MILLENNIUM DEVELOPMENT GOAL 6 AND THE RIGHT TO HEALTH: CONFLICTUAL OR COMPLEMENTARY?

Sarah Zaidi

1 Introduction

The eight Millennium Development Goals (MDGs), endorsed by 189 governments, are a careful restatement of development challenges related to poverty set to be achieved by 2015. Announced with great enthusiasm by Secretary-General Kofi Annan, the MDGs cover topics in key social and economic issues: eradication of extreme poverty (admittedly a proportion of only 50 percent of the people living on less than US$ 1 per day), universalization of education promotion of gender equality, reduction of child mortality, improvements in maternal health, fight against HIV/AIDS, malaria and other diseases, advancement of environment sustainability, and elaboration of a global partnership for development. They focus on how to tackle and improve the lives of the 1.2 billion persons who live on less than US$ 1 per day. The eight goals are associated with 21 targets and over 60 indicators, which represent societal averages of mainstream outcomes reflecting the processes of classic development sector measurements (NELSON, 2007, p. 2041).

The MDGs, seen to represent the human development agenda initiative of the United Nations Development Programme (UNDP), bypassed altogether a rights-based approach to addressing issues of poverty in the developing world as discussed in the UNDP-Human Development Report of 2000 (UNITED NATIONS, 2000a) and instead embraced the key income poverty monitoring measures of the World Bank (SAITH, 2006). The final MDG document sidestepped not only the 1997 Program for Reform which had human rights at the core of its activities (these reforms were designed by Kofi Anan's office and human rights were reflected in the Millennium Declaration) (UNITED NATIONS, 1997, 2000b), but also ignored the protracted struggle for economic, social and cultural rights and the right to

Notes to this text start on page 142.

development waged by civil society and Southern states (NORMAND; ZAIDI, 2008, p. 239). The formulation of the MDGs targets, outcomes, strategies, and policies lacked the recognition of substantive rights enshrined in the International Bill of Rights (the Universal Declaration and the two International Covenants on Civil and Political Rights and Economic, Social and Cultural Rights) as well as procedural rights such as the right to information, non-discrimination, and participation. Rather than building on mechanisms of accountability, internationally recognized human rights standards and principles to which governments are obliged to adhere, the MDGs focused on operational goals, indicators, and benchmarks aiming at showing international donors such as the G8[1] the effectiveness of foreign aid in poverty reduction (HULME, 2009). Nonetheless, the goal-oriented framework of MDGs has yielded limited results. Nearly four million more children survive each year, four million HIV positive persons now receive treatment compared to 400,000 in 2000, and many more children are in schools, with many countries crossing the 90 percent threshold since 2000 (UNITED NATIONS, 2010a). However, the MDG Report (UNITED NATIONS, 2009a) observed that many low-income countries especially across Africa still remain off track, and were unlikely to meet the 2015 targets. Moreover, the grim repercussions of the economic crisis were either stalling progress, or reversing the gains that had been made.

Would the progress on MDGs have been better under a human rights framework? Might it have been possible for states to be accountable for failures in meeting set targets? Human rights are a normative claim that human dignity entitles each person to certain kinds of treatment and protections from others, particularly the state. Rights are universal (same for everyone, everywhere); they are inalienable (cannot be taken away or given up); and indivisible (no hierarchy amongst different sets of rights - civil, political, and socioeconomic ones[2]). International human rights law has established legal obligations to respect, protect, and fulfil the rights of all people under their jurisdiction.

In theory, human rights appear a logical foundation upon which to build a more cooperative and just world, linking notions of freedom with social justice. Philip Alston comments that while the MDGs and the human rights agenda have a great deal in common, "neither the human rights nor the development community has embraced this linkage with enthusiasm or conviction," instead appearing to "resemble ships passing in the night, even though they are both headed for very similar destinations" (ALSTON, 2005, p. 755). Alston, however, is optimistic about the marriage between MDGs and human rights, suggesting that the human rights community needs to be more engaged in the realization of MDGs as it is the single most important and pressing initiative on the international development agenda and noting that there are a great many possible points of mutual reinforcement. Perhaps, MDGs and human rights are complementary so that the former lays out operational indicators and benchmarks while the latter provides a framework with a set of principles and standards. At the ten-year marker, the Secretary-General's report on the MDGs mentions the words "human rights" seven times in the text: as a foundation for the MDGs (UNITED NATIONS, 2010a, p. 2), references to the Millennium Declaration (UNITED NATIONS, 2010a, p. 3, 15, 28), as the

guiding principle of action (UNITED NATIONS, 2010a, p. 28), and with respect to affirmation of right to development and economic, social and cultural rights (UNITED NATIONS, 2010a, p. 32). But in the action agenda, human rights language is generally missing. The present article explores why there continues to be this disconnection between MDGs and human rights, examining the MDG 6 dealing with the combat against HIV/AIDS, tuberculosis, malaria and other infectious diseases and how it might have looked different in a human rights context.

Over the past quarter century, the link between health and human rights has been clarified best due to concerns regarding the HIV/AIDS epidemic and reproductive and sexual health, largely through raising issues of discrimination that prevent an individual from accessing health services, challenging the legal system and corresponding legislative reform, and by guaranteeing participation and the building of partnerships by different sectors of civil society. Gruskin, Mills and Tarantola (2007) comment that the HIV AIDS response has best exemplified these links between health and human rights through advocacy, application of legal standards, and programming including service delivery (GRUSKIN; MILLS; TARANTOLA, 2007, p. 451). This paper explores the role of human rights vis-à-vis MDG 6; explicitly measuring what steps states are required to take from the perspective of the right to health. Section two presents briefly the health and human rights frameworks, and section three examines MDG 6 and its relationship with the right to health. For example, are the outcomes of halting and reversing HIV/AIDS, malaria, and other infectious diseases anchored in human rights principles and standards? Does the MDG goal-oriented framework either through its targets or indicators consider issues of discrimination, participation, effective remedy and the right to information? What are the mechanisms of accountability if MDG 6 is not met? In the conclusion, the author explores whether the normative framework of international human rights can form the basis for a new construct to tackle poverty and inequality, after 2015.

2 The Right to Health

The human rights framework is based on the foundation of an International Bill of Rights, which includes the Universal Declaration of Human Rights (1948), the International Covenant on Civil and Political Rights and its Optional Protocols (1966), the International Covenant on Economic, Social and Cultural Rights (1966), and several core treaties including but not limited to the International Convention on the Elimination of All Forms of Discrimination, the International Convention on the Elimination of All Forms of Discrimination Against Women, the International Convention on the Rights of the Child, and several optional protocols.[3] The optional protocols aim at strengthening the implementation and monitoring of the Convention by establishing, first, a mechanism for individual communications through petitions, and, second, by empowering the treaty bodies to undertake inquiries of systematic violations of the Convention. These international treaties are meant to protect individuals from violations by the state, and also to place obligations on the state to respect, promote and fulfil rights as described (UNITED NATIONS, 2005).

