Early Childbearing in Nicaragua: A Continuing Challenge

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Key Points

•Among Nicaraguan women 20–24 years old, six in 10 had entered a union and almost half had had a child before their 20th birthday.

•A quarter of all births in Nicaragua—35,000 per year—are to 15–19-year-olds.

•Rural women, who have less education, on average, than their urban counterparts, are more likely than city dwellers to enter a union and become mothers during adolescence.

•The proportion of 20–24-year-olds who had a child during adolescence is more than twice as high among the poorest as among those in the highest socioeconomic category.

•Nearly half—45%—of births to adolescent women are unplanned, a level that varies little by women's urban-rural residence and their educational achievement.

•Among all sexually active women aged 15–19 (in union and not in union), 86% do not want a child in the next two years, and 36% have an unmet need for effective contraception. Unmet need for family planning is equally high in urban and rural areas.

•The strong link between low educational attainment and early motherhood suggests that improving educational opportunities for girls is a promising way of reducing high levels of adolescent childbearing in Nicaragua.

Early Childbearing in Nicaragua: A Continuing Challenge

Childbearing during adolescence is recognized worldwide as a factor that impairs the reproductive health and well-being of young women, as well as the overall pace and direction of a country's development.[1] In Nicaragua, where economic and political upheaval have severely compromised the country's health care, educational and social service systems, the challenge of reducing high levels of adolescent childbearing is great.

In light of the strong and persistent links between adolescent childbearing and the perpetuation of poverty and social marginalization, the Programme of Action from the 1994 Cairo International Conference on Population and Development (ICPD) established two important goals. The first is "to address adolescent sexual and reproductive health issues, including unwanted pregnancy, . . . through the promotion of responsible and healthy reproductive and sexual behavior, including voluntary abstinence, and the provision of appropriate services and counseling." The second is to substantially reduce levels of adolescent pregnancy.[2]

Along with 178 other countries, Nicaragua endorsed the 1994 ICPD plan, thereby agreeing that, "with the support of the international community, [it would strive to] protect and promote the rights of adolescents to reproductive health education, information and care."[3] It also agreed that, "in collaboration with non-governmental organizations, [it would strive to] meet the special needs of adolescents and to establish appropriate programmes to respond to those needs."[4] Responding to these pledges, the government of Nicaragua has embraced the need to improve

access to sexual and reproductive health services, including family planning, for all couples, but particularly for those among the poorest sectors of the population.[5]

In Nicaragua, births to adolescent women account for about one-quarter of all births each year.* (FN A) The rate of childbearing among women aged 15–19 is higher in Nicaragua than in any other Central American country except Honduras: In 2001, there were 119 births for every 1,000 women in this age-group,[6] compared with 137 in Honduras,[7] 114 in Guatemala,[8] 104 in El Salvador,[9] 95 in Belize,[10] 89 in Panama[11] and 78 in Costa Rica.[12]

Almost half of all births to adolescent women in Nicaragua are unplanned, and the large majority of sexually active adolescent women do not want to have a child until later in their lives.[13] Moreover, many are not using modern methods of contraception that would allow them to postpone motherhood.

With the availability of information from national surveys in Nicaragua, it is now possible to look closely at the issue of early childbearing and at related behaviors—sexual intercourse, union formation and contraceptive use—among adolescents there.

Early childbearing is generally not good for adolescents or for Nicaragua.

Understanding the context and consequences of Nicaraguan adolescents' sexual and reproductive behavior is crucial for several reasons. First, young people make up a very large proportion of the country's population. In 2005, an estimated 41% of Nicaraguans were younger than 15.[14] The consequences of the life choices made by this huge group of adolescents will resonate through

society for many years to come. Second, the timing of entering into union (defined as formal marriage or consensual union) and motherhood has serious implications for young women themselves and for the country's social and economic development. If young women in Nicaragua are to play an active role in social and economic change and to be adequately prepared for the future, they need education, training and work opportunities—goals that are often thwarted if they assume the responsibilities of entering into union and motherhood at an early age (sometimes against their wishes).

The links between adolescent childbearing and diminished prospects for social and economic advancement are well established. Women who become mothers as adolescents are likely to already be disadvantaged, and motherhood can have further adverse physical, economic and social consequences. Young women who give birth before they have fully developed physically (that is, before age 17) may have an increased risk of complications, and infants born to mothers aged 18 or younger have an increased risk of poor health outcomes and of dying in infancy.[15] All of these risks are compounded for adolescent mothers who are poor, who have inadequate nutrition and who have limited access to medical care. Early childbearing also leaves many young women with limited educational opportunities, reduced chances of joining the paid labor market and the prospect of less stable unions.[16] In contrast, completing their education and delaying childbearing until after adolescence may enable young women to better care for their children and make informed decisions about their own futures.[17]

This report provides a picture of the sexual, marital and childbearing experience of adolescent women in Nicaragua, and explores the characteristics associated with their high levels of

childbearing. It also identifies the reproductive health and educational needs that must be met if young Nicaraguan women are to avoid early and unplanned births.

Nicaraguan women face many types of adversity.

