



Moving Beyond
Solidarity Rhetoric
in Global Health

SOLIDARITY IN GLOBAL HEALTH: PERSPECTIVES FROM INDIA AND NEPAL

WORKSHOP REPORT



South Asia Regional Workshop

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INTRODUCTION AND BACKGROUND

The aim of the “Moving Beyond the Solidarity Rhetoric in Global Health” (Global Health Solidarity) project is to enrich current understandings of the concept of ‘solidarity’, in order to develop tools that will help support increased practice of solidarity in global health in the future.

The South Asia Regional Workshop is the fifth in a series of five regional workshops that have been held, in different languages and different parts of the world, to surface different meanings of solidarity and its practice. This exploration will, we hope, lead to revised, richer understandings of what solidarity could or should mean in the context of global health.

The project is being guided by the concept of ‘pluriversality’ – the recognition of the co-existence of multiple worlds (‘a rainbow of cosmologies, knowledges and vital worlds’), and hence of multiple understandings and meanings of solidarity (‘solidarities’ in the plural). Pluriversality involves recognising not only that workshop participants will bring different perspectives, but that the multiple stakeholders involved in this project exist in different realities – and that if we are to live together better as human beings, dialogue and collaboration is crucial. In exploring together how to transform the dominant world order, we thus need to recognise and account for differences as well as points of convergence.

This report seeks to capture the breadth of input provided during the two-day workshop, including the identification of tensions and contradictions. Contributions have been drawn together under broad themes, and may not necessarily follow the precise chronological order throughout the programme.

It should not be assumed that all present agreed with any particular statement expressed. All those attending the workshop have had the opportunity to review this report, and are listed in the Annex.

PART 1: GENERAL CONCEPTS AND EXPERIENCES OF SOLIDARITY

Encounters and experiences of solidarity

The workshop began with participants sharing what they each understood solidarity to mean from their own particular vantage point, including sharing examples or memories relating to solidarity.



Encounters and experiences of solidarity session

Examples and definitions offered included:

- **A community ethic of support for others**, encapsulated in concepts such as *'them before us'* and *'if we do not share, we will not survive as a community'*. This is expressed both through the provision of practical help at times of need, such as on the birth of a first child, and through *'showing up'* – being physically present in support.
- **Mutual support and sharing in response to crisis** – for example through collective action by people directly affected by a mudslide or in the communal welcoming home of those forced out of cities by the COVID lockdowns (*'in times of crisis and festival we need low walls and boundaries'*).

- Action in response to need, whether in times of happiness and grief, that **transcends normal divisions** (*‘It’s not that we don’t have social economic or caste-based differences in my village – but there is something that binds us together’*).
- Finding a **community of nurture** – organically finding a community which takes care of you and creates a safe space for you.
- **Reaching out to a ‘wider solidarity’** where power differentials mean that mutual support at community level cannot alone solve a problem – for example through using social media to communicate stories and thereby gain support.
- Giving power to people and **helping create an empowered space** – for example through supporting community health workers to be flexible and innovative in responding to health needs.
- Seeking and **receiving support from others when fighting for justice** – for example receiving support from international activists for a campaign to prevent a uranium mine being established in Nepal.
- Helping others in need **without conditionality** – not imposing your own ideas on them but simply doing what is asked for.
- **Acts of defiance** in offering support to someone in need – identifying with someone in that situation and taking action in response, including in ways that involve risks, or break rules.
- Being the **voice of your community** – for example speaking up on behalf of the scavenger community in response to constant practices of dehumanisation.

Both in sharing personal accounts, and in the subsequent group discussion, participants identified a number of **characteristics, challenges, uncertainties and problematic factors** associated with solidarity. Issues raised included:

- The importance of **not simply equating solidarity with individual acts of kindness**: it also requires a **sense of connectedness** – such as a shared goal, need or challenge, associated with the **seeking of justice** (*‘I am with you in this’*) or a desire to **shift the location of power**.
- The **timescales of solidarity** – if expressions of solidarity tend to have a ‘shelf-life’, as suggested by several participants (ie fading away over time), how can solidarity be sustained in daily life, and outside times of obvious crisis?
- The **limitations of solidarity** – how do you choose with whom to act in solidarity when there are so many with pressing needs?
- The **lack of a word for solidarity in many languages** because the concept is so embedded in a particular culture and way of life.
- The uncertain connection between the mutual support expressed within a community and what external organisations say and do about acting in solidarity with such communities. When is the latter purely **performative**?
- How self-help arrangements, such as sickness funds, are a form of a **coping mechanism** in which risk is pooled, and how these arrangements may be perceived as a threat by governments or by the market which may then seek to ‘institutionalise’ them to **limit their disruptive potential**. What forms of institutional design promote solidarity, as distinct from those that promote competition and contestation? Can any ‘institutionalised’ arrangements ever be fully solidaristic?

