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Self-Care Pathways to Financing Universal Health Coverage and Equitable Development

Policy Paper

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Executive Summary

The world faces a worsening health financing crisis. An estimated 4.6 billion people lack access to essential health services, 1.6 billion are pushed into or deeper into poverty by health costs, development assistance for health is declining, and governments across many low- and middle-income countries are struggling to finance even basic services. At the same time, there is renewed attention on how countries can do more with limited resources while advancing health, equity and sustainable development – following adoption of the Compromiso de Sevilla at the Fourth International Conference on Financing for Development and the 2027 Universal Health Coverage accountability review.

This report argues that publicly financed, supported, incentivized and regulated self-care represents an underutilized opportunity to advance Universal health Coverage (UHC) while supporting broader development objectives. Self-care includes a range of evidence-based interventions that enable individuals to promote health, prevent disease, diagnose conditions and manage illness with or without direct support from a health worker. When embedded within health systems and financed appropriately, self-care can help governments expand access, improve efficiency, strengthen financial protection and support economic growth.

The analysis presents a theory of change built around three mutually reinforcing pathways:

Pathway 1: Health System Savings, Efficiencies and Capital Gains
Self-care can reduce the cost of service delivery by shifting appropriate services from facilities to homes, communities, pharmacies and digitally-enabled platforms. Evidence from HIV self-testing, community-based service delivery, task-sharing and chronic disease management demonstrates that self-care can lower costs, reduce workforce pressures and expand coverage without proportionate increases in public expenditure.

Pathway 2: Financial Security Through Reduced Out-of-Pocket Spending
When governments and insurance systems finance self-care interventions, health costs shift from households to pooled financing arrangements. This can reduce catastrophic health expenditure, improve financial protection and free household resources for consumption, education, savings and productive investment. Evidence from Thailand and other settings demonstrates the substantial development benefits that can result from reducing direct payment requirements.

Pathway 3: Sustainable Growth and Economic Participation
By improving health, reducing caregiving burdens, increasing productivity and supporting participation in the labour force, self-care contributes to broader economic development. These effects may be direct, through healthier and more productive populations, or indirect, through new employment opportunities in community-based delivery models, digital services, supply chains and the wider care economy.

To assess current progress, the brief introduces a four-stage self-care financing-systems maturity spectrum. The spectrum tracks countries from **policy recognition and commitment (Stage 1)** through **strategic and fiscal prioritization (Stage 2), programmatic scale with emerging evidence (Stage 3)** and ultimately **systemic integration (Stage 4)** in which self-care is embedded within UHC financing, strategic purchasing, reimbursement, regulation and accountability systems. The review finds growing policy adoption across all regions, particularly in HIV and sexual and reproductive health, but substantially slower progress in financing integration and institutionalization. No country is observed to have yet fully achieved comprehensive Stage 4 integration as conceptualized on this spectrum.

The analysis also identifies four major risks that can undermine self-care's benefits if poorly designed: cost shifting from governments to households, policy commitments unsupported by implementation, inadequate regulatory and safety oversight, and exclusion of populations already facing barriers to care. Self-care therefore should not be viewed as a substitute for public investment, but rather as a means of improving how health systems deliver coverage and financial protection.

The brief concludes that the principal challenge is no longer whether self-care should be part of UHC systems, but how to finance, institutionalize and govern it at scale. Three priorities emerge:

1. **Finance self-care** through domestic resource mobilization, public budgets, strategic purchasing and sustainable financing arrangements.
2. **Institutionalize self-care** within UHC benefit packages, primary health care reforms, reimbursement systems and service delivery models.
3. **Govern, measure and sustain self-care** through stronger monitoring, accountability, costing and evidence generation.

For ministries of finance, ministries of health, multilateral development banks, development finance institutions, the World Health Organization, and global health financing initiatives, self-care represents an opportunity to advance UHC while generating efficiency gains, strengthening household financial protection and supporting sustainable development. In an era of constrained public resources and declining aid, self-care should be viewed not as a peripheral health intervention, but as part of a broader strategy for financing equitable development.

Contents

Acronyms and Abbreviations

CHW	Community Health Worker
DMPA-SC	Depot Medroxyprogesterone Acetate, Subcutaneous
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
INFF	Integrated National Financing Framework
LMIC	Low- and Middle-Income Country
NCD	Noncommunicable Disease
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
SDG	Sustainable Development Goal
SRHR	Sexual and Reproductive Health and Rights
UHC	Universal Health Coverage
UHI	Universal Health Insurance
WHO	World Health Organization

1. Introduction

1.1 Advancing Self-Care: Creating Opportunity From a Financing Crisis

The world is falling behind on advancing health and prosperity for all. The global Sustainable Development Goal (SDG) financing gap stands at $4–4.3 trillion annually.[1] Official Development Assistance fell nearly 24 per cent in 2025 and is projected to keep falling. Funding for health saw the deepest cuts – dropping by 29–46 per cent from 2024 to 2026, with the steepest falls impacting population and reproductive health (54.1 per cent) and the control of communicable diseases (40.4 per cent). Funding is projected to keep falling through 2030, compounding the pressure on already strained health budgets.[2]

The scale of unmet need is substantial. An estimated 4.6 billion people lack access to essential health services, and 1.6 billion are pushed into poverty or deeper into it by out-of-pocket health costs.[3] In roughly 62 countries, home to some 3.4 billion people, governments spend more on debt service than on health and education combined.[4] Where health financing does exist, it is unevenly distributed: in 2024, government and donor health spending in low-income countries fell below one-third of the $60 per capita minimum needed to deliver essential services.[5] In Africa in 2020, only 5 out of 47 countries countries hit the estimated health spending level associated with achieving SDG 3 and Universal Health Care (UHC).[6] In the face of this stark reality, self-care is emerging as a high-impact avenue for advancing UHC and development financing goals. It gives governments an opportunity to reduce cost per service, make better use of an overstretched health workforce, grow the economy and financially protect families, communities and societies. Countries that build domestic self-care financing capacity now will be better placed for the aid environment that has emerged in recent years.

What Is Self-Care?

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

Self-care can involve evidence-based interventions such as self-monitoring of chronic conditions (e.g. diabetes or hypertension), using over-the-counter medications, performing diagnostic tests like pregnancy or HIV self-tests and following prescribed treatments independently or with minimal guidance from healthcare professionals.

The Compromiso de Sevilla – adopted by consensus at the Fourth International Conference on Financing for Development in June 2025 – gives governments a framework for responding to health financing shortfalls. It recognizes that closing the SDG financing gap will require more than mobilizing new resources: it calls for smarter spending, greater efficiency and genuine system transformation.[7] In health, that transformation depends in part on how care is delivered – and to whom. At the same time, the 2027 High Level Meeting on Universal Health Coverage offers a key political moment to elevate and advance self-care, both multilaterally and through national strategies.[8]

This paper utilizes literature, project and policy document review, desk-based data collection and key informant interviews to explore evidence, analyse and map publicly incentivized, financed, supported and regulated self-care interventions and initiatives, as defined by the World Health Organization (WHO) 2022 Consolidated Guideline.[9] Working through three cumulative fiscal pathways, further detailed and discussed below as the theory of change,

1 United Nations, *Compromiso de Sevilla: Outcome Document of the Fourth International Conference on Financing for Development* (2025). The $4–4.3 trillion range reflects United Nations Department of Economic and Social Affairs and United Nations Conference on Trade and Development estimates of the annual Sustainable Development Goal financing gap for developing countries.

2 See Organisation for Economic Co-operation and Development, "ODA projections for 2026 and the near-term: implications for vulnerable countries and sectors", OECD Policy Briefs, No. 59 (Paris, OECD Publishing, 2026); and A. E. Apeagyei and others, "Tracking development assistance for health, 1990–2030: historical trends, recent cuts, and outlook", *The Lancet* (2025).

3 World Health Organization and World Bank, *Tracking Universal Health Coverage: 2025 Global Monitoring Report* (Geneva, 2025).

4 United Nations Conference on Trade and Development, *A World of Debt 2025* (Geneva, 2025). Available at unctad.org/publication/world-of-debt.

5 World Bank, *At a Crossroads: Prospects for Government Health Financing amidst Declining Aid* (Washington, D.C., 2025).

6 World Health Organization Regional Office for Africa, *WHO African Region Health Expenditure Atlas 2023* (Brazzaville, 2024). Available at https://www.afro.who.int/publications/who-african-region-health-expenditure-atlas-2023-0.

7 United Nations, *Compromiso de Sevilla* (2025).

8 See World Health Organization, "Preparing for the United Nations high-level meeting 2023 and achieving health for all". Available at www.who.int/activities/preparing-for-the-un-high-level-meeting-2023-and-achieving-health-for-all. See also Magda Robalo and Pamela Cipriano, "From commitment to action: why 2027 must mark the turning point for universal health coverage", *The Lancet Global Health*, vol. 14 (2026).

9 World Health Organization, *WHO Guideline on Self-Care Interventions for Health and Well-being, 2022 Revision* (Geneva, 2022).

the analysis assesses how self-care can simultaneously reduce what governments spend per service and contain costs, ease pressure on an overstretched health workforce, expand productive capacity and protect households from impoverishing health costs. Ministries of finance, ministries of health, multilateral development banks and international health financing institutions all have a role; this paper offers policy recommendations for how each can take advantage of the entry points created by the convergence of the WHO's draft Strategy on the Economics of Health for All (2026–2030),[10] the UHC 2027 accountability horizon and the Compromiso de Sevilla. As Costa Rica's then Second Vice-President and Minister of Health stated during an industry policy summit in 2024, "self-care is not an individual action, it requires a confluence of different circumstances from health literacy to public health policy, in order to realise its potential".[11] While this analysis is focused on public policy, government funding and system integration in low- and middle-income countries (LMICs) – particularly essential for priority interventions and populations facing affordability barriers – it is important to note that globally self-care is delivered in practice through a broader mixed ecosystem that also includes insurance, employers, pharmacies, regulated private expenditure and public-private partnerships.

Theory of Change: In a context of growing health needs and constrained public resources, publicly financed, incentivized, supported and regulated self-care can expand access while generating returns through three reinforcing direct and indirect pathways: health system savings, greater financial security and stronger economic participation for growth. Together, these gains can increase fiscal space and accelerate progress toward UHC, equity and sustainable development.

- **Pathway 1 — Health system savings, efficiencies and capital gains**
- **Pathway 2 — Financial security reducing out-of-pocket costs**
- **Pathway 3 — Opportunity for sustainable growth dividend**

It is important to note that some specific self-care interventions may be seen as complementary to, but distinct from self-management, community-based care, task-sharing and prevention. The definitions below help clarify how these concepts relate to one another.

Box 1: Key Concepts[12]

Self-care interventions - The tools, products and practices that individuals can use to promote health, prevent disease and manage health conditions, with or without direct support from a health worker.

Self-care products - Medicines, diagnostics, devices and digital tools designed to be used by individuals to support health promotion, disease prevention, diagnosis, treatment or ongoing management outside direct clinical supervision.

Supported self-care - A service model in which individuals undertake self-care with ongoing support from the health system, such as counselling, digital guidance, pharmacists, referral pathways, CHWs or follow-up care.

Self-management - The ability of individuals, particularly those living with chronic or ongoing conditions, to manage symptoms, treatment, lifestyle changes and psychosocial impacts in their daily lives.

Community-based care - Health promotion, prevention, treatment and support services delivered through community platforms rather than primarily through health facilities.

Task-shifting / Task-sharing - A workforce strategy that redistributes selected health care tasks from more specialized to less specialized health workers, or from facilities to community-level providers, to expand access and improve efficiency.

Prevention - Actions taken to avoid disease, reduce risk or maintain health before illness occurs, including health promotion, vaccination, screening and other preventive measures.

10 A79/5 Add.1.

11 Mary Munive Angermüller, remarks at a Global Self-Care Federation summit, Geneva, 2024, reported in Health Policy Watch, "Health advocates push for WHO self-care resolution by next year", 1 June 2024.

12 World Health Organization, *WHO Guideline on Self-Care Interventions for Health and Well-being, 2022 Revision*; World Health Organization, *Task shifting: global recommendations and guidelines* (Geneva, 2008). Available at https://iris.who.int/handle/10665/43821.

1.2 Self-Care for Universal Health Care: A Development and Macroeconomic Imperative

UHC is not a social goal separate from economic growth – it is a driver of it. Lower mortality accounts for roughly 11 per cent of recent economic growth in LMICs, with benefit-cost ratios on convergence investments of 9 to 1 to 20 to 1.[13] UHC is not simply an aspiration; it is a global commitment reaffirmed three times in two decades – by the World Health Assembly in 2005, by all United Nations Member States as SDG Target 3.8 in 2015, and by Heads of State at back-to-back High-Level Meetings in 2019 and 2023, the latter setting a 2027 accountability review.[14] Self-care is one of the delivery mechanisms the WHO identifies for advancing this mandate, supporting UHC's own pillars of equitable access, efficient delivery and financial protection.[15]

The economic case for health investment is not marginal. It can be transformational. Scaling proven health interventions could cut the global disease burden by about one-third and add $12.5 trillion to annual Gross Domestic Product (GDP) by 2050 – yielding a four-fold global return on investment.[16] Sixty-five per cent of achievable health improvement comes from prevention. Yet most countries allocate less than 2 per cent of health spending to it.[17] Even in Organisation of Economic Co-operation and Development (OECD) countries, prevention spending fell back to roughly 3 per cent of health expenditure in 2023, down from a COVID-era peak of 6 per cent.[18] This is not an oversight. It is a structural misalignment between what works and what gets funded, and it has a measurable cost.

