

Adolescent pregnancy in Eastern Europe and Central Asia



Although the countries of Eastern Europe and Central Asia are not affected to the same extent as other world regions, adolescent pregnancy is a major challenge in parts of the region, and in particular among some population groups.

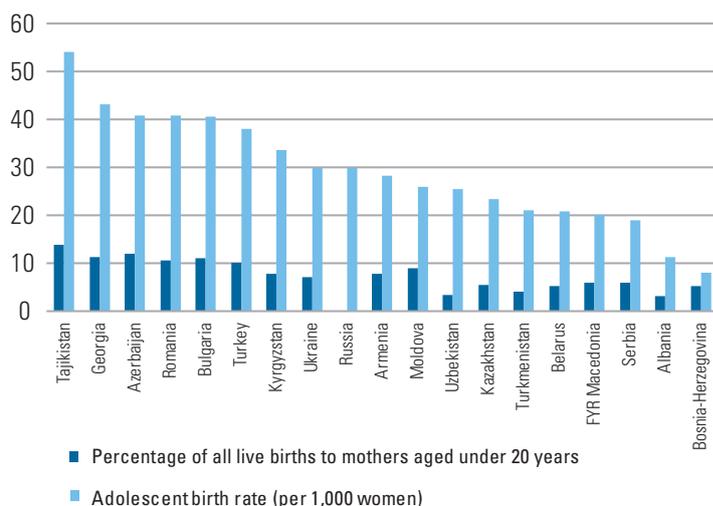
The State of World Population 2013, published by UNFPA, the United Nations Population Fund, highlights the main challenges of adolescent pregnancy and its serious impacts on girls' education, health and long-term employment opportunities. The report also shows what can be done to curb this trend and protect girls' human rights and well-being.

This brief was published as a supplement to the State of the World Population Report, focusing specifically on the situation in Eastern Europe and Central Asia.

The scope of adolescent pregnancy in the region

There are large disparities between and within the countries of Eastern Europe and Central Asia (EECA) in terms of adolescent birth rates.

Figure 1: Adolescent birth rates (by country)



Percentage of all live births to mothers aged <20 and adolescent birth rate, 2009-2011. Source: World Bank (<http://data.worldbank.org/indicator>) and Official MDG's website (<http://mdgs.un.org/unsd/mdg/Data.aspx>).

“When a girl becomes pregnant, her present and future change radically, and rarely for the better. Her education may end, her job prospects evaporate, and her vulnerabilities to poverty, exclusion and dependency multiply.”

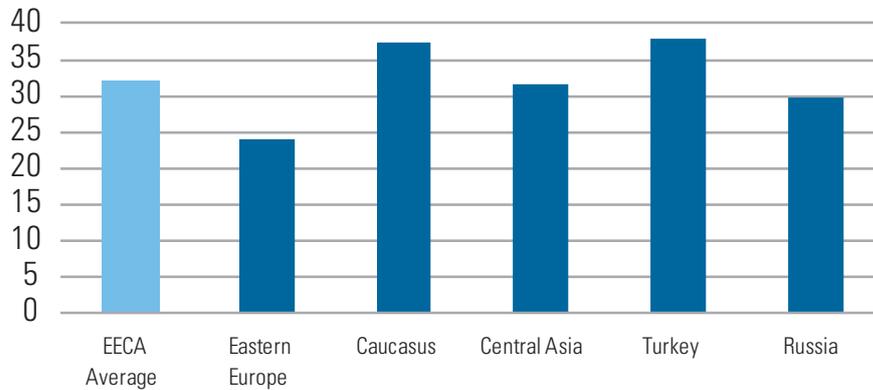
*Babatunde Osotimehin,
UNFPA Executive Director*

“I decided to have a child because I wanted to feel like an adult... Now I have to make it work. For the sake of my son, I need to go back to school and get a proper education. I now know that my destiny is not to change diapers. I want to be a lawyer and change the world. For my son.”

