



United Nations
Educational, Scientific and
Cultural Organization

DEVELOPING AN EDUCATION SECTOR RESPONSE TO EARLY AND UNINTENDED PREGNANCY

Discussion document for a global consultation
November 2014

DEVELOPING AN EDUCATION SECTOR RESPONSE TO EARLY AND UNINTENDED PREGNANCY

Discussion document for a global consultation
November 2014

CONTENTS

Acronyms	7
1. Introduction	9
1.1 Background	10
1.2 Decisions about pregnancy	13
2. Impacts of early and unintended pregnancy on education	15
2.1 Adverse educational outcomes and other socio-economic consequences	15
2.2 School policies on pregnancy and adolescent mothers	16
2.3 Stigma & discrimination	18
3. Gender inequality and education	20
3.1 Child marriage, early and unintended pregnancy and truncated education	20
3.2 Pregnancy-related school gender-based violence	21
3.3 Boys' and young men's attitudes towards early and unintended pregnancy	23
4. Ensuring the linkage between schools and health services	24
4.1 Challenges for the health sector	24
4.2 Need for collaboration between education and health	26
5. Taking action	28
5.1 Evidence on school-based interventions	28
5.2 Examples of ongoing programmes and initiatives	30
Conclusions	35
Appendix I	38
Appendix II	43
Bibliography	44

ACRONYMS

CSE	Comprehensive sexuality education
DHS	Demographic and Health Surveys
EECA	Eastern Europe and Central Asia
EMIS	Education Management Information Systems
FAWE	Forum of African Women Educationalists
GBV	Gender-based violence
GDP	Gross Domestic Product
GMR	Global Monitoring Report
ICT	Information and Communications Technology
IPPF	International Planned Parenthood Federation
IPV	Intimate partner violence
IUD	Intrauterine device
LAC	Latin America and the Caribbean
LMICs	Low- and middle-income countries
MENA	Middle East and North Africa
MICS	Multiple Indicator Cluster Survey
MoE	Ministry of Education
MoH	Ministry of Health
MoYS	Ministry of Youth and Sport
NGO	Non-governmental organization
SHS	School health services
SLHC	School-linked health centres
SRGBV	School-related gender-based violence
SRH	Sexual and reproductive health
SRHS	Sexual and reproductive health services
SSA	Sub-Saharan Africa
SSDP	Seattle Social Development Project
STI	Sexually transmitted infection
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNIFEM	United Nations Development Fund for Women
WHO	World Health Organization
YFHS	Youth friendly health services

1. INTRODUCTION

Being pregnant and having a child are major life events. For an adolescent girls (aged 10–19 years old), experiencing these events while still at school often means facing harsh social sanctions and difficult choices that have life-long consequences. It could mean expulsion from home and school; being shamed and stigmatized by family, community members and peers; increased vulnerability to violence and abuse, or greater poverty and economic hardship. At the social and political levels, adolescent pregnancy is an issue that is often contentious, divisive and prone to responses based on prejudice. The right to health, education, dignity and gender equality are at the heart of this issue – especially for girls and young women – and greater clarity is needed about the evidence and priority actions needed by policymakers, advocates, programme developers, implementers and other stakeholders.

“Like I say being pregnant can be a set-back in your journey sometimes, but it is not the end of the road. You can still pick up and go again and know that obstacles will come.” Adolescent mother, Jamaica (Wilson-Mitchell et al., 2014)

This discussion paper focuses on early and/or unintended pregnancies. The term “early” relates to the correlation between lower age and the increased health risk of birth-related death and complications.¹ Secondly, the paper focuses on the implications that a lack of education, or truncated education opportunities, can have on a girl’s future. The term “unintended” refers to unplanned or unexpected pregnancies, which the paper addresses separately from pregnancies that are early and planned. It is important to recognize girls’ rights to make decisions about pregnancy whilst also balancing the health, educational, economic and social consequences of having children at a very young age. Early and unintended pregnancy impacts on the lives of adolescents – especially girls – in terms of health, social, economic and education outcomes. At the same time, determinants of early and unintended pregnancy can also be social, economic and educational.

As such, this is an issue that cuts across the responsibilities of a wide range of institutions and service providers – including the family, schools, social protection agencies and health service providers. Adolescents spend much of their time in school or in other educational contexts and must be supported to fulfil their potential regardless of their health, social or economic status. Early and unintended pregnancy jeopardizes educational attainment for girls and for this reason the education sector has an obligation to prevent it by providing knowledge, information and skills; and by ensuring that pregnant girls and adolescent mothers have the right to continue their education. Education – including comprehensive sexuality education – needs to be considered as both an instrument to prevent adolescent pregnancy and a means towards better life chances. It is potentially a critical lever in girls’ empowerment that increases knowledge and self-confidence and improves girls’ awareness of themselves, their bodies, their rights and capabilities, including preventing pregnancy and fertility choices.

In most countries, children between the ages of five and thirteen, in particular, spend relatively large amounts of time in school. School systems benefit from an existing infrastructure, including teachers likely to be a skilled and trusted source of information, and long-term programming opportunities through formal curricula. School authorities have the power to regulate many aspects of the learning environment to make it protective and supportive, and schools can also act as social support centres, trusted institutions that can link children, parents, families and communities with other services (for example, health services). (UNESCO, 2009). Given that only 75 per cent of learners who start primary school reach the last grade (UNESCO, 2014), it is important to address pregnancy prevention before children complete or leave primary education. Primary school is also the optimal point to reach younger adolescents (10–14 years old) who need to be educated about pregnancy and pregnancy prevention before they leave the education system, or become sexually active, or are forced into marriage or child bearing soon after puberty.

In many country contexts, early pregnancy is linked closely to child marriage and there too the education sector has a responsibility to protect the rights of girls, to support girls’ retention in school and to educate parents and communities about the health risks and rights violations involved in child marriage. Importantly, policy reforms are increasing to prevent child marriage and to respond to early and unintended pregnancy. The challenge remains in the lack of ownership and enactment of these instruments of change, entrenched unequal gender norms that amplify the effects of uncoordinated actions, and the lack of sustained investments in programmes that directly build girls’ social, economic and health assets and support gender equitable outcomes.

1. There is no standard definition for “early pregnancy”. WHO’s guideline http://www.who.int/maternal_child_adolescent/documents/preventing_early_pregnancy/en/ uses the term to define any pregnancy before the age of 20.

This document aims to advance discussion about the role of the education sector in preventing early and unintended pregnancy and ensuring that pregnant girls and adolescent mothers also fulfil their right to education. The global consultation on education sector responses to early and unintended pregnancy, planned for 4–6 November 2014, will provide the opportunity to analyse the evidence, develop recommendations based on specific case studies and examples presented during the meeting, and to propose priority actions in the short and medium term by the education sector and its partners (including governments, civil society, young people's organizations).

The document is focused on the education sector's responsibility for and responses to early and unintended pregnancy on three levels:

- Providing effective education, including comprehensive sexuality education, so girls and boys are equipped to avoid and prevent early and unintended pregnancy and other health risks;
- Ensuring that pregnant adolescents and adolescent mothers (especially girls who go through pregnancy and have young children) have a right to be educated and to fulfil their potential in an environment free from violence, stigma and discrimination;
- Strengthening linkages with the health sector that facilitates access and referrals to adolescent-friendly health and social services.

This discussion paper addresses early and unintended pregnancy in the education context and is organized into five main sections. A first background section includes data on early and unintended pregnancy and the importance of recognizing young people's fertility choices. Section 2 highlights some key issues concerning early and unintended pregnancy in the education context. Gender inequality as a cause of early and unintended pregnancy is discussed in Section 3, with attention to the attitudes toward pregnant girls and adolescent mothers. In Section 4, health outcomes and challenges for adolescents to access sexual and reproductive health (SRH) services are discussed with the aim of helping the education sector to identify entry points and linkages with health sector programmes. Section 5 presents examples of promising approaches for the education sector and initial conclusions, and offers questions for further discussion. Appendix I offers a further analysis of the issues by region.

1.1 Background

Early and unintended pregnancy is a challenge affecting both high- and low-income countries.

As reported in Table 1.1, among high-income countries in 2012, the highest rates of adolescent fertility were in the US (32.73 live births per 1,000 girls), New Zealand (26 births per 1,000 girls) and UK (25.77 births per 1,000 girls).² Sub-Saharan Africa (SSA) had the highest fertility rate among 15–19 years olds (108.10 births per 1,000 girls), followed by Latin America and the Caribbean (LAC) (68.02 births per 1,000 girls) (World Bank open data). Whilst it is a concern for both developed and developing countries, the largest number of girls and young women experiencing early and unintended pregnancy are mainly in low- and middle-income countries (LMICs) (see Appendix I for a more detailed breakdown by region).

Developing countries account for 95 per cent of births to adolescent mothers. In these countries 2 million girls give birth before reaching the age of 15 (UNFPA, 2013c)

In 2010, 36.4 million women in developing countries between the age of 20 and 24 reported having given birth before the age of 18 (UNFPA, 2013c). Developing countries account for 95 per cent of births to adolescent mothers. In these countries 2 million girls give birth before reaching the age of 15 (UNFPA, 2013c).³ Also, 90 per cent of adolescent births among 15–19 year olds are within child marriages (34 per cent of women in LMICs are estimated to be married before the age of 18 and 12 per cent of them before the age of 15 (UNFPA, 2013c). There are six countries where adolescent fertility is high despite having less than 20 per cent of ever-married adolescent females: Kenya, Lesotho and Swaziland in SSA and Ecuador, El Salvador and Guyana in LAC. These data suggest that, in these countries, many births occur among unmarried adolescents (UN, Department of Economic and Social Affairs, 2013).

2. Total fertility rate represents the number of children who would be born to a woman if she were to live to the end of her childbearing years and bear children in accordance with current age-specific fertility rates.

3. These percentages do not take into account abortion rates and stillbirths, which in some cases are outcomes of, respectively, adolescent unintended pregnancies and birth complications for adolescent mothers.

■ Regional specificities

Early and unintended pregnancy has different regional dynamics and is also context specific within regions. For instance, while LAC and high-income countries have higher rates of adolescent pregnancy *outside marriage*, in South Asia the majority of adolescent pregnancies are *within marriage or union*. By contrast, SSA presents both scenarios (WHO, 2012).

90 per cent of adolescent births among 15–19 year olds are within child marriages (UNFPA, 2013c)

Table 1.1 Context-related determinants and specificities of early and unintended pregnancy

	Most affected countries ⁴	Main determinants	Specificities
High Income countries	United States New Zealand United Kingdom	<ul style="list-style-type: none"> ■ Socio-economic disadvantage ■ Low education ■ Family disruption ■ Risky lifestyle 	<ul style="list-style-type: none"> ■ No correlation between access to services (including family planning) and reduction of adolescent pregnancy ■ Some ethnic groups can be more affected (e.g. African-American and Hispanic in US) ■ Adverse attitude at school (lack of expectations)
Sub-Saharan Africa	Niger Mali Angola Chad Malawi	<ul style="list-style-type: none"> ■ Socio-economic disadvantage ■ Low education ■ Lack of access to quality sexual and reproductive health services (SHRS) 	<ul style="list-style-type: none"> ■ Child marriage (especially in West and Central Africa)
Latin America and Caribbean	Nicaragua Dominican Rep. Guatemala Honduras Venezuela	<ul style="list-style-type: none"> ■ Socio-economic disadvantage ■ Low education ■ Lack of access to quality SHRS 	<ul style="list-style-type: none"> ■ Adolescent fertility remains high or increase despite a general decrease in fertility ■ Most adolescent mothers are single ■ High rate of abortion (mostly unsafe) ■ Lack of interest in school and poor quality of education
Asia and the Pacific	Bangladesh Laos (PDR) Vanatu Afghanistan Nepal	<ul style="list-style-type: none"> ■ Socio-economic disadvantage ■ Low education ■ Lack of access to quality SHRS 	<ul style="list-style-type: none"> ■ High proportion of married children
Eastern Europe and Central Asia	Tajikistan Georgia Azerbaijan Romania Bulgaria	<ul style="list-style-type: none"> ■ Socio-economic disadvantage ■ Low education 	<ul style="list-style-type: none"> ■ Specific groups -such as married adolescents and youth from linguistic, religious and ethnic minorities- can be more affected ■ High rate of abortion
Middle East and North Africa	Iraq Yemen Egypt Syria Morocco	<ul style="list-style-type: none"> ■ Socio-economic disadvantage ■ Low education ■ Lack of access to quality SHRS 	<ul style="list-style-type: none"> ■ Unmet need for family planning and low use of modern contraception

Whilst early and unintended pregnancy affects young people in both developed and developing countries, the critical issue is limited access to education and health services and poorer health outcomes in LMIC contexts. In developed countries, early and unintended pregnancy usually concerns specific population groups. In all countries, socio-demographic and educational factors, cultural norms around adolescent pregnancy and gender inequalities exacerbate the issues raised by early and unintended pregnancies. The literature does not allow us to make a judgement about whether these conditions are causal, or whether there are other processes at work and these are contributory. What

4. According to Adolescent Fertility rates. See: <http://data.worldbank.org/>

it does highlight is that early and unintended pregnancy is one of the injustices associated with poverty and social exclusion. (As mentioned, regional specificities are detailed further in Appendix II of this paper.)

■ Determinants of early and unintended pregnancy

In all regions of the world poverty and socio-economic marginalization are the main determinants of early and unintended pregnancy. A systematic review of studies investigating the factors associated with adolescent pregnancy among 13–19 year olds in the European Union (Imamura et al., 2007) – conducted in 2007 – highlighted the strong relationship between socio-economic deprivation and adolescent pregnancy. US data shows that unintended pregnancy is mostly concentrated among poor and low-income women (Guttmacher Institute, 2013). In developing countries, poor and marginalized girls are among those more likely to become pregnant, not only after getting married very young – in some contexts in exchange for a dowry – but also because they may engage in consensual or forced transactional sex to support themselves and their families (UNFPA, 2013c). In qualitative research conducted in Uganda, young people described poverty as an impetus for having children as a source of income, labour and old age insurance (Beyeza-Kashesya, 2010).

Moreover, cultural norms around the value of abstinence until marriage fail to acknowledge that today a high proportion of adolescents are sexually active before marriage and thus should be able to access to good quality and friendly SRHS even if not married. These norms reinforce gender inequality and mostly affect girls whose main achievements in life are expected to be as a wife, a mother and in the home.

Lack of access to services such as family planning and modern contraception and the resulting unprotected sex contributes to early and unintended pregnancy. Adolescents are indeed naturally and normally interested in sex, since puberty marks the transition from childhood to adulthood and is accompanied by new and complex emotions, including sexual desire (UNESCO, 2014a). “Being sexual” is an important part of many young people’s lives and can be a source of pleasure and comfort and a way of expressing affection and love (UNESCO, 2009). However, this should go hand in hand with the knowledge and services that are required to take control over the decisions and outcomes involved with sexual activity.

■ Consequences of early and unintended pregnancy

The consequences of early and unintended pregnancy can be educational, economic, social and health-related. Table 1.2 lists these consequences and suggests how the education sector can limit specific adverse outcomes of early and unintended pregnancy.

Table 1.2 Consequences of early and unintended pregnancy and the role of the education sector

	Consequences	What the education sector can do
Education consequences	School dropout and absenteeism Poor academic performance Lower educational attainment	Ensure the right to education and a duty of care Keep girls in school or other education programmes to enable them to complete secondary education Provide good quality education, including CSE Ensure safe, non-discriminatory and violence free school environments
Economic consequences	Lower family income Increased poverty Increased dependency ratio	Quality education Keep girls in school Support educational achievements / career patterns
Health consequences	Elevated risk of maternal death (especially for younger than 15–16 year olds) Elevated risk of obstetric complications Low birth weight	Promote linkage between CSE and health services Develop young people’s confidence to access services Ensure that young people have education and skills on avoid pregnancy, contraception and decisions about pregnancy

	Consequences	What the education sector can do
Social consequences	Stigma and discrimination Less likely to get married Most likely to suffer abuse	Promote gender equality in schools Engage boys and young men in pregnancy prevention Prevent school-related gender-based violence (SRGBV) Support girls rights to prevent child marriage

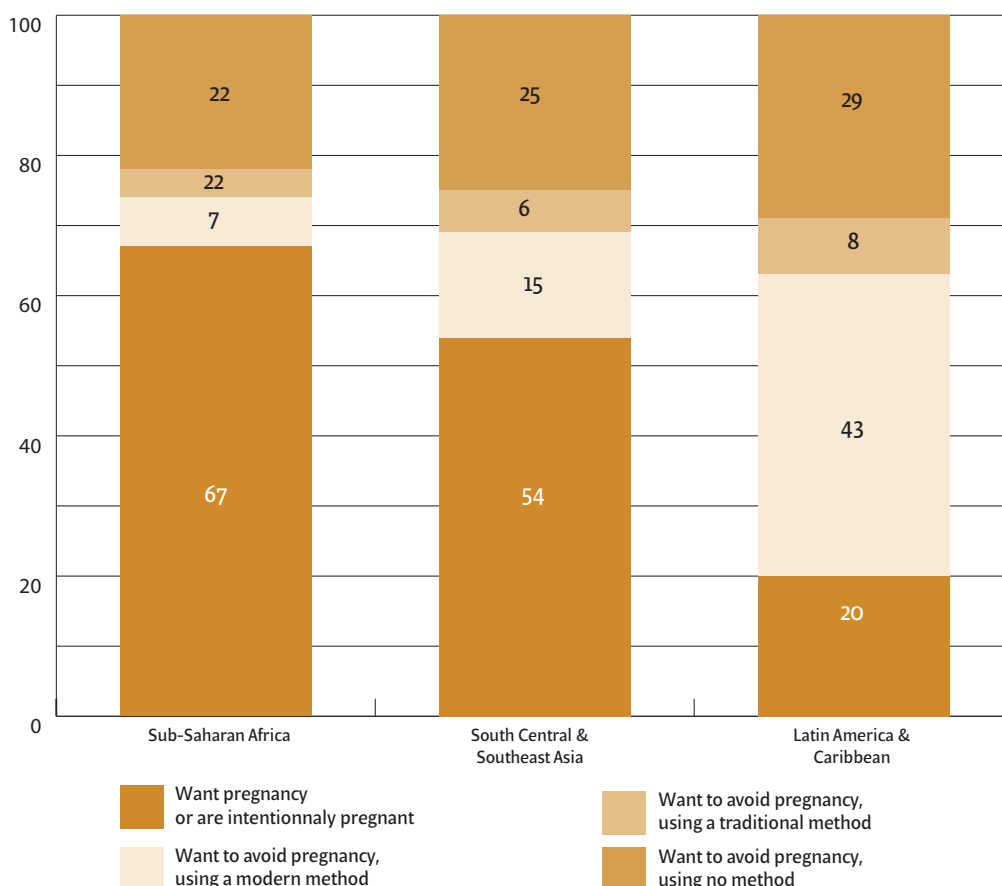
Content taken and adapted from Breheny, M. and Stephens, C. (2007), with additional column on the role of the education sector

1.2 Decisions about pregnancy

Due to its negative impact on different aspects of adolescents' and young women's lives, early and unintended pregnancy has become a public policy concern. Policies and programmes aimed at preventing adolescent pregnancy and reducing adverse health and educational outcomes have been developed at local, national and international levels, and are being implemented by governments and non-governmental organizations (NGOs).

