

The Pernicious, Continuing Impact of IMF Macroeconomic Constraint Policies on Domestic and Donor Health Spending

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1. Attacking IMF Macroeconomic Constraints

Introduction to the IMF

In addition to filling existing global health funding gaps, global health activists must also ensure that developing countries are able to spend increased domestic and donor financing for health. Standing in their way are the macroeconomic “stability” policies of the International Monetary Fund (IMF) that all too often prioritize restrained public sector spending and cool growth economic expansion to the more rigorous pro-growth and pro-health investment strategies that might make a big impact on multiple global health crises.

The IMF was created after World War II to help finance European reconstruction and to provide loans to countries which were importing more than they were exporting. It was also tasked with managing exchange rates via the par value system, which was unilaterally altered in 1971 when the U.S. suspended the convertibility of the dollar into gold. However, in the 1980s, the Regan and Thatcher administrations introduced a whole new set of free market and “free trade” policies into the international foreign aid system by attaching such “market fundamentalism” policy changes as conditions on aid and loans to developing countries. The IMF in particular prioritized extremely low inflation and government deficits over other goals such as higher employment, GDP growth, and public spending. While these policies may have seemed appropriate for tackling the huge debt crisis and macroeconomic instability afflicting many developing countries at the time, today these policies are no longer appropriate and are in fact be undermining the ability of poor countries to scale-up public spending to fight HIV/AIDS and other pressing health needs and to achieve the Millennium Development Goals for health and education (MDGs).

IMF control over countries’ macroeconomic policies is mediated via several mechanisms. First and foremost, the IMF gives loans to low-income countries experiencing protracted balance of payment problems through its Poverty Reduction and Growth Facility. For more temporary needs arising from exogenous shocks, it provides loans through the Exogenous Shocks Facility; it also provides Emergency Assistance to countries that have experienced a natural disaster or are emerging from conflict. Although the loan rates are concessional, loans must ordinarily be repaid over a period of 5 ½ to 10 years. (There are additional, non-concessionary loan programs including Stand-By Arrangements, Extended Fund Facility, Supplemental Reserve Facility, and Compensatory Financing Facility.) A second mechanism is via the Heavily Indebted Poor Countries (HIPC) Initiative and the Multilateral Debt Relief Initiative (MDRI), where certain macroeconomic conditionalities are imposed on debt relief. Nonetheless, there is evidence that in many countries debt relief has permitted larger amounts and greater shares of government budgets to be spent on health and education. Third, the IMF uses Policy Support

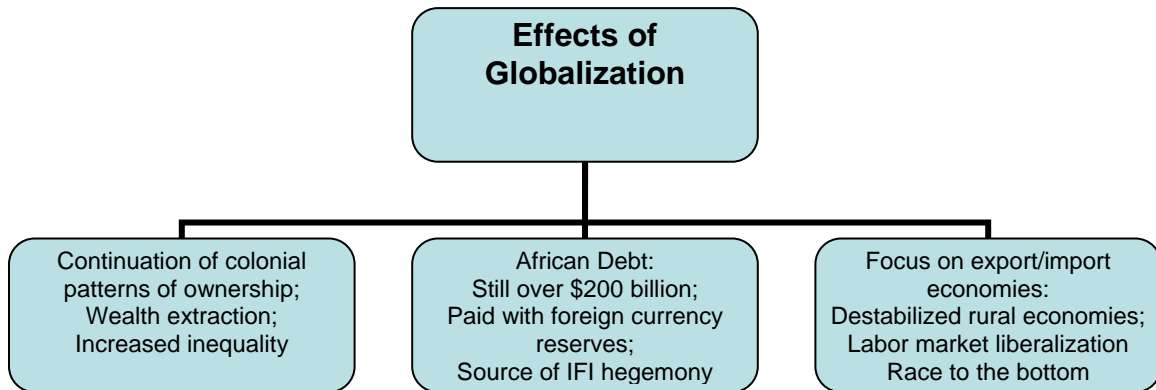
Instruments for countries that do not typically need financial assistance but want the IMF's advice, monitoring, and endorsement to provide "signaling" to donors, multilateral development banks, and the market. (Many donors look solely to the IMF for its signals about a country's macroeconomic stability.) Fourth, the IMF offers technical assistance, typically for free. It is through this technical assistance and so-called capacity building for finance ministries that the IMF creates of cadre of local officials who support the ideology of overly restrictive macroeconomic restraint. Finally, the IMF offers what it calls surveillance – its full range of policy advice on macroeconomic risks and vulnerabilities, institutional relations, reforms, etc. that result in overly restricted spending on health and education.

