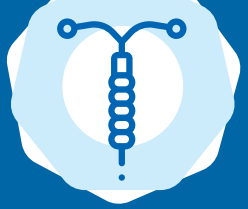
What is included within the term **New and Underused Reproductive Health Technologies?**

The Reproductive Health Supplies Coalition (RHSC) uses a number of implementing mechanisms as vehicles through which Coalition members collaborate. Since 2008 the New and Underused Reproductive Health Technologies (NURHT) Caucus has sought to improve user choice of available reproductive health (RH) technologies by focusing on common barriers and challenges associated with product introduction and scale-up. The NURHT Caucus works to expand the supply of new and underused RH technologies through public, private, and social marketing sectors and aims to facilitate information-sharing and collaboration in product introduction and scale-up. Historically, the NURHT Caucus focused on a set list of RH commodities.

However, over the years, the RH supplies environment has evolved: what was once considered 'new' or 'underused' might no longer be seen as such; the concept of 'underused' has been challenged for its unwelcome implication of use targets in the context of voluntary FP/RH; and interpretations of the RH category itself have expanded in recognition of the many tools used to uphold peoples' reproductive lives beyond contraception. It has also become clear that what distinguishes something as "new" or "underused" will vary by context, particularly the geography and highly localized setting in question.

Thus, to continue adding value to Coalition members and the broader community, Caucus members undertook an exercise starting in 2023 to **revisit the scope of RH technologies included within the remit of the NURHT Caucus**. This included deep-dive exercises held during the Caucus's session at RHSC's 2024 General Membership Meeting in Ghana, further synthesis during the Caucus's regular virtual meetings, and the work of a more focused, voluntary sub-group dedicated to the topic.






Reproductive Health
SUPPLIES COALITION

Summary of Recommendations

Four major shifts in the NURHT Caucus's remit are recommended:

SHIFT 1

FROM A defined list of 13 RH technologies

TOWARDS **A set of common criteria that can be interpreted within members' own contexts, yet around which shared learning can be organized**

SHIFT 2

FROM Focusing only on quality contraceptive and maternal health commodities

TOWARDS **A wider sexual and reproductive health (SRH)[1] remit that includes quality supplies and technologies that advance outcomes for menstrual health, sexual health, and beyond, including those in the development pipeline[2]**

SHIFT 3

FROM A focus only on material SRH products (i.e., those that travel through traditional supply chains)

TOWARDS **Including those that are also partially or wholly delivered digitally (e.g. fertility awareness method apps)**

SHIFT 4

FROM A focus on "new" and "underused"

TOWARDS **A focus on "new" and/or "under-accessible" within a given context**

SHIFT 1

FROM A defined list of 13 RH technologies

TOWARDS **A set of common criteria that can be interpreted within members' own contexts, yet around which shared learning can be organized**

Proposed Criteria

Answering mostly "yes's" to these questions indicates a fit for NURHT inclusion:

☐ YES ☐ NO

Are we in an early age of the SRH product's entrance to the global or local health market?
For this, consider when the product was developed, the timing of market entry, and the stage of regulatory approval (i.e., approval has not yet been granted, or was recent).

For example, the contraceptive implant might be considered "new" within the Indian market but not so in Kenya. Or a brand (i.e., Levoplant) might have only been introduced recently to a setting where the implant category is already well established. Or a new, generic brand may enter the market.

☐ YES ☐ NO

Is community and/or stakeholder awareness of and/or access to this SRH product lower than average, when compared to more-established SRH products?
For this, consider if and what individuals, communities, healthcare providers, and health system actors know about the product – and how to access it – at all levels, and in different geographies. Consider the product's coverage and penetration into target user groups, its acceptability, its reach within the channels in which it's eligible to be offered.

For example, community and stakeholder awareness of menstrual cups is often lower than that of more established menstrual products in many LMICs, largely due to cultural stigma and misconceptions such as fears about compromising virginity, and low levels of body literacy, all of which limit both knowledge and acceptability. Addressing these barriers through targeted education and normalizing cup use alongside existing options is critical for equitable assessment and adoption.

☐ YES ☐ NO

Is the SRH product missing from prevailing SRH policies, guidelines, supply chains used globally or locally?