However, the size of the return is not uniform. Lower-middle-income countries stand to gain most of any income group – an estimated six-fold return – while low-income countries show the lowest, at 1.9 times, constrained by health infrastructure and higher relative implementation costs.[19] The practical implication is that fiscal constraint, not income category alone, influences whether a health investment converts into a return – and that constraint is most severe, and most structurally embedded, in the lowest-income settings.

Sub-Saharan Africa shows this at its sharpest: government health spending has grown at about 3 per cent a year over two decades, half the pace in South Asia, and most governments remain well short of the Abuja target: 15 per cent of a government's budget.[20] More revenue is necessary but not sufficient, since without delivery efficiency, new money is absorbed by a system already underpowered.

The WHO's draft Strategy on the Economics of Health for All (2026–2030), released at the Seventy-Ninth World Health Assembly, gives this framing institutional standing: health is a strategic investment.[21] Against a projected health workforce shortfall of 11 million by 2030, alongside the 4.6 billion people lacking access to essential health services and the 1.6 billion pushed into or deeper into poverty by out-of-pocket health costs, The WHO calls for "innovative strategies that go beyond the conventional health sector response".[22,23] Self-care is emerging as just such a strategy.

The WHO endorses self-care for every country and income setting and identifies it as essential to advancing UHC, promoting health, safeguarding global health security and reaching underserved populations.[24] It positions individuals as active agents in their own health care, spanning health promotion, disease prevention and control, self-medication, care for dependent family members and rehabilitation, including palliative care. As one policy expert observed,

13 Dean T. Jamison and others, "Global health 2035: a world converging within a generation", *The Lancet*, vol. 382, No. 9908 (2013).

14 World Health Assembly, *Sustainable Health Financing, Universal Coverage and Social Health Insurance*, resolution WHA58.33 (2005); United Nations, *Transforming Our World: The 2030 Agenda for Sustainable Development*, target 3.8 (2015); A/RES/74/2; and General Assembly, political declarations of the high-level meetings on universal health coverage in 2019 (A/RES/74/2) and 2023 (A/RES/78/4). The 2023 declaration sets a 2027 accountability review.

15 World Health Organization, *WHO Guideline on Self-Care Interventions for Health and Well-being* (2022).

16 McKinsey Health Institute, *The Health of Nations: Stronger Health, Stronger Economies* (2026).

17 Ibid.

18 Organisation for Economic Co-operation and Development, *Health at a Glance 2025* (Paris, OECD Publishing, 2025). Available at www.oecd.org/en/publications/2025/11/health-at-a-glance-2025_a894f72e.html.

19 McKinsey Health Institute, *The Health of Nations* (2026).

20 Overseas Development Institute, "What do we know about health spending in sub-Saharan Africa?" (2024). Available at odi.org/en/insights/what-do-we-know-about-health-spending-in-sub-saharan-africa/; World Health Organization, Regional Office for Africa, *WHO African Region Health Expenditure Atlas 2023* (2023). Available at www.afro.who.int/publications/who-african-region-health-expenditure-atlas-2023-0. Half of countries in the region allocate less than 7 per cent of their budgets to health; South Africa is the only country to have sustained the 15 per cent Abuja target over 2014–2020, though other analyses name additional countries in individual years.

21 World Health Organization, *Draft Strategy on the Economics of Health for All (2026–2030)*, A79/5 Add.1 (2026).

22 World Health Organization and World Bank, *Tracking Universal Health Coverage: 2025 Global Monitoring Report* (2025).

23 World Health Organization, "Health workforce", update, *Global Strategy on Human Resources for Health: Workforce 2030* (Geneva, 2025).

24 World Health Organization, *WHO Guideline on Self-Care Interventions for Health and Well-being* (2022).

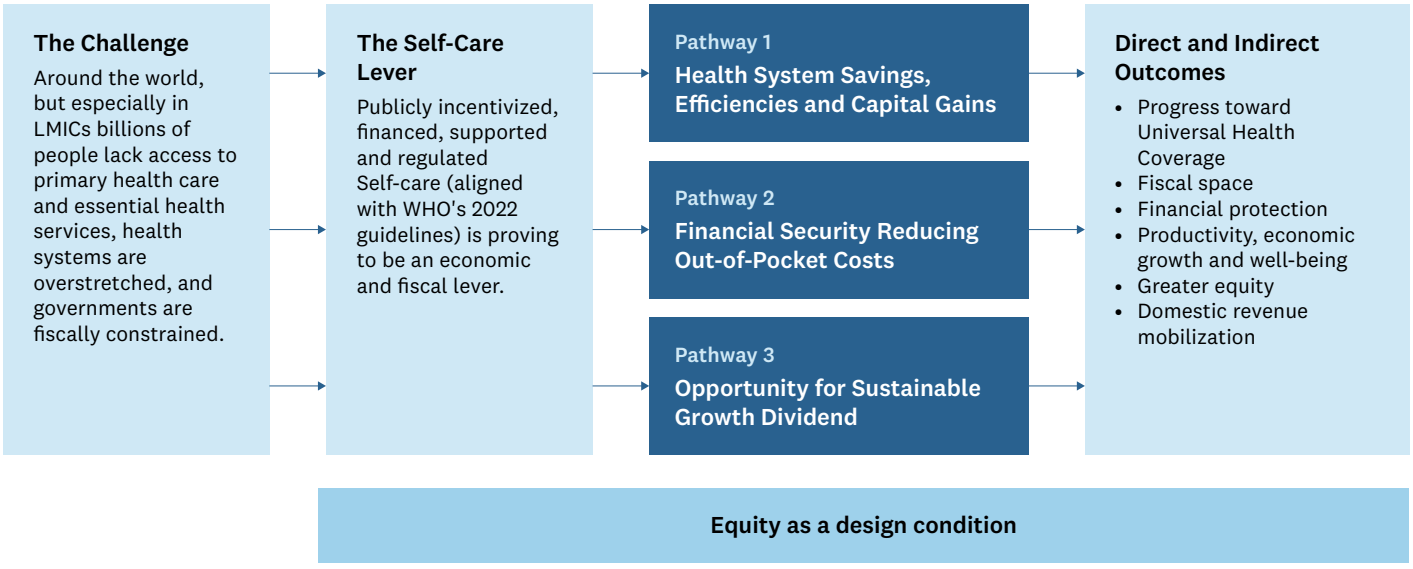
even with the WHO definition, self-care still means different things to different people and can be seen sitting somewhere between individual action and health promotion, which makes its relationship to cost relief harder to pin down.[25]

Self-care can offer in practice what Sevilla calls for in principle: shifting the health financing mix away from out-of-pocket spending and donor dependence toward efficient, domestically-resourced delivery. Countries that have built domestic self-care financing capacity are already better placed for the aid environment that now exists.[26,27] Self-care's contribution is not confined to health outcomes; it also operates directly on the fiscal space that Financing for Development commitments call on governments to expand.

2. How Self-Care Works to Generate Fiscal and Economic Returns: The Theory of Change

In a context of growing health needs and constrained public resources, publicly incentivized, financed, supported and regulated self-care is a lever that if pulled can expand access while generating returns through three reinforcing pathways: health system savings and efficiencies, greater financial security and – more indirectly – stronger economic participation for growth. Together, these gains can increase fiscal space and accelerate progress toward UHC, equity and sustainable development.

Figure 1: Theory of Change: How Self-Care Generates Fiscal and Economic Returns



2.1 Pathways for Economic Prosperity and Equity Through Self-Care

The self-care investment thesis begins with better health outcomes and operates through three distinct but cumulative fiscal and economic pathways. Together, the three pathways move the health financing mix in the direction the Compromiso de Sevilla calls for: away from out-of-pocket spending and aid dependence, toward domestically-mobilized public revenue. Self-care does not resolve the financing crisis. But it is among the few mechanisms that can directly and indirectly reduce what governments spend per service, protect households from financial hardship and support economic growth – with

25 Key informant interview, conducted via Microsoft Teams, 29 May 2026.

26 Organisation for Economic Co-operation and Development, *ODA Projections for 2026 and the Near-Term* (Paris, 2026). Available at www.oecd.org/en/publications/oda-projections-for-2026-and-the-near-term_d7c74fa2-en/full-report.html.

27 Priti Patnalik, "Impacts of the 2025 funding cuts on global health programs", Geneva Health Files, 6 January 2026. Available at https://genevahealthfiles.substack.com/p/what-are-the-actual-impacts-of-the-funding-cuts-2025-hiv-tb-malaria-mpox-health-systems-sara-meg-davis-warwick.

each simultaneously reinforcing the others. Fiscal return is not necessarily dependent on or the result of lower public expenditure overall; it is more often the outcome of cost effectiveness and longer-term productivity gains. Each pathway's gains are conditional, not automatic. They also depend on deliberate design; without which they tend to reach the educated, the urban and those who are more likely to already be able to pay out-of-pocket. These equity implications for each pathway are discussed below following the conceptual definition and supporting evidence.

2.2 Pathway 1 — Health Systems Savings, Efficiencies and Capital Gains

When people manage conditions safely outside health facilities – through at-home tools or with community health workers (CHWs) – governments spend less per service delivered, and clinical staff are freed for cases that require their training.

Evidence for these efficiency gains and cost containment is increasingly robust, especially from certain disease domains. Task-shifting to community-level delivery has been shown to reduce costs per service across LMICs, with the strongest evidence coming from HIV and tuberculosis programmes and a growing evidence base in noncommunicable diseases (NCDs) and reproductive, maternal and child health.[28] At the global level, self-care industry modelling estimates current health system savings of approximately $144 billion annually and suggests that self-care frees up roughly 2.2 billion hours of physician time each year, the equivalent of more than 800,000 doctors that would otherwise be needed worldwide, and generates $1.97 trillion in welfare gains attributable to higher productivity.[29] And an industry study from Europe further shows that the efficiency potential of annual self-managment of approximately 1.2 billion cases of minor ailments generates an estimated €23.3 billion in savings in medical services and products while reducing pressure on physician consultations.[30]

Quality does not appear to be sacrificed in this shift. In Uganda, CHWs trained to counsel clients on self-injected contraception (Depot Medroxyprogesterone Acetate, Subcutaneous, DMPA-SC) outperformed facility-based providers on every quality measure tested, with 96 per cent of their clients confident to self-inject following training.[31] At a national scale, Brazil's Estratégia Saúde da Família demonstrates that community-based delivery can remain effective over time, reaching the large majority of the population at approximately $50 per person per year through predominantly domestic financing.[32]

Among self-care interventions, HIV self-testing provides robust real world proof points of health system savings. Modelling of six distribution modalities in South Africa over a 20-year period found workplace HIV self-testing to be cost saving, generating estimated savings of $52–76 million, while an optimized scale-up to 6.7 million annually nearly tripled life years saved relative to status quo distribution.[33] The pattern holds region-wide: evidence from 65 studies across sub-Saharan Africa found HIV self-testing consistently to be the lowest-cost modality, averaging $12.75 per person tested compared with more than $27 for campaign-style and secondary-distribution models.[34] The Self-Testing AfRica Initiative subsequently demonstrated that these gains could be achieved at population scale, helping drive the HIV self-testing policies now adopted in more than 100 countries.[35]

The importance of these savings is structural as well as clinical. Primary care and community-based delivery already account for one of the largest addressable shares of health spending; often in settings where workforce shortages are most acute. The WHO projects a shortfall of 11 million

28 Gabriel Seidman and Rifat Atun, "Does task shifting yield cost savings and improve efficiency for health systems? A systematic review of evidence from low-income and middle-income countries", *Human Resources for Health*, vol. 15 (2017).

29 Cosima Bauer, Expanding the Analytical Framework on Access, Quality of Life and Prevention: An Addendum to the 2021 Global Study (Global Self-Care Federation, 2026). Available at: https://www.selfcarefederation.org/sites/default/files/media/documents/2026-08/EcoSoc%202.0%20-%20Scientific%20Report.pdf.

30 Association of the European Self-Care Industry (AESGP), *Self-Care in Europe: Economic and Social Impact on Individuals and Society* (Brussels, 2023). Available at: https://aesgp.eu/content/uploads/2022/01/AESGP-Summary-Report-Self-Care-in-Europe-Economic-and-Social-Impact-on-Individuals-and-Society.pdf.

31 Jane Cover and others, "DMPA-SC self-injection experiences of clients and providers in Uganda: the role of community health workers in reproductive self-care service delivery", *BMC Women's Health*, vol. 25, Suppl. 1 (2025).

32 Commonwealth Fund, "Brazil's Family Health Strategy: Using Community Health Care Workers to Provide Primary Care", case study (2016).

