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# The Impact of Economic Sanctions on Health and Well-being

by Richard Garfield

## Abstract

This paper reviews the impact of trade embargoes on health, health services and food security drawing on data available from Cuba, Haiti and Iraq. The argument is made that the impact of trade embargoes encompasses much more than restrictions on the availability of medicine. The case studies also suggest that mothers and children are not necessarily the only vulnerable group, and that studying changes in the health and mortality of under fives is more indicative than those of infants under one year old. The examples of Cuba and Iraq also highlight the importance of strengthening health monitoring systems, and of reforming health policy towards focused public health measures to maximise the use of scarce resources and stimulate preventive measures. However, trade embargoes cause macroeconomic shocks and economic and social disruption on a scale that cannot be mitigated by humanitarian aid, and which affects the well-being of a population beyond their state of health.

Three prerequisites for effective humanitarian advocacy are, therefore, reliability of data, integrity of the source and a credible link between the observed outcomes and the existing sanctions regime. The last section of the paper critically examines the current practice of measuring health impacts of sanctions, with particular emphasis on the case of Iraq. It identifies persistent weaknesses and suggests steps for improvement in future humanitarian assessments.

Improved practice will require:

1. A better assessment of vulnerabilities but also of existing strengths.
2. More valid indicators and appropriate methods to measure the impact of sanctions on vulnerable groups.
3. More potent advocacy that clearly shows how vulnerable populations have been affected and what needs to be done to achieve better outcomes rather than more inputs (underpinned by points 1 and 2).

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# Executive Summary

Trade sanctions, as a tool of coercive foreign policy, have been very popular in the 1990s. Most take the form of bilateral sanctions by the US, but the number of UN sanctions has also increased and regional groupings of states are also turning to the tool. Fairly comprehensive trade embargoes have been imposed, for example, against Cuba (US), Haiti (Organisation of American States, UN), Iraq (UN), Sierra Leone (ECOWAS, the Economic Community of West African States) and Burundi (neighbouring states).

There is now substantive cumulative evidence that trade embargoes cause severe civilian hardship and profound social and economic dislocation. Their impact goes beyond humanitarian crisis to induce serious economic recession and social impoverishment. In short, sanctions reverse 'development' gains, and their effects cannot be mitigated by humanitarian assistance alone.

There is no specific legal instrument to regulate sanctions but minimally they should respect basic principles in international humanitarian law, such as 'distinction' and 'proportionality'. Distinction directs those waging war to focus on military rather than civilian targets. Proportionality directs combatants away from targets that are likely to cause civilian harm disproportionate to military benefit.

This paper reviews the evidence of the impact of sanctions against Cuba, Haiti and Iraq, specifically on health and health services. It reviews current impact measurement attempts, identifies regular weaknesses in the choice of indicators and the measurement methodology, and recommends reform of in-country health policies and of the sanctions exemptions mechanisms to mitigate the impact of sanctions on health. Better monitoring and impact measurement will also allow more potent advocacy, because such data is reliable, the source considered objective, and a credible linkage can be established between the observed changes in well-being and the imposition of sanctions.

The impact of sanctions on health and health services is not limited to problems with the supply of medicine. Health and health services are dependent on functioning water and sanitation infrastructure, on electricity and other functioning equipment such as ambulances, X-ray facilities or refrigerators to store vaccines. Even if humanitarian exemptions were effective, which in practice they are often not, this would not be sufficient to maintain health and health services. Weakened physical and medical infrastructure – due to lack of vital imports, but also due to a reduction in state funds for capital investment, maintenance and running costs (itself the result of lost revenue as a consequence of an embargo) – strain the ability of the health system to provide services and respond to medical emergencies. As the quantity and quality of health services decline, people are less motivated to continue using them. Simultaneously, access and user rates go down because the civilian population is forced to engage in alternative social and economic activities to cope with the macroeconomic impact of sanctions on employment and livelihoods.

The evidence indicates that vulnerability should be assessed and not assumed. Mothers and infants are undoubtedly a vulnerable group, but appropriate public health measures and a concentration of scarce resources cannot only stop but even reverse negative mortality trends in this population group, as the example from Cuba shows. Changes in under-five rather than infant morbidity and mortality rates are more indicative than data on infants (under ones). But attention should also be paid to other, often neglected, vulnerable groups such as the chronically ill and the elderly, or other groups that are marginalised and excluded for economic, social or political reasons.

A review of the available evidence of excess mortality in Iraq, for example, indicates methodological weaknesses in many studies and statistics. More recent surveys which are methodologically sounder indicate 300,000 excess deaths among under five-year olds. Factors which contribute to this outcome include: Iraq's high dependency on external trade for earnings and essential goods; humanitarian aid that was delayed and provides less than what is estimated to be needed; a curative and high-tech oriented, hospital-based health service; no significant health policy reform towards public health measures; collapsed national health information systems; and uncoordinated actions by international technical experts that prevented the development of a comprehensive and consistent picture earlier on.

Impact monitoring can be improved by:

- strengthening the existing health information systems;
- a better choice of indicators;
- better survey methods;
- coordinating of monitoring and survey methods so that the results are compatible;
- combining quantitative with qualitative information, not only about health but also about the social and economic coping mechanisms of households in sanction-affected countries.

A better assessment of the nature of the health system and use of the health service can inform the design of sanctions and sanction exemption rules prior to their imposition. Improved impact monitoring of selected health and well-being indicators after sanctions have been imposed should inform subsequent reviews of the sanctions and exemptions design.

# 2

# Introduction

To sanction a country is to interrupt its communications, diplomatic and/or economic relations (see Table 1). There have been many trade sanctions instituted since the end of the cold war as direct military intervention by the major powers has become less strategically important. In recent years, the macroeconomic and political impact of sanctions have been heavily debated. This paper instead examines the impact of comprehensive trade embargoes on health, health services and human well-being. Trade sanctions may increase suffering and death among civilians, particularly among the most disadvantaged and vulnerable groups. Humanitarian policies and actions to reduce this damage are proposed and a comparative analysis of sanctions in Iraq, Haiti and Cuba is presented. All of these sanctions-related issues are pertinent to the wider field of human rights and humanitarian intervention in conflict situations.

Humanitarian agencies (for example, UNICEF and Save the Children), religious organisations (including the Quakers and the Vatican), networks of professional health organisations (for example the American Public Health Association and the World Medical Association) and human rights groups (such as Amnesty International and Human Rights Watch) have all been critical of sanctions. While no simple or uniform policy on sanctions may be possible, the major humanitarian effects can be anticipated and prevented or attenuated. In addition, affected countries can be helped to meet the basic needs of their citizens during sanctions, and their ability to recover and develop can be strengthened in the process.

This paper first reviews the political motivations behind the increased used of sanctions in the 1990s and the legal and moral constraints that should apply. Inasmuch as sanctions are imposed without formal declaration of war or without Chapter VII authorisation by the UN Security Council (permission to use force to impose a resolution), international human rights norms are applicable. Where sanctions are imposed in a context of hostilities and the use of force, international humanitarian law must apply. This requires the observance of basic principles, such as the 'distinction' between military and civilian targets and 'proportionality' in the pursuit of hostile acts that can cause civilian harm.

## Politics and Legal–Moral Constraints

### The Politics of Sanctions

During the twentieth century sanctions have widely been seen as a less violent alternative to war. In the second decade of this century, US president Woodrow Wilson called sanctions a 'peaceful, silent, and deadly remedy' that no nation can resist. Between the two world wars, sanctions were considered a prime tool for coercive foreign policy under the League of Nations; their importance was subsequently reaffirmed in the Charter of the United Nations after World War II. Yet prior to 1991 the UN had only instituted sanctions against Southern Rhodesia (1966) and South Africa (1977). Indeed, during the cold war period the superpowers could use their veto in the Security Council to prevent the imposition of UN sanctions, and could counter

the impact of bilateral sanctions by providing assistance to the affected state.

Since 1991 the UN or regional bodies have instituted 10 sanctions regimes (see Table 2). Following its military debacle in Somalia, the US has often opted for sanctions rather than military intervention. Indeed, between 1993–1996, 35 new sanctions regimes were initiated by the US. By 1997, US sanctions of some sort were in force against more than 50 countries containing 68 per cent of the world's population (Meyers, in *New York Times*, 20 April 1997. Most of these limit commercial relations or military cooperation. Comprehensive sanctions that attempt to cut-off a country economically and diplomatically are rare.

Sanctions are seen by some to be a positive tool to facilitate the resolution of conflict in a less violent manner. They are credited with preventing the regime that overthrew the elected president in Haiti in 1991 from gaining legitimacy. Sanctions have also been credited with influencing the regime in Iraq to allow the UN weapons inspectors to monitor and effect the destruction of weapons, the regime in the Federal Republic of Yugoslavia to sign the Dayton Peace Agreements, and the regime in Libya to facilitate the trial of suspects in the Lockerbie bombing. The most commonly cited success is South Africa, where sanctions helped to convince the apartheid government of the need to move to majority rule (Coovadia, 1999). The factors that made sanctions against South Africa effective – popular support among those most affected and a regime sensitive to international opinion – are rare.

Political scientists say the record of sanctions in achieving their stated objectives is low (Hufbauer *et al*, 1990; Dashti-Gibson *et al*, 1997; Pape, 1997). Why then are sanctions so popular? One reason is that sanctions send a clear signal of disapproval; in the extreme they will isolate a country from the international community as a 'bad example'. Another reason is their value for domestic audiences: they demonstrate quick action on the part of those who decide and promote sanctions to respond to constituent demands. Finally, although sanctions incur economic costs to domestic business interests they are considered cheap in relation to the financial cost of military intervention. The cost of military intervention in Haiti, for example, amounted to US$8bn, dwarfing the $US250m price tag for three years of humanitarian assistance during sanctions.

Sanctions externalise most costs onto the sanctioned country. Many of these costs, however, are born by the civilian population and not by the offending regime. Like other trends in economic globalisation, sanctions are almost exclusively employed by developed market economies against weaker and more dependent states. They can thus be seen as part of a general assault on states that resist the cultural, political or economic penetration of the US-led post-cold war world order.

Economic sanctions that affect trade and finance can cause severe economic destabilisation with grave impacts on the livelihoods and well-being of populations in affected countries. This is why many religious and humanitarian groups now oppose all sanctions. But assessing the harm done by a sanction must be compared to its alternatives: going to war or leaving unpunished important crimes, such as genocide.

