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Self-care competency framework

Volume 1. Global competency standards for health and care workers to support people's self-care

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Preface

All people have the fundamental right to the enjoyment of the highest attainable standard of health. Yet at the midpoint of the agenda for the Sustainable Development Goals, billions of people lack access to essential health services. There are about 90 million displaced persons and a perennial shortage of health workers in countries at all levels of socioeconomic development. There is a dire need for innovative strategies for health systems to address this challenge. Improving access to self-care interventions is one strategy to enable people to have a more engaged role in managing their own health, with the supervision of a health or care worker.

The *WHO guideline on self-care interventions for health and well-being* outlines the critical pathway that self-care interventions provide to reach universal health coverage. Self-care interventions span the spectrum of health promotion, diagnostics, disease and injury prevention, management and care. In many cases, self-care interventions can be safely administered to improve the management of one's own health with the support or supervision of a trained health worker.

This publication consolidates the evidence base and translates the *WHO guideline on self-care interventions for health and well-being* into the *Self-care competency framework*, published in three parts:

Volume 1

The **competency standards** define the competencies of health and care workers – and the specific behaviours that demonstrate them – for providing self-care in their practice. They focus on holistic health care, human rights, ethical practice, care through the life course and gender equity. They are framed by an ethos of social and professional accountability to improve health care for all. They serve as a standard for how health and care workers can support people with their self-care.

Volume 2

The **knowledge guide** describes how health and care workers can apply the competency standards to their practice, detailing the necessary knowledge, skills and attitudes that underpin these behaviours.

Volume 3

The **curriculum guide** is to be used by educational institutions and curriculum developers to develop competency-based education and training for health and care workers, including reflection on their personal conduct, so they can effectively support people's self-care.

The *Self-care competency framework* has been jointly developed by the World Health Organization (WHO) Department of Sexual and Reproductive Health and Research and the WHO Health Workforce Department to guide the development of health worker education programmes in national settings. It is intended to enable health and care workers to develop the competencies to support individuals, families and communities in making evidence-based decisions and taking action to manage their own health and the health of those in their care.

The *Self-care competency framework* clarifies the role of the health system, health-care facilities and health and care workers in supporting and supervising self-care interventions for health and well-being, and guides curriculum developers to update and integrate the competency standards into their educational curricula. This can lead to establishing appropriate strategies and tools to support people's self-care throughout life, leading to better health outcomes. We invite countries, health and care worker education institutions and employers to integrate these standards into education and practice, and to support and invest in a health and care workforce that is competent to provide people-centred, quality, evidence-based health services, including a focus on communication, collaboration and support for decision-making relevant to the use of self-care interventions, on the path towards universal health coverage.

Pascale Allotey, Director, WHO Department of Sexual and Reproductive Health and Research (SRH), including the UNDP-UNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP)

Pascale Allotey

James Campbell, Director of WHO Health Workforce Department (HWF)

James Campbell

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Glossary

This glossary includes terms used in this set of competency standards, drawing on the WHO *Global competency framework for universal health coverage (1)*. Where existing definitions have been adopted, the source is cited.

Agency	The power and autonomy people have to think and act for themselves. Agency can take individual and collective forms *(1)*.
Behaviour	Observable conduct towards other people or tasks that expresses a competency. Behaviours are measurable in the performance of tasks *(1)*.
Caregiver	A person entrusted with the care of a person with an illness or disability, a child, or a person with diminished decision-making capacity. Caregivers may be family members, volunteers or paid workers.
Care worker	Care workers provide direct personal care services in the home, in health-care and residential settings, assisting with routine tasks of daily life, and performing a variety of other tasks of a simple and routine nature *(2)*.
Collaborative practice	A process by which multiple health workers from different professional backgrounds work together with individuals, caregivers, families and communities to deliver the highest quality of care *(3)*.
Community health workers	A cadre of community members trained to provide specific health services within their community to meet unmet health needs, improve access to services, address inequities in health status, and improve the efficiency and performance of the health system *(4)*. Community health workers work to meet the immediate needs of individuals at the interface between the health sector and the community.
Community services	Community services offer support to the public, which may be related to housing, employment, recreation, legal aid and other welfare matters. The help may be information, advice, practical help, financial help or a combination of services *(5).*
Community worker	A person who facilitates community development initiatives and collective solutions within a community to address issues, needs and problems associated with recreational, health, housing, employment and other welfare matters *(6).*
Competence	The state of proficiency of a person to perform the required practice activities to the defined standard. This incorporates having the requisite competencies to do this in a given context. Competence is multidimensional and dynamic. It changes with time, experience and setting *(1)*.
Competencies	The abilities of a person to integrate knowledge, skills and attitudes in their performance of tasks in a given context. Competencies are durable, trainable and, through the expression of behaviours, measurable *(1)*.
Competency framework	An organized and structured representation of a set of interrelated and purposeful competencies *(7)*.
Continuum of care	The coordination of health and social sectors through effective governance, seamless transition across care settings from home to secondary to tertiary care, and coordinated provision of different roles *(8)*. For self-care, the continuum of care refers to the transitions in and out of various health-care sectors for long-term chronic illnesses, in which the individual finds themselves scaling up and scaling down the contribution of self-care to their diseases.

