Knowledge hub
-
Collection of best practices

Summary of the best practice

1. Title of the best practice (e.g. name of policy, programme, project, etc.) *

Unite for Body Rights

2. Country or countries where the practice is implemented *

Bangladesh

3. Please select the **most relevant** Action Track(s) the best practice applies to *

- [x] Action Track 1. Inclusive, equitable, safe, and healthy schools
- [ ] Action Track 2. Learning and skills for life, work, and sustainable development
- [ ] Action Track 3. Teachers, teaching and the teaching profession
- [ ] Action Track 4. Digital learning and transformation
- [ ] Action Track 5. Financing of education

4. Implementation lead/partner organization(s) *

Unite for Body Rights Alliance

5. Key words (5-15 words): Please add key descriptive words around aims, modalities, target groups etc. *

Trained teachers, youth-friendly service centers, counselling, focused on in- and out of school young people living in poor urban, semi urban and rural communities.

6. What makes it a best practice? *

UBR program interventions allowed for sustainability of the work enunciated by working with the relevant Government officials, parents and community leaders. SRHR of young people is not purely a health issue, it also goes beyond. Support from teachers, community leaders and policy makers need to create an enabling environment.

Description of the best practice

7. Introduction (350-400 words)
   This section should ideally provide the context of, and justification for, the practice and address the following issues:
   i) Which population was affected?
   ii) What was the problem that needed to be addressed?
   iii) Which approach was taken and what objectives were achieved? *

Bangladesh society is conservative and gender inequality is in every spheres of life. Talking about reproductive health or sexuality is embarrassing for most people with a culture of silence – both at home and at the policy level in society, open discussion regarding SRHR issues is not encouraged. In order to prepare adolescents & young people for a healthy sexual life and for healthy relationship, it is imperative that they are provided with accurate information and clarification for any misperceptions. Worldwide, it is highly recommended to adopt comprehensive sexuality education (CSE) to address increasing gender violence and gender inequality in the society. In order to realize such goals, The UBR Programme (2011-2020) was launched, supported by Dutch SRHR Alliance and the Embassy of the Kingdom of Netherlands in Bangladesh. The project worked towards realizing an enabling environment in which each individual can exercise his/her sexual and reproductive rights. Access to services and education, supportive laws and legislation, and increased acceptance of sexuality and sexual rights of all people were the building blocks of this enabling environment.
Project Objectives were:
1. Increased awareness on comprehensive sexuality education (CSE)
2. Increased utilization of comprehensive SRHR services, targeted at youth and poor people
3. Reduction of Sexual and Gender Based Violence
4. Increased acceptance of sexual diversity and gender identity

Besides the three pillars of i) sexuality education, ii) youth friendly services and iii) creating an enabling environment, UBR also intended to improve the SRHR situation of young people by building the capacity of civil society, and the implementing organizations. The program worked towards a society free of poverty in which all girls and boys are able to make safe and informed decisions on SRHR irrespective of their ethnic, cultural and religious background, age, gender and sexual orientation. It focused on improving SRHR knowledge and access to SRH services, by providing CSE as supplementary reading materials, improving health providers' capacity to provide YAFH services, and working with communities to create a more supportive environment in which young people can attain their SRH rights. Specific focus was on male engagement, women's rights (gender equality), sexual minorities, menstrual hygiene management and HIV/AIDS. New partners have been attracted to ensure the quality of these topics to be mainstreamed within the program.

8. Implementation (350-450 words)
Please describe the implementation modalities or processes, where possible in relation to:
i) What are the main activities carried out?
ii) When and where the activities were carried out (including the start date and whether it is ongoing)?
iii) Who were the key implementation actors and collaborators? (civil society organizations, private sector, foundations, coalitions, networks etc.)?
iv) What were the resources needed (budget and sources) for the implementation? *

Main interventions:
Capacity building of civil society
- Train teachers to deliver Comprehensive Sexuality Education in schools.
- Train Youth Officers to deliver Comprehensive Sexuality Education.
- Train health workers on Youth Friendly Service Delivery according to national standards.
- Build capacity of community stakeholders and young people to support advocacy strategy and hold the government to account.
Service delivery at clinic and community level
- Provide Youth Friendly Sexual and Reproductive Health Services through UBR health clinics.
- Organize SRHR sessions for parents, men, community and Government stakeholders.
Policy influencing
- Advocacy for inclusion of CSE in Teacher Training Curriculum and of YFSRHR service provision in national Health Worker Training Curriculum.

Project period:
UBR program started in Dec 2011 with the phase 1 implementation run till Dec 2015. In 2016, the phase 2 started for another 4 years (2016-2019). In December 2019, the project was further extended with a 'no-cost' extension for two (2) months (January-February 2020), followed by a costed extension from March –December 2020. The phase-out and sustainability process were mainly carried out during this extension period.

