

Health without Borders: International Intervention in Public Healthcare of De Facto Independent Entities

Patrick Yuk-tung Wong

*Lecturer of the Masters of Global Political Economy Programme
Chinese University of Hong Kong, HONG KONG*

Abstract

The fundamental goal of global health authorities is to improve health conditions of all people worldwide. In reality, millions of people are excluded from access to public healthcare due to civil armed conflicts. On certain occasions the conflicts were long-lasting with the insurgencies exercising permanent control over considerable part of territories. These *de facto* independent entities are outside the jurisdiction of international health regime. Such exclusion stems from the very nature of the sovereignty-based international order. It involves diverse positions and conflicting interests of various parties that cannot simply be resolved by technological means. This paper aims to discuss the limitations of international health regime in dealing with these situations and explore possible solutions. A structural framework is developed by identifying major stakeholders and their respective positions, perceptions and incentives (or otherwise) to intervene, and outlining the dynamic of intervention as basis for analysis. Existing approaches of international intervention will then be compared by using Gaza Strip, South Ossetia and Somaliland as examples. A number of suggestions are made to formulate an integrated framework of international intervention to achieve “health without borders” for humanity.

Keywords: *de facto* states, global health governance, public healthcare, WHO

(1) Prelude

In the website of Médecins Sans Frontières (MSF), the organization states at the very beginning its mission to offering assistance to the needy “irrespective of race, religion, gender or political affiliation” (MSF, 2012). So does the fundamental goal of global health governance that “places a priority on improving health and achieving equity in health for all people worldwide” (Feldbaum & Michaud, 2010: 2). I would call it “*Yǒu ‘Yī Wú Lèi*” in Chinese.¹ In reality, there are millions of people across the globe who are excluded from access to public healthcare. Civil armed conflicts are amongst major factors accounting for the tragedy. While conventional wisdom regards these conflicts as mostly partial and temporary, there exist a number of instances where the conflicts last for years (even decades) with the insurgencies (anti-government groups, separatist movements, etc) exercising effective and permanent control over considerable part of territories by setting up their own administration. These *de facto* independent entities (DFIEs), as I call them, are outside the jurisdiction of international health regime led by World Health Organization (WHO). Their exclusion has far-reaching impact on the health condition of their population and may pose risk to global health. Exhibit 8.1 lists out these entities with most of them located in the former Soviet Union or the Middle East and North Africa (MENA) region. Many of them have declared independence for over two decades but received very limited diplomatic recognition.

This paper aims to discuss the limitations of international health regime in dealing with these situations in the turn of the century, and explore possible solutions for consideration by international community particularly WHO. It first reviews the present international legal and organizational framework in the health arena with particular emphasis on its ineffectiveness to incorporate DFIEs and intervene in their public healthcare, and the implications for domestic and global health. A structural framework is developed by identifying major stakeholders and their respective positions, perceptions and incentives (or otherwise) to intervene, and outlining the dynamic as basis for analysis. It then goes through the existing approaches of international intervention in DFIEs’ public healthcare to

¹ The Chinese characters of this phrase are “有「醫」無類”, meaning “treat all and exclude none.”

compare and contrast contributions of the stakeholders in different situations and evaluate their effectiveness and constraints. A list of suggestions, which call for an integrated framework of international intervention, will be made together with some concluding remarks in the final section.

The major argument of this paper is that the exclusion of DFIEs from international health regime stems from the very nature and limits of the sovereignty-based international order. It involves diverse positions and conflicting interests of various parties that cannot simply be resolved by technological means, and failure to incorporate would bring about devastating outcomes. It must bring together all stakeholders to identify common interests and engage in institution-setting to form an integrated framework of international intervention so as to achieve “health without borders” for humanity.

(2) Limits of International Health Regime

The present international health regime traces its origins from the series of international sanitary conventions and treaties since mid-nineteenth century. At the center of the regime is International Health Regulations (IHR) supplemented by related protocols including the WHO Constitution and various international agreements and regulations. The most recent (2005) revisions of IHR accords countries “new obligations to prevent and control the spread of disease inside and outside” their borders and improve their “public health capabilities” (WHO WPRO, 2005:2). It marks the commitments of international community to develop a sophisticated legal framework for better governance of global health.

(2.1) *Confined application of international health law to de jure sovereign states (DJSSs)*

Notwithstanding its comprehensiveness, according to Articles 59-65 of IHR, the rights and obligations stipulated in the regulations and related protocols are confined to WHO members and associated members.² At present, all member

² Also applying to non-member states which are parties to prescribed international sanitary agreements or regulations or “which the Director-General [of WHO] has notified the adoption of these Regulations by the World Health Assembly” (WHA) (Article 64) (WHO, 2005b: 36-39).

states of United Nations (UN) except Liechtenstein³ are WHO members concurrently including the newly independent South Sudan (WHO, 2012). That means international health regime virtually covers all territories under the jurisdiction of *de jure* sovereign states (DJSSs).

(2.2) Lack of diplomatic recognition and legal position of de facto independent entities (DFIEs)

Apart from international territories like Antarctica, however, there are some DFIEs in different parts of the world which are beyond the reach of *de jure* sovereigns.⁴ DJSSs, as WHO members, are unable to take care of health issues in DFIEs and fulfil their responsibility to “notify WHO of all events that may constitute a public health emergency of international concern” taken place in these territories (WHO WPRO, 2005: 6). Theoretically speaking, the problem can be resolved through application of WHO membership by DFIEs.⁵ In reality it is extremely difficult to do so as these entities, which are often regarded as rebels, possess very limited or even no diplomatic recognition by international community. The lack of legal positions makes it difficult for them to gain technical and financial support and health intelligence from WHO and other international organizations (IGOs) to develop core capacities for their public health system (WHO WPRO, 2005: 12-13).

(2.3) Notion of sovereignty and non-interference in internal affairs of other countries

The exclusion of DFIEs from international health regime stems from fundamental limits of international order, i.e. the notion of sovereignty and non-interference in internal affairs of other countries. While “international law

³ According to bilateral agreements between Liechtenstein and Switzerland, the latter represents Liechtenstein diplomatically unless the country chooses to act on its own.

⁴ Examples of DFIEs include Abkhazia, the Hamas-controlled Gaza Strip, Nagorno-Karabakh, Northern Cyprus, Somaliland, South Ossetia, Transnistria, and Western Sahara. Palestine and Taiwan have become observers of WHA and enjoy certain rights and privileges of WHO members, while Kosovo has been close to obtaining sufficient diplomatic support for WHO membership. These three entities are thus not covered by the discussion in this paper.

⁵ According to Article 6 of WHO Constitution, non-UN member states may become members by obtaining simple majority vote in WHA, see WHO (2005a: 4).

treats insurgencies and civil wars as internal matters falling within domestic jurisdiction of the state concerned” (Kumer, 2007), in reality *de jure* sovereign has lost control of the scene. Being restricted by sovereignty principle, in many cases WHO cannot undertake statutory functions required by IHR to conduct on-site assessment (WHO WPRO, 2005: 14) in the territory of DFIEs where destruction of health facilities, displacement of population and outbreak of disease are commonly found in the wake of armed conflicts. Not to say integrating these entities into global disease surveillance system that is always impeded by political considerations of the country concerned and other sovereign states (McKee & Atun, 2006: 1224).

(3) Implications of Exclusion of DFIEs for Global Health

Geographically speaking, most of the DFIEs lie at locations that are too remote for them to catch enough attention. Nevertheless, it does not mean they are totally isolated without regional and global significance. The implications of their exclusion for global health are far-reaching that can be found in the following aspects.

(3.1) *Threat of humanitarian crisis*

DFIEs are common in securing their *de facto* independence after long struggles (usually involving massive violence) against the constitutional authority of DJSS. The “direct and indirect consequences of [these] conflicts”, such as breakdown of public healthcare, suspension of immunization program, food and water shortage, etc “amplify health risks due to communicable diseases” (Senessie, et al, 2007: 2). News about vulnerability of affected masses on the verge of humanitarian crisis spread through media and Internet that in a way help exert pressure on international community to take rapid response.

(3.2) *Pressing need for rebuilding public healthcare*

Massive destruction of public health facilities seriously dampens the capacity of local health authorities of DFIEs in disease prevention and medical treatment. As it takes long time to rebuild the whole system, in case of prevalence of particular disease in the territory, “strategies of integrated care programs may not

be feasible due to lack of infrastructure and security, and thus targeted medical interventions are needed” (Tong, et al, 2011: 7). It requires coordination of both “international and national responses across regions and borders” that accord increasing importance to IGOs like WHO in leading and coordinating international intervention in the affected territories.

(3.3) Blind spots on disease control

Despite the 2005 revised IHR “provides the legal framework for mandating countries to link and coordinate their action through a universal network of surveillance” (Calain, 2007: 2), the failure to include DFIEs creates blind spots on disease surveillance, prevention and treatment, hence adversely affecting effectiveness in disease control on global scale. The severe acute respiratory syndrome (SARS) incident in 2003 “showed us that WHO could have detected the disease and save more lives if all affected countries, including Chinese Taipei (Taiwan) [which has not become WHA observer then], were part of the global public health system” (Chan & Tsai, 2006: 1901). As many DFIEs “lie on the migratory paths of birds, a matter of considerable importance in view of the threat posed by avian influenza” (McKee & Atun, 2006: 1224), their incorporation into global disease control mechanism can brook no delay.

