Chapter 4

Women and the MDGs

TOO LITTLE, TOO LATE, TOO GENDERED

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The United Nations (UN) Millennium Development Goals (MDGs) represent an ambitious set of indicators, initiatives and calls to action. Specific goals such as MDG 6 to combat HIV/AIDS, Malaria and other diseases has seen ambition surge in the creation of new actors and sources of finance primed to address the issues and respond effectively to the indicators. Yet other goals have been found wanting, specifically MDG 5 to improve maternal health and MDG 3 to promote gender equality. These goals have seen increased interest since 2010, but the previous ten years of neglect suggests something quite telling about the relationship between the MDGs and women. Not only have these goals been somewhat neglected, but efforts to deliver on the other goals have in part undermined work towards gender equality and improving the lives of women through the reassertion of gendered norms of women as carers and mothers. Women have occupied a fundamental position in the delivery of the MDGs, yet their labor is seen as freely given. This chapter argues that despite the MDGs outlining ambitious plans for women; their equality, their health and that of their children, the goals have in fact been too little, too late and too gendered. Women have become the stubborn issue of development that fails to go away yet remains vital to its success.

The chapter explores the role of women in the MDGs and how interventions—projects, policies, poverty alleviation tools, and institutions—established to reach the goals have been too little and too late and have undermined efforts to help women living in poverty. It does so by first outlining the inclusion of women in the MDGs, the priority areas around issues of gender inequality and how the UN system has responded to such priorities. Second, the chapter focuses on the too little and too late by exploring the lack of action on MDG 5, the lack of gender in strategies for maternal and child health and the role of the UN Fund for Women (UNIFEM), now UN Women. Third, the chapter considers how the MDGs have been too gendered in delivery and strategy in their embedding of gender norms between men and women. This section explores how re-enforcement of gender norms—specifically women as carers and mothers—have delayed progress in poverty

alleviation rather than heightened it. The chapter then situates the issue of women and gender with wider institutional problems pertaining to the MDG process before offering several recommendations for how the future development agenda beyond 2015 could benefit women living in poverty.

Women in the MDGs

Previous to the MDGs women were included in the development process through the 1995 Beijing Declaration and Platform for Action that recognizes women's rights and gender equality as human rights fundamental to peace and development, exacerbated by poverty and conflict.[1] Women's rights have been advanced within the UN by various legal declarations and initiatives on the status of women in the world such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), Declaration of the Elimination of Violence Against Women, and the Declaration on the Right to Development within the UN's Declaration on Human Rights. As part of the UN such declarations are binding on member states around the world and compel the various bodies of the UN to action. Key UN agencies that are central to poverty alleviation and development include specialized units on women and gender—such as the Gender and Development section of the World Bank and the UN Girls Education Initiative housed in the UN Children's Fund (UNICEF)—established to eliminate gender inequality and to promote the rights and roles of women in all aspects of social, political and economic life. It is through these declarations, institutional responsibility and UN projects such as five year plans for the Advancement of Women that women were included in the development process prior to the MDGs. However, despite such inclusion these issues and projects tended to occupy a sideline in development policy-making and processes, with women and gender being tacked-on to existing projects. Since the introduction of the MDGs, specialized projects, units, and conventions have emerged to attempt to fully integrate women into the everyday workings of the UN and the wider development community.

In statement of intent, at least, women became the core objective of the MDGs. Women and gender are specifically highlighted as a stand-alone issue in MDG 3 to promote gender equality and empower women and feature in targets 1.B—full and productive employment including women and 2.A—both boys and girls complete primary education.[2] Such inclusion indicates specific recognition on the part of the UN and the international community of the link between

[1] UN, *Beijing Declaration and Platform for Action,* (New York: UN, 1995), http://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf.
[2] UN, *Develop a Global Partnership for Development,* http://www.mdgmonitor.org/goal8.cfm.

gender inequality and poverty. The goals are framed in a specific way to focus on the experiences of women living in poverty and to recognize women as fundamental to the development process. This is evident in the emphasis and support placed on training and developing the skills and campaigns of women as political candidates, increasing women's access to micro-finance and specific skill development for paid employment, and campaigns to end violence against women.[3] Commitment to such initiatives by a range of UN agencies—UN Population Fund (UNFPA), UNICEF, UN Women, UN Educational, Scientific and Cultural Organization (UNESCO) and the World Bank—in funding and leadership shows the broad-based institutional support for women within the UN system.

