The Fifth Millennium Development Goal
Gender Equality and Women's Empowerment
in Nicaragua

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10th Semester Master Thesis
20th December 2014
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Abstract

This study provides an input to the debate on the empirical estimations of the Millennium Development Goals, and makes a contribution to on-going Post-2015 debate about the next set of sustainable goals. The Millennium Development Goals are a set of time-bound and measurable goals, which address and seek to reduce the number of people living in poverty before 2015. Aside the focus on poverty, the goals make a pledge to gender equality and women's empowerment, marking their importance globally, and galvanizing worldwide attention to these issues.

This study employs a framework derived from the construct of gender, women's empowerment, gender equality and normative international relation theory to explore the two targets, and the six indicators of the fifth Millennium Development Goal, to improve maternal health. For this end, a single case has been selected, Nicaragua. While Nicaragua at a first glance may appear insignificant, a closer look reveals some grave data on the health of girls and women, including one of the highest rates of adolescent birth worldwide and wide-spread domestic violence.

Through an analysis based on data generated via an expansive desk review this study finds there to be a number of obstacles in Nicaragua, which prevents the country from further progress on the inbuilt six indicators of the fifth goal obstacles which in one way or another are closely interrelated with the status of women, as well as perceived gender roles inherent in the society.
It is argued that the influence of the both the Catholic Church and that of different governments through their actions and policies related to maternal and reproductive health, has significant consequences in the lives of Nicaragua's gendered citizens and how women and men are perceived. Policies and actions that in addition are found to exhibit contradictions towards Nicaragua's commitment to the Millennium Development Goals.

While the recognition of women's health is pivotal for its improvement and for sustainable development, this study shows that unless the underlying roots of the problem are addressed, namely the subjugation of women, development goals as normative objectives will find it difficult to attain success and promote true sustainable development.

Acknowledgement

There have been some personal trials and surprises in the writing of the thesis, and though it at times has been a challenging process, I am thankful for the people who have helped me along the way in one way or another.

First of all, thanks to Steen Fryba Christensen for his guidance and always demonstrating nothing but patience, and calmness.

Special thanks goes to Oddbjørn, Leona and Pia for the all the discussions, helping me to find my structure, reading, commenting on my ideas, providing good banter and inappropriate jokes.

Further thanks to Julian for listening to my at times, unconstructive and out of context conversation inputs.

Additionally, I would like to thank Nanna, my tech-sis, for helping me with IT issues beyond my comprehension and Sabrina for providing cups of Joes when most needed.

Finally, thanks to a very special cinnamon-seed, for keeping me company throughout the project, and providing me with an unforeseen emotional attachment to the subject.

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List of abbreviations

Beijing PfA	Beijing Platform for Action
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
ECLAC	Economic Commission for Latin America and the Caribbean
FSD	Foundation for Sustainable Development
ICPD	International Conference on Population and Development
IMF	International Monetary Foundation
IR	International Relation
MDG	Millennium Development Goal
MDG 3	Third Millennium Development Goal
MDG 5	Fifth Millennium Development Goal
NGO	Non-governmental organisation
OECD	Organization for Economic Cooperation and Development
OSAGI	Office of the Special Adviser to the Secretary-General on Gender Issues and Advancement of Women
SIGI	Social Institute and Gender Index
UN	United Nations
UN-DESA	United Nations Department of Economic and Social Affairs
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCRH	United Nations Office of the High Commissioner for Human Rights
UNICEF	United Nations Children's Rights & Emergency Relief Organisation
WHO	World Health Organisation

1. Introduction

1.1 The Background and context

The Millennium Declaration launched in 2000 laid down a range of measurable and time-bound goals for combating: hunger, poverty, disease, environmental degradation, illiteracy, and last but not least discrimination against women. Taking outset in the Declaration, eight development goals, the so-called Millennium Development Goals (MDG) were selected (Figure 1).

Figure 1: The eight MDGs
(Source: UNDP, 2013)

The overall purpose of these goals is to address and reduce the number of people living in poverty. Besides poverty, the declaration as well as the selected goals, makes a pledge to equal rights and opportunities for women and men.

Out of the eight goals, one is directly committed to gender equality and women's empowerment, explicitly the third Millennium Development Goal (MDG 3).

The agreement of a stand-alone gender goal, the MDG 3, is arguably an important indication that gender equality and women's empowerment have become universal priorities, or as stated by Subrahmanian:

"That gender equality and the empowerment of women figure as a specific goal in the Millennium Development Goals can be celebrated as symbolic of the significant impact of feminist advocacy over many years in making the case for gender-aware development" (2004: 184)

The MDG 3 has galvanized worldwide attention to its target, specifically; *eliminate gender disparity in primary and secondary education preferably by 2005, and at all levels by 2015* (Appendix 1). This has helped to track the achieved progress on narrowing gender gaps in education and participation in parliament, while at the same time helped to keep governments accountable, and stimulated the production of disaggregated gender data on the selected indicators (UN-Women, 2013a:5).

Latin America is, when compared to other developing regions of the world, lauded for its advances in gender equality. Argentina, as an example had by the end of the 19th century already received gender equality in primary school enrolment, and Colombia managed in just 20 years to reduce its fertility rate from six children to less than three per woman, a process that in comparison took 100 years to achieve in the United States (Muñoz, 2011). Furthermore, unlike other developing regions, the Latin American countries have met the target of the MDG 3. With just two years to go before the 2015 deadline, Latin America displays no major gender inequalities in access to education. In reality, the net enrolment rates by level suggest that the region, already as of 2007 had met the target on all three levels of education (UNFPA, 2007: 219-220).

Despite the advances, gender inequality persists within the region. It is for example estimated that the maternal mortality ration for the region have remained constant at about 190 per 100,000 births for the last ten years, revealing insufficient progress on the MDG5 Target (UNFPA, 2007: 277).

And as asserted by Neumann: *"Women in Latin America have long shouldered an "unequal burden" when it comes to development"* (2013: 799).

This study will focus on Nicaragua, and similar to the countries of Latin America, Nicaragua presents a case of historical political exclusion, oppression, and cultural barriers to women's and girls' full equality in citizenship. Its history of revolutions and its current political context makes it an interesting case to study the changes of gender equality and women's empowerment.
A study of the Latin American country Nicaragua is useful for a number of reasons. First, the countries making up Latin America are important in their own right and deserve examination, as they are home to several hundred million citizens, living in countries that are facing significant economic, social and development changes of progress. Second, the countries offer political histories of political exclusion, religious obstruction and *"traditional gender ideologies"* (Stepan, 1991: 7), which have served as barriers to women's empowerment and gender equality.

Similar to the other countries in the region Nicaragua has met the MDG 3 target. In fact, an 18 per cent disparity in favour of girls in the median gross enrolment rate at the secondary education could already be observed in Nicaragua as of 2007 (UNFPA, 2007: 219-220).

Figure 2: Gender Terms

Gender-Blindness:
Refers to ignoring the different roles, capabilities and responsibilities of males and females as shaped by social process. Moreover, it refers to the use of male-centric experiences as norm for polices, studies, strategies etc., and thus, assumes that everyone, no matter which sex, have the same needs and preferences.
(Otzelberger, 2011: 1).

Gender-Gap:
The disparity in any area between women and men as reflected in their levels of participation, access, rights, remuneration and/or benefits. (European Commission, 2004: 3)

Gender-Neutral:
The assumption that some policies, conditions, specifications, factors, strategies etc. are presumed to influence both sexes equally, (Otzelberger, 2011:1) and have "no differential positive or negative impact for gender relations or equality between women and men" (European Commission & EuropeAid, 2004: 3).

Gender-Mainstreaming:
Planning, organisation, improvement and evaluation of policy processes to include a gender equality perspective in all development policies, strategies and interventions, at all levels and at all stages. (European Commission & EuropeAid, 2004:3).

Nevertheless, the gender gap (Figure 2) between women and men remains to this date significant in Nicaragua, owing to an unequal power distribution between the sexes in public as well as private life (OXFAM, 2013a).

When it comes to the health, well-being and safety of girls and women, Nicaragua provides some of the gravest scenarios within the Latin American region.

The latest figures reveal the seriousness of the situation for girls and women in Nicaragua:

- The adolescent birth rate is 28 per cent, making it the highest in all of Latin America and twice the regional average (UNFPA, 2013: 4).

- 70 per cent of all women in Nicaragua are perceived to be or have been victims of domestic violence (SIGI, 2012a)

- The Police Unit for Women and Children received 1,862 reports of sexual violence, during the first six months of 2012. 1,048 cases involved children age 14 or under, and 80 per cent of all victims were age 17 or younger. While the data does not reveal the victims' gender, earlier government data has shown that women and girls make up the majority of the case (Amnesty Int., 2013). Finally, 16 per cent of the cases resulted in pregnancy and the majority of these were between 10 and 14 years old (Amnesty Int., 2009: 22).
- 62 per cent of the mothers' deaths were deemed 'preventable', 82 per cent were due to by deficiencies of the public health service sector. 30 per cent of the victims were less than 19 years old of which many died due to failed illegal abortions (FSD, n.d ; UNFPA, 2007: 289).

- Nicaragua has the third highest maternal mortality ratio within Central America and the eighth highest within the entire Latin American region, with 95 deaths per 100,000 live births (Figure 3)(UNFPA, 2013: 103).

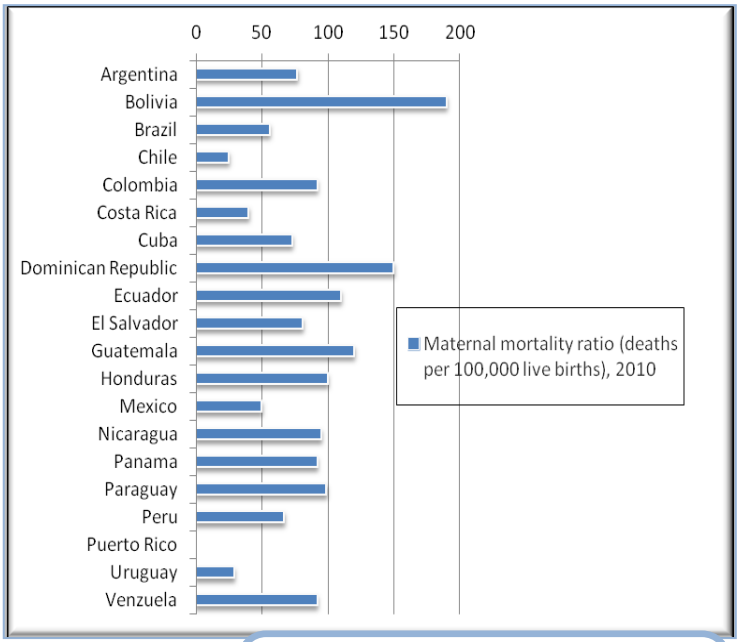

Figure 3: **Maternal Mortality Ratio in Latin America (deaths per 100,000 live births), 2010.**
Source: UNFPA, 2013: 100-104 .

It is clear from the data that the elimination of gender disparity in education has not been followed by gender equality and women's empowerment in relation to health, well-being and safety, suggesting that when exploring gender equality and women's empowerment within a Latin American context it would make little sense to apply MDG 3. Thus, the examination of the 'off-track' situation in connection to the overall goal of MDG 3, requires another focus than education.

The data suggests that Nicaragua presents a case of unfulfilled promises when it comes to women's and girls' health, and thus implicitly women's empowerment and gender equality. It is clear from the selected data still have some way to go to fulfill the fifth Millennium Development Goal (MDG 5) - on maternal health (Figure 1).

Gender equality and women's empowerment have been recognized as important drivers of the social and economic development of societies (Steans, 2006: 95), as well as for the achievements of the other MDGs, e.g. the fourth Millennium Development Goal, which seeks to reduce to under-five mortality rate (Figure 1 and Appendix 1). The correlation between gender equality and the accomplishment of the MDGs is recognized by several global actors, including the World Bank and the OECD, who states that *"There is no chance of making poverty history without significant and rapid improvements to the lives of women and girls in all countries"* (OECD, 2013: 1).

Women's ability to control their own fertility is absolutely fundamental to their empowerment and equality. When a woman has the autonomy to plan her family, she can plan her life. More, the promotion and protection of a woman's reproductive rights, gives her the ability to participate more

fully and equally in the society. Finally, a healthy woman is a more productive woman for the society as a whole (UNFPA, n.d.).

Yet, women's access to health is limited due to their disempowerment and lack of inequality, compounding of a set of socially constructed determinates such as, for example the double burden of responsibilities inside and outside the household, adolescent pregnancy, and limited decision right over own body, reproductive health and fertility (UNFPA, 2013: V; Lattof et al, 2013: 5-6).

Premised on the understanding that gender equality and women's empowerment is a condition for 'good' development and in itself a development goal; and that responses to maternal and reproductive health are not gender neutral, the rationale for integrating gender into development projects and programmes rests on three pillars:

- promoting gender equality and women's rights as an end in itself;
- as a condition for the accomplishment of the other MDGs; and
- as a condition for a truly sustainable development

Despite an increased global attention, gender blindness on communities, and humanitarian programming, seems to persist (Leach cited in Otzelberger, 2011:4). Understanding the consequences of this on maternal - and reproductive health on women, and identifying and challenge the channels that transmit them are crucial, for the development of gender-responsive policies, strategies and studies, which takes into consideration the socially determined roles, responsibilities and capabilities of women and men, as opposed to gender-blindness (Figure 2).

1.2 Research Problem Formulation

Since becoming a signatory to the MDGs, Nicaragua has included them in its National Development Plans as well as in its Poverty Reduction Strategy Programmes (ECLAC, 2009: 4).

As it could be observed from the above data, Nicaragua appears as a case of broken international commitments in relation to the overall goal of MDG 3. Thus, the paradox is, why does gender inequality continue to exist, when the country has already met the education target of MDG 3. Clearly, the roots of the gender inequality must be found elsewhere.