- **How individual agency intersects with the group dynamic** that is inherent in solidarity – who is entitled to speak for a community, and what happens when one individual within a community disagrees with prevailing attitudes and values?
- The risk that strongly internalised beliefs that others are more important than the individual (as found, for example, in Buddhism) can have **mental health impacts**, especially among young people.
- The implications of **urbanisation** – how can the solidarity found in village contexts operate within very different structures and eco-systems?
- The role of **funding, structures and hierarchies** in determining the levels of solidarity on the ground – noting, for example, the backlash on rights relating to gender and sexual and reproductive health, caused by current political rhetoric and action.
- The need to be alert to how **some forms of solidarity may lead to groups of people being stigmatised and excluded**: for example solidaristic action to combat the harms of HIV infection or drug abuse may be experienced as highly stigmatising for those already living with HIV or using drugs.
- The way in which solidarity can also be used to **protect the status quo** – for example among professionals who ‘protect their own’ against external criticism even where this may be justified, or in trade union arrangements that exclude all that fall outside defined categories. As such, it may even act as a barrier to challenging injustice.
- How such **excluding tendencies can also be challenged** – for example in creating a space for Dalit young people to come together (‘our space’), it was strongly argued that others should not be excluded (*‘we are not here to create more divisions in society’*) – being welcoming to people from other castes was understood as a crucial step in solving problems together.

Many of the themes touched on in this opening session of the workshop were repeated and explored in greater depth in the later sessions.



Encounters and experiences session.

Community based solidaristic practices in everyday life

The second session of the workshop focused on accounts of solidaristic practices in specific communities in India and Nepal, followed by reflections on solidarity in suffering and ill-health, on the expression of solidarity through culture and language, and on the lack of solidarity exemplified in the treatment and experiences of the manual scavenging community. A summary of these presentations is set out in Box 1 below, followed by an overview of common themes emerging across the presentations and in the discussion.

Box 1: Everyday solidaristic practices in India and Nepal

Tlawmngaihna of the Zo society

Tlawmngaihna is a social ethic – a source of identity and way of life – in the state of Mizoram, that has evolved throughout the Zo people's tumultuous history and migration from China to north east India and Myanmar. It includes elements of altruism, philanthropy and service to others, captured in the concept of 'standing with one another'. The concept is embedded in society through a devolved network of civil society groups (the Young Mizo Association) that provide social protection and of which everyone is a member by default. Membership provides many practical benefits – for example if your house is burnt down or damaged by a landslide, others will leap to action, collect donations, and rebuild the house. There are, however, sanctions for failing to adhere to social expectations and norms: people may be required to pay a fine, or even banished from their village. *Tlawmngaihna* has both ethnocentric and territorial limits with inclusion typically defined by language, tribe and village. Boundaries may, however, be negotiated – for example refugees from Myanmar may potentially be included although not technically 'kin'.

Lak Pler and Kui in Arunchal Pradesh

In the villages of the Monpa tribe in Arunchal Pradesh are found two distinct forms of coming together: *Lak Pler* ('exchange of hands') and *Kui* ('standing with each other'). *Lak Pler* arises in routine contexts, often in agriculture, and is usually directly reciprocal: people will work on each other's fields or in the forest when needed, in exchange for the same number of days' labour. *Kui*, in contrast, arises at specific times of need, such as births and deaths, and in the construction of a house, where every household in the village will provide at least three days' labour (with the nature of their contribution based on their skills) and be present at the point when the roof is set. While there is a social expectation of return for such support, this need not be immediate or direct. There is also a spiritual element to the collective building of a house, with community prayers offered when the roof is set and the house completed, and prayers offered every day, apologising to spirits of earth and air for hurting them and asking for protection. Motivations for *Kui* include the human response to recognition of others' needs; social and spiritual bondedness; karma (accumulating credits for future lives) and social pressure (anxiety as to what others will think if you do not contribute). While *Lak Pler* is governed by economic necessity, *Kui* is thus rooted in emotion. Both are relational and bounded by geography, excluding those outside these limits.



A participant presents about the two forms of coming together (*Lak Pler* and *Kui*) at the workshop.