After decades of dictatorship (1934–1978), Nicaragua endured a destructive civil war and an economic blockade by the United States that did not end until 1990, leaving the country all but destitute. Despite some recent improvement, Nicaragua is still one of the poorest countries in Latin America; it has a population of more than 5.9 million and, as of 2003, a gross national income per capita of US$3,650 (adjusted for purchasing power parity).[18] Its economy was further undermined by political changes in the 1980s and 1990s, by the migration of many skilled workers to other countries during the 1990s[19] and by the devastation wrought by Hurricane Mitch in 1998.* (FN B)

Almost half of Nicaragua's population (46%) live in poverty—15% of people live in extreme poverty.* (FN C) Families living in extreme poverty are heavily concentrated in rural areas, where nearly half of the population reside: Sixty-eight percent of rural inhabitants are poor, and 27% are extremely poor, compared with 30% and 5%, respectively, of those in urban areas.[20]

Nicaraguan women's educational attainment has grown very little in the past decade. In 1992, only 47% of women aged 20–24 had had at least a primary education; by 2001, the proportion had increased only to 53% (Figure 1 and Table 1, row 1). The same pattern of minimal growth is found among urban and rural women. However, rural women are particularly disadvantaged: Only 22% of them had at least a primary education, compared with 71% of their urban

counterparts.

Another factor shaping women's lives is HIV/AIDS. Although the rate of HIV infection is lower than that in neighboring countries, environmental factors such as high levels of migration and mobility suggest the potential for a larger epidemic, and the number of people who are HIV-positive has been rising since the 1990s.[21] HIV is transmitted mainly through heterosexual intercourse in Nicaragua, a fact that has serious implications for all young women and underscores the importance of education.[22] An estimated 1,700 women older than 15 are HIV-positive.[23]

Many young people need better information and education about sexual and reproductive matters.

A 1998 survey conducted in six of the country's 14 departments among young people aged 15–24 found that their reproductive aspirations and their knowledge of reproductive health were at odds with one another. Fully 97% of women not in union and 87% of women in union this age said they could see no benefit in having a child at this point in their lives. However, one-third believed that they could not get pregnant the first time they had sex, only one in 10 knew when during their menstrual cycle they were likely to conceive and about six in 10 believed that the use of contraceptives at a young age could result in infertility.[24]

Half of women not in union aged 15–24 have never talked to their parents about sexual matters.[25] In addition, only about half of 20–24-year-old women have had at least seven years of schooling (a primary education—Table 1, row 1); the other half are unlikely to have had any sex education

in school.

The majority of Nicaraguan women enter into union as adolescents.

One in four women aged 20–24 in 2001 had entered into union before their 16th birthday, and six in 10 had done so before their 20th birthday (Figure 2 and Table 1, row 2). Most adolescent women enter consensual unions rather than formal marriages. Among women aged 15–19 surveyed in the same year, the proportion in a consensual union was three times the proportion in a formal marriage (not shown).[26]

Entering into union before age 20 was most common among women with fewer than seven years of schooling (78–81% had entered into union) and those living in rural areas (73%—Table 1, row 2). But even in urban areas, 53% of women in their early 20s had entered into union during adolescence. And among young women with seven or more years of schooling, 43% had done so.

Women who enter into union at an early age are likely to become mothers at an early age as well, unless they practice family planning to postpone their first birth. A comparison of the proportion of young women who formed a union by age 20 with the proportion who had a child by that age (Table 1, rows 2 and 4) suggests that for most adolescent women, with the exception of those who are more educated, entering into union is strongly associated with having children.

Some adolescent women are not in union but are sexually active.

Some women in their early 20s report that they were involved in a sexual relationship during

adolescence while still single. Overall, 19% of women this age reported such premarital relationships in 2001, with little variation by urban-rural residence (Table 1, row 3).* (FN D) The proportion was above average among women with three or fewer years of schooling (25%). In general, however, most sexual activity during adolescence occurs within union. This pattern probably has implications for the risk of childbearing during adolescence, because women are usually expected to have a child soon after they enter into union, and many may themselves want a child as soon as possible.

The level of adolescent childbearing has declined in recent years but is still high.

The adolescent birthrate in Nicaragua declined about 25% between 1992 and 2001—from 158 to 119 births per 1,000 women aged 15–19 (Table 2). However, the annual number of births to adolescents has remained stable because there are now more women in this age-group, as a result of high fertility rates in the recent past. In 2001—as in 1992—about one in four births in Nicaragua were to adolescent women.

The adolescent birthrate varies greatly, especially by level of education. Among women with three or fewer years of schooling, the rate for 1998–2001 was 178 per 1,000 in both urban and rural areas. But among those with seven or more years of education, it was 89 per 1,000 in rural areas and 70 per 1,000 in urban areas.[27] Nevertheless, even these lower rates are high in absolute terms.

About a third of Nicaraguan women aged 20–24 in 2001 had had a child before their 18th birthday, and almost half had done so before age 20. A very small proportion had had a child before they turned 15 (Figure 2 and Table 1, rows 4–6).

Overall, the proportion of adolescent women who had given birth or were currently pregnant declined by about one-fifth between 1992 and 2001 (from 32% to 25%—Table 1, row 7). Most of this decline can be attributed to a 25% drop in the proportion among women in rural areas (from 40% to 30%); women in urban areas experienced a much smaller decline (from 24% to 21%). This difference suggests that the forces of change are being felt much more in rural areas than in urban ones.

Women who have little schooling or live in poverty are the most likely to become mothers during adolescence.

The proportion of women in their early 20s who had a child during their adolescent years varies widely by level of education and socioeconomic status. In 2001, women aged 20–24 with the least education had the highest levels of adolescent childbearing, while those with the most education had the lowest levels (Figure 3 and Table 1, row 4). For example, the proportion who had had a child by age 15 was 11 times as great among women with no more than three years of schooling (11%) as among their counterparts with seven or more years of schooling (1%). The proportion who had had a child by age 20 differed less on a relative basis, but it was still more than twice as great among the least educated women (74%) as among their most educated counterparts (29%).

