International Journal of Applied Research

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Need to combat HIV/AIDS, Malaria and other diseases with special emphasis to MDG 6th goal- in Indian context

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Abstract
Millennium Development Goal (MDG) 6 has two HIV/AIDS commitments: to have halted and begun to reverse the spread of HIV/AIDS by 2015. These goals were developed in 2001 as a tool for focusing attention on and mobilizing resources for, development. Yet in the case of MDG 6 to combat HIV/AIDS, malaria and other diseases significant treatment was already taking place around HIV/AIDS, and in this respect MDG 6 both reflected and supported an expanding infectious disease and broader health agenda. This paper begins with a discussion of one of the intellectual origins of MDG 6 that is the idea of health as development and then focuses on the subsequent prevention of HIV/AIDS, Malaria & Tuberculosis.

Keywords: MDG-6, HIV/AIDS, Malaria, Tuberculosis, Health, Development

Introduction

The United Nations Millennium Declaration, signed in September 2000, commits world leaders to combat poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women. The MDGs are derived from this Declaration. Each MDG has targets set for 2015 and indicators to monitor progress from 1990 levels.

Shri G. K. Vasan, Minister of State (independent charge), Ministry of Statistics and Programme Implementation, released the first Millennium Development Goals - India Country Report for the year 2005 on 13th February 2006 in a simple function at Delhi. The Millennium Declaration adopted by the General Assembly of the United Nations in September 2000 reaffirmed its commitment to the right to development, peace, security and gender equality, to the eradication of many dimensions of poverty and to overall sustainable development. These are intended for the Member Countries to take efforts in the fight against poverty, illiteracy, hunger, lack of education, gender inequality, infant and maternal mortality, disease and environmental degradation. The Millennium Declaration adopted 8 development goals.

The Millennium Development Goals

1. Eradicate extreme poverty and hunger.
2. Achieve universal primary education.
3. Promote gender equality and empower women.
4. Reduce child mortality.
5. Improve maternal health.
6. Combat HIV/ AIDS, malaria and other diseases.
7. Ensure environmental sustainability and
8. Develop a global partnership for development

Where we are?
Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS

- The prevalence of HIV among Pregnant women aged 15-24 years is showing a decreasing trend from 0.89 % in 2005 to 0.32% in 2012-13.

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- According to NFHS –III in 2005-06, Condom use rate of the contraceptive prevalence rate (Condom use to overall contraceptive use among currently married women, 15-49 years,%) was only 5.2 % in India.
- According to Behavioral Surveillance Survey (BSS, 2001 to 2006), the national assessments for Condom use at last high-risk sex (%) (Proportion of population aged 15-24 years who used condom during last sex with non-regular partner) registered a 19% increase from 51.9% in 2001 to 61.7% in 2006. According to 'Condom Promotion Impact Survey 2010', the national estimate for Condom use at last high-risk sex is 74%, it shows an improvement of 20% during 2006 to 2010.
- According to Behavioral Surveillance Survey (BSS), the national estimate for proportion of population aged 15-24 years with comprehensive correct Knowledge of HIV/AIDS (%) increased from22.2% in 2001 to 32.9% in 2006.

Target 8: Have halted by 2015 and begun to reverse the incidence of Malaria and other major diseases

- The Annual Parasite Incidence (API) rate – Malaria has come down from 2.12 per thousand in 2001 to 0.72 per thousand in 2013, but slightly increased to 0.88 in 2014 (P) but confirmed deaths due to malaria in 2013 was 440 and in 2014 (P), 578 malaria deaths have been registered.
- In India, Tuberculosis prevalence per lakh population has reduced from 465 in year 1990 to 211 in 2013. TB Incidence per lakh population has reduced from 216 in year 1990 to 171 in 2013. Tuberculosis mortality per lakh population has reduced from 38 in year 1990 to 19 in 2013.

Overview of Goal 6: Combat HIV/AIDS, Malaria and other Diseases

The Government of India has taken a step toward HIV/AIDS control. The 3rd phase of National AIDS Control Programme (NACP), which is designed to back the spread of HIV/AIDS, was implemented. Which contain treatment of sexually transmitted infections, voluntary counselling and testing, and condom promotion?

