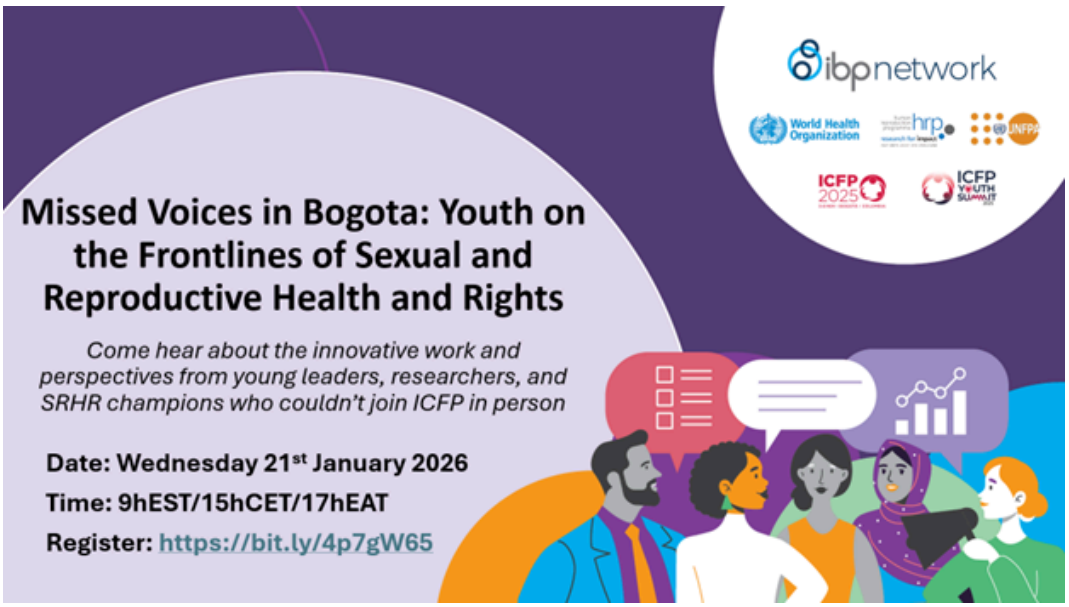

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I'm Nandita Thatte, and I'm Technical Officer at. WHO, where I lead the IBP network, a network of civil society organizations working to disseminate.

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And facilitate use of evidence-based practices in sexual reproductive health and rights.

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And we are delighted to be co-hosting this event today with the ICFP Youth Subcommittee.

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And I'm co-hosting it with my. Colleague and friend, Innocent Grant.

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Um, on behalf of both the IBP Network, WHO, and ICFP, we are delighted to have.

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All of you online, as well as our dynamic panel of speakers today.

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For some context, this session was… created in the context of the ICFP conference that happened at the end of last year in Bogota, Colombia.

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And organizers really made a lot of efforts to make sure that the conference was inclusive.

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Uh, welcoming, accessible. Um, and we really appreciate all those efforts. There was a lot of language diversity, diversity in topics.

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Lots of participation from around the globe. And yet, those of us working in global health know that despite these efforts.

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There are still barriers that remain. Structural challenges such as visa restrictions.

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Mobility constraints, cost. meant that there were some that were still unable to attend, particularly young professionals from certain countries.

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Um, and we recognize that this work is important, and.

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when we think about equity and health. We believe that equity in health must also be matched by equity in knowledge sharing, leadership, and visibility.

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And that's why we wanted to create the platform today, to highlight some of those innovative.

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experiences by young people who were not able to attend the conference in person.

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So, thank you again all for joining, and for your support. We are really grateful to all the presenters here today.

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And to all of you online, and we're looking for a very dynamic and exciting session.

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I'm gonna now turn it over to Innocent. Who's gonna walk us through the session and how it will look today.

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You have the floor.

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Yep. Thank you so much, Nandita. Again, good morning, good evening, good afternoon, everyone.

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Many thanks for setting time today and come to listen to our wonderful panelists, um, who.

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Uh, for some reason didn't make it to Colombia. As we know there are different challenges, uh, getting to the ICFB.

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Um, but again, in the light of equity, we made sure that we are setting time to make sure we listen to the presentation. So I'll just go through quickly, uh, the logistics. So, this webinar is going to be recorded.

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Um, we're going to use Wedley for lead time language translations.

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And, uh, just as a reminder, I'm going to paste the link of the Wedley in the chat, uh, for everyone to, um, to follow the.

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Um, the translation, you just click on that, uh, Wedley link, and then you can select the language that you want, uh, you want to.

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fall, and then it will give you real-time translations.

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Um, if you have any questions, please submit through the Q&A chat box.

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Um, and then please share comments in the chat as well, as presenters are going to, uh, present, um.

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In this, in this webinar. Now, this is going to be the program for our webinar today. Again, as we just did, welcome.

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And then, uh, we went through the logistics. Uh, we're going to do a little introduction of the, uh.

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Of all the speakers before they present. their presentation. Uh, but you're going to have two parts. One, we're going to have, um.

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open remarks from, uh, Dr. James, uh, from WHO SUNA, and then that will be followed by four panelists.

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Uh, presenting, and then we'll have. A short break of question and answers and feedback from you all, so feel free to utilize the chat box for that.

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And then we'll be having a second panel featuring four speakers again, and then.

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We'll have closing remarks from the ICFP Secretariat. Um, so without taking more time, I'll just give the mic back to Nandita.

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Uh, to, um… To take us, through open remarks.

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Super. Thank you, Innocent, and it is now my delight and honor to introduce Dr. James Kiarie.

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unit head of the Contraception and Fertility Care Unit here at WHO.

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in the Department of Sexual, Reproductive Health and Research, so… Doctor Kiarie, you have the floor. Thank you for providing some opening remarks.

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Yeah, thank you, and thank you, Nandita, and thank you, Innocent, for… the invitation. Good morning, good afternoon, good evening, and uh… Everyone, and uh… thank you so much for joining us today.

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For me, it's really an honor. To open this webinar on behalf of.

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I want the health organization. On behalf of the ABP Network.

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And also, the International Conference on Family Planning. And also to welcome such a diverse and inspiring group of young researchers.

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program implementers. And sexual reproductive health and rights experts.

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Today's session is especially important because. It creates space for voices.

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That are too often missing from global health conversations.

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Not because of lack of expertise. or impact, or importance.

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But because of structural and systemic barriers. Including visa restrictions.

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And I need access to global platforms. All the young professionals featured here today.

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were unable to attend the international conference on Family Planning.

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last year at Bogota. At WHO, we recognize that global health cannot truly be global.

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If participation is limited. To those who easily access borders.

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and access these international spaces. The ones that you'll be hearing about today.

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reflects the real life. on the ground, community-driven solutions.

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context-specific evidence. And courageous leadership.

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And often very challenging environments. These are exactly the perspectives needed.

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To strengthen sexual reproductive health and research policies. programs, and bring accountability.

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At national, regional, and global levels. I want to emphasize that this webinar is not a parallel.

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or secondary space. It is a credible and valuable platform.

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That contributes directly. SRHR agenda.

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The insight shared here. As with all WHO and IBP network hosted events.

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would be shared, and to influence our WHO in guideline development, in research.

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and work with our regional and country colleagues. Then professionals presenting today.

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Your work matters. Your expertise matters. And your leadership matters.

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WHO remains committed to supporting inclusive pathways. That recognize that.

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That recognize and elevate. your contributions, not… as… not only as future leaders.

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But also, as leaders today. I encourage everyone joining us to listen deeply.

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Engage actively and reflect on how we can collectively remove barriers.

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and create more equitable systems. for participation in global health.

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With that, I'm pleased to open today's webinar. And look forward to the important discussions ahead.

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I thank you very much. Thank you. Back to you, Nandita.

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Great. Thank you, James, for your inspiring remarks. And I will actually turn it over to Innocent to lead and moderate our first panel.

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Thank you so much, uh, Dr. Nandita and Dr. James for the opening remark.

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And without taking time, I'll move directly to the first panel.

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Um, that we have 4 speakers, but we're going to start with our colleague, Sheila Habib.

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Uh, who is the founder of Habib Fertility. 35 Fertility Awareness Educator, and social justice activist.

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with a master's degree in human rights law, and 5 years.

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more than 5 years of experience in gender equality and anti-discrimination.

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She advocates for body illiteracy as a fundamental human right.

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She teaches emancipatory menstrual education so people can read their cycles.

