Moving Beyond
Solidarity Rhetoric
in Global Health

PERSPECTIVES ON SOLIDARITY PRINCIPLES FOR GLOBAL HEALTH

WORKSHOP REPORT

Convivial Solidarity Workshop

Johannesburg, South Africa

February 17-18, 2026

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EXECUTIVE SUMMARY

This executive summary outlines the process undertaken over two days from the 17th to the 18th of February, 2026 of the Global Health Solidarity Project's *Convivial Solidarity Workshop*. It aims to briefly capture the discussion, the extremely focused and rigorous engagement that transpired and how it bears relevance to the development of the reworked and revised proposition document: *Principles for Embedding Solidarity in the Global Health Ecosystem*. It further offers key reflections in the discussion as well as sticky points that require consideration. Lastly, the report highlights the suggested way forward and gestures to how the solidarity principles may be taken up, the potential limits of only one tool, and an offering on how we may proceed together.

Participants at the Convivial Soildarity workshop, Johannesburg, South Africa.

OVERVIEW OF THE WORKSHOP

In 2022, we launched the "*Moving Beyond Solidarity Rhetoric In Global Health*" project, supported by funding from a Wellcome Trust grant. The project seeks to broaden discussions and deepen understanding of solidarity within global health, while also creating tools to more rigorously evaluate whether solidarity is genuinely present in global health initiatives. As part of the project's activities, six workshops were conducted in different countries between 2023 and 2025, bringing together diverse stakeholders to explore different perspectives of solidarity. The workshops provided rich learning on what solidarity is, what it is not, and how it is enacted in different contexts. The workshops, together with qualitative interviews, project webinars, and internal team discussions, generated a substantial body of insights on how solidarity is understood and practiced across different contexts. An interpretive synthesis of these materials identified twelve emerging themes on solidarity, which informed the development of a set of propositions. These propositions were designed to guide discussion on how actors across the global health funding ecosystem might more meaningfully understand and operationalise solidarity in practice.

The Convivial Solidarity Workshop represented a critical moment in the project's life cycle bringing together project team members and invited guests to collectively reflect and refine the propositions (see Annex 1 for more information on participants). The workshop commenced with a synopsis of the key research themes and findings, presented drawing from the series of six regional workshops (see Annex 2), literature reviews, case study fieldwork, and empirical findings from the interviews of seventy-five global health stakeholders. The overall project was situated – the lead co-investigators, research team members and partners highlighted; the projects pluriverse approach explained, and the global health context in which the project was conceived, and the impetus of the project objectives. An overview of the in-the-field research, the project in-person, and online monthly research meetings and numerous webinars which played a critical role in the research analysis, triangulation and verification process were shared as well as the concurrent state-of-the-art review of the literature pointed to. Additionally, a video-recorded presentation shared findings from a qualitative study of 75 interviews with diverse global health stakeholders exploring how solidarity is understood and enacted in practice. The speakers identified three core characteristics of solidarity — *shared goals grounded in moral responsibility and interdependence; action beyond rhetoric, often involving risk and sacrifice; and transformative impacts on living conditions, power relations, and organisational practices* — highlighting solidarity as both a process and an outcome within global health systems.

The current world context was noted, as well as how the rapidly changing international order and related implications for global health — particularly in light of unfolding events in 2025 and 2026, reinforce the importance of the project. There was an indication that there is need for structural change more so given how the discourse of solidarity has been usurped and deployed for tokenistic end — especially as significant funding cuts continue to reverberate in the global health ecosystem with dire consequences making apparent the fault lines and clear distinction between aid, charity, and solidarity. This framing anchored the importance of drawing on the experience of participants in the workshop, who work across the global health ecosystem space of funding, research, and implementation.

In this regard the workshop focused on:

1. **Engaging and refining the proposed solidarity propositions for the global health ecosystem and,** due to time constraints, to a far lesser extent

2. **Discussing the practical implications of solidarity for global health ecosystem.**

The following questions guided the discussion:

Table 1 **Convivial workshop guiding questions**

DAY 1 | Group Questions	DAY 2 | Group Questions
Are these Propositions a good reflection of the views of solidarity that we have encountered in our work so far? Are there any blind spots?	What do the "solidarity principles" mean for global health funding ecosystem? Examples, case studies, possible areas of application; What specific audiences do you imagine for the solidarity index/ tools?
As captured, are there overlaps and repetitions in the explanations in the Propositions? Should we compress or merge some of the Propositions? If yes, which ones? Should we rank the Propositions in order of importance or leave them? If yes, what criteria should we use for ranking?	What would they expect or need the tools/index to do? What are the limits of what can be imagined and demanded through solidarity. What are the fault lines?
Should the wording of any of the Propositions be revised. If yes, how?	How should we deal with the possibility of 'solidarity washing'? Is that our concern?
	Which kinds of tools do you suggest we develop (beyond the index)?