## Legal and Moral Constraints

Article 41 of the UN Charter authorises 'measures not involving the use of armed force...including complete or partial interruption of economic relations...' when a state threatens international peace and security. This can be followed by military action if the Security Council agrees. Embargoes against Rhodesia (now Zimbabwe), Libya, Iraq and Yugoslavia were enacted under this provision. Sanctions have also been established by the Organisation of American States (OAS) against Haiti, the Organisation of African Unity (OAU) against Burundi, and the European Community against the Federal Republic of Yugoslavia. Collective sanctions constitute only a minority of all sanctions. Many US sanctions, such as the one against Cuba, are purely bilateral. This raises the question of the relationship (and legality) between sanctions imposed by member states of the UN, bilaterally or in regional groupings, and sanctions authorised by the UN Security Council.

Also problematic is the UN's obligation to respect the sovereignty of member states. The debate over sanctions, therefore, argues that sovereignty rests with a country's government inasmuch as it fulfils its obligations towards its own citizens. If it grossly fails to fulfil these obligations, international intervention may be justified. In this way the international community may cause human rights violations while fighting against a nation's own violations of human rights.

The impact of trade sanctions on the citizens of some countries raises the question of the relationship between civil and political, and social and economic rights. Indeed, its Charter charges the UN with promoting higher standards of living and human development. The Universal

**Table 1: The Topology of Sanctions**

| |
|---|
| ***Diplomatic and Political Measures*** |
| • public protest, censure, condemnation;<br>• postponement, cancellation of official visits, meetings, negotiations for treaties and agreements;<br>• reduction, limitation of scale of diplomatic representation affecting status of post, diplomatic personnel, consular offices;<br>• severance of diplomatic relations;<br>• withholding recognition of new governments or new states;<br>• vote against, veto admission to international organisations; vote for denial of credentials, suspension or expulsion; removal of headquarters, regional offices of international organisations from target. |
| ***Cultural and Communications Measures*** |
| • curtailment, cancellation of cultural exchanges, scientific cooperation, educational ties, sports contacts, tourism;<br>• restriction, withdrawal of visa privileges for target nationals;<br>• restriction, cancellation of telephone, cable, postal links;<br>• restriction, suspension, cancellation of landing and overflight privileges; water transit, docking and port privileges; land transit privileges. |
| ***Financial Measures*** |
| • reduction, suspension, cancellation of development assistance, military assistance;<br>• reduction, suspension, cancellation of credit facilities at concessionary or market rates;<br>• freeze, confiscation of bank assets of target government, target nationals;<br>• confiscation, expropriation of other target assets;<br>• freeze interest, other transfer payments;<br>• refusal to refinance, reschedule debt repayments (interest, principal);<br>• vote against loans, grants, subsidies, funding for technical or other assistance from international organisations. |
| ***Commercial and Technical Measures*** |
| • import, export quotas;<br>• restrictive licensing of imports, exports;<br>• limited, total embargo on imports, exports (Note: arms embargoes);<br>• discriminatory tariff policy, including denial of most favoured nation trade, access to General Preferential Tariff;<br>• restriction, cancellation of fishing rights;<br>• suspension, cancellation of joint projects;<br>• suspension, cancellation of trade agreements;<br>• ban on technology exports;<br>• 'blacklisting' those doing business with the target;<br>• curtailment, suspension, cancellation of technical assistance, training programmes; ·<br>• ban on insurance and other financial services;<br>• tax on target's exports to compensate its victims. |

**Table 2: Sanctions Instituted by the UN**

| Country | UN Resolution No and Date Passed | Components of Sanction | Dates in Effect |
|---|---|---|---|
| **Southern Rhodesia** | 217 (20-11-65)<br>232 (16-12-66)<br><br>253 (29-05-68)<br>460 (21-12-79) | ·Arms and oil embargo<br>·Calls for member states to suspend economic relations<br>·Sanctions Committee formed<br>·Sanctions lifted | 1965–1979 |
| **South Africa** | 418 (04-11-77)<br>421 (09-12-77)<br>919 (25-05-94) | ·Arms embargo<br>·Sanctions Committee formed<br>·Sanctions lifted | 1977–1994 |
| **Iraq/Kuwait**<br><br><br><br><br><br>**Iraq (only)** | 661 (06-08-90)<br><br>670 (25-09-90)<br>687 (03-04-91)<br><br><br><br>712 (19-09-91)<br>986 (14-04-95)<br><br>1111 (06-04-97)<br>1143 (12-04-97)<br>1175 (06-19-98)<br>1210 (11-24-98)<br>1242 (6-04-99) | ·Comprehensive trade sanctions;<br>·Sanctions Committee formed<br>·Air embargo<br>·Cease-fire resolution; full trade embargo remains pending Iraqi fulfilment of established conditions<br>·Initial authorisation of oil for food arrangements<br>·Subsequent authorisations for oil for food programme | 1990–present until April (Kuwait 1991) |
| **Former Yugoslavia** | 713 (25-09-91)<br>724 (15-12-91)<br>757 (30-05-92)<br><br>820 (17-04-93)<br>942 (23-09-94)<br>943 (23-09-94)<br><br>1022 (22-11-95)<br><br>1074 (01-10-96) | ·Arms embargo<br>·Sanctions committee formed<br>·Comprehensive trade sanctions, flight ban, cultural/sport boycott on Serbia & Montenegro<br>·Sanctions strengthened<br>·Sanctions imposed against Bosnian Serbs<br>·Some sanctions against Serbia & Montenegro eased<br>·Indefinite suspension of sanctions following Dayton peace accord<br>·Termination of sanctions against Serbia & Montenegro and Bosnian Serbs | 1991–1996 |
| **Somalia** | 733 (23-01-92)<br>751 (24-04-92) | ·Arms embargo<br>·Sanctions Committee formed | 1992–present |
| **Libya** | 733 (23-01-92)<br><br>883 (11-11-93) | ·Arms and air embargoes; diplomatic sanctions; Sanctions Committee formed<br>·Libyan government funds frozen; ban on oil equipment | 1992–1999 |
| **Liberia** | 788 (19-11-92) | ·Arms embargo | 1992–present |
| **Haiti** | 841 (16-06-93)<br><br>861 (27-08-93)<br><br><br><br>873 (13-10-93)<br>917 (6-05-94)<br>944 (29-09-94) | ·Oil and arms embargo; foreign assets frozen; Sanctions Committee formed<br>·Suspension of oil and arms embargo following signing of Government Island agreement<br>·Oil and arms embargo reinstated<br>·Sanctions expanded to trade and financial assets<br>·Sanctions lifted effective 16-10-94 | 1993–1994<br><br>(Preceded by OAS Embargo 1991–1993) |
| **Angola** | 864 (15-09-93) | ·Arms and oil embargo against UNITA;<br>·Sanctions Committee formed | 1993–present |
| **Rwanda** | 918 (17-05-94)<br>1011 (16-08-95) | ·Arms embargo; Sanctions Committee formed<br>·Sanctions lifted 1-9-96 for Rwandan government; still in effect for non-government forces | 1994–present |
| **Sierra Leone** | 1132 (08-30-97) | ·Arms, economic, and diplomatic embargo | 1997–present |
| **Sudan** | 1054 (26-04-96)<br>1070 (16-08-96) | ·Diplomatic sanctions<br>·Conditional imposition of air embargo effective in 90 days; deferred pending further examination of sanctions effects | 1996–present |

Declaration of Human Rights and the Convention on the Rights of the Child, among others, condemn actions which obstruct the realisation of basic rights such as the right to shelter, healthcare and food, the lack of which might even affect survival. In a number of situations, then, such as in Haiti and Iraq, the UN finds itself in the dual role of hostile agent and humanitarian defender. Not surprisingly, UN organisations providing humanitarian assistance have sometimes found themselves rejected by affected people and their governments alike, as the UN was perceived to be creating the misery in the first place.

Sanctions may precede, accompany, or follow war. Yet they may be instituted without a declaration of war and do not fall under the rules of war. These rules were designed to provide protection to civilians and non-combatants. The Geneva Conventions (1949) and its Additional Protocols (1977) prohibit measures depriving a civilian population of goods indispensable to survival. Article 70 of Protocol I and Article 18 of Protocol II, for example, call for relief operations for civilians experiencing undue hardship due to a lack of essential supplies. Article 14 of Protocol II guarantees the protection of goods indispensable to survival: 'Starvation of civilians as a method of combat is prohibited. It is therefore prohibited to attack ... crops, livestock, drinking water installations and supplies and irrigation works.'

Two essential principles of the laws of warfare are proportionality and distinction. Proportionality directs combatants away from targets that are likely to cause unnecessary civilian harm relative to military benefit. Distinction directs those waging a war to focus on military rather than civilian targets. But sanctions, when not occurring during a state of war, do not fall under the laws of war. There is then no legal obligation on the sanction-imposing authorities to carefully select their targets, to take precautions to reduce civilian suffering and avoid civilian deaths, and to examine the relative merits and drawbacks of a proposed approach in terms of the harm it can cause to civilian populations. Thus it can be argued that comprehensive sanctions, when scrutinised under the principles of differentiation and proportionality, may violate more rights than war itself.

International legal instruments also do not facilitate legal redress, which makes it very difficult to hold the sanctioning authorities responsible for the impact of sanctions on civilians. Legal procedure typically requires an individual to demonstrate damages through the act of another individual. Since sanctions are experienced collectively and not individually, and because there is seldom a direct relationship between a sanction and its outcomes, this is difficult to demonstrate beyond reasonable doubt.

**Table 3: Human Rights which may be Violated by Economic Embargoes**

| Human Rights | Relevant United Nations Instruments |
|---|---|
| Right to life | UDHR(3), ICCPR(6) |
| Right to liberty and security of person | UDHR(3); ICCPR(9) |
| Right to freedom of opinion and expression | UDHR(19); ICCPR(19); CRC(13) |
| Right to adequate food, and to be free from hunger | UDHR(25); ICESCR(11) |
| Right to the highest possible standard of physical and mental health | CRC(24); ICESCR(12) |
| Right to the provision of medical assistance and healthcare | UDHR(25); ICESCR(12); CRC(24) |
| Right to adequate clothing and housing | UDHR(25); ICESCR(11) |
| Right to adequate environmental conditions | ICESCR(12) |
| Right to a standard of living adequate for health and well-being | UDHR(25); ICESCR(11), CRC(27) |
| Right to education | UDHR(26);ICESCR(13); CRC(28) |
| Right to work, and to just and favourable conditions of work | UDHR(23); ICESCR(6,7) |
| Right to social security | UDHR(22); ICESCR(9); CRC(26) |
| Right to participate in government | UDHR(21); ICCPR(25) |

Widest possible protection and assistance should be accorded to the family. Special protection should be accorded to mothers during a reasonable period before and after childbirth. Special measures of protection and assistance should be taken on behalf of all children and young persons.

International Covenant on Economic, Social and Cultural Rights (ICESCR), Article 10.

States Parties shall ensure to the maximum extent possible the survival and development of the child. States Parties recognise the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.