Malaria has been showing a decreasing trend from high incidence levels. The National Vector Borne Disease Control Programme (NVBDCP) frames technical policies and guidelines for the control of malaria in the country.

India accounts for nearly one fifth of the global burden of tuberculosis. The Revised National Tuberculosis Control Programme (RNTCP) applying the Directly Observed Treatment Short course (DOTS) which is new WHO TB strategy for TB control is a step toward achieving the TB-related MDGs.

4.1 Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS

In India, over the years the HIV/AIDs rate among various population groups has declined. The adult HIV frequency at national level has gradually declined from 0.41% in 2001 to 0.27% in 2011.
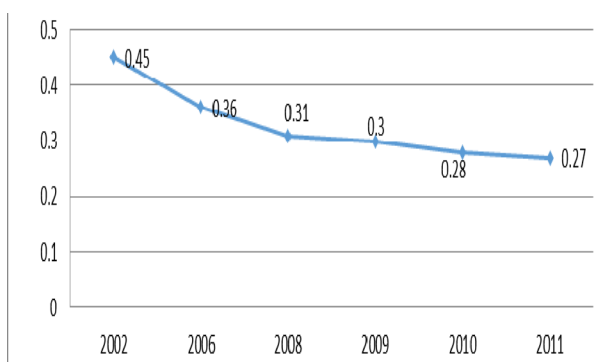

Fig: Trend in Estimated Adult HIV Prevalence in India

Source: HIV Estimation 2012, D/o AIDS Control

The disease burden has dropped from an estimated 24 lakhs people living with HIV /AIDs in 2009 to nearly 20.9 lakh in 2011.The number of people living with HIV /AIDs in India in 2009 to 2011 are as follows.

Table: People Living with HIV / AIDS(PLHA) in India

	2009	2011
The total number of people living with HIV/AIDS in India	Estimated at 24 lakh (19.3 – 30.4) in 2009.	Estimated at 20.9 lakh (17.2 lakh–25.3 lakh)
% of Children(<15 yrs) and Women of all PLHA	Children - 3.5% (0.84 lakh), Women - 39% (9.3 lakh).	Children - 7% (1.45 lakh) Women - 39% (8.16 lakh)
High prevalence States	Andhra Pradesh – 5 lakh, Maharashtra – 4.2 lakh, Karnataka – 2.5 lakh, Tamil Nadu – 1.5 lakh) account for 55% of all HIV infections in the country.	Andhra Pradesh–4.19 lakh, Maharashtra-3.16 lakh, Karnataka-2.09 lakh and TamilNadu-1.33 lakh) account for 53% of all HIV infections in the country.
States with more than 1 lakh People Living with HIV/AIDS each	West Bengal, Gujarat, Bihar and Uttar Pradesh and together account for 22% of HIV infections in India	West Bengal, Gujarat, Bihar, Uttar Pradesh and Odisha and together account for 29% of HIV infections in India

Source: D/o AIDS Control

The condition of new infected HIV / AIDs also matters a lot, in evaluating the disease burden. In India, it is expected to have around 1.16 lakh (0.72–1.99 lakh) annual new HIV infections among adults (15+ years) and around 14,500 (10,974–19,346) new HIV infections among children (<15 years) in 2011. States like Andhra Pradesh have the highest number (16,603) of new adult HIV infections in 2011 followed by Odisha (12,703).
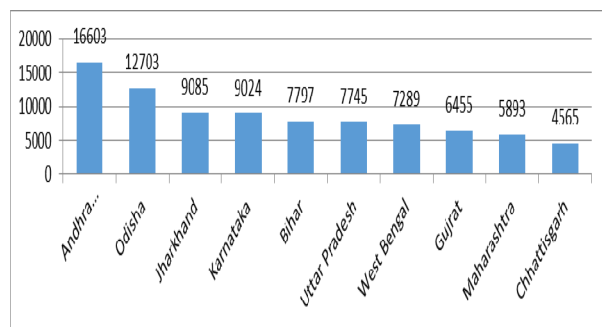
Fig 8.6.1: Estimated new HIV infections in 2011 -Top 10 states

Source: HIV Estimation 2012, D/o AIDS Control

It has been observed that, in 2011 out of the 1.16 lakh expected new infections among adults, the six high frequency states account for only 31%, while the ten low frequency States of Odisha, Jharkhand, Bihar, Uttar Pradesh, West Bengal, Gujarat, Chhattisgarh, Rajasthan, Punjab & Uttarakhand together account for 57% of new infections.

