Ahimsa Fund
Making good health contagious

Ahimsa Forum on Innovation in Global Health

June 24-28, 2019
Les Pensières Centre for Global Health, Annecy, France

SUSTAINABLE DEVELOPMENT GOALS

#AhimsaForum2019

Acknowledgements

The organisers would like to thank the sponsors of the 2019 Ahimsa forum: Bio-Rad; UNAIDS; Roche; Qiagen; Cepheid; Novartis; The Global Fund; the World Health Organization; Boehringer Ingelheim; the WHO Special Programme for Research and Training in Tropical Diseases (TDR); the World Faiths Development Dialogue (WFDD); and Les Pensières Centre for Global Health (Fondation Mérieux).

Particular thanks go to the chairs of the sessions—

- Zeina Abdo
- Reuben Coulter, CEO, Transformational Business Network
- Jean-François de Lavison, President and Founder, Ahimsa Fund
- Lily Gros, Enactus
- Béatrice Halpaap, WHO/TDR
- Pradeep Kakkatil, Director Programme Partnership and Fundraising at UNAIDS, Founder of the Health Innovation Exchange
- Setsuko Klossowska de Rola, UNESCO's Artist for Peace
- Kira Koch, Health Systems Governance and Financing, WHO HQ
- Renier Koegelenberg, EFSA, South Africa
- Katherine Marshall, Executive Director of the World Faiths Development Dialogue, Georgetown University
- Saba Al Mubaslat, CEO, Asfari Foundation
- Michael Moller, Director General, United Nations Office in Geneva
- Benjamin Rolland, Enactus
- Maria Salih, Enactus
- Jorge Vivanco, Vision Fund, Mexico

—and to the artists and practitioners whose work enlightened and supported the forum:

- Benoit Astier de Villatte, artist and craftsman
- Ivan Pericolli, artist and craftsman
- Countess Setsuko Klossowska de Rola, UNESCO Artist for Peace and President of the Balthus Foundation
- Isabelle Wachsmuth, painter.

Finally, our thanks are due to all the participants, for their efforts in supporting a rich, varied, and enlightening discussion.

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Abbreviations & acronyms

AI	Artificial intelligence
AMR	Antimicrobial resistance
ARV(s)	Antiretroviral(s)
CERAP	Centre for Research and Action for Peace
ECD	Early childhood development
EDARP	Eastern Deanery AIDS Relief Programme
ESFA	Ecumenical Foundation of Southern Africa
GAVI	Global Alliance for Vaccines and Immunisation
HPV	Human papilloma virus
ICRC	International Committee of the Red Cross
IFPMA	International Federation of Pharmaceutical Manufacturers & Associations
ILO	International Labour Organization
INERELA+	International Network of Religious Leaders Living with or Affected by HIV/AIDS
ITC	International Trade Center
MDR-TB	Multidrug-resistant TB
OECD	Organization for Economic Cooperation and Development
PaRD	International Partnership on Religion and Sustainable Development
PCR	Polymerase chain reaction
PEPFAR	US President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
R&D	Research and development
ROI	Return on investment
SDGs	Sustainable development goals
SIHI	Social Innovation in Health Initiative (WHO TDR)
SME(s)	Small and medium-sized enterprises
TB	Tuberculosis
TDR	Special Programme for Research and Training in Tropical Diseases (WHO)
TDR	WHO Special Programme for Research and Training in Tropical Diseases
UHC	Universal health coverage
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCRC/CRC	UN Convention of the Rights of the Child
UNDP	UN Development Programme
WFDD	World Faiths Development Dialogue
WHO	World Health Organization

Note to the reader

This report condenses discussions according to the themes addressed, rather than attempting to provide a chronological summary.

The summaries of the discussions and group work address the themes emerging from wide-ranging discussions among all speakers, and do not necessarily imply consensus.

Presentations and of points made in discussion are presented as the opinions expressed; no judgement is implied as to their veracity or otherwise.

Audio recordings

Audio recordings of many of the sessions are available at:

https://soundcloud.com/ahimsafund

Please keep checking back. More recordings will be placed online as they become available.

Introduction

***Jean-François de Lavison**, President and Founder of Ahimsa Fund*

Several of you have asked me how we envision our next forum, after this fourth edition. This is a very good question.

I believe that it is now time to move our projects forward in the field, applying our models and ideas, so we can come back with concrete solutions for access to healthcare for the world's most disadvantaged populations, using our network of faith-inspired communities around the world.

Ahimsa's aim is to focus on the common values that unite us rather than on our differences. We must work to pool our best skills and, together, solve the great conundrum of good health for all.

Ahimsa strives to be "the quiet force of calm", associating compassion, discernment and *joie de vivre* in this quest. We now have a network of partners, built up over many years, each with their own expertise and their own skills, who all strive toward the same goals. Each piece of the puzzle has its place and its importance, and the puzzle will not be complete unless all the pieces are united. We must build the solution together, rethinking our ways of working and setting aside competitive principles in order to build a new partnership based on sharing, compassion, altruism and tolerance.

Good health is a universal right, not the privilege of the few. It affects us all, and must be accessible to all. Good health must be contagious: it must apply to everyone and help us to fight inequalities. To achieve this, we need new models and a new culture, and we must challenge the status quo.

During this forum, we identified several projects which some of you intend to undertake.

Ahimsa will be—as Katherine Marshall of the World Faith Development Dialogue put it—the "prophetic voice" for each of these projects, contributing neutrality, leadership and a willingness to build bridges and create the most inclusive team possible, providing the solutions needed to bring these projects to fruition.

We know that we can address the fight against inequality in Global Health and make technological innovation accessible to the poorest through the worldwide network of the faith-inspired communities. We will be the quiet force behind every achievement, with the sole objective of making good health a universal right, accessible to all.

With the stones that life has placed in our path, we choose to build bridges, not walls.

So yes, let us meet again in two years' time, in June 2021, with real achievements and truly new experiences and new visions. Thank you for your support and your commitment. Let us work together to write the next page in the book of life. We will need you all.

Part one: faith communities and UHC

"It is not because things are difficult that we do not dare, it is because we do not dare that they are difficult."

Lucius Annaeus Seneca

Welcome

***Chairs: Jean-François de Lavison**, President and Founder of Ahimsa Fund; **Katherine Marshall**, Executive Director, World Faiths Development Dialogue (WFDD)*

2019's gathering began with a welcome to the Forum from the President and Founder of the AHIMSA Fund, **Jean-François de Lavison**. He thanked sponsors and participants from 46 countries, with a near perfect 51/49% gender balance, and outlined the forum's philosophy in six points: openness of discussion; compassion; listening; respect; participation; and dialogue. As ever at Ahimsa, efforts had been made to ensure that at least a quarter of those present were members of younger generations.

The future must be built on our strengths—we spend too much time on our differences—and the common objective of achieving health access for the most vulnerable gives everyone an opportunity to contribute. Breaking silos down in favour of bridges is possible with two things: political will and leadership.

The forum would have three main parts: addressing the ongoing task of engaging faith-inspired communities and faith-based organisations with civil society and governments in the joint task of achieving universal health coverage (UHC); an innovation track focussed on making the benefits of technology and progress accessible to the world's poorest; and an important, cross cutting theme examining how to balance our busy professional existences with our personal lives, giving

appropriate importance—and time—to the associations between physical and mental health, culture and art.

Life puts stones in our way: whether we use them to build walls or bridges is our choice.

Feedback on the G20 Interfaith Forum 2019, Tokyo, Japan

***Katherine Marshall**, Executive Director, World Faiths Development Dialogue (WFDD)*

"The question of who is at the table, whose voice is heard, is ever-present"—but, was much as 84 per cent of people in the world have some religious affiliation, the voices of religious communities are not always heard in international discussion.

One effort to remedy this takes place in the context of the G20. Religious voices are represented in G20 sessions through the G20 Interfaith Forum—one of the most ambitious meetings on the international landscape, with 2019's forum hosting 250 speakers and an audience of 4,000, and addressing a wide range of issues across themes of peace, people and the planet.

Presenting significant recommendations in a coherent, plausible way to G20 members is a challenge. The solution is to build a "network of networks" such as Ahimsa, the International Partnership on Religion and Sustainable Development (PaRD), the Network of Religious and Traditional Peacemakers, relevant UN task forces, etc.; and to conduct a joint learning initiative to draw the most significant ideas and recommendations from this network. Based on this process, the 2019 meeting started with five major areas of discussion:

- The need for a more thoughtful focus on the role of religion in countering violent extremism
- Leveraging the G20 to protect child rights (in concert with the 30th anniversary of the UN Convention on the Rights of the Child/CRC)
- Stewardship of the planet, particularly through the protection of rainforests, with a coalition of religious voices engaged in the issue across the Amazon, the Congo basin and South East Asia
- Rule of law and fighting corruption, addressing the grievances that drive extremism and populism
- Human trafficking.

The gathering is "turning into quite an academic conference"—but for the good. In the G20 meeting in Germany in 2017, the Merkel government was insistent that if religious bodies are coming together and "appropriating the G20 brand," they must

respond to the G20 agenda. In response, the Interfaith Forum has transformed into an organised association. There are many challenges: if you want to shape the agenda you need to think years, not weeks, in advance, and the forum has uncertain financial support—not to mention the fact that next year's G20 meeting will be in the Kingdom of Saudi Arabia, offering challenges to the free expression of ideas concerning religion.

Given the challenges, why engage with the G20? One advantage is that it is not the UN—it is a smaller, more flexible and more manageable group, with which it is still possible to engage, and which represents a real concentration of power.

The work of the Interfaith Forum is shaped by the Sustainable Development Goals (SDGs); but while these are a critical framework, the Forum faces the more particular challenge, distinctive to religious bodies, of "having a prophetic voice." It must remain willing to challenge the status quo, to look ahead frankly to the realities and challenges of tomorrow, and to remain unbound and able to face those challenges.

WHO Handbook on social participation

An ongoing descriptive mapping study by WHO, in partnership with Ahimsa and the WFDD, on faith-inspired organizations and their role in the health sector and UHC
Speaker: ***Kira Koch****, Health Systems Governance and Financing, WHO*

While the push for UHC enjoys a moment in the sun, WHO can use it to emphasise the importance of health systems governance and strong leadership. Participation is critical in achieving UHC: engaging populations, communities and civil society will provide governments with the information and understanding they require in order to draft people-centred, responsive policies, in turn allowing them to devise plans that are widely accepted and widely implemented. "Otherwise, we draft beautiful reports and don't implement anything." Involving populations, gathering their views and demands and making policies responsive, is critical to success.

In 2018, WHO convened a civil society task force? and released a report on engagement with civil society. This handbook is another push further in this direction. Its target audience is policy makers, and it fills a current gap in guidance in this area. Conceptually, the book addresses three "major engaging modalities," or ways to engage: directly with populations (e.g. through national health assemblies); through civil society; and through communities. WHO is currently collecting data and case studies to substantiate all of these.

Civil society is a broad church. WHO is seeking to improve understanding of the particularities and added value of faith inspired organisations (FIOs)—"the differences and challenges that help us understand." Literature is scarce, and what does exist is mainly focused on Anglophone sub-Saharan Africa, with a great deal of study on Christian organisations, but not much on those of other religions. In many

countries, data on their contribution to national health planning is limited. A research protocol was developed and interviewees were identified, selected for a spread of major religions. Around 20 interviews had been done at the time of the Forum, with more to come, and data collection is at an advanced stage. Questions have included how much "faith" is reflected in the work of in these organisations; what role they play in health provision and UHC, exploring the link between the drivers of faith and the concepts of UHC and primary health care; what populations they serve; and the particularities of the work of FIOs—i.e. how they collaborate with governments and others, and the similarities and differences to the mechanisms of civil society and NGOs.

A number of interesting themes are emerging, including the importance of the trust-based connections that many FIOs enjoy with communities, their ability to reach isolated populations, and the question of whether that trust is generated by the leader, or by something else more intrinsic to their work. Challenges include controversies around family planning and sexual and reproductive health (SRH)—an important recurring theme that must be acknowledged, but with recognition of the fact that there has been a great deal of interfaith dialogue as a mechanism to overcome those challenges. Different religious groups—particularly in countries where there are large groups—can convene and discuss different standpoints on how health care services should be provided. In fact, platforms for interfaith dialogue emerge as an important means to overcome these challenges: "through networks of faith inspired organisations we can really educate communities [about how] UHC is a means to achieve good health or wellbeing." Communities need to be made aware.

The handbook on social participation emphasises participatory governance mechanisms. Such mechanisms include national health assemblies (like in Thailand); societal dialogue (as in Tunisia); civil society's work with communities (e.g. in Burkina Faso, looking at the presence of civil society in the health financing process). One emergent conclusion is that "we can't stick to health too much… we have to look more broadly at social science work. Staying only in the health sector limits our approach."

The book can be used in lots of ways, and particularly as a guidance document for member states. Having an internal group at WHO in this area also means there can be an advocacy strategy to ensure that it is properly used.

How to better understand the role of FIOs in UHC efforts?

How to define faith inspired communities and UHC?

Moderator: **Katherine Marshall**, Executive Director of the World Faiths Development Dialogue, Georgetown University

Speakers for this session were **Marie-Paule Kieny**, Scientific Director, Inserm; **Laurel Sprague**, Special Advisor, Community Mobilization, UNAIDS; **Kira Koch**, Health Systems Governance and Financing, WHO; **Linda Mafu**, Head of Civil Society and Political Advocacy, The Global Fund; **Jill Olivier**, Associate Professor School of Public

Health and Family Medicine, Health Policy and Systems Division, Cape Town University; and **Mwai Makoka**, Programme Executive for Health and Healing, World Council of Churches (WCC).

Kira Koch again emphasised the importance of the question of who is at the table, and why, and pointed out how in certain situations, "some 'suspicious' groups are very well represented, and invited with a certain understanding on whose voices are *not* heard. In 'leaving no one behind' we need to figure out how to bring excluded voices to the table when governments are making decisions." Why are some voices excluded—are they convinced there's no need to be there, "is there a feedback loop, or a lack of true information exchange?" Talk about UHC often refers to it as a political choice by member states, "but strong focus on governance and participation can produce strategies more responsive to communities' needs, with accountability mechanisms, accepted by populations and communities and serving their needs."

Laurel Sprague (UNAIDS) examined the lessons of civil society responses and the work of FIOs and faith-inspired leaders. There is much on which to draw: rich traditions and histories of advocating for the most marginalised, and the fact that every faith tradition already has language that can be used with decision makers to advocate for including people suffering from ill health. Poor people must have access to health services, removing out of pocket expenses and user fees, and helping those who suffer stigma, criminalisation and discrimination. In this regard, inclusive, tolerant, supporting messages from faith-based communities can make all the difference in the world.

There are two main ways for faith communities to be involved in UHC. The first is at a global level, via—for example—the high-level UHC meeting in that will take place in September 2019 in New York, by accessing decision makers in their own communities, finding out who is negotiating high level commitments and "getting their language in it, then holding people accountable for their commitments." The second is in countries moving towards UHC, by engaging ministry-level health systems planning processes, getting involved and contributing a moral authority and conscience to push for the people most left behind—people who will not be considered if we don't fight for their inclusion.

Linda Mafu of the Global Fund picked up on the theme of leaving no-one behind. If we want UHC, we must ensure there are financial and human resources to back it, "to make sure it's not just another document." Commitments need to impact human lives: "leaving no one behind" means addressing real barriers to access to quality health services, and issues around poverty and the contexts that force people to choose between health services and food for their homes. The Global Fund plays a role in health financing, but "it's a drop in the ocean." Resources must be mobilised, invested and used efficiently and effectively in high impact interventions. Currently, "we're not doing it."

Faith-inspired communities often talk about inclusivity, but how do we make our communities inclusive? How do we make health care services available to people? Young people use different tools to provide and access information—how do we tap into their communities to make sure they get the information they need, at the right time, making sure they don't get into desperate situations because they are ignorant? We need practical guidance that that can be used by young people and by faith-based communities for real life purposes.

If we don't look at increasing national-level financing for public health, we're not having honest conversations. Sustainability cannot only come from global collaboration and solidarity: we must examine the workings of national and local health financing systems, then build them up where needed. The Global Fund is already transitioning out of certain countries, but what gaps will be left behind? Faith-inspired communities can have a huge role in achieving UHC, advocating where others will not, going where no one else will go. In the words of Mandela: "it always seems impossible until it is done." UHC can sound impossible, but it can be done.

Marie-Paule Kieny (INSERM) worked for many years as an Assistant Director-General at WHO, and oversaw the health systems area at the time the SDGs were being negotiated. While the effort to keep UHC as the preeminent aim of the SDGs was a failure, it was at least retained as a target under SDG3. It is obvious that civil society has a key role in achieving UHC; alongside major international behemoths like WHO, the world needs civil society and FIOs as crucial cogs in the international engine. What civil society must provide is a voice asking for participatory governance and access.

Ms Kieny was happy to be able to work on access to medicines while at WHO, but in that role she was unable to speak "the whole truth" about access, and why it isn't there: in such cases, it must be the role of civil society to be the truth teller, the asker of difficult questions. "We can't all be MSF: they're fantastic in what they do, but if we were all that disruptive it wouldn't work. How can we as combinations and as individuals have stronger voices in asking for the right to health?" Close links with faith-inspired leaders can bridge to faith communities to help address health as a fundamental human right for all, not solely a question of charity and compassion.

Mwai Makoka explained how the World Council of Churches (WCC) understands health as a "dynamic state of wellbeing, with the individual and the society in harmony with each other, with the material world, and with God." In this all-embracing view, health is not primarily medical—though medicine may be its most

visible expression. It is made or broken in the home, not at the hospital. The challenge for FIOs is to embrace a holistic understanding of health, in word and in action, and to be clear about the rights and actors in this process, and the tools we must use to achieve it. In Malawi as in many other places, the majority of the health budget is spent in a few institutions, a handful of hi-tech tertiary hospitals. In many developing countries, as much as 80 or 90% of the training budget tends to go to positions and professions that take care of the minority of the population.

When we look at resource mobilisation and allocation, it is clear that church hospitals and their facilities are often important parts of national health systems, contributing significantly to the push to UHC. Our role is not to pit one against the other, balancing prevention against cure, community against clinical and so on, but instead to participate in the search for solutions and a healthy balance. We need ways to mitigate extreme swings of the pendulum—"it's very medical at the moment"—in search of that balance, and a true people-centred approach to health through meaningful engagement of all relevant people and organisations.