The strong relationship between low educational attainment and an increased likelihood of childbearing during adolescence is evident in all four regions of Nicaragua. However, in the Atlantic region, where the proportion of residents living in poverty (61%) is highest,[28] even the better educated women are more likely than average to have a child before their 20th birthday—41% do so.[29]

Indeed, whether young women have been raised in poverty or in wealth can influence their reproductive behavior. In 2001, the proportion of women aged 20–24 who had had their first birth before age 20 steadily decreased as the household's socioeconomic status increased (Table 3). Young women from the lowest socioeconomic levels were more than twice as likely as their counterparts from the highest level to have started childbearing in their adolescent years.

Overall, these analyses indicate that women who have stayed in school for at least seven years and women coming from a well-to-do background are the most likely to postpone motherhood, presumably until they are of an age when they feel they will be better able to care for and raise a child.

Childbearing before first union is rare in Nicaragua.

Only 2% of women who were aged 20–24 in 2001 had had a birth before first union during adolescence (Table 1, row 8). This proportion varied remarkably little by residence or educational level. Because nonmarital childbearing is not acceptable in Nicaragua, sexually active single women might be particularly careful to avoid pregnancy by using contraceptives. They also may underreport births. Alternatively, some adolescents not in union who become

pregnant may enter into union with the father before the child is born. Others may decide to end the pregnancy by abortion. In fact, in 2003, abortions among adolescents made up one-quarter of all abortions that were reported to the Ministry of Health's Department of Statistics.[30] (Abortion is legal as a "therapeutic" procedure in Nicaragua only when the pregnancy endangers a woman's life.[31])

In some communities, early childbearing may not be perceived to limit adolescent women's life options.

The links between low educational attainment, poverty and early union formation and motherhood are complex. Some adolescent mothers may have little schooling because their pregnancy forced them to drop out of school. Alternatively, the family and community within which impoverished and less educated women live may expect and strongly support early union and motherhood. Yet another possibility is that young women who are poor and have little schooling may see entering into union and motherhood as their best options, if they believe that they have few better prospects.

It is not surprising that young women with little education might conform to cultural values that view union and motherhood as women's major roles, and might see these roles as their best life strategy. Indeed, this seems to be the case in Nicaragua, especially in rural areas, where educational attainment is lowest, traditional roles for women are the most deeply rooted and broader life options are almost nonexistent. Changing adolescents' marital and childbearing behavior will require changing social attitudes and cultural values regarding appropriate roles for

women. Advances in Nicaragua's level of economic development, especially in rural areas, also are necessary.

Almost half of births to adolescent women are unplanned.

Not all women who have a child during adolescence intended to become mothers, and not all pregnancies that lead adolescent women to enter into union were planned. In 2001, 45% of recent births to adolescents were unplanned (Table 1, row 15). The proportion was higher in urban than in rural areas (48% vs. 41%), and higher among women with at least a primary education than among those with three or fewer years of schooling (51% vs. 40%). Notably, between 1998 and 2001, the proportion of adolescent births that were unplanned increased sharply—from 26% to 45%—a pattern that was evident across urban and rural residence and level of educational achievement. An increase of this size in so few years is very unusual and hard to explain; understanding this change requires additional studies that are beyond the scope of this report.

Most sexually active adolescent women do not want to have a child soon.

In 2001, when all sexually active adolescent women (defined as women in union and women not in union who had had intercourse in the past three months) were asked whether they wanted to have a child in the next two years, the overwhelming answer was no. Overall, 86% said that they did not want a child in this period (Table 1, row 16). The proportion differed little between women in union (84%) and their counterparts not in union (93%–Table 1, rows 17 and 18).

Being a mother already appears to be associated with adolescent women's desire to have a child

soon. Some 75% of sexually active adolescents who did not already have a child did not want one soon, compared with 92% of those with one child and 97% of those with two. Even among those who were in union and childless, 69% did not want a child in the near future.[32] To achieve their reproductive goals, sexually active young women will have to use effective contraceptives.

Contraceptive prevalence is rising among all adolescent women, but it remains much higher among those who are in union than among those who are not.

Levels of knowledge of contraception are consistently high in Nicaragua. In 2001, at least nine in 10 women aged 15–19 knew about one or more modern contraceptive methods* (FN E) (Table 1, row 9). Nevertheless, just because adolescent women say they know about such methods does not necessarily mean that they choose to use one or that they know where to obtain methods or how to use them correctly.

Overall, 46% of sexually active women aged 15–19 reported that they were currently using a modern method (Table 1, row 10). However, the level of use was almost twice as high among adolescents in union (50%—row 11) as among their counterparts not in union (29%—row 12). (It was highest among adolescents in union who lived in urban areas or who had seven or more years of schooling—55–56%.) What might explain this marked difference? Are adolescents in union more motivated to delay childbearing than their counterparts not in union? Does shame or social stigma prevent sexually active adolescents not in union from seeking contraceptive services? Or do these adolescents confront more difficulties than adolescents in union in accessing both private and governmental family planning services? Whatever the answers, the low level of modern contraceptive use among sexually active adolescents not in union is

disturbing, because it suggests a potentially high risk of unintended pregnancy for this group.

Contraceptive use is rising, and the rates of use among all sexually active adolescents and those who are in union denote substantial changes since 1992, when the rates were only 20–21% (Table 1, rows 10 and 11). However, the most impressive increase occurred among the least educated women: The proportion of users in this group more than quadrupled, going from 9% to 38%. Between 1992 and 2001, the gap in modern contraceptive use between the least and the most educated sexually active adolescent women narrowed from 21 to 12 percentage points.

If contraceptive use is quite common, why are so many adolescent women already mothers?