(3.4) Delayed settlement of internally displaced persons (IDPs)

An inevitable outcome accompanying the emergence of a DFIE is large scale of displacement of local population as a result of massive violence and destruction. Increased abnormal mobility across borders causes higher risk of pandemic. As Shen puts it, “the spread of the epidemic proved unstoppable in the era of globalization” (Shen, 2004: 61). IDPs are usually forced to flee their home and live in places found by their own or arranged by the authorities on temporary basis. Their extremely poor living conditions are potential threat to public health. Immediate settlement for them (either returning home or moving to permanent residence elsewhere) is necessary. Further delay would deteriorate their health condition and heighten risks of outbreak of communicable diseases.

In most cases DFIEs lack necessary resources and expertise to solve the above problems. With people’s rising consciousness of interconnectedness of public

health in different parts of the world, and the cognitive change to popular acknowledgement of humanitarian solicitude above sovereignty, it is necessary to review the present situation and explore possible solutions to better deal with public healthcare of DFIEs.

(4) Framework of Analysis: Major Stakeholders and the Dynamic of Intervention

The failure to incorporate DFIEs formally in the IHR/WHO framework reveals major weakness of international health regime. To mitigate ill effects of such exclusion, throughout the years various parties of international community adopt different measures to intervene in public healthcare of DFIEs in areas of public health system rebuilding, disease surveillance and control, settlement of IDPs, and so on. Before moving on to discuss different approaches of intervention, it is necessary to identify the stakeholders involved in the scene. There are five major stakeholders in any international intervention, namely DFIEs, DJSSs, IGOs, non-governmental organizations (NGOs), and other countries (including neighboring states and major powers). Their respective positions, how they perceive the situation of the DFIE concerned, and their incentives (or otherwise) to intervene in the public healthcare of the territory all shape the dynamic of intervention, which shall form the basis for analysis in forthcoming sections. Generally speaking, at the two sides of the spectrum, DFIEs are willing to accept intervention for its own sake while *de jure* sovereigns are always reluctant and skeptical of tacit recognition of DFIEs. IGOs and NGOs are on the positive side to promote their missions and visions but the scope of their activities are likely constrained by other stakeholders. Other countries may intervene when they want to pursue their own agenda. The respective positions, perceptions and incentives of these stakeholders shall be discussed in detail below (a summary can be found at Exhibit 8.2).

(4.1) DFIEs

In contrast to other cases of insurgencies like guerilla warfare, DFIEs are mostly able to govern a considerable part of the territory for rather long period of time. For instance, Somaliland has self-proclaimed independence from Somalia for over two decades since 1991 (BBC, 2011). While insurgencies are always regarded as threats to order and stability, quite a number of them undertake to develop their areas of control and take care of people's needs. Even Tamil Tigers (LTTE) in northern Sri Lanka had set up a dedicated medical wing to provide services for its fighters and local population (Elliott, 2011). In most cases DFIEs face vulnerable socio-economic situation with serious destruction of public health and sanitary systems, risk of pandemic, etc. They are isolated due to absence of diplomatic recognition, hence difficult to seek external assistance for rebuilding public healthcare.

Under such unfavorable internal and external circumstances, DFIEs have strong incentive to develop effective governance by restoring/maintaining order and providing public goods including healthcare in order to gain support among local population. As Flanigan argues, "health and social service provision has helped increase their legitimacy vis-à-vis the national government, generate greater favorable opinion and political support for the organizations in the community" (Flanigan, 2008: 516). It can promote their image in order to develop relations with international community. So DFIEs are generally positive towards international intervention that can foster development of its public healthcare.

(4.2) DJSSs

In contemporary international order, DJSSs have been widely regarded by international community as continually being the constitutional authority of the DFIE-controlled territories until the entities obtain universal recognition for their independence (as marked by joining UN and/or its specialized agencies like WHO)⁶. However, such legal position of DJSSs is nominal as they have totally

⁶ As far as the matter of discussion is concerned, the legal status of DJSS and DFIE refers to the context of international law. As Chiu (2005: 313) puts it, there is no international body governing a political entity's eligibility for statehood under international law. Instead, it is subject to individual states' decisions that leads to the issue of recognition of states. No matter

lost control of the affected territories. The DJSS authority has limited grasp of local situation in DFIE and thus can do nothing for the recovery of order and public services there. As like recognition of the status of insurgency in international law that may “bring about the internationalization of an event” and turn insurgents from “lawbreakers” to “legal contestants” (Chelimo, 2011), DJSSs are suspicious of allowing international intervention in public healthcare of DFIEs that may bring about tacit recognition of their independence. For instance, in the aftermath of SARS incident a memorandum of understanding was signed between WHO and China in 2005 that allowed very limited official contacts between WHO and Taiwan, the latter of which was then ruled by the pro-independence Democratic Progressive Party (McKee & Atun, 2006: 1224).

Given its reluctance to international intervention, DJSSs often apply blockade at the affected territories with a view to weakening the strength of DFIEs. Such counter-insurgency measure, however, may further decimate people’s health in those territories (Suwanvanichkij, 2008: 1), and paradoxically bring in attention and intervention from outside in case conflicts are expanded with humanitarian disaster broken out across the border. In short, DJSSs generally lack incentive to promote public healthcare of DFIEs except on very rare occasions when their interests could be served.

(4.3) IGOs

WHO and other UN specialized agencies like World Food Programme (WFP) and UN Development Programme (UNDP) are amongst key actors of international intervention in DFIEs’ public healthcare. International Committee of the Red Cross (ICRC), which is given a mandate under Geneva Conventions of 1949 and

declarative theory or constitutive theory one would adopt, even though it is not dependent on the discretion of any single international organization as aforesaid, “since 1945 there has developed through admission to the United Nations and in other ways a process of certification that has fulfilled the function of certification [of statehood]” (Crawford, 2006: 98-99). So in determining the legal position of a political entity, apart from bilateral recognition between states, membership of IGOs in particular UN is of growing importance towards DFIEs’ legal personality in pursuance of their rights and obligations under international law. Notwithstanding, as there is yet consensus among scholars, politicians, lawyers and diplomats on what constitute *de jure* statehood, this article does not attempt to address this issue which should itself be considered as a separate subject of research and analysis.

additional protocols “to provide humanitarian help for people affected by conflict and armed violence” (ICRC, 2010), also plays a unique role.⁷ While these IGOs possess expertise and are dedicated to global health and humanitarian assistance based on international collaboration, their activities are inconveniently restrained by the notion of sovereignty in the sense that under present provisions they need to obtain endorsement of the constitutional authority of DJSS before getting access to the affected territory and engaging into contacts with DFIE. It is because according to Article 2 of UN Charter, UN (including its agencies) shall not “intervene in matters which are essentially within the domestic jurisdiction of any state” unless these matters pose threat to peace (Article 39) (UN, 2012). In the meantime, the scope and extent of these IGOs’ activities are subject to resolutions by their member states that may hold different positions on intervention. This to certain extent impedes the autonomy of IGOs in the health arena.

Notwithstanding these constraints, heightened risks of spread of disease and humanitarian disaster in the affected territories are left untouched by both DJSS (lack of control) and DFIE (lack of capacity) and thus require prompt actions by IGOs which can take the opportunity to extend their influence. So in most cases IGOs hold positive and proactive stance on intervention in order to fill the blind spots in global health and disease surveillance.

(4.4) NGOs

There exist thousands of NGOs (both international and local) which make contributions to global health and humanitarian assistance to the needy in different parts of the world. Notable examples include MSF and Oxford Committee for Famine Relief (Oxfam). In contrast to IGOs, they are lacking of mandate under international law to accord them legal status and authority to conduct health missions. This puts them in vulnerable position with limited protection and guarantee for their activities and safety inside the affected territories. In most extreme cases, some of them may even be prosecuted for “illegally financing

⁷ According to its Statutes, ICRC is governed by Swiss Civil Code and consists of fifteen to twenty-five members co-opted from Swiss citizens. Strictly speaking it is not an “inter-governmental” organization *per se*. Giving its humanitarian mandate under Geneva Conventions, it distinguishes itself from ordinary NGOs and thus is categorized as IGOs for the sake of discussion here, see ICRC (2003).

armed groups in conflict areas” (Gallmetzer, 2001: 955). While the main concern here is about weapons provision or sale (Gallmetzer, 2001: 955), the term “financing” is rather vague and prone to touching the “red line”. On the other hand, the non-governmental nature of these organizations allows them flexibility and impartiality in pursuing their vision and mission, which in turn gives them more incentives to intervene.

(4.5) Other countries (neighbouring states, major powers)

Apart from IGOs and NGOs, other countries particularly neighbouring states and major powers (MPs) also play a part in intervention of DFIEs’ public healthcare. As the border between DJSS and DFIE is always closed or under conflicts, neighboring states serve as alternative channels for transferring aid and other forms of health assistance into the affected territories. Their willingness to open border depends on a number of factors such as security, alliance consideration, etc (Harbom & Wallensteen, 2005: 628). Meanwhile, MPs (principally US) are widely regarded as guarantors of international and regional order and possess political and economic strength to intervene. Sometimes interventions are taken place in “a more asymmetric nature” by MPs for their specific agenda (Harbom & Wallensteen, 2005: 628).

No matter who intervene in the scene, both neighbouring states and MPs are constrained by the principle of sovereignty as like IGOs. Intervention in DFIEs’ healthcare may internationalize conflicts between DJSS and DFIE that breaches the aforesaid principle and may complicate the situation (Harbom & Wallensteen, 2005: 629). For neighboring states, it would increase tensions between them and DJSS if involving irredentist/territorial disputes. However, they may be willing to intervene when they are affected by spread of conflicts and influx of IDPs across the border, or if they want to pursue their own political agenda. For MPs, intervention is often related to broader context of power interplay between them as well as their own calculation of interests. Given the complexities, the attitudes of both neighboring states and MPs towards intervention vary depending on their own diplomatic agenda and interests.

