

**INSTITUTO CENTROAMERICANO DE LA SALUD  
ICAS.**

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**PROJECT PROPOSAL.**

**Improving the sexual and reproductive  
health of Nicaragua's youth.**

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## **Introduction.**

Protecting the sexual and reproductive health of today's youth in Nicaragua and other developing countries is urgent. Nicaraguan youth, like young people everywhere, encounter many challenges to their sexual and reproductive health (SRH) as they initiate sexual activity, form unions and start their families. Young people<sup>1</sup> in Nicaragua are a major group at risk of HIV, sexual transmitted infections (STI), and early and unwanted pregnancies, with a high number of unsafe abortions and increased maternal health risks.

Young people's responses to the risks can have lifelong repercussions. Besides the negative physical effects, poor sexual and reproductive health brings about social threats for young people, including limited educational and employment opportunities. Although recognized by policy-makers as a serious public health problem, the Nicaraguan health and educational system have not succeeded in responding adequately. Preserving young people's health is not only important for young people themselves; it is also a vital development priority.

Young people face increasing pressures in relation to sex and sexuality, including conflicting messages and norms. On one hand, sex is seen as negative and associated with guilt, fear and disease; on the other hand, through the media and friends, it is seen as positive and desirable. These conflicting pressures are compounded by the lack of correct information, skills and awareness of sexual and reproductive rights, as well as by expectations associated with gender. Young people lack a voice in the debate on their sexual and reproductive lives, while they often feel misunderstood in relation to the reality of their lives and the development of their sexual identity. This results in young people being unable to seek help when they need it and limits their contribution to the processes of policy development and decision making.

Taboos and socio-cultural factors play a large role in determining the level of risk. Early sexual activity outside of marriage is accepted, or even encouraged, for men, but condemned for women. Risky behaviors, such as having multiple partners, are seen as proof of masculinity. Young women, on the other hand, are encouraged to marry at a young age and stay chaste until then, even as they are pressured by their partners to have sex. These conflicting pressures can trap young women into forgoing contraception to avoid having to admit that they are sexually active. Also, accessing SRH services is difficult because of the unfriendliness of these services towards single young people and even refusal to provide services such as contraceptives, condoms, HIV testing, and counseling, unless accompanied by a parent. Only when a young person (girl or boy) is married or when a girl already has had a child, sexual and reproductive health services become better available.

### **Some facts:**

- Nicaragua has the highest adolescent fertility rate in Latin America with 106 births for every 1,000 women aged 15–19 in 2007<sup>2</sup>.
- A quarter of all births in Nicaragua—35,000 per year—are to 15–19-year-olds<sup>3</sup>.
- Almost half of young women (48%) in Nicaragua had their first child before their 20<sup>th</sup> birthday<sup>4</sup>
- The rate of unplanned adolescent births is increasing (34 per 1,000 15–19-year-olds in 1998 to 54 in 2001)<sup>5</sup>

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<sup>1</sup> For the purpose of this project young people consist of the age group of 12 to 21 years of age

<sup>2</sup> INIDE (Instituto Nacional de Información y Desarrollo), Encuesta Nicaragüense de Demografía y Salud 2006/2007, Managua, Nicaragua, 2007.

<sup>3</sup> Guttmacher Institute, Early Childbearing in Nicaragua: A Continuing Challenge, In Brief 2006 Series, No. 3, New York, 2006

<sup>4</sup> Guttmacher Institute, En resumen, datos sobre la salud sexual y reproductiva de la juventud Nicaragüense, New York, 2008.

<sup>5</sup> Guttmacher Institute, Ensuring a Healthier Tomorrow in Central America, protecting the sexual and reproductive health of today's youth, New York, 2008.

- Use of family planning among sexually active young women (15-19 years) is only 61%<sup>2</sup>
- The level of unmet need for modern family planning is high: 31% of sexually active young women (15-24 years) and this is even higher for single young women: 52%<sup>4</sup>
- The HIV epidemic has become increasingly feminized and is predominantly transmitted via heterosexual sex. Young people are at risk, but reported condom use at last sex is low: 11% among young single women (15-24 years) and 45% among young single men<sup>5</sup>
- Young people are at risk of STIs, but have insufficient knowledge and are reluctant to access health services when presented with symptoms of an STI<sup>5</sup>

Recent international research<sup>6</sup> has shown that to reduce the health risks and avoid the negative outcomes—specifically unintended pregnancy and STIs and HIV— youth not only need accurate information, sexual health education and services, but also a favorable community environment, facilitating youth to make use of the acquired information, tools and services. Existing community norms related to sexual risk behavior need to be addressed by engaging adults to create a safe and supportive environment to allow young people to change their behavior.