33 Lise Jamieson and others, "The cost effectiveness and optimal configuration of HIV self-test distribution in South Africa: a model analysis", *BMJ Global Health*, vol. 6, Suppl. 4 (2021).

34 Nurilign Ahmed and others, "Costs of HIV testing services in sub-Saharan Africa: a systematic literature review", *BMC Infectious Diseases*, vol. 24, Suppl. 1 (2024).

35 Heather Ingold and others, "The Self-Testing AfRica (STAR) Initiative: accelerating global access and scale-up of HIV self-testing", *Journal of the International AIDS Society*, vol. 22, Suppl. 1 (2019).

health workers by 2030,[36] while government and donor health spending in low-income countries averaged only $17 per capita in 2024 – well below the estimated $60 minimum necessary to deliver essential health services.[37] Under these conditions, self-care task-shifting becomes less a marginal efficiency gain than one of the more immediately available levers for expanding coverage without substantially increasing fiscal pressures or new public borrowing. This efficiency stems in part from shifting appropriate care toward lower-cost, community-based cadres – including CHWs, pharmacists and digitally enabled support roles – while preserving scarce clinical capacity for more complex services. Self-care therefore helps address workforce shortages not by expanding reliance on expensive facility-based models, but by making more effective use of existing human resources.[38]

The WHO Package of Essential Noncommunicable Disease Interventions[39] and the HEARTS hypertension package[40] illustrate how these gains can be realized in practice. Both provide practical models for extending public financed care beyond facility walls, reimbursing self-administered care through pharmacies, CHWs and digital channels while maintaining clinical oversight and continuity of care.

The broader fiscal context makes such approaches increasingly important. Across LMICs, primary health care expenditure rose from $41 to $90 per capita between 2000 and 2017. However, spending in low-income countries has plateaued at $17 per capita since 2014, despite data showing that higher primary health care spending is associated with lower maternal mortality, stronger antenatal care coverage, higher measles vaccination rates and better access to quality scores.[41] More strikingly, total government and donor health spending in low-income countries has now fallen to roughly that same level, meaning total health spending today purchases what primary health care alone bought a decade ago.[42] Prevention clearly illustrates the resulting imbalance: it accounts for an estimated two-thirds of achievable health improvement but receives less than 2 per cent of health budget spending.[43] Well established fiscal instruments exist to address this gap; for example the WHO's NCD "Best Buys" initiative, which through tobacco and alcohol taxation can generate returns of up to $7 for every dollar invested, reframing prevention not as social spending but as fiscal risk reduction.

The direction of evidence on self-care's own cost effectiveness is mounting, but notable gaps remain. Most economic evaluations report cost effectiveness or cost savings associated with self-care interventions.[44] However, confidence in the magnitude of these effects remain constrained by short follow-up periods, narrow cost definitions and a concentration of studies in high-income settings.[45] Economic evaluation has generally lagged behind implementation, particularly in low and lower middle-income countries where the fiscal case for self-care is potentially strongest. Evidence from sexual and reproductive health and rights (SRHR) self-care further suggests that sustainable scale depends not only on achieving cost savings but also on diversified domestic financing arrangements – including tax-based funding, insurance mechanisms and reduced out-of-pocket costs – rather than treating self-care as a stand-alone cost-containment tool.[46] As one diplomat with a health portfolio shared, the financing dimension is where self-care becomes most interesting, yet there has been no systematic effort to quantify its fiscal impact. Doing so is difficult, given that there are real data gaps and policy complications. But without the quantification governments will struggle to prioritize it.[47]

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36 World Health Organization, "Health workforce".

37 World Bank, *At a Crossroads* (2025).

38 World Health Organization, International Labour Organization and Organisation for Economic Co-operation and Development, *Working for Health and Growth: Investing in the Health Workforce* – report of the United Nations High-Level Commission on Health Employment and Economic Growth (2016). Available at www.who.int/publications/i/item/9789241511308.

39 World Health Organization, *Package of Essential Noncommunicable (PEN) Disease Interventions for Primary Health Care in Low-Resource Settings* (Geneva, 2010).

40 World Health Organization, *HEARTS Technical Package for Cardiovascular Disease Management in Primary Health Care* (Geneva, 2020).

41 Matthew T. Schneider and others, "Trends and outcomes in primary health care expenditures in low-income and middle-income countries, 2000–2017", *BMJ Global Health,* vol. 6, No. 8 (2021).

42 World Bank, *At a Crossroads* (2025).

43 McKinsey Health Institute, *The Health of Nations* (2026).

44 Gerry Richardson and others, "Cost-effectiveness of interventions to support self-care: a systematic review", *International Journal of Technology Assessment in Health Care*, vol. 21, No. 4 (2005).

45 Mitchel van Eeden and others, "Economic evaluation studies of self-management interventions in chronic diseases: a systematic review", *International Journal of Technology Assessment in Health Care*, vol. 32, No. 1 (2016).

46 Michelle Remme and others, "Self care interventions for sexual and reproductive health and rights: costs, benefits, and financing", *BMJ*, vol. 365 (2019).

47 Key informant interview, conducted via Microsoft Teams, 29 May 2026.

These savings materialize only if the populations furthest from facility-based care can actually reach the delivery channels that generate them. Privacy is often the deciding factor, recognized in the WHO's 2022 self-care guidelines that name people living with HIV, transgender and gender-diverse people, sexually diverse persons, sex workers, and people who use drugs as populations who risk exclusion or violence when they present for care in person. A systematic review and meta-analysis found HIV self-testing roughly doubled testing uptake and new diagnosis detection compared with facility-based services – confidentiality driving exactly the uptake that underlies estimated savings in South Africa.[48] The same holds for the Malawi and Uganda delivery-cost comparisons that assume women can physically and safely reach community-based self-injection, an assumption that design, not geography alone, determines.

Box 2: Illustrative Scenario - Fiscal Impact of a 10 Per Cent Demand-Side Shift

For a hypothetical LMIC of 50 million people with approximately 30 million annual outpatient visits attributable to conditions suitable for self-care management, a conservative 10 per cent shift of eligible visits to self-care delivery modalities implies 3 million fewer facility visits annually. At a blended public cost of $15 per facility visit (conservative for an LMIC setting), this would yield $45 million in gross annual system savings, representing approximately 8–12 per cent of a typical LMIC public health budget in this income range.[49,50]

In a real world country-level application, six assumptions in this scenario would need to be calibrated against national health accounts: (1) share of visits addressable through self-care; (2) blended government cost per facility visit; (3) government vs. household cost share; (4) cost of publicly financing the self-care product; (5) unit cost of the chosen delivery channel; (6) linkage and follow-up rates. National health accounts teams should run sensitivity analysis before using these figures in actual financing negotiations.

2.3 Pathway 2 — Financial Security Reducing Out-of-Pocket Costs

When governments publicly finance self-care interventions, households spend less while achieving the same health outcomes. Without public financing or a mixed-financing model with targeted consumer protections and affordability measures, self-care may shift the burden from government to families. With public financing, health expenditure moves from (often invisible) household budgets to pooled financing mechanisms where it can be planned, subsidized and strategically purchased. Pathway 2 is therefore the mechanism through which self-care contributes directly to financial protection and poverty reduction.[51]

Households already shoulder a disproportionate share of healthcare costs. Across 55 countries, household spending exceeds the combined contribution of governments and donors. Public financing of self-care is one mechanism for reversing that balance, reducing the need for people to pay for essential health services directly at the point of use.[52]

Thailand's Universal Coverage Scheme provides a robust demonstration of this pathway in practice. More than two

48 Cheryl C. Johnson and others, "Examining the effects of HIV self-testing compared to standard HIV testing services: a systematic review and meta-analysis", *Journal of the International AIDS Society*, vol. 20, No. 1 (2017).

49 The World Health Organization 'OneHealth Tool' is a costing and health system planning tool used to estimate the impact of changes in service delivery mix on health system costs and outcomes. Available at www.who.int/tools/onehealth-tool. The per-visit and demand-shift figures in box 2 are illustrative, author-constructed assumptions for a worked example – not drawn from a specific country study – and are intended to demonstrate the underlying methodology of the OneHealth Tool for ministry of finance and national health accounts teams. Actual unit costs vary substantially by country, condition and delivery channel; see footnotes 5 and 48 for sourced per capita and primary health care expenditure benchmarks used elsewhere in this brief.

50 World Bank, *Government Resources and Projections for Health (GRPH)* (2025). Per capita spending benchmarks ($60 for low-income countries; $90 for lower-middle-income countries) used as the calibration anchor for box 2's illustrative budget-share estimate. See footnote 5. Available at www.worldbank.org/en/topic/health/publication/government-resources-projections-health-financing-report.

51 World Health Organization, *Consolidated Guideline on Self-Care Interventions for Health and Well-being, 2022 Revision* (2022). Available at www.ncbi.nlm.nih.gov/books/NBK582356/.

52 World Health Organization, *Global Health Expenditure Report 2024* (Geneva, 2024). Available at www.who.int/news/item/12-12-2024-new-who-report-reveals-governments-deprioritizing-health-spending.

decades of zero co-payment reduced catastrophic health expenditure from 6.0 per cent to 2.0 per cent of households and health-driven impoverishment from 2.2 per cent to 0.3 per cent. Over time, resources no longer absorbed by healthcare costs shifted into household consumption and investment, generating measurable spillover benefits for the broader economy.[53]

Medicines are one of the principal channels through which these gains occur. Across South and South-East Asia and sub-Saharan Africa, pharmaceutical purchases consistently account for the largest share of out-of-pocket sending.[54] Public subsidizing of self-administered medicines and over-the-counter products therefore represent one of the most direct ways to reduce household financial burden, relieving a cost currently borne by families with publicly-financed alternatives.

Evidence from LMICs increasingly supports this pattern. A 2025 systematic review of self-management interventions for long-term conditions found consistent reductions in personal and out-of-pocket costs, although the economic basis remains less developed than the clinical literature.[55] A controlled trial in Egypt provides a concrete example: a community pharmacy-based diabetes self-management intervention reduced medicine costs by 1,581 Egyptian pounds (approximately $100) per one percentage point improvement in Hemoglobin A1c (a blood test) over three months, while also reducing insulin dosing frequency.[56]

The existing evidence also suggests that financial protection gains are most sustainable when self-care is embedded within broader health financing systems rather than funded through a single source. Durable scale depends on combining public revenue, insurance mechanisms and responsible private sector participation in ways that reduce reliance on out-of-pocket spending. In this sense, self-care could be viewed not as a stand alone cost containment measure but as part of a broader financing strategy that strengthens financial protection while reducing dependence on external funds or donor assistance.[57]

The equity condition in financial protection follows the same logic as system savings: it is least reliable precisely where it is needed most. An estimated 1.3 billion people – 16 per cent of the global population – live with significant disability and face roughly twice the risk of common NCDs, yet self-management tools are still designed by default around users without disabilities, with barriers spanning device design, information access and provider attitudes.[58] The WHO estimates disability-inclusive NCD prevention and care could return nearly $10 for every US$1 invested – a return only realized if the out-of-pocket reductions documented above are designed to reach a population that facility-based systems already underserve.[59]

2.4 Pathway 3 — Opportunity for Sustainable Growth

The direct benefits seen in pathways 1 and 2 have the potential to be compounded by the direct and indirect economic participation and growth opportunities related to self-care. At the same time, increased economic growth may itself be an outcome of health systems savings and reduced out-of-pocket costs. Health investment and economic growth are mutually reinforcing and cumulative. Healthier workers are more productive; longer lives raise savings, investment and labour force participation; healthier children learn more and earn more as adults; and reduced caregiving burden frees labour – disproportionately that of women – for productive economic activity. Self-care directly and indirectly contributes to these dynamics by improving access to prevention, disease management and continuity of care, particularly where facility-based services remain constrained.

The direction of the relationship between health and growth is well established, even where the precise magnitude remains difficult to quantify. As noted in section 1.2, reductions in mortality already account for roughly one-tenth of recent LMIC economic growth, while focused investments could cut premature deaths in half

53 Phatta Kirdruang and Paul Glewwe, "The impact of universal health coverage on households' consumption and savings in Thailand", *Journal of the Asia Pacific Economy*, vol. 23, No. 1 (2018).

54 World Health Organization, Regional Office for South-East Asia, "Financial protection analysis in eight countries in the WHO South-East Asia Region", *Bulletin of the World Health Organization* (2018).

55 Taim Akhal and others, "Self-management interventions for common long-term conditions in low- and middle-income countries: a synthesis of current evidence", *Journal of Global Health*, vol. 15 (2025).

56 Hassan Farag Mohamed and others, "A community pharmacy-based intervention in the matrix of type 2 diabetes mellitus outcomes (CPBI-T2DM): a cluster randomised controlled trial", *Clinical Medicine Insights: Endocrinology and Diabetes*, vol. 14 (2021).

57 Jesper Sundewall and others, "Self-care interventions for sexual and reproductive health: a strategic health systems investment", *BMJ Global Health*, vol. 10, Suppl. 6 (2025).