The biggest sign of intent is the inclusion of a specific goal to promote gender equality and empower women. MDG 3 emphasizes the need to increase rates of female employment in decent, paid work; decrease the amount of women working in informal employment[4] and promote women's access to top level jobs by understanding and addressing the barriers to them; and support women's inclusion in political positions and government through quotas and special measures.[5] A fundamental part of MDG 3, which cuts across many of the other eight goals has been the emphasis on eliminating gender disparity in education, specifically girls' access and continued uptake of primary and secondary education. The emphasis on women and girls in development similarly cuts across MDG 2 that stresses equality in access to primary schooling for "boys and girls alike" and MDG 6 that recognizes the role of education of women in the prevention of HIV transmission and giving women greater economic and social options.[6] MDGs 4 and 5 have significant implications for women, specifically pregnant women and women who are mothers or carers. The three health goals (4, 5 and 6) all emphasize the reproductive aspect of women's health and thus the position of women as central to the development agenda.

Some progress has been made in reaching these goals. People living with HIV are living longer, prevalence rates are down and new infections are seemingly in decline.[7] Child mortality has seen a

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[3] http://www.un.org/millenniumgoals/pdf/MDG_FS_3_EN.pdf.
[4] Informal employment can refer to a number of things, this chapter uses Razavi's understanding as "very *different* kinds of work, some akin to survivalist strategies with low returns that people resort to when economies stagnate, while other kinds of informal work (piece-rate, wage-work) are integrated with and contribute to processes of accumulation of a national or global scale" Shahra Razavi, "The Gendered Impacts of Liberalization," in Shahra Razavi, ed. *The Gendered Impacts of Liberalization* (Oxon, UK: Routledge, 2009): 16.
[5] UN, *Promote Gender Equality and Empower Women* (New York: UN, 2010), http://www.un.org/millenniumgoals/pdf/MDG_FS_3_EN.pdf.
[6] UNAIDS, *Women and Girls*, http://www.unaids.org/en/strategygoalsby2015/womenandgirls.
[7] UN, *The Millennium Development Goals Report* (New York: UN, 2010), http://www.un.org/millenniumgoals/pdf/MDG%20Report%202010%20En%20r15%20-low%20res%2020100615%20-.pdf#page=22.

28 percent drop since 1990 and more pregnant women living in rural parts of developing countries are receiving "skilled assistance."[8] Beyond these measurable statistics, women have become much more visible in the development process. Women are the main tools of new or innovative forms of development delivery such as micro-finance projects and conditional cash transfers. Women are seen as the main providers of community care for health and implementation of HIV/AIDS initiatives[9] and as such occupy multiple positions in this regard. Yet according to the UN's own research, those MDGs that have a direct impact on the lives of women living in developing countries have been found wanting. There are still more men in paid employment than women, men occupy the top jobs, and most politicians are men, with women disproportionately represented in informal work.[10] There has been little progress in reducing levels of teen pregnancy and huge disparities between the level of neonatal care afforded to the rich and poor and those living in rural settings remain.[11] There has been "little or no progress in recent years" in reducing child mortality[12] and maternal health has suffered from poor health infrastructure and inadequate financial support.[13] This lack of progress towards those goals that specifically affect women can be explained by the implementation of the MDGs being too little, too late and too gendered.

Too little, too late

2009/10 marked a turning point for maternal and child health. Previously unaddressed beyond efforts to reduce mother-to-child transmission of HIV, there has been a re-assertion of effort through the Global Strategy for Women's and Children's Health (2010); UNFPA's Safe Motherhood Strategy; the World Bank's Reproductive Health Action Plan 2010-2015 *Better Health for Women and Families*; the Global Consensus on Maternal and Neonatal Health (2009); and the promise of a new Department of Maternal, Newborn, Child and Adolescent Health within the World Health Organization to be launched in 2011. These strategies alongside various statements of intent by bilateral donors such as the UK Department for International Development (DFID)[14] suggest a shift in political will and intent towards reaching these previously neglected goals. However, such policies have come at a time which is arguably too late to implement before the 2015 deadline and have come into play during a period of financial crisis and austerity. Though attention to maternal and child health is currently at its height since 2000, reductions in public

[8] UN, *The Millennium Development Goals Report*, 22.
[9] Sophie Harman, "The Dual Feminisation of HIV/AIDS," *Globalizations* 8, no. 2 (2011): 213-228.
[10] UN, *The Millennium Development Goals Report*.
[11] UN, *The Millennium Development Goals Report*.
[12] UN, *The Millennium Development Goals Report,* 27.
[13] UN, *The Millennium Development Goals Report,* 34.
[14] DFID, *Reproductive, Maternal and Newborn Health,* http://www.dfid.gov.uk/Global-Issues/Emerging-policy/Reproductive-maternal-newborn-health/.

spending in North America and Western Europe during the current period of financial austerity will have a direct affect on the money available for overseas aid. Funding towards HIV/AIDS programs has started to decline and is set to decrease further.[15] This will impact on the number of children born with HIV and the maternal health of their mothers as efforts to support prevention of mother-to-child transmission and funding to support treatment and drug purchasing gets cut. In many countries the significant sums of money directed to HIV/AIDS has been used to support community health centers and resources. Many women only visit or are able to access such health centers and see medical professionals because of wider anti-retroviral programs and services for HIV prevention. Two and a half million children under the age of 15 are living with HIV;[16] a cut in funding to HIV-specific initiatives will see a reversal of MDGs 4, 5 and 6.

