Budgetary framework paper, specifically on domestic financing for SC. • The ongoing Investment Case on Self-care by benchmarking on Self-injection to see what costs/resources can be saved with SC interventions, should consider perimeters like distance, time saved, partner acceptance thus saved, and those related to GBV cases. • Need to have financial resources for testing policies and to address these challenges. • Need funding to support private sector brand. During this project, the pilot was implemented in the private sector but the scale up was done in the public sector because the public sector had commodity security, and also the conversion rate was higher in the public sector.
Funding Mukono SC pilot: • Has been a limitation, hence a number of facilities have dropped the SC activity.	There is need to invest more and perfect Mukono district into a model district such that it becomes a learning hub for other districts in Uganda and to the world.
Commitment by local leaders: • These require constant reminder to preach the selfcare agenda. The district leadership is not yet aware of the National SC month to be commemorated.	SCEG members should be promoters of self-care, noted that as MOH Self-care fits in several sectors like health promotion.
Data management, Monitoring and accountability:	

• Lack of capacity to use the newly introduced system (Client Self Service Portal) by the providers (e,g, nurses at HC II who are also multi-tasking): • There has been a gap in data capture in the private sector, hence difficult to gauge impact of SC in this sector in the pilot district. How can we track or monitor this intervention in the national database? • Selfcare data gaps exist at community level. • Selfcare data gaps in addition, exist at Pharmacies and drug shops where clients access over the counter medicines and health supplies. How do we strengthen data capture among these in the private setting? • There is information gap on the existence of official HMIS form for capture of HST and SI data introduced by some IPs several years back with data captured in the DHIS2 database which is also SC data. The District SC Focal Point is also not aware of the ongoing capturing of SI data and the HIVST data in the DHIS2. District data managers' lack of awareness about the ongoing SC pilot. • SCTG and CIFF indicators have never been shared with the district data managers. • Failure to engage the District Biostatistician in data management for the SC pilot is among the factors that have contributed to challenges in capturing and reporting on SC. • Sharing of SC data by IPs with other stakeholders including MOH is minimal.	• The revised HMIS tool has reporting provisions for SC and MOH is working with the IT department to develop a national repository for SC materials, and interventions. • Should institutionalize the reporting so that reporting does not depend on availability of partners. • Have revised the tools to capture all results including the HIVST that test negative. These revised HMIS tools should be availed to the health facilities and districts for use after orientation on them. • The human resource training data should be fed into the HRIS after retrieving it from IPs and MOH. • Revision of the HMIS tools should also cater for data on SC training (all the cadres trained), the available funding and availability of products for use for SC. • The districts recommends that SC should be pushed in the community at VHT level and household level, through building capacity of VHTs especially on data management on SC. • The M and E sub-committee, affiliated to the SCEG, should meet regularly to officially document the SC data. • The SCEG should subsequently use the dashboard to capture the SC data. • Prioritization and working with the minimal list of indicators that are critical for program monitoring are critical; Liaise with ongoing surveys (e.g. PMA, UDHS) to address data needs that are not captured in HMIS. • The regions lacking partners, should also report on SC. • Should institutionalize the reporting so that reporting does not depend on availability of implementing partners.

• Multiple programs competing for space in data reporting systems; challenging SC indicators. • Data capture in the private sector is a challenge. • The current reporting tool does not report on the negative HIVST. • The country at the end of each reporting period, identify key areas or interventions to be implemented in the subsequent 6 months. However, based on the available reports and information, it is somewhat not easy to obtain related information to document whether these priorities were realized or not in the next 6 months. For example, during the first 6 months of 2023, the Heads of the Uganda Midwifery Association and for the pharmaceutical society of Uganda pledged to influence incorporation of SC in their respective in-service training curriculum. In the same vein, country reports indicate that the country would also fast track these pledges. However, reports on what has transpired ever since is not readily available. • Data capture sometimes only relies on data captured during supervision. • Limited reporting at community level, in HFs not yet supported by partners. • Multiple programs competing for space in data reporting systems; challenging SC indicators:	• The M and E sub-committee, affiliated to the SCEG, should meet regularly to officially document the SC data. • The SCEG should subsequently use the dashboard to capture the SC data. • Prioritization and working with the minimal list of indicators that are critical for program monitoring are critical; Liaise with ongoing surveys (e.g. PMA, UDHS) to address data needs that are not captured in HMIS. • The regions lacking partners, should also report on SC. • Should institutionalize the reporting so that reporting does not depend on availability of implementing partners.
Medicines and related health supplies:	
• Weak coordination and communication gap with key departments such as logistics which is key in SC.	• Proper planning (quantification) and placing orders for SC products in a timely manner to ensure that there is un-interrupted supply of SC products and supply-chain for the products.