India has proved an overall reduction of 57% in estimated annual new HIV infections (among adult population) during the last decade from 2.74 lakhs in 2000 to 1.16 lakhs in 2011. This is one of the most important sign on the impact of the several involvements under National AIDS Control Programme and scaled-up prevention strategies.

Using globally known approaches and updated evidence on survival to HIV with and without treatment, it is expected that about 1.48 lakh (1.14 lakhs-1.78 lakhs) people died of AIDS related causes in 2011 in India. Deaths among HIV infected children account for 7% of all AIDS-related deaths. Wider access to ART (Antiretroviral Therapy) has led to 29% reduction in expected annual AIDS-related deaths in the country during National AIDS Control Programme (NACP)-III period (2007–2011). In high frequency States, estimated AIDS-related deaths have decreased by around 42% during 2007 to 2011. It is expected that the scale up of free ART since 2004 has saved cumulatively over 1.5 lakh lives in the country till 2011. With the current scale up of ART services, it is estimated to stop around 50,000–60,000 deaths annually in the next five years. As on 30/9/14, nearly 8.1 lakh People Living with HIV/ AIDS (PLHA) alive are on ART, among them nearly 4.05 lakh are adult males and 3.58 lakh are adult females, the rest 0.44 lakh are children and 0.02 lakhs are TS/ TG (Trans- Sexual/ Trans –Gender).
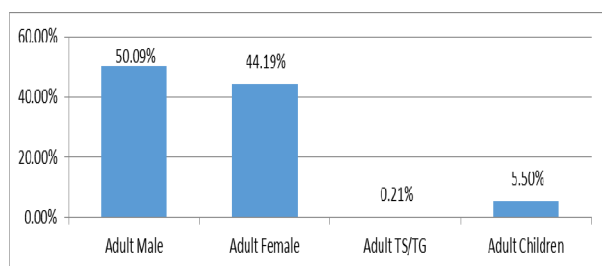

Fig: Number of PLHIV alive and on ART as on 30/9/ 2014

Source: D/o AIDS Control

The above statistics shows that the epidemic HIV/AIDs in India is under control, however, the disease burden continues to be substantial. The progresses of the specific MDG indicators are as follows.

Indicators
Indicator 18: HIV prevalence among pregnant women aged 15-24 years (%)
The frequency of HIV among Pregnant women aged 15-24 years is showing a decreasing trend from 0.86 % in 2004 to 0.32% in 2012-13.
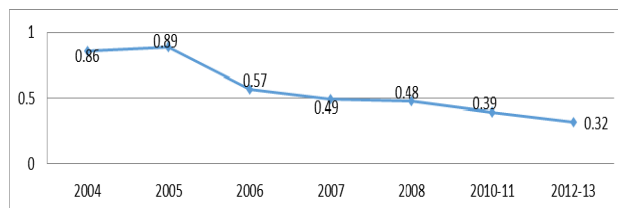

Fig: Trend in HIV prevalence among Pregnant Women aged 15-4yrs (%)

Source: HIV Sentinel Surveillance, D/o AIDS Control

The HIV frequency among pregnant women (15-24 yrs) is highest in Nagaland (1.16%) followed by Mizoram (0.97%). During 2008-13, the indicator showed a decreasing trend in all States except for the States of Arunachal Pradesh, Assam, Bihar, Gujarat, Jammu & Kashmir, Meghalaya, Mizoram, Nagaland, Punjab, Sikkim, Tamil Nadu, Tripura and Uttarakhand.

Indicator 19: Condom use rate of the contraceptive prevalence rate (Condom use to overall contraceptive use among currently married women, 15-49 years, %)
According to National Family health Survey (NFHS)–III, in 2005-06, condom use rate of the contraceptive frequency rate was only 5.2 % at all India level. The Condom use rate of the contraceptive frequency rate is highest in Delhi (22.9%) followed by Uttarakhand (15.7%) and Punjab (15.5%). The lowest Condom use rate of the contraceptive frequency rate was reported for Andhra Pradesh (0.5%) followed by Mizoram and Karnataka.