## Background.

### Instituto CentroAmericano de la Salud – ICAS.

The Central American Health Institute, ICAS, is a non-governmental organization based in Nicaragua and dedicated to improving the quality of life of the regional population and especially of the poorest and most vulnerable groups. ICAS has over 17 years of experience in the field of social science, medicine, action-research, prevention, health education, community work, social mobilization, voucher schemes and strategic partnerships. ICAS has worked in support of the health and rights of Nicaragua's most vulnerable groups, especially adolescents and young people, drug-addicts, sex workers, their partners and clients, men who sex with men, prisoners, mobile populations, poor rural women and other groups with insufficient access to social and health services and information. ICAS has implemented projects to increase access to sexual and reproductive health care, STI/HIV/AIDS services, cervical and breast cancer screening and treatment, to control tobacco use and prevent smoking initiation by young people ([www.icas.net](http://www.icas.net)).

### Competitive voucher schemes.

ICAS has developed a highly successful approach using competitive vouchers (see annex for more information) to increase access to sexual and reproductive health services for adolescents<sup>7</sup> (from 2000 to 2005), to STI/HIV/AIDS services for population at high risk for HIV<sup>8</sup> (1995-ongoing) and breast and cervical cancer screening for older poor rural women (1998-ongoing). ICAS voucher schemes were among the first to develop and there are now schemes in many countries of Africa and Asia. ICAS produced the Guide to Competitive Vouchers in Health published by The World Bank.

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<sup>6</sup> Mema kwa Vijana, *Good things for young people, Rethinking how to prevent HIV in Young People: Evidence from two large randomized controlled trials in Tanzania and Zimbabwe*, Policy Briefing Paper: No. 10, November 2008

<sup>7</sup> Meuwissen LE, *Improving sexual and reproductive health care for poor and underserved girls, Impact of a voucher program on access and quality of primary care in Nicaragua*, PhD book, Maastricht, Netherlands, 2006.

<sup>8</sup> McKay JE, Campbell DJ, Gorter AC, Lessons for management of STI treatment programs as part of HIV/AIDS prevention strategies, *American Journal of Public Health* 2006; 96:7-9.

## **The proposal.**

### **Methodology and evaluation**

Responding to young people's SRH needs is a formidable task, given the pervasiveness of cultural taboos surrounding sexuality and the resulting resistance to addressing those needs. Both young women and men need health services, information and skills if they are to delay sexual debut, resist pressure to have sex and engage in safer sex. A concerted effort is needed, combining the provision of information, skills and SRH services with the empowerment of the community to face the issues and allow young people to change their behavior.

The project will establish appropriate confidential youth-friendly SRH health services and make these services more accessible, especially to youth who need them most. This will be done through the development of a voucher program, which will furthermore strengthen the capacity of staff of service providers (public, private-non-profit or private-for-profit) in providing appropriate and timely care. To obtain sustainable changes, comprehensive sexuality education is needed, while it will be vital to address social and gender norms in the community related to sexual risk behavior and make sure the community in which young people live does understand their needs and facilitates them to change their behavior and take informed and responsible decisions.

The project will combine the voucher program with a communication and education campaign and community mobilization, actively involving young people, in and out of school, their parents, teachers, health service providers and local authorities to promote SRH rights for young people, greater acceptance among adults of young people's needs, address community norms related to sexual risk behavior and create a safe and supportive environment. The communication/education campaign will provide appropriate information, sexuality education and skills related to SRH issues and existing norms using peer education, skills based sexual education, entertainment, interpersonal and community communication and training of health staff and teachers. The strategy will improve youth friendliness of the service providers, raise community awareness and motivate young people to make use of the services and provide them and the community with tools to achieve the necessary changes in knowledge, attitudes, social and gender norms and behaviors at personal and community level to take informed and responsible decisions related to their sexual and reproductive lives. Community mobilization will increase citizen participation, empower the community to confront existing social and gender norms and to influence the local educational and health authorities to improve their response towards young people's needs.