• They use consumption method to project for supplies. If they get to know about an ongoing activity that may need extra supplies then they would cater for them. • Prior to the onset of the SC pilot, Mukono district had self-testing kits being supplied in small quantities by the IPs, and later Sayana came on board. Mukono pilot district registered a 5 months' stock-out of Sayana press in 2022 but no stock-out for Oraquick. Had those in charge of medicines management at the district been aware of the needs for the SC activity, they would have included in the items to be procured, extra quantities than usual to cover SC. Currently, the district is accessing health commodities without the SC component among the priorities hence reflecting a gap in communication and coordination on the SC pilot. • Stock out of SC products (e.g. Sayana, HIVST kits)	• Let's continue to give 3 doses to Self-injections to take home for continued use. • Last mile stockouts: Data use to inform supply chain needs; capacity building of providers charged with supply chain management. • For issues of stockouts and expiries, the country needs proper quantification for SC commodities thus a complete supply chain. • Are trying to support the facilities to make the orders and mentorship on rational use of the commodities. Also working with the warehouses to adhere to the delivery schedules. • Capacity building; Integration of SC and supply chain training modules in all ongoing trainings that target the focal person doing all these tasks. • Need for introduction of commodities for the private sector • Accreditation of Private health facilities to receive SC commodities • Develop good redistribution strategies, early ordering of commodities • We need well trained pharmacy professionals to properly handle SC commodities. • The IEC materials that have not yet been improved should include clear messages on some of these materials with clear amounts that can acceptably be taken by the pregnant women. • Need for introduction of SC commodities for the private sector
Service uptake among self-carers at the health facility:	
• In Mukono district pilot, although there has been an increase in Sayana uptake as a result of promotion of Sayana press, the uptake of LARCs has gradually been reducing.	

• Self-injections (SI) clients have to be convinced to continue SI especially on the 2nd visit due to fear of injection. • Lack of following instructions: e.g. allowing for 5 days to elapse before resuming conjugal activities to allow for Sayana to take effect. Some men are not patient to oblige. • Dispensed an entire packet of RDTs which comes with 1 buffer solution, is not feasible to facilitate the malaria self-testing. • Non-partner disclosure among some index clients. • Frequent change of client locator information by some index clients. • Difficulty in reaching out to index clients outside the catchment area of the HIVST project.	
Quality of care:	
• Technical skills and optimal care are a challenge. Some self-carers were reported by the district, to have had false positive tests after using poorly stored Oraquick. (NB: Quality and sensitivity of Oraquick is compromised by heat from the sun). False positives have been recorded among the youth and as such have affected continuation of use of Oraquick. • Quality of care by monitoring an individual to ensure that the procedure is done properly to reduce errors in administering selfcare is not guaranteed. • SC is time consuming; have to spend a lot on coaching the self-carers especially for the initial visit, thereby leading to health provider workload.	• Should harmonize the issue of counselling for the purpose of improvement of quality of care especially regarding HIVST results to ensure positive mental health outcomes. • SBCC (socio-behavioral change communication); Task sharing. • Mentorship of health care providers to implement a follow-up SOP for HIVST. • Proper storage of Oraquick to ascertain quality of care must be observed with close supervision by the service providers. • We should have in place, mechanisms for service providers to support self-carers in ensuring that they use SC products according to national quality of care standards; perhaps pass on information using a feasible communication channel.