(4.6) Dynamic of intervention

Overall, whether the major stakeholders choose to intervene in public healthcare of DFIEs is determined by their respective positions, perceptions and incentives. In the first place, DFIEs and DJSSs are at the two sides of the spectrum. On the one hand, DFIEs are generally willing to accept intervention for its own sake (rebuilding public healthcare, development of disease control mechanism, settlement of IDPs, etc). On the other hand, DJSSs are often reluctant and suspicious about tacit recognition of DFIEs by any form of international intervention, thereby posing major obstacles to humanitarian assistance by international community. As regards other stakeholders, IGOs and NGOs are on the positive side (due to the need to contain adverse effects of poor health conditions of DFIEs on global health and to promote their missions) but the scope and extent of their activities are likely constrained by other stakeholders (stance of DJSSs, interests of MPs, cooperation of neighboring states, etc). For other countries, neighboring states may have incentives to intervene when they see the need to stop proliferation of the conflict on their own soil, or if they want to pursue their own political agenda (irredentist claim, etc). If they choose to intervene, it would likely constrain IGO/NGO activities due to the need to protect and maximize their own interests. Whereas power and interest calculations determine MPs' action or inaction, they may constrain IGO/NGO intervention when such activities are perceived as acting against their interests. In short, with the unique positions of these two groups of countries (neighbors' proximity to the affected territories, MPs' massive political and economic strength), their attitudes play significant roles in determining the approaches and effectiveness of international intervention that will be discussed in the next section. A table showing the dynamic of intervention, i.e. the stance and approaches of the stakeholders, is available at Exhibit 8.3.

(5) Existing Approaches of International Intervention in Public Healthcare of DFIEs

Owing to prolonged conflicts, the conditions of public healthcare in most DFIEs are far from satisfactory, leading to pressing need for international intervention. Lack of comprehensive data poses difficulty in conducting overall assessment of the situation. Three approaches, namely (I) isolated/self-reliance,

(II) neighbor/MP-intervention, and (III) IGO/NGO-assistance are identified based on scattered information. The Hamas-governed Gaza Strip, South Ossetia and Somaliland will serve as examples for discussion of these approaches to see how the dynamic of intervention has come into play and evaluate their effectiveness in improving public healthcare, disease control and humanitarian assistance in these entities. The key features of these approaches are outlined at Exhibit 8.4.

(5.1) Approach (I): Isolated/Self-reliance (Case example: Gaza Strip)

The dispute between Israel and Palestine over the latter's independence has never been eased. In Palestine, the radical organization Hamas "has waged off-and-on war with Israel" for more than a decade (Byman & King, 2011). It led to "well over \$100 million in infrastructural projects" funded by the West including hospitals damaged or destroyed (Roy, 2004: 376). After Hamas took control of Gaza Strip in June 2007, Israel declared the place a "hostile entity" and imposed blockade that "greatly harmed Gaza's health system" (B'Tselem, 2010; WHO, 2007). Suspension of external supply and aid led to series of problems including shortage of drugs and medical facilities, postponement of treatment of chronic patients, deteriorating public hygiene, etc (B'Tselem, 2010). According to Oxfam et al (2008), hospitals experienced regular power cuts for 8-12 hours every day. In Jan 2008 the territory was short of 19% of necessary medicines for surgery, antibiotics, cancer, etc and 31% of vital medical equipment and "grave shortage of replacement parts" and disposable items (B'Tselem, 2010). The blockade also reduced access to medical services outside Gaza Strip, with Israel cutting back on issuing permits for hundreds of Gaza residents to enter the country for treatment in hospitals nearby. The number of rejected cases due to "security reasons" increased (from approval rate of 90% in early 2007 before Hamas takeover to 69% in late 2007) (B'Tselem, 2010). Patients needed to go through complicated application process and might still be denied access at the crossing even if they were granted permits (Berg, 2008; Oxfam et al, 2008). As a result, in the first half year since Hamas takeover 32 patients died while waiting for travel permits (Berg, 2008).

The situation worsened by the fact that the only international crossing between Gaza and Egypt at Rafah was closed down under Israel pressure

(B'Tselem, 2010). Attempts by some NGOs to provide medical and humanitarian aid from the sea received high-handed treatment by Israel, the most notable of which was the raid on Gaza Freedom Flotilla.⁸ It was not until late June 2010 that Israel eased the blockade partially for delivery of civilian aid by IGOs/NGOs into the territory (JPost.com, 2010). After five-year long blockade the “healthcare for 1.5 million people in Gaza has dramatically deteriorated” (Oxfam et al, 2008: 10). With the diplomatic backup of US (as principal MP), Israel could act in the way that “gravely breaches the right of the residents to optimal medical care” both inside and outside the territory (B'Tselem, 2010). Hamas could rely on nobody but its own charitable service networks to provide healthcare to the masses, which received skeptics about its use of social services as tricks to support terrorist activities (Levitt, 2006: 92). With virtually non-existence of international intervention under isolation, one can see no end in the vicious cycle of the deterioration in health condition in Gaza Strip that shall continue to be a time bomb of humanitarian crisis and epidemic outbreak. By then the cost of recovery of public healthcare will be astronomical.

(5.2) *Approach (II): Neighbor/MP-intervention (Case example: South Ossetia)*

The separation of South Ossetia from Georgia can be traced back to 1991. In the aftermath of the armed conflicts between the two sides in 2008, nearly half of healthcare facilities in rural area required refurbishment (IDMC, 2012a). International intervention in public healthcare has been facing fierce opposition from Georgia which is skeptical about consolidating legitimacy and strength of the separatist force.⁹ Its stance was shared by US and many countries.¹⁰ Entering South Ossetia was declared illegal and subject to criminal charges by Georgian government (Globalsurance, 2012).¹¹ As a result, assistance by IGOs/NGOs

⁸ For details of the attack, please refer to Black and Siddique (2010) and the *Thou Shalt Not Kill* website (2012).

⁹ While Georgia has once announced provision of health assistance to the territory for “restoring trust and confidence”, no concrete efforts were taken place due to hostile attitudes of both sides, see Interfax (2010); US GHI (2012: 28).

¹⁰ South Ossetia is diplomatically recognized by five UN members (Russia, Nauru, Nicaragua, Tuvalu and Venezuela) only.

¹¹ Very few personnel of IGOs/NGOs were granted access to South Ossetia since then, see

in South Ossetia had largely forfeited (ICG, 2010:19; WHO, 2008: 2-3). Organizations like MSF were unable to conduct needs assessment in the territory (MSF, 2008b).¹² With mandate in armed conflicts under international law, ICRC became the only organization permitted to work in South Ossetia (ICRC, 2011a). However, its mission was limited to providing basic items¹³ and remote areas where local clinics could hardly deal with simple treatment like headache (ICRC, 2008b). The organization was also responsible for transfer of patients for treatment in Georgian hospitals, but limited to urgent cases.¹⁴ Generally speaking, IGO/NGO intervention in South Ossetia was very limited.

Indeed, Georgia was not the only barrier to IGO/NGO intervention. As a major power and the sole neighbor of South Ossetia, Russia played a crucial role in determining the level of intervention. With irredentist claim¹⁵ and to prevent spread of conflicts across the border, Russia saw the interests to intervene by its own. Public finance of South Ossetia relied heavily on subsidy from Russia.¹⁶ Funding was earmarked for healthcare system including referral of patients to Russia for specialist treatment (Council of Europe, 2009; Sytnik, 2010). Meanwhile, Russia also provided medical aids and technical assistance.¹⁷ With a population slightly more than 70,000, it is doubtful whether the entity could survive without Russian aid.

Canadian Medical Association (2008: 763).

¹² While restrictions were partially released in early 2010 by allowing access from Russia to provide “urgent humanitarian assistance” like food and medical services (see ICG (2010: 21)), health assistance of WHO and other IGOs/NGOs was confined to settlement of IDPs on Georgian side (see CARE International (2008); SMOM (2008); WHO EURO (2008; 2012b)). This is also the case in WHO collaboration with Georgian authority in “disaster preparedness and response capacities and coordination mechanisms”, see WHO EURO (2012a).

¹³ Such as generators, cooking stoves, basic drugs and organizing short-term training workshops, see ICRC (2008a; 2009; 2011b: 327).

¹⁴ In 2011, only four medical evacuations were carried out, see ICRC (2011a).

¹⁵ There are voices advocating the merging of South Ossetia with Russia’s North Ossetia region.

¹⁶ For instance, the government budget increased by half from RUB2.7b (USD87m) in 2009 to RUB4.3b (USD140m) in 2010, 98.7% of which came from Russian aid, see ICG (2010: 4).

¹⁷ Including supply of medicine, sending doctors to provide free medical care in some districts, and refurbishment of 19 public health facilities alongside other public utilities, see BBC (2010); Interfax (2009).

In the absence of expertise and coordination by IGOs/NGOs, rebuilding public healthcare remained an issue in South Ossetia. Assistance from Russia could only alleviate the situation. Local medical facilities could only provide minimal treatment.¹⁸ People preferred treatment outside the territory but were blocked by Georgia in the south, while entitlement to healthcare in Russia was limited to those with Russian passports (ICRC, 2011b: 328; ICG., 2010: 6). Meanwhile, immunization and treatment programs provided by IGOs/NGOs were forced to suspend after 2008, hence heightening pandemic risk.¹⁹ Besides, permanent settlement and provision of medical service for about 300,000 IDPs on both sides of borders remained a big issue (Hauschild & Berkhout, 2009: 9; UNICEF, 2012).²⁰ As a whole, the experience of South Ossetia shows how the intervention of neighbors/MPs is driven by their own interests. Their proactive move caused condemnation of invasion and intrusion on sovereignty and inevitably politicized freedom of movement and access for IGO/NGO missions (ICG, 2010: 23). Though not as extreme as Gaza, it prevents the territory from receiving genuine assistance from IGOs/NGOs with better expertise and coordination, hence affecting overall effectiveness of intervention.