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is vital signs and make informed decisions about their own bodies.

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Shayla, please have the mic, and, um, welcome to present your work.

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Thank you so much, Annison, for your presentation. So, hi, everyone. I'm very happy to be here.

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I'm Shaila, I'm a certified fertility awareness educator with a background in human rights law at Next.

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I grew up between Portugal and Angola in an Indian family, half Catholic, half Muslim.

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We're talking about menstruation, contraception, or sex was really a taboo, so today I want to start by breaking down silence by asking a very simple, but I think a very important question.

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Our menstrual tracking app safe? So, the menstrual cycle was recognized as the fifth vital sign by the American College of Genecologists.

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alongside heart rate, blood pressure, temperature, etc. But I think many of us, we're still taught that severe cramps, heavy bleeding, irregular cycles were normal, but you're not.

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Our cycle is always communicating with us, and if we have any of those things, that's our cycle saying, okay, maybe something is wrong, it could be a hormonal imbalance, a nutritional deficiency.

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high levels of stress, or even conditions like PCOS, endometriosis, thyroid, or diabetes.

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But instead of learning this body literacy, we are sourcing it to period apps. In 2024 alone, more than 250 million people.

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use the menstrual app. Next. They promise to monitor our cycle, predict menstruation, ovulation, so they're quite useful.

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But in reality, they collect much more than our period dates. They collect our PMS symptoms, our flu intensity.

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which conceptives we use, our sexual activity, how we are doing physically and mentally.

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alongside our age, our location, our IP address. And if we think about it, that's not really about important, that's about extraction. Next.

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flow, one of the most popular period apps, was found guilty of sharing users' information with Google and Facebook without consent.

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And researchers from Cremage University called our menstrual data a goldmine for consumer profiling, meaning that from our menstrual data, they could reveal our productive choices.

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our health conditions and vulnerabilities that can be monetized and weaponized.

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And indeed, some of that data has been used for targeted cycle-based ads, meaning that.

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They're targeting ads based on where we are in the menstrual cycle. For instance, beauty products during ovulation, or household products during the luteal phase.

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Or, if we say we are pregnant, we're going to have baby ads, but if you have suffered a miscarriage, you're still going to get baby adds because the profile… you still have a profile as an expectant parent, so.

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Imagine that pain. But unfortunately, it doesn't really stop there. So, in the UK, Google search history was used to convict a woman for taking abortion pills beyond the legal limit.

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And in the United States, Facebook Messenger conversations were used to prosecute someone seeking abortion care, Nebraska.

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So, what is stopping from missile data being used next? Researchers from Cambridge University found that these menstrual data could… no, previous slide.

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Uh, researchers from, um, Cambridge University actually found that this menstrual data could be used to affect job opportunities, lead to discrimination in health insurance.

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Parting of transgender people, or even creates greater vulnerability in domestic violence and digital harassment.

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So we are living in an era where menstrual apps are not just lifestyle tools, they're actually a form of digital surveillance, posing a real threat to our menstrual and productive rights.

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And the most serious part is that, to date, there is zero oversight for period apps, so no one is really approving or overseeing most period apps.

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But unfortunately, that's not the only thing that makes it worse, is that also pre-depths are not accurate. So globally, nearly 1 in 4 women.

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do not feel that they have their family planning needs satisfied with their current contraceptive methods. So many have clearly turned to peer daps as a contraceptive method, so we have.

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period apps that tell us, oh, you ovulate on day X, or on this day you're fertile, you have a high or low probability of being pregnant on a given day.

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Relying then on counter methods or algorithms, but the issue is that ovulation isn't fixed.

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We can ovulate one cycle on day 12, another one on day 17.

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Because everything around us has an impact in our menstrual cycle, so our relationships with our stress levels, sleep, illness, travel, etc.

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And it's not just me saying this. One study found that only 30% of women are fertile between days 10 and 17.

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And that multiple studies also found that period apps inaccurately predict both menstruation ovulation.

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So what's alternative? Well, to me, it's body literacy, fertility awareness in particular, is a science-based hormonal method that teaches people to identify their fertile window.

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to real-time biological markers, like cervical mucus or cervix, by doing daily observations, not predictions.

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But I believe that this knowledge has been systematically denied. In 2024, the WHO found only 2 in 5 schools worldwide provide mental health education.

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And I could bet a fertility awareness almost never included. So, my message is very simple. Next.

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I had been fertility, I teach this method. To center autonomy, inform choice, and trust in the body, not in algorithms. So, if you're using a menstrual app, make sure you read a privacy policy, or choose apps that store the data locally, because if a company does not have your data, you can't sell it or hand it over to authorities.

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And for those of us working global health policy, let's remember that we can't achieve mental reproductive justice.

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While surveillance capitalism is exploiting our most intimate data. So I really call all of us to think about integrating menstrual health and fertility awareness education into schools.

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Creating a regulatory body for menstrual apps, regulating menstrual health data as sensitive health data like GDPR level protection.

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And above all, invest in mental health research. We need more recent endometriosis and other measure of health conditions.

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Next. So, thank you so much for listening. I really believe that body literacy is not a luxury, it's a human right, and we should all work towards that. You can connect with me at happy fertility.

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And thank you so much.

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Thanks so much, Shayla, for that wonderful presentation, and right within 5 minutes.

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Uh, many things, and please feel free to ask questions through the chat.

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Um, so yes, we can… we can follow up that… that chat, uh, later during the Q&A, um, session. Now, without taking time, I want to, um, welcome Wacha, Roosevelt Wacha

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who is a Cameroon-based adolescent and youth health advocate and youth policy researcher with over 7 years of experience in research.

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advocacy and community-based programming. He is the co-founder of the 2x2 Youth Cameroon.

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Um, a youth-led organization advancing the sexual and reproductive health and rights of adolescents.

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and young people in conflict-affected context. He's also a secondary school teacher in Cameroon, integrating education, research, and policy advocacy.

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to amplify youth voices and promote evidence-informed and youth-centered solutions.

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Watcha, please have the mic and, um, do your presentation.

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Thank you so much, uh… in a sense, and I am so glad.

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to be part of this webinar. Please, next slide.

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Um… As you all know, if I want to start with you.

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Cameroon is currently facing. crisis that broke out since 2016.

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Uh, the… since the… I'm complete in the Anglophone regions of Cameroon.

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That is displaced up to now more than 1 million people.

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And has led to the closure of schools and the shutdown of health facilities.

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Uh… Adolescents and youth are most.

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affected in this. And this is least studied.

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And, uh, I must say that I am in the Anglo… I am from the Anglo-fo region of Cameroon, and I have witnessed.

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first-hand the devastating effects of this crisis. And it's releasing that.

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y hacienda de. the assets of sexual and reproductive personal rights of adolescents.

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So the gap is that the conflict has… Wasn't sexual reproductive health and outcomes of adolescence.

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And as I have said before, youth are highly vulnerable.

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And there is no grounded community-level data from Cameroon in this aspect.

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So, this study, uh, the objective of our study was to describe the effect of the Anglophone crisis.

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on the sexual and reproductive health, right? of adolescence, and to identify stakeholder recommendations.

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for strategies to address the sexual reproductive health and rights of youth.

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in the, uh, crisis-impacted communities. And uh… the approach that we used is that we.

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had a quantitative secondary analysis of 12 community forums.

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Uh, wherein we had. 3,000 stakeholders, uh, across.

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So, we had to invite youths. Parents, teachers, and health workers.

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NGOs and Fed leaders. to have the idea on what can be done.

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strategies to address. These sexual and reproductive health and rights of adolescents that, uh, have been impacted.

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So, uh… This was conducted from May to July 2020, during the peak of the conflict.

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And the conventional content analysis. Using data was used to analyze this.

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And I must insist again that this is from lived realities, from inside an active conflict region and.

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It is still continuing up to now. So please, next slide.

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So, the key findings after having this community dialogues, and so I must insist again that.

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We had these dialogues to hear from them, people that are affected directly. So we had, with youth, as I said before, that we had dialogues with the youth.

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the field leaders… medical doctors, traditional rulers, and all these stakeholders.

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We wanted to hear the… yeah, view on what can be done as recommendations and strategies to address these limitations in accessing sexual and reproductive health and rights.

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And the key findings that we saw from the interviews that we conducted is that.

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The crisis has led to the displacement and hardiness that has led to extreme sexual and reproductive health and vulnerabilities.

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And it has also led to school closures. And displacement felt.