With less than two years to go until the deadline for reaching the MDGs, we are now at a critical juncture to reflect upon, evaluate and take stock of the achieved progress for the purpose of debating and constructing a Post-2015 framework.

Considering the grave data on women's health in Nicaragua as presented on the pages 8 and 9, the MDG 5 emerges as the most obvious MDG for exploring gender equality and women's empowerment. Maternal mortality is on its own important when seeking to assess the level of gender equality and women's empowerment, as Cook states:

"*The universal risk factor is the fact of being female. Maternal sickness and death may be triggered by pregnancy, but frequently result from cultural, medical, and socioeconomic factors that devalue the status and health of women and girls*" (Cited in Jones, 2011: 4).

A number of direct and indirect factors have been found to contribute to poor maternal health these include: births attended by untrained personnel, poor access to emergency obstetric services, women's social status, women's education, age of first marriage, age of first pregnancy, contraceptive prevalence, complications from unsafe abort and women's level of empowerment (Lubbock & Stephenson, 2008: 1; UNFPA, 2010: 1-2; Lattof et al, 2013: 5-6; Kennedy, 2013: 8). In societies where men traditionally control the finances of the household, women's health is often not considered a priority, and women are not in a position to choose if or when to become pregnant, the number, and timing of their children (UNFPA, 2010: 1-2; Lattof et al, 2013: 5-6), suggesting a male-biased perspective on women's health issues.

Taken together, the 2015 MDG deadline, and the direct link between maternal health and a women's empowerment, make a compelling case to explore the above problematic through MDG 5, as it deals

explicitly with maternal and reproductive health, and applies indicators for assessing the level which take their outset in some of the above mentioned factors.

1.3 Research Question

The purpose of this study is to assess the current progress in relation to MDG 5 - reducing the maternal mortality ratio. Specifically I seek to answer:

Why, in the context of Gender Equality and Women's empowerment, has the fifth Millennium Development Goal not been fulfilled in Nicaragua, what are the barriers for its full realisation?

As it can be deducted from the above question, I have decided to explore MDG 5 and what barriers there may exist within the Nicaraguan society towards its fulfillment and why the barriers are there. Currently, Nicaragua is off track to reach 40 maternal deaths or less per 100,000 live births by 2015 (MPTF, 2013). The issue of maternal mortality is important to girls' and women's rights and development as high rates of maternal mortality *"violates women's rights to life, health, equality, and non-discrimination*" (UNFPA, 2010:1).

Based on the above question the paper is structured as follows:
Section two, explores international gender equality initiatives with a particular focus on the MDG framework, and MDG 5.
Section three, outlines the methodological foundation on which the paper is resting.
In the acknowledgment that adopted and applied concepts have consequences for the study, section four is dedicated to the advancement of a number of definitions of key concepts and the sketching of normative theory, for the purpose of constructing a theoretical framework to be utilized during the analysis.
Section five presents the case study Nicaragua. In this section, four decades of changing population policies in the country will be framed, for the purpose of achieving a holistic understanding of the settings in which the MDG 5 is to be achieved and to grasp the inherent barriers towards its fulfillment.
Section six, presents an analysis and discussion based on the gathered qualitative data. Finally, a conclusion - based on the findings from the analysis - will be provided.

2. Selected Gender Equality Initiatives and the MDGs in the Global Development Agenda (The International Context)

In order to achieve a holistic understanding of the matter it is beneficial to present some background on the greater context of international gender equality initiatives, as well as specific information on the MDG framework, and the global development.

For this end, an overview of the development of gender equality and women's empowerment as an area of concern within the global development agenda is presented. Continued by a presentation of what arguably are the most coherent set of development goals to date and the most significant drivers for progress, the MDGs, where particular attention will be diverted to MDG 5. Finally, the study will first zoom out as to assess the current global progress on MDG 5, and second, zoom-in on the national progress on the goal in Nicaragua.

2.1 A Concise Overview of Selected International Initiatives

Feminist groups and women's organisations have for more than four decades actively engaged in UN human rights and development policy. They have used the opportunities offered by international conferences convened by the UN-system, particularly during the 1990s, as a platform to lobby for women's rights (Barton, 2005: 102; Pearson, 2006: 189).

Wide-ranging commitments to gender equality and women's empowerment are covered in a number of UN Security Council Resolutions, explicitly 1325, 1820, 1888 and 1889 and a range of global treaties, most notably the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) from 1979 (UNFPA, 2012a). The CEDAW currently ratified by 185 countries (including Nicaragua[1]), is pivotal in this connection for its commitment to decreasing the gender gap within health care as it requires signatories to: *"eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning"*(CEDAW, 1979: Art. 12.1)

During the 1990s, gender equality and women's empowerment experienced a significant increase in global interests. In June 1992, the UN Conference on Environment and Development, also known as the Earth Summit, took place. The ambition of this conference was to address present and future problems, which are perceived to erode sustainable development. The Earth Conference fueled an

[1] For an overview of Nicaragua's international commitments see JICA, 2012: Study of Gender and Development in Nicaragua

optimism that led to a decade of UN conferences that included commitments to gender equality and women's empowerment. These included, the 1994 International Conference on Population and Development (ICPD), the Beijing Platform for Action (Beijing PfA) in 1995, and a number of world summits in the 1990s, including the World Congress of Women for a Healthy Planet in November 1992 (Spieldoch, 2013: 3-4), where women's rights supporters stated: *"that the empowerment of women is essential for achieving equity between and among and within countries"* (Spieldoch, 2013: 4).

The 1994 ICPD, also referred to as the Cairo Conference, shifted the emphasis of population planning from reaching demographic targets to promoting human rights and sustainable development, changing the focus from numbers to people. The ICDP was important as it placed women's rights, empowerment and health at the heart of this effort (Lattof et al., 2013: 1).

The 1995 Beijing PfA was significant in the way, that the need to develop and mainstream the rights of women (Figure 2) came to underpin all policy areas of concerns (Steans, 2006: 109), including maternal and reproductive health. By signing the Beijing PfA, the signing countries (including Nicaragua) made among other things, a commitment to the *"right of all women to control all aspects of their health, in particular their own fertility ",* as it considered it as "*basic to their empowerment "* (Beijing PfA, 1995: Annex 1.17).

Year 2000 gave light to a new millennium and the adoption of the Millennium Development Declaration, which fed into the MDGs. Likewise to the 1990s a number of conferences took place and a range of declarations were adopted in the new millennium, e.g. the 2005 World Summit, the 2008 Accra Agenda for Action and Doha Declaration, and more recently the Conference on Sustainable Development, i.e. Rio+20 in 2012 (UN-Women, 2013c; UN Development Group, 2010: 6).

The UN has continued to actively promote and play a key role in developing an institutional machinery to advance the human rights of women, especially through the Commissions on the status of Women established in 1946 (Steans, 2006: 106).

The most recent of these, *Commission on the status of Women 57*, took place in March this year. The focus of this Commission was the elimination and the prevention of all forms of violence against women and girls (UN-Women, 2013c; UN Development Group, 2010: 6).

There can be little doubt that the numerous treaties, resolutions, declarations, and commission outcomes have created an expansive normative framework for intensifying actions, investments and accountability, through which, gender equality and women's empowerment can be promoted globally.

2.2. The Millennium Development Goals

The Millennium Declaration as mentioned above was launched in 2000 and adopted shortly after in 2001 by 189 UN member states.

Building on the UN Universal Declaration of Human Rights, the UN Charter, and the outcomes of several of key conferences on development during the 1990, including ICDP and Beijing PfA, the Declaration lays down a range of normative objectives (Fukuda-Parr, 2008: 3) for combating: hunger, poverty, disease, environmental degradation, illiteracy, and last but not least discrimination against women. As mandated by the member states, the UN Secretariat released a 'Road Map' for implementing the commitments. The Road Map, which takes outset in the Declaration, focuses on eight measurable and time-bound development goals (Figure 1), the so-called MDGs, to be used as universal benchmarks to measure advances toward the commitments from the Declaration. The eight Goals, which are supported by 21 quantified targets and 65 technical indicators (appendix 1), are tracking progress from the baseline year 1990 towards 2015 when they are due to be achieved (World Bank, 2010: 6; Barton, 2005: 101). The selected targets and indicators were developed in liaison with the IMF, the World Bank and the OECD (Barton, 2005: 101).

The MDGs were designed to create consent among world leaders at the 2000 Millennium Summit, and to persuade them to take a vow on concrete actions for which they would be held accountable. Said differently, the MDGs acted as and continue to act as normative objectives and benchmarks in global policy processes (Fukuda-Parr, 2008: 4).

2.2.1. The MDGs - a Normative Tool for Development

Despite originating from the UN, the MDGs are country-driven, thus, making nationally-owned efforts crucial for their fulfillment. The MDGs, as claimed by stakeholders, and scholars alike reflect a strong pledge to global development and poverty eradication as they offer the participating countries a shared vision of a better world by 2015 (Bourguignon et al., 2008: 4; World Bank, 2010: 3, 6). Or as pointed out by Sen: *"Few would deny that the MDGs successfully focused the global policy spotlight on some key development issues"* (Sen, 2013: 43).

By enlisting the support of national governments, international agencies, and civil society in a development partnership, the Goals contribute to greater coherence in a global development effort (Bourguignon et al., 2008: 4; World Bank, 2010: 3, 6).

With the MDGs the UN has constructed a powerful blueprint and framework for measuring global progress, which offer a comprehensive and long-terms agenda to replace the somewhat ad hoc development responses of the past. A framework, which is used greatly as a normative framework for global development (Fukuda-Parr, 2008: 13).

Based on the above, it seems fair to argue that the MDGs are significant, if not the most significant normative goals to date on the global scene of development. It offers governments all over the world a comparative assessment tool for tracking progress which have created an unparalleled and unified attention to hunger, poverty, disease, environmental degradation, illiteracy, and discrimination against women.

2.2.2. Gender Equality and Women's Empowerment within the MDGs

As motioned in the introduction, the MDG framework contains one single gender goal, yet Subrahmanian argues that gender enters the MDGs in two ways, first, through gender aware goals and second, by gender specific goals. An example of a gender aware goal is the second Millennium Development Goal - *Universal Education* (Appendix 1). This goal can be said to be gender aware as it includes both genders, through its focus to close the gender gap in primary education.
MDG 3 and MDG 5 are on the other hand, examples of gender specific goals, as they explicitly promote the interests of women and girls (Subrahmanian, 2004). Thus, while MDG 5 does not make a specific and direct reference to gender, it does suggest an inherent value placed on the health of women, although in their maternal role.

2.3. The Fifth Millennium Development Goal

In 1994 at ICPD in Cairo Egypt, representatives of 179 countries[2] committed their nations to an ambitious Programme of Action for improving sexual and reproductive health and rights over the world. The Programme of Action included two goals: one to reduce maternal mortality and another to ensure universal access to reproductive health care by 2015. These two targets were included in MDG 5 (Figure 4), thus explicitly merging the ICPD Programme of Action with the MDGs (Lattof et al., 2013:1)

[2] Initially Nicaragua did not join the programme due to peer-pressure from the Vatican State (page 38) and reservations towards including abortion into the programme, but they joined later on but keeping their reservations intact.

Similar to the other MDGs the MDG 5 contains one overall goal, namely to improve maternal health. The goal is supported by two targets, 5.A and 5.B. The first target is to reduce by three quarters the maternal mortality ratio, between 1990 and 2015. The maternal mortality ratio is defined by the UN as:

"The ratio of the number of maternal deaths during a given time period per 100,000 live births during the same time period." (ICPD, 2012: 4)

Whereas, maternal death refers to:

" *The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes* " (ICPD, 2012: 4).

The second target, 5.B was not included in the MDG 5 at the outset but was added to the framework in 2005.

MDG 5: Improve Maternal Health

Target 5.A:

Reduce by three quarters, between 1990 and 2015,the maternal mortality ratio

Indicators for 5. A:

5.1 Maternal mortality ratio

5.2 Proportion of births attended by skilled health personnel

Target 5.B:

Achieve, by 2015, universal access to reproductive health

Indicators for 5. B:

5.3 Contraceptive prevalence rate

5.4 Adolescent birth rate

5.5 Antenatal care coverage (at least 1 visit and at least 4 visits during pregnancy to monitor for complications)

5.6 Unmet need for family planning

Figure 4: MDG 5, Targets and Indicators
Source: UN Statistics Division, 2008

In 2005 the monitoring framework of MDG 5 was revised on the World Summit to include both a new target - 5B - , aimed at achieving universal access to reproductive health by 2015, as well as four new indicators (Figure 4), which were officially introduced into the framework in 2007 (Lattof et al., 2013: 1). Unlike MDG 5A, the MDG framework does not include a definition on the target for reproductive health, yet as mentioned above, MDG 5 builds upon the 1994 ICPD conference, where reproductive health was defined as the implication that:

"*people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.*"(ICPD, 1995: 40).

Thus, while a definition of reproductive health is missing from the MDGs, the Cairo Programme of Action presents and aids this project with a broad and holistic understanding. The absence of a clear definitions in the MDG framework is regrettable; as international recognized definitions are essential to their achievement, and the lack of them contributes to poor estimations of prevalence.

2.4. The Progress on MDG 5 in the Developing Regions

2.4.1. Target 5A: Reduce by Three Quarters, Between 1990 and 2015, the Maternal Mortality Ratio

Hulton et. al. (2010) state that the MDG 5 has shown the least progress of all the MDG's as indicated by the fact that maternal mortality ratio remains *"unacceptably high across much of the developing world"* (Hulton et. al, 2010: 5), demonstrated by the fact that 99 per cent of all maternal deaths in 2012 occurred in the developing world (WHO, 2012).

Data for *indicator 5.1* suggests that there since 1990 has been a 50 per cent decline worldwide in maternal mortality (WHO, 2012). Yet, worldwide it has decreased with less than 1 per cent per year between 1990 and 2005, which is far-off the 5.5 per cent annual improvement needed to reach the MDG 5A – indicator 5.1 target (Hulton et. al,. 2010: 5), thus the progress has in the latest WHO MDG assessment report been deemed insufficient (WHO, 2013a: 11).