Most IMF loans feature phased disbursements, which allow the IMF to verify that the country borrower is adhering to IMF conditionalities that take several forms, listed below in decreasing order of authority. Prior actions are measures that a country must take before the IMF's Executive Board approves a loan or completes a review. Performance criteria are specific conditions, either quantitative or structural, that have to be met for the agreed amount of credit to be disbursed. Quantitative PCs are typically macroeconomic policies addressing such variables as monetary and credit aggregates, international currency reserves, fiscal deficits, and/or external borrowing. Quantitative PCs may be supplemented with indicative targets set in softer form for later in the program. Structural PCS typical refer to such measures as financial sector operations, reform of social security, or sectoral reforms. Structural benchmarks are smaller steps in the reform process the non-attainment of which do does not justify an interruption of IMF financing. Inflation consultation clauses require new consultations when an inflation targeting framework, or the inflation band, has been breached. Finally, there are program reviews where the Board reports a broad-based assessment of a country-borrower's macroeconomic and structural progress.

A 2007 review of structural conditionality in IMF-supported programs found that the number of IMF structural conditionalities had not declined at that time, despite alleged IMF conditionality reforms adopted in 2002. The juncture of signaling power and conditionality in the IMF gives rise to what is called cross-conditionality – the decision of donors to depend on IMF signals that a country is worthy of receiving aid and their decision that the countries must abide by IMF conditionalities as a condition not only of IMF loans but also of continuing aid flows.

A Short History of the IMF's neo-liberal and macroeconomic policies

The persistent legacies of IMF-mediated neo-liberal and macroeconomic policies have caused disastrous injury to the general health of developing country economies and to the well-being of their health systems. Although this is not the place to document the entire story of failed neo-colonial "development," it is appropriate to trace some of the key aspects of neo-liberal and macroeconomic policies that have intensified the global health crisis. These include: (1) maintaining colonial patterns of ownership; (2) creating crushing debt through aid and loan policies; (3) deforming economies towards exploitation of natural resources and production of low-cost exports and importation of high-cost finished goods; (4) liberalizing capital controls, currency exchanges, and financial markets resulting in currency devaluations, market volatility, and net outflow of capital; and (5) enforcing structural adjustment programs, including (a) fiscal austerity and reduced government spending particularly in health and education and (b) privatization and commodification of public resources, goods, and services.



First, no story about the impact of globalization can start without first recognizing that most of the productive capacity in many developing countries resides in the portfolios of former colonial masters. Although local elites have been given managerial and occasional junior partner status, a significant portion of productive capacity in developing countries is owned by multinational corporations and global financial interests.

Second, Africa in particular, but other developing countries as well, have been buried in debt starting in the late 1960's. Although much of that debt was at one point private, frequently debt of private industry to private banks used in the capitalization of productive capacity, the debt increasingly became multilateral and bilateral, debt which was owed by developing country governments to individual governments and/or to the World Bank and IMF. After the oil shock of the 1970's and as trade terms worsened and the global economy suffered from stagflation, developing countries needed to borrow more and more money at higher and higher interest rates to refinance their foreign currency reserves and public expenditures. Similarly, as the World Bank lent money to governments to build physical infrastructure appropriate to an export economy and as First World governments bilaterally lent money to finance purchase of excess goods, military and non-military, from same-nation producers, the developing world's debt burden became more and more bloated. Fundamentally, low-income countries, particularly in Africa, became chronically indebted as a result of an inherently imbalanced pattern of trade between the under-priced agricultural/extractive and pre-industrial economies of the South and the overpriced industrial and information-based economies of the North.¹

Paying this old debt off is particularly problematic since so little of it resulted in increased productive capacity, job creation, or wealth redistribution. Not only was loan money used to buy expensive Western consultants, questionable showcase infrastructure projects, and Western luxury imports, a great deal of it was given to undemocratic and corrupt governments that were proxies to foreign business interests and lackeys to Cold War great powers. Needless to say, these debts incurred by old elites did not result in economic benefit to the poverty-stricken masses.

