ABSTRACT

Melissa McRae

A practical reflection on leveraging health as a means to another end

Our understanding of health has been expanding for decades but was boosted by COVID-19. The list of variables influencing health feels infinite, and what constitutes an actual health intervention by health professionals is no longer implicit. This paper explores if the discipline of global health is furthering the expansion of health and what that means for patients and health care providers who implement global health initiatives. Using the WHO Global Health for Peace Initiative (GHPI) as one example, the author explores if there is an increasing tendency to leverage healthcare for non-direct health outcomes. A particular focus is given to implementation impact for humanitarian populations if the medical mission is transformed from being an 'end goal' to a 'means to another end'. Médecins Sans Frontières (MSF) has been analysing the potential operational evolution and ethical implications of the GHPI. In this analysis the author brings together views on how global health is framed in the literature and why it is currently so popular as a specific field, followed by an analysis of three potential ethical risks at the implementation level: i) health as a means to another end, ii) upholding medical neutrality, and iii) supporting the health workforce.

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1. Introduction

The COVID-19 pandemic took a catastrophic toll on health, lowering global life expectancy at birth for the first time since the 1960s (Pirlea & Suzuki, 2023; World Bank, 2023). Declared as a global health emergency, it reaffirmed that health is universally morally important and demonstrated the co-dependencies between individual health, health systems and how societies are governed. Health clearly emerged from COVID-19 a political asset but also a moral good to be protected from politicisation (Sauter, 2023; Stekelenburg et al., 2023). Nations were affected and responded unequally, highlighting gross global health disparities and inter-variability in public health approaches. All this boosted support for the discipline of global health which promotes what public health specialists have been telling us for years: achieving optimal health necessitates more than *just* a healthcare response.

Global health places a *"priority on improving health and achieving health equity for all people worldwide*" (Koplan et al., 2009), promoting health inequities as morally problematic realities that persist due to structural, socially constructed political barriers. Since its emergence in the early 2000s, global health has scaled up from origins in epidemic disease control to now span a plethora of topics: health system strengthening, outbreak management, health security, border security, international relations, arts, and health, and recently the World Health Organisation (WHO) Global Health and Peace Initiative (GHPI) which has healthcare actors contributing to peace building and sustainability.

As explored in this paper, among the Pandora's box of global health initiatives, health is widely interpreted allowing numerous endpoints; many with direct health benefits, others with non-direct health benefits and for some, the link to health benefits can be tenuous. Global health has the difficult task of generating political and socioeconomic support to address inequities without slipping into the dangerous space of politicising health, a *"process, whereby political discourse and rhetoric seep into the legislation and governance of healthcare, [negatively impacting] its functioning and efficiency"* (Sibanda, 2019). This is a terrain well-suited to ethical deliberation, and yet global health ethical guidance has been found to be underdeveloped and an afterthought (Robson et al., 2019).

Historically, understanding health to be more than the absence of disease can be traced back to 1948 when the WHO reformed the definition of health to be a *"state of complete physical, mental and social wellbeing"* (WHO, 1948): pushing traditional medicine to recognise mental and preventative health needs, and the social determinants of health (poverty, education, housing, employment) as crucial for wellbeing. This act reframed a public health

orientated view of health as a *means* rather than an endpoint, a shift at odds for those who *provide* care to act in the best interest of patients' and populations' health as their end goal, the concept of health primacy (Galea & Vaughan, 2019). Thinking beyond the well-known ethical tensions between preventative and curative health, conceptualising health as a means through which *"individuals can live full and rich lives"* recognises just how many influential components lie outside the ethical remit of the health profession, also referred to as non-health dimensions of well-being (Galea & Vaughan, 2019; Merritt et al., 2018). Yet, despite this expansion, I suspect many people still associate the word health with the work of health professionals. How is global health balancing new space for these dimensions without creating confusion at the implementation level over the role of the profession and patients' access to health care?