Partners and collaborators:
UBR phase 1 was implemented by five organizations – Family Planning Association of Bangladesh (FPAB), Population Services and Training Center (PSTC), Dustha Shasthya Kendra (DSK), Christian Hospital Chandraghona (CHC) and Reproductive Health Services, Training and education Program (RHSTEP) – in 12 Upazillas. UBR phase 2 was implemented by 6 (six) implementing partners: Family Planning Association of Bangladesh (FPAB), Population Services and Training Center (PSTC), Dushta Shasthaya Kendra (DSK), Bangladesh Nari Progati Sangha (BNPS), Association for Prevention of Septic Abortion, Bangladesh (BAPSA), and Reproductive Health Services Training and Education Program (RHSTEP) along with 5 (five) Technical partners: Naripokkho, Bondhu Social Welfare Society, BRAC Institute of Educational Development, Simavi and Rutgers.

The program implemented a Whole School Approach (WSA) through a Taskforce. UBR school taskforce consists of representatives from School Management Committee & headmaster, teachers, students' cabinet/ alumni, parents, community gatekeepers, officials of relevant government departments (like department of education, health & family planning, local govt. & engineering, women & child affairs, youth etc.) and relevant experts. Taskforce being the nucleus of WSA, acts as auxiliary to School Management Committee and facilitates to continue the school activities and to keep the parents, students' cabinet and other bodies functioning well.

Resources:
UBR phase 1 was funded with Euro 5.863.000 through a pool fund of Rutgers, Simavi and the Netherlands Embassy in Dhaka. The 2nd phase was funded with BDT 515.332.129 for the local partners and with Euro 126.825 for the two Dutch partners.

9. Results – outputs and outcomes (250-350 words)
   To the extent possible, please reply to the questions below:
   i) How was the practice identified as transformative? (e.g., impact on policies, impact on management processes, impact on delivery arrangements or education monitoring, impact on teachers, learners and beneficiary communities etc.);
   ii) What were the concrete results achieved with regard to outputs and outcomes?
   iii) Has an assessment of the practice been carried out? If yes, what were the results? *

Impacts of phase 2:
Young people have become aware of rights violation and started preventing and taking steps against child marriage, SGBV in the community as Youth Volunteers. They have achieved the ability to take leadership role in preventing the early marriage of their peers or any sexual harassment or sexual assault with the support of local government institutes.

Client flow significantly increased in the YFS clinics and school health camps helped to increase the flow of YFS recipient in the NGO/GoB health clinics. Trained counsellor provided service to the adolescents on psychosocial counselling at government health complexes for two days/week.

Teachers were capable to facilitate the class on the sensitive issues to motivate and aware the students effectively. Madrasah teachers were enthusiastic and more regular in Me and My World (MMW) session and followed guidelines in the National Curriculum and Textbook Board (NCTB) sessions.

Almost all staff members (counsellor, paramedics, and trainers) were well trained and skilled to provide YFS among adolescents and youths. It has been observed that number of schools allowed necessary space/one room/library for organizing the youth corner enthusiastically. Youth corners in some schools and government health centers have started supplying logistics to these schools.

Youth Fora constitutes of 20 Youth Organizers (volunteers) per upazila were capacitated under the project. Trained, refreshed and experienced in SRH Youth Forum members taking part in advocacy initiatives from local to national level. They work as Change Makers of their community by organizing parents meeting, linking with LGIs, GBV Committees and with Management of Community Clinics (CG and CSG).

Results achieved:
• 2.6 million young people in and out of schools/madrashas received SRHR education and around 2 million young people received youth-friendly SRH services of whom 1,766 were from gender-diverse groups.
• Total 55,000 young people received counselling through schools and UBR health facilities (7,300 are gender-based violence survivors).
• 680 teachers trained on 'Me & My World (MMW)' were better able to create the learning environment on CSE for the students.
• Nearly 70% of parents in 12 upazillas were motivated and understand the impact of learning of CSE for their children.
• 240 (20 per upazilla) trained and graduated Youth Volunteers are the indicators of program output and a vehicle for the continuation of such practices as change agent.
• 21 YFS Corners have been established in 12 upazilla Health Complexes and 9 Union Health Complexes.

Major Advocacy Outcomes:

- sensitized government officers to implement CSE in schools and YFS service at health facilities for adolescent and young people.
- joint advocacy initiatives with government stakeholders/networks by organizing Day observation.
- capacitated teachers and Headmasters playing advocacy role on SRHR
- UBR YFS model adapted in government structure (through Embassy funded ADOHEARTS project)
- CSE included in national teachers training curriculum.