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And also through the transactional tax, uh, this is simply because.

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Uh, because of the crisis. In fact, it is difficult.

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Of course, to work and have money, so many people… engaged in the transactional sex and expectation, and also that we had a early pregnancy.

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Uh, the second finding was that sexual violence widespread.

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And was normalized. So, some of the two rape cases were reported during these community-led dialogues.

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And the perpetrators of these cases were armed actors. Remember that the fight is between the regular army.

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And people that are claiming to be marginalized. So, all of these armed actors were taking advantage of vulnerable people.

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And, uh, the community members as well. So, survivors face silence.

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Stigma and no support. So the next finding that we saw is the severe sexual reproductive health consequences on planned.

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Pregnancies, STDs, and HIV. Unsafe abortions and psychological trauma.

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Shame, grief, and societal thoughts. And the community solutions. So, this is what… these are the recommendations that we had.

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strategies to address this in this context. So we saw… we had from them that we can reduce hardiness through skill.

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skills, mentorship, youth groups. To prevent sexual violence through justice pathways, seeking justice.

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And to support parents and caregivers. Provide trauma-informed psychological care.

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Next slide, please.

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So, why does this really matter globally? So you see that conflict.

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It's normal, that conflict intensifies, sexual and reproductive health and right meets.

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And youth center community-driven solutions are possible. Sexual and reproductive health.

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is life-saving and humanitarian response. And the bottom line of this is that protecting.

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youth, sexual reproductive rights in conflict. is survival, and it is dignity.

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And it's a future issue. So, these recommendations were actually channeled and were presented.

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This is, uh, normally what also present during ICSD.

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And these recommendations were handed because the study was funded by FP2030.

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Rapid response mechanism. And uh… it was actually published, so you can download the article and see the findings, or more.

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So, next slide, if, um…

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I think… I think this was the last slide, Wacha.

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Your mic is on mute.

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Okay, um, well, thank you so much, Wacha, for, uh, for that wonderful presentation. I think, as Wacha mentioned, uh, this has been.

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published, so if someone wants to read more about this, we can go and look for it's article.

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And, uh, you can also, if you want to connect with Quatcha.

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Um, we can keep the discussion in the chat. Um, if what you can share the link as well in the chat, that would be wonderful. Uh, without taking time, I want to introduce our next speaker, who is Lucas.

00:23:50.000 --> 00:23:59.000
Lucas Kalama Fondo is a community health engagement expert, uh, specializing in advocacy, strategic communication, and social accountability.

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He advanced his sexual and productive health and rights.

00:24:02.000 --> 00:24:06.000
Um, uh, reproductive, maternal, newborn child, and adolescent health.

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human rights and gender-based violence prevention through policy influence, community mobilization, and rights-based programming.

00:24:15.000 --> 00:24:24.000
championing equitable healthcare access and techniques for all. Uh, Lucas, please have the mic for your presentation.

00:24:24.000 --> 00:24:31.000
Okay, thank you. Thank you again for the opportunity. Next slide.

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Once, I want to thank all my co-authors and my affiliation organization, and all the organizations which we are.

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just come to see how it all needs. So, on this, it's about Beyond Pills.

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It's a holistic approach to support adolescent and young people living with HIV.

00:24:52.000 --> 00:24:57.000
And AIDS in Clifi County through the operation 000 initiative.

00:24:57.000 --> 00:25:06.000
Next slide. Okay, on both the background information, as we see.

00:25:06.000 --> 00:25:15.000
A kilifies around in the Kenya. in Kenya, one of the counties in Kenya, so we have a population of about 1.5 million.

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And we have a high HIV burden. Among the adolescent, which have aged 10 to 24.

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10, 24 years, and which they bear a significant share of HIV infections.

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with a passage of 38.4. of the new infection occurring in that age group.

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Why we have a lot of unique challenges for the.

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LYHPF, and then address the young people living with HIV.

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Would they feel… they face self-stigma, discrimination, and limited access to adolescent.

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And friendly youth services. And we have transaction gap on movement from the pediatric to Adoles.

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adult HIV in poor support yet, leading to ART, non-adherence.

00:26:02.000 --> 00:26:12.000
and increased HIV transmission in it. So we said we need for… need for an action, call for an integrated youth approach that empowers.

00:26:12.000 --> 00:26:26.000
eligibility to achieve positive health outcomes and address. Diagnosis COVID shall be due. So this is an approach which we use, which we had the objective. Next slide.

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Next slide. So, on the objective. The main objective is to achieve a viral suppression rate of 95.

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percent among LOHPF in Califi County through the holistic approach that combines medical, psychologist, and.

00:26:40.000 --> 00:26:47.000
And social support. For this, we have the goal to achieve… it was about triple-zero outcome.

00:26:47.000 --> 00:26:52.000
0 missed appointments, zero missed doses, zero viral load.

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Next slide.

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So, on this, we had the results. After that, on this evaluation, we did around 2021 to 2024.

00:27:07.000 --> 00:27:18.000
who had achieved an overall. Viral suppression rate about 91% of that age group. Adolescent aged 10 to 14 attend 95.

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53% viral suppression rate adolescent which of the age group of 15 to 19 achieve an.

00:27:26.000 --> 00:27:41.000
18… 89.5 viral suppression rate at that time. Then the initiative significantly reduce stigma and improve treatment at theirs. Because of this, we need psychological support. We had session on those.

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cohort of the groups, and that… and participants reported an enhanced quality of life.

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Demonstrating the effectiveness of holistic youth-centered initiative. Next slide.

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So, on this, I have some of the recommendations for this, because we did it with other stakeholders, other groups, other people.

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We all need to scale up our support for LIGP across.

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Califfe County and beyond, even though there are other countries, region, because of the… this specific EU interest group.

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Stretched partnership with development partners, health providers, and government agents like NARD, because we have a lot of.

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Finding issues, cut off issues. So we have… we still need support for this.

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Conduct regular evaluation and adaptation intervention to maintain relativity and impact for this, and we need to see.

00:28:32.000 --> 00:28:39.000
More regular evaluation and adaptation of some of the support. Advocate for youth-friendly policies that promote inclusive adolescent-centered.

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across the HIV care. So, youth. They need to be included in this. We need youths to be involved in the policies.

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And we need enhanced community accountability mechanisms to reduce stigma and promote holistic well-being.

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Because of this, and thank you for that.

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Oh, thank you, thank you so much. Many thanks, Lucas, for that wonderful presentation, and if we have any question.

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Um, that you want to follow from Luca's presentation, please feel free to rewrite the chat.

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Um, for those questions. But without taking time, I want to welcome our next speaker, who's Qasum Sheila Bata.

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Uh, with the Public Health Office at the Minister of Health.

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Uh, at Gandhaki province in Nepal. She's an airy career researcher with over 5 years of experience.

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Our work focuses on sexual reproductive health and rights.

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health systems and the well-being of vulnerable populations. Uh, Kusumsheela Bhatta, please, um, have the mic for your presentation.

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Hello, hi, uh, thank you, Innocent, uh, for the introduction. Hello, everyone. I'm Kusumsheela Bhatta.

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I am a public health officer, and I work for the Ministry of Health here in Kendaku Province in Nepal.

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So, um, so regarding the adolescent pregnancy status in the context of Nepal.

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The NDSS data shows that it's 14% is. And over the years, if we look at the trend, there has been significant progress.

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So I think we should also acknowledge the government, the system, the partners who have made this possible.

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But at the same time, we also have to recognize that does this number actually reflect the status of the marginalized communities here in Nepal?

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So, in Nepal, there are many marginalized communities, and one of them is the Chipangs.

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So the chipangs are recognized as one of the most highly marginalized indigenous group in Nepal.

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as there faces a lot of isolation, poverty, and also limited access to even basic health services.

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So, uh, with this interest, with my personal interest, and the work, and the system that I work for.

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Um, I always had this question that, does national evasies reflect the vulnerability of these communities?

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So, um, next slide, please. So, I did a research on this community.

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Uh, so it's 200 Japan women were selected randomly. We did a… I did a semi-structured questionnaire and also did regression to understand the factors associated.

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And, uh, the findings were actually very much concerning because.

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7 among every 10 respondents were pregnant in their adolescent, so that's 72% is.

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And, um, after the analysis, the major factors were a poor knowledge of pregnancy and childbirth.

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significant unplanned pregnancies and also lack of. sex education.

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Um, so to further explore these numbers, to further understand why in this community.

