Early and unintended pregnancy & the education sector

EVIDENCE REVIEW AND RECOMMENDATIONS
Evidence review and recommendations

Early and unintended pregnancy & the education sector

Published in 2017 by the United Nations Educational, Scientific and Cultural Organization
7, place de Fontenoy, 75352 Paris 07 SP, France
© UNESCO 2017

The designations employed and the presentation of material throughout this volume do not imply the expression of any opinion whatsoever on the part of UNESCO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

The ideas and opinions expressed in this volume are those of the authors; they are not necessarily those of UNESCO and do not commit the Organization.

Cover photo: @UNHCR

ED/IP/HAE/2517/01
Contents

List of case studies and boxes............................................................................................................ 4
List of figures........................................................................................................................................ 4
Acronyms................................................................................................................................................ 5
Acknowledgement................................................................................................................................. 6
Summary .................................................................................................................................................. 7
Introduction ............................................................................................................................................. 8
Purpose and structure of this document.................................................................................................. 9
Section 1: Setting the context................................................................................................................ 10
Background............................................................................................................................................. 11
  Determinants and consequences of EUP .......................................................................................... 12
  The current status of the education sector response ....................................................................... 13
The importance of the education sector response ............................................................................... 15
  Linkages between education and early and unintended pregnancy .............................................. 15
  The role of the education sector ....................................................................................................... 16
Section 2: Recommendations................................................................................................................ 18
Access to quality education for all girls ............................................................................................... 19
Re-entry and continuation policies for pregnant and parenting learners ........................................ 21
Comprehensive sexuality education .................................................................................................. 23
School health services and links to external health services ............................................................. 28
A safe and supportive learning environment ....................................................................................... 30
Research gaps ........................................................................................................................................ 31
Section 3: Ensuring Sustainability ....................................................................................................... 32
Teacher training ..................................................................................................................................... 32
Parents and Community ...................................................................................................................... 34
Media for education and awareness .................................................................................................... 35
Multisectoral approach and partnerships ............................................................................................. 36
Monitoring and evaluation .................................................................................................................... 40
Conclusion .............................................................................................................................................. 42
Appendices ............................................................................................................................................. 43
Appendix 1: Detailed methodology for the evidence ranking.......................................................... 43
Appendix 2: Results from Evidence Ranking for Recommendations .............................................. 45
Bibliography.......................................................................................................................................... 58
List of case studies and boxes

Box 1: Education, health and rights
Country Case Study: Empowering girls to choose secondary education over child marriage in Nigeria
Country Case Study: The Jamaican re-integration policy
Country Case Study: Delivering schools-based CSE in the Netherlands
Country Case Study: Involving boys to promote gender equality in South Africa
Case Study: Girls Decide

Country Case Study: Delivering CSE to out-of-school adolescents in South Africa
Country Case Study: Establishing referral systems between schools and Youth Friendly Health Services (YFHS) in Mozambique
Country Case Study: Promoting linkages to services in Estonia
Country Case Study: Schools-based condom distribution programmes (CDPs) in the US
Country Case Study: Changing the School Environment in the US
Country Case Study: Delivering online teacher training in Mexico
Country Case Study: Developing a toolkit to support community engagement in Eastern and Southern Africa
Country Case Study: Delivering sexual health messages through radio and TV programmes in Zambia
Country Case Study: Developing a multi-sectoral approach to address teenage pregnancy in England
Country Case Study: Ensuring a multi-sectoral approach to The Zero grossesse à l’école campaign in Côte d’Ivoire

List of figures

Figure 1: Linkages between addressing EUP and achieving the Sustainable Development Goals (SDGs)
Figure 2: Determinants and consequences of early and unintended pregnancy
Figure 3: Summary of recommendations
Figure 4: WHO guidelines for preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries
Figure 5: Examples of monitoring and evaluation data to strengthen responses to EUP
**Acronyms**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>AYA</td>
<td>African Youth Alliance</td>
</tr>
<tr>
<td>BZgA</td>
<td>German Federal Office for Health Education</td>
</tr>
<tr>
<td>CDC</td>
<td>Center for Disease Control and Prevention</td>
</tr>
<tr>
<td>CDP</td>
<td>Condom distribution programme</td>
</tr>
<tr>
<td>CSE</td>
<td>Comprehensive sexuality education</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil society organisation</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
</tr>
<tr>
<td>EUP</td>
<td>Early and unintended pregnancy</td>
</tr>
<tr>
<td>FAWE</td>
<td>Forum for African Women Educationalists</td>
</tr>
<tr>
<td>GBV</td>
<td>Gender-based violence</td>
</tr>
<tr>
<td>HIC</td>
<td>High-income country</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>ICRW</td>
<td>International Center for Research on Women</td>
</tr>
<tr>
<td>ICT</td>
<td>Information, communication technology</td>
</tr>
<tr>
<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
</tr>
<tr>
<td>LAC</td>
<td>Latin America and the Caribbean</td>
</tr>
<tr>
<td>LMIC</td>
<td>Low- and middle-income country</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
</tr>
<tr>
<td>MOE</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
</tr>
<tr>
<td>OMC</td>
<td>‘One Man Can’ campaign</td>
</tr>
<tr>
<td>PSIPSE</td>
<td>Partnership to Strengthen Innovation and Practice in Secondary Education</td>
</tr>
<tr>
<td>RCT</td>
<td>Randomized control trial</td>
</tr>
<tr>
<td>SHS</td>
<td>School health services</td>
</tr>
<tr>
<td>SRGBV</td>
<td>School-related gender-based violence</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and reproductive health</td>
</tr>
<tr>
<td>SRHR</td>
<td>Sexual and reproductive health and rights</td>
</tr>
<tr>
<td>SSA</td>
<td>Sub-Saharan Africa</td>
</tr>
<tr>
<td>SSDP</td>
<td>Seattle Social Development Project</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary counselling and testing</td>
</tr>
<tr>
<td>WCJF</td>
<td>Women’s Centre of Jamaica Foundation</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>YFHS</td>
<td>Youth-friendly health services</td>
</tr>
</tbody>
</table>
Acknowledgement

The development of this volume was led by UNESCO’s Section for Health and Education by Marina Todesco, Joanna Herat and Jenelle Babb. We are particularly grateful to Jill Gay (What Works Association) for her work leading the evidence review and preparing the recommendations and Helen Parry (independent consultant) for editing and revision. The volume was produced under the supervision of Christopher Castle and with the overall guidance of Soo Hyang Choi with inputs and support from colleagues at UNESCO Head Quarters and field offices.

This volume would not have been possible without the cooperation and assistance of all those who contributed experiences and case studies for inclusion. UNESCO would especially like to thank the individuals and organizations who participated in the international consultation and who contributed much of the source material for this volume. We also acknowledge Nelly Slim for the work in identifying and writing case studies.

We would also like to thank the following reviewers: Valentina Baltag (WHO), Mona Kaidbey (UNFPA), Asha Mohamud (UNFPA), Sylvia Wong (UNFPA), Harriet Birungi (Population Council/ STAND UP), Stephanie Psaki (Population Council/ STAND UP), Chi Chi Undie (Population Council/ STAND UP), Gwyn Hainsworth (Pathfinder), Callie Simon (Pathfinder), Elaine Unterhalter (Institute of Education), Doortje Braeken (IPPF), Eka Williams (Ford Foundation) and Fern McFarlane (MOE Jamaica). UNESCO would like to thank the Swedish Ministry of Foreign Affairs for their generous financial support for this work within the wider scope of work on education and sexual and reproductive health.
Available evidence supports a clear and compelling role for the education sector in preventing early and unintended pregnancy and ensuring the right to education for pregnant and parenting girls.

Education has a key role in preventing early and unintended pregnancy – it is effective when girls:

- Can access and attend school
- Can begin their schooling early in life
- Can remain in school longer
- Are supported to continue their education, particularly by a supportive and welcoming school environment
- Are protected in school from expulsion, exclusion and violence
- Learn about their bodies, how to manage their reproductive health, about gender equality and power in relationships
- Are provided with access or referrals to services

Early and unintended pregnancy can be prevented through good quality comprehensive sexuality education that includes content on gender equality, and linkages with services ensuring the availability of contraceptives. When a girl becomes pregnant, re-entry and school resuming policies need to be put in place and should be well implemented to allow pregnant and parenting girls to fulfil their right to education.
Evidence review and recommendations

Early and unintended pregnancy & the education sector

Introduction

Early and unintended pregnancy (EUP) is a global concern affecting both high-income countries (HIC) and low and middle-income countries (LMIC). It has a major impact on the lives of adolescents – especially girls – in terms of their health, social, economic and education outcomes.

The term ‘early’ relates to the correlation between lower age and the increased risk of adverse health and social consequences for the mother and her new born. The term ‘unintended’ refers to unplanned or unexpected pregnancies, which should be addressed separately from pregnancies that are early and planned. It is important to recognize girls’ rights to make decisions about pregnancy, while also balancing the health, educational, economic and social consequences of having children at a very young age.

For adolescent girls (aged 10–19 years), experiencing pregnancy while still at school often means facing harsh social sanctions and difficult choices that have life-long consequences. Becoming pregnant could mean expulsion from home and school; vulnerability to early marriage; being shamed and stigmatized by family, community members and peers; increased vulnerability to violence and abuse; and greater poverty and economic hardship.

For adolescent boys, becoming a father very early in life may also lead to school drop-out and reduced life opportunities. However, the available data highlights EUP as a specific problem affecting adolescent girls; in many contexts the fathers in question are also generally older than the mothers of early and unintended pregnancies.

At the social and political levels, adolescent pregnancy may be a contentious issue, with the rights to health, education, dignity and gender equality paramount, especially for girls and young women. Greater clarity is needed relating to the evidence and priority actions required by policy-makers, advocates, programme developers, implementers and other stakeholders to tackle this issue.

At a global level, tackling EUP will contribute to the achievement of several of the Sustainable Development Goals (SDGs), developed to build upon the earlier Millennium Development Goals (MDGs), as illustrated in Figure 1.

Figure 1: Linkages between addressing EUP and achieving the Sustainable Development Goals (SDGs)

<table>
<thead>
<tr>
<th>Sustainable Development Goal</th>
<th>Linkages to addressing EUP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal 1 – End poverty in all its forms everywhere</strong></td>
<td>Preventing EUP and ensuring girls’ right to education will extend girls’ schooling, in turn increasing future employment and economic opportunities</td>
</tr>
<tr>
<td><strong>Goal 3 – Ensure healthy lives and promote well-being for all at all ages</strong></td>
<td>EUP prevention will reduce maternal and neonatal mortality</td>
</tr>
<tr>
<td><strong>Goal 4 – Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all</strong></td>
<td>Ensuring that pregnant and parenting girls can continue their education within a safe school environment, that is gender equitable and free from stigma and discrimination, will increase educational retention and attainment</td>
</tr>
</tbody>
</table>

1 There is no standard definition for ‘early pregnancy’. World Health Organization (WHO) guidelines use the term to define any pregnancy before the age of 20. See http://www.who.int/maternal_child_adolescent/documents/preventing_early_pregnancy/en/
Goal 5 – Achieve gender equality and empower all women and girls
Promoting gender equality and challenging harmful gender norms through the provision of comprehensive sexuality education (CSE) and ensuring the continued education of pregnant and parenting girls contributes to the empowerment of girls and young women.

Goal 10 – Reduce inequalities within and among countries
Teaching and promoting gender equality in school contributes to changing social and gender-based norms, leading to a more equal society in the long term.

Goal 16 – Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels
Teaching and promoting gender equality in school will reduce school-related gender-based violence (SRGBV) and gender-based violence (GBV) more generally in society by changing harmful social and gender norms in the long term.

Purpose and structure of this document

Based on a review of available evidence, UNESCO, in collaboration with partners, has developed recommendations to guide ministries of education (MoEs) around the world on actions that they can implement in order to prevent EUP and to ensure that pregnant and parenting girls can continue education in a safe and supportive school environment, free from violence, stigma and discrimination.

Significant literature is available addressing the determinants and consequences of EUP. Despite the lack of a systematic review of studies focusing on EUP and education, a number of publications and reports have already focused on the implications of EUP for the education sector, highlighting the importance of an education sector response (see, for example, UNFPA 2012; UNFPA, 2013; WHO, 2011). However, specific recommendations on how the education sector can contribute to preventing and addressing EUP, including examples of existing good policies and practice, has been lacking to date.

In order to address this, this document includes three sections:

- **Section 1** sets the context and rationale for the education sector response to EUP.
- **Section 2** provides specific evidence-based recommendations on how the education sector can prevent and respond to EUP. These include recommendations to ensure changes at the political and structural levels (for example, promoting relevant policy change and development), in addition to implementing changes to strengthen school-based responses. The recommendations relate to five key priority areas: promoting access to quality education for all girls; developing and implementing re-entry and continuation policies for pregnant and parenting learners; providing comprehensive sexuality education that includes a focus on gender and power and includes a component on pregnancy prevention; promoting school-based health services and links to external health services; and ensuring a safe and supportive learning environment through gender equality.
- **Section 3** includes recommendations to ensure the sustainability of a successful response to EUP in the long term.

---

2 UNESCO’s partners in education sector responses to early and unintended pregnancy include WHO, UNFPA, Population Council, IPPF, Ford Foundation and The Institute of Education, University College London

3 Comprehensive sexuality education is recognized as an ‘age-appropriate, culturally relevant approach to teaching about sexuality and relationships by providing scientifically accurate, realistic, non-judgmental information’. Across the world there are many different names for, and approaches to, comprehensive sexuality education. The objective of CSE is to ensure that young people are receiving comprehensive, life skills-based sexuality education to gain the knowledge and skills to make conscious, healthy and respectful choices about relationships and sexuality. Core elements of CSE programmes share certain similarities: CSE’s firm grounding in human rights – including the rights of the child, the empowerment of children and young people – and a reflection of the broad concept of sexuality as a natural part of human development (UNESCO, 2015)
Country case studies and examples are included throughout to illustrate the recommendations. Finally, two appendices provide detailed information regarding the methodology for the evidence ranking that forms the basis for the recommendations in Section 2, and the corresponding results.

Section 1: Setting the context

Based on a review of available evidence, UNESCO, in collaboration with partners\(^4\), has developed recommendations to guide ministries of education, and the education sector more broadly, around the world on actions that they can implement in order to prevent EUP and to ensure that pregnant and parenting girls can continue education in a safe and supportive school environment, free from violence, stigma and discrimination. Achieving this requires action at different levels in order to effect the necessary changes at the political level in terms of ensuring supportive policies and legal frameworks; ensuring a supportive environment to address EUP and change social and gender-based norms at the community level; and strengthening the response within individual school settings. The recommendations reflect the different dimensions of change required to effectively address the broad determinants and consequences of EUP.

The following recommendations address five priority areas for action:

- **access to quality education** for all girls
- **re-entry and continuation policies** for pregnant and parenting learners
- **comprehensive sexuality education** that has a focus on gender and power and which includes a component on pregnancy prevention
- **school-based health services and links to external health services**, including contraception, counselling and care and support services for girls who are pregnant and parenting
- **a safe and supportive learning environment**

Each of the recommendations is based on evidence that ranked as ‘strong’ during the analysis conducted through the literature review, with the exception of ‘safe and supportive learning environments’ and the specific recommendation to deliver CSE to out-of-school youth, for both of which more evidence is needed. The ranking used draws on the Gray Scale (Gray, 1997; Gray, 2009), with the strength of evidence divided into three categories: ‘strong’, ‘promising’, ‘limited and more needed’. This section presents detailed recommendations under each of the five priority areas for action identified above, together with a brief synthesis of the available evidence supporting each recommendation.

One limitation of the evidence review was that an overwhelming majority of the studies took place in the US, Europe and Australia. However, while further studies are clearly needed from LMICs, the existing evidence is relevant globally and provides justification for action by governments worldwide. Appendix 1 provides detailed information on the methodology used for this study, while Appendix 2 includes a table synthesising the evidence for each of the key recommendations that follow.

