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The Impact of Sexual Education on Decreasing Adolescent Pregnancy in Nicaragua

Allison Greenwood
Augsburg University

The Impact of Sexual Education on Decreasing Adolescent Pregnancy in Nicaragua

By

Allison Greenwood

Advisor: Dr. Holly Levine

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Introduction

Half of the females of Nicaragua will have given birth by their 20th birthday.[1] Nicaragua has one of the highest fertility rates in the world and exceeds the fertility rate average in Latin America with 109 (births per 1000 females aged 15-19) compared to the average of 79 births.[1,2] Young maternal age is linked to higher incidences of pregnancy complications such as preterm birth, low birth weight, and neonatal mortality.[2] Nicaragua's high adolescent pregnancy rate is a result of a multifactorial social and political climate. It is among the poorest countries in the Western hemisphere, with 48% living in poverty.[1] The predominant religion is Roman Catholic, and the church holds a strong influence on the education system and abortion laws. There is little education revolving around sexual health and females that become pregnant are often dismissed from school.[1] There remains a cultural double standard for females to not engage in sexual acts, however, the young men are taught with a notion of machismo and that they are superior to females.[3] It is understood in the culture that "real women" are compliant and must submit to the man's patriarchal privileges.[3] The rate of sexually transmitted infections (STIs) is also an issue that has been ignored. Little education is provided on the risk of infections and the sequela of human immunodeficiency virus (HIV).[4] In Latin America, 46% of all deaths by infections result from acquired immune deficiency syndrome (AIDS).[4]

Discussion about adolescent sexual and reproductive health (ASRH) was banned in schools up until 2008. Even now that it is part of the national curriculum, teaching is sparse and misrepresented by educators and even health care providers.[4,5] The inadequate education on ASRH, has contributed to high adolescent fertility rates, incidences of STIs

and poor health outcomes for mothers and infants. This has negatively affected Nicaragua's economic, educational and social prospects. Through this research, I aim to address the specific barriers to inadequate sex education in Nicaragua and highlight programs that have been successful in implementing ASRH services throughout the world. Considering the social-economic, religious, gender norms and health service availability within Nicaragua, effective, multifaceted strategies must be developed to reduce teenage pregnancies.

Background

Barriers to Sex Education

Culture and Gender Inequality: "How old does a person have to be to have sex?" This question resulted in the beating of a young Nicaraguan boy by his mother.[6] Discussion of sex is taboo in Nicaragua and many adolescents are turning to their peers for sex education. This has led to advice such as to avoid contraceptives because they will make one "too fat or skinny." [7] Throughout the past two decades the United States has identified that open communication between parents and teens has a positive impact on adolescent health outcomes. Global heath initiatives aim to improve family communication on sexual health. This movement is lagging in Nicaragua as many of the elders struggle with the idea of open communication on sexual health. There is a notion that if teens start asking about sexual health, then they are already sexually active. Many teens avoid conversations with adults out of this fear of judgment and potential punishment.[6] Furthermore, many young mothers may not provide effective sexual

education and maintain open communication with their daughters out of concern for their own daughter becoming pregnant at a young age.[6]

The Nicaraguan culture of machismo, the belief that men are superior to women, and should be tough, and domineering, has been a barrier for young men to receive appropriate sex education and maintain an open communication with male "role models."[3,6] Conversations on sexual health are seen as feminizing or for homosexuals among some adult males. The discussion of sex is considered shameful and should be silenced. In an interview with a young Nicaraguan man, he mentions that the only guidance he received about sex from an adult was to not use condoms.[6] Historically, Nicaraguan men's virility was recognized by the amount of children one could father without regard to expectations of supporting the mother or children.[1] Though gender equality is improving, traditional views of machismo still exist and impact young people's health.[3] Machismo is reinforced by marianismo, the idea that women should be compliant and passive to men. Marianismo is associated with Virgin Mary, a prominent figure in the Catholic Church, and her self-sacrifice, duty, caretaking and sexual mortality.[8] With the tainted sex information given to men and the expectation for multiple partners, the risk of transmitting HIV and other STIs puts teens at an increased risk.[3] According to a cross-sectional community-based study of 650 participants, age ranges from 15-49, 68% had insufficient knowledge on HIV as measured by an HIV-related knowledge survey[8]. The majority of the participants heard of HIV via mass media and only 13% learned about HIV from health care facilities.[8]