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Um, such significant adolescent pregnancy has been happening. I further did a qualitative analysis.

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So, next slide, please. So, on the qualitative analysis, I did 20 interviews with the Chepang adolescent mothers.

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And a lot of different factors, a lot of different reasons why this is happening turned out.

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So, first one being inadequate access, as well as lack of use of sexual and reproductive health services.

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Even the services that the government, that the system is providing, they are not using those services due to lack of information.

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The second one is gaps in programmatic implementation. We understand that the community has been facing a lot of marginality, and a lot of programs are also going there, but.

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Um, there's a significant gap in the effectiveness of those programs.

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The third one is elopement marriages. So, back then, parents used to enforce marriage upon the Chepang children, and they used to get married.

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But now they're doing it by their own will, but at the same time, it's also a thoughtful scape to come out of poverty, also to get out of their insecurity.

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has been, like, a thoughtful scape for them, which is, in turn, resulting into adrenals and pregnancy.

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Uh, the fourth one, very concerning out being discontinuation of education. There have been… there's been significant dropout in secondary level school education.

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And they rather get inclined into. Uh, getting married and schooling after marriage is also a major stigma here.

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And also, a limited anomalies and understanding, and in this community, early marriage and early pregnancy having a lot of children, it is also seen as a sign of prosperity. It is seen as a sign of wealth.

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So that also had led to, um, a lot of adolescent pregnancy.

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So, to sum up all of this, as someone… as a civil servant, as a government officer, and also an early career researcher.

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I've really tried my best to link this finding to the policy, to the system, and to integrate it, but again, with the limited resources, with a lot of constraints.

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I also take this as an opportunity, as a call for action to all the global community that are working in this sector.

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to work for this kind of marginalized, this kind of indigenous communities, because they are being masked out a lot.

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In terms of when we look at the national indicators versus when we look at the community, it's 14% versus 72%, so that's a lot of annuity, a lot of disparity.

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And a targeted evidence-based interventions are urgently needed, so I believe this global community will also.

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help build a kind of intervention for this community. So, thank you so much for organizing this and giving us a voice to raise this important issue.

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Thank you.

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Thank you so much, Gustamshella, for that wonderful presentation.

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Um, and I think now we can move to the next session, which is about, uh.

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A quick, uh, just a short pause for questions, and… and reflections. Um, so please, if, uh, anyone has a question.

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I think you can feel free to raise your hand, or you can use the chat. We have a few minutes for us to.

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Um, ask any questions and share our information. previous presentations.

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And the data, am I missing anything in the chat?

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Um, no, I think there are some, um… really some great comments, and appreciating all the excellent work that you all are doing.

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There were some questions in the Q&A box, so I would invite Lucas and some others to respond directly in the Q&A. You have access to that.

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Um… We have one hand up, I'm not sure if this is a question, but let me see if I can give the floor to.

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Abe bois? Do you have a question for our panelists?

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Isheti?

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Hmm.

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it might be… it might be just a hand that's accidentally up.

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Um, I think maybe we can just move on, innocent, and then we can see if there's time at the end for questions overall.

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Thank you so much, Nandita. Well, I think I can give the mic to Yonandita just to moderate the second panel.

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Super, thank you so much. Um, and just firstly, thank you again to all the panelists for this first session. I'm really… immensely impressed by the quality of the work.

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And really, the diverse questions that you were all asking, it's really impressive, and I'm just thrilled that you were able to share that with us today.

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So, for our next panel, we have four speakers, and I'm going to invite our first speaker. If you can go to the next slide, Innocent.

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Della Frida Ukaga, she is a public health practitioner.

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With years of experience in project management, strategic planning, program design.

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And her work spans maternal, child health, HIV, AIDS, prevention, and care.

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Um, she has a master's degree in public health, and is a MasterCard Foundation scholar.

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At the University of Edinburgh in the United Kingdom. So, Della Frida, you have the floor, and welcome.

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Thank you so much. license.

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Hi, um, thank you so much for the introduction. So, I'll be presenting the structural and social barriers.

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the face of female patents, perpetuous inventors. in Carlos State, Nigeria. So, for the purpose of this, um… presentation, I would like to highlight that the patent preparedness vendors are more like health-trained persons.

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who provide foster services and over-the-counter services in their communities.

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Next slide, please. So before I start, I want you to assume me to be Amina.

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who is representing the voice of many women in Northern Nigeria.

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Women like Amina make up most of the health workforce, but very few of them own health businesses.

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In Carlos State, for instance, we had this study was conducted.

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the ratio of one female PPAs to 16 female PPMVs, and constricting the.

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the religious constraints and barriers of women in counter states.

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It limits the object of family planning, as most women feel very comfortable.

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taking our family planning services from their female counterparts.

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In turn, through local government out of 44 local governments, there is no female PPMV, so that means that.

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In this ventrilo glucoma, there is low uptake of family planning services, so we conducted this story to understand the barriers.

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that limits females trained persons from having a PPM risk. Next slide.

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So this study was conducted among 96. female PPMVs that comprises both married and unmarried people, and we try to understand the financial, societies, and economic barriers that limit their participation in the FP service delivery. Next slide.

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Oh, Della Frida, you went on mute?

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Okay, sorry, sorry, yeah, okay, so they have. Um, through different, um, challenges that come off… that came up from this, um, research. The first one is financial exclusion. Unlike their female counterparts, the female PPMVs, the first strict our loan challenges.

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a higher interest rate. As a matter of fact, one of the women said that some.

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to show don't give loans to pregnant women. So imagine being told you can't expand your business.

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Simply because you have a child. The second one, uh, is, uh, business countries. Most women complained of debt, accumulation of unpaid clients, so most people clients come and they take up, um, some of their, um, products on credit and refuse to pay, and when they try to move further, they will call them heartless, or they are inserted.

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It makes it difficult for them to want to restock, so they just have smaller, um, products on the shelf.

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I'm not able to restock. The next one that came up is the Society challenges. Women running shops that offer family planning, they are often a target of stigma.

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some men intentionally don't go to female PPMV shop, because they are just… patronize women. Um, and sometimes one of these women, most of the marriage, when they succeed, they often.

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face pushback from their husband, and they are more successful than them, and from their families. So this particular challenge, or these three challenges.

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capture the vicious circle of. Barras are trapped swimming on the meet family uptake.

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in the communities. Next slide, please.

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So, identifying these challenges, what are we doing at Sites for Family Health? So, because we understand that this limits uptake of family planning.

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We had a project that we call a Supporting Women Increased Access to Family Planning.

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true patent and property medicine vendors. We call it the streets project. So basically, we are providing women with access to micro-credits. If some institutions refuse to give you, um, loans just because you might be pregnant or because they have a… we provide access to micro-credits.

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Where you can have access to, um, credits, and then, of course, the stimulator appointment of them that gives you the ability to pay at your own pace.

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We provide business mentorship, because that's one of the barriers that came up. People don't… most of these women don't know how to run a business.

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And then the vendor management system that helps them to track and stock their products. And the aim is just to establish foreign female PPMVs in Kerno states, ensuring that each community, because remember that admission, I mentioned that in three companies don't have any.

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So we want to ensure that at least each community has two or three main people, and they're serving.

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Provided, um, primary planning to women, and of course, other healthcare services to families.

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So through these initiatives, we hoped that women will gain financial independence, improve business management skills, and of course, increased.

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Um, confidence. Next slide, please.

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So, one thing that stood out that even amidst these challenges that, um, most of these women complain, they.

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They still say that even if it's hard, they will keep trying, because if they stop.

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who we help the women in their community, and this really touched us very well and made us go into, um, establishing or implementing these two projects. So, imagine if you remove these barriers, imagine how much women like Amina in Kendall State.

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what they can do. And remember that to empower women, we empower the communities.

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And this is not just for them, but the health and dignity of women across Nigeria, especially in making family planning services.

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available, at least on the South communities in Kerno State, Nigeria.

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Thank you so much.

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Wonderful. Thank you so much, Della Frida. Really inspiring work.

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Um, to all of you. We'd now like to move to our next presenter. I'm delighted to welcome Pushpa Joshi.

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She's a young feminist activist from Nepal. With years of experience to advance SRHR, and is the co-founder of Yoshan, youth-Led SRHR Advocacy in Nepal.

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So, welcome, Pushpa, you have the floor.

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Thank you so much. Um, next slide, please. Hello, everyone. Uh, today I will be presenting on the impact of, uh.