Curriculum	The totality of organized educational activities and environments that are designed to achieve specific learning goals. The curriculum encompasses the content of learning; the organization and sequencing of content; the learning experiences; teaching methods; the formats of assessment; and quality improvement and programmatic evaluation *(9).*
Decision-making capacity	An individual's capacity to make decisions about their own life and well-being. Decision-making capacity is decision- and context-dependent, and may fluctuate *(10).*
Dignity	Dignity is an inherent, absolute state for all humans reflecting their intrinsic worth *(11).* To treat someone with dignity is to treat them as being of worth, in a way that is respectful of them as valued individual *(12).*
Discrimination	Any distinction, exclusion, restriction or preference or other differential treatment that is directly or indirectly based on the prohibited grounds of discrimination and which has the intention or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of Covenant rights. Discrimination also includes incitement to discriminate and harassment *(13).*
Disinformation	Information that is false and deliberately created to harm a person, social group, organization or country *(14).*
Domain	A broad, distinguishable area of content; domains, in aggregate, constitute a general descriptive framework *(7).*
Evidence-informed practice	The integration of the best available evidence with the knowledge and considered judgements from stakeholders and experts to benefit the needs of a population *(15).*
Health	Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity *(16).*
Health literacy	The personal knowledge and competencies (mediated by organizational structures and availability of resources) that enable people to access, understand, appraise and use information and services to promote and maintain good health and well-being for themselves and those around them *(17).* Health literacy encompasses health systems literacy as well as functional literacy and numeracy.
Health literacy environment	The infrastructure, policies, processes, materials, people and relationships that make up the health system and have an impact on the way that people access, understand, appraise and apply health-related information and services *(18)*.
Health misinformation	A health-related claim that is false based on current evidence, and which is spread without intent to formally mislead, by error or mistake *(19).*
Health service manager	Health service managers plan, direct, coordinate, monitor and evaluate the provision of clinical and community health care services in hospitals, clinics, public health agencies and similar organizations *(2).*
Health worker	Any person engaged in actions whose primary intent is to enhance health *(20).*
Holistic health care	Health care that focuses on a person's experience of illness, and takes into consideration the cultural, psychosocial and environmental determinants of health and well-being *(21).*
Misinformation	Information that is false, but not created with the intention of causing harm *(18).*
Peer support	An organized strategy for exchanging knowledge, social, emotional and practical help among people who share experiential, demographic or occupational characteristics *(22).*

People-centredness	One of the essential characteristics or key features of good-quality care. Care that is organized in accordance with the comprehensive needs of people rather than individual diseases and respects social preferences. People-centred care also requires that patients have the education and support they need to make decisions and participate in their own care and that caregivers are able to attain maximal function within a supportive working environment. People-centred care is broader than patient- and person-centred care, encompassing not only clinical encounters, but also including attention to the health of people in their communities and their crucial role in shaping health policy and health services *(23).*
Reflective learning	A process of learning through conscious reflection on experiences and knowledge *(24).*
Self-awareness	The ability of individuals, families and communities to promote their health and self-efficacy through self-regulation, self-education and self-determination *(25).*
Self-care	The ability of individuals, families and communities to promote health, prevent disease, maintain health, and to cope with illness and disability with or without the support of a health worker *(25).*
Self-care interventions	Tools that support self-care. Self-care interventions include evidence-based, good-quality medicines, devices, diagnostics and/or digital technologies which can be provided fully or partially outside of formal health services and can be used with or without the support of a health worker *(25).*
Self-efficacy	An individual's belief in his or her capacity to execute behaviours necessary to produce specific performance attainment *(26).*
Self-management	The ability to use devices, medicines and knowledge to undertake self-medication, self-treatment, self-examination, self-injection *(25).*
Self-testing	The ability to use devices and knowledge to undertake self-testing, self-sampling, self-monitoring and self-diagnosis *(25).*
Shared decision-making	The joint process in which a health worker collaborates with a person to reach a decision about care. It may involve choosing tests and treatments based both on evidence and on the person's individual preferences, beliefs and values. It makes sure the person understands the risks, benefits and possible consequences of different options through discussion and information sharing *(27)*.
Skill	A specific cognitive or motor ability that is typically developed through training and practice, and is not context specific *(1).*
Standard	The level of required proficiency *(1).*
Substitute decision-maker	A person who is nominated by the individual to support them in making decisions in situations where their capacity is impaired to make a particular decision *(28).*

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The self-care competency framework: at a glance

The *Self-care competency framework,* jointly developed by the WHO Department of Sexual and Reproductive Health and Research and the Health Workforce Department, aims to guide health worker education programmes. It enables health and care workers to develop the competencies necessary for supporting individuals, families and communities in making evidence-based decisions and taking action to manage their own health and the health of those they care for.

The framework comprises three separate, but interlinked documents:

Volume 1 **Global competency standards** for health and care workers to support people's self-care

Volume 2 **Knowledge guide** for health and care workers to support people's self-care

Volume 3 **Curriculum guide** for health and care workers to support people's self-care

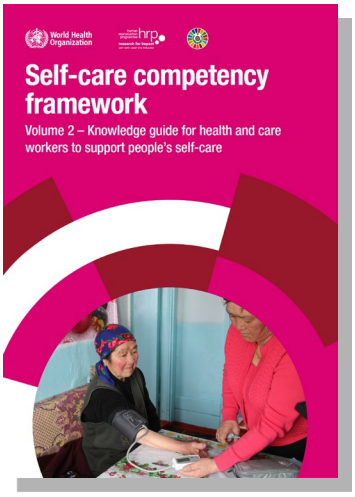
Volume 1

Defines the competencies of health and care workers (including specific behaviours) for providing self-care.