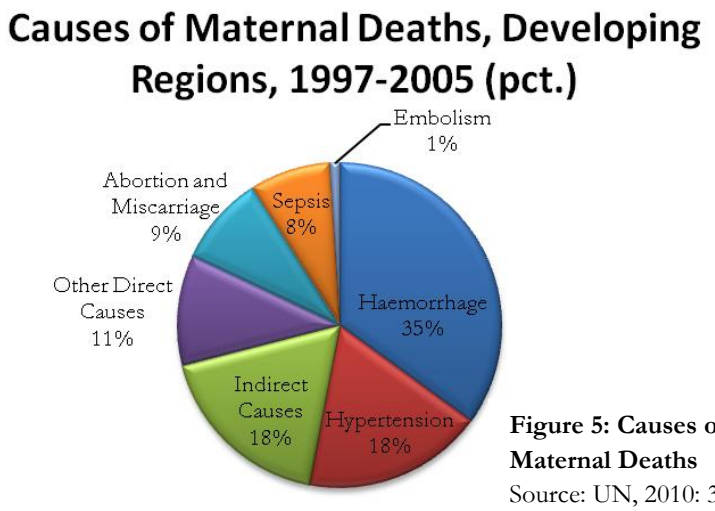

Figure 5: Causes of Maternal Deaths
Source: UN, 2010: 31

As indicated by figure 5, the main cause of maternal mortality in developing countries is haemorrhage, due to a lack of skilled medical care during or immediately after birth. The correlation between the number of maternal deaths and the number of skilled attendants available has been pointed out by the UN Population Fund (UNFPA, 2010: 1), and is further supported by the WHO, who has found that *"regions with the lowest proportions of skilled health attendants at births (…) have the highest number of maternal deaths"* (WHO cited in Jones, 2011: 5).

Indicator 5.2 for MDG 5A (figure 4), is dedicated specific to this problem as it serves as a benchmark for

the proportion of skilled birth attendants. The latest Millennium Development report shows that in the developing regions, the proportion of deliveries attended by skilled personnel increased from 55 per cent in 1990 to 66 per cent in 2011. Yet, in about 46 million of the 135 million live births in 2011, women either delivered on their own or with inadequate care (UN, 2013: 29).

2.4.2. Target 5.B - Achieve, by 2015, Universal Access to Reproductive Health

Looking at the first indicator for reproductive health, *indicator 5.3*, a 2009 survey estimates that the level of contraceptive prevalence (indicator 5.3) is high, with 61 per cent of women in the developing regions using contraception (UN-DESA, 2011: 1).

With regard to *indicator 5.4* the adolescent birthrate, 2013 study by UNPFA estimates that 19 per cent of young women and girls in the developing regions become pregnant before age 18 (UNFPA, 2013: V) and about 11 per cent gives birth before age 19 (WHO, 2013b), or 52 births per 1,000 girls (UN, 2013: 33). 95 per cent of the world's birth to adolescents occurs in developing regions (UNFPA, 2013: VII)

Looking at *indicator 5.5* antenatal care coverage, the proportion of women receiving antenatal care in the developing regions at least once during pregnancy was about 81 per cent in 2011, but for the recommended minimum of four visits or more the corresponding figure drops to around 51 per cent (UN Statistics Division, 2013). The current progress for this indicator has been deemed insufficient for meeting the 2015 deadline (WHO, 2013a: 11).

Indicator 5.6 – unmet need for family planning[3] - , shows a slight improvement from 16.6 per cent in 1990 to 12.7 per cent in 2011 (UN Statistics Division, 2013). This translates into around 140 million women (married or in a union) who would like either to delay or avoid pregnancy, but who are not using contraception (UN, 2013: 32). Despite the decrease the current progress has been deemed inadequate for reaching the 2015 deadline (WHO, 2013a: 11).

Considering the above data, it is hardly a surprise that OXFAM, the World Bank, the WHO (OXFAM, 2013b; the World Bank, 2011; WHO, 2013a: 14) and indeed UN itself have declared that MDG 5 globally is off track and *"falls far short of the MDG target"* (UN, 2013: 28).

[3] To clarify - Unmet need for family planning covers the number of women with unmet need for family planning, expressed as a percentage of women in the reproductive age who are either married or in a union. Women included in the data are those who are fertile and sexually active but not making use of any method of contraception, and who are reporting a desire for no more children or wanting to postpone the birth of their next child (ICPD, 2012: 4)

2.5. Nicaragua's Progress on the MDG 5's targets

2.5.1. Target 5.A - Reduce by Three Quarters, Between 1990 and 2015, the Maternal Mortality Ratio

The generated data for *indicator 5.1* used to create figure 6 suggests that the maternal mortality ratio in Nicaragua has decreased significantly over the past two decades. However, as stated in the introduction Nicaragua is yet to meet the 5A indicator 5.1, and given the annual decline of an average of 3 per cent per year it seems unlikely that they will have achieved it by 2015. Thus, while they are performing above the global annual improvement (see page 17), the country in underperforming as according to the UN desired benchmark of 5.5 per cent annual improvement. Given that the current development continues, it is predicted that 74 out of a 100,000 women will die during giving birth in 2015 (Figure 6), which is far above the MDG target of 40 maternal deaths or less per 100,000 live births a year in 2015.

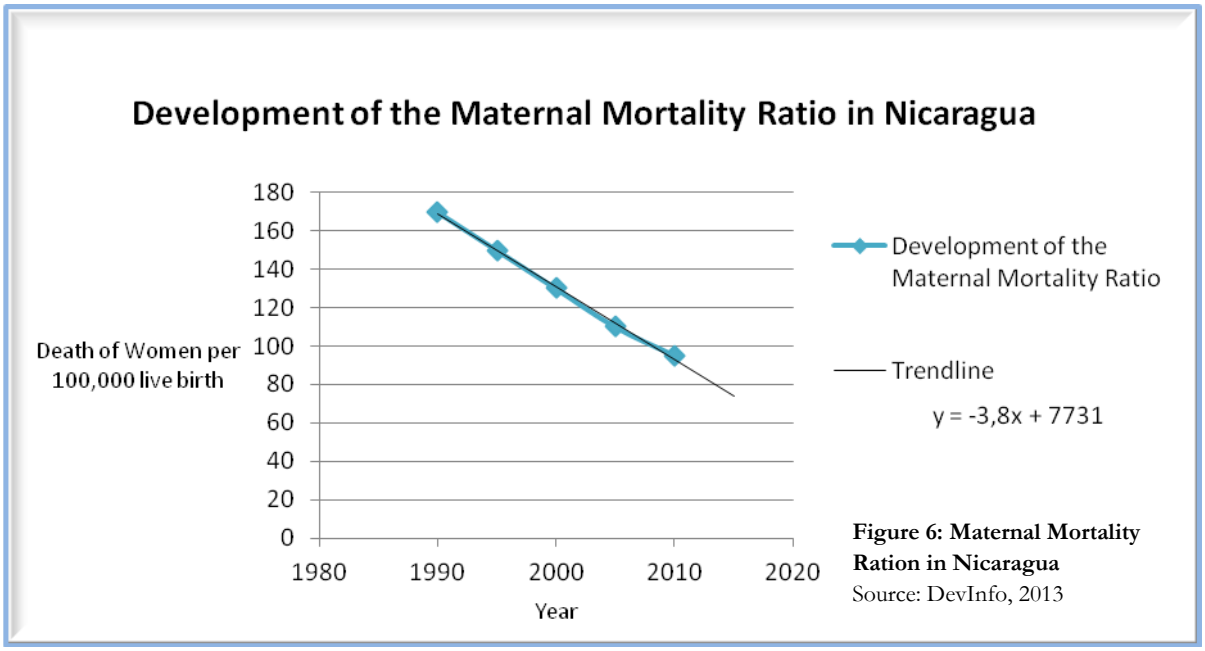

Figure 6: Maternal Mortality Ration in Nicaragua
Source: DevInfo, 2013

While the statics as seen in figure 6, shows a decrease in the number of maternal death, the validity and quality of the data is questionable, as pointed out by a number of regional and international organisation, e.g. the Central American organisation Network of Women against Violence, the WHO and Amnesty International (Kennedy, 2013: 8). As reported by the UNICEF, a large number of maternal death remains unreported as most gives birth at home (UNICEF, 2003).

Taking a look at the national progress on *indicator 5.2 - proportion of birth attended by skilled health personal* - the latest figures from 2006 suggests a 73.7 per cent attendance, which is above the global level

(Appendix 2), however 26.3 per cent of all birth remain unattended in Nicaragua, suggesting room for improvement. Yet, it should be noted, when compared to countries such as Afghanistan (Jones, 2011: 52), Nicaragua demonstrate a positive coalition between indicator 5.1 and 5.2, as the country when compared to Afghanistan, arguably demonstrate an insignificant maternal mortality rate.

2.5.2. Target 5.B - Achieve, by 2015, Universal Access to Reproductive Health

Data on the contraceptive prevalence rate in Nicaragua - *indicator 5.3* - reveals a significant increase in use from 48.7 per cent in the baseline year 1990 to 72.4 per cent in 2007, thus Nicaragua is well above the global average(Appendix 2). The narrowing of the gap is ascribed to the increase use of contraceptives, particularly among the poorest segment in Nicaragua, where the rate more than doubled in just one year from 24 percent in 1992 and 1993 to 52 percent in 2001(Siow, 2009) .

With regard to *target 5B indicator 5.4*, Nicaragua is performing significantly worse than the rest of the developing regions, with an adolescent birthrate of 28 per cent (see page 48) which is more than twice the global average for the developing regions. As in can be seen in appendix 2, the birthrate among teenagers has slightly decreased from 148 adolescent birth per 1000 women in 1993 to 108 births in 2005.

Looking at *indicator 5.5 - antenatal care coverage* - the proportion of women receiving antenatal care in the developing regions at least once during pregnancy was about 90.2 per cent in 2007, but for the recommended minimum of four visits or more the corresponding figure drops to around 77.7 per cent. The data reveals that Nicaragua is far above the global level for the developing regions (Appendix 2).

Data on *indicator 5.6 – unmet need for family planning* - , shows a considerable improvement from 23.9 per cent in 1993 to 7.57 per cent in 2007(Appendix 2). Despite having a worse starting point that the remaining developing regions, Nicaragua has managed to achieve a greater progress on this indicator, and are today faring better on this compared to the progress in the developing regions.

While Nicaragua appears to perform better on almost all the indicators when compared to the global average of the developing regions, namely the indicators 5.1, 5.2, 5.3, 5.5, and 5.6, they are doing remarkably worse on indicator 5.4, and if limited to a Latin America context, on indicator 5.1 as well. That Nicaragua is performing bad on indicator 5.4, but not on the other indicators on reproductive

health, is in itself interesting as there seemingly exists a correlation between the level of access to contraception and that of adolescent births, as it will demonstrated later in the study[4].

Despite some positive advances on MDG 5 the developments made in Nicaragua has similar to the global development been deemed off-track by the UN initiated Millennium Development Goal Monitor (2007).

[4] See page 49

3. Methodological Approach

To conduct coherent research, it is important to outline the methodological framework, what techniques are adopted, and why, what will be examined and how exactly it will be proceeded in order to find an answer to the defined problem.

While the topic, the problem-field, the research question and the MDG framework have been elaborated above, this section will focus on the methodology. Specifically, this section will first, outline the ambitions of this research, second, explain the selected research design, third, present the motivations for the chosen research topic, and fourth and final, put forward the specification and limitations of the study.

3.1. Ambition of the Research

The main objective of this study is to address and explore the advancement of MDG 5 within Nicaragua and what barriers counteract its advancement.

By utilizing various qualitative and quantitative data sources for the purpose on answering my stated research question, rather than a hypothesis, I will engage in inductive research, as oppose to deductive research (Perri 6 & Bellamy, 2012: 76; Bryman, 2012: 25 - 26). However, the applied inductive approach will entail a fragment of deduction as it involves *"a weaving back and forth between data and theory"* (Bryman, 2012: 26). This process is referred to as the *interactive* strategy by Bryman (2006: 26).

Observations from the generated data are not utilized to produce a new theory, but rather applied to develop a new understanding of failure to achieve development goals targeted at girls and women, and its connection with inherent barriers toward gender equality and empowerment in the case of Nicaragua, by using concepts of gender, gender equality, women's empowerment and normative International Relation[5] (IR) theory.

By applying a distinctive method within interdisciplinary research where gender, IR and development studies meet, I seek to stimulate the current debate about the MDGs and the future of development goals. As such this study seeks to contribute to existing literature on the study of the MDGs in Nicaragua, and it offers an input to the literature on empirical estimation of the MDGs, by identifying

[5] According to Brown, IR can broadly be understood as *"the study of cross-border transactions in general"* (2001: 8). For a more comprehensive and detailed IR definition Chris Brown's "Understanding International Relation" can be suggested.

significant characteristics that may affect the completion of the MDGs, specifically MDG 5. Thus, the project may be useful for an improved targeting of social development programs aimed at girls and women.

3.2. Research Design: Single-Case Design

The research design is the logical design/structure of the inquiry, which is constructed *"to ensure that the evidence obtained enables us to answer the initial question as unambiguously as possible"* (de Vaus, 2001: 9). Or said differently, more than a work plan, the research design is what links the collected data to the conclusion, and the originally formulated question.

Observations from a desk review are compared inductively to investigate the constructed research question. By conducting a macro-level analysis of the society and the state of Nicaragua, this study explores the contributing factors. The study takes on the form of a single-case design, as the number of cases examined is limited to one (Flyvbjerg, 2006: 2).

There can be several of rationales for selecting a single-case design as opposed to a multiple-case design, for example the 'object' at hand may represent; the critical test of a significant theory, an extreme or unique case, a typical case, a revelatory case, or finally, it provides the opportunity for a longitudinal case (Yin, 2009: 47-49). The rational for selecting Nicaragua for a single-case study is based on the availability of empirical data, as it allows for a longitudinal case.