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criminalization of adolescent sexuality in Nepal, so I'd like to begin my presentation. Next slide, please.

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So, the title of my presentation is From Restriction to Rights, uh, Reforms for Adolescent Human Rights in Nepal. So, as I have already told, I will be presenting on.

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Um, uh, the current laws. criminalizing adolescent sexuality in Nepal and its impact on adolescent's health and well-being.

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Next slide, please.

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Um, so in 2023, Yoshan, in collaboration with Center for Reproductive Rights, we conducted a small study titled Forbidden Desire, Impact of Criminalization of AIDS Made Consensual and Non-Exploitative.

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sexual activities among adolescent in Nepal. So, in this study, we conducted a study in five districts in Nepal, located at different geographical locations within Nepal.

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And we conducted 17. key informant interviews and 8 focus group discussion involving 64 participants, including.

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young people and adolescents. Next slide, please.

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Um, so, talking about the background, um, of the laws surrounding sexual consent in Nepal.

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Uh, so according to the National Penal Code Act 2017, the section.

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219 criminalizes, um, sexual intercourse between two adolescents. Uh, who are both minors, um, and even if the sexual intercourse has been taken place with consent and without any exploitations.

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So, the section, uh, the subsection 2 of, uh, section 219 says that where a man has sexual intercourse with a woman without her consent or with a girl child below 18 years of age, even with her consent, the man shall be considered to commit rape on such women or girl child, and this law is applicable in cases where both.

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boy and a girl, uh, both are, um, close in A's and both are minors.

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So, the objective of the study was to assess and understand the impact of criminalization of AIDS made consensual.

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Uh, and non-exploitative sexual activity to… and to provide appropriate policy recommendations to the government and other duty bearers.

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Next slide, please.

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During the study we, uh, we had some very, uh.

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shocking and interesting findings. So, some of them are listed here. So, first one is family and societal Response. So, when family and society get to know that two people, both minors who are close in age, are engaged in sexual activities, the family, what they do is they… if the class and caste of.

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Both the boy and the girl are similar, and then the family forces them to get married even if they are not ready to get married. And the society, um.

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uh, stigmatizes both of them, and look at them, uh, in a very.

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Degrading way and talking about the response of school, schools usually restate.

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and expel students if they, uh, caught two students involving in sexual activities.

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And talking about the sexual and reproductive health risks effect.

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Um, on, uh, these, uh, affected adolescents, their, uh, right to access sexual and reproductive health are compromised, because when adolescents know that the sexual activities that they are engaged in is criminalized, then they are very hesitant to access.

00:47:04.000 --> 00:47:14.000
sexual and reproductive health services such as contraception, STI testing, HIV testing, and safe abortion rights and services.

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And it had also a negative impact on the psychological safety and well-being of adolescents, and some of them who have been reported by this criminalization have reported depression, anxiety, and other forms of psychological stresses.

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And, um, it, uh, the criminalization itself also negatively, um.

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negatively, uh, uh, affects the attitude towards sex and sexuality in general.

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And it has also caused developmental and social impacts of incarceration during adolescence.

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And one interesting finding is that people in Nepal are also.

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Also, um, misusing this law by only targeting Dalit boys.

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So, Dalit means, uh, the community in Nepal who falls under… falls at the bottom of the caste hierarchy.

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So, um, when… when the… when the parents of the girls know that their daughter is engaged in sexual activity with Adalit.

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Boy, then they immediately, um, immediately reports for statutory rape against that boy, but if the cast of the boy is higher, or the class of the boy is higher, then they force marry their daughter with that boy.

00:48:29.000 --> 00:48:45.000
Next slide, please. So, based on these findings, uh, some of the key recommendations and way forwards include decriminalization of AIDS made consensual and non-exploitative sexual activities among adolescents, urgent need for effective implementation of comprehensive sexuality education.

00:48:45.000 --> 00:48:53.000
Establishing a strong support mechanism for adolescents affected by the criminalization of consensual and non-explorative sexual relationships.

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transformation from punitive measures to systematic solutions, recognizing right to self-determination and autonomy of adolescents.

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structural reforms for social transformation, and Nepal should also adopt the Convention on Rights of Children Committee's General Comment Number 20, which emphasizes that non-exploitative consensual sexual behavior among adolescents of similar ages should not be subject to criminalization.

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And Nepal should respect the agency and evolving capacities of adolescents, as mentioned in the CRC, while making policies concerning adolescence.

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Thank you so much for your attention.

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Thank you, Pushba. What a fascinating piece of research, and thank you for your presentation.

00:49:36.000 --> 00:49:47.000

Um, really interesting, and certainly lots of complexity. Um, that… that are… that you're dealing with, and that many of us deal with in the settings that we work in.

00:49:47.000 --> 00:49:52.000
Thank you so much. Um, I'll now like to introduce our next presenter.

00:49:52.000 --> 00:49:56.000
Tonny Muzira, he's a community-driven leader and SRHR advocate.

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Uh, policy specialist, as well, with over 9 years of experience working both in Africa and Canada.

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Um, he's led youth mail, and refugee engagement initiatives.

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And serves as the country coordinator for the IYAFP International Youth Alliance for Family Planning.

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Welcome, Tonny, you have the floor.

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Thank you so much, uh, everybody, and also the previous speakers for the.

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wonderful presentations, and I also want to take this opportunity to.

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Uh, appreciate. I think it's first of its kind, if I'm not correct.

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for having such a session for people that. missed, um, in attending the ICFP.

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Uh, so thank you to the organizers, Innocent, thank you, Fandita, for that.

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Uh, so, I'll go straight, uh, like, I'll not introduce myself, uh, Vandita's Danit. Uh, let's go to the next stage.

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For the interest of time. Yeah, so basically, uh, this is something that.

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I have been actually working on with a couple of.

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young people in Uganda and the organization that I was working with at that time, the Foundation for Male Engagement, a non-profit organization that works with men and boys.

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to end violence against women and girls. And one of the things that we were pushing.

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It is the Family Planning Male Engagement Strategy. with something that we're pushing in at the district level. In Uganda, we have a structure of administration where we have.

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Uh, districts and, uh, uh… Uh, ensuring that this strategy is being implemented.

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So that main tech, uh, parcel. And ensuring that, uh, for me… because men, actually, it's… it's evident that, uh, they don't support women, uh, in terms of, uh, they're actually a barrier.

00:51:58.000 --> 00:52:04.000
For women because of culture barriers. In accessing from your planning. Next.

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Slide. Yeah, so, uh… We did some research, and uh… The figures you see, those are three districts, Luoka, Mayuke, and Oyam.

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Those are districts from the eastern part of Uganda, and Oyama is the northern part of Uganda, which is extremely poverty-strickening.

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And those are the contraceptive prevalence rates. Uh, you can see that, oh yeah, Mayuge is actually, uh, higher than the others.

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So the uptick is really, really low in those rural.

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areas because of so many barriers, the harmful gender norms.

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the limited male involvement, the reproductive coercion, so the harmful gender norms is the cultural barriers against men, because.

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of the Pacheco system, so usually men don't believe that women should, you know.

00:53:03.000 --> 00:53:08.000
You know, tech family planning services and, uh, which is one of the barriers.

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The limited male involvement also is one of the barriers.

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In regards to see that women are updating family planning, and also the reproductive.

00:53:19.000 --> 00:53:24.000
portion that comes oftenly as a result of these cultural barriers.

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So, it is… we actually also came to find out that.

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often the mental control of reproductive decisions, limiting women's autonomy. So women.

00:53:36.000 --> 00:53:41.000
Put in a vulnerable situation where they can make.

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an informed decision because men are taking control. as I said, because of those cultural barriers. Next slide.

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Yeah, so these are some of the interventions that we took.

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Uh, we had to mail engagement advocacy campaigns. We sort of had.

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dialogues in all these three districts. We had media outreach, we had educational sessions.

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And in those education sessions is when we. sort of trying to debunk those negative.

00:54:15.000 --> 00:54:19.000
attitudes that men that, you know, arise from those cultural.

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Um, you know, cultural barriers, so we train men on how it's important for.

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For them to support women, but also to ensure that women are making informed decisions.

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Uh, who were training male, uh, community leaders as family planning advocates.

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Our ticket was about 1,000 men. And, uh, 500 women, including marginalized.

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groups. Next slide, please. So, some of the key results, uh… So, we had a 40% increase in male participation in FP decision making.