Box 1 (cont)

‘No monastery – no village’: solidarity in Limi Valley in Nepal

The three villages of Halsi, Dzang and Til in the remote Limi Valley of north west Nepal have been experiencing the consequences of climate change since 1996 in the form of glacier-related floods and landslides, with Dzang recently forced to relocate in its entirety. Governmental response tends to be too little too late, so villagers rely on each other to rebuild houses and temporary bridges themselves. Where government help is available, this is targeted on government priorities, such as a trans-national highway, while villagers would prioritise mending the road to the monastery which is at the heart of the community (*‘From birth to death – and everything in between – we depend on the monastery’*). This is because the monastery is where newborns are blessed, couples marry, elders are mourned; and in crisis, it becomes a village hall where information is shared, decisions are made, and fears allayed. Video story-telling by youth activists is an important way of seeking solidarity beyond the villages, and the diaspora population in the USA has been an important source of financial support. As the young people of the village have been able to access education, they are becoming better placed to demand support from the government. While the resilience arising out of grassroots solidarity is prized, it should not be glamourised: villagers should also be entitled to claim support from the state.

Box 1 (cont)

Solidarity in suffering: navigating inequality through Himachal's deity traditions

Solidarity in grief and loss is expressed through an active commitment to carry others' burdens together through collective engagement in mourning. Trauma is both isolating and communal: grief can become a catalyst for connection, with solidarity the communal glue. Yet hierarchies and divisions of caste, class and tradition mean that while all may grieve, not all are supported equally. In Himachal Pradesh, the *devta* system of gods and goddesses with their ritual roles and powers, provides a form of 'marginal inclusion' for those otherwise excluded: the presence of the deity offers an embodied experience of solidarity in communal mourning processions and provides public recognition of loss (while some are excluded from sacred spaces, the deity enters on their behalf). Such solidarity in grief and loss is also a cornerstone of community resilience in response to disasters.

Just as solidarity may be found in collective mourning, it is also found in the collective experience of 'being a patient': in India, in contrast with more transactional forms of healthcare common in the west, there is an expectation that experiences of ill-health are a shared event, not an isolated struggle. Patients feel embraced, not processed; supported, not left alone with their pain.

Preservation of culture and language

There are more than 600 'scheduled' tribes in India, with diverse languages and cultures which are of great emotional significance. Being part of a tribe and the sense of identification and belonging it confers is inherently solidaristic, involving practices to which members are expected to adhere. Despite differences between tribes, there are also well-established networks between them, out of necessity to protect common interests and combat discrimination and disadvantage. A key issue is that of land rights: tribal leaders, despite their great local knowledge, are inevitably at a disadvantage when faced with the global knowledge and power deployed by multi-national corporations; and international solidarity with tribal interests is essential in being able to negotiate on a more equal basis. Given pressures on tribal traditions, with loss of land, heritage and language, tribes are now having to face the question '*Are we still the same people we are claiming to be?*' – finding new ways of drawing on ancestral cultures and language to define solidarity within and between tribes.



The leader of the Movement for the Scavenger Community shares their experience on solidarity in the Dalit community.

Box 1 (cont)

The Movement for the Scavenger Community

India's caste system is solidly embedded in Indian society: while you can change your religion, you cannot change the caste into which you are born, and caste dictates your role and status – a concept that is antithetical to solidarity. The 'outcaste' or Dalit caste is regarded as the lowest, with those born into this community still often excluded from education and expected to undertake dirty and dangerous menial work (manual scavenging, sanitation work, cleaning sewers and streets), despite the protections set out in the Indian Constitution. The experience of COVID-19 reinforced the dehumanising treatment of sanitation workers, both in the tasks they were expected to undertake such as collecting dead bodies with inadequate protection, and in the way 'social distancing' reactivated old prejudices between social groups. The lived reality of being categorised as Dalit is that you meet people and build relationships – and then are rejected on the basis of your name, refused the tenancy of a house, unable to work despite your qualifications. The symbol of the [Movement for Scavenger Community](#) is the breaking of the handle of a broom – this should not be our identity!

