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POLICY BRIEF ON

STRENGTHENING DELIVERY OF COMPREHENSIVE SEXUALITY EDUCATION

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ABBREVIATIONS

AIDs	Acquired immunodeficiency syndrome
BBS	Bangladesh Bureau of Statistics
BDHS	Bangladesh Demographic and Health Survey
CPR	Contraceptive Prevalence Letter
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organisation
EmOC	Emergency Obstetric Care
FP2030	Family Planning 2030
HIV	Human Immunodeficiency Virus
KII	Key Informant Interviews
LMIC	lower/middle-income countries
MCH	Maternal and Child Health
MoHFW	Ministry of Health and Family Welfare
NGO	Non-Government Organisation
SDG	Sustainable development Goals
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
STD	Sexually Transmitted Diseases
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNICEF-EU	United Nations Children's Fund European Union
UPHCSDP	Urban Primary Health Care Project
WHO	World Health Organisation

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POLICY BRIEF ON STRENGTHENING DELIVERY OF COMPREHENSIVE SEXUALITY EDUCATION

COUNTRY SITUATION ANALYSIS ON COMPREHENSIVE SEXUALITY EDUCATION

Policymakers, public health professionals, and other stakeholders in Bangladesh are familiar with the fact that the adolescent (between 10 and 19 years) population in Bangladesh stands at 36 million (more than one-fifth of the country's total population (BBS 2015)). Despite these demographic imperatives as well as compelling demand for health in general, and SRHR services in particular, for this age group, there are not adequate options for them to access either information or services.

Bangladesh has practiced a progressive rate of CPR (contraceptive prevalence rate) in less than forty years from 8% in 1975 to 62% in 2014 to 64% in 2022 among currently married women aged 15–49 (BDHS, 2022), whereas the total fertility rate is 2.0% (BDHS, 2011). Though sexual and reproductive health and rights (SRHR) are people's fundamental rights, they are facing challenges in accessing them. Though SDG (sustainable development goal) 3.7 mandates the attainment of universal access to SRH by 2030, LMICs (lower/middle-income countries) still have limited knowledge regarding SRHR (Desrosiers, A., Betancourt, T., Kergoat, Y. et al., 2020). While SRHR education needs to be promoted, it is more important to make CSE (comprehensive sexuality education) available to challenge taboos that limit its acceptance by stakeholders and the community.

This means giving young people tools i.e. knowledge to understand and assert their rights and challenge non-productive societal conventions thus creating better futures for themselves and future generations. By 2020 it was targeted to access contraceptives for an additional 120 women and girls in 69 poorest countries; whereas only 46 million were reached. (The Arc of Progress 2019-2020. FP2030), hence there is a need to extend the target timeframe. Evidence shows that only 36% of even educated women and girls have knowledge of SRHR and that interventions tailored to specific country needs will assist success in CSE.

WHAT IS CSE

The goal of CSE is to enable youth to attain improved mental, social, and physical health. International standards state that CSE should include the fundamental topics that the curriculum must always teach. These include diversity, partnerships, freedom from violence, SRHR and HIV, sexual citizenship (the acknowledgment of one's right. to sexual self-determination and. the recognition of that equivalent. right in others.) rights, enjoyment, and gender equality. CSE contributes to the overall well-being of individuals by promoting sexual health, reducing the risk of unintended pregnancies and STIs, fostering healthy relationships, and addressing issues related to gender-based violence and discrimination.

INITIATIVES AND SITUATION ANALYSIS

It is a common scenario that an adolescent who is about to enter puberty must overcome these obstacles on their own, without assistance from parents, guardians, family members, educators, counsellors, or the government. Social, cultural, religious, and fear of societal repercussions prevent the involved parties from appropriately and freely giving the new adolescents the necessary "education" on the complexities of growing sexuality and reproductive health.

Evidence shows that adolescents still face significant obstacles when it comes to making wise decisions in life, participating in unsafe or undesired sexual behaviour, receiving inadequate care, and having unfavourable health outcomes (BDHS 2022). Both boys, girls, transgender, and other cis-gender experience discrimination; for girls, this takes the form of child marriages, high fertility rates, high risks of domestic violence, rising rates of sexual assault, and higher secondary school dropout rates as a result of Bangladesh's patriarchal societal norms. Again, boys face pressure to comply with prevailing norms of masculinity, which drives them to risky behaviours such as unsafe sex, violence, and substance use. All these factors have a direct as well as indirect influence on the health and well-being of adolescents, and form an essential component of the context within which health issues of adolescents should be understood. Early sexual risk, which includes getting married and engaging in sexual violence, can lead to unwanted pregnancies, poor mental health, and the acquisition of HIV and other STDs. The availability, accessibility, and utilisation of essential SRH services are adversely affected by gender disparities and the societal stigma attached to engaging in sexual activity throughout adolescence.