In this expanding domain of global health, what constitutes an actual health intervention delivered by health care providers (HCPs) might no longer be implicit for patients, the public, or those within the profession. This opens the door for the moral value of health to be leveraged for secondary agendas that may improve wellbeing but do not bring direct, tangible health benefits to patients and populations, all in the name of health. For years health professionals have questioned the utility of the WHO definition, referring to it as *"unhelpful"* and even *"counterproductive"* (Godlee, 2011; Smith, 2008). Firstly, it dismisses the positive attributes of human capabilities to cope and be well whilst living with ageing, chronic illness and disability (Godlee, 2011). Secondly, complete health is likely unachievable for most of us given biological imperfections, but more importantly is this morally what we should be striving for (Smith, 2008)? Health is shifted into an unmeasurable, unreportable state contributing to unclear, maybe unrealistic, expectations of healthcare practices, subsequently threatening the trusting relationship on which the health profession relies (Godlee, 2011; Smith, 2008). This trend did not begin with the field of global health, but this paper explores if it is being propelled by it and without ethical guidance.

Trust is required for HCPs to deliver care in all contexts, but when providing humanitarian response in armed conflict settings a loss of trust can have very severe consequences. Here it is the value of lifesaving care achieved via the medical mission that fosters trust and secures access to healthcare for those in need. The medical mission requires a clearly shared understanding by all parties of the role of HCPs and their exclusive assignment to medical duties: providing care being their first and only professional duty (Red Cross, 2011). This is a caveat for upholding medical neutrality, an ethical principle and legal construct to provide protective immunity from harm for patients and staff working in

armed conflict where attacks on health care still persist (WHO, 2023d). It is these aspects that must be weighed against the added value that health being so broadly interpreted and politically supported may bring more globally.

Médecins Sans Frontières (MSF) has been analysing the potential operational evolution and ethical implications of the GHPI as one example of a global health initiative that, from a humanitarian perspective, requires ethical reflection before implementation in conflict settings (MSF, 2023b). In this paper the author explores whether health is becoming so poorly defined that some global health initiatives are leveraging health 'as a means to another end'. The analysis draws on available literature (published and grey) and the author's experience in humanitarian contexts providing a practical probing of the potential implications for patients and HCPs if the medical ethical obligation to prioritise a patient's health as the primary endpoint is compromised (WMA, 2021). Section one brings together a summary of the vast terrain global health is attributed to in the literature and explores three pillars that contribute to its popularity as a specific field: partnerships, health equity and health politics. Section two provides an outline of the Global Health and Peace Initiative, and section three discusses from a humanitarian perspective the potential impact of three normative and operational risks, of GHPI implementation in conflict settings: i) health as a means to another end ii) upholding medical neutrality, and iii) supporting the health workforce. To be clear, this case study is dissecting just one of many global health initiatives, but one with potential operational implications which MSF has spent some time trying to better understand (MSF, 2023). It is written from the author's perspective as a humanitarian worker trying to better articulate potential opportunity costs related to well-intentioned global health initiatives in conflict affected humanitarian contexts.

2. What is Global Health?

It seems global health is frequently referenced but rarely defined, becoming an umbrella term which now covers a multitude of initiatives from the academic theories of human rights, medicine, natural science and social science (Beaglehole & Bonita, 2010; Hall-Clifford & Cook-Deegan, 2019b; Koplan et al., 2009). Global health aims to improve coordination within the sector whilst also cross fertilising health with traditionally non-health-related political sectors (employment, economics, finance) to better address the complexity of societal transactions required for healthy populations, often governed by politically influenced systems (FDFA, 2014; Koplan et al., 2009; Lincoln, 2021). Despite academic efforts, no universal definition exists, permitting enormous plasticity for global health to be framed to meet a myriad of different objectives (Abimbola, 2016; King et al., 2019; Koplan et al., 2009; Lincoln, 2021; Robson et al., 2019). As the normative global health body, WHO directs global health initiatives to *"tackle increasing global health threats, reduce disparities within communities and between nations and contribute to a world where people live healthier, safer and longer lives"* (WHO, 2023c) Many WHO supported initiatives exist[1], ranging from arts to climate change, whilst beyond WHO, global health is also viewed to tackle pharmaceutical evergreening, TRIPS Plus, the opioid epidemic, resource conflicts, healthcare infrastructure rebuilding in fragile & post-conflict states, rape as a weapon of war, drone warfare, or the global refugee surge (DeCamp et al., 2018). The scope seems boundless with any efforts that make our lives happier, safer, and longer now a health initiative!