A number of common themes arose in these presentations and were explored further in the subsequent group discussions. These included:

- the complex **interaction between formal legal requirements and the power exercised in practice by community structures or strongly embedded social traditions** – arising both at local level (for example in the influence exercised by tlawmngaihna authorities in allowing or rejecting COVID vaccination in their villages, regardless of government mandate) and at national level, in the ongoing and pervasive discrimination on the basis of caste, despite its illegality;
- the extent to which structures of solidarity can **act in repressive ways** when community members make different choices or decisions, challenging understandings of voluntariness and highlighting the importance of civil rights;
- the **patriarchal nature** of many community structures and practices – including where separate structures for women are in practice infantilising, lead to social exclusion or do not promote the independence of women;
- the significance in many solidaristic practices of **physical presence** – for example at times of sickness or death – and how this is being challenged as community members move from villages to cities (can text messages of condolence or money to pay for services ever be acceptable substitutes for ‘showing up’?);
- the importance of **sharing awareness, of opening the door to dialogue and communication, of walking together** with those from different social groups, religions or ethnicities, with the aim of working together from different perspectives to solve societal problems such as caste-based discrimination (*‘What can we do together?’*);
- in the light of historic and ongoing injustices, the tensions involved in **ensuring that allyship by those who are more powerful does not displace the voices of those experiencing discrimination and disadvantage.**



A participant presents on solidarity in the role of community health workers.

PART 2: SOLIDARITY IN GLOBAL HEALTH

Community health workers and lessons from queer community building

The third session covered two linked themes: everyday solidarities in the role of community health workers (CHWs) with associated challenges of undue burden and exploitation; and insights into the role of ‘quiet infrastructures’ provided through the experiences of queer community building. Box 2 below provides a summary of the participants’ presentations, followed by an account of common themes arising both in presentations and group discussion.

Box 2: Community health workers and lessons from queer community building

Exploitation and solidarity among CHWs

CHWs, who represent around half the healthcare workforce in India and the wider region, are healthcare workers who come from and live in the community they serve, with lower levels of formal education and training than professional healthcare workers such as nurses.

They play important roles in health education, and in facilitating access to essential public health services, that often go beyond the limited primary health services available at the local level. As their societal acceptance increases, they have been obliged to take on tasks that would otherwise have been undertaken by more highly qualified staff (‘task-sharing’ or ‘task-shifting’) including in the provision of mental health services to which 70-90% of India’s population does not currently have access. The organisation [Sangath](#) is working with ASHAs (the name for CHWs in many parts of India) to identify how best to provide training and support for them in extending their role (primarily with pregnant and lactating women) into mental health support.

A key concern is the extent to which task-shifting is simply a form of burden-shifting, without associated recognition in terms of training, pay or career progression. ASHAs receive very low pay – often on an insecure incentive-based system – and even those in states with more generous payment systems receive less than the minimum wage for skilled agriculture workers. They work long hours, around the needs of pregnant women, for example, with poor working conditions and little support or recognition; and often combine their role with the duties of being a daughter-in-law. While ASHAs’ work may be seen as an expression of their solidarity with their community, it is also exploitative: *‘We are everyone’s ASHAs but who is there for us?’*



A participant presents on the lived experiences of sahiya (ASHAs/ community health workers)

Box 2 (cont)

Lived experiences of sahiyas (ASHA workers) from Tribal Jharkhand

Jharkhand is a mineral-rich state: rich also in cultural practices among its 32 scheduled tribes, but poor in health and access to healthcare and education. The main source of employment (mining) poses a threat to tribal land rights and is a source of erosion. There is mistrust, based on long experience, in government and government schemes which leads, for example, to lack of confidence in vaccines. ASHAs have helped overcome such barriers and thereby increase access to the limited package of health services that governments provide at primary care level. The tribal cultural concept of sahiya judana – being a friend for life – underlies sahiyas' sense of duty in Jharkhand: *'If I don't do it, who will?'* *'When you are a sahiya you have to see everyone in the village'*. But the role of sahiya may also embody resistance: for example through supporting a pregnant unmarried 15-year old to access healthcare, against the wishes of her boyfriend and his powerful family – and in being supported in her actions by other women who have benefitted from her (sahiya) support. Blurred roles create scope for tension and exploitation and can undermine the authenticity and sustainability of solidaristic action: for example where sahiyas are expected to take on non-health roles for local government such as voter verification, or where local communities have expectations of health support which exceeds sahiyas' official role (are they 'part of government' or 'part of the community?'). Trust between sahiyas and their communities is fragile and relational: a sahiya may be recognised as *'a blessing'* or dismissed as *'only a woman from the village'* who undertakes tasks *'because she is paid for it'*.



A participant makes a presentation on the different activities conducted by the queer community.