As of 2000, sub-Saharan African countries owed the IMF, World Bank, and rich countries more than \$227 billion dollars, with an annual debt servicing charge of nearly \$14.5 billion, equaling 5% of GDP and 15% of export earnings. As a consequence of this enormous debt burden and usurious repayment schedule, many southern African countries spend more on debt repayment than on public health. For example, at the turn of the century, Uganda spent 1.6 percent of GDP on health and 2.4 percent on debt service; Zimbabwe 3.4 percent and 10.3 percent; and

¹ See Francisco G. Pascual, Jr., *The Development and Historical Context of the Debt Crisis* (1999) (http://jubileesouth.net/summit/19991119/address_pascual.html) (1/05/01).

Zambia 3.2 percent and 9.8 percent. The Jubilee Campaign and many other activist groups campaigned for cancellation of this debt.² Despite limited promises of debt relief from the World Bank (Highly Indebted Poor Country Initiative) and the G-8, only minimal debt has been forgiven and to date in only a small group of countries.

Third, the general effect of international trade policy, all too readily accepted in African and other developing countries, has been to dismantle rural subsistence economies and multi-sectoral economies in favor of import/export-oriented economies.³ Thus, it has become increasingly impossible for persons in the countryside, with minimal access even to marginal land, to make a living.⁴ Instead, agricultural economies have been restructured towards a narrow range of export farm products. People, particularly young men, dislodged from the countryside, have migrated in mass to the cities, where rumors of jobs far outweigh their actuality. Even here, in urban contexts, the new industries are export oriented and increasingly capital intensive.

Fourth, as if external ownership, crippling debt, and liberalized trade policy were not disruptive enough, globalization has also liberalized capital, financial, and currency markets – facilitating capital flight and financial market speculation. The volume of international currency speculation and financial market investment has increased thirty-fold or more in the last 40 years. Thus, international finance capital has become more interested in making money off “hot” financial markets than investing in productive capacity. This new focus on financial rather than productive investment has led to speculative bubbles in currencies and financial exchanges, with a temporary influx of external capital, followed, almost inevitably, by currency and market crashes such as those we are now experiencing.

Fifth, the debt and balance-of-payment crises in Africa, which consolidated debt within international financial institutions, set the stage for infamous structural adjustment programs that have further deflated and destabilized African economies. These structural adjustments, imposed by the IMF and the World Bank as a condition of extending and refinancing African debt, invariably included two phases. The first phase required macro-economic stabilization via (1) currency control deregulation, currency devaluation, and the build-up of foreign currency reserves so that foreign debt could be paid and so that imports could be paid for; (2) price stabilization through reduced inflation (5% target), and a reduction in real wages and consumption; and (3) budgetary austerity including, typically, a mandatory 3% cap on deficit spending. The budget austerities often included overall budget ceilings, wage caps, and/or wage reductions in the public sector. These restrictions led to inadequate wages and appalling working conditions for health professionals which in turn led to a growing brain drain problem. In addition, fiscal restraint reduced public investments in health infrastructure and health systems, leading to the tattered systems that we see today. Nonetheless, according to the IMF, restraining public spending had to be done because of the higher value of not “crowding out” private investment that was always presumed to be more productive.