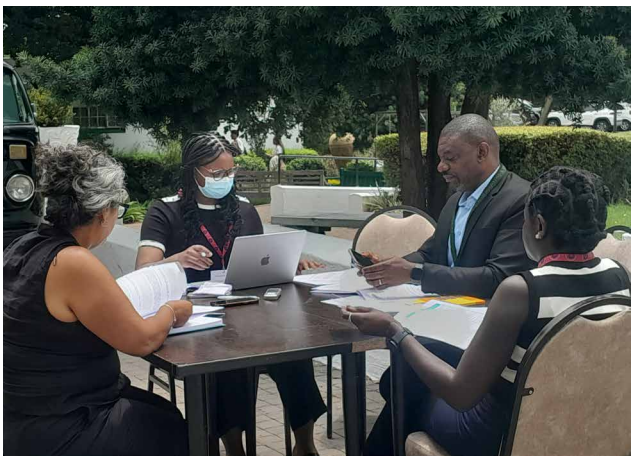
Workshop process

In terms of process, the workshop was structured as an iterative dialogical process that oscillated between plenary and breakout discussions. Participants were assigned to four small groups that stayed together over the course of two days, with some modifications to group composition over time. Participants received a copy of the draft propositions a day before the workshop. On Day 1 of the work-

shop, project team members broadly framed the work that led up to the draft propositions, including a broad introduction to the project overall, to selected empirical findings, the process of synthesising collective evidence into draft propositions, as well as a high-level overview of the propositions. In the second part of the morning, three invited guests provided input in the collective discussions. Drawing on their extensive knowledge and expertise in the Global Health Arena, health funding ecosystem, and positions in important continental and global networks, we asked them to offer critical reflections and input on the propositions and morning session project presentations.

The second part of Day 1 consisted of a deep engagement with the propositions both high-level (at the level of the propositions themselves) and at granular levels (language and framing). Key questions concerned overall clarity, framing, gaps, repetitions and so forth. Rapporteurs for each group captured discussions real-time online, and discussions were recorded. At the end of Day 1, participants re-convened in plenary for a discussion of sticking points, key concerns, strengths, suggestions for amendments, and any other impressions or feedback participants wanted to share. To close out the first day, the group visited Constitution Hill — a historic former prison complex in Johannesburg that once held political prisoners, including Nelson Mandela, and today serves as the seat of South Africa's Constitutional Court. The tour was a powerful reminder of the country's struggle for justice and human rights, and a fitting backdrop for the group's collective work on solidarity in global health.

On Day 2, the group deviated from the planned programme, in that selected members of the Secretariat that drafted the original propositions, with an additional member, focused on re-writing the propositions. That left the rest of the group to broadly discuss questions relating to applicability of the propositions for global health. Shortly before the lunch break, the group came together again in plenary, where the Secretariat presented the proposed revisions. After lunch, the small groups then went through and discussed the revised text, suggesting further revisions. The second part of the afternoon consisted of plenary discussions to discuss the overall direction of the revised list, possible areas of application, relevance to the field of global health and so forth. On the final day of the workshop, some of the group members took the opportunity to visit the Apartheid Museum — a landmark institution that chronicles the rise and fall of South Africa's apartheid regime — offering a moving and thought-provoking conclusion to the gathering. The visit highlighted the enduring importance of justice, equity, and solidarity in shaping more just societies.



Groups discussions during the workshop.

KEY REFLECTION POINTS

Funding is not merely technical

Emphasis was made that funding cannot be treated as neutral resource transfer; it is embedded in power relations, institutional histories, and political choices. Further, funding decisions were repeatedly described as expressions of values – determining which health problems are studied, who is prioritised, and what forms of knowledge are legitimised. This led to extended discussions about agency and power asymmetry. Participants noted that solidaristic practice must actively resist giver–receiver binaries that obscure the contributions and authority of communities, researchers, and civil actors. Instead, **solidarity was described as bidirectional and transformative:** all parties bring assets — knowledge, experience, resources— and are changed through engagement. The emphasis on voice and community followed from this framing, highlighting the importance of respectful engagement, inclusivity, and creating conditions where agency is exercised. More so, the context of aid and charity are distinct from each other but also different from the values which underpin solidarity.