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Uh, that is at a district level, so… Most of the men that we met, we actually were using different, uh.

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strategies. We're looking for men in bars, we're looking for men, uh.

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And different places where men converge, because literally men, these are things they don't want to speak about.

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So we're going into places of comfort. And uh… but using a non-judgmental.

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strategy in order to have their attention, in order to interest them into this sort of advocacy.

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And trust me, uh… It was… these were very interesting conversations.

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Uh, some of them were like, it was because of this, uh, this, uh, trainings.

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I'm now supporting my woman, I'm now taking her tenanto.

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We actually… we have 6 children, we have now agreed that we are going to have more children.

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I'm gonna ensure that my wife takes family planning, and most of them actually.

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They were actually confirming that they lacked this sort of.

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information, uh, out of lack of awareness. We also saw, uh, 35 increase better accompanying partners to FB clinics, I just.

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needed on that. We also saw 60% of women felt more empowered to make FP decisions.

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50% increase in men discussing FP with peers. Like I said, we used to go to bars.

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Uh, soccer tournaments, so you would find men are sharing this sort of testimonials.

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As a result of having this sort of conversations.

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Reduce reproductive coercion also reported, like I said earlier on in one of the issues.

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Uh, we saw women taking. making informed decisions, uh, that… that are really, really.

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Um, uh, mutual, mutual conversations with their men, uh.

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in their homes. Next slide. So, lessons and policy implications. So, one of the things we're actually emphasizing is we want to see.

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Male engagement works, but it must be a context-specific.

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Community leaders are powerful change agents, cultural resistance. persisted in rural OEM.

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Oyam is actually in the northern Uganda, like I said, initially.

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And there's a lot of cultural resistance there, so… So there's a lot need to be done that side.

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Uh, we also emphasize that policies should integrate male engagement component.

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at-risk gender norms and prioritize equity and marginalized groups, sustainable change requires long-term community advocacy.

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Next slide. Yeah, so in conclusion, we feel.

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If we have male engagement. That will address the issue of the uptick.

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That will address the issue of gender equity, which I'll have a shared responsibility that strengthens reproductive autonomy, most especially among women.

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And we also emphasize that this scalable model for rural Uganda and sub-Saharan Africa.

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Now, these are my words, that's why, in conclusion.

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It's important that all development partners and countries. sort of domesticate this and implement.

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The male engagement strategy is very important, because. Uh, because of so many cultural, um… you know, barriers, we find that men tend to make these decisions and then.

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Our goal is to ensure that there's autonomy among women and also optical family planning, you know, being increased.

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we were able to… to do this. actually project without funding.

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This is something I did with peers, and also.

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Organizational resources. I'll put this to everyone here. This is something we can actually scale up across in all countries.

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Because I feel, man, it is very important for us to involve men.

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Because when we are actually the perpetrators of most of these, uh.

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Uh, issues that are affecting women, and I will say this for everyone, including men that are on this platform.

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So it's important, uh… innocent and all other partners, we can have this sort of conversation next time. I didn't feel it came out really well.

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at the conference, and I feel it should be at the top of the conversation.

00:59:33.000 --> 00:59:41.000
If we are indeed to, uh… Uh, ensure that there's, uh, reproductive autonomy among women.

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Thank you so much, everyone, and thank you for the opportunity.

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Wonderful. Thank you so much, Tony, for your excellent presentation, and really.

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shedding some light on the importance of male engagement, and also.

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Um, showing that the research that you did is so… can be very impactful.

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Even with limited resources, so thank you for that.

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Um, I'd now like to invite our final speaker.

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Uh, to the floor, so if you can go to the next slide.

01:00:11.000 --> 01:00:19.000
Manisha Thapa, she's the program lead at Unity for Change, a youth-led organization working in SRHR in Nepal.

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Um, she's been working for reproductive rights policy advocacy, capacity building, and youth empowerment for over 5 years.

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And has championed over 200 young people, trained over 50 healthcare providers across Nepal. Very impressive.

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Um, welcome to you, Manisha. You have the floor.

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Thank you so much, Nandita. Um, hi everyone. I'm Manisha, uh, and I'm working as the program lead at Unity for Change.

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We are at Unifer Change is the organization led by trans men.

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And we work primarily for the SRHR of LBT plus individuals here in Nepal, specifically youths.

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I will be speaking about SRHR for Gender Diverse youth in Nepal.

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Could you switch to my slides?

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So, in Nepal, sexual and reproductive health and rights are still designed around, uh.

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Narrow binary understanding of gender and sexuality. Trans men and the LGBT plus individuals, many of whom are assigned female at birth.

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I rarely counted, consulted, or intentionally included in national SRHR policies and programs.

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This visibility has real and everyday consequences and people who menstruate but are not recognized as women still face stigma.

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And exclusion in schools, workplaces, and health facilities as well.

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Those who need emotion care often delay or avoid services altogether due to fear.

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Misinformation and discriminatory provider attitudes, while Nepal's constitution guarantees the right to live free from discrimination.

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SRHR systems continue to fail gender diverse communities and I believe that these gaps are not accidental, they are structural.

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And they determine who feels safe enough to secure, whose needs are legitimized, and whose bodies are left outside the system.

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Next slide.

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I've been working in SRHR in Nepal since 2021 after completing my undergraduate degree in public health.

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Over the years, I have coordinated a youth-heared SLHR initiatives across all 7 provinces of Nepal.

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With a strong focus on community ownership and inclusion in menstrual health, I coordinated school-based menstruation workshops and.

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Lead training of trainers for menstrual health activists explicitly integrating sessions on transmenstruation.

01:03:01.000 --> 01:03:11.000
Ah, which is the topic almost entirely absent from Nepal's SRHR discourse. Uh, this trained activists now lead com- conversations in schools and communities that challenge.

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Stigma and expand understanding of who menstruates in similarly in family planning and abortion, I coordinated community outreach.

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Media engagement and local government advocacy and through this work, 200 plus youth champions and volunteers collectively led.

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98 plus… Uh, community best sessions on safe abortion and family planning.

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And they raised over 6,000 people and engaged, um, 34 local governments across Nepal to push.

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For stigma reduction and service awareness. Um, as I recognized the deep gaps in the sedgehar for LBT plus communities.

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My work increasingly centered on gender diverse individuals, especially since the last year.

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Since last year, I have worked closely with trans men and LGBT plus groups to ensure.

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That SLHR information and. Um, SRHR information and services are inclusive as well as affirming. I contributed to Nepal's first research on transmensturation.

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Uh, titled Menstrual Discrimination Among Trans Men in Nepal, addressing a complete absence of evidence in this particular area.

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And through Unity for Change, we also continue to create mass media products, documentaries, sort animations, and digital campaigns.

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To shift public narratives around gender diverse HRHR. And, um, and, um, I was also fortunate to.

01:04:37.000 --> 01:04:47.000
Have they gotten the opportunity to coordinate, uh, media fellowship across all 7 provinces, supporting journalists to report responsibly on SRHR and abortion.

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And, um, laid valid clarification and attitude transformation. Bcat trainings for healthcare providers.

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Policymakers as well as, uh, content creators in Nepal.

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Um, while talking about this, this work is also challenging, but, uh, it is really, really essential, not just in Nepal.

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But, ah, for every part of the world. Um, and I have witnessed young trans and LBT individuals shed tears upon realizing confidence and relief when they felt seen.

01:05:18.000 --> 01:05:25.000
Safe and empowered through leading these initiatives, and this is why this work holds a very deep meaning to me.

01:05:25.000 --> 01:05:30.000
Um, next slide, please.

01:05:30.000 --> 01:05:36.000
Uh, Nepal's SRHR future depends on whether we move beyond token inclusion.

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Menstruation, family planning, and abortion must be recognized as sexual issues for all people who experience them.

01:05:42.000 --> 01:05:52.000
Including trans men and LGBT plus individuals, not only the cisgender. Snhr and pressing issues of mental health and climate change also cannot be treated in singular anymore.

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Community realities in Nepal, so that they are deeply interconnected, especially for gender diverse population facing.

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Who face layered stigma. And since youth across Nepal are already leading change in communities and local governments, it is time they are trusted not just as implementers, but as.

01:06:09.000 --> 01:06:17.000
But as decision makers and knowledge holders. Uh, thank you so much to ICFP for selecting me as a youth trailblazer Award winner.

01:06:17.000 --> 01:06:28.000
Um, at ICFP 2025, and platforms like this webinar, uh, matter especially when physical access to global spaces is denied due to passport privilege and.