Global health can be classified as belonging to the following disciplines: academic study, research and practice (Koplan et al., 2009). Alternatively, Peter Farmer et al. (2013) view global health to be "*not [an academic] discipline but a collection of problems [that] …turn on the quest for equity"*. In 2022, the search engine PubMed cited more than 21,846 articles containing the term "global health", up from 10,255 in 2015[2] (PubMed, 2023). In a systematic literature review searching for "global health" AND ethic*" between 1977 and 2015, the earliest articles dated back to the early 2000s and publications peaked in 2011 (29 articles) (Robson et al., 2019). The authors revealed two important but unlinked findings, firstly the 'global South' was underrepresented, with 88 per cent of articles by

[1] Access to COVID-19 Tools (ACT) Accelerator, Alliance for the Global Elimination of Trachoma by 2020 (GET 2020), Behavioural Sciences for Better Health, Alliance for Transformative Action on Climate and Health (ATACH), Arts and Health, Global Health, and Peace Initiative (previously Global Health for Peace), Advanced global health security: from commitments to actions, Action on Social Determinants of Health for Advancing Health Equity.

[2] Search last verified 04 August 2023

authors from high-income countries and secondly, the dimension of ethical guidance for global health *"incompletely understood or developed"* (Robson et al., 2019). The latter is supported by other authors who attributed this paucity of ethical guidance to the wide scope of global health themes trying to be addressed under one umbrella such that existing bioethical standards fall short (Godard et al., 2018; Hall-Clifford & Cook-Deegan, 2019a).

The nomenclature 'global health' hails from North American and was developed to complement the practice of International Health from the 1980s and 1990s (Koplan et al., 2009). International health had origins closer to Europe, amalgamating tropical medicine (infectious diseases) and public health, with a particular focus on maternal and child health, and critiqued to address health issues stemming from high-income countries institutions, and relating almost exclusively to work abroad in low-resource nations (Beaglehole & Bonita, 2010; Koplan et al., 2009). Global health has expanded the terrain; for example the Swiss government described international health to have "*focused primarily on bilateral relations between high-income and low-income countries [...] whilst global health places greater emphasis on the multiplicity of relationships required, on a global scale"* (FDFA, 2014). This evolution likely serves the purpose of ensuring the words we use reflect changes in values – actual or desired – such as how countries cooperate and navigate power dynamics, social relations, inequalities, and politics.

	Global health	International health	Public health
Geographical reach	Focuses on issues that directly or indirectly affect health but that can transcend national boundaries	Focuses on health issues of countries other than one's own, especially those of low-income and middle-income	Focuses on issues that affect the health of the population of a particular community or country
Level of cooperation	Development and implementation of solutions often requires global cooperation	Development and implementation of solutions usually requires binational cooperation	Development and implementation of solutions does not usually require global cooperation
Individuals or populations	Embraces both prevention in populations and clinical care of individuals	Embraces both prevention in populations and clinical care of individuals	Mainly focused on prevention programmes for populations
Access to health	Health equity among nations and for all people is a major objective	Seeks to help people of other nations	Health equity within a nation or community is a major objective
Range of disciplines	Highly interdisciplinary and multidisciplinary within and beyond health sciences	Embraces a few disciplines but has not emphasised multidisciplinarity	Encourages multidisciplinary approaches, particularly within health sciences and with social sciences

Table: **Comparison of global, international, and public health**

Table 1: Comparison of global, international, and public health (Koplan et al., 2009).

In attempting to understand the vast prevue of global health, authors have queried both 'what terrain global health covers' and 'what is new in global health'. As an overarching term, global health nearly always refers to the worldwide span of who is affected by a problem, to reference the UK government's global health definition: *"where the determinants [...] are beyond the capacity of individual countries to address through domestic institutions"* (Public Health England, 2014). Global health also embraces all three health system levels: the micro (individual, clinical), meso (regional, institutional) and macro (national and provincial), compared to public health prioritising the latter two. As explored below, it is an ambitious task to balance the old ethical tensions of public and individual

health, whilst also explicitly raising the political profile of health to address structural barriers to health equity.

Despite the diversity of initiatives, some common threads and recurring pillars are identified; partnerships, addressing health inequities and health politics are explored below.