Practical experiences related by participants from funding organisations showed that structural inequities persist even when equity is an explicit goal. Open calls often draw repeat applications from already well-resourced institutions, leaving other regions underrepresented. Adjusting dissemination alone does little to change outcomes because gaps in institutional and administrative capacity determine who can compete successfully. A hub-and-spoke funding model was presented as one attempt to address this imbalance. Established institutions act as hubs, supporting partner organisations (spokes). The model is promising and aligns with discussions around solidarity as an emancipatory practice. Improvements were visible but incremental, raising the question of whether such approaches transform underlying structures or merely soften their edges.

Incremental versus revolutionary

The distinction between incremental and more fundamental change became a focal point. Incremental strategies include embedding solidarity language into existing equity frameworks, revising assessment criteria, and expanding notions of partnership. These measures were seen as politically feasible entry points that can influence funding practice in the near term. However, such reforms can remain superficial if they do not confront structural asymmetries. A recurring critique was that many global health actors invite participation without relinquishing agenda-setting authority — effectively

Incremental strategies include embedding solidarity language into existing equity frameworks, revising assessment criteria, and expanding notions of partnership. These measures were seen as politically feasible entry points that can influence funding practice in the near term.

training others to operate within pre-defined rules. In this scenario, solidarity risks becoming rhetorical cover for unchanged hierarchies. The open question was whether incremental measures can serve as leverage toward such systemic shifts, or whether they ultimately stabilise the status quo.

Clarifying solidaristic relationships

A key theme during discussions was around the need to better articulate solidaristic relationships as distinct from other types of relationships or collaboration. Several groups cautioned that describing solidarity as "a specific type of relationship" was insufficient. Suggestions were made to qualify this relationship as a moral, non- transactional, grounded in trust and shared humanity. This sparked discussion on whether concepts such as trust should be considered as core to solidarity or as qualities that emerge and are sustained through doing solidarity. Cautions were raised against binary framings that imply solidarity only exists when ideal conditions are met. Instead, the language should reflect the dynamic process of solidarity, involving negotiation and ongoing commitment. Relatedly, the discussion turned to how solidarity operated in and across different levels – individual, community, organisational, institutional, national, regional, global – noting that expectations, obligations, and modes of engagement differ across these levels and should be made explicit to avoid confusion. This raised related questions about whether solidarity should be framed primarily as a value, principle, or set of actions. Participants broadly agreed that the document should clearly signal practical applications of solidarity to avoid ambiguity.

Audience, purpose, and scope

A recurring question concerned who the document is for and what it is meant to do in practice. It was noted that ambiguity around actors – whether funders, civil society organisations, research institutions – affects the tone, framing, and expectations. All agreed the preamble should clarify and provide guidance.

Language, framing, and consistency

Concerns around framing and language emerged repeatedly. Participants noted the proposition headings did not always reflect what was written in the text. There was a strong call for consistency in terminology and for simplifying phrasing to avoid overloading individual propositions with multiple dense conceptual definitions.

Participants cautioned that certain phrasing or words risk reproducing hierarchical or transactional assumptions (e.g. other-oriented). Suggestions were made to expand the glossary and clearly define key concepts such as humanity, and to make clear what we mean by solidarity.

Cases and sticky points

Several example cases were given to unpack and explore deeper questions around power, responsibility, and the limits of what can realistically be demanded from actors within the current global health system. Cases included:

- States funding refugee health while supplying arms to conflicts that lead to their displacement
- The Bill & Melinda Gates Foundation provides aid for expanded vaccine access and disease control. However, they simultaneously invest in technologies that benefit from expanded markets in the same countries.
- The World Bank providing health financing while country debt servicing constrains public health spending
- Opposition by Germany to intellectual property waivers proposed by South Africa and India during COVID-19

A major thread of discussion debated whether solidarity rests on shared goals or a shared response to injustice. This became one of the identified "sticky points" to unpack. An example illustrated how people might stand in solidarity with Palestine against injustice of genocide, however this goal may not necessarily align with the broader, long-term goals of the Palestinians. This raised the question: **if solidarity is grounded in identification and a shared commitment to justice, can actors be in solidarity with those they simultaneously dominate or exploit?** Funding refugee camps for example, was considered a reparational act, not solidarity. At the same time, participants acknowledged the imperfect nature of institutions. The practical question became whether morally imperfect organisations can nonetheless be required to meet solidaristic standards within the global health funding space.