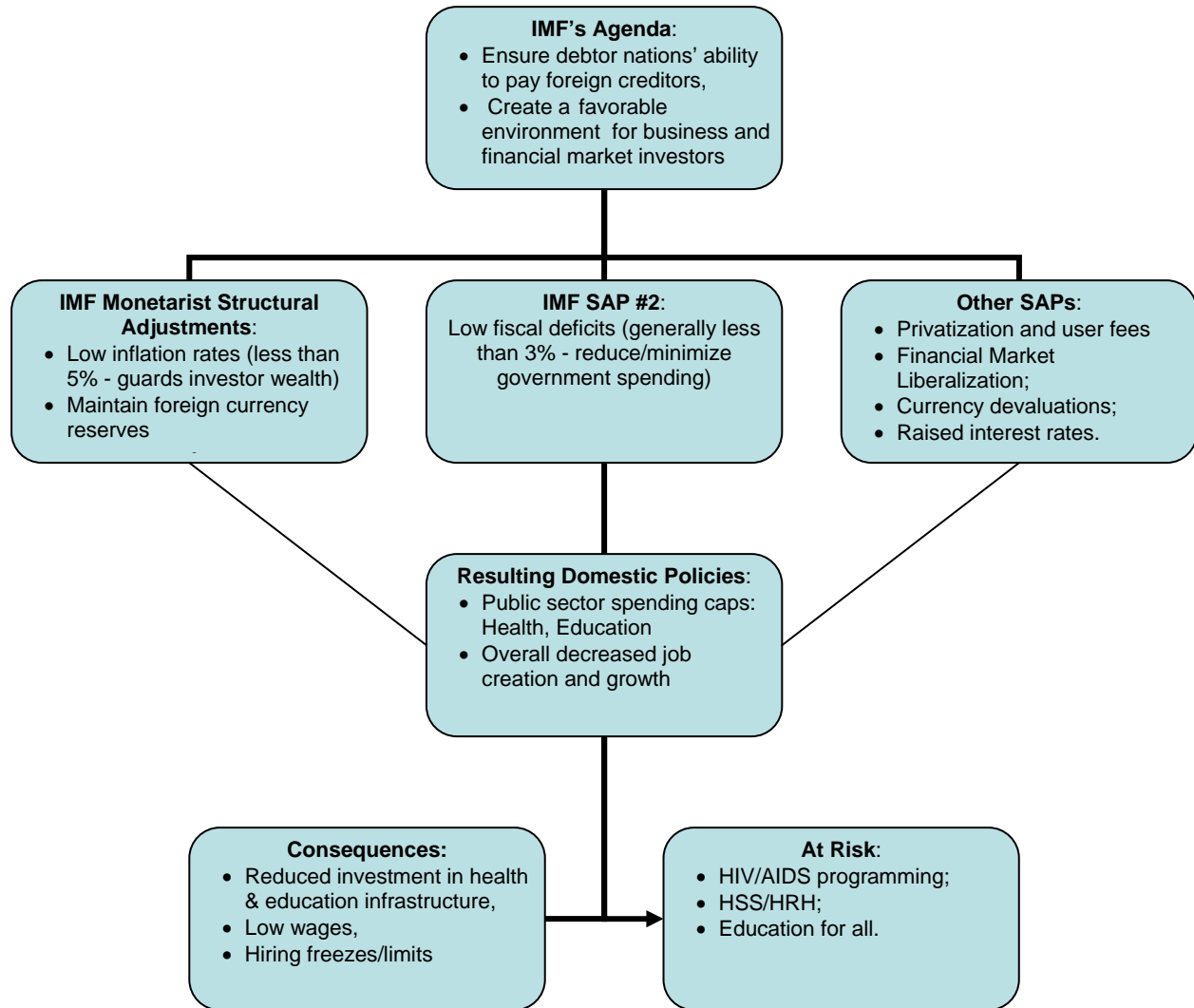
Phase two required trade liberalization (reduced tariffs and less subsidization of domestic industry), tax reform transferring tax burdens from businesses to workers and consumers (for example value added taxes), privatization/commodification of government services and assets,

² See Jubilee South, *South-South Summit Declaration: Toward a Debt-Free Millennium* (Nov. 21, 1999).

³ Patrick Bond, *Can Thabo Mbeki Change the World? Strategies, Tactics and Alliances Towards Global Governance* (The Frantz Fanon Inaugural Memorial Lecture, University of Durban-Westville School of Governance 17 Aug. 2000); Patrick Bond, *ELITE TRANSITIONS: FROM APARTHEID TO NEOLIBERALISM IN SOUTH AFRICA* (2000); Patrick Bond, *CITIES OF GOLD, TOWNSHIPS OF COAL: ESSAYS ON SOUTH AFRICA'S NEW URBAN CRISIS* (2000).

⁴ Joseph Collins & Bill Rau, *Aids in the Context of Development*, 18 (UNRISD Programme on Social Policy and Development, Paper No. 4 Dec. 2000).

and liberalization of labor laws including non-indexing of wages.⁵ In addition, at the same time that the global powers were using structural adjustment programs to force reductions in social spending, including social spending on health and education, they were imposing user fees (cost recovery) on medical visits, charging for condoms, and retailing medicines. World Bank and IMF “un”healthy user fees resulted in dramatic lower attendance in STD clinics in Kenya and in reduced condom use in Zimbabwe.⁶



The IMF also came up with special policies and ideological constructs to deal with fickle donor aid. Since donor aid was often volatile and unpredictable in the short term, the IMF warned countries against relying on donor aid in planning their public sector spending. In particular, it discounted the desirability of investing donor aid on recurrent costs that would have to be paid