Beyond budget cuts, the policy frameworks and project strategies to promote maternal and child health do not go far enough in recognizing gender and the difference in how women experience healthcare. Difference and the experience of healthcare has recently been the central focus of maternal health campaigns, and efforts towards decentralization and more community-based health delivery has been evident. Yet this is not for all women, just for pregnant women and mothers. MDGs 4 and 5 have become increasingly conflated with strategies to implement them. Global strategies for women's and children's health are not specific to maternal health but follow a similar pattern to multi-sectoral interventions developed within HIV/AIDS and neglected disease strategies. These strategies were initially developed and put into practice by the World Bank through programs such as the Multi-Country AIDS Program (MAP).[17] Such projects emphasize the role of multiple state and non-state actors in the planning and delivery of services, decentralization and the earmarking of specific funds to enhance civil society engagement. UNFPA's Safe Motherhood Strategy; the World Bank's *Better Health for Women and Families*; the Global Consensus on Maternal and Neonatal Health (2009) all bear clear similarities to such high profile AIDS projects: they clearly follow the same multi-sectoral framework, have similar indicators and lack a gender or women-specific approach to addressing the issue of maternal and child health.[18] In a way such a similarity should not be a problem as MDG 6 arguably presents one

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[15] Betsy McKay, "AIDS funding slides," *The Wall Street Journal* (16th August 2011) http://online.wsj.com/article/SB10001424053111903392904576510800738065130.html?mod=googlenews_wsj (accessed August 2011); and Sarah Boseley, "In spite of the Bruni glitzkrieg, Aids funding is set to decline," (October 2010), http://www.guardian.co.uk/society/sarah-boseley-global-health/2010/oct/06/hiv-infection-aids

[16] http://www.unaids.org/globalreport/Epi_slides.htm (accessed August 2011)

[17] Sophie Harman, "The Causes, Contours and Consequences of multisectoralism," in Sophie Harman and Franklyn Lisk, ed., *Governance of HIV/AIDS: Making Participation and Accountability Count* (Abingdon: Routledge, 2009): 165-179; Sophie Harman, *The World Bank and HIV/AIDS: Setting a Global Agenda* (Abingdon: Routledge, 2010)

[18] UNFPA, "Safe Motherhood," http://www.unfpa.org/public/home/mothers; World Bank, *Better Health for Women and Families: The World Bank's Reproductive Health Action Plan 2010-2015* (Washington: World Bank, 2010).

of the more successful goals and therefore it seems common sense to use a similar strategy. Yet this is problematic as it suggests that not enough has been done to address these goals in a manner which is issue and context-specific or cognizant of the differences between women and men. Moreover, research suggests that multi-sectoral forms of participation have tended, in practice, to be bureaucratic, confused and highly centralized by the donors and architects of the project.[19] Hence these strategies are not country, issue or gender specific or locally driven. Instead a blueprint model has been adopted and adapted to fit the issue. Strategies to combat maternal health have to address the complexities and specific needs of this health concern for them to be effective.

A key explanation for the lack of gender specific strategies to address maternal and child health has been the absence of a lead agency with a strong mandate and political support within the UN to address women's issues. Up until January 2011 the agency responsible for the empowerment of women and the promotion of their rights was UNIFEM. Despite recognizing the need for interventions that acknowledge gender, difference and women's experience, UNIFEM lacked financial, institutional and political support to effectively carry out a mandate for women independent from larger agencies such as UNDP. UNIFEM was sidelined from decision-making by exclusion from key meetings at both headquarters and country level.[20] UNIFEM was not a co-sponsor of the Joint UN Programme on HIV/AIDS (UNAIDS) that coordinates the UN's response to HIV/AIDS and hence mother-to-child transmission. Beyond UNIFEM, women and gender units within other agencies such as the World Bank have faced similar issues of sidelining and tokenistic integration within development projects and policies. Involvement of women and gender issues is often dependent on the type of project, individual interest, concern for gender projects and awareness of specialized support within a specific agency, and constant interaction and pressure on the part of the women and gender representative.[21] The lack of presence in meetings, in country, with governments, and independence from other UN agencies restricted UNIFEM and other women-specific agencies' ability to fully raise the profile and voice of women both within the UN and within member states.[22]

Effort to address these institutional shortcomings is evident in the formation of UN Women in January 2011. UN Women has a mandate to promote gender equality and empowerment by helping intergovernmental bodies create norms, standards and policy, supporting member states

