

Moving towards global health equity: Opportunities and threats: An African perspective

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Abstract

Background: The theme of the 13th World Congress on Public Health, “Moving Towards Global Health Equity: Opportunities and Threats”, strikes an optimistic note as the gaps within and between countries are greater than at any time in recent history. There is no consensus on what globalization is, but most agree that it will substantially shape all the other major trends in the world even though its impacts are highly asymmetric “with disproportionate benefits for rich countries and multinationals, leaving poor countries and people behind”. The current globalization has major influence on health.

Objective: This is a review article that attempts to reflect on the African perspective on health equity in view of the complex situations of globalization as well as diverse partnership in the sector.

Results: Equity has been a long quest in public health and global health equity could be seen as part of the new ‘global health diplomacy’ with recent major drives to meet the global equity gap made more complex by the growing involvement of private (in particular for profit) organizations. There are no ‘givens’ in globalization; Africa would have to ‘negotiate’ its position in the tide of globalization. Sub-Saharan Africa will remain an enduring preoccupation and target of global policies and interventions as “...the current rates of progress will not be able to provide satisfactory health care to its inhabitants by 2020” one reason being the effect of globalization as exemplified by the highly inadequate human resources for health.

Conclusions: Negotiating Africa’s future in a globalizing world complicated by conflicting interests, recurring and deepening economic crisis, and bewildering cacophony of actors, conditionalities and requirements will not be easy. Africa should continuously monitor developments and try to play a proactive role, define its priorities and strategize including developing its intellectual capital. [*Ethiop. J. Health Dev.* 2012;26 Special Issue 1:238-250]

Introduction

The theme of the 13th World Congress on Public Health in Addis Ababa, “Moving towards Global Health Equity: Opportunities and Threats”, strikes, some would say, an optimistic note. It is consistent as a follow up of the 12th Congress in Istanbul Call “Now is the time for all those who affect the lives of others, working in government, industry, and in civil society, and as health care workers, academics, community and faith-based leaders, and citizens, to affirm the fundamental and elemental importance of public goods, including public health, and to assert and practice the basic human values of solidarity, sustainability, morality, justice, equity, fairness and tolerance” (Istanbul Declaration). It might, from the African perspective, be considered optimistic because the challenges and threats globally and for Africa in particular, seem daunting, increasing and deepening - witness the seemingly endless ‘war on terrorism’, economic crisis, marginalization of “the bottom billion”... As Margaret Chan put it, “... the gaps, within and between countries, in income levels, opportunities, health status, life expectancy and access to care are greater than at any time in recent history” (as quoted in 1).

As we approach¹ the dates of the 13th Congress, it seems appropriate to start reflecting on and give an African touch to the theme in the hope not to give definitive answers but to raise questions and promote collective reflections in order to think-through/pave the way for an African/Ethiopian position on the issue.

Globalization

There is no consensus on what globalization is and even on whether it is something new or the ‘old [imperial/colonial] wine in a new bottle’. It is a multidimensional phenomenon with multiple definitions/understanding depending on the view point (not to say ideology) of the analyst (2, 3). Some see globalization as distinct from internationalization with the later viewed as inter-state relations to promote one interest or another – sometimes even a vestige of the colonial era - while globalization is seen as going beyond the conventional national state concerns and connotes more altruistic, real partnership approach. In the same vein international health is seen as distinct from global health (4-6). However the terms tend to be used interchangeably as, for example, in the International Health Partnership (IHP+) in which non-state actors participate (7) and the policy process is complex and

¹ This review was initially prepared as a discussion paper within EPHA in preparation of the Congress

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often reduced to overlapping metaphors (8). Most informed analysts tend to agree that globalization will be "a force so ubiquitous that it will substantially shape all the other major trends in the world of 2020" (2, 9, 10); "... an issue that has not attracted enough serious consideration by the majority of our [African] countries" (11). One central proposition of globalization is that the world has become so closely intertwined/integrated – a 'global village' - that people everywhere face the same dangers and enjoy the same benefits... the 'world is flat'... i.e. thanks to the technological revolution², ICT in particular, the world has become greatly interconnected - with mobile phone coverage of 90% of the world's total population and 80% of the global population living in rural areas (12) - ; 'national' boundaries and identities are becoming obsolete and the surest way of helping the poor is to open markets i.e. the Washington Consensus (13).

