Health impact assessment of foreign and security policy: A critical analysis

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1. Introduction

There has been little health impact assessment (HIA) of foreign policy to date. Foreign policy analysis has traditionally not considered social impacts of actions taken in the national interest; nor, despite certain exceptions, has HIA been widely applied to foreign policy (Kemm, Parry and Palmer, 2004; Lock, 2005). However, foreign policy has clear and demonstrable effects on health, and these have become increasingly debated and contested in recent years. This makes explicit consideration of how HIA may be applied to foreign policy timely.

This paper does not aim to show that foreign policy has health impacts (although some illustrative vignettes are presented). This has been done in numerous studies. The aim of this paper is to further the development of HIA of foreign policy by presenting a general conceptualisation and discussion. For Sukkumnoed and Al-Wahaibi (2005) (cited in Lee, 2005, p.4), HIA is an idea and tool for achieving healthy public policy, which aims:

«to put health on the agenda of policy-makers in all sectors and at all levels, so they are aware of the health consequences of their decisions, accept their responsibilities for health and strengthen their links with the health sector on relevant issues.»

The overarching purpose, then, is to consider how HIA may add value to these broader goals. This is important, because, as Labonte and Spiegel (2003, p.723) suggest, ‘Global health research outside a context in which policy makers, civil society, and the media are engaged risks generating more knowledge but little action’. The key points of this report are that the main contribution of HIA lies in its potential for such engagement via the application of structured and systematic procedures to the assessment of health impacts, and that while foreign policy presents a number of distinct challenges for HIA, these can be addressed meaningfully. Despite the apparent rise of non-state actors in foreign policy, states retain special roles and responsibilities. The analysis is therefore state-centric. In keeping with the UK global health programme, UK foreign policy represents one key point of departure.

The paper was produced in a number of stages. First, the key dimensions of health and key principles of health impact assessment were considered. Second, the nature of foreign policy was conceptualised through a review of foreign policy documents and academic literature. Third, a search for studies relevant to the health impact assessment of foreign policy was conducted using internet search tools and academic bibliographies. Publications were then
reviewed, and examples and ideas of particular importance identified. Fourth, following the recommendation of Labonte and Torgerson (2002) the main relationships were conceptualised graphically.

The paper begins by outlining what is involved in the health impact assessment of foreign policy, summarising its grounding in human rights and international humanitarian law, and elaborating the concepts of foreign policy and health. Health impact assessment is then considered in relation to two key, and often over-riding, foreign policy fields that are of particular significance for health: economics and security. Here, literature is reviewed to identify and develop frameworks that can be used to assist in the screening, scoping and appraisal stages of HIA. In the case of foreign economic policy, the paper is able to draw on extensive synthetic research examining the health impacts of globalisation. In the case of security policies, a small group of studies that have attempted to assess the potential health impacts of recent cases of the use of force are considered to generate a schematic analytical framework. Further synthetic work would enable the development of this area. Third, how HIA can feed into foreign policy processes is discussed, with particular reference to issues of participation and reporting to policy makers.

2. The grounding for HIA of foreign policy

Foreign policy can be conceptualised simply as the collective actions taken by a government to manage relations with the outside world. It is therefore an official enterprise, undertaken in the name of national interests. The World Health Organisation (WHO) defines health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’, and situates it in the context of a wider web of determinants. The intersectoral nature of health has been affirmed many times (Ritsatakis, 2004). HIA is predicated on the notion that many causes of ill health and disease lie outside the reach of health systems; therefore to improve health concerted action is required not just within health systems, but across a range of sectors, and particularly those that affect health the most. HIA is defined by the World Health Organisation as:

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\text{a combination of procedures, methods, and tools by which a policy, programme, or plan may be judged as to its potential effects on the health of population and the distribution of those effects within the population (cited in Lock, 2005, p.1).}
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HIA can influence decision makers in four ways (Lock, 2005, p.2):

1. By raising awareness among decision-makers of the relationship between health and other factors such as the physical, social and economic environment, so that they consider health effects in planning;

2. By helping decision-makers identify and assess the potential impact of a specific proposal on population health and wellbeing, and on the distribution of those effects within the population (i.e. issues of equity by considering health inequalities or the impact on specific vulnerable groups);

3. By identifying practical ways to improve and optimise the outcome of proposals, by producing a set of evidence-based recommendations that feed into the decision-making process;
The ultimate purpose of HIA is to inform and influence subsequent decision-making. HIA is not merely a research tool, it is a political tool to aid decision-makers (Lock, 2005, p.2). HIA is therefore located firmly within the scientific study of health, but with overlaps into governance processes. It is also grounded in a broad view of health, which sees its determinants as lying in a wide range of sectors, including public policy, socio-economic status, and the provision of and access to public services.

To summarise, the health impact assessment of foreign policy therefore involves the judgement of the potential effects on health of collective actions taken by states to manage relations with the outside world, with the goal of informing and influencing decision-makers about how to improve both health and foreign policy.

The case for HIA of foreign policy is underpinned by affirmations of human rights in international declarations, notably the Universal Declaration of Human Rights and UN International Covenant on Economic, Social and Cultural Rights (Labonte, 2004). A number of states also declare their support for human rights in their foreign policy documents (Bush, 2002; Foreign and Commonwealth Office, 2003). Additional support in the case of conflict comes from international humanitarian law. The WHO notes that 'Every country in the world is now party to at least one human rights treaty that addresses health-related rights, including the right to health and a number of rights related to conditions necessary for health' (WHO, 2005a), and the preamble to the Constitution of the WHO states that 'The enjoyment of the highest attainable standard of health is one of the fundamental human rights of any human being' (WHO, 1948). In this context, the right to health is judiciable and applies both to healthcare and underlying determinants, such as access to safe and potable water and adequate sanitation, healthy environments, and access to health education (Labonte, 2004).

In addition, there is a sense that foreign policies are affecting the everyday lives of increasing numbers of people and places as a result of economic globalisation (see Box 1). On this point, Millen et al (2000, p.388) argue that assessing impacts on the health of poor people would be an effective way to narrow the gap between economic theories and their practical consequences. Similarly, Woodward et al (2001, p.875) argue:

> the design and implementation of international rules need to take full account of their potential effects on the health care system and health related sectors. This implies the need for a full health impact assessment of international agreements and measures that may have significant effects on health related sectors, whether directly (e.g. through constraints or influences on sectoral policies) or indirectly (e.g. through the availability of resources and input costs), before they are implemented.