However, it is important to acknowledge that not all adolescent pregnancies are unintended and that girls may have reasons for becoming pregnant at an early age, especially, but not exclusively, within a marriage. These choices need to be taken into account and the contexts in which they are made need to be evaluated, to avoid victimizing girls and seeing them as passive executors of other people's decisions.

Figure 1.1 Married adolescent pregnancy desires and contraceptive use



Source: Guttmacher Institute, 2010

Up to 75 per cent of annually measured adolescent pregnancies are intended and/or planned (Presler-Marshall and Jones, 2012). In Latin America, procreation at a young age is promoted within many cultures (Organismo Andino de Salud ORAS CONHU, 2009). Girls in Peru and Paraguay report a desire to become pregnant (Näslund-Hadley and Binstock, 2010). Research conducted in developed countries shows that in the US, Australia and Canada, some pregnant girls and adolescent mothers report wanting to be pregnant and described pregnancy as the single most exciting and positive event in their life (Black et al., 2012).

In some circumstances to prove one's fertility to others or oneself is a push factor for girls to become pregnant. In South Africa, despite the disapproval of premarital sexual activity, pregnancy is one of the means of attaining respect in society (Williamson et al., 2009). In sub-Saharan Africa and South Asia, motherhood is often seen as "what girls are for" and a woman's status in the family, community and society depends on her reproductive ability (Presler-Marshall and Jones, 2012). In many regions of the world, pregnancy means entering into adulthood, acquiring social status and a position within the family (Presler-Marshall and Jones, 2012; Näslund-Hadley and Binstock, 2010). For some young women, pregnancy is a way to keep a male partner, satisfy one's desire to feel needed and in some cases obtain financial support (Näslund-Hadley and Binstock, 2010). For young brides, proving their fertility is often regarded as a duty, if they want to avoid divorce or polygamy. In some contexts, such as Uganda, infertile men are not supposed to exist, and women bear the full responsibility for a couple failing to have children (Beyeza-Kashesya et al., 2010).

"[If you are thought to be infertile] you won't be loved, especially if you have a mother-in-law who wants grandchildren. If you have a co-wife, at every opportunity she will boast that she has children and you don't. There are men who follow their parents blindly. If in your marriage you have a mother-in-law who asks her son to divorce you, he will do it without even thinking." (Williamson et al., 2009)

In societies where female children have a lower status and where not having a son is synonymous with not having children at all, brides can undergo repeated pregnancies until they give birth to a male child (UNFPA, 2013c; Campbell et al., 2006). Indeed, among married girls, contraceptive use seems to increase after the birth of a son.

2. IMPACTS OF EARLY AND UNINTENDED PREGNANCY ON EDUCATION

This section analyses the direct consequences of early and unintended pregnancy on educational outcomes that the sector needs to address, as well as the main challenges the sector itself faces today in trying to ensure educational attainment for pregnant girls and adolescent mothers.

2.1 Adverse educational outcomes and other socio-economic consequences

■ Drop out

Early and unintended pregnancy often leads adolescents to drop out of school. However, the correlation between early and unintended pregnancy and drop out is not clear, since adolescent pregnancy can be both the cause and the consequence of dropping out of school. A small study among Kenyan girls aged 10–19 found that 62 per cent of them were already out of school at the time of conception. However, a study conducted in Brazil among 3,050 young males and females found that, among those leaving school, most girls and boys dropped out after becoming a teen parent (Almeida and Aquino, 2009). A study in Chile found that being a mother reduces a girl's likelihood of attending and completing high school by between 24 and 37 per cent (Kruger et al., 2009; UNFPA, 2013c). Child marriage – with consequent pregnancy – can be another reason for dropping out of school. A study of Francophone African countries showed that only between 5 and 10 per cent of girls leave school – or are expelled – because of pregnancy, while most leave because of marriage or union and then become pregnant (Lloyd and Mensch, 2008; UNFPA, 2013c).

■ Disengagement and decreased quality of learning

Pregnant girls and adolescent mothers may stay in school but frequently disengage with learning and go unnoticed by teachers. Students opting out of learning and withdrawing can still attend school but may suffer from anxiety and depression, which affects the learning process (Lall, 2007).

The quality of learning (or the girl's educational experience) is likewise affected by a pregnancy, since pregnant students tend to feel tired and lack concentration at school, and are sometimes obliged to miss classes for medical reasons (Pillow, 2006). After delivery, adolescent mothers are generally described by teachers as restless and sleepy during lessons and at risk of falling behind with school work due to their double responsibility as students and mothers (Maluli and Bali, 2014). As a consequence, young mothers often struggle to achieve good academic results and pass their final exams. However, there are also cases of good performance where the mothering experience becomes a motivating factor for improving learning, especially when financial or psychological support is available for young mothers (Maluli and Bali, 2014; Mayzel et al., 2010): *“My son is my drive and new sense of direction... He has made me realize how important school is. I am working hard for him. I want him to be proud of me as a mother and lead a better life. He will not lack anything simply because he came a little bit earlier than anticipated.”*

■ Repercussions on employment opportunities and income

A truncated education has negative repercussions on the future of teen mothers, in terms of employment opportunities and general well-being (Fancy, 2012). A small study conducted in Texas (US) comparing teen parents who had dropped out of school with those who had stayed in school (McGaha-Garnett, 2007) found that those who dropped out were more likely to experience peer pressure, were less likely to assume parental responsibilities, had worse relationships with their parents, and tended to spend time with people with lower academic aspirations. Negative educational outcomes lead inevitably to negative economic impacts for the girls, their children and society as a whole. The lifetime opportunity cost related to adolescent pregnancy – measured by the mother's foregone annual income over her lifetime – ranges from 1 per cent of annual gross domestic product (GDP) in China to 30 per cent of annual GDP in Uganda (UNFPA, 2013c).

2.2 School policies and practices on pregnancy and adolescent mothers

■ Expulsion of pregnant girls from school

In some contexts, the reality for many girls is that they are deliberately expelled (or excluded) from schools as a consequence of getting pregnant or as a sign of sexual activity before or outside of marriage (Onyeka et al., 2011). However, this penalty often does not apply to a boy who is responsible for a girl getting pregnant and who is generally able to continue his education after a period of suspension in some cases. At worst, school staff may go to great lengths to identify, shame and exclude pregnant girls, often infringing their rights. Pressure from parents, communities and religious authorities also results in girls being excluded while pregnant, remaining out of education after childbirth and then being forced to find another school to continue their studies.

This may include mandatory or non-voluntary pregnancy tests being carried out on girls at regular intervals or sometimes in an ad hoc way. While in some cases this is individual school practice, in other cases it is covered by a broader school policy. These tests may include mandatory urine tests, or physical exams (e.g. palpation), which can be degrading, invasive, abusive and are sometimes not carried out with informed consent or by trained personnel. To avoid these violations of privacy and dignity, girls aware of their pregnancy may decide to drop out of school or to undergo an unsafe abortion (The Center for Reproductive Rights, 2013), which leads to the adverse educational or health effects described in Section 4. In Kenya, the 2009 National School Health Policy and Guidelines specify that girls will undergo voluntary medical screening once per term. A dissertation on mandatory pregnancy screening in secondary boarding school highlights that the screening is conducted either at the beginning or in the middle of school terms, or in some cases, at both periods of school terms (Olum, 2010).

Box 2.1 Case study – in-school pregnancy ‘testing’

In some schools in Tanzania, nurses or teachers have reportedly carried out unexpected ‘physical screening examinations’ to identify if any girls are pregnant. Without being given explanation about the purpose or the process, girls are brought together by staff who palpate, pinch or prod the girls’ abdomens and squeeze their breasts. If suspected of being pregnant, they are sent to the health clinic, again with no explanation. The clinics may be asked to confirm the pregnancy and to communicate the result directly with teachers, leaving girls with no information, scared and confused. In some cases, when the school acknowledges a pregnancy, staff may pass the information over to law enforcement officials who imprison the pregnant girl to force her to reveal who impregnated her. As a result of the pregnancy, girls are also expelled from school.

Source: The Center for Reproductive Rights, 2013.

■ Constraining re-entry policies

On a more positive note, education systems that previously excluded pregnant girls and teen parents have made progress towards a more supportive approach. A number of African countries⁵ have developed ‘re-entry policies’ allowing adolescent mothers to return to school after delivery. However, there are ongoing concerns about their arbitrariness, lack of ownership of the policy among governments and poor implementation due to scant monitoring or lack of involvement of schools and the sexual and reproductive health (SRH) community. Despite the positive intention of helping girls to continue their education, the policies also have a punitive edge due to strict requirements such as the obligation on girls to apply to a different school or to stay out of the education system for a fixed period of time before re-entry. Moreover, some re-entry policies have been driven by donors and are not fully supported by national education authorities, making the implementation harder for schools.

Features related to these policies can be categorized as follows:

- **Re-entry period** – girls are allowed to go back to school after a context-specific period of time. In South Africa, for example, the Department of Education in 2007 released *Measures for the Prevention and Management of Learner Pregnancy* supporting girls to return to school and recommending a two-year break from school after pregnancy (Willan, 2013). However, two years is a long time to be out of formal schooling and to have to catch up with an academic programme (Ramulumo and Pitsoe, 2013).

5. Botswana, Zambia, Mozambique, South Africa, Kenya, Mali, Swaziland, Namibia, Madagascar and Cameroon.

- **Conditionality for re-entry** – some countries require girls to satisfy specific conditions to be able to go back to school. Since 1993, for example, Malawi has a policy in place allowing teen mothers to return to school after one year, but it obliges them to write three letters to the head teachers in order to reserve their place, which is rarely done (Mchaju Liwewe, 2012). Girls sometimes choose to apply to a different school in order to avoid stigma and discrimination from peers and school staff. If accepted by the school, girls cannot drop out again, otherwise they will be permanently expelled (Mayzel et al., 2010).
- **Flexibility and support** – in some cases re-entry policies offer a certain level of flexibility for adolescent mothers in order to support their return to school. In Madagascar, for example, adolescent mothers can return to school immediately after delivery, while in Cameroon girls have the right to negotiate the duration of their maternity leave and can arrange for extra classes to catch up the content missed (Ministry of Education, 2008). In Kenya, the re-entry policy recommends counselling for girls after return (Omwancha, 2012). In Russia, Ukraine, Kazakhstan, Belarus and other countries in Eastern Europe and Central Asia (EECA), pregnant girls have a right to continue their school education. They can choose to attend classes at school or continue home-based education. They can take a leave of absence or postpone final examinations, if needed for medical or other reasons. Underage mothers are also entitled to social benefits like adult mothers. However, there are cases of expulsion from and discrimination in school.⁶

Overall, re-entry policies may be available but they are not consistently applied in schools because of lack of knowledge at district or school level or because of arbitrary and context-specific decisions made about their application. These decisions may depend on personal connections with the school staff or involve some sort of payment in exchange for readmission (Maluli and Bali, 2014). Among the problems affecting the implementation of re-entry policies is the lack of monitoring tools allowing for the collection of data on girls returning to school or not, their attendance or future drop out.

In 2012 the Forum of African Women Educationalists (FAWE) analysed re-entry policies in Malawi, Mozambique, Namibia, Swaziland, Zambia and Zimbabwe, and highlighted main challenges for their implementation (FAWE/OSISA, 2012). Most of them were related to the lack of training for teachers on how to apply the policies, or to scant action plans, support mechanisms or resources in schools for the implementation (difficulties in arranging activities, in allowing adolescent mothers to breastfeed), lack of monitoring. Others related to cultural norms preventing parents and the community to support and appreciate the policies, or perpetuating stigma and discrimination from teachers and fellows.

Re-entry policies might be implemented in different countries, but most of the available information relates to SSA countries. A systematic audit of these policies is needed to better understand their distribution and impact in the different contexts.

■ The challenge for teachers

Teachers are often unprepared to deal with pregnant girls and adolescent mothers in a classroom setting (Mpanza and Nzima, 2010). They may be afraid of physical accidents putting pregnant girls' safety at risk (Ramulumo and Pitsoe, 2013), or they may see girls as adults who do not fit in with the school environment (Shaningwa, 2007). Indeed, even if they would like to support girls and help them achieve better academic results, they feel unable to offer additional time for lessons missed or other forms of assistance because of lack of skills and absence of school structures for parenting learners (Bhana et al., 2010).

“All I say to her is, ‘Listen we have done a lot the past week when you were not here, so ask other learners what we have done and try to do your best’...Nothing is put in place.” (Bhana et al., 2010)

Conservative attitudes from teachers towards adolescent mothers also increase cases of stigma and discrimination. Girls who return to school often lack the support they need to manage their double responsibility as mothers and students, as well as being victims of stigma and discrimination (Maluli and Bali, 2014).

6. Conversation with the UNESCO regional advisor for EECA.

2.3 Stigma and discrimination

Pregnant girls and adolescent mothers are often stigmatized and discriminated against by family members, fellow students, school staff, community, the media and more generally by society. Stigma and discrimination affects young single mothers in particular, since marriage – also at an early age – confers on girls a recognized social status that legitimizes pregnancy. One reason for stigma is the opposition to young people being sexually active before or outside of marriage for moral, religious or other reasons. This applies less to boys than to girls who are subjected to greater social control and censure. The second reason is that adolescent mothers are often seen as irresponsible, naïve and inadequately prepared to properly take care of a child, especially by health professionals (Breheny and Stephens, 2007; Shaningwa, 2007), but they are in a position requiring them to act as adults (Yardley, 2008; van den Berg and Mamhute, 2013).

In high-income countries, adolescent mothers are regarded with low expectations by society, or often, they are treated with disrespect and derision. The effects of such stigma and discriminatory attitudes toward pregnant girls and adolescent mothers presented by a study conducted in the UK include isolation, loss of self-esteem, depression and drop out from school (Yardley, 2008).

In schools, stigma and discrimination against pregnant girls and adolescent mothers are common, not only because of the visibility of their sexual activity, but also due to school staff and peer attitudes to dealing with girls who hold adult responsibilities but are still pupils and part of a learning environment. Pregnant girls and adolescent mothers report challenging situations at school, such as teasing and bullying from fellow students and embarrassing public comments from teachers (Shaningwa, 2007; van den Berg and Mamhute, 2013; Yardley, 2008; SmithBattle, 2013). A study of South African schools highlights the dynamics of sexual shame and the extent to which schools are still considered places of ‘sexual innocence’, an environment in which visible displays of sexuality are not tolerated (Morrell and Shefer, 2012).

“Sometimes people talk things behind your back... and laugh at you because you have got a baby.”
(Chigona and Chetty, 2007)

Hurtful comments may lead adolescent mothers to feel isolated from the rest of the class and not supported by other students. Their motivation for remaining in school is negatively affected as is their willingness to ask classmates for help in catching up on classes missed when they cannot attend school to take care of their newborn baby. These comments hide the inability to reconcile cultural norms with the reality pregnant students face at school, but also the difficulty in connecting with other mothers who are perceived as distant in terms of their interests and responsibilities.

A study in South Africa on teenage mothers’ experiences as learners found out that, while boys often attack teen mothers at school with direct and aggressive verbal comments, girls tend to dissociate themselves from the teen mothers (Chigona and Chetty, 2007). The difficult position that teen parents occupy highlights their different roles and status as children, students and parents – with varying levels of autonomy in their lives.