Box 2 (cont)

Lessons from queer community building

References to ‘community’ imply solidarity – but in many cases multiple communities are inappropriately lumped together, implying a solidarity that does not exist. Trans men, for example, are often invisible, with media attention focused on trans women, while gay support groups are not well placed to work with lesbian or bi-sexual women. Stigma and prejudice can leave children and young people who do not fit gender norms isolated, having to hide their identity from families and schools to avoid retribution. Solidaristic support from others who ‘step up’ to be there for you – emotionally and financially – is crucial, highlighting the key role of emerging support groups such as [UMANG](#) (for lesbians, bisexual and trans-masculine people) and [Yaariyan](#), a voluntary LGBTQ+ youth initiative. But the standard expectations that funding NGOs have about how support groups should function don’t work for everyone: meetings are boring! Shifting to activities such as cricket matches, picnics and flashmobs has been transformative for these groups, with membership rising from ten people in a room to 10,000 people in the group over three years – but this model does not fit requirements for public funding. Another challenge of the ‘NGO-isation’ of civil society is the fractured focus: each group is set up and funded with a very specific remit, undermining scope for intersectional solidarity and action.

Themes explored further in discussion included:

- the resonance of the experience of CHWs as a wider question in solidarity: are we expected to be there for everyone? **How do those exercising solidarity get supported in turn?** What is the level of expectation, and when does it stop becoming fair?
- the intersection of **agency and vulnerability**, as illustrated in the lived experience of the sahiyas (for example in the backlash suffered when expressing agency by protecting girls or when seeking to diffuse conflict), reiterating how competing solidarities can be a source of both empowerment and threat.
- the role of **unconscious bias** in undermining the possibility of solidarity between different groups each seeking justice: people just don't think to examine and unpack the specific identities on which group membership is based, and 'within-group' status difference can undermine scope for collective or solidaristic action.
- the **key role of networks, structures and systems** in enabling, or hindering solidarity, whether in the form of the 'quiet infrastructures' and community networks that underpin solidarity, or in the gaps and flaws in the way institutions operate (such as in the lack of support for sahiyas) that interfere with solidarity. This highlights the associated importance of strengthening those systems rather than expecting individuals to fend for themselves and cope. (*'Need to focus on infrastructure to allow solidarity to blossom.'*)
- the **tension between the role of the state** (and also of others with power such as funding bodies/philanthropic organisations) and **the role of grassroots solidarity**. Where community-initiated solidarity provides support and services that the government is failing to provide, state actors may rely on, and instrumentalise, such solidaristic action to escape accountability for their own failures. Alternatively, governments and other funders may be the means by which grassroots initiatives can be scaled up and made sustainable. Much depends on **where decisions are made**: who decides that this is a priority and what should be done?
- the fact that **states have obligations** to their citizens, while civil society is organised around a shared interest: institutions can be born out of solidarity but need not themselves be solidaristic. Where this happens, **how can institutions keep their original solidaristic spirit?**

Panel discussion: Potential and challenges of operationalising solidarity – experiences from policy, practice and research



A panel discussion on the potential and challenges of operationalising solidarity.

A wide-ranging panel discussion, incorporating audience questions, explored the role that solidarity could play specifically in global health, and what this might mean for those working (as researchers, funders, campaigners) in the global health sector. Issues raised included:

- the importance of framing health and healthcare as **global public goods**, and the need to **contest transactional, commodified market-driven notions of healthcare**. Health is not 'produced' by the health system, but within the family in the way that we live – and our relationship with healthcare providers (who are, at best, 'co-producers' of our health) should be one of partnership and solidarity, not of commodity exchange.
- how solidarity can be manifest in global health in the form of **creating coalitions, bringing people together and breaking down barriers**: as, for example, during the COVID-19 pandemic when multiple government departments worked effectively together, alongside civil society and individual donors and facilitators, to ensure the reliability of oxygen supply; when effective civil society action enabled community members to be heard in global health negotiations 'shoulder-to-shoulder' with policymakers; or when countries from the global south came together to fight against the imposition of intellectual property rights in COVID vaccines that were preventing life-saving access for many people.