It has also been argued that globalisation is tightening the epidemiological community of fate between rich and poor (Farmer, 2001; Garrett, 2001). From this perspective, HIA of foreign policy is a rational counterpart to epidemiological globalisation. Given the increasing salience of health in foreign policy, widely-raised claims about the role of health in contributing to economic development and social stability, and the need to think more deeply about the nature of security, foreign policy practitioners may conclude that HIA is an increasingly relevant tool for improving their own policy making.
Foreign policy

Foreign policy conventionally refers to the conduct of external or international relations by states, i.e. ‘The activity whereby state actors act, react and interact’ (Evans and Newnham, 1998, p.179). From a realist perspective, this activity typically involves the pursuit of power and interests in the fields of economics and security, in the sense of threats to state sovereignty and national interests (Fidler, 2005). While states are not sole actors in the formation and conduct of foreign policy, they tend to occupy a privileged position as coordinators, enforcers and legitimators by virtue of their coercive, legislative, diplomatic, extractive and ideological capabilities. Policy is considered here, then, as the formulation and execution of particular courses of action by elected office holders and public officials. This process necessarily involves prioritisation, and deciding between competing priorities in limited time horizons with imperfect information.

Primary concerns with economics and security are reflected in the UK Foreign and Commonwealth Office’s (FCO) White Paper (FCO, 2003). Each of the FCO’s eight strategic policy priorities involves economics or security in some way (Box 2).

At the most schematic level, then, foreign policy activities can be grouped under two broad headings: economics and security. Both have implications for health and both involve flows across political borders. Commitments to human rights and sustainable development, which are in theory applicable to all the fields listed, in practice figure more or less prominently in each. HIA can therefore complement human rights and environmental impact assessment of foreign policy.

Box 1: Illustrations of health impacts of foreign policy

1. In rural China, high school student Zheng Qingming kills himself by jumping in front of a train. Friends say it was because he couldn’t afford the last US$ 80 of school tuition fees, which meant he could not take the college admission test. The overall annual tuition is more than the average village family in his region earns in a year. Health care, like education, has become scarce and expensive since China embraced the market economy, and his grandfather had already spent the family savings on treating a lung disease.

2. In Zambia, Chileshe waits painfully to die from AIDS. The global funds and antiretroviral programmes are too little and too late for her. She was infected by her now dead husband, who once worked in a textile plant along with thousands of others but lost his job when Zambia opened its borders to cheap, second-hand clothing. He moved to the city as a street vendor, selling cast-offs or donations from wealthier countries. He would get drunk and trade money for sex – often with women whose own husbands were somewhere else working, or dead, and who themselves desperately needed money for their children.

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1. This paper borrows insights from critical realism. In common with realists, material concerns with power and interests in the fields of economics and security are taken to exert powerful and often over-riding imperatives on the behaviour of states. However critical realism also involves the insight that power and interests are not all-determining or eternal, or necessarily perceived in rational or coherent ways, though policies may exhibit a certain logic. In other words foreign policy is an open system.
3. In northern Mexico, a young girl named Antonia is suffering from severe asthma. She is falling far behind in school. Her parents don’t have enough money to pay for specialists or medicines, and wonder whether her problems are connected to the industrial haze and foulsmelling water that come from the nearby factory. They can’t afford to move. All their savings were used up when corn prices plunged after the border opened to imports from the US, and it is not clear how they would make a living. How could so much corn grow so cheaply, her father Miguel used to wonder.

4. In a Canadian suburb, two people die when a delivery van swerves into oncoming traffic and slams into their car. The van driver, Tom, survives. He either fell asleep at the wheel or suffered a mild heart attack. No one knows, and he cannot remember. It was his 15th day of work without a rest. When the assembly plant where he once worked relocated to Mexico, driving the van became one of his three part-time jobs, at just over minimum wage and with no benefits. He alternated afternoon shifts at two fast food outlets, did early night shifts at a gas station and drove the van late nights as often as the company needed him. With the recession over, they had needed him a lot lately.

5. In Iraq, the number of traumatic injuries from shooting has increased greatly since the war, according to reports from major hospitals in the centre/south … The future burden of disability from traumatic injuries will inevitably rise as conflict continues. There are an estimated 10 million landmines and explosive remnants of war in north Iraq alone that could take up to 15 years to clear … Security problems restrict demining and removal of ordnance in central and south Iraq, where urban and rural populations face increased risk from munitions storage containers, explosive ordnance, mines and cluster munitions used during the war, though the extent of the problem is unknown.

Note: Example 1 is a real case cited in Labonte, Schrecker and Sen Gupta (2005). Examples 2-4 are composites, presented by the same authors, based on numerous other studies. 5 is an extract from Medact (2004).

Box 2: UK Strategic Policy Priorities (FCO, 2003, p.30)
- a world safer from global terrorism and weapons of mass destruction
- protection of the UK from illegal immigration, drug trafficking and other international crime
- an international system based on the rule of law, which is better able to resolve disputes and prevent conflicts
- an effective EU in a secure neighbourhood
- promotion of UK economic interests in an open and expanding global economy
- sustainable development, underpinned by democracy, good governance, and human rights
- security of UK and global energy supplies
- security and good governance of the UK’s overseas territories
Health

Health can be thought of here in terms of four related dimensions, whereby the determinants of health, equity and health services contribute to health outcomes. Outcomes relate to the manifold experiences of wellbeing, morbidity and mortality, which can be assessed using a variety of methods depending on the scale under consideration. The term outcome also signals that health is thought of as being the result of processes. This links to the idea that health is influenced by social determinants, a term that while defined differently by different authors, tends to refer to a recurring core group of phenomena, in particular poverty, income inequality and environmental conditions (Box 3).