On the other hand, "There is another side to globalization... which has far-reaching political implications. Globalization is in fact neither global nor total: it does not affect all states on the planet, nor all citizens within states" (14). Many observers point out that these relationships/movements are highly asymmetric and while goods and services (in favor of the haves) seem to move across borders easily, movement of people (in particular from the underdeveloped) is more and more constrained. In spite of exaggerated fears in some circles in the developed world, very few migrate from Africa (15). "Globalization has always affected Africa" (16) and to date the balance, as for most poor has been rather negative, "with disproportionate benefits for rich countries and multinationals, leaving poor countries and people behind" (17), and leading one to affirm that "Globalization Exploits Africa" (18) and another that "Globalization is a powerful and irreversible phenomenon - offering new opportunities to countries at the upper end of the competitive ladder – but also creating enormous difficulties for many low income countries" (19). African economy has in fact stagnated in the age of (the current) globalization with per capita income lower than the peaks attained in the 1970s (16); now even recognized, grudgingly, by IMF (13).

Another tension that globalization creates is related to 'identity seeking' in particular of the ethnic/cultural type since, as much as it purportedly generates solidarity and interdependence even homogenization³, it also pushes to fragmentation. While this is faced by many countries (the Irish in the UK, the Basque in Spain and France, the Kurds...), it is more pronounced in Africa because of the colonial past that has created overlapping frontiers and in-country divisions pronounced in resource-rich countries (20, 21). Thus from East to West – from the Horn to the Congo and from North to South – the Atlas

to the Cape of Good Hope, Africa is plagued by 'identity issues' (22) and, while globalization is not the only culprit, it plays an important role possibly also in eventually transcending this tension with the nation-state losing most of its mandate to global governance (23, 24)⁴.

Whether globalization is a "health promoter or a health hazard" is a subject of world-wide (not to say global) debate. That market-defined globalization could be harmful to health has been underscored and alternatives (alter-globalization) are being promoted by certain groups (25). Thus, however understood, the current globalization has major influence on health through, among others, growing interdependence and increased global nature of public health issues; the proliferation of binding multi-lateral agreements; dramatic increases in financial, capital and service flows resulting in global economic integration; the preeminence of neo-liberal forms (26) of state restructuring putting health in the 'market place'; increased and diverse patterns of population movements; changing modes of production and related shifts in patterns of consumption; increased cultural diffusion (Westernization?); the emergence of global citizenship, and the dramatic proliferation of Non-Governmental Organizations (NGOs) and Civil Society Organizations (CSOs) (2). Globalization also raises the issue of global equity because it seems incontrovertible that "Globalisation's rules favor the already rich (both countries and people within them) because they have greater resources and power to influence the design of those rules..." (27-29). In this context, it is appropriate to ponder on global health equity and what it could mean to Africa.

Health Equity

Equity⁵ has been a long quest in public health even though it has gained urgency recently in relation to the health sector reforms in many African countries (30). But, again, the word is used to depict differing concepts in differing contexts. Some distinguish between inequalities which are considered as uneven (sometimes unavoidable) distributions in or among populations and inequities that are inequalities attributable to determinants that fall within the capacities of peoples and communities to moderate (31). Some argue that the health MDGs – on infant mortality, maternal mortality, and HIV/AIDS – focus on health inequalities which in most cases reflect differences in constraints – lower incomes, poor education, poor housing – than they reflect differences in preferences and should therefore be seen not as inequalities but as inequities insofar as policy can help attenuate them (27, 29). In health, equity is often

² Whose nature has yet to be fully investigated (27)

³ "...the world's communities are being amalgamated into a single community through the dissolution of local identity and cultural distinctiveness, on the one hand, and the potential for sharing knowledge and resources on the other" (28).

⁴ When and how this 'revolution will come is debatable with Revel (24) seeing it as coming from the USA and Attali (23) from a phase of global conflagration.