Figure 3: Summary of recommendations

<table>
<thead>
<tr>
<th>Access to quality education for all girls</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommendation 1</strong>: Ensure universal access to quality education as a key strategy to prevent child marriage and promote gender equality</td>
</tr>
<tr>
<td><strong>Recommendation 2</strong>: Start education, particularly for girls, as early as possible as it is a key intervention for reducing early and unintended pregnancies and child marriage</td>
</tr>
</tbody>
</table>

\(^4\) UNESCO’s partners in education sector responses to early and unintended pregnancy include WHO, UNFPA, Population Council, IPPF, Ford Foundation and The Institute of Education, University College London
Re-entry and continuation policies for pregnant and parenting learners

Recommendation 3: Develop, implement and monitor policies allowing pregnant and parenting girls to continue education

Comprehensive sexuality education

Recommendation 4: Deliver curriculum-based comprehensive sexuality education (CSE) in schools prior to and after puberty to prevent early and unintended pregnancies

Recommendation 5: Introduce interventions to promote gender equality, address gender norms, roles and relationships, and engage men and boys to critically assess gender norms and normative behaviours in schools

Recommendation 6: Build skills to delay sexual debut and increase correct and consistent use of condoms and other contraceptive methods as an important component of CSE

Recommendation 7: Develop programmes to provide CSE for out-of-school adolescents in order to prevent EUP

School health services and links to external health services

Recommendation 8: Develop linkages between schools and health services as part of efforts to reduce EUP and support pregnant and parenting adolescents

Recommendation 9: Encourage and support school health services (SHS) that offer on-site contraception and counselling services as part of efforts to reduce early and unintended pregnancies, and antenatal care to support pregnant and parenting adolescents and to reduce school drop-out

A safe and supportive learning environment

Recommendation 10: Implement interventions to reduce stigma and discrimination against pregnant and parenting girls at school

Background

Early and unintended pregnancy (EUP) is a global concern affecting both high-income countries (HICs) and low and middle-income countries (LMICs). Amongst the former, in 2014 the highest rates of adolescent fertility were in the United States (US) (with 24 live births per 1,000 girls), New Zealand (23.94 births per 1,000 girls) and the United Kingdom (UK) (15.33 births per 1,000 girls). However, the largest numbers of adolescents under age 19 who become pregnant are in LMICs. In 36 LMICs, up to 25 per cent of women age 15–19 are either pregnant or have given birth, and more than 40 per cent of women marry before the age of 18 in 16 LMICs (Head et al., 2014). Sub-Saharan Africa has the highest fertility rate among 15–19 years olds (with 103 births per 1,000 girls), followed by Latin America and the Caribbean (LAC) (64.57 births per 1,000 girls) (World Bank open data).

The situation regarding EUP varies between different regions. For instance, while LAC and HICs have higher rates of adolescent pregnancy outside marriage, in South Asia the majority of adolescent pregnancies are within marriage or union. In contrast, Sub-Saharan Africa presents high rates of both scenarios (WHO, 2012). While EUP affects young people in different contexts, critical factors across all countries include limited access to education and health services and poorer health outcomes.

5 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 child-bearing years and bear children in accordance with current age-specific fertility rates.
In LMICs, lack of knowledge regarding pregnancy prevention often goes hand in hand with lack of access to sexual and reproductive health (SRH) information and services. In some countries, access to contraception can be particularly difficult for unmarried girls. Furthermore, barriers preventing girls from accessing health services – including lack of autonomy and freedom of movement, attitudes of health care providers and lack of financial resources – increase the risk of pregnancy, and pregnancy and birth related complications. This is compounded by poor quality antenatal and childbirth services, which may not meet the specific needs of adolescent mothers.

Section 1 presents a summary of the discussion paper Developing an education sector response to early and unintended pregnancy that was developed by the United Nations Educational, Scientific and Cultural Organization (UNESCO) for the global consultation on early and unintended pregnancy in Johannesburg in November 2014 (UNESCO, 2014c). For this reason this section does not aim to be comprehensive, but rather to highlight the key determinants and consequences of EUP. It also provides an overview of the education sector response to adolescent pregnancy to date, together with a rationale for the education sector to address the issue.

Determinants and consequences of EUP

Poverty and socio-economic marginalisation are the main determinants underpinning EUP. Low levels of education and lack of access to quality sexual and reproductive health services (SRHS) also increase the chances of EUP. In addition, cultural norms around the value of abstinence until marriage fail to acknowledge that a high proportion of adolescents are sexually active before marriage and consequently should be able to access SRHS irrespective of their marital status.

The health and developmental consequences of early pregnancy can be damaging. The impact on adolescent mothers’ health includes risks of maternal death; illness and disability, including obstetric fistula; complications of unsafe abortion; sexually transmitted infections, including HIV; and health risks to infants. Some 70,000 adolescents in developing countries die annually of causes related to pregnancy and childbirth. There are additional psychosocial harms, as a girl may experience stress or depression if she is not psychologically prepared for marriage, sex or pregnancy - especially when sex is coerced or non-consensual – if she is shunned by family or the community, or if she is unable to seek reproductive health services (UNFPA, 2013).

Beyond the adverse health consequences, EUP has economic and social consequences. This includes girls often facing social stigma and discrimination from communities and/or families, resulting in them having to leave their family home, consequently increasing their vulnerability to violence and abuse, and potentially facing increased poverty and economic challenges. EUP also has educational consequences. While the causal relationship between adolescent pregnancies and early school-leaving may be difficult to clearly establish, EUP can lead adolescents to drop out of school. For example, one 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, 2013). Dropping out of school reduces opportunities for girls’; they miss out on the overall benefits of education that contribute to their physical and emotional growth, including increases in knowledge and life skills, higher self-confidence and better outcomes in life.

Pregnant girls and adolescent mothers may stay in school but they may disengage with learning and go unnoticed by teachers. The quality of learning and their educational experience are likewise affected by a pregnancy, since pregnant students may feel tired and lack concentration at school, and are sometimes obliged to miss classes for medical reasons (Pillow, 2006). Adolescent mothers are at risk of falling behind with schoolwork due to their double responsibility as students and mothers (Maluli and Bali, 2014).

---

6 In developing countries overall, 22 per cent of adolescent girls (aged 15 to 19) who are married or in union use contraceptives, versus 61 per cent of married girls and women aged 15 to 49 years of age (UNFPA, 2012).
### Figure 2: Economic, educational, health-related and social determinants and consequences of EUP

<table>
<thead>
<tr>
<th>Consequences</th>
<th>Economic</th>
<th>Educational</th>
<th>Health</th>
<th>Social</th>
</tr>
</thead>
</table>
|              | • Lower family income  
|              | • Increased poverty  
|              | • Increased dependency ratio | • School drop-out and absenteeism  
|              |                          | • Lower educational attainment and outcomes | • Increased risk of maternal death  
|              |                          |                                          | (especially for mothers younger than 15–16 years old) |
|              |                          |                                          | • Increased risk of adverse pregnancy outcomes |
|              |                          |                                          | • Increased risk of adverse perinatal outcomes |
|              |                          |                                          | • Stigma and discrimination from family and/or community |
|              |                          |                                          | • Linkages with early marriage in some contexts, or unable to marry in others |
|              |                          |                                          | • Increased vulnerability to violence and abuse |

<table>
<thead>
<tr>
<th>Early and unintended pregnancy</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Determinants</th>
<th>Economic</th>
<th>Educational</th>
<th>Health</th>
<th>Social</th>
</tr>
</thead>
</table>
|              | • Poverty | • Low performance  
|              |          | • Absence  
|              |          | • Lack of aspirations | • Lack of SRH knowledge  
|              |          |                          | • Lack of accessibility and quality of SRHS, including contraception |
|              |          |                          | • Risk taking behaviours and/or inability to negotiate in sexual situations | • Marginalization  
|              |          |                          | • Cultural norms, specifically relating to gender or young people and sexuality |
|              |          |                          |                                  | • Gender inequality, impacting upon girls/young women’s decision-making and negotiation skills |

### The current status of the education sector response

The current status of the education sector response to EUP is still mixed. Policies and practices in schools that allow girls to continue their education when pregnant or parenting are either lacking or are not well implemented. This is due to a lack of knowledge at district or school level or because arbitrary and context-specific decisions continue to be made about girls’ applications.

Stigma and discrimination against pregnant and parenting girls at school remain common. In some contexts, the reality for many girls is that they are deliberately expelled (or excluded) from school as a consequence of getting pregnant, since this is regarded a sign of sexual activity before or outside marriage (Onyeka et al., 2011). Schools may even carry out non-voluntary pregnancy tests through mandatory urine tests, or physical exams (e.g. palpation), which can be degrading, invasive, abusive and sometimes not even performed with informed consent or by trained personnel. These scenarios further exacerbate gender inequalities, seeming to ‘blame’ girls.
However, some education systems have made progress towards a more supportive approach based on re-entry policies, although there remain challenges in consistently applying these at an implementation level, exacerbated by poor monitoring systems. Where such ‘re-entry policies’ do exist they often have punitive requirements, such as the obligation for girls to apply to a different school or to stay out of the education system for a fixed period of time before re-entry. In reality, context-specific decisions continue to be made and may depend on personal connections with the school staff or may involve some sort of payment in exchange for re-admission (Maluli and Bali, 2014).

Teachers are also often not well prepared 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); they may see girls as adults who do not fit in with the school environment (Shaningwa, 2007); or they may 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).

Conservative attitudes from teachers towards adolescent mothers also increase cases of stigma and discrimination towards pregnant and parenting girls due to the visibility of their sexual activity, and because of school staff and peer attitudes towards dealing with girls who hold adult responsibilities but are still part of a learning environment. Stigma and discrimination are forms of violence and can be exacerbated by gender inequality in the school context. Hurtful comments may lead adolescent mothers to feel isolated from the rest of the class and unsupported by their peers. This can impact negatively on their motivation to remain in school and their willingness to ask classmates for help to catch up on lessons if they miss school to take care of their new-born baby.

In many country contexts, early pregnancy is closely linked to child marriage. 90 per cent of adolescent births among 15-19 year olds occur within child marriage (UNFPA, 2013). Child marriage is also associated with limits on education. Both pregnancy and child marriage increase the chances of dropping out of school. In these situations 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 increasingly being implemented to prevent child marriage and to respond to EUP. Challenges however remain, due to entrenched unequal gender norms and the lack of enactment of such policy instruments.

Gender inequality is strongly correlated with EUP. Gender inequalities within a relationship and in society may limit access to contraception, as girls and young women are often considered by their partners to be responsible for preventing a pregnancy (Bankole and Malarcher, 2010), yet they face stigma if they carry condoms or use contraception as this is a sign of sexual activity. There may be social pressure against using modern contraception; young brides may be expected to give birth after marriage and may also be expected to become repeatedly pregnant until they produce a son. Boyfriends may ask their girlfriends to prove their fertility and love through pregnancy (Williamson et al., 2009). Emergency contraception provides an option for reducing the risk of pregnancy after contraceptive failure or after unprotected sex (UNESCO, 2013). 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). In child marriages, the power disparity is often reinforced by the age gap between the young bride and her husband. Married girls may lack both the skills and the decision-making power to refuse sex, to negotiate family planning options or to access health services, all of which can lead to early and unintended pregnancies (UNFPA, 2013).

Another negative outcome of gender inequality is gender-based violence. Gender-based violence in, or on the way to and from school (SRGBV), has also been documented as a cause of early and unintended pregnancy when it takes the form of sexual violence from teachers and fellow students. Pregnancy-related gender-based violence in schools also includes bullying and teasing perpetrated by classmates and teachers toward pregnant girls and adolescent mothers.

EUP is also strongly connected to unmet need for contraception. It is crucial that adolescents have access to quality comprehensive sexuality education (CSE) that includes discussions on contraception, as well as having access to SRHS and a full range of contraceptive methods. The world’s 1.8 billion adolescents have the highest rates of unmet need for contraception among any age group (Singh et al., 2014; UNFPA, 2014), and adolescents
have limited access to SRH services, either because these services are not always available, or are not accessible to young people as a result of location, cost or due to the need for adult consent (Bankole and Malarcher, 2010).

The education sector can make a significant contribution towards better health and social outcomes by promoting adolescents’ access to services through the development and reinforcement of an effective referral system and counselling service in school. A World Health Organization (WHO) review found that school health services were available in at least 102 countries globally, including 47 HICs and 55 LMICs. Among these, 59 countries have dedicated school health personnel (Baltag et al., 2015). Schools can also act as social support centres, trusted institutions that can link children, parents, families and communities with services in other sectors, such as health and child protection.

In addition, through management structures and education policies, school authorities have the power to define and monitor the school environment for both teachers and students, making it protective and supportive, inclusive and free from all forms of violence.

The importance of the education sector response

Linkages between education and early and unintended pregnancy

Early and unintended pregnancy can result in adolescents dropping out of school. However, the causal relationship 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 men and women found that, among those leaving school, most pupils 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, 2013). 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, 2006; UNFPA, 2013). There is also research to suggest that girls who become pregnant may already perform worse in school before becoming pregnant and that poor educational achievement and girls’ low educational aspirations may increase the likelihood of early pregnancy. These girls could potentially be offered additional educational guidance to reduce their risk of early pregnancy (Grant and Hallman, 2006; Näslund-Hadley and Binstock, 2010; Stoebenau et al., 2015).

Pregnant girls and adolescent mothers may stay in school but they may disengage with learning and go unnoticed by teachers. Students opting out of learning or who are 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 may feel tired and lack concentration at school, and are sometimes obliged to miss classes for medical reasons (Pillow, 2006). After delivery, adolescent mothers are described by teachers as restless and sleepy during lessons and at risk of falling behind with schoolwork 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 to 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).

---

7 Health services provided to enrolled students by health care and/or allied professional(s), irrespective of the site of service provision; the services should be mandated by a formal arrangement between the educational institution and the provider health care organization.
BOX 1: Education, health and rights

Education is a fundamental human right that is essential for exercising all other human rights. It promotes individual freedom and empowerment, leading to important developmental benefits.

The human rights approach to education includes:
- The right to access education on the basis of equality of opportunity and without discrimination on any grounds;
- The right to quality education enabling children to fulfil their potential; and
- The right to respect within the learning environment, including meaningful participation, freedom from all forms of violence, and respect for language, culture and religion.

Health is also a fundamental right. The right to health includes access to timely, acceptable and affordable health care of appropriate quality. It also includes sexual and reproductive health and rights (SRHR), which entitle women to appropriate and accessible sexual and reproductive health care services and commodities, including modern contraceptives. However, social and gender-based norms about women’s role within society frequently results in the violation of these rights.

In many contexts, women lack the ability to make choices about sex, reproduction, early marriage and pregnancy. Adolescent pregnancy, pregnancies spaced too closely together, and having large numbers of children all have an adverse impact on women’s health.

Increasingly there are calls, including from young people themselves, for all adolescents and young people to have the right to comprehensive sexuality education (CSE). Young people need comprehensive, life-skills-based sexuality education to gain the knowledge and skills to make conscious, healthy and respectful choices about relationships and sexuality, including family planning and preventing pregnancy. A comprehensive positive approach to sexuality education contributes to addressing not only the health and wellbeing of young people, but also their sexual and reproductive rights (Apter, 2011).

It is important to acknowledge that not all adolescent pregnancies are unintended and that there may be girls who have reasons for becoming pregnant at an early age, especially, but not exclusively, within a marriage. 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 many regions of the world, pregnancy means entering into adulthood, acquiring social status and a position within the family (Näslund-Hadley and Binstock, 2010; Presler-Marshall and Jones, 2012). These choices need to be taken into account to avoid victimizing girls and seeing them as passive ‘recipients’ of other people’s decisions. Providing young people – particularly girls – with the information to make informed decisions and choices regarding their sexual and reproductive health, and ensuring that they have the opportunities and services to realize their rights, is paramount.

The role of the education sector

The education sector has the responsibility and potential to respond to EUP for the protection of children and respect for their rights, including the right to education. The education sector has a responsibility to support adolescents to fulfil their potential, regardless of their health, social or economic status, and irrespective of their gender. EUP jeopardizes educational attainment for girls and for this reason, the education sector has an obligation to learners who are pregnant and parenting to ensure that they can fulfil their right to continue their education. This includes developing, implementing and monitoring policies to ensure that pregnant and parenting girls can continue their education in a safe and supportive environment, free from stigma and discrimination.

Education – including CSE – is a protective factor in the prevention of pregnancy amongst adolescent girls, as each additional year of education means a 10 per cent reduction in fertility and subsequent increase in contraception uptake (Presler-Marshall and Jones, 2012). Increased quality, quantity and access to education increases girls’ empowerment, their opportunities in life and reduces EUP. CSE forms a critical part of a quality education. Access to high quality CSE increases knowledge about issues including sexual reproductive health and
rights, sexuality, relationships, gender equity and family planning; it challenges attitudes and harmful gender and social norms; and it builds self-confidence, decision making and negotiation skills. Consequently CSE helps adolescents to make informed decisions about sex and pregnancy at an individual level, while the gender transformative approaches underpinning CSE benefit all learners and contribute towards a society that is healthier, better educated, more prosperous and more gender equitable.

In most countries, children between the ages of five and thirteen, in particular, spend significant amounts of time in school. Schools provide an existing infrastructure to address EUP, including teachers who are likely to be a trusted source of information, and long-term programming opportunities to address the issue through formal curricula. The education sector can also contribute to improved health and social outcomes by promoting adolescents’ access to health, including SRH services, by establishing effective linkages and referral systems and/or providing counselling in school. Schools can also act as social support centres, trusted institutions that can link children, parents, families and communities with services in other sectors, such as health and child protection (UNESCO, 2009). In addition, through management structures and education policies, school authorities have the power to define and monitor the school environment for teachers and students, ensuring that it is protective, supportive, inclusive and free from all forms of violence.