- Focuses on holistic health care, human rights, ethical practice, care through the life course and gender equity.
- Framed by an ethos of social and professional accountability to improve health care for all.
- Serves as a standard for how health and care workers can support people with their self-care.

Applied to:

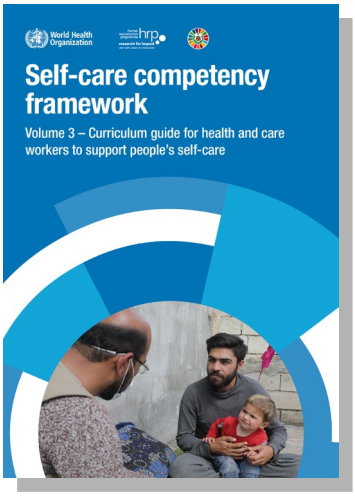
Volume 2



Describes how health and care workers can apply the competency standards to their practice.

Details the necessary knowledge, skills and attitudes that underpin these behaviours.

Volume 3



A resource for educational institutions and curriculum developers to develop competency-based education and training for health and care workers.

Includes reflection on their personal conduct, so they can effectively support people's self-care.

Links to:


Erasmus MC
Erasmus MC

Chapter 1. Introduction

Self-care is the ability of individuals, families and communities to promote health, prevent disease, maintain health, and to cope with illness and disability. Self-care complements, supplements and extends traditional health care in the health-care facility. Achieving universal health coverage (UHC) for all requires strong health systems, with a competent health workforce supporting individuals, families and communities to undertake self-care. While self-care can be undertaken independent of a health or care worker, for many self-care interventions, the support of health or care workers will be needed to facilitate effective self-care.

The competency standards for health and care workers to support people's self-care (hereafter referred to as the competency standards) are designed to outline the minimum behaviour standards and evidence-based clinical standards for health workers to support people's ability to undertake self-care. There are 10 competency standards, which are structured within six domains, aligning with the structure of the *WHO Global competency framework for universal health coverage (1)*.

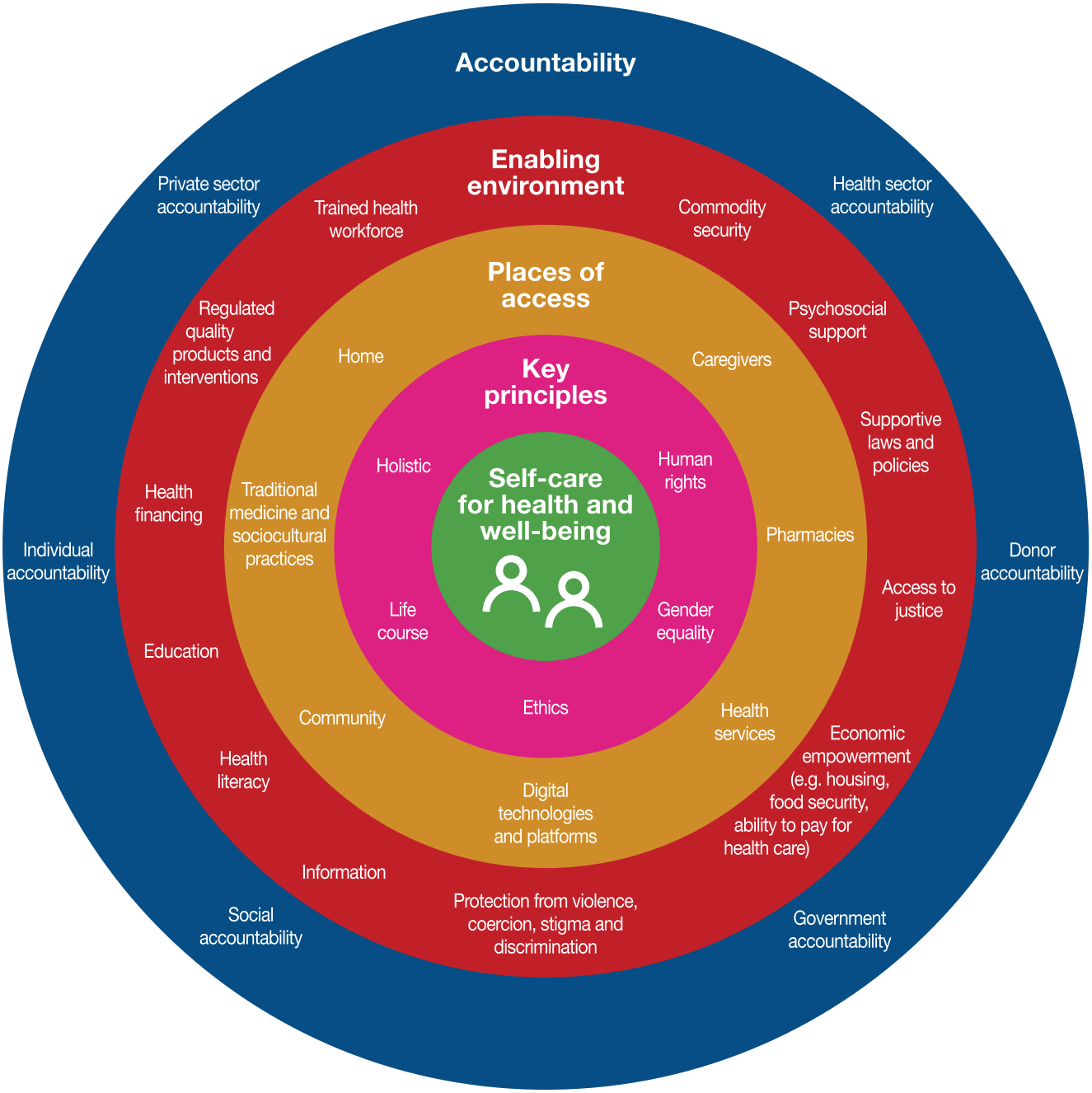
Principles and conceptual framework

The competency standards are based on the conceptual framework (Fig. 1) of the *WHO guideline on self-care interventions for health and well-being (2)*. They focus on holistic health care, human rights, ethical practice, care through the life course and gender equity. The competency standards are framed by an ethos of social and professional accountability by health and care workers to improve health care for all.