⁵ Equity assessment encompasses several dimensions such as equity strata (sex, race ethnicity, region, education, place...), health status (risk, disease, death social consequences of illness...) and health care (access, quality, cost...) [38]. Many prefer measuring inequities (e.g. 31,39) or disparities in USA (37).

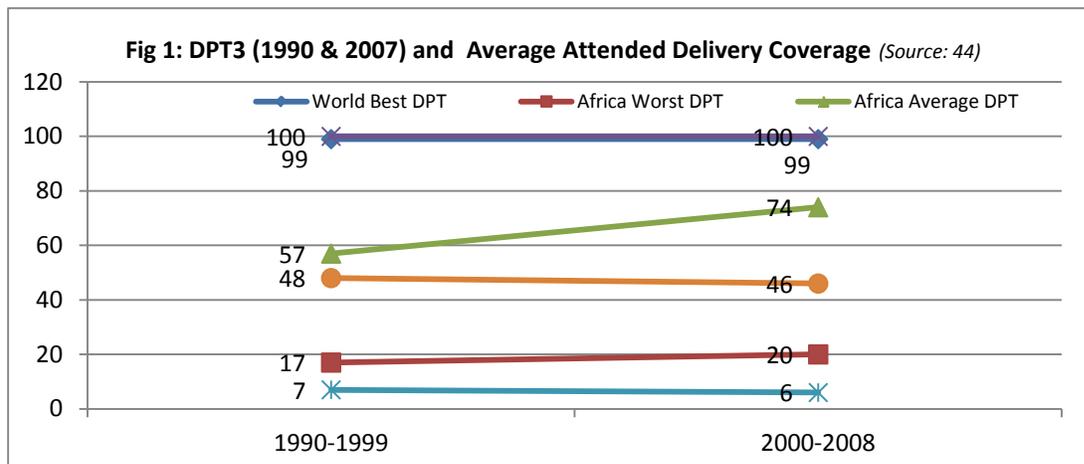
defined as “...an absence of systematic and remediable differences between population groups, that are not freely chosen and which may be considered unfair or unjust” (32-34). Or as the Commission on Social Determinants for Health put it, “Where systematic differences in health are judged to be avoidable by reasonable action, they are, quite simply, unfair. It is this that we label as health inequity” (35-37).

Health equity issues matter because they are unfair and ethically unacceptable as they are not the direct consequence of the deliberate choices that individuals made. Societal gains in public health are relatively greater from significant improvement in the health condition of the population group suffering the most health disadvantage. The economic benefits are also relatively greater for the poor people, those populations suffering poor health, as poor health status excludes these groups from active participation in the economy. The economy performs at below its potential as a result. Improvements in the health of the poor could therefore improve the performance of the economy to the benefits of wider segments of the population (30).

In the global health context of the Congress, global health equity could be seen as part of the new ‘global health diplomacy’ i.e. “the processes by which state and

non-state actors engage to position health issues more prominently in foreign policy decision-making” (8, 33, 38-40) even though, again the diplomacy role of health in Africa is nothing new. Thus, for example, after colonization attempts have been thwarted by the defeat of the Italians at Adwa, 1896, an important diplomatic overture by the big powers was inclusion of health teams in their diplomatic missions (41).

Equity problems are pervasive and considered as systemic crisis (42) but more glaring for Africa which is facing 25% of the world’s morbidity rate with only 3% of its healthcare personnel; consequences of years of neglect and underinvestment by African governments and the international community (43). Of course, this should not overshadow inequities within Africa between countries as Africa remains a highly fragmented continent in spite of over 50 years of OAU/AU. Identifying vulnerable populations is also important (44). Disparities among population groups, children (45) or women (2, 43) in particular, are very high. Notably, inequities are most extreme for delivery assistance, with the most equitable service observed for immunization (Fig 1) probably due to quasi universal coverage and close monitoring by national governments and donor agencies (30).



In recent years, “Equity as a shared vision for health and development” (46) as enshrined in MDGs seems to be gaining momentum even though its scope and drivers could be questioned (35, 47-49)⁶. There are major drives to meet the global equity gap e.g.