58 World Health Organization, "Disability", fact sheet, 7 March 2023.

59 Jonathan Howard and others, "Exploring the barriers to using assistive technology for individuals with chronic conditions: a meta-synthesis review", *Disability and Rehabilitation: Assistive Technology*, vol. 17, No. 4 (2020).

by mid-century.[60] The World Bank's *Unlocking the Power of Healthy Longevity* extends this case across the life course – from maternal health through NCD prevention and control – projecting 150 million lives saved by 2050 while strengthening the human capital increasingly needed in aging societies.[61]

Several mechanisms underpin this pathway allowing for self-care to contribute to economic growth, even if in more of an indirect manner. Labour productivity is among the most important. Evidence suggests health contributes productivity gains on a scale comparable to education, while improvements in early-life health generate lasting effects into adult earning. A longitudinal study in Guatemala, for example, found that a childhood nutrition intervention increased education attainment among women and translated into higher adult wages among men.[62] Demographic transition provides another growth channel. East Asia's demographic transition contributed as much as 1.9 percentage points annually to economic growth – about one-third of the "East Asian miracle"[63] – a mechanism that SRHR-related self-care can support by helping women plan and time pregnancies. A third lever operates through individual savings and capital formation, as longer, healthier lives increase savings rates, spending and productive investment (the latter of which can also generate taxes and revenues). Lastly, improved health strengthens human capital accumulation more broadly, with substantive positive effects on long-run economic growth demonstrated across multiple studies.[64]

Recent global modelling provides a sense of the potential scale of these effects for proven interventions – which could generate as much as $12.5 trillion in additional annual GDP by 2050, with approximately 85 per cent of the expected gains arising through increased labour force participation. Fewer premature deaths, reduced absenteeism, greater participation from informal caregivers and higher lifetime earnings all contribute to these projected returns.[65] An industry study of 30 countries across Europe also suggests that self-care has extended economic benefits; estimating approximately €10.4 billion annually in productivity gains associated with self-management of minor ailments and avoidance of unnecessary consultations, illustrating how health-related time savings can contribute to wider economic participation and welfare.[66]

A less documented but potentially valuable growth contribution from self-care is through the broader care economy. Self-care can offer income-earning revenue generation opportunities for community-based service delivery, distribution networks and health-adjacent microenterprise, particularly in last-mile and informal economy settings. Robust available evidence comes from CHW models that combine self-care commodity distribution with micro-entrepreneurship. In Uganda, a randomized evaluation of a community health promoter model found that promoters generated modest incomes through the reselling of self-care health commodities, including antimalarial bed nets, water purification tablets, soap and fortified foods.[67] While income effects themselves were more limited,[68] earnings are likely to re-enter the economy in household spending and the model shows how self-care delivery can simultaneously expand access, reduce the public financing burden (pathway 1) and create local economic opportunities.[69]

60 Dean T. Jamison and others, "Global health 2050: the path to halving premature death by mid-century", *The Lancet*, vol. 404, No. 10462 (2024).

61 World Bank, *Unlocking the Power of Healthy Longevity: Demographic Change, Non-communicable Diseases, and Human Capital* (Washington, D.C., 2024).

62 See David N. Weil, "Accounting for the effect of health on economic growth", *The Quarterly Journal of Economics*, vol. 122, No. 3 (2007); John A. Maluccio and others, "The impact of improving nutrition during early childhood on education among Guatemalan adults", *The Economic Journal*, vol. 119, No. 537 (2009); and John Hoddinott and others, "Effect of a nutrition intervention during early childhood on economic productivity in Guatemalan adults", *The Lancet*, vol. 371, No. 9610 (2008).

63 David E. Bloom and J. G. Williamson, "Demographic transitions and economic miracles in emerging Asia", *The World Bank Economic Review*, vol. 12, No. 3 (1998).

64 David E. Bloom, David Canning and Jaypee Sevilla, "The effect of health on economic growth: a production function approach", *World Development*, vol. 32, No. 1 (2004).

65 McKinsey Health Institute, *The Health of Nations* (2026).

66 Association of the European Self-Care Industry (AESGP), *Self-Care in Europe: Economic and Social Impact on Individuals and Society* (Brussels, 2023). Available at: https://aesgp.eu/content/uploads/2022/01/AESGP-Summary-Report-Self-Care-in-Europe-Economic-and-Social-Impact-on-Individuals-and-Society.pdf.

67 Martina Björkman Nyqvist and others, "Reducing child mortality in the last mile: experimental evidence on community health promoters in Uganda", *American Economic Journal: Applied Economics*, vol. 11, No. 3 (2019). Summary available from the Abdul Latif Jameel Poverty Action Lab (J-PAL) at www.povertyactionlab.org/evaluation/entrepreneurial-model-community-health-delivery-uganda.

68 Business Fights Poverty, "Delivering care to last mile communities", 1 June 2018. Available at https://businessfightspoverty.org/delivering-care-to-last-mile-communities/.

69 Social Innovation in Health Initiative, "Living Goods", case study. Available at https://socialinnovationinhealth.org/case-studies/living-goods/.

Evidence from the wider care economy (childcare, long-term care, elder care, health and social work) points to the potential scale of such effects. Modelling by the International Labour Organization estimates that doubling global investment in care services could generate 475 million jobs by 2030 through a combination of direct employment in health, education and social care, and indirect employment created elsewhere in the economy.[70] Although these estimates do not isolate self-care interventions, they provide a useful proof of concept and illustration of employment multipliers that may accompany expanded community-based and health-adjacent service delivery and sales. To the extent that self-care shifts delivery toward lower-cost community and primary-care platforms – including CHWs, pharmacists and digital-support roles – it may also generate employment and income benefits as a co-benefit of more efficient service delivery.

Evidence linking self-care interventions directly to productivity, employment and macroeconomic growth remains less developed than the evidence in efficiency gains and financial protection. While the theoretical channels are strong and the directional evidence is encouraging, few studies have isolated self-care's specific or direct contribution to labour force participation, earnings or employment creation. The principal evidence gap is therefore not necessarily whether self-care contributes to economic development, but the nature and magnitude of its calculated (primary and secondary) growth effects in low- and lower-middle-income settings where the potential returns may be greatest.

The magnitude of the growth channel's impact is similarly conditional on who is freed to participate in it. Reduced caregiving burden is disproportionately a woman's labour force question: when self-management lets a family member manage a chronic condition at home, the caregiver – usually a woman – recovers time with quantifiable economic value, hours that convert to paid work, education or community contribution. In Malawi, community-based self-injected contraception costs 31 per cent less per person per year than facility delivery, becoming cost-saving once 40 per cent or more of visits are self-administered – a threshold that several countries have already reached, and one that depends on women's continued ability to access that delivery channel.[71] The labour force gains assume this access holds; where it doesn't, the growth dividend narrows.

3. The Global Policy Landscape: Looking Across the Self-Care Financing-Systems Maturity Spectrum

The referenced WHO 2022 Consolidated Guideline on Self-Care Interventions established the first global normative framework for self-care. Countries are now translating that framework into national policy – unevenly, but with clear momentum. As the 2027 UHC milestone approaches, where a country sits along a self-care policy continuum increasingly determines whether self-care contributes to UHC progress or remains outside formal accountability and financing systems.

The broader supportive health policy architecture and self-care's place in it is now also taking shape. The WHO guideline defines self-care interventions, the standards they should meet, and the equity conditions under which they should be delivered, while the Addis Ababa Action Agenda and Compromiso de Sevilla supply the macro framework for mobilizing and aligning financing. Complementing this shift, the WHO Economics of Health for All Strategy (2026–2030) creates a new institutional pathway for framing health – including self-care – as an economic investment rather than a consumption cost. Together, they place self-care at the intersection of health system reform and sustainable financing.

The following policy landscape review utilizes a four-stage financing-system maturity spectrum (Figure 2), developed by the authors and grounded in the WHO guidelines (including the 12 enabling environment elements in the conceptual framework),[72] the UHC monitoring architecture and the financing principles reflected in the Compromiso de Sevilla. The stages move from self-care-specific policy recognition to benefits-package inclusion, programmatic

70 International Labour Organization, *Care Work and Care Jobs for the Future of Decent Work* (Geneva, 2018). Available at www.ilo.org/media/65231/download.

71 Holly M. Burke and others, "The case for investing in provider-administered subcutaneous DMPA: a costing study", *BMJ Global Health*, vol. 10 (2025).

72 The 12 enabling environment elements are: commodity security, psychosocial support, supporting laws and policies, access to justice, economic empowerment, protection from violence, coercion and discrimination, information, health financing, regulated quality products and interventions and trained health workforce.

scale and full domestic financing and systems integration. The spectrum is intended as a diagnostic and mapping tool rather than a formal classification or ranking mechanism. The illustrative country examples drawn from policy literature are not exhaustive or fully representative: countries may straddle stages, progression is rarely linear and countries' strengths (or weaknesses) in other aspects of the broader enabling ecosystem for advancing self-care (such as pharmacy delivery, health literacy or product availability) may not be accounted for. It is meant to offer another lens for understanding how countries are translating normative commitments into financed delivery systems – and where the challenges, policy and financing gaps remain. To that end, it is also worth distinguishing two related but separate dimensions of maturity that this framework considers into a single sequence: financing maturity, the extent to which self-care is embedded in benefits packages, strategic purchasing and domestic resource allocation, and systems implementation maturity, the extent to which countries have moved from strategic prioritization through piloting to institutionalized delivery. The stages of the spectrum are organized primarily around the former, since domestic financing is the central policy question at hand; a country can therefore sit at an earlier financing stage while having already accumulated considerable implementation experience, or vice versa. The examples in each stage should be read with that distinction in mind.

The spectrum presented here is complementary to existing efforts to assess national self-care environments. For example, reflecting an industry perspective, the Global Self-Care Federation's Self-Care Readiness Index[73] evaluates enabling conditions such as policy support, health literacy, stakeholder engagement, access to self-care products and services and broader system readiness. While these dimensions help explain a country's capacity to adopt and scale self-care, this spectrum focuses on whether these conditions have been translated into financed, institutionalized and accountable delivery. Further to the financing-implementation dynamic noted above, countries may therefore demonstrate high readiness while remaining at an early stage of financing integration, underscoring the distinction between preparedness and implementation.

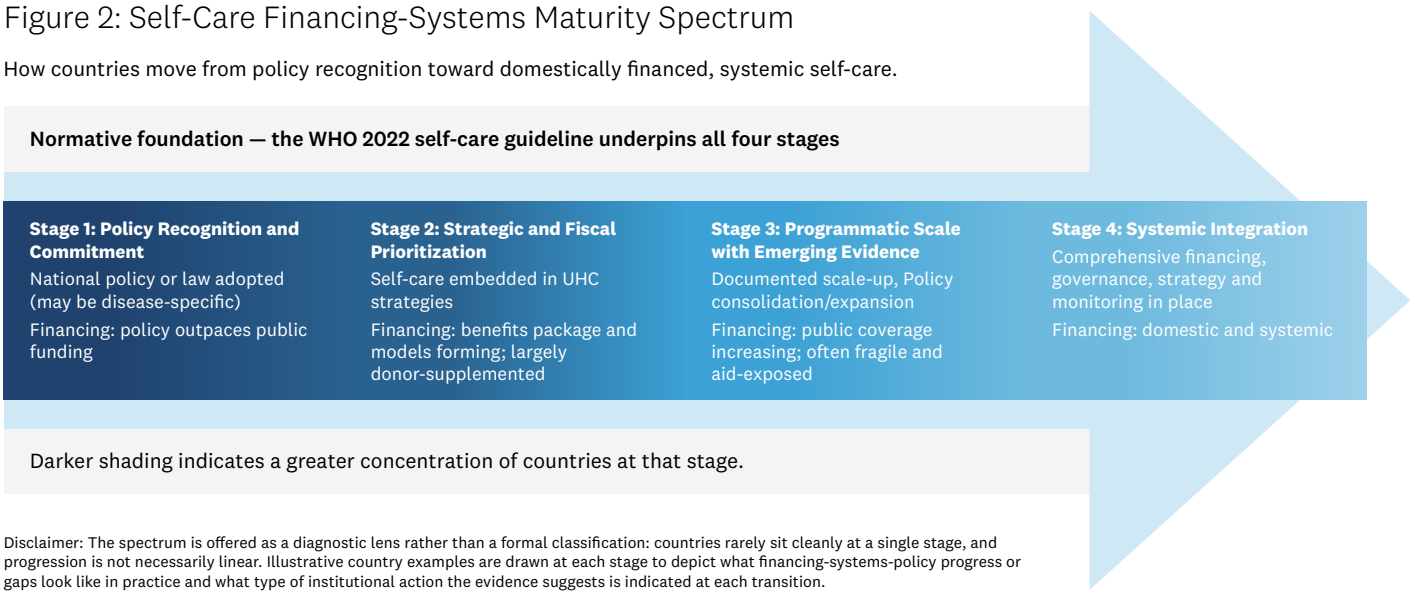
Notably, a large share of evidentiary data and examples are drawn from SRHR. This concentration partly reflects the field's own history: the WHO's first consolidated self-care guideline (2019) was scoped around sexual and reproductive health and rights, with the 2022 revision broadening it to health and well-being overall. Thus, to some extent, the evidence base for self-care policy is still catching up to the framework's broader scope.