The discussion reinforced the need for language that reflects solidarity as both morally motivated and action-oriented in ways that allow diverse motivations and strategic perspectives within collective engagement. This discussion also made clear that solidarity is not charity. Flourishing, dignity, and humanity surfaced here as framing ideas, suggesting that solidarity ultimately drives collective action in which agency and well-being are advocated for, protected, and sustained.

> *Another "sticky point" concerned whether solidarity, if institutionalised, becomes an obligation. Can it be legislated? Participants distinguished between solidarity as a moral relationship and institutions informed by solidaristic values. Once codified, solidarity generates obligations that may have legal components. Yet institutionalisation risks hollowing out the relational and ethical dimensions of solidarity, reducing it to compliance. The group recognised a pragmatic tension: while systemic transformation may be beyond the immediate scope of the project, it remains possible to define solidarity in practical terms — clarifying what can be held to account in the global health space, what undermines solidarity, and what enables it.*

Further, in relation to framing, a question was raised whether, when the document uses "health" it should rather use the term "health for all." This prompted discussion around scope — does "all" refer to all humans, or to all beings more broadly? The group also considered the object of solidarity, questioning whether actors stand with people or together against injustice. Participants reflected on this tension: solidarity may begin with identification with affected people, yet its actions are directed at transforming structural injustice. Ultimately, it was decided to retain the framing of "health," as "health for all" focuses solely on human health, which could limit inclusivity.

PRACTICAL AND WAY FORWARD

As a short-term goal, the group agreed to publish a consolidated document containing the preamble and propositions in a high-impact journal such as The Lancet. The aim is to articulate a shared position on what solidarity in the global health funding ecosystem entails. Co-authorship was proposed for all contributors, recognising the collective nature of the work. Another output will be a matrix mapping different types of actors, level of engagement and actions. This will be shared as we continue to engage with stakeholders to aid in populating the matrix.

This work will inform the next phase of the project aimed at developing tools to be used in practice. Two broad categories are envisioned – public facing evaluative tools and self-reflective tools for actors to interrogate their own practices. This is an iterative process as team members engage with regional workshop participants to feedback, validate, and ensure concepts are not diluted. This was framed not only as part of the methodological process, but also as a moral duty to those whose voices informed the project.

CLOSING REFLECTIONS

There was broad agreement that the workshop was useful and timely – the discussion reflected that the current context underscores the necessity of advancing solidarity in global health – challenges however continue to manifest in complex and visible ways, prompting greater openness among stakeholders to pursue structural reform.

The group emphasised the importance of being in the workshop space. The group reflections and conversations enabled thinking through potential limitations and possibilities of how to leverage the solidarity propositions to improve, strengthen, and embed core values of solidarity within the global health funding eco-system.

The workshop was successful, culminating in a finalised version of the ‘principles for embedding solidarity in the global health ecosystem’. This Prinicples’ document reflects the collective input of diverse actors and is a step towards strengthening solidarity as a global health practice. Below we share the document which can be used as a stand-alone report.

WORKSHOP OUTPUT: PRINCIPLES FOR EMBEDDING SOLIDARITY IN THE GLOBAL HEALTH ECOSYSTEM

Introduction

This document synthesises the deliberations arising from the Convivial Workshop convened by the Global Health Solidarity Project in Johannesburg on 17–18 February 2026. The Global Health Solidarity Project is a five-year Wellcome Trust–funded Discovery Award titled '*Moving Beyond Solidarity Rhetoric in Global Health: Pluriversality and Actionable Tools*.' It seeks to transform both the understanding and practice of solidarity in global health by examining how communities across five continents conceptualise and enact solidarity in their lived experiences with a commitment to pluriversality. Pluriversality is understood as an active acknowledgment that multiple distinct ways of knowing, being, and organising society can coexist without being reduced to a single universal framework.