Jill Olivier looked at the involvement of FIOs from a health systems research perspective, and listed 10 examples of faith-inspired responses relevant to UHC across different levels of the health system:

1. Faith-based health services provision to populations in areas where there is no other provision and access is difficult
2. Faith-based provision in fragile and conflicted states, where sometimes it is the only provision that exists
3. Faith-based communities providing resilience to whole systems, filling gaps where systems face shocks and stresses
4. Faith-based health services providers acting as hubs in the health system—for example, faith hospitals that act as public system hubs with a variety of public clinics/centres in operation beneath them. Faith-based hospitals are values-driven, and there is a values match between what they provide and similar public sector values of UHC, national health insurance, etc.
5. Finance innovation—for example, faith-based providers having sliding scales of user fees like "Robin Hood" systems, or giving poor people free services. This is UHC in action at facility level
6. Innovation in community-based financing mechanisms—the "forefathers of national health insurance"
7. Different faith groups having different approaches to financing UHC—e.g. local Islamic communities providing zakat (alms-giving as a religious obligation) to public hospitals
8. Work in communities—e.g. women's groups providing nutrition, civil society emerging from congregations and providing care to refugees, etc. There is a growing body of evidence around community health systems
9. Faith-driven volunteerism
10. Provision of peripheral health services—e.g. in some African countries it is only faith inspired organisations that will provide mental health services, or palliative care, filling in particular gaps in national systems.

There are three main gaps in this body of knowledge:

1. Hard data is missing: we need cost effectiveness analyses, research, clarification, and substantive evidence for policy- and decision-makers.
2. This conversation must not be about the exceptionalism of faith-based providers, but rather about how they fit into the whole of the health system, and how they contribute to UHC.
3. Better understanding is needed of the connections and interrelations between public and clinical health, and the different aspects of care, community, civil society and health services.

Discussion

A brief Q&A covered a range of themes.

- The model that relies on missionary financing is in many places dying, and many systems of faith-based provision need to be redesigned accordingly. In the 60s and 70s, Christian health services providers in Africa faced a similar change as international funds dried up and they had to adapt, moving towards reliance on public sector support and integrating more closely with public sector systems. With that came an anxiety about losing their values base, and the changes to the way in which they worked; but those organisations, for the most part, maintained their faith identity and found different finance models.
- Thinking about scalability, the example of public-private partnerships is informative. There are lessons to be learnt from countries with good relationships between Christian and Islamic health services and ministries of health around things like how we measure access, mapping and coverage, where to place facilities in relation to one another, and so on. Faith-based providers are in many ways no different to secular civil society, in that their work is based on good relationships, accountability, and trust.
- While FIOs contribute to the health of communities and societies, their work can often be insular, isolated, and siloed—often a reflection of the fact it is based on a community response. To make a solid case for this work, we must empower these communities to collect and consolidate data to boost a wider response. We speak of collaboration and coordination, but so often we go back to our respective spaces to continue community work, without coming together to establish best practices and avoid duplication, or propagate successful models. We must examine how we empower communities to gather data, and how we consolidate this information. WHO has gathered evidence to advance learning and south-south collaboration and propagate the best models. What happens in communities is often poorly reported, because reporting is not a priority for the actors. There is a need for greater self-examination and honesty about best and worst practices. A platform is required through which they are made accessible to all.
- There is a broader movement around values-based health care which defines value as that value perceived by patients; FIOs could adopt this, and similar

methodologies, to set standards for values-based health care and what might be adopted for UHC in countries. UHC involves questions about price and value, and cost effectiveness is an insufficient measure; we must examine the role of quality measures. There is a need for more emphasis on the patient's perspective (the OECD is currently developing markers for this); it is not easy to measure, but it is a good idea to integrate this kind of evaluation into the care provided by all kinds of organizations.

- As UHC is rolled out, we need frameworks for accountability that speak to all these questions—to fragmentation, to quality, to support for communities. What such frameworks can be put into place alongside the political declaration forthcoming in September, and how can we fund communities to do this kind of monitoring?
- The 2000 WHO World Health report on health systems framed key performance indicators (KPIs) for, among other things, responsiveness. The responsiveness area covers many themes of this discussion—responding to citizens' needs and ideas, ensuring that key populations receive quality care, etc.—and is a useful way to contextualise discussions about quality.
- FIOs are always faced with the burden to show and prove their work. This can eat up a lot of energy unnecessarily. "There is a political aspect of the conversion of data into policy… and our friends in some ministries will often make executive decisions without using the data." There are many political themes around data, and faith actors should approach the demand to prove things with caution.
- Politics can also be leveraged for good. Our critical objective is to keep people healthy so they don't fall sick—to promote peace, keep them safe, avoid accidents, and resolve conflicts of all intensities. Among other things, this saves money. If a Malawian hospital sees one gunshot wound a year and a similar facility in Cape Town treats 10 in an average night, political questions can be asked in how to improve outcomes, and lobbying and advocacy can be done to ensure a response.
- In the search to replicate and scale good work, some practices rooted in community responses have been researched and repackaged to the point of dysfunctionality. This is a trap to be avoided.
- What "community" is, who represents it and how to engage with it, is not always clear—especially in more complex urban settings where defining the nature of communities is tricky.

FIOs and engagement toward UHC – Session one of two

How do faith-based and faith-inspired organizations contribute to UHC?
Moderator: **Jorge Vivanco**, Vision Fund, Mexico

Speakers on this panel were **Stefano Nobile**, Caritas Internationalis, Italy; **François Kabore**, Centre for Research and Action for Peace (CERAP), Cote d'Ivoire; **Ngawang Tenzin**, Tibetan Volunteer Health Association, India; **Vinya Ariyaratne**, Sarvodaya, SriLanka; **Rick Bauer**, Maryknoll, Eastern Deanery AIDS Relief Programme (EDARP), Kenya; and **Neelam Kshirsagar**, Impact India.

Rick Bauer has been working with people living with HIV (PLHIV) in care, support, prevention and treatment for the poor and marginalised—in the midst of doubt, fear and anger—for years, back since HIV was GRID. Catholic health facilities were doing this from the beginning, all around the world, integrating faith with the belief in human dignity in order to provide care and support. Morality and ethics based in faith motivated tens of thousands of health workers to act on the belief that health care is a human right. Catholic social teaching has inspired the work of many, based as it is on the innate dignity of every human person not according to their productivity, but according to their being. The individual is sacred; but she or he is also social, and therefore human dignity is only protected and achieved if rights and responsibilities are met. The test of any society is how we treat the most poor and vulnerable, and how we address the dignity of work and the dignity of workers, including health workers. Non-discrimination is at the very basis of our discussion. No one can be excluded: not migrants, not refugees and not those who need integrated palliative care. Finally, we must respect the earth and take stewardship seriously, protecting the environment, including through waste management.

Health care must be comprehensive, integrating all aspects of human development for holistic care—the emotional, social and spiritual as well as the physical. This requires building not just health care systems, but "caring systems of health." To achieve UHC, national governments must acknowledge the importance of community-based systems that drive us towards community ownership, and thence to UHC. Most important in this setting is the golden rule of every theological tradition: do unto others as you would have them do unto you.

Neelam Kshirsagar explained how **Impact India** was born following in the early 1980s, "emerging from the house of Tata" in 1983. One early project was a polio immunisation campaign; after many partnerships, including with the Indian government, the Bill and Melinda Gates Foundation, the Rotary Club and other businesses—polio eradication was achieved in 2014. Realising the power of its large national network, Impact India hit upon the idea of using the railways, and asked for a train. This was the birth of the Lifeline Express. Now there are seven coaches travelling the country providing surgery, training for community health workers, cancer and diabetes screening, blood pressure testing and other services in

partnership with the government, serving over a million people from the train in districts all over 19 states of India. Its services evolve in response to communities' needs, and now also include preventive work, dental care, screening, corrective surgeries and promotion, prevention and wellness work. Its success was bolstered by the fact that the 2013 CSR Act obligated corporations in India to donate 2% of net profits to social philanthropy, addressing inequality and India's great health problems. The train is a very visible project, and is therefore attractive to private and business houses, many of which have joined the partnership.

Impact India's wider preventive health programme has been a community health initiative, running since 2005, which is today focused on reproductive and maternal health, with the goal of lowering maternal and child mortality and dealing with anaemia and malnutrition. It also provides behaviour change work and trains government health workers. These are long term goals and they take time: because this project does not show immediate results in the manner of surgery on a train, corporate investors are few, and sustainability is a challenge. More data is required to argue its case to governments.

Ngawang Tenzin's parents are from Tibet, but she has never been there; instead, like many in exile, she grew up in a refugee settlement, one of several scattered all over India. Now she works for the Tibetan Voluntary Health Association (TVHA), part of the central Tibetan administration that looks after Tibetan refugees in India and Nepal. Promoting UHC is one of the Association's biggest goals. Refugees face a range of challenges, and the biggest are to do with health: HIV, substance abuse, maternal and child health, other infectious disease and mental health. Tuberculosis (TB) is a particular problem, perhaps because of living conditions and the fact it spreads easily in student accommodation and monasteries. It can, however, be addressed: thanks to collaboration with the Indian government and a range of global health stakeholders, TB incidence in Tibetan refugees has fallen by over 47%, active case finding has started, and latent TB initiatives are in place. Infant mortality, over 40 per 1,000 live births in 1998, has fallen greatly, though obtaining accurate data is a challenge because of scattered populations and poor reporting. There have been no reported maternal mortality cases in the last three years. These improvements are also the work of the Department of Education, which ensures that health objectives are accompanied by education programmes. The TVHA has started targeting adolescents in Tibetan schools as well as mothers and children, providing health information and confidence building, and teaching life skills such as how to handle peer pressure.

As far as faith to concerned: Tibetan settlements in India are usually very remote and enjoy good relationships with other local communities. Mutual respect and understanding have made it possible for them to survive and thrive. More than 50 clinics across India now provide traditional Tibetan medicine, employing some 500 people, and more than 40% of the adult exiled population prefers to attend these hospitals for chronic ailments rather than Indian government facilities. It is important to understand the influence of faith on individuals and communities as a whole: each faith holds within it something that binds people together. Global

Health actors must understand the importance of faith for people seeking care—whether it blocks or promotes their efforts. In Tibetan communities it has had negative and positive sides. Mental health and faith are important to health, and compassion is present in all religions, and can be used to help people with physical and mental ailments—all is interrelated. Mental and physical health are deeply interconnected.

Viya Ariyaratne explained how **Sarvodaya** has touched more than 15,000 villages across Sri Lanka in over 60 years of work. Though its holistic approach is inspired by Buddhist teachings, Sarvodaya is a "very secular" organisation, working across all communities in Sri Lanka. This is a country in which people enjoy reasonable health despite low per capita income, and a people-centred free health system has evolved over decades—although out of pocket expenditures remain a key challenge. Shortly after Sarvodaya's inception, a national development ideology was needed: Sri Lanka was suffering from rampant poverty, and government services were not reaching the poorest. People were "dependent," believing that government should provide services, and took no initiative to remedy adverse situations—even though Sri Lanka has a great deal of natural and human resources. In response, groups of teachers and students from a Buddhist high school began a movement, travelling to live in different villages and sharing labour and teaching with the goal of uplifting communities. It was a two-way process: the students participating were also transforming their own lives, changing Sri Lanka in its early days after independence, and finding solutions to national problems together. From this humble start, Sarvodaya grew into a national movement that is now one of Sri Lanka's largest, and Sri Lanka itself has achieved a lot: low infant mortality, high life expectancy, low maternal mortality, and some baseline indicators already exceeding 2030 targets. But disparities and inequalities remain.

Buddhist notions of wellbeing have been mobilised to help communities through education systems that work across social divides, and which have played their part in elevating health status; but apart from that, Sri Lanka's ethnic and cultural differences have not been managed well over the years. A largely Buddhist country with significant Muslim, Hindu and Christian populations, Sri Lanka suffered from a terrible 30-year civil war that ended in 2009—though recent events have shown that tensions remain. Health systems were stressed by this conflict, and a range of FIOs filled some of the gaps created by the conflict—mainly in preventive services and addressing the socio-political determinants of heath with a rights-based approach.

Many national challenges to UHC targets remain, of which two are particularly important. Firstly, while the health sector is government run, the private sector is thriving. Sri Lanka is a middle income country with high economic indicators and receives little international money, but there are tremendous disparities and unacceptable pockets of deprivation. The private sector is improperly regulated, and people experience high out-of-pocket expenditure even though state health services are free. The second challenge is the difficulty of reaching some disadvantaged groups effectively, including ethnic and religious groups. Terrorist attacks in Easter 2019 killed over 350 people and may have marked a turning point in ethnic and

religious relations, creating or exacerbating a difficult new context in which fundamentalism and the work of divisive religious groups (funded from outside the country) pose huge challenges to peace. Faith is being defined in a way that divides communities and promotes suspicion, and now many challenges to public health come from faith communities themselves. Examples include people boycotting products from other communities, demanding to be treated by health workers from particular communities, or misusing statistics about demographic change to promote fear and psychosis. These are serious problems, and while Sri Lanka can expect to achieve its health targets, health is really about more than that: it is about total wellbeing. There is a need to use faith to address extremism and reconnect with deeper principles of spirituality, highlighting spirituality rather than religion.

Francois Kabore reminded the gathering that "innovation" need not only refer to engineering feats that create new products or services. Making something useful that already exists newly available to consumers is also innovation. Conversely, if new technical innovations don't reach the market, they're just lost money. Reaching UHC requires non-negotiable achievements of accessibility, quality and affordability. So how can innovation matter for UHC?

In Burkina Faso and Côte d'Ivoire, 75% of the population is younger than 25. In less than 20 years, the percentage of the Burkinabe population owning a mobile phone has risen from 0.2% to 93%. In Ivory Coast the current figure is 130%, because people own multiple phones—the same figure, with the same penetration, as in Switzerland. Here, Africa as a whole has an advantage: 75% of people are very young, and their lives are on their phones. Innovation is a given, and what do we do with it provides enormous potential. For example: in West Africa, because of the popularity of mobile banking, phone companies have requested official designation as banks; each day they move millions of dollars. Phone technology is revolutionising whole sectors.

The question is not about whether innovation can matter, but how it should matter; and to date, there has been no serious impact in the health sector. This is a huge missed opportunity. In Burkina Faso 81/1000 of children die before the age of five. In Côte d'Ivoire the figure is higher, about 90/1000. In Switzerland, it's 4/1000. These countries have abundant resources—Burkina Faso has a great deal of mining industry, Côte d'Ivoire produces 40% of the world's cocoa—and rich human capital in terms of youth; but poor delivery of health systems. But through phone companies, telecoms and other innovations already available elsewhere, we can improve the health systems by engaging the youth. There is a sore need for greater youth engagement: "at a typical meeting in Africa, the average age is about 75… and the presidents are all geriatric"; for the sake of participation, this must change. Innovation is risk, and youth are happy with risk.

We must think outside boxes, "without boxes at all," delivering health care to customers rather than vice versa; the Coca Cola supply chain is brutally effective in the most isolated communities; health can be the same. We must address how to deliver services in tough security conditions, where people are concerned with

everyday trade-offs between purchasing food or buying drugs, or where they risk death for celebrating Mass. We must make the most of traditional knowledge, especially given the data that suggests that sick Africans tend to choose traditional medicine first, and make governments enhance their approaches to health coverage by engaging traditional systems. Intellectual property (IP) may one of the best ways to promote innovation, "but in Africa a lot of health knowledge is traditional and communal knowledge." So we must find ways to make that knowledge available, impactful and subject to some new model of IP. "In an African context, we won't reach UHC without taking traditional medicine into account."

Stefano Nobile quoted Pope Francis' view of health care as a common good, and argued that **Caritas** and the Catholic Church are well placed to respond to this call. The Church runs health facilities around the world, and in 2018 provided health care through 5,287 hospitals, 15,397 dispensaries and over 15,000 elderly and care institutions. On average, it runs 100 health facilities in every country in the world. These are Catholic services only; other religions also do a very great deal. But is this structure enough to achieve UHC? No. Countries need funds to remove financial barriers to access, and very few low-income countries have any chance of generating such funds domestically. This highlights the need for true global solidarity in which high-income countries meet their commitments on development assistance.

The fight against poverty is above all a moral one. Caritas has national members around the world, and can apply the idea of global solidarity in real terms. The bodies with strong capacity share their strengths with weaker ones—for example, Catholic Relief Services in the United States of America supports a programme in Senegal to improve access to health services and strengthen prevention in vulnerable populations; and Caritas Netherlands supports programmes in Afghanistan to ensure the government allocates enough funding to health, and that the health workforce is ready to engage. In 2018, the latter programme provided over 8,000 people with access to clinics and hospitals, and enrolled over 300 students for training. This is the core of global solidarity: sharing capacities, resources and knowledge.

If we believe health is a human right and humans should be able to fulfil their potential in dignity, equality and health, and that the world should be somewhere people can have healthy productive lives, wherever they live, then we believe in UHC. Every single FIO believes this, every church. We should come together to apply this global solidarity.

Discussion

A brief Q&A covered a range of topics.

- Sri Lanka is "the poster child for malaria eradication." This was achieved not by focused action on malaria control, but by action on the total health infrastructure, and community engagement. Incidence was falling, but progress was poorer in areas affected by the war, so the government

partnered with NGOs that could access those areas even in conflict. By building trust with rebel groups and communities, they were able to provide organisation, impregnated bed nets, treatment of breeding sites, and early detection and treatment services. An integrated approach is the secret: bringing sectors together and carrying out sophisticated community education, social marketing and education programmes in schools. A ten-year period of intense action led to elimination.

- Communities are bound by common interests, but are subject to external pressures, not least when the media promotes hate speech and division. The answer is to strengthen interactions between communities. This must come from the bottom up, but at national level we can promote supportive environments that enable this, by ensuring law, order and accountability.
- Ultimately, health care should be turned over to governments, because it is their responsibility. The role of FIOs is to fill the gaps where no one else works. In the HIV epidemic in the early 1980s, "FIOs were *it* - there was nobody else." Once community based platforms are built up in these neglected areas, FIOs can exit and turn those systems over to governments. A values base is essential, and FIOs can establish that so that governments treat people, not diseases. "Our role is to work ourselves out of a job." A lot depends on national governments' willingness to engage; but "our role is to present what we do and to try to collaborate with governments."
- In some countries, the government itself cannot cover the whole country. The solution is to ensure participation from the bottom up, strengthening engagement with national plans.

FIOs and engagement toward UHC – Session two of two

How do faith-based and faith-inspired organizations contribute to UHC?