(5.3) Approach (III): IGO/NGO-assistance (Case example: Somaliland)

Following the overthrow of Siad Barre dictatorship in 1992, Somalia has been undergoing nationwide civil war between numerous clans and religious groups for two decades. In contrast to the chaotic situation in other parts of Somalia, Somaliland, which declared independence unilaterally in 1991, has been “experiencing political development, economic recovery, and relative stability” (WHO EMRO, 2008). However, prolonged civil war brought about destruction of health system, with “only three acute district hospitals [left for] serving the 3.5 million Somaliland population” (Leather, et al, 2006: 1121). Doctors and

¹⁸ According to ICRC (2008a), access to quality healthcare remains a problem in the countryside where “medical facilities are dilapidated”.

¹⁹ For instance, even a few days of suspension of treatment of contagious disease “can have dire consequences on the health of patients”, see MSF (2008a).

²⁰ There is little information about the conditions of IDPs in South Ossetia but according to a survey by an independent researcher, medical services for them remain at minimal level, see IDMC (2012b: 6); Koch (2009).

advanced medical facilities were mostly in the capital Hargeisa, albeit facing serious shortage.²¹ While the entity has formal budget, its weak economy could hardly generate revenue.²² Only 3% of expenditure was allocated for healthcare (Pavignani, et al, 2010: 47). This together with lack of expertise accounted for sometimes incoherent and unrealistic policy initiatives in such areas as drugs procurement, regulation of health sector, etc (Pavignani, et al, 2010: 19, 60). Furthermore, “its unrecognized status has discouraged aid and investment” that the entity is unable to join IGOs and thus can only passively rely on initiatives by outsiders (Byman & King, 2011).²³ All these weaknesses brought an imminent need to rebuild capacity in public healthcare.

Unlike Gaza Strip and South Ossetia, no functioning central government was in existence in Somalia for most of the time since 1992. Neighbouring states (Djibouti and Ethiopia) were poor, while MPs possess no strategic interest in the region. Both were thus apathetic towards the situation. All these helped remove obstacles to IGO/NGO intervention. WHO as the leading health agency was given a free hand to act by setting up large presence in Somaliland. A high-level delegation led by its Assistant Director-General met with President of the entity during his visit in Nov 2009 (WHO EMRO, 2010b: 34), which could hardly be imagined for South Ossetia. Following the visit, the organization set up two planning missions bringing together other UN agencies, local health authorities and NGOs to develop “a framework for health system strengthening” (WHO EMRO, 2011: 4). Under its coordination, various NGOs were assigned to different clusters to help rebuild public health system.²⁴ It also worked with local NGOs

²¹ For example, some basic surgical equipment like oxygen supplies, heart monitors, and routine medicine needed to be bought by patients’ relatives, see Farah (2003).

²² In 2007, the government budget was estimated between USD22-26m, with 80% from port of Berbera, see Pavignani, et al (2010: 12).

²³ Somaliland is diplomatically recognized by no UN member state.

²⁴ For instance, Save the Children (UK) worked side-by-side with WHO Somalia Office in the cluster to provide medical services, see WHO EMRO (2010a); King’s College of Hospital (UK) provided support and training to Edna Adan Hospital (a maternal and infant hospital set up by Madam Edna Adan, ex-First Lady of Somalia and renowned medical figure in the region (see Bradbury (2010)), sent lecturers to teach medical students in Amoud University, and set up revolving drug fund, community education, etc (see Leather et al (2006: 1120-22)); With UNICEF support, International Medical Corps (US) ran nutrition programs in Sool and Sanaag

like Somaliland Family Health Association (SFHA, 2012) for better coordination of activities.

The contributions of massive IGO/NGO intervention in Somaliland were apparent. For healthcare system rebuilding, achievements were made in standardization of drug list,²⁵ training of health personnel,²⁶ quality control,²⁷ child health,²⁸ and health education.²⁹ In terms of disease control, surveillance mechanism³⁰ and immunization programs³¹ were gradually rebuilt. Laboratory facilities in hospitals were improved to strengthen testing and monitoring capacity.³² Nowadays the territory has almost been malaria-free (IRIN, 2011).

regions, see IMC (2011) and Radosavljevic (2011); SOS Medical Centre (Canada) set up mother and child health care operation in Hargeisa in 2008, see SOS (2012).

²⁵ A Drugs and Therapeutic Committee was formed to draft “essential medicines list” for hospitals based on WHO model list. It provided technical support equipment to the central medical store in Hargeisa and the Pharmaceutical Association of Somaliland as well as main warehouses in the area, see WHO EMRO (2010b: 24).

²⁶ Including regular and formal training for midwifery teachers, nurses, etc, see WHO EMRO (2010b: 16).

²⁷ A quality control centre was set up in Hargeisa in 2009, see WHO EMRO (2010b: 14).

²⁸ In early 2012, WHO worked with UNICEF and other partners to implement the first Child Health Day (CHD) in all six regions of Somaliland with multiple child healthcare interventions including “immunization, de-worming, nutrition, oral rehydration salts promotion, and malaria control”, see WHO EMRO (2012).

²⁹ Hargeisa “adopted and introduced the ‘Healthy City’ concept that focuses on improving the quality of life of the urban population through education and promotion of healthy lifestyles... improve access to quality health care services and to safe water and sanitation” and so on. The project was fully implemented by end 2009, which was the first in Somalia and in surrounding regions, see WHO EMRO (2008; 2010b: 17).

³⁰ Examples include zone-wide survey for HIV/Syphilis sero-surveillance conducted in 2007 (see WHO EMRO (2008)) and measles case-based surveillance in 2008 (see WHO EMRO (2010b:6)).

³¹ Hepatitis vaccine was introduced in 2010, see WHO EMRO (2010b: 7); The “Reach-Every-District strategy”, a local district level immunization campaign was implemented by WHO in collaboration with local health authorities, UNICEF and other health partners. Expanded program of immunization (EPI) unit was set up to make assessments on the status of immunization and train personnel, see WHO EMRO (2010b: 6-7).

³² Medicines therapeutic committee at Hargeisa hospital was set up with WHO technical support alongside establishment of malaria reference lab and upgrading of other laboratories. As a result, the hospital was able to “provide communicable disease and cholera testing services although with limited diagnostic capacity”, see WHO EMRO (2008; 2010b: 25-26).

“Measles outbreak in Hargeisa was successfully controlled in 2010” (WHO EMRO, 2011:2), which is remarkable given pandemic of the disease in Sub-Saharan Africa. Besides, the IGO/NGO community set up mental health centres in the territory to deal with people suffering from mental disorders due to devastating outcomes of wars and natural disasters (WHO EMRO, 2010b: 20). Though not comparable to advanced societies, the progress of rebuilding public healthcare and disease control in the territory under the commitments of IGOs/NGOs was significant.³³ However, it must be pointed out that the achievements in Somaliland are largely attributable to absence of functional *de jure* sovereignty and apathy of neighbours and MPs that effectively removed obstacles to IGO/NGO intervention. It is uncertain about the stance of Somalia’s central government upon its recent re-formation (Gettleman, 2011) that may impact on the future scope and direction of intervention in the entity. Notwithstanding, the relatively effective approach of IGO/NGO intervention under WHO coordination in Somaliland serves as a useful reference for reforming the existing international health regime to better deal with the situations in DFIEs.

(5.4) *Brief comparison*

In the first two approaches (Isolated/Self-reliance and Neighbor/MP-intervention), the sovereigns served as major obstacles to intervention by imposing blockade on the entities. IGOs/NGOs could only provide limited assistance as a result. Meanwhile, MPs (principally US and EU members) are hostile to both Gaza and South Ossetia by seeing them as either terrorist or threat to territorial integrity. The major difference between these two approaches rests with intervention or not by neighboring states. In Gaza, Egypt was forced to close its border under the pressure of Israel (DJSS), while in South Ossetia interest calculations led Russia to intervene and become its major supporter. In the third approach (IGO/NGO assistance), absence of functional sovereign in Somalia and apathy of other countries gave IGOs/NGOs a free hand to pursue assistance in the territories of the entities.

³³ Here two indicators show the positive trend: Maternal mortality rate (deaths per 100k women) dropped from 1600 in 1991 to 1044 in 2006; Child mortality rate dropped from 275 in 1990 to 166 in 2006, see IRIN (2011).

When we compare outcomes of the three approaches, in Gaza total isolation made it difficult for intervention and the entity could only rely on its own. In South Ossetia, despite Russian support the progress was rather moderate due to lack of IGOs/NGOs involvement to bring in necessary expertise and resources. Relatively speaking, significant progress was made in Somaliland with better coordination of IGOs/NGOs working under WHO leadership, but it is uncertain whether the re-functioning of the sovereign authority would affect future development. In short, the experience in Somaliland demonstrates the potential and need for an integrated framework of intervention.