[19] Harman, "Causes, Contours and Consequences"; Harman, *World Bank and HIV/AIDS*.
[20] Harman, "Dual Feminisation"
[21] *Interview* Waafus Ofosu-Amaah, Senior Gender Specialist, World Bank, 28th April 2006, Washington DC; Harman, *World Bank and HIV/AIDS*.
[22] Harman, "Dual Feminisation."

to implement such standards and holding the UN system to account.[23] In terms of mandate, approach and staff it is similar to UNIFEM. Yet a crucial difference is its autonomy within the UN system from UNDP, which although collaboration is paramount to the working operations of the UN, provides space for women's issues to be consistently raised within the system and UN Women their own seat at the table of development discussions. Yet, the old problems of relations with sovereign states and effective gender mainstreaming that takes into account women's lives and difference between people whether men or women when delivering the MDGs remain. For UN Women to be successful requires a combination of building an effective and clear policy and program profile, fostering internal relations and networking outside of the UN to secure external support and pressure for change. Alone, UN Women's voice will not be heard and the activities of UN Women will similarly become too little, too late.

Too gendered

Part of the wider problem underpinning the too little, too late has been the embedding of gender roles by the very programs and policies set to empower women out of poverty and the successful realization of the MDGs. This is evident in poverty alleviation strategies that have focused on various forms of social protection and micro-finance as well as projects and programs aimed at specific goals such as MDGs 1, 4, 5 and 6. Inclusion of women in the development process often reasserts women's position in unpaid work and the informal economy that rests on gendered assumptions of women-as-carers and mothers, and actually sees women as secondary to the development process as they prioritize the lives and needs of others first. This section considers the gendered nature of poverty alleviation strategies in general before focusing more specifically on how such gender roles manifest themselves within MDG-specific interventions.

Since the mid-1990s the development community has been increasingly interested in the role of social protection as a form of reducing inter-generational poverty and giving more power in decision-making and aid spending directly to people. Social protection in the form of social assistance such as housing benefits, social insurance such as free health care for the elderly and labor market regulation have been dominant features of social policy around the world since the end of World War Two,[24] and have underpinned much development practice and aid giving. However, new forms of social protection such as cash transfers given direct from international aid

[23] UN Women, "About us," http://www.unwomen.org/about-us/about-un-women/.
[24] Theodore R. Marmor (ed), *Poverty Policy: A Compendium of Cash Transfer Proposals (2008 Edition)* (Transaction Publishers: USA, 2008).

agencies to families in need of support have been seen as a "revolution from the global south"[25] that have the potential for real long-term change in the fight against poverty. These programs emphasize intergenerational poverty reduction through increased school uptake, the promotion of access to primary healthcare, provision of food and nutrition, and giving the poor the ability to make their own decisions about where to spend aid money. Hence, cash transfers are provided to poor households as an efficient means of assisting or facilitating demand for public services that would equip individuals with the basic capabilities of education, nutrition and primary healthcare and thus poor households more equal opportunities in life.[26] These transfers have come to constitute a prominent feature of poverty reduction strategies throughout Latin America, involving hundreds of thousands of households, and billions of dollars of investment.[27] The scope and budgets of these projects are so large in part because of their perceived success. Development practitioners, specialists and politicians have all been keen to highlight the positive outcome of such projects and their potential for future practice.[28] In this sense they are very much seen by agencies such as UNICEF and the World Bank as a key tool in ending poverty and the successful realization of the MDGs. Fundamental to the success of these projects has been women.

New forms of social protection such as cash transfers are predominantly given to women, who are perceived to be more reliable in spending money on the human development of their children than men.[29] For many this has been seen as a source of empowerment for women as they have greater control over family budgets and household spending and promote education, empowerment and self esteem in young girls. They have thus been a central vehicle in which to assist in the delivery of MDGs 1 and 3. However, for others cash transfers perpetuate the notion

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[25] Armando Barrientos and David Hulme, "Social Protection for the Poor and Poorest: An Introduction," in Armando Barrientos and David Hulme, ed., *Social Protection for the Poor and Poorest: Concepts, Policies and Politics,* (Basingstoke: Macmillan Palgrave, 2008); Joseph Hanlon, Armando Barrientos and David Hulme, *Just Give Money to the Poor*, (Sterling: Kumarian Press, 2010).

[26] Natalia Caldes and John Maluccio, "The Cost of Conditional Cash Transfers," *Journal of International Development* 17 (2005): 151-168; Alain deJanvry and Elisabeth Sadoulet, "Making Conditional Cash Transfer Programs More Efficient: Designing for Maximum Effect on the Conditionality" *The World Bank Economic Review* 20, no.1, (2006): 1-29; Paul Gertler, "Do Conditional Cash Transfers Improve Child Health? Evidence from PROGRESA's Control Randomized Experiment," *Health, Health Care and Economic Development* 94, no.2 (2004): 336-341; Seth Gitter and Bradford Barham, "Women's Power, Conditional Cash Transfers, and Schooling in Nicaragua," *The World Bank Economic Review* 22, no.2 (2008): 271 – 290; Emmanuel Skoufias and Vincenzo Di Maro "Conditional Cash Transfers, Adult Work Incentives and Poverty," *Journal of Development Studies* 44 no.7(2008): 935 – 960.