Moderator: **Renier Koegelenberg**, EFSA, South Africa

Speakers in this session were **Peter Yeboah**, Christian Health Association Platform (CHAP); **Nelson Arns Neumann**, Pastoral da Crianza, Brazil; **Ramesh Kumar Maharjan**, Karuna Shechen, Nepal; **Dee Smith**, Health programmes to serve migrants and key populations, Guatemala; **Silvia Novoa**, World Vision Mexico; and **Asavari Herwadkar**, Ojus Institute, India.

Silvia Novoa argued that FIOs contribute a great deal to UHC. They have been established in communities sometimes for decades; they have political neutrality; they are perceived as driven by "true love for neighbours… as good people advocating for the most vulnerable;" they enjoy trust built over years; they have knowledge of traditions, language and cultures; and they can partner with others. In Mexico, where a very young population has a low average education level, people die of preventable disease, and 10% of the country's whole health budget is spent on treating diabetes, now the highest cause of death. Other killers are vascular disease; infectious disease (mainly in vulnerable communities affected by malnutrition, lack of access to clean water and sanitation facilities, and poor SRH); violence and accidents; and other degenerative diseases. All these preventable deaths can be traced back to a lack of education.

World Vision's focus is therefore on prevention. It has water, sanitation and health (WASH) programmes that raise awareness in order to change the culture of health. It has food and nutrition programmes to address the needs of a population that eats a great deal of corn, carbohydrates and fat, and often little else, meaning diabetes caused by obesity is a main cause of death. It trains mothers on good diet, and how to feed young kids. It has an infant and maternal mortality project in which health workers visit mothers six or seven times in the first six months after birth, which has decreased mother and child deaths dramatically. It works on adolescent pregnancy and the general treatment of children—including through interventions to decrease violence in education, which leads to emotional and psychological problems and a high suicide rates. This programme aims to reduce these problems through good education, including on SRH, positive parenting, and child rights and protection. Children's lives can be transformed if they understand their rights. Another programme addresses agricultural workers growing sugar cane and coffee, for whom long journeys in high heat and a lack of water produce high incidence of kidney disease. World Vision is training and advocating with partners, including growers, to decrease that.

In conclusion, and to quote Muhammad Yunus, "the poor are like Bonsai trees. When you plant the best seed of the tallest tree in a six-inch deep flower pot, you

get a perfect replica of the tallest tree, but it is only inches tall. There is nothing wrong with the seed you planted; only the soil-base you provided was inadequate." It is not the services we give to communities that will change them, but rather the empowerment of their leaders so they can be the engines of change in their own communities. Education can change lives.

Dee Smith was living in Kenya in the 1980s, at the start of the HIV epidemic. Seeing its effects, she wanted to get more involved in HIV education, so she became a religious sister. She trained in New York to be an HIV educator and counsellor; learnt Spanish; and was sent to Guatemala to establish a faith-based response to the country's own emerging HIV crisis. There, the Maryknoll Sisters—her order—founded a FIO offering free HIV testing and counselling services.

Many areas reported high TB death rates, and co-infection was suspected. In the first decade of work, the project attempted to educate the church on transmission and prevention. Ms Smith was "used to teaching tough students, but none were as difficult as the clergy… Many refused to receive me. They said SRH education didn't belong in the churches." This remained a problem until 1997, when a local bishop asked her to address a Diocesan retreat. It was the first time any sister had done this, let alone one talking about sex and condoms; but the majority responded well, and work was easier after that. Parishes took a long time to consider HIV a "we" rather than a "them" issue, but there was progress involving church educators. In 1999, an HIV treatment clinic was established outside the capital, with the goal of proving that a small clinic could offer and deliver top quality services, including antiretroviral drugs (ARVs)—and that being close to rural communities could avoid the loss of clients due to the expense of travel. The project advocated for two years to get the ministry of health to take responsibility for diversifying service provision.

Home visits continue, but work relies on monitoring in homes. Training focuses on national level advocacy and lobbying for health budgets for universal access to medicines: laws and agreements are in place, but most people outside cities do not know the rights of PLHIV. There is also a lack of sensitivity high up in the church, where approaches towards HIV are often based on "good Samaritan" attitudes that promote imbalances between "victim" and "saviour." Instead, we should be looking more closely at texts that challenge the idea that PLHIV need saving and care, and improving our perceptions of sex, diversity and stigma—working from the gospel message of justice and compassion.

In the last ten years Maryknoll has been involved in local, national and international efforts to reduce stigma. Normally, people only seek guidance when HIV makes itself felt locally, so work often centres on convening different groups to explore common responses, many of which become part of the voluntary sector and continue to support anti stigma efforts over time. With ARV treatment now available, Maryknoll is developing income-generating activities to offer sustainable answers to the poverty affecting rural women. There are many systemic challenges: "macho society," corrupt governments, inequality and lack of opportunity for the young among them.

Recent caravans of migrants heading for the USA have led to a request from UNFPA to provide assistance to refugees crossing the Guatemalan. The health system has effectively collapsed, and the government is working with a minimal budget that is hugely insufficient. More integral primary health care and services are required, along with further development of rural communities supported by initiatives for sustainability. FIOs and religious communities should be braver in challenging inequality and the degradation of the environment.

Asavari Herwadkar, was representing two organisations, the **Ojus Institute** in India and the **International Network of Religious Leaders Living with or Affected by HIV & AIDS (INERELA+)**. The Indian health system will be worth 280 billion dollars by 2020, but it remains characterised by high out-of-pocket expenditure, low financial protection and low health insurance coverage. Treatment pushes people into poverty. In September 2018 a health insurance initiative was launched to provide insurance for 100 million poor families and 500 million vulnerable families, reduce the financial burden of hospitalisation, and help provide access to quality health care. With regard to UHC, this will give each family about 500 million rupees worth of insurance, with priority for girls and those aged over 65, from a huge network of providers across the country. All this insurance will be cashless and paperless, and will help push India towards UHC. India is one of the fastest growing economies in the world—the second most populous country, the seventh largest in size, and home to the five most populous religions—and this is a gigantic task for the government. But if you can do this successfully in India, you should be able to do it anywhere.

Have worked with the faith community for many years on HIV sensitisation, helping them take ownership for stigmatising issues, it is clear that in order to address UHC to the fullest in India, the role of the faith community is very important. This is in addition to its crucial role in helping people achieve and maintain good mental health and spiritual wellbeing, without which nobody can be truly healthy. Progress is being made: one recent example was a camp set up at Kumbh Mela—a mass Hindu pilgrimage and one of the largest mass gatherings in the world—by the transgender community, an initiative of a type that will help reduce stigma and discrimination. Society must address and incorporate SRH and rights, particularly pressing issues in a country where 60% of the population is women and children.

Peter Yeboah is the executive director of Christian Health Association Ghana, and African chair of the CHA platform (CHAP). Together these associations provide a significant percentage of all health care in Africa—in some countries, more than 80%. This work is inspired primarily by the Luke gospel: healing the sick and setting captives free. As such, it contributes greatly to UHC.

This contribution can be seen in three main areas. The first is access to health services: bridging health inequalities, expanding outreach services and looking at service delivery. “Universal” presumes comprehensive services, but beyond high profile issues like malaria, many services are neglected, including mental health and palliative care. In Ghana, CHAP has worked on mental health, moving into an area initially characterised by a 98% treatment gap. One in four people will have some form of mental illness in their lifetime, but good progress is being made. Health care

has become so commercialised that health insurance approaches can incentivise treatment at the expense of prevention. In response, CHAPS is examining ways of "reigniting" primary health care as a way of achieving UHC.

The second area of contribution is in raising quality standards. CHAPS is active in areas where health care is of poor quality; so the organisation has become involved in WASH, which is essential for protecting both patients and staff. "If we are to achieve UHC, WASH should be the pathway—making the environment neat and safe and joining the fight against AMR at scale." Another quality issue is fake medication, rife across Africa: in Ghana, for example, one in five medicines is fake.

The third area is financing, where CHAPS works to explore community based health insurance schemes as a way of removing financial barriers to access.

FIOs help achieve UHC in many ways around the world. On the whole, the health systems strengthening approach is the best way of providing buffers and resilience. This was shown in the Ebola epidemic in 2014-16, where Sierra Leone and Liberia were hit much harder than Nigeria, because Nigeria's stronger health system acted as a buffer. Health systems strengthening provides stability. There are three main ideas in this area. The first is partnership development, "cooperation not competition." FIOs should align their service packages with those of governments, with a view to long-term cooperation—being careful to "integrate, not assimilate." The second is community participation and ownership, essential for UHC because it promotes social accountability. The third is research for health: any time faith-based actors pilot or pioneer innovations, they become proof of concept.

Finally, there is trust building—"the software of the health systems approach." Trust is one of the most valuable and essential resources in building UHC, and FIOs provide the compassion, dignity and value- or ethics-based health care that creates it. FIOs can use their material assets to provide safe social spaces: hospitals, schools and churches can be leveraged for health promotion, awareness raising and more. Once trust and safety is there, interfaith work becomes possible—for example, in Ghana Christian associations are visiting mosques on Fridays to talk about mental health. FIOs have the ability and the readiness to promote and preserve UHC.

Nelson Arns Neumann explained how **Pastoral da Crianza** would like to scale up its efforts in Brazil, but resources are lacking, the necessary bureaucratic infrastructure is not there, and work must remain simple. This is compensated in other ways: in the Catholic Church in Latin America, people in communities are willing to work for the church, and so it is possible for Pastoral da Crianza to run programmes providing skills to people, working with the poor. These programmes have shown that people can be encouraged from a position of illiteracy and shyness to being happy and confident working on municipal councils. When this progress is seen to happen, communities will start to trust in themselves.

Brazil has UHC in theory, but poor people cannot access it. The necessary level of social control of Brazilian politics is not there. In the meantime, 80% of women do not receive care that is up to government standards. The Church has created networks so that families can help one another, and offers the particular types of

leadership and pastoral care around deeply personal issues that sometimes only the church is able to provide. The church can leverage the compassion of whole communities to help those in need.

Ramesh Kumar Maharjan described the capacity issues facing Nepal—a "small, beautiful, but still developing" country. The limits to training and infrastructure available to citizens meant that Dr Maharjan had to take 25 years to become an emergency physician. A great deal of Nepali talent goes abroad.

"We do live on faith... Nepal is still deprived of health, and many other things, but people live happily with faith." Good health and wellbeing are products of many interrelated factors, faith included. Teaching medical staff about health alone is not sufficient: it is necessary to go into communities and train all people, as much as possible, summarising the complicated for those who do not have literate backgrounds, showing them how to know their own bodies and minds, how to understand others, and how to use the principles of preventive medicine. Dr Maharjan called it "kitchen theory:" giving people the basic knowledge of the principles of health so they can react to situations, like a hungry person who can choose ingredients and cook. They need a basic understanding of emergency health care, because they suffer quotidian emergencies and disasters. This is an environment where people learn from their parents, so they are taught simple first aid—chest compressions, CPR—to be passed through the generations. In a hospital, maybe 5% of people can be saved, but if the people who experience the problems have understanding and knowledge, many more can be helped.

The results of teaching can be surprising. These projects have reduced mortality by 70%. In this context, teaching simple things is innovation, even more so when done using a holistic approach that encompasses Ayurveda, homeopathy and traditional healers, as well as mobile technology running simple first aid apps push messages and knowledge into every corner of Nepal. People's investment in their own health means a lot can change.

Discussion

A brief Q&A highlighted interesting connections between the experiences of different countries—mainly common issues around governance and how FIOs and other non-state actors can support governments to achieve UHC commitments.

- World Vision, for example, forms community level committees that advocate to local authorities and work as examples for state level advocacy. When this is successful, the topics are discussed at national level. Networks allow alliances to be formed between different organisations, schools and churches to communicate best practices to policy makers.
- In countries with large Hindu and Buddhist populations, the lack of hierarchy in those faiths can make approaching the right leaders a complicated task. Care must be taken choosing the most effective leaders who represent the largest populations.
- "If you're not at the policy table, you get eaten"—representation at policy-making level is a necessity, and partnerships with governments are

important. In Ghana, CHAP has representation at all levels, but "if we're not invited, we go anyway, because we have a duty to represent the poor and most vulnerable." Non-state actors need to demonstrate the substance of their work, and offer options that complement government activities.

- Working with policy makers enables community organisations to fill particular policy gaps: for example, though everyone is vulnerable to medical emergencies and emergency medicine should be part of UHC, this is often not the case in sub-Saharan African nations. In Ghana road traffic accidents are the third highest cause of mortality, but non-state actors have not yet responded. FIOs and others can influence legislation because they represent the communities who so often constitute the evidence base for unmet needs.
- Civil society should work with corporations. Consumer power is the future: consumers who set trends in how and what to consume. People effectively voted out child labour in Mexico, because products aren't consumed in the USA if they're not certified free of child labour. Côte d'Ivoire produces 40% of the world's cocoa but can't provide its people with a decent standard of living: consumers of cocoa should be able to change that.

Networking & collective intelligence sessions

Moderator: **Lily Gros**, **Benjamin Rolland** and **Maria Salih**, Enactus

This and several other sessions throughout the forum were facilitated by **Enactus Lab**. Enactus is a global non-profit organization active in 38 countries, the main project of which is to create and maintain a programme for higher education students to use entrepreneurial action and business innovation to tackle societal challenges in their local communities, thereby creating values-driven leaders for tomorrow. Enactus France supports 1,000 students and 200 projects each year, as well as 1,000 high school students.

Enactus Lab is the organisation's for-profit arm, and "develops teaching engineering and the animation of experiential training on the themes of collaboration, commitment, entrepreneurship and social innovation," with the goal of "inspiring and helping our partners become actors of the society in which they live."

Enactus expresses its "DNA" in three points:

- *We want to act with and for the youth to build an inclusive, sustainable world*
- *We think dreaming is good, but acting—and acting together—is better*
- *We believe we can make business pragmatism and societal and environmental impact work together.*

The "collective intelligence" sessions at the Ahimsa Forum were based on conversation. The participants gathered in small groups to discuss different subjects—for example, how faith inspired communities might work with governments to reach UHC. The Enactus team used a range of facilitation tools for these sessions, to help participants engage in authentic sharing, understand each other's perspectives, share challenges, and find ideas to advance their projects.

These sessions continued late into the night, and were summarised the following morning with a presentation of the different groups' ideas.

This particular session examined how best to engage faith communities in advancing UHC. The groups' conclusions, which inevitably overlapped in places, were presented the next morning and can be summarised together as follows.

- FIOs have many roles in UHC: they address the social determinants of health; they advocate for health; and they advocate for the wellbeing of the whole person, not just medical intervention. While governments are accountable to citizens, populations and donors, FIOs provide balance by accounting to different stakeholders. They have different flows of accountability to other organisations, and hence different ways to influence roles, challenges and engagements with governments. While governments should ensure provision of high quality, accessible, equitable health services to populations, FIOs are different in that they ensure provision of high quality, accessible, equitable health services to *humans:* they see, and fill, gaps that governments do not.
- As such, FIOs have a duty to come together and form an integrated approach, as integral parts of the health system, ensuring mutual benefit and values, filling the right gaps, and avoiding fragmented or duplicative work.
- There are challenges: often, FIOs pop up and work without spending time integrating into the health system, "so you don't know if they're filling gaps or doing their own thing." Sometimes, faith traditions are actively opposed to good public health practice. Such challenges prevent good collaboration with governments.
- One key to FIOs accomplishing UHC is to—instead of "carrying faith as our label"—consider and display the fundamental values that drive them.

Pragmatic steps towards engagement with UHC include:

- Using research to identify barriers between FIOs and implementing organisations, sharing and analysing differences and similarities in experience, and building an evidence base for the values and benefits of partnership.
- Creating representative roles inside FIOs to deal with corporate relations, propagate FIO values and create partnerships. The purpose of this would be threefold: to help clarify the FIO's values and goals; to reach larger portions of populations affected by health programmes through partnership; and to foster more innovation around health programmes.
- For FIOs to engage policy- and decision-makers in the right challenges, and to build partnerships with other communities—particularly in areas where populations are divided along religious or ethnic lines—dialogue and engagement are crucial. The next Ahimsa Forum could contain a dedicated session on engagement between policy-makers and non-state systems of all kinds, including FIOs. This can be particularly useful in areas where there is a fear of extremists: "you don't have to engage all of them, but if you know

people that will participate, get them in. It is impossible to move ahead by excluding people or having preconceptions about their extremism."

- The media can perpetuate divisive ideas. A dynamic, accountable, socially conscious media platform is needed to spread true communications and connect widely, reaching out to media organisations, especially those that connect with youth.
- To make innovation accessible to the most vulnerable, especially in marginalised communities such as refugee camps, concrete case studies are needed so actionable ideas can be presented.
- "Without food on the plate, you can't engage populations to talk about health. If you want the youth to progress you need social entrepreneurship and economic opportunities so they can move ahead in life."
- To improve collaboration with governments, a number of steps are possible. Where reimbursement agreements exist, governments should ensure that they process reimbursements in a timely fashion. Other models also exist: FIOs can set up social enterprises to sell products to government and generate revenue in order to provide more services to the community. Such steps are significant in that they build sustainability, provide complementary services to those of the state, help maintain independence from that state, and provide services that the state needs.
- FIOs may benefit from strengthening their brand image, hiring digital experts and designers, creating branding strategies, and engaging celebrities and brand ambassadors in the UHC project—connecting with the wider world. Building on this, there is a need to make gaps and projects visible. For this, a platform is required that can geolocate needs and existing solutions, making gaps obvious and facilitating the process of finding persons to fund the filling of those gaps. Such a platform could be bolstered by communications and engagement strategies using video, direct links to communities, etc.
- There are several possible pathways for FIOs to engage with UHC, but one commonality is very clear: the need for data. Data visibility for FIOs and the lack of evidence to support the effects of their work have always been challenges, but they are also an opportunity: data is a pathway for FIOs to get to the decision-making table. As such, an aggressive data collection effort would greatly serve FIOs, and by extension governments, in measuring gaps and progressing towards UHC. This would begin with data mapping of FIOs, collating "where we are and what we're doing." This could be followed by the creation of a dialogue mechanism to facilitate discussion of the essence of data, what is relevant, and how it can be leveraged to achieve UHC.
- There is a need to create a shared understanding among FIOs of what UHC actually, so that partnership is easier and the goal more achievable. Mapping would help here too, recording the work already underway and identifying commonalities. This would allow the building of regional, national and international communities to bring visibility of FIOs' contributions.
- Once the landscape is surveyed and the key players understood, informed dialogue can happen and improved collaboration and coordination among FIOs becomes possible, creating spaces where people can debate ideas and

decide shared understandings. From there, FIOs can work together with other key stakeholders towards the common goal.

- Implementation of this roadmap needs a neutral facilitating body and spaces for discussion, and resources to fund those discussions; plan meetings and gather participants.