(6) In Search for an Institutional Solution: Towards an Integrated Framework of International Intervention in DFIEs

In the above we have gone through the implications of the exclusion of DFIEs from international health regime and how various stakeholders have adopted different approaches of intervention to mitigate adverse effects of poor health conditions of DFIEs on global health. As these approaches rely on intervention by individual stakeholders, they are mostly not well organized and may not be fitted in other situations. An integrated framework of international intervention in DFIEs' public healthcare is thus necessary. As then UN Secretary-General Kofi Annan had called for better protection of healthcare which did not only rely on UN members' responsibilities but should also acknowledge "the reality of armed groups and other non-state actors in conflicts, and the role of civil society in moving from vulnerability to security and from war to peace" (Southall, 2011: 739-40).

Although the present international order is rather anarchic where states seek to maximize their power and interests, as neo-liberalists argue, to further national interests countries as "competing, self-interested 'rational actors'" (Armstrong et al, 2004: 12) will come together to construct international regime for seeking wealth, power and other values (Keohane, 1984: 22). So do non-state actors like DFIEs, IGOs and NGOs. According to Keohane and Martin (1995: 42), "institutions can provide information, reduce transaction costs, make commitments more credible,

establish focal points for coordination and, in general, facilitate the operation of reciprocity”. It corresponds to the scenario where “cooperation is most likely to occur not only when there are shared interests but when international institutions exist that facilitates cooperation on behalf of those interests” (Keohane, 1984: 240). Based on this institutionalist claim, two factors determine the creation of the new framework, namely identification of common interests and institution-setting.

As demonstrated in the three cases, the stakeholders possessed very diverse interests vis-à-vis others. Notwithstanding, as discussed in the early parts of this paper, they share imminent needs to deal with cross-border adverse effects of DFIEs on global health thanks to breakdown of public health system, absence of disease surveillance mechanism, massive mobility of IDPs and resultant humanitarian crisis in the entities concerned. These serve as the foundation of cooperation in intervention by which resources and efforts of IGOs, NGOs and other relevant parties are to be better organized and coordinated. It should take into consideration four pillars (aspects), namely (a) legal foundation, (b) WHO leadership and coordination, (c) scope of intervention, and (d) external representation in the process of institution-setting so as to create an integrated framework of intervention. Exhibit 8.5 summarizes the main points of the proposal to be discussed below.

(6.1) Legal foundation: Criteria setting, assessment and decision of intervention

In the first place, there is an essential need to set the criteria for activating the mandate for intervention. Some scholars like Hoffman have explored possibilities to develop new epidemiological standards to identify “trigger points for application of international humanitarian law” and other legal instruments (Hoffman, 2001: 239-43). Factors like proportion of IDPs to entire population, spread of disease with high risk of pandemic across border (say number of cases and death caused), degree of destruction of public health system (say types and percentage of medical facilities damaged) may also be included. Besides these technical indicators, the following criteria is crucial: Whether the constitutional authority of DJSS can “develop certain minimum core public health capacities” and “notify WHO of events that may constitute a public health emergency of international concern

according to defined criteria” for territories under its jurisdiction (WHO, 2005b:1). Obviously, DJSS has lost effective control of areas under DFIE, hence failing to fulfill its obligations under international law. This provides the legal basis for intervention above sovereignty.³⁴ By then DJSS endorsement as a major obstacle to intervention shall be removed.³⁵

No matter what the set of criteria would be, on-site assessment of situation should be conducted by an independent and impartial party acceptable to all major stakeholders. With its century long prestige and humanitarian mandate under Geneva Conventions, ICRC, which adheres to “absolute political neutrality in a conflict” (Flanigan, 2008: 295), is the most appropriate authority for the assessment. Its involvement will enhance credibility of investigation. Based on the results of assessment, WHO as the highest global health authority will decide whether to activate the mandate for intervention by resolution of its Assembly or Executive Board. It should be less difficult than the procedures for UN Peacekeeping Mission that must go through UN Security Council where each of its five permanent members can exercise veto.

(6.2) WHO leadership and coordination

As the supreme managing authority of international health regime, WHO may follow the present practice of its country offices by deploying “Health Mission” to lead and coordinate the work of IGOs, NGOs, neighbouring states and other parties in international intervention. The experience in Somaliland sets a precedent in this regard. Meanwhile, the role of NGOs should be enhanced by according them higher responsibilities under the integrated framework. Given the diversity of NGOs, it may require some sorts of “code of conduct for global networks that lay out minimum standards for NGO integrity and performance” (Edwards, 2000) to decide which NGOs are capable of carrying out long-term intervention in the affected territories. Neighboring states should also be incorporated into the framework to act as “health corridor” for IGOs/NGOs and others to get access to

³⁴ It may also make reference to the classification of armed conflicts for application of international humanitarian law. Under international humanitarian framework, the behaviour of belligerent parties is subject to regulation, see Chelimo (2011).

³⁵ It requires more careful and comprehensive study by experts in international law and global health governance.

the affected territory.

(6.3) Scope of intervention

To avoid complication of the situation, international intervention in the affected territories must be confined to those areas with direct impact on public health. They include (but are not necessarily limited to) provision of aid and technical assistance for rebuilding public healthcare for local population, proactive participation in disease control (surveillance, testing, reporting, etc) in case DFIEs lack such capacities, and supply of humanitarian assistance for IDP settlement. The overall goal of the WHO-led “Health Mission” is to support recovery of public health and hygiene in the affected territories as soon as possible to eradicate possible health risks to both the locality and the rest of world.

(6.4) External representation

As the subject of intervention, to define the status, rights and obligations of DFIEs in the context of global health is the most difficult part in the creation of the framework. On the one hand, such definition should refrain from formal recognition of independence of the entities that is beyond the mandate for health intervention. On the other hand, it should move beyond the stereotype of “casting insurgents [including DFIEs] as mere criminals [that] may... reinforce existing aversions of the international community to undertake humanitarian interventions” (Ballentine, 2003: 279-80). Here the definition of “insurgency” under Geneva Convention may serve as reference.³⁶

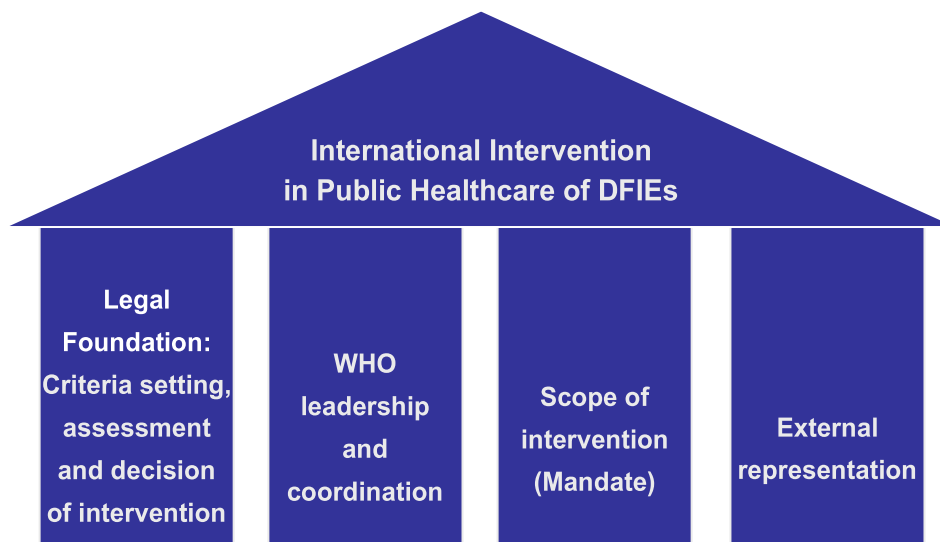
Given political sensitivity of the above, as an immediate measure it would consider letting third parties like ICRC or NGOs to act as “white gloves” (agents acting on behalf) of DFIE health authorities to fulfil some legal obligations under IHR and other international health laws and regulations. The rationale behind is that ICRC/NGOs are widely regarded as unofficial, independent and impartial (albeit subject to controversy sometimes) vis-à-vis IGOs that are restrained by resolutions of their member states. In the long run, with the growing trend of

³⁶ “When rebels or insurgents come to occupy and effective control a substantial part of the State territory, it may become necessary for the recognizing States to take cognizance of the state of insurgency” and give these entities formal status of belligerency (in turn, becoming subjects of international law) that involves both rights and duties, see Kumer (2007).

international institutions to include non-state entities,³⁷ it may follow the precedents of Palestine and Taiwan to incorporate them partially by giving DFIEs observer status in WHA so that they can enjoy certain rights and privileges of WHO members short of voting and other statutory powers.³⁸

With such an integrated framework as illustrated above, the stakeholders shall be able to carry out their work in a more organized and effective manner.

Four Pillars of the Proposed Integrated Framework of Intervention



(7) Final Remarks: The Cost and Potential for Change

In the preceding sections we have discussed the limitations of the international health regime that fails to incorporate DFIEs and reviewed existing approaches of international intervention in their public healthcare to mitigate negative impact on domestic and global health. An institutionalist solution was proposed by creating an integrated framework of intervention with due regard to

³⁷ Examples include World Trade Organization (WTO) (membership by independent “customs territory”), Asia-Pacific Economic Cooperation (APEC) (by separate “economy”), Financial Action Task Force on Money Laundering (FATF) (by legal “jurisdiction”), and Western and Central Pacific Fisheries Commission (WCPFC) (by “fishing entity”).

³⁸ In the case of Taiwan, its acceptance as WHA observer in 2009 was arguably subject to tacit consent of the People’s Republic of China (in the capacity of *de jure* sovereign of Taiwan), see Wicaksono (2009a; 2009b).

legality, effectiveness, comprehensiveness and representation. By bringing together stakeholders under WHO leadership, the resources and efforts of IGOs, NGOs and other parties shall be better coordinated and utilized for the improvement in public healthcare of DFIEs.