[27] Sarah Bradshaw, "From Structural Adjustment to Social Adjustment," *Global Social Policy,* 8, no.2 (2008): 188-207; deJanvry and Sadoulet, "Conditional Cash Transfer Programs"; Skoufias and DiMaro "Conditional Cash Transfers."

[28] Sarah Barber and Paul Gertler, "Empowering Women to Obtain High Quality Care: Evidence from an Evaluation of Mexico's Conditional Cash Transfer Programme," *Health Policy and Planning,* 24 (2009):18-25; Tania Barham and John Maluccio, "Eradicating Diseases: The Effect of Conditional Cash Transfers on Vaccination Coverage in Rural Nicaragua," *Journal of Health Economics* 28 (2009): 611 – 621; Armando Barrientos and David Hulme, "Chronic Poverty and Social Protection: Introduction," *European Journal of Development Research* 17, no.1 (2005): 1-7.

[29] Gitter and Barham, "Women's Power."

that women are the solution to the male problem of intergenerational and family poverty[30] and in application have come to support gender norms of women as carers and asymmetric gender roles.[31] In placing women as the central recipients of personal aid budgets, cash transfers represent an extension of what Chant calls the "feminization of poverty alleviation"[32] wherein women bear the burden of responsibility and become the site of international development initiatives.[33] The view that social protection projects leads to women's emancipation from poverty just through their participation is thus somewhat problematic. It presupposes that the main role of women in poverty alleviation is to prioritize the lives and needs of others and to implement the strategies devised by governments and international aid agencies. Their freedom and input into decision-making only exists within the narrow framework of a specific government project. Women's inclusion in micro-finance and social protection strategies continues to position "poor women" as community-focused and family-based, reinforcing gender stereotypes and distinctions between men and women in terms of reproduction, with little consideration of women's lives and needs. Underpinning such a position is two gender norms that have become intrinsic to the development process: i) that women are mothers and carers first and women second; and ii) women give their labor for free. These two norms are particularly evident when considering the role of women in the realization of MDGs 4, 5 and 6.

Framing women primarily as mothers or carers in the goal process is particularly evident in the equating of women's health with maternal and child health in MDGs 4, 5, and 6. The MDGs position women and their health as only important in their role in childbearing and childrearing. The strategies for maternal health and child health share the same priorities, types of intervention, and overlapping mandates between the agencies that are set to deliver them. This is evident in the common strategy for areas in maternal and child health such as the Global Strategy for Women's and Children's Health and the formation of joint Departments and policy approaches that tend to conflate the two issues. Within each of the strategies developed since 2010 to address maternal health and child health there is no direct reference to how women experience healthcare

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[30] Bradshaw, "Structural Adjustment."
[31] Maxine Molyneux, "Conditional Cash Transfers: A 'Pathway to Women's Empowerment'?" *Pathways to Women's Empowerment* Working Paper 5 (Brighton: Institute of Development Studies, 2008).
[32] Sylvia Chant, "Re-thinking the 'Feminisation of Poverty' in Relation to Aggregate Gender Indices," *Journal of International Development*, 7, no.2 (2006): 201-220.
[33] Sarah Bradshaw and Ana Quiros Viquez, "Women Beneficiaries or Women Bearing the Cost? A Gendered Analysis of the *Red de Protecion Social* in Nicaragua," *Development and Change* 39, no.5 (2008): 823-844; Maxine Molyneux, "Mothers at the Service of the New Poverty Agenda: Progresa/Oportunidades, Mexico's Conditional Cash Transfer Programme," *Social Policy and Administration* 40, no.4 (2006):425-449; Maxine Molyneux, *Change and Continuity in Social Policy in Latin America: Mothers at the Service of the State?* Programme on Gender and Development, Paper No. 1 (UNRISD: Geneva, 2007).

differently.[34] The MDGs recognize the importance of caring for pregnant women and mothers and the urgent need to address the needlessly high rates of maternal mortality, yet they also do so to the exclusion of women's other needs. Whilst the MDGs have been forward looking in addressing women's maternal health, in conflating much of this with child's health they have adopted and promoted a gender norm within the goals that only recognize women in development for their role in childbearing and childrearing, or in other words social reproduction. This emphasis sidelines other efforts to empower women in roles beyond the family and social reproduction in the production of private capital in which they have claim to and presence in public life through government positions. Women are seen as fundamental to the development process, but only within a narrow gendered frame that sees their role as the production and protection of children and carers within the community.