The roots of the right to health are in the public health movement of the 19th century (TOEBES, 1999, p. 12-13). The first health conferences held under the auspices of the League of Nations identified the need for primary services for the population as a whole. The International Labour Organization, established in 1919, predominantly dealt with work-related health issues. However, it was through the creation of the United Nations and its human rights system that the right to health[4] was enshrined in legally binding treaties. Thee Constitution of the World Health Organization (WHO), whose provisions were later adapted to the Universal Declaration of Human Rights (UDHR), mentions health as part of the right to an adequate standard of living (article 25[5]), which, however, is not particularly well-defined. Nonetheless, the UDHR is well known and represents customary international law and is therefore considered binding on states by some experts (STEINER; ALSTON; GOODMAN, 2007, p. 133).

Article 12 of the International Covenant on Economic, Social, and Cultural Rights (ICESCR) and article 24 of the Convention on the Rights of the Child (CRC) formulate the right to health in similar manner as the WHO constitution: *everyone's right to enjoy the highest attainable standard of physical and mental health*.[6] The Director-General of WHO was deeply involved in drafting the ICESCR article, and noted that governments should create systems of health professionals and services (TOEBES, 1999, p. 43).

The right to health as part of an economic, social, and cultural rights framework, has to be read in conjunction with articles 2 and 3 of the ICESCR. Article 2(1) of the ICESCR is on *progressive realization* and reads (UNITED NATIONS, 1966):

> *"Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures."*

The above clause allows governments to give insufficient resources as an excuse for not meeting their treaty obligations, and secondly, alleging progressive realization they can postpone their obligations ad infinitum (TOEBES, 1999, p. 294). General Comment number three by the Committee on Economic, Social and Cultural Rights (CESCR) tried to plug this loop hole by suggesting that steps must be taken within a reasonable period of time and that, regardless of their level of economic development, States are to ensure a minimum core obligation of these rights, the so-called core content of the right (UNITED NATIONS, 1990). Moreover, Article 2(1) already mentions the role of international assistance to some extent and recognizes that meeting these rights also involves international development cooperation (CRAVEN, 1995, p. 144).

Articles 2(2) and Article 3 are non-discrimination clauses, the latter regarding sex discrimination. Both are considered to have immediate effect, and discrimination of any type is prohibited under the Covenant. The International Convention on the Elimination of All Forms of Racial Discrimination (CERD)

includes direct reference to the right to health by giving each person a right (without any discrimination) the right to public health and medical care. The International Convention on Elimination of All Forms of Discrimination Against Women (CEDAW) also obligates states to end discriminatory practices in health care and provide adequate health services and counselling. The right to health is also included in the constitutions of many states (KINNEY; CLARK, 2004). The Constitution of the WHO, the Declaration of Alma-Ata, and other important documents recognize the right to health (UNITED NATIONS, 2008a).

The Committee on Economic, Social and Cultural Rights has further elaborated upon and clarified the nature of the right to health and how it can be achieved through its General Comment number 14. Although not legally binding, some salient concepts from the general comment include the requirement that health facilities and services be available, accessible, culturally acceptable, and of appropriate scientific and medical quality. In addition, the general comment notes that the right to health requires not only that certain minimum standards of care be met or exceeded, but that basic preconditions such as food, housing and sanitation, adequate supply of safe and potable water, education, and essential drugs as defined under WHO, also be met (UNITED NATIONS, 2000c).

In terms of **availability**, governments must ensure a functioning health-care system and programs for all sectors of the population, including the underlying determinants of health (food, potable water, sanitation, hospitals, clinics, trained medical staff, and essential drugs). However, the precise nature of the facilities, goods, and services provided can vary depending on the developmental level of the State party. **Accessibility** requires that basic health care services, goods, and facilities be physically accessible, affordable, available without any discrimination, including also the right to information concerning health issues as long as personal health data be treated with confidentiality. In General Comment 14, **acceptability** is defined as health care that meets ethical standards and is also culturally appropriate, i.e. respectful of minorities, marginalized communities, and sensitive to gender and lifecycle requirements. The quality of health care implies skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation as part of health services.

In addition to these substantive elements, there are several procedural protections. For example, discrimination of any sort - individual or systemwide - is a human rights violation and requires the state to provide remedies to redress the abuse either through civil or criminal penalties or by introducing changes in policy or governing legislation. States must also ensure participation of patients and affected communities when it comes to decisions about their own health. Information about health care and health issues should be presented in a public manner and be accessible to everyone. The state should not backslide in terms of its obligation once the right is recognized, and, if it does, then the burden of demonstrating that retrogression was unavoidable lies with the state.

Over the past two decades, increasing intellectual attention has been paid to the right to health. Since 1994 the Harvard School of Public Health has produced a journal exclusively dedicated to health and human rights with the focus "on

challenging - through conceptual analysis and practical action - the interlocking orthodoxies that defraud poor people of the minimal requirements for a healthy life, while fortifying privileged minorities in their lifestyles" (FARMER, 2008, p. 8). The Commission on Human Rights (now replaced by the Human Rights Council) created in 2002 the mandate for a Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Paul Hunt, the first person to serve in this role between 2002-2008, produced several key documents on better understanding the right to health.[7] In 2004, he published a report highlighting the contribution that the right to health can make to the realization of health-related MDGs that noted:

> *The right to health involves an explicit normative framework that reinforces the health-related Millennium Development Goals. This framework is provided by international human rights. Underpinned by universally recognized moral values and backed up by legal obligations, international human rights provide a compelling normative framework for national and international policies designed to achieve the Goals (UNITED NATIONS, 2004).*

3 MDG 6 and the Right to Health

3.1 MDG 6 Overview

Millennium Development Goal 6 is one of three health goals, and its focus on the fight against HIV/AIDS was expanded to include 'malaria and other major infectious diseases', an inclusion that appears to have been the result of successful advocacy of health lobbyists who argued that focusing exclusively on HIV/AIDS created the danger of distorting health budgets, aid flows and health plans in a manner that could negatively impact on health status (HULME, 2009, p. 30-31). The other two health-related goals include MDG 4, on reducing child mortality, and MDG 5, on improving maternal health. In addition, it must be pointed out that Goal 7, on reducing by half the proportion of people without sustainable access to safe drinking water, Goal 1, on eradicating extreme poverty and hunger, and Goals 2 and 3, on education and empowerment of women, are social determinants of health. It is well documented that educated girls and women provide better care and nutrition for themselves and their children. Underpinning the MDG paradigm is the global partnership for development, which facilitates access to financial resources, market access and debt restructuring, as well as access to essential medicines. Eight of the 16 MDG targets and 17 of the 60 indicators are health-related as well. Recent evidence is emerging on how dependent the MDGs 4, 5, and 6, are of each other. For example, an increase in access to AIDS treatment has been linked to a reduction of maternal mortality (HOGAN et al., 2010) and child mortality (RAJARATNAM et al., 2010).

The global progress on MDG 6 on combating HIV/AIDS, malaria, and other diseases reveals that much has been achieved but it is not yet enough to reverse the trajectory of the HIV epidemic: for every two people started on treatment, there are five new HIV infections (UNITED NATIONS, 2010a, p. 7). The burden of tuberculosis

remains high, but of greater concern is the emerging epidemic of multi-drug-resistant tuberculosis and of extensively drug-resistant tuberculosis, and, while great progress has been made in distribution of bed nets to reduce the incidence of malaria (200 million out of the 340 million nets needed were delivered to countries in Africa during 2004 to 2009), there are still 140 million nets needed to achieve universal coverage (defined here as one net for every two people) (UNITED NATIONS, 2010a, p. 8). An effective response to MDG 6 extends well beyond the health sector, as most of these diseases are facilitated by and exacerbated by conditions of poverty, vulnerability, discrimination, and social marginalization or exclusion. Therefore millions of individuals faced health-related disadvantages prior to the introduction of the HIV virus due to their economic and/or social situation (MANN; TARANTOLA, 1998, p. 7).