10. Lessons learnt (300 words)
To the extent possible, please reply to the following questions:
i) What were the key triggers for transformation?
ii) What worked really well – what facilitated this?
iii) What did not work – why did it not work? *

Key triggers for transformation:
The National Adolescent Health Strategy 2017-2030 focuses on SRH including other issues, However, SRH education is more sensitive and stigmatized. It is found to be difficult to deliver the messages to the students for the teachers and considered taboos in Bangladesh's conservative and religious culture. Traditional attitude and perception regarding sexuality education/promotion still exist among the society in different socio-economic level.

Youth are motivated and trained and this is the high time to link the Youth Fora with other youth and social organization networks and government relevant departments which provides a registration of such to ensure sustainability. Meaningful involvement of the young people as the driving force of the program facilitated a lot to achieve the target, quality, visibility & acceptance of the program. They were connected to other youth platforms to spread the learning & leadership among mass young people at the different arena.

Provision of subsidized sanitary napkins make social awareness on the menstrual hygiene management. As a result, there is a high demand of low-cost sanitary napkins in both school and community. Partnership between NGOs and private organizations will be sustainable approach towards improving menstrual hygiene. An extensive network of field workers and service centers will be an effective measure towards the goal.

UBR successfully implemented CSE at madrashas (religious educational institutes) in its implementation areas. Incorporation of Islamic interpretation of SRHR could further strengthen CSE in all kind of religious institutes in Bangladesh. There is SRHR discourse in Fiqah (the theory or philosophy of Islamic law, based on the teachings of the Koran and the traditions of the Prophet). Strategy could be taken how Fiqah could be used in CSE.

COVID-19 pandemic changed the implementing plan and activities during 2020. The implementing NGOs had to adjust their work pattern in align with the situation, affecting the program implementation. Implementing activities through maintaining social distance, accomplished program with the help of online platform has also proved as a unique strategy.

What worked:
UBR 2 has shown that it is possible to undertake an assignment that is a taboo in the Bangladeshi society, with some effective social mobilization process and orientation of the stakeholders. Establishment of youth corners in schools and bodies formed in schools to sustain the efforts initiated in the MMW schools to sustain. It has also shown that if students and teachers are interested to teach and learn even the existing national curriculum with some additional reading materials may be replicated in other schools, without any financial support. However, training of the teachers would be required, which can be undertaken by the education department.

Good advocacy and liaison have proved to be useful to sensitize the government Family Planning Department to continue the youth corners and counseling with their own staff at the union/upazilla facilities. The same could be replicated with the Health Service Department at upazilla level with some additional efforts and keenness. The benefit of mobilizing the health department had been two folds- opening a new vista of youth corners to cater YFS and provision of RTI/STI from the same spot.

What did not work:

• The Project website, MMW mobile application and the Project Face Book were potential resources for keeping the lessons learnt and taught alive. UBR could have used social media platform more efficiently and widely. Also, the intended beneficiaries should been involved from the beginning.
• Partners could have developed and implemented a more coherent and interactive relationship for seamless management of the project; The introduction of an Alliance Secretariat didn't worked as planned and lack guidance from the Steering Committee (the forum of Organization Heads).

11. Conclusions (250 words)
Please describe why may this intervention be considered a "best practice". What recommendations can be made for those intending to adopt the documented "best practice" or how can it help people working on the same issue(s)? *

The UBR programme in Bangladesh can be taken as a 'Best Practice'. It is a replicable model. UBR has successfully focused on improving SRHR knowledge and access to services, by providing CSE in and out of school, improving health providers' capacity to provide YFSRH services. It worked with communities to create a more supportive environment in which young people can exercise their SRH rights. The winning strategies those has been introduced and strengthened by continuous assessment an adjustment proved to be successful in rendering information and services in taboo issues like SRHR. The holistic approach of working with communities, education institutes, health facilities, local government institutes, networks and likeminded organizations and national government and institutes were result oriented.

UBR program interventions allowed for sustainability of the work enunciated by working with the relevant Government officials, parents and community leaders. SRHR of young people is not purely a health issue, it also goes beyond. Support from teachers, community leaders and policy makers need to create an enabling environment.

The project should work with the government system from the very beginning. The WSA (whole school approach) was also result oriented. CSE component should be worked out with Education Ministry and included in the Teachers Training College Curriculum. Use of social media and other medias is crucial for wider inclusion and awareness. The consortium approach of different expert organization can also increase effectiveness of implementation.

12. Further reading
Please provide a list and URLs of key reference documents for additional information on the "best practice" for those who may be interested in knowing how the results benefited the beneficiary group/s. *

UBR Alliance – Official website of UBR Alliance (ubrbd.org)
Unite for Body Rights - SRHR Alliance. End-of-programme evaluation, synthesis. - Kaleidos Research (http://kaleidosresearch.nl/publication/ufbr-evaluation/)