In addition to these thematic points, one group took the route of engaging with a "real world solution to real world problem:" that of cervical cancer, screening and vaccination against human papilloma virus (HPV). The project in question has encountered resistance from FIOs around uptake of vaccination, screening and treatment, mostly to do with the fact that HPV is sexually transmitted. Suggested solutions to this problem were to engage with female leadership in FIOs, who might more easily be able to absorb information and convince their wider organisations of the importance of vaccination. This would require development of appropriate content targeting different religions and organisations and informing them in a contextually appropriate fashion about vaccination, cancer, sexual transmission, screening, etc. Culturally sensitive content would be needed for each FIO. In the meantime, the project should engage with researchers to develop less invasive methods for screening and treatment of cervical cancer, using technology and searching for "longer horizon" solutions for cancer treatment for young women that might be more easily absorbed and adopted by FIOs.

One overriding point did emerge that underlined a key challenge to all the approaches outlined in the session: restricted resources.

Faith communities and UHC: a shared vision—conclusion & next steps

Speakers: ***Setsuko Klossowska de Rola****, UNESCO artist for Peace;* ***Katherine Marshall****, WFDD; and* ***Isabelle Wachsmuth****, WHO.*

Moderator: **Jean-François de Lavison**, Ahimsa Fund

Setsuko Klossowska de Rola recalled the blaze that consumed much of the Cathedral of Notre Dame in Paris in early 2019. "That moment was extraordinary, because people gathered in front of the fire and demonstrated spiritual faith and

consciousness—not only in France, but around the world. Why did it burn, what did it mean? Maybe it was to remind us of the importance of faith beyond nationality, beyond everything. This was a precious moment… as if Notre Dame sacrificed itself to remind us of that importance."

The Ahimsa Forum is composed of people from different countries and religions, working together—and we will continue thus. We speak a lot about technology, and indeed the extraordinary efficacy of technology is what allows us all to come together in this way; but how can we ensure we remain the masters of technology, not the other way round? Society demands that we use technology, interface with it, in order to be effective; but at the same time it is important that we remain as human beings. Our memories are weakening: instead of remembering things, we look at them; and that gesture of looking at everything—addresses, dates, documents—stops us from memorising. To remain human, we must safeguard our senses. Neglecting them could in the future be a real health problem.

If our faith is beyond everything for us, it can be powerful. But to really address bout health, or world peace, we have to think beyond nationality and religion. This is difficult, because we're also obliged to think about profit; these things are linked intrinsically. But if we want efficient progress towards peace, it is necessary.

Katherine Marshall spoke about the Fes Festival of World Sacred Music and its president, Faouzi Skali. Mr Skali founded the Festival as a means of "giving soul to globalisation," basing it on the rich spiritual & cultural patrimony of Sufism endemic to Fez, and with the goal of respecting all faiths. A further forum – the Fez Festival of Sufi Culture – was founded to help develop these values and identify, through faith and spirituality, ways of acting on political and economic issues. These events address two issues: working across different silos and finding simple ways to communicate across disciplines, traditions and cultures, benefiting from our differences; and addressing the tensions, anger and fear that drive so many parts of the world today. At the Festival, "because of the special environment of that place, its history, its significance and beauty—and the spontaneity of it, how you never knew what was going to happen, but often there was magic—because of all this inspiration of beauty, fear, concern and passion, all these things came together in special alchemy." We have to recreate that kind of environment at events like the Ahimsa Forum.

Isabelle Wachsmuth described the discussion so far as testament to a "fantastic, unique event… a rare opportunity to bridge the left and right brains." We tend to create a false dichotomy between art and science, but it is possible to live both, and art can inspire health. What can be provided through Ahimsa is a reflection on universality, the common things that we all bring to the table, and not the elements that divide us. Everybody has similar emotions, independent of culture, religion and everything else: everybody feels. You can have different emotions on the same day. This platform allows us to reflect not just on science but also on emotion, feeling, and shared humanity. Such opportunities are rare in international discourse, and this group is a particularly powerful mechanism to inspire international communities and

a range of stakeholders, convening people of different disciplines and backgrounds, in the service of wellbeing for all.

“Art invites us to demonstrate our pathways, because it is an invitation to go from ‘I’ to ‘us,’ and it is not often that we have the opportunity to engage in this type of reflection.” It is important in helping us confront what we are as individuals, at organisational level and in society. The Ahimsa Forum allows us to experiment, to create a situation where we feel we are in harmony, to create together to design solutions together. We need to have courage: without courage, the status quo remains and we cannot move together. It is our task to think about human nature, link it to characteristics of nature more widely, from the micro to the cosmos, and thereby to create the beautiful collective wellbeing we seek.

Advice for others

The panel members were asked to offer small pieces of advice to the rest of the forum.

Setsuko Klossowska de Rola argued for acting always “with consciousness”—especially environmentally. As a species we prioritise humans, we kill 75% of animals, we use a great deal of technology, electricity and from energy; but from now on we need real consciousness. In younger generations this might provide us with hope—that future people might change a little, live more in harmony with the natural world. We use the world’s resources so easily, in rich and in poor countries, but we must think everything through again from the beginning: what we do and how we live. This is a fascinating moment in history.

Katherine Marshall pointed out that our generation has unique gifts and challenges with which to addressing, and change, the ancient reality that the poor will always be with us. We know that we can do it: we have societies and communities that have gone from uneducated, sick, poor populations to ones that are thriving and enjoying opportunities. We have hope and responsibility as drivers. The innovation sessions at the Forum challenge us in real terms, bringing disparate groups together in different geometries and finding ways to work together, an important tradition here. Reflecting both the power and the dangers of technology, and trying to harness and ride them for the benefit all, leaving no one behind, is a critical role: it’s a gift that Ahimsa and others have brought us, and it’s an opportunity we should seize.

We must remember that religion is not warm and fuzzy: it is about the fundamental ways in which people see their creation and their roles, and it comes with deep passions and motivations that are widely misunderstood. The benefits and hidden fears about religious convictions do not grow from thoughtful understanding and discourse. Forums like Ahimsa offer opportunities to improve our shared understanding of the complexity of the emotional, rational and historic contemporary changes reshaping religious communities across the world. Having the chance to look these in the face is special opportunity that must be maximised.

Isabelle Wachsmuth argued for the need to associate leadership and consciousness, and for the need for “another level of leadership” in the face of today’s societal

challenges. To overcome survival needs and reach consciousness means reflecting on right and meaningful relationships in all aspects of our lives. Self-esteem is crucial, especially with regard to the experiences of the young, migrants, refugees, the many thousands of young people without access to health care or human rights. Consciousness and self-esteem lead to transformation, and transformation is individual: if each of us starts with ourselves we will transform the organisations and the society we want to see, focusing on wellbeing, beauty and harmony, and giving us the ability to overcome pain and suffering through change. Confronted by such pain, you may have no other choice but to transform, and you can do it negatively or positively: all the capacity and potential of humans is in each of us. We have resilience, and, crucially, we have the ability to reflect collectively on what it means for us to provide unselfish service.

Discussion

A wide ranging discussion followed.

On inequality

- There has been more progress in fighting poverty in last 20-40 years than in all human history, and most of us experience that in a practical way—not least through 20 extra years of expected life. More people are educated, fewer children die, and many of the numbers are moving in the right way. The lesson of all this is simple: it can be done. In our despair and anger and frustration, we should never forget that there has been this stunning change in outlook. The number one issue in the world is now inequality: there is no good discussion about this, and if in any way we can contribute to the discussion of what to do about it, we must.
- The day before this panel, the Guardian published a picture of the bodies of a father and his two-year daughter, Oscar Alberto Martinez Ramirez and his daughter Valeria, who had died trying to cross the Rio Grande en route from Mexico to a new life in the USA. Along with the memory of Aylan Kurdi, a young Syrian refugee who died in the Aegean in September 2015, this picture inspired a discussion. If you need a reason to understand why we attend forums like this one, it is the world reflected in images like these. It is difficult to understand, sometimes: we look at global health inequities and gaps in care, and assume they are symptoms of the base maladies of the economic and social constructs in which we live. Chris Hedges refers to moral gaps in end state capitalism, a world where profit is paramount and human dignity and freedom take a back seat. Is this true—do global health inequities just reflect this basic problem in how we all operate? And in providing the services we do, are we just keeping populations barely alive in order to keep the system running? Ultimately, it was argued, we have to focus on people like those unfortunate children, and subjugate any personal convictions that get in the way of us doing so. What gives us the possibility to get faith and other communities working together is the final objective of working for the most vulnerable.

- Private sector business models are adapted for the developed world, but cannot be ignored for developing countries just because we lack the skills to make their products more widely available. If we alone lack the capacity we need, we must use networks to make these products accessible to these populations.
- We must also contemplate how far economic growth is sustainable—must it be the core engine that keeps things going and allows for progress? There are many views on this, but a "lousy debate." How do we temper what we hear, again and again, about greed, overconsumption and inequity with some kind of engine that creates and innovates for a different, more sustainable model?
- Inequality is a lack of holistic understanding of how sectors influence each other. If we focus only on health, we will not understand the root causes of the problem, because it is impossible—all causes run together.
- With regard to over-commercialisation of health care, it is important to separate belonging and ownership. Owning a hospital is one thing, but a sense of belonging is more, and requires dedicated service. As humans we would do well to reduce our need for ownership: how can we create a sense of belonging to organisations, to service, to people? Everything starts with intentions, with a vision and a value. Everything we do, we can do better. We don't have to own the results.

On the relationship between art, health, nature and sustainability

- The uses of art in health provoked discussion. Art can be used to address mental health issues, for example, or to get health information to young people and hard to reach populations. Democratising access to art at community level can help vulnerable and marginalised populations, bringing people together. It is efficient: it doesn't give solutions, but rather encourages them through pathways that allow people to reflect on the potential they have. It is the trigger for a wider process of interfacing with health professionals, community health workers and others to teach populations about themselves, their health risks and behaviours, and how they communicate and establish relationships with others.
- Today, "everything is art"… but originally, art should be sacred. It should not be explained by the world. Art should re-explain how you see, and it's very difficult to see art. Music is the same: you don't explain music, you listen to it. Painting, sculpture… all these things must be seen. "You need training, to see... but nobody sees anymore." This is a very difficult moment for the young: you're permitted to do everything, say anything is art; but art is situated in a very special, professional part of the self. The young should experience art, look at masterpieces, examine how they feel. It is the only way to approach art. It is crucially important to observe. Even Picasso, at the start, made very academic drawings. Whatever you see and approach, you must approach with the most honest vision you can.
- Art and aesthetics can be useful in many areas of health. For example, children with mental health challenges find art essential; or the fact that one measure of patients' perceptions of quality is how hospitals with neat natural

environments lead to the perception of higher quality care. The need and uses for art in health are clear. We must promote the uptake of art and nature, identifying the barriers and educating health care workers to embrace the adoption and co-option of nature for health. Social media can encourage the consciousness that is key to real transformation, accessing vulnerable communities and encouraging their consciousness of how to be empowered and transform their reality.

- Concerning nature, the world and sustainability: as we seek to bring people out of poverty, we must keep the natural environment in mind. What is the role of aesthetics in the provision of health care, and how do we bring beauty and nature into how we deliver care? Thinking beyond our technology and our products, how do we contribute in this area? We are nothing without a link with nature—we literally could not exist. Trees give us oxygen, the food cycle is dependent on plants and insects, yet we continue to separate ourselves from nature, and it is a wrong approach. Art is important to science because it provides another perspective, and opposing these different perspectives is a mistake. Humanity will be more in harmony and peace when we are able to link these dimensions together.
- Harmony with our surroundings is a must for nature. We all live together, and keeping nature as wild as possible is important. The importance of the connection to nature for our health is more and more obvious.
- Modern medicines can be dehumanising. Insofar as a poetic vision can do something about that, it can be a big step in the right direction. Art can address the cultural issues about why people do not seek health care.
- Another tension, on same level as inequality, comes from the raw fear of people talking about the crisis of the earth, the environment, a genuine existential crisis. This could lead us to conclude that we can allow poverty, disregard health, in order to deal with the environment, slow economic growth and reconceptualise. This urgency can clash with our commitment to giving every human being chance and opportunity, and it is a deep and important conflict that we must face. We have to do both and be conscious. We must keep these tensions in our minds—and here, maybe art can help.
- There is a field called “empowerment for psychology” that “empowers how people feel about the environment.” Studies have shown that patients recover better from surgery in an environment that is restorative, with views of greenery and nature.
- Social media is a tool that can achieve good and bad: what is important is the intention with which we use it. It was argued that our education systems often fail to teach about values and intentions. This should be discussed and debated in the international discourse.
- When we discuss voice and who is at the table, we remember that one power of social media is the potential for much broader participation than we’ve ever seen, bringing communities into important conversations in a genuine way. But the tools and the habits to make the most of this are not yet there, and we are struggling with a global leadership crisis, with questions of political will and mobilisation and the democratic process. Political mobilisation is crucial. The HIV community may have provided a prototype, in

that it may be the first example in human history of such a broad community committing themselves, as a community, to care for all those afflicted with the same problems. They remain powerfully represented. Insofar as that is a new model, it is a critical one.

On happiness and wellbeing

- You can argue that nothing is as important as culture in your hierarchy of needs: but if you are hungry, sick, poor and unemployed this is an abstract question. And when people are sick, they're not happy. How often might people be worried about their family, but unable to afford health care for them? The question of happiness is more closely related to the health challenge than we recognise.
- It was argued that "in Nepal people are happy living in small houses and small farms"—what therefore is the definition of poor? When people are content, what can we change to make them happier? Bhutan is arguably another good example of harmony between culture, creativity and nature (and unique in that it has a national index to address happiness). It is important to bring people's reflections and cultures into spheres where health and wellbeing are discussed and shaped, and it is important to preserve culture. It was also argued, though, that "the perfect is the enemy of the good:" if you're happy, perhaps remain as you are.
- **Zeina Abdo** raised the example of Smile for Hope in Nepal, where yes, there is happiness in many places; but there are always opportunities to improve. Smile for Hope looks after paediatric cancer patients from remote villages who come to Kathmandu for treatment—usually very poor children. Children in the city for treatment often live in terrible conditions, surrounded by refuse, in shelters with no windows and bad or absent water and hygiene facilities. These are impossible conditions for recovery. Smile for Hope has taken a holistic approach, recognising it could contribute little from a medical standpoint, but could provide a nice environment. So the organisation rented a house where the children could come and have art therapy lessons, show their art, plant their gardens and play in the sun. It was very simple, not a sexy technology project: just bringing traumatised children into a nice environment. They did the same after 2015, assisting frightened children through art therapy to overcome trauma and loss.
- Diversity of language and culture are "part of our design as human beings and need to be considered when we want to interact with each other." This is sometimes problematic, as in the fact that few people in the world speak English, yet the language dominates scientific literature and discussion. Art should be in harmony with its natural context and free to express its spiritual connection with the country where it is made.
- Culture, environment and creativity can all make people happy. Ancient Indian scriptures talk about how trees and animals are our relatives, and when we are one with them we feel real happiness. All these things help us have dialogue with ourselves, know ourselves and what our challenges and responses must be.

- One simple notion for happiness and wellness is simply to smile more. The smile is something we all have and can all give to one another.

Part two: Ahimsa Roundtable (ART) on Innovation

Global health innovations

Moderator: **Pradeep Kakkattil**, Director of the Office of Innovations, UNAIDS

Pradeep Kakkattil introduced this part of the meeting with a reminder that the word "ahimsa" means "non-violence." Technology can be violent. It has the potential for to tear down the fundamental principles of society as much as it has the potential to promote and build. So how can we ensure it is best used for promoting and building?

There is an epidemic of innovations, but there are also challenges: much innovation is focussed on rich countries, blind to the problems of those who really need it, or happening outside the context of those who will eventually own and scale it. The question we face is how to get communities to lead and engage with technology. The cause for optimism is that many are already doing this, and transforming lives.

This session consisted of a series of short pitches of innovative projects impacting, or about to impact, the global health landscape.

Boehringer Ingelheim: Making more Health — **Manuela Pastore**

The Making more Health programme examines health conceptually, and the things that need to be put in place to enable it. The project is "not talking about health initiatives that change the world, but about putting people in the centre so you see they have a lot of different needs and wants." The longer the programme continues, the more obvious it is that it has the responsibility to connect people. "Everyone has to think - who can I bring in, beyond my own borders or business, to become more impactful?" Everything the programme does should be "more of a movement than an activity." Projects are based on three steps: building a network with social entrepreneurs; helping startups; and helping them scale. Two main regions have been selected in which to run projects together with local doctors, bringing in social entrepreneurs where they fit the needs of the people, going beyond health to create the prosperity that facilitates it. With the help of NGOs Making More Health engages with communities, understanding their needs and abandoning the old models in favour of empowering communities to do things themselves. Mindsets are changed from the inside out, sharing entrepreneurship with students, universities and others. Leadership programmes have been started within Boehringer Ingelheim in which candidates participate actively in the Making More Health projects, learning that innovation is not just digital and technical, but also that implementation is crucially important. If you want companies to change from the inside, you need to build networks so people can connect, have ideas, and have those ideas accepted.

For more information, please see more about Making More Health at:

https://www.makingmorehealth.org/media/mmh-download-library

Boehringer Ingelheim has been named a best practice example for innovative Corporate Citizenship in Germany by CC-survey: https://www.boehringer-ingelheim.com/corporate-profile/making-more-health/boehringer-ingelheim-best-practice-innovative-corporate

UNAIDS Youth Programme - **Ruben Pages**

UNAIDS has had to adapt to changing languages and times and is the only UN organisation with civil society on the board. The Youth Programme came from an exercise in which young people told UNAIDS what the programme should do, resulting in the first ever UN document to be crowdsourced in this manner (this set an example, and the SDG agenda later did something similar). This gave UNAIDS the mandate to work with youth, and that was bolstered by the creation of a global coalition of 15 prominent networks of youth affected by HIV. UNAIDS is a permanent co-chair of the network, establishing close links with organisations of young people that can now constantly feed in to UNAIDS programmes.

With the SDG agenda coming together in 2015, bureaucracy and structure became a real challenge. Everybody was aware that young people had to engage but didn't know how to help it happen. UNAIDS gathered young people and taught them about advocacy and how to amplify their voices. They began to provide those voices to governments and be heard in negotiations, and this didn't stop with the SDG agenda, because they were empowered to monitor the progress of the commitments their governments had made. Using community-based research, they informed governments about what was working and where the gaps were. The movement was so successful that youth in countries like Kenya, India and Zimbabwe started to receive invitations to national delegations to the UN in New York, to tell the world how their governments were doing on the SDG agenda. Young people in regional networks started rating clinics, helping to improve services.