Self-care interventions can be classified as self-management, self-testing and self-awareness as elaborated in Fig. 2, which also illustrates where self-care

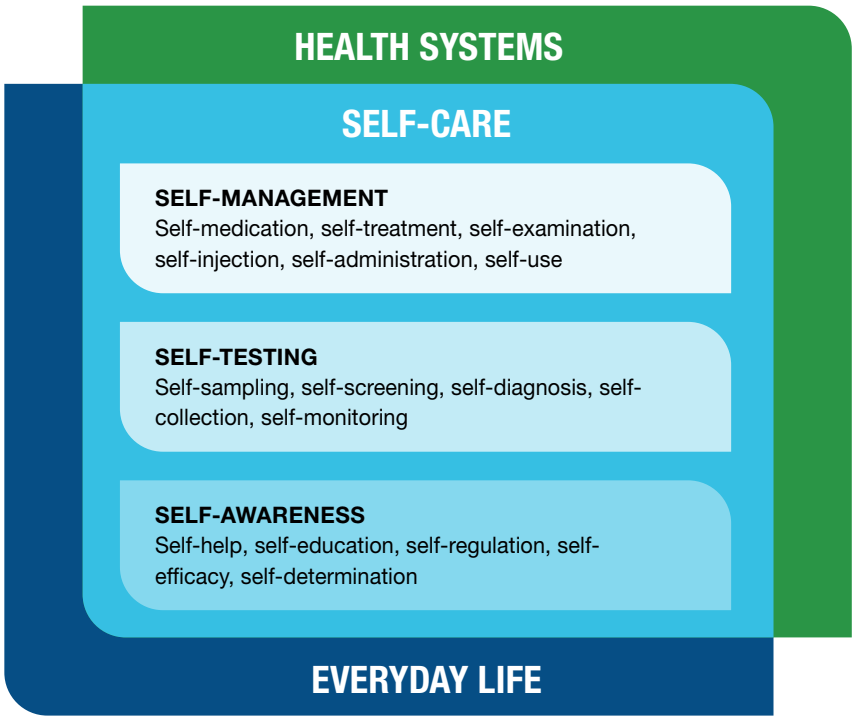
sits in the intersection between health systems and "everyday life". Self-awareness interventions are typically considered to be outside the normal work of health-service providers, although they can help to promote better health and thus support health systems. Self-testing interventions are often performed by self-carers, sometimes independently of health or care workers, and sometimes in collaboration with health or care workers and/or caregivers. Self-management interventions generally require the support of health workers who collaborate with the self-carer.

Figure 1: Conceptual framework for self-care interventions



Source: WHO, 2022 *(2)*.

Figure 2: Self-care in the context of interventions linked to health systems



Source: WHO, 2022 *(2)*.

Aims of the competency standards

The competency standards are intended to be used:

- to serve as a standard for how health and care workers can support self-care among the people they are in contact with as health and care workers;
- to guide health system administrators on how and what behaviours should be promoted among health and care workers who are in contact with people to improve support of self-care;
- to guide educational institutions and curriculum developers when developing competency-based education for health and care workers to support the self-care of people they are in contact with as health and care workers.

The competencies and behaviours in the competency standards are organized under six key domains.

Domain I: People-centredness
Domain II: Decision-making
Domain III: Communication
Domain IV: Collaboration
Domain V: Evidence-informed practice
Domain VI: Personal conduct

For each domain, competencies and behaviours relevant to the support of self-care are specified. The competency standards focus on behaviours that are specific and measurable, noting that behaviours are underpinned by knowledge, skills and attitudes that are developed interdependently and over time.

While the behaviours associated with each competency standard are designed to be sufficiently broad to be applied across different health systems and countries, there is scope for behaviours to be tailored to specific settings. For example, in disaster-affected settings, where health systems are fragile or overburdened, there is often an urgent need for people to undertake self-care. The competency standards can be adapted to highlight the competencies and behaviours health and care workers need to support people to initiate or increase self-care.

Development of the self-care competency framework

The development of the self-care competency framework – including the competency standards (this document), knowledge guide *(3)* and curriculum guide *(4)* – was guided by the framing and conceptual and taxonomy development undertaken by the WHO Department of Sexual and Reproductive Health and Research *(5–7)*. The related guidance has been published as the *WHO guideline on self-care interventions for health and well-being (2)*, originally developed as the *WHO consolidated guideline on self-care interventions for health: sexual and reproductive health and rights (8)*.

Expert advice was provided by the Technical Advisory Group, which comprised experts in health care, health systems, and health of priority groups. The Technical Advisory Group reviewed the draft competency standards to ensure relevance and applicability for health and care workers and communities in a wide range of settings and countries.

How to use this document

The competency standards should be read in conjunction with the accompanying explanatory notes, presented in Chapter 3 of this document, which provide a review of the evidence that underpins the competencies and behaviours and the associated knowledge, skills and attitudes.