A single-case study is valuable as it *"may be of generalized importance (...) if carried out in some numbers"* (Giddens cited in Flyvbjerg, 2006: 8). The obvious advantages of using a single-case study are depth and detail, while its problem is one of breadth. Thus, it is beneficial for the development of social sciences and for the process of learning, for instance, in understanding the degree to which certain phenomena are present within a selected society, and how they may vary across a number of cases (Flyvbjerg, 2006: 7, 26).

The main 'object' of this study and the holistic unit of the analysis is the female population. Yin distinguishes between units as a whole, and units compromised by a number of levels or components, categorizing the difference as 'holistic' or 'embedded'. (Yin, 2009: 50 - 51). Since embedded units are levels that are a part of the larger united - *the holistic united* - , disempowered women and embedded gender values, are the embedded units of analysis, and constitute the smaller and intermediate units of the larger united being characterized - the female population. Thus, within the selected single-case,

attention is also diverted to a subunit/s. This design is advantageous, as it will allow me to focus on different subunits if needed, but also allow me to return to the main unit of analysis. This should grant opportunities for extensive analysis as well as increasing the insight into the single-case.

3.3. Motivation for the selected topic

The scope of the research is limited to Nicaragua as opposed to including all, or a number, of Latin American countries. Nicaragua, was chosen due to its particularity and not because it necessarily represents other cases or can illustrate a specific trait or problem. Thus, it cannot be taken as a general, all-encompassing study of the advancement of MDG 5 in Latin America or as a substitute for another country, however similar the state structure and perceived environment may appear.

In recognition that gender equality and women's empowerment is *"both an end and the means for making progress in all the MDGs"* (Antrobus, 2006: 49), the study will evolve around MDG 5, thus excluding the remaining seven MDGs. The rational for this choice is based on the acknowledgement that the remaining MDGs, with the exception of MDG 3, do not unequivocally embrace issues of gender equality and women's empowerment into their ambitions.
Incorporating the MDG 3 in the scope of the study was considered, as it is the only goal in the MDG framework, which is directly devoted to gender equality and women's empowerment. However, early in the process it became evident that exploring gender equality and women's empowerment against MDG 3, as mentioned in the introduction, is pointless within a Latin American context, as the region has already reached the target, yet gender inequality has persisted.

The motivation for selecting and focusing solely on MDG 5 rests on the notion that this specific goal considers solely the needs of girls and women, by focusing on treatments only they require. Hence, the MDG 5 may aid to uncover gender-discriminatory practices within a country.

The MDG 5 provides us with the possibility of going behind the numbers and look at the roots. The act of giving birth presents in itself a high risk for women, but women's maternity may also be complicated further by political and/or socio-cultural circumstances, such as the influence of the Catholic Church. In Nicaragua the Catholic Church holds a strong influence over women and their maternal and reproductive health (Pizzaro, 2004; Lion et al., 2009).

Finally, as indicated in the introduction, Nicaragua, as well as the region as a whole has found it difficult to manage to reduce the maternal mortality ratio. Arguably, the persistence of the mortality ratios are

important in their own right and deserve examination as it may provide us with an answer to what the barriers may be for the full realisation of MDG 5, and gender equality and women's empowerment.

3.4. Specifications and Delimitations

There are many things to consider when conducting a study; the limitations serve to increase the focus, feasibility and quality of the research.

To undertake this study, a qualitative stocktaking and evidence-gathering process, which included a desk-based review of academic and grey literature,[6] was undertaken, on which the empirical base of this paper rests. Thus, the empirical data presented is a more indirect approach for exploring the chosen problem, as opposed to conducting interviews or making first-hand observations. The paper makes use of qualitative data as well as, though to a lesser degree, quantitative data. This combination of the two allows me to some extent to gain a more in depth understanding of the issue at hand.

The analysis is mainly based on qualitative data. The resources consist of reports from intergovernmental organisations, mainly WHO and various branches of the UN, journals, working papers, and books.

There are some methodological limitations to the quantitative data. An obvious limitation of this paper is the available data, as recognized by the UN High Level Panel, satisfactory data on national-level progress of the current MDGs does not exist (Post-2015, 2013). Moreover, databases worldwide suffer from a lack of gender disaggregation. This is not specific to the MDGs per se, but after years of governments committing to gender equality and women's empowerment, they have lacked the political will to make good on their promises – reflected among other things in their will to collect gender disaggregated data. A problematic well-known to the UN High Level Panel, who have laid down a practical goal for the post-2015 framework to replace the MDGs, explicitly:

"*that data must also enable us to reach the neediest, and find out whether they are receiving essential services. This means that data gathered will need to be disaggregated by gender, geography, income, disability, and other categories, to make sure that no group is being left behind*" (Post-2015, 2013).

As a result, the available data is often gender-blind and social and economic indicators are only to a

[6] Grey literature is informally published written material which, can be difficult to trace via conventional channels such as published journals as it is not published commercially or/and is not widely accessible. It may nonetheless be an important source of information for researchers, because it tends to be original and of a more recent date. Examples of grey literature include patents, technical reports from government agencies or scientific research groups, working papers from research groups or committees, white papers, and preprints (Debachere, 1995).

limited extent gender disaggregated e.g. life expectancy and school enrollment (Spieldoch, 2013: 5; BRIDGE, 2007: 13; Antrobus, 2005: 101).

There are some specific limitations with regard to data on MDG 5. A key limitation of this report is the lack of adequate data to represent current trends on MDG 5, as some of the most current data dates back to 2010. Further, as pointed out by UNFPA, the reported numbers may be underestimated due to under-reporting and misclassification of causes of death (2007: 277). National registration systems are frequently fraught with missing or poor quality data, making it a difficult task to compile material and assure confidence in the existing data (Lattof et al., 2013: 12). In continuation, Standing, points out that on a global scale only 78 countries record cause of death. And adds that those countries that do, tend not to be those worst off, where child bearing often is the most risky (2004: 242-243), illustrated by the fact that a woman's lifetime risk of dying from pregnancy and childbirth-related causes is 1 in 150 in developing countries, and 1 in 3800 in Developed Countries (WHO, 2012).

The problem of reliant data is also an issue in the selected case-study, as highlighted by Pizarro who stated that Nicaragua is a country *"where no statistic is remotely reliable"* (Pizarro, 2004: 3), exemplify by the fact that latest maternal mortality ratio (2010) in Nicaragua has been estimated to range from 70 maternal deaths per 100,000 live births (Nicaragua Ministerio de Salud cited in Silva, 2010), to 95 (UNFPA, 2013), to 170 (Human Rights Watch cited in Silva, 2010)

In lack of more precise data, this study will rely on figures as reported by the UN, and the World Bank, as they have developed a method to adjust existing data in order to take into account these data quality issues. Yet, in recognition that reliable data is a rather complex matter, the above methodology consideration will be respected throughout the project, when treating the data and concluding on the base of it.

The most apparent weakness of this study, which occurred outside of my control is that the observations were completed in limited time due to an overall time restrictions of three and half month to complete the study. More time spent on the collection of data would undoubtedly have increased the quality and wide-ranging applicability of the results, as well as the validity of the study by having a greater base of cases and data.

Due to the complex nature of gender inequality and women's disempowerment, the relevant research avenues are abundant and beyond the scope of this study, e.g. to present all working concepts within

gender studies and well as to present all international agreed upon frameworks and declaration for the betterment of women and their human rights, would simply be too time-consuming.

4. Theoretical Framework

In this section working definitions of gender, empowerment and gender equality are presented, followed by a presentation of normative and behavioristic theory thinking. This is undertaken for the dual purpose of reaching both a definition and establishing a normative theoretical framework.

4.1. Defining the Utilized Concepts: Gender, Women's Empowerment and Gender Equality

To fully understand the usage of the 'concepts' applied in this study one must firstly define what they are and involve. Definitions matter because the employed notions in the study cannot be said to have an essential existences in the real world, rather it is a *"continual interplay between the 'real world' and the world of knowledge"* (Brown, 2001: 1). Thus, the concepts explanation, possible implications and meanings are an obvious condition for their usage as variables in an analyzing context and how we understand the 'world'. Finally, definitions are useful for limiting the study as we arguably without definitions would not be able to study anything at all.

As stated in the beginning, this paper seeks to discover: *Why, in the context of Gender Equality and Women's empowerment, has the fifth Millennium Development Goal not been fulfilled in Nicaragua, what are the barriers for its full realisation?*

This question begs for a definition of three theoretical concepts - gender, empowerment and gender equality.

4.1.1. Gender

Gender in development studies has moved from being a political irritant to being 'de rigueur'. While gender and development depicts a different development analysis, it should not be understood as an alternative paradigm of development, but rather as the application of a gender lens to inform and shape policies and practices on all levels of development activity (Pearson, 2006: 189).

Early writings on women's and men's roles and relations in society, considered women as the sole focus of an analysis, thus excluding the experiences of and with men. The shift from women to gender was first promoted by Feminist scholars who in the late 1970s started to question the adequacy of focusing

on women in isolation, as they argued that to understand the limitations faced by women one had to include and examine the male power and its reproduction. Thus, the analytical focus shifted from 'women' to 'gender' in development (Subrahmanian, 2004: 192; Colclough, 2008: 58).

Before engaging further in the definition of gender, it is important to notice that gender as a concept is highly contested, and can be viewed in a number of ways. Overall there can be said to be three perceptions of gender; the essentialist, the performative and the constructivist.

The *essentialist* perception considers that differences in gendered social behaviours are a direct result of the biological sex, and as stated by Sheperd *"there is an 'essence' of man/women that determines behaviour in spite of socialisation"*(2010: 8). An example of this is the idea that the mother-role is perceived as being more natural to women than men. Thus gender, in the eyes of the essentialist conception, is a substantial difference, which expresses an underlying natural sexual division as the 'membership' of one of the two groups as set in stone. It presents social inequality as natural, unavoidable, uniform and absolute, and inherently supports the status quo between the sexes (Haslam et al., 2002: 88). As the aim of the MDGs is to change the status quo of women, this understanding is not deemed apt for the purpose.

This gender perception is often criticized as being based on misrepresentation. As they by grounding humans in two groups present differences as profound, sharply defined and fixed, obscuring the ways in which ideas of gender are changeable both historically and culturally (Haslam et al., 2002: 88).

In contrast, the *performative* understanding of gender perceives it as a social and biological constitute. The term gender performative originally derives from Judith Butler. For Butler, 'gender' is a performative effect brought about through the repetition of acts, or said differently; gender is rehearsed, a making of oneself, i.e. doing gender. These acts do not express an interior identity but produces the 'product' gender. Thus, gender is an internalized belief that men and women are *essentially different*, which makes men and women behave in ways that appear essentially *different* (Boucher, 2006: 114 - 118; Shepherd, 2010: 8). To clarify, the performances normalize the essentialism of gender categories. By doing 'male' and 'female' identities in accordance with social norms and ideas repeatedly, the gender categories are manifested, and thereby create the appearance of a naturalized and essential dyadic.

Gender is maintained as a category through socially constructed display of gender. Boucher points out, that Butler's theory with its emphasis on the individual, remains limited to the view of the isolated individual, who either is resisting their subjectification or confronting their oppressor (Boucher, 2006:

114), arguably reducing gender to the sum of binary interpersonal encounters, thereby ignoring the social space within which the repetition of acts happens. Thus, this understanding will not be applied, as the focus of the project is mainly on the state as an actor and the space wherein the acts take place.

Finally, *constructivists* argue that our *sex* is biological and gender is a constructed social reality. Thus, a gendered behaviour is a socialised behaviour, meaning a certain acceptable behaviour, which has been created through relations with society and diverges according to a society's social and historical context. Gender in this perception is interactional rather than individual, and it is developed through social interactions (Shepherd, 2010: 8). Hence, rather than an inner natural drive, women and men are acting accordingly to produced ideas in the society about women and men.

Unlike the essentialist perception, gender, through a constructivist lens, rejects biology and physiology as the only explanation for power hierarchies that privilege men over women, and turns towards socially differentiated aspects of gender and *long-standing past practice* that assigns them with a normative meaning (Colclough, 2008: 58).

For the purposes of this study, the following workable definition of gender is constructed :

Gender is the: *"[…]roles, attitudes, values and relationships regarding women and men […] constructed by societies"* (UNHCRH, 1995: Paragraph 13),which *"[…]have been learned, are changeable over time and have wide variations both within and between cultures*" (European Commission in European Commission & EuropeAid, 2004: 2) and the *"opportunities associated with being a man or a woman"* (UNDP cited in Otzelberger, 2011: 16).

This definition stresses the idea that gender similar to identity is a social and symbolic construct. On one hand it refers to a likeness – *other women* - and on the other hand, it refers to a divergence –*'the other'*, in this case, men. Moreover, it seeks to avoid the failures of the past by recognizing the need for including the experiences of both *women and men,* as to avoid gender-blindness. Finally, it stresses that gender, as a concept, must be placed within a cultural context, rather than with a universalistic idea of woman, as it makes space for variations.

Hence, when talking about gender inequalities in the political, social and cultural sphere the target is to make these structural gender differences visible.

Having established the meaning of gender for this paper, I now move to empowerment as a concept.

4.1.2. Empowerment of Women

As pointed out by UNFPA, a critical aspect of advancing gender equality is the empowerment of women, with a focus on detecting and 'naturalizing' power imbalances and providing women with more autonomy to control their own lives (UNFPA, n.d).

I will in this section I draw on Naila Kaaber's work on women's empowerment and the criteria proposed by The Office of the Special Adviser to the Secretary-General on Gender Issues and Advancement of Women (OSAGI)[7], for the purpose of constructing a finite definition, which will take us beyond mere language and define what empowerment is and entails.