Table: Condom use rate of the contraceptive prevalence rate (2005-06)

State/ UT	Condom use rate of the contraceptive prevalence rate	State/UT	Condom use rate of the contraceptive prevalence rate
Delhi	22.9	Madhya Pradesh	4.8
Uttarakhand	15.7	Sikkim	4.1
Punjab	15.5	Tripura	3.2
Haryana	11.8	Odisha	3
Himachal Pradesh	11.5	Chhattisgarh	2.9
Uttar Pradesh	8.6	Arunachal Pradesh	2.8
Jammu &Kashmir	8	Jharkhand	2.7
Goa	7.5	Nagaland	2.6
Maharashtra	6.2	Meghalaya	2.4
Gujarat	5.8	Assam	2.3
Rajasthan	5.7	Bihar	2.3
Kerala	5.5	Tamil Nadu	2.3
India	5.2	Karnataka	1.7
West Bengal	4.3	Mizoram	1.4
Manipur	4.1	Andhra Pradesh	0.5

Source: National Family Health Survey -3 (2005-06)

It is a cause of concern that, the high prevalence States like Andhra Pradesh, Mizoram, Karnataka and Tamil Nadu are at the last rank positions for the indicator Condom use rate of the contraceptive prevalence rate.

Indicator 19 (A): Condom use at last high-risk sex
The Behavioural Surveillance Survey (BSS) conducted to monitor the changes in knowledge and behaviour indicators in different risk groups with respect to HIV/AIDS, indicates that Condom use in between non-regular sex partners is quite low. According to BSS conducted in 2001 & 2006, the national estimations for Condom use at last high-risk sex (%) (Proportion of population aged 15-24 years who used condom during last sex with non-regular partner) registered a 19% increase from 51.9% in 2001 to 61.7% in 2006. As per the 'Condom Promotion Impact Survey 2010', the national estimate for Condom use at last high-risk sex is 74%, thus recording rogress of 20% during 2006 to 2010. In 2009, BSS was conducted in six states (Uttar Pradesh, Andhra Pradesh, Karnataka, Tamil Nadu, Maharashtra and Manipur) as part of Mid-Term Review of NACP-III.

Table: Condom use at last high-risk sex (%) - Proportion of population aged 15-24 years who used condom during last sex with non-regular partner

States	2006	2009
Uttar Pradesh	48.8	46
Andhra Pradesh	63.6	89
Karnataka	81.1	87
Tamil Nadu	46.4	-
Maharashtra	77.8	92
Manipur	76.6	

Source: Behavioural Surveillance Survey, D/o AIDS Control

Among the above States, in which Behavioural Surveillance Survey was conducted in 2006 and 2009, the Condom use at last high-risk sex (%) showed an improvement except the State of Uttar Pradesh.

Indicator 19 (B): Proportion of population aged 15-24 years with comprehensive correct Knowledge of HIV/AIDS (%)
According to Behavioural Surveillance Survey, the national estimation for percentage of population aged 15-24 years with comprehensive correct Knowledge of HIV/AIDS percentage in 2006 was 32.9 % reporting betterment from 2001 (22.2%). The evaluations of the indicator for the States in which BSS was conducted in 2009 are as follows:

Table: Comprehensive Correct Knowledge about HIV Transmission and Prevention

States	2006	2009
Uttar Pradesh	29	21
Andhra Pradesh	28	19
Karnataka	23	10
Tamil Nadu	30	56
Maharashtra	49	24
Manipur	43	-

Source: Behavioural Surveillance Survey, D/o AIDS Control

It is shocking to note that, among the above States in which BSS 2006 & 2009 were conducted, a decline in the complete and correct knowledge about HIV was detected in the States of Uttar Pradesh, Andhra Pradesh, Karnataka, Maharashtra whereas Tamil Nadu showed a significant improvement.