It is expected that the impact of the three interventions (health service delivery through the voucher program, communication/education campaign and community mobilization) will be greater than the sum of the effects of the interventions alone and obtain a sustained change in social and gender norms, attitudes and behavior and in access to SRH information and services for young people, thereby improving young people's health, life and future.

The project will serve as an example of the willingness of young people to take responsible decisions, once the information, tools and services are made available to the community and as such it will serve as a strong advocacy tool to raise awareness among key stakeholders and demand an improved response from the Nicaraguan authorities. The project will promote participation, mobilization and empowerment of young people, in and out of school, and the community to achieve comprehensive sustainable solutions and initiate a strong lobby and advocacy process to make the local educational and health authorities more responsive to the SRH problems young people face. Through the formation of strategic partnerships the project will also actively lobby for an improved response from the national educational and health system.

The project period is 2 years. ICAS will implement the intervention and will evaluate its impact through baseline and endline surveys measuring knowledge, attitudes, norms related to sexual risk behavior, and practices regarding SRH issues of young people and the community.

### **Intervention**

Through the implementation of the combined strategy the project will provide comprehensive information and skills based sex education and promote gender equity; contribute to increase access to confidential youth-friendly SRH services; and promote participation, social mobilization and empowerment of the community to achieve comprehensive sustainable changes and solutions and make the educational and health system more responsive to the SRH problems young people face. The impact of the intervention will be assessed.

### **Overall Objective**

Contribute to the improvement of sexual and reproductive health of Nicaragua's youth in the context of gender equity and sexual and reproductive rights.

### **Specific Objectives and Activities**

#### **1. Promote participation, social mobilization and empowerment of the community to achieve comprehensive sustainable changes and solutions and make the educational and health system more responsive to the SRH problems young people face**

There will be a communication and education campaign directed towards the community (parents, young people, community leaders, teachers) targeting those actors who have the potential to influence community norms, behavior, and socio-cultural factors that affect the SRH of young people. The campaign will emphasize the acquisition of skills by the community which are necessary to develop critical thinking, to promote civil engagement and initiate social action to obtain changes within the community to enable adequate sexuality education of the new generations. The campaign will be highly participative and utilize interactive methods such as:

- Workshops with teachers, health staff, community leaders, religious leaders and local authorities, who can have a positive influence on young people, the community and the educational and health system, to increase citizen participation. Formation of a platform to advocate for the fulfillment of SRH rights of young people.
- Achieve opportunities for participation in local radio broadcasts and other community activities (e.g. discussion forums), where an exchange of ideas can take place and joint solutions discussed for the SRH problems of young people, and which concern in one way or another the community and its development.
- Organize meetings and workshops with parents at school sites, to discuss issues related to SRH of young people and increase their knowledge and communication skills to overcome cultural barriers and discuss SRH issues with their children and provide them with sound advice.
- Train counselors of schools and health centers located in the community to improve their technical and communication skills related to SRH issues to provide appropriate and timely information to young people. Counselors will be equipped with a stronger understanding of sexuality, gender, SRH and the self-awareness, values and skills to play an effective role in their schools and the community.

- Develop community taskforces to implement strong lobby and advocacy efforts to achieve a more comprehensive approach towards the needs of young people from the local educational and health system.
- Develop strategic partnerships with relevant key stakeholders at national level to bring advocacy efforts, using the experiences of the project and results of the impact study, to the national level and obtain a more comprehensive approach towards the needs of young people from the national educational and health system.

**2. Provide comprehensive information, sex education based on the development of skills, abilities and positive life values and promote gender equity.**

To develop a comprehensive sexuality education; iterative learning methods, discussion and reflection will be used, instead of the paradigm of teaching and imposing knowledge and norms. This will promote a different form of learning whereby young people develop their own values and attitudes, learning from each other and involving their communities.