Political and Social Climate: Nicaragua has a dynamic political climate that has affected education and health services for many years. Following the Sandinista revolution in 1990, a conservative government took charge and reduced many social programs including access to health care and education.[2] Since 2007 the government is back under the Sandinistas and is working on social reforms. However, the new policies are not well defined and the Catholic Church heavily influences ethical issues.[2]

A study of 2,803 Nicaraguan youths (ages 13-18 years old) aimed to address determinants of sexual onset and the role society has on the youth's perspectives of sexual health. Nearly one-quarter of females and over one-third of males report being sexually active.[2] High incidence of sexual activity is linked to those not living with their parents, or whose father no longer lives at home. The absence of the father and sexual behavior has a greater impact among females over males.[2] With Nicaragua's poor political and social climate, more parental figures are emigrating to support their family from abroad.[2] The increase in emigration may contribute to the high teenage pregnancy rate. In another study of 2,766 females under 20 years old, identified that those with the lowest wealth index and no religion, engaged in sexual activity at a younger age. Communities that were more developed and offered greater access to schooling, employment and health care had decreased adolescent pregnancy.[9]

Religion: There are over one billion Catholics worldwide, and half of these individuals live in North and South America.[10] Nearly 60% of Nicaraguans belong to the Catholic Church.[11] The Catholic Church is not allowed to make laws and governmental regulations, however, it strongly influences decisions of politicians and healthcare

providers on contraceptive use, sex education in school and abortion.[1,10] The Catholic Church teaches that sexuality is not a sin but should be reserved for married couples. The church is opposed to premarital sex, non-natural contraceptives, and abortion.[10] Abortion is illegal in Nicaragua.[1] This law is heavily influenced by the Catholic teachings that reproduction is the fruit of marital bond. It is their belief that procreation is a gift given from the Lord and humans do not have the right to end any form of life.[10] ASHR among Catholic doctrine is heavily focused on chastity with little regard to safe sex practices.[1] Interestingly, 73% of teenagers affiliate with the church and there is evidence that Catholic teenagers use condoms more consistently than non-religious teens.[2] Priests are aware of the incidence of unwanted pregnancies and agree with the reality of our time and that education on contraceptive use may be necessary.[10]

Poverty: Nicaragua is the second poorest country in the Western hemisphere and the poorest country in Central America. Over half of the adolescents ages 15-19 live in poverty.[12] Young men living in homes below the poverty level are less likely to consistently use condoms and report an earlier onset of sexual activity than those living above the poverty level.[2] The result of low-socioeconomic status results in underutilization of health care services and poor access to education which contributes to poor adolescent sexual and reproductive health.[2] Furthermore, it is common for Mesoamerican's to lack health insurance, less than 8% of individuals are insured which in turn affects access to health care[13]

Low Quality of Care: Many health care providers lack proper training and skills to provide sexual and reproductive health education to adolescents.[14] Sexual and reproductive health centers are not confidential and do not provide specialized services to adolescents.[14] There have been multiple studies identifying the barrier between practitioners and adolescents on providing effective ARSH.[4,15] Teenagers struggle to find trust in their provider and feel that they speak to them like a parent. On the other hand, providers feel that the lack of parental involvement puts them in situations where they believe an adult needs to intervene, which may come across as patronizing or judgmental.[15] In Latin America, some providers maintain a gender bias and have outdated knowledge.[4] Health care providers are not familiar with standards of care on providing modern contraceptives or ARSH.[2] In Managua, Nicaragua, health care is provided by the government and private practices are neither available nor affordable for many. The government implemented, Family and Community Health Model, failed to create an adolescent only clinic, which again may discourage teens from accessing health care.[4] The transition of the Nicaraguan health care has created poor job security for health care providers. A provider may not take the initiative of seeing an unaccompanied adolescent and prescribe contraceptives out of fear of being criticized and potentially losing their job.[2]