Furthermore, social, cultural, and religious taboos prevent children from utilising the little resources that are accessible to them; also, these same taboos prevent school counsellors, guardians, and instructors from providing them with individual counselling and assistance. They lack the necessary information and training about sexual and reproductive health for the same reasons. CSE, which is unfamiliar to most people, aims to provide adolescents and young people with the knowledge, skills, attitudes, and values they need to achieve their health, well-being, and dignity.

The causes of these issues include systemic poverty, a lack of knowledge and resources, unfavourable societal norms, low educational attainment, prejudice against the sex industry (productive of FP commodities), child marriage, and early adolescent girls' childbearing. The obstacles faced by individuals who are disadvantaged and vulnerable due to their living situations are diverse and compound the difficulties they face as they grow from childhood to adolescence.

Throughout the findings from field interviews, it has been found that students expressed that the absence of support from reliable sources (guardians, teachers, or other relevant community members) drove them to seek information from unreliable sources i.e. their fellow students and or the internet. They felt that each category of adolescents has a different need e.g. adolescents who live on the streets, in slum dwellings, in char and haor areas, who suffer from a disability, married and/or pregnant adolescent girls, those who are child labourers, or those who are in detention or are refugees and/or live in refugee camps will need special interventions to meet their overall health needs. It was also stated that students were not examined on the CSE topic hence there was no pressure on the students to learn the contents; teachers were also not interested in teaching these topics.

However, the teachers from the field interviews, acknowledged that they had no control over the lessons that were scheduled to be taught. They avoided taking a rights-based approach to gender and sexuality and instead gave messages that were outdated and unconnected to the realities of the youth. Their reluctance to share information and ideas about sexuality and reproduction also harmed their training and sensitiation initiatives. Documented evidence (Zakaria M, Karim F, Mazumder S, et al. 2020, Bangladesh Demographic and Health Survey 2014; 2016) also shows that existing cultural norms/ taboos, social upbringing, religious codes, and superstitions prohibit them from accessing appropriate education/ information about sexual and reproductive health resulting in unplanned and out of marriage pregnancies, STIs and HIV/AIDs (1%). These have been identified as probable causes of CSE and national adolescent health programs falling short of their targets.

It is also found from the field findings that a significant impediment to the availability and accessibility of authentic resources for adolescents is the absence of suitable teaching/ learning materials, the teachers' inhibitions, and their lack of professional training to offer CSE. The lack of progress and adoption of CSE in educational institutions may be attributed in large part to bureaucratic shifts, sluggish decision-making and funding distribution procedures, and a lack of cooperation among several ministries (including youth affairs, health, and education).

RATIONALITY OF THE POLICY BRIEF

Considering the facts, and learning from documented evidence and meetings conducted in schools with teachers, parents, guardians, and girls and boys reveal that there is a need for these adolescents to have free and ready access to knowledge products and physical services. A study conducted jointly by SERAC-Bangladesh, Agni, and Share-Net Bangladesh identified the need to tailor CSE in line with adolescent preferences and social norms of Bangladesh.

This concise survey of the literature demonstrates differing degrees of understanding on many facets of this wide-ranging subject. Over the past 20 years, the government of Bangladesh, non-governmental organisations, development partners, and civil societies have all made significant financial and effort investments. We have also learned a great lot about participant-oriented CSE and adolescent-focused healthcare delivery systems. There are several chances to modify these lessons as the stakeholders work together to fulfil a national aim of shifting the emphasis of long-term services and support from institutional to community settings. Since the CSE idea is around long-term services and support, this corpus of literature containing evidence-based approaches will serve as a solid foundation.

It is essential to examine both inside and across the many disciplines involved in creating services for a varied and expanding adolescent population to fully comprehend the range of methods for creating adolescent-friendly communities. We must create innovative solutions based on multidisciplinary teams bringing together their complementary areas of expertise in public health, health care, social work, public policy, urban planning, housing, transportation, and engineering, to name a few, to address the complex needs

of young people. Perhaps a beginning in the right way would be to create organic collaborations between Ministries, Departments, Development Partners, CSOs, and other pertinent stakeholders to realign their objectives and prevent wasteful spending of limited resources.