• Anxiety among self-carers following positive HIV self-tests or cervical cancer screening results was reported by the district authority to affect uptake of SC services. Integration of counseling and patient education into the follow up or home visits of this category of self-carers has not yet been instituted. • Discrepancies in the self-test results and facility confirmation results • Temperature monitors at the health facilities are sometimes broken down, yet the HIVST kits and pregnancy tests are sensitive to warm temperature. • Training and supervision of self-carers is time consuming; having to spend a lot of time on coaching the self-carers since demonstration on procedures/ instructions has to be done meticulously to ensure quality of care, especially for the initial visit. This is bound to lead to work load for providers.	• Accreditation of Private health facilities to receive SC commodities should be done.
Capacity building:	
• Limited coverage of the Capacity building efforts.	Support the national scale up and ensure 100% coverage.
Socio-cultural issues:	
• In settlements, refugees come from different countries with varying cultures (e.g. from Sudan, DRC, Kenya) some of who may not embrace SC. IPs responsible for such settlements are carrying out their role to see that there is acceptance and understanding of SC. • Poor male involvement • Adolescents have not been involved	
Technical issues:	

• PFP facilities fear the SC concept because they invested a lot in diagnostics and clinical management of clients, which contravenes SC principles. SC downgrades the importance of a client seek care at their facility. Should devise an activity to convince the Doctors in private and Govt facilities to embrace the SC concept. • Dispensed an entire packet of RDTs which comes with 1 buffer solution, is not feasible to facilitate the malaria self-testing.	• Need to engage the media and also follow up on the parliamentarians for the commitments they made during the previous engagements.
Multi-sectoral issues:	
• SC not being fully integrated across all the sectors.	Strengthen multi-sectoral collaboration to advance SC. Need to tap into the already existing platforms by slotting in an agenda on SC in order to get SC to run beyond MOH sector. This will create demand for Sc outside the health sector.

4.1 VIEWS OF THE NATIONAL SELF-CARE CHAMPION ON THE FUTURE FOR SELF-CARE

As interventions are designed, the following factors should be translated into strategies, but after ranking them according to which ones are most feasible and beneficial to the individual/ family/ community:

1. Address high burden NCDs (Hypertension, especially since it is among the top causes of maternal mortality; Diabetes).
2. Organizing for social-behavioural factors that should be part of SC e.g. life style, washing hands, food hygiene, diet (limiting sugar, limiting salt), personal hygiene, water and sanitation, reducing burn out for health workers, organizing for a day for physical activity.
3. Handle Quality of SC. e.g. the referral pathways which need to be set up; the fear issues, because most time they are provider initiated especially in the private sector.
4. SC among the young people should be linked to School Health Program. Need to identify a package for this for the respective department should then take up the packages.
5. Focus on what should be empathized for the Individual, Family and Community perspective.
6. Relate data on literacy rates to SC.
7. As interventions are designed, the following factors should be translated into strategies, but after ranking them according to which ones are most feasible and beneficial to the individual/ family/ community:
8. Address high burden NCDs (Hypertension, especially since it is among the top causes of maternal mortality; Diabetes).
9. Organizing for social-behavioural factors that should be part of SC e.g. life style, washing hands, food hygiene, diet (limiting sugar, limiting salt), personal hygiene, water and sanitation, reducing burn out for health workers, organizing for a day for physical activity.
10. Handle Quality of SC. e.g. the referral pathways which need to be set up; the fear issues, because most time they are provider initiated especially in the private sector.
11. SC among the young people should be linked to School Health Program. Need to identify a package for this for the respective department should then take up the packages.

