

Self-care in the Context of Primary Health Care

*Report of the Regional Consultation
Bangkok, Thailand, 7–9 January 2009*



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1. Introduction and background

Self-care is a deliberate action that individuals, family members and the community should engage in to maintain good health. Ability to perform self-care varies according to many social determinants and health conditions. In the series of international conferences on health promotion held in 2006 from Ottawa to Bangkok, self-care was emphasized as the key strategy for health promotion and disease prevention.

Self-care is an integral part of primary health care (PHC). However, in the era of high medical technology and medical treatment, the concept has not been much emphasized and implemented. With the high burden of disease and increase in noncommunicable diseases, there is a need to refocus on health promotion, disease prevention and self-care during illness and in revitalization of PHC. In this context, a regional conference on revitalizing primary health care was convened in Jakarta, Indonesia in August 2008. The Sixty-first session of the WHO Regional Committee for South-East Asia adopted a resolution (SEA/RC61/R3) to revitalize PHC through health systems strengthening to achieve health for all with the emphasis on health promotion and disease prevention.

At the regional conference in Jakarta, a new definition of Health for All was proposed : “A stage of health development, whereby everyone has access to quality health-care or practices self-care protected by financial security so that no individual or family experiences catastrophic expenditure that may bring about impoverishment”.

At the Sixty-first session of the Regional Committee, the Regional Director was requested to support capacity building for strengthening equitable health systems and support capacity of Member States in formulating healthy public policy to revitalize PHC.

As a follow-up of the Jakarta conference and the Sixty-first Session of the Regional Committee for South-East Asia (SEA) Region, a regional consultation was organized to reconceptualize self-care. The consultation

was to determine the strategies/approaches in enhancing self-care in countries of the SEA Region in revitalizing PHC.

2. General objective

The general objective of the consultation was to determine the way forward in strengthening self-care for revitalizing PHC in Member States of the SEA Region.

3. Specific objectives

The following specific objectives were set forth:

- to review the regional and countries' current policy and strategies on self-care;
- to identify and discuss the lessons learnt as well as the challenges for self-care; and
- to identify key strategies, best practices and main activities for strengthening self-care.

4. Inaugural session

The WHO Regional Director for the SEA Region, Dr Samlee Plianbangchang, while inaugurating the regional consultation mentioned that it was one in the series of follow-up actions emanating from the Regional Conference on Revitalizing Primary Health Care, and reiterated that PHC is the key to the attainment of the social goal of health for all, and an important contribution by people of all walks of life to achieve the goal. Good self-care or effective self-care depends on knowledge and understanding of individuals, and depends on their ability to be in control of their own selves.

Promotion of self-care needs policy direction and professional support, and it is best pursued within the social and cultural contexts of the community. Promotion of self-care is an educational and empowering process that ensures that people with the right information can make the right decision as far as their own health is concerned. Skills in education

and communication are indispensable for effective promotion of self-care. Access to information, the quality of information and the ability to interpret and apply information are important elements of a self-care promotion process.

Self-care has to be seen as an integral part of promotive, preventive, curative and rehabilitative care. The role of community health workers and community volunteers is crucial for people to implement self-care. Health information may need to be demystified to make self-care easily understood by all people. On the other hand, health is an industry within which health-related goods and services are being marketed. People also receive information through the media and have difficulty to choose the right information. Not all available information is the right information for effective self-care, therefore it is the duty of health professionals to help people to be able to choose and select the right information in that situation. However, advancement in information and communication technology (ICT), if properly harnessed, can also greatly contribute to efficiency and effectiveness of self-care promotion.

At individual and family levels, self-care can have a positive impact on the economy. If well managed on a large scale, it can substantially contribute to poverty alleviation, especially in poor communities. Self-care, if correctly practised, can contribute immensely to the rational use of medicines.

“Social control of health technology” can greatly facilitate the development of effective self-care practice. Appropriate technology, which is socially and culturally acceptable, should be practised by individuals, families and communities. For all this to happen, people must be in control of the technology that is made available for their use.

The government’s policy and commitment are a prerequisite for promotion of self-care as an integral part of PHC on the national scale. Its promotion on a large scale has to be planned and implemented systematically.

The Regional Director reiterated the role of research to assess the contribution of self-care practice to health improvement. The important research areas mentioned were the use of ICT in educating and empowering people to practise effective self-care; and collection and

compilation of success stories of self-care in the family and community for further promotion.

Dr Prat Boonyawongvirot, Permanent Secretary, Ministry of Public Health, Royal Thai Government, welcomed the participants. He said that this meeting was an opportunity to review the regional and countries' current policy and strategies on self-care, discuss the lessons learnt and challenges for self-care and to identify key strategies and best practices for strengthening self-care. Self-care includes all health decisions people make for themselves and their families to become and remain physically and mentally fit such as eating healthy food, exercising regularly, practising good hygiene, and avoiding health hazards. People in good health, those who are ill or with disability can engage in self-care.

Dr Boonyawongvirot also mentioned that PHC is a means to promote health literacy including self-care. He hoped that the long experience of PHC in the SEA Region to be shared and discussed in the meeting, will contribute to strengthening self-care for revitalizing PHC.

5. Gist of presentations

Dr Ilsa Nelwan, Regional Adviser for Health Systems, WHO Regional Office for South-East Asia, introduced the working paper on **“Self-care in the context of Primary Health Care”**. She said that self-care is health-related decision-making and care undertaken by individuals, family and communities and that the decision-making process depends on local sociocultural aspects. She reiterated that studies and data showed the potential of self-care to improve health-care effectiveness, including health-care cost. The shift in epidemiology from infectious to chronic diseases, the change in philosophy from cure to care and the escalating cost of medical care demanded a new strategy to revitalize PHC in strengthening the health system. Thirty years after the Alma-Ata declaration, the changing social, political and cultural scenarios at global, national and local levels were affecting health. Other challenges such as the current global financial crisis, epidemiological transition leading to an increase in noncommunicable disease mortality, widening inequity between and within countries that threaten PHC values and a significant number of people in this Region impoverished due to catastrophic health expenditure, will all aggravate the situation further. WHO affirms that PHC is still an approach leading to health equity and social justice. However, it has to be revitalized or

renewed in the context of the changing world scenario through health system strengthening.

The conceptual framework began with the equity issue. Health equity is the most salient feature of PHC. To achieve an appropriate and equitable level of health is a question of how the health system is organized at different levels, financed and manned, so as to prevent barriers to access for the whole population.

Worldwide, there is a lot of evidence that health systems based on the PHC approach produce better outcomes in terms of effectiveness, efficiency and equity. The PHC approach encompasses four principles — (i) universal coverage; (ii) community participation; (iii) multisectoral collaboration; and (iv) use of appropriate technology. Self-care embraces all of these principles. Use of appropriate ICT is essential in empowering the community. Finally, self-care will ease the burden of the overstretched health systems, reduce cost and increase its effectiveness, all of which facilitate efforts in achieving universal coverage.

Self-care permeates all types of care pertaining to public health and medical care. Whereas the focus of PHC is on public health, it does not mean that medical care is not taken care of. Public health puts the emphasis on preventive, promotive and disease control measures that can significantly reduce the burden of disease compared with medical care. Self-care should follow a continuum of care using the life-cycle approach from birth, childhood, adolescent, adulthood and elderly. In the reproductive health programme, good results have been achieved by using adolescents for behavioural change. With regard to the level of self-care, the focus should be on primary level of care where most illnesses can be prevented in a cost-effective manner by any individual. The individual will be the centre of self-care, supported by the family and the community.

To attain good health, several efforts need to be made. This includes maintaining good health by taking health action or performing proper self-care. Another effort is to receive good health services. Health service is part of the health system. The health system has a broader scope, since it includes all the organizations, institutions and resources that are devoted to producing health actions. A health action is defined as any effort, whether in personal health-care, public health services or through intersectoral initiatives, whose primary purpose is to promote, restore and maintain health.

In revitalizing PHC, issues related to health workforce and health-care financing have been given special emphasis. The health workforce is important because without a sufficient number and good quality workforce, health service delivery will be severely affected. Community-based health workers (CBHWs) and community health volunteers (CHVs) need to be relied more to supplement the shortage of institutional-based health workforce. Self-care can be viewed as a supplementary measure to reach the individuals. The manner in which health-care is financed will determine how equitable access to and outcomes of the service delivery are. Unfortunately, no matter what financing scheme is chosen, a significant increase in cost over the years is usually unavoidable. In some developed countries health-care accounts for the high proportion of inflation.

Within the context of PHC, self-care can be primarily viewed as the translation of community participation in health development. To elicit active community participation, the community, with the emphasis on women, has to be empowered. Information is an important component to empower people in making informed decisions. Access to the information, the quality of information, as well as skill in interpreting and applying information are important to support a self-care promotion process. Empowerment is an important concept and should be a continuum with inter-related, overlapping stages with information and consultation with communities by professionals at one end, to collaboration and assuming full responsibility by communities at the other. Another community participation concept that relates to self-care is the community-based initiative (CBI). In revitalizing PHC, a different approach needs to be pursued namely “shifts from service delivery to development approach”. The development approach necessitates a community-based initiative.

The possible ways forward are research on the extent of self-care practice, advocacy on self-care within and beyond the health sector and development partners, development of various guidelines on self-care, incorporation of self-care in health workforce education, training for health workforce and community in self-care, and inclusion of self-care in the collaborative activities in the field of CBI.

Dr Sonja Roesma, in her presentation on “Role of community participation in promoting maternal, neonatal and child health”, mentioned self-care as a health promotion mechanism along with mutual aid and healthy environment. Fostering public participation is one of the implementation strategies along with strengthening community health

services and coordinating healthy public policy. These health promotion mechanisms and implementation strategies have to respond to the challenge of attaining health for all by reducing inequities, increasing prevention and enhancing the ability to cope. To address the issue of maternal, neonatal and child health, community financing and also health insurance support are needed. Community participation with health promotion and active community health worker's involvement will multiply the effect of media on self-care implementation. She mentioned that health policy and health politics are fundamental to attaining health for all.

Dr Suniti Acharya made a presentation on "Self-care in adolescents", and said that of an estimated number of 1.2 billion adolescents globally, 350 million or more than 30% are in countries of the SEA Region. Proportionally, in this Region, the population of adolescents ranges from 15% in Thailand to 26% in Myanmar. There are several risk behaviours affecting adolescent health — unbalanced diet (including inadequate diet and excess diet); inadequate consumption of micronutrients; early pregnancy; unwanted pregnancy; exposure to alcohol; tobacco and substance abuse; risky and rash behaviour predisposing people to injuries and violence; early initiation of sex; unsafe sex and physical inactivity.

Self-care offers unique opportunities for health promotion, disease prevention and for staying healthy. There are roles to play for peers, schools and the community in adolescent health. Adolescents could play an important role in influencing the health of others in the family and community such as by promoting healthy practices and influencing parents, family and neighbours with regard to healthy practices.

Reproductive health issues are one of the important felt-needs of adolescents. The level of knowledge and information about reproductive health issues is improving as also access to public health facilities for Reproductive Tract Infection/Sexually Transmitted Infection (RTI/STI) and other conditions. Nepal district health system data on health-seeking behaviour among adolescents show that among young people reporting symptoms of sexually transmitted infection, less than 10% consulted health-care workers, more than 30% got medication from a pharmacy and almost 30% went to general practitioners.

Lessons learnt: Adolescents are better informed and are more knowledgeable than adults about RH issues. Their care-seeking behaviour for antenatal care and delivery is better than adults. If oriented and trained

properly “Self-care” may be one of the most important ways of promoting and protecting adolescent health and the health of their peers, family and community.

The important issues in self-care and adolescents are Self-care among adolescents; role of service providers for promoting self-care among adolescents; scope of self-care in adolescents; and specific examples of self-care in adolescents.

Dr Acharya concluded by suggesting the way forward: Policy support for self-care, develop multisectoral linkages; develop guidelines; promotion of adolescent-friendly services; development of referral centres linked to self-care; and adolescent-friendly health services.

Dr Somchit Hanucharunkul in her presentation on the “Role of family and in community sickness and disability”, quoted Khun with regard to paradigm shift in health-care in the way we look at the world, and the way we think about it have changed and continue to change. She explained the paradigm shift from the biomedical model to the holistic model where the physical, psychological, social and spiritual aspects were comprehensively perceived. Another paradigm shift is from acute care to chronic care in which primary care is provided in a community setting with patient participation. The chronic disease pattern required more caring approach. The community- base can support the patient to go through his/her sickness in the healing process. If the disease is not curable, to support the patient with a peaceful death.

To be effectively implemented, this concept needs team work among health professionals, health workers and the community. Self-care can also be perceived using a medical or holistic approach where ways to meet self-care requisites are learned through culture and habit and people perform self-care according to situation. Participatory learning is important to promote self-care. Building friendly relationships/trust with patients and listening to their experiences regarding self-care are important features of such learning. There is a change of role for health-care providers to that of facilitators and partners; health-care providers need to learn from patients and their families as well.

Dr Hanucharunkul further explained the changes from a medical to holistic approach in terms of the change in provider and consumer relationship, from facility to community-based service. She also elaborated

upon the other positive features of self-care such as making people self-reliant to make judgments related to factors having an impact on the health of an individual, family and community, and seeking health-care from professionals when appropriate. Self-care is a key to success in universal health-care coverage. Further, she elaborated on the role of families and communities in community-based care and components of community-based care, physical care, nursing care, and physiotherapy, psychological, spiritual and nutritional support. After explaining the benefits of community-based care, she elaborated on the different roles of (i) Health workers - provide technical support to patients, the family care-givers and community health workers; (ii) Patients and family members: Family – identify and meet care needs of the patients; Patient – perform self-care, carry out the daily duties when possible and control disease; and (iii) Community members - implement health-care activities at the community level.

The challenge of motivation and incentive for care-providers and volunteers could be addressed by empowerment through training and seminars, community recognition, recognition and awards for good practices and best-care providers. Periodic meetings to encourage participatory programme implementation review, exchange programme and exposure trips to other home and community care projects, providing mentorship and on-the-job training and recognition at the health facility level when they accompany or refer patients for further specialized facility-based services.