For this, consider relevant policies, service delivery and clinical guidelines, healthcare provider training materials, essential medicines lists, etc. Consider also how use of the product may influence health indicators and if collaboration with health information systems will be needed.

For example, until recently, emergency contraception and hormonal IUDs were only available in private clinics and pharmacies in many countries, and not yet adopted into the public health system. As such, these products were often absent from national guidelines and systems, requiring effort to bring them into the mainstream.

☐ YES ☐ NO

Is the SRH product being offered in a new way (even if the product itself is not new)?

For this, consider new product indications and uses, changing eligibility criteria, and new administration modes including self-administration, provider task-sharing, and device updates.

For example, the World Health Organization has made a strong recommendation for self-injection, stating that it should be made available as an additional approach to deliver injectable contraception for self-care. However, while DMPA-SC is widely available for administration by a health facility-based provider, many countries are still considering whether to introduce self-injection or are in early stages of rolling out self-injection programming and/or expanded access through community-based providers or private pharmacies and drug shops.

SHIFT 2

FROM Focusing only on quality contraceptive and maternal health commodities

TOWARDS **A wider sexual and reproductive health (SRH) remit that includes quality supplies and technologies that advance outcomes for menstrual health, sexual health, and beyond, including those in the development pipeline**

An expanded scope that includes contraception (e.g., implants or contraceptive diaphragms), maternal health products (e.g., heat-stable carbetocin and tranexamic acid for treating postpartum hemorrhage), menstrual health products (e.g., menstrual cups), sexual health products (e.g., personal lubricants), and pipeline products (e.g., the 6-month injectable or male contraceptive implants) enables broader discussions reflective of the current state of SRH and enables programs, governments, manufacturers and partners to improve access to products that are comprehensive and relevant across a lifetime. Products within RHSC's remit must offer a clear, evidence-based pathway to improved SRHR outcomes.

SHIFT 3

FROM A focus only on material SRH products (i.e., those that travel through traditional supply chains)

TOWARDS **Including those that are also partially or wholly delivered digitally (e.g. fertility awareness method apps)**

SRH products have expanded beyond tangible, physical items to include services and SRH coverage that can be delivered in a hybrid manner– such as fertility awareness-based contraceptive apps that also have a digital thermometer–or even fully digitally–such as smart devices used for tracking and managing menstrual periods. While these products may not travel through traditional supply logistics mechanisms, they can confront similar needs within the supply chain context when offered with the intention to expand quality choice for end users. This includes [1] regulatory and policy considerations for the product or app's access and use, [2] outlining the role of 'retailers' in making this method available and through which channels (e.g. whether medical eligibility screening or other services preclude use), [3] addressing consumers' awareness and use, and [4] population measurement of such product use within the relevant SRH portfolio. Altogether, stakeholders may also share concerns and practices around last mile availability and equity for these products in ways similar to tangible SRH products. This may be a gray area for now, but as this field evolves, the NURHT Caucus is keen to explore how to best support access to a wider range of SRH products.

SHIFT 4

FROM A focus on “new” and “underused”

TOWARDS **A focus on “new” and/or “under-accessible” within a given context**

Historically the NURHT Caucus has assumed that “underuse” can be defined as some quantitative level and underuse would eventually grow to ‘adequate use’. However, this framing implies the presence of a definable target for usage levels, raising concerns around full, free, and informed choice, particularly in the contraceptive product space. To better communicate the NURHT Caucus’ intention to protect voluntarism and expand access to a wide range of products, we have reframed our focus to products that are new or have limited availability within the given context. As a benchmark, the index product could be compared to more established SRH products to estimate its accessibility.

Endnotes

1. To this end, ‘SRH’ is used in place of ‘RH’ throughout this document. This is an intentional edit from RH to SRH, in light of this recommended shift. While RHSC as a whole still defines its focus and remit on ‘RH’ supplies, the NURHT Caucus intentionally creates space to explore areas beyond the Coalition’s focus, including for products in the development pipeline.

2. To this end, ‘products’ is used throughout this document to represent the supplies and technologies covered under the focus of the NURHT Caucus.