12. Focus on what should be empathized for the Individual, Family and Community perspective.
13. Relate data on literacy rates to SC.
14. Investment case:
    » Explore issues of cost for care in comparison to when she uses SC. By how much does SC avert illness when someone self-cares (e.g. using SI to avert unplanned pregnancy).
    » Expect the investment case to look into how much money is saved by using SC; the potential benefits to the individual and the country. Key aspect is to see that SC is integrated everywhere in communicable, non-communicable programs, etc within MOH.
    » Use SC investment case to mobilize funding for SC. Govt current contribution needs to be quantified and need to identify the gap.
15. Which governance structure should house SC (RH, NCDs, Health education and promotion)?
16. Identify SC champions from the Mukono pilot.
17. Engage young people to talk to other young people in order to render SC more acceptable by other young people.
18. Quantify the commodities for SI, HIVST, self-PAP smear, self-test for malaria (MRDT) in adults.
19. Community level:
    » Incorporate SC into the training of the Community Health Extension Workers (CHEWS), in-service training for those who have already been trained; What is the package that we need to include for the CHEWS (in Ethiopia CHEWs can insert implants). Use evidence before empowering CHEWS to insert implants.
    » CHEWS: Aspects of build capacity, referral mechanisms, data management, research, implementation, advocacy should be strong.

4.2 FUTURE PLANS BY THEMATIC AREA

Laws /Legislation & Policies

- Want to see all the departments in MOH integrating or mainstreamed SC into Government line Ministries, departments and programs so that people are able to understand what SC is all about. It was proposed that SC is further mainstreamed into non-health sectors including UNRA and other Government MDA (Ministries, departments, agencies) so that SC ceases to be a MOH issue. It would help to improve literacy about SC in other sectors. Other sectors can then demand for SC e.g. HIVST. SC can be main streamed under HIV interventions and could encourage own staff to do HIVST thereby leveraging a budget for HIVST. Under HIV main streaming, it would become more feasible for the ACHS of ACP to advocate for

HIVST under the Multi-sectoral coordination committee for HIV response.

- Would like to hold periodic/ regular coordination meetings for updating each other on ongoing activities to avoid duplication.
- Want to ensure that SC is integrated in the FP-CIP and the District work-plans for the two districts hosting refugees and their host communities.
- Need to strengthen legal and policy environment for self-care through putting in place enabling laws on self-care

Regulatory approvals

- Fast track pledges made by the Midwifery Association and the Pharmaceutical Society of Uganda pertaining to inclusion of SC in the in-service training curriculum.

Service delivery practices: **Programme strategies and guidelines**

- Following finalization of updating he National Consolidated SC guidelines, the next step is to have the guidelines signed the final signed guideline will be submitted on 15th March 2024.
- Will further update the SC Consolidated guidelines on the area of "personal wellbeing".
- Samasha working with PROPEL Health have developed a how to guide development and piloting of SC Guidelines and Policies based on the Uganda experience. We hope this will help other countries to develop their guidelines. This guideline is coming out by mid-March 2024.
- Implement the SC interventions at a full scale in order to harness the desired impact of SC.
- Countrywide, see most HFs offering SC interventions (HIV self-testing, Contraceptive self-injections).
- Mukono district pilot needs to have proper reporting tools on SC.
- IEC materials are needed Mukono district pilot.
- As part of a global commitment, countries were tasked with coming up with a country resolution on SC to be presented during the 2024 World Health Assembly (scheduled for May 2024). Uganda is yet to submit this resolution. Uganda looks at how best to make SC visible at global forum such as showcasing best practices at the World Health Assembly. Countries such as Senegal and Nigeria that are implementing SC have already showcased their SC work at the World Health Assembly and Uganda also needs to do the same.
- WHO came up with a new guidance that includes the wellbeing, so the national consultant was requested to update the guideline to include the wellbeing before signing the National Consolidated SC Guideline. The final signed guideline with

wellbeing incorporated will be submitted on 15th March 2024. Want to update the guideline to cater for.

- Two IPs have developed a how to guide development and piloting of SC Guidelines and Policies based on the Uganda experience. It is hoped that this will help other countries to develop their guidelines. This guideline is coming out by mid-March 2024.
- Want to see that the SC card which is used to promote use of SI and other SC services among AGYW living among refugees and host populations, is adopted by MOH and other stakeholders.
- Would like to disseminate the report or findings from the study carried out on SC readiness assessment and promoter Knowledge Attitude and Practice (KAP) survey in two refugee settlements.
- Want to see that the National SC Consolidated Guidelines are completed and disseminated for use.
- Deliberate efforts to have youth friendly SI services
- Approving guidelines for private sector guidelines to administer and dispense SI.
- Commodity security.
- Strengthen supply chains.
- What are the needs of young people at any point in their lives? For young people there should be a continuum of care as far as SC is concerned. ensuring that SC is looked at in totality by integrating it into all available health care packages e.g. HIV, FP.