2.1 Partnerships

Two-way collaboration and cooperation via multisectoral partnerships (local and international) is a flagship pillar of global health, an innovative step to welcome non-traditional actors into the health sector and an attempt to rebalance North-South dynamics (FDFA, 2014; Koplan et al., 2009; Public Health England, 2014). A focus on subsidiarity, reaffirms that local and proximate collaboration is essential to achieve health equity and positively challenges previous North-South power imbalances that plagued international health from colonial days (Abimbola, 2021). However, diverse partnerships, particularly if formed without common ethical values, also creates space for new power dynamics to emerge introducing a potential lack of transparency of intentions and agendas (Lincoln, 2021). Global health has been described as an avenue for *"some of the world's most powerful political and economic institutions to advance their [own] interests"* (Lincoln, 2021). As explored in Section three, in humanitarian contexts, a proliferation of actors with mandates beyond health services may divert attention from the medical mission and concerningly lower the value of lifesaving action where direct healthcare remains the largest need.

Governments, military forces, universities, private sector philanthropists, as well as non-governmental humanitarian organisations, such as MSF, are all embracing global health initiatives (King et al., 2019; Lim & Blazes, 2015). Research shows that global health partnerships exist along a spectrum, with political economic partnerships at one end and interpersonal (healthcare provider -patient) relationships at the other; rarely are both found in a single initiative (Robson et al., 2019). This may demonstrate that the holistic spanning of all system levels is not feasible in practice, a problem for successful implementation, but coincidently may provide a protective separation where health systems and governance need political support individual care must remain impartial and non-politically influenced to prioritise patient needs and protect health primacy.

Whilst a government health system focus is crucial in addressing equitable access to care, in humanitarian contexts an unchecked health system focus can be problematic for minorities and marginalised populations whose needs maybe justifiably excluded via the 'greater good' logic of utilitarianism. Health systems in these contexts can be fragile,

impeded from optimal performance, and political support is either not readily available or health is being politicised to exclude such populations from accessing healthcare. Section three provides examples of operational risks related to global health confabulating these two ends of the spectrum.

2.2 Addressing health inequities

Global health promotes the popular view that all global citizens are equally deserving of the opportunity to be healthy. Striving to address inequities everywhere – between and within low-, middle- and high-income countries – is an aspect that Professor Abimbola (Editor-in-Chief, BMJ Global Health Journal) believes is the salient distinction of global health (Abimbola, 2016). Of course, since decades public health has been working to address the social determinants of health, *"the causes of the causes"* to quote Sir Michael Marmot, and strengthen health systems but is also said to be plagued with implementation challenges attributed to the chronic underdevelopment of the politics of health as expanded below (Kusnanto et al., 2018; Marmot, 2018).

Addressing inequities is one reason for the popularity of global health as Nation States can simultaneously uphold moral obligations owed to less privileged nations, whilst also protecting the health of their own citizens, heeding the warning of WHO Director-General Dr Tedros Ghebreyesus (2020) that *"we are only as safe as the weakest link".* This aspect firmly cements global health as a pillar of foreign policy, framed under another new term: Global Health Diplomacy (GHD). GHD is *"the process by which government, multilateral and civil society actors attempt to position health in negotiations foreign policy and to create new forms of global health governance"* to reduce poverty and inequalities. GHD is said to have created high expectations and many collaborations but only so far amounted to good intentions and not delivered a positive change in the relations between high- and low-income countries (Rubbini, 2018). Additionally, this aspect of global health is linked to another broadly interpreted concept of global health security, which is beyond the scope of this paper (FDFA, 2014; Lim & Blazes, 2015; Rubbini, 2018).

2.3 Health and Politics

So, in this quest for equity, global health is explicitly seeking political partnerships, financial and socioeconomic, to abolish the ideological belief that health is apolitical (Bambra et al., 2005). Again, the WHO health definition has been critiqued for promoting this belief by solely focusing on individuals, not societies. Health then becomes a product of individual

factors with the flow on effect that health is incorrectly reduced to healthcare (Bambra et al., 2005). Bambra et al. assert that health *is* political, as the determinants of health are amenable to political action and influenced by political ideology of how societies should co-exist; yet the politicisation occurs when the political agenda influences how healthcare is accessed by patients and delivered by HCPs (Bambra et al., 2005).