The fact that half of adolescents in union say they are using modern contraceptives is initially puzzling, given that about 35,000 births occur per year among 15–19-year-old women (Table 2) and nearly all childbearing occurs within union (Table 1, row 8). However, only 28% of adolescents in union who have no children are using a modern contraceptive, compared with 62% of those who have a child.[33] Thus, most adolescents in union probably do not start to practice family planning until they are mothers.

Three in 10 sexually active adolescent women need but do not use modern contraceptives.

Although most sexually active Nicaraguan adolescents do not want to have a child in the near future, fewer than half of these women are using modern methods of family planning. Many who are not using such methods are at high risk of an unintended pregnancy. In 2001, more than one-third (36%) of sexually active adolescent women did not want a child in the next two years but

were not using a modern method (Table 1, row 19).

The level of unmet need for family planning among all sexually active adolescent women varied little by residence or education in 2001. However, the level was far lower among women who were in union (30%) than among their counterparts who were not (64%—Table 1, rows 20 and 21).

Many young women do not receive adequate prenatal and delivery care.

The infant mortality rate in Nicaragua is estimated to be 39 per 1,000 live births overall; it is below average in urban areas (32) but above average in rural areas (48) and among women with no schooling (62).[34] The adjusted maternal mortality ratio is estimated to be 230 maternal deaths for every 100,000 births, much higher than the ratios estimated for almost all other Central American countries.[35]

High-quality health care during pregnancy and at the time of delivery are important for ensuring the health and well-being of mothers and their infants. In Nicaragua in 1992, 72% of 15–24-year-old mothers had received prenatal care, and 66% had had a professionally trained doctor or nurse in attendance at delivery (Table 1, rows 13 and 14). In 2001, these proportions reached 87% and 74%, respectively.

The improvement in prenatal care was proportionately greatest among those most in need—women with little schooling. Some 56% of women in this group in 1992 had received prenatal care during their most recent pregnancy in the past five years, compared with 74% in 2001—a

32% increase (Table 1, row 13). This compared with a 20% rise among all women aged 15–24. However, the proportion who had had a doctor or nurse in attendance at the time of delivery stayed the same among the least educated women in 1992 and 2001 (45–46%), but increased moderately among other groups (Table 1, row 14). This finding suggests that different factors affect women's access to health care. The gains in prenatal care are attributable primarily to increased availability of medical professionals during the 1990s in rural areas.[36]

Professional prenatal and delivery care provide opportunities for women to receive family planning information. The increases in use of maternal services may be contributing to the higher levels of contraceptive use among young women who have already had a child.

The government should implement its policies for reducing high levels of adolescent childbearing.

Nicaragua's official 1996 National Population Policy enumerated specific goals to reduce rates of adolescent pregnancy overall and especially among women not in union.[37] Furthermore, in 2002, the Ley de Promoción del Desarrollo Integral de la Juventud (Law 392) directed the National Education Commission to provide sex education that would enable adolescents to avoid unintended pregnancies, and charged the Ministry of Health with guaranteeing specialized youth services and counseling in family planning.[38] However, very few programs are in place to further these directives and goals. One exception is the Centro de Salud Reproductiva para Adolescentes: Hospital Bertha Calderón, in Managua, which was initiated by the Ministry of Health with support from the United Nations Population Fund in 1994. This center offers adolescent-friendly counseling and contraceptive services; prenatal and postnatal care; diagnosis

and treatment of sexually transmitted infections; adolescent clubs; and family counseling for parents of adolescents. Unfortunately, the center serves just the immediate vicinity of the capital, Managua.

Education will likely be crucial in efforts to reduce early childbearing.

The importance of educating adolescents, especially those living in rural settings or in poverty, about delaying sexual activity and avoiding early childbearing cannot be emphasized enough. In 1999, the Nicaraguan Ministry of Education launched Project PIVES (Proyecto Implementación de Valores en la Educación Secundaria) with an aim of increasing the age at sexual initiation and at first union. However, the project is limited to promoting abstinence-only messages and imparting moral perspectives on sexual values. Despite the accumulation of evidence that abstinence-only efforts do not delay sexual initiation and may even deter contraceptive use among adolescents who are sexually active,[39] Project PIVES does not provide adolescents with factual information on sexual and reproductive health. Moreover, because many Nicaraguan adolescents either initiate sexual activity before they enter secondary school or never get that far in school, fact-based sex education needs to be introduced in earlier grades, as well as in settings other than formal schools.

The media can play an important role too.

In Nicaragua and throughout the developing world, increases in the pace of modernization, globalization and urbanization have fostered changes in attitudes toward early union formation and childbearing. Many adolescents are exposed to these changes through the mass media, which increasingly reach Nicaraguans. For example, after Hurricane Mitch, the Estrella Azul campaign

successfully targeted health education messages at women with young children.[40] This campaign's success suggests that the mass media can also be used to effectively disseminate messages about the importance of contraceptive use to prevent unintended pregnancy and the benefits of medical care during pregnancy and delivery.

Addressing the challenge of precocious childbearing requires focused, coordinated efforts. There have been several positive developments in Nicaragua's efforts to address early childbearing, evident in forward-looking laws and policies. But much more needs to be done at the national level to ensure that these policies are fully implemented.

• Policymakers must continue to improve the educational infrastructure in rural areas, and educators should encourage students—even those who have already had a child—to stay in school. Rural adolescents should have the same opportunities as their urban counterparts to reach higher levels of schooling and thus reap the benefits of delayed first union and childbearing. These educational efforts need to be redoubled in areas such as the departments of Jinotega and Río San Juan, and in the Región Autónoma del Atlántico Norte and the Región Autónoma del Atlántico Sur, all of which have both extremely low levels of educational attainment and very high levels of adolescent fertility.