Kaabeer puts forward a simple and illustrative definition of women's empowerment: *"the expansion in people's ability to make strategic life choices in a context where this ability was previously denied to them"* (1999: 437). She expands on the choices by emphasizing that the "*choices has to be qualified in a number of ways (...)* and that *choice necessarily implies the possibility of alternatives*" (Kaaber, 1999: 437), furthermore, these alternatives *"must also be seen to exist"* (Kaaber, 2005: 14).

Turning towards OSAGI, who define women's empowerment as:

> *"women gaining power and control over their own lives. It involves awareness-raising, building self-confidence, expansion of choices, increased access to and control over resources and actions to transform the structures and institutions which reinforce and perpetuate gender discrimination and inequality"* (OSAGI, 2001: 2).

It is obvious that the two definitions hold three things in common:
First, empowerment is a process of change, where individuals who earlier have been denied the ability to make choices of their own acquire this ability. Thus, empowerment is an increased power to make and act on own choices in life.

Second, empowerment entails the emergences of more than one option to choose from, which offers an individual the option to make a different choice.

Third, disempowerment is caused by internal structures in society. As Kaaber explains, *"Gender often operates through the unquestioned acceptance of power"* (2005:14). Leading us to Kaaber's last point, namely

[7] OSAGI was created on 1st of March 1997. The office is a part of UN-Women and is headed by the Special Adviser on Gender Issues and Advancement of Women and comprises a Principal Social Affairs Office in charge of Gender Mainstreaming and the Focal Point for Women in the Secretariat. The main objective of the office is to promote and strengthen the effective implementation of the Millennium Declaration, the Beijing Declaration and the Platform for Action, and the Outcome Document of the special session of the General Assembly on Beijing+5. (UN-Women, 2013d)

alternatives must be seen to exist. This point refers to power relations between the two sexes, a power structure which may hamper whether a choice is 'seen to exist'.

As pointed out by both Kaaber and OSAGI, certain power hierarchy structures exists within a society. The acceptances of these, as pointed out by Kaaber, can make alternatives appear as outside the realm of possible choices (Kaaber, 2005: 14). An illustration of such a situation may be women who accept gender-based violence, e.g., domestic violence and sexual harassment in the hands of their husband. A sad example of this is Ethiopia, where merely 17.84 per cent of the women, according to a 2013 study, object to domestic violence (Fisher, 2013). The acceptance of the violence may rest on a notion that to behave differently is outside the spectrum of possible and accepted choices. Thus, alternatives may exist in theory but not in praxis within a society.

To conclude, empowerment is in this project is understood as a process, in which persons who previously had no set of *real* alternatives to choose from, acquire this ability and gain control over the choices in their life.

4.1.3. Gender Equality

The Millennium Declaration makes an explicit reference to equality by recognizing that *"the equal rights and opportunities of women and men must be assured"* (UN, 2000). While referring to it, it lacks to define the understanding of gender equality within a MDG context. Nonetheless, definitions are essential for the achievement of any development goal, thus for the purpose of this project a brief notion of gender equality will be constructed drawing on criteria proposed by three different sources; the European Commission, OSAGI, and Sylvia Walby.

According to a definition by the European Commission, gender equality refers to a *"concept meaning that all human being are free to develop their personal abilities and make choices without the limitations set by strict gender roles",* or as clarified by OSAGI "*rights, responsibilities and opportunities of individuals will not depend on whether they are born male or female."*(OSAGI, 2001: 1). OSAGI furthermore emphasizes in their definition, that gender equality in their optic *"does not mean " the same as""*, meaning *"gender equality does not mean than women and men will become the same*" [SIC] (OSAGI, 2001: 1).

Underlying the concept of gender equality are different perceptions and types of gender equality. Usually, three major types are distinguished, namely; sameness, difference, and transformation. Each of these three types contain theory aspects of gender relations and their connections with different policy domains (Walby, 2003: 2).

Sameness, draws on the idea of equal opportunities or equal treatment. Next, *difference*, rests on special programmes, the explicit tailoring of situations to fit the needs of women, e.g. gender quotas. Finally, *transformation* refers to the introduction of new standards for both men and women to substitute segregated institutions and standards linked to ideas of masculinity and femininity (Walby, 2003: 6-7).

The three types should not be considered as mutually exclusive but as a *"three-legged stool",* as they are interconnected and dependent on each other (Boot and Bennett cited in Walby, 2011: 9).

4.2. Normative Theory in IR

International politics has an inescapable ethical dimension, where crisis, such as famine, climate disasters, genocide, and state suppression, call upon a range of actors, e.g. states, international organisations, and individual citizens, to have/take a moral responsibility to engage in counteractive actions. The same actors are deemed guilty, and held to account for being unresponsive to such calls or for having trigged or contributed to the crisis in the first place (Erskine, 2013: 36).

Judgments of wrong and right, blame for certain actions, assessments of moral obligation warrant equal ethical reflections, and are according to Erskine *"powerful and prevalent aspects of international politics"* (2013: 37). But on what background are these ethical appraisals made? Normative IR theory addresses this question and furthermore seeks, to answer additional problems such as; how values and ethical principles invoked to respond to practical problems in international politics best can be explained and understood. From where authority is derived, how to evaluate, criticize and revise them. Who matters, to what degree, and when can we talk about obligations to others? And, who - or what - are the agents charged with fulfilling these obligations (Erskine, 2013:37).

Said differently, normative IR theory deals with, the ethical dimension of the relations between a whole range of actors in the global sphere. It is the complex task of "*explaining the meaning of, setting out the relationship which hold between, and seeking to evaluate different comprehensive patterns of core normative concepts"* (Frost, 2008: 260) such as, equality, justice, human rights, and women's empowerment, just to mention some. Norms facilitate the identification of problems to be explored, and furthermore what needs to be done (Frost, 2008: 260) and what a state's attitude ought to be (Brown, 2001: 11). In other words, normative theories seek to explore how *things ought to be*, and not *what will be* or *what is.*

By terming the MDGs as *"a normative framework backed with a moral imperative"* (Cornwall & Brock, 2005: 1049), a reference is made to the idea of shared moral commitment of individuals, states and groups,

and moreover, their adherence to international law; and historical and social structures of the international system (Roach, 2008: 227). Moreover, norm implies legitimacy, consent, prescriptions and in the case of deviation from the norm, sanctions (Abercrombie et al., 2000: 243).
Thus, when setting up moral objectives for how a state ought to behave as it is the case with the MDG framework, one becomes engaged in normative theory thinking. By applying normative objectives the UN can create a pressure on one or a number of member states to act in a way, which meets the goals and interests of the UN.

It should be noted that assigning the label 'normative IR theory' to a body of work, does not in any way signify that other theorizing or work being undertaken in IR is in some way not normative, understood in a way that it is unadvised by values or lacking underlying ethical notion. The main differences between other work in IR and normative IR theory is that the latter is first and foremost concerned with the ethical dimension of international politics in ways that former is not. Theorist of Normative IR, do not seeks to separate themselves from the rest of IR, rather they seek to re-define the boundaries so that the 'objects' we study comes to include the values that define who we are and guide our behaviour (Erskine, 2013: 38,41).

In contrast to this stands behaviorism. Behaviorism, as a theoretical paradigm concentrates on observable behavior and disregards the subjective aspects of human activity e.g. consciousness, intention and/or the meaning of life of the involved persons, on which normative thinking is based. Behaviorism engages in observation, for the purpose of establishing general trends, which then are transmitted to relationships in the social sphere. The aim is to understand the doing of persons today and tomorrow, through scientifically produced data (Andersen in Andersen, 2005a: 156,162; Abercrombie et al., 2000: 25-26). Thus, behaviorism seeks to explore *what is* and predict *what will be* through observations.

Despite appearing so, behaviorist thinking is not disconnected from normative thinking. Through observations, behaviorism clarifies and sheds light to the basis of public debate and how the different ideas of morality are shaped within it. Despite claiming to be objective, behaviorism can hardly be considered so, as claiming objectivity is inherently subjective (Andersen in Andersen, 2005b: 287-288). By acknowledging that nothing exists on its own but rests on some sort of values/ideas/thoughts, it is made clear that the observations gathered in connection with this study inherently are resting on a subjective foundation on what ought to be (either willingly or unwillingly), in this case the goals, targets and indicators of MDG 5.

5. Women and Maternal and Reproductive Health in Nicaragua (The National Context)

The case in this study is drawn from Latin America, a region notorious for its numerous conflicts and revolutions, which time after time have blocked further development. The case study provided here, Nicaragua is no exception to this tendency. Before embarking on the analysis, Nicaragua's historical background will be sketched in order to achieve an in-depth understanding of the topic at hand and to reach a more holistic understanding of the settings in which the MDGs are to be achieved. For this reason, attention will be diverted to the numerous and frequently contradictory shifts in social policy on contraception, maternal, health, sex education, and abortion in Nicaragua. The focus will be on the period 1960s up to present day.

Though it arguably is a herculean task, to provide a summary-like chronological order of the population policy history of Nicaragua, it will be attempted. With risks of missing important nuances, the following will be a simplified version. Nonetheless, this task needs to be undertaken to fully comprehend the issue at hand.

The explored period can roughly be divided into three phases of population policies: Pronatalism and the rise of reproductive rights; Re-traditionalisation of genders; and the elimination of therapeutic abort.

5.1. The 1960s-1980s: The FSLN - Sandinista National Liberation Front - From Forced Sterilisation to Pronatalism[8] and the Rise of Reproductive Rights

During the two decades leading up to the 1980s Latin American revolutionaries had opposed any sort of population control or/and family planning proposals, including even the use of contraceptives. This opposition may be perceived as a response to alleged U.S. sterilization projects aimed at poor, indigenous, and black women abounded in Brazil, Bolivia, and other Latin American countries during the 1960s and 1970s. Thus, population control arguably came to be perceived as a means of controlling rebellion and increase US dominance within the region Aramburu, 1994:165-166; Pizzaro, 2004).

In 1968 Somoza in Nicaragua, adopted a birth control programme that was strongly influenced by the US. The targets of the birth control programme were geographic locations known to be hiding grounds for the opposition groups (Mann, 2005: 13; Pizzaro, 2004), this programme aimed to *"kill the guerilla in*

[8] An attitude or policy that encourages childbearing

the womb" (Collinson cited in Mann, 2005: 13). Needless to say, the programme became a symbol of US imperialism.

This association contributed to a contradictory policy climate on population control when the FSLN - Sandinista National Liberation Front overthrew the regime in 1979. While the Sandinista government (1979-1990), led by Daniel Ortega, introduced free universal health care in 1979, which included reproductive health care and access to in theory free contraceptives, a population policy as such was never officially created (Mann, 2005). Yet aspects of one for Nicaragua can be detected in the speeches and actions of the Sandinista government.

Unlike the former regime, the Sandinista government led a pronatalist discourse that encouraged women to have as many children as possible. Mothers were presented as selfless and self-sacrificing, a discourse that was intensified in 1982 when the contra war against US began. As of 1982 motherhood was re-imagined as a patriotic act (Aramburu, 1994:161; Pizzaro, 2004; Mann, 2005: 16), and it became the duty of women as mothers to produce soldiers for the state as to *"to replace those killed in the war"* (Pizzaro, 2004: 1) thus, the reproductive health of women and their identity became *"secondary to greater political goals of unity and development*" (Fernandes cited in Bradley, 2012: 3).

Abortion continued to be a contentious issue during the 1980s. By the end of the 1980s, maternal mortality records confirmed that one third of all maternal deaths were the direct effect of self-induced abortion. Despite the anti-abort position, the police as of 1980 stopped taking legal action against women for having illegal abortions. As a matter of fact during the Sandinista administration not a single doctor, midwife or/and patient was prosecuted for violating abortion statutes. The somewhat tolerant attitude is further illustrated by the fact that abortions during the first three months of pregnancy became available at European-funded non-governmental agencies in 1988 (Mann, 2005: 17, 23).

Turning the blind eye to abortion, and thereby unofficially permitting it, arguably illustrates one more aspect of the unofficial population policy of the Sandinistas. Thus, while the Sandinista government promoted a pronatalist discourse they did not do so, by reducing the reproductive rights of women, rather they increased it both officially and unofficially.

It is worth noticing that young people played an active role in the changes during the 1980s, as they had become actively involved in the revolutionary process. The mobilization of women set the stage for the emergence of a feminist movement (Kampwirth, 2008: 125). Moreover, both educational and employment opportunities for women saw an immense expansion during this time (Berglund et al., 1997: 2; Mann, 2005: 16-18), together with the introduction of equal salaries, and pre- and postnatal

benefits (Neumann, 2013: 803). Nevertheless, as noted by Mann and Berglund et al. these changes were not accompanied by a transformation of machismo culture of Nicaragua (Berglund et al., 1997: 2; Mann, 2005: 16-18), thus the support to women's empowerment was not without internal tensions and contradictions.

5.2. 1990 - 1996: National Opposition Union - Re-traditionalisation of Genders

In 1990, when the Sandinista administration was replaced by a conservative coalition government, elected that same year, the maternal mortality ratio was at 170 deaths per 100,000 live birth (DevInfo, 2012). During the election, the coalition led by Violeta Barrios de Chamorro, from the National Opposition Union, had similar to the former administration, utilized the image of the altruistic mother, by presenting Chamorro as *"the traditional mother"* (Kampwirth cited in Bradley, 2012: 6), who *"simply wished to reunify the Nicaraguan people"* rather than to be a politician. This was done in order to appeal to women who had not been widely mobilized in the Sandinista reforms and, thus had benefitted little from them (Bradley, 2012: 6).

Chamorro was an outspoken anti-feminist who spoke out against the former administration's moderate gender policies and *"encouraged women to return to their rightful places at home"* (Kampwirth, 2008: 127). Among other things, she blamed them for a *"moral decay of the country for promoting loose sexuality, a high divorce rate, and the increase in women working outside the home"* (Chavez cited in Mann, 2005: 19).