The politicisation of health is said to have effectively started in Western countries in the 1970s. With increasing public spending going towards individual curative care to address preventable illness (diabetes, obesity, accidents), politicians took note of the cost efficiency promoted via public health interventions (Sibanda, 2019). Two consequences arose: firstly positive political support saw politicians supporting national public health policies but secondly, health became politicised by the reinforcing of privatised healthcare. Health was elevated to a super value market commodity for affluent individuals; money meant access to healthcare and represented all that is good in life (Crawford, 1980; Sibanda, 2019). Of course, for the non-affluent, health inequity gaps widened that ghlobal health is now trying to close. However it was not an expansive definition of health that brought these changes but the large-scale financial involvement of government in individual care which made politicisation inevitable (Sibanda, 2019). Some readers might find this not surprising, even economically pragmatic and yet it highlights the reality gap between global health aspirations and what can be concretely implemented in practice (Rubbini, 2018).

Calls urging for high-level political support have been made by MSF, among others, during, but often heard loudest after, international health crises such as the HIV-AIDS pandemic, West African Ebola epidemic, and of course the COVID-19 pandemic (MSF, 2002, 2014). All highly political public health events requiring political solutions and clearly demonstrating the ways in which power, political and ideology influence health (Bambra et al., 2005). Whilst recognition of the distribution and excision of power exists, the political nature of health is infrequently featured in global health discourse (Gore & Parker, 2019). As explored in the case study, ethical guidance is needed safeguards health's political profile for optimal societal benefit, whilst simultaneously protecting the professional ethics of the medical mission from secondary agendas. If successful, much needed political support to health systems and policies will emerge. Alternatively, and likely if ethical guidance is lacking, politicisation will expose the conflicts that exist in different system layers, between policymakers who follow government agendas and healthcare professionals and patients orientated to health primacy (Ball & Corbis, 2015; Sibanda, 2019). At the implementation level, this politicisation has been shown to be most detrimental for patients and HCPs, not

policy makers or health management (Sibanda, 2019). Putting the two in competition maby be an ethical reality but is not productive.

"On some issues, ... the position of physicians may have to be promoted forcefully against those of governments, health system administrators and/or commercial enterprises." World Medical Association Medical Ethics Manual. (Ball & Corbis, 2015, p28)

Providing care to an individual patient must remain a non-political act, especially in conflict zones, where any misinterpretation of political alliances can be fatal (WHO, 2023d). Having said that, unfortunately attacks on healthcare happen everywhere (Fast & Roborgh, 2020). COVID-19 research demonstrated that HCPs are frequently perceived to be incorrectly held accountable for politically orientated health decisions and inaccurate government information plays a role in citizen distrust towards HCPs (Stekelenburg et al., 2023). All this has led to different forms of aggression experienced in their professional and personal lives, partially attributed to the politicisation of the COVID-19 response (Fast & Roborgh, 2020; Stekelenburg et al., 2023).

Finally, global health has not come from nowhere, it is a product of evolving past practices, theories, and perceptions of how we view health in today's world, yet how that those ideals are implemented in day-to-day practice at the health programming level, often delivered by HCPs, is not without challenges. Whilst the agendas of global health are positive and aspirational, concerns are raised over negative implementation impact leading to calls for *"substantive reconceptualisation of the political, ideological and material foundations of global health interventions*" (Lincoln, 2021). Examples given include global health practices which, hopefully unintentionally, lead to the withholding of clinical resources in crisis settings, removal of public health assistance when programme targets failed to be met and concerningly, the planned commercialisation of medicine amid economic collapse (Lincoln, 2021). The next section analyses some other potential implementation risks.

3. A global health case study: Global Health and Peace Initiative

In the words of Dr Tedros Ghebreyesus, *"there cannot be health without peace, and there cannot be peace without health"* (WHO, 2021). The merit of this tenet highlights the importance of contextualising the following analysis specifically to humanitarian response in conflict settings (WHO, 2022). *"Enhancing the existing links between health and peace"* is the driving force behind a relatively new WHO initiative, sponsored by the States of Switzerland and Oman, launched in 2019 as 'Global Health for Peace Initiative' (GHPI) and

brought for consultation with Member States and WHO Non-State actors in Q4 2022 and Q1 2023 (WHO, 2023b).