Convention on the rights of the Child (CRC), Articles 6 and 27.

Relevant Human Rights Instruments:

- Universal Declaration of Human Rights (UDHR)
- International Covenant of Economic, Social and Cultural Rights (ICESCR)
- International Covenant of Civil and Political Rights (ICCPR)
- Convention on the Rights of the Child (CRC)

*Source*: Hoskins, 1998.

# 3

# Country Case Studies: Cuba, Haiti, Iraq

## Overview

Those countries likely to be most affected by trade sanctions are those with:

- the greatest import dependency, especially for food and energy;
- dependence for export earnings on one or a few easy to monitor products;
- geographic and political isolation;
- rapid implementation of sanctions, without time to reorganise sources of supply;
- a lack of financial reserves with which to import essential goods;
- disruptions due to other concurrent social crises;
- the least ability to cope by engaging in small-scale agriculture and other subsistence occupations;
- a health infrastructure which is oriented mainly toward sophisticated hospital-based curative care depending on imported products;
- weak information systems, and thus poor ability to modify the health system and other safety net activities efficiently when diseases change and resources become short.

Cuba is geographically but not politically isolated; many countries continue to trade with Cuba despite the US embargo. Haiti's porous border with the Dominican Republic helped provide it with a minimal amount of gasoline during sanctions. Urban populations in both Cuba and Haiti returned to rural family farmsteads when urban jobs dried up, providing relief from the worst impact of sanctions. Iraq has had none of these advantages. Indeed, it is difficult to think of any country more vulnerable to comprehensive sanctions.

**Cuba**

In the 1980s, Cuba was one of only several developing countries with infant, child and maternal mortality rates approaching those of developed countries. But while the other 'good outcome' countries – China, Costa Rica, Kerala state in India and Sri Lanka – also had moderate to high rates of economic growth, per capita income in Cuba declined.

The US instituted trade sanctions against Cuba in 1964. During détente in the 1980s sanctions were relaxed, permitting Cuba to purchase goods from US companies through third countries. In 1992, the US embargo was made more stringent with the passage of the Cuban Democracy Act, a congressional bill which took advantage of the decline in the Cuban economy and Cuba's political exposure with the dissolution of the former Soviet bloc. All US subsidiary trade has since been effectively prohibited. Ships from other countries are not allowed to dock at US ports for six months after visiting Cuba, even if their cargoes are humanitarian goods. Although embargo legislation since World War II has usually included exemptions for humanitarian goods, the 1992 embargo legislation on Cuba does not permit sales of food and requires unprecedented 'on-site verification' for the donation of medical supplies. The legislation does not state that Cuba cannot purchase medicines from US companies or their foreign subsidiaries; however, such license requests have usually been delayed or denied. Despite criticism from most US allies, and a slight loosening following papal intervention in 1998, sanctions continue at present.

**Haiti**

Haiti has been the poorest country in the western hemisphere for most of its two centuries of post-colonial history. When Aristide became Haiti's first elected president in February 1991 half of the labour force was unemployed, half of all adults were illiterate, and one-third of the people lacked access to modern health services. A military coup ousted Aristide the following September, and sanctions were initiated by the US and the OAS in October .

Initial sanctions froze Haitian government assets in the US and prohibited payments to the de facto regime. Later, sanctions included the prohibition of most imports and exports from Haiti (with the exception of humanitarian goods), restriction of commercial flights, and a freeze on arms and oil shipments. Sanctions were only lifted in 1994 after a US/OAS military contingent enforced the Governor's Island Accords (for peaceful transition of power in Haiti) which led to a re-establishment of the elected government. During sanctions, NGOs and governments provided essential functions outside of government structures in order to avoid legitimising the military regime. Many good staff left government employment at that time, never to return. This has left Haiti with a weakened infrastructure.

**Iraq**

Sanctions began on all items imported to Iraq, except medicines, on 6 August 1990. Following the Gulf war of January and February of 1991, sanctions were reaffirmed by the UN. On 3 April 1991 Iraq was permitted to import food in addition to medicine. In reality, only about 10 per cent of previous levels of either commodity was imported. From 1991 to 1993, humanitarian organisations imported only 5 per cent of the medicines and foods that they considered necessary for Iraq as their appeals went unfunded by governments hostile to the country.

To address Iraq's humanitarian needs the UN Security Council passed Resolution 706 in August 1991 authorising limited sales of oil to pay for imports humanitarian goods. In 1995 the Security Council again authorised sales of oil for the purchase of humanitarian goods. The government of Iraq, citing sovereignty concerns and betting that the Security Council would end sanctions before stockpiled goods ran out, only approved the plan (UNSCR 986) in 1996, and the first deliveries of humanitarian goods began in 1997. This Oil for Food programme (OFF) is now the largest relief programme in the world. The UN General Assembly voted to carry out a comprehensive field evaluation of the OFF programme by March 1999. However, political manoeuvring among Security Council member states prevented a team from being fielded to collect original information. The resulting Humanitarian Panel report was a compromise document produced by staff at headquarters, drawing upon existing UN reports.

**Case Study: Evaluation of the Oil for Food Programme in Iraq**

Eight years after the end of the Gulf war of 1991, the most comprehensive trade sanctions ever imposed in the twentieth century are still in place on Iraq. Other than claims of more than a million excess deaths there has been little assessment of sanctions-related changes to the lives of the 22 million Iraqis. Such assessment is essential for evaluating the Oil for Food programme (OFF) of the UN to supply humanitarian goods to Iraq. This programme, begun in 1996, is now the largest relief effort in the world. An evaluation was mandated by vote in the UN General Assembly in January 1999, which included a budget of US$100,000 in non-Iraqi UN funds. An evaluation team leader was contracted, evaluation procedures were elaborated, and UN agencies in Iraq began to collect background information. But no terms of reference were forthcoming and no evaluation team was fielded. Though no security council member vetoed the plan to evaluate OFF, behind the scenes actions by some of the major powers froze plans to field an independent evaluation team. In the end, several diplomats and staff members of the UN secretariat in New York used existent reports to negotiate and synthesize a summary document describing humanitarian conditions. Even this group's modest recommendations to improve humanitarian conditions in Iraq have gone unheeded; at the time of writing, six months after the release of the Humanitarian Panel report, none of their recommendations have been voted on by the Security Council or General Assembly, and none is in the process of being put into practice by the UN office of the Iraq programme.

A humanitarian assessment of Iraq should focus on well-being of the general population and of vulnerable groups. It should collect information on changes in poverty levels, income levels and sources, and the proportion of income spent on food. The particular effects of economic and social welfare changes on women should be investigated, as well as the effects on fertility, marriage, and choices of internal and international migration. This will assist in the identification of more and less effective coping mechanisms in various population sectors, and modifications needed to make the programme more effective.

The extended period of neglect to infrastructure for water, sanitation, roads, agriculture, and electricity should be specified. Problems and complexities in administering the OFF programme, and differences in administration and the roles of NGOS in the centre and south of Iraq compared to the autonomous Kurdish governorates in the north, should be reviewed. The OFF programme is heavily weighted toward the distribution of commodities without training, information systems, and administrative infrastructure development characteristic of relief-to-development programmes. This may help to explain the frustratingly limited impact of OFF thus far on child malnutrition, particularly in the centre and south of Iraq as compared to the UN-administered Kurdish region in the north.

**Table 4: Recommendations for Humanitarian Modifications to Sanctions in Iraq**

| UN Humanitarian Panel Report (March 1999) |
|---|
| ***Secure increased funding for SC986 OFF programme***: |
| · Lift the ceiling for oil exports;<br>· Authorise bilateral production sharing agreements to raise production;<br>· Authorise private investments in oil and food industries;<br>· Try to bring non-986 oil exports into the 986 programme;<br>· Seek humanitarian funding from non-Iraqi sources;<br>· Temporarily suspend deductions from 986 programme for Kuwait repayments, etc;<br>· Release Iraqi assets held by other countries into programme. |
| ***Improve approval procedures for contract requests***: |
| · Pre-approve unambiguous humanitarian goods;<br>· Permit the Iraqi government to purchase such goods, with payments from escrow funds when goods reach the border;<br>· Speed the approval process to 2 days turn-around for non-pre-approved, non-dual use goods. |
| ***Modify the humanitarian programme***: |
| · Establish a cash component in center/south Iraq;<br>· Use 986 funds to purchase rather than undercut the market for Iraqi grain;<br>· Include installation and training in contracts to purchase equipment;<br>· Establish financial incentives for early delivery of goods;<br>· Encourage NGOs and others to develop programmes oriented to education and youth. |
| ***Further recommendations from individuals not associated with the OFF programme:*** |
| (McHugh, undated; Garfield, unpublished):<br>· Equalise humanitarian programme funding levels between north and center/south;<br>· Stop bombings of humanitarian supplies or provide reparations when humanitarian targets are hit;<br>· Change from a 'no-objection' procedure to a 'majority consensus' mechanism to approve Iraqi contract requests;<br>· Require states that often vote to put contracts on hold to justify their objections;<br>· Redefine relief to permit training, infrastructure, evaluation, communications;<br>· Develop planning/spending cycles longer in duration than 6 months;<br>· Initiate longitudinal evaluation studies;<br>· Progressively increase the cash component and gradually move funding from the UN escrow account to a transparent Iraqi account;<br>· Permit Iraq to sell natural gas to generate more income;<br>· Make deliberations of the sanctions committees transparent. |
| ***Recommendations from UK–Netherlands Proposal*** (June 1999): |
| · Suspend the prohibition of all Iraqi exports;<br>· Give the UN Secretary General direct authority to approve humanitarian contract requests. |
| ***Recommendations from French Proposal*** (June 1999): |
| · Suspend prohibition of both imports and exports from Iraq except for military goods;<br>· Move from Security Council decision-making power to notification of contracts. |
| ***Annan Post-UNICEF Mortality Study*** (24 August 1999): |
| · Spend $1 billion in anticipated excess revenue on child health and nutrition. |

## Macroeconomic Impacts

**Overview**
Comprehensive trade embargoes constitute a major economic shock. The severe restrictions of imports and exports reduce overall production, not only in industry but also in agriculture inasmuch as this relies on imported inputs. Employment falls in export-oriented sectors. Foreign currency reserves decline, and debt servicing falls into arrears. The decline in state revenue is likely to lead to reduced capital investment and infrastructural maintenance, and to lower levels and lower quality of social services. While the overall decline in GNP and per capita income affects virtually everyone, the poorer are hit disproportionately. Therefore the degree of inequality in society is likely to increase. None of these macroeconomic impacts can effectively be off-set by humanitarian assistance, nor will they quickly be reversed when sanctions end.