The new administration adopted a range of neo-liberal economic policies as devised by the IMF in order to reduce inflation and modernize the economy. The agreement with the IMF included among other things cutbacks in the public sector and government spending on social services, like health care (Mann, 2005: 11, 20 ; Neumann, 2013: 801, 803). The cutbacks soon took its toll on women, and women were increasingly pushed into the informal employment sector, while at the same time forced to take on greater responsibility for the needs of the household, e.g. child care (Neumann, 2013: 803). Moreover, in extension of the IMF formulated policies Chamorro's government introduced a number of changes which reflects her anti-feminist stance, and which arguably were meant to re-traditionalize the Nicaraguan society and roll back the initiatives of the former administration.

First, women's access to reproductive control was restricted. The government actively promoted abstinence rather than contraception, and the access to contraception was limited by introducing a full stop on the handing out of it on public hospitals (Bradley, 2012: 8). Arguably this initiative is in line with the normative values of the Catholic Church who is firmly opposing the use of condoms, and is

advocating abstinence and fidelity (Pizzaro, 2004: 5). Further, legal punishment for procuring or performing abortions was introduced, denying doctors and midwives the legal right to offer abortions. And unlike the former government the new policy was implemented, the government took action against abortion clinics that insisted on staying open and in April 1991, a poor, single mother with five children was arrested by the police for procuring an abortion (Mann, 2005: 20-21, 23), demonstrating the firmness of the Chamorro government.

Second, the sexual education which had been incorporated into the school programs during the Sandinista years, became limited to (religious) moral and biological aspects of human reproduction (Berglund et al., 1997: 2).

Third, the government reformed the Penal Code through Law 150 in 1991, making rape a public crime for the first time. While the law introduces an improvement, which made it possible for the state of Nicaragua to charge a suspected rapist, rather than leaving it to the victim to sue for private compensation, it also had some severe consequence for girls and women. First, the law came to protect the *"inviolacy of family and the reproductive basis of the male-female relationship"* (Isbester cited in Mann, 2005: 22) meaning that a man could not be charged with raping his wife, and next, if raped and pregnant as a result of this, the victim was not allowed access to abortion (Mann, 2005: 21-22).

Fourth, by not modernizing certain aspects of the original penal law, Law 150 continues to promote an ideal of a heterosexual and paternalistic family, e.g. while single, a woman is considered as her parents belonging, but once married, she becomes the property of her husband (Mann, 2005: 23), thus keeping women sub-ordinary to men.

Death ratio from clandestine and self-induced abortions began to rise, together with an increase in the birthrate. A 1996 government study estimated that 36,000 abortions were performed every year, and Pizarro found the often unsafe, clandestine abortions to be among the leading causes of death for Nicaraguan girls and women (Chan, 2003). In between 1993 and 1998, the maternal mortality ratio rose with approximately 59 per cent, reaching 200 deaths per 100,000 births (Mann, 2005), arguably as an effect of the heightened control over and the limitation of women's reproductive health.

In 1994 the ICPD was held in Cairo. During the conference two progressive concepts saw the light: *sexual rights* and *reproductive rights*. Broad consensus was achieved around these ideas and in the end only

eight participants did not initially sign the Cairo declaration: Argentina, El Salvador, Honduras, Guatemala, Ecuador, Malta, the Vatican and last not least Nicaragua (Pizarro, 2004: 2).

5.3. 1997-2006: From Aléman & Bolaños to Daniel Ortega - The Introduction of a Total Ban on Abortion

The 1997 election of the Liberal Party candidate *Arnoldo Aléman* from the Constitutionalist Liberal Party, meant a continuation of the familialist[9] politics of the Chamorro government, including the teaching of sex in schools within a framework of 'family values' where sex was presented as a necessary evil for preserving the species as well as abstinence until marriage, rather than the use of contraception (Mann, 2005: 25). Regardless of the prevalence of clandestine abortion as a major cause of the maternal mortality, as indicated earlier, the Aléman administration launched a new campaign to outlaw all type of abortions. (Mann, 2005: 26).

The Liberals intensified the conservative familialism in policies on reproduction and sexuality initiated by the Chamorro government, and began to roll back the more progressive measures by dismantling the Nicaraguan Institute for Research on Women and integrating Christianity further into state polices (Mann, 2005: 27).

In 2000 the maternal mortality ratio had fallen to 130 deaths per 100,000 live births (DevInfo, 2012).

In 2002 the vice-president to Aléman, *Enrique Geyer Bolaños*, was elected for the presidential seat, and like Aléman, he too was a member of the Liberal Party (Kane, 2008) .

The above motioned integration of Christianity into state policies is reflected in at least two instances during Bolaños, first in 2002 and again in 2004.
In 2002, protests were voiced over a document titled *"For a national sexual and reproductive health program in the health sector reform*" from the Ministry of Health, and in 2004 concerns were raised over sex education manuals to be distributed to teachers around in the country as an educational tool. In both instances, the government after outcries from the church were forced to withdraw the material circulation on the argument that they did not *"reflect our values, our customs, our philosophy of life, and the Christian nature of its ethical and moral principles"* (Bolaños cited in Pizarro, 2004: 3).

[9] *Familial* is normally associated with patrimonialism. It refers to the merger between family lineage and political authority; and are considered to be a type of 'regime' in which actual familial principles and norms make up the political structure and elite (Mann, 2005: 13)

By 2005 the maternal mortality ratio had fallen to 110 deaths per 100,000 live birth (DevInfo, 2012)

The most remarkable action of Bolaños, as with regard to reproductive health, was the removal of an article from the country's penal code that permitted abortion for therapeutic reasons - Article 165 – the so called *"life-of-the-mother exception"* in 2006(Kampwirth, 2008: 6). Under article 165 abortions had been allowed to protect the health of the mother, in the case of rape or incest, or when severe fetal malformation was detected. Abortion for any other reason had been illegal in Nicaragua since 1870. With the approval of the law, Nicaragua became the sixth country in the world to criminalise all types of abortion (Kane, 2008: 365; Amnesty Int., 2009: 11 - 14).

A few days after the vote on abortion, on 6 November 2006, *Daniel Ortega,* from the Sandinista National Liberation Front regained the presidential seat, as they won the 2006 presidential election by a comfortable 10 per cent majority (Kane, 2008: 365).

The president and his administration have arguably started on a path to desert former Sandinistas' ideals, illustrated by the fact that the Sandinistas shortly before the 2006 election not only established an alliance with the local Catholic Church hierarchy, but also unanimous supported the above mentioned law introduced by the former president Enrique Bolaños (Kampwirth, 2008: 123). This stands in a diametrical opposition to the party's former laissez-faire attitude towards abortion and Ortega's own out-right support for abortion during the 1980s (Kane, 2008: 365).

Observers argue that this unexpected change of direction took place due to a close-run election that made the candidates prone to the demands of different interest groups, here among others the Catholic Church, which is the dominating religion in Nicaragua. According to statistics, 64 per cent of Nicaragua's population is Catholic, although only 30 per cent declare themselves practicing Catholics (Pizarro, 2004).
The two main parties stroke an alliance with the Church, as they needed their support in order to gain votes, and they therefore picked up their call to introduce a total ban on abortion (Amnesty Int., 2009: 11). The leverage of this alliance for the election outcome is confirmed by Leonel Arguello, a Nicaraguan doctor who asserts:

"The abortion ban is the result of a political deal between the Church and the Sandinista ruling party (…) It was done to ensure that the Sandinistas could secure votes they needed to get into power" (Moloney, 2009: 677)

At the moment, any abortion carried out in the country carries a criminal punishment of one to two years for the woman, one to three years for the person who performs it, and if induced by a medical

professional a concurrent ban of between two and five years from working in medicine or the health sector (Amnesty Int., 2009: 4). More, there is currently still no law in Nicaragua explicitly establishing the right of women in Nicaragua to decide freely on the number and spacing of children they want to have (SIGI, 2012a).

Thus, the re-election of the Sandinista Daniel Ortega has done little to advance women's reproductive rights.

6. Analysis and Discussion

In this section an analysis and discussion of the barriers to the fulfillment of the MDG 5 will be provided.

As demonstrated in the historical account, shifts in political regimes since the 1979 revolution have led to significant changes in social policy specifically related to maternal and child health, contraception, sex education, abortion, sexual orientation and sexual violence. Yet it evident from the presented historical account, that girls' and women's health often is secondary to political ambitions and religious normative values.

The issues considered in the analysis and discussion will consider a number of factors mentioned in the introduction, theoretical framework and historical account. These will be taken into account as they are considered to have an impact on maternal health (MDG 5) and implicitly gender equality and women's health, the factors are, religion, constructed power relations, and the political context, incl. total ban on abortion. The three factors will be used in the exploration of the six MDG 5 indicators, which will serve as a guide for the exploration. The factors leave space for the acknowledgement that *"women actively make choices, but many of the circumstances under which they act are not of their own making"* (Walby, 1996:16).

Clearly, there are more aspects to maternal health, gender equality and women's empowerment than the ones mentioned here, such as; age of first marriage, inter-pregnancy intervals, economic class, and women's education, to mention some but these are outside the scope of this study, as the six indicators for the MDG 5 will serve as a guide for the exploration. However, some of the indicators will receive more attention than others, depending on the national progress on the examined indicator and material available for the analysis.

6.1. Target 5A Reduce by Three Quarters, Between 1990 and 2015, the Maternal Mortality Ratio

6.1.1. Indicators 5.1 and 5.2

Indicator 5.1 and 5.2 will be analysed in conjunction, as they are considered as overlapping, and thus many of the barriers to their achievement are intertwined and to separate them would arguably be a herculean task.

As it was mentioned in the introduction, 62 per cent of the cases of maternal mortality in Nicaragua are caused by obstetric complications and are avoidable. The leading direct cause of maternal deaths in Nicaragua, is similar to the rest of the developing regions haemorrhage (38.7 pct), followed by hypertensive disorders (22.6 pct.) of pregnancy and sepsis (9.7 pct.) (UNDP, 2010b: 203). As mentioned earlier 99 per cent of all maternal death occurs in the developing regions, suggesting that these deaths are preventable.

However, maternal mortality in Nicaragua occurs for other reason as well. Reasons that are beyond the scope of births attended by trained personnel - *indicator 5.2*, and therefore suggesting a barrier which cannot be removed by the mere attendance of professional personal during birth.

In 2004, the Ministry of Health conducted an analysis of maternal deaths not related to obstetric complications but rather due to violence, unwanted births and suicide. Their report revealed that 11 per cent of all maternal deaths were due to homicide, and another 69 per cent were suicidal deaths of which female adolescent were accounting for 69 per cent (Lubbock & Stephenson 2008: 35).

As mentioned in the introduction domestic violence is widespread within the society, and while the figure suggests a decrease when examining domestic violence during women's pregnancy, the figure remains alarming high with a reported 31 per cent incidences of gender-based violence. Of these 70 per cent reported that the abuse was either of same intensity or stronger compared to when not pregnant, thus indicating an increasing level of intensity during pregnancy. More, 50 per cent of the women reported to have received direct blows to the stomach (Ellsberg et al., 2000: 1660). Gender-based violence affects the health of girls and women in the country, which in turn affects the maternal mortality ratio - *indicator 5.1*, and reinforces gender inequality (UNFPA, 2012b). Pregnant women are found to be particularly vulnerable to gender-based violence, as they run twice the risk of miscarriage (UNFPA, 2013) and therefore are exposed to further pregnancy complications, which may result in their death.

Around 34 per cent of Nicaragua women accept domestic violence under certain condition, i.e. *"burning food, arguing with [husband], going out without telling [husband], neglecting the children, [and] refusing sex"* (Fagan cited in Jones, 2011: 44). As pointed out in the empowerment concept section, there exists certain power hierarchy structures within a society, and the acceptance of these invisible structures, makes alternatives of change appear as outside the sphere of possible choices. Moreover, applying the constructivist gender concept, the rational for tolerating domestic violence may rest on it being a long-standing practice, which have been assigned a connotation, namely as an instrument of disciplinary

instruction, pointing towards socially differentiated aspects of gender within the society. The wide use of gender-based violence, and the acceptance of this by one third of the female segment, points towards the existences of a power hierarchy structure that builds upon ideas of patriarchy and machismo within Nicaragua.

Throughout history, different forms of patriarchy and machismo have dominated in most human societies, reinforced by cultural values descended from a system of male dominance. Its common use and continued practice has made it appear as an almost natural construct rather than a man-made constructed social order. A patriarchal constructed system claims a male superiority over females and organizes this inequality in a hierarchical social order (People's movement for Human Rights Learning cited in Jenkins & Reardon in Webel & Johansen, 2012: 398-399).

The data indication of the existences of a patriarchal power structure in Nicaragua, is supported and confirmed by findings from a number of studies, such as Lubbock and Stephenson, who argue that *"Women in Nicaragua live in a society in which machismo and conservative religious ideology prevails"*(Lubbock & Stephenson, 2008: 63); and Berglund et al.: *"in the culture of machismo in Nicaragua, (...) men continue to dominate women's lives both in public and in private"* (1997: 2).

As it could be observed in the historical account, this structure is formally endorsed by Law 150, which, as stated earlier, promotes the idea of a paternalist family, i.e. a family structure based on patriarchy, where a woman is considered the property of her husband, together with the provision in the Civil Code which contains a formulation naming the father as head of household, and representative of the family (SIGI, 2012b). Thus, there is arguably a lack of law provisions which establishes the principle of gender equality between husband and wife.

The domination over women and maternal health results in that birth and obstetric emergencies are often influenced by male family members (Lubbock & Stephenson, 2008: 47), or said differently women may need the permission of men to access health care which may save their lives. Thus, the subjugation of women coupled with the male veto over their maternal health, including domestic violence, may be considered as contribution factors to the level of the maternal mortality ratio - indicator 5.1 - and a barrier for an increase of births attended by skilled personnel - indicator 5.2.

An additional barrier is the total ban on abortion. The correlation between unsafe abortion and maternal death is well-known (Lubbock & Stephenson, 2008: 1; Kennedy, 2013: 8), and complications from unsafe abortions together with lack of access to emergency obstetric care continue to slow the

progress on reducing the maternal mortality ration in the developing regions (Lubbock & Stephenson, 2008: 1).