Jipara, 17, Kyrgyzstan

Adolescent birth rates¹ range from 8 in Bosnia and Herzegovina to 54 in Tajikistan. Other countries with high fertility rates among women under the age of 20 include Georgia, Azerbaijan, Romania, Bulgaria and Turkey. The Caucasus is the sub-region with the highest adolescent birth rate (an average of 37.3), while the average for the entire region is 32, significantly higher than the rates found in Western Europe.

Figure 2: Adolescent birth rate (per 1,000 women)

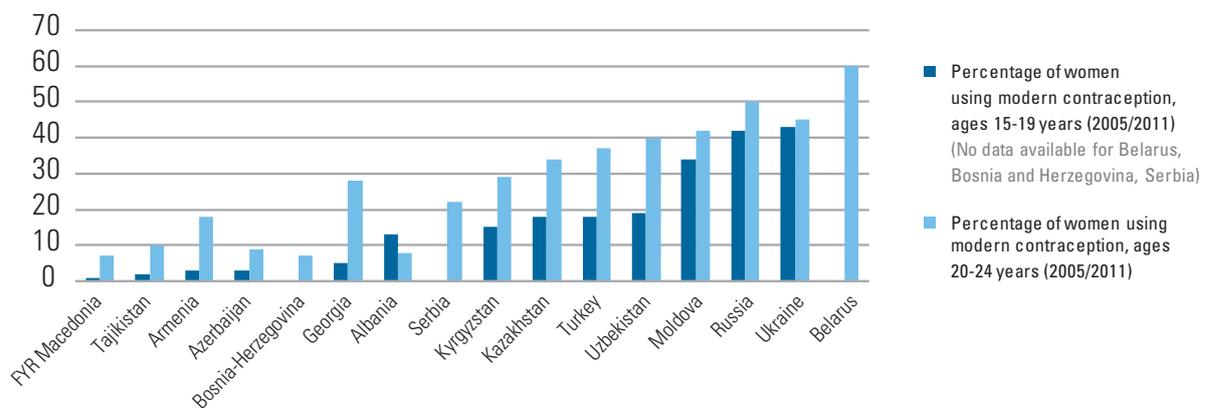


Adolescent birth rates per subregions and for Turkey and Russia, 2006-2011. Source: Official MDG's website.

Data on the number of sexually active young women and girls reporting use of modern contraception is not available for all EECA countries. Data on contraceptive use by girls from the younger age group (15-19) is even less systematically collected. In Eastern Europe (excluding Russia and Turkey), 22% of women age 15–19 years report the use of modern contraception versus 13% for Central Asia and only 3.6% in the Caucasus. While there is evidence that young people tend to have better access to information on contraception than older generations², the overall use of modern contraceptives is very low in the EECA region for both adolescent and adult women.

Teenage abortion rates are often unreliable because it tends to be underreported or unavailable. According to official statistics, abortion rates among women below 20 years of age are significantly higher in Eastern European countries, particularly Moldova and Romania, than in other subregions.

Figure 3: Modern contraceptive use (ages 15-19, 20-24 years)

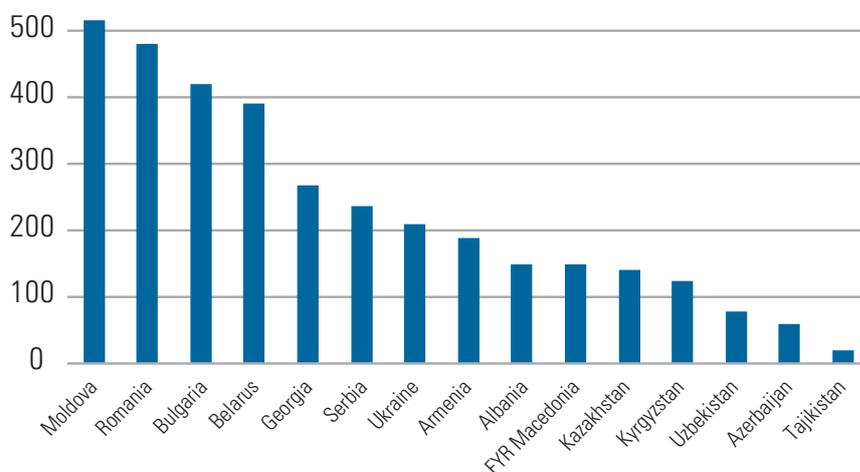


Reported use of modern contraception among women aged 15-19 and 20-24, 2005-2011. Source: Population Reference Bureau, Youth Data Sheet 2013.