Developed as a collaboration between WHO and the peacebuilding organisation Interpeace, the GHPI aims to *"position health as an influencer of peace"* and the WHO as a sustaining peace actor: strengthening WHO's and the health sector's role as contributors to equitable access to healthcare, health system strengthening, and the expansion of universal healthcare, whilst also contributing to the Triple Billion targets (WHO, 2023). WHO is seeking a means for health actors to be better able to address the underlying drivers of critical health needs in *"fragile, conflict-affected, and vulnerable settings"*. Settings broadly framed by WHO to include humanitarian crises, protracted emergencies, and armed conflicts, where peace is desperately needed. Approximately 80% of WHO's humanitarian caseload and 70% of the disease outbreaks to which they respond are found in such settings (WHO, 2023).

Early drafts of the GHPI Roadmap (September 2022) primarily frame the initiative to contribute to creating and sustaining peaceful societies, relating *"to 'small p' peace, such as social cohesion, trust, inclusion, resilience to violence (rather than 'big P' Peace, in the form of high-level political processes/solutions)"* (WHO, 2023). The complexities of defining peace in order to obtain a common understanding during the consultation period proved challenging. Additionally health actors were proposed (September 2022) to transition from working 'in' conflict to working 'on' conflict, building on a notion of health actors working in conflict in previous WHO programming known as 'Health as a Bridge for Peace' (1980s and 1990s) (Schneider, 1987; WHO, 2022). Working on conflict includes delivering health programmes, where feasible and appropriate, integrated with peacebuilding strategies, hence aiming to *"deliver peace dividends through health interventions*" (WHO, 2022). Staying true to global health thinking, system strengthening is prioritised to improve the delivery of health services by focusing on key challenges: disruption of routine health service organisation, increased health needs, complex and unpredictable resourcing issues, and/or vulnerability to multiple public health crises. MSF provided feedback that considerations of the micro layer initially appeared scant, with little attention to patient factors: standards of care, quality of care or ethics of any kind– neither medical, public health or humanitarian (MSF, 2023b). Through consultation these aspects have been included in later drafts.

The GHPI Roadmap includes six workstreams and four principles (WHO, 2023). The principles are context specificity, equity and inclusiveness, participation and local ownership and leadership. The six workstreams include: 1) Evidence generation through research and analysis, 2) Development of a strategic framework, 3) Advocacy and

awareness-raising, 4) Capacity-building, 5) Mainstreaming of the Health for Peace approach and 6) Partnership development. The GHPI Roadmap draft (January 2023) included medical ethics and humanitarian principles as a fifth principle.

The GHPI defines its target audience as 'health actors', implicitly understood to refer to the entire heterogenous group of professionals working across all three layers of the health system. Clarification was sought to differentiate the various professional roles and responsibilities, especially for HCPs where ethical obligations to patients might raise ethical concerns, real or perceived, through involvement in delivering peace dividends. In later drafts, it became clear that the GHPI is fundamentally targeting a political public health audience, Member States' Ministries of Health (MoH) and the WHO Secretariat, roles more aligned with the political aspect of health at a programming and policy level. The current Roadmap states that healthcare workers at the implementation level are *"not expected to take on responsibilities outside their existing medical mandate and GHPI programming will always comply with medical ethics"* . This version was produced for the World Health Assembly (WHA) in May 2023 and introduced a significant change of name, from Global Health *for* Peace to Global Health *and* Peace (WHO, 2023).

4. A humanitarian conflict setting orientated analysis

Through work done with MSF, the author is still trying to understand the GHPI in concrete operational terms, including the actual ask of MSF HCPs and the government appointed HCPs MSF staff work alongside through MSF-MoH partnerships in more than 60% of MSF Switzerland operations[3]. This level of partnership brings MSF operations in conflict settings into close contact with global health initiatives supported by WHO Member States.

Without doubt, the ideology behind this initiative comes with good intentions, peace is essential for healthy living, but without a better understanding of the implementation approach it is prudent to stay alert to potential opportunities and risks explored below. This analysis focuses on the impact for patients under MSF care and MSF staff if healthcare interventions are used, or perceived to be used, to deliver peace dividends in conflict zones. Recognising this is done pre-emptively as the GHPI Roadmap is still in consultation phase

[3] MSF Switzerland internal data. As an international movement MSF is operational in 72 countries in 2023. MSF Switzerland is operating 58 projects in 27 countries. A total of 22 (38%) are in armed conflict or unstable contexts. Of those, 80% are run in partnership with the local MoH.

although the potential impact of the GHPI could be significant and wide-reaching given the influential normative role of WHO policies across the entire global workforce.