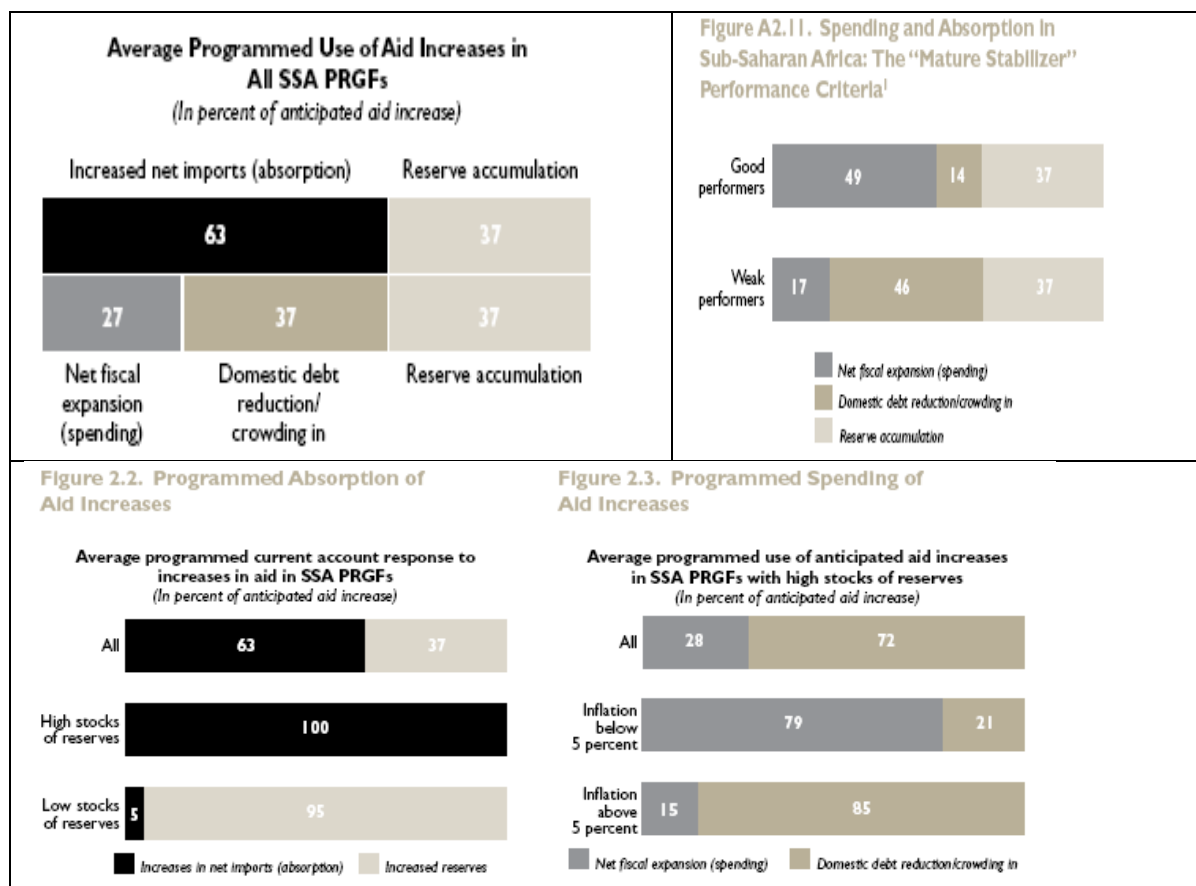
⁵ See Pascual, *supra* note *; Eric Toussaint, *From North to South: The Debt Crisis and Structural Adjustment Policies* (trans. Vicki Biault, 2000) (http://jubileesouth.net/documents/discussions/debt_crisis_saps.html) (12/12/00). As a matter of institutional competence, the IMF and the World Bank play two different roles. The IMF is typically involved in policy negotiations regarding the exchange rate, currency exchange, financial market deregulation, and the overall budget deficit. The World Bank micro-manages government spending and infrastructure investment.

⁶ See Collins & Rau, *supra* note 16, at 18 and sources cited; Sanjay Basu, Kedar Mate & Noor Jehan Johnson, *Poverty's Pathologies: Global Inequalities and the Lives of the Destitute Sick* 3 (Draft 9/5/00).

over the long haul. Likewise, since the IMF considered donor aid to be unreliable in the long-run, it also advocated an ideology of self-sufficiency or sustainability wherein countries had to calculate their future public spending on the assumption that such spending would depend on domestic resources only (within their own fiscal space).