Given that only 75 per cent of learners who start primary school reach the last grade (UNESCO, 2014a), it is important to start 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 receive information about pregnancy and pregnancy prevention before they leave the education system, or become sexually active, or are coerced/forced into marriage or child bearing soon after puberty.
Section 2: Recommendations

Based on a review of available evidence, UNESCO, in collaboration with partners, has developed recommendations to guide ministries of education, and the education sector more broadly, around the world on actions that they can implement in order to prevent EUP and to ensure that pregnant and parenting girls can continue education in a safe and supportive school environment, free from violence, stigma and discrimination. Achieving this requires action at different levels in order to effect the necessary changes at the political level in terms of ensuring supportive policies and legal frameworks; ensuring a supportive environment to address EUP and change social and gender-based norms at the community level; and strengthening the response within individual school settings. The recommendations reflect the different dimensions of change required to effectively address the broad determinants and consequences of EUP.

The following recommendations address five priority areas for action:

- **access to quality education** for all girls
- **re-entry and continuation policies** for pregnant and parenting learners
- **comprehensive sexuality education** that has a focus on gender and power and which includes a component on pregnancy prevention
- **school-based health services and links to external health services**, including contraception, counselling and care and support services for girls who are pregnant and parenting
- **a safe and supportive learning environment**

Each of the recommendations is based on evidence that ranked as ‘strong’ during the analysis conducted through the literature review, with the exception of ‘safe and supportive learning environments’ and the specific recommendation to deliver CSE to out of school youth, for both of which more evidence is needed. The ranking used draws on the Gray Scale (Gray, 1997; Gray, 2009), with the strength of evidence divided into three categories: ‘strong’, ‘promising’, ‘limited and more needed’. This section presents detailed recommendations under each of the five priority areas for action identified above, together with a brief synthesis of the available evidence supporting each recommendation.

One limitation of the evidence review was that an overwhelming majority of the studies took place in the US, Europe and Australia. However, while further studies are clearly needed from LMICs, the existing evidence is relevant globally and provides justification for action by governments worldwide. Appendix 1 provides detailed information on the methodology used for this study, while Appendix 2 includes a table synthesising the evidence for each of the key recommendations that follow.

**Figure 3: Summary of recommendations**

<table>
<thead>
<tr>
<th>Access to quality education for all girls</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommendation 1:</strong> Ensure universal access to quality education as a key strategy to prevent child marriage and promote gender equality</td>
</tr>
<tr>
<td><strong>Recommendation 2:</strong> Start education, particularly for girls, as early as possible as it is a key intervention for reducing early and unintended pregnancies and child marriage</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Re-entry and continuation policies for pregnant and parenting learners</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommendation 3:</strong> Develop, implement and monitor policies allowing pregnant and parenting girls to continue education</td>
</tr>
</tbody>
</table>

---

* UNESCO’s partners in education sector responses to early and unintended pregnancy include WHO, UNFPA, Population Council, IPPF, Ford Foundation and The Institute of Education, University College London
Evidence review and recommendations

Early and unintended pregnancy & the education sector

**Comprehensive sexuality education**

**Recommendation 4**: Deliver curriculum-based comprehensive sexuality education (CSE) in schools prior to and after puberty to prevent early and unintended pregnancies.

**Recommendation 5**: Introduce interventions to promote gender equality, address gender norms, roles and relationships, and engage men and boys to critically assess gender norms and normative behaviours in schools.

**Recommendation 6**: Build skills to delay sexual debut and increase correct and consistent use of condoms and other contraceptive methods as an important component of CSE.

**Recommendation 7**: Develop programmes to provide CSE for out-of-school adolescents in order to prevent EUP.

**School health services and links to external health services**

**Recommendation 8**: Develop linkages between schools and health services as part of efforts to reduce EUP and support pregnant and parenting adolescents.

**Recommendation 9**: Encourage and support school health services (SHS) that offer on-site contraception and counselling services as part of efforts to reduce early and unintended pregnancies, and antenatal care to support pregnant and parenting adolescents and to reduce school drop-out.

**A safe and supportive learning environment**

**Recommendation 10**: Implement interventions to reduce stigma and discrimination against pregnant and parenting girls at school.

---

**Access to quality education for all girls**

**Recommendation 1**: Ensure universal access to quality education as a key strategy to prevent child marriage and promote gender equality.

A review of evidence found that educating girls increases gender equality (Skider et al., 2014). Child marriage is a consequence of gender inequality and a human rights violation and often leads to early pregnancy. Each year, 15 million girls are married before the age of 18. They are often disempowered, dependent on their husbands and may be deprived of their fundamental rights to health, education and safety. With little access to education and economic opportunities, they and their families are more likely to live in poverty. UNESCO has noted that a ‘strong body of evidence indicates that girls’ participation in formal education is itself an important factor in delaying marriage and child-bearing’ (UNESCO, 2015, p. 169). In November 2014 the UN adopted a resolution to end child marriage, stating that ending this practice has enormous impacts on improving girls’ health and contributes to the development of a nation (Walker, 2013). The education sector can offer a protective role to girls who are at risk of child marriage or who are already married by ensuring that all girls stay in school, and by allowing pregnant and/or married girls to stay in school (Lee-Rife et al., 2012).

There is strong evidence that promoting quality education for girls is an effective way to increase gender equality and to reduce the number of child marriages, therefore reducing EUP.
Evidence review and recommendations

Evidence

- **Girls with education are more likely to avoid child marriage.** A review of 58 programmes in India found that girls with secondary schooling were 70 per cent less likely to marry as children than illiterate girls (Gupta et al., 2008). Enhancing access to education (including access to higher levels of education) and improving the quality of girls’ education, as well as reducing costs associated with education, also deter child marriages (Walker, 2013; Warner et al., 2014). Each additional year of education results in a 10 per cent reduction in fertility and subsequent increase in contraception uptake (Presler-Marshall and Jones, 2012). In schools where girls received free uniforms to encourage them to continue their education, these pupils were less likely to be married than girls not receiving free uniforms (Lee-Rife et al., 2012).

- **Girls with no education are three times more likely to marry or enter into union before 18 than girls who have a secondary or higher education (UNFPA, 2012).** A review of 23 child marriage programmes found that girls with low levels of schooling are more likely to be married early and child marriage typically results in girls terminating education (Lee-Rife et al., 2012, p. 288).

- **Education influences girls’ attitudes toward child marriage.** In Malawi, a baseline study revealed that 70 per cent of girls disagreed with the statement that it was acceptable for a teacher to get a girl pregnant as long as he married her. However, after a training programme based on a curriculum on Safe Schools, 90 per cent of girls disagreed with the same statement (USAID, 2008).

Recommendation 2: **Start education, particularly for girls, as early as possible as it is a key intervention for reducing early and unintended pregnancies and child marriage**

Increased quality, quantity and access to education are linked to girls’ empowerment. Girls who start their education later than age five or six, have lower levels of education, or who repeat a grade are more likely to experience EUP. Supporting girls to begin their education early and to continue their learning is a key intervention for reducing child marriage, reducing EUP and increasing gender equality since education increases the life choices of adolescent girls (Lloyd and Mensch, 2006; Grant and Hallman, 2006).

Child marriage is highly correlated with early pregnancy, as girls who are married under the age of 18 are more likely to become pregnant at younger ages. Those girls who can stay in school are less likely to become married and give birth at a young age.

There is strong evidence that girls who begin their education early have reduced EUP.

Evidence

- **Chances of early and unintended pregnancy decrease when education starts earlier.** In Uganda, girls who started school at age nine were 1.4 times more likely to have EUP, leading to school drop-out, than girls who started school at younger ages (Stoebenau et al., 2015). Repeating a grade and being older than other students in the same grade also increased girls’ risk of child marriage and EUP, with corresponding risks of dropping out of school (Grant and Hallman, 2006; Lloyd and Mensch, 2006).

- **Girls who continue their education in school are less likely to become pregnant and marry early (Grant, 2012), as education and school attendance in both HICs and LMICs are associated with reduced fertility, and delayed marriage and first birth (McQueston et al., 2012; Mmari and Sabherwal, 2013; Skider et al., 2014).** Lower levels of education – which are compounded by children starting school late- were associated with increased risks of an adolescent first birth in Uganda, Tanzania and Kenya (Neal et al., 2015). A study in Brazil also found that girls who became pregnant at least once during adolescence were less likely to complete basic education (Almeida and Aquino, 2011).
Country Case Study: Empowering girls to choose secondary education over child marriage in Nigeria

The Partnership to Strengthen Innovation and Practice in Secondary Education (PSIPSE), aimed to build support of ministry officials, teachers and secondary school girls in two North Western states of Nigeria – Kano and Jigawa – about the relevance of girls’ secondary school education as a strategy to enable them to choose employment or continuing education over child marriage. The initiative was implemented by the development Research and Project Centre (dRPC) between 2013-2015 with support from the MacArthur Foundation. Activities included study tours for Ministry of Education officials to understand best practices in girls’ education in southern states; leadership development training for principals; teacher training; mentoring for girls; mobile library; and career guidance support.

At the end of the project, the end-line survey found a 1 per cent increase in PSIPSE girls choosing post-secondary school empowerment options over marriage, while the number of girls in the control schools choosing empowerment options fell by 5.8 per cent. The PSIPSE schools also recorded a greater improvement in pass rates, increasing their self-confidence and impacting positively on their social and educational aspirations. Girls in the PSIPSE project reported that they felt valued and that they now placed a greater value on school. They also reported that the project gave them a sense of pride and a sense of possibilities. Senior MOE officials reported an increased understanding of the opportunities for empowering girls.

For further information, please see the following websites:

Re-entry and continuation policies for pregnant and parenting learners

Recommendation 3: Develop, implement and monitor policies allowing pregnant and parenting girls to continue education

In a number of countries, pregnant and/or parenting girls are prevented from continuing with their education simply because they are pregnant or have become a parent. In some contexts ‘re-entry policies’ do exist but they often have punitive requirements and conditions for re-entry, such as requiring girls to apply to a different school or to stay out of the education system for a fixed period of time before re-entry. Even where such policies exist, they are often not systematically recognised or implemented at the school level, and are rarely monitored. Countries that deny pregnant girls and adolescent mothers’ re-entry to school are forcing these girls to drop out of school prematurely and consequently denying their right to education.

Laws and policies can create an enabling environment for the promotion and protection of health, including sexual health and the prevention of EUP, but they also may pose barriers, particularly for young people in terms of accessing education and health services, leading to detrimental consequences for sexual health, including EUP. It is important to develop and implement specific policies that codify the rights of adolescents to continue their education regardless of whether they are pregnant and/or parenting. Such policies also need to address the practical support necessary to allow parenting girls to return to school – for example, through the provision of cash transfers to girls or by providing child care - and consequently require allocated budgets to support their implementation. This should then be reflected in national policies, and within individual schools’ policies, with efforts to inform pregnant and parenting adolescents of their right to continue their education and initiatives to sensitise and train school principals/administrators, teachers, and school authorities about the needs of pregnant and parenting girls, as key components of the policy implementation process. Finally, data should be collected to monitor the implementation and adherence of these national policies at school level.

Strong evidence exists that drop-out prevention programmes can increase school enrolment for those girls who are at risk of pregnancy-related dropout. Providing child care offers practical support to allow parenting adolescents to continue their education.
Evidence

- **Official policies support pregnant and parenting adolescents to stay in school**, which reduces drop-out rates and increases the attendance of female students (Onyeka et al., 2011). Mozambique and Zambia have recently changed their policies to allow adolescent mothers to attend school (Munthali, 2012). Where re-entry and continuation policies do not exist, budgets are not allocated to support their implementation, and where MOE officials, teachers, adolescents and parents of adolescents do not clearly understand these policies, there is a significant body of evidence to show that girls who experience EUP have high rates of drop-out from school (FAWE/OSISA, 2012; Gender Research and Advocacy Project Legal Assistance Centre, 2008; Improve Group and Thammasat University, 2014; Liwewe, 2012; Ngabaza and Shefer, 2013; Omwancha, 2012; Stoebenau et al., 2015).

- **Drop-out prevention programmes increase school enrolment rates** for those adolescents who have had or are at risk of EUP (Steinka-Fry et al., 2013). Cash transfers, for instance, are found to be effective in supporting parenting girls to continue their education. South Africa has a law that prohibits schools from dismissing pregnant adolescents, and also provides unconditional cash transfers to assist mothers of young children and adolescent girls who are pregnant. One study found that parenting girls who received unconditional cash transfers are statistically as likely to graduate from high school by age 22 as girls who have never been pregnant (Ranchohod et al., 2011).

- **Integrating practical support (eg providing child care) within re-entry and continuation policies helps parenting girls to fulfil their right to education.** Child care provided by the education sector is effective in enabling a parenting girl to continue her studies (Brosh et al., 2007; Bhana et al., 2010).

**Country Case Study: The Jamaican re-integration policy**

The Ministry of Education of Jamaica established a national policy to ensure the re-integration of school-age mothers into the formal school system in 2013, drawing upon international human rights frameworks such as the Convention on the Rights of the Child (UNICEF, 1989), the Convention on Elimination of All Forms of Discrimination against Women (Assembly U.G, 1979) and national policies such as the Education Regulations (1980).

The policy aimed to strengthen collaboration between state agencies by partnering with the Women’s Centre of Jamaica Foundation (WCJF) and the Ministry of Health to provide psycho-social, economic and family-focused support for adolescent mothers and their children. It built upon and expanded existing programmes implemented by WCJF, to register WCJF as an approved education facility; to monitor and support pregnant students and school-age mothers reintegrated to schools; and to foster inter-agency coordination to support school-age mothers.

The policy also aimed to increase community support for adolescent mothers’ right to continued education by implementing a public awareness campaign with civil society, including faith-based organisations. Stakeholder consultations discussed different options for re-integrating adolescent mothers into the formal school system, including re-integrating students into the same school they attended prior to becoming pregnant by mandating schools to reserve their space, or reintegration at the same level within a new school. The advantages and disadvantages of each are reflected in the policy document. The MOE also developed training for MOE and school staff, children’s courts and NGOs to promote the acceptance of parenting adolescents and reduce stigma and discrimination within schools.

Comprehensive sexuality education

Recommendation 4: Deliver curriculum-based comprehensive sexuality education (CSE) in schools prior to and after puberty to prevent early and unintended pregnancies

School-based interventions for CSE can reach large numbers of young people in a setting already equipped to promote learning. CSE provides students with knowledge and skills concerning all potential options to prevent EUP, and it can delay the age at which girls and boys first have sex (Fonner et al., 2014). Globally, girls attend primary school in greater numbers than they do secondary school and are less likely to complete secondary education than boys (Hardee et al., 2014). Ensuring that CSE is delivered in primary schools, and continues during secondary education, will reach greater numbers of children and adolescents (particularly girls) and ensure that information on puberty, sex and contraception is timely, delivered prior to puberty, and before adolescents become sexually active. In some countries, such as Nigeria, CSE was offered at later ages, when some adolescent girls had already experienced sex and pregnancy, clearly reducing its potential impact (Ochiogu et al., 2011).

The education sector has a responsibility to prevent EUP by providing CSE as a key component of a quality education. The UN has issued guidance for implementing CSE (UNESCO, 2009), as well as noting the importance of scaling up CSE (UNESCO, 2014b). Globally, CSE is not yet implemented across all countries, and despite progress regarding the number of countries including CSE within their policy development, there remains a critical gap in many contexts between the development of these policies and the delivery of CSE in practice. In Nigeria, for instance, despite a nationally approved CSE curriculum, a study showed that most schools do not have a CSE curriculum as part of their academic curriculum and more than half of teachers could not list its content (Onyeka et al., 2011).

The impact of CSE is increased when delivered by trained professionals, for example school nurses. Conversely, there is evidence to suggest that peer education as a single strategy to deliver CSE within schools is less effective (Mavedzenge et al., 2014). EUP prevention programmes using ‘pretend infants’, such as eggs, dolls, etc. to care for have also been found to be ineffective (Somers, 2013).

Strong evidence exists that CSE is effective in reducing EUP. Conversely, there is no evidence that CSE leads to earlier or increased sexual activity. CSE should be provided prior to puberty so that adolescents can understand the changes in their bodies and have the information and skills needed, prior to becoming sexually active, to prevent EUP.

Evidence

- School based CSE is one the most important ways to help adolescent improve their reproductive health and prevent EUP (WHO, 2009). In Finland, a national sexuality education curriculum was made mandatory in schools in 1970, resulting in low adolescent fertility rates for 15 to 19-year-old girls. However, when CSE was made optional in 1994, this correlated with increased number of girls aged 14 and 15 having sexual intercourse, increased numbers of girls who did not use contraception, and a 50 per cent increase in adolescent abortions. When CSE became compulsory again in 2006, the numbers of adolescents initiating sexual intercourse at age 14 and 15 reduced, with those engaging in sex reporting an increased use of contraception. Adolescent maternal delivery rates and abortion rates among adolescents decreased from 16.3 in 2002 to 12 in 2010 (Apter, 2011).