• The Ministry of Health, together with relevant nongovernmental organizations, needs to commit more resources to proven strategies that prevent pregnancies among adolescents. Successful programs, such as the Centro de Salud Reproductiva para Adolescentes: Hospital Bertha Calderón, should be used as a model for expanding services.

• The high proportion of adolescents with an unmet need for modern contraception—more than one-third of all those who are sexually active—highlights the inability of existing services to

reach this population and partly explains why nearly half of recent births to Nicaraguan adolescents were unplanned. The mass media must be used more effectively to disseminate messages about both family planning and the availability of adolescent-oriented services. Furthermore, the stigma against sexual activity among adolescent females who are not in union likely contributes to their high levels of unmet need, by preventing them from obtaining contraceptive services; these adolescents must be assured that they can seek services without fear of being rejected by their family or peers.

• Because early first union is relatively common in Nicaragua, young women's husbands and partners need to be involved in efforts to achieve couples' fertility preferences and to protect women's reproductive health and well-being.

• Finally, official government bodies need to better coordinate and collaborate with international nongovernmental organizations that are already working in the country to improve and protect adolescent health in Nicaragua.

Footnotes

FN A

*Because of constraints on data availability, in this report, adolescent women are defined as those aged 15–19; many experts believe that wider age ranges (10–19, for example) are more relevant in today's society.

FN B

*Hurricane Mitch, which battered Central America from October 22 through November 5, 1998, was one of the most powerful hurricanes ever observed, with maximum sustained winds of 180 miles per hour. It was the second deadliest Atlantic hurricane in history, killing as many as 18,000 people. It also caused billions of U.S. dollars in damages.

FN C

*Poverty and extreme poverty are defined by annual per capita food expenditures of less than US$384 and US$200, respectively. (Source:INEC and MECOVI, 2002, reference 20.)

FN D

*The measurement of premarital sexual activity may contribute to this finding. In 2001, the age at first intercourse and the date of first union were obtained, rather than the dates for both events; as a result, the percentage who were sexually active before first union is an approximation. In 1992, the dates were obtained for both events, and analyses showed that a higher proportion of urban than of rural adolescents had premarital sexual experience, a pattern that is also found in

other countries of the region (source: reference 9).

FN E

*The pill, injectables, implants, male and female sterilization, the IUD, the diaphragm, spermicides, the condom and the sponge.

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31. Center for Reproductive Rights, *The World's Abortion Laws,* 2005, <http://www.reproductiverights.org/pub_fac_abortion_laws.html>, accessed Mar. 20, 2006.

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38. Reglamento de la Ley No. 392, Ley de Promoción del Desarrollo Integral de la Juventud, Decreto No. 25–2002, <http://www.presidencia.gob.ni/buscador_gaceta/BD/DECRETOS/2002/Decreto%2025–2002%20Reglamento%20de%201a%20Ley%20No.%20392.pdf>, accessed Feb. 17, 2006.

39. Kirby D, *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy,* Washington, DC: National Campaign to Prevent Teen Pregnancy, 2001.

40. Blandón LF et al., 2002, op. cit. (see reference 6).

Data Sources

Data presented in this report were extracted mainly from two national-level reproductive health surveys in Nicaragua—the 1992–1993 Encuesta sobre Salud Familiar Nicaragua (ESFN), carried out by PROFAMILIA and the U.S. Centers for Disease Control and Prevention,[1] and the 2001 Encuesta Nicaragüense de Demografía y Salud (ENDESA), carried out by the Instituto Nacional de Estadísticas y Censos (INEC) and the U.S. Agency for International Development, in collaboration with ORC Macro.[2] The 1992–1993 survey interviewed 7,150 women aged 15–49, both married (including those in a consensual union) and unmarried, and the 2001 survey interviewed 13,060 married and unmarried women aged 15–49. Both surveys obtained information on sexual activity, partnerships, reproductive preferences, fertility experiences, contraceptive use, and maternal and child health. The latter survey also collected information on exposure to messages from the national reconstruction and development campaign in response to Hurricane Mitch, La Estrella Azul. The surveys have large enough samples to permit analyses of adolescents by urban or rural residence, level of education and household socioeconomic level. This report also draws on the 1998 ENDESA.[3] Population estimates come from the United Nations Population Division.

1. Stupp P et al., *Encuesta sobre Salud Familiar Nicaragua 92–93 (ESF-92–93), Informe Final,* Managua, Nicaragua: PROFAMILIA, 1993.

2. Blandón LF et al., *Encuesta Nicaragüense de Demografía y Salud 2001 (ENDESA–2001), Informe Final,* Managua, Nicaragua: Instituto Nacional de Estadísticas y Censos (INEC), 2002.

3. INEC, Ministerio de Salud and Macro International, DHS+: *Encuesta Nicaragüense de Demografía y Salud 1998 (ENDESA-1998), Informe Final,* Managua, Nicaragua: INEC, 1999.

Table 1. Selected Demographic and Reproductive Measures

Nicaraguan women's experiences often vary over time and with their residence and level of schooling.