- Group of 7/20 meeting in Gleneagles (50);
- Accelerating Universal health Coverage was the topic of the 1st Global Symposium on Health Systems Research in 2010 in Montreux;
- The right to health - calls for governments to generate conditions in which everyone can be as healthy as possible (48);
- The World Economic Forum in its Innovation in Healthcare Delivery project, aims to address:
 - Lack of sufficient and/or adequate infrastructure in health systems including hospitals and care centers
 - Inadequately trained medical workforce (i.e., doctors and nurses) and/or limited supply of trained workforce
 - Improper and unsustainable funding mechanisms both in public and private systems to deliver the required care to patients
 - Mismatch in quality where either standards are lacking or higher costs is not leading necessarily to higher quality
 - Inadequate level of incentives for innovation within health specifically in products, services and the effective use of technology
- There are even talks of Global Health Governance (51).

The motives behind these moves vary and are complex:

- Altruism – There is, at least in rhetoric, a belief that the existence of health disparities is a moral wrong that needs to be addressed (36, 52). “Pity and compassion are as much a part of being human as is our impressive potential for brutality...The humanitarian impulse has long been a core value of what used to be called international health—what we now style as global health... Enormous barriers to health equity remain, of course, and the lives of the bottom billion are not improving anywhere nearly as quickly as justice and human dignity demand” (53, 54)⁷.

⁶ “The health MDGs – on infant mortality, maternal mortality, and HIV/AIDS – focus on health inequalities. But as O’Donnell et al (32) argue, these health inequalities in most cases reflect differences in constraints – lower incomes, poor education, poor housing – than they reflect differences in preferences and should therefore be seen not as inequalities but as inequities insofar as policy can help attenuate them” (30).

⁷ That this has difficulties anchoring itself in reality even in the most affluent country is clear from the problems Obama’s health care bill is facing in the USA which continues to have the highest disparities, “the worst health system of them all” (54 and the life expectancy of 65

- But conventional national interests are probably more determinant. “...most states, even when committed to health as a foreign policy goal, still make decisions primarily on the basis of the ‘high politics’ of national security and economic material interests. Development, human rights and ethical/moral arguments for global health assistance, the traditional ‘low politics’ of foreign policy, are present in discourse but do not appear to dominate practice” (33). Thus some have argued that it is in the (security, economic...) interest of developed world to improve (health) conditions in the ‘south’ in order to contain terrorism, pandemics, (unwanted/uncontrolled) migration... (see, for example, 55).

The situation is made more complex by the growing involvement of private (in particular for profit) organizations; “While public-private partnerships are conceptually appealing, many concerns have been raised regarding their impact on global health equity” (56). The good faith and undeniable impact of major philanthropies (Rockefeller, Gates...) should not be written off hand but it will be naïve to believe that the public good, in the sense of the Istanbul Declaration, is their only or even main end. Perhaps an extreme example in view of the Gulf Spill, note the following “Shortly after taking over as CEO of British Petroleum (BP), Tony Haywood said, “We have too many people [at BP] who want to save the world...we need to concentrate on our primary goal: creating value for our shareholders...We’re not in business for your health” (57). This should not be glibly dismissed as the figment of the imagination of conspiracy theorists as there is no ground to believe ‘economic hit-men’ are history. It is apparent that a major struggle to restructure the world order (competition versus regulation, market versus government...) is going on. The current dominant orthodoxy, neo-liberalism has shown little ability to rationalize health care systems even in its heartland the USA (26, 58). Because of unbalanced power structure (unequal trade, capital flights ...) we live in a highly divided world. Globally, production has grown tremendously but disparities in living standards between the poor and the rich have grown beyond comprehension (59-61) [Table 1] and the flow of resources does not augur well as it has reversed to the affluent since the mid-1980s (table 2). Net transfers financial resources (as measured by the total receipts of financial and other resource inflows from abroad and foreign investment income minus total resource outflows, including increases in foreign reserves and foreign investment income payments) from developing to developed countries increased in 2010, and the trend of increasing resource transfers from developing countries is set to continue. Western Asia and

years attained by USA white men in 1944 was only attained by USA black men some 50 years later (54) .

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Africa experienced the greatest increase in outward resource transfers again (62).