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Other structural barriers. Um, thank you to all, and I hope to see you all in person somewhere.

01:06:38.000 --> 01:06:44.000
Super. Thank you so much, Manisha. That was really inspiring, um, and really excellent work.

01:06:44.000 --> 01:06:54.000
Um, so thank you to all of our. presenters, um… both of the second panel, but even the first panel, it's really impressive.

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to see the range of work that you all are doing.

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Um, in research, so we heard about some of the fertility work.

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Um, we heard about work in humanitarian settings, we heard about linkages.

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With health sectors like HIV. We heard about linkages with non-health sectors, like microfinance.

01:07:14.000 --> 01:07:19.000
Mm-hmm, that we heard about male engagement, working with trans and diverse gendered people.

01:07:19.000 --> 01:07:26.000
Um, really quite a range of topics. Um, so really, congratulations to all of you for your excellent.

01:07:26.000 --> 01:07:32.000
work and commitment to SRHR in your, in your communities.

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We do have a little bit of time, so we'd like to open it up for some questions.

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Um, before we go to our closing, um… And I'm gonna stop my sharing so that we can sort of have more of a dialogue.

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And then I'll go back when we go to our closing.

01:07:47.000 --> 01:07:54.000
So, raise your hand if you have a question, and I see, uh, one recon has a hand up. Go ahead, Juan.

01:07:54.000 --> 01:08:02.000
I'll let you go first. And if you can just introduce yourself quickly, that would be great.

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Okay. We've seen a lot with some of the.

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Colleagues on the team. I was part of the.

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Icfp Youth Subcommittee specifically with the Regional Youth Movement Work Stream. So.

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We've been working really closely with innocent and. Well, some other people here.

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I'm part of the pro familia youth network based in Bogota, Colombia.

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And I think that's it. I've been doing a little bit of arts and Lgbtq plus advocacy, so that I think that would be like my introduction.

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And well, I just had. Couple thoughts. 1st is regarding the last presentation. Manisha's presentation.

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I got excited, because I think that. Kind of link between earth as Rhr. And Lgbtq plus rights.

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Is really important, and I don't. Sometimes I don't see it that much.

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But it's great to have that, and it's something that also was discussed during the youth summit.

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The importance of bringing that differential focus.

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And populations, and also just.

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A bit excited, because here in Colombia. There are several organizations that are working towards creating a national translaw.

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Or also there is a Transhealth League. So there is a lot of work that's being done in a lot of political that's been done. So that's pretty interesting to see that's happening in.

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Other parts of the world. In just a second thought is the.

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I've heard a little bit about the work in rural spaces.

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And I've heard that conversation, but I just wanted to.

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Maybe highlight. The. Kind of the complexity of the Territories, because I live in the city, and if you go local well, if you imagine, like a.

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Bogotá. You see, you might think there's no barriers to family planning, or Srhr.

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But if you go really local. Bogotá, for example, is divided into 20 localities, and some are the South.

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I was talking to.

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I've reference from the Health Secretariat, and she told me, like.

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There's been a raising in. Early pregnancy rates here in some part of the south of the city, so I think that kind of brings us perspective, a more complex perspective regarding urban spaces and access.

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So I just wanted to share those couple thoughts. And thank you very much.

01:10:44.000 --> 01:10:55.000
Super. Thank you, um… For your work and great points. Do any of our panelists wanna… reflect a little bit, or respond. Um, I think the point about, sort of.

01:10:55.000 --> 01:11:02.000
access in rural, but. Having similar challenges even in urban spaces, is important.

01:11:02.000 --> 01:11:07.000
Betty? Thank you. Thanks, Juan.

01:11:07.000 --> 01:11:13.000
Um, other questions or comments from our… participants online.

01:11:13.000 --> 01:11:21.000
We have a few more minutes. No.

01:11:21.000 --> 01:11:28.000
It seems like our panelists, you've blown everyone away with your incredible work, um… Let me go to… let me go to Jacqueline.

01:11:28.000 --> 01:11:31.000
Mm-hmm, yeah.

01:11:31.000 --> 01:11:40.000
Tungbe, you have your hand up, you have the floor.

01:11:40.000 --> 01:11:46.000
Oh, okay. Um, thank you so much for the contributions.

01:11:46.000 --> 01:11:59.000
In presentation and also remarks from different speakers.

01:11:59.000 --> 01:12:02.000
Jacqueline, we lost you. Are you still there?

01:12:02.000 --> 01:12:10.000
And… in this discussion, I have caught here.

01:12:10.000 --> 01:12:11.000
Yes, but it's breaking up a little bit, but go ahead, let's see if it goes through.

01:12:11.000 --> 01:12:15.000
Can you hear me?

01:12:15.000 --> 01:12:21.000
Okay, thank you. So, um…

01:12:21.000 --> 01:12:33.000
Presentation is the contributions. I have caught, uh, some few things, and… Which I would like, uh, to take from this meeting, and also to… encourage both of us to work on.

01:12:33.000 --> 01:12:40.000
Uh, to make sure that we bridge this gap, uh, on contraceptive sex.

01:12:40.000 --> 01:12:47.000
I've seen that there is a great barrier to information. Uh, we still lack a lot of information, especially in.

01:12:47.000 --> 01:12:59.000
at the community. Uh, we… I have also seen the… There is a big gap to the service provisions. The service and the information available, also, they are not tailored, uh.

01:12:59.000 --> 01:13:04.000
to fit, uh, all diversity, tip of all diversity is a.

01:13:04.000 --> 01:13:10.000
LGBTQ community… people with disabilities.

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of violence, so these inpatience. In programs, in information, they should… we should give it an eye.

01:13:19.000 --> 01:13:26.000
on how are we going to improve them? Uh, to make sure that we… include all the groups, um.

01:13:26.000 --> 01:13:32.000
within our community. But also, also want to… I have seen… I have seen also a gap in.

01:13:32.000 --> 01:13:38.000
foreign laws. I think most of the… Uh, countries, we still have, um.

01:13:38.000 --> 01:13:44.000
a huge gap on the policies and laws, uh, regarding SRR issues.

01:13:44.000 --> 01:13:56.000
And contraceptions. I think we need to work more on finding, um… ways to have lolliforms.

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But also, uh, encourage promotions of new roles, which.

01:14:00.000 --> 01:14:05.000
uh, guide the provision of services, and also the protection against.

01:14:05.000 --> 01:14:12.000
3 months around these areas that we're looking for. I think this is my contribution for today. Thank you so much for this project.

01:14:12.000 --> 01:14:28.000
Thank you. Thank you, Jacqueline, for your comments, and… Let me give the floor to one last question from Oluwafemi. You have the floor, and then I'll turn it over to our panelists to see if they can respond.

01:14:28.000 --> 01:14:34.000
Oh, okay, so, uh, thank you, uh, excellent presentation thus far. So, this is Fermi Wolabi.

01:14:34.000 --> 01:14:42.000
I work in the NGO space, uh, particularly HIV program, and also integrating sexual reproductive health for particularly adolescents and young persons.

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So my question is that in the course of the conversation, there were no mention of one of the components of, um.

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sexual reproductive health, the post-abortion care, particularly for. young person, so it's important we also strengthen that, even though abortion is illegal in Nigeria, but that doesn't mean that, uh.

01:15:00.000 --> 01:15:06.000
We shouldn't cater for them, particularly when it comes to Manuel vacuum association, and also the administration of antibiotics.

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So those are conversations that we also, particularly WHO, that's also join us.

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that you'll also be integrated into the SR ratio, because, uh… Abortion happens practically every time, and we need to have the girl child have, uh.

01:15:20.000 --> 01:15:25.000
I like the story painted by S. Fish. happening in a carnal state, so.

01:15:25.000 --> 01:15:36.000
Those are things that we need some level of policy makers to engage a federal mutual to ensure that these things are well integrated for access. Thank you.

01:15:36.000 --> 01:15:43.000
Thank you so much for that point, and it's true, I think we need… we… and I think we did hear it, sort of the range of SRHR.

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issues, and it's important to address. the range, and we know that the range of services is quite.

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quite large. Thank you all for your participation. Let me turn it over to our panelists to see if anybody wants to.

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comment on some of the questions, or just give some reflection.

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Before we turn it over to Kelly for our closing.

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Name of our panelists want to reflect a little bit?