Stigma and discrimination perpetuated by teachers is different and more complex: teachers are usually seen as people who are supposed to support and motivate girls to stay in school and perform well. Studies in South Africa, however, indicate that some teachers embrace negative social norms viewing early and unintended pregnancy as a sign of moral failure. They contribute to stereotypes describing teen mothers as lazy, distracted, low-performing and at risk of ‘contaminating’ other female classmates with their immoral behaviour (Chigona and Chetty, 2007; Runhare and Vandeyar, 2012; Bhana et al., 2010). Others find it difficult to cope with the dual identity of young mothers, who have adult responsibilities as parents and are therefore also required to act as adults in the school setting. A report from a Namibian study indicated teachers making humiliating comments: *“Some of you are adult people and have children. You are not supposed to make noise” or “why should a mother allow such behaviour to happen in the class?”* (Shaningwa, 2007)

Literature describing stigma and discrimination towards married pregnant girls or adolescent mothers in school is scant. It is also difficult to differentiate between married and unmarried girls in studies addressing stigma and discrimination towards pregnant girls and adolescent mothers and draw conclusions about married ones.

A study investigating responses to teenage pregnancy and motherhood in schools in South Africa offers a possible answer when describing the different attitude a teacher had toward a married young mother compared to unmarried ones:

“The fact that she [Indian young woman] was married also made a difference. You see most of the girls that get pregnant in school and have children don’t get married. This affects the child negatively.” (Bhana et al., 2014)

Box 2.2 Stigma and discrimination against pregnant girls and adolescent mothers in society

What happens in schools is a reflection of the stigma and discrimination surrounding pregnant girls and adolescent mothers in the community context. Views about pregnant girls and adolescent mothers range from a *conservative* approach, which considers teen pregnancy a moral issue related to girls’ sexual experience, to a *liberal* approach which considers it as a challenge to academic opportunities, financial independence and life choices (Shaw, 2010).

Unmarried pregnant girls can be discriminated against by family members, especially in contexts where single women are generally discredited. In some countries pregnancy outside of marriage can have economic and social consequences for the family, as marrying a daughter can be impossible if her ‘loss of virginity’ is regarded as a cause for shame by the community.

A study in Nigeria indicates that parents associate adolescent pregnancy with their daughter’s failure in terms of education, employment and life opportunities (Agunbiade, 2009). Also, poor families may not have the resources to take care of a new child. Girls who become pregnant may be compelled to leave their parental home to preserve their family’s reputation, which increases their vulnerability, including the risk of becoming homeless, living in extreme poverty and the risk of abuse, sexual exploitation or human trafficking (The Center for Reproductive Rights, 2013).

In this way, the public context (society) reflects the dynamics of stigma and discrimination, which plays out in the private setting (the family) (Unterhalter, 2013).

Pregnant girls and adolescent mothers also experience discrimination from health professionals who have often been found to be rude and unfriendly (Santhya and Jejeebhoy, 2007; WHO, 2004). Cultural barriers arising from the association of teen pregnancy with immorality play a significant role (Bhana et al., 2010). Qualitative interviews conducted in New Zealand revealed the negative perceptions of health professionals towards young mothers who are perceived as bad mothers (Breheny and Stephens, 2007); mothers who have never contemplated what kind of mothers they want to be, and neglect their baby’s needs whilst preferring to spend their money on clothes, junk food, cigarettes, drinking and parties.

Media stereotypes around adolescent motherhood re-enforce these perceptions. They present teen mothers on the one hand as lacking in ambition in terms of their careers or their desire to become financially independent (Yardley, 2008) and, on the other hand, good mothers who function as role models able to exercise control over their life despite their “mistakes” (Shaw, 2010). Many authors describe adolescent mothers in the US and UK as feeling strongly stigmatized by the media (SmithBattle, 2013; Achoka and Njeru, 2012; Yardley, 2008).

3. GENDER INEQUALITY AND EDUCATION

Gender inequality is strongly correlated to early and unintended pregnancy, therefore making societies more equal would reduce early and unintended pregnancy. The education sector has a critical role to play in promoting gender equality, through sensitizing children, adolescents and young people, and challenging values and norms that maintain inequality. In doing so, schools and other educational institutions have to engage boys and young men, who need to be part of the change as much as girls to make it sustainable in the long term.

This section describes the different dynamics of gender disparity correlated to early and unintended pregnancy and education – such as child marriage and gender-based violence (GBV). It also highlights the importance of involving more boys in issues related to adolescent pregnancy, as well as analysing their attitudes towards early and unintended pregnancy.

3.1 Child marriage, early and unintended pregnancy and truncated education

As we have discussed above, child marriage is closely related to early and unintended pregnancy and school drop out, and it can sharpen the dynamics of gender inequality. In countries where child marriage is still legal,⁷ power disparity within this union is often reinforced by the age gap between the young bride and her husband. A 2005 study conducted in SSA highlighted that the age difference ranged from 3.3 years in Southern Africa to 6.6 years in Western Africa (Barbieri and Hertrich, 2005). Questionnaires administered among 200 girls in Afghanistan showed that the age difference was up to 50 years: 28 per cent of respondents had up to five years of difference between their own age and the age of their husbands, while 26.70 per cent had a 6 to 10 year age gap and 21.6 per cent from 11 to 15 years (Women and Children Legal Research Foundation, 2008). The difference in age, experiences and knowledge make equal and fruitful conversations difficult. The husband tends to control and educate his young wife, who often becomes a victim of verbal and physical violence within the marriage.

If all girls in SSA and South and West Asia had primary education, child marriages would be reduced by 14 per cent, while if all girls had secondary education, child marriages would be reduced by 64 per cent. Girls in school for 10 years marry six years later

Intimate partner violence (IPV) may become the norm, including sexual violence. Married girls lack both the skills and the decision-making power to refuse sex, and often become victims of forced and coerced sex perpetrated by their husbands, who are sexually more experienced than they are. Whilst still children, girls are married and are instantly considered adults with responsibilities that they may not be aware of or be able to

handle, such as the need to prove fertility and have children. This limits a young bride's ability to negotiate family planning options and leads to early pregnancies. The situation is exacerbated by the effect that power disparity within marriage can have on a girl's ability to access health services: sometimes husbands, lacking knowledge or resources, prefer not to spend money on their wives' antenatal and postnatal care and force them to give birth at home with unskilled birth attendants, increasing their chances of death or complications (see Section 4). A study conducted in SSA found that the likelihood of using modern contraception is inversely correlated to the age difference between the couple (Barbieri and Hertrich, 2005).⁸

Child marriage and limits on education are also closely linked. Despite the lack of evidence on a causal relationship between educational attainment and child marriage, which hinders drawing conclusions about the protective role of education in keeping girls at school to avoid getting married, it is clear that adolescent pregnancy is correlated to child marriage in many contexts. Both pregnancy and child marriage increase the chances of dropping out of school.

7. In 146 countries, marriage under age 18 is still legal if girls have parental consent, and in 52 countries it is also legal with parental consent under age 15.

8. When the age difference is less than five years, the likelihood of using modern contraception is 2.4 higher than when the age difference is 15 years or more, and 1/3 higher than when it is between five and 15 years.

Girls may drop out after marriage due to their new responsibilities as wives and mothers, but more generally they tend to drop out because of poverty and subsequently get married and become pregnant. Data indicate that girls with lower levels of education are more likely to get married before the age of 18. Demographic and Health Surveys and Multiple Indicator Cluster Surveys (DHS/MICS) from 78 developing countries over the period 2000–2011 show that 63 per cent of girls reporting being married before age 18 had no education, compared with 45 per cent with primary education and 20 per cent with secondary education (UNFPA, 2013c).

Each additional year of education means a 10 per cent reduction in fertility (Presler-Marshall and Jones, 2012)

Based on modelling, the Education for All Global Monitoring report (GMR) 2013–2014 (UNESCO, 2014b) estimates that if all girls in SSA and South and West Asia had primary education, child marriages would be reduced by 14 per cent, while if all girls had secondary education, child marriages would be reduced by 64 per cent. Girls in school for 10 years marry six years later, since schooling increases autonomy and decision-making and increases economic independence, which results in postponing marriage. Each additional year of education means a 10 per cent reduction in fertility and subsequent increase in contraception uptake (Presler-Marshall and Jones, 2012).

Box 3.1 Reasons behind child marriage

Economic reasons – In some contexts, poverty puts pressure on families to marry daughters in order to reduce the costs of food and education, which become husband’s responsibilities. In countries where a dowry is received for brides, poor families can have an economic incentive to marry their daughters. Where employment opportunities for girls are scarce, marriage can be an option to secure a girl’s future, since marriage becomes a way to improve a woman’s economic situation and social status.

Normative reasons – Social norms around unequal gender roles create expectations about women being wives, mothers and caregivers and relegates them to a domestic role in society, together with lower education and unemployment expectations. The most important option for a girl is a “good marriage” so she is able to ensure a future of security and prosperity. In some contexts, girls may be identified as “rebels” if they oppose their family or community, and child marriage becomes a way to punish them.

Safety reasons – The onset of puberty may raise parents’ concerns about sexual harassment and abuse towards their daughters. For this reason they may decide to give their girls in marriage in order to protect them and their pre-marital virginity, whose loss may invalidate their respectability in the community and damage their future prospects.

3.2 Pregnancy-related school gender-based violence

Gender-based violence (GBV) is another negative outcome of gender inequality. Worldwide 50 per cent of sexual assaults are committed against girls under 16 (UNIFEM, 2010). The UN Population Fund (UNFPA) reported that between 15 per cent and 40 per cent of young women in Latin America and the Caribbean (LAC) respectively have their first sexual experience under coercion and without using a condom (UNFPA, 2012b). The very high levels of gender-based violence reported amongst adolescent girls is a matter of major concern.

Unintended pregnancies are two or three times more likely to be associated with abuse than intended ones (Miller et al., 2007).

GBV is related to pregnancy in two different ways. On the one hand, pregnancy may be the result of sexual violence in the form of rape, coerced and forced sex, or the consequence of psychological violence (reproductive coercion).

On the other hand, verbal, psychological, physical and sexual violence are also perpetrated during pregnancy. In both cases violence is mainly perpetrated by partners. Structured interviews among 750 sexually active 15–19 year old girls in Jamaica (Baumgartner et al., 2009) showed that 49 per cent of young women have experienced sexual coercion or violence sometime during their lives: for one third of the respondents, sexual debut was characterized by coerced or forced sex. Cases of forced sex were also highly prevalent in the Asia Pacific region where the likelihood of being a victim of coerced sex was found to be higher for girls experiencing sex for the first time at a younger age, and lower for girls whose sexual debut took place at a later age (UNFPA, 2013b). Unintended pregnancies are two or three times more likely to be associated with abuse than intended ones (Miller et al., 2007).

Sexual abuse leading to pregnancy can also happen in school in the form of school-related gender based-violence (SRGBV) inflicted by male students or teachers on girls. A survey by the Ministry of National Education of Côte d'Ivoire, for example, found that approximately 50 per cent of teachers reported having sexual relationships with students, with figures as high as 70 per cent in one region (Ministry of National Education of Côte d'Ivoire, 2010). A study in Yemen revealed that 31 per cent of schoolchildren were exposed to sexual abuse (Leach et al., 2013). Pregnancy-related GBV in schools also includes bullying and teasing perpetrated by classmates and teachers toward pregnant girls and adolescent mothers, described in Section 2.3 on stigma and discrimination.

Globally, as many as 1 in 4 women experience physical or sexual violence during pregnancy (UN UNiTE campaign)

Given the prevalence of stigma and silence, there is concern about GBV and how little support exists for pregnant girls at school. The obligation to guarantee a safe environment for all learners free from GBV must be a priority.

Box 3.2 Pregnancy-related violence

Violence resulting in pregnancy

As many as 7 in 10 women around the world are victims of physical and/or sexual violence at some point in their lifetime (UN Secretary General Campaign UNiTE to End Violence Against Women). A World Health Organization (WHO) interview-based study conducted in 10 countries⁹ on women's health and domestic violence showed that the prevalence of sexual IPV ranged from 6 per cent in one Japanese city to 59 per cent in one Ethiopian province and that the risk of sexual violence was highest for girls aged from 15 to 19 (WHO, 2005).

Early and unintended pregnancy can result from explicit violence or psychological pressure exercised by one partner who desires a pregnancy. The reasons for this can be many, such as the male partner wishing to have children, the desire to prove the girl's fertility or the will to keep the female partner in a relationship (Williamson et al., 2009). A qualitative study in the US among girls aged 15–20 aimed to investigate male partners' behaviours interpreted by girls as an intention to impregnate them (Miller et al., 2007). In this study, 26 per cent of respondents mentioned manipulation of condom use (e.g. poking holes), sabotage of birth control use, or explicit statements about the desire to have a family; 32 per cent of these girls got pregnant in this abusive context and for 58 per cent of them the pregnancy was unwanted. Some girls reacted to this form of abuse by hiding contraceptive use to their partners.

"I was on the birth control, and I was still taking it, and he ended up getting mad and flushing it down the toilet, so I ended up getting pregnant. I found out that [before this] he talked to my friends and he told them that we were starting a family. I didn't know that. I didn't want to start a family. I wanted to finish school." (Miller et al., 2007)

Violence during pregnancy

Globally, as many as 1 in 4 women experience physical or sexual violence during pregnancy (UN Secretary General's Campaign UNiTE to End Violence against Women). However, the prevalence of violence during pregnancy is difficult to measure and findings are not consistent: some studies show an increase of violence during pregnancy, while others describe pregnancy as a break for previously abused women (Jasinski, 2004). Despite the lack of specific data on girls, there is data to show that IPV is prevalent among adolescents (Clark, 2013). In countries where child marriage is the norm, young brides are often victims of IPV (UNFPA, 2013c). Data collected on IPV in 19 countries highlight that IPV prevalence is relatively constant among women aged 15–35 years old, declining after the of age 35 (Devries et al, 2010).

Violence during pregnancy is dangerous for the health of the mother and the baby. Studies allude to miscarriage, premature labour or delivery, low birth weight, foetal trauma, depression and anxiety as direct outcomes. It can also lead to an increased risk of unhealthy behaviours – such as substance abuse – and reduction in antenatal and postnatal care as indirect effects (Devries et al, 2010; Jasinski, 2004; Finnbogadóttir et al., 2014; Menezes Cooper, 2013; Cook and Bewley, 2008; O'Reilly, 2007; WHO, 2005). One study also highlighted that women victims of IPV are more likely to undergo repeated induced abortions (Finnbogadóttir et al., 2014).

9. Bangladesh, Brazil, Peru, Thailand, United Republic of Tanzania, Ethiopia, Japan, Namibia, Samoa, Serbia and Montenegro.

3.3 Boys' and young men's attitudes towards early and unintended pregnancy

Early and unintended pregnancy is generally considered to be a girl's problem, and boys and men are often left out of the equation despite their obvious role in a girl becoming pregnant. Stigma and discrimination towards early and unintended pregnancy and resulting blame and punishment are rarely addressed towards male partners. Boys often stay unnoticed, retain their status in school and the community and are able to continue their education and careers without any consequences. A study from Uganda indicated that unmarried boys and men may decide not to take on the responsibility of having a baby and/or exercise pressure on girls to undergo an abortion (Atuyambe et al., 2007).

Whether fathers are still adolescents, or older husbands within child marriages, responses to early and unintended pregnancy must involve male partners. Instead, their involvement is often neglected and their lack of knowledge results in a lack of empathy and ability to support pregnant girls and adolescent mothers. A questionnaire administered among students in South Africa (Chigona and Chetty, 2007) showed that only 50 per cent of boys were empathetic towards teen mothers vs. 80 per cent of girls. In school, teen mothers report being bullied mostly by boys (Luttrell, 2003).

"I do appreciate the way the girls are treating me compared to boys. Boys are using bad words such as some you are an old woman, why are you here? You suppose to stay at home and continue breastfeeding your child instead of coming back to school. It makes me unhappy and I feel very bad but I do not respond to them." (Shaningwa, 2007)

Bullying of pregnant girls and adolescent mothers may be a reflection of the lack of knowledge and awareness about early and unintended pregnancy and challenges faced by affected girls, but also of beliefs surrounding virility and masculinity (Watts and Borders, 2005). These perceptions of male roles have implications for pregnancy prevention, since those who support more traditional male roles and attitudes are less favourable towards condom use. To prevent pregnancy, men prefer to delegate the responsibility of hormonal contraception to women, despite the loss of control over potential unintended pregnancy and the level of anxiety that results from this (Smith et al., 2011).

A questionnaire administered among students in South Africa showed that only 50 per cent of boys were empathetic towards teen mothers vs. 80 per cent of girls (Chigona and Chetty, 2007)

Literature on boys' perception of early and unintended pregnancy is scant and relates overall to the responsibility they may have in deciding about the outcomes of pregnancy (Lohan et al., 2010). Most available studies are conducted among boys living in high-income countries where issues related to gender equality may be different (Lohan et al., 2010). For example, in Australia boys have been found to be highly interested in choices around pregnancy; concerned about their future and the future of their partner and child; and unconcerned about the routine of parenthood (Corkindale et al., 2009). There is a need for more research on boys' attitudes towards early and unintended pregnancy and their perceptions of the importance of involving them in pregnancy prevention in school.

4. ENSURING THE LINKAGE BETWEEN SCHOOLS AND HEALTH SERVICES

Early and unintended pregnancy is related to a range of adverse health outcomes for both young mothers and babies. Whilst acknowledging the principal role of the health sector in developing programmes aimed at reducing the negative impacts on the health of pregnant girls, adolescent mothers and their babies, the education sector can make a significant contribution towards better health and social outcomes. It can do so by promoting adolescents' access to services through the development and reinforcement of an effective referral system and counselling service in school, and equipping adolescents with appropriate health knowledge about how to prevent early and unintended pregnancy.

This section outlines the main challenges for the health sector due to early and unintended pregnancy and how the education sector can collaborate with the health sector to begin to overcome these challenges.