The activities will provide young people a framework which will facilitate them to learn about their sexual and reproductive rights; acquire information to dispel myths; provide references to resources and services in health and education; obtain skills in communication, negotiation, self development, decision-making; and develop a sense of self, confidence, assertiveness, capacity to take responsibility, ability to ask questions, seek help and a sense of responsibility. Among the activities are:

- Training of peer educators and providing them with life skills so that educators can recognize, demand and enforce young people's SRH rights, resist social pressures and translate knowledge, attitudes, values, social and gender norms, into healthy behavior and provide accurate information and education to their peers. Peer educators will assist in the development of the other project activities.
- Development of peer information and sex education at the community level: through individual and group sessions, recreational activities (health festivals, cultural events, mobile cinema, sport, radio spots, etc.), distribution of educational materials (brochures, flip charts, posters, etc) and workshops.
- Develop spaces for discussion and/or debates between young people (in and out of school) themselves and with the community (in and out of school youth, parents, teachers, health staff, community authorities) aimed at identifying the problems, including existing community norms related to sexual risk behavior, and the needs and solutions related to SRH of young people.
- Organization of mobile cinema, discussion forums, focus groups and other forums for discussion and socialization, where young people (male and female) can address the various topics related to comprehensive sexual health. The activities have as objective to establish common issues in terms of needs and problems of young people; to promote their SRH rights; and to assist them to make informed and appropriate decisions in relation to their sexual life, taking into consideration biological, psychological and socio-cultural factors. These activities also serve to promote a process of advocacy led by young people and assisted by the community, where young people demand from the authorities comprehensive sex education; respect for their rights and access to health services appropriate to their needs and characteristics.

Those persons from the community who will provide sexuality education (whether these are parents, teachers, young people, peer educators, medical staff, etc.) should have information, training, tools, skills and appropriate personal qualities; an adequate understanding of young people and their way of thinking; an interest to inform, assist and prepare other people; they

should be persons in whom young people can trust and feel comfortable with and who know how to create an enabling environment; impart knowledge; facilitate the development of skills; be accessible; and who have no bias or a personal agenda to impose norms.

Essential components in the education and awareness raising activities in the community and with young people are: sexual and reproductive health, gender, sexual diversity, social commitment, entertainment and interpersonal relations.

### **3. Contribute to increase access to and improve the quality and youth friendliness of SRH services for young people**

- Development of the competitive voucher program.
- Identification and development of a network of service providers from the public, NGO and private sector, which will participate in the voucher program.
- Training of health staff of participating providers to raise awareness about the SRH needs of young people and improve their knowledge and technical and communication skills to prepare health staff to provide youth-friendly, confidential, accessible SRH services consistent with the needs of young people.
- Diversification of services offered through the vouchers:
  - a. one type of voucher which will provide free SRH services at the public health centers, where the project will negotiate youth friendly spaces and special opening hours to attend young people,
  - b. discount voucher which can be used at private health centers (non-profit and for-profit) and for which young people have to give a symbolic contribution for the SRH services offered. The last type of vouchers is specifically meant for adolescents who fear recognition and judgmental treatment at the public health centers and/or prefer private centers.
- Distribution of vouchers to young people, in and out of school, in the different community settings, including schools, and during project activities.
- Provision of SRH counseling services, a wide range of contraceptive methods, condoms, STI/HIV/AIDS services, detection of pregnancy and prenatal control, and other SRH needs, all according to 'best-practice' protocols adapted to the characteristics of young people.

### **4. Monitoring and evaluation of the impact of the intervention**

Baseline and endline surveys will assess knowledge, attitudes, social and gender norms and behavior regarding SRH issues of young people, parents and relevant community leaders.

- Definition of a participatory quasi-experimental research design, actively involving young people, their parents and the community as key informants concerning existing community norms, including gender norms, and the SRH needs and problems young people face. In addition, the research should provide inputs for changes, if needed, in the methodology and strategies used by the project, and for the monitoring and evaluation of the project.
- Implementation of a 'before and after' population survey design. Semi-structured and partly self-administered interviews will be used. A random cluster-based sample of young people and parents in poor neighborhoods will be administered in the intervention clusters. Neighborhood clusters in Ciudad Sandino and Tipitapa (poor areas in Managua department near the capital city of Managua) will be identified. Households within clusters will be enrolled by stratified sampling. Estimated sample size will depend on final agreement on measured indicators and the anticipated magnitude of effect. A representative sample of community leaders, including teachers and health staff will be interviewed.
- The analysis will assess whether the intervention was associated with changes in young people's sexual and reproductive knowledge, attitudes, norms and behavior; social and

gender norms in the community (parents, teachers, community leaders etc); discussion of sexual and reproductive health issues in the community (between young people, parents/other adults, community leaders); and utilization of SRH services. STI prevalence proportions are too low for reasonably sized samples to measure an effect. We cannot measure reduction of unwanted pregnancies, because the occurrence is not big enough, so we will have to measure proxies, such as the utilization of SRH services and use of contraceptives among other outcomes.