In his presentation on “Health system support for self-care”, Dr J.P. Gupta mentioned several basic issues: WHO’s definition of health (1948); natural history of disease and five levels of prevention — health and disease is a continuum of health of individuals, families and communities that are to be quantified in absolute terms. There is a hierarchy of systems and subsystems. He then explained the boundaries of district health system and responsibility for health. Health is a fundamental human right, and it is the responsibility of individuals, families and communities to preserve/maintain health. To discharge this responsibility, they require knowledge related to the five levels of prevention, continued motivation to look after their health, support from health system particularly of primary care-level workers as well as volunteers. Further, he elaborated on the health system tasks. Providers need to know the attributes of individuals, families and communities, identify common health problems affecting people in a given setting, devise mechanisms for increasing awareness, empower people with

knowledge of what they can do themselves and for which they need support from health systems, prepare materials (manual with texts supported by diagrams and illustrations), educate and train people with the prepared material; carry out training periodically; continuously monitor and evaluate the process and take corrective measures in order to improve the processes. These tasks need to be carried out for a healthy population, those with minor health problems, hospitalized patients (for post-hospitalization care) and persons with disability. For doing these tasks, the health system needs to be strengthened through continuous review and reforms of policies (health and healthy public policies), structures, functions and financing.

He elaborated the dimensions of health system support, which included providers, consumers and organizations.

Dr Oratai Rauyajin, in her presentation on the “Role of socio determinants on self-care”, referred to the historical background, medical pluralism where the mainstream is professional sector/modern self-care and the alternative is traditional care – *ayurvedic*, Chinese and traditional medicines. She explained that there are cultural practices in self-care that can be categorized as beneficial (drinking hot tea for diarrhoea), harmless (praying to god, sacred/spirits), uncertain: *Possibly beneficial or harmful* (lying near the fire by postpartum women, drinking ‘Jamu’) and harmful (drinking fresh poultry blood, use of cow dung dressing on the umbilical stump).

Self-care practices, both lay and professional, stem from the interaction between several factors, including psychosocial, economic, cultural and environmental factors. These contributing factors may be classified into two major categories as individual (micro level) and macro levels (family, community, and society).

At individual level, several factors including cognitive factors determine individual self-care practices. Health value means that people who value health will practise self-care provided she/he has sufficient knowledge (health literate). However, people’s health behaviour is also influenced by their belief in illness etiology, such as people who believe that filariasis is caused by *karma* do not allow blood test; if one believes that malaria infection depends on luck (external locus of control) then they do not use bed nets. People who have high fatalism will have low acceptance of cancer screening and low adherence to diabetic treatment.

At macro level: these include broader socioeconomic and cultural environments of an individual at family, community and society levels from both the demand and supply sides of health service delivery system. She then elaborated about the family role: Family (parents) is the influencing role model for their children's behaviour, especially food habit, smoking, drinking and hygiene behaviours. Family is responsible for holistic self-care for minor ailments; decision-making for health-seeking behaviour; providing social and moral support such as motivating TB patients (HIV positive) to adhere to TB treatment. At the community level, community facilitates holistic self-care with social and moral support and social network such as lay referral system, physical and psychological care and self-help groups. Community can also have a negative effect on self-care such as social stigmatization, when social discrimination and devalued patients react with delay in self-care, delay in seeking care, noncompliance with medical appointment and early termination of long-term treatment.

Socioeconomic factors are also determinants such as the poor economic and education status determines that such people are the last in line for health information and services, e.g. Thailand experience with TB patients who could not complete treatment in spite of the free service due to poverty. The environmental effects on self-care practice are migration, urbanization and politics. Migration, particularly urbanization, is another determinant since migrants are marginalized population for health-care due to the language barrier, and the people's illegal status prevents them from access to health information and services. Politics is a determinant and plays a role in the selection of the type of health-care system (traditional, modern, and mixed), distribution of health resources, equity and access to self-care by income. Developed countries push medical care with the focus on its curative aspect.

To revitalize self-care effectively, beneficial lay/traditional self-care practices should be integrated into alternative community-based self-care interventions. Dr Rauyajin advocating a strategy to shift from biological model to social model using a participatory approach through CBHWs and CHVs.

Country presentations

Bangladesh: Dr Amirul Hassan made a presentation on "Self-care in the context of primary health-care". PHC meets the needs of society and

promotes self-reliant development. Priorities are set in terms of local needs and resources. Available resources are mobilized and potential resources developed, using simple, locally existing skills for the benefit of the masses that address equity concerns and efficiency at the same time.

Lessons learnt: In PHC, social mobilization contributed significantly to the success of EPI; Demand-side financing (DSF) increased emergency obstetric care services and utilization.

PHC best practices: Antenatal services for every pregnant woman, skilled birth attendant for every birth, clean and safe delivery at home or health facility, exclusive breastfeeding up to six months and weaning afterwards, appropriate newborn care, proper young child-feeding, use of long-term contraceptives, prevention of violence against women, prevention of STD/HIV.

Challenges: 24-hour emergency obstetric care services; retention of skilled human resources at every level, particularly in remote villages and urban areas; timely supply of equipment/drugs/logistics; functional coordination of MoH infrastructures (such as between Directors-General) and intersectoral collaboration, community ownership of ongoing programmes, and building management capacity.

Bhutan: Mr Penden Dorji presented the Bhutan experience. After introducing the health-care system in Bhutan, he explained the strength of primary health-care – voluntary health worker/systemic health-care, indigenous base, herbal remedies, religious/ritual base. The common self-care practices included traditional medicine integrated into modern medicines, promotion of herbal medicines in collaboration with the Ministry of Agriculture, application of herbal medicines for management of fractured bones and for skin problems. Promotion of self-care needed a health and religion programme, training of traditional healers on PHC, sensitization on PHC components especially on reproductive health/safe motherhood, sexually transmitted diseases, sanitation and hygiene. He elaborated the strategies to strengthen voluntary health workers and community development for health. It began with the water and sanitation programme with involvement of the basic health unit staff and trainees. There is a need to strengthen and empower the community in identifying the problems, prioritizing, planning, decision-making, resource mobilization and implementation of programmes. In conclusion, he mentioned two

issues: globalization and the increase in health-care cost as challenges for self-care promotion.

India: Dr S.K Sikdar presented “Self-care in the context of primary health care”. After a brief overview, he described commonly practised self-care in the preventive, promotive and curative, as well as rehabilitative areas. He elaborated the role of self-care in revitalizing PHC – realizing self-reliance, promoting community participation, empowerment for control over one’s health and towards use of appropriate technology. Self-care initiatives in India include: National Rural Health Mission (addresses the determinants of health) with a powerful steering group consisting of various sectors, intersectoral coordination, regular NGO consultations. NHRM encourage practices, community monitoring by NGOs, support *ayurveda, unani, siddha and homeopathy (AYUSH)*. The standard PHC centre structure include an *AYUSH* unit with a doctor and pharmacist, village health and sanitation committee, village health and nutrition day, and accredited social health activist (ASHA).

Steps for promoting self-care include: (1) documentation of self-care: knowledge and practices, research, extent of self-care practices, rapid assessment of practices, policy and operations studies for strengthening self-care; (2) dialogue for mutual exchange and learning intra- and inter-country lessons; (3) advocacy for promotion of self-care (at political, bureaucratic and community levels); (4) communicate regularly with the public on the relevance and need for revitalization, understand the drawbacks in existing situations for protecting traditional knowledge and (5) formulate operational guidelines for organizations/community/country also to feed into the training programme.

Indonesia: Ms Dunanty Sianipar presented “The development and implementation of traditional medicine on self-care”. After touching upon the Indonesian situation, she explained the growing interest in traditional medicine and that in the context of self-care, traditional medicine is used as self-medication. The shift in the pattern from infectious to chronic diseases influences the health-care cost and medicines, the burden for patients and families for treatment. Implementation of self-care depends on community participation. Steps to be followed were developed by health providers and the community itself supported by NGO, the university and relevant partners.

Key strategies: National movement on cultivation of medicinal plants (TOGA) in each household and gradual implementation at every level.

Best practices: Acupressure and herbal medicines.

Main activities: Create a model of self-care to cater to community needs, at least two districts in each province. Promotion of specific medicinal plants for health maintenance and community empowerment for healthy life.

Maldives: Ms Naila Abdul Majeed presented “Self-care in the context of PHC”. Commonly practised self-care –: community level (NGO roles to providing safe drinking water, educating communities (e.g. chronic lifestyle diseases), family level (e.g. managing chronic diseases, general hygiene, childhood diseases) and individual level (self-managing chronic conditions, decision-making, protecting gender-based violence and abuse). There are no existing rules or regulations for self-care. However, according to Maldives’ health master plan for 2006-2015, the goal is to ensure that all citizens have equitable and equal access to comprehensive PHC. Revitalizing PHC in the role of self-care: organizing primary care networks, providing more opportunities to train health professionals e.g. midwives, community health workers at community level to conduct community nutrition programmes. Revitalizing PHC will be done through strengthening the health system using the PHC approach – perceived self-care in enhancing community participation for health development, involving women’s committee or community health practising personnel in the health planning process and introducing new and initiatives, healthy working settings, families and community groups.

Steps for promoting self-care: Strengthening the health workforce, including community-based health workers, ensuring a supportive environment for effective functioning of community-based health workers and community volunteers, strengthening partnership with civil society that includes the community, the private sector and NGOs, and foster more effective multisectoral collaboration for establishment and implementation of self-care policy.

Nepal: Mr Khem Bahadur Karki presented “Self-care in the context of PHC”. Female community health volunteers (FCHVs) are main agents who promote self-care through health systems related to health programmes. FCHVs in the communities provide information and counselling on child

care, family planning, safe motherhood, immunization, and hygiene and sanitation, etc. and distribute Vitamin A, Albendazole, ORS, zinc, iron/folic, pills and condoms, referral and accompany patients to health facilities for delivery and emergency services, etc. Mothers' group meetings are held every month and they share the self-care practices in the village.

Self-care practices outside the health programmes are traditional practices, use of locally available herbs, spiritual healings, naturopathy, food-related practices, and noncommunicable disease-related self-care practices.

Way forward: Self-care should be recognized as a component of the health system. Policy and system support should be provided to further promotion of self-care.

Sri Lanka: Dr Haritha Aluthge presented the Sri Lanka country presentation, translating the concept of PHC in policy and action through community participation, intersectoral actions for health and service provision. New programmes have been developed to respond to the changing health challenges, such as child development, male participation in MCH, adolescent health, care for the elderly, community-based rehabilitation, prevention of NCD and implementing model village concept.

Challenges and limitations: Conflict situation in the north and the east, district variations, and the global economic crisis.

Take-home message: The PHC success depends on intersectoral collaboration.

Thailand: Dr Supachai Kunaratanapruk presented "Self-care and health promotion in Thailand". He began the presentation by categorization of self-care and self-care support. The biggest part of self-care is for maintenance of good health, and ill-health prevention. The other parts divided among self-care of minor illness, acute illness and self-care for long-term conditions with all the necessary professional support. Self-care support is necessary for the whole system. Patient's education, self-care skill training, health and social care information, care plan approach, self diagnosis tools, self monitoring devices, peer support network and home adaptation.

Components of self-care support: Device and technology, information, skill training, self-care support network, personalized self-care plans, community services, professional education and awareness-raising campaign. Self-care support should be provided to enable the individual to stay fit and healthy. Dr Kunaratanapruk also explained self-care in the Thailand context and relating to the pre-primary health-care and primary health-care eras. In the present context, there is a new paradigm, in which self-care is perceived as people's right for better care and it is people's responsibility for maintaining health. The highlights are development of healthy public policy, community empowerment and health promoting hospital. The healthy public policy examples are establishment of Health Promotion Fund, National Health Security Act, National Health Act, Tobacco Consumption Control Act, and Alcohol Consumption Control Act. Examples of community empowerment are plans and the process of enacting the Decentralization Act 1999, health capacity building, national health campaign, health clubs and peer support. He then explained the key points of innovative PHC approach. People are very interested and supportive of self-care, especially in health promotion. Supporting systems are key to motivate, empower and build up confidence. Information and support from self-care professional is crucial for the family; friends and peers are also an important support group. Regarding healthy lifestyles, even though people seem to have the knowledge, and have the motivation to perform self-care, it is not practised at the level it should be. For strengthening public health, there is a need to discourage health risk behaviours using healthy public policy such as laws, fiscal measures, and taxation. For further development, there are issues that need to be addressed: evidence-based, effective self-care activities; technologies; community; people; capacity building; motivation; development of self-care peer groups' networks; financial scheme for self-care support; and professional attitudes and skills.

Take-home message: People's power is needed to move closer to self-care and PHC targets.

Timor-Leste: Mr Duarte Ximenes presented the paper on "Self-care in the context of PHC". After touching upon the comprehensive PHC model, he mentioned that self-care policy is found in health policy framework. Specifically in the intersectoral action framework and national health strategic plan in programme interventions, process, outcome and impact to enhance community health and well-being. There are three

components in the health-care system structure – Servisu Integrado Saude Comunitario (SISCa) at community level, district services, and hospital services. All the components deliver basic health package that covers individual, family and the community through a multisectoral approach. Under integrated community health services, self-care is promoted in a systematic way, and it is seen as an effort at the first level of individuals and the family, prior to seeking help from health services.

Take-home message: to focus on community participation and family health promotion.

6. Group work

Two group work sessions were conducted viz:

Group work 1 – “Self-care definition, mechanism for stakeholders to promote self-care”

Proposed working definition (2009)

“Self-care is the ability of individuals, families and communities to promote health, prevent disease, and maintain health and to cope with illness and disability with or without the support of a health-care provider”

The scope of self-care: Health promotion; disease prevention; disease control; self medication, reactive and restorative care; referral for institutional/specialist care; and rehabilitation including palliative care.

Mechanisms to promote self-care: Community empowerment appropriate to the socio-cultural, environmental and linguistic contexts; reviewing the roles and responsibilities of supportive institutions; strengthening support networks beyond the health sector; identification and collection of self-care practices, and listing the health effects; ICT; and media; and schools. Celebrities should be utilized to promote self-care. Messages through the mass media should be vetted for appropriateness and for institutionalization of beneficial self-care practices.

Self-care promotion can be at various levels:

National and subnational levels: Policy and legislative support, national plan for self-care with adequate budget. To include self-care intervention in all relevant programmes and projects.

Community level: Adequately funded microplanning and sustained support/sponsorship for self-help groups can be promoted, ensuring adequate representation by women.

Family and individuals: Continuing education, support and follow-up including self-care advice, post-hospitalization.

Institutions for self-care promotion: Health workers' communication skills need to be improved, through pre-service education and in-service reorientation; local government and other relevant public sector offices/organizations; faith-based groups; self help groups; CBOs/NGOs/professional associations; and private sector schools; multisectoral actors: education; information; industry and the media.

Group work 2: “Self-care: Key strategies, best practices and main activities for strengthening self-care in the context of PHC”.