01:16:10.000 --> 01:16:11.000
Yes. Go ahead, Delafrida, you have the floor.

01:16:11.000 --> 01:16:20.000
Hi, yeah, um, let me just… Okay, yes, yes, so, um, I just want to, um, reflect on what, um, I think I've forgotten his name, mentioned about.

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I'm the lessons and persons in the urban areas. Um, I, um, I'm going to use Nigeria as a case study here.

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So, you cannot compare the services that are in the urban area to those in rural areas. You cannot, um, compare the advantages that those in urban areas have as well.

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Marissa's access to healthcare facilities in urban areas. When newer areas, a lot of questions have to go a long way, many kilometers just assess the basic, simple care.

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So, which means, like, sometimes, um, the interventions are targeted towards those people.

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I'm going to also reflect back on one of the, um… documentation by WHO, why didn't Mrs. X die? I don't know if anybody had access to that. And when you look at some of the reasons why she died.

01:17:06.000 --> 01:17:21.000
is because she didn't have access to healthcare facilities. She didn't have access to aftercare, pregnancy care, and these are things that are very easily accessible in urban areas. So, which is why it looks like… it's not like this urban areas have really been neglected at all, it's just that.

01:17:21.000 --> 01:17:28.000
more effort are put into the rural areas, because those are the people who suffer the most. And also, when you compare the economic, um.

01:17:28.000 --> 01:17:36.000
economic capabilities of these two people in these two different areas, then you understand why interventionals go to this. I just want to highlight that, so it doesn't look like.

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of course, I just go into the writing. So just based on these facts. And there's data to back it up as well.

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Thank you so much.

01:17:46.000 --> 01:17:55.000
Thank you, Della Frida, for that comment. And I think, clearly, all of your work and the comments from our guests online illustrate the complexity.

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Of working in SRHR, and the number of nuances, and that's why.

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Research is so important, and here at WHO, we believe in generating that evidence that's based on local realities.

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And making sure that everything that we're doing programmatically is driven by the science and the evidence.

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This is why the research that you're doing is so important, because there is that nuance, there are contextual.

01:18:19.000 --> 01:18:24.000
differences, um, but this is why this work is so, so critical.

01:18:24.000 --> 01:18:31.000
So thank you again to all of our panelists. There's a lot of dynamic discussion in the chat as well, so thank you to our audience.

01:18:31.000 --> 01:18:36.000

for staying engaged. Um, I'm going to now turn it over to, um.

01:18:36.000 --> 01:18:44.000
Kelly Wellborn, to give some closing remarks. Um, Innocent, can you pop the slide up quickly? I just want to introduce.

01:18:44.000 --> 01:18:51.000
Kelly, give her a proper introduction. Um, Kelly Wellborn is, uh, from the Gates Institute.

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At the, uh… what's it called now? Senior Gates Institution of Population?

01:18:58.000 --> 01:19:02.000
Um, Kelly, you can correct me, I know they changed the name recently.

01:19:02.000 --> 01:19:09.000
Um, but more importantly, Kelly is sort of the brains and the passion behind the International Conference on Family Planning.

01:19:09.000 --> 01:19:15.000
And has worked tirelessly to make sure that. The conference is as inclusive.

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And as diverse as possible, and so we really appreciate all of her efforts.

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And her support, um, for this session here today.

01:19:24.000 --> 01:19:28.000
So, Kelly, uh… Welcome, and you have the floor.

01:19:28.000 --> 01:19:36.000
Thank you so much to each and every one of you for taking the time to come together with us and present your work.

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It's a… it's… Uh, nature of international conferences, unfortunately, these days, that it's, you know, difficult to get everyone.

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into the same place, um, especially when we're trying to.

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expand the locations across the globe. Where we host the ICFP.

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But this was the first time that the ICFP was hosted in Latin America, which was something that the community across ICFP had been clamoring for.

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For a long time. And so we were just really delighted to be able to host it in that… in that area of the globe.

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But really understanding that there would be some people that would not be able to make it there, so… We really love to lean into these moments that we have, uh, virtually.

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to ensure that light is being shined on the work that you're doing, because it is so incredibly important, especially the next generation of leaders in this work.

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You all are… The reason why we continue to progress and we continue to.

01:20:43.000 --> 01:20:59.000
to push, uh, for. these… this… incredibly wide range of issues that you've all raised today, uh, between body literacy and advocacy, for sure, male engagement, etc.

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we look to utilize not just the conference at ICFP, but the platform on which it sits.

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Um, that really has activities and things moving in between the conferences year over year.

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To really bring all of these different topic areas and areas of work, not just research, but program implementation and advocacy efforts.

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to the fore, so that we can continue as a larger collective.

01:21:29.000 --> 01:21:32.000
to move our work forward and to ensure that.

01:21:32.000 --> 01:21:37.000
Reproductive… sexual and reproductive health and rights do not fall off the global agenda.

01:21:37.000 --> 01:21:46.000
Which seems to be at risk these days, so… I just… I want to appreciate you, each and every one of you, for your work.

01:21:46.000 --> 01:21:54.000
And for doing this work in, in, um… in this time that we're in, and advocating for, uh.

01:21:54.000 --> 01:21:58.000
all of these different… all of these different populations.

01:21:58.000 --> 01:22:03.000
Um, and I… I want to make sure that.

01:22:03.000 --> 01:22:10.000
That we are continuing to highlight. the work that young people are doing across the field.

01:22:10.000 --> 01:22:16.000
Uh, so that we can elevate your voices and ensure that the SRHR community.

01:22:16.000 --> 01:22:23.000
Uh, is… is listening. And is… is moving things in a direction that you'd like to see it move.

01:22:23.000 --> 01:22:29.000
So, really, kudos to each and every one of you for the work that you're doing.

01:22:29.000 --> 01:22:33.000
and the impact that you're having in your communities and across the globe.

01:22:33.000 --> 01:22:43.000
And I'm just looking forward. to engaging with you across the ICFP platform and in other ways. I know we have so many here from IYAFP, and.

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and other, you know, partnerships that we have, so… Thank you so much, and we look forward to.

01:22:50.000 --> 01:22:56.000
Continuing to see you on youth subcommittees and other subcommittees across ICFP.

01:22:56.000 --> 01:23:04.000
Uh, to really ensure that we're. collectively moving things forward together, so… Thank you.

01:23:04.000 --> 01:23:10.000
Thank you so much, Kelly, for your commitment and support and passion for this work.

01:23:10.000 --> 01:23:16.000
Um, so with that, I think we are coming up to the end of our time.

01:23:16.000 --> 01:23:21.000
Um, I just wanted to, um… highlight a couple of things.

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One, the webinar will be recorded. Actually, Innocent, sorry, if you can pop up that last slide, just so people know where to access things.

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Um, the webinar will be recorded. We're going to try to post it on the IBP Network site, as well as the ICFP.

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site, um, the Youth Subcommittee and the program implementation pages.

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Um, I have shared the slides as a PDF in the chat, so you can look at them there.

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And we can also share them more widely. Please do visit the ibnetwork site to learn more about our network.

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And the many communities of practice that we have, including on.

01:23:58.000 --> 01:24:03.000
Uh, fertility care, male contraception, some of the topics we heard today, trans health and others.

01:24:03.000 --> 01:24:10.000
Um, and also, please do visit the ICFP site as well. As Kelly mentioned, there's a lot of resources there as well.

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including various communities and ways to get involved. So with that, I think we will close our session. I would like to thank our panelists once again.

01:24:22.000 --> 01:24:26.000
For your dynamic work and commitment to this field.

01:24:26.000 --> 01:24:32.000
Thank our participants, and thank our… my co-chair, Innocent. Innocent, do you have any last words?

01:24:32.000 --> 01:24:40.000
Um, well, no, I think Gary and Tionadita said it all. I'm just happy as we're talking and see conversations online.

01:24:40.000 --> 01:24:51.000
Uh, been tagged on LinkedIn and other platforms, so please keep sharing your reflections, um, so we can make the conversation moving forward. And maybe this shouldn't be the last. We should keep organizing this.

01:24:51.000 --> 01:24:58.000
Conversations, I think it's very, very important. So, looking forward and many, many, many thanks to everyone who attended, but also to our wonderful speakers today.

01:24:58.000 --> 01:25:01.000
Really great lessons. Every one day.

01:25:01.000 --> 01:25:09.000
Thank you. Thank you, everyone. Thank you, Innocent. Um, enjoy the rest of your day, and let's keep this conversation going.