- CSE was found to be effective in preventing and reducing early and unintended pregnancy in reviews and studies from different contexts, including across LMICs, the US, Europe, Nigeria and Mexico (Chandra-Mouli et al., 2013; Kohler et al., 2008; Oringanje et al., 2009; Rosenthal et al., 2009; WHO, 2011). Global reviews of 13 studies found that CSE led to reduced pregnancy rates in three studies; nine studies did not find a significant impact and one study in the US found that CSE was correlated with an increase in pregnancy rates (Gay et al., 2012; Kirby et al., 2007; Kirby et al., 2006; Kirby et al., 2005). Another 2015 US review found that school-based CSE reduced age of sexual debut (Goestling et al., 2015).
Programmes with a CSE component help adolescents reduce EUP and achieve positive educational outcomes. Adolescents receiving CSE at least once a week, including a component of counselling by trained professionals, were 40 per cent less likely to have an EUP and 30 per cent more likely to have graduated from high school (Coalition for Evidence-based Policy, 2015). CSE delivered prior to puberty, along with academic assistance and negotiation skills, resulted in a significantly reduced likelihood of pregnancy or birth prior to age 21 (Lonczak et al., 2002).

Country case study: Delivering schools-based CSE in the Netherlands

**Long Live Love (Lang Leve de Liefde – LLL)** is an evidence-based sex education programme aimed at adolescents aged 13-15 years. It is the most widely used sex education curriculum in the Netherlands, implemented in an estimated 50 per cent of target secondary schools, and first developed in 1990 by the Dutch STI Foundation (now STI/AIDS Netherlands). In 2012, the fourth generation of the programme was launched, consisting of a student magazine, a teachers’ manual, a film series of six episodes and two optional computer-based lessons.

Programme development and implementation is managed by STI/AIDS Netherlands, with teachers trained by Municipal Health Services. Updating the programme every five to ten years allows it to reflect changes in youth culture and images making it more relevant, incorporate new research and educational approaches, and respond to implementation challenges, making it more effective. The updated curriculum pays specific attention to sexual, cultural and gender diversity.

The programme was officially certified as effective in 2014.

For further information, please see [http://www.longlivelove.nl](http://www.longlivelove.nl) or contact SMeijer@soaaids.nl

**Recommendation 5:** Introduce interventions to promote gender equality, address gender norms, roles and relationships, and engage men and boys to critically assess gender norms and normative behaviours in schools

Gender equality is important both as a goal in and of itself (UNESCO, 2014d), and as a means to reducing EUP. Promoting education for girls and women is a particularly effective strategy to contribute to achieving gender equality.

Addressing issues of gender equality and discussing power within relationships is a critical component of effective CSE, supporting adolescents and young people to negotiate when to initiate sexual intercourse, with whom, under what circumstances and with what contraceptive methods. CSE programmes that address gender are up to five times more effective at achieving a significant decrease in pregnancy, childbearing or STIs than those that do not address gender or power (Haberland, 2015). Strengthening the focus on gender is critical to ensure that CSE has maximum impact and to respond to the needs and realities of girls and young women worldwide. Gender-focused discussions present an important entry point to address the vulnerability of adolescent girls and young women, and to protect them from sexual exploitation and abuse. They help to build the skills and knowledge of boys and girls to address gender inequality and power dynamics, gender norms, gender inequality, gender-based and sexual violence, EUP and child early and forced marriage. Addressing gender equality can also play a significant role in reducing school-related gender-based violence (SRGBV), which – in the form of sexual violence from teachers and fellow students – is a cause of early and unintended pregnancy. Global guidance on addressing school-related gender-based violence has recently been published (UNESCO and UN Women, 2016).

Involving boys in discussions about pregnancy and contraception also contributes to the promotion of gender equality in school, as a way to overcome inequitable gender norms around masculinity and femininity. Boys have been largely omitted from efforts to reduce EUP, but boys should choose if and when they want to become fathers, understand the responsibilities of early parenthood, and gain the skills to discuss desire for children with their sexual partners. Providing adolescent boys with SRH information and services to prevent EUP, as well as meeting their own reproductive health needs, will promote gender equality. Supporting adolescent boys to become better fathers can also promote gender equality (Levtov et al., 2015).
There is strong evidence that CSE programmes addressing gender equality and power dynamics within relationships are largely more effective in reducing EUP than CSE programmes that do not include the dimensions of gender equality and power. By contrast, there is a lack of evidence available on interventions about boys’ involvement in pregnancy prevention.

**Evidence**

- **Addressing gender and power within CSE programmes makes them up to five times more effective** at achieving reductions in pregnancy, childbearing and STIs. A review of 22 curriculum-based sexuality education programmes (including ten that were schools-based) found that 80 per cent of the programmes that addressed gender or power were associated with a significant decrease in pregnancy, childbearing or STIs, and were five times as likely to be effective than programmes that did not address gender or power. Examples of topics covered included: explicit instructions on how to handle sexual harassment; critical thinking about gender norms; recognizing one’s own power and agency; assessing how harmful notions of masculinity and femininity affect behaviours and can be transformed; unequal power in intimate relationships; and gender dynamics of negotiating condom use (Haberland, 2015, p. 36).

- **Involving boys and young men in discussions about gender and pregnancy has a positive impact on their sense of empathy and responsibility.** Only 50 per cent of boys in South Africa were empathetic towards teen mothers compared to 80 per cent of girls (Chigona and Chetty, 2007). CSE can increase boys’ gender equitable attitudes including a sense of shared responsibility to prevent EUP (Trivedi et al., 2009).

- The nature and impact of SRGBV in and around schools has been documented.⁹

**Country Case Study: Involving Boys to Promote Gender Equality in South Africa**

The ‘One Man Can’ (OMC) campaign was launched in 2006 by the Sonke Gender Justice Network in South Africa, in partnership with other civil society organizations. The campaign supports men to advocate for gender equality, including speaking out against domestic and sexual violence.

As part of this campaign, the Sonke Gender Justice Network have developed an ‘Action Kit’, which provides men with the resources to act on their concerns about domestic and sexual violence, HIV and AIDS. The Action Kits have also been disseminated to representatives from governments, NGOs, civil society organizations (CSOs) and community groups who work with both men and women to address issues of gender-based violence and HIV and AIDS.

The OMC campaign also provides workshop materials, designed to help men take action in their own lives and in their communities to promote gender equality. The campaign creates positive models of masculinity around voluntary counselling and testing (VCT) for STIs, HIV prevention, home-based care, violence, multiple concurrent partnerships and alcohol abuse.

An evaluation showed that 25 per cent of the men and boys had accessed VCT, 61 per cent increased their condom use and 50 per cent reported acts of gender-based violence that the men had witnessed so that appropriate action could be taken to protect women. Pre- and post-test surveys showed positive changes toward gender equitable attitudes. For example, prior to the workshop, all the men thought that they had the right to decide when to have sex with their partners; after the workshop, this decreased to 75 per cent. Prior to the workshop, 63 per cent of the men believed that it was acceptable for men to beat their partners; after the workshop, 83 per cent disagreed with the statement.

For further information, please contact info@genderjustice.org.za

---

Recommendation 6: **Build skills to delay sexual debut and increase correct and consistent use of condoms and other contraceptive methods as a critical important component of CSE**

By the end of adolescence, many young people have initiated sexual activity (Fonner et al., 2014). CSE provides the knowledge and skills for adolescents to use condoms and/or additional contraceptive methods to delay EUP, once they are sexually active. Adolescents need CSE to make informed choices about engaging in sex, and the skills, information and commodities to choose freely and responsibly, recognizing that they may experience peer pressure to initiate sex and that girls in particular may experience coerced sex. Knowledge of what constitutes coercive sex, skills to seek help in case of coercive sex, and skills to reject unwanted sexual activity are critical to delaying first sex and EUP. Once engaged in voluntary sexual activity, adolescents need the full knowledge of how to obtain and use contraceptives, including condoms. CSE also helps girls to make conscious decisions about repeat pregnancy; studies in the US found that CSE that specifically addressed the issue of repeat pregnancy with adolescent mothers reduced instances of repeat pregnancy (Kan et al., 2012; Sadler et al., 2007).

**There is very strong evidence to show that CSE delays the age of first sex. Additionally, there is very strong evidence that, once a young person is sexually active, CSE increases consistent use of effective contraception – including condoms - thus reducing the likelihood of EUP.**

**Evidence**

- **CSE delays sexual debut and does not increase risky sexual behaviours.** A review by UNESCO of 83 studies globally found that CSE delayed the age of first sex in 42 studies (22 studies found no impact and only one study found the contrary) (UNESCO, 2009). Teaching sexuality education also builds self-confidence (Unterhalter et al., 2014), a necessary skill to delay the age of first intercourse, and for the use of contraception, including condoms. A study among boys in the US found that CSE reduced risk behaviours (Trivedi et al., 2009). In Kenya, CSE provided in primary schools led to delayed sexual initiation, and once young people were sexually active, increased condom use after students reached secondary school (Maticka-Tyndale et al., 2010).

- **CSE increases contraceptive use once adolescents become sexually active.** CSE led to increased contraceptive use in 15 studies (UNESCO, 2009). Increased contraceptive use was found also in a study conducted in Mexico (Speizer et al., 2003) and in a review of 14 CSE programmes in the US, which specifically highlighted increased condom use (Advocates for Youth, 2012).

- **CSE increases the use of condoms.** A review of 98 CSE interventions in the US and Africa found increased condom use (Johnson et al., 2011). This was also the case in a study conducted among adolescents in Tanzania (Ross et al., 2007), one conducted in the Bahamas (Chen et al., 2010), and a review of 13 studies conducted in the US (Lavin and Cox, 2012). Another review of 28 studies in sub-Saharan Africa found that CSE resulted in greater intention to use a condom (Michielsen et al., 2010)

**Case Study: Girls Decide**

‘Girls Decide’ is an advocacy campaign led by the International Planned Parenthood Federation (IPPF) to promote the sexual and reproductive health and rights of girls and young women. It has produced a range of materials to support research, awareness-raising, advocacy and service delivery. These include a series of films on SRH decisions faced by six young women in six different countries.

The Girls Decide campaign aims to raise awareness of the benefits of CSE for girls, promoting this through a gender and human rights approach and portraying girls’ sexuality in a positive and empowering light. It advocates for increased research and data about issues facing girls and young women, investing in programmes and services for girls and young women, removing punitive policies that have a negative impact on girls’ rights and stigmatising girls’ sexuality, and ensuring that girls are involved in every decision that affects
Evidence review and recommendations

Early and unintended pregnancy & the education sector

Evidence review and recommendations

Early and unintended pregnancy & the education sector

them. The Girls Decide campaign strongly urges policy-makers to support women facing early and unintended pregnancies.

For further information, please see http://www.ippf.org/our-approach/programmes/girls-decide or contact info@ippf.org

Recommendation 7: Develop programmes to provide CSE for out-of-school adolescents in order to prevent EUP

Adolescents who do not attend school are among the most disadvantaged globally. Young people who face discrimination and abuse of their human rights – including the right to education - are at greatest risk of poor SRH outcomes, including high risk of EUP (UNESCO, 2015). Failing to provide marginalised adolescents and young people with CSE will deepen the social exclusion that many experience, limit their potential, and put their health, futures and lives at greater risk.

Reaching marginalised youth who are out-of-school is therefore critically important, yet few large-scale CSE programmes have been designed for out-of-school adolescents. In line with the Convention on the Rights of the Child, states have an obligation to ensure that all adolescent girls and boys, including those who are out-of-school, are provided with accurate and appropriate information on how to protect their health and SRH (Convention on the Rights of the Child General Comment 4 (2003) para. 26). In order to involve out-of-school youth, it may be important to work with other sectors, such as health services, community outreach programmes, youth programmes, workforce programmes, civil society, and others. NGOs have played an important role in developing innovative strategies for reaching vulnerable and hard-to-reach young people through internet and mobile technologies, new media, community and youth centres, and sports.

Despite the great need, no evidence was found of the education sector delivering effective CSE programmes to out-of-school adolescents.

Evidence

- No evidence was found of effective CSE programmes by the education sector for out-of-school youth, particularly in LMICs (Hardee et al., 2014), although the need among out-of-school youth is compelling. Indeed, studies have found that young people out of school often lack knowledge about contraception, HIV and other important topics that are critical to the well-being of adolescents (UNICEF, 2011b; Zaw et al., 2012).

- Studies involving programmes that have provided CSE for young people in school and out of school have not correlated their results by educational status, making it difficult to draw conclusions for out-of-school CSE provision (Williams et al., 2007).

Country Case Study: Delivering CSE to out-of-school adolescents in South Africa

The South African organisations Lifeline and Rape Crisis PMB offer community activities targeting out-of-school youth and helping to prevent unplanned pregnancies. These activities are run mainly in rural communities where neither health services nor information is easily available.

The ‘HIV Prevention Education and Sexual Reproductive Health’ sessions are delivered to boys and girls, with the aim of engaging them in dialogue and motivating them to take action. They include a session on adolescent pregnancy, while other sessions tackle the issues of family planning, contraception and termination of pregnancy. The session on adolescent pregnancy aims to empower learners to discuss the issue and its consequences, including for the mother and father of the child, the baby and the rest of the family. It also aims to help adolescents prevent early and unplanned pregnancy by promoting knowledge, building skills and understanding the alternatives.

For further information, please contact director@lifeonline.co.za

27
School health services and links to external health services

**Recommendation 8:** Develop linkages between schools and health services as part of efforts to reduce EUP and support pregnant and parenting adolescents

Creating and fostering linkages between schools and health services averts EUP. UNESCO notes that the impact of CSE increases when delivered together with efforts to expand access to high quality, youth-friendly services that offer a full range of services and commodities, particularly in relation to contraceptive choice (UNESCO, 2015). Girls who experience EUP whether due to lack of knowledge, contraceptive failure, coerced sex or lack of adequate access to contraception need to know how to access — where legal — safe abortion services, and post-abortion care. Access to safe abortion is associated with higher educational outcomes. Easier access to safe abortion is associated with higher female secondary school enrolment, decreasing the probability of school drop-out due to pregnancy (Azarnert, 2015). For adolescents who are pregnant and/or parents, creating and fostering linkages with health services will provide needed support for these young families. Quality health care services for adolescents are characterized by eight different standards defined by WHO and UNAIDS (WHO/UNAIDS, 2015).

Globally, many schools lack health services as part of the school system, particularly in LMICs. Where schools lack health services, school staff and/or teachers should be trained to be able to refer adolescents to health services outside the school. They should also receive training to keep information confidential.

*There is strong evidence that schools that create linkages with health services are more effective at reducing EUP and supporting pregnant and parenting adolescents than schools without such linkages.*

**Evidence**

- No evidence was found of effective CSE programmes by the education sector for out-of-school youth, particularly in LMICs (Hardee et al., 2014), although the need among out-of-school youth is compelling. Indeed, studies have found that young people out of school often lack knowledge about contraception, HIV and other important topics that are critical to the well-being of adolescents (UNICEF, 2011b; Zaw et al., 2012).

- Studies involving programmes that have provided CSE for young people in school and out-of-school have not correlated their results by educational status, making it difficult to draw conclusions for out-of-school CSE provision (Williams et al., 2007).

**Country Case Study: Establishing referral systems between schools and Youth Friendly Health Services (YFHS) in Mozambique**

In Mozambique, the government is implementing the Programa Geração Biz, which includes an educational and counselling SRH programme led by peer educators supervised by teachers, and a referral system between the school and Youth Friendly Health Service (YFHS) facilities. The programme was launched in 1999 and implemented by the MOE, the Ministry of Health and the Ministry of Youth and Sports, with the support of Pathfinder and UNFPA.

Peer educators created the referrals and linkages with health services, recognising this as a critical component of the programme, and the need for services to be high quality and welcoming to adolescents. National curricula at secondary level were revised to include SRH content, integrated across different core subjects (e.g. the maths curricula used HIV percentages to learn percentages; the biology curricula included sexuality education, etc). The MOE developed a policy whereby peer educators did not have to pay school fees and had their enrolment ensured for the following year if they received good grades and could demonstrate that were working as a peer educator. This was a huge benefit to young women whose families rarely prioritized them attending school (WHO, 2009).

For further information, please see WHO (2009), or contact Emidio José Sebastião Cuna sebastiao@unfpa.org

---

10 Adolescent’s health literacy, community support, appropriate package of services, providers’ competencies, facility characteristics, equity and non-discrimination, data and quality improvement, adolescents’ participation.
Recommendation 9: Encourage and support school health services (SHS) that offer on-site contraception and counselling services as part of efforts to reduce early and unintended pregnancies, and antenatal care to support pregnant and parenting adolescents and to reduce school drop-out

Globally, particularly in LMICs, few schools offer on-site, school-based health clinics that provide contraception and/or antenatal care.

There are many advantages of schools as a location for delivering health care services: schools are where most young people are; services are therefore easily accessible, reducing the embarrassment and/or stigma that young people may feel about going to health services; and provide links between schools and communities (Mason-Jones et al., 2012). However, studies have also indicated that a significant proportion of adolescents remained underserved by school-based health services, and therefore, they should be used to complement, not replace, health care services for adolescents located outside schools (Mavdzenge et al., 2014, p. 162).