The Continuing Impacts of IMF Policy on Health Spending

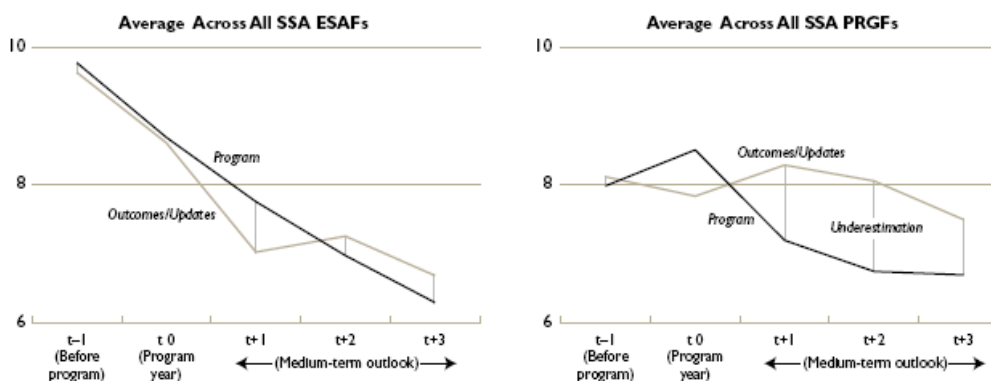
There is now ample proof that IMF macroeconomic policies have resulted in constrained spending on health and education, even in an era of increased global resources for health aid. Thus, the IMF's Independent Evaluation Office (IEO) examined IMF loan programs to 29 Sub-Saharan African countries between 1999 and 2005 and found that 37% of all annual aid increases to these countries in these years was diverted into building internationally currency reserve levels and that another 37% was devoted to debt repayment.⁷ That left only 27% of annual aid increases for actual spending on health, education, infrastructure, or other pro-development needs. So-called weak performers (inflation above 5% and foreign currency reserves less than 2 months of imports) spent only 17% of new aid. Countries with less than 2 ½ months of reserves put 95% of increased aid into reserves; countries with high reserves absorbed 100%. Countries with more than 5% inflation put 85% of increased aid into debt reduction. Countries with inflation below 5% put 21% into debt reduction. According to the IEO report, the “main drivers” in decisions to curtail spending of the aid was the IMF’s insistence on very low levels for inflation, its excessive concerns about the volatility of aid, and its desire for ever higher currency reserves to protect against “shocks.”



⁷ "The IMF and Aid to Sub-Saharan Africa" <http://www.ieso-imf.org/eval/complete/pdf/03122007/report.pdf>

The IEO also found that the IMF Poverty Reduction Growth Facilities have continued to limit domestic financing of aid shortfalls and required full saving of windfalls. In essence, the IMF discounts the availability of future aid flows, which reduces the amount of aid actually spent.

Figure 2.6. Programmed and Actual Aid Flows: PRGFs Underpredicted Medium-Term Inflows¹
(In percent of GDP)



The IMF Executive Board reacted to the IEO Report with cool indifference, essentially business as usual (PIN no. 07/83, July 19, 2007). There would be no pursuit of increased donor aid; no alternative scenarios provided unless asked; countries must continue to ensure competitiveness via low inflation targets; countries should smooth their aid expenditures (with aid volatility reserves); and countries should reduce aid reliance over time. The only recommendation that the Executive Board accepted was that the IMF would reduce and monitor use of wage bill ceilings, though they would still be appropriate in certain circumstances. The IMF also issued a follow-up report, *The Spending and Absorption of Aid in PRGF Supported Programs* (2008), which claimed that its review of evidence in a larger number of countries over a longer period of time showed that almost all increases in aid were used within a “few years” and that 70% was used within two years of disbursement.

The Center for Global Development has also undertaken a recent assessment of IMF macroeconomic restraint policies and their impact on countries' health spending. It found that:

- The IMF has not done enough to explore more expansionary, but still feasible options.
- Empirical evidence does not support pushing inflation to the 5% level in low-income countries.
- IMF should consider the supply side benefits of additional spending on spare capacity utilization, investment, and future output growth.
- Wage bill ceilings have been overused (but were included in ½ of recent IMF programs in low-income countries).

The UNDP conducted a real world study to explore the impact of IMF policies on Zambia health spending after it received significant debt relief. The report found that IMF and World Bank conditionalities imposed as part of Zambia debt relief package resulted in “less capacity to invest in human needs,” including health, than Zambia had before debt relief. The report also found that alternative policies were needed to allow Zambia to raise taxes, expand the fiscal deficit, and obtain and spend foreign aid that would buttress Zambia's efforts to reach MDGs.