**Cuba**
Cuba's gross national product declined by 35 per cent during the 1989–1994 period. While it is impossible to quantify the amount of economic decline caused by each 'source event', it is widely thought that the embargo has had less impact than the loss of trade and aid relations with the former Soviet bloc. There is a high degree of social equity in Cuba; the ratio of income among the highest 20 per cent compared to the lowest 20 per cent, at two to three times difference, is among the lowest in the world. Through 1994, this gap declined further as the economic crisis reduced income broadly while housing, education, rationed food and healthcare remained public access goods not acquired through market mechanisms and so less affected by economic decline. Since 1994, however, the economy has grown by about 3 per cent a year. This growth has been predominantly in non-traditional sectors. It is associated with a growing social gap between those with peso and those with dollar income.

**Haiti**
It is widely believed that the military and traditional elites have one of the highest concentrations of wealth in the world amidst a general population predominantly in poverty.

Although there has been a downward trend in both industrial and agricultural output in Haiti since 1986, the rate of decline accelerated from 1991 to 1994. In the five years between 1986 and 1991, assembly industry employment declined 8 per cent; between 1991 and 1994 under sanctions employment in this sector plunged 80 per cent. The embargo is associated with the loss of about 30,000 jobs in Haiti's garment, electronic, sports and toy assembly industries. Similarly, agricultural production in the 1980s declined at an average rate of 1 per cent per year; between 1991 and 1994 it fell a total of 20 per cent – more than four times faster.

During the three years that sanctions were in force, per capita GNP declined by US$120, or 30 per cent; over the same period the international community (mainly the US government) provided Haiti with humanitarian assistance totalling an estimated US$250m, or US$35 per capita. This off-set by about a third the income lost during sanctions. Around 15 per cent of this assistance was provided through the UN system; the bulk of the remainder was provided by the US government which contributed close to US$190m over the three years. Although this represents an enormous sum for humanitarian assistance, in comparison the US Coast Guard's seizure, processing, detention and transport of Haitian boat people between 1993 and 1994 cost as much, and the 1994/1995 military intervention cost eight times more than three years of humanitarian assistance, at US$2bn

**Iraq**
In 1990, prior to sanctions and the Gulf war, Iraq produced about 3 million barrels of oil a day, of which it exported 2.5 million. This generated export earnings of US$19bn a year providing 95 per cent of the funds for the national budget and 64 per cent of the country's GDP. However, this foreign trade was cut by an estimated 90 per cent by sanctions. In the first eight years of the embargo, Iraq estimates that it lost US$120bn in foreign exchange earnings. During this time Iraq received about US$1bn in humanitarian donations. Such donations have been declining and have virtually disappeared since OFF started to provide Iraqi-funded humanitarian goods in 1997.

Per capita income is estimated to have declined by about three-quarters from 1990–1993, increasing inequality between rich and poor. Representative household surveys in 1988 and 1993 showed that high earners lost half of their income, average earners lost two-thirds of income, and low earners (representing two-thirds of all families) lost more than three-quarters of income.

Oil sales from the first five six-month rounds of the OFF programme generated US$7.7bn for humanitarian goods. However, goods actually purchased with these funds amounted to a little over half of this total (53 per cent of all funds generated are destined for supplies; the rest go towards UN administration, reparations etc). This represents US$394 per capita in the centre and south of Iraq and US$480 per capita in the north (the latter being a mainly Kurdish area and UN administered). Even though far more goods are being imported to Iraq

under OFF than at any time since the initiation of the embargo, the US$3–$4 worth of food and medicines distributed per capita per month represent only a fraction of the estimated US$12 imported per capita per month during 1988–1989.

## Impact of Sanctions on Health and Healthcare

**Overview**

The impact of trade sanctions is not limited to problems with the supply of medicine. Health and health services are dependent on functioning water and sanitation infrastructure, on electricity and on functioning equipment, such as ambulances, X-ray facilities and refrigerators to store vaccines. Even if humanitarian exemptions of medicines were effective, which in practice they are often not, this would not yet be sufficient to maintain healthcare and health.

Infant mortality (under one-year olds) is not the best indicator for measuring the impact of sanctions on health. It is comparatively easy to concentrate scarce resources and healthcare on pregnant and lactating women and infants. This can be effected through national policy adaptation towards focused public health measures – something that international agencies and experts can help with. Indeed in practice, infant mortality may actually decline under conditions of sanctions as a result of these measures. This has been done effectively in Cuba, but not in Iraq where health policy and the medical profession was geared towards high-tech, hospital-based curative medicine. A much better measure of the impact of sanctions is under-five mortality. Often overlooked vulnerable groups, however, are also the chronically ill, in need of specialised medicines and treatments, and the elderly.

**Cuba**

Despite short-term setbacks in some areas since 1992, infant, child and maternal health outcomes, already among the best in Latin America, have continued to improve. Infant deaths, for example, reached an all time low of 7.1/1000 live births in 1998. Despite a big drop in available calories, the percentage of all births below 2.5 kilos (5.5lbs) reached an all time low of 6.7 per cent in that same year. During this period more than 99 per cent of all births occurred in health institutions and an all time low of 47 maternal deaths per 100,000 births was recorded.

Some of the factors associated with these good outcomes are a strong family doctor programme, food rationing, routine monitoring of weight and weight gain among pregnant women and young children, medical surveillance of pregnancies, long-range investments in general education, a high degree of social unity regarding child health, and wide public education on public health issues. Instead of losing ground in monitoring health and well-being, Cuba greatly improved its health information systems. Since the tightening of the embargo Cuban authorities have thus been able to make far more timely, efficient decisions on the use of very scarce resources.

Only during the worst years of the economic decline and retooling of the health system, in 1993 and 1994, were poor health outcomes recorded. For example, maternal mortality among Cubans rose sharply from formerly low levels during this period. Extraordinary efforts to provide extra food rations to pregnant women and revamp birthing procedures rapidly reversed this trend. During this time, infant mortality remained stable. Subsequent efforts to improve maternal nutrition and conditions for delivery led to a subsequent decline in this rate, as outlined above.

Total mortality per 1000 inhabitants in Cuba rose from 6.4 in 1989 to 7.2 in 1994. This increase was almost entirely due to a 15 per cent rise in mortality among those aged 65 years and up, accounting for 7500 excess deaths. From 1992 to 1993 the death rate for influenza and pneumonia, tuberculosis, diarrhoea, suicide, unintentional injuries, asthma, and heart disease among older adults rose by at least 10 per cent. This was mainly due to shortages of essential medicines and laboratory reagents for those with chronic diseases requiring regular monitoring. In other age groups mortality rates remained stable or declined.

Poor nutrition and deteriorating housing and sanitary conditions in Cuba have been associated with a rising incidence of tuberculosis, from 5.5 per 100,000 in 1990 to 15.3 per 100,000 in 1994. During the 1980s Cuba had a serious housing shortage and has built virtually no residential housing since. Consequently, 15 per cent of the country's housing stock is in poor condition (including 1000 homes that collapsed in Havana in 1994) and 4000 more that are now precarious. In addition, medication shortages were associated with 48 per cent increase in tuberculosis deaths from 1992 to 1993. From 1989 to 1993, these conditions were also associated with a 67 per cent increase in deaths due to infections and parasitic diseases (from 8.3 to 13.9 per 100,000 population) and a 77 per cent increase in deaths due to influenza and pneumonia (from 23.0 to 40.7 per 100,000 population).

**Haiti**

Despite the difficulties caused by sanctions in Haiti, widespread famine was avoided, epidemics were contained and at least minimal social services were maintained. But though a humanitarian disaster was averted – due to feeding programmes, immunisation supplies, and a humanitarian fuel programme, for example – economic decline and social dislocation were not.

Access to professional health services and hospitals was far poorer in Haiti than in Cuba or Iraq. Indeed, much of the population had only occasional access to health services at best. Few useful health information systems existed, and many of these were NGO-based and had little coordination with the government and its services.

A 1994/1995 USAID-financed demographic and health survey found that between 1987 and 1994 the mortality of children aged between one and four years rose from 56/1000 to 61/1000. Such high a rate had last occurred 17 years earlier, in 1977. During the same period infant mortality declined 38 per cent, from 101 to 74/1000. Among the country's 237,000 infants the total number of deaths are thus estimated to have declined by about 6400 per year while among the country's 882,000 one to four-year olds 4400 excess deaths are estimated to have occurred per year. Overall average life expectancy for Haitians decreased by 2.4 years during the crisis and in 1994 stood at 54.4.

Much of the increased mortality among the one to four-year olds was due to a measles epidemic from June 1991–November 1993.The Immunisation Programme Technical Committee, composed of representatives of international organisations and NGOs, as well as representatives of the ministry of public health, debated whether a measles campaign should be launched under the coup government. Aristide supporters argued that the security situation did not permit large crowds to assemble around health posts as there was a risk they would be attacked by military forces. In addition, a large-scale campaign would have to use state structures and thus lend legitimacy to the de facto regime. Thus a large cohort of children were left malnourished and unprotected, creating conditions for a potent epidemic.

**Iraq**

During sanctions, grain and meat production fell, purchasing power and educational achievement receded, and the energy, water, medical, and transportation infrastructure declined throughout the country. These changes left all Iraqis at greater risk of poor health outcomes. This risk was greatest among those in rural areas, with lower income and often lower educational levels.

Iraq had invested heavily in health and education services in the 15 years prior to the embargo, and in 1990 it had an advanced curative medical care system. Information systems and public health services, however, were less advanced and have since deteriorated the most. Starting in March 1991, reports of an impending humanitarian disaster were common. Sadruddin Aga Khan, former UN High Commissioner for Refugees, reported in June 1991, 'We are neither crying wolf nor playing politics, but it is evident that for large numbers of people of Iraq, every passing month brings closer the brink of calamity.' Similar impressions were provided in 1996 when Philippe Heffinck, UNICEF representative in Iraq, said 'The situation is disastrous for children. Many are living on the very margins of survival' (UN Inter-Agency Humanitarian Programme for Iraq, 1991; UNICEF, 1996).

Diarrhoea and war-related mortality rose steeply in Iraq during and following the Gulf war and post-war insurrection in 1991 due to destruction of medical supplies, food stocks, and water and electric systems. Starting in 1991, a marked increase in malnutrition occurred among those reaching 12 months of age (when the protection offered by breast feeding has waned and risks from poor weaning practices rise). Those unprotected by breast feeding were at far greater risk. In addition, malnutrition among women giving birth led to a high rate of low-weight births and high perinatal mortality. Without significant improvements in sanitation, food sources, or medical care, many of the children with acute malnutrition after weaning became chronically malnourished as toddlers. As a result they were at increased risk of serious disease and death, especially from measles, diarrhoea, and respiratory infections.