Best practices

Health information/communication/documentation: Involve the media, youth information centres; document the experience of self-care, in particular the outcome and validation of positive and negative practices; community-based workers facilitate the community to learn; use popular figures on the mass media to convey messages on relevant topics and issues; use officials and offices; produce appropriate literature on best practices for policy-makers as well the community; create a platform; empower and facilitate effectively; establish dialogue between the community and health-service providers.

Promotion: Promote community participation through multisectoral task forces at district/subdistrict levels assisted by specific technical committees e.g. TB, HIV/AIDS, provision of information centres, health campaign e.g. breastfeeding, polio eradication, measles, Vitamin A supplementation, deworming, promotion of healthy schools, healthy homes, healthy

workplace, healthy cities, healthy villages; assist the community to develop the capability to negotiate with other partners/ stakeholders.

Human resources for health: Health volunteers, paramedical professionals, family health volunteers, community health volunteers, self-help groups for the community and home-based care such as women's groups, adolescents' groups, youth and adult groups, elderly groups; yoga and meditation; users' groups for sanitation, drinking water; family caretakers of particular problems become 'experts' in taking care; patients through their own personal experience may become resource persons; identify the natural leaders in the community and empower children to be agents of change.

Enabling environment for self-care accessibility: Complete/correct/precise information leaflets after discharge from hospital; examples from community-based rehabilitation; school health programmes: for juvenile diabetes, oral health, personal hygiene, iodine and iron deficiency. For a comprehensive and sustained effect of medical intervention, several important aspects are: learning from failures; strengthening of local administration; support and enable the peers, colleagues and caretakers.

Coordination/collaboration: Multisectoral collaboration and pooling of resources and collaborative allocations.

Training: capacity-building training, motivational team building. Studies on what approaches are and would be effective (factors that might hinder or promote adoption of self-care at individual, family and community levels).

Pros and cons of self-medication

Pros

Self-medication might reduce the need for medicine. There would be reduced burden on the government. Self-medication reduces indirect/opportunity costs. Self-medication can provide psychological support to chronic patients. It may pressurize medical practitioners to behave more rationally and to regulate dispensing of drugs. Self medication can safely use allopathic medicine vis-à-vis traditional medicine/home-based therapies; self- medication can be safe if people are well informed.

Cons

Inadequate knowledge about medicine including local culture barriers. Self-medication may increase inconsistencies with rational use of drugs. It can increase dependency on guidelines/set-thinking. It can be expensive if the country depends on imported medicines. It might also delay treatment in serious conditions.

Role of community-based health workers and community volunteers

Capacity building: Training, refresher training. Monitoring/evaluation and supportive supervision. Strengthening basic health workers for self-care.

Information and communication: facilitate people to take initiatives for better self-care; advocacy role on behalf of marginalized people; facilitating the community with other health professionals such as doctors; Advocacy for self-care; reporting and documentation.

Key strategies

- (1) *Policy and legislation* for self-care are important for self-care promotion.
- (2) *Networking* among different players will improve collaboration among health stakeholders and improve access to self-care.
- (3) *Information*, education and communication for supporting self-care promotion.
- (4) *Planning*: Bottom-up planning to integrate the grassroots initiatives supported by adequate resources through resource allocation and resource mobilization.
- (5) *Interventions*: Establish and strengthen the community-based posts for launching SC interventions and for bringing the community and the service providers closer. Strengthen the capacity of community-based, private and nongovernmental organizations.
- (6) *Research* and studies on existing self-care practices.

7. Conclusions and recommendations

Conclusions

- Sustained promotion of self-care should be an essential component of revitalization of PHC for achieving national and international health goals.
- Self-care is an integral part of the continuum of health-care. For it to be effective, health system strengthening including provision of appropriate referral care is necessary.
- Promotion of effective self-care is important not only to reduce health-care costs, but it can also lead to improvement of equity in health.
- Self-care practices are influenced by sociocultural, economic and political determinants.
- While it is recognized that self-care is the responsibility of individuals, families and communities, multisectoral efforts are needed to assist people to practise self-care.
- In addition to the health sector, other sectors like education, industry, information, NGOs and the private sector, the community and faith-based organizations need to be involved in self-care promotion.
- Self-medication is widely practised in the Region and may significantly contribute to reducing health-care costs. However, there is a need to carefully review and evaluate the role of self-medication with reference to safety, delay in seeking treatment in serious conditions, and emergence of drug resistance.
- A carefully selected list of medicines that could be used for self-care needs to be prepared and a programme based on these drugs should be implemented.
- To enable people to practise appropriate and effective self-care, correct information delivered in a culturally sensitive manner is essential.
- Public-private partnerships (including private-for-profit) can play an important role in supporting self-care initiatives.

- Community-based health workers and volunteers can be effective promoters of self-care.
- Health policy and strategy need to recognize the importance of self-care in primary health-care.
- Necessary support structures, legislation/regulation and financing mechanisms should be created within the country context to promote self-care.
- Education and training of the health workforce and community change agents should include capacity building for assisting people to practise self-care.
- There is a need to conduct participatory action research and operational research specific to the SEA Region to develop evidence-based, effective self-care practices.

Recommendations

Member States should:

- Give serious consideration to including strengthening of self-care as a programme in their efforts to revitalize PHC.
- Re-examine national health policies and strategies to strengthen support structures, legislation and financing for self-care.
- Document existing local self-care best practices and conduct operational research to develop evidence-based, effective self-care practices.
- Establish a network of individuals and institutions for self-care promotion.

WHO should:

- Advocate for strengthening self-care in the context of revitalizing PHC.
- Provide technical support to Member States in their efforts to promote effective self-care.
- Provide support to Member States in documentation, assessment and evaluation and research on self-care practices.
- To develop common tools and guidelines.

Annex 1

Self-care in the Context of Primary Health Care

1. Introduction

Primary Health Care (PHC) is an approach for health development envisioned in the Alma-Ata Declaration of 1978. PHC aims at equity in health through accessible, affordable and quality health care for all with the full participation of all people in the spirit of self reliance and self determination. Health care is delivered through the health system, which comprises all organizations, people and actions whose *primary intent* is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities. In short, the health sector is not the sole owner of the health system. Hence, the performance of the health system is influenced by other sectors beyond health ⁽¹⁾.

Self-care (SC) is a term representing the range of health-related decisions and care undertaken by individuals on their own behalf ⁽²⁾. Decisions made at the individual level, in turn, influence decisions made at the family and ultimately at the community level. The process on how decisions are made at these three levels largely depends on the prevailing socio-cultural settings. In many developed countries, efforts to exercise self-care and more control over one's health and health care matters are gaining momentum. Studies and data collected over time show how self-care can make a difference in terms of health care effectiveness, including the health care cost aspect. The shift in focus from infectious to chronic diseases, the change from "cure" to "care" philosophy, and the escalating cost of medical care, are some of the reasons why efforts at self-care have continued to grow ⁽³⁾. The health consumer at the individual, family and community levels is better informed and assumed to be more active and more responsible by implementing self-care. The health providers have, therefore, begun to change their role to be facilitators, ensuring that the patients can access health care according to need and by providing supporting information.

The WHO Regional Office for South-East Asia convened a Regional Meeting on Strengthening Health Care at Home in 1990. Since then various programmes have implemented self-care, although not under the special banner of self-care. A systematic approach is needed to make self-care more effective and more efficient within the context of PHC ⁽⁴⁾.

Thirty years after the Alma-Ata Declaration, the changing scenario in politics, the economy and the socio-cultural arena at national, regional and global levels is affecting health. The spiraling health care costs, inefficiency due to allocative and technical factors, climate change, and the current global financial crisis will further aggravate the situation. The negative impact on health is clear. Meanwhile health systems are ineffective in meeting the demands, needs and expectation of the society. WHO affirms that PHC is still an approach leading to health equity and social justice; however, it has to be revitalized or renewed in the context of the changing world through health system strengthening. With this belief, all six WHO Regions convened meetings related to revitalizing/renewing PHC. WHO/SEARO convened a Regional Conference on Revitalizing PHC in Jakarta during 6-8 August 2008 which also served as the Technical Discussions prior to the Sixty-first session of the Regional Committee for South-Asia held in September 2008. As a follow up, a High Level Consultative Meeting on Accelerating the Achievement of MDGs 4 and 5 was held in Ahmedabad, India, in October 2008. This regional consultation on self-care is the follow up actions on revitalizing PHC recommended by the Jakarta conference.

The World Health Report 2008 entitled, "Primary Health Care – Now More Than Ever", was dedicated to the renewal of PHC. The report was launched on 14 October 2008 at Almaty, Kazakhstan to commemorate the 30th anniversary of PHC ⁽⁵⁾.

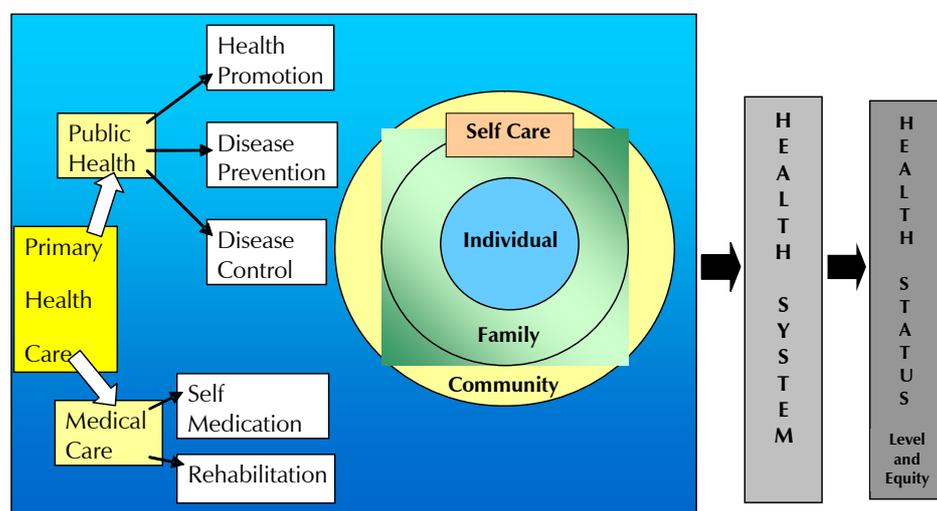
This working paper covers the general conceptual framework and describes the focus of PHC i.e. emphasis on public health with its main areas of work (preventive, promotive, disease prevention and control), without neglecting medical care. The type of self-care in various areas of work is identified as well as the link with health systems in achieving the main objective of PHC, namely, health equity. Several research studies related to self-care are also described. The working paper concludes with recommended actions to move forward.

2. Conceptual framework

Health equity is the most salient value of PHC. It is generally used to measure the performance of the health systems along with the level of health using various indicators, such as life expectancy at birth and maternal mortality ratio. To achieve an appropriate and equitable level of health is a matter of how the health system is organized at different levels, financed and manned, so as to prevent barriers to access for the whole population.

Worldwide, there is a lot of evidence that health systems based on the PHC approach produce better outcomes in terms of effectiveness, efficiency and equity. The PHC approach encompasses four principles: universal coverage; community participation; multi-sectoral collaboration; and use of appropriate technology. Self-care embraces all of these principles. Self-care is the translation of community participation through community empowerment that necessitates involvement of other sectors beyond health. Use of appropriate information and communication technology is essential in empowering the community. Finally, self-care will ease the burden of the overstretched health systems, reduce cost and increase its effectiveness, all of which facilitate efforts in achieving universal coverage.

Figure 1: *Self-care in the context of Primary Health Care*



Self-care permeates all types of care pertaining to public health and medical care. Whereas the focus of PHC is public health, does not mean that medical care is not taken care of. Public health puts the emphasis on preventive, promotive and disease control measures that can significantly reduce the disease burden compared with medical care.

Self-care should follow a continuum of care using the life cycle from birth, childhood, adolescent, adulthood and elderly. In the reproductive health programme, good results have been achieved by using adolescents for behaviour change. With regard to level of care approach institutional care, the focus should be on primary level of care where most illnesses can be prevented in a cost-effective manner by any individual. The individual will be the centre of self-care, supported by the family and the community.

3. Health equity

Attaining good health is one of the fundamental human rights as well as a human investment for national development programmes. Health is defined as a state of complete physical, mental and social well-being, and not merely the absence of disease and infirmity.

To attain good health, several efforts need to be made. Among them efforts is to maintain good health by taking health action or performing proper self-care. Another effort is to receive good health services. Health service is part of the health systems. Health system has a broader scope, since it includes all the organizations, institutions and resources that are devoted to producing health actions. A health action is defined as any effort, whether in personal health care, public health services or through inter-sectoral initiatives, whose primary purpose is to promote, restore and maintain health.

The Health for All (HFA) movement was part of the Alma-Ata Declaration on Primary Health Care adopted in 1978. HFA was to be achieved by the year 2000. Even though HFA has not been achieved, it is still vision or inspirational goal of health development. It is believed that this could be achieved through revitalizing PHC

While equity and social justice are the salient values of PHC, the recent global economic crisis will certainly worsen the inequity gap.

Equity is an ethical concept that eludes precise definition. Although equality and equity are used interchangeably, equity should be differentiated from equality. Equality does not take into account whether the existing disparity/gap/difference is fair or just. Simply put, inequity is unfair or unjust inequality.

Recently, an inequity analysis was conducted in Bangladesh, India, Indonesia, Maldives, Nepal, Sri Lanka and Thailand in the South-East Asia Region covering several stratifiers.

An example in the area of maternal health is illustrated below:

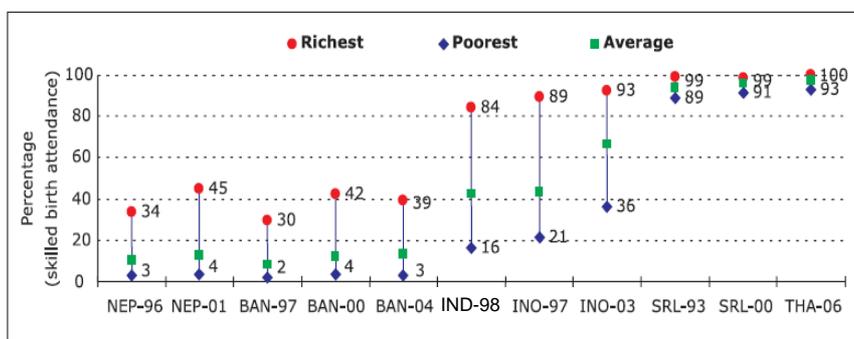
Having a skilled birth attendant during the birth of a child improves the likelihood of a safe delivery. A skilled birth attendant is a medical doctor, midwife, nurse or other category of the health workforce who has been given appropriate training to care for mothers giving birth. The global experience and scientific evidence is very clear that skilled birth attendance and access to emergency obstetric care at adequately equipped hospitals are essential and critical to substantially reducing maternal mortality, which is one of the key health MDGs.