### **Social and gender issues**

As mentioned above it is important to address the social and gender norms to create a safe and supportive environment to allow young people to change their behavior. The project will implicitly and explicitly address the community norms and promote gender equity in the target population and entities with which the project works. All services provided to the community will be based on the specific needs and support community members need, independent if they are male or female, to improve their health. The different project activities will be culturally sensitive and consistent, promote non-sexist language, encourage the participation of female *and* male young people and adults, and provide the same opportunities based on the particular needs.

Through a gender focus the project seeks to implement activities aiming at real equity between female and male young people when it comes to decisions related to their sexual and reproductive health and access to information, sex education and SRH services. The integration of gender as a cross-cutting issue will promote equality and positive discrimination to compensate for the historic inequality between men and women. Particular attention will be given to:

- Specific needs of women and of men
- Specific risks linked to activities or tasks originally defined as female or male
- Gender perceptions related to disease, specifically STIs/HIV/AIDS
- Health care seeking behavior in relation to SRH
- Difference in access to SRH information and services
- Training of health staff in appropriate and specific treatment of female *and* male youth

The final objective is to obtain not only improved SRH among youth, but also improved physical, mental and social well-being.

### **Areas of Intervention**

The areas of intervention will be poor neighborhoods of Ciudad Sandino and Tipitapa. Both are semi-urban areas, located in the department of Managua, not far from the capital city Managua, with high levels of poverty, low levels of educational attainment, poor access to sexual and reproductive health services, high numbers of unwanted pregnancies in adolescents and other problems affecting the sexual and reproductive health of young people. Furthermore the department of Managua is the department most affected by the HIV epidemic and as a result young people in this department are at increased risk of HIV and other STIs.

Ciudad Sandino has about 130,000 inhabitants with an estimated 28,000 inhabitants (22%) between 12 to 21 years old. There are over 25 secondary schools and around ten health service providers (public and private-for-profit and non-profit). Tipitapa has about 110,000 inhabitants with an estimated 24,000 inhabitants (22%) between 12 and 21 years old. There are nine secondary schools and around ten health service providers (public and private-for-profit and non-profit).

### **Beneficiaries**

The direct beneficiaries are young people, in and out of school, in the age of 12 to 21 years with low educational levels, inadequate knowledge regarding SRH issues and limited access to SRH services and living in poor neighborhoods and spontaneous settlements of the cities Ciudad Sandino and

Tipitapa. Other direct beneficiaries are the parents (mothers and fathers) and key members of the communities (such as religious leaders, community leaders, teachers) who can have an important positive or negative influence on SRH behaviors of young people. The project will also work with health staff from the public and private service providers and school counselors, who will benefit from the training efforts and increase their capacity to attend young people.

In order to reach the direct beneficiaries, the project will coordinate directly with the relevant actors in the community and through community activities, in which outreach work will play an important role. The project will make sure that young people, in and out of school, will be active participants in each step of the project. The intervention will not only benefit the direct beneficiaries, but also the communities as a whole, supporting a healthier growing-up of new generations and indirectly benefit the over 50,000 young people living Ciudad Sandino and Tipitapa.

The direct beneficiaries of the project are:

- At least 10,000 adolescents and young women and men (5000 in each intervention area) with information, education activities and access to health services.
- At least 150 teachers from different schools in both intervention areas will be trained in relevant topics related to sexuality education, including the ability to work with adolescents and youth.
- At least 500 parents (fathers and mothers).
- At least 50 community leaders.
- At least 50 staff members of health facilities.
- At least 20 school counselors.