The workshop brought together a diverse range of stakeholders from across the global health funding ecosystem, including researchers from multiple academic disciplines, funding bodies, multilateral institutions, civil society organisations, and advocacy groups. Participants engaged with a series of propositions developed by the Global Health Solidarity research group to address a central question:

> ? How should actors across the global health funding ecosystem — not only funders — understand and operationalise solidarity when it is taken seriously as both a normative commitment and a guiding principle for practice?

The propositions deliberated during the workshop were derived from twelve emerging themes on solidarity, identified through an interpretive synthesis by the project team of its research and related workshop materials. These materials include insights generated from five regional workshops, analysis of qualitative interviews conducted between 2023 and 2025, and reflections drawn from project webinars, thematic workshops, and internal team discussions over the same period. Together, this body of work informed the framing and substance of the propositions presented for discussion.

Workshop participants engaged in structured subgroup discussions of three to four individuals, complemented by plenary sessions. Through these processes, participants refined, reorganised, and reformulated the initial set of propositions, while also identifying areas requiring greater emphasis, clarifying ambiguities, addressing gaps, and eliminating redundancies. Initial revisions were consolidated into a draft document and circulated to participants for further deliberation. The present document incorporates the substantive feedback and refinements that emerged from this second round of discussions into a 3-3-3 framework of principles for embedding solidarity in the global health funding ecosystem.

Rationale

There are several reasons why it is necessary to clarify what solidarity in global health means, how it should be enacted, and the purposes it is intended to serve.

- Efforts to advance global health equity have **increasingly invoked the language of solidarity, particularly during crises** such as the COVID-19 pandemic and subsequent outbreaks such as Mpox. However, these appeals have resulted in limited tangible outcomes, especially in relations between countries.
- Despite frequent references to solidarity, **prevailing conceptions within global health remain aspirational, vague, and insufficiently theorised.** Consequently, they provide limited practical guidance and lack the conceptual clarity required to translate solidarity from principle into practice.
- A consistent theme emerging from the Project's workshops, interviews, and webinars –engaging diverse actors and communities across different world regions– has been a call for more genuine and authentic expressions of solidarity in global health. Participants emphasised the need for solidarity that is not instrumental, manipulative, or merely rhetorical. They also highlighted **the need to distinguish solidarity from other current global health practices premised on charity and international power imbalances.**
- Since the Project's launch, the global political landscape has shifted significantly. A **resurgence of political nationalism has weakened international cooperation,** evidenced by withdrawals from multilateral institutions and substantial reductions in global health funding. These developments heighten the urgency of clearly defining solidarity in global health and establishing mechanisms to evaluate whether actors are genuinely committed to practising it, rather than simply invoking it rhetorically.
- The May 2025 WHO **Pandemic Agreement calls on states to be "guided by equity and the principle of solidarity** with all people and countries" in preventing, preparing for, and responding to pandemics and other public health emergencies of international concern. The framework in this document offers high level tool for reflection as countries seek develop policies for the implementation of the Agreement's recommendations.

Scope

The field of global health comprises multiple actors operating with varying degrees of interest, influence, and power at various levels. Funding for research and implementation programmes is a central component of this field and takes place within a broader context shaped by historical, political-economic, epistemic, and social dynamics that structure relationships both between countries and within national systems.

Against this complex backdrop, the overarching intended outcome of this Project is the advancement of what we term **solidaristic funding**. *This refers to a funding ecosystem grounded in and structured by the core features and ideals of solidarity* as articulated in these Principles. Given the breadth and heterogeneity of actors within the global health funding ecosystem, it would be neither realistic nor analytically precise to require that every actor (e.g. funding bodies, international organisations, gov-

Given the breadth and heterogeneity of actors within the global health funding ecosystem, it would be neither realistic nor analytically precise to require that every actor (e.g. funding bodies, international organisations, governments) be fully driven by solidaristic commitments alone. However, our empirical findings support the normative claim that actors operating in this space ought to align their conduct with solidaristic ideals and principles.

ernments) be fully driven by solidaristic commitments alone. However, our empirical findings support the normative claim that actors operating in this space ought to align their conduct with solidaristic ideals and principles. Accordingly, even where national government agencies are motivated in part by considerations of soft diplomacy, or private actors are guided by philanthropic objectives, participation in the global health funding ecosystem entails accountability to the principles of solidarity in the exercise of their respective roles.

In light of the foregoing, the Principles set out in this document are intended to function as a high-level normative framework to guide reflection on how solidarity can be embedded as a foundational principle within the global health funding ecosystem.