Unfortunately, skilled attendance at childbirth is relatively uncommon in most countries of South-East Asia, except Sri Lanka, Maldives and Thailand, where skilled birth attendance is almost universal. Almost all babies in Sri Lanka (96%), Maldives (85%) and Thailand (97%) are born with a skilled birth attendant present. In these countries, coverage rates are high regardless of socioeconomic, educational and geographical differences.

The low accessibility to SBAs and institution is partly due to large percentage of the population in the other countries lives in rural areas, where access to medically trained individuals is limited. This is the case in Bangladesh and Nepal, where only 13% of children were delivered with a skilled birth attendant present. Rural areas accounted for 84% and 74% of the total population in Nepal and Bangladesh respectively in 2006.

The gap in coverage of skilled birth attendance is high between the rich and poor, and has remained the same or increased between the 1990s and post-2000 (Figure 2). However, in India the richest 20% of women are five times more likely to receive skilled attendance and, in Indonesia, they are four times more likely to do so than among the poorest 20% ⁽⁶⁾.

Figure 2: **Inequities in skilled birth attendance between the poorest and richest wealth quintiles by country and survey year**



Source: WHO-SEARO, 2007

Legend: NEP: Nepal; IND: India; BAN: Bangladesh; INO: Indonesia; SRL: Sri Lanka; THA: Thailand

4. Health system

The physical infrastructure of health services in many countries of the South-East Asia has expanded significantly since the 1980s, particularly at the primary and first referral levels. Most countries have given priority to upgrade the health infrastructure, particularly in rural areas. Practically all Member countries have comprehensive networks of health facilities that extend to the village level. The establishment of a primary care infrastructure in rural areas, supported by a strong referral system, intersectoral collaboration, and community participation are the characteristics of the health systems development based on primary health care in the Region.

The activities or programmes implemented depend on specific health problems encountered and the ability to solve them. All countries in the Region implement both medical care as well as public health services. In some countries, public health services play more significant roles. Through organized community efforts, these countries implement public health services that reach the very remote areas. Water and sanitation conditions and community nutrition programmes could be improved through community participation and mobilization.

Provision of medical care by family physicians, as practiced in many developed countries, is available only in big cities. The service, however, is still not optimized. The practice of continuous, comprehensive and integrated health services is not fully implemented, as the payment system is mostly out-of-pocket ⁽⁶⁾.

In revitalizing PHC, issues related to health workforce and health care financing have been given special emphasis in strengthening the health systems. Health workforce is important because without a sufficient number and good quality workforce health service delivery will be severely affected. Besides, expenditure incurred for health workforce constitutes a big chunk of the total health expenditure. Together with medicines it may account for 80% of the expenditure. We need to rely more on community-based health workers (CBHWs) and community health volunteers (CHVs) to supplement the shortage of institutional based health workforce. Self-care can be viewed as a supplementary measure of CBHWs and CHVs to reach the individuals.

The manner in which health care is financed will determine how equitable access to and outcomes of the service delivery are. Unfortunately, no matter what financing scheme is chosen, a significant increase in cost over the years is usually unavoidable. In some developed countries health care accounts for the high proportion of inflation. The good news is that there is anecdotal evidence to show that self-care has led to the reduction in health expenditure.

5. Self-care

Basically, when people feel there is something wrong or there is some symptom, they will attribute that to some causes and then try to get well by doing something to get rid of such symptoms. The ways in which they help themselves is called "lay self-care". How they practice self-care to get relief from their ailments depends on what they believe are the causes of their ailments. Before the era of modern medicine, there were many theories explaining the causes of illness, for example, the imbalance of the substances in the human body, karma, supernatural causes, including black magic, evil spirits, luck, faith, etc. Therefore, self-care practices in many societies include a wide range of options such as using herbs, body massage, ointment, body heating, holy water, religious and cultural rituals and ceremonies, spirit possession, and so on.

It is generally accepted that self-care as practiced by the lay people includes both treatment and health maintenance. However, self-care in illness attracts more public and scientific interest. One line of thought more germane to public health thinking limits self-care activities to the primary care level; self-care is the base of the health care pyramid.

A broader framework emphasizes the behavioural and cognitive dimensions of self-care in illness behaviour research. Self-care carried out by the sociologists and anthropologists in illness may be defined as “the range of individual behaviour involved in symptom recognition and evaluation, and in decisions regarding symptom responses, to treat the symptoms by self determined actions or to seek advice regarding treatment. Self-care thus include consultation in the lay, professional and alternative care networks as well as evaluation and decision regarding action based on the advice obtained in consultation” ⁽⁷⁾.

5.1 Various definitions of self-care

WHO/SEARO working definition 1991⁽⁶⁾

“Self-care in health is behaviour where individuals, families, neighborhoods and communities undertake promotive, preventive, curative and rehabilitative action to enhance their health”.

Pharmacist and health promotion context

Self-care is what people do for themselves to establish and maintain health, and to prevent and deal with illness. It is a broad concept encompassing hygiene, nutrition, lifestyle, environmental factors, socio-economic factors and self medication ⁽⁸⁾.

Self-care includes all health decisions people (as individuals or consumers) make for themselves and their families to get and stay physically and mentally fit. Self-care can be regulatory, including routine health maintenance activities such as eating, sleeping and personal hygiene. It can also be health promotion or disease prevention such as exercising, dieting, self-examination practices, and immunization ⁽³⁾.

The Ottawa Charter on health promotion

Health promotion is the process of enabling people to have control over and to improve their health. Self-care can be viewed as a part of health promotion with regard to decisions and actions individuals take in the interest of their own health ⁽³⁾.

The Regional Conference on Revitalizing Primary Health Care, 6-8 August 2008 Jakarta: Self-care as part of efforts to achieve Health for All.

The conference proposed the HFA definition as “A stage of health development whereby everyone has access to quality health care or **practice self-care** protected by financial security so that no individual or family is experiencing catastrophic expenditure that may bring about impoverishment” ⁽⁶⁾.

5.2 Self-care at various population levels

- **Individual level:** Exercising to maintain physical fitness and good mental health. It also includes eating well, self medicating, practicing good hygiene and avoiding health hazards such as smoking, as well as safe behaviour for injury prevention. Self-care has a role in early detection for disability prevention and could also mean compliance to a professionally prescribed medication regimen.
- **Family level:** Self-care is supporting a family member who needs help. Children, elderly and the chronic patients need the family support as part of their self-care.
- **Community level:** Self help groups support self-care at the community level by creating an enabling environment. Experience-sharing in self-care and care for vulnerable family members, as well as improving required skills to support self-care are important examples.
- Even at **secondary and tertiary levels**, care effectiveness operates through the individual, who assimilates the influence and determines the care. Self-care is taking care of minor ailments, long-term conditions, or one’s own health after discharge from secondary and tertiary health care.

5.3 Scope of self-care

- Self-care is not limited to self medication or medical care only. It should prioritize the **Public Health** area i.e. preventive and promotive actions as well as disease control, communicable and noncommunicable alike. Self-care in these areas is described in point 8 later. Self-care is also an important part of rehabilitative care.
- A focus on public health is important if self-care is to have a positive impact on disease burden. Currently, in the Region, deaths due to noncommunicable diseases have surpassed those caused by communicable diseases. PHC as a tool in health development focuses on public health interventions (health promotion, disease prevention and disease control) without neglecting interventions delivered through medical care.
 - (a) **Self medication** is one element of self-care. It is the selection and use of medicine either western and/or traditional medicine by individuals to treat self-recognized illness symptoms. Self-care for chronic patients including prolonged drug treatment is one of the options in limited resource settings.

Self medication needs special attention. Many of those who do not have access to health services turn to self medication. In Indonesia, self medication in 2006 was practiced by 50% of the population. This should be linked with how medicines are regulated in each Member country. Unfortunately, in many Member countries although there is a clear boundary between prescription medicines and over-the-counter (OTC) medicines, this regulation is not strictly adhered to. It is acknowledged that the practice of traditional medicine, in particular herbal medicine, in self-care is quite widespread.

- (b) Self-care in **rehabilitative measures** is compliance to a professionally prescribed medication regimen. In the context of disability rehabilitation, self-care includes all measures aimed at prevention of complications, improving recovery rate, reducing disability and enhancing independence. Self-care for management of chronic conditions includes medical management, role management and emotional management. Self management needs six self management skills: problem

solving; “decision making”; “resource utilization”; patient-provider partnership; “action planning”; and self tailoring⁽⁹⁾.

6. Research and studies related to self-care

A large number of studies across different countries, using a variety of research methods have consistently shown that SC is the most dominant form of primary care in both developed and in developing countries, where the majority of people are poor and do not have access to professional health care.

- (a) In the health diary method to study health care behaviour, participants record perceived illness symptoms and how they respond to them over a period of time. Several health studies reveal that only a small proportion of illness is treated by the professionals, and that the major proportion is taken care of by the individuals and the family.

Mothers take the most active part in caring for ill children within the family. Use of over-the-counter medicines was the most frequently reported illness management activity in some studies.

It is estimated that 65%-85% of health care is provided by the individual or the family without professional intervention using traditional, non-allopathic or allopathic technology. Self-care appears to encompass activities related to health promotion, disease prevention, illness and injury treatment, chronic disease management and rehabilitation. The family functions as a basic health care unit with an elaborate system of beliefs and procedures, many of which are rooted in the local culture. All levels of professional primary care are thus only supportive to self-care and modest facilitation of it has the potential to improve the health and socioeconomic status of the whole population (3).

- (b) Studies in the developed world have showed that self-care and health promotion interventions work. Intensive educational interventions among college students produced substantial improvement in health related knowledge, health skill performance and health action in the intervention group compared to the control group. However, there was no evidence that the intervention had any effect on health status or medical care utilization.

Self-care promotion has been found to be effective in improving the conditions of patients for a variety of chronic diseases such as chronic pain, headache, back pain. Self-care interventions are effective in improving the outcome and reducing the use of health services in adults with asthma. Conveying appropriate self-care information to the patient reduces the use of health services by 7%-17%. The effectiveness of self-help groups has been studied and is found that self-help groups are associated with higher improvements compared to the control ⁽³⁾.

- (c) A review of several international surveys on self-care practices has concluded that these practices are often beneficial and self-care appears to be a universal behaviour.

At the workplace, providing information on self-care to employees is an effective way of reducing the employer's health cost. A study in 1997 in a company revealed that a programme was implemented using a guide which contained information on self-care and when to refer to professionals. Claim data analysis at baseline and one year after the programme indicated a saving of \$39.65 per employee (24% reduction in cost) ⁽³⁾.

- (d) A community-based self-care project using an information handbook, a telephone line and a website on self-care was found to be effective in empowering people to manage their illness resulting in reduction in the use of professional services. Following this success similar projects were initiated in the United States and Canada. Evaluation of the project indicated that the use of the handbook resulted in reduced hospital visits with an estimated cost saving of \$34.5 million during 30 months of the initiative. For every dollar invested there was a saving of 11 dollars on health care ⁽³⁾.
- (e) There is also evidence that large health promotion programmes are effective in reducing morbidity, mortality and in improving the quality of life. In Canada health promotion programmes began in the 1970s. There was an increase in life expectancy at birth and reduction of IMR in Canada between the 1970s and 1990s. Nearly 10 million Canadians have reported improvement in their personal health practices such as reduced alcohol consumption, improved eating habits, increased physical activity and 67% of them attributed this to increased awareness of health risks. The validity of this reported behaviour is further supported by the fact that there has been a

corresponding decline in cardio-vascular mortality attributed to these healthier lifestyle and improved medical care ⁽³⁾.

- (f) In the developing world, the self-care developed along with the primary health care movement during the 1970s-1980s. Self-care has been able to compensate the shortage of health workers and mal-distribution. In the PHC context, the trained community health volunteers together with community health workers implement various programmes.
- (g) In the South-East Asia Region, attempts by the community to prevent and limit the spread of diseases go back to antiquity. Many traditional approaches to health and diseases were based on traditional beliefs and observations (such as ayurvedic medicine and other traditional remedies), the worship of supernatural spirits and astrological practices. There have been many beliefs about effective practices such as avoiding eating inadequately preserved food without an understanding of the etiology of diseases ⁽¹⁰⁾.
- (h) A self-care study among women in the informal sector in Thailand in 2005 revealed that the women learned their health problems were related to work and placed them at a risk of illness. When they realized the gravity of the situation they attained a sense of empowerment and took the initiative in establishing an action plan to address their problems (11).
- (i) Four studies on self-care practices in India and Nepal carried out over a 10-year period in 7,400 households comprising over 48,000 people in three Indian states and three districts of Nepal revealed that, the proportion of ill individuals using self-care over a two-week period ranged from 19% to 42 %. This involved 5% to 9% of the total population in self-care activities during these two weeks. Much larger differences were found between India and Nepal in self-care during pregnancies. Self-care or care by relatives and friends was the predominant source of maternity care in Nepal, including deliveries, while Indian maternal care was dominated by traditional birth attendants (12).
- (j) In study of post-surgery self-care in Thailand, 40 subjects participating in the study were randomly assigned to either an experimental (n = 20) or a control group (n = 20). Patients in the experimental group participated in their self-care through nurse-patient interaction in

addition to the usual care received in the setting. Results of the study indicated that patients in the experimental group had significantly less pain sensation and distress, used fewer analgesics, ambulated more, had fewer complications, and had higher satisfaction with care than patients in the control group. Since the experimental intervention was based on Orem's and King's theories, these findings support the value of application of these two nursing theories in practice⁽¹³⁾.

- (k) Kleinman in his study on health-seeking process in Taiwan reported that 73% of total illness episodes in the preceding month were treated in the family only, and 93% were first treated in the family. A study of self-care behaviour in Northeastern Thailand employing a one-month recall period, found 88% of all reported illnesses were minor ailments and about 96% of these received self-care only. A study of self-medication practice with modern pharmaceuticals for childhood illnesses in a rural Filipino village found 38% of 422 illnesses in 51 children were self-medicated with modern pharmaceuticals and another 42% were non-medication self-treatment (7).

Although the South-East Asia Region does not have sufficient documentation on self-care components, it is believed that many of them are closely linked to prevailing socio-cultural factors. Therefore, in efforts to advocate and expand safe and effective self-care, the socio-cultural approach needs to be embedded.

7. Community participation as the main PHC pillar for self-care

Within the context of PHC, self-care can be primarily viewed as the translation of community participation in health development. To elicit active community participation, the community, with emphasis on women, has to be empowered. Information is an important component to empower people in making informed decisions. Access to information, quality of information, skill in interpreting and applying information are important to support a self-care promotion process.