¹ The adolescent birth rate measures the annual number of births to women 15 to 19 years of age per 1,000 women in that age group.

² UNFPA, Emerging Population Issues in Eastern Europe and Central Asia. Research Gaps on Demographic Trends, Human Capital and Climate Change. 2010: UNFPA, p. 32.

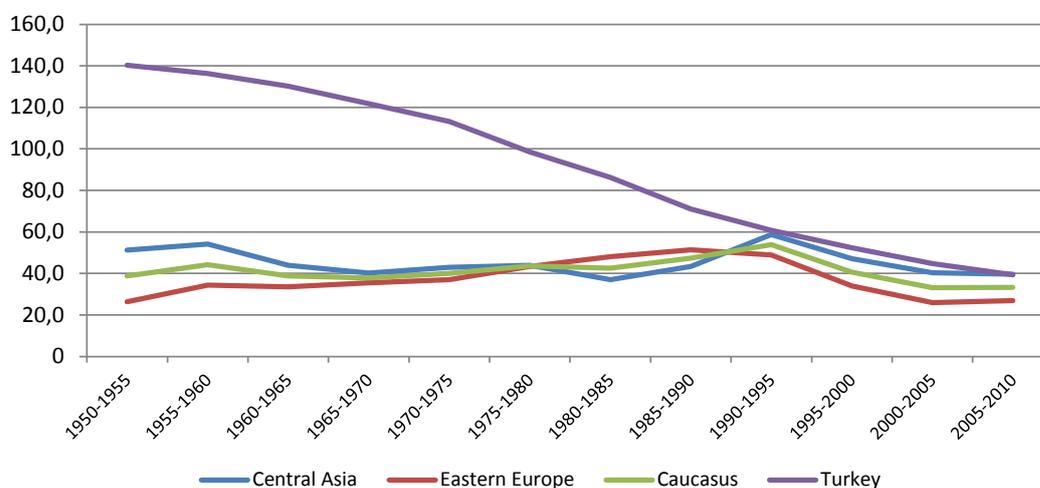
Figure 4: Abortions/1000 live births, women aged under 20 years, 2008-2011



Abortion rate (abortion per 1000 live births) among women below 20 years old, 2006-2011, per country. Source: Official MDG's website, MICS.

Overall, teenage pregnancy has declined since 2000 in Eastern Europe, in the Caucasus and to a lesser extent in Central Asia, with uneven progress across regions and countries.³ While the overall adolescent fertility level in the region was estimated to have remained lower in 2008 than in 2000, in Bulgaria, Romania, Ukraine, Russia and some countries of the Caucasus the trends showed a slight increase in the second half of the decade.⁴

Figure 5: Adolescent birth rates (trends)



Trends in adolescent fertility rate (births per 1,000 women ages 15-19) per sub regions, from 1950 to 2010.

Source: United Nations, Population Division, Department of Economic and Social Affairs, World Population Prospects: The 2012 Revision. Note: the Eastern Europe Region includes Russia and countries which are not in the UNFPA EECA

3 Part, K., Teenage pregnancies in the European Union in the context of legislation and youth sexual and reproductive health services. Acta Obstetrica et Gynecologica Scandinavica, 2013.

4 WHO, Adolescent Pregnancy. Make Pregnancy Safer. October Note, 2008.

Adolescent sub-groups at risk of early or unwanted pregnancy

Adolescent pregnancy in the EECA region affects some population subgroups disproportionately: married adolescents, youth from linguistic, religious and ethnic minorities including Roma youth, adolescents from lower income groups or from rural areas, migrants or internally displaced persons, out-of-school youth, street children, and other vulnerable and marginalized groups.