### **Expected Results**

1. Increased knowledge, improved attitudes, social and gender norms and skills in young people, in and out of school, to resist social pressures, change behavior and take informed decisions regarding their sexual and reproductive health.
2. Parents communicating on SRH issues: parents are better informed, have improved attitudes, social and gender norms and are equipped to communicate with their children and committed to support young people in relation to SRH issues.
3. Increased number of school counselors trained in providing sex education to young people.
4. Increased number of schools implementing sex education.
5. Increased number of health service providers providing confidential youth-friendly services using 'best-practice' protocols to attend young people in the intervention areas.
6. Increased utilization of SRH services by young people: counseling, contraceptives, condoms, diagnosis and treatment of STIs/HIV, pregnancy testing and prenatal control.
7. Increased use of contraceptives by young people to prevent unintended pregnancies and of condoms to prevent STI/HIV.
8. Communities informed, with improved social and gender norms and empowered with greater levels of citizen participation and contributing to find solutions for the SRH needs of their young people.
9. Young people empowered and participating in the process to make the educational and health system more responsive to their needs.
10. Local community task forces demanding a comprehensive response from the educational and health system towards the SRH needs of young people.
11. Strategic partnerships between communities and national stakeholders, demanding an improved response from the educational and health system.
12. Increased awareness and knowledge regarding SRH issues of young people, among key actors in the educational and health system.

13. Impact of intervention evaluated.

**Budget and timing**

The project period is 2 years, including the baseline and endline surveys. The total estimated budget is US\$200,000. ICAS will be administrating the funds and will file periodic reports and an end-of-project financial audit as requested by the foundation.

## Annex 1. Competitive voucher schemes

### Introduction

Competitive voucher schemes are one of many demand-side financing approaches to health care, which links public funding to delivery of basic health services. The schemes have the potential to target specific segments of the population effectively and provide them with priority services such as family planning. When a voucher scheme is built on the principle of competition, it not only empowers clients by allowing them to bring their business to the provider of their choice (be it public, private-non-profit or private-for-profit) but also gives incentives for service providers to be innovative, cost effective, and responsive to the clients. Vouchers also encourage the use of specific health services because they provide information about the existence of the services and guide potential users to where these can be obtained, contributing to the potential ability of vouchers to reach underserved population groups. Summarizing some of the strengths:

- Vouchers are good at targeting population sub-groups
- Encourage use of specific services by those most in need
- Increase efficiency and improve service standards
- Payment of services are linked to services actually provided: also called Output Based Aid (OBA)
- Vouchers facilitate monitoring and evaluation

ICAS implemented and manages a voucher program targeting populations at high risk for HIV (e.g. sex-workers, drug-addicts) with STI and HIV/AIDS services (1995-ongoing), poor adolescents with sexual and reproductive health services (2000-2005) and older poor rural women with breast and cervical cancer screening (1998-ongoing). Two impact evaluations were carried out – quasi-experimental intervention study in 2000 and 2001 and prospective cohort study 1995 to 2005.

### How does the voucher scheme function?

ICAS acts as the voucher management agency: contracting clinics (public, NGO and private sector); organizing training; defining service package; analyzing data; and monitoring quality. ICAS staff and when possible, community-based organizations regularly distribute vouchers and health educational materials to all members of targeted populations (at prostitution sites, markets, poor barrios, public schools etc). The vouchers entitle the bearer to a package of ‘best practice’ services free of charge at any one of the over 50 contracted clinics. Clinics compete for contracts on the basis of price, quality, and location. Clinics are reimbursed at a fixed fee per voucher.

### Impact studies

The quasi-experimental study of the voucher scheme for adolescents showed female adolescent voucher receivers to have a higher use of services compared with non-receivers (OR 3.1, CI 2.5–3.8). At schools, sexually active receivers had a higher use of contraceptives than non-receivers (OR 2.3, CI 1.2–4.4); in neighborhoods, condom use was greater among voucher receivers than non-receivers (OR 2.5, CI 1.4–4.5)<sup>9</sup>. Technical and perceived quality of the participating service providers increased considerably<sup>7</sup>.

The cohort study showed a considerable reduction of STIs in female sex-workers from 1996 to 2005 (syphilis 9% to 3%, trichomonas 16% to 8%, both  $p < 0.00001$ ), while HIV prevalence remained less than 5%. Unplanned variations in the time between STI treatments (due to irregular funding) allowed attribution of overall STI reduction to the program<sup>8</sup>.

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<sup>9</sup> Meuwissen LE, Gorter AC, Knottnerus JA. Impact of accessible sexual and reproductive health care on poor and underserved adolescents in Managua, Nicaragua: A quasi-experimental intervention study. *Journal of Adolescent Health* 2006;38(1):56.e1-56.e9.