For this to materialize, the involvement of various sectors beyond health is indispensable.

There are two levels of community participation. The first is the participation at personal level. At this level, self-care relates to the determination of one's life styles and other health-seeking behaviours and avoidance of risk behaviours that compromise personal health. The second concerns participation at family and community level. Communities should be involved in the decision making process relating to policy formulation, planning and implementation. Both approaches are strongly rooted in the Alma-Ata definition of PHC which recognizes that the first level of health care should be focused on the individual, the family and the community.

- (a) Community participation as per recent developments is viewed as empowerment, where people exercise more control over the decision making process and participate from the planning stage. Participation has also been viewed as a ladder with different levels. Empowerment should be a continuum with inter-related, overlapping stages; with information and consultation with communities by professionals at one end, to collaboration and assuming full responsibility by communities at the other.
- (b) Community-Based Initiative (CBI): the Regional Conference on Revitalizing Primary Health Care held in Jakarta in August 2008 and the subsequent Sixty-first session of the Regional Committee in September 2008 recommended among others, that in revitalizing PHC a different approach needs to be pursued namely "a shift from service delivery to development approach". The development approach necessitates a community-based initiative. CBI was first introduced in Thailand by Dr Amorn Nondasuta under the Basic Minimum Needs (BMN) programme. This approach was later adopted and expanded by WHO' Eastern Mediterranean Region and named Basic Development Need. The CBI programme is an integrated bottom-up approach to socioeconomic development, including health, aiming at achieving better quality of life for communities. CBI is based on full community involvement in the development process, supported by intersectoral collaboration. Self-care can be easily promoted in CBI, since the programme is self-sustained and focused on people. It addresses the diverse basic needs of the community and recognizes health as a key element of social cohesion. Both the South-East Asia and the Eastern Mediterranean Regions are working together to carry CBI.

8. Self-care in various health programmes

8.1 Self-care in health promotion

The definition of PHC also mentions that health care should be "... at a cost that the community and country can afford". It means that public health services should be affordable, since affordability relates to the ability of an individual or a family, community and country to pay for health care¹. Thus self-care also influences health care financing. The present status of expenditure by countries in the Region shows that government health expenditure is very small (about \$3-\$5/capita/year), even though, there is a high proportion of population in developing countries categorized as living below the poverty line. In the light of these challenges, the double burden of disease creates a spiraling cost for individuals, the community as well as for the whole country's health care financing. Self-care related to health promotion can reduce the cost of improving health and *disease prevention* at personal, family and health care system levels, since self-treatment accounts for a big chunk of the family's health expenditure. Overall, the benefits of self-care include lower costs for the entire health care system.

At the individual and family level, self-care is determined by lifestyle and behaviour. Here the lay person plays the most predominant role for his/her own health promotion. At the community level, PHC provides the first contact for individuals, the family and the community with the national health system. At this level too, the lay person plays a major role in his/her health care supported by health professionals. At the secondary care and tertiary care level where progressively complex health problems are dealt with, health professionals play the predominant role.

A big health challenge for the Region is the high rate of maternal and newborn deaths. The Region accounted for 170,000 maternal deaths in 2005 and over 1.3 million neonatal deaths in 2004. Immediate and effective professional care before, during and after delivery can make the difference between life and death for both women and their newborns.

¹The maximum ability to pay has been estimated not to exceed 40% of *non-food expenditure* of an individual's or family's income. Thus, any health expenditure within this limit is called *affordable*. Expenditure beyond this limit is categorized as *catastrophic expenditure* that may impoverish the spender.

An analysis of the relationship between the proportion of deliveries assisted by skilled birth attendants and maternal/neonatal mortality in the Region shows that both newborns and mothers have a better chance of survival if they have skilled attendance at birth. The higher the proportion of deliveries by a health professional, the lower is the maternal mortality ratio and neonatal mortality rate ⁽¹⁴⁾.

Efforts of Member countries to increase skilled birth attendance might be accelerated by the promotion of self-care and increasing the demand for skilled birth attendants.

Primary health care can support self-care through creating an information environment that will improve capabilities, responding to population health needs, supporting specific care, enabling coordination of care and integration of services, and improving performance and evidence-based decisions.

8.2 Self-care in communicable disease control

In the South-East Asia Region the following communicable diseases have been identified as public health priorities: Diarrhoea, Acute Respiratory Tract Infection (ARI), Malaria, Tuberculosis and HIV/AIDS.

Diarrhoea

In spite of the availability of simple and highly cost-effective interventions, the disease burden is not declining as fast as expected. Apart from causing considerable morbidity across all ages, in the 0-5 years-old age group, acute respiratory infections (ARI) and diarrhoeal diseases are responsible for almost 50% of the estimated 3.1 million deaths annually in the South-East Asia Region.

In recent years, there have been new developments in case management and preventive strategies. Home management with high-dose oral amoxicillin has been found to be just as effective as hospitalization for severe uncomplicated pneumonia. Using low-osmolarity solutions of oral rehydration salts and zinc in the case management of acute diarrhoea improves the outcome.

Hand-washing alone can reduce the incidence of ARIs and diarrhoeal diseases by 30%-50%. Improving the quality of water, especially at the point of use, is effective in preventing diarrhoea ⁽¹⁴⁾.

The programme advocates for an integrated approach to surveillance, prevention and control of diarrhoeal diseases and ARI, implemented by a broad variety of disciplines including institutions, the community and at home levels.

Self-care at the family level is important for decision making to begin home treatment and to seek professional help if the problem persists. In this case there are several points that can be improved if self-care knowledge and practice are widely available in the communities; (i) the care giver will identify the symptoms earlier (ii) the child will be taken at an earlier stage to the health facility (iii) the home treatment will be according to the prescribed standard. The result will be less deaths and less suffering for the patients and increased and effective service utilization from the provider.

Tuberculosis

The WHO South-East Asia Region carries over a third of the global burden of tuberculosis, representing a case burden of nearly 5 million TB cases. In addition, it is estimated that over half a million people continue to die of tuberculosis each year in the Region.

The prevalence of HIV/AIDS among TB patients was estimated to be 1.3% in 2006, and between 50-80% of AIDS cases in the Region are reported to have active TB. Mortality rates between 30% and 79% are being reported among TB/HIV co-affected people while on treatment for TB. Over 86% of TB patients were reported as having been successfully treated in 2006, while the case-detection rate increased from 37% in 2001 to more than 67.5% in 2006, closing in on the target of 70%.

Challenges to TB control are the increasing prevalence of HIV-TB co-infection in some countries and areas in the Region which requires urgent and decisive action. There are several very encouraging examples of community-based approaches in countries of the Region, which need to be better documented for replication of the most successful approaches ⁽¹⁴⁾.

Self-care promotion at the family and community level can increase health knowledge and improve TB prevention, case detection, and compliance to TB treatment.

Malaria

Malaria is endemic in virtually all countries of the Region except Maldives. Though an estimated 30.99 million cases occurred in 2006, only about 2.45 million laboratory-confirmed cases were reported. However, reported deaths due to malaria dropped significantly (with approximately a 37% reduction in 2006 as compared to 1995). There was a slow decline in reported cases (3.6 million in 1995 to 2.45 million in 2006). The proportion of *Plasmodium falciparum* cases, however, increased steadily (from 19.6% in 1970 to 49% in 2006).

Malaria affects mainly the poor, underserved and marginalized populations in remote rural areas which are characterized by inadequate control measures and limited access to health care. Higher malaria prevalence has been reported among ethnic minorities and tribal groups living in remote forested and border areas, as well as among mobile and migrant populations. Under-reporting of malaria cases and deaths remains a major challenge. Drug-resistant parasites, poor treatment-seeking behaviour and the presence of counterfeit anti-malarial drugs further hinder control efforts ⁽¹⁴⁾.

Self-care promotion can improve knowledge at the individual and family level for prevention as well as on where to obtain health services, have the right attitude and in practicing malaria prevention and control. Community-level self-care can disseminate the right information and can initiate action for malaria prevention and for support to the control programme ⁽¹⁵⁾.

HIV/AIDS

With an estimated 260 000 new HIV infections and 300 000 HIV-associated deaths in 2007, HIV continues to be a major public health problem in the Region.

Targeted interventions guided by reliable surveillance can reverse epidemics. HIV and other Sexually Transmitted Infections (STIs) can be controlled by scaling up STI services, promoting 100% condom use in sex work and involving target populations in programme implementation. Injecting Drug Users (IDUs) can benefit from harm reduction measures if applied effectively at a sufficient scale.

Despite the significant progress achieved in scaling up targeted interventions, there is need for more efforts to keep pace with the expanding epidemic. Access to prevention programmes has been limited to only 20% of sex workers and 3% of IDUs in the South-East Asian countries in 2005.

While access to services has increased since 2001, it is still low for IDUs, (Men having Sex with Men (MSM), sex workers, and prisoners. Coverage also remains low for VCT (Voluntary Counseling and Treatment), PMTCT (Prevention from Mother to Child Transmission) and care and treatment services ⁽¹⁴⁾.

Stigma is one of the major problems associated with HIV/AIDS. If the community, family and individuals have more information about HIV/AIDS there is a greater chance to improve awareness and reduce stigma for HIV positive people. Self-care can also promote healthy lifestyle for disease prevention and to encourage the HIV-positive people, to obtain early diagnosis and anti-retroviral therapy for pregnant women so that their infants can be spared from the disease. For the family, self-care provide home care including basic and chronic care to the patients and emotional support for the family members. For the community, self-care can support community information meetings as well as establish and support self-help groups to provide psychological, social and medical support to people affected with HIV/AIDS in the community.

9. Self-care in noncommunicable disease control

9.1 Noncommunicable diseases

Noncommunicable diseases, which include cardio-vascular diseases, stroke, cancer, chronic respiratory diseases and diabetes, have emerged as major causes of death and disability in the Region. They accounted for 47% of the

Region's disease burden; 54% of the deaths in the Region during 2005 were NCD-related.

The main risk factors for major NCDs include: (a) tobacco and alcohol use, (b) unhealthy diet (high in total energy, fat, salt and sugar, low in fruit and vegetables) and (c) physical inactivity. These behavioural risk factors are closely related to hypertension, overweight and high blood levels of glucose and cholesterol.

Results of NCD Risk Factor STEP surveys in countries of the Region during 2003-2005 showed:

- High prevalence and levels of major NCD risk factors in all countries not only in urban but also in rural areas.
- High burden of NCD risk factors both in men and women.
- Very low consumption of fruit and vegetables, especially fruits (>80% eat <5 servings of fruit and vegetables per day).
- Highly prevalent consumption of tobacco (current smokers 16%-32%) and alcohol (3%-41%), especially among males.
- Emergence of overweight (9%-44%), especially in urban areas, as a public health problem.
- Sufficiently high (though variable) prevalence of raised blood pressure (8%-42%) in most settings to warrant a public health response.
- The extensive variability in the prevalence of individual NCD risk factors between countries, within countries, between urban and rural areas as well as between sexes ⁽¹⁴⁾.

9.2 Tobacco use

Population-wide interventions to reduce tobacco consumption and to promote physical activity and healthy eating habits coupled with interventions targeting high-risk groups and individuals could greatly improve public health outcomes.

When applied in an integrated way at population, community and individual levels, available public health interventions have the potential to

prevent at least 80% of cardiovascular diseases, stroke and type 2 diabetes, and over 40% of cancers ⁽¹⁴⁾.

9.3 Mental health

The current regional prevalence of three mental health problems is epilepsy 4.5/1000⁽¹⁶⁾; schizophrenia 7.5/1000⁽¹⁷⁾; depression 5% to 10%⁽¹⁸⁾; and mental retardation 2% to 3%⁽¹⁹⁾. Community-based mental health programmes in the Region have shown that training of CBHWs, drug availability at sub-district level, combined with self-care can be implemented effectively and can increase the quality of life of patients, the family and the community.

Illustrations of self-care in various health programmes at individual, family and community levels are attached as annexures to this working paper.

10. Role of health professionals in promotion of self-care

The role of health professionals in promoting self-care include training of community-based health workers, receiving referral cases and supervisory visits to primary health care settings.

To support self-care promotion, health workers need relevant resources and competencies such as health services management, person-centered care, specific problem solving skills, comprehensive approach, and community orientation that includes psychosocial and cultural dimensions of a person's life. These competencies are based on the attitude of the health professionals and patients; the evidence base or science of medical management and treatment; the context of the primary care setting and the individuals. The clinical protocol and patients' pathways need to be adjusted and applied for the primary care and referral levels and other related health professionals. Training health workers for self-care is not just about their gaining new knowledge and skills but changing the health worker's attitude in empowering individuals, families and increasing their confidence in self-care. Empowering the client means that health

professionals should use enabling language consistently and encourage the adoption of self-care ⁽²⁰⁾.

11. Role of social determinants in self-care

The social determinants of health (SDH) lie beyond the purview of health. WHO has advocated the importance of other sectors in promoting health through healthy public policy. On the other hand, health also influences many social determinants such as education and wealth. Good health will improve one's ability to pursue better education and employment. In fact, health security plays an important role in national and global security.

To practice effective self-care, individuals and communities should address a wide range of determinants that socially produce health. For example, access to health information is a pre-requisite for behaviour change. However, the language in which the information is provided is a key determinant of the uptake of such information. In addition, the channel of communication used, cultural relevance and the credibility of the source of information are key determinants to utilization of information by individuals, the family and communities. An illiterate individual does not require written information but may find pictures and other forms of verbal communication valuable.

The community health volunteers, nongovernmental organizations or health professionals at local clinics and health centres should be aware of the barriers associated with social determinants such as language and cultural issues in order to enable and/or reinforce health seeking behaviours and information acquisition and utilization among individuals and communities. Ultimately, it is critical that individuals and communities are engaged in all aspects of developing health communication messages for various public health issues including water, sanitation and hygiene education, food preparation or access to essential health care services.

12. The way forward

The following are some suggested actions to take forward and strengthen self-care practices:

- (a) Research/study to elucidate the following:

- the extent of self-care practice, including self medication at individual, family and community levels
 - identification of useful and harmful practices in self-care
 - cost effectiveness of various self-care practices
- (b) Advocacy on self-care within and beyond the health sector as well as with development partners
- (c) Development of various guidelines on self-care
- (d) Incorporation of self-care in health workforce education curriculum
- (e) Training for health workforce and community in self-care
- (f) Inclusion of self-care in the collaborative activities between WHO/SEARO and WHO/EMRO in the field of Community-Based Initiative.