The HIV/AIDS epidemic often affects those in the prime of their economic productive and sexually reproductive period, and therefore was seen to pose an imminent threat to social and economic development, a formidable challenge to human life and dignity and the effective enjoyment of human rights. The UN Declaration of Commitment on HIV and AIDS, signed by 189 countries, established time-bound targets on HIV AIDS prevention, treatment, care and support as well as human rights to which governments and the UN could be held accountable (UNITED NATIONS, 2001). These targets were seen to support MDGs as governments were concerned that the continuing spread of HIV/AIDS would constitute a serious obstacle to their achievement.

The Declaration of Commitment stated that governments by 2003 would enact and enforce laws, regulations and other measures that prohibit discrimination on the grounds of HIV/AIDS; and ensure to people living with HIV/AIDS and members of vulnerable groups the full enjoyment of human rights, including access to education, inheritance, and health care. Nonetheless, the framing of goal six, its targets and indicators are stated in neutral terms and do not refer to human rights principles or the right to health framework. There are no indicators on discrimination, participation, and equality, right to information, informed consent in testing and treating or legislation protecting those from violations. Even when the target and indicators[8] for meeting goal six were revised in 2008 by the Inter-Agency and Expert Group on the MDG Indicators, the only inclusion was the need to achieve universal access to treatment for HIV/AIDS for all those who needed it by 2010. No concrete obligations was spelled out, including how governments should address discrimination, social exclusion, violence against women, and economic and social rights in measuring and/ or monitoring indicators.

The current targets and indicators are formulated in terms of societal averages, part of a traditional development paradigm having nothing to do with the human rights framework (SARELIN, 2007, p. 465). Even in the statement of this general goal, there is no mention of health systems or a call for a rights-based universal access to decent health services and medicines (SAITH, 2006, p. 1189). The most vulnerable groups, economically marginalized, mentally or physically disabled, or key vulnerable groups such as men-who-have-sex-with-men (MSM), transgendered, injecting drug users (IDUs) or sex workers are not even mentioned as groups that need special consideration. Take, for example, the target and indicators for malaria.

Malaria is an illness for which there is evidence that, in the presence of poverty, its prevalence is elevated and access to treatment diminished, Furthermore it is known that malaria can increase poverty (BRENTLINGER, 2006, p. 17). However, in the MDGs there is no specific indicator on facilitating treatment for the most at risk. The most effective treatment of artemisinin-based combination is outpriced for use by poor countries. Under MDG 6, the issues referring to the availability or accessibility to affordable essential drugs could be addressed but, as Nelson (2007, p. 2049) notes, the trade rule-making process at the World Trade Organization is at odds with human rights-based prescriptions for improved health care and access to medicines. The next section discusses how a human rights perspective can explicitly add to measures that states are required to take in order to tackle Goal 6.

3.2 What a right to health perspective can add to MDG6?

As noted above, the human rights framework is premised on the rights of an individual (rights-holders) vis-à-vis the state (duty-bearers). There are a number of steps that a state can take to make the MDGs framework rights-based. First, the state can recognize that MDGs are rights-based goals with targets subject to state obligations. In the current reaffirmation of the MDGs by the UN General Assembly (September 2010) this should be a key objective. How would the addition of human rights language, or specifically the right to the health framework, change MDG 6? In this connection, below I discuss only three human rights concepts: non-discrimination and equality; participation; and accountability. There are other key concepts such as accessibility, availability, acceptability and affordability of services.[9] Which shall not be taken into consideration.

Non-Discrimination and Equality: A rights-based approach to MDG 6 would begin with addressing issues of discrimination and stigma.[10] There is evidence suggesting that those with HIV face discrimination that jeopardizes testing and the adherence to treatment (HORN, 2010; UNITED NATIONS; THE WORLD BANK, 2009). As is often the case, those groups already marginalized tend to experience more severe discrimination and stigma. The People Living with Stigma Index reports that people living with HIV in diverse settings affirm being excluded from social and family events, being denied health care, sexual and reproductive health care, and family planning services, as well as being insulted, threatened or subject to physical attack. Many reported that their children (who were not necessarily HIV positive) have been forced to leave school (ICRW; UNAIDS, 2009). Often these groups are marginalized because of their sexual orientation, drug use, sex work, being a prisoner, or other high-risk characteristics that makes them vulnerable. For example, the close connection between TB and HIV, often referred to as co-epidemics, such that a person with HIV progresses from TB infection to death more frequently and rapidly than those who are not infected (HARRINGTON, 2010), makes it urgent that discrimination and discriminatory practices must be addressed to achieve MDG 6.

As a first step, it would be important to disaggregate the data by gender, minority groups, and social class, and their situation in the context of those most at risk for HIV, key vulnerable groups such as men-who-have-sex-with-men (MSM),

transgender, intravenous drug users (IDUs), sex workers, and other high risk groups such as those with co-infections (in particular tuberculosis). It is important to gather this knowledge so that materials and information for education and communication can be appropriately developed for communities, legislators, and policymakers. Second, a review and revision of current laws and legislation must be made, to protect people living with and at risk of HIV or other infectious disease from discrimination, violence and vilification, and the lack of due process. Laws related to HIV or those at risk of HIV are highly punitive. A report to be released at the International Aids Conference in Vienna notes that 19 of 48 countries in the Asia Pacific region criminalize male-to-male sex (APCOM, 2010). In fact, legislation and law enforcement protecting key vulnerable groups often lag behind national HIV policies undermining the effectiveness of programs. One of the key targets for MDG 6 could include an agenda for legal reform to establish better protection from discrimination and to remove punitive laws, policies and practices.

Furthermore, women and girls - as a result of harmful gender norms regarding social expectations, stereotypes, lack of status and power, and lack of resources - often face discrimination and discriminatory policies that make them more vulnerable to HIV. Often structural and deeply embedded attitudes put women and girls at higher risk of violence and faced with discrimination at work, in education, in marriage, reproductive choice, and sexual decision-making. Women living with HIV are often counselled to avoid pregnancy or forced to terminate pregnancy or coerced into forced sterilization (ICW, 2009; UNITED NATIONS; THE WORLD BANK, 2009, p. 16). In addition, women sex workers have reported that they face threats of increased violence not only from their clients for requesting the use of condoms but also of being raped by men in uniform such as local police tasked to protect them (HUMAN RIGHTS WATCH, 2003). Therefore, a focus on women and girls is necessary in designing of targets and indicators.