**Box 3: Determinants of health**

*Dahlgren and Whitehead* (1991)
- age, sex and hereditary factors
- individual lifestyle factors
- social and community influences
- living and working conditions
- general socioeconomic, cultural and environmental conditions

- the social gradient (between rich and poor)
- stress
- early life
- social exclusion
- work
- unemployment
- social support
- addiction
- food
- transport

*Lock* (2005)
- Pre-conceptual/in utero
- Behavioural/lifestyle
- Psycho-social environment
- Physical environment
- Socio-economic status
- Provision of and access to public services
- Public policy
- Trans-border and global policy issues

*WHO* (2002a, 2002b)
- Violence
In addition to those factors listed, the WHO has specifically recognised violence (defined as 'The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation', WHO, 2002a, p.5) as a leading public health problem worldwide, and called for a shift towards violence prevention strategies (WHO, 2002b, WHA49.25).

Equity is further important dimension of health. For the WHO (2005b):

\[ \textit{Equity is the absence of avoidable or remediable differences among populations or groups defined socially, economically, demographically, or geographically; thus, health inequities involve more than inequality—whether in health determinants or outcomes, or in access to the resources needed to improve and maintain health—but also a failure to avoid or overcome such inequality that infringes human rights norms or is otherwise unfair.} \]

The reference to resources needed to improve and maintain health signals, finally, that access to health services, \textit{inter alia}, is an essential part of health. Implicit in these frameworks is the basic insight that the distribution of power shapes each of these dimensions of health. Labonte and Torgerson (2002) advocate making power (in relation to gender, race and migration) an explicit component of frameworks analysing the health impacts of globalization.

Health outcomes can also be thought of in terms of levels of causation (Figure 1). The purpose of this figure is, first, to illustrate the multiple and complex causes of health outcomes. Second, it indicates that a narrow focus only on biomedical outcomes may obscure the role of deeper social processes and structures in generating patterns of outcomes overall (Farmer, 2001; O’Manique, 2004). This approach to public health has some affinities with critical realism in the social sciences, which sees events arising from underlying structures and processes. Different disciplines (biomedicine, public health, political economy, anthropology, political science, international relations, history, geography) and methods (qualitative, quantitative) may reveal different parts of this complex reality; HIA therefore may involve multiple approaches to build up a richer picture than would be possible from just one perspective.

Finally, there is the problem of complexity potentially descending into chaos. If the field under study involves complex webs of causation, how is it possible to attribute reliably causes and effects? This issue may be addressed on three levels. First, it points to the prime need for rigorous application of research methods, to the highest intellectual standards. However, philosophical or normative differences may lead to different health impact assessments that may not necessarily be solved by appeals to rigour alone; parties may not accept certain accounts of causation. Second, then, reference can be made to clear international standards about responsibilities for respecting and realising human rights. For example, the laws of war attribute particular responsibility for occupied territories to the occupying power; during conflict, certain responsibilities are incumbent upon belligerent parties. Third, differences of analysis and interpretation can only be adequately addressed in open and democratic political cultures and processes. This represents the ultimate context for considering competing claims.
Figure 1: Levels of causation of health outcomes (after Medact, 2002, p.6)
3. Assessing the health impacts of foreign economic policy

Globalisation (or transnational economic integration) forms the main context for the formulation of foreign economic policy; according to the FCO strategy the stated goal of the UK in this sphere is: ‘Promotion of UK interests in an expanding global economy’. Official international development policy can be seen as lying largely within this field, given the extent to which increased participation in the global economy is taken as an axiomatic part of development itself (Blair, 2000; Rist, 2002).

The debate on globalisation and health has been polarised by the nature of some interventions. For example, a reading of reductive econometric studies based on aggregate multi-country analysis led one advocate for neoliberal globalisation to assert:

In summary, globalisation, economic growth, and improvements in health go hand in hand. Economic growth is good for the incomes of the poor, and what is good for the incomes of the poor is good for the health of the poor. Globalisation is a key component of economic growth. Openness to trade and the inflow of capital, technology, and ideas are essential for sustained economic growth (Feachem, 2001, p.504)

This is significantly at odds with much, if not most, other scholarship on these relationships in other fields, and studies that take a more grounded and contextual approach, or, in other words, analyse the specific health effects of specific policies in particular places. Responding to Feachem’s intervention, Lee et al (2001) refer to a ‘complex web of cause and effect’. As Labonte and Torgerson (2002, p.4) recognise, ‘the links between globalization and health (or environment) are complex, contingent and often indirect’. And for Huynen, Martens and Hilderink (2005), population health is characterised by ‘complex multi-causality’. This underlines the need for health impact assessment to be sensitive to context, and suspicious of ahistorical and aspatial abstraction, as well as empirically rigorous and undertaken within clear analytical frameworks.

The failings of neoliberalism led to a major debate during the 1990s about the extent to which the ‘Washington Consensus’ represented an adequate template for economic growth and poverty reduction (Maxwell, 2005; Kim et al, 2000). According to Birdsall et al (2005, p.145-146), ‘Almost all successful cases of development in the last 50 years have been based on creative – and often heterodox – policy innovations… Conversely, countries that have adhered more strictly to the orthodox structural reform agenda – most notably in Latin America – have fared less well’ (see also Chang, 2002). And Weisbrot et al (2001) argue across a range of development indicators that the period of neoliberal globalisation (1980-2000) delivered less rapid progress than the preceding 20 years. However, the policy consensus has been slow to catch up with findings such as these. As Perin and Attaran (2003, p.1217) note in relation to the dominant policy consensus, ‘aid donors spent the 1990s absorbed in how to run gutted health systems with the greatest managerial efficiency, while doing much less to restore the lost health services that could have saved lives’.

Following criticism of neoliberal economic strategies, poverty reduction was adopted by the World Bank and other major institutions as a second policy goal; however, poverty reduction is still seen within a neoliberal framework, that is, predicated upon market-led growth and increasing economic integration. While this can under certain circumstances lead to reduced poverty and improved health, this is by no means automatic, and is dependent on a range of
intervening variables. Even where it delivers growth and poverty reduction (themselves generalised concepts that need to be unpacked), market-led strategies can produce other undesirable health impacts.

Labonte and Torgerson (2002) provide the most comprehensive critical review of conceptual frameworks linking globalisation and health. Huynen, Martens and Hilderink (2005) claim to go beyond Labonte and Torgerson by recognising that links between globalisation and health are 'more complex' than do the latter. However, their framework in fact adds little further understanding of this complexity, and downplays the significance of power and of people as active agents shaping globalisation. Given the importance of power to foreign policy, and of agency in health impact assessment, the work of Labonte and Torgerson, and the study by Labonte et al (2004) which is in large part based on it, are taken as the main reference points here.