Taking into consideration that abortion as of 2006 has been an illegal act in Nicaragua, as described in the historical background, it is likely, as suggested by Amnesty International, that the ban encourages women to avoid the public healthcare system altogether (Amnesty Int. cited in Kennedy, 2013: 8), and therefore placing them in a more vulnerable position all in all.
As reported by WHO, 13 per cent of all global incidences of maternal deaths can be ascribed to complications due to unsafe abortions, and the 2012 Central America Women's Network's report on maternal health, confirms this as the leading cause of pregnancy deaths in Nicaragua (Kennedy, 2013: 8). Women who die from unsafe aborts often do so from severe infections, bleeding caused by the procedure or organ damage, i.e. haemorrage. The Nicaraguan MDG Report informs that only 3 per cent of all maternal deaths in the country result from abortion complications (UNFPA, 2007: 288- 289), whereas 38.7 per cent are due to haemorraging. It is hard not to believe that a significant share of deaths attributed to haemorrage in fact had their origin in unsafe abortion -, or pregnancy complications that require a therapeutic abort.

The new penal code has also affected the provision of health services to women and girls not seeking a provoked abortion. The likelihood of developing complications that require a therapeutic abortions is increased in adolescent girls, the ban is therefore particularly devastating for them. For example, cephalopelvic disproportion, often seen in girls yet to reach physical maturity , this is a life-threatening condition that appears when the pelvis is too narrow for allowing the fetus through (Kennedy, 2013: 8). Yet, health professionals, are not inclined to help girls whose life is at risk by performing a therapeutic abort, fearing criminal prosecution. Even trying to save the foetus during a difficult delivery which, through no negligence or intention to do harm, results in the death of the foetus, is subjected to prosecution. According Amnesty International, a study demonstrated that at least 12 deaths out of a 115 in Nicaragua could have been prevented had therapeutic abortions been accessible (Amnesty Int., 2009: 10).

It may be argued that the total ban on abortion in Nicaragua is aimed at protecting the right of the unborn rather than those of women already born, and it, thus, stands in conflict with the moral norms of the ICPD Declaration, the Beijing PfA and the MDG 5. Further, the law contradicts a body of medical evidence that clearly demonstrates a correlation between maternal deaths and unsafe abortions. Applying the generated concept of empowerment, it is clear that the abortion ban represents a

disempowerment of women. First, the *"ability to make strategic life choices"* (Kaaber, 1997: 437) has not been expanded but rather reduced, as the Nicaraguan women prior to 2006 had some degree of access to abortion. Second, the total ban neither gives women the *"control over own life"* nor *"expansion of choices"* (OSAGI, 2001: 2). Women are disproportionately affected by the law, as their right to control their own body and reproduction arguably is state-controlled, thus the ban also represent an example on a gender inequality initiative.

It is clear that some of the most apparent barriers towards the full realisation of target 5A (indicator 5.1 plus 5.2), are the formally prevalent patriarch power structure, manifesting itself in gender-based violence during pregnancy and male veto over the maternal health of women, and the total ban on abortion, leading women to avoid the health care system, thus increasing their vulnerability to complications of pregnancy or of unsafe abortion, and following thereof an increased risk of death during pregnancy.

6.2. Target 5B - Achieving, by 2015, Universal Access to Reproductive Health

6.2.1. Indicator 5.3 Contraceptive Prevalence Rate

As it will be demonstrated a number of times during the analysis of target 5.B and as already mentioned in the analysis of target 5A, women are arguably sub-ordinary to men in the Nicaraguan society due to a culture of patriarchy and machismo. This certain type of power hierarchy structure poses itself as a barrier to the fulfillment of the two targets of MDG 5 in a number of ways, including indicator 5.3.

As seen in section 2.5.2 contraception use among sexually active women is fairly high, yet other studies have suggested far lower rates on use of contraception when examining individual encounters, signifying inconsistent use. A 2001 study found that merely 3 per cent of Nicaraguans aged 15-19 were using protection (Lion et al, 2009: 92).

Use of contraception was in study of 2009 found to be determined largely by access to contraception, but not as in the physical sense. While contraception is widely available and affordable in Nicaragua, societal stigmas associated with premarital sex and the lack of confidential services at pharmacies and clinics, hinders the access for unmarried women (Lion et al., 2009: 95; Berglund et al., 1997: 8).

The societal stigmas towards premarital sex are intensified by the lawmakers and the church (Berglund et al., 1997: 1).
The lack of political dedication can be seen in the conservative leader Chamorro's blaming of *"loose sexuality"* for decaying the moral of Nicaraguans, together with the numerous articulations of abstinence

rather than contraception, by both the Chamorro and the Aléman administration, have hardly had an encouraging affect on the use of contraception.
The religious influence is clear in the church's rigid opposition towards the use of contraception, as exemplified by the teaching in schools that *"pills and contraceptive injections can make women sterile and increase risks for breast cancer*" (Berglund, 1997: 9), and its advocating of moral values as the best protection, as seen in the following proclamation by a Nicaraguan church representative who claimed that: *"the cause of AIDS infection is the lack of Christian values [and] infidelity and promiscuity"* (Dahlman, 2006: 17). Thus, the church merges medical persuasion with normative religious leverage to intimidate unmarried women and men.

The prevalence of patriarchy within the society may have negative consequences on the reproductive health of women. As stated by Berglund et al. "*the most tangible characteristics of the Nicaraguan society in machismo* (1997: 7). As it was found with regard to maternal health, this phenomenon has great explicatory power in the studied settings.

Often contraceptive use, birth and obstetric emergencies are found to be influenced by male family members in Latin America, for example, a woman may need the authorization of a man to authorize a health care worker to insert an intrauterine device or conduct a tubal ligation or provide other forms of contraception (Lubbock & Stephenson, 2008: 47). This arguably provides the man with the full decision power over the reproductive health of women, and reinforces the inequality between the sex.

Having unprotected sex in Nicaragua may involve a symbolic importance for men in, as it is the manifestation of their power (Berglund et al., 1997: 7), indicating that the non-use of contraception are for some men considered more masculine, and hence, induces a risk-taking behaviour. This merger of contraception and perceived gender ideas can prove dangerous for women who wish to use contraception. In a study by Berglund et al it was found, that if a woman opposes to the man's reproduction power by seeking contraception without his consent, it may result in gender based violence (Berglund et al., 1997: 7).

The application of the empowerment concept, lends itself to the interpretations that the cutbacks on health care in conjunction with negative attitudes towards contraception are attempts from the government to disempower the female section of Nicaragua and continue to deny them the decision-making power over their health care needs.

By promoting more 'conservative' ideas of women and families from political side the alternatives that may had existed prior to Chamorro, ceased to exist in reality. This inhibits them from obtaining

contraception for complex interacting barriers of power hierarchy structures, personal autonomy, and a political and in particular, a religious climate advocating self-restrain rather than contraception. Thus, the state and the church contribute to creating a societal stigma in which the use of contraception by unmarried women is seen as a lack of moral values.

The observed barriers progress on indicator 5.3 shed light on the close relation between the state and the church, and how they together are prescribing normative values for how its citizens ought to behave, despite contradicting with its commitment to the MDG framework. This is evident it the outspoken opposition towards contraception, as well as sex before marriage.

As it will be made evident later, a similar pattern in the contraception context, is seen with regard to married women and their unmet need for family planning, indicator 5.6.

6.2.2. Indicator 5.4 Adolescent birth rate

As it could be read in the introduction and in section 2.5.2, Nicaragua has with 28 per cent a high adolescent birthrate.

For many adolescent, particularly those younger than 15, pregnancies are often not the outcome of a deliberate choice, rather, they are as pointed out by UNFPA: *"the result of an absence of choices and or circumstances beyond a girl's control"* (2013: VII). This statement, if applying this study's utilized empowerment concept, lends itself to the interpretation that adolescent pregnancies in Nicaragua is a symptom of disempowerment, as they; first, have no knowledge of existing alternative, due to a lack of sexuality education; second, hold no power to *"transform the structures and institutions which reinforce"* their disempowerment, as they are underage; and third possess no ability to make a strategic life choice, as the choice to choose differently is outside the realm of possible choices, due to a number of barriers on a number of different sub unites/levels.

To shed light on the constellation of forces that conspire against the adolescent girl and increase the likelihood that she will become pregnant, and thus prevent the accomplishment of MDG 5, an ecological model, developed by Robert Blum at the Johns Hopkins Bloomberg School of Public Health can be utilized (Appendix 3). The model accounts for numerous and multi-layered barriers, found on five levels[10], which are considered to be drivers of adolescent pregnancy, thus it provides a tool that allows the study to focus on different sub-units (UNFPA, 2013: 32-33). Out the five levels, merely four are utilized here, as the fifth level - the individual level - was deemed inaccessible for the study.

[10] The five levels are: the national - , the community-, the school/peers -, and the family -, and finally individual level. (UNFPA, 2013: 32-33)

On the national level, the drivers of a high adolescent birth rate are: the cutbacks on health care; the initiatives to limit the access to contraception; as accounted for above; together with the arguably the low level of government dedication to meeting international obligations, such as the commitment to the ICDP objectives to *"promote the rights of adolescents to reproductive health education, information and care and greatly reduce the number of adolescent pregnancies"* (ICPD cited in UNFPA, 2013: 32); as well as the MDG 5, as indicated by their current progress on the MDG 5 indicators (see section 2.5.1 and 2.5.2). Despite originating from the UN, the MDGs are country-driven, thus, making nationally-owned efforts and dedication to them are crucial for their fulfillment

Despite being a secular state according to the constitution, Catholic values have especially during the last two decades informed national policies (Pizzaro, 2004: 2-3) and the country's international positions, i.e. ICPD in 1994. Their influence can be tracked on several of the different sub-units, and their moral norms have arguably had an effect on the level of adolescent pregnancies in Nicaragua.

On the community level, a number of socio-cultural factors contributes to a high adolescent birth rate, these are: the negative attitudes towards contraception, as accounted for above; gender-specific attitudes and behaviour, such as the persisting and deep-rooted patriarchal attitudes (SIGI, 2012c); and an extensive scale of gender based violence in Nicaragua.

First, societal stigmas towards premarital sex based on religious norms and actively state promoted, may affect many adolescent to not seek contraceptive health services out of fear of societal repercussions, manifesting itself in a lower rates on use of contraception among adolescent, as shown on page 46. Thus, indicating a correlation between use of contraception and the level of adolescent birth.

Second, social constructed norms that claim a male superiority over females, such as patriarchy, reinforces gender inequality and, according to the UNFPA, translate into risk-taking behaviour that can have negative reproductive health outcomes, e.g. adolescent pregnancy (UNFPA, 2013: 38)

Third, the culture of patriarchy further manifests itself through gender based violence in Nicaragua, which as observed in indicators 5.1 has a critical level. The spread of gender based violence, lends itself to two interpretations in this connection. On the one hand, it makes obvious the vulnerability of Nicaraguan girls, and on the other hand it reinforces the effects of the patriarchal system on the health of girl, as it increases adolescents' vulnerability to pregnancy in the first place (UNFPA, 2013: 39; UNFPA, 2012b).

On the school level, the lack of scientific informed and objective based education on sexuality education, as well as the partner's view on gender roles.

The negative influence of the church are reflected in the sexuality educational policies, where the Nicaraguan state as mentioned in the historical account had to modify material on sexuality education after pressure from the church. Rather than discussing sexuality education based on scientific and objective information is regrettable, Nicaraguan adolescent are taught to be open to conception in school text books *"The sexual act should be open for the possibility of transmission of life...Life is the work of God, and only He has the power over it, we are transmitters of life"* (Escobar cited in Berglund et al. 1997: 9)
The lack of sexuality education free from moral values of religion is regrettable, as it can reduce risk-taking behaviours, decrease girls' vulnerability to pregnancy, encourage adolescent to delay sexual activities and behave responsibly when engaging in it (UNFPA, 2013: 44, 55). While the government, and implicitly the church in Nicaragua, argues that the teaching of safe sex goes against the values, customs and philosophy of life in Nicaragua, as demonstrated on the pages 38 to 39, and claims it encourages adolescent to have sex, research from US and four African countries indicates that sexuality education neither hasten the initiation of nor increase sexual activity (UNFPA, 2013: 44-45).

As mentioned above, socially constructed perceptions of masculinity among males have been found to be driving force for male risk-taking behaviour, including unsafe sexual practices (UNFPA, 2013: 46). Patriarchal attitudes do not limit themselves to the older generation, but are also evident in the socialization of youth in Nicaragua where men are taught to be strong, dominating and active, and demonstrate this by participating in intimate partner violence, having several sexual partners and fathering numerous of children. While women, on the other hand, are expected to sub-ordinate and remain sexual passive (Dahlman, 2006: 16; Lion et al., 2009: 91), reinforcing men's power and their own inequality and disempowerment. This drives and increases, according to the ecological model, poor reproductive and sexual outcomes (UNFPA, 2013: 47).

On the family level, drivers contributing to the level of adolescent pregnancies, is in Nicaragua, the prevalence of child marriage, defined as a marriage where one of the partners is 18 or under. In Nicaragua 28,4 per cent of girls aged 15 to 19 are either married, divorced or widowed (SIGI, 2012b), thus the level of child marriage is significant. Marriage may be perceived as a way to secure the future of the daughter (UNFPA, 2013: 48), thus the explanation for the significant level, may be found in the fact that Nicaragua is one of the poorest countries in the Latin America region (SIGI, 2012c). Yet, there has been found to exist a strong correlation worldwide between the level of child marriage and that of adolescent pregnancies (UNFPA, 2013: 48).

It is clear from the model that adolescent pregnancies do not take place in a vacuum but are the outcome of an intertwining set of factors and society levels, which when mapped can be used to craft interventions which may reduce the level of adolescent pregnancies, and in return lift the barriers to girls' empowerment

Further the high level of adolescent pregnancies in Nicaragua testifies to that targeting girls as the problem and seeking to change their behavior through moral values of the church is far from the solution.