ADOLESCENT PREGNANCY AMONG ROMA POPULATION

In Eastern Europe, adolescent birth rates are significantly higher among Roma minority groups than the overall population. In Serbia, for example, the adolescent birth rate among the Roma population is 158 (number of adolescent births per 1,000 women 15-19 years), more than six times the national average of 23.9 and higher than the rate in many of the least developed countries.⁵ In Bulgaria, more than 50 percent of Roma adolescent girls gave birth to a child before turning 18⁶, and in Albania the average age of Roma mothers at the birth of their first child was 16.9 years.⁷

The high adolescent birth rates among Roma populations

are linked to the practice of child marriage which remains prevalent in Roma communities. Facing social and economic exclusion from mainstream society and pressures within their communities, Roma girls often have no choice but to follow tradition, leave school and get married with the onset of adolescence, thus perpetuating a cycle of lack of education, poverty and early child birth. Recent data from Bosnia and Herzegovina shows how this cycle can be broken: Roma girls with secondary education were dramatically less likely to have had their first child as an adolescent (only 5.6 percent, compared to 26.9 percent among all Roma women aged 15 to 19).⁸

In addition, adolescents may face various physical, emotional, and socioeconomic challenges that compound their vulnerability. Adolescent girls in such circumstances are at increased risk of pregnancy when they encounter multiple forms of discrimination and when their special needs for reproductive health are not met.

Multiple impacts of pregnancy

Health impacts of pregnancy on adolescent mothers and their children. Adolescent pregnancy is associated with the risk of low birth-weight for newborns, higher pre-natal, neonatal and infant mortality and morbidity, and higher mortality rate for adolescents giving birth. Nearly 30% of maternal deaths are caused by unsafe abortion in some countries of Eastern Europe and Central Asia.⁹ In some countries legal, social and financial barriers to contraceptive use may be increasing abortion rates.¹⁰

Adolescent pregnancy and HIV. Adolescent pregnancy trends in Eastern Europe and Central Asia are to be put in perspective with the growing HIV epidemic affecting young people in the region. Today, Eastern Europe and Central Asia has one of the world's fastest growing HIV epidemics. One third of new HIV infections in the region occur among the 15–24 age group and more than 80% of people living with HIV in the region are under 30 years old. Women, who now account for 40% of new cases compared to just 24% ten years ago, are increasingly affected by HIV. The total number of HIV-positive pregnancies has doubled during the past five years.¹¹

5 See: http://www.childinfo.org/files/MICS4_Serbia_FinalReport_Eng.pdf, p. 14

6 508.8 per 1,000, according to data from 2001. http://www.undp.org/content/dam/undp/documents/projects/SVK/00060975/UNDP_WB%20interim%20report%20II_2011_revised_F.doc, p. 21

7 According to a 2001-2003 study. Referenced in: <http://eeca.unfpa.org/webdav/site/eeca/shared/documents/publications/ALBANIA%20-%20English.pdf>, p.3.

8 See: http://www.childinfo.org/files/MICS4_BiH_RomaSurvey_FinalReport_2011-12_Eng.pdf, p.57.

9 WHO EURO, Facts and figures about abortion in the European Region. Undated.

10 ASTRA, Reclaiming and redefining rights: setting the adolescent and young people SRHR Agenda Beyond ICPD+20. Eastern Europe Region Fact Sheet. 2012

11 UNICEF, Blame and banishment: the underground HIV epidemic affecting children in Eastern Europe and Central Asia. 2010.

Economic costs of adolescent pregnancy. Early childbearing can perpetuate intergenerational poverty. Pregnant adolescents may drop out of school, have limited opportunities to acquire vocational skills, and have reduced economic prospects. Social and economic costs associated with adolescent pregnancies are likely to affect not only the adolescent mother and her child but also the larger community in charge of supporting them.¹²

In addition, the costs associated with abortions and the health consequences of pregnancy for adolescent mothers and newborns exert a high financial pressure on the limited resources of national health systems. In Kazakhstan, for example, substantial financial saving can be realized by reducing the number of abortions. A recent study demonstrated that family planning is a much more cost-efficient intervention than abortion. Assuming that 80% of all abortions could be avoided through more effective delivery of family planning services, cost savings would be enough to finance all immunization programs in Kazakhstan or could be directed to providing better family planning services.¹³

Understanding the determinants of adolescent pregnancy

Many of the interventions to reduce adolescent pregnancies neglect the underlying determinants such as economic, social, legal and other circumstances, structures, systems, norms and rights violations, as well as the role of men and boys.