Chapter 2. Six domains of competency standards

Domain I: People-centredness

Competency standard 1:
Promotes self-care by individuals, caregivers, families and their communities

Behaviours

1.1 – Supports the individual to adapt options for self-care interventions, taking into account their personal situation, community, environment, gender, age, life stage and the health system

1.2 – Supports ongoing adjustment of self-care interventions, taking into account fluctuations in the individual's physical and mental health and their health-care needs

1.3 – Supports the development of health literacy in relation to self-care

1.4 – Identifies self-care interventions that have been previously undertaken by the individual, their caregiver, family and community

1.5 – Supports the individual, their caregiver and their family to access and continue using self-care interventions, taking into account individual, social and system-level barriers

1.6 – Demonstrates an awareness of the risk of harm that can be linked to self-care practices, including violence, coercion, stigma, discrimination and harassment, which reflect institutional, cultural, gender and racial biases

Competency standard 2:
Provides people-centred support for self-care by individuals, caregivers and families

Behaviours

2.1 – Ascertains each individual's priorities for self-care interventions, taking into account physical, psychological, social and emotional factors, including issues of intra-familial agency and power

2.2 – Demonstrates awareness and sensitivity about the ways in which beliefs and values, as well as legal, gender, financial and cultural considerations may impact upon an individual's self-care choices and practices

2.3 – Identifies vulnerabilities of individuals, caregivers and families with respect to financial exploitation linked to the consumption of self-care products

Domain II: Decision-making

Competency standard 3:
Takes an adaptive and collaborative approach to decision-making about self-care by individuals

Behaviours

3.1 – Supports the individual to make informed decisions about using self-testing and self-management tools and devices, including medication, monitoring technologies and home-based testing

3.2 – Ensures self-care decision-making is supported by the individual's nominated substitute decision-maker in situations where the individual's decision-making capacity is reduced or fluctuates

3.3 – Supports the individual to identify goals and desired outcomes of effective and acceptable self-care, including through digital self-care

3.4 – Anticipates and collaboratively plans for the individual's changing needs for self-testing and self-management tools throughout the continuum of care

3.5 – Demonstrates respect for the individual's decision not to undertake self-testing and self-management

3.6 – Supports informed consent for self-care activities

3.7 – Provides informed advice to support the individual's decision-making about self-care, particularly where evidence is limited

Domain III: Communication

Competency standard 4:
Communicates effectively with individuals, caregivers and families

Behaviours

4.1 – Uses appropriate verbal and non-verbal communication methods to support self-care, including the use of interpreters where appropriate

4.2 – Uses a non-judgemental and open communication style

4.3 – Uses appropriate visual, language and literacy communication aids

4.4 – Uses communication approaches that address motivation and support the self-efficacy of the individual, their caregiver and family

4.5 – Uses a range of verbal and practical techniques to ensure that the individual, their caregiver or family can use and respond to self-testing and self-management tools

Domain IV: Collaboration

Competency standard 5:
Collaborates with other health and care workers and community workers to support self-care

Behaviours

5.1 – Shares support regarding self-management, self-testing and self-awareness with other health and care workers and community workers

5.2 – Refers to other health or community services that can support self-management, self-testing and self-awareness

Competency standard 6:
Promotes trust, agency and collaboration among individuals, caregivers and families with regard to self-care

Behaviours

6.1 – Encourages and supports the individual to use their own social and community networks to support their self-care

6.2 – Refers the individual to peer support opportunities to support their self-care, as needed

6.3 – Refers families and caregivers to appropriate services to help them support the individual with their self-care

Domain V: Evidence-based practice

Competency standard 7:
Supports evidence-informed self-care practice by individuals, caregivers and families

Behaviours

7.1 – Integrates current best available evidence into advice and communications with the individual, their caregiver and family about self-care interventions

7.2 – Promotes the ability of individuals to access and apply reliable, evidence-based information about self-care, including information from the internet

7.3 – Identifies, discusses and challenges misinformation about self-care

Domain VI: Personal conduct

Competency standard 8:
Demonstrates high standards of ethical conduct

Behaviours

8.1 – Upholds legal and ethical principles relevant to self-care, including confidentiality, conflict of interest, duty of care, dignity, privacy and safeguarding the best interests of individuals

8.2 – Consults with others (e.g. peers, other health or care workers) in situations when ethical concerns arise with regard to self-care

Competency standard 9:
Undertakes reflective learning and practice about self-care

Behaviours

9.1 – Seeks to address any negative impact of their own attitudes, behaviours and gaps in knowledge or skills

9.2 – Demonstrates continued commitment to ongoing learning about self-care interventions and practices

Competency standard 10:
Manages own health and well-being

Behaviours

10.1 – Engages in one's own self-care practice to maintain one's own health, emotional well-being and resilience

Chapter 3. Explanatory notes for the 10 competency standards

Competency standard 1: Promotes self-care by individuals, caregivers, families and their communities

Health literacy

Health literacy (see Glossary) is a key factor in the ability of individuals and their caregivers and families to use self-care interventions. Health workers need specific communication skills to assess people's baseline health literacy, and to provide individuals with information and advice to help support their choices and ongoing use of self-care interventions.