A large proportion of the world population lives in absolute poverty⁸. “The real confrontation in our present world is between those who have and those who do not... This is true within any society we know and it applies to nations as well as individuals” (63). It is also sometimes claimed that the inhabitants of richer countries would like their assistance to be spent on issues that matter most to them, which may or may not be the priorities of the inhabitants of the poorer countries receiving and implementing the assistance (6). Under these circumstances, “The WHO must not pursue public-private partnerships without ensuring safeguards against corporate influence over policy making and pernicious conflicts of interest” (64).

Thus equity seems to be pursued in a globally inequitable and unsustainable (39) world order. There are no ‘givens’ in globalization; Africa⁹ would have to ‘negotiate’ its position in the tide of globalization. The stakes are great and the cards seem to be highly stacked against Africa even though there seem to be opportunities “to leap-frog”; the more reason for Africa to try to develop a better bargaining position for the future.

Health Prospects in Africa

Sub-Saharan Africa is – and for the foreseeable future will remain – an enduring preoccupation and target of global policies and interventions (65). As seen above, SSA has the highest burden of diseases but is the least equipped to mitigate their impact (43, 66) and as for marginalization in the global economy, many fear “that at the current rates of progress, sub-Saharan Africa will not be able to provide satisfactory health care to its inhabitants by 2020” and one reason is the effect of globalization (67). There are evidences that current focus is on diseases that threaten developed countries (e.g. HIV/AIDS, TB) at the cost of other diseases that might be as important (e.g. neglected tropical diseases). This tends to lead towards a push for disease centered/ vertical programs at the expense of comprehensive health services strengthening approaches. Global health some argue should not only, not even mostly, be about pandemic threats or infectious diseases but about disease control, health systems, social and economic

determinants... (51)¹⁰. “...global health so far has been mainly about richer countries advancing their own interests and about politicians in richer countries bowing to the sometimes more altruistic concerns of their constituencies” (6). On the converse side, the health scenario for Africa looks bleak caving under war and natural disasters, economic collapse, alone or in combination (53).

Africa is beleaguered by galloping demography and urbanization; low level and quality of education and health; high -unemployment/underemployment; perianal insecurity and the related refugee situation. “Economic and political reform efforts continue to be complicated by structural obstacles, the influence of “neighborhood effects,” such as the cross-border spillover of conflict, and a fate increasingly tied to the whims of international markets whose operators focus exclusively on profits. Some African countries also are substantially affected by structural factors that profoundly influence their economic and political performance. Coastal countries tend to have tremendous advantages, especially compared to the landlocked countries of the Sahel and Central Africa” (67). As they come more and more under the clutches of the World Bank and IMF, African governments forfeited control of their domestic spending priorities and had to make cutbacks in health budget and privatize health services eroding previous advances. Staff salaries in the public sector often fell substantially below a living wage. The Bank ‘encouraged’ ‘cost-recovery’ mostly user-fee to cut government expenditure further with major impact on the rural poor¹¹. In many countries, this led to exodus of doctors, nurses and technicians, and compounded by declining or stagnating public expenditure in health, culminated in a virtual collapse of the health infrastructure. Thus, the average expenditure in the health sector in sub-Saharan Africa rarely exceeds 5% of GDP, far from the 15% agreed upon on AU forums (53, 68).

Achieving the MDGs under these conditions seems highly problematic (46, 49, 53). Increase in life expectancy has not reached expected levels with some countries even recording declines (Fig 2) and is projected to remain much lower than any region by 2030 (69).

⁸ 23% (1,225 millions, 65% in SSA) of the world population in 1989; 1,100 millions in 2000; over 45% of the population in SSA and increasing (56); 25.6% globally and 53% in Africa in 2000-2007 (63).

⁹ Africa is a diverse continent and whether it is acceptable to speak of ‘one’ African future is a moot question in spite of over 50 years of AU/OAU; as Berhst (16) says, “A few African nations are now poised to take advantage of the new international economy while, at the other extreme, there are a significant number of countries that are simply trying to preserve their basic institutions with little hope of successful engagement with the world.”