Reviewing criteria for 'good' frameworks, Labonte and Torgerson outline three models, of simplified, mid-level and high-level complexity linking globalisation and health (Figure 2). They state (p.8) that in this context a good framework:

… is one that is comprehensive, yet also layered so that it can also be simplified for policy and public communication purposes. It is supported by theory, empirical evidence or, at least argumentative text. The framework incorporates elements indicative of both positive and negative globalization/health effects. It identifies people as social actors, and the elements of differing levels of the framework accommodate an analysis of the social distribution and use of power, for instance, by incorporating gender and race as important analytical and conceptual elements. Most, if not all, elements have data available, or such data could be reasonably obtained. New elements lacking current data sources are only introduced because there is convincing theoretical argument supporting them.

The lack of data on any particular variable is not a sufficient reason to abandon or reject HIA; the principle is that HIA is undertaken with the best available data. Theoretical frameworks linking economic globalisation and health are useful in pointing to where relevant data can be sought.

The framework identifies multiple pathways and elements by which economic globalisation influences health. It is made up of interacting levels (super-ordinate categories and a series of global, domestic, community and household contexts) and categories (e.g. political systems, pre-existing endowments, macro-economic policies, policy capacities, geographic disparities and health, education and social expenditures). While the model is not exhaustive, it is capable of elaboration and adaptation to context, and provides a useful template for screening the potential effects of foreign economic policy on health. The paper also provides pointers to an extensive array of literature analysing and substantiating linkages between specific globalisation processes and health.

Drawing on this literature, it is possible to identify a wide range of foreign economic policies that have demonstrated health impacts. This framework provides a tool for screening, scoping and appraising the health impacts of foreign economic policies.
Box 4: Causal pathways linking globalisation and health (from Labonté et al, 2004, online)

1. How contemporary globalization affects health depends on the historical context of particular countries, specifically their political, social and economic traditions (e.g. democratic, oligarchic, patriarchal, theocratic, dictatorial); and their stock of pre-existing endowments (e.g. level of economic development, environmental resources, human capital development).

2. Globally, the major vehicles or processes through which contemporary globalization operates are imposed macroeconomic policies. One category consists of the Structural
Adjustment Programs (SAPS) of the World Bank and IMF, which were the precursors to and a key component of today’s ‘free trade’ agenda, and the more recent Poverty Reduction Strategy Papers (PRSP) program of the World Bank and IMF, required for debt relief and, increasingly, for development assistance. A second category consists of enforceable trade agreements (notably those administered by the WTO) and associated trans-border flows in goods, capital and services. Third, official development assistance represents a form of wealth transfer for public infrastructure development in poorer nations. Fourth, there are ‘intermediary global public goods’ – the numerous yet largely unenforceable multilateral agreements we have on human rights, environmental protection, women’s rights, children’s rights and so on.

3. These vehicles, in turn, have both positive and negative health effects on domestic policy space, by increasing or decreasing public sector capacity or resources and regulatory authority. Key domestic policies that condition health outcomes include universal access to education and health care, legislated human and labour rights, restrictions on health-damaging products, such as tobacco, or exposure to hazardous waste and environmental protection. Liberalization, whether through trade agreements or through SAPs, lowers tariffs on imported goods. This has been particularly hard on developing countries, which derive much of their national tax revenue from tariffs and which lack the capacity to institute alternative revenue-generating sources. This affects their abilities to provide the public health, education and water/sanitation services essential both to health and to economic development. Global and regional trade agreements, in turn, are increasingly circumscribing the social and environmental regulatory options of national governments.

4. National policies and resource transfers affect the abilities of regional or local governments to regulate their immediate environments, provide equitable access to health-promoting services, enhance generic community capacities (community empowerment) or cope with increased and usually increasingly rapid urbanization.

5. At the household level, all of the above determine in large measure family income and distribution (under conditions of poverty, for example, when women control household income, children’s health tends to be better), health behaviours and household expenditures (both in time and in money) for health, education and social programs.

In addition, each level affects, and is affected by, environmental pathways. Among the most important of these are resource depletion (water, land, forests), biodiversity loss, pollution, and the loss of ecosystem services such as the sequestration of carbon by forests.

4. Assessing the impacts of security policies

Where security policies involve the use of force the effects are on some levels simple, straightforward and predictable. However, even in the case of violence, many of the links between security policies and health are also complex, contingent and indirect. HIA of security policies therefore also needs to be able to identify and take account of multiple causal pathways.
Evans and Newnham (1998, p.490) define security as ‘The absence of threats to scarce values’, and state that ‘Historically, security has been seen as a core value and ultimate goal of state behaviour’. Security problems threaten the ‘sovereignty or independence of a state in a particularly rapid or dramatic fashion, and deprive it of the capacity to manage by itself’ (Waever, 1995, p.54). The primary instruments of security policy are usually thought of as the state’s coercive bodies: the military, foreign intelligence and counter-subversion agencies, but broadening out into the use of political, economic and diplomatic policies to protect the state and its citizens from threats, ensure stability in regions of particular interest, and foster a generally favourable international environment. Of these, sanctions are the most coercive. Security can therefore be seen in narrow or broad terms. This section focuses on the use of force and sanctions.

In one sense, security policies can be seen as promoting the well-being of the citizenry of the home country, and in this way, having positive health impacts. From this perspective, it might be possible to argue that during the Cold War, the defence of the West through the NATO alliance, nuclear deterrence, and under Reagan, rollback protected the security, and therefore health, of Westerners. But this would be to adopt a political rather than public health perspective, and advance a highly specific and partial analysis. A more comprehensive and systematic approach would require the analysis of health impacts across political and ideological dividing lines, extending outside the narrow context of Western Europe. On a more basic level, the use of coercion and other forms of leverage involve harm to the health of others. Each phase of the current ‘War on Terror’ (the invasion of Afghanistan, the invasion of Iraq, the extension of counter-terrorism across state borders, and the franchising of the War on Terror by other states) has been accompanied by widespread concern about its humanitarian effects and implications, not to speak of its strategic wisdom and potential for ‘blowback’.