Identification of past self-care interventions

All people undertake some form of self-care as a customary or routine practice, reflecting their social and cultural milieu. People's past experiences of self-care helps to frame their current attitudes to self-care interventions and provides them with a repertoire of prior knowledge and experiences, which will inform their response to the discussion with the health or care worker about self-care. For example, a person whose previous experience of self-care has involved regular ingestion of milk for added calcium during pregnancy may easily recognize the importance of additional nutritional supplements throughout pregnancy, such as vitamin D or folic acid. On the other hand, a person whose previous experience of self-care for mechanical back pain involves bedrest may find it difficult to accept a self-care regimen suggested by the health worker that involves regular exercise.

Individual barriers to self-care

Gender

It has been documented internationally that women in general have less autonomy in health-related decision-making, with these decisions being made by husbands or male relatives *(9)*. This is of particular relevance to

reproductive health interventions that are specific to women *(10,11)*, but gender differentials in self-care have also been reported in relation to diabetes *(12)*, obesity *(13)* and heart failure *(14)*.

Service barriers to self-care

Health service organizational culture

Organizational culture refers to some of the long-standing or institutionalized ways of "doing work" in an organization, such as shared ways of thinking, behaviour norms and interactions between staff members *(15)*. Organizational culture can become manifest in the patterns of care provided by health and care workers at a particular health-care facility or network of facilities. Within the health sector, an organizational culture that has rigid power relations and processes of work *(16)* may not be able to support self-care activities and interventions, and may take an overly bureaucratic approach when responding to people who express a wish to engage in self-testing, self-screening and self-management.

System-level barriers to self-care

Financial barriers

The "fee-for-service" model of health care funding may lead to practices that incentivize individuals to visit the health-care facility repeatedly for a service they pay for (e.g. screening tests, contraceptive injections), rather than supporting self-management of certain health care tasks by people in the community *(17)*. "Pay-for-performance" models (where the provider or facility receives funding based on evidence of good performace) may pose different disincentives for self-care; for example, the measures used to assess quality performance may focus on processes, or the model may not provide sufficient incentives for the provider to improve their practice *(18)*.

Funding models in which consumers are direct fund-holders and can decide which services they use and which activities they undertake are, in principle, better suited to supporting self-care. While these incorporate the fundamental ethos of self-care – people-centred ownership – many such packages are premised on the requirement to purchase packages of health and social care services *(19,20)*, rather than self-care interventions and technologies.

Professional culture

The notion that health workers may best serve their patients by trusting them to take on their own care may be challenging for health workers who were trained to embrace a professional ethos that views patients or clients as passive recipients of care *(21)*.

Risk of harm from self-care interventions

The introduction of self-care may lead to direct or indirect harm to the individual. Direct harms may arise if the person uses a self-care intervention that is ineffective or implements it incorrectly. For example, in the case of a person with diabetes using a glucometer at home to monitor and control their condition, direct harm may arise if the person cannot read the glucometer, or does not know how to respond to the readings of the glucometer or if the device is faulty. Indirect harm may occur in situations where the individual may experience negative social consequences as a result of using the self-care intervention. For example, in the case of self-management of medical abortion, indirect harm may result if the person is sanctioned within their family or community for this self-care intervention. The example of direct harm points to the importance of good communication and health literacy in mitigating the risk of direct harms, as well as the importance of ensuring product quality. The example of indirect harm points to the importance of confidentiality, informed consent and context-informed practice to mitigate the risks of indirect harm.

Competency standard 2: Provides people-centred support for self-care by individuals, caregivers and families

Intersectionality

This competency standard addresses the intersectionality of gender, ethnicity, disability, poverty and age. Mumtaz and Salway have pointed out that complex interweaving of determinants occurs, which can compound constraints around self-care *(22)*. Most of these determinants function at the system level. Health and care workers with capabilities in promoting self-care are well positioned to act as powerful enabling agents to unpick some of these complex webs of inequity.

Risk of financial exploitation

Warnings that people engaging in self-care could be subject to exploitation by commercial interests have been raised since self-care became part of public policy for management of chronic illnesses *(23)*. In countries with ready access to medicines through formal and informal vendors, self-carers or families engage in making sophisticated judgements about when they should purchase the medicines they wish to use for common ailments, and when they should seek advice from health workers. Having a trusted vendor of medicines mitigates against some of the risks of being exploited by vendors selling ineffective or over-priced treatments *(24)*. Traditional and alternative medicines are generally not subject to regulation within countries *(25)*. The increasing availability of traditional medicines *(26)*, pharmaceuticals *(27)* and self-care products via online vendors creates potential challenges to safe and sustainable self-care that is not financially exploitative.

Health workers should be prepared to discuss with self-carers how best to access approved and effective self-care products and the reasonable costs of those products.

Competency standard 2.3 overlaps with competency standard 1.3 on health literacy.

Competency standard 3:
Takes an adaptive and collaborative approach to decision-making about self-care by individuals

Decision-making capacity

Decision-making capacity is the ability of a person to make their own decisions *(28)*. Everyone has the right to make their own decisions or, if needed, the right to have support to make their own decisions. In some situations, this right must be balanced against the need to protect a person who cannot make a particular decision from harm to themselves or from exploitation by others. Many countries have legal definitions of whether or not a person has decision-making capacity. The criteria may be different across different areas of life (e.g. the test for capacity for disposal of personal assets may be different from the test for capacity for making a health-related decision), and may vary across different countries.