Measure	All		Residence				Years of education					
			Urban		Rural		0–3		4–6		≥7	
	1992	2001	1992	2001	1992	2001	1992	2001	1992	2001	1992	2001
Unweighted Ns												
Women 15–19	1,251	3,146	797	1,689	454	1,457	295	649	390	993	566	1,504
Women 20–24	1,473	2,402	940	1,346	533	1,056	351	622	405	666	717	1,114
(1) **% aged 20–24 who have ≥7 years of education**	46.8	53.4	68.9	71.4	18.9	22.3	na	na	na	na	na	na
(2) **% aged 20–24 who entered union before age 20***	63.5	60.1	56.8	52.5	71.9	73.1	76.3	80.6	76.3	78.1	48.9	43.4
(3) **% aged 20–24 who had premarital sex before age 20**	8.3	19.2	10.7	19.1	5.1	19.4	4.7	24.6	9.2	17.7	9.7	17.9
% aged 20–24 who gave birth before specific age												
(4) Age 20	48.1	47.9	41.7	39.5	56.3	62.3	64.7	73.8	61.8	66.2	31.0	29.0
(5) Age 18	27.9	28.1	22.0	22.1	35.4	38.4	47.6	52.9	34.7	39.8	13.1	12.8
(6) Age 15	3.7	4.4	2.8	2.9	4.7	6.9	8.7	11.2	3.4	5.8	1.0	1.0
(7) **% aged 15–19 who have given birth or are pregnant**	31.5	24.7	24.4	21.3	40.4	30.2	52.0	43.7	34.6	28.8	17.6	16.3
(8) **% aged 20–24 who had a premarital birth before age 20**	2.8	1.6	2.4	1.2	3.3	2.4	4.0	3.2	3.0	2.1	1.9	0.9

(9) **% aged 15–19 who know of any modern method of contraception†**	91.6	96.1	97.1	98.7	84.7	91.9	78.5	87.6	93.8	95.5	97.2	99.2
% **aged 15–19 and sexually active‡ using a modern method§**												
(10) All	19.5	45.6	29.7	47.9	11.9	42.8	8.6	38.1	24.2	47.3	29.8	49.6
(11) In union	20.7	49.8	30.4	55.2	13.5	44.5	9.5	40.0	25.9	52.2	31.0	55.9
(12) Not in union	11.4**	28.5	25.7**	27.8	††	29.8**	††	24.1**	††	30.3	††	28.2
(13) % aged 15–24 who received professional prenatal care‡‡	72.2	86.7	77.2	91.8	67.7	80.7	56.2	74.2	74.1	88.9	86.0	94.6
(14) % aged 15–24 who received professional delivery care‡‡	66.3	73.7	83.6	89.6	50.7	55.1	45.4	45.8	68.1	75.5	85.3	94.1
	1998§§	2001	1998§§	2001	1998§§	2001	1998§§	2001	1998§§	2001	1998§§	2001
Unweighted Ns												
Women 15–19	3,357	3,146	1,903	1,689	1,454	1,457	747	649	1,050	993	1,560	1,504
Women 20–24	2,443	2,402	1,357	1,346	1,086	1,056	696	622	654	666	1,093	1,114
(15) **% of adolescent births that were unplanned*****	25.6	44.7	26.7	48.2	24.4	41.3	25.4	39.9	23.9	43.4	27.9	51.0
% aged 15–19 and sexually active who do not want a child soon†††												
(16) All	82.9	85.6	85.6	90.5	79.6	79.8	82.9	79.5	82.5	84.9	83.2	90.6
(17) In union	82.2	83.7	85.2	90.2	79.0	77.6	82.5	77.2	82.1	82.2	81.6	90.4
(18) Not in union	88.1	92.9	87.5	92.1	87.9**	95.8**	86.2**	96.6**	86.1**	93.9	91.5**	91.0
% aged 15–19 and sexually active with an unmet need for effective contraception‡‡‡												

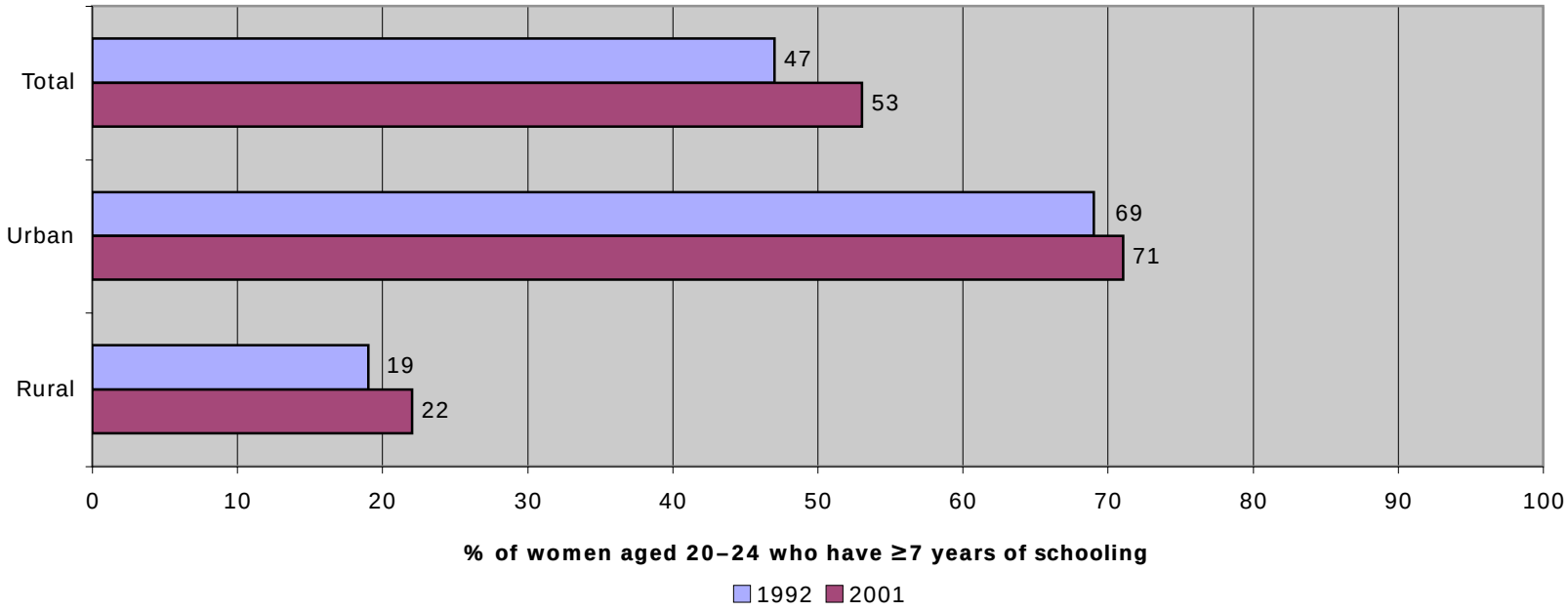
(19) All	40.4	36.3	38.5	35.4	42.5	37.3	45.6	42.6	37.2	34.2	39.2	33.4
(20) In union	37.3	29.6	33.4	25.9	41.2	33.1	43.5	38.8	34.6	26.1	34.0	24.5
(21) Not in union	64.0	63.5	65.8	61.9	59.4**	68.8**	65.5**	72.4**	61.1**	60.6	66.0**	62.8