The role of carers within the community is particularly evident in regards to MDG 6 to combat HIV/AIDS and other diseases. Similar to MDGs 4 and 5, there have been considerable efforts on the part of the international community to address the disproportionate rates of female HIV prevalence. Globally there are more women living with HIV than men. This difference is particularly acute in sub-Saharan Africa. Women are disproportionately infected and affected by HIV not just because of physiological factors but by gender inequality.[35] The last ten years have seen a strong emphasis on community-based decision-making and project delivery as a means of combating HIV/AIDS. At the forefront of this have been women who act as peer educators and home-based carers looking after their family and neighbors affected by the disease. HIV/AIDS has given women a quadruple burden of responsibility as they now have to look after their own family, work, care for the orphans of their extended family and local community, and engage in community action such as home-based care.[36] This burden is endemic throughout Africa, and is often a great strain on grandmothers.[37] Women give this labor—home-based care, peer education, pastoral care of orphans and vulnerable children—for free. Despite advocacy campaigns on the part of agencies such as the Stephen Lewis Foundation to pay for such labor, the majority of agencies responsible for combating HIV/AIDS and delivering the MDGs assume that women will

[34] The only acknowledgement of these types of issues can be found in the appendices of the World Bank's Action Plan for Maternal Health, see Sophie Harman, *Global Health Governance* (Abingdon, UK: Routledge, 2012) for further detail.
[35] Harman, "Dual Feminisation."
[36] Ibid.
[37] For further information on the role of grandmothers please see the grandmothers campaign run by the Stephen Lewis Foundation, http://www.grandmotherscampaign.org/index.php?option=com_content&task=view&id=12&Itemid=46&limit=1&limitstart=1.

perform such tasks for free. Despite these roles, women's participation in community decision-making and formal bodies such as community or district AIDS councils is not proportionate to the work they do.

What is somewhat pertinent about the gender roles ascribed to women within the MDG process is the absence of men and boys. Men feature in discussions of how the goals should affect men and women, boys and girls equally and pay attention to both, but strategies to involve men in the development process are lacking. This can be explained in several ways. First men are already considered to be active in the design and implementation of development strategies and thus special dispensation towards them is not necessary. Second, development activities are not attractive to men as other than decision-making and agenda-setting roles, project delivery and implementation tends to be unpaid. Alternatively, and third, development delivery is seen as an extension of women's work and role in unpaid social reproduction. Taken together these factors show a need for wider recognition to increase women's activity beyond the family and the informal economy as well as the role of men within the family and the communities in which they live. This recognition is evident in the directives and statements in support of the goals, specifically MDG 3,[38] yet these statements in practice are somewhat separate from the policies and projects designed to improve the role of women.

Despite some evidence that the UN system recognizes the problem of women's unpaid labor and role in social reproduction, and the need to see how interventions affect men and women differently, in effect this has not been interwoven in the *delivery* of MDG strategies. In practice, it is women not gender and a very specific type of "woman" that is emphasized in delivering the goals. The combination of the emphasis on women, their role as mothers and carers, and the assumption that their labor is free in the practical delivery of MDGs 4, 5 and 6 undermines any gains or the successful realization of MDG 3. Seeing women's labor as freely given traps women in these roles and reduces space for their wider inclusion in political office and community decision-making or involvement in paid labor and good jobs. For parts of the UN to promote the need for formal, paid employment of women, and then for other parts of the UN to engage women in free unpaid services, contradicts the over-arching aims of the MDGs for women and in so doing reduces the potential of the goals to fully combat poverty.

Vogue goal-setting and the UN system

[38] UN, *The Millennium Development Goals Report* 24.

The problem of the MDGs being too little, too late, and too gendered on the issue of women and poverty alleviation is symptomatic of a lack of acknowledgment as to how the successful realization of different goals inter-relate and in some areas undermine or contradict the over-arching goal. This is evident in the funding portfolio of specific agencies, the tendency for funding to cluster around "vogue" development issues, and the problem of goal-based strategies for development. All of which are endemic within the UN system.

A key factor in explaining the sidelining of women and gender from the MDG process has been the ability of key agencies to attribute significant funds to specific issues that fit within their institutional objectives. With the exception of UNICEF, UN agencies are able to make large statements of intent but lack the funding capacity for on-the-ground projects. This is where institutions with special status in the UN such as the World Bank have been able to sway certain agendas and prioritize specific interventions through the large-scale funding support they are able to offer. Agencies such as UNIFEM and UNFPA have set targets and advocated for greater investment in maternal and child health for the last 40 years, yet widespread action did not come fully onto the agenda until the World Bank pledged significant funds through its 2010-2015 *Better Health for Women and Families*, a US$1.3 billion project that saw a substantial 59 percent increase towards maternal health funding on recent years.[39] A key problem for UNIFEM was it lacked the budget to implement and fund specific projects in pursuit of its overarching objectives, hence could only tack-on or frame its objectives to the wider agenda of those actors with the budgets to implement. Of course, agencies such as the World Bank has UN specialized status and are thus mandated to work in support of the wider UN system and high-profile objectives such as the MDGs. This tends to be the case in practice at the country and headquarter level but can also vary across country, issue and individual personality as rivalries, jealousy and claims to ownership of success come to the fore. In practice partnerships among and within agencies can be hierarchical and dependent on country presence, timing, knowledge exchange and budget.[40] The result of this is that those agencies with large funding portfolios and presence having greater say on which development issues and strategies are prioritized.