Profound gender inequalities represent one of the key drivers of the HIV epidemic, and also contribute to the high maternal mortality rate as noted by a recent study in *The Lancet* (HOGAN et al., 2010). Addressing gender inequality is an effective strategy for reducing HIV impact and transmission and enhancing the status of women. MDG 5 on maternal health can be associated with HIV and mutually re-enforcing benefit of treatment can be seen in reducing maternal deaths as well as prolonging life and reducing transmission. In the political arena, when more women are engaged in the process there is greater benefit. For example, in Rwanda where women occupy 56% of parliamentary seats, legislation has been passed to prevent gender-based violence, to recognize women's right to inheritance, and to grant women the right to work without her spouse's authorization (UNITED NATIONS, 2010b, p. 15).

Participation: In a rights-based framework, participation is essential and necessary for the expression of human agency, instrumental to self-determination, and allows the individual to challenge socio-political, economic, and other forms of exclusion particularly in decisions and processes that affect health (YAMIN, 2009, p. 6). In terms of MDG 6, participation would imply not only an active involvement of people living with HIV and affected communities in the agenda-setting and decision-making but also challenging power hierarchies in communities

and society at large. Sarelin (2007, p. 477) notes that "the process of challenging and transforming power relations and creating new relations is often described as empowerment…[that] implies a participatory process that engages people in reflection, inquiry and action…[not only for] expanding people's opportunity but empowerment in relation to the possibility to claim and realize their human rights". Civil society involvement in formulating and implementing the MDGs has been limited. In our network on HIV treatment preparedness, most community groups have no idea how the MDG process works or why it is important. The Millennium Development initiative, while highly commendable, continues to exhibit features of non-participatory approaches to development programming at national levels, in which people are viewed as programmatic targets, and passive recipients of international aid and national programs (SAITH, 2006). What is required is a shift in development thinking to include the participation of disadvantaged individuals and communities, groups for whom such policies are formulated and are intended beneficiaries of development programs. In terms of MDG 6, there is already the Joint United Nations Programme on HIV/AIDS (UNAIDS) concept of the Greater Involvement of People Living with AIDS (GIPA) that could be brought into the process of policy formulation and implementation. In addition, the Global Fund to Fight AIDS, TB, and Malaria (GFATM) has at the domestic level coordinating mechanisms (CCMs) to address these diseases and, while there are community delegates on this body, it might consider adding human rights representatives, and also coordinating its plans with the national MDGs strategy.

Accountability: While the principles of empowerment and participation have been part of the development agenda, the added value of a human rights approach is the principle of accountability that has been conspicuously absent. A rights-based framework demands accountability as the approach emphasizes obligations and requires that all duty-holders be held accountable for their conduct. If the system lacks an accountability mechanism then it becomes no more than window-dressing. The human rights framework has generally lacked enforceability and that has been an issue. At the national level, individuals have used the judicial system to gain access to health care or medicines. In 2004, an HIV/AIDS-positive person submitted an "Amparo" action against Peru's Health Ministry requesting full medical care, including permanent supply of drugs and periodical testing, as well as CD4 and viral load tests. The petitioner alleged lack of financial resources to face the high cost of treatment. The Court accepted the "*Amparo*" action and ordered government agencies to comply with Article 8 of Law 26626, which set forth that a Plan to Fight AIDS should have top priority in the budget. In addition, the Court also noted that social rights as true guarantees of protection of citizens before the State (information on this case along with other HIV AIDS case law examples can be found on www.escr-net.org). The Treatment Action Campaign (TAC) based in South Africa brought a case against the Minister of Health challenging the South African government's prevention of mother to child transmission of HIV policy that limited the provision of a drug, Nevirapine, known to prevent transmission, to a small number of pilot sites. While TAC relied on litigation, it also launched an intensive public mobilization campaign in the form of rallies, vigils, and marches across the country. Activists,

health professionals, and media showed up in TAC's trademark 'HIV-positive' t-shirts. By the time the judgment was handed down, the people had already won the claim to essential drug for PMTCT (quoted in POTTS, 2007, p. 31).

In addition, to the legal or judicial mechanisms of accountability there are also a number of non-judicial means such as ombudsmen, treaty bodies, parliamentary processes, or watchdogs (UNITED NATIONS, 2008b, p. 15). In addition, there is the traditional strategy of 'naming and shaming' with respect to human rights violations. Monitoring and evaluation mechanisms have also been used to determine the performance of the health sector. Furthermore, civil society has demanded better services from the state or private actors. Potts (2007, p. 4-5) discusses mechanisms of accountability for the right to health, noting that:

> *Accountability in the context of the right to the highest attainable standard of health is the process which provides individuals and communities with an opportunity to understand how government has discharged its right to health obligations. Equally, it provides government with the opportunity to explain what they have done and why. Where mistakes have been made, accountability requires redress. It is a process that helps to identify what works, so it can be repeated, and what does not, so it can be revised.*

In the MDGs Framework the accountability mechanisms are weak, but evidence gathering of targets and indicators with respect to each goal can be used for more than monitoring purposes (FUKUDA-PARR, 2004, p. 394). The targets indicators can be applied to an accountability framework that holds the duty-bearer, in this case the state and international donors, responsible for meeting these goals. What is unclear is how (or through which mechanism) can national citizens and communities hold the state responsible, and by extension donor countries, for the failure to meet the MDG targets or regress from achieved gains. Furthermore, it needs to be determined how states and citizens can hold non-state actors accountable under this framework. Despite these shortcomings, there are innovative ways to ensure some level of accountability. At the moment, there are over 60 national level reports, based on which one could discern and evaluate which health policies and institutions are working and which are not, and why, with the objective of improving the realization of the right to health for all (UNITED NATIONS, 2004, p. 9). The Human Rights Council or the treaty bodies could evaluate these reports with the criteria of minimum standards of human rights core standards. Special Rapporteurs could be invited for visits to monitor the situation. Additionally, the national HIV/AIDS body or citizens' watchdogs could be involved in monitoring the MDGs. Notwithstanding, the issue of accountability would remain, as well as the problem of defining what effective remedy or redress should be activated in case of violation or inability to meet the targets of Goal 6. The recent global economic crisis poses a threat to the fulfilment of the MDG objectives as it is already affecting the scale up of HIV prevention and treatment, as donor funds are becoming scarcer (UNITED NATIONS; WHO, 2009). UNAIDS observes that households may experience increased mortality and morbidity if the commitments pledged by the international community to sustain and increase access to anti-retrovirals are not honoured or if governments reduce expenditures on

AIDS. Slight interruptions in treatment access or failure to enrol new AIDS patients in treatment will have devastating and costly effects which will result in unnecessary loss of lives and contribute to resistance to anti-retrovirals.

The last two points in this section address the importance of MDG 8 on a global partnership and other MDGs linked to MDG 6.

Relationship with Other MDGs: MDG 6 is related to other MDGs as discussed earlier, and the relationship is mutually re-enforcing with other health MDGs. Recent studies published in the **Lancet** have demonstrated a strong association between maternal mortality and HIV, MDG 5 (HOGAN et al., 2010). Moreover, Rajaratnam et al. (2010) demonstrate a steep decline in mortality of children attributing it to immunization, insecticide-treated bed-nets for malaria, treatment of HIV positive women in preventing vertical transmission, and the availability of antiretroviral drugs. In addition, hunger or under-nutrition included under Goal 1 is strongly linked to MDG 6, in particular for those with HIV and TB. Those who are ill need better nutrition, and impediments to accessing food affects their illness. Sarelin (2007) observes the importance of a rights-based framework in the context of Malawi, a highly HIV AIDS endemic country with national adult prevalence of 15 to 18 percent, with 81 percent of the population classified as subsistence farmers. In this case, the national government under the human rights framework has taken steps to protect the most disadvantaged. While these linkages are emerging in the literature, they are not reflected in the MDGs, which continue to exist independently of each other in terms of strategies and policies.