3.1 Stage 1 — Policy Recognition and Commitment

Countries start by adopting self-care policies, guidelines or legislative commitments but lack the financing, delivery and regulatory systems needed for implementation at scale; and Stage 1 countries have typically established some of the enabling environment elements identified in the WHO framework – most notably supporting laws and policies, information and health literacy initiatives, stakeholder

Figure 2: Self-Care Financing-Systems Maturity Spectrum

How countries move from policy recognition toward domestically financed, systemic self-care.



Disclaimer: The spectrum is offered as a diagnostic lens rather than a formal classification: countries rarely sit cleanly at a single stage, and progression is not necessarily linear. Illustrative country examples are drawn at each stage to depict what financing-systems-policy progress or gaps look like in practice and what type of institutional action the evidence suggests is indicated at each transition.

73 Global Self-Care Federation, *Self-Care Readiness Index Report 2025* (2025). Available at www.unitedforselfcare.org/wp-content/uploads/2025/05/Self-Care-Readiness-Index-Report-2025-160525.pdf.

coordination mechanisms and in some cases workforce training – while progress on financing, commodity security and regulated access remain uneven. At the same time, policy commitment has outpaced public investment, creating a substantial gap between formal recognition and real access.

A common characteristic of Stage 1 is that self-care is typically embedded in disease-specific policies or service guidelines rather than supported through an explicit national self-care strategy with dedicated financing. This is further evidenced by the WHO's 2023 SRMNCAH policy survey, suggesting that self-care policy adoption is increasingly visible within SRHR, with nearly 50 countries (42 per cent of those reporting) incorporating self-care interventions into family planning, HIV and reproductive health policies and guidelines.[74]

Stage 1 also appears to be where countries engaging in self-care policy adoption are concentrated, with supportive HIV self-testing a particularly visible illustration. As of July 2024, 107 countries had national policies supporting HIV self-testing, a 2.7-fold increase since 2017, with 71 routinely implementing self-testing and another 25 developing policies.[75,76] As shown in Figure 2 below, Eastern and Southern Africa, as well as Western and Central Europe and East Asia Pacific have a high concentration of implementing countries, while Central and South America and Eastern Europe and Eurasia include larger clusters of countries that were lacking self-testing policies.

Kenya, Nigeria and Uganda illustrate this pattern. All three recognize most WHO self-care recommendations, permit self-administered DMPA-SC within national family planning guidance, allow over-the-counter oral contraceptives and have implemented HIV self-testing programmes since at least 2017. Uganda registered DMPA-SC in 2014, while Kenya has emerged as one of the more operationally advanced HIV self-testing implementers. Yet implementation remains constrained by recurring barriers: weak infrastructure and supply chains, low health literacy, inadequate self-injection training, inconsistent over-the-counter regulation and legal ambiguity. Coverage remains concentrated in urban areas, limiting access for populations with the greatest unmet need.[77] Nigeria's National Guidelines on Self-Care for Sexual, Reproductive and Maternal Health sets a target of reaching 30 per cent of potential users by 2025 with a costed implementation plan, but acknowledges that self-care is still financed mainly out-of-pocket, with insurance and government subsidy named only as future ambitions.[78]

India sits around the boundary between Stage 1 and Stage 2 through its accredited social health activist network and wide over-the-counter access, giving it significant self-care reach. But that reach operates through family-planning and disease-specific programmes rather than a consolidated, financed national self-care strategy.[79]

The financing constraints underlying this gap are not self-care-specific – they reflect the broader underfunding of public health systems that Stage 1 self-care commitments inherit. Of 47 countries in the WHO African Region, only 5 met the recommended $249 per capita health spending threshold in 2020 – a general health financing shortfall that shapes what any self-care policy commitment can realistically deliver.[80]

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74 World Health Organization, *Report on the 2023 Policy Survey: Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health* (2024). Available at https://iris.who.int/server/api/core/bitstreams/afe43a94-aa8f-435f-aa2f-4615b358e0a0/content.

75 For SRMNCAH survey — national policy or guideline on self-care interventions (2023–2024) see World Health Organization, "Sexual and Reproductive Health and Rights: Policy Portal". Available at https://platform.who.int/data/sexual-and-reproductive-health-and-rights/national-policies/srh/national-strategy-or-policy-on-self-care-interventions. See also Self-Care Trailblazer Group, *State of Self-Care Report 2025* (2025). Available at https://media.psi.org/wp-content/uploads/2025/10/31142827/State-of-Self-Care-Report-_-2025.pdf.

76 World Health Organization, *WHO HIV Policy Adoption and Implementation Status in Countries, 2024*, WHO/UCN/HHS/SIA/2024.12 (Geneva, 2024). Data source: Global AIDS Monitoring (UNAIDS/WHO/UNICEF). Available at https://cdn.who.int/media/docs/default-source/hq-hiv-hepatitis-and-stis-library/j0482-who-ias-hiv_factsheet_v3-2.pdf.

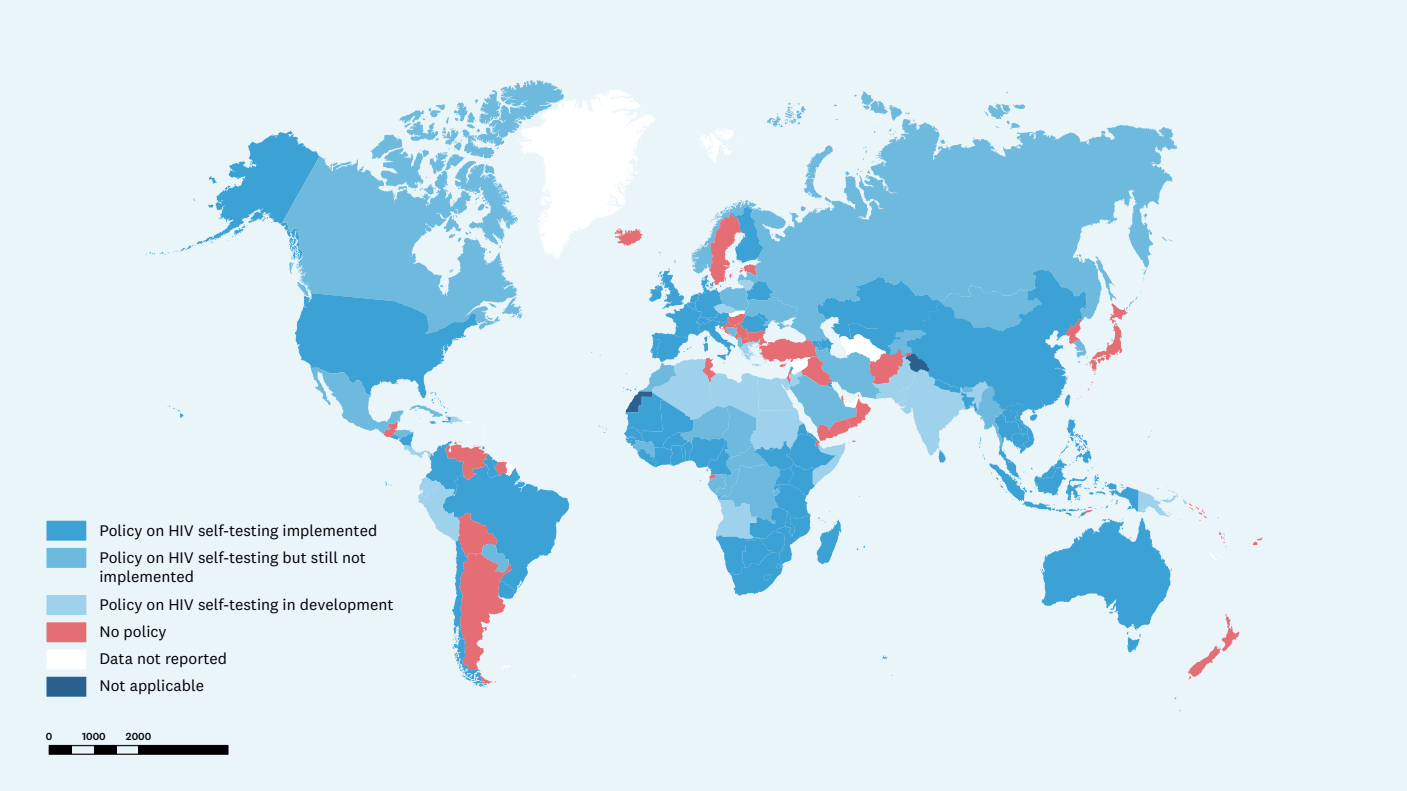
77 Austen El-Osta and others, *Policy Mapping: Assessing Implementation of the WHO Consolidated Guideline on Self-Care Interventions in Kenya, Nigeria and Uganda* (Self-Care Trailblazer Group and Self-Care Academic Research Unit, 2021). Available at https://media.psi.org/wp-content/uploads/2021/06/30234816/SCTG-SCARU-Policy-Mapping-Rapid-Analysis-Final.pdf.

78 Nigeria, Federal Ministry of Health, *National Guidelines on Self-Care for Sexual, Reproductive and Maternal Health* (2020). Available at https://platform.who.int/docs/default-source/mca-documents/srh-policy-documents/nga-national_guidelines_on_self-care_for_sexual-reproductive_and_maternal_health_2020.pdf.

79 World Health Organization, *Self-Care Interventions for Sexual and Reproductive Health and Rights: Country Cases* (2024) – covering Burkina Faso, Ethiopia, India, Kenya, Nigeria and Uganda. Available at www.who.int/publications/i/item/B09126. See also Organisation of Pharmaceutical Producers of India and Havas Life Sorento, *Value of OTC in India: Assessing the Economic Potential of Self-Medication* (Mumbai, Organisation of Pharmaceutical Producers of India, 2021). Available at www.indiaoppi.com/wp-content/uploads/2026/01/Value-of-OTC-in-India-1.pdf.

80 World Health Organization, Regional Office for Africa, *WHO African Region Health Expenditure Atlas 2023* (2023). Available at www.afro.who.int/publications/who-african-region-health-expenditure-atlas-2023-0. See also Human Rights Watch, "African governments falling short on healthcare funding", 26 April 2024. Available at www.hrw.org/news/2024/04/26/african-governments-falling-short-healthcare-funding.

Figure 3. National Policy on HIV Self-Testing and Implementation Status, As of July 2024[81]



Sources: Global AIDS Monitoring (UNAIDS/WHO/UNICEF) and WHO Department of Global HIV, Hepatitis and Sexually Transmitted Infections Programmes, 2024.

3.2 Stage 2 — Strategic and Fiscal Prioritization

At Stage 2, self-care is no longer merely permitted; countries have moved beyond policy recognition and begun embedding self-care into UHC strategies, insurance arrangements or health sector reform, incorporating it into how services are financed and organized. However, financing generally remains incomplete, donor-supplemented or insufficiently institutionalized. This dynamic sets up exposure points as the policy commitment exists, but the financing architecture needed to sustain delivery remains fragile. In the context of declining external assistance, this vulnerability is becoming increasingly apparent.

Kenya and Ethiopia illustrate this dynamic in East Africa. Self-care is embedded within UHC implementation strategies and delivered through extensive CHW networks. However, CHW financing remains substantially donor-supported, exposing a structural weakness in the transition from policy commitment to domestically-financed service delivery. Ethiopia illustrates why progression across the specturm is not always linear or clear cut. The country has moved beyond policy recognition alone through the development of national self-care guidelines, integration of self-care across multiple national health strategies, establishment of a National Self-Care Network and the use of CHWs and regional pilots to support implementation. These advances correspond to several WHO enabling environment elements, including supporting laws and policies, information, stakeholder engagement and workforce capacity; and these characteristics suggest a level of institutional development beyond a typical Stage 1 profile. At the same time, many activities remain pilot-based, while financing, strategic purchasing and routine integration within UHC financing arrangements remain under development. Ethiopia therefore sits toward Stage 2, demonstrating how readiness, implementation capacity and financing institutionalization can advance at different rates – and why countries often progress unevenly across different dimensions of self-care maturity.