Information presented on the level of excess mortality has been confusing and contradictory. The Iraqi government provided data showing a rapid rise in mortality among the under fives, up from 592 per month in 1989 (all figures are per 100,000 children) to 2289 per month in 1991 and 4409 per month in early 1994. This data was derived from hospital-based death reports; it represents an unknown but changing proportion of all deaths and cannot be considered a reliable indicator of mortality change. In 1996 the Iraqi ministry of health, with the assistance of a consultant from WHO, printed a report showing an average monthly excess of 4500 deaths among under fives (WHO, 1996). WHO reported this data as its own; UN humanitarian agencies henceforth reported 4500 embargo-related deaths as a verified fact. Other Iraqi officials

reported 6000 excess deaths per month among the under fives in 1998. At such high rates of excess mortality it was estimated that 560,000 under fives and 1.2 million people of all ages (including the under fives) had died as a result of sanctions by 1995. This claim rose to 1.5 million people by mid-1998. In early 1999, Iraqi minister of health Umeed Mubarak stated that more than one million children had died due to sanctions.

Advocates for ending sanctions have accepted Iraqi claims without critical examination. An early report, later retracted because of data inconsistencies and errors in survey methods, estimated excess deaths of children under five at 500,000 in 1995 (Zaidi & Smith Fawzi, 1995). Despite its subsequent retraction (Zaidi, 1997) the study is still often referred to. Press reports have sometimes stated that Iraq was the poorest country in the world or had the highest rate of infant mortality in the world. Others argue that Iraqi mortality data has been falsely elevated, that there are inconsistencies in the data sets, or that the total population data from the 1997 national census shows that no elevated levels of infant and young child mortality exist (see, for example, Clawson, 1998; Cordesman, 1997). These sceptics suggest that the humanitarian crisis exists mainly as a propaganda tool of the Iraqi government.

Two studies in 1999 established more reliable estimates of change in mortality among children under five. The first estimated changing mortality rates among this age group during 1996 by using valid data on social indicators such as water quality, adult literacy, and nutritional stunting, in addition to known rates of mortality in other countries (Garfield, 1999). The second was a large-scale demographic survey carried out by UNICEF in the first half of 1999. This second study trained Iraqi investigators, undertook field checks during data collection, regularly checked data for errors, and kept the original data sets for further analysis. Both showed that mortality levels after 1995 were double the rates in the late 1980s and that mortality in the north was lower than the centre and south.

The first study estimated under five mortality at 87 +/- 7/1000 live births; the more definitive UNICEF study estimated mortality at 125 during the 1994–1999 period. Regardless of the assumptions used for demographic variables, these studies confirmed beyond any reasonable doubt that a grave and sustained rise in mortality had occurred in Iraq. They also demonstrated that the rise was far less than that claimed by the Iraqi government, accounting for about 300,000 excess deaths among under five year olds.

## Impact on Health Services

**Overview**

Limited access to clinical services and shortages of medicine and equipment frequently characterise less developed countries. These characteristics can be compounded by sanctions.

Almost all sanctions legislation in recent decades has had provision for exemptions for medicines (and/or food). Nonetheless, sanctions commonly lead to limitations on the importation of medicines and foodstuffs due to disruption of commercial arrangements, complications in transportation, or lack of capital in the embargoed country with which to purchase the exempted goods. Despite exemptions for medical goods, many companies producing equipment and medicines failed to fill orders from embargoed countries for lack of iron-clad assurances that the item indeed was exempted from the embargo. In many countries, sanctions-related lack of capital has had more of an impact than direct restrictions on importing medicine or food. In sanctioned regimes, including Cuba and Yugoslavia, direct prohibition on the purchase of medicines has existed. Yet although effected countries routinely blame shortages of essential drugs, medical supplies, and surgical equipment almost entirely on sanctions, it has seldom been possible to demonstrate that prohibitions against purchase rather than a shortage of funds was responsible for the lack of these goods.

Weakened physical and medical infrastructure strain the capacity of a health system to respond to emergencies during childbirth. Even in Cuba, where maternal mortality is far lower than in Haiti or Iraq, reports of women delivering far from hospitals because of lack of ambulance parts or in the middle of Caesarean deliveries when electricity shut down became common. More women give birth without medical assistance or within a medical system lacking electricity, transportation facilities, or equipment and supplies for emergency interventions. If women know that hospitals lack medicines or are no longer cleaned for lack of supplies, many prefer to deliver outside the health system; their obstetric emergencies often go uncounted. The maternal mortality rate in all three countries rose during sanctions.

Most of the assessment of sanctions' effects on health focus on clinical health services. In addition, shortages of medicines, inability to diagnose or treat common illness, and the functional loss of equipment due to lack of access to spare parts is common. These data seldom describe the most important effects on people's lives, and are nearly impossible to blame on sanctions alone.

**Cuba**
From 1990 to 1994 the number of laboratory exams provided in the country's 273 hospitals declined by 36 per cent and the number of X-rays declined by 75 per cent. Cuba used to have an accessible national formulary of 1300 products; in recent years this has been reduced to 889, and at least a third of these products have been unavailable at any time. About half of all new pharmaceuticals in the last 20 years have been produced by US-patented companies only. Thus they are not available to Cuba at any price except by smuggling. Doctors sometimes spend much of their day not treating patients but going from centre to centre in search of a scarce medicine for a single patient. Ambulance access has become scarce as spare parts are increasingly difficult to obtain. Most Cuban ambulances were in working order in the 1980s; fewer than half worked in 1994.

**Haiti**
Humanitarian goods provided to Haiti during its embargo included medical supplies – though many NGOs held back their supplies so as to not imply 'business as usual' and thus legitimise the coup regime. Other key goods such as fuel to run kerosene lanterns, vaccine refrigerators, or deliver supplies was lacking.

**Iraq**
The dislocation caused by sudden resource shortages in a country used to a health system based on high quality curative care was great. In Iraq, this decline was partly alleviated through the importation of medical goods through the OFF programme since 1997. Limitations resulting from the heavily curative focus of the health system are still great. Money is often spent on high-tech equipment rather than common and preventable conditions such as immunisations and simple curative medicines. In addition, many of the goods imported via OFF require other unavailable equipment; about a quarter of all imported medical equipment remained in central level warehouses for more than a year awaiting complementary parts. About half of all equipment sent to hospitals in Iraq has not been put into service for fear of misfunction or destruction with Iraq's now unreliable electric system. Continuing the pro-curative prejudice of the system, more funds have been devoted to acquiring some of the most recent treatment and diagnostic tools rather than on basic sanitation, which remains in crisis even within hospitals after a decade of near complete neglect. In Baghdad in 1996, since spare tires were not permitted during sanctions due to their potential military use, only five of the 100 public ambulances were working; the car parks were more like car grave yards.

## Impact on Food Security

**Overview**
Those countries with the greatest import dependency experienced the greatest decline in child nutrition during sanctions. Sanctions are often associated with a dramatic increase in the price of staple goods. Those most affected include pregnant and lactating women, children under five years of age, those with chronic diseases, and the elderly. When food becomes scarce, the risk of inadequate weight at the start of pregnancy, poor weight gain during pregnancy, and micro-nutrient deficiencies all increase. Each of these increases the risk of a poor pregnancy outcome, malnutrition in childhood, or the worsening of medical conditions among adults.

It is telling that although adequate calories were available in Haiti and Iraq during sanctions, child nutrition suffered. While rationing can provide equity in the distribution of food to households, the long chain of events from arrival at the house to absorption of nutrients by a young child can be affected by changes in access to fuel for cooking, water quality and quantity, a mother's educational level, breast feeding, child-rearing habits, and health education for child nutrition. If women must spend more time in income seeking or income-substitution activities, less time and attention is available for child care and feeding. This has been accentuated in Iraq where the government has insisted on putting infant formula on the ration, thus decreasing breast feeding.

**Cuba**
About half of all proteins and calories in Cuba were imported prior to sanctions. Importation of foodstuffs declined by about 50 per cent from 1989 to 1993 and milk production declined by 55 per cent from 1989 to 1992 due to loss of imported feed and fuel. Reduced imports and a shift toward lower quality protein products are significant health threats: a daily glass of milk used to be provided to all children in schools and daycare centres through age 13; it was subsequently provided only up to age six.

It is estimated that sanctions on Cuba create a 'virtual tax' of 30 per cent on all imports. These have higher purchase and shipping costs because they have to be purchased from more expensive and more distant markets.

Cuba's approach has been based on the dual policies of equity and priority for vulnerable groups. The government was already skilled at rationing food and other scarce goods prior to 1989. It has since used mass media and workplaces to promote the use of bicycles in place of cars, animals in place of

tractors and trucks (for which fuel and parts are lacking), and the consumption of vegetable-based foods in place of scarce animal protein. In hospitals, rooming-in and other baby friendly changes have further promoted breast feeding. Eighty per cent of all births now occur in such baby friendly hospitals. The percentage of breast feeding rose from 63 per cent in 1990 to 97 per cent in 1994.

Distribution of food, clothing, and other scarce goods to target groups, including women, the elderly and children, is facilitated via social service institutions, workplaces, pre-schools and maternity homes. The number of children in pre-schools doubled and the use of maternity homes among those waiting to give birth rose by 26 per cent from 1988 to 1993. Weighing of pregnant women and young children to monitor weight gain has become routine. This provides an opportunity to educate mothers about nutrition.

**Haiti**

In Haiti, the price of staple foods increased fivefold from 1991 to 1993, unemployment rose rapidly, and the export of mangoes, on which many poor depended, was halted. The value of the national currency plummeted and hyperinflation occurred, making an average monthly salary equivalent to the market price of eighteen eggs.

A 1994 national demographic and health survey showed that 18 per cent of women suffered from protein-energy malnutrition in Haiti; for rural women the rate was 21 per cent. Estimated rates of low birth weight increased from 10 per cent to 15 per cent of new-borns. In addition, 7.8 per cent of children under five were shown to suffer acute malnutrition compared to 3.4 per cent in the 1990 survey. An important factor in the increase in malnutrition was the mother's absence from home due to economic activity. In the Haitian context, this resulted in less attention to breast feeding, weaning foods for young children, and care for ill children. Women's time use may have a key – but seldom measured – bearing on the nutritional health of the entire family.

A longitudinal study among rural Haitians showed an increase in the proportion of chronically malnourished children from 5 per cent to 23 per cent from 1991 to 1992. This rose further still as sanctions prevented the import of agricultural inputs. However, throughout the crisis, pre-school children in Port-au-Prince suffered higher levels of malnutrition than did children elsewhere in Haiti, with the exception of the drought-prone northwest. Data from 42 health facilities across the country showed that 18 per cent of under fives attending the clinics were moderately or severely malnourished in 1993. In Port-au-Prince facilities, 21 per cent were moderately or severely malnourished in 1993. By September 1994, the rate rose to 24 per cent in the same 42 health facilities; areas outside the capital had deteriorated to the level of Port-au-Prince.