The priority afforded to certain development initiatives is indicative of a wider problem within the MDG process: vogue development aid. Vogue development aid refers to the ability of key actors

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[39] World Bank, "Reproductive Health and the World Bank: The Facts," http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/EXTPRH/0,,contentMDK:22965013~menuPK:376861~pagePK:148956~piPK:216618~theSitePK:376855,00.html

[40] Harman, *World Bank and HIV/AIDS*.

within the development community to focus on a specific issue or set of issues and galvanize political will and financial support for such an issue. This can occur through the setting of clear objectives, seed funding, or effective issue framing. Within the MDGs, specific goals have been framed in a particular way to elicit wider support and global attention towards the cause. This is often seen to be the case with HIV/AIDS. The international community built around HIV/AIDS successfully made the case for support among the political community through framing the issue as more than a development problem but one of international security[41] and a disease that is having an enormous impact on the lives of children in developing countries. Whilst both of these frames can be seen as true to a certain extent, they are also true for other MDGs that have received less attention. The HIV/AIDS response was effective in snowballing political will and support to combat the disease and position it as something exceptional, a comprehensive development concern. Yet HIV/AIDS is now going out of fashion with maternal and child health coming into vogue. As gender equality undercuts an array of development issues it is thus difficult to maintain the relevance of gender beyond the role of women in specific issues such as HIV and maternal health as bloody women become too complex to address. Whilst the rhetoric of the UN towards "One UN" or "Delivering as One" would suggest an integrated system that addresses inter-related issues as a whole,[42] in practice the eight goals are often addressed as individual entities.

The issue of addressing specific goals alone or at best with cross-over benefits and influence is part of a wider issue of goal setting as a means of promoting development. On the one hand this form of goal setting allows the international community—UN agencies, governments, civil society, private donors and individuals—to be held to account, it gives a real measure of progress and a clearly defined agenda in which to work towards. Yet it also excludes that which cannot be measured, and importantly does not address development as a cohesive whole that has inter-related processes, impact and outcomes. Gender is stubborn in its inability to be neatly compartmentalized into a specific goal or objective, and where efforts to do so exist they have been undermined by competing goals. Numerous issues that are central to the realization of the eight goals—infrastructure, road building, training of specialized staff, education and sanitation systems etc—are omitted from the MDG process. For example, provision of access to neonatal care requires the building of health centers in rural communities, safe and affordable transportation to health centers, nutritional support, and the training and payment of community-based midwives

[41] Colin McInnes and Kelley Lee, "Health, Security and Foreign Policy," *Review of International Studies* 32, no.1 (2006): 5–23.
[42] Delivering as one has long been an issue within the UN, see http://www.un.org/events/panel/resources/pdfs/HLP-SWC-FinalReport.pdf and Margaret Joan Anstee *Never Learn to Type* (West Sussex, UK: Wiley and Sons, 2003).

and provision of incentives to keep those trained experts in developing countries. Hence a key challenge for MDG 5 is the provision of effective, community-responsive health care systems, and long term investment in the health workforce. Though in practice agencies have tried to use funding towards the MDGs to tackle some of these broader infrastructure issues, investment is still desperately required and initiatives to do so have, in the main, been found wanting. The trick is how to balance much needed investment in infrastructure with specific targets and emergency development concerns.

To 2015 and beyond

Despite this critique of the MDGs being too little, too late and too gendered to fully confront the position of women living in poverty, there are several small and large adjustments that could be made. The first would be to recognize women's role in social reproduction and the implementation of development strategies. To fully achieve MDGs 1, 2, 3, 4, 5, and 6 the development community needs to value and rethink how they see such roles, and understand that women's labor is currently freely given to assist in the implementation of the goals and in so doing is anathema to their overarching objectives. As such, core parts of development budgets should be cognizant and remunerative of women's unpaid work. Such recognition would foster greater progress in women gaining access to paid, full time employment as their skills become identified as such and the care economy becomes less stigmatized and less gendered. Gender equality can only be achieved through more than equal pay but equal recognition of women and men's work and the breaking down of boundaries between them. The UN system should not work to exacerbate this: where interventions rest on women's labor they should be paid.