The first level for the HIA of security policy is therefore at the level of ideology and discourse (this corresponds to Labonte and Torgerson’s discussion of political systems and processes in economic globalisation). For the purposes of conceptual analysis, four broad strategic approaches may be outlined: neo-conservatism, realism, liberal internationalism and peace.2 These categories are not exhaustive, and are arguably Eurocentric. They correspond both to philosophical positions in international relations theory and practical realisation in social movements (Table 1). They are important because they inform, influence and help to explain the formulation and conduct of foreign and security policy. Because each takes a particular standpoint on conflict and the use of force, each can plausibly be related to different sets of implications for health. Each is therefore significant at the level of primary violence prevention.

The first two derive from Cold War strategy, but find analogues in the current global strategy in the War on Terror. Neo-conservatism emerged originally in relation to the Reagan administration strategy of not just limiting, but overthrowing Communist influence in strategic regions and in the present equates with strategy of military primacy, prevention, pre-emption and regime change pursued by the current Bush administration. Realism corresponds with the more limited objectives of containment pursued for much of the Cold War, under

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2. This approach is similar to that of Fidler (2001), who examines how health as a foreign policy issue might be framed by different perspectives on international relations. He applies different categories, however.
principles of balance of power and deterrence. Liberal internationalism corresponds to the vision of conflict resolution through multilateral institutions and international law. Peace draws on the practices of peace, human rights and environmental movements and scientific communities that sought to build bridges across Cold War ideological and political barriers. In the present context, this corresponds to approaches addressing the putative ‘root causes’ of structural violence as well as conflict.

In practice some, at least, of these categories overlap (for example, realism and liberal internationalism often appeared as two sides of the same coin in US Cold War strategy) and they span competing philosophical and normative orientations. For example, neo-conservatives are unlikely ever to see conflict resolution as lying in practical terms in the transformation of society away from hierarchical and conflictual patterns towards peace, or pragmatic containment, or multilateral cooperation. Proponents of peace strategies are unlikely ever to come to power in many states. Yet these are the values that animate many concerned about the health impacts of foreign policy.

The second and third levels of HIA deal with the decision to use force in any given situation, and the conduct of the use of force. In relation to the decision to go to war, Murray et al (2001, p.346) are prepared to consider that while war might cause a sudden increase in direct and indirect mortality but might result in fewer deaths in the long term ‘if it led to the deposition of a regime whose policies cause high mortality’. This appears implicitly, at least, to endorse the viability of ‘regime change’ strategies, but leaves many difficult and possibly intractable questions, including: is the trade off between deaths now, and lives (potentially) saved later acceptable? To whom? What are the probabilities? Who decides? In practice, such a position is difficult to reconcile with peace/human rights perspectives. In contrast, Medact (2002) adopt the position that ‘war is a major hazard to health and prevention must always be better than cure’.

On the conduct of war, Murray et al (2001) suggest that the health impacts of conflict can be thought of in terms of direct and indirect effects. Direct effects relate to death and injury caused by violence ‘on the battlefield’ itself. Indirect effects refer to the health impacts of the destruction of infrastructure, population displacement, disruption of health services, and increased susceptibility to disease outbreak. Health impacts may also result for many years after conflict. Current attempts to assess the health impacts conflict offer a range of approaches that may be used to conduct health impact assessments of future conflicts. Murray et al (2001) identify a number of sources and methods: intercensal analyses and other demographic studies; civil registration of vital statistics; surveys; eyewitness accounts; and official reports.

HIA before the onset of conflict is complicated by the inherent difficulty of predicting the course of conflicts. The wider humanitarian crisis triggered by NATO intervention in Kosovo (itself a response to internal repression) in 1999 undoubtedly had untoward health impacts, but was largely unforeseen in NATO countries. Some agencies predicted that the 2003 invasion of Iraq would generate a major humanitarian crisis that did not emerge in the way that was projected.3 The envisaged potential for use of weapons of mass destruction likewise

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Table 1: Strategic security orientations

<table>
<thead>
<tr>
<th>Orientation</th>
<th>Neo-con</th>
<th>Realist</th>
<th>Lib. Int.</th>
<th>Peace</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Worldview</strong></td>
<td>Power as an instrument of liberty</td>
<td>Tragedy of power</td>
<td>Power civilised</td>
<td>Power abolished</td>
</tr>
<tr>
<td><strong>Approach</strong></td>
<td>Primacy; pre-emption; prevention; regime change</td>
<td>Containment; balancing; pragmatism</td>
<td>International law; multilateral institutions</td>
<td>Transformation of society; demilitarisation</td>
</tr>
<tr>
<td><strong>Use of force</strong></td>
<td>Necessary and welcome</td>
<td>Unfortunate but possible</td>
<td>Avoidable through rational politics</td>
<td>Illegitimate</td>
</tr>
<tr>
<td><strong>Health impact implications</strong></td>
<td>Increased conflict</td>
<td>Unhealthy stability</td>
<td>Addressed via multilateral institutions</td>
<td>Part of human rights work</td>
</tr>
<tr>
<td><strong>Health issues of concern</strong></td>
<td>Equivalent to moral issues</td>
<td>Impact on national interests</td>
<td>Impact on international peace and security</td>
<td>Human right to health</td>
</tr>
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failed to materialise. For Medact (2002), analysis of the potential health impacts of an invasion of Iraq:

"was hampered by the quality of the data and many discrepancies. Much data is not available, not collected and/or not published, or its quality is questionable. Statistical, methodological and interpretive errors bedevil most of the available information but erroneous figures are repeated from one apparently authoritative source to the next."

Murray et al (2001) highlight further challenges in quantifying the public health impacts of conflict: health information systems often cease to operate, and conflicts are inherently politicised, making intentional misrepresentation of effects (or their non-representation) likely. The statement by US General Tommy Franks about Iraq that ‘We don’t do body counts’ is but one manifestation of this issue (cited in BBC, 2005). Although called further into question by the conduct of the War on Terror, from the first Gulf War onwards, Western military planners and foreign policy makers foregrounded the idea of clean war, surgical strikes and precision targeting. However, as Dardagan et al (2005, p.3) state, that ‘Assurances that military forces “make every effort to avoid civilian casualties” are no substitute for real data-gathering and analysis, and can have no basis without it’ (see also Roberts et al, 2004).