Indonesia's Jaminan Kesehatan Nasional and the Philippines' PhilHealth (government insurance schemes and agencies implementing national health insurance laws) have

81 World Health Organization, *WHO HIV Policy Adoption and Implementation Status in Countries*, 2024 (2024).

incorporated elements consistent with self-care delivery and financial protection. Indonesia's 2022 Integrated National Financing Framework (INFF) Assessment further identified health as one of ten national Investment Opportunity Areas, creating a potential institutional entry point for integrating self-care financing into broader domestic resource mobilization efforts (see Section 3.5). In the Philippines, a review[82] of 13 self-care policies implemented over five years identified the Universal Health Care Law as the principal driver of policy development, while also highlighting Thailand's CHW programmes and tax-funded insurance model as a regional benchmark for further advancement. Also in the Philippines, following the Food & Drug Administration's Review of Over-The-Counter Applications in 2022, the registration requirements were streamlined and the registration lead time was reduced for over-the-counter and household remedy products.[83]

Egypt offers an example in the Middle East and North Africa region. Its Universal Health Insurance (UHI) Law established a strategic purchasing architecture through a purchaser-provider split, pooled financing arrangements and subsidized coverage for people living in poverty. In parallel, the 2024 National Guidelines Programme and the WHO Country Cooperation Strategy 2024–2028 have strengthened the policy environment for UHC reform. Yet despite these advances, explicit self-care integration remains limited. Given Egypt's relatively high out-of-pocket expenditure and low levels of public health spending (see Section 2), the UHI benefit package represents a potentially important instrument for expanding financial protection, making the absence of explicit self-care integration a notable gap.[84]

Colombia and Chile have integrated NCD self-management protocols into social health insurance frameworks, offering a clear regional illustration of Pathway 3 operating as intended. Digital self-care is entering benefit package discussions most actively in Asia and Latin America and the Caribbean, though regulatory frameworks lag the technology almost everywhere. Yet, Mexico may be viewed through a different Stage 2 lens: self-care is operating at scale informally but remains largely outside public financing arrangements. Over-the-counter contraceptives are widely available, pharmacists routinely provide preventative and chronic disease services and one-third of Mexicans report seeking pharmacist advice for health decisions. The 2026 Servicio Universal de Salud reform, which creates a single public health network with a universal digital health credential (a notably explicit UHC commitment), creates a potential pathway for formal integration, but self-care remains only partially incorporated despite fiscal pressures, including low public health spending and high out-of-pocket expenditure. The concept of *autocuidado* already appears in Mexico's Primary Healthcare Framework and the PrevenIMSS guidelines.[85] The elements of a system exist but are largely invisible to the benefit package and unprotected by public subsidy.

Across these examples, the common challenge is not policy adoption but financing transition. Stage 2 countries have largely established the policy and institutional foundations for self-care. What remains unresolved is how to move from donor-supported, fragmented or informal delivery models toward sustainable domestic financing. Egypt, Colombia and Chile sit further along fiscally – purchasing architecture in place, and in Colombia's case, already offering self-care within this architecture. What is still missing, however, is the documented implementation evidence – and the level of fiscal implementation to generate additional evidence. The transition to Stage 3 occurs when financing commitments begin generating programmes of sufficient scale, duration and institutionalization to produce measurable implementation and outcome evidence.

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82 Leonardo Iii Jaminola and others, "The policy environment of self-care: a case study of the Philippines", *Health Policy and Planning*, vol. 38, No. 2 (2023).

83 EU-ASEAN Business Council, *Empowering ASEAN Health: The Strategic Role of Self-Care for a Sustainable Healthcare System* (2024).

84 Egypt, Universal Health Insurance Law No. 2 of 2018; P4H Network, "Country profile — Egypt", updated 2025. Available at https://p4h.world/en/countries/egypt/; World Health Organization, Regional Office for the Eastern Mediterranean, "Launch of the national guidelines programme of Egypt — 30 guidelines covering 15 health issues", 2024. Available at www.emro.who.int/media/news/regaional-director-address-on-the-launch-of-national-guidelines-for-egypt.html; and World Health Organization, *Country Cooperation Strategy for WHO and Egypt, 2024–2028*. Available at www.who.int/publications/i/item/9789292746926.

85 Mexico, National Health Compact (2025) and Servicio Universal de Salud, presidential decree (April 2026). Sources: Mexico UHC High-Level Forum, National Health Compact, Tokyo, December 2025. Available at https://thedocs.worldbank.org/en/doc/0273f33ab6ee48c5d842108b9b55c789-0140022025/related/Mexico-Compact-Final.pdf; NCD Alliance, "Mexico announces plan to achieve universal health coverage by 2027", 15 April 2026. Available at https://ncdalliance.org/stories/news-blogs/2026/mexico-announces-plan-to-achieve-universal-health-coverage-by-2027; Global Self-Care Federation, *Self-Care Readiness Index 2.0* (2022). Available at www.selfcarefederation.org/sites/default/files/2024-10/self-care-readiness-index-report-2022-05122022-v2.pdf; and Asociación Latinoamericana de Autocuidado Responsable (ILAR), *Self-care literacy survey: Mexico and Colombia* (2025). Available at https://static1.squarespace.com/static/6175aa74c8e33e3a7fd45f2f/t/68c871dcb9d593318a752a7e/1757966812110/Self+Care+Literacy+Executive+Summary+ILAR+2025+%281%29.pdf.

3.3 Stage 3 — Programmatic Scale With Emerging Evidence

Stage 3 countries have real programmes, real data and real impact, but programmes remain largely vertical or primary care-adjacent, and financing to sustain them is not yet fully secure. By Stage 3, countries typically demonstrate progress across a broader set of WHO enabling environment elements, including trained workforces, regulated products and interventions, delivery platforms and commodity access. What distinguishes them, however, is not simply the presence of these enabling conditions; but the fact that unlike earlier stages, self-care is operating at sufficient scale to generate evidence on implementation, access, health outcomes, equity and cost-effectiveness; although these programmes often remain concentrated within specific interventions, disease areas or delivery platforms rather than fully embedded within broader UHC financing and purchasing arrangements.

South Africa offers a Stage 3 example: HIV self-testing at scale, DMPA-SC and human papillomavirus (HPV) self-sampling provide documented access, equity and cost-effectiveness data (cost-effectiveness evidence is reviewed in Section 3). Yet South Africa's financing model for these programmes remains substantially dependent on the United States President's Emergency Plan for AIDS Relief and the Global Fund. The 2025 aid retrenchment has made this exposure acute.[86,87] South Africa illustrates another characteristic of Stage 3 maturity: the ability to generate and use implementation evidence. HIV self-testing, DMPA-SC and HPV self-sampling programmes have progressed beyond pilot adoption to generate evidence on access, equity, uptake and cost-effectiveness at scale. The result is not simply policy recognition, but a growing body of operational experience demonstrating how self-care can be delivered through routine health services and community-based platforms. Yet the continued dependence of many programmes on external financing highlights a defining feature of Stage 3: implementation capacity and evidence generation have advanced further than financing institutionalization.

Brazil's Estratégia Saúde da Família (Family Health Strategy) demonstrates domestically financed delivery at national scale, covering approximately 160 million people. Several WHO-aligned self-care interventions – including community-supported NCD self-management and free contraceptive provision – are already embedded in service delivery. However, the explicit self-care integration within strategic purchasing and benefit-package frameworks, conceptualized as stage four in this framework, remain absent.[88] The 2025 Self-Care Readiness Index similarly identifies Brazil as one of the more advanced self-care environments globally, citing widespread health-literacy initiatives, incorporation of self-care across multiple health policies, professional training programmes and evidence of substantial productivity and health-system benefits. Brazil's experience also demonstrates the interaction of several enabling environment elements identified in the WHO framework, including health literacy, workforce training, supportive policy environments and regulated access to self-care products.

India shows Stage 3 maturity across multiple self-care domains. For example, eSanjeevani, the national telemedicine platform, has logged over 340 million consultations nationwide, with peer-reviewed analysis confirming substantial use for diabetes and hypertension management; although the same study notes programmatic data can't yet establish unique users or patient-level outcomes, continuity of care or equity.[89] Separately, the Jan Aushadhi generic-medicine network, a government-subsidized franchise model, has grown from roughly 3,200 outlets in 2018 to over 20,000 today, with 2025 analysis[90] finding that most Jan Aushadhi generics meet the WHO/Health Action International affordability benchmark against branded equivalents, though some medicines remain financially burdensome even at generic prices. Both programmes rely on public financing, at national scale with

86 Lise Jamieson and others, "Correction: The cost effectiveness and optimal configuration of HIV self-test distribution in South Africa: a model analysis", *BMJ Global Health* (2023). Available at https://pmc.ncbi.nlm.nih.gov/articles/PMC10083760/.

87 Self-Care Trailblazer Group, *State of Self-Care Report 2025* (2025). Available at https://media.psi.org/wp-content/uploads/2025/10/31142827/State-of-Self-Care-Report-_-2025.pdf.

88 Commonwealth Fund, *Brazil's Family Health Strategy* (2016). Available at www.commonwealthfund.org/publications/case-study/2016/dec/brazils-family-health-strategy-using-community-health-care-workers; Ana Carolina Gomes Pinheiro and others, "Availability of emergency contraception in large Brazilian municipalities", *Frontiers in Pharmacology* (2023). Available at https://pmc.ncbi.nlm.nih.gov/articles/PMC10711045/; "Disruption and recovery of family planning services in Brazil", *Reproductive Health* (2025). Available at https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-025-02088-w; and Thais Moura Ribeiro do Valle Nascimento and others, "A pilot study of a community health agent-led type 2 diabetes self-management program using motivational interviewing-based approaches in a public primary care center in São Paulo, Brazil", *BMC Health Services Research* (2017). Available at www.ncbi.nlm.nih.gov/pmc/articles/PMC5237239/.

89 Sanjay Sood and others, "Adoption and utilization of India's eSanjeevani national telemedicine service", *Oxford Open Digital Health*, vol. 3 (2025).

90 Deepak Kumar Behera and others, "Medicine affordability and access in India: lessons from generic–branded price variation under the Jan Aushadhi Scheme", *Frontiers in Public Health*, vol. 13 (2025).

evidence behind them, yet neither sits within India's strategic purchasing architecture: Ayushman Bharat/PM-JAY (India's national public health insurance scheme providing free coverage for low-income earners) covers hospitalization not outpatient telemedicine or retail medicines. India thus shows the Stage 3 pattern – implementation and evidence outpacing financing institutionalization – holding across more than one intervention type at once.

These characteristics are consistent with a Stage 3 profile in which self-care is operating at scale and generating measurable outcomes, even if it has not yet been comprehensively integrated into strategic purchasing and financing arrangements.

Among high-income countries for comparison, England's National Health Service (NHS) 10-Year Health Plan (July 2025) includes an explicit commitment to embedding self-care across the health system, with seven of nine recommendations from a national self-care strategy blueprint incorporated into NHS primary care policy since 2023. Self-care is formally named as a strategic direction, but it is not yet operationalized as a reimbursed care category within NHS strategic purchasing.[91] As such, England demonstrates that even advanced health systems may stall along the spectrum. Self-care is now explicitly reflected within NHS strategic planning and primary care reform, yet remains only partially embedded within reimbursement and purchasing systems. This suggests that implementation at scale can proceed significantly ahead of financing integration.

Across these cases, a common pattern emerges. Unlike Stage 2 countries, where self-care remains primarily a policy aspiration or reform objective, Stage 3 countries are generating measurable implementation experience and outcomes. Self-care interventions are operating at sufficient scale to produce evidence on access, quality, cost-effectiveness, health outcomes or equity impacts. Yet these gains are frequently concentrated within disease-specific programmes, primary healthcare initiatives or donor-supported interventions rather than systematically embedded within strategic purchasing and domestic financing arrangements. This helps explain why relatively few countries have progressed toward Stage 4 integration.

3.4 Stage 4 — Systemic Integration

At Stage 4 of spectrum maturity, countries are envisioned to have fully integrated self-care into domestically financed UHC systems through regulation, monitoring, public reimbursement or benefit-package inclusion, and strategic purchasing. While many countries have established individual enabling conditions for self-care, Stage 4 is distinguished by their functioning as a coherent system in which financing, governance, workforce capacity, regulation, commodity access and accountability mechanisms are aligned and routinely support self-care delivery. The defining feature is not simply implementation at scale, but the institutionalization of self-care within the core architecture of UHC. It represents the point at which self-care interventions are no longer financed primarily through households or donors but are incorporated into routine financing arrangements, including public budgets and social insurance schemes, with clear accountability for coverage, quality and equity. Currently, this remains largely an aspirational stage in the spectrum, as few if any countries have achieved such integration comprehensively.

Thailand's Universal Coverage Scheme provides a close approximation to what this could look like in terms of UHC, having incorporated self-care modalities with domestic financing as the primary source, and zero co-payment sustained through strategic purchasing (evidenced as discussed in section 2).[92] Chile and Colombia have built Stage 4 elements for NCD self-management without yet extending them across the full self-care spectrum.[93] Among high-income countries, Germany's DiGA (Digitale Gesundheitsanwendungen, or Digital Health Applications) scheme illustrates Stage 4 maturity in digital self-care specifically – making prescribed digital therapeutics reimbursable under statutory health insurance for

91 NHS England and Department of Health and Social Care, *Fit for the Future: 10 Year Health Plan for England* (2025). Available at www.gov.uk/government/publications/10-year-health-plan-for-england; and Self Care Forum and Self-Care Strategy Group, *A Blueprint for a National Self-Care Strategy for England* (2023), incorporated into NHS England, *Delivery Plan for Recovering Access to Primary Care* (2023). Available at https://www.selfcareforum.org/2023/05/25/seven-of-the-nine-recommendations-from-the-self-care-strategy-groups-blueprint-published/.

92 Viroj Tangcharoensathien and others, "Financial risk protection of Thailand's universal health coverage: results from series of national household surveys between 1996 and 2015", *International Journal for Equity in Health* vol. 19, No. 1 (2020), p. 163. Available at https://link.springer.com/article/10.1186/s12939-020-01273-6.