4.1 Challenges for the health sector

■ Adverse health outcomes associated with early and unintended pregnancy

Recent evidence suggests that, even if the risk of maternal mortality for adolescents is lower than expected, economic and bio-demographic factors increase their risk of maternal mortality.

Higher risks of maternal mortality are associated with socio-economic deprivation and consequent limited access to health care. The concentration of most adolescent births among poorer and less educated girls increases their risk of death, together with the lack of access to antenatal and delivery care. A higher risk of mortality is also associated with first pregnancies and the chances of being primiparous (i.e. giving birth for the first time) increase with lower age. For this reason, adolescents younger than 15 or 16 years old are at higher risk of maternal mortality (Nove et al., 2014).

Babies of adolescent mothers have a higher risk of low birth weight, perinatal asphyxia, jaundice, respiratory distress syndrome, preterm birth and higher foetal and neonatal mortality (Banerjee et al. 2009). Low birth weight results from the biological immaturity of girls, whose weight gain during pregnancy is lower compared to adult women. This leads to the competition for nutrients between the mother and the developing foetus, to the detriment of the latter (Kumar et al., 2007). Neonatal mortality is indeed higher for babies born to mothers aged from 10 to 17 compared to those aged between 20 and 24 (Chen et al., 2008).

Moreover, stigma around adolescent pregnancy and difficulties faced by adolescents in accessing health services both lead girls to undergo unsafe abortions, which increases their risk of abortion-related complications and death. Data from 2008 show that 15 per cent of girls aged 15–19 years old underwent unsafe abortions; Among the 3.2 million unsafe abortions in young women aged 15–19 years old, almost 50 per cent were in Africa; in Africa, 22 per cent of all unsafe abortions were among adolescents aged 15–19 years, compared to 11 per cent of those in Asia (excluding Eastern Asia) and 16 per cent of those in LAC (Shah and Ahman, 2012).

■ Access to services and contraception

WHO guidelines recommend the provision of sexual and reproductive health (SRH) services, including contraceptive information and services, for adolescents without mandatory parental and guardian authorization/notification, in order to meet the educational and service needs of adolescents (WHO, 2014).

However, adolescents have limited access to SRH services, despite the confidence and trust they generally have in the health system (Bankole and Malarcher, 2010). Barriers to accessing SRH services depend on the availability, accessibility and quality of health services, but also on context-specific attitudes among adolescents towards their use, as well as

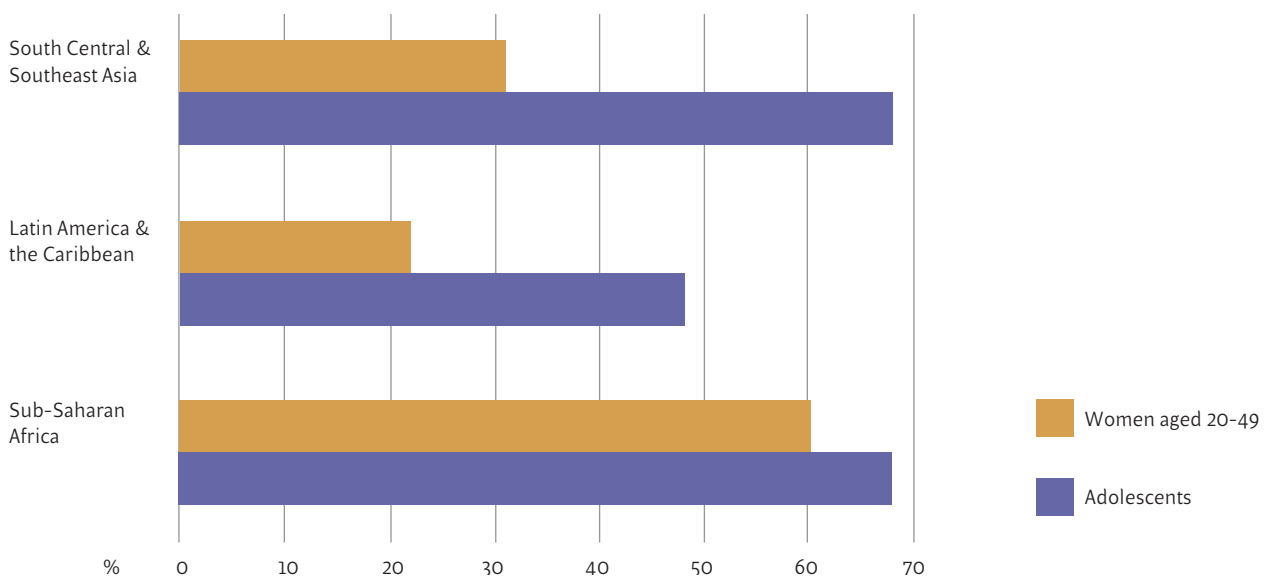
decision-making powers and social norms around adolescents' use of health services (Tylee et al., 2007; Bankole and Malarcher, 2010). In some developing countries, health services are not available or are not accessible by young people due to location and costs (Bankole and Malarcher, 2010). In other contexts, adults may decide whether or not adolescents need health care, as well as when and where (Bankole and Malarcher, 2010). In rural Bangladesh, for example, family members prefer adolescents to give birth at home with traditional birth attendants (Reynolds et al., 2006).

Today, 82 per cent of unintended pregnancies occur among women with an unmet need for contraception (Darroch et al., 2011). In Eastern Europe and Central Asia, South and Southeast Asia, and Latin America, East and Southern African and the Caribbean, unmet need is highest among the youngest women, while in the Middle East and North Africa unmet need increases with age. In nearly all regions and for both married and unmarried women aged 15–24, unmet need is higher with the greatest difference among sexually active, unmarried women in East and Southern Africa, West and Central Africa, and in Latin America and the Caribbean (MacQuarrie, 2014). Social norms in Kyrgyzstan and Tajikistan place a high value on virginity, making it difficult for young people to access information and services at all (Colombini et al., 2011).

82 per cent of unintended pregnancies occur among women with an unmet need for contraception (Darroch et al., 2011).

A 2009 Guttmacher Institute report estimated that, if all women who wanted to avoid pregnancy were using modern contraceptives, the number of unintended pregnancies in developing countries would fall from 75 million to 22 million annually (Singh et al., 2009). This would translate to 22 million fewer unplanned births, 15 million fewer unsafe abortions, and 90,000 fewer maternal deaths (Population Reference Bureau factsheet). Unmet need for contraception is higher for adolescent girls in many regions (see Figure 4.1) (IPPF, 2010).

Figure 4.1 Unmet need for contraception



Source: IPPF

Gender inequality within a relationship and in society plays a role in access to contraception, since girls are often considered by their partners to be responsible for preventing a pregnancy (Bankole and Malarcher, 2010), yet they are stigmatized if they carry condoms or use contraception as a sign of their sexual activity. Pressure around not using modern contraception often takes place between couples: young brides are supposed to give birth after marriage and they are sometimes obliged to become repeatedly pregnant until they produce a son, while boyfriends may ask their girlfriends to prove their fertility and love through pregnancy (Williamson et al., 2009).

The proportion of adolescents who give birth to their first child within seven months of union formation ranges from 3 to 39 per cent in 27 African countries, 9 to 29 per cent in six Latin American and Caribbean countries, 1 to

25 per cent in 12 Asian countries, and 4 to 20 per cent in three European countries (UN Department of Economic and Social Affairs, 2013). Moreover, adolescents may not know all types of modern contraceptives available, and providers may also lack the knowledge to help them (Bankole and Malarcher, 2010). Or providers may decide to give limited information about contraception they believe adequate or acceptable for young people, because of their own judgements (Campbell et al., 2006).

A study conducted in the US and Canada among 10–24 year olds showed that, of all contraceptive methods, participants were least likely to have heard of etonogestrel implants, rhythm method/natural family planning, and intrauterine devices (IUDs) (Sokkary et al., 2013). In another study among 14–19 year old girls, only 21.1 per cent of them had heard of IUDs (Barrett et al., 2012).

Emergency contraception provides an option for reducing the risk of pregnancy after contraceptive failure or after unprotected sex (UNESCO, 2013b). However, a study found that the majority of women in low-income countries have never heard about these options and that providers do not make them easily accessible (Westley et al., 2013).

4.2 Need for collaboration between education and health

As already discussed above, the education sector has a key role to play in contributing to the reduction of health risks related to early and unintended pregnancy. It needs to work closely with the health sector to ensure appropriate knowledge on adolescent pregnancy and support for pregnant girls and adolescent mothers. This support should be based on health counselling, including a referral system to health services or school health services available for adolescents in schools.

■ Lack of appropriate knowledge on pregnancy prevention

In a study based on a nationally representative survey conducted in SSA, less than one third of girls had a level of knowledge detailed enough to prevent pregnancy (Biddlecom et al., 2007). In India, girls were found to be unable to associate a missed period with a potential pregnancy (Presler-Marshall and Jones, 2012). A study in Zimbabwe revealed that 78 per cent of girls and 71 per cent of boys knew little or nothing about preventing pregnancy (Cowan et al., 2008).

Knowledge about and access to modern contraception are among the main challenges for adolescents. Both the lack of formal education about contraception, and in some settings, strong religious opposition to contraception has led to a major gap in correct and comprehensive information. Some young people believe that contraception can affect the reproductive system and lead to infertility. In some countries, adolescents consider abortion or getting pregnant to be a less dangerous option (Were et al., 2007; Williamson et al., 2009; Campbell et al., 2006). Pregnancies can happen due to the failure of contraception use, since practical knowledge is also lacking (Chandra-Mouli et al., 2014). Some girls reported taking contraceptive pills only before having sex instead of daily (Williamson et al., 2009).

“I take a pill when I know my boyfriend is coming and we probably going to make love. I sometimes forgot to take it before we make love so I take it after we made love.” (Richter and Mlambo, 2005)

Among boys aged 15–19 a study found that knowledge about correct condom use was low; 32 per cent of boys in Burkina Faso and 50 per cent in Ghana did not know that the condom should be used only once (the proportion was higher for girls) (Banole and Malarcher, 2010).

The health and education sector should coordinate their efforts in ensuring appropriate and accurate knowledge during comprehensive sexuality education (CSE) classes. Sessions should cover adolescent pregnancy prevention as well as the health implications of early and unintended pregnancy – such as increased risk of mortality for younger girls, unsafe abortion complications etc. Proper information should also be given to teachers through pre- or in-service training, and to school health staff (where they are available).

■ School health services

School health services have the potential to help prevent adolescent pregnancy, and ensure that the education of pregnant adolescents and adolescent mothers meets their health and development needs. Bridging the gap between adolescent needs and available services is crucially important for children and adolescents, whose health literacy and autonomy in knowing when and where to seek advice is often limited. School health services – with their unique position at the intersection of the health and education sector – are very well placed to ensure a continuum of health promotion, prevention and referral, thus making the necessary link between education and health. According to an ongoing WHO review on school health services (SHS), they are available in at least 104 countries globally, including 48 high-income countries, 56 LMICs. Among them 61 countries have dedicated school health personnel. A wide range of professionals are routinely involved in SHS provision such as nurses, doctors, psychologists, psychiatrists, social workers, counsellors and other providers including community health workers, gynaecologists and other specialists.

However, the role of this system of care in the prevention of adolescent pregnancy, and supporting the education sector to create healthy conditions for the adolescent mother, is currently underutilized. Increased interest in strengthening the role of the education sector in the prevention of adolescent pregnancy and ensuring good health and educational outcomes for pregnant adolescents and adolescent mothers might benefit substantially from leveraging these resources.

A survey conducted by WHO/Europe highlights that challenges related to school health services include: inadequate funding; shortage of personnel; insufficiently defined position of school health services in educational institutions; and unclear division between the responsibilities of school nurses, school doctors and family doctors.¹⁰ A review conducted in the UK (Owen et al., 2010) shows the diversity in school-linked sexual health services for young people and categorizes them into three different types:

- ones staffed by school nurses and including drop-in sessions and individual appointments, and offering a minimal or basic level of service;
- ones staffed by multi-professional teams including school nurses, youth workers and other professionals but not medical practitioners, and also offering outreach services; and
- ones staffed by multi-professional teams including medical practitioners offering a comprehensive level of services.

The review highlights some evidence of positive effects in terms of reductions in births to teenage mothers and chlamydia rates among young men. Another review based on studies in the US, Finland and Australia (Strunk, 2008) on the effect of school-based health clinics offering counselling, health care, health teaching and education about childhood development specifically on adolescent pregnancy showed reduced absenteeism and drop-out rates for pregnant and parenting adolescents and positive impact on pregnant girls' decisions to use contraception and on their desire to not repeat pregnancy until they feel ready for parenting. The linkage between school and services therefore needs to be reinforced through a closer collaboration between the education and health sectors.

10. See : <http://www.euro.who.int/en/health-topics/Life-stages/child-and-adolescent-health/adolescent-health/school-health-services>

5. TAKING ACTION

As the above discussion has shown, the education sector can do a lot to prevent early and unintended pregnancy and ensure that pregnant girls and adolescent mothers fulfil their right to education. Previous sections discussed early and unintended pregnancy in the educational setting highlighting the educational, social and health challenges faced by pregnant girls and adolescent mothers in school, and outlined the role of the education sector in helping girls to overcome them. This final section focuses on programmes and interventions in educational settings, including educational components aimed at preventing early and unintended pregnancy or at supporting pregnant girls and adolescent mothers.

5.1 Evidence on school-based interventions

As a consequence of dropping out of school, girls' opportunities are reduced in terms of the overall benefits of education that contribute to their physical and emotional growth, increase in knowledge and life skills, higher self-confidence and better outcomes in life. Outside of the education system, girls also have fewer chances to access the knowledge and skills aimed at preventing early and unintended pregnancy, increase their use of contraception and live healthier sexual and reproductive lives.

Access to comprehensive sexuality education (also as part of life-skills and health education) can help to prevent early pregnancy, or delay the first pregnancy, increase birth spacing (Hubbard, 2009), and more generally reduce risky sexual behaviours.

Comprehensive sexuality education (CSE) – which goes beyond biological information on body changes and pregnancy prevention and includes skills related to the ability to interact, build relationships and have control over your body and actions – is the key to reducing early and unintended pregnancy. Indeed, when looking at the effectiveness of interventions in reducing early and unintended pregnancy rates, evidence suggests that a broad approach to developing life skills, confidence, self-efficacy, the ability to plan for the future, gender equality and non-violence among children and young people is critical. A WHO review on preventing early pregnancy and poor reproductive health outcomes found that interventions combining curriculum-based sexuality education with contraceptive promotion to adolescents helped to reduce pregnancy rates before the age of 20 years. In addition, efforts to retain girls in school, both at the primary and secondary levels, reduced the risk of child marriage, which, as discussed above, is one of the determinants of early pregnancy (Chandra-Mouli et al., 2014).

■ Curriculum-led interventions

A comprehensive review (Kirby et al., 2007) based on 83 studies from both developed and developing countries found strong evidence that curriculum-based sex and HIV programmes do not increase sexual activity. The same review also found some evidence that these programmes can delay sexual onset, reduce the frequency of sex, or improve the use of contraception. 48 per cent of programmes showed increased condom use and half of them reduced sexual risk taking. 65 per cent of programmes had a significant impact in one or more sexual behaviours, and only 7 per cent had a negative impact. Overall, sexuality education programmes based on abstinence were found to be less effective in reducing sexual activity and early and unintended pregnancy (Kohler et al., 2008). Narrowly focused sexuality education programmes alone may not be adequate or effective. Adopting a holistic approach to building confidence, decision-making skills and educational aspiration among children from a young age is therefore critical.

For schools to play an effective role in the response to early and unintended pregnancy, a number of preconditions are critical. A curriculum-based response requires:

- A good quality, age-appropriate comprehensive sexuality education programme available to all children and young people from primary education onwards;
- Programming that emphasizes human rights, gender equality, equitable and respectful relationships, life skills such as communication skills, conflict negotiation, future planning etc.

- Programming that is focused specifically on knowledge and skills on puberty and menstrual hygiene, pregnancy, pregnancy prevention, abstinence, safer sex, contraception, prevention of sexually transmitted infection (STIs) (including HIV), as well as the confidence and referrals to seek and access health services;
- Trained and well-supported teachers;
- A school community – especially parents – who support the need for education on pregnancy and pregnancy prevention.

Evidence from studies in Finland and Chile shows that sexuality education including clear messages about contraception has a significant impact on improved levels of knowledge, reduction in the incidence of pregnancy in schools and in rates of abortion amongst adolescents (Apter and Molina, 2012). Early indications from an evaluation of a major sexuality education programme in the Netherlands also show similar impacts¹¹.

However, whilst the scale up of comprehensive sexuality education is advancing rapidly in some regions, such as Latin American and the Caribbean (International Interagency Meeting, 2014), there are still significant gaps reflected in the knowledge outcomes of schooling. A ten-country review of school curricula in 2012 in the East and Southern Africa (ESA) region showed that pregnancy as a specific topic was covered in four out of ten countries, but only one curriculum – the Zambia Basic Education Syllabi Grades 1 to 7 – was sufficiently comprehensive. Eight countries addressed contraception more broadly but in all of them major gaps were found (UNESCO, 2012).

■ Broader school health programmes

A review of more than 150 studies conducted in the US in 2002 (Manlove et al, 2002) highlighted the effectiveness of programmes with a specific focus on youth development, including time for reflection after activities, early childhood programmes such as preschool or childcare to stimulate social and academic development, and nurse’s support to pregnant girls through home visits in reducing early and unintended first and subsequent pregnancies. There were no significant results for studies focusing only on sexuality education.