It can be argued that the difficulty of conducting HIA of the use of force does not obviate the rationale for attempting it; it merely reinforces the need for clarity and rigour, and for learning from previous cases. Foreign policy itself is not always distinguished by these qualities.
Decisions to use force are also taken under conditions of imperfect information, and foreign policy outcomes cannot be predicted with certainty. But this is not an excuse for low intellectual standards in either foreign policy or health impact assessment. Foreign policy makers themselves ought to be held to intellectual standards as high as those analysing the potential effects of their decisions. Also, the availability of good data is in part a function of political will and social concern. If this is low, HIA can itself be targeted to address this problem.

HIA is premised not on the ability to make perfect predictions, but on the best use of the best available evidence. There is also a question of how evidence is interpreted, and the extent to which the uncertainties around projections are made explicit. The use of scenario-based methods (themselves widely employed in foreign and security policy analysis) may offer ways to counter this problem, though this may also lead to wide margins of error.

International humanitarian law represents an attempt to regulate and minimise the effects of collective violence that provide ways to assess its effects during conflict. International humanitarian law (IHL) provides clear statements that are directly relevant to health, and which can be taken as a basic starting point for health impact assessment (Box 4) (International Committee of the Red Cross, ICRC, 2004). Furthermore, for Dardagan et al (2005, p.3), ‘the continuous detailed tracking, recording, analysing, understanding, and responding to the effects of violent conflict on its innocent victims is, in our view, among the highest humanitarian imperatives, an imperative which has particular application to governments who conduct military interventions.

IHL specifies principles in relation to specific facets of conflict: protected persons and property, conduct of hostilities, women, children, refugees, internally-displaced people, missing persons, and weapons. Here it is perhaps worth noting that protected persons include civilians and the staff of relief operations, and protected objects include all civilian objects, plus military medical facilities and ambulances. IHL, then, provides a framework for how the health impacts of the use of force can be categorised and how they should be collated.

Figure 3 presents an attempt to conceptualise in simplified terms the health impacts of the use of force, drawing on a number of studies (REFS). Further synthetic research would help to develop this framework and the nature and strength of the causal relations it represents. The framework begins with the forms of violence employed.
Figure 3: HIA of security policies: use of force

- Forms of violence:
  - Sanctions
  - Weapons systems
  - Targeting strategies
  - Respect for IHL
  - Humanitarian and relief access

- Determinants of health:
  - Equity
  - Health systems

- Health outcomes:
  - Direct
  - Indirect

- Ideology and discourse:
  - Neo-conservatism
  - Realism
  - Liberal internationalism
  - Peace

- Contexts:
  - Health, foreign policy and security
Sanctions, for example, can have clear effects on health. By undermining the economy of the targeted country they may hit key determinants of health, such as income, poverty levels, nutrition and availability of medical supplies. Given the ability of elites to evade the direct effects of sanctions, they are also likely to be detrimental to equity within countries (‘smart’ sanctions are intended to circumvent this problem). Second, the range of weapons systems is vast, and each has a range of direct and indirect impacts, relating to how they affect people, infrastructure and the environment. These may have considerable legacy effects, for example in the case of unexploded ordnance, landmines and environmental contamination. Third, the extent to which IHL is respected influences the health effects of the use of force. This may or may not enter into the application of sanctions, choice of weapons systems, and targeting strategies in addition to the actual conduct of operations. Fourth, the extent to which IHL is respected influences targeting strategies. This has many implications, regarding, for example, whether civilian populations are targeted directly or are exposed to the effects of the targeting of military objects. The extent to which electricity, water, sewage, transport and communications networks are targeted is also of profound significance. Finally, and again related to respect for IHL, the nature and quality of humanitarian access and response and military relief is likely to influence health impacts.

Each of these dimensions of violence interacts with the dimensions of health. To use Dahlgren and Whitehead’s listing of the determinants of health, the use of force impacts social and community activities, living and working arrangements, as well as the general socioeconomic, cultural and environmental conditions. Second, this can be extended to consider the political dynamics set in chain by conflicts. What kind of entity emerges from conflict? For example a functioning democracy, able and willing to respect the human rights of its citizens, or a failed state? Third, there are impacts on health systems themselves, where are embedded in these contexts, and are reliant on reliable supplies as well as more general security. Fourth, because elite, rich and poor segments of societies experiencing conflict have unequal wealth to draw upon, they may be able to insulate themselves from the effects of conflict to differing degrees, and to obtain different levels of healthcare. Conflict may also affect unevenly the situation of men, women, children, the disabled and the elderly, and different ethnic and religious groups. Conflict therefore has implications for health equity.

Each of these dimensions may interact with others and feed through into direct and indirect health impacts. Indirect health effects are likely to persist long after the cessation of hostilities. As with economic globalisation, contextual analysis must be given particular priority in addition to comparisons with other cases and previous phases of conflict.

Box 5: Basic rules of international humanitarian law in armed conflicts (ICRC, 1988)

1. Persons hors de combat and those who do not take a direct part in hostilities are entitled to respect for their lives and their moral and physical integrity. They shall in all circumstances be protected and treated humanely without any adverse distinction.

2. It is forbidden to kill or injure an enemy who surrenders or who is hors de combat.
3. The wounded and sick shall be collected and cared for by the party to the conflict which has them in its power. Protection also covers medical personnel, establishments, transports and equipment. The emblem of the red cross or the red crescent is the sign of such protection and must be respected.

4. Captured combatants and civilians under the authority of an adverse party are entitled to respect for their lives, dignity, personal rights and convictions. They shall be protected against all acts of violence and reprisals. They shall have the right to correspond with their families and to receive relief.

5. Everyone shall be entitled to benefit from fundamental judicial guarantees. No one shall be held responsible for an act he has not committed. No one shall be subjected to physical or mental torture, corporal punishment or cruel or degrading treatment.

6. Parties to a conflict and members of their armed forces do not have an unlimited choice of methods and means of warfare. It is prohibited to employ weapons or methods of warfare of a nature to cause unnecessary losses or excessive suffering.

7. Parties to a conflict shall at all times distinguish between the civilian population and combatants in order to spare civilian population and property. Neither the civilian population as such nor civilian persons shall be the object of attack. Attacks shall be directed solely against military objectives.