In 2016 the HIV political declaration was being discussed, and it was a time of reflection. Many promises had been there for many years—for example, in 2001 UNAIDS promised that in five years time 95% of young people would know how to protect themselves from HIV; today the figure stands at 36%. Until we address the root causes that put young people at risk—discrimination, exclusion, violence—it will be difficult to end it. In response, UNAIDS now we has a youth agenda focused precisely on these root causes. It has three pillars: challenging harmful laws and policies; supporting youth participation in decision-making spaces concerning their own health; and building and nurturing partnerships between youth organisations and young people—for example, nurturing relationships between medical students and PLHIV so that sensitisation to PLHIV needs is built into medical training.

Internally, UNAIDS has revised HIV monitoring indicators, including indicators around age of consent, education and youth participation (it is one of very few UN organisations that monitor youth participation at national level). The executive

director recently sent a memo to all staff outlining how the results of collaboration with youth networks should shape all work with young people, and that memo was drafted by the young people themselves. There is much to improve, but the successes so far highlight a few important lessons:

- Involve young people in design, implementation and monitoring. “They know what’s best.”
- Don’t just bring them to the table and ask them their thoughts, but also give them financial and political resources to do their work.
- If we all committed to building strong youth engagement platforms to advise our decision makers, it would be an outstanding innovation.

Novartis: SMS for life - **Rebecca Stevens**

SMS for life was built on the experiences of a Novartis-run malaria initiative to supply medicines to countries. In 2009, through interactions with the Global Fund and others, the company discovered that a lot of the medicines it shipped never actually reached people. They would innovate and develop great drugs that people would not receive. Instead, they were ending up in ports and logistic bottlenecks, failing to reach patients, especially in remote rural areas. Within the company this finding inspired two contrasting schools of thought: “it’s not our problem;” and “what’s the use of making drugs if the patients can’t take them?”

Novartis brought in students from IBM to analyse the problem, and they presented solutions to manage stockouts in affected countries. These solutions were simple: use mobile phones; train community health workers and others to send text messages, whenever they ran low on stocks of certain drugs, to a central facility that would then restock their own facilities. The programme started in Tanzania in 2009 with the help of the Swiss Development Agency, the Swiss Tropical and Public Health Institute, and Roll Back Malaria. Results were extraordinary: a month into the programme, stockouts in these facilities had fallen by 80%. Very simple technology was providing life-saving solutions to many patients. Over time, SMS for Life was developed and enhanced, and now version 2.0 of the programme can provide training as well—for example, through iPads.

When we talk about innovation, we don’t need new, novel, extraordinary things: instead, we can look at new and better ways of doing things with the tools we already have.

For more information, please see:

https://www.novartis.com/our-company/corporate-responsibility/expanding-access-healthcare/novartis-social-business/sms-life

TogetHER: Accelerating Progress towards cervical cancer elimination - **Celina Schocken**

Most people who die of cervical cancer are in low-income countries, because the screening and treatment capacity isn’t there; but the disease is preventable and

treatable, and prevention and treatment are affordable. A vaccine exists for girls and boys, women can be screened (increasingly using visualisation and artificial intelligence/AI), and women can be treated (new tools for this include thermal coagulation, a very cheap intervention). Despite all this, we do little, and international funding for cervical cancer is very scarce. Adult women aged over thirty are not a priority; donors are worried about involvement in new areas; and cervical cancer is broadly (and wrongly) considered a non-communicable disease (NCD).

Thankfully, this picture is starting to change. Last year Dr Tedros, WHO Director General, called for elimination of the disease. It is a viable target, but funding and organisation are needed to get programmes off the ground. There are 1 billion women alive today who have never been screened. The good news is that programmes can be integrated into things already happening—for example, HIV programmes, as women with HIV are 5-6 times more likely to get cervical cancer. Every woman with HIV should be screened, and programmes spending huge amounts on HIV interventions should want to do it. Cervical cancer should also be integrated into family planning programmes. It is known that if you offer IUDs, family planning and cancer screening at the same time, you get a 4000-fold increase in IUD insertion rate. The goal of this campaign is not only to promote new technology into elimination of cervical cancer, but also to increase the integration of cervical cancer work into existing programmes.

For more information, please see a two-age presentation on TogetHER, available at:

https://www.ahimsa-fund.com/wp-content/uploads/TogetHER-Two-Pager-May-2019.pdf

Joep Lange Institute: Developing and advocating innovative health financing on the road to Universal Health Coverage - **Christoph Benn**

Mobile phone technology is a revolution. Almost everybody in the world has access to phones. Billions of them will probably never have a landline, a bank account or a health insurance card, because all these things will be done through the phone. How can this be used for health?

Digital health is many different things: SMS technology, community health workers using phones and tablets to track patients, and—crucially—phone technology making services affordable and accessible through mobile wallets. The Joep Lange Institute's project in Kenya used existing networks and a payment platform (M-PESA) as a basis to build M-TIBA, a tool whereby people can save or receive money or link it to a health insurance scheme specifically for the purposes of medical treatment. They can go to any prequalified health facility, show their phone—or even just their SIM card, if they happen to share a phone with someone else—and get treatment. There is a pre-payment scheme to bring down out-of-pocket expenses.

These innovations are always tools, not ends in themselves; but if we use them smartly, they can become critical for UHC. M-TIBA is a tool to help people access quality health services and ensure they're paid for. Similar progress is happening elsewhere in Kenya, Nigeria, Ghana and other places, in attempts to make national

health insurance schemes work affordably for people. Mobile health technology could make that possible, at the same time creating links between international organisations, health and faith communities. Another interesting scheme is using mobile technology to link hospitals, making it possible for facilities to fund their work in new and innovative ways; digital health and AI are progressing; WHO is working on digital technology; the Global Fund has signed a related MOU with big funders; a new civil society coalition is being established for digital health and AI and how we use it. All this exciting work requires regulations and ethical frameworks to regulate the huge amounts of data created and who controls and owns it. Something very exciting is happening in the fight to get health to everyone.

Bio-Rad: engagement towards biotechnologies - **Giovanni Magni**

After a rocky start in the early 1950s, Bio-Rad is currently worth about USD 2.4 billion and has 60-70 offices around the world. Spending 10% of revenue on research and development (R&D) they are leaders in markets including polymerase chain reaction (PCR), biopsy, diabetes and rheumatology, and are one of the top diagnostics companies in the world; but they have very little public visibility. This is partly because most countries cannot afford their expensive products, and they have no manufacturing in emerging markets. The reality of this was brought home a few years ago when, shortly after acquiring a Swiss rheumatology company, a Bio-Rad team was travelling Brazil. They visited a state of the art hospital that was interested in their new technology; then, later, a small blood bank in Rio, where people worked in very difficult conditions to help poor patients. One issue there was the ability to test large quantities of blood quickly; but when it was suggested they buy the new product, they pointed out that it would take them ten years to be able to purchase it.

The company was missing a huge opportunity for business, and to help people around the globe, because they were too expensive. So they began discussion with Ahimsa to change things—mainly through developing “less fancy” products with the same sensitivity and specificity as the expensive ones, but fewer bells and whistles. They talked to the R&D team, “but they like big products, more features, more sensitivity and so on,” and it was decided not to do the work in house; so a venture fund was created, some of which is now used to invest in corporations that develop products for use in low income countries. These products are do not sacrifice quality: instead they lose features not needed in those contexts, but develop new technology that will be available in poor countries when it is new, not years down the line. Technical solutions alone are not enough to effect change—there is always the need to understand how people can add to existing solutions.

To engage a community with new technology, it must be understood, and people must have time to think and engage. It takes big corporations a while to learn these things. People are not out there waiting for big companies; instead companies must listen first before explaining what they want to do. Bio-Rad is learning, and hopes in the next few years to be able to produce useful tools for use in low income countries.

Bioaster: A new model for technology innovation in microbiology - **Philippe Leissner**

Bioaster is a private, not for profit, French technology research institute that works on microbiology, and infectious disease in particular. It is based in Lyon and within the Institut Pasteur in Paris, and is "not a basic research institute, but rather an R&D accelerator" with a mission to promote cross-sectoral research and public/private partnerships, building, leading and co-founding research programmes using an integrated approach to add economic, scientific and medical value.

Bioaster has four main priorities for developing and developed countries: vaccination, antimicrobials, microbiota and diagnostics. All are supported by research groups, with 80 people working on different areas including access to clinical samples, collaborative projects, a genomics hub, and a data management and analysis group. There are over 50 ongoing collaborations with over 28 companies and over 30 academic and clinical partners. Budgets for these projects range from very small to tens of millions of euros. Bioaster presents a new model for tech innovation by offering scientific and technological de-risking for innovation projects between public and private partners, and financial and risk sharing for high-risk innovation.

Praesens Foundation: from a sketch to reality - **Emmanuel Vidal**

The Praesens Foundation was born of field experience. During the 2014-16 Ebola outbreak, founders Peter Piot and Rudy Paevels went to Sierra Leone to see how feasible it would be to deploy Ebola assays for testing and were surprised by the inefficiency of systems: they had a breakthrough technology for detecting Ebola, but no capability to get it close to communities. In frustration, Dr Paevels sketched the concept of a mobile lab. It was not a novel concept in itself, the idea has existed for a century, but this was an up to date model with enhanced capacities: a mobile lab with a built in isolator, integrated connectivity, completely autonomous in terms of energy. 2014-17 were spent on developing and co-creating the model with partners including the Institut Pasteur in Senegal. Once conceived, it was validated by the Belgian Army, and then by a deep and extensive process of visiting communities and training lab technicians. Last year, the Foundation donated the lab to the Institut Pasteur, which has been using it ever since on dengue outbreak containment, and has recently been asked to deploy it in the current Ebola outbreak in DRC.

In 2018, partners suggested that the lab might also be useful for routine diagnostics, used as part of a hub and spoke distribution model. It is now being seen more as an open, polyvalent platform to be reconfigured according to need. An MOU has been signed with the African CDC to scale it up, and the Foundation is calling for projects to add other kinds of diagnostic ability. What has made this work successful has been uniting around these projects with people who share the same values.

Roche Global Access Program – **Jonathan Keytel**

The Roche Global Access Program was formally announced in 2014, and is focused on access to HIV treatment. To understand it, we need to go back to around 2002, as

ARVs were coming online and civil society and activists were pressuring for availability. As a diagnostics company making complex machines, Roche was trying to engage with this and determine the right thing to do to provide their products in a sustainable way. They created an Africa-focused programme, Amplicare, with three pillars: sustainable access to Roche HIV testing capacity; capacity building; and education. All of these recognised that solutions created in the US and Europe tended not to work well in poorer settings. Education was designed to counter barriers to access, including a massive continental skills shortage. There was a range of projects, including a partnership with the Clinton Foundation for early infant diagnostics; capacity building around transporting blood samples, applying large scale manufacturing to make dried blood spot transport easier for ministries; building new assays to meet African needs; and building an access programme.

The Global Access Programme was created in response to UNAIDS' call to end HIV. It has taken the good aspects of Amplicare and put them into a formal global programme impacting many countries around the world. Roche's belief is that health systems strengthening is key to driving value for patients. The company's internal motto is "doing now what patients need next"—doing what can be done today as an organisation to prepare for the future, on the principle that wherever the patient might be, they should have same level of health care, and taking accountability for UNAIDS' 90-90-90 treatment target.

Delivering UHC is a different thing, but from a product perspective Roche has moved in that direction by standardising, making the same products available at lower prices, with additional support, so that they can work in lower income countries. The company has a legacy of partnering and trying to fix things on the ground, and would encourage approaches from anyone with good ideas and a desire for partnership. Further "exciting announcements" will be forthcoming shortly…

London School of hygiene and Tropical Medicine (LSHTM): An introduction to crowdsourcing in health research - **Dan Wu**

It is important to engage communities, including marginalised populations, in solving public health problems. Dr Wu's team believes crowdsourcing—groups of experts and non-experts collecting information and sharing solutions with the wider public—is an effective way to do this. In principle, it taps into crowd wisdom and group efforts to solve public health problems. Wikipedia is another, more modern example. Dr Wu's team uses a common format for crowdsourcing, the open challenge contest (an approach used most often in China). It has five stages:

1. A steering committee is organised to determine the problem to solve, and organise and monitor the process. This is usually a group of individuals from range of backgrounds, including community representatives. The committee holds regular meetings.
2. The problem is framed and the contest promoted. The committee makes a call for submissions. These could be descriptions of experiences or ideas, images, videos or other media to help solve the problem. The call is promoted via different channels.

3. There is an evaluation and eligibility screening process, then the "crowd" is invited to choose its favourite submissions. A panel, including experts, scores submissions to select finalists.
4. Exceptional finalists are recognised, and maybe offered small prizes. Others are recognised too, to sustain engagement (e.g. by offering certificates of participation from an established authority).
5. Finalists' submissions are shared and implemented as an output (e.g. through creation of a website, or use of materials in a health programme).

Dr Wu's team has published a practical guideline, which is available online at:

https://www.who.int/tdr/publications/year/2018/crowdsourcing-practical-guide/en/

Details of previous crowdsourcing contests can be explored on the SESH website: http://www.seshglobal.org

Caritas: Galvanizing Religious Leaders for Accelerated Identification and Linkage to Pediatric ART – The GRAIL Project - **Stefano Nobile**

The Caritas international network has shown over time that a portion of the HIV response was being neglected: children, and especially those aged 0-5. We are supposed to take care of most vulnerable, and it was precisely them who are being left behind. In 2015 UNAIDS contacted Caritas and others regarding an initiative to strengthen the capacity of FIOs to respond to HIV. Caritas came onboard to address the paediatric element, and carried out a global consultation in 2016 to understand FIOs' challenges in the field. The results showed a lack of sufficient drugs and diagnostics. Caritas attempted a call to action at regional level with the objective of drafting national operational plans for FIOs to respond to HIV in a coordinated fashion. But without the actual move to operations, this was not enough.

Paediatric HIV was facing many challenges. One major problem was that previous interventions focussed on hospitals and health facilities, but parents often do not bring patients to facilities because of barriers from stigma, logistics and other things. At the same time, in certain areas, children are in church related facilities during the day, and religious leaders are often the people who spend most of the day with them. This presented an opportunity: train the leaders to understand the pastoral HIV setting and to detect preliminary symptoms of paediatric infection—such as lack of physical development, skin problems, recurrent diarrhoea and so on. Then use the leaders' moral role in the community to push families/caregivers to bring the children to health facilities. This project was implemented with good results, but still was not enough—mainly because so many people lived too far away from the health facilities. So, within the framework of the PEPFAR/UNAIDS FIO initiative, Caritas used faith inspired health facilities to bring care to communities. This saw very good results, but was still hampered by problems with availability of drugs—not because of the supply chain, but at the production stage. In 2016, a high level dialogue with CEOs of pharmaceutical companies and others took place in order to overcome everybody's challenges—those of international organisations, donors, regulators, companies, etc.—resulting in the Rome Action Plan on Paediatric HIV.

To quote Pope Francis' Encyclical on the environment and climate change, "We need a new dialogue about how we are shaping the future of our planet… we need a new and universal solidarity." Together, we have shown that we can catalyse this shift.

For more information, please see reports from the GRAIL project in Nigeria and DRC:

https://www.ahimsa-fund.com/wp-content/uploads/Caritas-Internationalis-GRAIL-Nigeria-Report-of-Activities-Apr-2019.pdf

https://www.ahimsa-fund.com/wp-content/uploads/Caritas-Internationalis-GRAIL-DRC-Rapport-dactivit%C3%A9s-Apr-2019-2.pdf

Impact India: Community Health Initiative (CHI)—an innovative, unprecedented and challenging opportunity to reduce disability in a population of 1.5 million persons - **Neelam Kshirsagar**

The Indian government has introduced a new health insurance scheme, a significant step towards UHC. But improving access to primary health care and linking this new scheme to a hospital improvement plan, instead of just providing insurance, would go even further. Impact India's Community Health Initiative (CHI) is a model in support of the Government's National Rural Health Mission to establish a fully functional, community owned, integrated, health-delivery system. It covers a population of about two million tribal people in rural Thane District, Maharashtra. Having exceeded its objective of 50% reduction in disability, through prevention and cure, by 72%, Impact India seeks partners to replicate the CHI elsewhere in rural India. To facilitate this, a Process Document prepared by Tata Consultancy Services is available to interested parties.

The CHI addresses the continuum of care, targeting pregnant women, infants, adolescents, girls and potential mothers to lower infant and maternal mortality; communicates with boys, communities and village health WASH committees to empower them to demand and access government health services; provides training; addresses nutrition in holistic way, teaching people about micronutrients; and more. It works in partnership with government, with MOUs with district authorities, and seeks to create robust and reputable health care models through partnerships. More partners are warmly welcomed.

For more information, please watch view student films made on the CHI:

https://www.facebook.com/iifimpactindia/videos/1898871580208936/UzpfSTI1MDQ3MzAzODMwMDc4MToyNDEwMTk0MjUyMzI4NjM4/

https://drive.google.com/file/d/12NoHVeXsayXMev_2rdShPZUPhSK1WnzP/view?usp=drivesdk

Global Fund: Ambassadors Programme – **Linda Mafu**

The Ambassadors Programme is a group of phenomenal women who react, support and inspire others "to think big and do amazing things: soul sisters, fixers." When one woman in the community has an issue, they pray, listen, intervene in some way, and provide support. When fixers are needed—to escape abusive relationships, obtain clothes, feed children—they work out the solutions.

Ms Mafu provided an example from real life: at 1013hrs that morning, just prior to her presentation, sitting in the hall at Les Pensières, she received a message telling her that one woman known to the group was considering suicide: she was in an abusive relationship, living with HIV, unemployed, not on ARVs, with no food in the house, feeling unable to care for her kids, and had lost hope.

The response: find the woman's number.

At 1015hrs, Ms Mafu had the number. She went outside and called to ask what she needed.

The response: "I don't know where to start."

"One step at a time. What's the first thing you need?"

"Food for my kids. Anything. There's nothing in this house, not even a single onion. You don't even see a cockroach because it's empty."

Using WhatsApp, the Ambassadors were activated to respond to this crisis. The address was circulated and they visited the woman: they provided solutions and sisterhood, sat with her, made it OK. Simple technology activated people. By 1204hrs she had bought food, "and now her tears are of relief and joy." At 1703hrs, another text: "You are all angels of God."

At the time of this presentation—at 1730hrs—her children still had a mother.