¹⁰ Again these concepts are not new as the fact that health development is more than health services was stressed in the 1960s (McKeon etc.) and reiterated in Alma-Ata even though side tracked by Selective PHC etc. Africa will also have to prepare itself proactively for the challenges of increasing chronic diseases (70)

¹¹ “Too often health sector reforms seem to be based almost entirely on efficiency concerns while rights and equity issues receive little attention” (71).

Table 1: **Gap in Income Per Capita between High and Low Income Countries (Constant PPP 2005 International \$)**

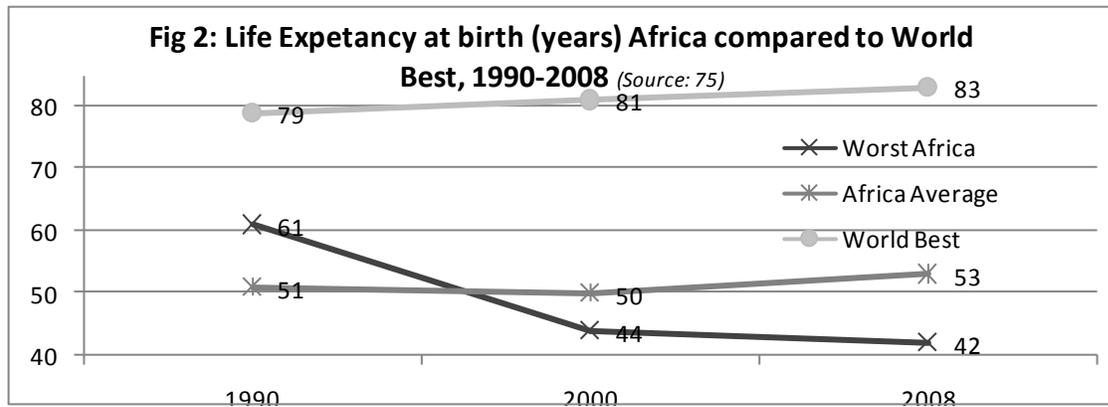
Year	High and Low Income Countries	High and Lower Middle Income Countries	High and Upper Middle Income Countries
1980	18,509	17,754	15,688
2007	32,863	30,976	26,209
2010	32,134	29,946	24,502

Source: The World Bank 2012

Table 2: **Net transfer of financial resources to developing economies and economies in transition, 1998-2010 (Billions of dollars)**

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Developing economies	-41.1	-128.0	-0194.0	-164.4	-210.2	-302.7	-379.5	-597.2	-807.8	-881.1	-876.4	-545.1	-447.0
Africa	2.9	1.6	-31.7	-16.4	-4.2	-16.1	-34.5	-76.4	-108.3	-100.9	-99.1	2.9	-35.3
Sub-Saharan Africa (excluding Nigeria and South Africa)	115	79	2.3	6.4	4.4	5.3	3.5	-0.6	-10.5	-9.1	-4.8	27.3	14.6
East and South Asia	-129.8	-139.8	-122.8	-120.8	149.2	175.6	183.4	265.7	385.7	529.8	481.3	427.5	352.9
Western Asia	34.5	2.7	-35.3	-29.7	-23.2	-46.7	-76.3	-143.7	-175.6	-144.0	-222.5	-48.4	-112.7
Latin America and the Caribbean	41.5	7.4	-4.2	2.5	-33.6	-64.3	-85.4	-111.4	-138.0	-106.4	-73.5	-72.1	-56.1
Economies in Transition	0.7	-25.1	-51.6	-32.9	-28.0	-38.0	-62.5	-96.0	-117.1	-95.9	-149.1	-81.1	-133.0