**Iraq**

Iraq was even more dependent on imported foods with about 70 per cent of all proteins and calories imported prior to sanctions. From 1991 to 1996, acute malnutrition among under fives rose from 3 to 11 per cent. Chronic malnutrition rose from 19 to 31 per cent. The percentage of children born in hospitals under 2.5 kilos rose from 5 to 22 per cent.

During the first 18 months of the OFF programme no significant improvements were noted in malnutrition among children in centre and south. Reductions in chronic malnutrition did occur in the north, however, followed by some reduction in the centre and south Iraq by mid-1999. Still about one-quarter of all under five-year olds remain malnourished. The enhanced rations provided via OFF undoubtedly improve the overall nutritional situation of Iraqi families throughout the country: the price of non-rationed food has declined, rationed foods provide more meals per month than before, and people are spending less of their total income on foods outside the ration. The north has also experienced other advantages: it receives more money per capita through OFF, receives some of those funds as cash rather than just commodities. It also benefits from the work of many more NGOs. In addition, the UN administration encourages education to promote child nutrition, efforts to encourage breast feeding, decentralised administration to facilitate agricultural development, and expanded programmes to provide nutritional supplements to those in need. Drought in 1999, however, took a toll on nutritional status in the north, raising the rate of acute malnutrition from 1 to 3 per cent.

**Table 5: Comparative Indicators for Case Study Countries**

| | Cuba 1992 | Cuba 1996 | Iraq 1990 | Iraq 1996 | Haiti 1990 | Haiti 1994 |
|---|---|---|---|---|---|---|
| **Average calorie availability** | 3100 | 1865 | 3150 | 2277 | 2125 | N/A |
| **Calories available via ration** | 1400 | 1200 | N/A | 1500 | N/A | N/A |
| **Gross Domestic Product per capita** | 2000 | 1300 | 3508 | 540 | 370 | 250 |
| **% mothers breast feeding** | 63 | 97 | 60 | 80 | N/A | 96 |
| **% of births under 2.5kilos** | 7.3 | 8.7 | 4.5 | 22.1 | 10.0 | 15.0 |
| **% of calories imported prior to sanctions** | 50.0 | N/A | 70.0 | N/A | less than 50% | N/A |
| **Malnutrition Among Under Five Year Olds (percentage of all children under 2 SD of the norm)** | | | | | | |
| **Stunting** (low height for age; measure of chronic malnutrition) | 5 | 5 | 22 | 32 | N/A | 32 |
| **Underweight** (low weight for age; measure of chronic and acute malnutrition) | 5 | 5 | 12 | 23 | 18 | 28 |
| **Wasting** (low weight for age; measure of acute malnutrition) | 5 | 5 | 3 | 11 | N/A | 8 |
| | | | | | | |
| **Value of national currency/US$** | 1 | 35 | 1 | 1500 | 7 | 15 |
| **Value of imports for health (millions)** | $70 | $135 | $500 | $50 | N/A | N/A |
| **Value of sanctions-related lost production** | N/A | $2bn | N/A | $120bn | N/A | $850m |
| **Value of humanitarian assistance** | N/A | $1bn | N/A | $1bn | N/A | $250m |
| **Minimum estimate of excess deaths per year of sanctions** | N/A<br>N/A | 7500*<br>7500* | N/A<br>N/A | 5500**<br>5500** | N/A<br>N/A | 27,000***<br>27,000*** |

*Source*: Gibbons, 1999; Garfield & Santana, 1997; Red Cross, 1998.

* Among adults over 65
** Among children aged 1–4
*** Among children aged 0–4

# 4

# Coping Strategies

Coping strategies in the three countries have many similarities, and have been well-documented for Haiti (for example, Gibbons, 1998).

In Cuba and Haiti (but not Iraq), small-scale agriculture lured people from the cities, leading to an increase in the proportion of all people in rural areas. In Haiti, for example, where 80 per cent of Port-au-Prince families lived in marginal areas without basic services, some 300,000 people fled the city for rural areas. Though poor and living at subsistence level, farming families were able to provide for some of the survival needs of their unemployed urban relatives. In addition, during the crisis international food aid was made more plentiful in rural areas.

To raise income, many people sold personal assets. In a 1994/1995 survey of the northwest, 32 per cent of respondents reported having sold utensils, jewellery or other objects of value in the previous six months. In poor urban areas, families even sold tables and chairs. In one neighbourhood of Fort Liberte, 42 per cent of households owned a television set in 1986; by 1993, only 11 per cent owned one. Similarly, only 55 per cent of marginal households had electric services in 1993 compared to 90 per cent in 1986. In addition, embargo-induced shortage of propane gas resulted in an 18 per cent increase in charcoal consumption and a price rise of 82 per cent between August 1991 and June 1993. To compensate for the sale of basic assets and to reduce housing costs, families moved in together. In the 1986 survey, 53 per cent of households had three or more residents per room; by 1993, 73 per cent of households were sheltered in such crowded conditions. Women, especially those with children, were more likely to continue living with abusive partners and formal unions became less common.

Informal sector employment was the first economic refuge for those workers laid off from the assembly factories. This included food preparation, tailoring, barbering, shoe polishing, tire repair, handicraft production, and petty commerce. In 1993, 39 per cent of men and 29 per cent of women living in marginal areas worked in the informal sector. With a national decline in purchasing power the absorptive capacity of the informal sector was limited: 27 per cent of men and 12 per cent of women stated they had no remunerative work of any sort. Even more became unemployed later, as the embargo forced the small shops and businesses owned by Haiti's middle class to close.

Declining incomes forced people to reduce household expenditure. The quality and quantity of foods declined and the dominant staple food changed from rice to plantain and then to breadfruit. In the rural northwest two meals a day is typical; during the crisis, in 70 per cent of households only one meal a day was eaten and 17 per cent were reduced to eating every other day. In addition, the time women spent at the market or travelling in search of income also impacted on family nutrition.

## Methodological Challenges

**Overview**

There is ample evidence to suggest that humanitarian assistance cannot provide an effective

safety net under a comprehensive trade embargo. At the same time, not every problem can be simply attributed to sanctions. Credible advocacy about the impact of sanctions depends on three key elements: reliability of the data, integrity of the source, and an argument that establishes a credible link between the outcomes identified and the sanctions regime. The humanitarian community can and should improve its performance in this regard.

The methodological challenges to establishing a valid assessment of the impact of an embargo are daunting:

- Embargoes spread a small increase in risk of death, illness, or social stress among a large group of people. Small risks are difficult to measure with precision.

- This small change in risk may be obscured by concurrent events that contribute independently to the negative outcomes which may result from an embargo, such as war, mass migration, or economic crisis.

- The impact of trade sanctions on health and well-being is mediated by a country's economic and social systems. However, sanctions impact considerably on the production, importation and distribution of essential goods. There are thus multiple pathways and steps by which influence is exerted on health and well-being outcomes.

- Each sanction on economic trade is a type of 'natural experiment', where the intervention is national in scope and control groups with which to make comparisons do not exist. Baseline information available in sanctioned countries is usually limited in coverage or quality and, with the exception of Cuba, the quality of information on health and well-being has declined under sanctions.

- Change in the distribution of essential goods within the family or due to political or social mobilisation modify the impact of resource change brought on by trade sanctions. These modifying influences are difficult to isolate and often go unrecognised or unmeasured. Even a dramatic decline in key resources does not always or immediately lead to an increase in morbidity or mortality due to the resilience of 'health assets' as public education, healthy behaviours, trained health workers, and infrastructure, which deteriorate only gradually.

- Much available information comes from service statistics provided by health or social service provider institutions. These organisations have information on services provided or people served (a numerator) but seldom have information on the underlying populations (the denominator) from which service users come. Such information usually cannot be used to establish valid rates or identify changing levels of demand, need or severity.

- A prejudice in favour of quantitative measures often generates an excessive focus on these service statistics or incomplete population indicators when there are, in reality, only partial counts. More attention should be given to identifying key changes occurring in people's lives (qualitative indicators) to focus on the most effective interventions for improving life chances and reducing mortality. To do so, special studies have to follow groups of people over time; studies carried out at one point in time cannot identify such trends.

- Where quantitative indicators are used the information is almost always presented as a single number, for example, a death rate of 100/1000. This form of data presentation fails to communicate the relative level of precision possible for the numbers presented. More accurate would be the inclusion of a 95 per cent statistical confidence interval – for example, 100/1000 +/- 10/1000. Researchers should also describe their impressions of the imperfections in the data drawn upon and the biases inherent in them in order to communicate the level of uncertainty associated with a numerical indicator.

**Problems with Measuring and Communicating Information About Deaths**

Even when data collection is efficient, the data of greatest interest, such as infant mortality rates, usually cannot be assessed accurately and rapidly. Hospital records to not capture all births and deaths. In light of this, representative population surveys are needed to assess infant or under five mortality. In most cases other indicators such as cause of death, the nutritional status of living children, and the quality of the public health infrastructure are the best real-time health indicators available. Thus, while changes over time in large population sectors are of greatest interest, cross sectional information on small population groups which may not be generalisable to larger population groups may be the only reliable information sources available.

Advocates to ban sanctions often fail to distinguish between the effects of sanctions and other woes affecting a population. It is important to at least distinguish between social conditions and health indicators at the time that sanctions were imposed and indicators of change that occur in the course of the following years.

Infant mortality rate is of great interest because, more than any other single number, it is used to represent overall health conditions in a country. However, precisely because it is an outcome indicator affected by many different social and medical factors it is analytically difficult to determine if or how sanctions cause increases in mortality. Added to this is the difficulty of identifying short term trends in infant mortality in a timely and valid way, and one can see why public health is often overwhelmed by politics in arguing for or against sanctions on the basis of data on infant deaths.

**Avoiding Methodological Dilemmas**

Indicators of inputs (such as food distributed or the value of medicines imported) or process (number of medical visits, number of diarrhoea or measles cases reported, or the number of children out of school) are easier and more rapid to collect and more reliable than outcome indicators (such as mortality rates). Additionally, other outcome indicators such as the percentage of children malnourished or the percentage of homes with access to clean water, while only partial expressions of the overall health situation, are relatively easy to collect in special surveys and prove very useful for monitoring of humanitarian conditions. By contrast, a small increase in risk of death, which is a rare event even at relatively high rates, is far more difficult to establish accurately.

If an outcome indicator concerning the health of young children is desired it is better to focus on under-five mortality than under one-year old mortality. Mortality among under one-year olds can be modified by a number of selected interventions; mortality among under fives provides a more accurate indicator of overall health and well-being.