There is a need for an “ecological” approach to adolescent pregnancy which takes into account the full range of complex drivers of adolescent pregnancy and the interplay of these forces. In the context of the EECA region, these determinants are multilevel and specific to some sub-regions or subgroups more profoundly.

Regulatory environment of sexual and reproductive health services. The national laws, policies, and governmental commitment to enforce human rights standards are factors which can potentially affect adolescent pregnancies. The legal, policy and regulatory environment that underlies girls’ control over her sexuality, as well as her access and use of sexual and reproductive health services can deeply impact adolescent pregnancies. In the EECA region, several countries apply a legal age restriction to accessing SRH services without parental consent. In Belarus, Kazakhstan, the former Yugoslav Republic of Macedonia, Moldova, Tajikistan, Turkey and Uzbekistan, young people either have to be at least 18 years of age or married to access such services without the consent of their parents. The legal age restriction for accessing SRH services in Bulgaria and Russia is respectively 16 and 15 years.¹⁴ Recent evidence shows that reported adolescent pregnancy rates are generally lower for countries where parental consent for abortion is not required, youth SRH services are available in all areas and contraceptives are affordable for the youth, compared to countries where these conditions are not met.¹⁵ In addition the requirement to present a prescription for contraceptives further limits access by youth.

12 World Bank, *Teenage Pregnancy and Opportunities in Latin America and The Caribbean. On Teenage Fertility Decisions, Poverty and Economic Achievement*, 2012: International Bank for Reconstruction and Development.

13 Lule, E., *Fertility Regulation Behaviors and Their Costs Contraception and Unintended Pregnancies in Africa and Eastern Europe & Central Asia*. Health, Nutrition and Population (HNP) Discussion Paper. 2007.

14 UNFPA, *The right to decide: Family Planning in Eastern Europe and Central Asia. Key Messages on Family Planning*. 2012.

15 Part, K., *Teenage pregnancies in the European Union in the context of legislation and youth sexual and reproductive health services*. *Acta Obstetrica et Gynecologica Scandinavica*. 2013.

Inadequate health systems and barriers to access and use sexual and reproductive health services. Young people in the EECA region have limited access to family planning services. Use of modern contraception among sexually active youth is low with heavy reliance on withdrawal and abortion as means of avoiding pregnancy. For example, in Albania 12.9% of currently married young people aged 15-19 use modern contraception while 54.6% of them rely on traditional methods. Lower access to modern contraception significantly increases the risk of adolescent pregnancy.¹⁶ Low levels of information on sexual and reproductive health and family planning, and unaffordable contraception are additional barriers faced by adolescents. Youth friendly services that provide family planning counselling and contraceptives to young people are not institutionalized in most countries of the region. Such services are still heavily reliant on support from the international community and donors.¹⁷ In addition to barriers specific to the young people, adolescents also face the same barriers limiting contraceptive use as the general population such as insufficient political commitment to family planning and reproductive health services more broadly, lack of contraceptive security, misinformation and distrust towards modern methods of contraception, limited choice in the range of modern methods of contraception, costs of contraception, service providers with inadequate knowledge, stigmatising attitudes, limited availability of service providers, restrictive social norms related to sex and sexuality, as well as gender power dynamics.¹⁸

Lack of sexuality education programs. Despite the well documented positive results of sexuality education in Western Europe¹⁹, sexuality education in schools remains poor across the EECA region. Availability, implementation and comprehensiveness of sexuality education programs vary widely between countries. In several countries, the national sexual education curriculum fails to meet the WHO standards.²⁰ When sexuality education is available in schools, it concentrates mostly on biological issues, without addressing social and psychological aspects of sexuality. Sexuality education in non-school settings is mainly supported by civil society organisations.