No matter how comprehensive and ideal the proposed framework is, one should not deny the fact that the existing international order is still state-centric and thus its change relies “heavily on the political will of states to classify the situation” (Chelimo, 2011). Amongst them the role of MPs is dominant. As Drezner (2007:5) puts it, a “great power concert is a necessary and sufficient condition for effective global governance over any transnational issue”. While “globalization increases the rewards for policy coordination”, it depends on the adjustment costs that sovereign states (MPs in particular) have to “face in altering their preexisting rules and regulations. When the adjustment costs are sufficiently high, not even globalization’s powerful dynamics can push states into cooperating” (Drezner, 2007:5).

The issue of adjustment costs shows no easy task for reforming the present sovereignty-based international order. Notwithstanding, health is an area with strong potential for supra-sovereign collaboration giving its borderless implications for humanity. The threat of epidemic diseases “posed to the health security and economic well-being” (Feldbaum & Michaud, 2010: 2) requires prompt and comprehensive response of all as demonstrated in such instances as SARS outbreak. Cooperation in global health between rival camps during the Cold War “as exemplified by the award of the Nobel Peace Prize to the International Physicians for the Prevention of Nuclear War” (joint efforts by doctors from the two blocs in research and promotion of medical effects of nuclear war) set a good example for cooperation and gave us a sense of optimism for the future (McKee & Atun, 2006: 1225). After all the objective of international health regime “shall be the attainment by all peoples of the highest possible level of health” (WHO, 2005a: 2). All nations should work together to strive for “health without borders” for humanity. Here the words of a renowned physician are quoted as the ending for this paper (O’Neil, 2008: 153):

It is time that we again find our collective voice and venture forth into the world, leading others in a struggle to bring social justice and health equity to all people.

Exhibit 8.1 – DFIEs at a Glance

DFIE (Non-UN members)	Size (km²)	Population (million)	Unilateral Declaration of Independence (UDI)	Recognition by UN members	DJSS
Abkhazia (Republic of Abkhazia)	8,660	0.241	1990	6	Georgia
Gaza Strip (Hamas government in Gaza)	360	1.657	2007*	0	Israel
Nagorno-Karabakh (Nagorno-Karabakh Republic)	11,458	0.141	1991	0	Azerbaijan
Northern Cyprus (Turkish Republic of Northern Cyprus)	3,355	0.295	1983	1	Cyprus
Somaliland (Republic of Somaliland)	137,600	3.500	1991	0	Somalia
South Ossetia (Republic of South Ossetia)	3,900	0.072	1991	5	Georgia
Transnistria (Pridnestrovian Moldavian Republic)	4,163	0.519	1990	0	Moldova
Western Sahara (Sahrawi Arab Democratic Republic)	Claim: 266,000 Actual: 66,500	Claim: 0.503 Actual: 0.100	1976	57	Morocco

* Hamas takeover of Gaza Strip from Palestinian National Authority

Note: Kosovo, Palestine and Taiwan are either close to obtaining WHO membership (Kosovo) or have been granted WHA observer status (the latter two), hence not covered by the discussion here.

Sources: Websites of the authorities of respective entities, CIA World Factbook, Wikipedia.

Exhibit 8.2 – Positions, Perceptions and Incentives of Major Stakeholders

Exhibit 8.2 – Positions, Perceptions and Incentives of Major Stakeholders

Exhibit 8.3 – Dynamic of Intervention: Approach adopted depends on positions, perceptions and incentives (or otherwise) to intervene by major stakeholders

Attitude	Stakeholder	Stance	Approach
Positive	DFIEs	Generally willing to accept international intervention for own sake	Isolated/ Self-reliance
Positive	IGOs / NGOs	Scope and extent of activities depend on stance of other stakeholders	IGO/NGO- assistance
Varying	Neighboring states	Have incentives if affected by the conflict or want to pursue own agenda If intervene, likely constrain IGO/NGO activities to protect own interest	Neighbor/ MP-intervention
Varying	MPs	Whether to intervene depends on own diplomatic agenda and interest Likely constrain IGO/NGO activities if they act against own interest	
Negative	DJSSs	Generally reluctant, suspicious of tacit recognition of DFIE	Blockade

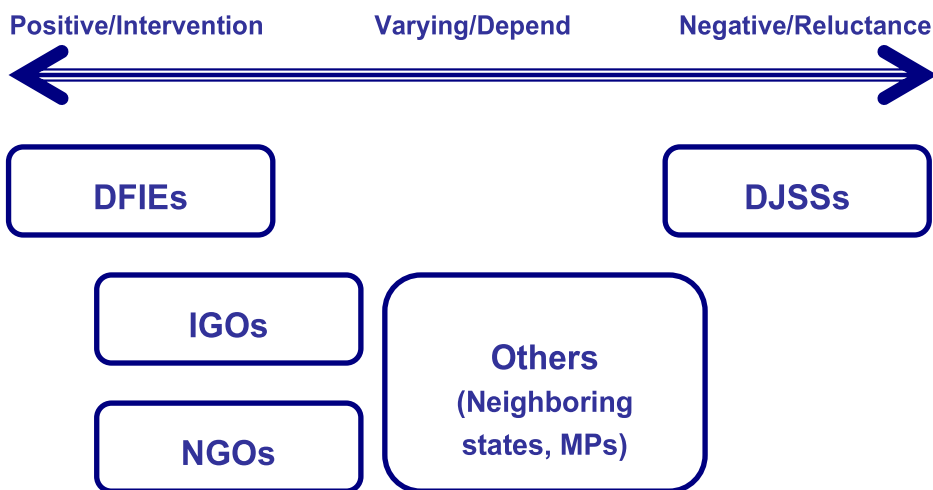


Exhibit 8.4

Exhibit 8.5 – Proposal for an Integrated Framework of International Intervention in DFIEs (an Institutionalist Solution)

(1) Identification of Common Interests

<i>Imminent needs for major stakeholders to deal with cross-border adverse effects of DFIEs on domestic and global health</i>
(a) Rebuild public health system in DFIE
(b) Incorporate DFIE into disease surveillance mechanism
(c) Settlement of IDPs to prevent disease outbreak and humanitarian crisis caused by massive mobility and displacement

(2) Institution-Setting (Four Pillars)

(a) Legal foundation	<ul style="list-style-type: none"> ➤ Based on the understanding that DJSS failed to fulfil legal obligations to handle health issues in DFIE territories. ➤ Set out criteria for activating mandate for international intervention. ➤ ICRC to conduct on-site assessment based on the prescribed set of criteria. ➤ WHO to decide whether to activate the mandate for intervention (by resolution of WHA or Executive Board).
(b) WHO leadership and coordination	<ul style="list-style-type: none"> ➤ Deploy “Health Mission” to lead and coordinate the work of IGOs, NGOs, neighbouring states and other parties in DFIE territories. ➤ Enhance role of NGOs by according them higher responsibilities. ➤ Incorporate neighboring states to act as “health corridor” for IGOs/NGOs/etc to get access to the territories.
(c) Scope of intervention (mandate)	<ul style="list-style-type: none"> ➤ Focus on those areas that may have an impact on public health. <ul style="list-style-type: none"> ● Provision of aid and technical assistance for rebuilding public healthcare for local population. ● Proactive participation in disease control (surveillance, testing, reporting, etc). ● Humanitarian assistance for IDP settlement. ➤ Overall goal: Recovery of public health and hygiene as soon as possible to eradicate possible health risks.
(d) External representation	<ul style="list-style-type: none"> ➤ Define the status, rights and obligations of DFIEs in the context of global health, if possible. ➤ Immediate measure: ICRC or NGOs act as “white gloves” (agents) of DFIE health authorities to carry out obligations under IHR and other international health laws and regulations. ➤ Long-term solution: Give DFIEs observer status in WHA to enjoy certain rights and privileges of WHO members short of voting and other statutory powers (as in the cases of Taiwan and Palestine).

References

- Armstrong, David, Lorna Lloyd, and John Redmond. 2004. *International Organization in World Politics*. Hampshire: Palgrave Macmillan.
- Ballentine, Karen. 2003. "Beyond Greed and Grievance: Reconsidering the Economic Dynamics of Armed Conflict," in Ballentine, Karen, and Jake Sherman, eds. *The Political Economy of Armed Conflicts: Beyond Greed and Grievance*, pp. 259-83. Boulder: Lynne Rienner Publishers.
- BBC. 2010. "Russia doctors provide free medical care to population in South Ossetia." *BBC Monitoring Former Soviet Union*, August 24.
- BBC. 2011. "Somaliland Profile." December 9 (<http://www.bbc.co.uk/news/world-africa-14115069>) (2016/5/31).
- Berg, Raffi. 2008. "Israel's Dilemma over Sick Gazans." April 30 (http://news.bbc.co.uk/2/hi/middle_east/7375439.stm) (2016/5/31).
- Black, Ian, and Haroon Siddique. 2010. "Q&A: The Gaza Freedom Flotilla." *Guardian*, May 31 (<http://www.guardian.co.uk/world/2010/may/31/q-a-gaza-freedom-flotilla>) (2016/5/31).
- Bradbury, Paul. 2010. "Maternity Health Care in Hargeisa, Somaliland, and Xray of a Foot." December 13 (<http://paul-bradbury.suite101.com/maternity-health-care-in-hargeisa-somaliland-and-xray-of-a-foot-a320195>) (2016/5/31).
- B'Tselem. 2010. "Health situation in the Gaza Strip." September 27 (http://www.btselem.org/gaza_strip/medical_system) (2016/5/31).
- Byman, Daniel L., and Charles King. 2011. "The Phantom Menace." *New York Times*, August 15.
- Calain, Philippe. 2007. "Exploring the International Arena of Global Public Health Surveillance." *Health Policy and Planning*, Vol. 22, pp. 2-12.
- Canadian Medical Association. 2008. "Emergency Medical Response Strategy Proved Critical to Sustaining Georgia's Health Infrastructure." *Canadian Medical Association Journal*, Vol. 179, No. 8, pp. 762-63
- CARE International. 2008. "Crisis in South Ossetia: CARE's Response." (<http://www.care-international.org/Featured-Articles/crisis-in-south-ossetia-cares-response.html>) (2016/5/31).
- Chan, Chang-Chuan, and Feng-Jen Tsai. 2006. "Taiwan and the Global Outbreak Alert and Response Network." *The Lancet*, Vol. 367, No. 9526, pp. 1901-1902.