93 Pan American Health Organization, *HEARTS in the Americas Technical Package* (2023). Available at www.paho.org/en/hearts-americas/hearts-americas-technical-package.

approximately 73 million insured people. It does not yet extend to the broader WHO self-care intervention.[94] Thailand's experience also illustrates how multiple enabling environment elements can reinforce one another. Domestic financing is complemented by strong primary care and community health infrastructure, trained health workers, regulated access to services and medicines, strategic purchasing and sustained investment in health promotion. The result is not simply financial protection, but a broader ecosystem through which self-care can be supported, monitored and scaled as part of routine service delivery.

The Stage 3-to-4 transition is structurally underdeveloped across health systems at every income level, not only in LMICs with the most persistent gaps in digital self-care governance and formal strategic purchasing articulation. The global health financing system has not yet developed the instruments, incentives or governance architecture to move countries reliably from Stage 3 to Stage 4.

3.5 Cross-Cutting Patterns and Financing Implications

Along the spectrum, several patterns recur consistently – distinct from what any individual country case shows, and not fully captured by the stage characterization alone.

Financing Is a High Hurdle in the Stage 2-to-3 Transition
Countries have largely demonstrated policy commitment, while sustainable domestic financing is less observed. Recent aid declines have exposed the vulnerability of donor-supported models and accelerated pressure for domestic financing solutions.[95] This is an acute pressure point in the current global self-care landscape – not because Stage 2 countries have failed, but because the financing environment has shifted faster than planning horizons anticipated or can adapt to. Recent findings from the Self-Care Readiness Index reinforce this conclusion. Across a diverse set of countries, self-care is increasingly reflected in policy commitments, health promotion efforts, stakeholder coalitions and disease-specific programmes. Yet far fewer examples demonstrate systematic integration into UHC benefits packages, strategic purchasing arrangements, domestic financing systems or accountability frameworks. The result is a growing gap between readiness and institutionalization where many countries appear increasingly prepared to expand self-care, while relatively few have yet embedded it within the financing architecture needed for sustained scale.

Other conceptualizations of self-care financing[96] suggest that the challenge is not simply mobilizing additional resources but designing sustainable financing arrangements. This includes distinguishing between funding sources (such as governments, donors, households, insurance or commercial markets), financing mechanisms (taxation, strategic purchasing, out-of-pocket, benefits packages), and delivery channels. Seen through this lens, many countries have established policies and programmes but lack clear means for moving self-care from donor-supported or household-financed to public-financed and strategically-purchased services.

Self-Care Policy Has Grown Faster in SRHR and HIV Than Across the Full WHO Guideline Scope
SRHR and HIV were the entry points for the WHO's initial 2019 guideline; expanded in 2022 to cover NCDs, chronic disease self-management, mental health and infectious disease more broadly. The policy landscape has not yet caught up. Early movers and adoption in these spaces created a more robust evidence base. Digital self-care is expanding the frontier faster still in some settings – though in many cases governance and regulatory frameworks are lagging behind adoption, creating liabilities that are not yet visible but that experience in other digital health domains suggests will emerge.[97]

Self-Care Strategy Is More Likely To Be Dispersed Than Stand-Alone
Across countries, self-care is more commonly dispersed through vertical, disease-specific programmes or service guidelines, and primary care reforms than through dedicated and holistic national self-care strategies. While this can support or facilitate implementation, it also makes

94 Germany, Federal Institute for Drugs and Medical Devices (BfArM), "DiGA — digital health applications: listed DiGAs", 2025; as of late 2025, 56 DiGAs were listed (48 permanently, 9 provisionally). See www.bfarm.de/EN/Medical-devices/Tasks/DiGA-and-DiPA/DiGA/_node.html. See also Germany, Federal Ministry of Health, *Digital Care Act (Digitale-Versorgung-Gesetz, DVG)*, establishing the DiGA fast-track pathway. Available at www.bundesgesundheitsministerium.de/en/press/2019/digitale-versorgung-gesetz.html.

95 Geneva Health Files, "Impacts of the 2025 funding cuts on global health programs" (2026).

96 Self-Care Trailblazer Group, *A Conceptual Framework for Costing and Financing Self-Care Interventions in Low- and Middle-Income Countries* (Washington, D.C., Population Services International, 2023). Available at www.psi.org/wp-content/uploads/2023/10/Costing-and-Financing-Conceptual-Framework-V212.pdf.

97 World Health Organization, *Global Strategy on Digital Health 2020–2025* (Geneva, 2021). Available at www.who.int/docs/default-source/documents/gs4dhdaa2a9f352b0445bafbc79ca799dce4d.pdf.

self-care difficult to finance, monitor and account for within domestic planning and UHC reporting systems.[98]

A Financing Architecture That Could Help Address These Gaps Exists, but Not Generally Applied to Self-Care

Integrated National Financing Frameworks (INFFs), now used in 86 countries, provide a potentially important mechanism for closing these gaps by linking health priorities to medium-term fiscal planning and engaging finance ministries directly in health financing decisions; with existing technical guidance identifying health system coherence as a potential INFF objective.[99] Indonesia's 2022 INFF Assessment, which identified health as an investment opportunity area, demonstrates how self-care financing could potentially be incorporated into broader domestic resource mobilization strategies.[100]

Across all four stages, a consistent pattern emerges: normative adoption has advanced faster than financing integration. Countries are increasingly recognizing self-care in policy and, in some cases, delivering it at scale. Yet financing, strategic purchasing and accountability mechanisms have lagged behind. The central challenge is therefore no longer whether self-care should be part of UHC systems, but how countries and financing institutions can close the gap between policy commitment and sustainable implementation.

Box 3: Digital Self-Care — Scale, Equity and Data Governance

Remote monitoring, AI-assisted triage and app-based self-management are powerful tools for reaching people that facility-based systems never will.[101] But the digital divide threatens to exclude the very populations self-care is meant to reach – low-income and remote populations and those without smartphones or reliable connectivity. LMICs also face genuine data sovereignty concerns: sensitive health information generated by digital self-care platforms is often managed by private or foreign entities, with limited national oversight. The WHO Global Strategy on Digital Health provides the normative anchor for data governance, interoperability and equity and baseline for governments advancing policy, regulation or data agreements.

Box 4: Self-Care in Fragile, Humanitarian and Climate-Affected Settings

When health facilities are damaged, overwhelmed or unreachable – through conflict, climate shocks or pandemics – self-care becomes not a complement to facility-based systems but a lifeline in their absence. The WHO's 2022 self-care guideline recognizes this directly: a dedicated good practice statement calls for tailored, timely support for self-care interventions, including for SRHR, to form part of emergency preparedness plans and ongoing humanitarian response.[102] Experience from fragile and crisis-affected contexts shows that self-care can maintain continuity for HIV testing, contraception, chronic disease management and mental health support when conventional delivery chains have broken down. As climate-related health shocks increase in frequency and severity, facility-independent care options become structurally more important – not just in emergencies, but as a permanent feature of resilient health system design. This dimension of self-care aligns directly with the Compromiso de Sevilla's emphasis on resilience and the adaptation of public services to compounding shocks and vulnerabilities.

98 World Health Organization and World Bank, *2025 Global Monitoring Report on UHC* (2025). Available at www.worldbank.org/en/topic/universalhealthcoverage/publication/2025-global-monitoring-report-gmr.

99 United Nations Development Programme, INFF Facility, *Making Finance Work for People and Planet: How Countries Are Building Their Sustainable Finance Ecosystem through Integrated National Financing Frameworks* (2024). Available at www.undp.org/publications/making-finance-work-people-and-planet-how-countries-are-building-their-sustainable-finance-ecosystem-through-integrated-national; and United Nations Development Programme, INFF Facility, "INFFs and health finance", technical guidance note, 15 May 2023. Available at https://sdgfinance.undp.org/sites/default/files/2024-08/inffs-and-health-finance.pdf.

100 Indonesia, Ministry of National Development Planning (BAPPENAS) and United Nations Development Programme, *Indonesia's Integrated National Financing Framework (INFF) Assessment 2022* (2022). Available at https://inff.org/resource/indonesias-integrated-national-financing-framework-inff-assessment-2022. The UNDP SDG Investor Maps for Nigeria and Ghana – a related but distinct market-intelligence instrument, not the countries' INFF assessments themselves – include health care as an investment opportunity area (15 of 113 across 7 completed sub-Saharan Africa SDG Investor Maps: Ghana, Kenya, Namibia, Nigeria, Rwanda, South Africa and Uganda).

101 World Health Organization, *Global Strategy on Digital Health 2020–2025* (2021).

102 World Health Organization, "Implementation Considerations and Good Practice Statements on Self-Care", *Consolidated Guideline on Self-Care Interventions for Health and Well-being* (WHO, 2022). Available at www.ncbi.nlm.nih.gov/books/NBK544149/.

4. What Can Go Wrong — and How To Prevent It

The economic and health case for self-care is strong, but benefits are not automatic. Analysis and experience demonstrate that poorly designed self-care systems can create new risks, particularly when financing, regulation, implementation capacity or equity safeguards lag behind programme expansion. These risks are not arguments against self-care; they identify the conditions under which self-care can better contribute to UHC, financial protection and more equitable health outcomes.

4.1 The Privatization Risk: When Self-Care Becomes a Cost Transfer

A primary risk is that self-care is deployed as a rationale for reducing public health financing, shifting costs from government budgets to households. While the discussion in section 2.2 reveals evidence that publicly-financed, incentivized and regulated self-care can reduce out-of-pocket expenditure, the unsubsidized liberalization of self-care markets without appropriate financing or targeted affordability measures can mitigate that benefit or even have the opposite effect on families' costs. In LMICs especially, studies show households already pay more for healthcare than governments and donors combined.[103] Any self-care policy that expands individual responsibility without expanding financial protection or affordability risks shifting costs rather than reducing them – transferring a fiscal burden from public budgets to households, often those least able to absorb it. As one leading researcher cautioned, the cost-shifting concern is real. For many people, especially informal workers, the true cost of seeking facility-based care is higher still: they face long waits, or cannot get care at all, so self-care is often the first and only realistic option. The task is to make it work responsibly, with safeguards and investment in health literacy and education, rather than to avoid it.[104]

4.2 The Implementation Risk: Policies Without Delivery

Policies do not implement themselves. Even where regulations permit, encourage or finance WHO-recommended self-care interventions, access is frequently constrained by infrastructure deficits, supply-chain failures, health literacy gaps, inadequate user training, inconsistent governance and legal ambiguity. The result is a recurrent implementation gap between formal policy adoption and real-world access. Experience in East Africa[105] demonstrates that permission alone is insufficient. Self-care products may be legally available yet remain difficult to obtain or use safely in practice, particularly in underserved settings. Medical abortion illustrates the broader challenge: legal authorization does not automatically translate into access when stigma, provider uncertainty, weak referral systems or limited counselling infrastructure persist. Such legal grey area can suppress both supply and demand simultaneously. Illustrating the supply chain governance risk, the market for mifepristone and misoprostol in Nigeria operates substantially outside quality-assured channels – products therefore reach people through informal pathways where safety, correct dosage and follow-up care cannot be guaranteed.

4.3 The Safety Risk: Advancing Regulation That Keeps Pace With Delivery and Expands Access

While self-care can improve access and efficiency, rapid expansion without corresponding regulatory capacity can create new safety risks. Regulation could also be seen as an enabler of access, not only as a mechanism of control. Risk-based regulatory approaches, prescription to over-the-counter switch pathways, clear labelling, pharmacovigilance, referral systems and regulatory reliance can increase access while safeguarding quality, safety and public trust.[106] Governance must scale alongside delivery, not after it. HIV self-testing demonstrates this principle. The success of HIV self-testing depended not only on the availability of tests but also on quality assurance, user support, linkage-to-care systems, post-market monitoring and regulatory oversight.[107] Programme scale and regulatory stewardship evolved together. The same principle applies across self-care interventions, particularly as digital health tools become increasingly prominent. Sensitive health data are frequently controlled by private or

103 World Health Organization, *Global Health Expenditure Report 2024* (2024).
104 Key informant interview, conducted via Microsoft Teams, 1 June 2026.
105 Austen El-Osta and others, *Policy Mapping*.
106 World Health Organization, "Good reliance practices in the regulation of medical products: high-level principles and considerations", WHO Technical Report Series No. 1033, Annex 10 (Geneva, 2016). Available at https://www.who.int/publications/m/item/annex-10-trs-1033.
107 World Health Organization, *Guidelines on HIV Self-Testing and Partner Notification: Supplement to Consolidated Guidelines on HIV Testing Services* (Geneva, 2016). Available at www.who.int/publications/i/item/9789241549868.

foreign actors, leaving many LMIC governments with limited visibility or control.[108] Data sovereignty is therefore not only a governance concern but also a public health safety issue that should be addressed before scale, not after a breach.[109] The policy lesson is not to delay self-care innovation and adoption, but to finance the regulatory and stewardship functions that make innovation safe and sustainable.