Special surveys may provide high quality information by assuring comprehensive coverage or a representative sample in a small population. By contrast, national systems for recording reportable diseases or deaths may suffer biases, omissions and errors. Interpretation of such data from national ministries of health requires detailed knowledge of the quality of information systems. In Cuba, for example, the quality of information systems, already good prior to 1992, have been strengthened further. Every provincial ministry of health office forwards information on deaths and reportable diseases via fax and phone to the national office at least once a week. In Iraq information systems are greatly deteriorated. Where much of the system had been computerised prior to sanctions, a lack even of paper has reduced reporting to the use of odd scraps of paper, the backs of old charts, and package inserts from pharmaceuticals. Added to this, the decreasing proportion of cases being seen at public hospitals and clinics means that direct interpretation of this data is nearly impossible.

## Weaknesses in Current Monitoring/ Survey Practices

Special studies on health and well-being in Haiti, Cuba, and Iraq have often been one-time affairs, providing interesting information but unable to elucidate trends or causation over time. In future sanctions research, plans should be made for continuous or repeated surveys whenever possible. In Iraq, national level household demographic and nutrition surveys were carried out every five years (1983, 1988, 1993). Questions on sources and levels of income, family formation, and child bearing provide variables to monitor over time in order to identify changes affecting peoples' lives. The last such survey was done in 1993; the Iraqi government has accepted in principle a plan to carry out another such survey, but awaits international funding to do so.

Information sources are often not specified adequately in reports on sanctions. Was the data from national routine reporting systems? If so, what is the estimated level of coverage of the system? How has the utilisation of services grown or shrunk? Are vulnerable groups more or less likely to use these services in recent years?

Did the information come from a survey? If so, how was the sample selected? How large was it? Who was excluded from the sample? Were any procedures used to make the sample representative of a larger population? If so, what were they? To simply describe the sample as 'random' is not convincing that the researchers did, or even know, what randomisation is. Very often, for example, some systematic procedure is used to select a sample. This may be the best procedure in a given situation, but it is not then random and has implications for generalising about the results. How many potential participants in the survey refused or were excluded from it? Were any checks used to determine how the sample differed from the general population? What is the statistical confidence interval?

It is especially important to specify methodology when collaborative studies between international researchers, NGO representatives, and national authorities in embargoed countries are undertaken. Did internationals take part in supervision of field workers or in-country data analysis? Were individuals fluent in the local language? Were checks of any kind used to confirm or correct the data collected? How and by whom were field staff trained? Were staff observed in the field? Were there any checks to determine logical inconsistencies in the information generated? How were questions asked? Were possible biases considered in the design of the project? If so, how were they dealt with?

Results are often not reported in reliable ways. Where multiple sources provide different estimates, differences between them can be reported and compared to provide an indication of the level of confidence that exists with the data. Most reports of damages seek to state a maximum number of events, such as 'more than 1 million deaths'. If we calculate with precision how many deaths occurred, we should specify it as, say, 1.2 million. But such numbers are often exaggerated guesses or projections. A conservative estimate is often more relevant, specific, and clear, for example 'at least 300,000 excess deaths have been recorded'.

Humanitarian agencies with on-the-ground assistance programmes represent a great potential, but under-utilised, resource for assessing humanitarian conditions. Their information is often qualitative; such information can be systematised and compared to those of other agencies and to quantitative data to contribute to an overall assessment. It will be important to develop skills, standardised procedures, and co-ordination among the many small and large agencies in order to contribute to these assessments.

In Iraq, for example, more than 40 nutritional assessments were carried out by international investigators during the 1990s. With the exception of four of these assessments the data were not comparable due to different measurement approaches, age groups included, or sample selection method used. Advanced co-ordination among agencies and investigators could have greatly increased comparability of the data and improved the contribution of each small study to the overall picture of malnutrition over time. Similarly, although hundreds of individuals and groups have visited Iraqi hospitals over the past decade, only one group used a list of standard questions and observation goals to set a baseline level for comparisons (Garfield *et al*, 1997). With minor coordination the others could have done the same, thus contributing to an identification of changing trends and conditions around the country during sanctions. Instead, the qualitative and non-systematic impressions of observers have contributed little to an overall assessment of hospitals and their conditions.

National authorities are often unaware of externally initiated assessments and are, in any case, either lacking in expertise to advise on these studies or too busy running a national system of care to focus on the topic. It thus falls to international investigators not only to try to 'do something useful' in a humanitarian crisis but to define priority populations for assessment of vulnerability, and coordinate and discuss their efforts with one another and with national authorities to assure that they make a useful contribution. Given the problems of methodology in assessing sanctions, comparisons over time, between population groups, or among regions should be encouraged. At the same time internationals can identify the weaknesses of national institutions and focus on strengthening national research and assessment capacity.

But information, even when generated in valid ways, does not speak for itself. NGO representatives and international investigators should present the results of their research to appropriate national technical authorities to make more credible, in-depth interpretations of what the data means. This process facilitates the combination of qualitative and quantitative information in summarising the 'big picture'. Internationals also may also be in a position to encourage non-traditional players in humanitarian assessments. These may include government groups not usually considered humanitarian, such as ministries of energy and transportation, national students in higher education in planning or sociology, or students from foreign institutions who can do thesis research on relevant local topics.

International personnel also have a key role to play in terms of strengthening national capacity to carry out studies to assess humanitarian conditions. In each sanctioned country respected researchers and their institutions should be identified, provided with technical support to prevent isolation, and supported in a politically neutral way to expand their research and monitoring efforts. No such groups were identified in Haiti. Several private research institutes in addition to the '[Epidemiologic] Analysis Unit' in Cuba have served a key function, with some international involvement. The major Iraqi institutions capable of these activities – the Central Statistical Organisation and the National Nutrition Research Institute, and the Statistical Office of the Ministry of Health – received no international support prior to 1995 and have had little support since.

## Future Humanitarian Assessments

Case study analysis indicates that vulnerability should be assessed rather than assumed. Although women and children constitute a vulnerable group, they may not be the only one, or the most vulnerable one. This paper has pointed at the chronically ill and the elderly as other groups that suffer disproportionately from declining healthcare under trade sanctions, and there may be other socio-political or socio-economic groups that are marginalised and highly vulnerable. Second, clinical medical data is a necessary but insufficient measure of the impact of embargoes. There is a need to combine macroeconomic data, with meso-level information and micro-level household data. Comprehensive trade embargoes cause severe disruption to the economy as a whole. These economic disruptions, and the coping strategies that people develop in response, affect the overall well-being of a population and can affect social changes that will outlive the existence of the sanctions regime.

Although a narrow focus on clinical medical issues provides a sense of objectivity sorely lacking in the politicised atmosphere of sanctions issues, it misses many key humanitarian issues. Future assessments should focus more on the 'well-being' aspect of 'health and well-being'. Among children this includes research on changes in mental capacity, educational achievement and access to learning materials among those in school, and employment and survival strategies among those not in school. Changes in learning and employment opportunities in higher education and in-service training should similarly be explored. Changing types and levels of delinquency and familial and governmental responses should be studied. Changing patterns and levels of family formation, family functioning, and family-related social pathologies should be identified. The changing knowledge and practice base of professionals, cut off from routine international exchange, should also be identified. We should learn more about the nutritional status of older children and adults along with that of younger children, and pursue research to identify the pathways by which changes occur. Changing patterns of resource generation and utilisation, including both formal (money) and informal (unpaid labour) resources should be identified. These measures of well-being will assist in identifying effective coping strategies, existing strengths in a society, and opportunities for relief and reconstruction.

The excessive prejudice among the press and researchers toward medical expressions of sanctions' effects has tended to lead to an undervaluing of qualitative information on how people live and use the limited resources available. Combining both will assist in elucidating the chain of events leading to humanitarian damage, resilience, and mitigating and modifying factors. To do so will require insights and measures not only from clinical medicine but also from demography, sociology, economics, anthropology and psychology.

**Mitigating Humanitarian Damage**

In a decade of debate about the relative merits of sanctions, a systematic approach to assess and minimise their humanitarian impact has been critically lacking. After the debacle of Iraq, where there have been many more sanctions-related deaths than death resulting from the Gulf War, the world community can no longer assume that sanctions are a less violent approach. In order to reduce damage the following should be considered:

- Prior to initiating sanctions, baseline data on health and well-being should be gathered as well as information on the likely impact of sanctions. This was done in the case of Sudan and resulted in the indefinite postponement of a flight ban. Notably, it was the example of several hundred patients who would lose routine access to air transport for specialised cancer treatment in other countries each year – such as Jordan – that convinced the UN General Assembly that humanitarian damage would result from such a ban.

- Anticipate likely vulnerabilities of the target society and respond proactively via aid and development agencies to ameliorate them. Vulnerability may be based on physiological status (such as young children and immunisations, elderly and medicines for chronic disease), social position (such as the role of women), political/religious/or ethnic group status (such as minority groups). It is essential to determine the likely level of suffering to assess if such damage can be ameliorated pro-actively. For example, the loss of mango sales by Haitian peasants and loss of the vaccine cold chain due to the fuel embargo could have been anticipated and prevented with specific exemptions or humanitarian aid.

- Put in place a stepped-up monitoring capacity from day one of sanctions to facilitate the early identification of deteriorating well-being. Monitoring should include at least indicators of public health, economic status, population dynamics, and governance in sanctioned countries (see Table 6). It should also include indicators of baseline population status (that is, levels of social indicators at

the time sanctions are instituted), as well as related measures of short-term change. For example, under one-year old and under five-year old deaths are good baseline indicators, but short-term changes in mortality rates can be assessed better on the basis of data on the number of measles cases, the percentage of all deaths due to diarrhoea, or the changing prevalence of malnutrition among children. Similarly, while baseline information on school attendance and educational achievement are key, short-term changes in the number of schools with good roofs and walls or with chalk board and books would be more effective indicators for on-going monitoring.

- Create streamlined procedures to speed up the approval of essential humanitarian goods. This could involve both a standard list of exempt items and blanket exemptions for a select group of international relief organisations. This should also involve the empowerment of a technical group to specify what goods are essential, what goods are unambiguously humanitarian, and which have a credible potential for dual use. In most sanctions regimes it is not technical experts but politicians who define how to handle a given exemption request. While the desire of politicians to control matters is understandable, the result has been greater confusion among potential supply companies, delays in decision-making, and the politicisation of humanitarian assistance. Tragic examples include the denial of purchasing rights for spare parts for breast X-ray equipment for Cuba for the stated reason of the potential for 'medical terrorism'[sic] and the denial of permits to import nitro-glycerine paste for Iraqi angina patients due to the mistaken belief that the medicine had a potential application in building bombs.