Early childhood interventions and youth development programmes aimed at stimulating social and academic development among 11–18 years old have been demonstrated in a systematic review of literature to have effective results on pregnancy outcomes (Harden et al., (2006). These interventions, which were conducted with control groups, reduced the number of young women in the intervention settings reporting a teenage pregnancy by 39 per cent. A review investigating pregnancy prevention specifically among adolescents in the US, Italy, Mexico, Canada, England and Scotland (Oringanje et al., 2009) found that multiple interventions (a combination of educational and contraceptive interventions such as contraception–education with or without contraception distribution) lowered the rate of unintended pregnancy among adolescents over the medium-term and long-term period. The study also found positive statistically significant effects of educational intervention on condom and hormonal contraception use.

Box 5.1 Jamaica re-integration policy

In May 2013, a *Policy on the Re-Integration of Adolescent Mothers into the Formal Education System* was launched by Jamaica’s Ministry of Education. By 2011/2012, the Adolescent Mothers Programme run by the Women’s Centre Foundation in Jamaica had served 42,799 young mothers since its inception in 1978 (UNFPA, 2013c). An estimated 716 teen mothers returned to formal education or training after pregnancy, and the secondary pregnancy rate is below 2 per cent.

A recent review focusing on a comparison between different interventions aimed at decreasing fertility among adolescents in LMICs (McQueston et al., 2012) showed increased knowledge of reproductive health, changes in beliefs around abstinence and condom use, awareness of contraception and increased self-efficacy about safe sex. Multi-media campaigns and cash transfer programmes were found to be effective in decreasing sexual activity or encouraging abstinence, while neither of the school-based interventions led to changes in sexual activity. Contraception use increased as a result of school-based interventions, but no significant results were found after two years, suggesting that these types of interventions may not have long-term lasting effects. Interventions effective in preventing adolescent pregnancy have been found to include incentives for girls to stay in school, such as cash transfers and distribution of uniforms (Duflo et al, 2011).

11. Personal communication from evaluators of Long Live LOVE, which has been implemented over 20 years in the Netherlands.

5.2 Examples of ongoing programmes and initiatives

This is a collection of examples providing a snapshot of the range of ongoing programmes and initiatives aimed at preventing early and unintended pregnancy and supporting adolescent mothers in the education context. Some of them specifically address the education sector, while others have a more multi-sectoral approach that also includes the education sector.

■ Comprehensive sexuality education (CSE)

In **Finland**, where adolescent fertility rates are very low (9 per 1,000 15–19 year old girls in 2012), a national sexuality education curriculum has been mandatory in school since 1970. The curriculum is developed by educators together with parents and students' inputs. It includes theoretical, social, emotional, functional and ethical skills along with information acquisition skills. It helps students to increase their knowledge of basic sexual health and contraception; identify bullying and other forms of violence; be aware of services available in their own schools or municipalities; be able to express emotions and their reasons; and reflect on lifestyle choices related to health (Apter, 2011).

A recently completed report on early pregnancy in **Scotland** (Scottish Parliament, 2013), where there are stubbornly high levels of early pregnancy in the European context, is more far-reaching in its recommendations and clearly singles out the role of education:

“There is a view that efforts to prevent teenage pregnancy should begin as early as possible, pre-school even; the most formative years for those children likely to go on to experience what are usually blandly termed ‘poor outcomes’ in their teens and into early adulthood. Such an approach sits well with the premium value that the Chief Medical Officer has placed upon early-years support and positive intervention.

The young mums who spoke to the Committee said sex education was too biologically focused and not enough about relationships. Research shows a correlation between quality sex education and use of contraception, delay of first sexual experience, and having fewer sexual partners. A head teacher told us: ‘Evidence points out that discussing sexuality and sexual health does not encourage promiscuity or early adoption of sexual behaviour – quite the opposite.’”

Across the **UK** (Arie, 2014), a country reputed to have the highest levels of early pregnancy in Europe, the prevalence rates have declined rapidly over the past decade. Part of the solution was a government-launched, ten-year teenage pregnancy strategy, which invested over \$415 million into a multipronged approach that aimed to halve the rate of conceptions among under 18s by 2010. In this context too there is an on-going debate about how to sustain these changes, including the need to make sexuality education compulsory and to address young people's sexual and reproductive health issues more openly.

The Seattle Social Development Project (SSDP) is an intervention aimed at fostering healthy behaviours through the improvement of the school environment. It builds skills for young people's participation, promoting bonding between adolescents and schools and family. The intervention includes teacher training on proactive classroom management and interactive teaching, parent training on how to support children and emotional skill development for students based on helping them to identify problems and solutions, recognize and resist social influences and find alternatives to staying out of trouble and strengthening friendships. A panel study integrated within the intervention showed that participants reduced the number of sexual partners and, for girls, reduced the likelihood of both becoming pregnant and experiencing a birth by age 21 (Lonczak et al., 2002).

■ Ensuring linkage between education and health sectors

Best practices developed by Advocates for Youth¹² include school nurses, school-based health centres, school-linked health centres and partnerships between schools and health departments as the four main strategies used by schools in the US to provide health services and referrals to care for students. School-linked health centres have the advantage of being able to provide services. The document stresses the importance of confidentiality for dealing with pregnant and parenting adolescents, and the need for school staff to be able to ensure privacy and to refer young people to the clinics of pharmacies where discretion is guaranteed and that are easily accessible in terms of costs and location.

In **Mozambique**, the government is implementing the Programa Geração Biz, which also includes the establishment in school of an effective referral system between teachers, adolescent corners and Youth Friendly Health Services (YFHS) facilities. The programme was launched in 1999 and implemented by the Ministry of Education (MoE), the Ministry of Health (MoH) and the Ministry of Youth and Sports (MoYS), with the support of Pathfinder. Schools had school-based peer educators as well as school health corners where services were offered. The providers in the school health corners and the peer educators created the referrals and linkages with health services. National curricula (including all the subject curricula) were revised to include SRH content (e.g. the maths curricula used HIV percentages to learn percentages; the biology curricula included sexuality education, etc). The MoE created a policy that peer educators did not have to pay school fees (which was a huge benefit to young women whose families rarely prioritized them attending school) (WHO, 2009). Today the programme is more multi-sectoral and includes interventions in the schools (under the MoE), health sector (under the MoH) and the community (under the MoYS).

The Youth Peer Education model implemented by the Planned Parenthood Global is another example of linkage between the education and health sectors. The basic idea is that young people not only have the knowledge to help develop, implement and evaluate programmes, but the right to participate in all decision-making processes that affect them. According to this model, trained peer educators are involved in providing SRH information, services and referrals, through youth centres and outreach activities, to young people in-school and out-of-school.¹³

■ Multi-sectoral approach

Most UN agencies promote a multi-sectoral approach to early and unintended pregnancy.

WHO Guidelines on preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries (Chandra-Mouli et al., 2013) offer a comprehensive approach to the topic. They take into account all the major determinants of adolescent pregnancy and correlated health outcomes, and focus on preventing child marriage, creating understanding and support for early pregnancy prevention, increasing use of contraception, reducing coerced sex and unsafe abortion, increasing the use of skilled antenatal childbirth and postpartum care. Some recommendations are closely linked to the role of the education sector and can be transformed into action in line with the ideas developed by this discussion paper (see Table 5.1).

12. See: <http://www.advocatesforyouth.org/storage/advfy/documents/bp-youth-friendly-services.pdf>

13. See: http://www.plannedparenthood.org/files/8313/9611/6485/PP_Global_YPP_Manual.pdf

Table 5.1 WHO guidelines for preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries

Domain	Contributing factors	Action recommendations	Research recommendations
Preventing early marriage	<ul style="list-style-type: none"> Prevaling norms, traditions, and economic constraints No legal prohibitions or ineffective legal regime 	<ul style="list-style-type: none"> Clear and effective legal prohibition Engage community leaders to change norms Keep girls in school 	<ul style="list-style-type: none"> Effective legal prohibition of early marriage Explore the effect of economic incentives and livelihood programs Take existing interventions to scale
Creating understanding and support for preventing early pregnancy	<ul style="list-style-type: none"> Lack of knowledge and understanding about sexuality Contextual factors (e.g., peer pressure) Cultural reticence to address sexuality in adolescents 	<ul style="list-style-type: none"> Engage legal support for contraceptive provision Reduce financial barriers to their use Build community support for contraceptive provision Make contraceptive services adolescent friendly Educate about sexuality and contraceptive use 	<ul style="list-style-type: none"> Explore the effect of increasing employment, school retention, and social support Take existing interventions to scale
Increasing use of contraception	<ul style="list-style-type: none"> Lack of access Misconceptions Community norms oppose contraceptive provision Contraceptive services not user-friendly 	<ul style="list-style-type: none"> Enable legal support for contraceptive provision Reduce financial barriers to their use Build community support for contraceptive provision Make contraceptive services adolescent friendly Educate about sexuality and contraceptive use 	<ul style="list-style-type: none"> Increase use through pro-contraceptive policies, cost reduction, community support and over-the-counter access Change gender norms about contraceptive use Take existing interventions to scale
Reducing coerced sex	<ul style="list-style-type: none"> Powerlessness Lack of effective law enforcement and protection Shame and stigma 	<ul style="list-style-type: none"> Effectively enforce laws to punish perpetrators of coerced sex Promote community norms that do not tolerate coerced sex Engage men to reexamine gender norms Empower girls to resist unwanted sex by building their self-esteem, life skills, and links to social networks 	<ul style="list-style-type: none"> Improve the formulation and application of laws to prevent sexual coercion
Reducing unsafe abortion	<ul style="list-style-type: none"> Lack of knowledge about the danger of unsafe abortions Lack of access to safe abortion services 	<ul style="list-style-type: none"> Provide access to safe abortion where legal Enable access to post-abortion care, including contraception services Improve family and community support for access Educate about dangers of unsafe abortions and on access 	<ul style="list-style-type: none"> Reduce legal and policy barriers to safe abortion Identify and eliminate barriers to care
Increasing the use of skilled antenatal, childbirth, and postpartum care	<ul style="list-style-type: none"> Lack of knowledge and of when and where to seek care Lack of access to skilled- and sensitive-care 	<ul style="list-style-type: none"> Enable access to skilled antenatal, childbirth, and postpartum care Educate on birth and emergency preparedness Education about the risks of foregoing skilled care, for mother and baby 	<ul style="list-style-type: none"> Increasing awareness of the need for skilled care Tailor the provision of care to adolescents Identify and eliminate barriers to care

Source: WHO, 2013

UNFPA focuses on enhancing adolescent opportunities to access CSE, sexual and reproductive health information and services, and leadership opportunities. Ending child marriage and preventing adolescent pregnancy are major areas of work. The recent UNFPA publications *Motherhood in Childhood: Facing the challenge of adolescent pregnancy* (UNFPA, 2013c) and *Marrying too Young: End Child Marriage* (UNFPA, 2012a) offer a global view of the topics, describing the evidence base and good practices, and set out policy and programmatic recommendations to empower girls and deal with these challenges. UNFPA's global Action for Adolescent Girls Initiative also operates in 12 countries to reach the most marginalized adolescent girls at risk of rights violations and exclusion by building their social, economic and health assets. UNFPA also supports regional initiatives, such as in the Andean region, which promote a cross-sectoral approach to addressing adolescent pregnancy, involving the education and health sectors as well as communities.

UNICEF is particularly active in the Asia and the Pacific Region, where it organized a multi-sectoral consultation on adolescent pregnancy in September 2013 in Thailand. Representatives from governments, WHO, UNFPA, UNESCO and young people from the Youth Peer Education Network China (Y-Peer) met and discussed the regional situation and how adolescent pregnancy is related to poverty, low education – including sexuality education – and lack of access to contraception. The consultation aimed to develop strategic recommendations for a cross-sectoral response, and indeed led to a joint action plan for each of the countries participating in the meeting (Report on Multi-sectoral Consultation on Addressing Pregnancies. 2013).

Some countries are already addressing the issue in this way. For example, **Thailand** is now looking at developing a strategic framework for adolescent pregnancy, as shown in Table 5.2.

Table 5.2 Draft of strategic framework for mounting a national programme in addressing adolescent pregnancy (Thailand)

Determinants	Consequences	Strategic actions	Outcomes
<p>Individual</p> <ul style="list-style-type: none"> Puberty with lack of SRH education Early sexual debut and premarital sex <p>Family</p> <ul style="list-style-type: none"> Parents-adolescent interactions Poverty <p>Community</p> <ul style="list-style-type: none"> Socio-cultural norms on sexuality Gender norms and relations <p>Social environment</p> <ul style="list-style-type: none"> Peer pressure Media <p>Policy</p> <ul style="list-style-type: none"> Legal age of marriage Limited access to contraceptives 	<ul style="list-style-type: none"> Loss of educational opportunity and the benefits of: <ul style="list-style-type: none"> education life skills/SRH education Loss of economic opportunity Risk of experiencing gender-based violence Risk of transmission of sexually transmitted/HIV infections Health-related risks for the mother and her newborn baby 	<p>Broad programmes</p> <ul style="list-style-type: none"> Advocacy Well coordinated multi-sectoral programmes for adolescents Raising awareness/campaign for preventing adolescent pregnancy Mapping of adolescent pregnancy – disaggregated by age, education, location, residence, wealth, ethnicity <p>Specific programmes</p> <ul style="list-style-type: none"> Sectoral actions for preventing and managing adolescent pregnancy: <ul style="list-style-type: none"> Empower Educate Protect Serve 	<ul style="list-style-type: none"> Reduction of adolescent fertility rate by a third from 2010 to 2020 80 per cent EAP countries implement laws/ policies to enforce girls' minimum age of marriage to 18 years by 2020 50 per cent increase and closing boy-girl gap of secondary school enrolment rate from 2010 to 2020 Increase by a third current proportion of modern contraceptive use among adolescents by 2020

Source: Report on Multisectoral Consultation on Addressing Pregnancies, 2013

Cambodia's national youth policy recommends to “provide quality education, support and care for teenage pregnancy before married age by appropriately trained health staffs with the participation of relevant stakeholders and communities” (Royal Government of Cambodia, 2011).

In **the Philippines**, many programmes have been implemented in line with the Philippine Youth Development Plan 2012-2016, which includes among its objectives the improvement of young mothers' health through the reduction of maternal mortality and the increase of access to counselling and other assistance. In improving access to health facilities, for instance, the Department of Health has initiated an adolescent health insurance package with PhilHealth.

This includes a maternity care package, a newborn care package and provisions for adolescents and victims of alleged sexual abuse or violence. There are also efforts to provide comprehensive sexuality education, parenting skills and harnessing technology for access to SRH information using social media. Inter-sectoral collaboration and meaningful participation of young people are carried out under the “Batang Ina” Task Force – a government and NGO forum for improving adolescent health. The interventions include measures to keep girls in school, conditional cash transfer (for adolescent mothers who continue their schooling) and evidence-based advocacy for young adults.¹⁴

Box 5.2 Advocacy actions

The Forum of African Women Educationalists (FAWE) advocated for the implementation of re-entry policies in Zambian schools. In 1997 the Minister of Education announced that pregnant and mother students would no longer be expelled from school. However, resistance arose and not all schools implemented the policy. FAWE Zambia (FAWEZA) started educating the public about the policy, through drama performances organized around the country and the dissemination of guidelines including a monitoring system for re-entry policies.¹⁴

Girls Decide is an **IPPF** programme combining advocacy, education and information materials to improve sexual health and rights for girls and young women. Six engaging short films describing the stories of girls around the world were produced in 2011. They show the different challenges girls face and the importance of youth-friendly health services and skilled staff.¹⁵

Plan International is also promoting the *Because I am a Girl* campaign, working with girls, communities, traditional leaders, governments, global institutions and the private sector to address barriers preventing girls from completing their education. The campaign aimed to reach 4 million girls. The main objectives are to persuade leaders about the importance of prioritizing girls’ education; to encourage the completion of secondary education; to increase funding for girls’ education; to end child marriage; to end SRGBV; and to enhance youth participation in the decision-making process.¹⁶

Côte d’Ivoire launched its own campaign in 2014 under the title *Zéro grossesse à l’école* (Abidjan.net, 2014). The six strategies for the reduction of pregnancy in school 2013–2015 included:

- Building an enabling environment at administrative, social, legal and media levels;
- Informing, educating and communicating with students about SRH to drive behavioural changes;
- Using arts, culture and sport in order to promote SRH in school;
- Making use of ICT to promote SRHS to young people;
- Reinforcing the availability of SRHS in schools;
- Reducing the vulnerability of girls in school.

In **Sierra Leone**, the government recently launched a national strategy on early pregnancy with a three-year time frame (2013–2015) and a \$35.5m budget (Republic of Sierra Leone, 2013) based on five main pillars:

- Improved policy and legal environment to protect adolescents and young people’s rights;
- Improved access to quality SRH, protection and education services for adolescents and young people;
- Comprehensive age-appropriate information and education for adolescents and young people;
- Communities, adolescents and young people empowered to prevent and respond to teenage pregnancy;
- Coordination, monitoring and evaluation mechanisms in place and allowing proper management of the strategy.

14. Conversation with the UNESCO regional advisor for Asia Pacific.

15. FAWE. *FAWE Zambia’s Campaign for an Enabling Readmission Policy for Adolescent Mothers* http://www.fawe.org/Files/fawe_best_practices_-_school_re-entry_for_adolescent_mothers_zambia.pdf (Accessed 12 June 2014).