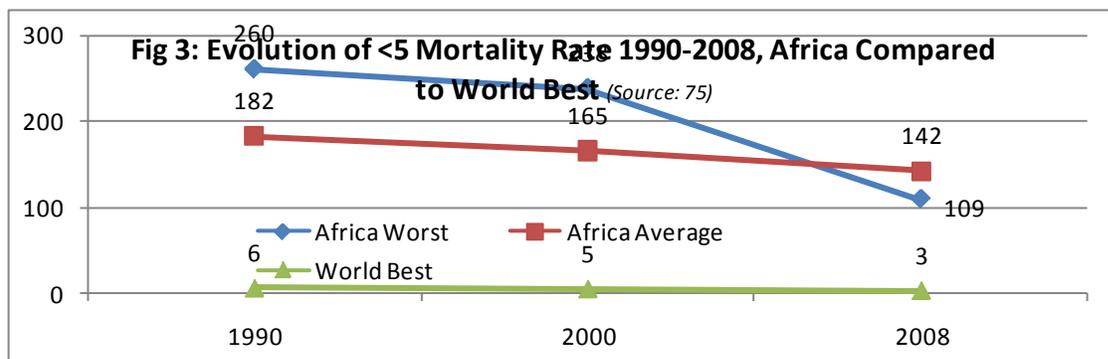
Source: United Nations 2011



Under-5 mortality remained very high with gap between average for Africa and the best in the world increasing (Fig 3) and there are possibilities that whatever reduction there might have been could be eroded by the current economic crisis whose full effects might not be apparent before some decades (44).

HIV/AIDS, other epidemics, climate induced health problems are becoming not only health but security

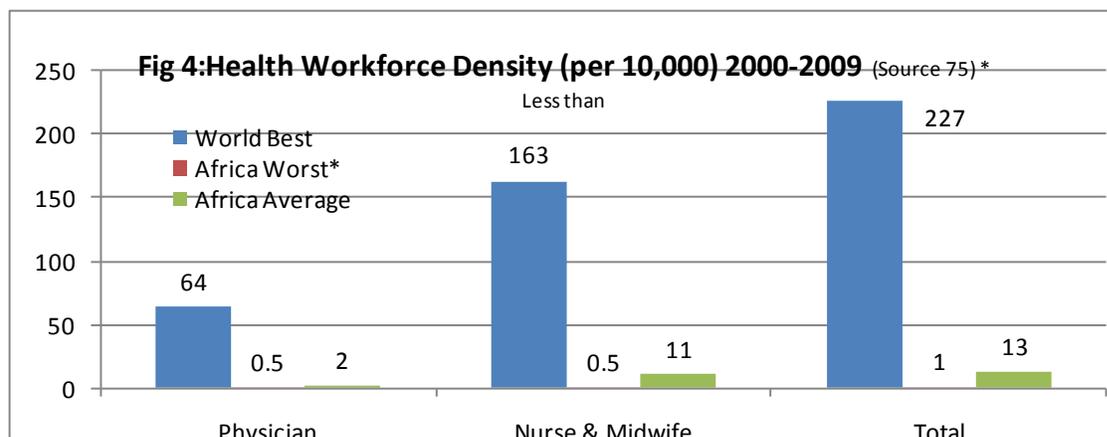
threats (22). Immunization rates for children less than one year of age continues to increase but they are still below 80%, leaving significant proportion of children exposed to vaccine preventable illness and death. Of even more concern is the very low coverage by trained birth attendants so critical for reduction of maternal deaths (Fig 1).



The end of the tunnel does not seem to be in sight; in fact health in most of the developing world continues to deteriorate in spite of the promises of new technologies (69). As exemplified by the highly inadequate human resources for health (Fig 4), key for alleviating health problems, the absence of faculty and infrastructure; problems in accreditation, postgraduate education, and

coordination between ministries of health and education; inadequate provision of doctors and other health workers, especially in rural areas; and problems of retention of graduates (brain drain) spurred by push and pull (a glaring shortage in developed countries¹²...) factors show that major inequities in health development will persist (70, 71).

¹² The shortage is expected to reach 155,000 doctors and 500,000 nurses by 2025 in USA alone and selectively attracting highly skilled workers is evolving as a policy position in the US and Europe (79) ... "emigration of African professionals is one of the greatest obstacles to Africa's development" (80).