As women, the Ambassadors mobilise technology to face down challenges in their communities. The resources they need to respond to these crises come from selling clothes and beads. The previous week there had been serious floods in Cape Town, and half of this woman's house was affected; this morning she felt like everything was against her; but because she found women who were supportive, by the afternoon she knew she had people to help her out of crisis. And she could take her treatment too.

Using technology to facilitate community support can be particularly effective in addressing problems related to mental health.

Impact Hub Geneva and Lausanne – **Alexandra Boëthius**

Impact Hub is a unique network spanning over 100 cities across the world. In a bottom up arrangement, each hub is co-owner of a joint organisation with a mission to support a range of assets and activities: entrepreneurial communities and ecosystems; hackathons; searching for new solutions for society; incubation and

acceleration; and entrepreneurial innovation across the world. The unique value of the Geneva hub is its proximity to the UN ecosystem, a range of investors and large corporates. Its key goal has been to connect human resources and entrepreneurs with wider global resources.

The Hub was approached by UNDP in 2016 and a global programme was born: Accelerate 2030. Its goal is to identify solutions to achieve the SDGs—especially SDG3—and support them to scale.

Why is scaling always important? It's a sexy word, but do we always need to do it? How do we build scale readiness on different levels? Entrepreneurs often fail, for many reasons: burnout, leadership issues, not having the right competencies, not being able to speak to the right partners. The Impact Hub runs a programme across 16 countries supporting a readiness to scale programme, identifying needs, roadmaps and key objectives, finding access to finance, building leadership and resilience, measuring impact, and assisting partnerships and collaborations.

In October 2019, in one week in Geneva, the Hub will assemble key partners and its top 10 most scalable ventures, initiating a global scaling programme, connecting them with partners, investors and others. The focus is on health, and already the programme is finding interesting things, with both disease-specific and more holistic approaches. Another programme takes place in Swiss Sustainable Finance Week, through a range of events with UNDP and others trying to build connections. If this work is done, these entrepreneurs can be supported to make positive impacts around the world.

To learn more, please see the Accelerate 2030 concept note on scaling innovative solutions for the achievement of SDG3, available at:

https://docsend.com/view/dsrxjbs

Unite: Global parliamentarians' network to end infectious diseases - **Victoria Grandsoult**

Unite is committed to ending HIV, viral hepatitis and other infectious diseases in line with the SDGs. An independent charity based in Lisbon, it was founded in 2017 by a Portuguese parliamentarian and infectious disease physician to ensure that parliamentarians lead in eliminating infectious disease. It is members of parliament who approve budgets, change laws and implement policies; who keep governments and international organisations accountable; and who are at the intersection of civil society and communities. Unite wants a clear political response to all areas of infectious disease by 2030. The priority countries are those with the highest disease burdens and the greatest need according to human resources, scientific and policy indicators. What current responses lack is the political awareness that it is possible to end infectious disease; the political will to move from declaration to action; and the political advocacy and leadership to promote changes and budgets in line with SDG3. Parliamentarians can ensure the political accountability of all stakeholders.

Unite is non-partisan, seeking only members to uphold the vision of world free from disease. It seeks to translate political statements into life changing public policies. Members are referred by other current members or trusted partners, and are subject to a code of conduct and values. Unite is the only political network focussed on eliminating infectious disease; it has a multidisciplinary secretariat supporting parliamentarians to achieve this goal; it aims to empower parliamentarians with data and science-based evidence; it promotes cooperation with civil society; it is a peer led, collaborative network; it provides a platform to facilitate connections that otherwise wouldn't happen; at addresses the socio-political determinants of health; and it works with soft power diplomacy to influence change in laws, budgets and policies. Though a new organisation, it has already seen success in key ways, boasting 91 members from 49 countries and five continents, in ten regional chapters. Two flagship events since 2017 have brought together 30 MPs and 300 other participants, involving visits to community centres doing harm reduction work, and both led to the signing of calls to action. Unite has supported policy change and political reform in several countries. Its goals are to continue to grow and encompass 300 countries by 2020; to increase its funding and pro bono support; and to continue planning events to bring together parliamentarians and stakeholders to facilitate innovative political responses to end infectious disease.

Discussion

A Q&A covered a range of topics and panel responses.

- With so many overlapping digital innovations in the world, how do we prevent "pilot-it is" and ensure local communities engage with all this work? It is often the case that new technology is chaotic at the start, and it may be that the only way to integrate it all is government regulation. In Kenya, for example, the problem is reduced because 80% of people use a single mobile platform. WHO should play a role in providing guidance, and the Lancet Commission can set parameters. The international community and international governments must collaborate to ensure there is only a limited number of platforms, and that they interact properly.
- People around the world already use technology for many reasons, but we need to be at a point where communities see it as a solution to their challenges. Information can be circulated so easily now, and a platform is needed that enables civil society to embrace digital health.
- Not all innovation needs to be created globally then made local. So many innovations are already being created locally, but have no channel to connect with global technical and financial resources. We tend to pressure ourselves and say that unless innovation is taken to scale it's a failure, but many do not need scale: they are created for local problems. Instead of all this contextualising and equilibrating, we should work more with what people are already creating, and there is plenty of that.
- We must understand what communities already have, what they can do, and how to work with solutions that exist already. A shared vision is critical, and time should be taken to figure out properly who are the right partners to work with—then it becomes much easier to work together.

- Getting actors to engage together can be a challenge. Caritas has been successful in getting UNAIDS, PEPFAR and others to engage in high level dialogues with company CEOs to ensure production and rollout of fixed dose combinations—so dialogue is possible. It is a matter of respect, of getting to know one other. Often the first one or two dialogues in a series are required just to learn how to talk to each other. It is a long process that requires patience and understanding.
- Building simple technology, creating effective partnerships and ensuring replication rather than duplication are hard. The private sector is often asked to finance activities, but it is undergoing a paradigm shift whereby it wants to be an equal partner at the table. It's hard to get to that point when it is currently seen solely as a funding source. All partners need true respect for all the others at the table, and what they can bring to the partnership. Each partner likes to be valued, and to feel like they bring something to the work.
- Building trust between the private and public sectors is done by listening to people and trying to understand them. We must own up to our deficiencies and shortcomings, and be willing to learn from others. We must respect the power of the ordinary—ordinary people coming up with workable solutions—and give space to simple ideas. "Start small, decide what you want to achieve, set a KPI or measure for each party, work to deliver that, use the lessons to build trust and bigger programmes." The fundamental thing for all new projects is to start small, define it, measure it, and improve it. Innovation starts with humility.
- Building trust with communities can also be hard. There is a need for lots of engagement with end users—and this can also greatly improve the effectiveness of the innovation. For example, in building M-TIBA the development team spent a lot of time in very deprived neighbourhoods, talking to women, and testing the technology. It was this that brought the realisation that they should work with SIMs, because people often share phones. Now when people go to clinics they have dignity—they don't have to go and beg, they go because they're entitled to. M-TIBA gives them dignity, hope and trust. Mobile technology can reinforce trust—for example, looking at things from the provider's point of view, before they had M-TIBA they had to treat but they wouldn't know if they'd get paid; now they do.
- Bridging and sharing is built on trust. This is a historical thing. Health and wealth come together. When we go to countries where wealth has been used and misused, having benefactors come from outside can be a barrier to trust. We should talk less of "capacity building:" it's learning exchange. People know what to do in the places where they've survived until now by being very innovative despite hugely limited resources; and now, these are people, customers, with the right to assess and value the services we provide. Communication is key: if you use the wrong language work is very difficult, and companies, field people and end users may all speak different languages. Experiences in community HIV testing in Peru bore that out: when asked why communities were disinterested in the project, it transpired they didn't understand the academic language of the testing teams. The teams learnt how they spoke, communicated differently, and it worked. There were

similar experiences talking to young people: the teams brought computers to the interviews, and the children wanted to play with the computers—so the team let them do that while they talked. Finding common ground is essential.

Ahimsa round table gala dinner

*Keynote speaker: **Michael Moller**, Executive Director, UN Offices in Geneva, with the contribution of seven young leaders of the world.*

During dinner that evening, UN Director Michael Moller shared his vision of the world just two days before his many years of high-level responsibility in the United Nations came to an end. After speaking, he engaged seven of the younger participants in a conversation about "the future and where we are now, what you intend to do about it… because whatever one thinks about our world, you've inherited it, we've left it in a bit of a mess, and you better have a plan."

We live in a difficult, fragmented world with massive existential problems, climate change being perhaps the major one, but only one among many. Climate, migration and health issues have become existential threats to the way that we live. We have problems that are more and more integrated, but the solutions we apply are increasingly disintegrated. This is a recipe for disaster, and we have to counter it by being collaborative and inclusive; but at the same time, we are walking away from rules, regulations and international law at precisely the wrong moment, rejecting multilateralism and collaboration. There is zero chance for our planet to survive unless we work together, reinventing multilateralism to be more inclusive and inventive, cutting across different lines of work.

This is not something we can leave to governments—if we sit back and let them address these problems, we are in for a big and terminal surprise. We are all responsible for the current situation, and we need international solidarity and multilateralism to do it.

There are solutions, and there are causes for positivity. As a species we are in the best place we have ever been according to any human indicator you care to look at. This is due to a wellbeing and prosperity we have created almost in the blink of an eye, mostly the last 70 years, through the international structures we have created—admittedly in an asymmetric way, with great inequality: but on average every human

is at a better place now than they have ever been in human history. We live better and longer, we enjoy better health, we travel and communicate better than we have ever done. The price for this rapid growth is the problem we have now: we have damaged the planet to a very dangerous degree and we are running out to time to fix it.

Surprisingly, though, even as we walk away from regulation and law, we have put in place some of the tools we need. The Paris Climate Agreement, the SDGs, the 2030 development agenda, new approaches to financing for development, new agreements on managing cities and making them into smart cities: all of these offer hope for a way out.

These frameworks—all voluntary, none binding—give us a new global roadmap. Hope comes from the fact that people are adopting them to an extent that we have never seen—particularly the SDGs, which have become a tool for bringing together actors who have never spoken before, sparking collective action in an extraordinary way. The big problem with this is that it is not going fast enough—and this is where our conversation starts. We need to accelerate action if we are to solve our problems.

Further hope comes from the "deus ex machina" appeal to the young: young people are much more engaged, in general, than they have been in the past, across different parts of the world and different levels of society. Much more than the generations that came before, they want to be engaged, to be part of the solutions to our problems. They take ownership of the solutions. Our interest should be to listen to them.

After speaking, Mr Moller engaged seven of the younger Forum participants in discussions about their own personal projects and engagements with the world. Their testimonies were great cause for hope, as they explained their current work and plans for the future with realism, optimism, and inspiring will to engage with the world for the sake of a better tomorrow.

Day three introduction

***Jean-François de Lavison**, President and Founder, Ahimsa Fund*

The day began positively, with an exploration of causes for hope from the previous day's discussions. A number of interesting initiatives are emerging across the UN system, involving civil society, the private sector and others, and these initiatives are starting to gain traction. Innovation should come from the bottom, not the top—one size does not fit all—and hope is coming from the ground. The next stage is not just another iteration of things we've seen before.

Young people's conviction that they can make a difference is inspiring. The conversation over dinner made some of the more senior people present "feel better about giving up control—showing humility," and about acknowledging and accepting the need for change. We cannot expect the young to adapt to us. We have to evolve to them.

There were, however—and as always—causes for concern too. With so many pilots, the eternal question of how to bring them to scale remains. In the past, leaping into the future has involved a lot of disruption, often revolution—so this time, how do we avoid the chaos that comes with change? In addition: while we acknowledge the inspiration of the young, it is those of us who are over 40 who still have power, resources, money and influence—and it is us who have to do the work. We do not have time.

Meanwhile, problems are being created at a higher level—politics means we are making big messes and "hoping that micro innovations will solve the macro mess." Connecting the gaps between the dreamers and those who do real things is an important task. The real way forward may have to be to break down existing systems. "None of this is working," said one participant. "It hasn't worked. We have to dismantle it to recreate… I feel I wasted my last 35 years of hard work." Institutional barriers that stop people from contributing must be dismantled so we can leverage raw talent and grant opportunities in a practical way.

The private sector should not underestimate its power to help communities. It has financial capacity and other resources, but corporate values are not currently aligned with the needs of the bigger picture. Can we rely on young people to realign them? Change is not a single process; evolution is continuous, and we need systems that respond to changing needs far more than we do one-off dramatic moments of "change."

Transformational Business Network

Reuben Coulter, CEO, Transformational Business Network
https://www.tbnetwork.org/

The population of Africa will double by 2050 to over 2 billion, with more NCDs and increased demand for better, more affordable health care. Meanwhile, 90% of innovations fail, and there are deep problems. In this context, how do we achieve SDG3?

The Transformational Business Network works through investment. While most investors think in a linear fashion—looking at markets, business models, the technologies and the teams behind them—the Network takes a broader vision, using systems thinking, analysing the bigger picture and how to leverage wider forces to succeed. Ecosystems for health innovation require capital, policy, mentoring, and partnership. Innovators' challenges include lack of access to markets; challenges to scale; and affordability of expansion capital. The Network offers confidence in future revenues, a de-risked pipeline, the ability to deliver required returns on capital, an entrepreneurial ecosystems with stakeholder engagement, and a strong pipeline of 100+ enterprises every year.

Mr Coulter gave several examples of businesses the Network is currently working with. These include Kasha, which is widening access to feminine hygiene products in developing countries by creating a delivery service with online ordering, aggregating demand and getting local sellers to act as discrete delivery agents. Another is Zana, which works in advocacy for women's rights and access to hygiene products, and is developing high quality, low cost products for African markets, including new pads and a menstrual cup made of a material that can be washed without access to water. The challenge for the latter project was the fact that while it was developed through the grant funding system, it "fell off a cliff" when the grant funding came to an end, because investors would not get involved; here, the Network helped them transition from donor to investment funding. Bluewave is another, an insurance technology company trying to link financial technology with insurance, getting people to pay micro amounts into health insurance policies. The Network was able to link them with partners who helped them to scale.

As we build these networks and systems, though they are very different from one another, the key ingredient remains the same: trust between stakeholders.

Health Innovation Exchange

Leveraging innovation and technology is essential to fast-track progress to reach UHC and other health-related SDG targets.

Pradeep Kakkattil, Director of the Office of Innovations, UNAIDS
http://www.healthinnovation2030.org/

Challenges to the HIV response have included huge changes in worlds of technology and innovation—much of which has not been incorporated into the HIV response. The response has grown vertically, in isolation, responding to an emergency, while in the meantime the PLHIV themselves have changed significantly. For example: they are living longer with treatment, and are now vulnerable to NCDs, and the response has not changed to address the issues that this brings. UNAIDS "thought [it was] super innovative but there was a disconnect between what we said and what we did… after a point, innovation becomes institutionalised." Change from within was required, so UNAIDS began to set up small pockets of excellence within the institution, examining its own role in responding through innovation, and bridging innovation and implementation.

The first idea that came out of this was to set up a fund to start innovations and "discover the magic thing that changed everything;" but clients and ministries said they didn't want more innovation; instead, they simply wanted to know what was going on, and they felt they were always the last to find out. The innovators said the

same thing in reverse: they were committed to SDG3, but had no access to policy makers and health implementers, and they felt they weren't trusted.

If you don't listen or invest, impact will not happen. Ministers told UNAIDS: even if we want to embrace innovation, there are huge gaps in terms of taking innovations to scale—disconnects between innovation, implementation and investment. A lot of investment in the developing world relies on overseas development assistance, and that is not going to increase. Staying constant is a best case scenario. And while these investments are currently critical, if you compare them with the private equity market, worth between USD 200 and 300 trillion, you see a very different game. In light of this big picture, how best to contemplate sustainability? UNAIDS asks for more money every year, but a businesses would not do that. In the long term, why should development be different?

UNAIDS started to examine how to become an interlocutor, engaging with communities to ascertain whether products are suitable for use and speaking to investors over time, trying to match them with investable opportunities. How could UNAIDS help connect it all, leveraging its traditional role as a neutral facilitator and convener? The answer was to provide a simple platform that gives visibility to innovations relevant to health problems in countries. So: the Health Innovation Exchange (HIE) was set up, as a pure partnership initiative bringing equal partners together, identifying innovations that fill gaps, taking them to countries, linking them to needs and finding a way to feed in investment—in an effort that should continue regardless of whether the exchange survives in its current form within the UN. HIV is really the starting point, but the goal is to work with other partners on different health issues as well.

HIE was launched at the World Health Assembly in 2019, where over 100 ministers and their teams were gathered in one place. 24 innovations were selected to be showcased in a three-day marketplace. Ministers and many others came to touch and feel the products, do real tangible things like experience a two-minute diagnostic process and see the results in practice—a very different experience to being presented with a concept note. A panel discussion tried to identify next steps. The initial outcomes included follow up requests from 16 countries. It was the first that many entrepreneurs had had access to the people who design health programmes in countries, or could get feedback from ministers and others on what is needed. Governments were similarly engaged: Dr Kakkattil "never used to get calls back from ministers… but now I do."

No one sector will find solutions alone. For example, the Ethiopian ministry of health has 3,500 primary health care facilities, but many lack electric power—what they need is cost effective solar systems. In situations like this UNAIDS can be a facilitator, looking for partnerships to solve these problems, expanding the innovators' network, fostering partnerships and building fundraising capacity.

A call for innovations will soon be launched for upcoming events—there will be a high level leadership event announcing investments and deals at the UN General Assembly in September 2019—and further information is available on the HIE website (see above).

Discussion

A brief period of discussion followed.

- From the innovator's perspective (Roche, in the speaker's case), the HIE meeting in Geneva was an amazing opportunity to engage with ministers, ministries and other innovators asking questions not previously considered. It was a powerful experience to interact with other stakeholders, get a sense of the scope of innovation that's out there for health care, and understand better the place of the Roche innovation in the health care landscape. The meeting included innovations from different types of organisations—corporations, startups and NGOs—and partnerships are already coming from that. From Qiagen's point of view it was the first opportunity they had had to interact with different organisations, and showed that "alone, we won't work; we need to be together. We can make difference only if we interact."
- In "approaches that come from Geneva," there is a dominant mindset that follows North American and European traditions of thinking—but in reality, many young innovators are going to places like Shenzhen and participating in networks not present in meeting like the Ahimsa Forum, which have very different frames of reference to our "politically correct" views of the world. It is jarring: these are people with very different goals and mores to our own. How do we adapt to that future?
- It should be borne in mind that while Ministers are interested in "cool stuff" and photo opportunities, they tend not to be so good at providing ongoing money for maintenance, repairs and the quotidian tasks needed to make sure devices are working, properly used, and generating continuous value.
- There is a fundamental need to rethink innovation in terms of the cultures within ministries of health, and to re-examine the roles of those ministries. It was argued that "ministries are terrible at running services:" instead, they should concentrate on holding service providers accountable, setting policies and frameworks, and avoiding the service delivery business. As well as building bridges, we must also examine the policy shifts that need to happen.
- There may be a space to use innovative technologies, such as AI, to bridge gaps in more innovative ways than have been done before.
- In the Middle East alone there is USD 2.9 billion in family trusts and endowments, sat in bank accounts waiting for interest or appropriately conservative investment opportunities. It is important to find ways to de-emphasise the risks associated with health care investments so that organisations such as these can be socially and morally invested in the future, but still guaranteed the returns that allow them to grow and the endowments to be sustainable. The current disconnect is in how to convince boards of trustees to invest in the innovations we're discussing instead of Shell. If private money is not invested in socially responsible businesses, our struggles will never end. Most of use still in old ways of doing business, and there are three critical actions required to change this: money has to be made at the bottom of the pyramid that gives a social as well as a financial return; the development model has to change, moving from donations and

handouts to a point where the private sector feels like equal partners; and innovation must move into the financial sector.