Current practice in community

- See Community health workers (CHWs) reaching out to more women in the community with information on SC
- Proposed to have SC implemented by all stakeholders under the National Advocacy Strategy for better engagement of the community so that they understand what SC is about.

Political commitment including financing for self- care

- Political engagement: Future trajectory: How Parliament envisions to allocate a budget for SC. Most of the funds for SC are Donor-funding and not sustainable; we need to engage MPs to make a specific budget allocation for SC. The issue of a enacting a law on SC.
- As part of a global commitment, countries were tasked with coming up with a country resolution on SC to be presented during the 2024 World Health Assembly (scheduled for May 2024). Uganda is yet to submit this resolution. Uganda looks at

how best to make SC visible at global forum such as showcasing best practices at the World Health Assembly.

- The new HMIS tools are coming in force by July. We should see better data capture on HIVST, better utilization and reporting.
- MOH to host a meeting for all partners implementing Self-care interventions in April 2024.
- The SCEG to reach out to UNHCR to join the next meeting to benchmark on their experience in humanitarian settings to bring the equity conversations to reality.
- The SCEG to reach out to the private sector and have them for the next SC meeting.
- Amplify selfcare at the 2024 World Health Assembly through submission of a country resolution.
- Having SC investment case completed and presented to Members of Parliament for improved funding.

4.3 MAJOR LIMITATIONS OF THE ASSIGNMENT

The time for stakeholder consultation was limited, hence some stakeholders were not interviewed, such as the Members of Parliament and the community leaders. For the same reason, stakeholders from only one district (the pilot district) and one health facility from the pilot district, were included in the consultation.

The data reflected in the report is from a few IPs who availed their data for this report, together with the DHIS2 that captures data as of when the HMIS Addendum capturing self-care data became operational. Data from some of the implementation partners who were actively implementing self-care may therefore not be fully represented in this report.

Clients who test negative on HIV self-test, are not reported in the DHIS2. This therefore poses as an information gap.

5. ANNEXES

ANNEX 1: TOOLS USED FOR CAPTURING SELF-CARE DATA

Year	District	Sub - region	Category e.g. HST kits distributed assisted; HST kits distributed unassisted; HST positive; HST confirmed positive.	Monthly number of HIV Self-test (HST) clients											
				J	F	M	A	M	J	J	A	S	O	N	D

Year	District	Sub-region	Category e.g. SI CBDs; SI Outreach; SI Pharmacy; SI Unit	Monthly number of self-injections											
					F	M	A	M	J	J	A	S	O	N	D

ANNEX 2: STAKEHOLDER CONSULTATION ASSESSMENT FOR NATIONAL, DISTRICT, HEALTH FACILITY AND COMMUNITY LEVELS

The consultant used the following Assessment Matrix to generate data collection tools, e.g., Key informant interview structured questionnaire, Focus Group Discussion guide, Health facility KII questionnaire:

QUESTION(S)	OBJECTIVE	METHOD	STAKEHOLDERS/ INFORMATION SOURCE
What do you understand by selfcare?	To assess knowledge of the respondents about self-care.	FGD guide	Self-carers and other community members
Describe the method(s) of selfcare which you are using or you have used in the past 6 months.	To obtain insights on the ongoing SC approaches interventions	FGD guide	Self-carers and other community members
Where or which health facilities have you accessed these self-care services? Explore if there are private /public clinics, pharmacies etc.	To assess access to service pro-viders who can su-pervise self-care implementation and access to SC products in the catchment area	FGD guide	Self-carers and other community members
What selfcare methods have you seen or heard that your friends or neighbors are using?	To assess the most commonly used SC inter-ventions in the community	FGD guide	Self-carers and other community members
Before you started using selfcare in preventing pregnancy, what were you or other women relying on to prevent pregnancy?	To assess awareness among women about SC in regard to contraceptives	FGD guide	Self-carers and other community members