Although the health-related MDGs do no specifically mention health systems, the synergies between the response to these vertically initiated goals and programs and broader health policies and structures are becoming apparent. In 2009, the Global Fund solicited proposals for broad-based strengthening of health care systems. In addition, educational systems will also need to be strengthened, and in particular MDG 3 on equal access for women and girls in education, economic benefits, and sexual and reproductive health issues. Policy-makers or planners are failing to make linkages, mutually reinforcing or jeopardizing achievement, across the eight MDGs, their targets and indicators.

MDG 8: MDG 8 calling for a global partnership for development resonates strongly with the human rights concept of international assistance and cooperation. While the parameters of the MDG 8 are not yet clearly drawn, it is certain that this MDG is critical for the poor in terms of realizing their right to health. For MDG 8, there is a lesson to be learned from the global HIV response which gave rise to pioneering partnerships in health through the 2001 Declaration of Commitment and led to the establishment of the Global Fund to Fight AIDS, Tuberculosis, and Malaria, a path-breaking source of funding. The GFATM, supported by the G8 countries, promised to give $10 billion a year but so far have delivered only about $3 billion a year (GLOBAL FUND, 2010a). In March 2010 the GFATM estimated that it needed $20 billion for three years (2011-2013) to help meet the health related MDGs (GLOBAL FUND, 2010b), but donors are backtracking on raising even the minimal needs of $13 billion for three years using the global economic crisis as an excuse. Nonetheless, the GFATM has emerged as an effective channel

for health care financing and its investment in these three specific diseases has paid back substantial dividends in terms of averting deaths (GLOBAL FUND, 2010c). Another interesting example of global partnership is the funding from the international airline tax for UNITAD, supporting HIV treatment for more than 226,000 children and supplying second-line antiretroviral drugs to 59,000 patients in 25 countries (UNITED NATIONS, 2010a, p. 17).

The accountability mechanisms in relation to Goal 8 are especially weak. For a long time there were no targets or indicators, and very few countries report on MDG 8. A few developed States, including the Netherlands, Denmark and Sweden, have published reports on their progress towards Goal 8, and although self-report is a step in the right direction it does not constitute an adequate form of accountability. While official development assistance has increased to about 0.30 percent of developed countries combined income but it remains well below the UN target of 0.7 percent of gross national income (HISTORY..., 2002; FUKUDA-PARR, 2006, p. 966). In 2008, the only countries to have reached the UN target were Denmark, Luxembourg, the Netherlands, Norway, and Sweden. The accountability arrangements for all MDGs, and MDG 8 in particular, are of critical importance. Otherwise, the MDGs are in danger of being classified as yet another failed attempt at addressing poverty. Unfortunately, the manner in which the MDGs story is unfolding confirms the long-standing perception among developing nations that accountability arrangements are imbalanced and only applicable to them, while developed countries can escape any measures to hold them accountable when failing to fulfil their international commitments (UNITED NATIONS, 2009c).

3.3 Additional Considerations

Meeting a minimum core obligation and non-retrogression are the other two key concepts part of a rights-based health framework. The Committee on Economic, Social, and Cultural Rights in General Comment 3, regarding the interpretation of article 2(1) on progressive realization notes that there is a minimum obligation to protect the most vulnerable in society, and there is a further obligation upon the state not to regress on progress that has already been made (UNITED NATIONS, 1990). One of the key targets of MDG 6 is 'universal access' to HIV treatment. The commitment to universal access was made in the 2006 Political Declaration and established a mutually re-enforcing bond with MDG 6 (UNITED NATIONS, 2006a). Therefore any deviation from this target is a violation that needs to be immediately addressed by the duty-bearer (i.e. state and other related parties). Human rights jurisprudence can assist practitioners and policy makers in planning and evaluating MDGs initiatives according to human rights standards at the national level through special committees or tribunals, or the country reporting mechanisms of the Human Rights Council, set up not only to measure progress but also to provide remedy. The HRC could possibly even convene a special session over the next five years.

The United Nations Office of the High Commissioner on Human Rights have gone further in their thinking and developed four indicators explicitly named as human rights indicators for MDG 6, in order to establish whether countries

have: laws to protect against discrimination of people living with HIV/AIDS; laws to protect against discrimination of groups of people identified as being "especially vulnerable to HIV/AIDS"; policies to ensure equal access for men and women to prevention and care, with an emphasis on "vulnerable groups"; and policies to ensure that HIV/AIDS research protocols are reviewed and approved by an ethics committee. Additionally, gender should be mainstreamed throughout Goal 6, its targets and indicators, and issues of discrimination and exclusion particularly of key vulnerable groups are addressed immediately, ensure that existing indicators are rights-sensitive. While broad in scope, these indicators have limitations. For example, they measure whether or not policies are in place and do not attempt to explore the quality or degree of implementation.

The basic question remains: will the countries that have formulated the MDGs and who are meeting this September 2010 in New York at the United Nations High-level Plenary Meeting on the Millennium Development Goals[11] with an objective of leading to concrete strategies for action incorporate human rights into their plan of action for the remaining five years?

4 Conclusion

The Millennium Development Goals have clear communicable outcomes. They are ideologically neutral and results-based. They set out a strategic vision for the United Nations to address poverty and offer an opportunity to realize promises made through a series of world conferences on environment, nutrition, women, population, and social development over the preceding three decades. The MDGs also provide the vehicle to bring together many separate organizations of the United Nations, including the World Bank, under a singular banner, allow governments to prioritize national development policies protecting the most vulnerable in society, and provide a means to channel international aid into the social sector with an assessment of its impact. While this is the sunny-side view of the MDGs, the reality, ten-years into the agenda, is mixed (UNITED NATIONS, 2009a). Moreover, the *Global Monitoring Report* co-published by the World Bank and the International Monetary Fund observes that with the recent financial crisis the situation will worsen with 53 million more people falling into extreme poverty, mostly in sub-Saharan Africa, a continent that is already far off-track from achieving the MDGs. The authors note that the global recession combined with the 2008 food and fuel crisis will have a lasting, negative impact on critical human development indicators and, unless international efforts are redoubled to mitigate the damaging effects, it is likely that many countries, in particular those with greatest need, will fail to achieve any significant progress in meeting the MDGs (WORLD BANK, 2010).