A person with a disability or medical impairment can have decision-making capacity; a diagnosis of dementia, psychiatric illness, or acquired brain injury does not automatically mean a person cannot make their own decisions *(29,30)*. Therefore, health workers should assess a person's decision-making capacity on the basis of whether or not they are able to make a particular decision at a particular time *(31)*. A person can have decision-making capacity for some health-related decisions but not others. For example, a person may have capacity to decide which asthma treatment device to use, but may lack the capacity to decide about complex self-care interventions, such as home-based peritoneal dialysis. A person's decision-making capacity can also fluctuate due to medical reasons. A person with a complex medical illness may have impaired decision-making capacity during exacerbations of their illness, but not at other times *(32)*.

Substitute decision-makers

In many countries, there are legal mechanisms that support the appointment of a substitute decision-maker *(33)*. In the case of minors, the United Nations Convention on the Rights of the Child states that a child capable of forming a view on his or her own best interests must be able to give it freely and it must be taken into account (Article 12). This consideration may be applied to young people when considering their capacity to give informed consent for self-care interventions, such as contraception.

Digital self-care

Digitally enhanced health services can improve access to care and help people to move away from reactive towards proactive approaches to maintaining health. Digital tools can assist people in monitoring their health and their health care, and can help them to receive rapid feedback from health workers on emerging health issues. The utility of such tools was demonstrated during the COVID-19 lockdowns when many people with chronic illnesses scaled up their self-care efforts, using digital tools in collaboration with health and care workers.

Competency standard 4: Communicates effectively with individuals, caregivers and families

Use of interpreters

Interpreters can provide assistance with oral communication between an individual and the health worker. Care should be taken to respect the confidentiality, autonomy and dignity of the individual in cross-linguistic communications with language supports, including interpreters. It may not be appropriate to involve family or community members as interpreters for some self-care interventions, particularly in the areas of mental health, and sexual and reproductive health. Family interpreters may also lack sufficient language or communications capabilities to assist with discussions related to medical treatments (e.g. self-adjustment of insulin). Health workers may wish to use a set of questions to determine if the informal interpreter has the necessary capability for the medical consultation *(34)*.

If the health worker is working within a health system that has access to professional on-site or telephone interpreters, these interpreters should be used in health-care communications about self-care involving complex treatments or devices, in situations where the decision-making capacity of the individual is unclear, and when discussing personal and sensitive matters, such as sexual or reproductive health *(35)*.

Communication aimed at supporting self-efficacy and motivation

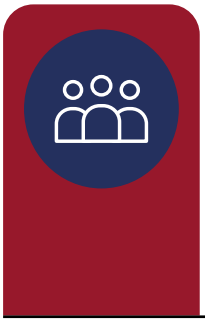
Communications about self-care will usually need to cover the concepts of self-efficacy and motivation to some extent. Many theories about learning and cognition support the concept of self-efficacy as an intervening cognitive state between knowledge acquisition and behaviour *(7,8,36)*. Motivation to change is a cognitive variable that is generally positioned in health communication theory as a created internal state, ranging from pre-contemplative to a state of maintenance where the behaviour has occurred *(37)*.

In situations where the individual is highly motivated to undertake a particular self-care intervention, the communication is likely to simply focus on the intervention itself and any barriers and enablers to using the intervention. In other situations, where the individual may have a desire to reach self-efficacy but has not been able to implement a self-care activity (e.g. the person may have become discouraged when trying to self-manage hypertension or diabetes), there are a range of models of health-care communication that can be employed, focusing on motivation and the development of self-efficacy and emphasizing the importance of respectful, iterative and person-focused engagement with individuals *(38,39)*.

Competency standard 5:
Collaborates with other health and care workers and community workers to support self-care

Collaboration and team work

Self-care models of practice often involve the person as coordinator of their own health care. This can impose a burden upon the person if the various health and care workers involved in their care are not in agreement amongst themselves about their different roles in supporting the person's health care *(40)*. This competency standard addresses the ability of health and care workers to engage effectively with other health and care workers in a systematic approach to support people's self-care. This may involve having shared protocols to support self-care, or multidisciplinary case conferences involving self-carers and their health and care workers, or team-based primary care models, such as health care medical homes *(41)*.



Competency standard 6:
Promotes trust, agency and collaboration among individuals, caregivers and families with regard to self-care

Peer support groups

Peer support for self-care is organized support provided by people with similar health conditions and experiences managing their health *(42,43)*. Peer support groups can be informal or formal. Informal peer support does not use formal structures, trained group leaders or facilitators, and focuses on providing mutual support between people with similar experiences. Common types of informal peer support include groups on social media platforms, community-based meetings, online forums, and email or telephone-based support. Formal peer support programmes are organized groups led by an accredited or trained paid peer support leader, sometimes with the support of a health worker. These groups or programmes often focus on effective self-management of health conditions, and they may be run through disease-specific associations, local health districts or consumer groups *(44)*.

Peer support groups for self-care interventions are likely to include online forms of peer support. Online peer support has been most studied as an adjunct to mental health programmes, including online mental health programmes *(45)*. In addition, there has been an apparent escalation in the use of informal online peer support during the COVID-19 pandemic, particularly among young people *(46)*. Although the evidence for impact is limited at present *(47,48)*, health and care workers should be aware that in technology-rich environments, informal peer support may form part of the self-care management approach used by individuals, caregivers and families.

Competency standard 7: Supports evidence-informed self-care practice by individuals, caregivers and families

Evidence for consumers

Health workers should have a regularly reviewed set of websites, manuals and guidelines that provide reliable, evidence-based information about health conditions and treatments. Examples include the health-care consumer websites run by disease-specific advocacy groups, such as MS International for people with multiple sclerosis, the International Diabetes Federation and Alzheimer's Disease International.