* All measures referring to union or marital status include formal and consensual unions. †The pill, injectables, implants, male and female sterilization, the IUD, the diaphragm, spermicides, the condom or the sponge. ‡All women in union, as well as women not in union who have had intercourse in the past three months. §Unweighted Ns in 1992 are 437 for all women, 421 for women in union and 46 for women not in union; for 2001, unweighted Ns are 889, 750 and 139, respectively. **Unweighted N is small (25–49). ††Suppressed because unweighted N is less than 25. ‡‡Refers to most recent birth within the last five years. Professional care is care provided by doctors and nurses at private- and public-sector hospitals and clinics. §§Information in the 1992 survey is incomplete. ***Denominator is all births to women younger than 20 in the five years before the interview. †††Want no children or want to wait two or more years before their next birth. Unweighted Ns in 1998 are 975 for all women, 870 for women in union and 105 for women not in union; for 2001, unweighted Ns are 889, 750 and 139, respectively. ‡‡‡Women are considered to have an unmet need if they are sexually active, do not want a birth in the next two years and are not using an effective method. *Note:* na=not applicable. *Sources:* 1992–1993 ESFN, 1998 ENDESA and 2001 ENDESA.

Table 2. Adolescent Childbearing Trends				
The birthrate among adolescents has declined since the early 1990s.				
Year	Birthrate per 1,000 women 15–19	No. of births to women 15–19 (in 000s)	No. of women 15–19 (in 000s)	% of all births that are to adolescents
1992–1993	158*	34	213	24.0
1998	130†	32	248	24.9
2001	119†	35	298	25.7
*Annual rate, based on births that occurred five years before the survey. †Annual rate, based on births that occurred three years before the survey. *Sources:* **Birthrate**—1992–1993 ESFN, 1998 ENDESA and 2001 ENDESA. **Number of women**—United Nations, 2003 (reference 13).				

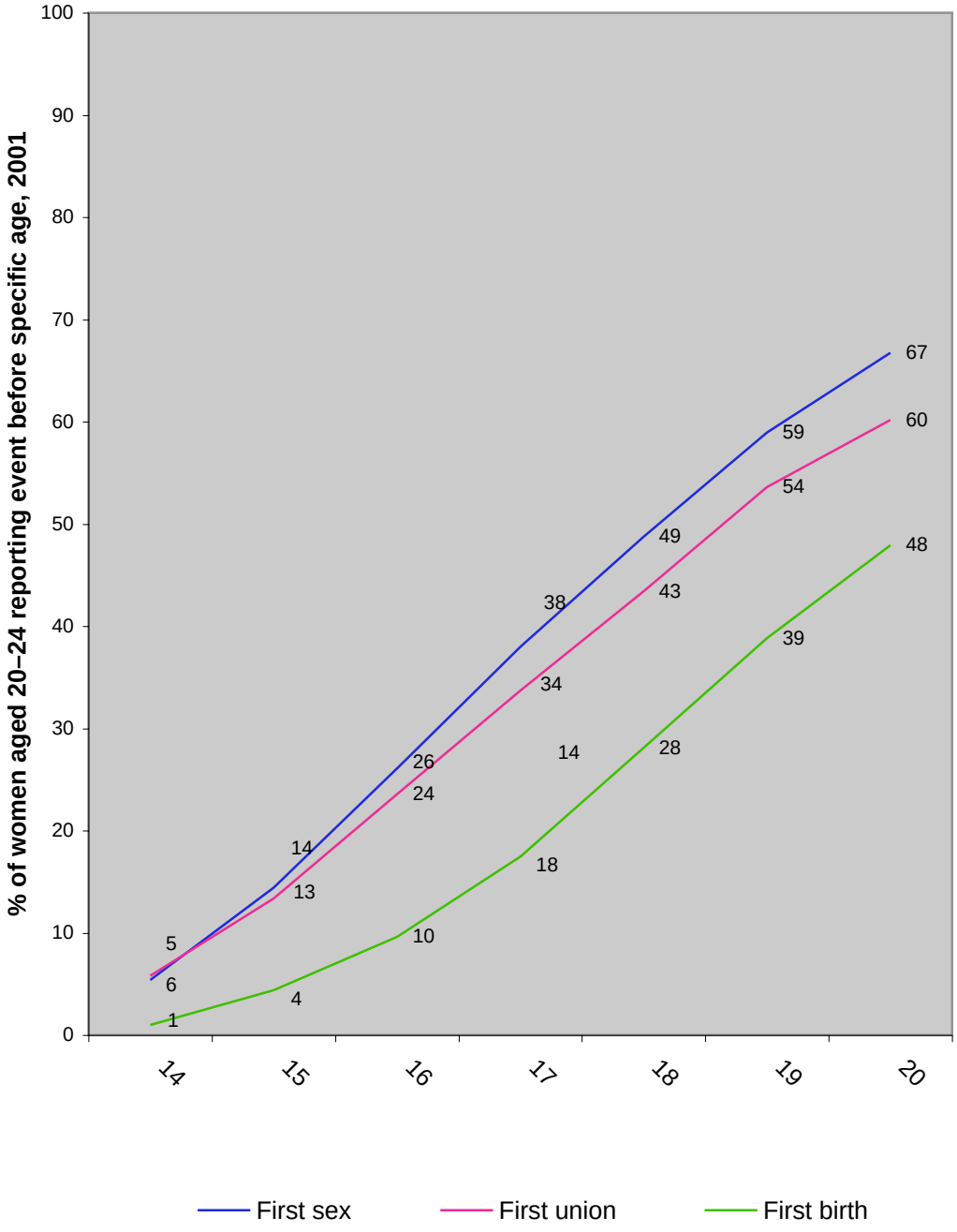
Table 3. Childbearing and Socioeconomic Status	
Adolescent childbearing is most common among the least advantaged.	
Household socioeconomic level	% of women 20–24 who gave birth before age 20
Lowest	69
Second lowest	63
Medium	52
Second highest	40
Highest	27
Note: Household socioeconomic level is based on an index of household amenities and characteristics. *Source:* Special tabulations of the 2001 ENDESA.	