Where schools provide on-site, school-based contraceptive services, there is strong evidence that these services reduce early and unintended pregnancies. In addition, for pregnant adolescents, school clinics that also provide prenatal care increase school attendance and reduce repeat pregnancies.

Evidence

- **School-based health services were found to reduce EUP** in the UK (Owen et al., 2010) and the US (Strunk, 2008). A study in the US found that the provision of school-based health services also increased adolescent girls’ use of hormonal contraception and emergency contraception at last sex (Ethier et al., 2011). In South Africa, school-based reproductive health services increased the numbers of adolescent girls counselled and initiated on contraception (Frolich et al., 2014). Where school-based health services also offer counselling by trained staff, this further reduces the chances of EUP. One US study found that students who received comprehensive health services with counselling by a school-based social worker were 33 per cent less likely to have an adolescent pregnancy than a comparison group (Key et al., 2008).

- **Provision of contraception at school is effective in preventing EUP** (Trivedi et al., 2009). A randomized controlled trial in the US found that the pregnancy rate for adolescents with access to school-based contraceptive services declined by 30.1 per cent, while increasing 57.6 per cent in control schools without these services (Improve Group and Thammasat University, 2014). School-based contraceptive services were also found to reduce repeat pregnancy in Finland, Australia and US (Blank et al., 2010; Strunk, 2008).

- **School-based Health Services increase school attendance for those at risk of EUP and pregnant girls.** Two studies have shown that school-based health services can reduce adolescent drop-out rates (Mason-Jones et al., 2012). A study in the US found that a programme providing prenatal care on school premises for adolescents resulted in a 14.2 per cent increased attendance at school for pregnant adolescents compared to prior years where prenatal care was not provided at school (Griswold et al., 2012).

**Country Case Study: Schools-based Condom Distribution Programmes (CDPs) in the US**

A number of schools in the US implement Condom Distribution Programmes (CDPs). Studies show that CDPs have been proven to increase the use of condoms, prevent HIV and STDs, and save money. However, despite evidence to the contrary, distributing condoms within school settings remains sensitive, with vocal opposition groups fearing that increased access to condoms may result in increased sexual activity among students. These fears are inconsistent with the evidence. In a comparison between public schools in New York City offering CDPs and those in Chicago without these programmes, the numbers of high school seniors engaging in sexual activity was the same, but in New York students were more likely to report using a condom during their last sexual encounter than in Chicago where the programme was not in place (Guttmacher et al., 1999). This finding is correlated by the American Medical Association Council on Scientific Affairs (now the Council on Science and Public Health) that states that programmes that make condoms available in schools usually demonstrate increased condom use (Wetzstein, 1999). Increasing students’ use of
Evidence review and recommendations

Early and unintended pregnancy & the education sector

Condoms, amongst those who are already engaging in sexual activity, has a protective impact on their sexual and reproductive health, including reducing EUP, STIs and HIV.

CDPs have increased effectiveness if they are implemented in small schools; in schools that have high staff to pupil ratios; and when condoms are made freely available to students in the most barrier-free and non-restrictive way, for example having baskets of condoms where students can help themselves.

A safe and supportive learning environment

Recommendation 10: Implement interventions to reduce stigma and discrimination against pregnant and parenting girls at school

Stigma and discrimination against pregnant and parenting girls at school remains common, particularly in those contexts with strong social norms prohibiting sex outside marriage (Onyeka et al., 2011). Conservative attitudes from teachers and peers towards adolescent mothers increase cases of stigma and discrimination towards pregnant and parenting girls due to the visibility of their sexual activity, and because of attitudes towards dealing with girls who hold adult responsibilities but are still part of a learning environment. Schools may even carry out non-voluntary pregnancy tests, which can be degrading, invasive, and abusive, seeming to ‘blame’ girls for their pregnancy.

Stigma and discrimination are forms of violence and can be exacerbated by gender inequality in the school context. Hurtful comments by teachers and/or peer students may lead adolescent mothers to feel isolated and unsupported, impacting negatively on their motivation to remain in school and consequently jeopardizing educational outcomes as they can cause school drop-outs. As such, stigma and discrimination represent a form of SRGBV that also needs to be eradicated from schools. The education sector must ensure a safe environment for pregnant and parenting girls that is also free from stigma and discrimination.

While little evidence of effective interventions exists, there is a clear need for policies that reduce stigma and discrimination against pregnant and parenting adolescents. Evidence on how to address SRGBV has recently been published in the UNESCO/UN Women global guidance on addressing school-related gender-based violence.

Evidence

- **Stigma against pregnant and parenting girls negatively impacts educational outcomes** for adolescents (EPPI Centre, 2006).
- **Stigmatizing and discriminatory attitudes and behaviours can contribute to pregnant and parenting girls dropping out of school.** A study conducted with pregnant and parenting girls in the UK identified the following impact of stigma and discrimination: isolation, loss of self-esteem, depression and drop out from school (Yardley, 2008).
- The nature and impact of SRGBV in and around schools has been documented.¹¹

Country Case Study: Changing the School Environment in the US

The Seattle Social Development Project (SSDP), based at the University of Washington, conducted a long-term study with fifth grade students in elementary schools and their parents to examine the bonds between students, schools and families and to positively influence the school-based environment in order to improve young people’s sexual and reproductive health, including supporting them to avoid risky sexual behaviour.

---

¹¹ For evidence on how to prevent and respond to SRGBV at school, please refer to the UNESCO, UN Women (2016). Global guidance. Addressing school-related gender-based violence.
The SSDP intervention provided five days of in-service training for teachers each year, training for elementary schoolchildren, and voluntary parenting classes for parents.

An evaluation found that the SSDP programme led to delayed initiation of sexual intercourse, reduced number of sexual partners, increased condom use and reduced rates of adolescent pregnancy and birth in the long run. For example, at age 21, 56 per cent of comparison females reported ever having been pregnant, versus 38 per cent of females in the full intervention. By age 21, 40 per cent of comparison females had given birth, versus 23 per cent of females in the intervention group.

For further information, please see http://ssdp-tip.org/SSDP/index.html

Research gaps

Based on the evidence review conducted, research is still needed to answer to the following questions:

- Does CSE have positive health outcomes for pregnant and parenting adolescents, and their children?
- Does CSE lead to improved school completion rates and better educational outcomes for pregnant and parenting adolescents?
- Do condom distribution programmes in schools lead to increased condom use and prevent EUP?
- What is the acceptability, feasibility and effectiveness of health care providers offering comprehensive information on pregnancy prevention and services in schools?
- What are effective ways to engage adolescent boys in preventing EUP?
- What is the effectiveness of promoting gender equality interventions for all students and teachers in terms of reducing stigma and discrimination against pregnant and parenting girls in schools?
Section 3: Ensuring Sustainability

Early and unintended pregnancy is an issue that cuts across the responsibilities of a wide range of institutions and service providers. Addressing this issue requires increased commitment and multi-sectoral collaboration, particularly across health, education, social protection and gender. The impact and sustainability of efforts to address EUP are therefore contingent on the implementation of multi-pronged actions at all levels of the education system, engaging a range of implementing partners.

Strong leadership by ministries of education is central to the sustainability of EUP prevention and response strategies in which the various components require linkages and coordination. Recommendations on these components that support sustainability in the long term include:

- **Teacher training**
  Involving teachers through training on appropriate CSE content and methodology on how to overcome challenges due to social norms around adolescent pregnancy is fundamental to ensuring a sustainable change in the school environment.

- **Community engagement**
  Including parents and community in the response to EUP can also help pregnant and parenting girls to fulfil their right to education and to sexual and reproductive health information and services.

- **Media for education and awareness**
  In addition, the use of media and social media is an effective way to anchor changes in society, as these tools are widely used by adolescents.

- **Multi-sectoral response and partnerships**
  A multi-sectoral approach, characterized by the collaboration of different actors - ministries, international organizations, non-governmental organizations and civil society organizations – is required in order to make the response more holistic and therefore sustainable.

- **Monitoring and evaluation**
  Consistent collection of data and analysis of the rates of girls’ retention in school, pregnancy-related drop-outs, the application of policies, and the effectiveness of different programmes is essential.

This section discusses these issues in depth and offers specific recommendations on each for the education sector to ensure sustainability and increase the effectiveness of the response to EUP.

**Teacher training**

**Recommendation:** Ensure that MoEs provide both pre-service and in-service teacher training on CSE and that all components related to early and unintended pregnancy are integrated in teacher training content. Specifically, teachers should:

- Understand and implement re-entry policies and record cases of pregnancy in school and related educational outcomes (drop-out, re-entrance, performance)
- Be confident to deliver content relating to contraception and pregnancy prevention in class as an integral component of CSE, addressing issues highlighted in the recommendations on CSE in Section 2
- Be knowledgeable about available health services within or out of school and be able to refer students to those services
- Ensure a safe and supportive environment in school for all students, addressing gender equality issues in class, punishing perpetrators of SRGBV and supporting pregnant and parenting girls who may experience stigma and discrimination.
Evidence review and recommendations

Early and unintended pregnancy & the education sector

Although in some contexts, external experts may be invited to address specific CSE topics in class, CSE in schools is delivered mainly by teachers, who cover the topic as part of other subjects (integrated curriculum) or as a specific subject (stand-alone curriculum). The quality of CSE delivered therefore depends on teachers’ ability and willingness to cover the different topics and the pedagogy used (Boonsstra, 2007). However, teachers may have little or no interest in teaching sexuality education or may find it challenging to provide comprehensive knowledge on sexuality, as it requires them to deal with their own personal values and attitudes, which are in turn shaped by the social and gender-based norms of their community.

A qualitative study on the views and experiences of teachers in sex education programmes in primary schools in Australia identified that teachers’ main concerns included parents’ reaction to the topics being taught; feeling uncomfortable engaging in detailed discussions on this topic; and the challenge to accommodate differences in maturity, experience, comfort and knowledge among children. Teachers often omit subjects perceived as being more ‘sensitive’, including contraception or STIs, even when these are included within the curriculum. This issue was highlighted in the study, with one teacher considering it unnecessary to talk to children assumed to be sexually inactive about those issues (Milton, 2003). Similar issues were highlighted in a qualitative study in South Africa, with primary school teachers employing classroom strategies such as not directly answering students’ questions or avoiding a response altogether to ‘preserve child innocence’ (Bhana, 2009).

It is important that teachers are supported to examine their own attitudes and values regarding issues of sex and sexuality and have the information, confidence and skills to deliver accurate, non-judgmental information on a comprehensive range of topics in order to fulfill their role of giving children and adolescents all the instruments they need to learn to be, to know, to do and to live together.

Ensuring the provision of pre- and in-service training on CSE is essential to support teachers to deliver high quality CSE, including understanding the most effective pedagogical approaches to teaching these subjects, which are based on participatory and empowerment approaches and consequently may differ from more traditional ‘didactic’ teaching approaches. An evaluation of the in-service teacher training component of the Sexual Health and Relationships – Safe, Happy and Responsible (SHARE) programme implemented in Scotland showed teachers were more comfortable, more confident and more aware of their own perceptions and prejudices after the training, as it helped to decrease teachers’ embarrassment and judgements when delivering sex education (Wight and Buston, 2003). One year later the self-reported confidence had fallen but still remained higher than at baseline, and the study also found trained teachers were more likely to encourage discussion than those who had not received training.

Research also suggests that the whole school staff needs to be equipped with information that will be useful in supporting students with knowledge aimed at improving their health. A study conducted in France highlighted that the involvement of school staff – especially teachers – in health education also depends on their perceived responsibility toward learners’ health (Jourdan et al., 2010).

### Country Case Study: Delivering online teacher training in Mexico

Afluentes is a civil society organization (CSO) working to promote the sexual rights of adolescents and young women in Mexico, focusing on CSE and preventing EUP. A key component of their work is to provide online teacher training on CSE and to produce accompanying educational material on sexuality.

Since 2012, Afluentes has been providing a 120-hour online teacher training course that leads to the Building knowledge – sexuality education and migration diploma. This diploma is delivered by Afluentes in cooperation with the Federal Administration of Education Services in Mexico City and the Ministry of Health’s National Centre for Gender Equality and Reproductive Health. It is particularly aimed at teachers and health care providers who work with rural and indigenous communities and focuses on preventing EUP and promoting sexual rights. It also includes pedagogic approaches and educational material in order for teachers and health care providers to be able to talk about pregnancy and CSE-related issues with secondary and higher education students. Afluentes has trained around 2,000 teachers and health care providers through the programme.

Afluentes, in collaboration with government partners and civil society, has also produced a manual aimed at teachers to provide them with the necessary information on SRH, including pedagogical tools to initiate
discussion among adolescents from 10–19 years old about these topics. It aims to promote young people’s sexual and reproductive rights, thus empowering women and involving boys to prevent EUP.

For further information, please see http://www.afluentes.org/quienes-somos/sintesis-curricular/ or contact gabriela.afluentes@gmail.com

Parents and Community

Recommendation: Sensitize communities and parents about all aspects related to EUP, in order to contribute to the prevention of EUP, to encourage the education of pregnant and parenting girls, help them to access SRH services and reduce stigma and discrimination through empathy and support

Parents, caregivers and communities also play an important role in helping adolescents to avoid EUP and engaging in risky behaviour more generally. Increased social capital reduces the risks of adolescent pregnancy rates (Crosby et al., 2006). Parents, caregivers and communities play an important role in facilitating adolescent access to, and use of, health information and services (WHO, 2015). The involvement of community and parents in CSE can also help to redefine social norms around adolescent pregnancy and to foster a supportive attitude towards pregnant and parenting girls, including increasing their awareness and support for continued education.

A qualitative evaluation of the Teenage Mothers Project in Uganda – including community sensitization, teenage mother support groups, continued education and income generation, counselling and advocacy – demonstrated an increase in mothers’ self-confidence and autonomy, in addition to improved future opportunities for adolescent mothers, such as delaying marriage and continuing education. The most significant change was the large number of parenting girls returning to school, with parental support identified as the most important factor determining whether young mothers continued with their education (Leerlooijer, 2013).

Parents also play an important role in communicating about sex with their children, as parental involvement in the lives of their children has a protective effect on sexual behaviour (DeVore, and Ginsburg, 2005). A study conducted in the US found that young people were less likely to report having had sexual intercourse if their parents talked to them openly about problems, understood their point of view, demonstrated affection and had high expectations for them (Aspy et al., 2007). Similarly, when parents talked to children about sex and contraception these young people were less likely to report having had sexual intercourse; had fewer sexual partners; and, amongst those engaging in sexual activity, were more likely to report using contraception during their last sexual encounter (Aspy et al., 2007).

The relationship between parent/teen communication and EUP is not straightforward. Although many studies found communication about sex and contraception was associated with later age of sexual intercourse, greater condom use and less sexual risk-taking behaviours, others studies found that talking about sex and birth control was associated with a greater likelihood that the teen was sexually active (Eisenberg et al., 2006). In addition, the style of parent-child communication influences sexual behaviour. Ease of communication about sex is associated with later age of sexual debut (Wight et al., 2003). Adolescents receiving friendly, attentive, more open and receptive communication are less likely to engage in risky sexual behaviour compared to young people reporting contentious and dramatic styles of communication (Eisenberg et al., 2006). However, a review of parents’ involvement in sexuality education in the UK found parents approaching boys and girls differently when talking about sex. Girls received warm and confiding information, including advice about romance, while boys reported a cold and impersonal manner of receiving information from parents. Boys may also be more likely to have risky sexual behaviours than girls, when perceiving parents as unsupportive (Aspy et al., 2007; Turnbull et al., 2008). Most parents start talking about sex when they think children are involved in romantic relationships, while research shows that communication about condom use prior to the adolescent’s sexual debut is associated

12 The networks of relationships among people who live and work in a particular society, enabling that society to function effectively.
with greater likelihood of condom use. However, the same communication during the year of first intercourse does not translate into later condom use (Eisenberg et al., 2006).

**Case Study: Developing a toolkit to support community engagement in Eastern and Southern Africa**

Recognizing the importance of involving parents and community members in sexuality education, UNESCO commissioned the Southern African NGO SAF AIDS to develop a toolkit to engage communities on CSE which is subsequently being implemented in Lesotho, Malawi, Mozambique, Namibia, South Sudan, Tanzania, Uganda and Zambia.

The toolkit includes a capacity building guide on CSE; a manual for programmers in schools and communities; and a guide to holding CSE dialogue with communities. It also includes community tools on CSE aimed at children and young people; an information booklet for communities; guides for families (talking to children, talking to parents); and guides for religious, traditional and political leaders.

The toolkit aims to build support for CSE and SRH services for young people through the engagement of key community gatekeepers. Engaging with communities in this way contributes to achieving positive health outcomes for young people, while also changing social norms around adolescent pregnancy, child marriage, intergenerational sex and taboos around sex and sexuality.