Misconceptions of ARSH Knowledge: Only 39% of teens that attend high school will earn their high school degree. And although, sex education is now part of the school curriculum, it lacks effective and progressive sex education.[3] Furthermore, women are not educated on the options of contraceptives. Few women are able to identify more than two forms of contraceptives and emergency contraceptives are nearly unknown.[13] There

is evidence that women with more years of education, obtain a job, or get counseling at health facilities are more likely to use contraceptives. [13]

Realizing the Need for Change

The incidence of teenage pregnancy, poor access to health care and inadequate ASRH education has been identified and efforts are moving in the right direction to start implementing changes. Primary care providers have addressed the issue of deficiency in their skills to provide quality care to adolescents and the requirement to stay current on their contraceptive and ASRH knowledge. Health care facilities have identified the lack of adolescent friendly clinics and the importance to harbor an atmosphere of trust and confidentiality.[4] Some parents have realized the little discussion of sexual health in the household and the need for enhanced open communication.[6] Finally, the Catholic Church has come to the reality that safe sex education is imperative to make an impact in their teenage parishioners.[2]

Methods

The research was conducted by finding scholarly articles using Cochrane Database of Systematic Reviews, U.S. Department of State, PubMed and Google Scholar search engines. Phrases that were typed in the search engine bar included; “Sex education programs in Nicaragua”, “Teen pregnancy in Nicaragua”, “Sex education in Nicaragua”, “Birth control in Nicaragua”, “Teen pregnancy in Latin America” “Catholic Church and sex education.” Articles of interest were further reviewed by its abstract. Abstracts that addressed the topics of this research were then critically evaluated. Articles that were not

available online, were requested through the Augsburg Lindell Library interlibrary loan request process. In an effort to critically evaluate each article for its reliability the CARS Checklist for Information Quality by Robert Harris was used.[16] Each article was critically evaluated for its credibility, accountability, reasonability, and support.[16] Sources of various articles were cross-referenced and led to searches using the PubMed search engine toolbar with the phrase; "Teenagers and primary care providers view of each other." After reviewing each article, an outline was created that organized the subthemes of the paper. Supplemental information was gathered from Public Radio International and Blue Pass Independent Coverage to obtain interview content from Nicaraguan teens. Articles were grouped together in each subtheme to strengthen the concepts presented in this research.

Discussion

Each year, 13 million teenage females that live in a developing world, have an unplanned birth. The bulk of individuals affected with STIs are among our youth and at least one-third of the population that is affected by HIV are adolescents.[17] Nicaragua is a major contributor to the teen pregnancy rates in developing nations, as it has one of the highest teen pregnancy rates in the world. It is clear that interventions must be implemented to decrease these preventable outcomes. Adolescent promiscuity in Nicaragua is a multifaceted phenomenon. Education, socioeconomic status, age, religion, gender norms and access to health care are a few of the diverse determinants of sexual behavior among teens.[2] It is evident that open communication between teens and parents on ASRH is lacking, the school's ASRH curriculum is deficient of evidence, there is a

strong negative impact of the ingrained gender roles and machismo, and the poor access to health care and contraceptives contribute to rate of adolescent pregnancies and STIs. Thus, superficial interventions that target one issue are not enough to end this epidemic.

Many nations have implemented sex education in the school curriculum. This is a plausible idea as such programs are offered during the vital time in a child's life of development and maturity. However, there is little evidence to support its effect on decreasing rates of teen pregnancy, HIV, and STIs.[18] In a large meta-analysis investigating sexual and reproductive health education programs in schools, sex education was found to have no effect on reducing incidences of STIs and unwanted teen pregnancies.[18] Additionally, research has been done on the effectiveness of youth centers on increasing use of SRH services. Youth centers are buildings that provide a safe and youth friendly environment for SRH, as well as family planning education, HIV and STI testing, contraceptives and SRH counseling. Its aim is to attract females and those engaging in high-risk sexual activity. The data reveals that the majority of the teens that utilize youth centers are educated males. The vulnerable population (e.g. HIV positive youth, homeless, drug users, sex workers, teens not in school) do not use these facilities due to lack of knowledge about such services or difficulty in accessing the centers. Youth centers have not decreased the rate of STIs nor teen pregnancy among those that use the programs, however, they have increased the amount of HIV and STI testing. Unfortunately, these programs are expensive and not as effective as planned.[17]