Global Fund replenishment

***Linda Mafu**, Head of Civil Society and Political Advocacy, The Global Fund*

The Global Fund has saved 16 million lives so far, needs support for replenishment in order to save more: to avert new infections, reduce mortality, and impact economic growth.

The cost of inaction is—and has been—many millions of lives lost, and huge resources squandered. The urgency of this work comes from the need to minimise death. If we do not act and invest in high impact interventions, people die, and despite great progress thousands of people are still infected with HIV every day. In sub-Saharan Africa there are 1,000 new infections a day, mostly young women aged 15-24; in South Africa alone there are 200 a day. Marginalised communities are vulnerable for many reasons.

We have, despite all this, come a long way, saving millions of lives. The Global Fund alone has worked in partnership to save over 27 million people from death, and is working continuously to save more. The new replenishment round aims mobilise USD 14 billion, inspiring more pledges, increased investment from implementing countries, and efforts to showcase tools, achievements and programmes.

Social innovation and social consciousness

How art and meditation can enhance social innovation and accelerate UHC

Moderator: **Béatrice Halpaap**, WHO/TDR

Dr Halpaap gave a brief introduction to TDR, the WHO Special Programme for Research and Training in Tropical Diseases, and its research on how best to engage the power of community. A recent mapping of the innovation landscape showed that the now-copious extant funds, technology and approaches to social innovation are unworkably disparate and isolated. As previously discussed, many innovations fail after only a short time—in Uganda, for example, 90% of social innovations last less than a year. Lessons are not collected or shared. In response, TDR established

the Social Innovation in Health Initiative (SIHI) to trigger research to improve understanding of what works, and how to duplicate and scale when needed. Country hubs have been established that focus on research, capacity building and advocacy.

This session explored how to nurture and trigger the benefits of art and meditation for health, by examining a selection of case studies from around the world.

Art to enhance health and human rights

***Isabelle Wachsmuth**, Artist, WHO*

Art provides a unique means of establishing authentic relationships between different partners and organisations. It inspires "conscious leadership," which leads to wider social consciousness and innovation.

After years focussed exclusively on science it was a happy step for Dr Wachsmuth to be able to run a project within UN and WHO on the importance of art and how it can inspire people over the world. This itinerant art exhibit "explored how to go from 'I' to 'us,' treating art as a universal concept that can speak to all the humans in the world." The art was exhibited in different places around the world from global to local level, in hospitals, community associations and ministries. It had a simultaneous impact on the workforce —community health workers, nurses, midwives and doctors)—patients and the public. It was adapted to local contexts, translated into a range of languages, and accompanied by workshops on conscious leadership and interviews.

Yoga and health

***Geetha Gopalakrishna**, Officer, Traditional Complementary and Integrative Medicine Unit, WHO*

The use of traditional medicine is essential if we are to achieve UHC as quickly as we say we want to, but by and large, health systems and policy makers are ignoring it. Around the globe, it is still the first line of treatment for millions: in efforts to provide or strengthen health for communities, it is important to integrate the things that are in place already. Without social consciousness, sustainable health is a distant dream.

Dr Gopalakrishna sketched out some case studies.

In 2018, severe flooding in Kerala displaced about a million people and killed 1,000. Traditional medicine was able to help more than 100,000 of the displaced. Evidence and data were captured by the government to show its effects, and these are being further analysed by WHO. In a disaster response scenario such as this it is important to note how much of the financial burden can be carried by traditional approaches—the Keralan disaster would certainly have been significantly more expensive without it.

The second example was that of robotic thoracic surgery. It has been shown that when patients start a regime of yoga immediately after this major surgery, they are able to leave critical care 24 hours before other patients.

The final example was that of the progression of non-communicable disease, and the move away from health care as treatment for illness towards a more proactive caring for health. Are we healthier when surrounded by doctors, as certain interpretations of the data suggest, or when we are aware of our health? If traditional medicine can make us aware of our health and our environment, and the relationship between them, then it is an important public good.

WHO will soon be releasing an app for teaching pranayama, a formal practice of controlling the breath, and a free yoga app that uses video and audio to help people access health-enhancing yoga practices.

Art and social innovation

Arturo Ongkeko, University Research Associate, University of the Philippines, Manila

With huge and increasing amounts of digital content online, the average human attention span has allegedly dropped to eight seconds—"sub goldfish levels." Regardless of the verity of this statistic, what mental capacity we have can only process limited information—so we need more meaningful ways of attracting human attention. Digital art is one. 70% of the world's youth are online. More and more of us are digital natives, and we need to communicate accordingly.

Digital art, in this context, could be any technology-based media, including digital collage, film and photography. There is a range of ways in which this can be useful in health. Examples include the use of virtual reality for pain management and to alleviate anxiety in clinical settings; creative videos for public health promotion; and the use of celebrities for in advertisements for health promotion. Dr Ongkeko's team has a portfolio of communications products, and he encouraged participants to visit the SIHI YouTube channel—

https://www.youtube.com/channel/UCDbbGLlkWMaovofaBrDHCwQ

—and explore a wide range of innovations from low and middle income countries.

Infographics are another proven, effective method of using artistic technique to make important information accessible and memorable—to quote Paul Klee, "Art does not reproduce the visible, but makes visible." Visual abstracts are another. The SIHI Philippines team is running a visual abstract contest to crowdsource visual art, giving students and researchers access to a scientific database so they can transform its contents into digital abstracts. This work capture attention because "no one will read five pages of technical jargon in size 8 font," and because it is done not for the appreciation of academics and scientists, but in order to popularise information, make it viral, and make it the new way of effecting change.

The role of the artists, the reason we need them, is because they appeal to people's emotions. As humans, we're emotional and we love interaction - and the way to interact is by engaging people. "Touch their emotions and they'll absorb the content."

Youth engagement to advance social innovation in health

***Barwani Msiska**, Project Manager, University of Malawi College of Medicine*

The world of health uses too much jargon, making language a barrier to participation. Art offers a solution. “Scientific language is imposed, our beings don’t speak it… but art is an interpretation of my being. It understands my depths and my needs.”

This Malawian project challenges young people: it asks, who is an innovator to you? Do they look like you, have they the same experiences? What are your perceived needs to help you engage differently? Do you have the humility/empathy to walk those steps? Then the young people are shown images of Malawian innovators. The innovations they tend to cite beforehand are things like Google and international NGOs; but being shown other relatable achievements can change their perspective. Young Malawians think they lack the resources to compete; but when they are shown their circles of influence, and their circles of concern, they begin to understand that they can connect with peoples and systems in so many ways. They exist at the intersection of different complexities, and they are shown that everything is multi-layered. We tend to box people in, limit them, but this way we can open them up. Young people are dynamic, but if we limit them and fail to appreciate what they bring, they will not progress.

Another part of this project is to “curate” the work of others. People on the ground often lack the time, access and knowledge they need to communicate their work and make it as visible and effective as possible. This project conducts research and documents it so others can understand the work being done, and have the opportunity to duplicate it. They make posters, collaborate with field teams to make their work accessible, and “provide a package so that they can communicate better when they meet people or when they have opportunities.”

Youth engagement to enhance social innovation in health

***Shrestha Priyanka**, Social Innovation in Health Officer, TDR SIHI*

SIHI works with fantastic people in the field, with WHO and the big international organisations and on the major international initiatives like UHC and the SDGs, and there is huge enthusiasm in the field and in the international community; “but there is also something lacking.” What is it, and how can we foster and nurture collaboration? TDR’s social innovation in health initiative (SIHI) values storytelling, bringing together health practitioners, community workers, investors and innovators. Storytelling in health care is about communication and reaching people’s real lives, using emotional connection to break boundaries. Art is a key tool, with infographics helping communicate complex messages and clarify how we impact on and connect with one another. Impact stories and case studies are used to personalise messages, describing real people’s lives and vulnerabilities to clarify the need for action and enhance social consciousness.

That consciousness means awareness of being part of a community; being mindful of actions and goals; reflecting on the self and being aware of your focus; and being respectful of the needs of those you serve and with whom you collaborate. Social

change at its heart is born of compassion - and compassion is fostered through mindfulness.

Discussion

There was a brief discussion.

- One powerful way of nurturing social consciousness is in a classroom—especially through storytelling, which is a visceral way of developing students' understandings of contexts and struggles and resilience of individuals. Photography is another excellent method. Art presents many useful tools for challenging learners to think more deeply, holistically and empathically in terms of understanding issues and thinking about solutions, and can be embedded in all we teach, across all subjects.
- While storytelling and the media have great power, we hear a lot about ineffective interventions, especially counter-messaging on extremism. It is important to consider the conscious use of social media and storytelling tools, and to analyse the best ways of assessing effectiveness. Large-scale disinformation and misinformation campaigns are another problem. It was argued that we all have critical roles, and experts and scientists should be active on social media, implementing the knowledge and expertise they have to counter fake news and misinformation. Answering false messages is a responsibility—and here in Ahimsa we have a large number of people powerful enough to counter those points.
- It can be frustrating for scientists when good research is published "in journals five people read." It is an exciting time to be alive, and information is more accessible than ever before in human history, but people live in a world where so much is happening it is hard to keep track, and very few people are distilling all that information into something they can consume. We must take this work and present it so people can participate fully in this wonderful time in which we live, understanding the implications of scientific advances—HIV treatment, for example—for their own lives. The Bertha Centre at the University of Cape Town is already doing some of this work.
- We have to use business tools, thinking and knowledge if we want to reach large numbers of people and talk to the world, to be seen and to be powerful; and we have to provide opportunities for people to learn the basic steps of those tools. The private sector has a lot to contribute to the effective combination of business processes with social projects.
- Art projects can have unforeseen positive impacts. Storytelling is important in itself; but often those involved in telling the story, especially if the project is successful and ultimately visible, can gain long term respect, self-esteem, empowerment and opportunity from being involved in the telling. Many different impacts come from initiatives that use art, and it is important to document and share them to improve understanding of their positive effects.
- Art is a good feedback mechanism for young people to understand how programmes work for them. With feedback, young people can open up and share a lot about what they are doing—"but concentration spans are low,

and people want to look at visually engaging things." The power of poetry, dance and music provide a way—sometimes the only way—for people to answer the unanswered questions.

- There are some things that cannot be answered by young people alone, and often those of us in positions where we should be helping will take the easy route and "give them preconceptualised answers, just so we can carry on being ourselves." We need to be flexible, ready to adapt to new innovations and collaborations, and always considering new ways of initiating change for young people.
- In our haste to promote as widely as possible and make information easily digestible, we should be wary of encouraging quick but superficial engagement with information. The world needs communities that think a little more, and we need tools to make communities think a little more deeply. Yoga might be an excellent tool for that.

Pitch session: two-minute pitches on new health technologies

Moderator: **Lily Gros**, Enactus

Lumos Diagnostics: Neonatal HIV p24 Diagnostic Test - **Jeff Bauer**

Dr Bauer demonstrated Lumos' all-in-one point of care diagnostics platform with onboard sample treatment; a blood collection method; and a digit reader that provides quantitative results that connect to an app on a phone, and thence to an HPA-compliant cloud and data hub. Lumos wants to reach the 40% or so of babies across Africa not tested for HIV at birth, and has partnered with Northwestern University to develop an assay which is currently in clinical trials in South Africa. The project will adapt that assay to Lumos' point-of-care platform, then deploy it in regions where it is needed.

DDTD: Ultrasensitive rapid diagnostic test to support the endgame of the Global Program for the Elimination of Lymphatic Filariasis - **Marco Biamonte**

Embracing the idea of eliminating diseases that do not belong in the 21st century, DDTD specialises in diagnostics to map neglected tropical diseases. The initial focus is on Loiasis, or African eye worm, which affects 10 million people in central Africa and which can be lethal. DDTD is the first organisation to take a targeted approach to diagnostic mapping of this disease, and are happy to have received interest from the WHO Regional Office for Africa. Four additional programmes are in the pipeline, including one for lymphatic filariasis—currently the most ambitious mass drug administration ever from WHO, with 7 billion treatments to date, it needs an ultra-sensitive test to certify elimination.

In Tune for Life (ITFL): Creative media solutions to improve health in local communities – **Charlie Walker, Mark Nunn and Joe Herrmann**

Founded in 2007, ITFL uses professional film, animation and music production to

engage and empower the creative talent within communities seriously challenged by poor health and poverty, producing health promotion materials generated by and resonant in those communities, for ongoing use by local and international NGOs, community organisations, schools, youth facilities, and broadcasters. ITFL uses participatory approaches to develop materials in line with the needs of target audiences, and maintains working relationships with local and international non-governmental and community service organisations with solid track records who will use these materials, to ensure the creative process is aligned to their implementation needs from the beginning. ITFL welcomes partnership approaches.

For more information, please see www.itfl.org. Past animation and video projects can be found on YouTube—

https://www.youtube.com/channel/UC3SKBInmOlIm8k4_2QEClHw

—and past music projects can be explored and enjoyed on SoundCloud:

https://soundcloud.com/in-tune-for-life

Impact India: LifeLine Express - **Chandrakant Deshpande**

Impact India's Lifeline Express train has taken hospital treatment to rural populations that otherwise have no access to health services. Treating over a million people across India, its need for technology is "humungous," including in programmes for cancer screening, awareness and treatment. The train has a mammography machine and an x-ray; images captured on the train are sent to a web server so radiologists stationed elsewhere can read them and provide reports to the most remote parts of the country in the shortest possible time. The Express also maintains electronic medical records that assist in follow up. Technology is also useful in raising awareness of the train's imminent arrival in communities, and to mobilise patients through bulk messaging.

For more information, please see the SBS Australia TV film on the LifeLine Express, which followed the 193rd Lifeline Express mission to Latur, Maharashtra in June 2018:

https://www.youtube.com/watch?v=3WyWMeLGT6w

Brianet: HIV test kits - **Paul Tosapol**

Brianet started in 1983, making radioimmunoassays—high-tech back then. These days the company has operations in Thailand, Laos, Vietnam and Cambodia. It is working to produce HIV test kits, serving the needs of WHO and funded by the Bill and Melinda Gates Foundation and the Wellcome Trust. Brianet manufactures about a million tests per month for work across South East Asia, and is scaling up, with positive links in hospitals across the region. Brianet is happy to partner with others seeking to make use of this network.

Digital Medic GMBH: Own Doctor - **Evgeny Gorodny**

Health care has many well-known problems: high costs, the difficulty of getting health care workers to patients, and a widely disrupted information landscape. "Everyone owns our information except us." There is, however, a current trend by which health care is getting closer to patients, providing them with more access to information, checking their own health via wearable devices and challenging the views of doctors. Younger generations live within this world: in every village with a smartphone, there is a fast and convenient global communications tool. In the push for efficiency in health care, the number and proportion of human errors should be decreased; currently, we can only guess how many there are each day. Value is for outcomes not services, and innovation should decrease costs and increase availability. Digital medic is a remote consultation tool that enables patients and doctors to consult over great distances, in a manner fully traceable from both sides, checking prescriptions and their compatibility with each patient's health needs.

An investor presentation for Own Doctor can be found at:

https://www.ahimsa-fund.com/wp-content/uploads/Own-Doctor-InvestorPresentation.pdf

London School of Hygiene and Tropical Medicine: Pay-it-forward strategy to enhance uptake of dual gonorrhoea and chlamydia testing among Chinese men who have sex with men - **Dan Wu**

This project "is not hi-tech, just human love:" a patient receives a service for free, and is then asked whether they are willing to pay for some or all of the next patient's service, contributing to a pool of funds that allows others to access the same service. If the next person needs a diagnostic test, but there is no public funding for it and they cannot pay—or do not trust the public health services that are available—this scheme that can help them. LSHTM has found that this model creates a significant increase in service uptake rate—57% rather than 18%—and a very high participation rate, with 95% of patients donating something. The average donation amount is nearly USD 8USD, one third the cost of the test. This is a model that spreads love and good health using the power of community, and it needs ways to move it forward.

ZOO.LOOh International Holdings: Smart Village Health Care - **Lwazi Mlaba**

In South Africa, many adolescent girls, young women and boys do not engage with primary health care clinics, leading to dangerously high HIV infection rates. One reason for this is because their relatives and community members work in the clinics, meaning that issues of privacy and stigma prevent them engaging with services. ZOO.LOOh is working on an app called Smart Health that will allow young people to engage one other, creating "a community of people who want smart information in their hands." Access to this information should provide them with some of what they are currently missing, and enable them to make informed health decisions.

QuroMedical: Remote Fetal Heart Rate Monitoring – **Vuyane Mhlomi**

Six million babies die each year, half of them in sub Saharan Africa. A third of these die because of oxygen deprivation during childbirth. These deaths are easily prevented, with risk easily detectable by listening to or detecting foetal heart rate (FHR)—it's just that we're not very good at doing it. Lower income countries are stuck with old technology—unreliable, out of date single-use devices—while the rest of the world has electronic heart rate monitoring that significantly reduces deaths, but which remain prohibitively expensive in poor countries. In response, QuroMedical has transformed a new technology into something more cost effective: a device the size of a fist that is rechargeable, affordable and robust, and which detects foetal heart rate to the gold standard and sends information to a smartphone app via Bluetooth. On the app, algorithms analyse the information and give clear indications of when immediate delivery is required to protect the baby. QuroMedical wants to enter the most remote communities. Dr Mhlomi appealed for help tapping into human, financial and intellectual resources to reach sub-Saharan communities outside South Africa.