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Current and expected practices of Self-care by programme area at individual family and community levels²

Programme area	Individual	Family	Community
Health Promotion and Education	<p>Acceptable/Beneficial</p> <ol style="list-style-type: none"> Exercising Taking adequate rest and relaxation personal hygiene including hand washing before and after eating, after using the toilet or touching dirty objects; brushing teeth; taking a body bath Eating nutritious food, less in fat and salt; drinking plenty of clean water keeping a clear mind – Not using alcohol or drugs, reducing emotional stress through conflict resolution Breast self examination (female) Regularly monitor vital signs - Blood pressure, temperature and weight Recognize serious health problems and seek eek medical care quickly.; and if had chronic conditions that require medical attention Complying with prescribed medication regimen Self-care of minor ailments such as stuffy nose, minor aches, cold, diarrhea, dry skin. 	<ol style="list-style-type: none"> Family care giver seek information on basic knowledge of the nature of minor illnesses that affect family members, specifically the signs and symptoms and what to do; Family members requiring assistance and the family care communicate clearly between themselves in order to minimize suspicions and lack of trust; Family members maintain confidentiality of information as a pre-requisite for effective self-care. None of the family members discloses the cause or nature of illness with other people outside the family without the consent of the family member receiving self-care assistance; In the case of food preparation, the family considers the nutritional needs of any family member on self-care; The elderly are given more family and community support in administering SC, therefore a family or community member is assigned to monitor. Family members resolve conflicts within members of the family and with neighbours 	<ol style="list-style-type: none"> Community members listen/watch multiple mass communication channels (radio, television or newspaper) to promote self-care at community level; The content of information received shared with the general public does contain conflicting messages; Interpersonal communication, obtained through credible sources (such as local community health personnel (such as nurses and medical doctors) used to disseminate health messages to others. Feed back mechanism established to monitor the effects of the SC initiatives from community members; SC tips are disseminated through campaigns, books, leaflets, audiotapes, videos, brochures as well as through traditional approaches to SC Cultural relevancy is maintained in crafting and dissemination of messages; particularly the language used and age specificity. Community members monitor closely and constantly specific population groups such as the elderly, handicapped or young people under SC. The community/family provide all needed support.-physical, emotional, psychological, information.

² Self care “behavioral outcomes” implemented at individual, family and community level

Programme area	Individual	Family	Community
Nutrition for Health and Development	<p>Eat healthy during pregnancy:</p> <ul style="list-style-type: none"> • Increase food intake to provide for the baby; • Eat a nutritious diet to gain weight at the recommended rate; • Iron-rich animal food include red meat and eggs; • Vegetarians should consume more iron-rich foods such as whole cereals, soya beans and green leafy vegetables. <p>Give your baby only breast milk for the first six months of life:</p> <ul style="list-style-type: none"> • Do not give your baby any other milk or water for the first six months of life; • Breast feed your baby whenever the baby is hungry; • Continue to breast feed your baby up to 2 years. <p>After six months, gradually increase age-appropriate and safe complementary foods in the baby's diet:</p> <ul style="list-style-type: none"> • Feed your growing child a mixed diet; • Gradually introduce soft cooked cereals, legumes, fruits and vegetables in your baby's diet; • By 12 – 18 months of age, the child should be able eat the family diet; • Include a combination of milk products, cereals, pulses, fruits, green leafy vegetables, oils and sugar, nuts and seeds in your child's daily diet. <p>Aim for a healthy weight:</p> <ul style="list-style-type: none"> • Aim for a Body Mass Index (BMI) of 18.5 – 24.9 kg/ sq.m; • Include more whole grain cereals, whole pulses, fibrous vegetables and fruits in the diet; • Restrict intake of fried foods, sweets and confectionaries. 	<p>Make vegetables and fruits an essential part of every meal:</p> <ul style="list-style-type: none"> • Include 1-2 vegetables or fruits in every meal; • Eat green, red, yellow, orange, purple vegetables and fruits; • Prefer seasonal and locally available vegetables and fruits. • Limit consumption of fats and oils: • For a healthy adult, use only 4-5 teaspoon of oil in cooking daily; • Use at least two different oils for cooking – soy, sunflower, mustard or corn oil; • Prefer low fat dairy products, lean meats like chicken and fish, nuts and seeds; • Avoid processed foods made with hydrogenated fat or margarine. <p>Eat less sugar and salt:</p> <ul style="list-style-type: none"> • Use less than 4 teaspoon of sugar daily; • Choose and prepare foods and beverages with little added sugars; • Use salt sparingly while cooking; • Consume less than 1 teaspoon (5 gm) of salt per day. • Restrict intake of fried foods, sweets and confectionaries. 	<ul style="list-style-type: none"> • Maintain a healthy body weight • Be active • Eat a variety of foods everyday • Eat cereals, preferably whole grains, as the basis of most meals • Eat more vegetables and fruits everyday • Eat legume-based dishes • Limit intake of fats and oils • Limit intake of sugars especially sweetened foods and beverages • Limit salt intake • Consume milk/dairy products daily (preferably low fat) • Eat fish at least twice a week (for non-vegetarians) • Choose poultry and lean meat (for non-vegetarians) • Drink lots of clean water, at least eight glasses of water per day for adults. • Eat clean and safe food

Programme area	Individual	Family	Community
Disability Prevention and Rehabilitation	<p>Preconceptual stage:-</p> <ul style="list-style-type: none"> • Avoid extremes of age for conceiving • Check RH incompatibility of marriage partners • In case of previous history of congenital disability in the family, individual history of stillbirths, miscarriage, maternal diabetes, or marriage between close relatives, check with doctor for further investigations. • Ensure Rubella immunization of teenage girls before conception • During pregnancy <p>Avoid:</p> <ul style="list-style-type: none"> • X-rays, Medicines that are not prescribed by doctor, exposure to Measles, Alcohol, smoking drugs and chewing of tobacco <p>After delivery</p> <ul style="list-style-type: none"> • Please check with health worker if there are the following signs in the newborn baby:- • Delayed birth cry, Preterm and low birth weight, blue colour of baby, low or high muscle tone of baby, very small or very large head-size, lack of response from baby to noise and visual stimuli 	<p>Habilitation and Rehabilitation</p> <ul style="list-style-type: none"> • Children with disabilities have a right to remain in the family • Acceptance of the person with disability as a valued member of the family is the first step in rehabilitation • If the child does not seem to be developing in the same way as other children, in physical development, hearing and communication, visual responses and mental alertness, then contact the health worker for advice. If the child has a problem, and then start training the child immediately as per the WHO Community-based Rehabilitation guidelines. • Request for training in home-based rehabilitation services from health workers is to be made (please access WHO training manual in CBR for different disabilities) • Provision of age-appropriate intervention/ services for the specific problem(if there is delay in physical development then simple exercises for motor development is to be given) The child is to be stimulated and talked to especially during daily living activities like toileting, eating etc. • Provision of other rehabilitation services including assistive devices to increase development, mobility, hearing and speaking, and independence • Inclusion of person with disability in all family activities • Ensure access to health, education, play, food, hygiene clothes and other amenities at par with siblings • Make home environment caring, accessible, inclusive, and participatory • Respect the inherent dignity of the person with disability 	<ul style="list-style-type: none"> • The community has to take the responsibility for the full integration of it's disabled members on an equal basis with others and this process must begin with the birth of a disabled child. The community must support the family 's efforts to accept, care for, and bring up the disabled child on an equal basis with other children. Community –based rehabilitation is the best way to ensure that all persons with disability are accepted, included, and involved in all areas of mainstream community life. • All services, facilities, poverty – reduction programme including social, cultural, economic, civil and political life, needs to be accessible and participatory for the persons with disability • Opportunities and rights must be provided on an equal basis with others. • Public places, transportation, schools, healthcare facilities, workplaces, parks and common places of community-activities, to be made accessible to persons with disabilities • Persons with disabilities have the same rights as every other member of the community

Programme area	Individual	Family	Community
		<ul style="list-style-type: none"> • Discrimination on the grounds of disability may be avoided • For girls with disabilities, protect reproductive rights, privacy and information on menstruation, family planning etc. in accessible formats. • Respect the right to marry, have children and raise a family • In case of disabled persons who require more intensive forms of support, family care for life may be needed and a group of volunteers including family members and friends may be trained for this purpose. For this too, the WHO manual on CBR in the community is available. • Encourage the development of friends and mentors of the disabled person. • If there is ear or eye discharge, • Seek advice from health worker immediately to avoid hearing loss. • Treat the child with disability the same as the other children in the family 	
Essential Drugs and Medicines	<ul style="list-style-type: none"> • Knowing when to self medicate or not • Avoid over medication 	<ul style="list-style-type: none"> • Encourage of appropriate self-care with medicine <p>Support patients on correct use of long-term medication (DM, Hypertension, Rub)</p>	<ol style="list-style-type: none"> 1. SC in medicines means taking correct drugs as well as not taking incorrect drugs 2. Making appropriate self medication legally available 3. Information & education on appropriate use of medicines in self-care
Make Pregnancy Safer/Reproductive Health and Research	<p>During pregnancy:</p> <ul style="list-style-type: none"> • Good nutrition, care of breasts for preparation of breastfeeding, maintains personal hygiene. • Appropriate exercises, sufficient rest, maintain a peaceful mind. • Regular pregnancy check-up by midwife/doctor. 	<ul style="list-style-type: none"> • Birth preparedness, including awareness of danger sign, emergency plans and save funds for childbirth. • Provide emotional support and ensure the welfare of pregnant women. • Someone significant (i.e. husband or mother) to accompany during labour. 	<ul style="list-style-type: none"> • Registration of pregnant women. • Promote skilled care for antenatal, childbirth and post-natal care and support midwives to do their tasks safely. • Support the family when referral is necessary (i.e. through communication, arranging transfers and costs).

Programme area	Individual	Family	Community
	<ul style="list-style-type: none"> • Stimulate foetal growth and development through relaxing music, communication by heart with the foetus, monitor foetal movement (after 4-5 months gestational age). • Use of ITN in malaria-endemic area when sleeping. <p>During childbirth:</p> <ul style="list-style-type: none"> • Ask for a skilled birth attendant (midwife/nurse or doctor) to assist childbirth and ensure a clean environment for labour. • Ensure sufficient intake of meal and fluid, maintain a peaceful mind and avoid exhaustion. • Ensure empty bladder before labour, proper breathing during labour and choose an appropriate position for labour. • Skin-to-skin contact with the baby immediately after birth, preparation for breastfeeding and initiate bonding. <p>Postpartum/post-natal:</p> <p><i>For the mother:</i></p> <ul style="list-style-type: none"> • Personal hygiene, including breast, perineum and vaginal care. • Awareness on danger signs, including lochia monitoring. • Initiate breastfeeding within half an hour after birth and to give colostrums to the baby and continue to breastfeed exclusively up to 6 months. • Good nutrition, sufficient rest and maintain a peaceful mind. • Established bonding with newborn, early stimulation of child development. • Regular postpartum check-ups, including postpartum FP service. • Use of ITN in malaria-endemic area when sleeping. <p><i>For the newborn:</i></p> <ul style="list-style-type: none"> • Avoid hypothermia, i.e. by skin-to-skin contact with the mother, cover newborn with appropriate/warm clothes and 	<ul style="list-style-type: none"> • Aware of danger sign and discuss with skilled birth attendant when it occurs for immediate actions/referral. • When necessary, arrange for immediate referral with the skilled birth attendant and ask her to accompany. • Assist mother in taking a good care of herself and the newborn and facilitate contacts with skilled birth attendant for essential care. • Provide an emotional environment that allows the mother and her newborn live a healthy and happy life within the family. • Aware of danger signs and refer immediately when there is one in mother or newborn. <ul style="list-style-type: none"> • Promote good RH practices in the family. • Promote gender-sensitive practices in matters related to RH. 	<ul style="list-style-type: none"> • Make arrangement before the time of delivery to ensure that families with pregnant women will be attended by skilled birth attendant at childbirth. • Implement referral plans, when necessary. • Encourage midwife to make visits as schedule to postpartum mothers and their newborns. • Assist in referral, when there is a need to refer mother/newborn to a higher health facility. <ul style="list-style-type: none"> • Advocate for good RH and gender-sensitive practices. • Address RH problems in the community and discuss it for possible actions at community

Programme area	Individual	Family	Community
	<p>head cap and avoid bath immediately after birth.</p> <ul style="list-style-type: none"> • Immediate breastfeeding (see above) and maintain adequate breast milk intake. • Clean cord care and overall care of newborn. • Awareness on danger signs. • Regular neonatal check-ups: after birth at least once in the first 3 days and then once afterwards within the first week and once afterwards within the first month. Immunization should be started. <p>Related to reproductive health:</p> <ul style="list-style-type: none"> • Personal hygiene/cleanliness, including during menstruation for women at reproductive age. • Practices that reflect healthy images of boyhood/manhood, i.e. responsible practices in interactions with girls or partner. • Safe sex and good knowledge of basic RH information. • Delay the age of marriage to at least 20 years. • Healthy timing and spacing of childbirth. • Regular breast check up and Pap smear. 	<ul style="list-style-type: none"> • Support women and men at reproductive age in the family to meet their RH needs in an appropriate manner. 	<p>level and ask for support from the health and relevant sector – both public and private.</p>
Child Health and Development	<p>For Neonates</p> <ul style="list-style-type: none"> • Put the newborn to the breast soon after birth. • Breastfeed baby on demand, day and night. Normally a baby will feed 8 times in 24 hours. • Protect the baby from getting cold. Baby must be dried soon after birth and kept in skin to skin contact with the mother. As soon as possible clothe the baby. Ensure that head is covered with a cap. • Do NOT give a bath to baby immediately after birth. • Recognize when baby is sick to seek help immediately. Seek 	<p>For Neonates</p> <ul style="list-style-type: none"> • Ensure the baby is delivered by a skilled birth attendant or in a health facility. • Help the mother to breastfeed the baby immediately after birth and round the clock thereafter. • Help the mother keep the baby dry and warm. • Assist the mother recognize when baby is sick. 	<p>For Neonates</p> <ul style="list-style-type: none"> • Ensure that facilities for clean and safe deliveries are available to all women within a reasonable distance from their homes. • Ensure emergency transport for mothers and babies who need emergency medical assistance.