Following the 2007-2008 sharp escalation of food and fuel prices and the risks of imported inflation on developing countries, inflation rates, currency reserves, and fiscal deficits, the IMF's policy advice embodied its typical litany of fiscal, monetary and trade policy recommendations.⁸ According to a Dec. 2008 NGO Report, Quick Fixes or Real Solutions: World Bank and IMF Responses to the Global Food and Fuel Crises, "The central gist of the policy advice is to pass the higher prices onward from the state to the consumer in order to ease the external imbalance and budget deficit, tightening monetary policy in order to abate inflation levels, and employing exchange rate depreciation as a 'shock-absorber.'" For the IMF, the risk of lower credibility if inflation targets were missed outweighed probably output losses from raising interest rates. Likewise, the IMF's policy advice on fiscal deficits was to reduce universal fuel subsidies, reduce taxes and limit public sector wage increases. Despite the continuation of its cookie-cutter advice, the IMF has also augmented existing lines of credit for 11 countries with Poverty Reduction and Growth Facility (PRGF) arrangements and has entered into new PRGF loan programs with four other countries. In these new arrangements, the IMF has temporarily relaxed budget deficit and inflation targets, but it simultaneously advises countries to drive inflation and fiscal deficits level back to unnecessarily restrictive level over the next couple of years, as shown in the following chart.

Table 2: Inflation and Deficits on PRGF Programming

Country with PRGF augmentation or a new PRGF program	Inflation		Deficit (% GDP)	
	2008	Target	2008	Target
1. Burundi	14.6 %	Down to 6% by 2011	0.5%	1.3% by 2011
2. Djibouti	13.9%	Down to 5.5% by 2009	1.9%	0% (balanced budget) by 2011
3. Mali	2.5%	2.5% by 2009	4.4%	2.9% by 2009
4. Niger	2.2%	2.0 by 2009	3.3%	2.7% by 2011
5. Benin	5.5 %	2.9% by 2010	4% (excluding grants)	Under 4% (excluding grants)
6. Burkina Faso	3.3%	2.1% by 2010	5.4%	4.5% by 2010
7. CAR	4.6%	2.5% by 2010	0.1%	0.1% by 2009
8. Grenada		no info available		no info available
9. Guinea	15%	Down to 7% by 2010	1.0%	0.4% by 2010
10. Haiti	16%	Down to 9.5% by 2009	7.8% (excluding grants)	Down to 6.5% by 2009 (excluding grants)
11. Kyrgyz Republic	20%	Down to 15% by end-2008	1.5%	Keep at 1.5%
12. Madagascar	10%	Down to 6% by 2010	4.4%	Down to 2.8% by 2010
13. Malawi	8.2%	Down to 6.8% by 2011	3.8%	Down to 2.7% by 2011
14. Nicaragua	17%	Down to 7% by 2010	1.8%	Down to 1.0% by 2010
15. Togo	9%	Down to between 3.5% and 4.1 %	2.4%	Down to 1.3% by 2010

Source: Quick Fixes or Real Solutions

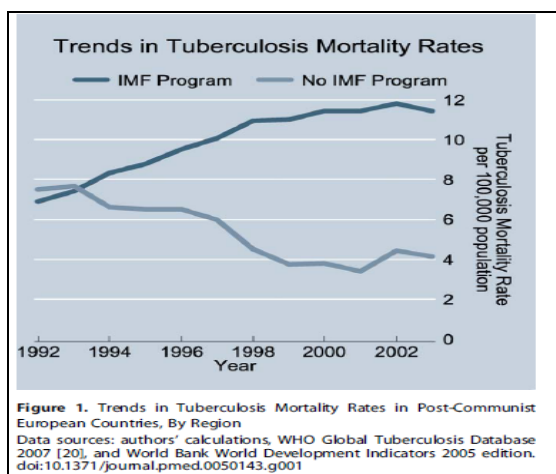
The IMF and its supporters continue to claim that it is relaxing its policy prescriptions for low-income countries, but a review in Tanzania showed the same old-school policies. Thus as part of Tanzania's agreement with the IMF, the government must aim to shrink its budget deficit from 3.7% of GNP in fiscal year 2008/2009 to 3.1% of GNP in FY2009/2010. A January 2009 IMF review of the agreement stated further that any decrease in revenue—whether tax revenue, official development assistance, or remittances from African Diaspora that might come about in the wake of the financial crisis—should be met with "expenditure restraint." Furthermore, the

⁸ IMF, Food and Fuel Prices – Recent Developments, Macroeconomic Impact, and Policy Responses (June 19, 2008). Available at www.imf.org/external/pplongres.aspx?id=4266.

agreement restricts the government from seeking domestic sources of financing, and it aims to reduce inflation to 5% through monetary policies that reduce economic activity, “including through rising interest rates when necessary.” These restrictive policies, that will impact health as well as other spending, continue to be enforced at the same time that rich countries are using expansionary economic policies to spend their way out of the global recession.