Modest progress has been made towards achieving MDG 6, largely for tuberculosis and malaria (UNITED NATIONS, 2009a, p. 32). For TB better diagnosis of the disease has helped to initiate people into early treatment, but new cases continue to rise with multi-drug resistant TB posing a huge challenge and TB co-infection with HIV leading to early death. For malaria the progress has been

good because of the increase in use of bed nets. Progress in HIV AIDS has been insufficient in meeting targets across all regions. The number of people newly infected with HIV peaked in 1996 and has since declined to 2.7 million in 2007, but infection rates continue to rise in Eastern Europe and Central Asia, where the numbers of people living with HIV has doubled since 2001 to 1.6 million over six years (UNITED NATIONS; THE WORLD BANK, 2009, p. 48). The continent of Africa, particularly southern Africa, continues to be worst affected with one third of new HIV infections and 38 percent of AIDS deaths. Gender inequities continue to put women at higher risk of infection and death. Women account for 60 percent of those infected in sub-Saharan Africa and for over half the people living with HIV worldwide. AIDS orphans, specifically mentioned in the Millennium Declaration and not even included in the MDGs, continue to pose a tremendous challenge for families, communities and states. Many of the AIDS-affected children face discrimination and early death impacting upon other MDGs such as MDG 2 on education and MDG 4 on child mortality. In sub-Saharan Africa, less than a third of young men and just over a fifth of young women demonstrated a comprehensive and correct knowledge of HIV (UNITED NATIONS, 2007a, p. 20). The use of anti-retrovirals (ARVs) in the past five years has resulted in a dramatic decline in the number of AIDS deaths. Although an estimated four million people are on ARVs, the need is closer to 10-12 million (roughly 69 percent of people who need treatment do not have access to the required drugs). A new study by the Treatment Monitoring and Advocacy Project reports that funds from major donors such as the U.S. President's Emergency Plan for AIDS relief (PEPFAR) and the Global Fund are flat lining, resulting in cut-backs in domestic funds and availability of treatment and prevention programs in developing countries (ITPC, 2010). Stalling on the AIDS response will impact upon not only on MDG 6 but also all the related MDGs, and also affect the building of stronger health systems.

In *Pathologies of Power*, Farmer argues that gross social inequalities that ravage communities and countries create a pattern of ill health and disability and also limits the ability of people to fully participate in society (FARMER, 2008). Health is not only a reflection of a person's biology or behavioural factors but also contextualized within society and prevailing norms and power relations. Diseases such as HIV/AIDS or TB have additional layer of discrimination and stigma such that individuals and group who are perceived as sick are even more vulnerable—in other words, having HIV or TB itself is a main factor of vulnerability in society. Therefore, a human rights response and inclusion in the MDGs framework is not only essential but also ethically necessary. Human rights framework allows for one global standard but gives room for state particularities through *progressive realization to the maximum available resources*. It also does not permit retrogression on achievements. Finally, it does not let high - or middle - income countries off the hook with respect to their obligation for a global partnership. The MDGs agenda is again on centre-stage, and unless this opportunity is taken to shift the direction of MDGs towards a more nuanced approach such as human rights, then the world will continue in its trajectory of addressing poverty in a rather *ad hoc* manner without any moral or normative underpinnings.

REFERENCES

Bibliography and Other Sources

ALSTON, P. 2005. Ships passing in the night: the current state of human rights and development debate seen through the lens of the millennium development goals. **Human Rights Quarterly**, Maryland, v. 27, n. 3, p. 755-829.

ASIA-PACIFIC COALITON ON MALE SEXUAL HEALTH (APCOM); UNITED NATIONS DEVELOPMENT PROGRAMME (UNDP). 2010. **Legal environments, human rights, and resource concerns among men who have sex with men and transgender people in the Asia-Pacific Region**. Available at: <http://www.msmasia.org/>. Last accessed on: May 18, 2010.

BRENTLINGER, P. 2006. Health, human rights, and malaria control: historical background and current challenges. **Health and Human Rights**, v. 9, n. 2, p. 10-38.

CRAVEN, M. 1995. **The International Covenant on Economic, Social and Cultural Rights:** A Perspective on its Development. London: Clarendon Press.

FARMER, P. 2008. **Pathologies of Power**: Health, Human Rights, and the New War on the Poor. Los Angeles: University of California Press.

FUKUDA-PARR, S. 2004. Millennium Development Goals: Why They Matter. **Global Governance**, v. 10, n. 4, p. 359-402.

_____. 2006. Millennium Development Goal 8 for International Human Rights Obligation. **Human Rights Quarterly**, Maryland, v. 28, n. 4, p. 966-997.

GLOBAL FUND. 2010a. **Elimination of HIV Transmission from Mother to Child by 2015 Within Reach**. Press Release, Mar. Available at: <http://www.theglobalfund.org/en/pressreleases/?pr=pr_100308>. Last accessed on: May 18, 2010.

_____. 2010b. **By 2015 We Can**. Available at: <http://www.theglobalfund.org/documents/replenishment/2010/Global_Fund_Achieving_by_2015_en.pdf>. Last accessed on: May 18, 2010.

_____. 2010c. **Progress Report 2010**: The Global Fund 2010: Innovation and Impact. Available at: <http://www.theglobalfund.org/en/publications/progressreports/2010/>. Last accessed on: May 18, 2010.

GRUSKIN, S.; MILLS, E.J.; TARANTOLA, D. 2007. History, principles, and practices of health and human rights. **The Lancet**, v. 370, n. 9583, p. 449-455.

HARRINGTON, M. 2010. From HIV to Tuberculosis and Back Again: A Tale of Activism in 2 Pandemics. **Clinical Infectious Diseases,** v. 50, suppl. 3, p. 260-266. Supplement article viewpoints.

HISTORY of the 0.7% ODA Target. 2002. **DAC Journal**, v. 3, n. 4, p. III-9-III-11. Available at: <http://www.oecd.org/dataoecd/16/38/45539274.pdf>. Last accessed on: May 18, 2010.

HOGAN, M.C. et al. 2010. Maternal mortality for 181 countries, 1980-2008: a systematic analysis of progress towards Millennium Development Goal 5. **The Lancet**, v. 375, n. 9726, p. 1609-1623.

HORN, T. 2010. Global Survey: Stigma, Isolation, and Discrimination Still

Pervasive. **POZ**, 28 July. Available at: <http://www.poz.com/articles/hiv_stigma_discrimination_761_18850.shtml>. Last accessed on: May 18, 2010.

HULME, D. 2009. **The millennium development goals (MDGs)**: A short history of the world's biggest promise. Manchester, Brooks World Poverty Institute. Working Paper. Available at: <http://www.bwpi.manchester.ac.uk/resources/Working-Papers/bwpi-wp-10009.pdf >. Last accessed on: May 18, 2010.

HUMAN RIGHTS WATCH. 2003. **Ravaging the Vulnerable:** Abuses Against, Persons at High Rish of HIV Infection in Bangladesh. New York, Human Rights Watch, v. 15, n. 6(C), p. 1-51.

ICRW; UNAIDS. 2009. **HIV-related Stigma and Discrimination:** A Summary of Recent Literature. Available at: <http://data.unaids.org/pub/Report/2009/20091130_stigmasummary_en.pdf>. Last accessed on: May 18, 2010.

INTERNATIONAL COMMUNITY OF WOMEN LIVING WITH HIV/AIDS (ICW). 2009. **The Forced and Coerced Sterilization of Positive Women in Namibia**. Available at: <www.icw.org/.../The%20forced%20and%20coerced%20sterilization%20of%20HIV>**.** Last accessed on: May 18, 2010.