4.1. Normative risk: Leveraging health interventions for a means to another end

"If, in performing their professional duty, physicians have conflicting loyalties, their primary obligation is to their patients; Privileges and facilities afforded to [...] healthcare professionals [...] must never be used other than for healthcare purposes". (WMA, 2022b)

This ethical guidance from the World Medical Association (WMA) is clear and echoes Kantian moral philosophy: to *"act in such a way that you treat humanity [...] never merely as a means to an end, but always at the same time as an end"* (Kant & Reath, 1997). A HCP must prioritise patients' health as the primary endpoint above other competing interests (WMA, 2021). This ethical norm safeguards a transparent and thus trustworthy person-orientated relationship between provider and patient and safeguards access to care.

By proposing to *"deliver peace dividends through health interventions*", healthcare becomes a means to achieve another end (WHO, 2022). The two may not be mutually exclusive endpoints but health primacy is compromised. If addressing direct health needs is no longer the primary objective of a healthcare intervention led by HCP, then the profession is entering into ethically uncertain waters. The repurposing of health interventions as a means to another end is an old, not new, lesson global health must adhere to. Past examples are numerous (syphilis study in Tuskgekee 1932, medical experiments to the Nuremberg Code 1947), both foundational in creating the discipline of bioethics HCPs must follow today (British Medical Journal Publishing Group, 1996; Butler, 1973). Another more recent example is the fake vaccination campaign which took place in Pakistan in 2011, associated with the capture of Osama bin Laden (Kennedy, 2017). Whilst an extreme example, it demonstrates that health being used for secondary agendas is not just a theoretical risk, health can be politicised. More than a decade on, the consequence is reduced community trust towards HCPs, fueling vaccine hesitancy and resulting in a 23-39% decline in childhood immunization and an increase in preventable disease prevalence (Martinez-Bravo & Stegmann, 2022). When leveraging occurs, it is patients and populations who suffer the consequences.

HCPs do have an ethical obligation to ensure they "*avoid acting in such a way as to weaken public trust in the medical profession"* (WMA, 2022a). Leveraging health impacts how patients (and populations) both receive and perceive healthcare. Firstly, healthcare risks being disconnected from delivering direct health benefits and secondly, the roles and responsibilities of HCPs, who directly interact with patients, will be negatively perceived and reshaped. Non-maleficence and beneficence are questioned, and transparency lost. This could ultimately diminish trust in the profession which impedes access to quality care. If this eventuates, it may also contribute to implementation challenges if HCPs feel their professional ethical obligations are compromised. Acknowledging the GHPI does commit to health outcomes remaining a priority, there is a lack of ethical guidance to help enforce this endpoint and prevent a slippery slope towards leveraging and crucially, HCPs being perceived as doing the leveraging. A clear definition of what a health intervention is within the remit of the GHPI would also assist in formulating more concretely the implementation reality.

Of note, it is this normative risk that the author believes prompted a change in the initiative title from Global Health *for* Peace to Global Health *and* Peace.

4.2. Operational risk: WHO, Member States and all parties to a conflict must uphold, protect, and promote medical neutrality

This operational risk centers around HCPs being assigned additional non-health duties in order to deliver peace dividends and work 'on' conflict. By interpreting medical neutrality as non-interference and exclusive assignment of HCPs to 'medical duties', then reassignment compromises the specific protection given to HCPs under International Humanitarian Law (Red Cross, 2011). The principle of medical neutrality permits immunity from being a target *only* if HCPs exclusively deliver medical duties (Red Cross, 2011). Perhaps more influential than law in some contexts, medical neutrality is also part of a social contract. Contributing to social cohesion practices and peaceful coexistence in its own way, immunity from attack is granted via a 'convention of agreement', not a moral imperative, and everyone pays the cost of breaching this convention (Gross, 2007).

In humanitarian operations it is respect for medical neutrality that helps protect healthcare facilities as non-political safe havens where respect for human life and optimal health take priority. Adherence to medical neutrality is what permits HCPs to be both beneficiaries and

contributors to peace. When HCPs are no longer believed to be solely providing healthcare, political influences and suspicions of secondary agendas can very quickly emerge, local rumours start to circulate and HCPs and patients can become targets, often executed via an attack on the healthcare facility they work in (Fast & Roborgh, 2020). Whilst ideologically the relationship of health and peace may be symbiotic virtuous endpoints, in conflict zones misinformation and disinformation are rampant, and transparency of action is foundational in promoting a safe working environment.