Declining trends in education and skills among youth. There is evidence that interventions encouraging school attendance are effective in reducing overall adolescent fertility, making a case for expanding educational opportunities for girls and creating incentives to keep girls at schools.²¹ This is to be put in perspective with current education trends in the EECA region where almost 4 million people aged 15 to 24 fail to complete primary school and are in need of basic skills for employment.²² Central Asia is the region with the highest rate of out-of-school children who are expected to never enter school.²³ In Tajikistan, only 50% of girls having completed basic education continue their studies beyond 9th grade.²⁴

Cultural norms, attitudes and beliefs at community, family and individual levels. In the EECA region, the return to old traditions and practices is considered a major factor contributing to the high adolescent pregnancy rates.²⁵ Harmful traditional practices in the region include bride kidnapping and child marriage.

16 UNFPA, The right to decide: Family Planning in Eastern Europe and Central Asia. Key Messages on Family Planning. 2012.

17 ASTRA, Reclaiming and redefining rights: setting the adolescent and young people SRHR Agenda Beyond ICPD+20. Eastern Europe Region Fact Sheet. 2012.

18 UNFPA / IPPF, Key factors influencing contraceptive use in Eastern Europe and Central Asia. Findings from a qualitative study in 7 countries and recommendations for improving access to modern contraception in the region. 2012: IPPF, 32 p.

19 BZgA, W.E., Standards for Sexuality Education in Europe A framework for policy makers, educational and health authorities and specialists. 2010.

20 ASTRA, Reclaiming and redefining rights: setting the adolescent and young people SRHR Agenda Beyond ICPD+20. Eastern Europe Region Fact Sheet. 2012.

21 UNFPA, World Population Report. 2013.

22 UNESCO, Youth and skills: Putting education to work. Education For All Global Monitoring Report, 2012.

23 UNESCO, Out-of-school children: new data reveal persistent challenges. 2011. UIS Fact Sheet(12).

24 United Nations, The Millennium Development Goals Report 2012. 2012: UN, 72 p.

25 UNECE, The UNECE Report on achieving the Millennium Development Goals in Europe and Central Asia. 2012.

Cultural norms, stigma and taboo related to adolescent sexuality are factors limiting access to contraception for youth and thus affecting adolescent pregnancies. In the context of such restrictive social and cultural norms, early marriage and child bearing are often seen by families as protective, as they are often unaware of the increased risk this may bring to the young bride or mother.²⁶

CHILD MARRIAGE

Any marriage before the age of 18 is considered by international human rights standards as child marriage. It is a complex issue driven by a variety of factors such as poverty, social exclusion and cultural values maintaining gender inequalities.

In Eastern Europe, child marriage is particularly high among the Roma. In 2011, 31% of Roma girls in Albania, and 44% of Roma girls in Serbia, respectively in the age groups 13-17 and 15-19, were married or in a union.²⁷

In Central Asia, a return to traditionalism in gender roles and reasserted ethnic and religious identities has led to an increase in child marriage: for example, 12.2% of women in Kyrgyzstan get married before they are 18. More than 90%

of adolescent births in Central Asia occur within marriage.²⁸ Girl brides are usually vulnerable to violence, sexual abuse and health risks related to pregnancies. Once married, girls usually stop their education.²⁹ It is widely documented that girl brides living with their family-in-law in Central Asian countries are victims of abuse and exploitation.