Target 8: Have halted by 2015 and begun to reverse the incidence of Malaria and other major diseases reducing malaria cases
Before launching of the National Malaria Control Programme (NMCP, 1953) malaria was a major plague in India with 75 million cases and about 0.8 million deaths yearly. The widespread DDT indoor residual spray (IRS) in the country under the NMCP resulted in a sharp decline in malaria cases later on the GOI changed the NMCP into the National Malaria Eradication Programme (NMEP) in 1958. The NMEP was firstly a great success with the malaria incidence dropping to a 0.1 million cases and no deaths due to malaria reported in 1965. The rebirth of malaria in the country resulted in growth of 6.4 million cases in 1976. The repetition was due to various operational, administrative and technical reasons, including emergence of drug resistance in the parasites and insecticide resistance in the vectors. In 1977, the Modified Plan of Operation (MPO) was implemented with the objectives of stopping deaths and reducing morbidity due to malaria. Under the MPO, IRS was recommended in areas with Annual Parasite Incidence (API) ≥ 2 in addition to early diagnosis and prompt treatment. By 1996, there was another malaria increase with 3.03 million cases and 2,803 deaths reported.

Since the emphasis shifted from eradication to control, the programme was renamed as National Anti-Malaria Programme (NAMP) during year 1999. It is important to note that the Directorate responsible for prevention and control of malaria at central level was also made responsible for prevention and control of filariasis, Kala-azar, Japanese Encephalitis, Dengue and Chikungunya. With the merging of prevention and control of other vector borne diseases, the Directorate of NAMP was renamed as Directorate of National Vector Borne Disease Control Programme (NVBDCP) in 2003. The NVBDCP is presently one of the most comprehensive and multi-faceted public health programmes in the country. The NVBDCP became an integral part of the NRHM launched in 2005.

In India from the last one decade the malaria cases were brought down from 2,031,790 cases in 2000 to 1,816,569 cases in 2005 and further brought down to 1,067,824 cases in 2012. The Country is heading towards achieving target of 50% reduction in incidence of malaria cases against the baseline. The annual incidence rate (cases of malaria/1000 population) of Malaria has come down from 2.57 per thousand in 1990 to 1.10 per thousand in 2011, and to 0.88 cases (provisional) per 1000 population in 2012. The malaria death rate in the country was 0.09 deaths per lakh population in 2000 which has come down to 0.04 deaths per lakh population in 2012.

The Annual Parasite Incidence (API) rate has consistently come down from 2.12 per thousand in 2001 to 0.72 per thousand in 2013, but marginally increased to 0.88 in 2014 but confirmed deaths due to malaria in 2013 was 440 and in 2014, 578 malaria deaths have been registered.

Table: Malaria situation in India

Year	Total Malaria cases(million)	Deaths Due to Malaria	Annual Parasite Index(per 1000 Population)
2000	2.03	932	2.09
2001	2.09	1005	2.12
2002	1.84	973	1.82
2003	1.87	1006	1.82
2004	1.92	949	1.84
2005	1.82	963	1.68
2006	1.79	1707	1.66
2007	1.51	1311	1.39
2008	1.53	1055	1.36
2009	1.56	1144	1.36
2010	1.60	1018	1.37
2011	1.31	754	1.10
2012	1.06	519	0.88
2013	0.88	440	0.72
2014	2.07	578	0.88

Source: M/o Health and Family Welfare

As may be seen the annual incidence has been constantly declining, which reveals that the increasing trend of malaria incidence has already been halted and being reversed.

Combating TB
Indicator: Incidence, prevalence and Death rates associated with TB
Today in India, two deaths occur every three minutes due to tuberculosis (TB). With proper care and treatment, TB patients can be cured. Tuberculosis (TB) disease is caused by Bacteria, Mycobacterium tuberculosis. It is spread through the air by a person suffering from TB. A single patient can infect 10 or more people in a year. TB is the most common infection in people living with HIV virus. As we know the HIV breaks down the immune system, HIV infected people are at greatly increased risk of TB. Without HIV, the lifetime risk of developing TB in TB infected people is 10%, compared to at least 50% in HIV co-infected. HIV is also the most powerful risk factor for advancement from TB infection to TB disease. Thus, TB and HIV are closely interlinked. With large numbers of HIV-positive individuals in India, it is likely that HIV may worsen the TB epidemic in the absence of a strong TB control programme. However, even among HIV infected people, TB can be cured. Directly Observed Treatment, Short-course (DOTS) is as effective among HIV infected TB patients.
According to WHO, in India, Tuberculosis occurrence per lakh population has reduced from 465 in year 1990 to 211 in 2013. TB Incidence per lakh population has reduced from 216 in year 1990 to 171 in 2013. Tuberculosis mortality per lakh population has reduced from 38 in year 1990 to 19 in 2013.