These Principles are directed at *global health researchers, decision-makers, and implementers engaged in funding, research, and implementation activities*. They are designed as structured prompts for reflection, enabling relevant actors to identify the practical implications of solidarity within their respective roles and organisations. The Principles are also intended to catalyse sustained dialogue regarding the operationalisation of solidarity across the ecosystem. In addition, the Principles serve as a normative reference point for structuring funding arrangements, research partnerships, and implementation collaborations in a manner consistent with solidaristic commitments. The Project remains committed to continued engagement with stakeholders to develop more concrete and actionable tools to support implementation.

The Principles do not prescribe specific actions for individual actors operating as funders, knowledge producers, or program implementers at various levels (e.g. micro, meso, and macro levels). Examples of those levels include relationships between individuals, between institutions and at the country level, as well as the interactions and dynamics that connect these levels to one another. The development of more detailed operational guidance will form part of the subsequent phase of the Project.

The Principles are organised into a 3-3-3 Framework addressing three core dimensions of solidarity in the global health funding ecosystem: *what solidarity entails, how it is enacted, and to what ends it is directed*. Together, they form a foundation for reshaping how actors relate, make decisions, and work toward justice and more equitable health outcomes.

The **first triad** defines what solidarity in global health entails, *a commitment expressed through action and grounded in relational identification with others, oriented toward the advancement of im-*

proved health outcomes. It emphasises that, while agile and responsive initiatives remain useful in some contexts, solidarity drives towards sustained relationships and not only episodic engagement.

The **second triad** addresses how this *solidaristic relationship is enacted, highlighting mutuality, trust-building, respect, and inclusivity as core commitments*. By foregrounding mutuality, this triad distinguishes solidarity from charitable models that position certain actors primarily as donors and agenda-setters, and others as passive recipients.

The **final triad** articulates the *ends toward which solidaristic practices aspire*, including the redistribution of power, emancipation, and ultimately attaining health equity and fairness within the global health funding ecosystem.

The Principles are both aspirational and normative in character. They are intended to guide implementation along a continuum that accommodates incremental reform as well as transformative change. **No single Principle defines solidarity on its own, but they are distinct features that when assembled together reveal a picture of what solidarity looks like.** They should not be treated as a compliance checklist, but as evolving standards of reflection and practice that inform and strengthen the realisation of solidaristic ideals across the global health funding ecosystem.

Principles for embedding solidarity in the global health ecosystem

These principles articulate a 3–3–3 framework for embedding solidarity as a normative pillar of the global health funding ecosystem. Each triad defines what solidarity entails, how it is operationalised, and the ends it is intended to serve.

First Triad WHAT

A commitment expressed through action and grounded in relational identification with others, oriented toward the advancement of improved health outcomes and reducing inequities.

Principle 1 | Solidarity is action that entails standing with and for others

Solidarity is expressed through concrete actions, institutional practices, and structural arrangements (e.g. systems, mechanisms) towards a common goal. These actions lead to measurable improvements of health and well-being. Solidarity is enacted, not merely proclaimed; it consists of commitments and practices that carry cost (e.g. financial, time, emotional, political) rather than mere sentiments or rhetoric. Solidaristic actions are other-oriented: their primary purpose is not narrow self-interest, but the protection and promotion of common health goals.

Principle 2 | Solidarity is a form of “identifying with”

Solidarity is constituted through relationships of identifying with one another through a shared desire to achieve better health and close existing health gaps, often spurred and accompanied by feelings of empathy, irrespective of race, nationality, gender, and other differences. It recognises context-specific relevant connections (e.g. shared exposure, interdependence, or common commitments) that do not presume sameness, erase differences in power, vulnerability, and position, or imply identification in all respects.

Principle 3 | Solidarity is a specific type of relationship

Solidarity is a specific type of relationship characterised by willingness and availability to support (e.g. material, emotional, moral, physical). This can build on existing ties, making networks of connections more visible while also generating new relationships. As support is offered and recognised, patterns of mutual reliance become clearer, allowing both established and emerging connections to take shape around shared responsiveness.

Second Triad HOW

Modalities of enactment, highlighting mutuality, trust-building, respect, and inclusivity as core commitments

Principle 4 | Solidarity entails commitment to mutuality

Solidarity as acting together toward a common goal highlights the strength of collective actions compared to isolated efforts. This shared commitment is grounded in mutuality which, unlike reciprocity that carries expectation of payback, rejects the framing of relationships as transactions between givers and receivers. Acting together for common health goals does not require agreement on every analysis, value, or strategy; it relies on mutuality as a commitment to remain in relationships that may include disagreements, recognising difference as a resource that values the diversity of contributions towards the common goal.