What benefits have you or your friends and neighbors, experienced when you use selfcare methods?	To get insights on what women regard to be benefits of SC	FGD guide	Self-carers and other community members
What good effects has selfcare had in your households or in the community?	To assess awareness among women about the benefits of SC	FGD guide	Self-carers and other community members
Mention some benefits of using SC methods	To assess knowledge of women about the benefits of SC	FGD guide	Self-carers and other community members
What bad effects has selfcare had in your households or your community?	To get insights on what women regard to be bad effects of SC	FGD guide	Self-carers and other community members
What challenges have you experienced while using or accessing selfcare?	To get insights on challenges that women are experiencing in accessing SC	FGD guide	Self-carers and other community members
What challenges have your friends or neighbours, expressed or experienced while using or accessing selfcare?	To get insights on challenges that the	FGD guide	Self-carers and other community members
Suggest ways for improvement of these challenges/what recommendations do you have to address these challenges.	To obtain the community perspective on solutions to address challenges	FGD guide	Self-carers and other community members
What are your additional needs for selfcare to work very well for you?	To obtain the community perspective on their needs regarding SC	FGD guide	Self-carers and other community members

Describe what you understand by Selfcare	To assess knowledge of service providers on SC	Health facility KII	Service provider responsible for SC at the health facility
Describe the SC activities that you conduct at the health facility	To explore the health workers' perspective on the role of health workers at a health facility in SC	Health facility KII	Service provider responsible for SC at the health facility
Explain the benefits to the health facility of implementing SC in the community	To assess awareness among health care workers about the benefits of SC to the health facility	Health facility KII	Service provider responsible for SC at the health facility
Describe the positive effects that SC has led to at the health facility.	To assess views of the service provider on the positive effects that SC implementation has had on service delivery at the health facility	Health facility KII	Service provider responsible for SC at the health facility
In case there are negative effects of SC to the health facility, describe them	To get insights on what service providers regard to be negative effects of SC to the health facility	Health facility KII	Service provider responsible for SC at the health facility
What challenges have you experienced regarding implementation of SC by the health facility?	To get insights on challenges that service providers are experiencing in implementing SC	Health facility KII	Service provider responsible for SC at the health facility

What should be done differently to avoid these challenges? What are the SC needs at the health facility?	To obtain the health workers' perspective on their needs regarding SC	Health facility KII	Service provider responsible for SC at the health facility
State the nature of your involvement in selfcare (e.g. Development partner, Policy maker, Decision maker, Implementer, Advocate, Political, Technical expert, Researcher, etc).	To assess the role of the respondent in SC in the district	District facility KII	District SC Focal person, District Health Educator, District Records Officer, District Medicines Supervisor
What are the ongoing selfcare interventions in the community? (e.g. SRHR, Family Planning, STD/ HIV, ANC/ PNC, post-abortion care, cervical cancer, adolescent health, etc). Which are your districts of coverage? intervention(s)?	To assess the status of SC implementation in the district	District facility KII	District SC Focal person, District Health Educator, District Records Officer, District Medicines Supervisor
Describe the past selfcare projects, extent of coverage for SC interventions, where you started from, and the Major milestones of achievement, that your district has experienced from the beginning while implementing selfcare	To describe the achievements made in SC implementation in the district	District facility KII	District SC Focal person, District Health Educator, District Records Officer, District Medicines Supervisor