This policy brief strives to identify existing knowledge and gaps in CSE among the community people including adolescents, youth, women, men, and other diversified people. After considering the facts and reviewing demographic, social, and economic forces establishing the need for youth-friendly initiatives, this advocacy toolkit summarises key government interventions expanding their scope and utilisation. It will also draw the attention of policymakers for further advocacy opportunities. It also fills a gap where adolescent health issues were not addressed comprehensively in other policy documents. This brief also summarises the research findings on adolescents and young people's experience of SRHR from early adolescence, with a special focus on those living with HIV. It also highlights key programming considerations to support SRH and rights for this population including multi-sectoral action. This brief is part of a broader series that aims to support the translation of research into improved adolescent SRHR and HIV programming.

It is anticipated that the aforementioned policy brief's recommendations will be given careful thought by development partners and policymakers when creating future SRHR policies, as well as by educators, parents, teenagers, communities, and other stakeholders when putting the policies into practice.

CSE INITIATIVES

The Government of Bangladesh has taken positive steps by creating The National Adolescent Health Strategy 2017–2030, which envisions that by 2030, all adolescents in the country will be able to enjoy a healthy and productive life. The government is aware that investing in adolescent health will have an immediate and direct impact on Bangladesh's health goals as well as the achievement of the Sustainable Development Goals (SDGs), particularly goal 3 (ensure healthy lives and promote well-being for all at all ages), 4 (ensure inclusive and equitable quality education and promote lifelong learning opportunities for all), 5 (achieve gender equality and empower all women and girls), and 8 (promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all). Entrusted with the responsibility of ensuring the successful execution of this policy, which would improve the general health and well-being of all Bangladeshi adolescents, is the Ministry of Health and Family Welfare.

INTERVENTIONS OF THE GOVERNMENT SECTOR

- The Ministry of Health and Family Welfare (MoHFW) has the primary responsibility for addressing the health needs of adolescents and providing quality services for the same. It includes the provision of Adolescent Friendly Health Services (AFHS), school health programmes, counseling, and raising awareness among adolescents on reproductive health issues and preventing STIs and HIV/AIDS through education and treatment services;

- Expansion of Emergency Obstetric Care (EmOC) services including 24/7 delivery centres, immunisation programmes for adolescent girls, and establishing referral linkages between school health clinics and other health facilities are other initiatives that will directly contribute to improving the overall health of adolescents;
- The Ministry of Local Government, Rural Development and Cooperatives, under the Urban Primary Health Care Project (UPHCP) provides adolescent health services in a majority of municipalities and all City Corporation areas.
- The Ministry of Education has included adolescent health issues in the formal school curricula and the Ministry of Social Welfare, through its centres for street children and juvenile delinquents, is providing valuable support, including health-related services, to extremely marginalised groups of adolescents.
- Legal support and skills training provided to women, including adolescent girls, by the Ministry of Women and Children's Affairs, and youth advocacy
- The Ministry of Youth and Sports provides livelihood training and peer education through Youth Clubs.

ROLE OF DEVELOPMENT PARTNERS

Development Partners, including UN agencies i.e. UNFPA, WHO, UNICEF, and UNAIDS and bilateral and multilateral donors in conjunction with the Ministry of Health and Family Welfare (MoHFW) have played a noteworthy role in addressing adolescent health issues including education, nutrition, rights, empowerment and systemic issues such as monitoring progress and promoting adolescent participation. Bilateral donors have primarily provided technical and financial support through their partners and have highlighted the importance of adolescent health issues and to a certain extent ensured the availability of services to meet the health needs of adolescents.

ROLE OF CIVIL SOCIETY ORGANISATIONS AND THE PRIVATE SECTORS

Under the leadership of the Directorate of Health, Maternal and Child Health (MCH) Services Unit, a large number of national and international NGOs have been involved in designing and implementing education programs, raising awareness through knowledge and information on health issues, the delivery of health services for adolescents and the provision of peer education and life skills for capacitating adolescents to claim their rights, addressing the health needs of highly marginalised groups such as adolescents living on the street, adolescents employed in risky jobs and adolescents working in hazardous environments.

CHALLENGES, MYTHS AND FACTS TO IMPLEMENT CSE

Even after decades of supporting sexuality education, it still faces social antagonism in communities that are not at par with the changed times. This in turn negatively impacts (UNESCO, 2019)-

- policy-makers and civil servants' diligence in taking the necessary measures;
- lack of access to appropriate curricula and training resources covering a comprehensive range of key CSE topics;
- teachers' attitudes and readiness to deliver a curriculum and create the right classroom conditions for effective teaching and learning;
- students' motivation; and
- parents' cooperation.