- the **tension between the local and the global**, and what can be lost in translating local knowledge and systems based on relationships to the global level. Turning the role of ASHAs into an arm of the state, for example, with market driven enrolment systems and incentive payments, risked destroying the whole concept. It has only survived because of the agency of the ASHAs themselves, who have made a greater meaning of their work than envisaged by the system – but at the cost of being exploited.
- the need to recognise how **solidarity in global health can only happen in a decentralised way** – using science, for example, to support effective local practices (such as giving birth standing or sitting, rather than lying down), rather than automatically importing practices from outside ‘experts’. This requires humility on the part of such experts (coming with a real willingness to learn), and a recognition of the banality of standard hierarchies of knowledge. (*“If you’re not intersectional, you’re doing your science wrong.”*)
- the challenging role of those working within the current architecture of global health systems which is not itself designed to support solidarity. On the one hand, **those with power and privilege need to ‘get out of the way’** to enable those with relevant knowledge to be heard. On the other hand, those inside the system are needed to **help challenge injustices embedded in routine practices** – whether by directly calling out practices that undermine solidarity, such as standard contract terms that allocate all intellectual property rights from collaborative projects to high income country partners, or by being creative in operating within existing rules to ensure as much funding as possible goes to local recipients who can use it to best local effect. *“Even in the most restrictive spaces, there are ways in which one can express solidarity.”*
- how solidarity at both individual and global level can be about **overcoming fear**: from the example of Bhanwari Devi, the government worker raped for challenging child marriage in a higher-caste family (whose subsequent courageous campaign for justice led to workplace protections for many other women) to the willingness of civil society organisations at national and global level to call out current injustices and work towards rectifying them.
- how solidarity **provides a sense of direction for where we want to go**, even if it may not be directly compatible with working within current systems. It is aspirational but not unrealistic. The Alma Ata Declaration was a high point: while it has since been undermined, the fight is not lost.
- recognition that, in our current system of global health governance, **the unit at which solidarity can be exercised is that of member states**, who accept particular responsibilities when they sign up to international treaties with solidaristic elements (for example in the TRIPs waiver agreement for COVID-19 vaccine patents spearheaded by India and South Africa).

The Panel discussion ended with broad agreement of the value of coming together collectively to challenge unjust systems and corporate power:

“You don’t realise the value of collectiveness in this – the people who come and build together are putting pressure on the system to evolve... If communities can come together, there is no way they can be suppressed.”

Partnerships in global health



A participant shares his experience and perspectives on the role of health partnerships in solidarity.

The fifth and final session of the workshop explored the role of global health partnerships in solidarity, with reflections from personal experience of such partnerships from within Nepal, and the presentation of a case study of a global south philanthropist organisation (Box 3). Key issues to be addressed if solidarity in global health partnerships is to be meaningful were identified as:

- The need to **identify who the ‘partners’ are in any partnership** – who are the stakeholders in solidarity? – are multi-lateral agencies such as WHO, bilateral agencies, philanthropists, civil society, academics, beneficiaries, all stakeholders?
- In particular, the need to be clear **who the beneficiaries are** – and how they (and other stakeholders) perceive their role.
- The **power relationships** between partners/stakeholders – whether donors actually see themselves as ‘partners’, and whether relationships between donors and beneficiaries are conducted on a hierarchical basis or one of equity.
- The significance of the **goal and objective of any solidaristic action** – whether it extends beyond the relief of suffering to tackling root causes, and **who is involved in identifying the nature of those root causes**.
- The ongoing need to be alert to the ‘10/90 gap’ in health research with 90% of health resources globally spent on the needs of 10% of the world’s population – and how this gap continues in existence, despite the loss of focus on it.
- The need for **shared conceptual understandings** both as to what is included within ‘global health’ and what solidarity entails – otherwise how can progress be made?

Box 3: Blockchain for Impact: a funding approach

Blockchain for Impact emerged as a new health funder in response to the levels of unmet need during COVID-19 in India, raising \$400 million in two weeks in response to an appeal to engineers and others from within the blockchain community. Alongside working with established partners such as UNICEF to support immediate needs such as access to vaccine delivery, provision of oxygen, and sequencing capacity, the organisation aimed to use their funding to help build sustainable systems and processes in India, including reducing dependencies on outside technologies and promoting a ‘ground-up’ approach to building systems. The funding approach has three core values: trust (avoiding restrictions on funding so local knowledge determines priorities); problem-centric (avoiding ready-made solutions); and systems change (not one-off projects). It aims to:

- move from paternalistic charity to partnership built on shared goals and mutual respect;
- listen, co-design and build health systems solutions *with* communities – starting with a shared analysis of problems and recognising the need to involve wide populations in that analysis;
- focus on system building rather than just immediate relief – breaking down silos and bringing together multiple stakeholders at district level in order to achieve this;
- think long term – spending more time on problems, supported by three-year-long ‘fellowships’ to co-ordinate local action;
- embody transparency and accountability;
- reimagine impact, asking what outcome data are actually meaningful;
- champion learning and accept failure – highlighting the importance of reporting failures to avoid wasted research; and
- respect the dignity and autonomy of all stakeholders involved.