State the ongoing selfcare projects; What progress has been made in terms of expansion to other geographical areas/ health facilities and human resource oriented/ trained, and expansion made? Increase in funding modalities, advances regarding M & E, human resource engagements, community mobilization mechanisms, core health area(s) covered (e.g. SRHR, Family Planning, STD/ HIV, ANC/ PNC, post-abortion care, cervical cancer, adolescent health, etc).	To describe the achievements made in SC implementation in the district	District facility KII	District SC Focal person, District Health Educator, District Records Officer, District Medicines Supervisor
Between July and December 2023, describe the broad ACHIEVEMENTS (Activity, outputs or outcomes with numbers) that that the district has registered under any of the following thematic areas, for the priority health areas (e.g. SRHR, Family Planning, STD/ HIV, ANC/ PNC, post-abortion care, cervical cancer, adolescent health etc): a. Policies, strategies, laws. b. Regulatory processes.	To describe the achievements made in SC implementation in the district	District facility KII	District SC Focal person, District Health Educator, District Records Officer, District Medicines Supervisor

c. Service delivery including implementation, quality of care, capacity building, medical supplies, M & E (including data capture, reporting, use), coordination. c. Advocacy, community mobilization, community awareness, c. Political commitment. c. Funding for SC.			
Tell us the Best Practices for SC experienced in the district that should be promoted.	To showcase Uganda's unique SC interventions or mode of implementation that can be replicated elsewhere.	District facility KII	District SC Focal person, District Health Educator, District Records Officer, District Medicines Supervisor
Tell us the Lessons Learnt in the district, regarding SC, that should be shared with other stakeholders.	To gather information on what worked well or did not work well in the past	District facility KII	District SC Focal person, District Health Educator, District Records Officer, District Medicines Supervisor
What challenges have you experienced in implementing SC?	To identify bottlenecks in SC implementation	District facility KII	District SC Focal person, District Health Educator, District Records Officer, District Medicines Supervisor

What good effects has selfcare had on the district and the community?	To obtain the district perspective on the effect of SC on the district health care.	District facility KII	District SC Focal person, District Health Educator, District Records Officer, District Medicines Supervisor
What bad effects has selfcare had on the district and the community?	To obtain the district perspective on the effect of SC on the district health care.	District facility KII	District SC Focal person, District Health Educator, District Records Officer, District Medicines Supervisor
What do you recommend to address the challenges?	To obtain the district perspective on what should be done to improve SC implementation.	District facility KII	District SC Focal person, District Health Educator, District Records Officer, District Medicines Supervisor
Tell us your plans for SC in the next 6 months or for the future. What commitments (if any) have been made in the district on SC?	To explore future SC plans in the next reporting period	District facility KII	District SC Focal person, District Health Educator, District Records Officer, District Medicines Supervisor
List funding agencies for selfcare in the district.	To find out the status of funding for SC	District facility KII	District SC Focal person, District Health Educator, District Records Officer, District Medicines Supervisor

State your nature of involvement in selfcare (e.g. Development partner, Policy maker, Decision maker, Implementer, Advocate, Political, Technical expert, Researcher, etc).	To identify the category of respondent in SC	National stakeholder KIIs	Government leadership, Development partners, Policy makers, Program managers, Professional associations, Legislature, Members of Parliament, Researchers, Academia.
Describe to us the extent of coverage for SC interventions, where you started from, and the Major milestones of achievement, that your organization has experienced from the beginning while implementing selfcare. State the ongoing or past selfcare projects; What districts are covered? What progress has been made in terms of expansion to other districts, increase in funding modalities, advances regarding M & E, human resource engagements, community mobilization mechanisms, core health area(s) covered (e.g. SRHR, Family Planning, STD/ HIV, ANC/ PNC, post-abortion care, cervical cancer, adolescent health, etc).	To describe the achievements made in SC implementation in the country	National stakeholder KIIs	Government leadership, Policy makers, Program managers, Professional associations, Legislature, Researchers, Academia.

Between July and December 2023, describe the broad ACHIEVEMENTS (Activity, outputs or outcomes with numbers) that your organization has registered by the following thematic areas, for the priority health areas (e.g. SRHR, Family Planning, STD/ HIV, ANC/ PNC, post-abortion care, cervical cancer, adolescent health etc):	To assess progress made in implementation of SC in the country.	National stakeholder KIIs	Government leadership, Policy makers, Program managers, Professional associations, Legislature, Researchers, Academia.
• Policies, strategies, laws	To gather information on what worked well or did not work well in the past	National stakeholder KIIs	Government leadership, Policy makers, Program managers, Professional associations, Legislature, Members of Parliament, Researchers, Academia.
• Regulatory processes	To identify bottlenecks in SC implementation	National stakeholder KIIs	Government leadership, Development partners, Policy makers, Program managers, Professional associations, Legislature, Members of Parliament, Researchers, Academia.