For further information please see [http://www.safaids.net/](http://www.safaids.net/) or contact: mc.njelesani@unesco.org

**Media for education and awareness**

**Recommendation:** Consider the wide use of media and social media to reach adolescents and young people with CSE and SRH information

Media, social media and information and communication technologies (ICTs) are very powerful communication tools, as they help to reach a large number of people. Adolescents and young people in particular make wide use of these tools and have developed a specific language to communicate through them. Recent UK statistics reported Facebook as the fourth most popular source of health information (Dawson, 2010).

The use of ICT in sexuality education has demonstrated positive results. A review of ten studies evaluated the impact of digital media-based interventions on the sexual health knowledge, attitudes and/or behaviours of adolescents and youth. Interventions included question/answer quiz modules, role model stories, moderated online discussion and video. The use of these tools was found to increase knowledge of HIV, STIs and pregnancy, as well as influencing psychosocial outcomes such as condom self-efficacy and abstinence attitudes. Two studies also reported delayed initiation of sex (Guse et al., 2012). A study conducted in Australia among young people between 16 and 29 years old revealed that short text messages (SMS) designed to address knowledge, STI testing and condom use are effective in increasing knowledge on sexual health and STI testing, especially for girls (Gold et al., 2011).

Social media for health communication have different advantages: in some contexts they can be accessed by people who may not have easy access to health information, such as younger people, ethnic minorities and lower socio-economic groups, and video can replace text and therefore can be useful when literacy is low (Moorhead et al., 2013). However, privacy and confidentiality are huge concerns as social media users – especially the youngest – may be unaware of the risk of disclosing personal information online, and the availability of social media may reduce visits to health professionals, as users are able to find the information they want (Moorhead et al., 2013).

New digital media offer the advantage for young people of being able to create a personal profile that is useful to tailor information targeted at them. Focus groups among 29 adolescents in the US not only highlighted their interest in using social networks and text messaging for sexual health education, but also their desire to have access to appropriate and understandable information provided by a knowledgeable person – such as a physician, nurse or social worker – who does not judge them. Privacy and anonymity offered by these means of
communication was described as particularly important by adolescents. Topics of most interest were: pregnancy prevention, sexually transmitted infections and relationships. Adolescents also suggested that websites or text messaging should provide information on available health services, such as where you can get help if you are pregnant (Selkie et al., 2011).

The use of mass media campaigns are also effective in contributing to changing SRH behaviours. Family planning campaigns have been particularly important in low-income countries, and those aimed at preventing HIV in both low- and high-income countries. Family planning campaigns have been found to be effective in increasing the use of condoms to prevent pregnancy in countries across Africa even if, in general, these campaigns had the greatest impact amongst those people who were already considering using family planning methods (Wakefield et al., 2010).

Country Case Study: Delivering sexual health messages through radio and TV programmes in Zambia

In collaboration with SAfAIDS, UNESCO launched a radio and TV programme across Eastern and Southern Africa that aims to reduce HIV infection and improve sexual health outcomes for young people. The programme seeks to promote open and frank dialogue between young people, teachers, health workers and parents or guardians on SRH and rights for adolescents and young people in Zambia and other countries across the region. The radio and TV programme targets young people aged from 10–17, as well as their parents and guardians aged 18–45. A 26-series radio programme is aired by the national radio station Zambia National Broadcasting Corporation Radio 4 and two community radio stations, while a 13-series TV programme is aired on the national television station. Using radio and TV in this way has helped to engage parents, caregivers and community gatekeepers to understand the benefits of sexuality education for children and young people.

One of the radio programme sessions focuses on the issue of EUP and its causes. It encourages the audience to acknowledge the need for adolescents and young people to have access to CSE and SRH services, including contraception and safe abortion. The session also aims to highlight the right of school girls to continue with their education regardless of their pregnancy or motherhood status. A sexuality talk challenge is linked to a pre-recorded programme and has been designed as an important platform to engage listeners by posing a real life sexuality challenge that many young people encounter and that could be addressed by scaling up CSE and SRH services.

For further information, please contact p.machawira@unesco.org

Multisectoral approach and partnerships

Recommendation: Work closely with different sectors and actors in both the planning and implementation of interventions to ensure effective and sustainable results

A multisectoral approach, characterized by the collaboration of different actors - ministries, international organizations, non-governmental organizations and civil society organizations –is required in order to make the response more holistic, effective and therefore sustainable. As discussed in Section 1, the issue of EUP has complex social determinants and consequences which require actions by different actors at different levels. Despite the fact that inter-agency working and collaborative decision-making may slow down the process of implementation, the advantage of inter-sectoral collaboration is that a greater number of resources and strategies to tackle a problem are pulled together (Nicholls et al., 2012).

Ensuring a multi-sectoral approach is critical in order to create a supportive political and social environment, while also ensuring the quality of health education and service delivery at community level. The legal/policy framework needs to be conducive; the community engaged and supported in order to maximize impact on adolescents and young people, including pregnant and parenting girls. Critical to this are: government buy-in, investment and resources; trained and sensitized teachers; enabling school policies; effective linkages with
Evidence review and recommendations

Early and unintended pregnancy & the education sector

health services; media engagement and sensitization; community engagement with parents, caregivers, religious leaders and the wider community; and adequate monitoring for quality and outcomes.

Country Case Study: Developing a multi-sectoral approach to address Teenage Pregnancy in England

In most Western European countries, the rates of unintended pregnancies among adolescents have steadily declined in recent years. The adolescent pregnancy rate in the UK was the highest in the region, and the UK government designed a 10-year Teenage Pregnancy Strategy for England (1999-2010) in order to address this.

England and Wales experienced a 56% reduction in the under-18 birth rate between 1998 and 2013 (Office for National Statistics, 2015). This success is attributed to the National Teenage Pregnancy Strategy, which ensured a multi-sectoral approach in order to promote more widespread contraceptive use by expanding the provision of high quality sexuality education, facilitating easier access to services and improving training for healthcare providers to meet young people’s needs (Hadley et al., 2016).

Key elements of the approach, illustrated below, included the following: ensuring strong political will; ensuring effective linkages between central and local authorities; identifying clear objectives and target setting; establishing effective monitoring and evaluation systems; and included sex and relationship education in schools; advice and access to contraception and services; and a sensitization campaign including parents’ involvement.

Source: Hadley et al. (2016)
WHO have subsequently developed guidelines for preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries, promoting a multi-sectoral approach (Chandra-Mouli et al., 2013). Actions for the education sector are highlighted in bold.

**Figure 4: WHO guidelines for preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries [Chandra-Mouli et al., 2013].**

(Actions specific to the education sector are highlighted)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Determinant</th>
<th>Action recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing early marriage</td>
<td>• Prevailing norms, traditions and economic constraints</td>
<td>• Clear and effective legal prohibition</td>
</tr>
<tr>
<td></td>
<td>• No legal prohibitions or ineffective legal regime</td>
<td>• Engage community leaders to change norms</td>
</tr>
<tr>
<td></td>
<td>• Cultural reticence to address sexuality in adolescents</td>
<td>• <strong>Keep girls in school</strong></td>
</tr>
<tr>
<td>Creating understanding and support for preventing early pregnancy</td>
<td>• Lack of knowledge and understanding about sexuality</td>
<td>• Engage community leaders to lead efforts to prevent early pregnancy in culturally acceptable ways</td>
</tr>
<tr>
<td></td>
<td>• Contextual factors (e.g. peer pressure)</td>
<td>• <strong>Curriculum-based sexuality education linked to contraceptive provision</strong></td>
</tr>
<tr>
<td></td>
<td>• Cultural reticence to address sexuality in adolescents</td>
<td></td>
</tr>
<tr>
<td>Increasing use of contraception</td>
<td>• Lack of access</td>
<td>• Enable legal support for contraceptive provision</td>
</tr>
<tr>
<td></td>
<td>• Misconceptions</td>
<td>• Reduce financial barriers to contraceptive use</td>
</tr>
<tr>
<td></td>
<td>• Community norms oppose contraceptive provision</td>
<td>• Build community support for contraceptive provision</td>
</tr>
<tr>
<td></td>
<td>• Contraceptive services not user-friendly</td>
<td>• Make contraceptive services adolescent friendly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <strong>Educate about sexuality and contraceptive use</strong></td>
</tr>
<tr>
<td>Reducing coerced sex</td>
<td>• Powerlessness</td>
<td>• Effectively enforce laws to punish perpetrators of coerced sex</td>
</tr>
<tr>
<td></td>
<td>• Lack of effective law enforcement and protection</td>
<td>• Promote community norms that do not tolerate coerced sex</td>
</tr>
<tr>
<td></td>
<td>• Shame and stigma</td>
<td>• <strong>Engage men to re-examine gender norms</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Empower girls to resist unwanted sex by building their self-esteem, life skills and links to social networks</td>
</tr>
</tbody>
</table>
### Evidence review and recommendations

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Determinant</th>
<th>Action recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reduced unsafe abortion</strong></td>
<td>• Lack of knowledge about the danger of unsafe abortions</td>
<td>• Provide access to safe abortion where legal</td>
</tr>
<tr>
<td></td>
<td>• Lack of access to safe abortion services</td>
<td>• Enable access to post-abortion care, including contraception services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Improve family and community support for access</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Educate about danger signs of unsafe abortion that require trained health assistance</td>
</tr>
<tr>
<td><strong>Increased use of skilled antenatal, childbirth and postpartum care</strong></td>
<td>• Lack of knowledge about when and where to seek care</td>
<td>• Increasing awareness of the need for skilled care</td>
</tr>
<tr>
<td></td>
<td>• Lack of access to skilled and sensitive care</td>
<td>• Tailor the provision of care to adolescents</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Identify and eliminate barriers to care</td>
</tr>
</tbody>
</table>

### Country Case Study: Ensuring a multi-sectoral approach to the Zero grossesse à l’école campaign in Côte d’Ivoire

The Zero grossesse à l’école campaign (Zero Pregnancy at School) was launched in Côte d’Ivoire by the Ministry of National and Technical Education in 2014. It aimed to reduce pregnancies in school by developing a multi-sectoral response, working in partnership with ministries in charge of youth, women and health and NGOs such as the Association Ivoirienne pour le Bien-Etre Familial (AIBEF) and the Agence Ivoirienne de Marketing Social (AIMAS).

The campaign includes six strategies. First, it aims to build an enabling environment by mobilizing partner organisations at central and local levels and involving parents and unions. Secondly, it aims to improve students’ knowledge about SRH and promote behavioural changes by integrating CSE into the national curriculum and encouraging school activities, including peer education on related topics. The third objective of the campaign involves using arts, culture and sport in order to promote SRH in schools, for example through the National School-based Arts and Cultures Festival supported by UNFPA in 2013. The campaign also uses ICT to promote SRHS to young people through a multimedia campaign, a free phone line and a website connected to social networks with a forum dedicated to young people. More than 16,320 calls to the phone line have been registered and 12,000 internet users shared their experiences and their opinion on teenage pregnancy online. The campaign also aims to advocate at local and national levels to reinforce the availability of SRHS in schools and to reduce girls’ vulnerability in school. Finally, the campaign also includes some ‘leçons de vie’ (life lessons) that are promoted during international days and address specific themes, such as STIs and HIV; GBV and child marriage; early and unintended pregnancy; parent-child communication on SRH; contraception and SRHR.

After one year, the Zero grossesse à l’école campaign had demonstrated a significant 20.5 per cent reduction in the cases of teenage pregnancy.

Monitoring and evaluation

Recommendation: Monitor and evaluate relevant policies and actions in order to investigate their effectiveness, to improve their efficacy and to scale them up when successful.

Systematically collecting data on programmes and policies will help decision-makers and implementers to improve processes and outcomes. A lack of monitoring and evaluation of re-entry policies and actions – including the integration of pregnancy-related content in CSE curricula; the establishment of linkages between schools and SRHS (whether through referrals or school-based health services); data on pregnant and parenting adolescents and their educational outcomes; and monitoring data in relation to ensuring a safe, supportive and gender-equitable environment at school – jeopardizes the implementation and sustainability of these policies and actions.

Strengthening monitoring and reporting systems to accurately capture this data promotes learning and accountability and informs future decision-making and programmes. Monitoring can also establish key benchmarks by which to evaluate progress and results. An objective assessment will help stakeholders to determine the validity, efficacy and sustainability of a given policy and programme.

MoEs, in collaboration with other key stakeholders, should aim to strengthen monitoring and reporting systems in order to accurately record data and evaluate the priority actions described in this guidance document. This is critical to strengthening accountability mechanisms and ensuring that policies and actions are successfully implemented, to achieve the goal of preventing EUP and ensuring that pregnant and child-bearing mothers are able to exercise their right to education (UNESCO, 2014a).

Figure 5 illustrates examples of the type of information that MoEs should record to track re-entry policies and priority actions, to be adapted as appropriate, based on available resources and context-specific issues.

**Figure 5: Examples of monitoring and evaluation data to strengthen responses to EUP**

<table>
<thead>
<tr>
<th>Monitoring and evaluating re-entry policies</th>
<th>Monitoring and evaluating pregnancy content in CSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>· Cases of pregnancy</td>
<td>· Pregnancy prevention content in curricula</td>
</tr>
<tr>
<td>· Drop-outs among pregnant and parenting girls</td>
<td>· Change in knowledge, attitudes, behaviour</td>
</tr>
<tr>
<td>· Returns to school after delivery</td>
<td>· Challenges in teaching and learning pregnancy related content in curricula</td>
</tr>
<tr>
<td>· Academic performance of pregnant and parenting mothers (re-entering/not)</td>
<td>· Academic performance (changes due to CSE content)</td>
</tr>
<tr>
<td>· Acknowledgement of the re-entry policy by school staff</td>
<td></td>
</tr>
<tr>
<td>· Number of schools implementing the policy</td>
<td></td>
</tr>
<tr>
<td>· Perceptions of the re-entry policy (by girls, school staff, parents, etc.)</td>
<td></td>
</tr>
<tr>
<td>· Challenges in implementation and context-specific solutions (included at school level)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Monitoring and evaluating linkages between school and SRHS</th>
<th>Monitoring and evaluating supportive environment in schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>· Availability of referral system or SHS at school level</td>
<td>· Changes in perceptions about adolescent pregnancy</td>
</tr>
<tr>
<td>Evidence review and recommendations</td>
<td>Early and unintended pregnancy &amp; the education sector</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>• Use of SHS or referral system (cases referred) for pregnancy related issues</td>
<td>• Effectiveness of training for boys on equitable gender norms and SRH</td>
</tr>
<tr>
<td>• Access to SHS or referred out-of-school SRHS for pregnancy related issues</td>
<td>• Changes in the level of support for pregnant and parenting girls</td>
</tr>
<tr>
<td>• Perception of SHS and/or referral system by students and school staff</td>
<td>• Increased reporting and reduced levels of stigma and discrimination episodes (including SRGBV)</td>
</tr>
<tr>
<td></td>
<td>• CSE content on gender equality taught and tested</td>
</tr>
</tbody>
</table>
Conclusion

Based on the evidence 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 to education for pregnant and parenting girls. EUP prevention is one piece of a bigger puzzle of rights-based, quality education, and the connections between girls’ access to school, CSE, child marriage, health services, SRGBV and a safe, supportive environment at school, which require the effective response of the education sector, in collaboration with other actors.

With great strides being made in improving access and retention for girls in education, one piece of the puzzle is already being addressed. To contribute more effectively to the prevention and management of learner pregnancy, greater focus should be placed on the implementation of policies that ensure that pregnancy does not spell the end of a girls’ education, and that curriculum content, particularly CSE is strengthened. Without access to appropriate services, including SRH and contraceptive services, either through school or outside, pregnancy prevention efforts will not be realized.

In addition, promoting a supportive environment that fosters gender equality is key to avoiding violence and stigma and discrimination towards pregnant and parenting girls, which may jeopardize their willingness to continue education, thereby negatively impacting their future prospects.
Appendices

Appendix 1: Detailed methodology for the evidence ranking

The literature review was conducted using the following sources of information:

3. Search details for searches for ERIC; POPLINE; Medline:
   - Medline: ‘adolescent pregnancy’; 2015; 2014; 2013; reviewed 300 out of 4,975 i.e. the most recent.
   - Key websites: Advocates for Youth, Family Planning High Impact Practices ICRW, WHO, Population Council; SEICUS; PAHO; UNESCO; UN Women; UNGEI; STEP-UP.

The review did not aim to be systematic. The ranking used to evaluate the evidence for UNESCO’s global guidance for education sector responses to EUP draws on the Gray Scale (Gray, 1997; Gray 2009) to rank the evidence. Sir John Muir Gray was the founder of the Cochrane Collaboration (http://www.cochrane.org), which promotes evidence-informed health decision-making by producing high-quality, relevant, accessible systematic reviews and other synthesized research evidence. The strength of evidence has been categorized using a modification of the five levels identified by Gray (Gray, 1997), shown in Table 1. This rating scheme, labelled the ‘Gray Scale’, was originally identified for use in developing the Cochrane Collection of Systematic Reviews of evidence-based medicine (http://www.cochrane.org/about-us/evidence-based-health-care) and was expanded in a 2009 edition to include evidence-based health care (e.g. public health programming).