Economics is a major factor driving child marriage, both in terms of perceived financial burden of girls in the family and bride price.³⁰ Recent trends of massive male emigration from Central Asian countries to Russia and the subsequent decrease in the number of men available for marriage, coupled with the strong marital norms, have further encouraged early marriages and polygamy.³¹

Poverty and sexual exploitation. In the EECA region, poverty levels and patterns of gender inequality and gender discrimination can dramatically influence adolescents' vulnerability to pregnancy. Over one million children in the region are estimated to be living or working on the streets and are at increased risk of violence and sexual exploitation.³² Sexual exploitation of women and girls in the EECA region is widespread: 30% of victims of cross-border trafficking in Western and Central Europe are from the Balkans. Among victims of trafficking detected in Eastern Europe and Central Asia between 2007 and 2010, 78% were women and 6% were girls. At the same time, trafficking for sexual exploitation accounts for 62% of all forms of exploitations detected in Europe and Central Asia for the same period.³³ Failure to protect girls from poverty, violence and sexual exploitation increases their risk of unwanted pregnancy.

26 Gitano, F.S., Health and the Roma community: analysis of the situation in Europe. Madrid, FSG, 2009.

27 WHO EURO/UNFPA, Child marriage, in *Entre Nous: the European Magazine for Sexual and reproductive Health* 2012.

28 WHO, Adolescent Pregnancy. Make Pregnancy Safer October Note, 2008. 1(1).

29 WHO EURO/UNFPA, Child marriage, in *Entre Nous: the European Magazine for Sexual and reproductive Health* 2012.

30 Ibid.

31 Poletaev, D., Linkages between labour emigration to Russia and early marriage and divorce in the Central Asian Countries, 2013, Central Asia Regional Migration Program.

32 UNICEF, Blame and banishment: the underground HIV epidemic affecting children in Eastern Europe and Central Asia. 2010.

33 UNODC, The Global Report on Trafficking in persons 2012.

Addressing adolescent pregnancy in policies and programmes: need for a paradigm shift

Adolescent pregnancy is a human rights issue. Rights violations are often an underlying cause and frequently a consequence of adolescent pregnancy. It is imperative to shift from interventions focusing on girls as the source of the problem to interventions addressing the underlying determinants of adolescent pregnancy through a human rights based approach.³⁴

A human rights based approach. The compounded forms of vulnerability to pregnancy that adolescents can face can best be addressed using a human rights based approach to break the vicious circle of rights violations, poverty, inequality, exclusion and adolescent pregnancy.

All countries in the EECA region have committed themselves to the ICPD Programme of Action and are signatories to the legally binding Convention on the Rights of the Child and other relevant global and regional human rights instruments. States can therefore be held accountable for respecting, protecting and fulfilling girls' human rights, such as the right to health (including quality maternal health services), the right to education and the right to be free from violence and coercion.

For the EECA region, protecting adolescents and creating the conditions for them to avoid unwanted pregnancy requires as a priority ensuring the right to access affordable sexual and reproductive health information and services, including contraceptives; access to safe abortion where legal; providing comprehensive and age-appropriate sexuality education both in and out of schools; and the ban of marriage under the age of 18. A human rights based strategy should also ensure that States combat conditions that perpetuate discrimination and inequality, including those based on social and cultural beliefs that contribute to the lower status of women and girls.

Multidimensional programmes investing in girls' human capital. Given the compounded determinants of adolescent pregnancy, there is a need for holistic strategies to develop girls' human capital such as life skills and empowerment programmes, to maintain girls in schools and to ensure quality education for all. Sub-groups of girls with increased risk of vulnerability to pregnancy should benefit from targeted interventions. Programming to develop girls' human capital should prioritise and challenge gender norms and gender inequality at all levels.

Make the health system and the education system responsive to pregnant girls. In general, adolescents seek pregnancy care later and receive less.³⁵ Better access to quality health services can help prevent adolescent pregnancy. Youth-friendly health services help meet the needs of adolescents to access sexual and reproductive health information and services. In 2010, WHO published a review of youth-friendly health policies and services in the European region, providing insights on supportive legislative and policy environments for youth-friendly health services and evidence-based practices in countries from the EECA region such as Moldova, Georgia and the Russian Federation. In parallel, health systems should develop services that support pregnant adolescents and give them access to quality maternal health services.

Similarly, the education system should be responsive to the needs of pregnant girls. A non-supportive environment for pregnant girls may mean expulsion or school drop-out, stigmatization and further vulnerability. The education system should therefore facilitate the return to school and continuation of education of teenage mothers to prevent their further marginalisation and to strengthen their resilience.