Whilst the goals provide a good mechanism for measurement and holding different actors to account, greater space needs to be given to that which cannot be measured. For the MDGs to be successful the UN must integrate specific goals with more horizontal development projects that engage with infrastructure. Infrastructure can take on a variety of forms including but not limited to: judicial systems that promote equal land rights, transportation and road-building that allows people to access health and education facilities, integrated local support centers where people can access prescription drugs and advice on a range of social issues. Working with the government and society of a state, donors and development practitioners need to address the infrastructural issues that limit the successful realization of the MDGs. Provision of basic services must be fundamental to development.

Efforts by the UN to fully address gender issues through the introduction of UN Women should be supported by member states, specialized agencies, civil society and private actors internal and external to the UN. Support should come from budgetary commitments that allow UN Women to identify and implement a strategic vision and collaborations with civil society, academics and the private sector that helps position the agency as an effective source of knowledge and expertise. For the disproportionate infection rates and burden of HIV on women to be fully recognized, UN Women must become a co-sponsor of UNAIDS. Fundamentally, the issue of women has to be at the cornerstone of all discussions of development, thus UN Women has to be fully represented in key decision-making forums within the UN. Attitudes towards women, gender and UN Women need to see women as something more than a stubborn issue that is best addressed through maternal and child health strategies or anti-violence programs. Strategies and projects to implement such initiatives must recognize differences between women and men, and women in different cultures, societies, class, heritage and country. Reducing the complex and varied nature of the lives of women living in poverty to homogenous responses restricts any full engagement with their needs and experiences.

Conclusion

The MDGs have been too little, too late and too gendered to help the lives of women living in poverty. Policies, projects and strategies to address maternal health have come ten years too late and do not go far enough in taking into account women's lives, experiences, gender, and the differences between maternal health and child health. Recent strategies bind issues of maternal and child health together and replicate existing health interventions into areas such as HIV/AIDS. This is problematic as it sidelines women's experience from the process and does not recognize the specific needs and arrangements for different health concerns.

Inclusion of women in the MDG process is too gendered. It is gendered in regards to the widespread recognition of the role and position of women in delivering development for free. Women are the central focus of projects and programs that are designed to break intergenerational poverty and deliver on goals for child health, nutrition and education. The result of which has been the positioning of women in unpaid care roles that presupposes their labor is freely given and reasserts gender norms of women as carers or women as mothers. It is women's role within the development process not their lives that has become central. Women's needs are seen as secondary to that of their children, family and society within the MDGs. The permeation of such gender

norms in the delivery of MDGs 1, 4, 5 and 6 has contradicted and undermined the successful realization of all the goals, especially MDG 3.

The too little, too late, and too gendered aspects of the MDGs can be explained by the processes and institutions responsible for their effective delivery. Institutions mandated to combat gender inequality and promote the lives of women such as UNIFEM have been under-funded and under-represented, and similar to gender strategies have come too late. UN Women was formed in 2011, just four years before the MDG deadline. The lack of institutional presence has limited the voice for women within the UN. Although the UN supposedly represents men and women equally, evidence suggests the need for an agency to raise the issues of women and gender at high level meetings and garner wider support. The ability of UN Women to do so will depend on both internal and external alliances, knowledge expertise and effective issue framing.

Issue framing reflects the culture of vogue development aid that has been built around the MDGs. Goal-setting has led to the prioritization of specific issues within the UN to the exclusion of others. Such exclusion can refer to specific MDGs over others – for example HIV/AIDS over maternal health – or the sidelining of wider issues such as infrastructure. Goal-setting and vogue development aid has led to the MDGs being addressed on an individual basis rather than a cohesive whole. This has specific implications for women as their involvement in reaching some of the goals, notably MDGs 1, 2 and 4, has undermined the realization of other goals, specifically MDGs 3, 5 and 6. For the MDGs to be realized and to have a better impact on the lives of women, development must be understood in broader terms than eight specific goals. These goals are important but they lead to swings in priority and funding allocation from one goal to another. Ultimately this will lead to the neglect of these specific issues altogether as the fashion for development swings back towards infrastructure and the continued sidelining of women's needs.

Change towards greater gender equality is possible within the future development agenda beyond 2015 but only if women are recognized for not only their role in delivering better development for the lives of others, but the different lives they lead and their needs. For this to occur women have to be seen beyond issues of childbirth, childrearing, and HIV/AIDS, and the gender norms endemic to the MDG process recognized. The UN has the ability to lead the way with this in supporting the work of UN Women and fully recognizing and rewarding women's work in delivering the goals. As the UN highlights, women are the centre of development and poverty alleviation strategies but focusing on the free work of women obscures greater understanding of

the lives and needs of women. It is the needs of all women that must be at the centre of the development agenda beyond 2015.