16. See: <http://www.ippf.org/Girls-Decide>

17. See: <http://plan-international.org/girls/index.php?lang=en>

CONCLUSIONS

Based on the evidence, challenges and opportunities outlined in this report, there is a clear and compelling role for the education sector to play in preventing early and unintended pregnancy and ensuring the right of education for pregnant girls and adolescent mothers.

The following suggested framework for action is intended to guide ministries of education and other key partners in the development of effective responses to early and unintended pregnancy. This framework proposes a three-pronged approach that integrates knowledge development with access to education and links to health services. Based on the evidence available globally, this framework provides a global approach that does not necessarily respond to the specific needs in each region or country. Tailored responses based on data, socio-cultural contexts and resources will need to be developed for each region or country.

Strengthening the education sector response to early and unintended pregnancy – a framework for action

1 Increasing knowledge and skills to support girls' empowerment, foster behaviour change and prevent adolescent pregnancy:

- **Implement high-quality comprehensive sexuality education for girls and boys including knowledge and skills on pregnancy, pregnancy prevention, contraception and STIs**
 - **Strengthen skills-based education that begins in early childhood** and builds confidence, resilience, self-efficacy and critical skills whilst addressing gender inequality. Focus on youth development and critical decision-making skills for older children and ensure that education is relevant to the realities in their lives as an important foundational approach to preventing pregnancy, when coupled with CSE.
 - **Integrate knowledge and skills on pregnancy and pregnancy prevention including promotion of contraception in CSE, puberty education or other health curricula.** Children and adolescents need clear, scientific accurate education about puberty, reproduction and pregnancy prevention and contraception. In addition to knowledge, they need to consider attitudes and values in relation to gender and relationships, critically analyse cultural and social influences on decision-making and build skills to make healthy choices, refuse unwanted sexual intercourse and negotiate contraceptive use.
 - **Integrate prevention of GBV in sexuality education curricula and teacher training** to improve gender equality and reduce the prevalence of violence that also contributes to unintended pregnancy and perpetuates harmful gender norms.
 - **Involve boys in pregnancy prevention education.** As future partners and parents, boys need to be aware that early pregnancy will have educational and socio-economic consequences for them as adolescent fathers, and health consequences for their young pregnant partners. Furthermore, especially in countries where child marriage is prevalent, boys need to be educated on gender equality and gender-based violence (GBV), to increase the chances of changing social and cultural norms towards child marriage and, more generally, to eliminate gender inequality.

2 Promoting good policies and practices in the education sector

- **Enforce child protection policies which guarantee access to education, health care and support for all children and young people, regardless of their health status.**
- **Eradicate policies and practices that result in the expulsion or exclusion of pregnant girls and teen mothers.**
 - Through the **promotion of girls' rights to education, regardless of their health status**, governments need to ensure that all girls remain in school and have access to good quality education. This includes putting in place re-entry policies allowing girls to continue their education during and after pregnancy, including alternative education programmes that are relevant to the needs of pregnant adolescents and adolescent parents. Educating girls on their rights and keeping them in school are also effective strategies against child marriage. Access to education must be ensured, even if a learner is pregnant or has had a child. Linked to this, ministries should **prohibit practices such as mandatory pregnancy screening**, which are a breach of rights to privacy.
 - Ensuring supportive environment for adolescent mothers, such as parenting instructions or classes, breastfeeding space, counseling, etc.
- **Promote a safe school environment free of gender-based violence, stigma, discrimination and bullying against pregnant adolescents and adolescent mothers.**
 - In line with UNESCO's work on **promoting safe school environments, and eliminating school-related gender-based violence**, school environments must, through policy and action, promote equality and respect. GBV in schools must not be tolerated and can be explicitly addressed through education policies, improved monitoring, teacher training initiatives and support for girls' clubs where female learners have a safe space to express themselves, and to report violence or abuse.
 - CSE or health education should be aimed at ensuring that girls feel physically and emotionally safe in schools. Teachers and other school staff need to be aware of **the needs pregnant girls and adolescent mothers face in school**, and support them in ensuring dialogue and linkages to services.
- **Promote changes in social norms on gender equality, pregnancy prevention and child marriage through engagement with parents and communities.**
- **Engage with teachers and school directors to ensure support to pregnant girls and adolescent mothers and to guarantee a safe school environment in schools.**

3 Ensuring the linkages between schools and health services

- **Facilitate and promote effective linkages between schools and adolescent responsive services, both within and outside the health sector.**
 - Girls and boys need the knowledge and confidence to seek and make use of primary and referral level services that provide adolescent responsive care in line with quality standards.¹⁸ In addition, adolescents may need services outside the health sector – such as social care and support, vocational training, legal advice etc. Mechanisms should therefore exist to link schools with those services and ensure that adolescents, including pregnant adolescents and adolescent parents, have easy and timely access to these services.
- **Strengthen the role of school health services in pregnancy prevention, and in coordinating health and education sector actions to support pregnant adolescents and adolescent mothers to achieve better health and educational outcomes.**
- **Strengthening the link between educational institutions and communities to enhance their support for adolescents' use of health services.**
 - Parents, guardians and communities play an important role in adolescent access to, and use of, health services. Without their support adolescents' use of services may be limited. It is important that schools work with parents, guardians and other community members and community organizations to enhance their recognition of the value of providing health services to adolescents, and to increase their support for adolescents' utilization of health services.

This framework is complemented by a set of questions for further discussion in Appendix II.

18. See: <http://apps.who.int/adolescent/second-decade/>

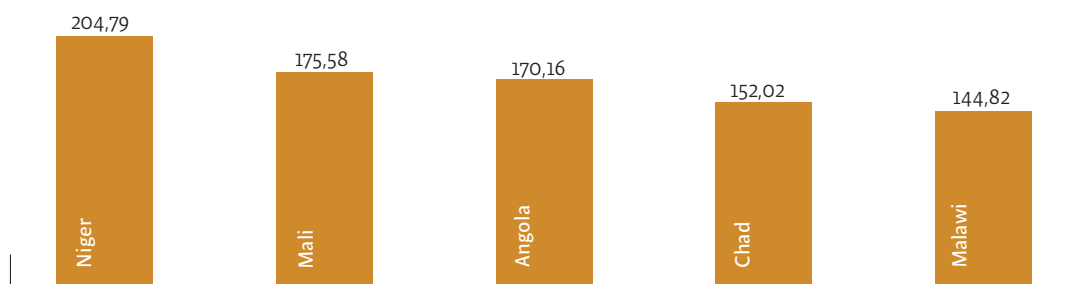
APPENDIX I

Snapshot of regional variations

Sub-Saharan Africa (SSA)

Sub-Saharan Africa has the highest adolescent fertility rates (108.10 live births per 1,000 girls), with particularly worrying levels in Niger, Mali, Angola, Chad and Malawi (see Figure I.1).

Figure I.1 Fertility rates among 15-19 years old girls in SSA



Source: World Bank data, 2012

Chad has the highest percentage of motherhood before the age of 16, followed by Guinea, Niger and Mali (Neal, 2010). DHS data from Rwanda, Kenya, Zimbabwe, Malawi and Lesotho show that the percentage of childbearing 15 years olds decreased from 2005 to 2010 in all countries but increased in Zimbabwe, Lesotho and Malawi.¹⁹

Lack of knowledge of modern contraception and low access to family planning are among the main causes of early and unintended pregnancy in SSA. In the 2009 Human Science Research Council Report, the lack of use of condoms was mentioned by interviewees as a major reason for teenage pregnancy in South Africa.²⁰

Sub-Saharan Africa has the highest adolescent fertility rates (108.10 live births per 1,000 girls)

Child marriage is also linked to adolescent pregnancy in this region, where percentages of very young adolescent mothers already married at age 16 are high in West (80 per cent), Central (75 per cent) and East (67 per cent) Africa, while they are lower in Southern Africa (32 per cent). However,

pregnancies preceding marriage and resulting in a birth after a “shotgun marriage” in SSA are more common than in other regions (UN Department of Economic and Social Affairs, 2013).

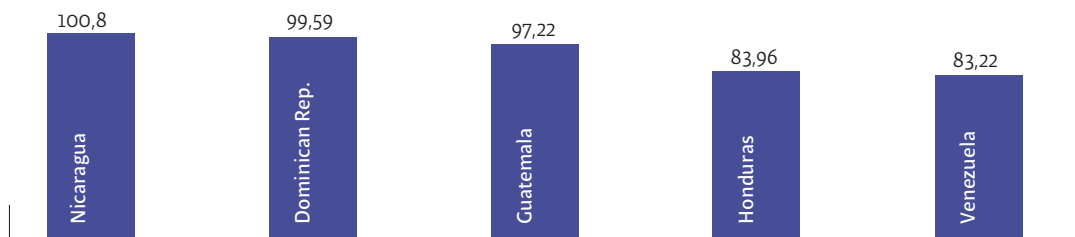
19. Presentation from the UNICEF Eastern and Southern Africa Office on Teenage Pregnancy. March 2012.

20. Ibid.

Latin America and the Caribbean (LAC)

In Latin America and the Caribbean, one birth in every five is to adolescent mothers and 38 per cent of young women become pregnant before the age of 20.²¹ Countries with higher fertility rates among 15 to 19 year olds include Nicaragua, the Dominican Republic, Guatemala, Honduras and Venezuela (see Figure I.2). Unexpectedly, despite a general decrease in fertility, adolescent fertility rates remain constant and are even increasing in some countries (Gomes, 2012).

Figure I.2 Fertility rates among 15–19 year old girls in LAC



Source: World Bank data, 2012

Although many girls marry before the age of 20, most adolescent mothers are single, and often the father is four to ten years older. Indeed, while teen parenthood concerns one in every ten women, it only concerns one in every 50 men. Many pregnancies are unintended (in Jamaica, for instance, 88 per cent of adolescent pregnancies are unintended) (Baumgartner, 2009) and this is also reflected in the high rate of abortions, which are mostly unsafe due to its illegal status in many LAC countries (Warriner and Shah, 2006).

Lack of knowledge about contraceptives – often due to the low quality of sexuality education in schools – and scant use of modern contraception are highly correlated to teen pregnancy in this region. In some countries, one out of five teenage mothers has a second baby less than 17 months after the previous one (Gomes, 2012). Despite low use of contraceptives in countries such as Colombia and the Dominican Republic, health services seem to function well for teen mothers. Girls often give birth in clinics with trained staff. In other countries such as Bolivia, Ecuador, Guatemala, Haiti, Honduras, Nicaragua, El Salvador, Paraguay and Peru, 20 per cent to 40 per cent of births take place at home, particularly among poor and uneducated people (Gomes, 2012).

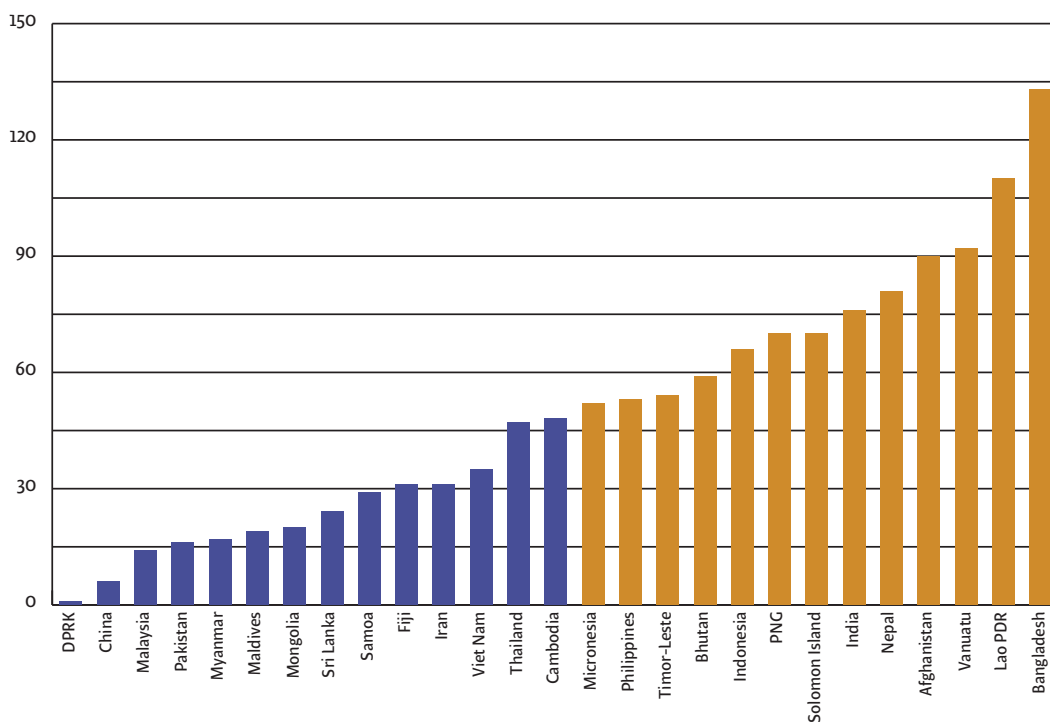
In this region, a common characteristic of girls who drop out of school due to pregnancy is lack of interest and poor quality or insufficient future employment opportunities. Some girls become pregnant as a form of redemption (Näslund-Hadley and Binstock, 2010).

21. See: <https://www.ippfwhr.org/en/content/test-infographic>

Asia and the Pacific (AP)

In Asia and the Pacific, the highest rates of adolescent fertility are in Bangladesh, Laos (PDR), Vanuatu, Afghanistan and Nepal (see Figure I.3). In some countries, rates between rural and urban areas differ hugely (in Laos, for instance, adolescent fertility rates are 114 and 44 births per 1,000 adolescents, in rural and urban area respectively).

Figure I.3 Fertility rates among 15–19 years old girls in Asia Pacific



Source: UNFPA State of the World Population 2013

Asian countries account for the highest proportion of married girls. It is estimated that 60 per cent of girls in South Asia are married by the age of 18 and one quarter are married by the age of 15. The mean age for child marriage is 15.9 (Raj et al, 2010), which places sexual activity among young people predominantly in the context of marriage. Husbands are generally older and may exercise their control over brides, also preventing them from accessing family planning services and contraception (UNFPA, 2013c). Contraception use is low, also as a result of cultural norms. In India, for instance, policies on family planning focus more on sterilization than on modern contraceptive use (Presler-Marshall and Jones, 2012). 11 per cent of unsafe abortion among 15–19 year olds are in Asia, and 3.6 unsafe abortion among young women takes place in the Asia Pacific region (Shah and Ahman, 2012).

Mean age for child marriage is 15.9 (Raj et al, 2010)

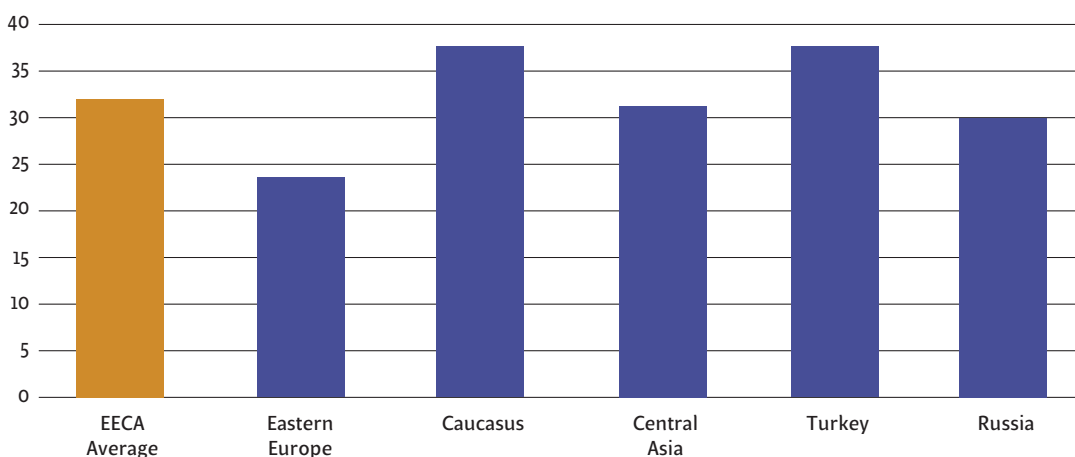
In the Pacific region, early pregnancy has decreased over the last decade, but Marshall Islands, Nauru, Papua New Guinea, Solomon Islands and Vanuatu still have high fertility rates (more than 50 births per 1,000 15–19 year olds). In some countries 3 per cent to 8 per cent of girls have their first sexual experience before the age of 15. Also here contraceptive use is very low and in many cases pregnancies are a consequence of forced sexual intercourse (the younger the girl, the higher the chances that sex was forced) (UNFPA, 2013b).

In the Philippines, the age of consent to sex is 12 years old, but access to services and contraception is often restricted to adolescents who are married or who are over the age 18. Even if the person is married some health workers discourage the use of contraception if the person does not have children. In China, Indonesia and Malaysia, access to SRHS is often limited to married couples (UNESCO, 2013a).

Eastern Europe and Central Asia (EECA)

Early and unintended pregnancies rates in this region are lower compared to those in other regions of the world. However, adolescent pregnancy is a major challenge among specific population groups, such as married adolescents, and young people from linguistic, religious and ethnic minorities, particularly Roma communities. In Serbia, for instance, the adolescent birth rate in the Roma population exceeds the national average by more than six times. Despite a general decrease of early and unintended pregnancy since 2000, in Bulgaria, Romania, Ukraine, Russia and some countries of the Caucasus, rates slightly increased in the second half of the decade. Today, birth rates in EECA range from eight per 1,000 in Bosnia to 54 per 1,000 in Tajikistan. There are higher fertility rates among women under the age of 20 are in Georgia, Azerbaijan, Romania, Bulgaria and Turkey. The sub-region of Caucasus has the highest adolescent birth rate (see Figure I.4).