³⁴ UNFPA, World Population Report. 2013.

³⁵ Ibid.

Policy and programmatic recommendations

- **More research on the determinants of adolescent pregnancy in the EECA region:** there is a need for more data on adolescent pregnancy in EECA, disaggregated by age groups, including the 10-14 year age period for which data is critically missing. Research should investigate determinants of adolescent pregnancies among vulnerable groups and at sub-national levels.
- **Support periodic human rights based reviews of sexual and reproductive health policies and services in the EECA region:** regulatory environments can be rapidly changing and there is a need to regularly monitor how policies and services address the needs of adolescents. UN treaty monitoring bodies offer platforms to hold States accountable for their duty to ensure that sexual and reproductive health of adolescents is respected in all spheres of life. Independent national human rights accountability systems should be developed or strengthened.³⁶
- **Support the development of comprehensive sexuality education programs for adolescents in schools and out-of-schools:** in 2009, UNESCO developed “International Technical Guidance on Sexuality Education” which is aimed at education and health sector decision-makers and professionals, and focuses on the rationale for sexuality education, provides technical advice on characteristics of effective programmes.³⁷ Similarly, the WHO Regional Office for Europe published “Standards for Sexuality Education in Europe” in 2010.³⁸ These standards provide guidelines on holistic sexuality education and on their implementation, specifically in Eastern European and Central Asian countries. Countries of the EECA region should be supported in their efforts to develop comprehensive sexuality education programs which meet these standards and reflect the needs of young people and adolescents.
- **Support the development of holistic youth-friendly health services:** it is imperative to provide universal access to accurate sexual and reproductive health information and services, including a range of safe and affordable contraceptive methods, sexuality counselling, quality obstetric and antenatal care for all pregnant girls, and the prevention and management of sexually transmitted infections, including HIV. These services should also be available for marginalized or hard to reach adolescents.³⁹
- **Support the development of strategies to keep girls at school:** education can help foster greater gender equality and has a protective factor against adolescent pregnancy. It also prepares and empowers girls for a wide range of roles in the society. Education strategies should enable pregnant girls and adolescent mother to continue their schooling, with appropriate support measures to accommodate their needs as parenting adolescents.⁴⁰
- **Support interventions to protect girls from violence:** gender discrimination and violence limit adolescent girls’ ability to manage their sexual and reproductive health, and expose them to unwanted pregnancy and sexually transmitted diseases. A human rights approach is needed to protect girls from violence at all levels and in both public and the private spheres.
- **Enrol men and boys in supporting efforts to address adolescent pregnancy:** an inclusive approach is needed to provide a response to adolescent pregnancy which is no longer focused on girls only but which also sensitizes boys and men to gender inequality, and addresses gender-based violence and sexual coercion as human rights violations. Enrolling men and boys is essential to bring about change and reshape social norms and traditions.⁴¹
- **Support the inclusion of young people’s health and rights in the post-2015 development agenda:** the post-2015 agenda should recognize the importance of women’s empowerment, equality, sexual and reproductive health, and the rights of young people to quality education, effective livelihood skills and decent employment opportunities, as the necessary conditions to reach their full potential. The post-2015 agenda should have a human rights based approach whereby young people are seen as rights holders and therefore should be empowered and particularly in the areas of their sexual and reproductive health.⁴²

36 ASTRA, Reclaiming and redefining rights: setting the adolescent and young people SRHR Agenda Beyond ICPD+20. Eastern Europe Region Fact Sheet. 2012.

37 UNESCO, International Technical Guidance on Sexuality Education, An evidence-informed approach for schools, teachers and health educators, 2009: UNESCO, 123 p.

38 BZgA, W.E., Standards for Sexuality Education in Europe A framework for policy makers, educational and health authorities and specialists. 2010.

39 UNFPA, Youth-Friendly Services. undated; Available from: <http://www.unfpa.org/public/home/adolescents/pid/6484>.

40 UNFPA, World Population Report. 2013.

41 Ibid.

42 Ibid.

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