Misinformation and disinformation

Misinformation is fake or misleading information that spreads without anyone having an intention to cause harm. Disinformation, on the other hand, is the intentional creation and dissemination of wholly or partly false information for the purpose of causing harm and/or financial/commercial gain. Social media provides an amplifying mechanism for the rapid spread of misinformation and disinformation, so health and care workers should pay particular attention to these risks when referring individuals to online peer support networks or to online information sources *(49)*.

In the field of health, misinformation and disinformation are often intermingled, and pose a challenge to a person's ability to seek correct information online to improve their self-care capabilities. Self-care interventions that are particular targets for misinformation and disinformation include vaccines *(50)*, dietary interventions and e-cigarettes *(51)*. Medical treatments, while still being targets for misinformation and disinformation, tend to have smaller dissemination networks. This suggests that misinformation and disinformation are likely to be most active in the field of preventive health, rather than in the more technical self-care domains of self-testing and self-management.

Health and care workers can mitigate the impact of misinformation by using messaging that refutes it, directing the user to reliable, evidence-based information platforms, and supporting the development of health literacy *(49)*.

Nothing is gained by humiliating or refusing to engage with a person who has consumed misinformation or disinformation. Instead, health and care workers can address misinformation by employing the three Cs *(52)*:

- Compassionate understanding. Identify what matters most to an individual, which leads them to believe the misinformation; for example, individual values, cultural characteristics, in-group norms and approved behaviours.
- Connection. Health and care workers are in an ideal position to empathetically explore the underlying concerns that have led to people believing and sharing the misinformation, and they are also in a position to share reliable evidence about what is true and what is not.
- Collaboration. Health and care workers should try to find common ground between the person's self-care goals and the aim of optimizing health outcomes; they should also offer recommendations and allow opportunities to review and readdress the plan *(53)*.

Competency standard 8: Demonstrates high standards of ethical conduct

Ethical problem-solving

Ethical dilemmas in self-care may arise in situations where the individual's desire to engage in self-care is not supported by guidelines for clinical practice for the health condition or need in question. It may include, for example, a person deciding to use alternative self-procured remedies for a condition for which an evidence-based medical treatment exists (e.g. antiretroviral therapies for HIV), and for which – if the approved treatment is not taken – health outcomes may worsen (e.g. HIV disease is likely to progress and be fatal). Another example of a self-care ethical dilemma is the case of a person with fluctuating decision-making capability (e.g. a person with poorly controlled bipolar disorder), whose relative requests the health worker prescribe psychiatric medication that can be administered to the individual without them knowing.

Kerridge, Lowe and Stewart (2013) propose a seven step model for ethical decision-making in complex settings, as outlined in Box 1.

Box 1: Seven-step model for ethical decision-making in complex settings

Step 1. Identify the ethical problem.

Step 2. Get the facts – understand the person's narrative and background, and any epidemiological, biomedical or other evidence to illuminate the ethical problem.

Step 3. Consider core ethical principles.

- Autonomy: what are the person's preferences, goals and values?
- Beneficence: what benefit may the person obtain?
- Non-maleficence: what are the risks, and how can they be minimized?
- Justice: how can equity or fairness be optimized?
- Confidentiality and privacy: how can these be secured and maintained?
- Veracity: has the person been honestly informed, and if not, is there a reason that they cannot be informed about their health condition?

Step 4. Consider how this problem may be viewed from another perspective. It can be helpful to obtain input from another health worker.

Step 5. Identify ethical conflicts and consider how these may be mitigated.

Step 6. Consider the law – is there a legal framework for the ethical problem? Reflect on the relationship between the law and the ethical issue and how it may or may not influence your response.

Step 7. Identify a way forward.

Source: Kerridge, Lowe and Stewart, 2013 *(54)*.

Competency standard 9: Undertakes reflective learning and practice about self-care

Reflective learning about self-care

Reflective learning is "the process by which knowledge is created through the transformation of experience" *(33)*. Health and care workers who engage in reflective learning about self-care may find this to be a useful process for considering ways to support their patients to undertake self-care, and for understanding personal barriers to undertaking self-care. In the context of busy clinical practice, many health workers may find it easier to fall back on a directive, top-down approach to health care rather than supporting patients to manage their own care. The same environments can also lead to health workers blaming individuals for not undertaking self-care, or for not achieving the desired health outcomes when undertaking self-care.

There are many models for reflective learning about one's own practice, individually or in groups *(55)*. All provide the opportunity for health and care workers to reflect upon their experience and challenge themselves to review and improve their practice. Reflecting on their attitudes to self-care more generally will lead health and care workers to reflect upon their own self-care practices, and the barriers that they personally face in undertaking their own self-care.

Competency standard 10: Manages own health and well-being

Self-care practices

Health and care workers should be able to model self-care to their patients. Unfortunately, many health and care workers practise relatively poor self-care, partly reflecting the ethos of service and hard work in the health-care professions. Health and care workers often do not recognize the signs that they are overwhelmed, including becoming irritable, less willing to engage in discussions with patients and peers, and less flexible in problem-solving. It can follow personal vicissitudes, or surges in demand at work, such as occurred during the COVID-19 pandemic *(56)*.

Supporting individuals to undertake self-care often requires a health or care worker to invest time in exploring options, developing the self-care plan, and reviewing it. Exhausted health and care workers may find it easier to prescribe, order treatment or disengage, than to commit the time needed to support someone's self-care. The success of self-care interventions for a patient is often impacted by the health or care worker's ability to undertake self-care for themselves.

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