Figure 1. Schooling
Educational levels among young women are rising slowly, but remain fairly low.



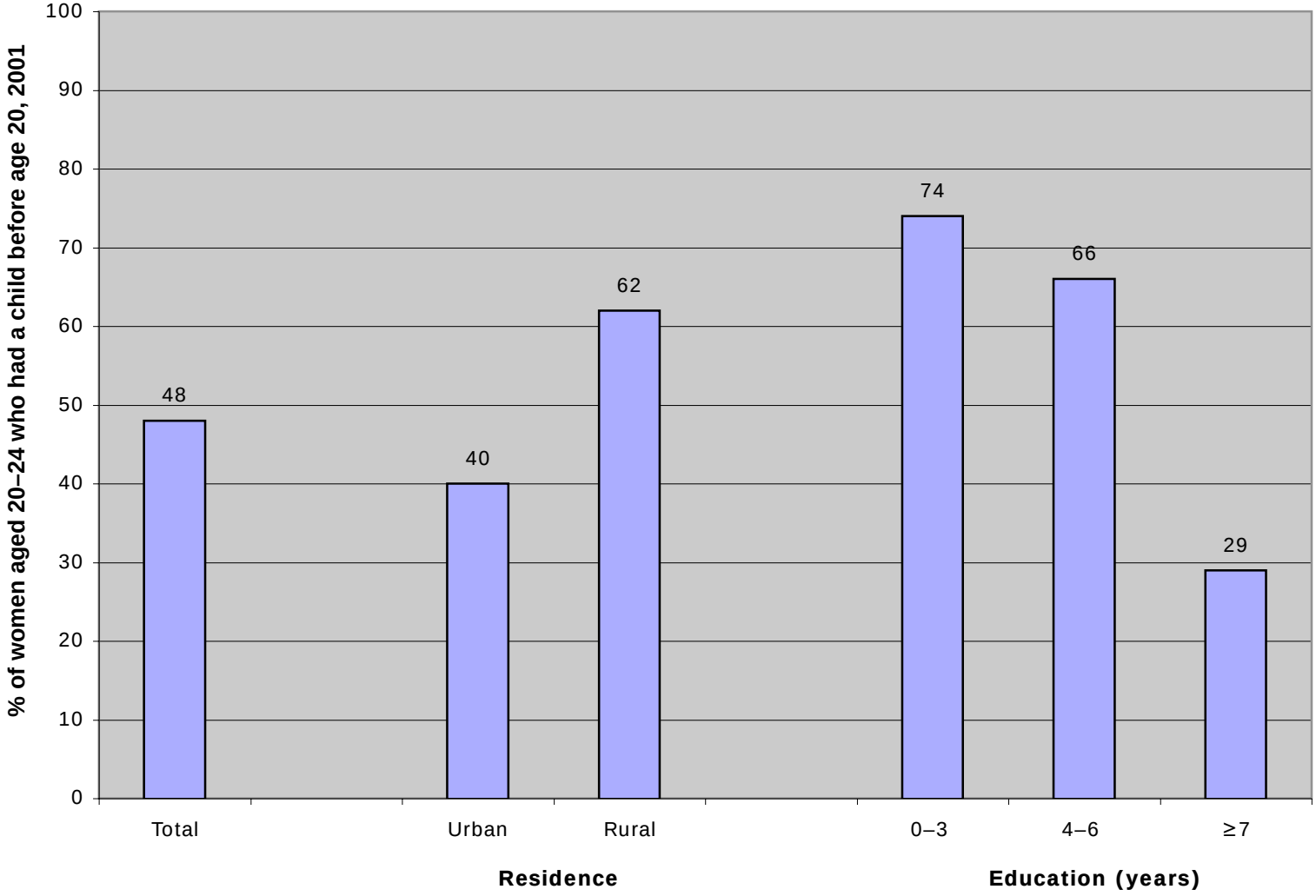
Sources: 1992–1993 ESFN and 2001 ENDESA.

Figure 2. Transitions to Adulthood
First sex, first union and first birth occur very early among Nicaraguan women.



Source: 2001 ENDESA.

Figure 3. Early Motherhood
The proportions of women giving birth as teenagers are highest among rural women and women with the least education.



Source: 2001 ENDESA.

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