4.4 The Exclusion Risk: Designing for the People Most Left Behind

Self-care can expand access (as discussed in section 2.3), but poorly designed self-care systems can reproduce or deepen existing inequalities. The same interventions that increase convenience for some populations may create new barriers for others. Gender norms, literacy requirements, smartphone dependence, digital connectivity, disability status, language barriers and geographic isolation all influence who is able to benefit from self-care interventions.[110] These factors are not peripheral design considerations; they determine whether self-care reduces inequities or reinforces them. Equity therefore requires deliberate design choices, including integration into UHC benefits packages with minimal user charges, investment in health literacy and community support systems, strong referral pathways and context-specific approaches that reflect the needs of populations with the greatest barriers to care. Inclusion is not an automatic outcome of self-care; it is a policy choice.[111]

5. What Needs to Happen: Policy Recommendations for Realizing the Returns to Self-Care

The evidence reviewed in this paper points to three mutually-reinforcing pathways through which self-care contributes to UHC and sustainable development: improved health system efficiency, stronger household financial protection, and long-term economic productivity. Realizing these benefits, however, is not automatic. The policy landscape analysis demonstrates that while normative adoption has advanced rapidly, financing integration and institutionalization have lagged behind. The central challenge goes beyond establishing the value of self-care, to financing, embedding and governing it at scale. To this end, one health diplomat shared that there has not been an effort to schematically quantify the financing benefit of self-care, which will be difficult given data gaps and policy issues. Without it, though, prioritization of self-care will be difficult.[112]

The recommendations below are therefore organized around three objectives derived from the analysis in this brief; functions that countries typically need to strengthen as they progress along the self-care financing-systems-policy spectrum. The first is to finance self-care as a mechanism for generating efficiency gains, reducing out-of-pocket spending and supporting domestic resource mobilization. The second is to institutionalize self-care within UHC systems through benefits packages, strategic purchasing and delivery reforms. The third is to strengthen governance, measurement and accountability so that self-care can be tracked, financed and sustained as a core component of health systems rather than remaining fragmented across programmes and policy documents. While countries may be at different starting points and progress non-linear, the analysis in section 3 suggests these three functions repeatedly emerge as key to advancing from policy commitment to sustainable implementation and integration.

The relative priority of these recommendations will differ depending on country context and maturity. Applying a spectrum view, countries at earlier stages, for example, may focus primarily on policy recognition, costing and financing strategies; while countries with more established programmes may place greater emphasis on institutionalization, scale purchasing, accountability and long-term sustainability. The recommendations should therefore be viewed as a menu of actions rather than a sequential roadmap.

108 A. Ferretti, E. Ronchi and E. Vayena, "From principles to practice: benchmarking government guidance on health apps", *The Lancet Digital Health*, vol. 1, No. 2 (2019).

109 World Health Organization, *Global Strategy on Digital Health 2020–2025* (2021).

110 Taim Akhal and others, "Self-management interventions for common long-term conditions in low- and middle-income countries", *Journal of Global Health*, vol. 15 (2025); see footnote 53. Available at https://jogh.org/2025/jogh-15-04148.

111 World Bank, *Unlocking the Power of Healthy Longevity* (2024). Available at www.worldbank.org/en/topic/health/publication/unlocking-power-healthy-longevity.

112 Key informant interview, conducted via Microsoft Teams, 29 May 2026.

5.1 Finance Self-Care

A critical step toward realizing the efficiency, financial protection and productivity gains associated with self-care is financing it. Sustainable scale-up requires self-care to move from a health-sector intervention to a recognized investment within national budgeting, domestic resource mobilization and development financing processes. Advancing self-care requires investment in the short term for longer-term investment, as one leading public health development NGO researcher and practitioner noted.[113]

Ministries of finance (working with ministries of health and national planning authorities)

- Recognize self-care as a health system efficiency, financial protection and human capital investment within national development plans, fiscal strategies, health financing frameworks, INFF processes and digital strategies.
- Incorporate self-care into public expenditure reviews, medium-term expenditure frameworks and domestic resource mobilization strategies, reflecting its potential contributions to efficiency, financial protection, labour force participation and productivity.
- Develop financing pathways (including public-private partnerships) that clarify the respective roles of public budgets and other actors in sustaining self-care delivery over time, with clear financing milestones, transition plans and accountability arrangements.

Ministries of health

- Conduct costing, investment and fiscal space analyses for priority self-care interventions to inform budget negotiations, financing decisions and benefits-package design.
- Identify opportunities where self-care (including community-based) can safely deliver equivalent or improved outcomes at lower cost than conventional facility-based models.
- Generate and present evidence on the efficiency, financial protection and productivity impacts of self-care to support integration into national financing strategies.

Multilateral development banks and development finance institutions

- Support countries that have adopted self-care policies but lack the financing, infrastructure (including digital), regulatory capacity or implementation support needed to achieve scale.
- Integrate self-care into primary health care reform, health-system strengthening, health supply chain and domestic resource mobilization initiatives.
- Support country-based data gathering and independent empirical analyses.
- Develop financing instruments that support both service-delivery expansion and the institutional reforms required for long-term sustainability; including public-private partnerships.

Vertical health financing initiatives

- Position self-care as a sustainability and transition strategy, using successful disease-specific interventions – particularly in HIV, SRHR, tubercolosis and chronic disease management – as entry points for application to other conditions, broader health system integration and domestic financing.
- Incentivize explicit plans for integrating proven self-care interventions into national financing arrangements, health benefits packages and routine service delivery systems.

5.2 Institutionalize Self-Care

Financing alone is insufficient. Many countries have established policy commitments but have not yet translated them into routine service delivery. Institutionalization requires moving self-care beyond policy recognition and embedding it within UHC benefit packages, strategic purchasing arrangements, delivery systems and regulatory frameworks.

Ministries of health

- Integrate WHO-recommended self-care interventions into national UHC strategies, benefits packages and primary health care reforms, including consideration of whether self-care activities currently dispersed across disease-specific programmes, derive guidelines and primary care initiatives should be applied to other conditions or consolidated within a national self-care strategy.
- Establish reimbursement and procurement arrangements for self-care interventions, products or services that demonstrate safety, effectiveness and value for money.
- Strengthen regulatory, quality assurance, supply-chain and delivery systems so that expansion of self-care improves access, safety and equity simultaneously.
- Expand CHW, pharmacy and digital-based delivery models, including in partnership with the private sector where evidence demonstrates improvements in access, efficiency and financial protection.

113 Key informant interview, conducted via Microsoft Teams, 27 July 2026.

- Assess opportunities for integration within publicly-financed UHC arrangements to strengthen equity, quality assurance and financial protection, where self-care is already occurring at scale informally.

WHO
- Work with Member States and UHC partners in preparation for the 2027 UN High-Level Meeting on Universal Health Coverage to ensure self-care is explicitly reflected in UHC political commitments, accountability frameworks and implementation guidance as a mechanism for advancing coverage, financial protection, health system efficiency and equity.
- Work with Member States, United Nations Secretariat and other stakeholders to advocate for self-care to be included in the post-2030, post-SDG agenda; the process for which formally begins at the 2027 High Level Political Forum on Sustainable Development.
- Support countries in translating the WHO Self-Care Guideline into UHC benefit packages, reimbursement arrangements, strategic purchasing mechanisms and primary health care reforms.
- Promote self-care as a practical mechanism for advancing UHC, financial protection, efficiency and health equity through country, regional and global policy processes.
- Support countries considering national self-care strategies and provide technical guidance on financing, implementation and integration.
- Ensure self-care is included in relevant World Health Assembly resolutions; explore advancing a stand-alone resolution on self-care.
- Increase engagement and create structured dialogue with key private sector stakeholders, including pharmacists, insurers and manufacturers.

Multilateral development banks and development finance institutions
- Support the infrastructure required for scale, including CHWs, pharmacies, digital platforms, supply chains and regulatory systems, rather than financing products alone.
- Ensure self-care is incorporated into broader health-sector modernization and primary care transformation programmes.
- Include self-care entrepreneurs and workers in jobs and skills projects and small business financing and supply chain initiatives; including, for example, in the World Bank's "Health Works" initiative.
- Support countries in developing strategic purchasing arrangements and translating policy commitments into operational delivery systems capable of generating sustained implementation and outcome evidence.

Vertical health financing initiatives
- Incorporate self-care integration requirements into programme design, implementation and sustainability planning.
- Support the transition of proven self-care interventions from externally supported pilots to routinely financed services delivered through domestic systems.
- Align programme reporting and service-delivery indicators with national UHC monitoring frameworks to avoid reinforcing disease-specific silos.

5.3 Govern, Measure and Sustain Self-Care

Self-care often remains difficult to finance and scale because it is poorly measured and frequently dispersed across programmes, guidelines and disease-specific initiatives. Sustainable integration requires governance, accountability and monitoring systems that make self-care visible within UHC frameworks, financing decisions and national development planning.

WHO
- Make self-care visible within UHC monitoring frameworks by tracking coverage, financing, equity and financial protection outcomes.
- Develop a monitoring and evaluation framework, including baseline indicators, to monitor progress; expand global policy and implementation tracking beyond SRHR and HIV to encompass the full range of WHO-recommended self-care interventions, including NCDs, mental health and digital self-care.
- Develop standardized guidance on measurement, costing, reimbursement and strategic purchasing of self-care interventions.
- Use the Economics of Health for All Strategy as a platform for embedding self-care within broader economic and development policy discussions.
- Host a learning platform to share best practices and lessons learned within and across countries and regions; establish a research and evidence agenda that includes and collaborates with key private sector stakeholders, including pharmacists, insurers and manufacturers.

United Nations financing for development system
- Incorporate self-care as a practical delivery-efficiency and financial protection mechanism within financing for development follow-up processes.
- Support development of health-specific INFF guidance linking health outcomes, domestic resource mobilization, fiscal planning and national development strategies.
- Convene ministries of finance and ministries of health jointly around delivery efficiency, prevention and sustainable health financing.

- Develop learning platforms and case studies documenting successful financing transitions from policy adoption to scaled implementation.

National governments (including ministries of health, finance and development planning)

- Track self-care financing, coverage, quality, equity and outcomes through national health accounts and routine monitoring systems, using the resulting evidence to inform budgeting, health planning, strategic purchasing and benefits-package decisions.
- Treat implementation learning as a policy and financing function rather than solely a research activity, ensuring programmes generate evidence that can guide future investment and reform decisions.

Development partners, multilateral development banks and development finance institutions

- Support countries in developing self-care monitoring, evaluation and learning systems.
- Promote common metrics and reporting standards that improve comparability and cross-country learning.
- Invest in implementation learning around financing transitions, strategic purchasing, digital governance, equity outcomes and long-term economic returns.

6. Conclusions and Way Forward

A reframing of the self-care policy and financing debate is warranted. Under current fiscal trajectories, the efficiency, financial protection and productivity gains associated with appropriately financed, regulated, incentivized and supported self-care are not supplementary to UHC strategy; they are increasingly central to it. As external financing contracts and domestic fiscal pressures intensify, self-care represents one of the more promising approaches capable of simultaneously reducing the cost and increasing the efficiency of service delivery, strengthening household financial protection and supporting broader economic participation and growth. These effects and outcomes operate through different mechanisms, but they reinforce one another.

The current policy environment creates a genuine window of opportunity. The Compromiso de Sevilla calls for more efficient and sustainable use of public resources, while the 2027 UHC accountability milestone creates a clear horizon for demonstrating results. The onset of the post-2030 Agenda process in 2027 provides another political moment and the emergence of the WHO Economics of Health For All strategy offers further grounding. Together, they provide both a financing rationale and a policy imperative for integrating self-care more systematically into health systems.

The evidence reviewed in this brief suggests that the central challenge is no longer whether self-care should be part of UHC systems, but how countries can incentivize, enable, finance, regulate and institutionalize it at scale. The policy maturity spectrum illustrates where progress is occurring and where bottlenecks remain. While normative adoption has accelerated, financing integration, strategic purchasing and accountability mechanisms have lagged behind. No country has yet been observed to have achieved comprehensive Stage 4 integration as conceptualized, and the transition from policy commitment to sustainable financing surfaces as a principal constraint across many settings.

Three priorities emerge. First, self-care should be embedded within UHC financing and governance frameworks, including benefit packages, strategic procurement or purchasing arrangements, and regulatory systems. Second, governments and partners should finance and support the enabling conditions necessary for integration, beneficial switch and equitable access, including independent evaluation and periodic verification, health literacy, community-based delivery systems and digital governance. Third, domestic and international financing should be aligned around delivery reform, ensuring that both public resources and development assistance, including philanthropic capital, support long-term system transformation rather than temporary programme expansion.

Important evidence gaps remain, particularly around economic evaluation in low-income settings, financing transitions from Stage 2 to Stage 3, the implementation of national self-care strategies, the care-economy impacts of self-care investments, and effective governance approaches for digital self-care. These may be less academic questions than policy and implementation questions. They can – and should – be answered through the routine monitoring, evaluation and financing decisions that countries, multilateral institutions and development finance partners are already making. At the same time, this analysis exposes the need for deeper technical, academic and policy evidence of self-care applications beyond SRHR, including, for example, mental health, chronic disease management or NCDs. The task now is not to establish whether self-care matters, but to translate growing evidence and policy momentum into financed, equitable and sustainable delivery systems.

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