The workshop concluded with feedback from small group discussions, drawing both on these final presentations and four prompting questions:

? 1. What is the relationship between equity and solidarity?

- They are **mutually dependent**.
 - Health equity requires the eradication of exclusion and dehumanisation.
 - Solidarity involves a fight against abuse of power, in a context of shared recognition of injustice – and equity is a stepping stone to justice.
 - Equity represents the aim towards which solidarity work aspires.
- Equity can sometimes be transactional (for example focusing on meeting targets on gender), rather than transformative.

? 2. How can solidarity be built into institutional architectures, funding mechanisms and governance structures, rather than being left to individual good will?

- Ensuring that **communities are involved** from the very beginning, so community perspectives are built into structures and mechanisms (while recognising the risks of assuming that any one individual can 'represent' an entire community). This applies to practice as well as research – for example ensuring healthcare workers have an input into the setting of priorities in their work, and how outcomes will be measured.
- Promoting **parity of respect** for lived experience and scientific knowledge.
- Challenging and rethinking the **framing of funding systems** – the assumptions embedded within current funding systems automatically exclude many applicants, or force them to use a different language (conceptually as well as linguistically).
- Retaining a perspective on **health as a political issue**, not simply a matter for technical delivery (don't allow 'technical logic' to replace 'moral logic').

- Ensuring that **safeguards are built in** for people who are suffering discrimination or at risk of violence.
- Avoiding **incentive structures** that are narrowly ‘performance based’.
- Looking at how **education systems** can not only better support STEM subjects, but also promote knowledge and discussion of politics, history and human rights.

? 3. If we took solidarity seriously as a design principle, what is one thing we would have to do differently in research, policy or funding, starting tomorrow?

- Involving people from the relevant communities from the beginning in planning and funding teams, so that the ‘**insider view**’ is embedded and transformative.
- Providing ‘**training for governance**’ to enable those directly affected by the planned policy or research to access the skills and knowledge needed to become active and equal partners.
- **Allowing for flexibility** in systems – recognising that goals cannot always be precisely determined in advance, and local context will always be important in how aims are achieved.
- Promoting the **role of smaller low-income countries** in regional bodies.

? 4. In the current geopolitical climate of nationalism and competition, what are promising strategies to sustain global solidarities?

- Building movements: **mobilising** and promoting **learning exchange**.
- Creating spaces for **more reflective interactions**.
- **Engaging actively with different and conflicting views** – recognising that opposing perspectives cannot simply be ignored (albeit recognising also that current political systems tend to favour those who foster division, rather than inclusivity). *‘For solidarity to be seen in action there has to be partnership and so there has to be engagement.’*
- Given the power of disinformation and misrepresentation, **ensuring that structures are in place before flashpoints with powerful actors arise**, so that people know where reliable information can be obtained.
- **Taking inspiration from the powerful solidarity movements** that have been seen in recent years – it can be done.

In closing remarks, the project lead, Caesar Atuire, thanked all participants for the rich discussions which have contributed to understandings both of how solidarity is enacted by communities in the region, and of how these insights might be applied in the field of global health. These discussions will feed directly into the project’s development of ‘solidarity goals’ for global health, and the subsequent creation of tools to help support global health organisations in achieving those goals.

ANNEX 1: WORKSHOP PARTICIPANTS



Prachee Agrawal, *George Institute*, Delhi, India

Agathine Asamoaning, *Global Health Solidarity Project*, Ghana

Caesar Atuire, *University of Oxford, UK and University of Ghana*, Ghana

Ramnath Ballala, *Blockchain for Impact*, India

Anant Bhan, *Sangath*, Bhopal, India

Deepshika Bhateja, *Indian School of Business*, Hyderabad, India

Neymat Chadha, *George Institute*, Delhi, India

Kavita Chauhan, *Oxford Policy Management*, Delhi, India

Sonal Giani, *Quirk Story*, Bangalore, India

Ashish Giri, *University of Oxford*, UK & India

Sonali Gupta Agarwal, *Himalayan Institute of Cultural and Heritage Studies*, Himachal Pradesh, India

Anuradha Jain, *Indian School of Public Policy*, Delhi, India

Arenzungla Jamir, *Sisterhood Network*, Nagaland, India

Unni Karunakara, *Yale University*, USA

Arpana Kullu, *Tata Institute of Social Sciences*, Mumbai, India

Vimal Kumar, *Movement for Scavenger Community (MSC)*, Assam, India

Dennis Lallienzuol, *Youth Leader Fund for World without Nuclear Weapons*, Mizoram, India