- Chelimo, Gertrude C. 2011. "Defining Armed Conflict in International Humanitarian Law." *Student Pulse*, Vol. 3, No. 4 (<http://www.studentpulse.com/a?id=508>) (2016/5/31).
- Chiu, Hungdah. 2005. *Modern International Law* (in Chinese). Taipei: Sanmin.
- Council of Europe Committee on Migration, Refugees and Population. 2009. "Humanitarian Consequences of the War between Georgia and Russia: Follow-up Given to Resolution 1648 (2009)." April 9 (<http://assembly.coe.int/Documents/WorkingDocs/Doc09/EDOC11859.pdf>) (2016/5/31).
- Crawford, James. 2006. *The Creation of States in International Law*. New York: Oxford University Press.
- Drezner, Daniel W. 2007. *All Politics is Global: Explaining International Regulatory Regimes*. Princeton: Princeton University Press.
- Edwards, Mike. 2000. "Time to put the NGO House in Order." *Financial Times*, June 6.
- Elliott, Tim. 2011. "The Australian Professor Who Taught the Tamil Tigers." *Trans Currents*, May 7 (<http://transcurrents.com/news-views/archives/274>) (2016/5/31).
- Farah, Abdirizak M. 2003. "Somaliland's Health Care System Needs Special Attention!" *Somaliland Times*, No. 75 (<http://www.somalilandtimes.net/2003/76/7604.shtml>) (2016/6/28)
- Feldbaum, Harley, and Joshua Michaud. 2010. "Health Diplomacy and the Enduring Relevance of Foreign Policy Interests." *PLoS Medicine*, Vol. 7, No. 4, pp. 1-6.
- Flanigan, Shawn Teresa. 2008. "Nonprofit Service Provision by Insurgent Organizations: The Cases of Hizballah and the Tamil Tiger." *Studies in Conflict & Terrorism*, Vol. 31, pp. 499-519.
- Flanigan, Shawn Teresa. 2010. *For the Love of God: NGOs and Religious Identity in a Violent World*. Sterling: Kumarian Press.
- Gallmetzer, Reinhold. 2010. "Prosecuting Persons Doing Business with Armed Groups in Conflict Areas: The Strategy of the Office of the Prosecutor of the International Criminal Court." *Journal of International Criminal Justice*, Vol. 8, pp. 947-56.
- Gettleman, Jeffrey. 2011. "Harvard-Educated Technocrat Chosen as Somalia Premier." *New York Times*, June 23 (http://www.nytimes.com/2011/06/24/world/africa/24-somalia.html?_r=1&partner=rssnyt&emc=rss) (2016/5/31).
- Globalsurance. 2012. "Georgia: Healthcare System." (<http://www.globalsurance.com/resources/georgia>) (2016/5/31).
- Harbom, Lotta, and Peter Wallensteen. 2005. "Armed Conflict and Its International Dimensions, 1946-2004." *Journal of Peace Research*, Vol. 42, No. 5, pp. 623-635.

- Hauschild, Tobias, and Esme Berkhout. 2009. "Health-Care Reform in Georgia: A Civil-Society Perspective: Country Case Study." (<http://www.oxfam.org/sites/www.oxfam.org/files/healthcare-reform-georgia-report-0905.pdf>) (2016/5/31).
- Hoffman, MH. 2001. "Physicians and International Humanitarian Law in Complex Emergencies: Controversies and Future Opportunities." *Prehospital and Disaster Medicine*, Vol. 16, No. 4, pp. 239-43.
- Interfax. 2009. "Corridors of Power: Russia to Give 11.5 Bln Rubles to S. Ossetia in 2009 – Source." *Interfax: Russia and CIS Military Information Weekly*, April 30.
- Interfax. 2010. "Trouble Spots: Georgia's New Strategy on Abkhazia, S. Ossetia Offers Nothing New – Tskhinvali." *Interfax: Russia and CIS Military Weekly*, July 9.
- Internal Displacement Monitoring Centre (IDMC). 2012a. "Georgia: Access to Medical Care." March 19 ([http://www.internal-displacement.org/idmc/website/countries.nsf/\(httpEnvelopes\)/5886C5CB600829A6C12579C70008F21F?OpenDocument](http://www.internal-displacement.org/idmc/website/countries.nsf/(httpEnvelopes)/5886C5CB600829A6C12579C70008F21F?OpenDocument)) (2016/5/31).
- IDMC. 2012b. "Georgia: Partial Progress towards Durable Solutions for IDPs." March 21 ([http://www.internal-displacement.org/8025708F004BE3B1/\(httpInfoFiles\)/644AA960D7FD85C6C12579C80036B27D/\\$file/georgia-overview-mar2012.pdf](http://www.internal-displacement.org/8025708F004BE3B1/(httpInfoFiles)/644AA960D7FD85C6C12579C80036B27D/$file/georgia-overview-mar2012.pdf)) (2016/5/31).
- International Committee of the Red Cross (ICRC). 2003. *Statutes of the International Committee of the Red Cross* (<http://www.icrc.org/eng/resources/documents/misc/icrc-statutes-080503.htm>) (2016/5/31).
- ICRC. 2008a. "Georgia/South Ossetia: Remote Areas Lack Food, Proper Access to Health Care." October 22 (<http://www.icrc.org/eng/resources/documents/update/georgia-update-221008.htm>) (2016/5/31).
- ICRC. 2008b. "Georgia: Georgia/Russian Federation: Three Months Later, the Impact of Conflict Endures." *ReliefWeb Report*, November 6 (<http://reliefweb.int/node/286274>) (2016/5/31).
- ICRC. 2009. "Georgia/South Ossetia: The Long Road to Normalization." August 6 (<http://www.icrc.org/eng/resources/documents/update/georgia-update-090809.htm>) (2016/5/31).
- ICRC. 2010. "About the International Committee of the Red Cross." October 29 (<http://www.icrc.org/eng/who-we-are/overview-who-we-are.htm>) (2016/5/31).
- ICRC. 2011a. "Central and Western Georgia/South Ossetia: Three Years after the Conflict." August 8 (<http://www.icrc.org/eng/resources/documents/update/2011/georgia-update-2011-08-05.htm>) (2016/5/31).
- ICRC. 2011b. "ICRC Annual Report 2010: Georgia." (<http://www.icrc.org/fre/assets/>)

- files/annual-report/current/icrc-annual-report-2010-georgia.pdf) (2016/5/31).
- International Crisis Group (ICG). 2010. "South Ossetia: The Burden of Recognition." June 7 (<http://www.crisisgroup.org/~media/Files/europe/205%20South%20Ossetia%20-%20The%20Burden%20of%20Recognition.ashx>) (2016/5/31).
- International Medical Corps (IMC). 2011. "Somalia: Nutrition in Somaliland" (<http://www.internationalmedicalcorps.org.uk/wherewework.asp?pageid=76>) (2016/5/31).
- IRIN. 2011. "Somalia: Healthcare, education gains as Somaliland marks 20th anniversary." May 20 (<http://www.irinnews.org/Report/92769/SOMALIA-Healthcare-education-gains-as-Somaliland-marks-20th-anniversary>) (2016/5/31).
- JPost.com. 2010. "Report: Gaza medical aid is expired." *Jerusalem Post*, July 21 (<http://www.jpost.com/MiddleEast/Article.aspx?id=182120>) (2016/5/31).
- Keohane, Robert. 1984. *After Hegemony*. Princeton: Princeton University Press.
- Keohane, Robert, and Lisa Martin. 1995. "The Promise of Institutionalist Theory." *International Security*, Vol. 20, No. 1, pp. 39-51.
- Koch, Erin. 2009. "Health Effects of Displacement in Post-war Georgia." (<http://www.irex.org/system/files/0910-Koch.pdf>) (2016/5/31).
- Kumer. 2007. "Recognition of Insurgency and Belligerency." *Lone Ranger*, August 2 (<http://kumar-theloneranger.blogspot.com/2007/08/recognition-of-insurgency-and.html>) (2016/5/31).
- Leather, Andrew, et al. 2006. "Working together to rebuild health care in post-conflict Somaliland." *Lancet*, Vol. 368, No. 9541, pp. 1119-25.
- Levitt, Matthew. 2006. *Hamas: Politics, Charity, and Terrorism in the Service of Jihad*. New Haven: Yale University Press.
- McKee, Martin, and Rifat Atun. 2006. "Beyond borders: public-health surveillance." *The Lancet*, Vol. 367, No. 9518, pp. 1224-26.
- Médecins Sans Frontières (MSF). 2008a. "MSF Assessing Needs in South Ossetia/Georgia Conflict" August 12 (<http://www.doctorswithoutborders.org/news/article.cfm?id=2997&cat=field-news>) (2016/5/31).
- MSF. 2008b. "MSF Continues Seeking Access to South Ossetia, While Assisting People Displaced by the Conflict." August 20 (<http://www.doctorswithoutborders.org/news/article.cfm?id=3052>) (2016/5/31).
- MSF. 2012. "About MSF" (http://www.msf.org/msf/about-msf/about-msf_home.cfm) (2016/5/31).
- M2 Presswire. 2008. "United Nations: Multi-Agency Humanitarian Assessment Mission to Visit South Ossetia, Georgia." September 17.