Additionally, the below-mentioned factors are also explored and brought out through the study process including (UNESCO, 2017):

- Systemic issues that the education sector faces, including budgetary and human resource limitations, deteriorating facilities, and conflicting agendas.
- Changes in important persons or turnover in the education system are necessary to guarantee that enough teachers are educated, both at the classroom level and at higher levels where political commitment is formed and maintained.

- Modifications to the educational system affect implementation plans and their momentum in addition to causing a loss of political capital.
- At the local level, coordination and cooperation are still lacking. These have been reinforced in certain places, but much more work has to be done to guarantee that all parties involved national, regional, and local stakeholders understand their respective roles and duties and that the necessary systems are in place to allow for the effective implementation of CSE and, potentially, its scaling up.
- Weak linkages between schools and ASRH services and low demand creation in many countries affect the usage of SRH services and rights, and thus the SRHR outcomes of adolescents and young people.
- Financial limitations, which prevent some nations from implementing or expanding CSE. While outside assistance can be crucial, without government backing there would be no full implementation or scale-up, and no possibility of long-term sustainability.
- The decisions of governments concerning funding social policies and services are critical to children. If allocations are insufficient, concentrated on better-off groups, or used poorly, all children, and especially the most disadvantaged, risk losing access to services and programmes that enable them to survive and thrive, learn, be free from violence and exploitation, live in a safe and clean environment and have an equitable chance in life.

IMPACT OF LOW-QUALITY EDUCATION AROUND CSE

Public finance management (PFM) issues are directly responsible for a large number of difficulties of drop-out students, low-quality education, etc. For instance, increased teacher absenteeism frequently results in low-quality education; this in turn may be caused by delayed wage payments as a result of inadequate financing flows. Adolescent health outcomes are negatively impacted or non-existent when essential SRHR supplies and services are unavailable as a result of inadequate funding allocation or poor cost estimation (UNICEF-EU Public Finance Facility for South and Southeast Asia, Third Interim Report, August 2021 – July 2022).

Even though there have been major national initiatives to increase the choices for providing SRHR services to adolescents and youth through CSE, there are undoubtedly still a lot of objectives unmet in this field. The government of Bangladesh, development partners, national and international NGOs, civil societies, and other key stakeholders have expressed interest in working together to create opportunities that will allow adolescents, both boys and girls, to learn and live with dignity in a community. But for this to take place, there has to be political will to support the suggested activities, together with a consistent and timely supply of funding.

RECOMMENDATIONS

Increasing the amount of comprehensive sexuality education taught in schools to foster adolescent-friendly cultures is a challenging aim that calls for the coordination of several financial and human resources. There are several tiers and categories of services, including timely and sufficient funding for teacher preparation, content appropriateness reviews of the current curricula, political will, and a nurturing atmosphere. As a starting point, the following recommendations aim to expand the existing capital.

- Time and resources allocated for generating this knowledge product allowed only a cursory glance at this important topic. Many elements are too many to evaluate or investigate in detail. As a result, enough time and resources should be set aside for thoroughly reading the body of knowledge already available on the subject.
- If these instructors are not available, efforts should be made to designate a health expert who has previously completed such extensive training to visit a certain number of schools and provide these types of courses. Naturally, money needs to be set aside to cover the cost of the services.

- Secondary as well as primary data collected from the KII (key informant interviews) with school teachers, adolescent boys and girls, and parents/guardians indicate that the teachers entrusted with the tasks of teaching CSE lack training on these specific topics. The few who have received short training inputs are inhibited by their upbringing, societal norms, and community scrutiny; they are ill-equipped to deliver such content. Each school should have dedicated teachers, with rigorous training in content delivery; because girls and boys learn differently, training should also be imparted to the teachers on how to deliver said content to boys and girls.
- Examining students on these topics should be mandatory so that both students and teachers feel responsible to teach and study them.
- Schools should have in-house, trained counselors to assist students through difficult periods of their transition into useful and productive adolescents equipped with life skills.
- CSE content must be addressed through life skill-based education and edutainment content so that boredom can be eradicated. Incorporate Comprehensive Health and Life Skills Education, which encompasses the fundamental components of CSE, into both in-class and after-school programmes and merge Life Skills and Comprehensive Health.

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