<table>
<thead>
<tr>
<th>Type</th>
<th>Strength of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Strong evidence from at least one systematic review of multiple well-designed, randomized controlled trials.</td>
</tr>
<tr>
<td>II</td>
<td>Strong evidence from at least one properly designed, randomized controlled trial of appropriate size.</td>
</tr>
<tr>
<td>IIIa</td>
<td>Evidence from well-designed trials/studies without randomization that include a control group (e.g. quasi-experimental, matched case-control studies, pre-post with control group).</td>
</tr>
<tr>
<td>IIIb</td>
<td>Evidence from well-designed trials/studies without randomization that do not include a control group (e.g. single group pre-post, cohort, time series/interrupted time series).</td>
</tr>
<tr>
<td>IV</td>
<td>Evidence from well-designed, non-experimental studies from more than one centre or research group.</td>
</tr>
<tr>
<td>V</td>
<td>Opinions of respected authorities, based on clinical evidence, descriptive studies or reports of expert committees.</td>
</tr>
</tbody>
</table>

Note: Gray includes five types of evidence (Gray, 1997). The Gray levels were adopted in Gay et al., 2012 following an expert methodological review that led to modification of Gray III. Level III has been subdivided to differentiate between studies and evaluations whose design includes control groups (IIIa) and those that do not (IIIb). Qualitative studies can fall in both levels IV and V, depending on a number of factors, including study size.
Ratings issued under EPPI-Centre methods for conducting systematic reviews (EPPI Centre, 2010) have been modified to match a Gray rating as closely as possible.

**Identifying Strong vs. Promising Evidence:** Two other dimensions of the methodology are the depth of evidence (how many studies support the intervention), and the breadth of evidence (how many countries contribute evidence to support the intervention).

The evidence has been divided into three categories, based on an expert methodological review of Gay et al., 2012

1. **Strong evidence:** Gray I, II or IIIa studies for at least two countries and/or five Gray IIIb, IV or V studies across more than one country.
2. **Promising:** Gray I, II or IIIa studies but in only one setting or at least two studies rated Gray IIIb, IV or V in only one country or region.
3. **Limited and more needed:** Insufficient number or studies or quality of studies to make a recommendation; more research, implementation science or operations research is needed.

The table used to generate the recommendations lists the country where the study was conducted. An overwhelming majority of the studies took place in the US, Europe and Australia. While further studies are needed from LMICs, the evidence that already exists for many of the recommendations should provide evidence for action by governments globally.
## Appendix 2: Results from Evidence Ranking for Recommendations

<table>
<thead>
<tr>
<th>Topic, Reference</th>
<th>Sample Size (n or type of study)</th>
<th>Outcomes</th>
<th>Gray Scale</th>
<th>Countries/Regions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access to quality education for all girls</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Recommendation 1:</strong> Ensure universal access to quality education as a key strategy to prevent child marriage and promote gender equality</td>
<td></td>
<td>Evidence: Strong</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lee-Rife et al., 2012</td>
<td>Review of 23 child marriage prevention programmes</td>
<td>'The evidence is strong that girls with low levels of schooling are more likely to be married early, and child marriage typically puts an end to a girl’s education’ (p. 288)</td>
<td>Illa</td>
<td>Global</td>
</tr>
<tr>
<td>Duflo et al., 2006</td>
<td>n.a</td>
<td>Girls in schools where teachers received HIV training and girls received free uniforms were less likely to be married than girls in control schools</td>
<td>Illa</td>
<td>Kenya</td>
</tr>
<tr>
<td>Selim et al., 2013</td>
<td>N = 2,119</td>
<td>A programme for out-of-school girls to increase their educational skills resulted in re-entry to school for 70% of girls, and the belief among the community that girls should marry after age 18</td>
<td>Illa</td>
<td>Egypt</td>
</tr>
<tr>
<td>Warner et al., 2014</td>
<td>N = 3,321 girls plus 1,775 boys plus 5,000 parents of girls and boys</td>
<td>A programme for out-of-school girls to increase their educational skills resulted in the belief that girls should marry after age 18</td>
<td>Illa</td>
<td>Egypt</td>
</tr>
<tr>
<td>Brady et al., 2007; Selim et al., 2013</td>
<td>N = 3,321 girls; 1,775 boys</td>
<td>Increasing literacy skills of 12–15-year-old out-of-school girls was correlated with wanting to be married after age 18; 69% of girls re-entered school on completing the programme</td>
<td>IIib</td>
<td>Egypt</td>
</tr>
<tr>
<td>Walker, 2015</td>
<td>N = 3,600</td>
<td>Targeting at-risk girls to improve educational scores led to a commitment of girls to stay in school, as opposed to marrying early</td>
<td>IIib</td>
<td>Nigeria</td>
</tr>
<tr>
<td>USAID, 2008</td>
<td>N = 800 students and 400 teachers</td>
<td>In Malawi, at baseline, 70% of girls disagreed with the statement that it was OK for a teacher to get a girl pregnant as long as he married her;</td>
<td>IIib</td>
<td>Malawi and Ghana</td>
</tr>
</tbody>
</table>
Evidence review and recommendations

**Early and unintended pregnancy & the education sector**

<table>
<thead>
<tr>
<th>Topic, Reference</th>
<th>Sample Size (n = or type of study)</th>
<th>Outcomes</th>
<th>Gray Scale</th>
<th>Countries/Regions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skider et al., 2014</td>
<td>Expert review of global data</td>
<td>Educated women are more likely to delay marriage and first births</td>
<td>IIla</td>
<td>LMIC</td>
</tr>
<tr>
<td>Neal et al., 2015</td>
<td>DHS data sets, disaggregated by age</td>
<td>Higher levels of education and literacy skills were associated with increased odds of not giving birth during adolescence</td>
<td>IIla</td>
<td>Uganda, Kenya, Tanzania</td>
</tr>
<tr>
<td>McQueston et al., 2012</td>
<td>Review of programmes</td>
<td>‘Interventions that encouraged school attendance proved more effective in reducing overall adolescent fertility’ (p.2)</td>
<td>V</td>
<td>LMIC</td>
</tr>
<tr>
<td>Lloyd and Mensch, 2006</td>
<td>Global reviews, SSA and Malawi</td>
<td>Girls who stayed in school were less likely to become pregnant and marry early</td>
<td>IIIb, V</td>
<td>Global</td>
</tr>
<tr>
<td>Stoebenau et al., 2015</td>
<td>N = 800</td>
<td>Starting school at a later age was associated with EUP and child marriage</td>
<td>IIIa</td>
<td>Sub-Saharan Africa</td>
</tr>
<tr>
<td>Grant and Hallman, 2006</td>
<td>n.a.</td>
<td>Prior poor school performance, as measured by grade repetition, was strongly associated with EUP</td>
<td>IIIa</td>
<td>South Africa</td>
</tr>
<tr>
<td>Almeida et al., 2011</td>
<td>N = 4,364</td>
<td>Girls who became pregnant at least once during adolescence were less likely to complete basic education</td>
<td>IIIb</td>
<td>Brazil</td>
</tr>
<tr>
<td>Almeida et al., 2009</td>
<td>N = 3,050</td>
<td>Level of education was correlated with EUP both among mothers and their subsequent daughters; i.e. the</td>
<td>IIIb</td>
<td>Brazil</td>
</tr>
</tbody>
</table>

*Evidence: Strong*

**Recommendation 2:** Start education, particularly for girls, as early as possible as it is a key intervention for reducing early and unintended pregnancies and child marriage.

- Girls with secondary schooling were 70% less likely to marry than illiterate girls (IV, India).
- Increased access to education is correlated with reduced levels of child marriage (V, West Africa).

**Evidence: Strong**
## Evidence review and recommendations

### Early and unintended pregnancy & the education sector

The impact of early and unintended pregnancy (EUP) and education is intergenerational.

### Re-entry and continuation policies for pregnant and parenting learners

**Recommendation 3:** Develop, implement and monitor policies allowing pregnant and parenting girls to continue education.

**Evidence: Strong**

<table>
<thead>
<tr>
<th>Topic, Reference</th>
<th>Sample Size (n = or type of study)</th>
<th>Outcomes</th>
<th>Gray Scale</th>
<th>Countries/Regions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steinka-Fry et al., 2013</td>
<td>Meta-analysis from 15 studies, including randomized controlled trials (RCTs)</td>
<td>Drop-out prevention programmes reduced school drop out and increased school enrollment rates among adolescent mothers</td>
<td>I</td>
<td>US but also seems to be global</td>
</tr>
<tr>
<td>Ranchhod et al., 2011</td>
<td>N = 4,800</td>
<td>In South Africa, which by law prohibits schools from dismissing female students due to pregnancy or childbirth and provides childcare grants to facilitate schooling, adolescent girls who experienced pregnancy have graduated high school at the same rates by the age of 22; ‘this suggests a catch-up effect, whereby girls’ education is delayed in the immediate aftermath of childbirth but is often resumed at a later point’ (p. 15)</td>
<td>II</td>
<td>South Africa</td>
</tr>
<tr>
<td>Miller, 2012</td>
<td>N = 10 young women, 6 family members, and 9 members of the school community</td>
<td>Alternative schools with child care, emotional and academic support resulted in excellent academic long-term outcomes</td>
<td>IIIb</td>
<td>New Zealand</td>
</tr>
<tr>
<td>Munthali, 2012</td>
<td>Review of policies</td>
<td>Changes in policies allowed adolescent mothers to attend evening classes and regular school classes</td>
<td>IV</td>
<td>Mozambique, Zambia</td>
</tr>
<tr>
<td>Brosh et al., 2007</td>
<td>54 pregnant and parenting adolescents</td>
<td>Adolescents stated that childcare is critical to continuing their education and while currently they depended on family members, they wanted formal childcare support to continue their education</td>
<td>V</td>
<td>US</td>
</tr>
<tr>
<td>Reference</td>
<td>Method</td>
<td>Description</td>
<td>Quality</td>
<td>Country</td>
</tr>
<tr>
<td>-----------</td>
<td>--------</td>
<td>-------------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>Mayzel et al., 2010</td>
<td>N = 63</td>
<td>Clubs for adolescent mothers to support them to return to school, plus encouragement to their husband to use contraception</td>
<td>V</td>
<td>Malawi</td>
</tr>
<tr>
<td>Munthali, 2012</td>
<td>Review of policies in six countries</td>
<td>In order to avert EUP and prevent repeat pregnancies, resources are needed in addition to policies; awareness campaigns for teachers and communities; alternatives via evening classes; childcare; monitoring and evaluation with compliance data should be collected</td>
<td>V</td>
<td>Malawi, Mozambique, Namibia, Swaziland, Zambia, Zimbabwe</td>
</tr>
<tr>
<td>Bhana et al., 2010</td>
<td>79 teachers</td>
<td>Teachers had very negative attitudes towards pregnant and parenting girls, seeing it as a moral failing</td>
<td>IV</td>
<td>South Africa</td>
</tr>
<tr>
<td>Onyeka et al., 2011</td>
<td>Expert opinion</td>
<td>Official policies for re-entry are needed to stop girls dropping out and increase attendance</td>
<td>V</td>
<td>South Africa</td>
</tr>
<tr>
<td>Stoebenau et al., 2015</td>
<td>N = 248</td>
<td>81% of 248 girls who had dropped out stated that they wanted to continue school if given the opportunity</td>
<td>IIIa</td>
<td>Uganda</td>
</tr>
<tr>
<td>De Rosa et al., 2012.</td>
<td>29,823 students</td>
<td>Training for school staff to comply with policy to have condoms available to students</td>
<td>IIIa</td>
<td>US</td>
</tr>
<tr>
<td>FAWE/OSISA, 2012</td>
<td></td>
<td>Pregnant girls were expelled from school and not readmitted, both in countries where national policies allowing re-entry were in place and universally in countries where no policy for re-entry existed</td>
<td>IIIb</td>
<td>Zambia</td>
</tr>
<tr>
<td>Improve Group and Thammasat University, 2014</td>
<td></td>
<td>Without a policy in place, 49.3% of pregnant girls were suspended or expelled from school for being pregnant</td>
<td>IIIb</td>
<td>Thailand</td>
</tr>
<tr>
<td>Ngabaza and Shefer, 2013</td>
<td>N = 15</td>
<td>Despite a national policy in place allowing pregnant and parenting adolescents to re-enter school, girls are still excluded from school and are made to suffer for being pregnant due to lack of implementation of policies</td>
<td>V</td>
<td>South Africa</td>
</tr>
<tr>
<td>Liwewe, 2012</td>
<td></td>
<td>Despite a national policy, there was no budget for implementation. Schools did not have a copy of the policy and few teachers and students knew the policy; lack of childcare was also an obstacle; an estimated 1,852 adolescent mothers dropped out of school in 2011</td>
<td>V</td>
<td>Malawi</td>
</tr>
<tr>
<td>Evidence review and recommendations</td>
<td>Early and unintended pregnancy &amp; the education sector</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------</td>
<td>----------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Recommendation 4:</strong> Deliver curriculum-based comprehensive sexuality education (CSE) in schools prior to and after puberty to prevent early and unintended pregnancies</td>
<td><strong>Evidence: Strong</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Topic, Reference</th>
<th>Sample Size (n = or type of study)</th>
<th>Outcomes</th>
<th>Gray Scale</th>
<th>Countries/Regions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chandra-Mouli et al., 2013; WHO, 2011</td>
<td>Two systematic reviews</td>
<td>CSE prevents EUP</td>
<td>I</td>
<td>LMIC</td>
</tr>
<tr>
<td>Goestling et al., 2015</td>
<td>35 studies, some were RCT</td>
<td>CSE reduces EUP</td>
<td>I</td>
<td>US</td>
</tr>
<tr>
<td>Oringanje et al., 2009</td>
<td>N = 95,662 with 41 RCTs</td>
<td>CSE reduces unintended pregnancy</td>
<td>I</td>
<td>US, Europe, Nigeria, Mexico</td>
</tr>
<tr>
<td>Kirby et al., 2005; Kirby et al., 2006; Kirby, 2007</td>
<td>83 studies</td>
<td>Of 13 studies, three reduced pregnancy rates, nine had insignificant effects, one in US found significant negative effect. Studies also reported that CSE had impacts on contraceptive use: of the 15 studies measuring impact, six showed increased contraceptive use, eight showed no impact, and one (in US) showed decreased contraceptive use</td>
<td>I</td>
<td>Global</td>
</tr>
<tr>
<td>Fonner et al., 2014</td>
<td>N = 33 studies</td>
<td>CSE significantly increased self-efficacy in refusing sex and using condoms</td>
<td>I</td>
<td>LMICS in Africa, Asia,</td>
</tr>
<tr>
<td>Study</td>
<td>Intervention Description</td>
<td>Evidence Strength</td>
<td>Country</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td>-------------------</td>
<td>---------</td>
<td></td>
</tr>
<tr>
<td>Coalition for Evidence-based Policy, 2015</td>
<td>RCT with 1,163 adolescents aged 13–15 at high risk who were not parenting or pregnant with 7-year follow up</td>
<td>Daily academic assistance, along with CSE one to two times per week with a trained RH counsellor, resulted in girls 40% less likely to have ever been pregnant; 50% less likely to have ever given birth, 30% more likely to have graduated from high school; 37% more likely to be enrolled in college</td>
<td>II</td>
<td>Latin America</td>
</tr>
<tr>
<td>Coalition for Evidence-based Policy, 2015</td>
<td>N = 1,000</td>
<td>Seven years later, those who had CSE had a 40% less likelihood of EUP</td>
<td>II</td>
<td>US</td>
</tr>
<tr>
<td>Lonczak et al., 2002</td>
<td>N = 144 intervention; N = 205 control, long-term follow up</td>
<td>Programs including training for academic success, CSE, negotiation skills, communication and decision-making skills resulted in a significantly reduced likelihood of becoming pregnant and experiencing birth by age 21</td>
<td>IIIa</td>
<td>US</td>
</tr>
<tr>
<td>Kohler et al., 2008</td>
<td>N = 1,719</td>
<td>Adolescents who received CSE were significantly less likely to report teen pregnancy than those who received no formal CSE; abstinence-only education had no impact on adolescent pregnancy</td>
<td>IIIa</td>
<td>US</td>
</tr>
<tr>
<td>Rosenthal et al., 2009</td>
<td>N=350</td>
<td>CSE, alternative education, academic support for high-risk youth resulted in only one adolescent pregnancy, for a rate of 40 per 1,000 adolescent pregnancies, compared to similar populations, which would have a pre-high school graduation birth rate of 94.10 per 1,000 girls</td>
<td>IIIa</td>
<td>US</td>
</tr>
<tr>
<td>Apter, 2011</td>
<td>National data for all of Finland</td>
<td>Compulsory CSE was associated with delayed initiation of sex and decreased rates of births among adolescents</td>
<td>IIib</td>
<td>Finland</td>
</tr>
<tr>
<td>WHO, 2009</td>
<td></td>
<td>‘School based SRH education is one of the most important ways to help adolescents ...improve their reproductive health’</td>
<td>V</td>
<td>Mozambique</td>
</tr>
<tr>
<td>Hardee et al., 2014</td>
<td></td>
<td>CSE took place after pregnancy occurred</td>
<td>I</td>
<td>LMIC</td>
</tr>
<tr>
<td>Ochiogu et al., 2011</td>
<td></td>
<td>CSE took place after pregnancy occurred</td>
<td>IIIb</td>
<td>Nigeria</td>
</tr>
</tbody>
</table>