- Standardise procedures used in sanctioned countries for handling exemptions requests, distribution of goods, and on-site verification so as to reduce the politicisation of humanitarian exemption procedures.

- Acknowledge that infrastructure, including water and sanitation systems, information systems for health services administration, laboratory equipment and reagents, and energy sources (that is, electricity and petrol) may be essential components for an effective humanitarian assistance programme. As almost any item can arguably be used for commercial or military use rather than humanitarian purposes, careful definitions and principles must be developed to avoid subjective and shifting interpretations by embargoing powers.

**Table 6: Recommended Minimum Monitoring Indicators for Sanctions**

| Category | Baseline Indicators | Change Indicators |
|---|---|---|
| **Public Health** | Infant Mortality | • Increase in infant deaths as reported by hospitals and in vital events recording systems |
| | Hospital and Medical | • Decrease in numbers of operations and X-rays performed |
| | System Capacity | • Diminished availability of vaccines<br>• Reduced number of visits to health system |
| | Low Birth Weight | • Rise in reported percentage of low weight infants<br>• Rise in number of pregnant women with low weight gain |
| | Access to Safe Drinking Water | • Decline in percentage of population receiving pumped water<br>• Breakdowns in the availability of chlorine |
| **Economic Conditions** | Level of Economic Development (as measured by GDP/capita)<br>Dependence on Imports and Exports | • Changes in income distribution across different income groups<br>• Declining availability /rising market price of foodstuffs<br>• Declining availability/rising price of pharmaceuticals |
| | Form of Economic Specialisation | • Change in urban/rural population mix |
| **Migration** | Presence of Refugee Camps and Populations of Displaced Persons | • Increase in involuntary migration<br>• Start of new migratory population flows<br>• Creation or rapid expansion of refugee camps and/or concentrations of internally displaced persons (IDPs) |
| **Governance and Civil Society** | Status of Civil Society | • Changes in government budgetary allocations<br>• Increases in crime and civil unrest<br>• Decline in number of independent civic organisations |
| | Degree of Political Freedom | • Suppression of political parties<br>• Decline in number of independent media outlets<br>• Increasing number of political arrests |
| **Humanitarian Activities** | Level of Humanitarian Activity | • Change in ratio of people served by aid programmes relative to the people making demands on those services<br>• Decline in the ability of humanitarian agencies to perform services |

*Source*: Minear *et al*, 1998.

**Table 7: Indicators of Health and Well-being**

| |
|---|
| ***Nutrition*** |
| · % of under five-year olds undernourished (weight-for-age, height-for-age, and/or weight-for-height)<br>· % of low weight births<br>· % of under one- or under two-year olds breast fed<br>· average number of calories provided by ration per day<br>· average duration of rationed food in households per month<br>· average number of times meat eaten per month<br>· % of disposable income spent on food<br>· % of adolescents, adults, or elderly with low body mass index |
| ***Sanitation/Water*** |
| · number of liters of water delivered per capita per day<br>· number of households with piped water access<br>· % of water sources contaminated<br>· % of clean water treatment facilities without chlorine<br>· capacity of clean water treatment<br>· capacity of waste water treatment |
| ***Hospitals*** |
| · no of doctors and nurses per population<br>· medical visits per population<br>· hospitals and health centres in operation<br>· hospitalisations, lab exams, X-rays, and operations performed per population;<br>· deaths registered in hospitals<br>· cases of gastrointestinal diseases or acute respiratory illnesses diagnosed and treated<br>· presence or absence of key medicines |
| ***Education*** |
| · % of school aged population attending school<br>· % of schools with books or other supplies<br>· % of students passing exams |
| ***Infrastructure*** |
| · number of houses deteriorated or destroyed<br>· energy generating capacity · number of power cuts |
| ***Social Welfare*** |
| · % of population in poverty or extreme poverty<br>· number of minors incarcerated<br>· number of minors working, out of school, or living without families<br>· % of population disabled<br>· changes in the frequency of murders, assaults, or other interpersonal violence<br>· persons per household<br>· frequency of changes in household composition<br>· changes in depression, coping methods, behavioural changes |
| ***Economy*** |
| · Gross National Product per capita<br>· average household income<br>· households below poverty level<br>· purchasing power of average salary or minimum salary |

**Table 8: Guidelines for Good Practice in Assessing the Impacts of Sanctions**

- Establish baseline and change indicators for monitoring humanitarian conditions.
- Identify relevant comparison groups within or outside the country.
- Identify not only outcomes of interest, but also sources of information on inputs and process, including coping strategies.
- Assess the quality of information systems used, including changes in coverage and data collection and reporting capacity.
- Identify biases in routine information sources.
- Specify not only how many cases are found, but the number of people in the population from which the cases come if the population is changing in size.
- Focus not so much on possible changes in infant mortality but focus on deaths or non-mortal changes in other age groups and vulnerable populations.
- Provide not only the estimated number of events, but explain why that estimate is likely to be the best, and how much range there is among other estimates.
- Provide and combine qualitative and quantitative information.
- Avoid over generalisations of results from a small study to a large national population.
- Coordinate and combine information from small studies by standardising and describing how theinformation was collected.
- Involve relevant national participants and NGOs in studies.
- Collect information that can be compared over time.

# 5

# Conclusions

Following a war, the winning powers often administer governmental administration in the vanquished country. Under sanctions, the 'enemy' power remains in control. In such a situation there has been a tendency to use the provision of humanitarian goods to further intervene in the country's politics. The UN, for example, insisted on establishing and supervising the regulations for distribution of humanitarian goods provided via the OFF programme in Iraq. While this is necessary to administering the relief programme, Security Council rejections of Iraqi purchase requests have sometimes expressed political or commercial interests rather than humanitarian concerns. In Cuba, the US insists that it carry out on-ground supervision of the distribution of humanitarian goods from private US groups. Charitable goods were permitted only after the US and Cuban authorities worked out arrangements for supervision by more neutral third parties.

Sanctioned governments rail against such interventions by embargoing powers as violations of their national sovereignty. In the case of Iraq, this politicisation and fear of intervention in the country's internal policies were major reasons for the six-year delay in initiating the OFF programme.

Trade sanctions which have the greatest impact on the health of the general population are those which are multilateral and comprehensive, occur in countries with heavy import dependence, are implemented rapidly, and occur along with other economic and social blows to a country. Iraq has all these characteristics, and is thus especially vulnerable. Haiti is characterised by the deep disruptions which occurred among families both during and after sanctions. During this period the US aggressively tried to replace essential goods with humanitarian assistance; no other sanctioned country has received as much as a third of lost income in humanitarian assistance and it is thus a sobering thought that Haiti has not yet recovered. Indeed, years after sanctions ended economic, social and political processes catalysed by sanctions appear to be deepening into a more permanent crisis.

On the other hand it has been shown that, for example, infant mortality has declined in some embargoed countries even during periods of severe resource shortages (Garfield, 1992). This occurs when scarce resources are distributed more efficiently, health and national leaders mobilise child health actions, and when the social and political emergency moves parents to special actions. Cuba, for example, moved from about half to more than 90 per cent breast feeding during the first three months of sanctions when leaders promoted breast feeding to make up for lost formula imports. Similarly, a campaign to boil water before drinking gained support when it was broadcast that the embargo resulted in a lack of chlorine to treat water supplies. In other countries, campaigns promoting growth monitoring of children and pregnant women, vaccinations, the promotion of herbal medicines, and community participation in peri-domestic sanitation to reduce malaria and dengue transmission have been successful under the special conditions of externally-imposed resources shortage caused by embargoes. In Iraq, the development of community-based child

nutrition and community development programmes have been stimulated in recent years. Of course all of these basic health measures would have been beneficial prior to the embargo but were stimulated by a collective sense of emergency and the recognition of an opportunity to respond. Political scientists argue that embargoes can be counter-productive when a population 'rallies round the flag' to identify with the nation's leaders in the presence of a foreign threat. This social solidarity can, however, be built on by humanitarians to stimulate locally integrated development and health activities that can benefit a country long after the embargo has ended. To do so, NGOs must develop close working relations with nationals working in humanitarian affairs and recognise a country's and a people's strengths and resources, even when new weaknesses and disadvantages arise. Such forward looking approaches require creativity, leadership. Awareness of a decline in importing capacity is often acute during sanctions; recognition and utilisation of existent valuable human and material resources is often less apparent.

The objectives of a trade sanctions regime should be better determined in the light of the extensive experience in the 1990s. Sanctions are seldom associated with a hoped-for overthrow of repressive regimes; military action is needed for that. Policies of 'containment' or isolation of a nation under the guise of attempts to overthrow a pariah government may be a form of collective punishment, illegal and abhorrent under both international and customary law. When a few individuals are at fault, asset freezes, halting of cultural exchanges and travel bans may result in the desired policy changes.

There is currently a great hope that such targeted sanctions will avoid the major humanitarian impacts described above while affecting the offending policies of the sanctioned regime more effectively. More targeted sanctions can indeed improve compliance with the principles of differentiation and proportionality, but will likely still cause humanitarian damage when targeting is not precise, when elites respond by punishing other nationals, or when capital shortages occur in an unstable political environment. Thus, improved monitoring, expanded humanitarian action, and the modification of national policies to protect the most vulnerable with simple low cost public health actions will still be needed to reduce humanitarian damage and to speed recovery.

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# RRN

## Background

The Relief and Rehabilitation Network was conceived in 1993 and launched in 1994 as a mechanism for professional information exchange in the expanding field of humanitarian aid. The need for such a mechanism was identified in the course of research undertaken by the Overseas Development Institute (ODI) on the changing role of NGOs in relief and rehabilitation operations, and was developed in consultation with other Networks operated within ODI. Since April 1994 the RRN has produced publications in three different formats, in French and English: Good Practice Reviews, Network Papers and Newsletters. The RRN is now in its second three-year phase (1996-1999), supported by four new donors – DANIDA, SIDA (Sweden), the Department of Foreign Affairs (Ireland), and the Department for International Development (UK). Over the three year phase, the RRN will seek to expand its reach and relevance amongst humanitarian agency personnel and to further promote good practice.

## Objective

To improve aid policy and practice as it is applied in complex political emergencies.

## Purpose

To contribute to individual and institutional learning by encouraging the exchange and dissemination of information relevant to the professional development of those engaged in the provision of humanitarian assistance.

## Activities

To commission, publish and disseminate analysis and reflection on issues of good practice in policy and programming in humanitarian operations, primarily in the form of written publications, in both French and English.

## Target audience

Individuals and organisations actively engaged in the provision of humanitarian assistance at national and international, field-based and head office level in the 'North' and 'South'.

The Relief and Rehabilitation Network is supported by:

Ministry of Foreign Affairs
DANIDA

Sida

DFID

Department of Foreign Affairs,
Ireland