5. HIA and foreign policy processes

If the paper so far has focused on the analytical functions of HIA, this section considers its function in influencing policy makers. HIA as it has developed to date aims to meet a number of goals:

- Raise awareness among decision makers
- Help decision makers identify and assess impacts
- Identify ways to optimise and improve policies through evidence based recommendations
- Help affected stakeholders to participate and contribute to policy

HIA therefore involves an interaction between systematic analysis and governance processes, and the ability of a governance system to take HIA into account can be seen not just as an index of the value it places on health, but as a test of its democratic credentials and adherence to human rights and humanitarian standards. Indeed, such standards are one of the main levers practitioners of HIA have to place HIA on political agendas.

It is by no means the case at present that health effects are analysed systematically as part of foreign policy. Even within policy fields where health is supposed to be a priority, likely impacts are not always studied rigorously. Indeed, the debate about globalisation has shown that its impacts on health have been inadequately conceptualised, analysed and recognised in policy processes. Relatively explicit and systematic health impact assessments were attempted for a recent case of the use of force in international relations, the invasion of Iraq, but the
extent to which awareness was truly raised among the relevant policy makers is doubtful. So, an assumption of a linear relationship between research, awareness and policy response appears unrealistic (Overseas Development Institute - ODI - 2005).

This raises the question of who does HIA of foreign policy. Example so far have originated outside official policy processes, but have sought to contribute to them. It might be possible to envisage a situation where HIA becomes an embedded explicit, meaningful, legal responsibility (as part of, or alongside, human rights impact assessment) on the part of policy makers. At present, this is not the case. Hence, HIA is still more likely to be undertaken outside official structures, with a view to influencing them. This section therefore considers some of the kinds of networking that may help the development of HIA of foreign policy.

If the goal of HIA is to influence policy processes, under what conditions can this happen? ODI (2005) suggests a number of mechanisms based on analysis of 50 case studies of research and policy in development (Box 5).

This programme also identified three broad domains shaping the influence of research. Political context is considered the most important, and relates, first, to political demand (to what extent is high level political commitment forthcoming?). Political demand can make it difficult to ignore findings; however, striking findings can also ‘shake up the balance of political forces and enable movement’. The quality of the evidence is also important – it needs to be relevant, credible and well-communicated. The final domain is to do with the nature links between researchers and policy makers. Though open questions remain, these appear to be crucial, with long term commitment and a strategic approach to building and maintaining relationships important factors.

The ODI programme also shows that where research findings go outside the current wisdom, ideology or discourse of policy makers, or where they challenge powerful vested interests, they are much less likely to be incorporated. In these cases, HIA may imply a move from a more neutral research-policy interaction to embrace politics and social movement strategies that aim to reframe the terms of discourse and bring new interests into the political equation in order to achieve change (Tarrow, 1994). Hence HIA is potentially radical; indeed, it is the fact that it is positioned both in terms of science and politics that gives it its utility.

Box 6: How research can influence policy development and implementation

**Expanding Policy Capacities**
- Developing new talent for research
- Improving the knowledge of certain actors
- Providing support to develop innovative policy ideas

**Broadening Policy Horizons**
- Providing opportunities for networking/learning (locally and internationally)
- Introducing new ideas on the agenda, or stimulating public debate
- Stimulating quiet dialogue among decision-makers
**Affecting Public Policy Regimes** (i.e. strategy documents, work-plans, budgets, legislation, regulation, legal precedents)

- Modification of existing policies
- Fundamental re-design of policies
- Initiation of new policies

**Affecting Practice** (i.e. programs, approaches, funding levels, communication)

- Modification of existing practice
- Fundamental re-design of practice
- Initiation of new practice

HIA can help public health gain salience in foreign policy processes by addressing each of the areas highlighted by ODI. It can aim to generate political demand by highlighting to political constituencies the centrality of HIA to human rights and humanitarian declarations, and by making explicit health impacts that were either unperceived or not part of political debate hitherto. Through the development of more systematic templates, more rigorous methods and more effective public communication strategies, it may enhance the quality of evidence available on foreign policy issues. If it begins to develop these two features, HIA researchers may be better able to foster links with policy makers on a more stable long term footing.

Participation by potentially affected communities is a central element of HIA. ODI found that participation was also likely to facilitate the uptake of research in policy. However, the idea of participation has been subject to extensive critique (ref). The original idea supporting participation in policy making (particularly in international development) came out of a number of critiques of policy failure, around the key insight that policies have failed, or done more harm than good, or had avoidable untoward effects, because they have been made for communities, often by outsiders rather than with them. Hence, bad policy results where policy processes do not take local reality, wishes, or interests adequately into consideration. Participation is thus envisaged as a remedy to social exclusion, democratic failure, and bad policy. This has led to the rise in focus on ‘participation’ (as well as ‘empowerment’ and ‘consensus building’) in a number of policy spheres, founded on the principle that people should not be excluded from decisions that affect their lives (Bühler, 2002).

As Bühler discusses, such approaches have been the subject of severe criticism, on a number of grounds. Participation can mean depoliticisation, co-optation and incorporation, a means of attaching legitimacy to a pre-conceived course of action. Second, ‘experts’ may dominate and distort the process. Third, there may be an over-emphasis on formulae rather than substance (a risk with HIA itself). Fourth, participation may be used to reinforce existing patterns of authority; and fifth, participation may be dichotomised as ‘salvation’, and other approaches unreasonably maligned. Thus, ‘participation’ and its promise of change becomes an instrumental tool to ensure that things proceed smoothly for the initiators of policy. Finally, participation may over-emphasise the ‘local’, obscuring wider questions and power relations.
This critique raises profound issues, that cannot be examined in full here. However, Bühler asks whether, if exclusion is indeed part of the problem, can participation still be part of the solution? Labonte and Spiegel (2001) suggest that global health research ought to prioritise, for example, research that represents concerns or questions defined by developing countries; research that ‘solidly’ engages civil society; and research that increases equity in knowledge capacities. Bühler suggests that participation needs to be thought of not just in terms of process, but of dignity and respect. For Perin and Attaran (2003), assessing the record of international health, find that:

_policies, instead of reflecting needs of the recipient countries, have evolved in response to donors' ideologies…This lack of dialogue underscores most of the failures of international health and suggests the urgent need for a restructured aid process, in which policies and projects are not merely guided, but actually designed, by recipients._

Buhler (2002, p.15) therefore argues that:

_dignified participation needs certain conditions: The ‘right’ degree of politicisation, a commitment to serious engagement, the recognition of the dignity of all participants, and procedures that ensure that both participation itself and any outcomes reached are real and effective._

Where these criteria cannot be secured, the meaning of ‘participation’ may be called into question.