**Recommendation 5:** Introduce interventions to Evidence: Strong
### Evidence review and recommendations

#### Early and unintended pregnancy & the education sector

Promote gender equality, address gender norms, roles and relationships, and engage men and boys to critically assess gender norms and normative behaviours in schools

<table>
<thead>
<tr>
<th>Topic, Reference</th>
<th>Sample Size (n = or type of study)</th>
<th>Outcomes</th>
<th>Gray Scale</th>
<th>Countries/Regions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Haberland, 2015</strong></td>
<td>A review of 22 studies, included 15 RCTs</td>
<td>The ten CSE programmes that promoted gender equality were five times as effective in decreasing EUP, childbearing and STIs as those CSE programmes that did not address gender equality</td>
<td>I</td>
<td>US, LMIC and two other HiCs</td>
</tr>
<tr>
<td><strong>Trivedi et al., 2009</strong></td>
<td>N = 14,992, out-of-school boys</td>
<td>CSE to increase awareness of boys’ role in pregnancy prevention resulted in higher condom use and resulted in higher use of contraception by their female partner at last sex; attitude toward contraception as a shared responsibility increased</td>
<td>IIIb</td>
<td>US</td>
</tr>
<tr>
<td><strong>UNESCO, 2014</strong></td>
<td></td>
<td>Gender equality is critical for the education sector</td>
<td>V</td>
<td>Global</td>
</tr>
<tr>
<td><strong>Chingona and Chetty, 2007</strong></td>
<td></td>
<td>Only 50% of boys were empathetic towards teen mothers vs. 80% of girls</td>
<td>V</td>
<td>South Africa</td>
</tr>
</tbody>
</table>

#### Recommendation 6: Build skills to delay sexual debut and increase correct and consistent use of both condoms and other contraceptive methods as a critical component of CSE

*Evidence: Strong*

<table>
<thead>
<tr>
<th>Topic, Reference</th>
<th>Sample Size (n = or type of study)</th>
<th>Outcomes</th>
<th>Gray Scale</th>
<th>Countries/Regions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Johnson et al., 2011</strong></td>
<td>N = 51,240</td>
<td>A review of 98 CSE interventions found increased condom use relative to controls</td>
<td>I</td>
<td>US, Africa</td>
</tr>
<tr>
<td>Source</td>
<td>Study Information</td>
<td>Evidence</td>
<td>Countries</td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>-------------------</td>
<td>----------</td>
<td>------------</td>
<td></td>
</tr>
<tr>
<td>Michielsen et al., 2010</td>
<td>28 studies including 11 randomized studies</td>
<td>CSE resulted in higher intention to use a condom, a validated predictor of condom use</td>
<td>I</td>
<td>SSA</td>
</tr>
<tr>
<td>UNESCO, 2009</td>
<td>83 studies</td>
<td>42 studies found that CSE delayed sex; 22 had no impact and one hastened initiation of sex</td>
<td>I</td>
<td>Global</td>
</tr>
<tr>
<td>UNESCO, 2009</td>
<td>87 studies</td>
<td>Of 15 studies, CSE led to increased contraceptive use; 8 showed no impact; one in US showed decreased contraceptive use</td>
<td>I</td>
<td>Global</td>
</tr>
<tr>
<td>Unterhalter et al., 2014</td>
<td>Systematic review</td>
<td>‘Teaching about personal, social and health issues linked with sex education, both at school and in complementary programs, may have a positive impact on participation’ (p. 5) and builds confidence (p. 6)</td>
<td>I</td>
<td>Global</td>
</tr>
<tr>
<td>Advocates for Youth, 2012</td>
<td>Systematic review</td>
<td>CSE prevents EUP; 16 programmes demonstrated a statistically significant delay in timing of first sex, one of these programmes started in elementary school; 16 programmes helped sexually active youth to increase condom use; and 9 programmes increased use of contraception other than condoms; 14 programmes were in school settings</td>
<td>I</td>
<td>US</td>
</tr>
<tr>
<td>Ross et al., 2007</td>
<td>N = 9,645 in control and intervention</td>
<td>Condom use was higher in intervention group that received CSE</td>
<td>II</td>
<td>Tanzania</td>
</tr>
<tr>
<td>Lavin and Cox, 2012</td>
<td>13 studies including RCTs</td>
<td>Increased condom use with CSE in schools</td>
<td>II</td>
<td>US</td>
</tr>
<tr>
<td>Chen et al., 2010</td>
<td>N = 1,360 in control and intervention</td>
<td>1.49 higher condom use in intervention group</td>
<td>II</td>
<td>Bahamas</td>
</tr>
<tr>
<td>Maticka-Tyndale et al., 2010</td>
<td>N = 6874 in intervention and 6,287 in control from 18,500 primary schools</td>
<td>Delay in sexual initiation and higher condom use when surveyed in secondary school</td>
<td>IIIa</td>
<td>Kenya</td>
</tr>
<tr>
<td>Speizer et al., 2003</td>
<td></td>
<td>CSE resulted in increased contraceptive use among sexually active youth</td>
<td>IIIb</td>
<td>Mexico</td>
</tr>
<tr>
<td>Trivedi et al., 2009</td>
<td>N = 130 high-risk boys</td>
<td>CSE resulted in no pregnancies at follow up after 5 years</td>
<td>IIIb</td>
<td>US</td>
</tr>
<tr>
<td>Kan et al., 2012</td>
<td>N = 1,038 pregnant or parenting adolescents</td>
<td>Enhanced CSE, additional teaching support for education plus childcare, increased using long-acting reversible contraception (LARC) and was associated with</td>
<td>II</td>
<td>US</td>
</tr>
</tbody>
</table>
### Evidence review and recommendations

#### Early and unintended pregnancy & the education sector

<table>
<thead>
<tr>
<th>Topic, Reference</th>
<th>Sample Size (n = or type of study)</th>
<th>Outcomes</th>
<th>Gray Scale</th>
<th>Countries/ Regions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zaw et al., 2012</td>
<td>N = 444</td>
<td>Out-of-school adolescents had low rates of access to CSE</td>
<td>IIIa</td>
<td>Myanmar</td>
</tr>
<tr>
<td>UNICEF, 2011b</td>
<td>Global</td>
<td>Women with little education are more likely to have married as children, even in countries where the prevalence of child marriage is low</td>
<td>IIIb</td>
<td>Global</td>
</tr>
<tr>
<td>Hardee et al., 2014</td>
<td></td>
<td>No effective CSE programmes were found that only reached out-of-school adolescents</td>
<td>V</td>
<td>LMIC</td>
</tr>
<tr>
<td>School health services and links to external health services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Recommendation 7: Develop programmes to provide CSE for out-of-school adolescents in order to prevent EUP

*Evidence: Limited*

---

**Sadler et al., 2007**

- N = 65
- CSE plus on-site childcare resulted in only 6% of adolescent mothers having repeat pregnancies and a graduation rate or continued school enrollment rate of 91%

**McQueston et al., 2012**

- Girls enrollment was 7% higher in countries with liberal abortion laws than in those countries with restrictive abortion laws after controlling for income, Total Fertility Rate, and boys’ school enrollment

**Azarnert, 2015**

- Access to safe abortion services was associated with school enrollment for girls

**Chandra-Mouli et al., 2013**

- WHO expert opinion

- ‘Provide access to safe abortion where legal’; ‘Enable access to PAC’ (p. 519)

**Singh et al., 2014**

- DHS data globally

- Young women aged 15–19 have highest level of unmet need for contraception

---

**Recommendation 8: Develop linkages**

*Evidence: Strong*
### Evidence review and recommendations

**between schools and health services as part of efforts to reduce EUP and support pregnant and parenting adolescents**

<table>
<thead>
<tr>
<th>Topic, Reference</th>
<th>Sample Size (n = or type of study)</th>
<th>Outcomes</th>
<th>Gray Scale</th>
<th>Countries/ Regions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oringanje et al., 2009</td>
<td>41 RCTs</td>
<td>Promoting contraception reduces EUP</td>
<td>I</td>
<td>US, Europe, Nigeria, Mexico</td>
</tr>
<tr>
<td>Corcoran and Pillai, 2007</td>
<td>N = 8,200 including 11 RCTs N = 6,387</td>
<td>A range of services, including education and individual counselling was associated with a statistically significant reduction in pregnancy rates compared with controls at 19.3 months</td>
<td>I</td>
<td>US</td>
</tr>
<tr>
<td>AYA, 2007; Gay et al., 2012; Karim et al., 2009; Williams et al., 2007</td>
<td>N = 3,416 in Ghana; 1,900 in Tanzania; 3,176 in Uganda</td>
<td>Policy changes, CSE in schools, with referral to youth-friendly services resulted in significant increases in the number of adolescent women obtaining condoms, insisting that a partner use a condom, ever use of condoms, use of condom at first sex, use of condoms at last sex and modern use of contraception</td>
<td>IIIa</td>
<td>Ghana, Tanzania and Uganda</td>
</tr>
<tr>
<td>Denno et al., 2015</td>
<td>Systematic review</td>
<td>'The evidence base can be used to set policies and laws that promote a package of interventions, including linkages to other settings (e.g. schools) to promote utilization of services’ (p. S39)</td>
<td>IIIa</td>
<td>Global</td>
</tr>
<tr>
<td>Bhuiya et al., 2006</td>
<td>N = 4230 in experimental; N = 1,367 control</td>
<td>Linking school, community and health services, with teachers informing students of health services, resulted in female adolescents accessing services at 3.7 times higher rate than in the control; female adolescents in experimental group had higher rates of condom use</td>
<td>IIIb</td>
<td>Bangladesh</td>
</tr>
<tr>
<td>Blank et al., 2012</td>
<td>N = 2,978</td>
<td>Close links between clinics and local schools increased the number of new users from 280 in the six months before the intervention to 959 after the intervention; the number of young people who cited a school sex education class as their source of information about the clinic increased 5 fold, but the</td>
<td>IIIb</td>
<td>UK</td>
</tr>
</tbody>
</table>
### Evidence review and recommendations

#### Early and unintended pregnancy & the education sector

**Evidence: Strong**

<table>
<thead>
<tr>
<th>Topic, Reference</th>
<th>Sample Size (n = or type of study)</th>
<th>Outcomes</th>
<th>Gray Scale</th>
<th>Countries/Regions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strunk, 2008</td>
<td>Meta-synthesis</td>
<td>Decrease in repeat pregnancies</td>
<td>I</td>
<td>US, Finland, Australia</td>
</tr>
<tr>
<td>(both cited in Trivedi et al., 2009)</td>
<td>2 systematic reviews</td>
<td>Providing contraception prevents EUP</td>
<td>I</td>
<td></td>
</tr>
<tr>
<td>Blank et al., 2010</td>
<td>4 RCTs plus additional studies</td>
<td>School clinics were effective in reducing EUP and repeat EUP, especially when contraceptive provision was available at schools</td>
<td>I</td>
<td>US</td>
</tr>
<tr>
<td>Improve and Thammasat University, 2014</td>
<td>RCT</td>
<td>With access to school-based contraceptive services, the pregnancy rate in intervention schools declined by 30.1% and increased 57.6% in control schools</td>
<td>II</td>
<td>US</td>
</tr>
<tr>
<td>Ethier et al., 2011</td>
<td>N = 2,603</td>
<td>Girls who went to school with a school-based health centre had increased odds of having received pregnancy prevention care; having used hormonal contraception at last sex and were more likely to have used emergency contraception at last sex</td>
<td>IIIa</td>
<td>US</td>
</tr>
<tr>
<td>Key et al., 2008</td>
<td>Intervention = 63; Comparison, N = 252</td>
<td>With a school-based social worker and comprehensive health services,</td>
<td>IIIa</td>
<td>US</td>
</tr>
</tbody>
</table>

**Recommendation 9:** Encourage and support school health services (SHS) that offer on-site contraception and counselling services as part of efforts to reduce early and unintended pregnancies, and offer antenatal care to support pregnant and parenting adolescents and reduce school dropout.

**Linkage of schools with adolescent-friendly services resulted in significant increase of services and condom use.**

**Evidence: Strong**

**Implication:**

- **Strunk, 2008**: Meta-synthesis
  - Decrease in repeat pregnancies
  - US, Finland, Australia

- **Blank et al., 2010**: 4 RCTs plus additional studies
  - School clinics were effective in reducing EUP and repeat EUP, especially when contraceptive provision was available at schools
  - US

- **Ethier et al., 2011**: N = 2,603
  - Girls who went to school with a school-based health centre had increased odds of having received pregnancy prevention care; having used hormonal contraception at last sex and were more likely to have used emergency contraception at last sex
  - US

- **Key et al., 2008**: Intervention = 63; Comparison, N = 252
  - With a school-based social worker and comprehensive health services,
  - US

*Note: Glinski et al., 2014 - Linkage of schools with adolescent-friendly services resulted in significant increase of services and condom use.*
Evidence review and recommendations

### Early and unintended pregnancy & the education sector

<table>
<thead>
<tr>
<th>Study</th>
<th>Findings</th>
<th>Study Design</th>
<th>Strength of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denny et al., 2012</td>
<td>Subsequent births were 33% more common in the comparison group</td>
<td>N = 2,745 sexually active students</td>
<td>IIIa New Zealand</td>
</tr>
<tr>
<td>Owen et al., 2010</td>
<td>School services are associated with fewer pregnancies among students when the availability of doctor and nursing time exceeds 10 hours per 100 students per week; in schools with more than 10 nursing and doctor hours per week per 100 students, sexually active students had one-third the odds of reporting involvement with pregnancy than sexually active students in schools with no school-based health services</td>
<td>Systematic review</td>
<td>IIIa UK</td>
</tr>
<tr>
<td>Frolich et al., 2014</td>
<td>A pilot project that provided CSE and provided referrals within school settings referred students for clinical services in school, at a mobile in-school clinic or in public sector primary clinics and these referrals increased those counselled and initiated on contraception</td>
<td>N = 8,867</td>
<td>IIIa South Africa</td>
</tr>
<tr>
<td>cited in Strunk, 2008</td>
<td>Prenatal/postnatal school-based clinic programme demonstrated significant decrease in repeat births among participating adolescent mothers</td>
<td>N = 305; case controlled cohort study</td>
<td>IIIa US</td>
</tr>
<tr>
<td>Mavedzenge et al., 2014</td>
<td>Mixed evidence for uptake of services and behaviour change outcomes</td>
<td>Review of systematic reviews, including Blank et al., 2010</td>
<td>IIIa, b, IV and V; mixed results Global</td>
</tr>
<tr>
<td>Ricketts and Guernsey, 2006</td>
<td>Significantly greater decline in births to female adolescents in neighbourhoods with school-based health services than adolescents in neighbourhoods that did not have school-based health services</td>
<td>N = 3,833 high school students</td>
<td>IIIb US</td>
</tr>
<tr>
<td>Griswold et al., 2012</td>
<td>A programme of prenatal care at school for adolescent mothers resulted in a 14.2% increased attendance compared to peers enrolled before the programme started, and a 42% increase in pregnancy and childbirth knowledge</td>
<td>N = 28</td>
<td>IIIb US</td>
</tr>
<tr>
<td>Mason-Jones et al., 2012</td>
<td>School-based health services (not necessarily providing contraception) reduced school drop out</td>
<td></td>
<td>IIIb North America</td>
</tr>
</tbody>
</table>

A safe and
<table>
<thead>
<tr>
<th>Topic, Reference</th>
<th>Sample Size (n = or type of study)</th>
<th>Outcomes</th>
<th>Gray scale</th>
<th>Countries/Regions</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPPI Centre, 2006</td>
<td>15 studies</td>
<td>Pregnant girls experienced stigma</td>
<td>II</td>
<td>UK</td>
</tr>
<tr>
<td>Yardley, 2008</td>
<td>22 studies</td>
<td>Pregnant girls experienced stigma</td>
<td>IV</td>
<td>UK</td>
</tr>
</tbody>
</table>

**Recommendation 10:** Implement interventions to reduce stigma and discrimination against pregnant and parenting girls at school

_Evidence: No evidence_
Bibliography


Evidence review and recommendations
Early and unintended pregnancy & the education sector


UNESCO. (2014b). *Comprehensive Sexuality Education: The challenges and opportunities of scaling up*. Paris, UNESCO.