Table: Tuberculosis situation in India

Year	Incidence (Per lakh population)	Prevalence (Per lakh population)	Mortality (Per Lakh Population)
1990	216	465	38
1995	216	465	38
2000	216	438	39
2005	209	365	36
2009	190	289	29
2010	185	269	27
2011	181	249	24
2012	176	230	22
2013	171	211	19

Source: M/o Health and Family Welfare

Indicator: Proportion of TB cases detected and cured under DOTS
Every patient who is cured stops spreading TB, The strategy of DOTS is based largely on research done in India in the field of TB over the past 35 years. Since 1997, after successful piloting DOTS has been implemented in India as the Revised National Tuberculosis Control Programme (RNTCP). In the RNTCP, the proportion of TB cases which are confirmed in the laboratory and the cure rate are both more than double that of the previous programme. The operational feasibility of DOTS in the Indian context has been demonstrated, with 8 out of 10 patients treated in the programme being cured, as compared with approximately 3 out of 10 in the previous programme. Multidrug -resistant tuberculosis (MDRTB) is a result and symptom of poor management of TB patients. DOTS have been shown to prevent the emergence of MDRTB and to reverse the trend of MDRTB in communities in which it has emerged. TB is the most common opportunistic infection among people living with HIV. The Ministry of Health and Family Welfare has reported that, the latest status of treatment of TB under DOTS reveals that, the proportion of TB cases detected is 70% and cured is 85% under DOTS.

Mitigation Strategies & Recommendations
After conducting a structured interview in a village of Allahabad we found that rural people are not too much aware regarding HIV/AIDS, Tuberculosis and Malaria. People don't like to talk about HIV, some time they doesn't want to go hospital because they think if they will go hospital society people will know they are suffered from such type of disease. In some cases these people totally ignored by their society. Any child, who has such type of disease, facing lots of problem to continue their study, no one wants to be their friend or play with them.
No doubt Indian government doing lots in this field but there is still need to focus on the rural areas. As we find after analysis is that infected people want social security in case of HIV/AIDS and TB. In Allahabad areas near Sangam having numbers of slum colony which leads to migrant labours staying away from families. Illiteracy and poor awareness expose them to high risk group. Working groups like rickshaw puller, truck & auto driver are especially at risk.
To achieve MDG Goal 6 following steps are necessary to be taken.
1. Strategic use of Anti Retro Viral for HIV treatment and prevention.
2. Eliminating HIV in children and expanding access to treatment.
3. An improved health sector response to HIV among high risk group.
4. More innovation is required for HIV prevention, diagnosis, treatment and care.
5. Strategic information for effective scale up.
6. Stronger links between HIV and related health outcomes.
7. Address TB/HIV, multidrug-resistant TB and the needs of poor and vulnerable populations.
8. Contribute to health system strengthening based on primary health care.
9. Engage all care providers.
10. Empower people with TB, and communities through partnership & by spreading awareness.

11. Malaria prevention with long-lasting insecticidal nets and indoor residual spraying.
12. Diagnostic testing and treatment with quality-assured anti-malarial medicines.
13. Preventive therapies for infants, children and pregnant women.
14. Tracking every malaria case in a surveillance system.
15. Scaling up the fight against emerging drug and insecticide resistance.

Conclusion
India is well struggling to move beyond the HIV/AIDS, Malaria, TB target of the MDGs and progress towards elimination. However, in addition to its existing interventions, the country will need to sustain its financing for HIV/AIDS, Malaria control and support programmed reorientation towards elimination and scale up active surveillance coupled with treatment at the community level. Moreover collaboration needs to be sustained and scaled up to prevent the re-introduction of HIV/AIDS, Malaria, and TB into the country. To achieve this, in addition to its existing interventions, India will need to scale up active surveillance coupled with treatment at the community level. Moreover, health systems strengthening, as advocated by others, will be a key component to the HIV/AIDS, Malaria, TB program. Programs will especially need to focus on human resources, information systems infrastructure, transport systems coupled with strengthening and sustaining effective cross-border and health promotion strategies.

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