Principle 5 | Solidarity is built on and maintained by trust

Solidarity arises against the background of and is maintained by trust understood as the confidence to rely on one another across unequal positions with a specific common goal. This trust is neither automatic nor static; it is continually reinforced or undermined through behaviours and experiences that accumulate over time. Solidarity involves trusting that all actors will do their part while recognising that responsibilities differ according to role, capacity, context and over time.

Principle 6 | Solidarity requires respectful and inclusive engagement

Solidarity requires recognition and valuing of distinct contexts, knowledge systems, and experiences in which different actors live and operate, including their strengths, opportunities, constraints, responsibilities, and vulnerabilities. It is expressed by ensuring that different forms of agency are respected (e.g. shape priorities and influence outcomes), and accessible space is created for engagement (e.g. listening and learning) without overriding local knowledge, disrupting existing systems, or imposing disproportionate control, particularly in relationships marked by asymmetries of power. Inclusivity is not symbolic participation but meaningful involvement in shared decision-making oriented toward health as a common goal.

Third Triad TO WHAT END

The ends toward which solidaristic practices aspire to achieve health equity, fairness, and justice within the global health funding ecosystem.

Principle 7 | Solidarity challenges power differentials

Solidarity seeks to challenge and dismantle entrenched and structural power imbalances that contribute to health inequities. It requires critical examination of existing power structures, often rooted in historical patterns of inequality, that shape decision-making, governance, and control

over resources. Practicing solidarity creates opportunities to redistribute power so that those most affected actively participate in decision-making processes, governance structures, and the equitable sharing of benefits. This would entail prioritising decisions to be made at the most local level capable of addressing them effectively, ensuring that those affected have influence over the processes and outcomes.

Principle 8 | Solidarity pursues emancipatory ends

Solidarity has often been invoked in moments of crisis or mobilisation (e.g. pandemics, health emergencies, or struggles over access to medicines) where actors come together to resist external threats, exclusion, or harm. While these forms of collective response are important, solidarity in global health must move beyond episodic mobilisation and instead commit to long-standing actions and practices that generate and sustain the conditions necessary for people everywhere to attain positive health outcomes. Thus, solidarity is not only reactive but transformative, it provides a foundation for advancing more just and inclusive health systems, embedding a commitment to addressing the structural drivers of inequities, including those shaping patterns of disease, access to care, and knowledge production. Solidarity thus requires decentering of the political, economic, and social structures away from dominant institutions and actors towards enabling underserved and underrepresented populations to advance their own health.

Principle 9 | Solidarity is key in the pursuit of health equity and fairness

Solidarity in the global health funding ecosystem emerges as a social and political process intrinsically linked to the pursuit of justice rather than a purely technical or humanitarian response. By focusing on the quality of the relationships that are generative of equitable outcomes, solidarity fuels the pursuit of equity. At the same time, the pursuit of equity, understood as the elimination of unfair and avoidable differences in health across populations, anchors solidarity as a binding moral principle.

One of the organisers of the workshop makes a presentation to the participants.

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ANNEX 2: TABLE 2
OVERVIEW OF REGIONAL WORKSHOP REPORTS

Regional workshop reports	Year	Organisers
Solidarity: Embodied and Enacted – Learning with the Rural Women's Assembly – Southern African Workshop	2026	Rural Women's Assembly & EthicsLab
Solidarity in Global Health: Perspectives from India and Nepal – South Asia Regional Workshop	2025	Ashish Giri & Agathine Asamoaning
Mesoamerican Workshop on Solidarity and Global Health	2025	Gabriela Arguedas Ramírez
Exploring and Enabling Theories and Practices of Solidarity and Adjacent Concepts in Australia, Aotearoa New Zealand, and the Wider Pacific	2024	Bridget Pratt & Jae-Eun Noh
Solidarity and Global Health: Perspectives from Francophone Africa	2024	Elysée Nouvet, Oumou Younoussa Bah-Sow, Agathine Asamoaning & Eugene Ankamah
Exploring and De-Silencing African Conceptualisations and Praxis of Solidarity Applications in Global Health	2023	Samuel Asiedu Owusu & Caesar Atuire

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