Furthermore, health providers must transparently and consistently act in accordance with their professional competences and ethical code to not do harm and continue to develop trust from patients and the community. This is a fragile relationship, particularly in conflict zones, often an unwritten agreement between strangers that is easily lost and hard to regain, both at the patient and community level for individual HCPs and organisations. Whilst now removed from the language of the GHPI Roadmap, what triggered MSF's thinking on this normative risk was HCPs being asked to work 'on' conflict (MSF, 2023b; WHO, 2022). This shift potentially introduces a conflict of interest for the roles and responsibilities of HCPs, recognizing the perception of a conflict of interest can be just as damaging to a patient-provider relationship as a real conflict. Patients must have no reason to suspect that a HCP is not acting in the best interest of their health.

4.3. Normative risk: Inappropriate allocation of responsibility to healthcare providers, an already fragile workforce

This risk can be analysed as a normative risk seeking clarification in the GHPI on the roles and responsibilities of HCPs, but also touches on the operational impact for HCPs when those roles are not clear or misunderstood by patients. This risk is pertinent as it is those who implement a system whose lived experience acts as a mirror of the ethical status of that system.

Contributing to peace is the responsibility of all global citizens, and HCPs should not be burdened with a higher moral responsibility than others to address the drivers of conflict and deliver peace dividends. The health workforce should not be inappropriately given responsibilities that do not fall within their professional scope of practice; working within one's professional competence is an ethical obligation (WMA, 2022a). Beyond the risk of reassigning HCPs away from medical duties discussed above, this risk focuses on the physical and mental wellbeing of HCPs and their job satisfaction.

A recent editorial in the Lancet Global Health titled 'Health-care workers must be trained and retained' highlighted that working as a HCP is already an extremely difficult role and a profession people are opting out of (The Lancet Global Health, 2023). The WHO 'Health workforce support and safeguards list progress report' added eight countries with critically low workforce densities to the 2020 list of vulnerable countries (WHO, 2023a). Of 55 identified countries, 26 are currently in active conflict, 65% of these being contexts where MSF has operations (MSF, 2023a). Drawing lessons from the COVID-19 pandemic, HCPs are vulnerable to being overworked, to workplace violence, and are increasingly questioning demands from authorities and employers which compromise their professional ethical integrity (Fast & Roborgh, 2020). Whilst the concrete activities linked to the GHPI for HCPs is still not clear, new global health initiatives should help, not exacerbate the already high burden on the health workforce, especially those who work in high-risk contexts such as conflict.

Conclusion

In conclusion, global health is picking up speed and evolving in many directions with a firm moral intention of "*improving health and achieving health equity for all people worldwide*" (Koplan et al., 2009). Yet global health is now a widely shared space introducing diverse agendas from multiple partners, many of whom are explicitly trying to make inroads in health through optimising political support to address health inequities. Whilst still theoretical at the time of writing, this analysis highlights the need for stronger ethical deliberations for risks that could eventuate during the implementation of global health initiatives; taking the GHPI implementation as one case in point but realising it is likely relevant to other initiatives.

Conflict undeniably costs human lives and health outcomes are categorically worse in conflict settings so, whilst we do need initiatives to sustain peace they must be implemented to protect health primacy and reinforce a trusting patient-provide relationship. Equally, both health primacy and peace need to be protected, one should not come at the cost of the other. If via global health thinking, health is leveraged as a means to another endpoint – even if a very noble one like peace – we must simultaneously ensure that HCPs are supported in their roles and able to uphold their professional ethical obligation to patients.

In conclusion, an uncritical acceptance of the solid moral objectives of global health contributing to a greater social good, ignores the potential negative impact of the leveraging and politicisation of health for secondary agendas. This will be highly detrimental to the

immediate health needs of people living in conflict zones, patients, and front-line HCPs. Global health ethics is an underdeveloped area and would benefit from more ethical rigor and nuance to not negatively impinge on patient's access to care and the trust and safety of the global health workforce.

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