INTERNATIONAL TREATMENT PREPAREDNESS COALITION (ITPC). 2010. Treatment, Monitoring, and Advocacy Project. **Rationing Funds, Risking Lives**: World Backtracks on HIV treatment. Available at: <http://www.itpcglobal.org/images/stories/doc/ITPC_MTT8_FINAL.pdf>. Last accessed on: May 18, 2010.

KINNEY, E.; CLARK, B. 2004. Provisions for health and health care in the constitutions of the countries of the world. **Cornell International Law Journal**, v. 37, p. 283-355.

MANN, J; TARANTOLA, D. 1998. Responding To HIV/AIDS: A Historical Perspective **Health and Human Rights**, v. 2, n. 4, p. 5-8.

NELSON, P. J. 2007. Human Rights, the millennium development goals, and the future of development cooperation. **World Development**, v. 35, n. 12, p. 2041-2055.

NORMAND, R.; ZAIDI, S. 2008. **Human Rights at the UN:** The Political History of Universal Justice. Bloomington: Indiana University Press.

POTTS, H. 2007. Accountability and the Right to the Highest Standard of Health. University of Essex. Available at: <http://www2.warwick.ac.uk/fac/soc/csgr/events/conferences/2007/hivaids/papers/hrc_accountability_mar08.pdf>. Last accessed on: May 18, 2010.

RAJARATNAM, J.K. et al. 2010. Neonatal, postneonatal, childhood, and under-5 mortality for 187 countries, 1970-2010: a systematic analysis of progress towards Millennium Development Goal 4. **The Lancet,** v. 375, n. 9730, p. 1988-2008, May 24.

SAITH, A. 2006. From universal values to millennium development goals: lost in translation. **Development and Change**, v. 37, n. 6, p. 1167-1199.

SARELIN, A.L. 2007. Human rights-based approaches to development cooperation, HIV/AIDS, and food security. **Human Rights Quarterly**, v. 29, p. 460-488.

SHUE, H. 1980. **Basic Rights:** Subsistence, Affluence and U.S. Foreign Policy. Princeton: Princeton University Press.

STEINER, H.; ALSTON, P.; GOODMAN, R. 2007. **International Human Rights in Context:** Law, Politics, and Morals. 3. ed. Oxford: Oxford University Press.

TOEBES, B.C.A. 1999. **The Right to Health as a Human Right in International Law**. Antwerpen: Intersentia-Haart.

UNITED NATIONS. 1966. **International Covenant on Economic, Social and Cultural Rights**, UN Doc. GA Res 2200A (XXI) 16 Dec. 1966. Available at: <http://www2.ohchr.org/english/law/cescr.htm>. Last accessed on: May 18, 2010.

_____. 1990. Committee on Economic, Social and Cultural Rights (CESCR). **General Comment 3**. The nature of State parties obligations. Fifth Session. Available at: <http://www.unhchr.ch/tbs/doc.nsf/0/94bdbaf59b43a424c12563ed0052b664?Opendocument>. Last accessed on: May 18, 2010.

_____. 1997. **Renewing the United Nations:** A Program for Reform, Report of the Secretary General, UN DOC. A/51/1950.

_____. 2000a. United Nations Development Programme (UNDP). **Human Development Report 2000**: Human Rights and Human Development. Available at: <http://hdr.undp.org/en/reports/global/hdr2000/>. Last accessed on: May 18, 2010.

_____. 2000b. "**We the Peoples**"**:** The Role of the UN in the 21st Century. Millennium Report of the Secretary-General of the United Nations, UN DOC. A/54/2000.

_____. 2000c. Committee on Economic, Social and Cultural Rights (CESCR). **General Comment 14.** The right to the highest attainable standard of health, UN Doc. E/C.12/2000/4. 11 August 2000.

_____. 2001. United Nations General Assembly Resolution. **Declaration of Commitment on HIV AIDS,** UNGA RES. S-26/L.2. 27 June.

_____. 2004. **The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Health**, Report of the Secretary General, UN DOC. A/49/422. Available at: <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N04/543/38/PDF/N0454338.pdf?OpenElement>. Last accessed on: May 18, 2010.

_____. 2005. Office of the High Commissioner for Human Rights (OHCHR). **The United Nations Human Rights Treaty System**: An introduction to the core human rights treaties and the treaty bodies. Fact Sheet, n. 30, June. Available at: <http://www.ohchr.org/EN/PUBLICATIONSRESOURCES/Pages/FactSheets.aspx>. Last accessed on: May 18, 2010.

_____, 2006a. United Nations General Assembly Resolution. **Political Declaration of on HIV AIDS,** UNGA RES. 60/262. June.

_____. 2006b. Joint United Nations Programme on HIV/AIDS (UNAIDS); Office of the High Commissioner for Human Rights (OHCHR). **International Guidelines on HIV/AIDS and Human Rights**. Geneva.

_____. 2007a. **The Millennium Development Goals Report**. Available at: <http://www.un.org/millenniumgoals/pdf/mdg2007.pdf>. Last accessed on: May 18, 2010.

_____. 2007b. United Nations Development Programme (UNDP). **Human rights and the millennium development goals**: making the link. Available at: <http://hurilink.org/Primer-HR-MDGs.pdf>. Last accessed on: May 18, 2010.

_____. 2008a. Office of the High Commissioner for Human Rights (OHCHR). **The Right to Health**. Fact Sheet, n. 31, June. Available at: <http://www.ohchr.org/EN/PUBLICATIONSRESOURCES/Pages/FactSheets.aspx>. Last accessed on: May 18, 2010.

_____. 2008b. Office of the High Commissioner for Human Rights (OHCHR). **Claiming the millennium development goals**: a human rights approach. Geneva, p. 1-52.

_____. 2009a. **The Millennium Development Goals Report**. New York. Available at: <http://www.un.org/millenniumgoals/pdf/MDG_Report_2009_ENG.pdf>. Last accessed on: May 18, 2010.

_____. 2009b. **The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Health**, Report of the Secretary General, UN DOC. A/64/272. Available at: <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N09/450/87/PDF/N0945087.pdf?OpenElement>. Last accessed on: May 18, 2010.

_____. 2009c. Second Committee. **Panel discussion on Achieving the MDGs by 2015**: Preparing for the 2010 UN MDG Summit. 12 Oct. 2009. 64th General Assembly. Available at: <http://www.un.org/ga/second/64/mdgs.pdf>. Last accessed on: May 18, 2010.

_____. 2009d. Human Rights Council. **The protection of human rights in the context of the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS)**, UN DOC. A/HRC/RES/12/27. 22 Oct. 2009. Twelfth session.

_____. 2010a. **Keeping the Promise: A forward-looking review to promote an agreed action agenda to achieve MDGs by 2015.** Report of the Secretary General, UN DOC. A/64/665. Available at: <http://www.un.org/ga/search/view_doc.asp?symbol=A/64/665>. Last accessed on: May 18, 2010.

_____. 2010b. **Progress made in the implementation of the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS.** Report of the Secretary-General, UN DOC. A/64/735.

UNITED NATIONS; WORLD HEALTH ORGANIZATION (WHO). 2000. Joint United Nations Programme on HIV/AIDS (UNAIDS) **AIDS epidemic update:** December 2000. Geneva. Available at: <http://www.aegis.com/files/unaids/WADDecember2000_epidemic_report.pdf>. Last accessed on: May 18, 2010.