Programme area	Individual	Family	Community
	<p>help if baby is lethargic, not able to breastfeed, has fast or difficult breathing, has fever or is cold to touch, has yellow soles, has convulsions.</p>		
	<p>Feeding Children</p> <ul style="list-style-type: none"> • Exclusively breastfeed all children up to attaining the age of 6 months. • Continue breastfeeding up to two years and beyond. • From 6 months to 12 months start semi-solid, well mashed food 5 times a day. • From 1 year to 2 years give semi-solid food 3 times a day. In addition, give snacks twice daily. 	<p>Feeding Children</p> <ul style="list-style-type: none"> • Allow enough time and opportunity to the mother to breastfeed the baby. • Help mother feed the infant above six months of age. 	<p>Feeding Children</p>
	<p>Preventing Illness</p> <ul style="list-style-type: none"> • Always wash your hands before feeding and preparing meals for the baby and after going to the toilet. • As far as possible use sanitary latrines. Encourage children to use latrines from an early age. • If sanitary latrines are not available defecate far from houses, water bodies and play areas. After defecation cover with mud. • Ensure that children are immunized as per the national immunization schedule at the right age. • Make children sleep under bed-nets, especially if malaria is prevalent in the area. • Children need love and protection for optimal development. Talk or sing to the child when feeding or bathing. Find time to play, hug and cuddle the child. Make age appropriate toys from easily available objects at home for the child to play with. • Ensure that the child is protected from injury. Keep your children close to you while working. 	<p>Preventing Illness</p> <ul style="list-style-type: none"> • Make facilities available to mothers and children for hand washing, sanitary defecation. • Ensure that pregnant women and children receive immunization as recommended by national immunization schedule. • Inculcate habit of sleeping under bed nets. • Find opportunities and time to interact and play with young children in the family. • Ensure that the home is safe for children. 	<p>Preventing Illness</p> <ul style="list-style-type: none"> • Work for making available safe water and sanitary latrines to every household. • Ensure immunization facilities are available to pregnant women and children at least once a month in every habitation.

Programme area	Individual	Family	Community
	<p>During Illness</p> <p>(a) When child has diarrhea</p> <ul style="list-style-type: none"> • Continue breastfeeding the child under two years. For older children continue giving age appropriate meals. • Actively encourage the child to take home made available fluids. Do not force. Give a few sips at a time. <p>(b) When child has cough/cold</p> <ul style="list-style-type: none"> • Most coughs/colds are self limiting and do not require medicines. To comfort the child give safe home made remedies to relieve the cough/cold e.g. tea with lemon; honey and ginger; hot soups, etc. • If nose is blocked use saline water to clear it. <p>(c) When child has fever</p> <ul style="list-style-type: none"> • Mostly fevers are self-limiting and will cure themselves in a few days. However, if you live in an area where malaria is common, you must visit a health worker for appropriate anti-malaria treatment. <p>(d) When you must take a child to a health worker</p> <p>If the child has any of the following, he has serious illness and in the presence of any of the following symptoms seek medical assistance without delay:</p> <ul style="list-style-type: none"> • child is not able to drink or breastfeed • has high fever • has fast and difficult breathing • is vomiting persistently • is very sleepy and difficult to wake up • has blood in stool • has convulsions 	<p>During Illness</p> <ul style="list-style-type: none"> • Support the mother or caregiver in looking after the sick child. • Identify the health care provider/health institution where the child should be taken in case he has a danger sign. • Keep resources available for handling medical emergencies. 	<p>During Illness</p> <ul style="list-style-type: none"> • Ensure that people have access to a health care provider/health facility in case of emergency.

Programme area	Individual	Family	Community
	<p>After Illness</p> <ul style="list-style-type: none"> • Children need extra food to recover completely. Give at least one extra meal for one week after the symptoms of illness disappear. 	<p>After Illness</p> <ul style="list-style-type: none"> • Help the mother/care-giver to take extra care of children recovering from illness. 	
Noncommunicable Diseases	<ul style="list-style-type: none"> • Learning on, generating motivation and developing skills for and practicing healthy behaviours related to diet and physical activity • Quitting tobacco consumption • Periodically checking blood pressure and body weight (also blood glucose and lipids if in high risk group) • Complying to non- and pharmacological treatment of NCDs (if present) • Requesting prescription of low-cost generic medicines (if at all required) • Seeking initial advice at PHC rather than secondary/ tertiary health care institutions 	<ul style="list-style-type: none"> • Ensuring smoke free environment at home • Introducing healthy dietary practices (purchasing healthy products, applying healthy cooking practices) • Introducing family practices promoting physical activity (family walks, games) • Provide home care to patients with NCDs • Emotional and financial support to family members requiring chronic treatment • Ensure home rather than health facility-based palliative care in terminal stage of illness 	<ul style="list-style-type: none"> • Ensuring smoke free environment in workplace and public places • Establish community infrastructure promoting physical activity (safe sidewalks, bicycle lines, parks, playing grounds etc.) • Facilitate local production of and access to inexpensive fruits and vegetable • Discourage consumption of aerated soft drinks and junk food especially among children • Community information meetings on NCDs and their risk factors • Establish facilities to measure and provide advice on major NCD risk factors • Establish self-help groups to provide psychological, social and medical support to people affected with chronic diseases in the community • Promoting healthy behaviours at schools and workplace. • Ensuring equitable access to essential preventive and curative health services • Ensure access to low-cost basic medicines • Introduce social insurance schemes to provide financial protection against catastrophic health expenditures • Promote partnerships among sectors: local authority, NGOs, civil society, health facilities • Ensure adequate access to emergency services

Programme area	Individual	Family	Community
HIV/AIDS	<ul style="list-style-type: none"> • Seek awareness of health information, disease prevention, care and treatment • Avoid risk to HIV/AIDS, e.g., sex with casual partners and sex workers, injecting drug use • Practice healthy lifestyles including: <ul style="list-style-type: none"> – Healthy nutrition – Exercise for health – Meditation – Routine health check up • Use preventive measures, e.g., condom for unsafe sex, needle and syringe exchange for drug use • Attend antenatal care for pregnant women • Compliance to drugs in treatment of AIDS and opportunistic infections 	<ul style="list-style-type: none"> • Provide home care including basic and chronic care to HIV/AIDS patients • Provide love, compassion, social and emotional bonds between family members to persons living with HIV/AIDS • Provide care of children, orphans and elderly affected by HIV/AIDS • Generate income to help people living with HIV/AIDS 	<ul style="list-style-type: none"> • Community information meetings • Door-to-door visits in the community by local volunteers • Build life skills and impart knowledge about sexually transmitted infections, including HIV/AIDS, through youth peer approach and the voluntary participation of young people and other local community members • Establish self-help groups to provide psychological, social and medical support to people affected with HIV/AIDS in the community • Combating stigma and discrimination against people affected by HIV/AIDS in the community • Using Buddhist ethics as their guideline, monks teach villagers how to avoid high-risk behavior, help to set up support groups, train people with HIV/AIDS in handicrafts, take care of AIDS orphans and AIDS patients. • "HIV-friendly" temples encourage people to participate in community activities. They also provide training in meditation as well as grow and dispense herbal medicines in collaboration with local hospitals. • Establish referral system for care and support of people living with HIV/AIDS to the nearest health and social facilities • Participate in social and resource mobilization campaigns on HIV/AIDS for self reliance • Partnerships among sectors: local authority, NGOs, civil society, health facilities

Programme area	Individual	Family	Community
Tuberculosis	<ul style="list-style-type: none"> • Early diagnosis and treatment to the nearest health facility having cough more than 3 weeks; • Regular intake of drugs as prescribed by health facility in front of a health worker; • Consult with health worker if the symptoms persists or got worse; • Promote others having cough more than 3 weeks for diagnosis and treatment. 	<ul style="list-style-type: none"> • Motivate to take anti- TB drugs daily as prescribed by the health facility; • Compliance with the treatment prescribed by the health facility; • Supporting the patient with care, taking him/her to the doctor on time. 	<ul style="list-style-type: none"> • Create awareness among the community on signs and symptoms of TB; • Refer suspects having cough more than 3 weeks for diagnosis and treatment to the nearest health facility; • Provide Directly Observed Treatment to the TB patients; • Refer TB patients to doctor if any adverse effects arises due to drugs; • Participate in social mobilization campaigns on TB.
Malaria	<p>Knowledge: Awareness of malaria symptoms, how they contract malaria, consequences of the disease, malaria prevention and treatment and where to obtain these services</p> <p>Attitude: individual should have correct attitude towards malaria control and prevention and be ready to cooperate with Government officers.</p> <p>Practices:</p> <ul style="list-style-type: none"> • To prevent malaria through mosquito protection (mosquito net, insecticide treated mosquito net, mosquito coil, repellent, etc) • To take malaria chemoprophylaxis (if applicable) • To seek services when there is fever. (Malaria diagnosis and treatment at health facilities (private and public)) • To take full course of medicines as advised by health care providers. 	<p>Practices:</p> <ul style="list-style-type: none"> • To cooperate with malaria field officers in malaria prevention and treatment: • To comply with malaria field officers and allow officers for house spraying and mosquito net treatment • To educate other neighbors in malaria prevention • To encourage family members to seek proper services from reliable sources when having fever 	<p>Practices:</p> <p>Malaria prevention:</p> <ul style="list-style-type: none"> • To initiate community action in clearing mosquito breeding places and in source reduction (Bio-environmental control) • To involve in malaria campaign (IEC) activities • To volunteer for house spraying during spray season <p>Malaria treatment:</p> <ul style="list-style-type: none"> • To set up village volunteer for malaria diagnosis and treatment <p>Malaria information</p> <ul style="list-style-type: none"> • To report of fever cases to concerned officers or village health volunteers (if exist) • To notify health officer if there is unusual events (e.g. migrant population to and from the village)

Programme area	Individual	Family	Community
Water, Sanitation and Health	<ul style="list-style-type: none"> • Always drink safe water (boiled or filtered if not sure of the safety of the water source) • Cover water storage containers properly, to avoid re-contamination as well as mosquito breeding. • Boil water for one minute prior to its use in the preparation of infant formula. • Do not defecate in open air especially near water sources. • Wash hands after defecation, before cooking, after wiping children faeces and before eating food or feeding children. • Always dispose children faeces in the latrine 	<ul style="list-style-type: none"> • Always provide safe water (boiled or filtered if not sure of its safety) to all family members. • Inculcate a habit of covering water storage containers at home to avoid re-contamination as well as mosquito breeding. • Ensure that no one from the family defecates in open air especially near water sources. • Ensure that each member of the family washes hands after defecation, before cooking, after wiping children faeces and before eating food or feeding children. • Keep drainage systems around the house clear to avoid stagnation of water and mosquito breeding. • Ensure a practice of disposing children faeces in the latrine. • Ensure that the household latrines are clean after use. 	<ul style="list-style-type: none"> • Protect water sources of the community from contamination. • Advocate the need for latrines in each household and initiate declaration of open defecation free communities. • Advocate the importance of hand washing by everyone in the community especially mothers/care givers who are responsible for cooking food and feeding children.
Adolescent Health and Development	<p>1. Healthy eating</p> <ul style="list-style-type: none"> • Eating a sufficient amount and a wide variety of healthy foods is important for you to grow and develop normally. • You should eat lots of rice/ cereals and noodles, as well as lots of fruits and vegetables. You should also have some meat in your diet as well as milk, yoghurt or cheese. • You should limit the amount of food you eat which contains a lot of fat or sugar. • While it is important that you eat enough so make sure that you grow, it is important that you do not eat so much that you become overweight as this is not good for your health. 	<ul style="list-style-type: none"> • You should provide your son or daughter with good role models. Prepare healthy meals for yourself and all the family. • Talk to your son or daughter about healthy foods and healthy eating. 	<ul style="list-style-type: none"> • Advocacy and support for food supplementation with nutritious foods to adolescents especially those who are from poor segments of the population, street children etc. • Participation and support for iron and folic acid tablets once a week for control of anaemia where nutritional anaemia is a public health problem • Support to mid day meal program in schools

Programme area	Individual	Family	Community
	<p>2. Physical activity</p> <ul style="list-style-type: none"> • Around sixty minutes of physical activity on most, if not all days, can provide you with the following benefits - healthier bone and muscles, you will remain fit and trim, you will be able to build your self confidence and self-esteem, it can help you study and work better, you will calm down when you are anxious, sad or angry. • Participating in sports can help you meet people and develop a sense of camaraderie. • It can also help you learn how to play by the rules, how to cooperate with members of your team, and how to deal with both victory and defeat. • Too little activity can lead to overweight and associated health problems. Too much activity, not balanced with an adequate diet, can lead to poor growth and development. 	<ul style="list-style-type: none"> • Encourage your son or daughter to have regular physical activity for around 60 minutes on most, if not all days. Encourage them to match their physical activity with an adequate diet. • Provide incentives and opportunities for your son or daughter to have regular physical activity. • Provide your son or daughter with good role model, by having regular physical activity yourself. 	<ul style="list-style-type: none"> • Provide support for sports activities with the help of youth clubs • Physical activity and sports in schools
	<p>3. Sexual activity</p> <ul style="list-style-type: none"> • Many adolescents, including older adolescents, have not started having sexual intercourse (i.e. the insertion of the penis into the vagina, mouth or anus). The decision to start to have sexual intercourse is an important one. Wait till you feel ready to do so. Do not begin because other people want you to do so. • Even if you have already had sexual intercourse in the past, it is important that whenever you have sex you feel ready and comfortable about this. • Talk to your friends, parents or other trusted adults about how to make decisions about sexual activity, and about how to resist pressure from others to have sex. • As far as you can, avoid being 	<ul style="list-style-type: none"> • As your son or daughter grows and develops from childhood into adolescence, provide them with information on an ongoing manner about their changing bodies and about sex. Ask them if they have any questions or concerns. Show them that you are open to talk to them about this subject. • Explain that sexual feelings are normal, but that having sex should be a well-thought through decision. • Explain that abstaining from sex is the only completely sure way to prevent pregnancy and sexually transmitted infections. • Talk to your son or daughter about how to prevent pregnancy and sexually transmitted infections, even if you have stressed the importance of abstaining from sex till they are ready. Explain 	<ul style="list-style-type: none"> • Promote safety of sex through advocacy messages include delay sex and practice abstinence, be faithful and use condoms consistently and correctly for safe sex • Support availability of good quality condom in the community to adolescents as a right of the adolescents • Assist in provision of accurate information about safe sex to adolescents through community based organizations • Provide support to organizations government and non government in the programs that address the high risk groups like men having sex with men, injection drug users • Support for timely referral of adolescents for medical termination of pregnancy, voluntary testing for HIV and