Despite having committed themselves to the normative objective of the MDG 5 Nicaragua does not adhere to this, but rather the normative values of the Catholic Church which become evident from the application of Robert Blum's ecological model. These normative values together with the prevalence of a patriarchal society are arguably not contributing to the empowerment of girls but rather the opposite. Further the model points back and verify one of the elements in this study's understanding of empowerment, i.e. that "*Gender operates through the unquestioned acceptance of power relations*" (Kaaber, 2005: 14) between the genders. One of the outcomes by accepting the values attached with a patriarchal society, is the disempowerment of girls, as they become subordinate to boys/men, which in connection with adolescents sexuality induces a risk-taking behaviour that in return makes girls more susceptible to pregnancy at a young age.

6.2.3. Indicator 5.5 Antenatal Care Coverage

The antenatal period presents opportunities for reaching pregnant women with a number of interventions that may be imperative to their reproductive health and well-being, yet its relation to the level of maternal deaths remains inconclusive (Lubbock & Stephenson, 2008: 2, 29). A fast research reveals that this indicator has received less attention in academia, than some of the other indicators, thus the barriers towards its progress are less clear.

As it could be observed in section 2.5.2, Nicaragua is performing well on this indicator, in particular in relation to receiving care at least once during their pregnancy. It is clear from the data, that coming from a somewhat low 1993 and 1997 level Nicaragua has experienced a tremendous progress on this indicator, that no major barriers seem to exist towards receiving care at least once during pregnancy.

Clearly, the changing governments have influenced the level. While the Sandinistas introduced universal health care which included reproductive health care, and thereof regular check-ups during pregnancy as an integral part of maternity care, the governments that followed this cut back on this, due to the

demands of IMF, thus providing a somewhat unstable access to reproductive health care, which may explain the low levels in the mid-1990s.

Again one of the barriers women face when deciding whether or not to seek antenatal care is the same as one of the influential factors discussed in relation to indicator 5.1 and 5.2, namely the influence of men on their access to care (Lubbock & Stephenson, 2008: 47).

As seen, Nicaragua is a country in which patriarchy and machismo are manifested within the political, social and cultural environment and may be exposed in the behaviors of individual men (Ellsberg et al. 2000; Lion et al. 2009: 91; Lubbock & Stephenson, 2008: 63, 78). It is a dominant, dynamic power structure that justifies the subordination of women and grants men the authority, both in the work place and in the home, to dictate women's mobility and autonomy in accessing maternal health care services. A husband's perception of the relevance of accessing maternal health services is an important factor influencing a woman's health care seeking behavior. While a preceding study in reveals that men believe they have the right to decide when a woman should have children, further research concerning husbands' perceptions regarding maternal health care is necessary toward understanding women's health care seeking behaviors in Nicaragua (Lubbock & Stephenson, 2008: 78.)

6.2.4. Indicator 5.6 Unmet Need for Family Planning

As it can be observed from the data presented in section 2.5.2, there exists a correlation between use of contraception and unmet need for family planning, thus it may be assumed that many of the barriers to achieve indicator 5.6 are similar to those of indicator 5.3

The patriarchal structure of the society is found to limit and place a barrier to *"women's reproductive health choices while encouraging a powerful male role in making choices regarding sex and reproductive health"* (Lubbock & Stephenson, 2008: 63). Thus women may have little say in family planning this can lead to unwanted pregnancies. Although the fertility rate has experienced a slight decrease from 2.9 per cent in 2004 to 2.6 per cent in 2011, (World Bank, 2013) one in three is reported an unwanted pregnancy (Jones, 2011: 45).

The prevailing gender ideologies in Nicaragua seems to be contrasting with the actual desire of women, as it can be detected from the historical account, conservative family values have played a significant part for the different administrations, and motherhood has been portrayed as the principal call of Nicaraguan women.

The idea of motherhood as the primary call for women is evident in two instances; first, in the 1980s actions and speeches of the Sandinistas, where high fertility rates were promoted together with the portrayal of mothers as patriots, who could prove their affection to their home-country by having more children; and second, in the conservative lead coalition in 1990s image of their candidate Chamorro as the altruistic and traditional mother, and her encouragement to women to return to their homes to care of the needs of the family, rather than working outside the home.

These finding are confirmed by Berglund et al., who states that: *"motherhood is the central theme which defines Nicaraguan women's lives and identities*" (1997: 7).

While women's primary identity is the mother identity, men are identified by the machismo ideology, connected with patriarchy, which endorse men to prove *"their virility by fathering numerous children"* (Lion et al., 2009: 91), fuelled with the idea that men believe they have the right to decide when a woman should have children (Lubbock & Stephenson, 2008: 78). Moreover, studies indicate that some husbands deliberately seek to keep their wives pregnant as they perceive it as way to ensure her faithfulness as demonstrated in the common saying in Nicaragua *"women should be kept like a farm shotgun: always loaded*" (Ellsberg et al., 2000: 1604).

Arguably, women's acceptance of an idealized notion of motherhood and serving the family leaves them economically dependent on men, and make alternatives appear outside the realm of possible choice.

Similar as in the case with contraception and antenatal care coverage, husbands exercise marital control over the use of contraception within the marriage (Ellsberg et al., 2000: 1604), and contraception is discourage by both government and the Catholic Church. The Church by its rhetoric of God being the only transmitter of life (see page 49), and the government by expressly attempting to reinforce traditional roles for women, as reflected in cut-backs on health care and day care services, and the promotion of school textbooks which highlights traditional 'family values', as exemplified by the importance of legal marriage, their continues discouragement of contraception and premarital sex, and finally their total ban of abortion.

The constructed ideas of gender roles are arguably bound to clash with the normative values of married women's right to control own reproductive health, and thus they present themselves as barriers towards further progress on indicator 5.6.

6.3. Sum Up

The influence from the Catholic Church, national and continuously changing political leadership have for decades determined the social structure of Nicaragua (Pizzaro, 2004: 1-3; Jones, 2011: 39) and it forms the backdrop on which the MDG 5 is to be achieved before the 2015 deadline. As observed above there are a number of barriers towards accomplishing MDG 5 in Nicaragua.

First, there can be little doubt that the state of Nicaragua continuously has sought to conduct a paternalistic control of women's sexual and reproductive behavior, manifesting itself in laws and policies, which arguably are promoting certain stereotypes about women, but also hinders women's empowerment and gender equality. For example, the law that prescribe younger ages for women to marry that for men (SIGI, 2012b)[11], as well as the denial of rights which otherwise could provided women with equal opportunities to that of men, such as Law 150, which establishes the wife as the property of her husband, and the Civil Code naming the father/husband as head of household (see page 43), thus reinforcing the inequality between the sexes by law.

Second, while NGOs and the UN point towards gender equality and women's empowerment as a driver of development, it is clear in a Nicaraguan context that these normative values inherent in the MDG framework and their augments are no match for religion and its interpretations of the bible, and the supremacy of God on lawmaking. In a country like Nicaragua which on paper is a secular state with no official religion, it is striking how influential the Catholic Church remains (Pizarro, 2004: 3). Examples of this includes, the total ban on abortion, discouragement of contraception and premarital sex, and the disapproving attitudes towards sexual education in school. Arguably, the spread of information, science and rationality, have had little effect on the influence of religion. It is clear that the MDGs do not exist in a vacuum, free of pre-existing values, thus the shaping of diverging ideas of morality as oppose to those already existing needs to be considered.

Third, the issue of unsafe abortion must be dealt with as a part of the MDG 5 target 5A on improving maternal health, as it is a preventable cause of maternal mortality. Further it also needs to be included in relation to indicator 5.4. Considering Nicaragua has one of highest rates of teenage pregnancy worldwide, the abortion ban is particularly devastating for adolescent girls, confirmed by figures which suggests that 30 per cent of all maternal deaths were girls aged 19 or under, of which many died due to failed abortion (FSD, n.d.), in fact for Latin America as a whole, the risk of maternal death is four times

[11] With parental authorisation, the minimum legal age for marriage in Nicaragua is 14 years for women and 15 years for men. Without such authorisation, it rises to 18 years for women and 21 years for men (SIGI, 2012b).

higher among adolescents younger than 16 years than among women in their twenties (WHO, 2013b). As found, the probability of developing pregnancy related complications that require therapeutic abortions is increased in adolescent girls, yet this option does not exist.

Fifth, an additional barrier towards fulfilling MDG 5, is gender-based violence. This arguably has a devastating effect on their maternal and reproductive health, and is rooted in gender inequality. As seen on page 38, the state of Nicaragua is playing its part in 'permitting' violence within a marriage as the *"inviolacy of family and the reproductive basis of the male-female relationship"* in protected by law (Isbester cited in Mann, 2005: 22), meaning that a husband cannot get charged with raping his wife. This arguably reinforces the inequality among the sexes, as it is considered the right of the husband to reproduce himself, despite the wishes of his partner. The inequality between husband and wife, is further highlighted by the fact, that even in cases of marital rape, the wife is not allowed access to abortion, thus violating the victim's right to make decisions about her own body. Reducing gender-based violence, inside and outside marriage, is therefore a key strategy for the achievement of the MDGs, and should be included in a post-2015 framework.

In relation with gender-based violence it is clear that the prevalent culture of patriarchy and machismo is devastating for the maternal and reproductive health. While men, as demonstrated in the study, are encouraged to take on a powerful role in making choices regarding sex and reproductive health of women, women are encourage to fulfill a destiny of motherhood. The compound of these, together with women's acceptance of an idealized notion of motherhood leaves them economically dependent on men, and makes alternatives appear outside the realm of possible choice.

These notions about gender roles in Nicaragua clearly obstruct the further progress on the normative values and objectives of the MDG framework, as well as a number of declarations on women's human rights, in fact they are arguably in stark contrast to the ethnical dimension of the internal framework, to which Nicaragua has committed themselves to.

7. Conclusion

This study examined the advancement of MDG 5 within Nicaragua and asked the question, why, in the context of gender equality and women's empowerment, has the fifth Millennium Development Goal not been fulfilled, and what are the barriers for its full realisation?

Besides the concepts - *gender, gender equality and women's empowerment* - a theoretical framework from *normative theory* revolving around the notion of the MDG being a normative framework has been applied to the analysis.

The analysis established the existence of a number of barriers that contribute to an underperformance on MDG 5. These are: the existences of a patriarchal society that manifest itself via gender-based violence; the normative values of the Catholic Church, coupled with political ambitions, that reinforces traditional gender roles; a lack of dedication to the MDG 5, and finally the total ban on abortion.

This study demonstrates the devastating effects of gender-based violence on the maternal and reproductive health of women, as it a contributing factor to a high level of maternal death. The significance of this barrier is intensified by the state, as it does not specifically disapprove of marital rape. Thus it contributes to and reinforces, the subjugation of women upheld and established by a patriarchal society. This study further, highlights that gender-based violence needs to be recognized as detrimental to both the health of women, as well as the overall development of the country, as gender equality and women's empowerment are considered as drivers for not only the social, but also the economic development of a country. Meanwhile, the widespread use of gender-based violence in Nicaragua continues to be a significant barrier towards accomplishing the MDG 5.

By utilizing the concepts and the theoretical framework it was demonstrated how a formed relationship between the state and the Church reinforce the prevailing gender roles. One outcome of this relationship, is the casting of women as primarily mothers, and properties of their husband. Thus, increasing male dominance, and reinforcing the implications of patriarchy. This contestation relates to the concept of empowerment, as it demonstrates the effects of the internal structures on the subjugation of women in health issues only concerning them. Thus, it demonstrates a male-biased perspective on MDG 5. The prevailing gender roles, in connection with the ability to make one's own decision and choices in life, is found to have a negative influence on the MDG 5, and hence, it presents itself as a barrier towards its fulfillment.
More, it is found that these established gender roles do not fit with the normative goals of the MDG

framework, and in the context of the conceptualized gender equality, it unmasks that women are not free to make choices without the limitations set by strict gender roles and norms. Therefore, confirming the influences of gender roles as a barrier to accomplishing the MDG 5.

In regard to the dedication of Nicaragua for committing themselves to the gender goals of the MDG framework, this study casts some serious doubts upon the sincerity of this pledge. Despite having committed themselves to the normative objective of the MDG 5, it is found that Nicaragua does not adhere to this, but rather the normative values of the Catholic Church, as exemplified by the total ban on abortion, the disapproval of premarital sex, use of contraception and sexuality education in schools. This confirms the leverage of pre-existing norms on objectives of development, as the Church similar to the MDG framework has their own normative framework backed with moral imperatives, which are found to be a barrier for the advancement of all the indicators linked to MDG 5. It can therefore be concluded that a lack of dedication to the normative values of MDG framework, presents itself as a barrier to the fulfillment of MDG 5.

This argument is related to the total ban on abortion. A ban which has not only had negative consequences for the progress on reducing the number of maternal deaths, but also contributes to a further disempowerment of women.

A woman who is forbidden from accessing contraception, information about preventing a pregnancy and abort in case of a life-threatening pregnancy condition is denied her right to health. The ability to control one's own health, including maternal and reproductive health is fundamental to women's empowerment and equality. Without it they can neither plan their family; as in whether they want children, the number and the timing; nor their life, and it further prevents them from participating fully and equally in the society.

In relation to the Post-2015 agenda - this study demonstrates that addressing the obstructions that prevent the improvement of maternal and reproductive health and rights is not possible without efforts to engage men as partners in the process. Thus, relating to this study's gender concept, as it confirms the need to place gender within its cultural context, rather than applying a universalistic, gender-blind, idea of women and men.

Finally, the study demonstrates the need for national plans and indicators on how to achieve overall goals and target rather than a one-size model. As they do not exist in a vacuum but as suggested by the findings, co-exist next to individual country settings and pre-existing norms, which needs to be taken into consideration.

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