Another recent review by the Third World Network of nine new IMF loans in Eastern Europe and Pakistan and El Salvador that have been negotiated in response to the global financial crisis to emerging market countries summarizes the persistent of IMF policy advice and conditionality in the areas of fiscal policy, monetary and exchange rate policy, and financial sector policy. In sum, in these nine agreements there are myriad examples of public wage and public employment cuts, freezes, and eliminations, including pension system reforms, tax cuts and tax exemption reductions, sectoral budget cuts, development budgets cut in half (Pakistan), and an overall reduction in current expenditures (public spending/current account expenditure reductions) across all nine countries. Fiscal deficit reductions in all 9 country cases are set for targets of 3% or lower. Monetary policy in all 9 cases involves highly restrictive inflation targeting regimes that have already been, or are soon to be, established. The IMF’s monetary policy remains focused on reducing inflation levels by hiking up official interest rates (Iceland’s 18% being the most extreme), reducing money supply, and in Pakistan’s specific case, eliminating all State Bank of Pakistan financing of the government.

One might hope that the deepening global recession would cause the IMF to rethink its policies, especially in Africa, so that it too might be able to pursue more expansionary fiscal policies to offset precipitous declines in export earnings and aggregate demand and to address additional demands for social spending. However, a March 2009 report from the IMF, *Impact of the Global Financial Crisis on Sub-Saharan Africa*, continues to prioritize macroeconomic fundamentalism. Although a few countries with low debt and no financing constraints (stable tax revenues) might undertake fiscal easing, the IMF said that most countries must “preserve hard-won gains in economic fundamentals” by avoiding excessive borrowing that crowds out the private sector or fiscal measures that might exacerbate the loss of foreign exchange reserves. In sum, the IMF advises: “To support growth and create fiscal space, all countries would be well-advised to persevere with structural fiscal reforms.” The IMF paper also prioritizes continuing efforts to prevent inflation. Paradoxically, the IFM also continues to discourage capital controls, arguing that they are unlikely to be ineffective, while at the same time it argues that scarce government revenues should be used to protect the safety and functioning of the financial system.



Source: Stuckler et al (2008)

Finally, a recent academic study has correlated higher tuberculosis disease rates and death rates with the presence of IMF policies in post-Soviet countries. IMF programs in 21 post-communist countries over a 20 year period were correlated with a 13.9% increase in TB incidence, a 13.2% increase in TB prevalence, and a 16.6% increase in TB mortality. There was a 30.7% decrease in mortality associated with exiting IMF programs. Introduction of IMF programs was also correlated with large decreases in government expenditure, TB program coverage, and the number of physician per capita.

Conclusion:

The IMF frequently claims that it has modified its macroeconomic policies in response to criticisms of structural adjustment programs and of on-going adverse effects on health spending. A review of the most recent evidence is that the IMF continues to prioritize what it calls “macroeconomic stability,” including low inflation rates, low fiscal deficit, and high currency reserves, over all other development and health concerns. Assumptions that Dominique Strauss-Kahn, the new French socialist Managing Director of the IMF, would change IMF policy mandates or that the IMF has turned in new directions because of food, fuel, and recessionary shocks imported into developing countries have proven illusory at best. Global health activists are pursuing new channels of domestic and donor resources for health so that Millennium Development and other health goals might be reached. If the IMF’s hydraulic pressures constrained increased fiscal expenditures continue, then developing countries will continue to restrict expansion of health financing by substitution (decreasing domestic health funding as donor funding increases), by refusing to invest in recurrent costs for additional health workers, and by neglecting needed investments in health infrastructure and health system strengthening. The Health Eight, the Taskforce on Innovative Financing, the IHP+, multilateral and bilateral donors, and health activists must all demand immediate and profound changes to the IMF’s lock-down policies on health sector spending. Members of the Executive Board of the IMF must be instructed by their governments to change overly restrictive IMF policy prescriptions and to widely publicize those changes to line officials and to developing country ministries of finance. The time for false assurances has ended – it is a time for action.

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