Figure I.4 Adolescent birth rates per EECA sub-regions and for Turkey and Russia, 2006-2011



Source: Official MDG's website

The overall use of contraception is low. In Eastern Europe (excluding Russia and Turkey) 22 per cent of girls aged 15–19 report using modern contraception, compared to 13 per cent in Asia and 3.6 per cent in the Caucasus. Contraception relies overall on withdrawal and abortion, which is highly practised in this region. In Albania, 12.9 per cent of married young women use modern contraception while 5.6 per cent still rely on traditional methods. Sexuality education in school is poor and access to services is difficult for adolescents since many countries apply a legal age restriction in accessing services without parental consent (UNFPA, 2013a).

Early marriages and pregnancies are quite common in central Asia, putting young women at risk of maternal mortality and morbidity. In Tajikistan, for instance, 15 per cent of young people are married by the age of 18, with higher rates among poorer or less educated young people. Contraceptive use is low among young people in central Asia, despite increased awareness in recent years. For instance, in Tajikistan, only about 9 per cent of married or in-union girls aged 15–19 used any form of modern contraception in 2005, compared to 50 per cent of women aged 35–49. Due to the low use of family planning methods, high abortion rates among teenage girls are a rising problem (WHO and UNFPA, 2011).

In Serbia the adolescent birth rate in the Roma population exceeds the national average by more than six times (UNFPA, 2013a)

Middle East and North Africa (MENA)

In the Middle East and North Africa, the highest fertility rates are in Iraq, Yemen, Egypt, Syria and Morocco (see Figure I.5). Arab states are in second position – after SSA – in relation to unmet need for family planning and prevalence of modern contraceptive methods among 15–49 year old women (UNFPA, 2013c).

Figure I.5 Fertility rates among 15–19 year old girls in MENA



Source: World Bank data, 2012

APPENDIX II

Open questions to discuss at the Global Consultation

- 1 How countries should ensure that re-entry policies are developed and implemented?
 - a. How can re-entry policies be monitored?
 - b. What kind of structures need to be put in place for teachers and school staff to ensure counselling and support for pregnant girls and adolescent mothers?
- 2 How can pedagogy be adapted to the needs of pregnant and mothering girls?
 - a. How can it be ensured that girls do not fall behind with the academic programme?
 - b. Are separate schools a good or bad option in terms of outcomes and resources required to put them in place?
 - c. What are feasible options to ensure basic education for adolescent mothers deciding not to go back to formal institutions?
- 3 What are the topics of sexuality education where the link to pregnancy prevention needs to be addressed more clearly (e.g. contraception, peer-pressure, decision-making power, etc)?
- 4 How can teachers concretely explain to adolescents different types of contraceptive methods, use and side effects? Or should they involve school health personnel (e.g. school nurse) to conduct classroom or individual information and counselling?
- 5 What are the challenges faced when teaching gender equality?
 - a. How can these challenges be overcome?
 - b. What skills need to be developed by the school staff in order to effectively respond to SRGBV towards pregnant girls?
- 6 What is the best way to involve boys in pregnancy prevention and sensitize them about pregnant girls and adolescent mothers' challenges?
 - a. Should there be mixed or separate sexuality education classes?
 - b. What kind of content related to early and unintended pregnancy should be taught to boys (adapting content for girls vs for boys)?
- 7 How do we need to imagine referral systems in schools?
 - a. Who should be the "referent" (teacher, peers, trained school staff, trained health staff)?
 - b. How can confidentiality be ensured?
- 8 What role does the curriculum and education have in promoting condoms as an appropriate method for dual protection from STI (including HIV) and pregnancy for young people?
- 9 What type of information about possible choices in case of unintended pregnancy should adolescent students receive?
 - a. What are the challenges in addressing this topic in school and how can these challenges be overcome?
- 10 What can the different actors do?
 - a. How can ministries (e.g. health and education) effectively collaborate to address early and unintended pregnancies? What kind of policy and other mechanisms can be leveraged for this collaboration?
 - b. What role does civil society, including youth-led civil society, play in the education response to early and unintended pregnancy?
 - c. How can adolescents themselves play an active role in preventing and responding to early and unintended pregnancy within the education sector setting?

BIBLIOGRAPHY

- Abidjan.net (March 2014) *La ministre Kandia Camara lance la campagne «Zéro grossesse à l'école» à Bondoukou* (retrieved 11 August 2014 from <http://news.abidjan.net/h/490567.html>).
- Achoka, J. S. and Njeru, F. M. (2012). De-stigmatizing teenage motherhood: Towards achievement of universal basic education in Kenya. *Journal of Emerging Trends in Educational Research & Policy Studies*, 3(6), 887–892.
- Advocates for Youth. Best Practices for youth-friendly sexual and reproductive health services in schools (retrieved 23 September 2014 from <http://www.advocatesforyouth.org/storage/advfy/documents/bp-youth-friendly-services.pdf>).
- Agunbiade, O.M., Titilayo, A. and Opatola, M. (2009). *Pregnancy stigmatisation and coping strategies of adolescent mothers in two Yoruba communities, Southwestern Nigeria* (retrieved 17 April 2014 from <http://iussp2009.princeton.edu/papers/92893>).
- Almeida, M. D. C. C. and Aquino, E. M. (2009). The role of education level in the intergenerational pattern of adolescent pregnancy in Brazil. *International Perspectives on Sexual & Reproductive Health*, 35(3), 139–146.
- Apter, D. (2011). *Recent development and consequences of sexuality education in Finland*. BZgA FORUM 2.
- Apter, D. and Molina, R. (2012). Sexuality Education: Finnish and Chilean Experiences. *Pediatric and Adolescent Gynecology. Evidence-Based Clinical Practice. 2nd, revised and extended edition*. *Endocr Dev. Basel, Karger*. 22, 332–356.
- Arie, S. (2014). Has Britain solved its teenage pregnancy problem? *British Medical Journal*, 348:g2561.
- Atuyambe, L., Mirembe, F., Johansson, A., Kirumira, E. K. and Faxelid, E. (2007). Experiences of pregnant adolescents – voices from Wakiso district, Uganda. *African Health Sciences*, 5(4), 304–309.
- Banerjee, B., Pandey, G. K., Dutt, D., Sengupta, B., Mondal, M. and Deb, S. (2009). Teenage pregnancy: a socially inflicted health hazard. *Indian Journal of Community Medicine*, 34(3), 227–231.
- Bankole, A. and Malarcher, S. (2010). Removing barriers to adolescents' access to contraceptive information and services. *Studies in Family Planning*, 41(2), 117–124.
- Barbieri, M. and Hertrich, V. (2005). Age difference between spouses and contraceptive practice in sub-Saharan Africa. *Population* (English edition), 60(5), 617–654.
- Barrett, M., Soon, R., Whitaker, A. K., Takekawa, S. and Kaneshiro, B. (2012). Awareness and knowledge of the intrauterine device in adolescents. *Journal of Pediatric and Adolescent Gynecology*, 25(1), 39–42.
- Baumgartner, J. N., Waszak Geary, C., Tucker, H. and Wedderburn, M. (2009). The influence of early sexual debut and sexual violence on adolescent pregnancy: a matched case-control study in Jamaica. *International Perspectives on Sexual and Reproductive Health*, 35(1), 21–28.
- Beyeza-Kashesya, J., Neema, S., Ekstrom, A. M. and Kaharuza, F. (2010). "Not a Boy, Not a Child": A qualitative study on young people's views on childbearing in Uganda. *African Journal of Reproductive Health*, 14(1), 71–82.
- Bhana, D., Morrell, R., Shefer, T. and Ngabaza, S. (2010). South African teachers' responses to teenage pregnancy and teenage mothers in schools. *Culture, Health & Sexuality*, 12(8), 871–883.
- Biddlecom, A. E., Hessburg, L., Singh, S., Bankole, A. and Darabi, L. (2007). *Protecting the next generation in sub-Saharan Africa: Learning from adolescents to prevent HIV and unintended pregnancy*. New York, Guttmacher Institute.
- Black, A. Y., Fleming, N. A. and Rome, E. S. (2012). Pregnancy in adolescents. *Adolescent Medicine: state of the art reviews*, 23(1), 123–38.
- Breheny, M. and Stephens, C. (2007). Irreconcilable differences: Health professionals' constructions of adolescence and motherhood. *Social Science & Medicine*, 64(1), 112–124.
- Campbell, M., Sahin Hodoglugil, N. N. and Potts, M. (2006). Barriers to fertility regulation: a review of the literature. *Studies in Family Planning*, 37(2), 87–98.
- Chandra-Mouli, V., Camacho, A. V. and Michaud, P. A. (2013). WHO guidelines on preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries. *Journal of Adolescent Health*, 52(5), 517–522.
- Chandra-Mouli, V., McCarraher, D. R., Phillips, S. J., Williamson, N. E. and Hainsworth, G. (2014). Contraception for adolescents in low and middle income countries: needs, barriers, and access. *Reproductive Health*, 11(1), 1–8.
- Chen, X. K., Wen, S. W., Fleming, N., Yang, Q., & Walker, M. C. (2008). Increased risks of neonatal and postneonatal mortality associated with teenage pregnancy had different explanations. *Journal of Clinical Epidemiology*, 61(7), 688–694.

- Chigona, A. and Chetty, R. (2007). Girls' education in South Africa: special consideration to teen mothers as learners. *Journal of Education for International Development*, 3(1), 1–17.
- Clark, V.A. (2013). *Intimate partner violence among adolescents: Causes and correlates*. LFB Scholarly Publishing LLC, El Paso, Texas.
- Colombini, M., Mayhew, S. H. and Rechel, B. (2011). *Sexual and reproductive health needs and access to services for vulnerable groups in Eastern Europe and Central Asia*. London: London School of Hygiene and Tropical Medicine.
- Cook, J. and Bewley, S. (2008). Acknowledging a persistent truth: domestic violence in pregnancy. *Journal of the Royal Society of Medicine*, 101(7), 358–363.
- Corkindale, C. J., Condon, J. T., Russell, A. and Quinlivan, J. A. (2009). Factors that adolescent males take into account in decisions about an unplanned pregnancy. *Journal of Adolescence*, 32(4), 995–1008.
- Cowan F.M., Pascoe S.J.S., Langhaug, L.F., Dirawo, J., Chidiya, S., Jaffar, S., Mbizvo, M., Stephenson, J.M., Johnson, A.M., Power, R.M., Woelk, G. and Hayes, R.J. (2008). The Regai Dzive Shiri Project: a cluster randomised controlled trial to determine the effectiveness of a multi-component community-based HIV prevention intervention for rural youth in Zimbabwe – study design and baseline results. *Tropical Medicine & International Health*, 13(10), 1235–1244.
- Darroch, J. E., Sedgh, G. and Ball, H. (2011). *Contraceptive Technologies: Responding to women's needs*. New York: Guttmacher Institute.
- Devries, K. M., Kishor, S., Johnson, H., Stöckl, H., Bacchus, L. J., Garcia-Moreno, C. and Watts, C. (2010). Intimate partner violence during pregnancy: analysis of prevalence data from 19 countries. *Reproductive Health Matters*, 18(36), 158–170.
- DiCenso, A., Guyatt, G., Willan, A. and Griffith, L. (2002). Interventions to reduce unintended pregnancies among adolescents: systematic review of randomised controlled trials. *British Medical Journal*. 324(1426), 1–9.
- Duflo, E., Dupas, P. and Kremer, M. (2011). Education, HIV and early fertility: Experimental evidence from Kenya. *UCLA manuscript*. http://web.stanford.edu/~pdupas/DDK_EducFertHIV.pdf (retrieved on 23 June 2014).
- Erulkar, A. and Mekbib, T. (2007). Reaching vulnerable youth in Ethiopia, *Promoting Healthy, Safe and Productive Transitions to Adulthood*. Brief no. 6. New York, Population Council, 1–3.
- Fancy, K. (2012). *Because I am a girl. The state of the world's girls 2012. Learning for life*. Plan International, (retrieved on 4 June 2014 from <http://plan-international.org/girls/reports-and-publications/the-state-of-the-worlds-girls-2012-learning-for-life.php?lang=en>).
- FAWE. *FAWE Zambia's Campaign for an Enabling Readmission Policy for Adolescent Mothers* http://www.fawe.org/Files/fawe_best_practices_-_school_re-entry_for_adolescent_mothers_zambia.pdf (retrieved on 12 June 2014).
- FAWE/OSISA. (2012). *Final Narrative Report. Joint project on analysis study of re-entry policy in 6 countries in Southern Africa*. Nairobi, FAWE.
- Finnbogadóttir, H., Dykes, A. K. and Wann-Hansson, C. (2014). Prevalence of domestic violence during pregnancy and related risk factors: a cross-sectional study in southern Sweden. *BMC Women's Health*, 14(63).
- Gipson, J. D., Koenig, M. A. and Hindin, M. J. (2008). The effects of unintended pregnancy on infant, child, and parental health: a review of the literature. *Studies in Family Planning*, 39(1), 18–38.
- Gomes, C. (2012). Adolescent fertility in selected countries of Latin America and the Caribbean. *Journal of Public Health and Epidemiology*, 4(5), pp. 133–40.
- Gordon, P., Boler, T., Burgin, J. and Brett, T. (2010). *What women want: meeting the global demand for medical abortion*. London: Marie Stopes International.
- Guttmacher Institute. (2013). Unintended pregnancy in the United States. Fact Sheet December (retrieved on 14 May 2014 from <http://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.html>).
- Guttmacher Institute. (2010). Facts on the Sexual and Reproductive Health Of Adolescent Women in the Developing World. Brief April (retrieved on 6 October 2014 from <http://www.guttmacher.org/pubs/FB-Adolescents-SRH.pdf>).
- Harden, A., Brunton, G., Fletcher, A., Oakley, A., Burchett, H. and Backhans, M. (2006). *Young people, pregnancy and social exclusion: A systematic synthesis of research evidence to identify effective, appropriate and promising approaches for prevention and support*. London: EPPI-Centre, Social Science Research Unit, Institute of Education, University of London.
- Hord, C. E., Benson, J., Potts, J. L. and Billings, D. L. Unsafe abortion in Africa: an overview and recommendations for action in Warriner, I.K. and Shah, I.H. 2006. *Preventing unsafe abortion and its consequences: Priorities for research and action*. New York, Guttmacher Institute, 115–150.
- Hubbard, D. (2009). Realizing the right to Education for All: School policy on learner pregnancy in Namibia, Edited by Oliver, C.R. 2009. *Children's Rights in Namibia*. Windhoek: Konrad Adenauer Stiftung.

- Imamura, M., Tucker, J., Hannaford, P., Da Silva, M. O., Astin, M., Wyness, L. and Temmerman, M. on behalf of the REPROSTAT 2 group. (2007). Factors associated with teenage pregnancy in the European Union countries: a systematic review. *The European Journal of Public Health*, 17(6), 630–636.
- International Interagency Meeting: Current Evidence, Lessons Learned and Best Practices in Adolescent Pregnancy Prevention in Latin America and the Caribbean. A draft concept note. March 17–19, 2014. Managua, Nicaragua.
- International Planned Parenthood Federation. (2010). *The unmet need of adolescents* (retrieved on 2 May 2014 from <https://www.ippfwhr.org/en/news-room/the-unmet-need-of-adolescents>).
- Jasinski, J. L. (2004). Pregnancy and domestic violence: A review of the literature. *Trauma, Violence, & Abuse*, 5(1), 47–64.
- Kirby, D. (2007). *Emerging Answers: Research findings on programs to reduce teen pregnancy. National Campaign to Prevent Teen Pregnancy*. Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy.
- Kohler, P. K., Manhart, L. E. and Lafferty, W. E. (2008). Abstinence-only and comprehensive sex education and the initiation of sexual activity and teen pregnancy. *Journal of Adolescent Health*, 42(4), 344–351.
- Kruger, D. I., Berthelon, M. E. and Navia, R. (2009). *Adolescent motherhood and secondary schooling in Chile* (No. 4552). IZA Discussion Papers (retrieved on 18 April 2014 from <https://www.econstor.eu/dspace/bitstream/10419/36191/1/615362729.pdf>).
- Kumar, A., Singh, T., Basu, S., Pandey, S. and Bhargava, V. (2007). Outcome of teenage pregnancy. *The Indian Journal of Pediatrics*, 74(10), 927–931.
- Lall, M. (2007). Exclusion from school: teenage pregnancy and the denial of education. *Sex Education*, 7(3), 219–237.
- Leach, F., Dunne, M. and Salvi, F. (2013). *A global review of current issues and approaches in policy, programming and implementation responses to school related gender-based violence (SRGBV) for UNESCO Education Sector*, University of Sussex.
- Lloyd, C. and Mensch, B. S. (2008). Marriage and childbirth as factors in dropping out from school: An analysis of DHS data from sub-Saharan Africa. *Population Studies*, 62(1), 1–13.
- Lohan, M., Cruise, S., O'Halloran, P., Alderdice, F. and Hyde, A. (2010). Adolescent men's attitudes in relation to pregnancy and pregnancy outcomes: a systematic review of the literature from 1980–2009. *Journal of Adolescent Health*, 47(4), 327–345.
- Lonczak, H. S., Abbott, R. D., Hawkins, J. D., Kosterman, R. and Catalano, R. F. (2002). Effects of the Seattle Social Development Project on sexual behavior, pregnancy, birth, and sexually transmitted disease outcomes by age 21 years. *Archives of Pediatrics & Adolescent Medicine*, 156(5), 438–447.
- Luttrell W. (2003). *Pregnant bodies, fertile minds: Gender, race, and the schooling of pregnant teens*. New York: Routledge.
- MacQuarrie, Kerry L.D. (2014). *Unmet need for family planning among young women: Levels and trends*. DHS Comparative Reports No. 34. Rockville, Maryland, USA: ICF International.
- Maluli, F. and Bali, T. (2014). Exploring experiences of pregnant and mothering secondary school students in Tanzania. *Research on Humanities and Social Sciences*, 4(1), 80–88.
- Manlove, J.M., Terry-Humen, E., Papillo, A., Franzetta, K., Williams, S. and Ryan S. (2002). Preventing teenage pregnancy, childbearing, and sexually transmitted diseases: what the research shows. *Trends and Research Brief. American Teens*. Washington DC: John S and James L. Knight Foundation.
- Mayzel, M., Kachala, F. and Kerner, B. (2010). *Reaching out to teen mothers in Malawi* (retrieved on 16 April 2014 from http://www.k4health.org/sites/default/files/Reaching%20Out%20to%20Teen%20Mothers%20in%20Malawi_0.pdf).
- McGaha-Garnett V. (2007). *Teenage parenting and high school dropouts: understanding students' academic, social, and personal influences*. A dissertation in Educational Psychology. Texas Tech University (retrieved on 22 April 2014 from http://repositories.tdl.org/ttu-ir/bitstream/handle/2346/10097/McGaha-Garnett_Valerie_Diss.pdf?sequence=1).
- Mchaju Liwewe, O. (2012). *Re-entry policy. The case of Malawi*. Final Report.
- McQueston, K., Silverman, R. and Glassman, A. (2012). *Adolescent fertility in low- and middle-income countries: Effects and solutions*. Working Paper. Washington DC: Center for Global Development.
- Menezes Cooper, T. (2013). Domestic violence and pregnancy: A literature review. *International Journal of Childbirth Education*, 28(3), 30–33.
- Miller, E., Decker, M. R., Reed, E., Raj, A., Hathaway, J. E. and Silverman, J. G. (2007). Male partner pregnancy-promoting behaviors and adolescent partner violence: findings from a qualitative study with adolescent females. *Ambulatory Pediatrics*, 7(5), 360–366.
- Ministry of Education by Gender Research & Advocacy Project Legal Assistance Centre. (2008). *School policy on learner pregnancy in Namibia: Summary of background information* (retrieved from <http://www.lac.org.na/projects/grap/Pdf/learnerpregnancyfull.pdf>).