Tashi Lhazom, *Mountain Youth Hub*, Nepal

Gunjal Munda, *Piramal Swasthya*, Hyderabad, India

Devaki Nambiar, *George Institute*, Delhi, India

Julian Natukunda, *University of Oxford*, UK

Golan Naulak, *India Mountain Agenda*, Manipur, India

Pema Norbu, *Adhyayan Quality Education Foundation*, Arunachal Pradesh, India

Elysee Nouvet, *Western University*, Canada

Sharad Onta, *People's Health Movement*, Nepal

Adithyan Suresh, *World Bank*, Chennai, India

Sundararaman Thiagarajan, *People's Health Movement*, India

Jantina de Vries, *University of Cape Town*, South Africa

Katharine Wright, *Global Health Solidarity Project*, UK (rapporteur)

ANNEX 2: PROGRAMME

DAY 1			
S. No	Activity	Responsibility/Speaker	Time
1	Welcome note and Introduction to the project	Prof Caesar Atuire and Ashish	9:30 – 9:45 am
2	Project Approach – <i>Pluriversality and listening</i>	Prof Elysee Nouvet	9:45 - 10:00 am
3	Encounters and Experiences of solidarity	Led by Prof Jantina de Vries	10:00 – 11:30 am
TEA BREAK			11:30 – 11:50 am
4	Encounters and Experiences of solidarity continued	Led by Dr Unni Karunakara	11:50 – 12:30 am
LUNCH BREAK			12:30 – 1:30 pm
5	Community Based Solidaristic Practices in everyday life	Mr Golan Naulak – Tlawmngaihna of the Zo society: <i>Solidarity in Action – experiences from uncertain times</i>	1:30 – 1:45 pm
		Mr Pema Nurbu – <i>Solidarity in times of need – Arunachal</i>	1:45 – 2:00 pm
		Ms Tashi Lhazom – <i>Solidarity in times of crisis – Nepal</i>	2:00 – 2:15 pm
		Dr Sonali Gupta – <i>Shared Suffering, Sacred Support: Navigating Inequality through Himachal's Deity Traditions</i>	2:15 – 2:30 pm
6	Plenary - Panel questions		2:30 – 2:45 pm
TEA BREAK			2:45 – 3:05 pm
		Mr Gunjal Munda – <i>Preservation of culture and Language</i>	3:05 – 3:20 pm
		Dr Vimal Kumar – <i>The Power of Us: Leading with Solidarity to End Manual Scavenging</i>	3:20 – 3:35 pm
8	Small group discussions and reporting		3:35 – 4:00 pm

DAY 2

S. No	Activity	Responsibility/Speaker	Time
9	<i>Experiences of solidarity among community health workers – Exploitation and solidarity</i>	Dr Anant Bhan	9:30 – 9:45 am
	<i>Everyday Solidarities in Practice: Lived Experiences of Sahiyas (ASHA Workers) from Tribal Jharkhand</i>	Dr Arpana Kullu	9:45 -10:00 am
10	<i>Quiet Infrastructures of Solidarity: Lessons from Queer Community Building</i>	Ms Sonal Giani	10:00 – 10:45 am
	Question and answers with speakers		10:45 – 11:15 am
TEA BREAK			11:15 – 11:35 am
	Group Photo	Ms Agathine Asamoaning	11:35 – 11:55am
11	<i>Potential and challenges of operationalising solidarity – Experiences from policy, practice and research</i>	Panel Discussion – Dr T. Sundararaman, Dr Anuradha Jain and Dr Devaki Nambiar	11:50 – 12:30 am
12	Questions to the panel	Prof Elysee Nouvet	12:40 – 1:10 pm
LUNCH BREAK			1:10 – 2:10 pm
13	<i>Solidarity in Global Health Partnerships: Experiences from Nepal</i>	Dr Sharad Onta	2:10 – 2:25 pm
14	<i>Need for changes in funding/partnerships – Perspectives from Philanthropist from the Global south</i>	Dr Ramnath Ballala	2:25 – 2:40 pm
15	Small Group Discussions and Reporting	Dr Julian Natukunda	2:40 – 3:30 pm
16	Vote of Thanks – Invitation for further engagements	Prof Caesar Atuire	3:30 – 3:45 pm



Moving Beyond
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in Global Health

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