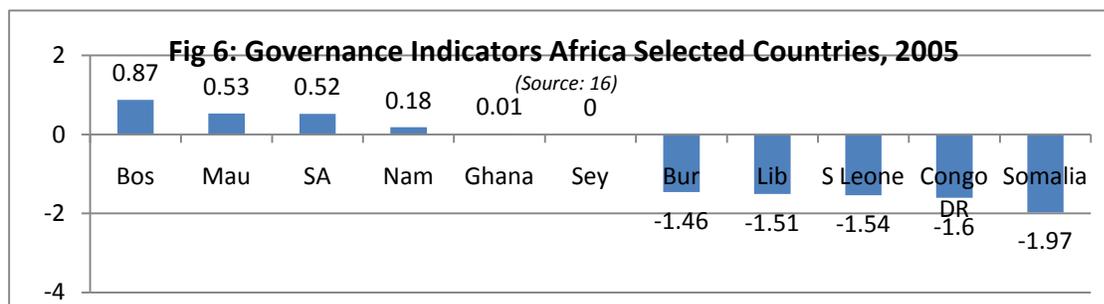
The Shape of Things to Come

Negotiating Africa's future in a globalizing world implies some visualization of what this future holds. 'Future scenarios'¹³ for African countries (as opposed for Europe [14] and USA [9] for example) are rare (72) but some general conclusions can be drawn from global, USA and European projections.

With the fall of the Berlin Wall and the collapse of Soviet Communism, Western patterns of organization, 'liberal economy' in particular seemed to triumph leading some to proclaim the end of ideologies ('end of history' Fukuyama [73]). But the brief lull and 'paxa-Americana' was followed by not only the jockeying for position of Europe and the emerging/aspiring 'super-powers' of Asia and Latin America but also by 'Allah Akeber!' and what some have called the 'clash of civilizations' (74). These have led to major uncertainties/instabilities and, after 9/11, a seemingly endless/ (un-winnable?) war against terrorism and "The history of Western powers demonstrates that it is perfectly possible to have democracy at home and excessive tyranny abroad" (75).

There is also the related recurring and deepening economic crisis. It seems that we might have to contemplate the future, at least in the immediate, in the shadow of continuing, even deepening crisis (44). "In 2008 ...it felt as if the crisis of the century was upon us. But if the world continues on its current path, the historians of the future will say that the great financial collapse of three years ago was simply the trailer for a succession of avoidable crises that eroded popular consent for globalization itself" (76). Already some dramatic impacts are apparent (77) and it is easy to estimate that its impact on health through increase in poverty and decrease in growth will fall most strongly on African countries least responsible for the crisis (44). ODA alone is apparently undergoing several revolutions including a diversification of its goals, adding financing access to essential services and protecting global public goods to its traditional objective of ushering convergence between less and more developed economies; very high increase in the number and diversity of its players (Fig 5) leading to a bewildering cacophony of conditionalities and requirements (44, 78).

¹³ The values of scenarios to guide policy decisions is well recognized but very few address health (82)



Global aid delivery fell short of amounts pledged for 2010 at the Group of Eight (G8) 2005 Gleneagles Summit. On the positive side, grants and the grant element of concessional loans have increased over time, especially in aid directed towards LDCs (93). In terms of official development assistance, the global financial crisis and economic recession of 2008 and 2009 negatively impacted many developing countries and has placed severe strain on many low-income countries, making ODA delivery even more critical. The MDG Gap Task Force Report 2010 estimates the gap in delivery towards this commitment at \$153 billion in 2009.

Of course, there are also positive developments in terms of the contributions of the Global Fund (that invested USD 23 billion in 150 countries and 1,000 projects), PEPFAR (that invested USD 21 billion since 2004 in 80 countries, mostly in Africa), the Roll Back Malaria, Child Survival, etc Initiatives as well as the recent US Global Health Initiatives that focused on health systems strengthening, women's health and Child Survival). There is also a significant contribution from the Public Private Partnerships (PPPs) involving western governments, philanthropists through the WHO and UNICEF and the respective beneficiary governments. This may be one of the reasons for the positive net transfer of financial resources to the Sub-Saharan African Region between 2009 and 2010. However, the net transfer to developing countries in general and specifically to Africa is negative (62).

Sufficient resources must be available to developing countries, especially needed to accelerate progress towards the achievement of the MDGs and for investments in sustainable and resilient growth, especially for the LDCs. Fiscal austerity among donor countries has also affected aid budgets, as seen in the decline of ODA in real terms in 2011 (82).

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