- Natsios, Andrew S. 1997. "NGOs and the UN System in Complex Humanitarian Emergencies: Conflict or Cooperation?" in Paul F. Diehl, ed. *The Politics of Global Governance: International Organizations in an Interdependent World*, pp. 287-303. Boulder: Lynne Rienner Publishers.
- Nichol, Jim. 2008. "Russia-Georgia Conflict in South Ossetia: Context and Implications for U.S. Interests." *Congressional Research Service*, September 22 (<http://fpc.state.gov/documents/organization/110841.pdf>) (2016/5/31).
- O'Neil, Edward Jr. 2008. "Who We Are and Might Be: In Global Health, Excellence Demands Equity." *American Journal of Kidney Diseases*, Vol. 51, No.1, pp. 145-54.
- Oxfam, et al. 2008. "The Gaza Strip: A Humanitarian Implosion." March 1 (http://www.oxfam.org.uk/resources/policy/conflict_disasters/downloads/gaza_implosion.pdf) (2016/5/31).
- Pavignani, Enrico, Renato Correggia, and Nigel Pearson. 2010. "Steps towards Harmonizing External Support Health Care Provision for the Somali People." (http://www.unicef.org/somalia/SOM_SupportandHealthcareforSomaliPeopleReport_7-WEB.pdf) (2016/5/31).
- Radosavljevic, Ognjen. 2011. "International Medical Corps Provides Urgently Needed Nutrition Services in Drought-Hit Somalia and Somaliland." January 26 (<http://internationalmedicalcorps.org/page.aspx?pid=1931>) (2016/5/31).
- Roy, Sara. 2004. "The Palestinian-Israeli Conflict and Palestinian Socioeconomic Decline: A Place Denied." *International Journal of Politics, Culture and Society*, Vol. 17, No. 3, pp. 365-403.
- Senessie, Charles, George N Gage, and Erik von Elm. 2007. "Delays in Childhood Immunization in a Conflict Area: A Study from Sierra Leone during Civil War." *Conflict and Health*, Vol.1, No 14, pp. 1-8.
- Shen, Simon. 2004. "The 'SARS Diplomacy' of Beijing and Taipei: Competition between the Chinese and Non-Chinese Orbits." *Asian Perspective*, Vol. 28, No. 1, pp. 45-65.
- Somaliland Family Health Association (SFHA). 2012. "About Somaliland Family Health." (<http://www.somalilandfamilyhealth.org/somaliland-family-planning.php>) (2016/5/31).
- SOS Children's Villages. 2012. "SOS Medical and Social Centres in Somalia." (<http://www.sos-medical-centres.org/africa/somalia>) (2016/5/31).
- Southall, David. 2011. "Armed Conflict Women and Girls Who Are Pregnant, Infants and Children; A Neglected Public Health Challenge. What Can Health Professionals Do?" *Early Human Development*, Vol. 87, pp. 735-42.

- Sovereign Military Order of Malta (SMOM). 2008. "Helping the Georgian Population." September 4 (<http://www.orderofmalta.int/news/40841/helping-the-georgian-population/?lang=en>) (2016/5/31).
- Suwanvanichkij, Voravit. 2008. "Displacement and Disease: The Shan Exodus and pp. 1-5.
- Sytnik, Irina. 2010. "Georgia's Rebel South Ossetia Approves 2010 Budget." *BBC Monitoring Central Asia*, July 1.
- Thou Shalt Not Kill website. 2012. (<http://www.ihh.org.tr/oldurmeyeceksin/en>) (2016/5/31).
- Tong, Jacqueline, Olaf Valverde, Claude Mahoudeau, Oliver Yun, and Francois Chappuis. 2011. "Challenges of Controlling Sleeping Sickness in Areas of Violent Conflict: Experience in the Democratic Republic of Congo." *Conflict and Health*, Vol. 5, No. 7, pp. 1-8.
- United Nations (UN). 2012. *Charter of the United Nations* (<http://www.un.org/en/documents/charter/index.shtml>) (2016/5/31).
- UNICEF. 2012. "UNICEF Georgia Fact Sheets." (http://www.unicef.org/ceecis/media_9447.html) (2016/5/31).
- U.S. Global Health Initiative (GHI). 2012. "Georgia Global Health Initiative Strategy." (<http://www.ghi.gov/documents/organization/175130.pdf>) (2016/5/31).
- Wicaksono, Pakchai D. 2009a. "WHA: Victory of Taiwan's Pragmatic Diplomacy? (1 of 2)" (in Chinese) May 20 (<http://pakchai.wordpress.com/2009/05/20/wha-taiwan1>) (2016/5/31).
- Wicaksono, Pakchai D. 2009b. "WHA: Victory of Taiwan's Pragmatic Diplomacy? (2 of 2)" (in Chinese) May 22 (<http://pakchai.wordpress.com/2009/05/22/wha-taiwan2>) (2016/5/31).
- World Health Organization (WHO). 2005a. *Constitution of the World Health Organization* (http://www.who.int/governance/eb/who_constitution_en.pdf) (2016/5/31).
- WHO. 2005b. *International Health Regulations*, 2nd ed (http://whqlibdoc.who.int/publications/2008/9789241580410_eng.pdf) (2016/5/31).
- WHO. 2007. "WHO statement on the situation in the Gaza Strip." September 25 (http://www.who.int/hac/crises/international/wbgs/sitrep_25sept2007/en/index.html) (2016/5/31).
- WHO. 2008. "Georgia Health Cluster Bulletin." No. 3, November 6 (http://www.who.int/hac/crises/geo/sitreps/georgia_sitrep_2nov2008.pdf) (2016/5/31).

- WHO. 2012. "Countries" (<http://www.who.int/countries/en>) (2016/5/31).
- WHO East Mediterranean Regional Office (EMRO). 2008. "WHO Somalia – December 2008." (<http://www.emro.who.int/somalia/pdf/WHO%20in%20Somalia.pdf>) (2016/5/31).
- WHO EMRO. 2010a. "Health Cluster Focal Agencies in Somalia – March 2010." (<http://www.emro.who.int/somalia/pdf/Health%20Cluster%20Focal%20Agencies%20in%20Somalia%20March%202010.pdf>) (2016/5/31).
- WHO EMRO. 2010b. "WHO Somalia Biennial Report 2008-2009." (<http://www.emro.who.int/somalia/pdf/WHO%20Somalia%20Biennial%20Report%202008-09.pdf>) (2016/5/31).
- WHO EMRO. 2011. "WHO Somalia Report 2010." (http://www.emro.who.int/somalia/pdf/report_somalia_web.pdf) (2016/5/31).
- WHO EMRO. 2012. "First round of Child Health Days Conducted in Somaliland." February 23 (<http://www.emro.who.int/somalia>) (2016/5/31).
- WHO Regional Office for Europe (EURO). 2008. "Georgia Conflict 2008: Internally Displaced Persons (IDP) in Georgia." (<http://www.euro.who.int/en/what-we-do/health-topics/emergencies/disaster-preparedness-and-response/country-work/georgia/georgia-conflict-2008>) (2016/5/31).
- WHO EURO. 2012a. "Disaster Preparedness and Response Country Work: Georgia." (<http://www.euro.who.int/en/what-we-do/health-topics/emergencies/disaster-preparedness-and-response/country-work/georgia>) (2016/5/31).
- WHO EURO. 2012b. "Georgia Areas of Work: Disaster preparedness and response." (<http://www.euro.who.int/en/where-we-work/member-states/georgia/areas-of-work/disaster-preparedness-and-response>) (2016/5/31).
- WHO Western Pacific Region Office (WPRO). 2005. "International Health Regulations 2005: Guidance for national policy-makers and partners." (http://www2.wpro.who.int/NR/rdonlyres/3C5F7E4B-A7E5-41E3-9759-B0DC7D7FF564/0/IHR_booklet_2007_web.pdf) (2016/5/31).

有醫無類：國際介入事實獨立實體 公共衛生事務之分析

黃旭東

香港中文大學全球政治經濟碩士課程講師

摘要

全球衛生治理的根本目標是改善全人類的健康狀況，然而，實際上數以百萬計的人因國內發生武裝衝突而未能獲得公共醫療衛生服務。在某些情況下，衝突持續多年，武裝組織甚至永久控制可觀面積的領土。這些事實獨立實體處於國際衛生體系的管轄範圍以外，其原因在於國際秩序建基於國家主權的本質，由於各方的立場和利益迥異，並非以技術方式所能輕易解決。本文旨在討論國際衛生體系在處理上述情況的局限及探討可能的解決方法，並建立分析框架以鑒定主要持分者對於國際介入事實獨立實體之衛生事務的立場、認知和誘因（反之亦然），梳理國際介入背後的脈絡，作為研究分析的基礎。文中以加薩走廊、南奧塞提亞和索馬利蘭為例，比較現時各種國際介入模式，並提出一些建議，務求建立一個經整合的國際介入架構，從而為全人類實現「有醫無類」的理想。

關鍵詞：事實獨立國家、全球衛生治理、公共醫療衛生、世界衛生組織