- Ministry of National Education of Côte d'Ivoire. (2010). *Survey of knowledge, attitudes and practices of students and teachers on STIs, HIV/AIDS, and pregnancy and a situation analysis of orphans and other children made vulnerable by HIV/AIDS in Abidjan-1, Aboisso, Man and Korhogo*.
- Morrell, R., Bhana, D. and Shefer, T. (2012). *Books and/or Babies: Pregnancy and young parents in school*. Cape Town: HSRC Press.
- Mpanza, N. D. and Nzima, D. R. (2010). Attitudes of educators towards teenage pregnancy. *Procedia-Social and Behavioral Sciences*, 5, 431–439.
- Näslund-Hadley, E. and Binstock, G. (2010). *The miseducation of Latin American girls: Poor schooling makes pregnancy a rational choice*. Technical Notes N° IDB-TN-204, Inter-American Development Bank (IDB) (retrieved on 24 April 2014 from <http://publications.iadb.org/handle/11319/3699?locale-attribute=en>).
- Neal, S. (2010). Very early adolescent motherhood in sub-Saharan Africa. (Retrieved on 16 April 2014 from http://www.google.fr/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=OCC8QFjAA&url=http%3A%2F%2Fwww.norad.no%2F_attachment%2F142502%2Fbinary%2F76958%3Fdownload%3Dtrue&ei=dcEdU9TSDqbB7AawuoCIAQ&usg=AFQjCNGtxErE-t09cgma57HWkbMClrEWNw&sig2=3av0th1Bl2THtH2JvbpKlg).
- Nove, A., Matthews, Z., Neal, S. and Camacho, A. V. (2014). Maternal mortality in adolescents compared with women of other ages: evidence from 144 countries. *The Lancet Global Health*, 2(3), e155–e164.
- Olum, M. A. (2010). Competing ideas on adolescent girls' sexuality: Mandatory pregnancy screening in secondary boarding schools in Kenya (retrieved on 26 June 2014 from <http://thesis.eur.nl/pub/8618/>).
- Omwancha, K. M. (2012). The implementation of an educational re-entry policy for girls after teenage pregnancy: A case study of public secondary schools in the Kuria District, Kenya (retrieved on 20 June 2014 from <http://researcharchive.vuw.ac.nz/handle/10063/2382>).
- Ongera Mokeira, E. (2013). *Beyond re-entry: the impact of childbearing on the academic performance and educational aspirations of student mothers in Kenya*. Research paper. London: Institute of Education.
- Onyeka, I. N., Miettola, J., Ilika, A. L. and Vaskilampi, T. (2011). Unintended pregnancy and termination of studies among students in Anambra state, Nigeria: Are secondary schools playing their part? *African Journal of Reproductive Health*, 15(2), 109–115.
- Organismo Andino de Salud ORAS CONHU. (2009). *Situación del embarazo de la adolescencia en la subregion Andina*. Lima, ORAS CONHU.
- O'Reilly, R. (2007). Domestic violence against women in their childbearing years. A review of the literature. *Contemporary Nurse*, 25(1–2), 13–21.
- Oringanje, C., Meremikwu, M. M., Eko, H., Esu, E., Meremikwu, A. and Ehiri, J. E. (2009). Interventions for preventing unintended pregnancies among adolescents. *Cochrane Database of Systematic Reviews*, 4(4), 1–86.
- Owen, J., Carroll, C., Cooke, J., Formby, E., Hayter, M., Hirst, J., Jones, M.L., Stapleton, H., Stevenson, M., Sutton, A. (2010). School-linked sexual health services for young people (SSHYP): a survey and systematic review concerning current models, effectiveness, cost-effectiveness and research opportunities. *Health Technology Assessment*, 14(30).
- Philippine Youth Development Plan Highlights – Health. Unpublished.
- Pillow, W. (2006). Teen Pregnancy and Education: Politics of Knowledge, Research, and Practice. *Educational Policy*, 20(1), 59–84.
- Planned Parenthood Global. Youth Peer Provider Program Replication Manual (retrieved on 24 September 2014 from http://www.plannedparenthood.org/files/8313/9611/6485/PP_Global_YPP_Manual.pdf).
- Population Reference Bureau. *Unmet Need for Contraception*. Fact Sheet (retrieved on 2 May 2014 from <http://www.prb.org/Publications/Media-Guides/2012/unmet-need-factsheet.aspx>).
- Presentation from the UNICEF Eastern and Southern Africa Office on Teenage Pregnancy. March 2012.
- Presler-Marshall, E. and Jones, N. (2012). *Charting the future: Empowering girls to prevent early pregnancy*. London: Overseas Development Institute.
- Raj, A. D., Rabi, B., Amudha, P. and Glyn, C. (2010). Factors associated with teenage pregnancy in South Asia: a systematic review. *Health Science Journal*, 4(1), 13–14.
- Ramulumo, M. R. and Pitsoe, V. J. (2013). Teenage pregnancy in South African schools: Challenges, trends and policy issues. *Mediterranean Journal of Social Sciences*, 4(13), 755–760.
- Report on Multisectoral Consultation on Addressing Pregnancies. Bangkok, Thailand, 3–4 September 2013.
- Republic of Sierra Leone. (2013). *Let Girls be Girls, Not Mothers! National Strategy for the Reduction of Teenage Pregnancy (2013-2015)* (retrieved on 4 July 2014 from http://hivaidsclearinghouse.unesco.org/search/resources/Sierra_Leone_National_Strategy_for_the_Reduction_of_Teenage_Pregnancy.pdf).
- Reynolds, H. W., Wong, E. L. and Tucker, H. (2006). Adolescents' use of maternal and child health services in developing countries. *International Family Planning Perspectives*, 32(1), 6–16.
- Richter, M.S. and Mlambo, G.T. (2005). Perceptions of rural teenagers on teenage pregnancy. *Health SA Gesondheid*, 10, 61–69.

- Royal Government of Cambodia. *National Policy on Cambodia Youth Development. 2011* (retrieved on 7 August 2014 from <http://yrdpcambodia.files.wordpress.com/2013/10/cambodia-national-youth-policy-en-version.pdf>).
- Runhare, T. and Vandeyar, S. (2012). Perceptions of policy duty bearers on the inclusive education policy for pregnant teenagers in South Africa. *Social Science Journal*, 31(1), 51–62.
- Santhya K.G. and Jejeebhoy, S.J. (2007). *Young people's sexual and reproductive health in India: Policies, programmes and realities*. New Delhi: Population Council (retrieved on 24 April 2014 from <http://www.popcouncil.org/pdfs/wp/seasia/seawp19.pdf>).
- Shah, I.H. and Ahman, E. (2012). Unsafe abortion differentials in 2008 by age and developing country region: High burden among young women. *Reproductive Health Matters*, 20(39), 169–173.
- Shaningwa, L. M. (2007). The educationally-related challenges faced by teenage mothers on returning to school: a Namibian case study. Doctoral dissertation, Rhodes University (retrieved on 8 May 2014 from <http://eprints.ru.ac.za/1646/>).
- Shaw, A. (2010). Media representations of adolescent pregnancy: The problem with choice. *Atlantis: Critical Studies in Gender, Culture & Social Justice*, 34(2), 55–65.
- Singh, S., Darroch J. E., Ashford, L.S. and Vlassoff, M. (2009). *Adding it Up: The costs and benefits of investing in family planning and maternal and newborn health*. New York: Guttmacher Institute and UNFPA.
- Smith, J. L., Fenwick, J., Skinner, R., Merriman, G. and Hallett, J. (2011). Young males' perspectives on pregnancy, fatherhood and condom use: where does responsibility for birth control lie? *Sexual & Reproductive Healthcare*, 2(1), 37–42.
- SmithBattle, L. I. (2013). Reducing the stigmatization of teen mothers. *MCN: The American Journal of Maternal/Child Nursing*, 38(4), 235–241.
- Sokkary, N., Mansouri, R., Yoost, J., Focseneanu, M., Dumont, T., Nathwani, M., Allen, L., Hertweck, S.P. and Dietrich, J. E. (2013). A Multicenter survey of contraceptive knowledge among adolescents in North America. *Journal of Pediatric and Adolescent Gynecology*, 26(5), 274–276.
- Strunk, J. A. (2008). The effect of school-based health clinics on teenage pregnancy and parenting outcomes: An integrated literature review. *The Journal of School Nursing*, 24(1), 13–20.
- The Center for Reproductive Rights. (2013). Forced Out: Mandatory pregnancy testing and the expulsion of pregnant students in Tanzanian schools (retrieved on 16 April 2014 from <http://reproductiverights.org/en/document/tanzania-report-forced-out-mandatory-pregnancy-testing-expulsion>).
- The Scottish Parliament. Health and Sport Committee. (2013). Report on Inquiry into Teenage Pregnancy. 5th Report (retrieved on 4 July 2014 from <http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/65047.aspx>).
- Tylee, A., Haller, D. M., Graham, T., Churchill, R. and Sanci, L. A. (2007). Youth-friendly primary-care services: how are we doing and what more needs to be done? *The Lancet*, 369(9572), 1565–1573.
- UNESCO. (2009). *The International Technical Guidance on Sexuality Education. An evidence-informed approach for schools, teachers and health educators, Vol. II Topics and learning objectives*. Paris: UNESCO.
- UNESCO. (2012). *Sexuality Education: A ten-country review of school curricula in East and Southern Africa*. Paris: UNESCO.
- UNESCO. (2013a). *Young people and the law in Asia and the Pacific: A review of laws and policies affecting young people's access to sexual and reproductive health and HIV services*. Bangkok: UNESCO.
- UNESCO. (2013b). *Young People Today. Time to Act Now. Why adolescents and young people need comprehensive sexuality education and sexual and reproductive health services in Eastern and Southern Africa*. Paris: UNESCO.
- UNESCO. (2014a). *Booklet 9: Puberty Education & Menstrual Hygiene Management. Good Policy and Practice in HIV & AIDS and Education* (booklet series). Paris: UNESCO.
- UNESCO. (2014b). *Global Monitoring Report 2013/4. Teaching and Learning: Achieving quality for all*. Paris: UNESCO.
- UNFPA. (2012a). *Marrying Too Young. End Child Marriage*. New York: UNFPA.
- UNFPA. (2012b). Preventing teen pregnancy and sexual violence. Bulletin UNFPA LACRO. Issue no.2 (retrieved 7 May 2014 from <http://unfpa.org/webdav/site/lac/shared/DOCUMENTS/2012/Boletines/Octubre%202012/Ingles/3EmbarazoE.pdf>).
- UNFPA. (2013c). *Adolescent Pregnancy in Eastern Europe and Central Asia. Regional brief* (retrieved 9 May 2014 from <http://eeca.unfpa.org/publications/adolescent-pregnancy-eastern-europe-and-central-asia>).
- UNFPA. (2013b). *I am not a lost cause! Young Women's Empowerment and Teenage Pregnancy in the Pacific*. Suva, Fiji: UNFPA.
- UNFPA. (2013b). *Motherhood in Childhood. Facing the challenge of adolescent pregnancy*. New York: UNFPA.

- UNGEI and UNESCO. (2013). School-related gender-based violence (SRGBV). Discussion Paper SRGBV discussion paper (retrieved on 5 June 2014 from http://www.unesco.org/new/fileadmin/MULTIMEDIA/HQ/HIV-AIDS/pdf/UNGEI_UNESCO_SRGBV_DiscussionPaperFinal.pdf).
- UNIFEM. (2010). *Get the Facts: Violence against Young Women and Girls* (retrieved on 16 May 2014 from http://www.endvawnow.org/uploads/browser/files/FactsheetAdolescent_Aug2010_en.pdf.pdf).
- United Nation Secretary General's Campaign UNiTE to End Violence against Women (retrieved on 8 May 2014 from <http://www.un.org/en/women/endviolence/situation.shtml>).
- United Nations, Department of Economic and Social Affairs, Population Division. (2013). *Adolescent fertility since the International Conference on Population and Development (ICPD) in Cairo* (retrieved on 15 May 2014 from http://www.popcouncil.org/pdfs/events/2012ICCR_Askew.pdf).
- Unterhalter, E. (2013). Connecting the private and the public: pregnancy, exclusion, and the expansion of schooling in Africa. *Gender and Education*, 25(1), 75–90.
- van den Berg, G. and Mamhute, R. (2013). Socio-educational challenges of pregnant students and student mothers. *Anthropologist*, 15(3), 305–311.
- Warriner, I.K. and Shah I.H. (2006). *Preventing unsafe abortion and its consequences: Priorities for research and action*. New York: Guttmacher Institute.
- Watts, R. H. and Borders, L. D. (2005). Boys' perceptions of the male role: Understanding gender role conflict in adolescent males. *The Journal of Men's Studies*, 13(2), 267–280.
- Were, M. (2007). Determinants of teenage pregnancies: The case of Busia District in Kenya. *Economics & Human Biology*, 5(2), 322–339.
- Westley, E., Kapp, N., Palermo, T. and Bleck, J. (2013). A review of global access to emergency contraception. *International Journal of Gynecology & Obstetrics*, 123(1), 4–6.
- WHO. 2004. *Issues in Adolescent Health and Development: Adolescent Pregnancy*. Geneva, WHO Department of Child and Adolescent Health and Development.
- WHO. (2005). *WHO multi-country study on women's health and domestic violence against women: summary report of initial results on prevalence, health outcomes and women's responses*. Geneva: WHO.
- WHO. (2009). *From inception to large scale: the Geração Biz in Mozambique*. Geneva: WHO.
- WHO. (2012). *Early marriages, adolescent and young pregnancies*. Report by the Secretariat (retrieved on 11 April 2014 from http://apps.who.int/ebwha/pdf_files/WHA65/A65_13-en.pdf).
- WHO. (2014). *Ensuring human rights in the provision of contraceptive information and services: guidance and recommendations*. Geneva: WHO.
- WHO and UNFPA. (2011). Consequences: what determines our sexual and reproductive health? *Entre Nous. The European Magazine for Sexual and Reproductive Health*, n:73.
- Willan, S. (2013). A review of teenage pregnancy in South Africa – experiences of schooling, and knowledge and access to sexual & reproductive health services. *Partners in Sexual Health*, 1–63.
- Williamson, L. M., Parkes, A., Wight, D., Petticrew, M. and Hart, G. J. (2009). Limits to modern contraceptive use among young women in developing countries: a systematic review of qualitative research. *Reproductive Health*, 6(3), 1–12.
- Wilson-Mitchell, K., Bennett, J. and Stennett, R. (2014). Psychological health and life experiences of pregnant adolescent mothers in Jamaica. *International Journal of Environmental Research and Public Health*, 11(5), 4729–4744.
- Women and Children Legal Research Foundation. (2008). *Early Marriage in Afghanistan*. Kabul: Women and Children Legal Research Foundation (WCLRF).
- World Bank Open Data (retrieved on 18 June 2014 from <http://data.worldbank.org/>).
- Yardley, E. (2008). Teenage mothers' experiences of stigma. *Journal of Youth Studies*, 11(6), 671–684.