How, then, can these concerns be integrated through the HIA process? HIA typically involves four stages (Lock 2005, see also Table 2). To these may be added the policy proposal stage, when details of policies may become known, and the post-reporting stage, when implementation is monitored, and findings fed back into new rounds of policy making. HIA in foreign policy faces the challenge of securing knowledge of new proposals in a timely fashion, as potentially controversial policies are often formulated in secret, as was the case with the initial stages of the Multilateral Agreement on Investment (eventually abandoned once details became more widely known) and planning of the war in Iraq (Woodward, 2004; Hersh, 2004). HIA of foreign policy therefore necessitates networking between parts of the public health and foreign policy communities that have interest in the public scrutiny of policy. At this stage, the main dimensions of participation may be considered.

Screening may utilise specific tools, such as the frameworks presented in figures 2 and 3, to identify potential impacts. Participation also becomes relevant at the screening stage. This should involve communities likely to be affected by the policy under consideration. In some foreign policy situations, particularly involving security, this is likely to be challenging. Pre-existing links with academic and professional communities are likely to facilitate participatory screening, but specific political situations may present difficulties. The CESR team that assessed potential health impacts of the war in Iraq did conduct fieldwork with the participation of Iraqi citizens, but report that their visit was managed by political minders. Roberts et al (2004) also demonstrated that it is possible to collect public health information during periods of violence, though with inevitable limitations. Scoping is also likely to be aided by participation. One question here is to do with the extent to which the domestic scale
is a relevant frame of analysis. For example, might there be beneficial or harmful feedbacks into the health of the domestic population through trade liberalisation? What might be the impact on the health or health systems of the home country of embarking on military interventions abroad?

Next, appraisal has key technical dimensions that depend on securing relevant expertise to ensure credible, rigorous assessments of health and foreign policy dimensions and their interactions. Here public health communities may again benefit from closer links with foreign policy analysis, and systematic application of scenario-based methods.

The influence and communication strategy assumes particular importance during the reporting phase, when foreign policy windows may be opening and closing in more or less predictable fashion. Here, it may be possible to tap into and align with other governance processes (such as parliamentary enquiries, hearings or debates) scrutinising foreign policy questions. Finally, HIA of foreign policy does not end with implementation; monitoring and reporting may help to sustain public health issues on the political agenda and feed into new rounds of policy making.

Table 2: Stages of HIA of foreign policy

<table>
<thead>
<tr>
<th>Stage</th>
<th>Tasks</th>
<th>HIA in foreign policy</th>
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<tbody>
<tr>
<td>Policy proposals</td>
<td>Identify potential relevance to health</td>
<td>Consider potential dimensions of participation – foreign &amp; domestic</td>
</tr>
<tr>
<td>Screening</td>
<td>Quick preliminary assessment of relevance to health</td>
<td>Screening tools, e.g. figures X and Y Participation of key actors Assess political demand, communication and influence strategy, links with policy makers</td>
</tr>
<tr>
<td>Scoping</td>
<td>Identify key questions and scope of assessment</td>
<td>Identify relevant geographical regions Ensure participation Identify technical expertise</td>
</tr>
<tr>
<td>Appraisal</td>
<td>Assess risks, hazards, opportunities</td>
<td>Consider alternative foreign policy scenarios</td>
</tr>
<tr>
<td>Reporting</td>
<td>Meet political timeframes</td>
<td>Target policy windows Influence and communication strategy</td>
</tr>
<tr>
<td>Post-reporting</td>
<td>Track impacts</td>
<td>Maintain focus Monitor implementation Feed into next rounds of policy making</td>
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6. Conclusions

This paper has considered how health impact assessment of foreign policy may be developed. It has suggested that HIA of foreign policy presents particular challenges, and ideas have been advanced on how they can be addressed. The discussion also suggests how HIA of foreign policy may be developed further along a number of lines. In relation to analysis, these include:

- Further development of conceptual (screening and scoping) and technical (appraisal) tools under the explicit integrative heading of HIA of foreign policy
- Identification of further pathways linking health and foreign policy
- Research exploring further the literature on HIA in relation to foreign policy
- Identification of case studies of HIA of foreign policy already completed
- Identification of better frameworks linking security policies and health impacts
- Further case studies of HIA of foreign policy under common analytical frameworks

In terms of HIA process, these include:

- Using HIA as a mechanism for greater networking between health and foreign policy communities
- Using HIA as a mechanism for greater networking between countries
- Increased dialogue between researchers, NGOs and funding bodies regarding the development of HIA of foreign policy

What might be the broader prospects for HIA of foreign policy? The two cases of economics and security are instructive in this regard, and indicate potential limits to HIA. Foreign economic policy has in some respects and some countries, shifted away from neoliberal orthodoxy in the last five years, in response to a mix of evidence and advocacy. In 2005, the UK government announced that it would no longer make development aid conditional on particular policy choices (such as privatisation) by recipient governments (Department for International Development, 2005). Though this movement was only achieved after huge effort, this indicates that some movement is possible. In Canada, assessments have been conducted of the implications of trade agreements for Canada’s own health system have been conducted, and were used to inform the Romanow Commission’s official review of health policy. The further development and application of HIA may serve to entrench gains that have been made and support further progress.

The picture with security is perhaps less encouraging. On one level, some studies indicate that globally, human security has improved with the passing of the Cold War and major phases of decolonisation (Human Security Centre, 2005). But there are still major sources of insecurity associated with new terrorist movements, global security policies under the War on Terror, regional conflicts, state failure and competition for access to energy resources. Security policy is also the most resistant field to public scrutiny and participation. However, rather than encouraging pessimism, this may only increase the rationale for developing HIA by whatever means possible. HIA must be tried properly before its utility can be judged fully.
References