_____. 2009. Joint United Nations Programme on HIV/AIDS (UNAIDS). **AIDS epidemic update:** November 2009. Geneva. Available at: <http://data.unaids.org:80/pub/Report/2009/JC1700_Epi_Update_2009_en.pdf>. Last accessed on: May 18, 2010.

UNITED NATIONS; THE WORLD BANK. 2009. Joint United Nations Programme on HIV/AIDS (UNAIDS). **Global Economic Crisis and HIV Prevention Treatment Programmes**: vulnerabilities and impact. Available at: <http://data.unaids.org/pub/Report/2010/economiccrisisandhivandaids61_en.pdf>. Last accessed on: May 18, 2010.

WORLD BANK. 2010. **The MDGs after the Crisis**. Global Monitoring Report 2010. Available at: <http://siteresources.worldbank.org/INTGLOMONREP2010/Resources/6911301-1271698910928/GMR2010WEB.pdf>. Last accessed on: May 18, 2010.

YAMIN, A.E. 2009. Suffering and powerlessness: The significance of promoting participation in rights-based approaches to health. **Health and Human Rights**, v. 11, n. 1, p. 5-22.

NOTES

1. Hulme (2009) discusses in detail the history of the formulation of the MDGs in his paper. He observes that the overseas development agencies of rich countries wanted to draw up an authoritative list of concrete development goals that ould be used to reduce poverty and demonstrate the effectiveness of foreign assistance to developing countries. The big players in the conceptualization of the MDGs included the U.S., U.K., Japan, E.U., IMF, World Bank, and U.N.

2. I have purposefully excluded a reference to cultural rights, as it is under this category that many states have asked for reservations with respect to certain rights expressed in treaties.

3. There are currently nine international treaties, and in addition to those mentioned above there is the Convention on Torture, the Convention on Protection of All Forms of Migrant Workers and Their Families, the Convention on the Protection of All Persons From Enforced Disappearances, and the Convention on the Rights of Persons with Disabilities (all text of treaties are available through the OHCHR offices at: http://www2.ohchr.org/english/law/index.htm).

4. The recognition of health as a human right is attributed to President Franklin D. Roosevelt (USA) in his Four Freedoms Speech which states that the third freedom, freedom from want, "will secure to every nation a healthy, peacetime life for its inhabitants (1941, Four Freedoms Speech)."

5. Article 25(1) of the UDHR states: "Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control." (UDHR, 1948).

6. Article 12 of the ICESCR states: "1. The State Parties to the present Covenant recognize the right to everyone to the enjoyment of the highest attainable standard of physical and mental health. 2. The steps to be taken by the State Parties to the present Covenant to achieve the full realization of this right shall be include those necessary for: (a) The provision for the reduction of the still-birth rate and of infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness."
Article 24 of the CRC states: "1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services. 2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures: (a) To diminish infant and child mortality; (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care; (c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution; (d) To ensure appropriate pre-natal and post-natal health care for mothers; (e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents; (f) To develop preventive health care, guidance for parents and family planning education and services. 3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children. 4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries".

7. For a complete reference to the work of the two Special Rapporteurs thus far see the International Federation of Health and Human Rights Organisations at <http://www.ifhhro.org/main.php?op=text&id=27>.

8. The five indicators for HIV/AIDS focus on (1) HIV prevalence among population aged 15-24; (2) condom use at last high-risk sex; (3) proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS; (4) ratio for school attendance of orphans to school attendance of non-orphans aged 10-14 years; and (5) proportion of population with advanced HIV infection with access to antiretroviral drugs. In addition, there are four indicators for reversing the incidence of malaria and other major diseases as follows: (6) incidence and death rates associated with malaria; (7) proportion of children under-five years sleeping under insecticide-treated bed nets; (8) proportion of children under-five with fever who are treated with appropriate anti-malarial drugs; (9) incidence, prevalence, and death rates associated with tuberculosis; (10) proportion of tuberculosis cases detected and cured under directly observed treatment short course (DOTS). The full revised list is available on the DAC website at: <http://mdgs.un.org/unsd/mdg/Host.aspx?Content=Indicators/OfficialList.htm>.

9. Several resources can be found on the website for the journal Health and Human Rights available at: <http://www.hhrjournal.org/index.php/hhr>. In addition, the Office of the High Commissioner and the World Health Organization published a resource on the right to health available at: <http://www.who.int/hhr/news/hrba_to_health2.pdf>. The Harvard School of Public Health has a short manual on the topic found at: <http://www.hsph.harvard.edu/pihhr/files/homepage/program_resources/HIVHR_nutshell-english.pdf>.

10. The principle of non-discrimination, based on recognition of the equality of all people, is enshrined in the Universal Declaration of Human Rights and other human rights instruments. These texts prohibit discrimination based on race, color, sex, language, religion, political or other opinion, property, birth or other status. In 1996, the Commission on Human Rights including HIV/AIDS in the 'other status' category, and noted that discrimination based on actual or presumed HIV status is prohibited. Although the term stigma does not appear in any international treaty, the UN Human Rights Treaty Bodies recognize the link between stigma and discrimination in the context of HIV.

11. The United Nations High-level Plenary Meeting on the MDGs will take place from 20-22nd September at UN Headquarters in NY. It's primary objective is to accelerate progress towards the MDGs. Information on the Summit is available at: <http://www.un.org/en/mdg/summit2010/>.

RESUMO

Os Objetivos de Desenvolvimento do Milênio (ODMs) são a maior promessa mundial para redução da pobreza global e da privação humana. Formulados como objetivos nacionais e baseados em resultados, os ODMs aparentam não incluir qualquer compromisso com os direitos humanos. Este artigo explora como os ODMs se encaixam num marco de direito internacional e como o objetivo 6 de combate ao HIV/AIDS, à malária e à tuberculose pode ser integrado no direito à saúde. A discussão determina se o ODM 6 pode ser utilizado ou deve ser reajustado para promover participação real, não discriminação e igualdade, *accountability* e acesso. Poderão os principais proponentes de ambos os lados criar um novo caminho que integre direitos e estratégia de redução da pobreza por meio dos ODMs?

PALAVRAS-CHAVE

Direitos humanos – Saúde – Objetivos de Desenvolvimento do Milênio (ODMs)

RESUMEN

Los ODM son la mayor promesa mundial para reducir la pobreza en el mundo y las privaciones de los seres humanos. Formulados como metas nacionales y con un enfoque basado en los resultados, parecen carecer de todo compromiso con los derechos humanos. El presente artículo explora de qué modo los ODM cuadran dentro del marco del derecho internacional y cómo el ODM 6 sobre la lucha contra el VIH/SIDA, el paludismo y la tuberculosis puede integrarse al derecho a la salud. El artículo analiza si el ODM 6 puede ser reformulado o adaptado para promover una participación real, la no discriminación y la igualdad, la rendición de cuentas y el acceso a la salud. ¿Pueden los principales propulsores de ambas partes –derechos humanos y los ODM– trazar un nuevo camino que pueda integrar los derechos y la estrategia contra la pobreza a todos los ODM?

PALABRAS CLAVE

Derechos humanos – Salud – Objetivos de Desarrollo del Milenio (ODMs)