Tackling the epidemic of teen pregnancy in Nicaragua needs a comprehensive approach. Schools have recently added SRH education in the curriculum, yet research proves that education only based programs are not effective. Adolescent health services

must provide options for the teenager on contraceptives and reproductive health services.[18] Incentivizing staying in school combined with SRH education has shown a decrease in teen pregnancy.[18] Furthermore, to have effective SRH youth programs, they must cater to the vulnerable. Perhaps bringing programs to the streets of the inner city may make it more accessible for those most in need for SRH services.[17]

Other programs that have tried to increase SRH services to adolescents are peer provider programs. As identified above, teens express a distrust issue with health-care providers and adults when it comes to SRH. They fear judgment and breach of confidentially. However, peer provider programs have harvested a sense of trust between the adolescent and their peer educator. Youth have expressed that peer education has increased their knowledge, attitude, and behaviors on SRH. The Nicaraguan Youth Peer Provider program, Luisa Amanda Espinoza Association (AMNLAE) reaches nearly 7,500 youths and provides education and contraceptives.[19] Youth Peer Programs have health care Coordinators that train and supervise Youth Peer Providers. These youth providers must complete several weeks of training before offering basic education or condoms to peers. Additional training can be completed to provide advanced SRH services such as offering other contraceptive methods and counseling. Youth providers must meet monthly with Coordinators and participate in ongoing training to ensure a quality of care.[19] Though this program does have its barriers of cost and logistics for obtaining contraceptive supplies as well as criticism from the community, adolescents have positively benefited from the program. Nearly 50% of teens that are part of the program report increased knowledge on pregnancy prevention, contraceptive methods and STIs.[19] Teens report an improvement in self-esteem and communication skills

revolving SRH. Twenty-seven percent of participants in the program reported an improvement in their family relationship and open communication. This program has positively impacted adolescents' attitudes on SRH by reducing barriers to information and care. However, it does not provide evidence of decreased incidences of adolescent pregnancy.[19]

Perhaps the most effective method for improving contraceptive use and thus decreasing the incidence of teen pregnancy and STIs is by increasing access to health care for teens via a voucher program targeting those of high vulnerability. As mentioned above, education alone has not proven to decrease pregnancy rates in teens but does prove to increase STI testing, knowledge, and a healthy open communication with family members and peers on SRH. Yet, there lack effective interventions addressed to those most in need. In an interventional study aiming to address the impact of SRH accessibility, found that providing vouchers were effective. Managua youth living in poor neighborhoods were provided with vouchers that were valid for three months that provided a health care consultation and follow-up visit for counseling, family planning, pregnancy testing, pregnancy care, contraceptives and/or treatment of STIs. The study identified that adolescents that received vouchers utilized sexual and reproductive healthcare services significantly more than those that did not receive vouchers (33.5%, 18.9% respectively with a 95% confidence interval of 2.45-3.84).[14] Furthermore, individuals that had less education utilized the health care vouchers more than those with more education (56% vs. 26% and a 95% confidence interval of 2.11-4.20).[14] There was a significant increase in condom use among individuals that received vouchers (95% confidence interval 1.11-3.03).[14] Vouchers did provide benefit on increased health care

services and knowledge of contraceptives, however, depending upon the population the type of SRH services had differing results. Women living in markets may have started a family and benefited from the perinatal care offered, individuals in poor neighborhoods were already sexually active and benefited from condom distribution and STI treatment, and individuals at schools were less likely to be sexually active and thus aided from the education and obtaining modern contraceptives. Interventions such as providing access to sexual and reproductive health care services to individuals regardless of their social context can significantly help decrease the risks of sexual relations.[14]

Conclusion

The initiation of a teen's sexual debut is complex and hinges on multiple factors from socioeconomic factors, education and gender equality. Providing access to health care, educating youth on SRH, having Peer Providers, accessible youth centers and open communication between adults and teens are all vital components to help curb adolescent pregnancy. Evidence has proven that sex education alone is not enough to deter the sexual acts of adolescents. It is essential for parents, teachers, priests, providers, peers, and community members to collaborate on implementing effective sex education and promoting access to sexual and reproductive health care to end the epidemic of adolescent pregnancy in Nicaragua.

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