Programme area	Individual	Family	Community
	<p>with people or in places where you could be forced to have sex against your will.</p> <ul style="list-style-type: none"> • Be aware that there are ways of having and giving sexual pleasure that carry no risk of becoming pregnant or getting a sexually transmitted infection. This includes kissing, caressing and touching/rubbing genitals. (Contrary to popular belief, handling your genitals does not lead to any negative effects). • If you decide to have sexual intercourse, always use a condom from start to finish. • If you have had sexual intercourse without any condom or other form of contraception, it is possible that you may be pregnant or have a sexually transmitted infection, including HIV. You should seek help from a health worker as soon as possible. Most sexually transmitted infections can be treated with simple medicines. In some cases, pregnancy and HIV can be prevented. • If you suspect that you may be pregnant, or have got a sexually transmitted infection, seek help from a health worker. 	<p>that while there are different options for contraception, only condoms, if used properly, can reduce the risk of both pregnancy and sexually transmitted infections.</p> <ul style="list-style-type: none"> • Discuss the pressures that they could face to have sex before being ready for it. Discuss how they could resist such pressures. • Encourage them to seek help from a health worker for advice and support if and when they need to do so. 	<p>treatment of STI</p>
	<p>4. Emotional well being</p> <ul style="list-style-type: none"> • Adolescence is a time of enormous change in one's life. These changes can be stressful. • Spending time every day doing things that you enjoy, being with people whom you like and doing some physical activity can help to prevent and reduce stress. • Feeling anxious, sad or angry from time to time is normal. Talking to friends, your parents or other trusted adults can be helpful. They can give you comfort and support, and help you to think things through 	<ul style="list-style-type: none"> • Make every effort to communicate with your son or daughter. Encourage them to share their hopes and expectations, fears and concerns with you. Show interest in their activities and viewpoints. Show that you care for them through your words and actions. Let them know that you will always be there to support them when needed. Encourage them to contribute to family and community activities. • Talk to your son or daughter about health ways of dealing 	<ul style="list-style-type: none"> • Organize and support social, cultural and sports activities that help the adolescents to be able to relax • Support peers groups to reach out to adolescents and help the adolescents who feel depressed, angry or aggressive to overcome them. • Identify adolescents who persist to have these problems and support them in accessing mental health services

Programme area	Individual	Family	Community
	<p>clearly.</p> <ul style="list-style-type: none"> • Do not use tobacco, alcohol or other substances as a way of coping when you are under pressure, or are feeling anxious, sad or angry. Alcohol and other substances can make feelings of depression and anxiety worse. You may become addicted to these substances. • Do not act hastily or impulsively when you are under pressure or are feeling anxious, sad or angry. You may be tempted to pick a fight or ride a motorcycle fast as a way to deal with these feelings. This will put you and others at great risk of injury. • If you have sad, anxious or angry thoughts and feelings every day for several days and especially if they affect you from doing your daily activities (for example, doing your school work), or if you have thoughts of harming yourself or others seek help from a health worker. 	<p>with the stresses and strains of everyday life, such as doing activities that they find relaxing, being with people they like, and doing some physical activity.</p> <ul style="list-style-type: none"> • Warn them of the dangers of using tobacco, alcohol or any other substances as a means of dealing with negative thoughts and feelings. Also, warn them that when they are upset they could do things – such as picking a fight or driving dangerously – which could cause harm to themselves or others. Talk to them about the importance of asking for help when they feel that they cannot handle their problems by themselves. • Be watchful for changes in the mood or behaviour of your son or daughter. Common signs of stress or mental illness include: changes in sleeping patterns, changes in eating patterns, decreased school attendance or performance, difficulties in concentration, a persistent lack of energy, frequent crying or persistent irritability, frequent complaints of headache or stomach ache and the excessive use of alcohol or other substances. If any of these changes are marked or last for several days, seek help from a health worker. • Seek help from a health worker immediately, if your son or daughter has thoughts of harming or killing himself/herself or others. 	
	<p>5. The use of tobacco, alcohol and other substances.</p> <ul style="list-style-type: none"> • Do not be pressured into using tobacco, alcohol or other substances by people around you, or by images in the cinema, on television, etc. • Talk to your friends or parents about drugs you may have 	<ul style="list-style-type: none"> • Talk to your son or daughter about the dangers of using tobacco, alcohol or other substances. Do this in early adolescence. Do not wait till their use has started. • Discuss with your son or daughter the influence that peers and media have on 	<ul style="list-style-type: none"> • Prevent access to alcohol, tobacco and other substances through community decision making and action. These should not be accessible near the school and community places • Accurate knowledge about their ill effects through schools

Programme area	Individual	Family	Community
	<p>seen or have been offered. You should discuss how you could avoid using these substances.</p> <ul style="list-style-type: none"> If you do use alcohol or other substances that can impair your judgement, avoid driving a car, motorcycle or bicycle while under the influence of these substances. If you have started using alcohol or substances, seek help from your friends, your parents or and adult you trust. If you do use alcohol, or other substance that impair judgement, do so with a friend. Avoid using drugs when alone. You are more likely to overdose and die if you take drugs alone. You are more likely to be a victim of crime or violence when using drugs if you are not with friends. 	<p>young people initiating substance use. Explain to them the importance of deciding what is best for themselves.</p> <ul style="list-style-type: none"> Make clear what your expectations regarding their behaviour are. Provide a good role model through your own behaviour. Be watchful for sign of substance use by your son or daughter. If and when you notice them, discuss the matter, and together seek help from a health worker. 	<p>and peer groups</p> <ul style="list-style-type: none"> Adults and influential people in the community to be role models. Such people should abstain from tobacco, alcohol and other substances Arrange for referral of adolescents who are emotionally disturbed and are taking on to these habits
	<p>6. Unintended injuries</p> <ul style="list-style-type: none"> There are several things that you could do to reduce the chance that you will be killed or hurt as a result of an injury: Road traffic crashes: <ul style="list-style-type: none"> When driving a car always use a seat belt. When riding a motorcycle or bicycle, always use a helmet. They may feel uncomfortable and may not look attractive to you, but they save your life. Learn and respect the traffic rules as a bicycle or motorcycle rider or a car driver. Never drive or ride if you have been consuming alcohol or other substances that affect your thinking. Never get into a car or on a motorcycle if the driver-rider has been consuming alcohol or other substances. Never drive or ride when you are upset. 	<ul style="list-style-type: none"> Discuss with your son or daughter, the risks and consequences of injuries. Teach them what they could do to reduce the likelihood of injuries. Clarify your expectations of their behaviour, and demonstrate good behaviour through your own example. Road traffic crashes: Talk to your son or daughter about the importance of not driving/riding if they are under the influence of alcohol or other substances. Help them make a plan for what to do in case the driver of their car/rider of their motorcycle has consumed alcohol or other substances. Talk to them about the importance of paying attention to traffic as a driver or as a pedestrian, especially when poor light, rain or fog hinder visibility. Drowning: <ol style="list-style-type: none"> Encourage your son or daughter to learn to swim. 	<ul style="list-style-type: none"> Promote the use of helmets and resolve to prevent adolescents from driving cars or motor cycles Advocate the dangers of driving after drinking alcohol Arrange transport and referral of injured adolescents Organize promotional events to inform the adolescents about safety on the roads

Programme area	Individual	Family	Community
	<p>Pay attention to the traffic when you are walking on a footpath or dirt track alongside a road. Both as a driver/rider and as a pedestrian, be particularly attentive when it is dark, or if visibility could be hindered by rain or fog. If available, use bright colouring or reflective materials to alert drivers of your presence.</p> <ul style="list-style-type: none"> • Drowning: <ul style="list-style-type: none"> (a) Learn to swim, if there are opportunities to do so. Avoid getting into water above your waist if you do not know how to swim. Even if you are an able swimmer, do not swim when you have consumed alcohol or other substances. 	<p>Insist that they do not get into water above their waist if they do not know how to swim. Stress to them that they should never swim if they have consumed alcohol or other substances, even if they are able swimmers. Talk to them also about whom to contact if someone is seriously injured. Work with family and community members to make your home and community a safer place (e.g. by petitioning local authorities to install/ repair street lights in your neighbourhood).</p>	
Injury Prevention	<ul style="list-style-type: none"> • Build safety practice behavior for prevention and control of injuries through education and training; • Should be informed age specific common injuries and their risk factors – <ul style="list-style-type: none"> – Infant – suffocation and falls – < 5 years – drowning, burn, falls etc. – 5-10 years – drowning, falls, road traffic accidents etc. – 15-45 years – road traffic accidents • 60+ years - falls • Change traditional perception of injuries as an “inevitable” event by dissemination of information on injury prevention interventions. 	<ul style="list-style-type: none"> • Family members’ training on identification of injury risk and hazards at household level; • Family members’ training on “First Aid”; and • Family safety rules to apply and disciplined. 	<ul style="list-style-type: none"> • Promote “injury watch” to identify important causes and their risks for community interventions. • Community care: mobilize whole community to develop community-based injury prevention activities e.g. community swimming learning program, day-care centre for children of working mothers and formation of peer-support group, fencing of water resources and covering wells etc. • Training of community volunteers on “Emergency Trauma Care” and “Referral System”. • Introduction of injury prevention and control curriculum in the existing education system. <p>All these activities could be done under the umbrella of “Safe Community” concept.</p>

Annex 2

Agenda

- (1) Inauguration
- (2) Self-care in the context of Primary Health Care
- (3) Regional and countries' current policy and practices on self-care
- (4) Self-care of healthy people
- (5) Self-care of sick and disabled people
- (6) Role of socio-cultural determinants on self-care
- (7) Lessons learnt and challenges for self-care : Country experiences
- (8) Key strategies, best practices and main activities for strengthening self-care in the context of Primary Health Care
- (9) Conclusions and recommendations
- (10) Closing

Annex 3

Programme

Venue : 3rd Floor, Tower Wing, The Ambassador Hotel

All sessions in Cattelya 2. Group Work in Cattelya 1 and 2

Day 1 – Wednesday, 7 January 2009

08:00–09:00 Registration

09:00–09:30 **Opening session**

- Remarks by Dr Samlee Plianbangchang, Regional Director, WHO/SEARO
- Inauguration by Dr Prat Boonyawongvirot, Permanent Secretary, Ministry of Public Health, Royal Thai Government

Master of Ceremonies: Dr Prakin Suchaxaya

Chairperson: Dr Myint Htwe and Co-Chair: Dr Hasbullah Thabrany

10:00–10:15 Introduction of participants: *Ms Laksami Suebsaeng*

10:15–11:00 **Technical session**

- Self-care in the context of primary health care
Dr Ilsa Nelwan
- Discussion

Rapporteurs: Dr Sudhansh Malhotra and Dr Somchai Peerapakorn

- 11:00–12:30 **Panel sessions**
- Session I: Self-care of healthy people**
- Self-care in the promotion of health among healthy people
 Dr Supachai Kunaratanapruk
 - Adolescents as self-care promoter at family and community level
 Dr Suniti Acharya
 - Role of community participation in promoting maternal, newborn and child health
 Dr Sonja Roesma
 - Discussion
- Rapporteurs: *Dr Davison Munodawafa, Dr Neena Raina and Dr Sudhansh Malhotra*
- Administrative announcements: *Dr Ilsa Nelwan*
- Chairperson: Dr N. Kumara Rai and Co-Chair: Ms Naila Abdul Majeed**
- 13:30–15:00 **Session II: Self-care of sick and disabled people**
- Role of family and community in self-care during sickness and disability
 Professor Dr Somchit Hanucharunkul
 - Health system support for promoting self-care
 Dr J.P. Gupta
 - Discussion
- Rapporteurs: *Ms Laksami Suebsaeng and Dr Prakin Suchaxaya*
- 15:30–16:00 **Session III: Role of socio-cultural determinants on self-care**
 Dr Oratai Rauyajin
- Discussion
- Rapporteur: *Dr Davison Munodawafa*
- 16:00–17:30 **Session IV: Country presentations and discussions**
 Bangladesh, Bhutan, India, Indonesia and Maldives (10 minutes each)
- Discussion

Day 2 – Thursday, 8 January 2009

Chairperson: Dr Sultana Khanum and Co-chair: Dr Than Lwin

- 08:30–09:00 Reflection of day 1: *Dr Prakin Suchaxaya*
- 09:00–10:30 **Session IV: Country presentations and discussions** (continued)
Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste (10 minutes each)
➤ Discussion
- 11:00–11:15 Introduction of group work I: *Dr Ilsa Nelwan*
- 11:15–12:30 **Group work I**
Self-care: Concept and relevant factors
- 13:30–14:30 **Group work I** – continued
- 15:00–17:00 Plenary Session: Reporting of group work I
➤ Presentations and discussions

Day 3 - Friday, 9 January 2009

Chairperson: Dr Ranjit Roy Chaudhury and Co-chair: Ms Quamrun Nahar Khanam

- 08:30–08:45 Introduction of group work II: *Dr Ilsa Nelwan*
- 08:45–10:30 **Group work II**
Self-care: Key strategies, best practices and main activities for strengthening self-care in the context of PHC
- 11:00–12:00 Plenary Session: Reporting of group work II
➤ Presentations and discussions
- 13:00–15:00 Drafting group meeting on recommendations
- 15:30–16:30 Conclusions and recommendations/Closing:
➤ *Dr N. Kumara Rai*

Annex 4

List of participants

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Member States in the South-East Asia Region agree that primary health care is the right approach to strengthen the health systems, taking into account the social determinants of health for achieving the MDGs, and ultimately to achieve equitable health for all. The PHC approach encompasses four principles: universal coverage; community participation; multi-sectoral collaboration; and use of appropriate technology. Self-care embraces all of these principles and translates community participation through community empowerment that necessitates involvement of other sectors beyond health. Use of appropriate information and communication technology is essential in empowering the community. Finally, self-care will ease the burden of the overstretched health systems, reduce cost and increase its effectiveness, all of which facilitate efforts in achieving universal coverage.

The regional consultation on "Self-care in the context of PHC" was held from 7-9 January 2009 in Bangkok, Thailand. The objectives were to determine the way forward in strengthening self-care for revitalizing PHC in countries of the Region, specifically to review the regional and countries' current policy and practices on self-care, to identify best practices and challenges for self-care and to identify key strategies for self-care.

The regional consultation concluded with the following recommendations: For Member States – (1) Give serious consideration to including strengthening of self-care as a programme in their efforts to revitalize PHC; (2) Re-examine national health policies and strategies to strengthen support structures, legislation and financing for self-care; (3) Document existing local self-care best practices and conduct operational research to develop evidence-based, effective self-care practices; and (4) Establish a network of individuals and institutions for self-care promotion. For WHO – (1) Advocate for strengthening self-care in the context of revitalizing PHC; (2) Provide technical support to Member States in their efforts to promote effective self-care; (3) Provide support to Member States in documentation, assessment and evaluation and research on self-care practices; and (4) To develop common tools and guidelines.

The consultation also suggested the way forward to enhance community participation and self reliance in health, with the improved role of the health work force to empower the community in a comprehensive understanding of health to improve social and economic productivity.



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