• Service delivery including implementation, quality of care, capacity building, medical supplies, M & E (including data capture, reporting, use), coordination. Have the professional associations incorporated SC prior to rolling out the curriculum?	To obtain the district perspective on the effect of SC on the district health care.	National stakeholder KIIs	Government leadership, Development partners, Policy makers, Program managers, Professional associations, Legislature, Members of Parliament, Researchers, Academia.
• Advocacy, community mobilization, community awareness,	To obtain the district perspective on the effect of SC on the district health care.	National stakeholder KIIs	Government leadership, Development partners, Policy makers, Program managers, Professional associations, Legislature, Members of Parliament, Researchers, Academia.
• Political commitment	To assess the national perspective on what should be done to improve SC implementation.	National stakeholder KIIs	Government leadership, Policy makers, Program managers, Members of Parliament.
• Funding for SC	To explore future SC plans in the next reporting period	National stakeholder KIIs	Government leadership, Development partners, Policy makers, Program managers, Professional associations, Legislature, Members of Parliament, Researchers, Academia.

State any Best Practices experienced in SC that should be promoted.	To showcase Uganda's unique SC interventions or mode of implementation that can be replicated elsewhere.	National stakeholder KIIs	Government leadership, Development partners, Policy makers, Program managers, Professional associations, Legislature, Members of Parliament, Researchers, Academia.
State the Lessons Learnt in SC that should be shared with other stakeholders, including lessons learnt in implementing SC interventions in unique situations such as refugee settlement.	To gather information on what worked well or did not work well in the past	National stakeholder KIIs	Government leadership, Development partners, Policy makers, Program managers, Professional associations, Legislature, Members of Parliament, Researchers, Academia.
What challenges have you experienced in implementing SC?	To identify bottlenecks in SC implementation	National stakeholder KIIs	Government leadership, Development partners, Policy makers, Program managers, Professional associations, Legislature, Members of Parliament, Researchers, Academia.
• What do you recommend to address the challenges?	To explore future SC plans in the next reporting period	National stakeholder KIIs	Government leadership, Development partners, Policy makers, Program managers, Professional associations, Legislature, Members of Parliament, Researchers, Academia.

What SC-related area should Uganda invest in the next 6 months or for the future?	To explore future SC plans in the next reporting period	National stakeholder KIIs	Government leadership, Development partners, Policy makers, Program managers, Professional associations, Legislature, Members of Parliament, Researchers, Academia.
List funding agencies for selfcare in Uganda	To explore future SC plans in the next reporting period	National stakeholder KIIs	Government leadership, Development partners, Policy makers, Program managers, Professional associations, Legislature, Members of Parliament, Researchers, Academia.
What has facilitated responsiveness to selfcare from MOH	To showcase Uganda's unique SC interventions or mode of implementation that can be replicated elsewhere.	National stakeholder KIIs	Government leadership, Policy makers, Program managers, Legislature, Researchers, Academia.

ANNEX 5: **LIST OF STAKEHOLDER ORGANIZATIONS CONSULTED**

- Director Health Services
- MOH: Sexual and Reproductive Health
- MOH: AIDS Control Program
- Center for Health, Human Rights and Development (CEHURD)
- Reach a Hand Uganda
- International Rescue Committee
- Population Services International-Uganda
- PATH
- Samasha
- School of Public Health
- Mukono District Local Government (DHO, Doctor in charge of self-care pilot; ADHO Focal person for self-care pilot; District Biostatistician; District Medicines and health supplies supervisor.
- Kyabazaala HC IV (Midwife supervising self-care clients);
- Community (self-carers).

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