Inovaya: Sustainable solutions for drinking water access - **Guillaume Longchamp**

Drinking water is unsafe in many places around the world. Inovaya has an affordable, sustainable drinking water solution with low environmental impact: a machine that can provide 1,000 beneficiaries with 20 litres litre of safe water per person per day for 10 years, for the cost of thee euros per person per year. Working to implement this technology, they have hit a glass ceiling in scaling up. A survey of 300 organisations working on water-related problems has shown that 80 per cent are drilling, or using chlorine or standard UV filters—not innovative methods—but the conditions of current tenders are too conservative to allow Inovaya's solutions to be implemented.

Qiagen: Access Latent TB - **Linda Lecomte Betroune**

Every minute three people die of TB, eight more are diagnosed positive, and many are misdiagnosed: we can do something about this. WHO and other UN organisations have come together and declared the need to test TB differently. Business as usual will not end TB; instead, we need to use today's tools in a more optimal way, including for prevention and for detection and treatment of latent TB. Qiagen has a best-in-class latent TB test, but it is designed for rich countries and is not affordable in low-income settings. This is being adapted to create a test that is affordable, mobile, and easily usable everywhere without the need for a lab or training—but which is still best in class in terms of detection and design. If we want to be successful, we need to work closely together and increase access to testing. Technology and policy alone are not enough: without implementation there can be no impact.

Hemex: Gazelle Diagnostic for malaria and sickle cell disease - **Patti White**

The Hemex Gazelle is a recently developed portable device that will launch in 2019, initially with two applications: a one-minute, one-dollar malaria test, and a sickle cell disease test. 750 people die each day of sickle cell disease, mostly children in low-income countries; if those children were diagnosed in their first year, 70% of them could live, helped only with education and affordable interventions—but there is no affordable test. To fill this gap Hemex is offering tests that can be done by entry-level health care workers on an affordable, portable device that is chargeable with a phone charger and which has no cold chain requirements. The Gazelle has GPS, wifi and Bluetooth connections and can store all information both in the reader and in a cloud app, or send it directly to printers. Hemex will be adding further tests (diabetes, thalassemia, etc.), with the vision of taking simple, cheap testing into the field. They need to increase access and are appealing for help to "make it so people can access this test affordable and effectively."

WorldVision Mexico: Symphonies for Change - **Silvia Novoa**

Music can unite people, make them conscious, and transform lives and communities. Mexico has a population of 120 million people, 50% of whom are under 25, and 70% of whom are overweight. Heart disease, diabetes, accidents and homicides—all preventable—are leading causes of death. This project is run in one municipality near Mexico city, one of the country's most violent areas, with problems of irregular settlement, no vegetation, poor sanitation and hygiene infrastructure, and a population in which many adults work hours away, leaving their children alone in the streets where they eat what they find and risk exposure to drugs and crime. World Vision devised a music-based project to engage these children and expose them to disease prevention information and behaviour and value change interventions. When the project was announced, it was hugely oversubscribed—200 people applied immediately. "After two years, it had changed their lives and the whole community was engaged." Participants changed their eating and hygiene behaviours due to education provided during the music classes, with a wider impact on their families and communities. They became more conscious of the environment, improved their health and nutrition, and "changed their lives with discipline and courage." World Vision is looking for funding, and would be grateful for donations to this project.

A video on Symphonies for Change can be watched at:

https://youtu.be/wentDS4KyP0

Avesthagen Limited: Avestagenome Project - **Villoo Patell**

"Much of what we discuss today has been attempted, has been seen before, in the ecosystem of entrepreneurship," but is being pursued by countries and international organisations based on outdated ideas about R&D. A better understanding of patterns is needed, and Avesthagen—an Indian innovation company—is trying to fill that niche "by bringing convergence of the knowledge economy, R&D, policy and lead-in to harmonised entry of the developing world into emerging markets." The

resultant platform has resulted in new mindsets and partnerships, based on proven multidimensional platforms and innovative pipelines using technology to release information to create new products for a new world. It is the "business of science and the science of business," and has brought in many big partners, including Biomerieux, Nestlé and others, de-risking the project and thereby attracting USD 60 million in private equity funding, 20 million in partnerships and 5 million in soft debt. On the back of this Avesthagen is now building a new genetic database with the goal of identifying genes linked to diseases, improving risk prediction and planning, accelerating development of diagnostics, and identifying new gene therapy targets. The company is currently partnering worldwide, writing up population-specific projects for funding. These are innovation concepts not only for dreamers, but which also present real opportunities today. Further partners are welcome.

Montrose: Saving Lives in Sierra Leone: Monitoring, Evidence, Learning and Review - **Elizabeth Onyango**

There are often contradictions between the results of health monitoring data collected by government health facilities via health information management systems like LMIS, DHIS2, and others; and data collected by management committees through accountability mechanisms. Data collection approaches returning different results are often funded by the same donors, with these discrepancies making it hard to provide an evidence base for decision making, resource allocation, or supervision of the public health sector. In Sierra Leone, for example, Montrose sees a number of factors that could improve. The ministry of health has made strides in the use of phone- and tablet-based technology for collecting and analysing data. Citizens take it seriously, and phone use is widespread, including for health tracking during the recent Ebola epidemic. Sierra Leone is a small country with about 1,000 health facilities, so it is relatively easy to realise change and see improvement. Montrose is proposing a development platform to bring data collected in health facilities down to communities so they can carry out social audits of the data versus what they provide through governance mechanisms. Ministries of health should own such systems. In Sierra Leone it is proposed to select a few key indicators that could be developed in concert with communities, health facilities and governments at district and national level. The ministry will assign health facilities unique codes, and those facilities will text their results monthly to a central database and obtain a simple summary of the results of select indicators. Technical support is needed to make this a possibility at minimal cost to the ministry.

Smile for Hope: Learn and Act - **Zeina Abdo**

Smile for Hope is attempting to provide holistic, integrated support to paediatric cancer patients while bringing a personal dimension to health care, to the children they support and to their families. Smile for Hope was founded from passion, and at its inception moved a lot around the market, asking questions, experiencing a great deal trial and error, and growing organically. Now Smile for Hope has a home in Kathmandu, "Smile for Hope Home Away From Home," which brings a holistic service to its patients, including nutritional, emotional and psychological support, while also helping them keep track of their schooling. Smile for Hope has partnered

with the Nepal Cancer Council to take children out of poor conditions and host them in the home during their treatment. They want to scale up by building a small village to offer mindfulness and meditation to these patients, providing a supportive community in which people come together to maximise their recovery period and minimise the negative effects of chemotherapy, and which remains sustainable through social entrepreneurship and the preservation and marketing of local artistic traditions.

Roche: Paper-based card HIV test - **Jonathan Keytel**

The third part of UNAIDS' 90-90-90 commitment is about the suppression of HIV. The measurement used to track this is a patient's viral load, and the gold standard means of doing this is by testing blood plasma. Normally plasma requires a complex cold chain to transport it. To end that, Roche has created a simple, cheap paper-based card. When a drop of blood sample is dotted onto the card, it gets filtered into plasma. Within the card is a filter paper impregnated with a stabiliser: the plasma is drawn through this, dries, and then remains stable up to three weeks, allowing it to be transported to a central laboratory for testing. This simple technology thereby provides access to everyone who needs a viral load test, and represents one contribution to 90-90-90.

Ramathibodi hospital, Mahidol University: E-nose detection of early liver cancer - **Taya Kitiyakara**

In Thailand most liver cancer patients see a doctor too late, so cure is impossible. Liver cancer is the third highest cause of cancer death in the world; in Thailand is it the highest for men and the third highest for women. There are no symptoms in early disease, and screening requires an inconvenient, expensive ultrasound. Ramathibodi hospital proposes a machine that detects earlier disease using the breath—and "electronic nose" that uses biosensors and algorithms to detect and recognise smell patterns in the breath of patients with the disease. Pilots and proofs of concept have been carried out using dogs, which have been shown to be able to detect cancer patients. The test would be cheaper, faster and more accessible. Once such a test is established for one disease, it will become a platform for monitoring other diseases. Financial and intellectual help is required to develop and commercialise this idea.

miDiagnostics: Silicon nanofluidic technology platform - **Marijke Van der Auwera**

This project is a point of care diagnostic platform based on a nanofluidic processor containing a chip that allows it to works on small smartphones. This technology can help make diagnostics smaller, cheaper and usable anywhere at any time. Versatility comes from a range of applications—complete blood count testing, PCR, and small molecule and protein detection—and the platform offers different combinations in a completely portable format. It is not an instrument, it contains no valves or pumps, and no maintenance is required, making it more affordable than other options. It works with only a single drop of blood on the test card.

Alfajiri Safe Space Programme - **Bryahn Otienoh**

The Safe Space programme was founded three years ago to focus on access to health for young people. “Imagine an Uber service for young people with mental health problems—experiencing panic attacks, depression, other worrying episodes, and without any idea where to start seeking help.” 44.3 million people in Europe suffer from depression. People with mental health problems die on average 20 years younger than the general population, and one in ten people has such issues. The Alfajiri app works like Uber in that it helps the patient make an appointment with any provider within a certain distance, and allows them to log in to the platform and obtain services anonymously, wherever they are, booking appointments with any care provider on the platform. The entrepreneurial part comes from the fact that those providers can sign in and provide services wherever they are, and can also get market information from the app that allows them to develop their businesses.

Mercy Ships - **Jørn Lemvik**

Mercy Ships has been running a hospital ship that moves between Guinea, Senegal and Liberia for forty years, going country to country, providing a huge range of medical services. The ship has four operating theatres onboard, all free of charge, with all staff serving on a voluntary basis. The ship comes to a port, stays 10 months, then leaves. As well as medical interventions, in the last few years the services provided have included capacity building of local doctors, helping them do operations and providing mentoring and training—but these services have been provided ad hoc. A new project, dubbed Ship to Shore, proposes making this element of the work permanent by partnering with local ministries of health to choose a local hospital at each visit; taking the hospital’s surgical unit onboard and training them; following them back to their hospital and upgrading its infrastructure so the local doctors can continue to do the operations they learnt onboard; and following up with the programme over time. After two to three years the local team should be able to give neighbouring hospitals the same training they received. This intervention hopes to strengthen the surgical capacity of health systems. If other potential partners are working in other areas of medicine, “we could join hands and do it together.”

Social Innovation in Health Initiative marketplace: your gateway to catalyzing and replicating community-based and powered healthcare delivery solutions - **Art Ongkeko** and **Barwani Msiska**

Despite advances in health care, complex challenges remain and we still fail to leverage efficient solutions to replicate their impact and make it consistent. SIHI is a global network of individuals, organisations and institutions advocating for social innovation in health and advancing research in social innovation. Launched in 2014, the SIHI Network is growing, with localised multidisciplinary collaborative platforms across six lower income countries, and offline and online markets of comprehensive documentation of social innovation in health. To date, SIHI has conducted six public crowdsourcing innovation calls and has identified 249 eligible innovative projects, with over 40 full case studies across 17 countries. The SIHI hub supports

integration—for example, the Malawi platform (SIHI Malawi at College of Medicine) works to identify social innovations in Malawi, studying them to understand how the Malawian healthcare system can be strengthened through social innovation, and sharing that information. It provides a platform for all individuals and organisations interested in social innovation to network, share and collaborate, and recognise, promote and build the skills of innovators and citizen-led ideas that can improve the health of Malawians. SIHI wants to make this model more sustainable by collaborating with business development people to nurture it and make it last, and is looking for new for collaborators.

Collective intelligence session

Moderator: **Lily Gros**, **Benjamin Rolland** and **Maria Salih**, Enactus

In this session, the Forum again split into different working groups, each of which examined real life obstacles and issues affecting the participants' work. These included such diverse topics as:

- How to balance local content and staffing strategies with technical needs when those needs cannot be locally met
- Maintaining reach, keeping volunteers engaged and managing the Diocesan relationship during a process of digital transformation within a Catholic parish
- How to perform market analysis of profit models for diagnostics for neglected tropical diseases in developing world markets
- Decisions around when and how to scale—and when to decide not to
- Business models and value propositions: finding and cultivating partnerships that meet the right business, moral and philosophical criteria.

Following the methodology of the exercise, the groups examined real world problems faced by their members' organisations and projects, then came together to offer suggestions and solutions to those problems. These case studies were analysed at length then presented to the plenary session the next morning, where all participants had the opportunity to offer suggestions for the benefit of those projects.

Spiritual development: a basis of real change

Why the language of development refers only to technological and financial development, and not spiritual development.

Moderator: **Countess Setsuko Klossowska de Rola**

This session was remarkable not only for the stories the speakers told, but also for creation of a painting by **Isabelle Wachsmuth** as they spoke. Each person on the panel recounted the importance of the spiritual in their own work, providing a broad range of perspectives on a universal question.

Zeina Abdo of **Smile for Hope** knows “a lot about failure—more than about spirituality.” The first nine years of her life were spent under bombs in Lebanon, confronted daily with fear, anger, frustration and the basic need for survival; but she and her family lived outside the city and despite the hardships she also enjoyed constant contact with nature. These contradictory situations taught her very early on to understand the dichotomy between negativity at the human level and what nature is able to provide in terms of a sense of peace and harmony. Though she escaped Lebanon with her family at nine, this knowledge meant she always retained “a sense of nonsense,” of questioning, in the back of her mind.

Life and a career caught up with her, and “suddenly I was a young single mum, overworked, a high flying traveller… then one day I woke up and had lost the sight in my left eye overnight. The voice inside me was becoming louder because I was trying to repress it… so I had to stop and think.” As a working mother with two young children, wanting to grow but not knowing how, she found she could centre herself on the yoga mat, but off the mat there was no sustainability to it; so she had to “take a break and go deep and understand many things.” Ultimately, children are the best teachers: they bring us back to the present moment, and unless we are really in the present moment, we are not in the best place.

Innovation is transformation, and the core essence of transformation is coming back to the human. Nature is a perfect cycle, in which everything has its own space, perfectly in place; we as humans must accept that we are all in it together, instead of here for our own purposes, trying to be what we’re not. Ms Abdo reached the point where she felt that if she gave herself the right to be, she’d also give the space to others to have the same right. It is a daily commitment: to be conscious as possible of everything we say and do, so we don’t slip back into autopilot. And it is hard, and it means continual moments of failure. When we decide to embark on this journey of looking at unconditional truth and love, we will be challenged.

Pradeep Kakkattil, joined UNAIDS “with a great deal of arrogance, knowing everything that needed to be done;” three months later, harassment by a supervisor meant he was he was ready to quit. “Our problem today is we’re a blessed generation, with not to much to worry about, and we don’t question the purpose of life until we’re in trouble. For me, this was the time I did that: why am I here?”

In this search for purpose and meaning, Dr Kakkattil found faith. The first step from there was forgiveness: he had to forgive his supervisor on a daily basis, and work with the part of himself that "wanted vengeance." So he examined how he might start every morning afresh, walking out of the office without the baggage that was affecting his work and personal life. Forgiveness was the first step; the second was "learning to be 100%." All of us walk into the office and become something that we're not 100%; we take the parts of us we want people to see, and leave other parts behind. Although fundamentally it is the ability to love, give and empathise that distinguishes humans, we go into work not being our full selves. As humanity we need to move from that, and that progression must be built into our workplaces. At UNAIDS, Dr Kakkattil is trying to build that into his team: "if human beings don't demonstrate vulnerability… the workplace has been sanitised."

Between the 1950s and the 1970s, "we took faith out of public life." Secularisation is hugely important in some aspects, but elimination of faith from all aspects of our lives is dangerous. We are getting away from the fundamentals of life because we've sanitised it or avoided the debate, and we don't trust each other any more because we don't know what we stand for. So we sit in our workplaces and our trust in public institutions has gone, our trust in each other has gone, and we've lost our faith in our ability to distinguish between right and wrong, good and bad. Flexible truth is an idea we all live by, and that represents a huge challenge. We need to stop it. How can we open up our workplaces and be ourselves; how do we listen to each other?

Benoit Astier de Villatte and **Ivan Pericoli**, both artists and craftsmen at the **Astier de Villatte** ceramic company, recounted their experience of working with communities of Tibetan refugees in their Paris workshop, which they characterised as a place with "a different atmosphere, wonderful harmony [that comes from] conflict with respect." Their collaboration with the Tibetan community was "a very rich experience" for them from which they hoped to share something universal. It is not common to have 50 Tibetans in a workshop in Paris. Most are refugees who have lost everything: country, families and religion. Strangely, they remain on the whole happy and relaxed, and the atmosphere in the workshop is peaceful.

We are all trying to find meaning in what we do: profit is not enough to keep us happy. The Tibetan culture is based on Buddhism, and motivation is important: good motivation on a daily basis—as broad as possible—not just doing things for today, for our lives now, but also for all sentient beings, for animals and for the environment. Astier de Villatte has taken something from that Tibetan worldview: "we would like to be able to remove suffering, not just of people but of all sentient beings, all of it: we'd like to help everyone reach happiness forever."

If daily motivation is incredibly vast, as vast as possible, it makes it easier to face daily problems. It provides daily lives with perspective, direction and certain ethics. As one example, there was a problem with mice in the workshop. The boss wanted to kill them, and poison was put down. The Tibetan workers removed it all, replaced it with cages, and fed and cherished the mice. Eventually, the animals were released into a park, and the problem was resolved in a different way.

“It seems to us that our Tibetan friends have very much integrated spirituality into their daily lives: they won’t kill anything, won’t steal or lie; but no-one is preaching anything. It’s the way they live and the way they react, and that is a teaching for us. We are very grateful.”

Astier de Villatte is a craft company, making everything by hand. It is in some ways a strange business model. “Profit is good, because it allows us to do other things that are not profitable;” there is a need to make profits or the company is “nonsense,” but the first motivation is always “to do our best, to make beautiful things, and it happens that we’re lucky, and it works.” There is no time pressure in the shop: people work at the speed they can. They are not hurried and the chain is never reorganised to improve production. The fact that the company works shows it is possible to have a business model without overbearing focus on profit. The motivation is to make beautiful things, both from the perspective of the products and from the perspective of our Tibetan friends, attempting to behave well for the sake of all beings. Combined together, these create a business that works.

Saba Al Mubaslat, CEO of the **Asfari Foundation**, started by claiming to be the wrong person to talk about spirituality. She was a troublemaker in school, and by her late 20s had a masters and two children, and was driven by a rush to be active, running around, doing things, achieving, driven by a sense that we literally don’t have enough time. When she was 32, she was deployed in a humanitarian response in the Middle East, during which she stayed one night with a family because her organisation’s headquarters had been attacked. That night, the family’s grandmother and the mother were at home, with seven other children; the father and another child were missing. No-one knew if they were alive. They wished one another goodnight, and goodbye—in genuine ignorance as to whether or not tomorrow was coming. It was a night of bombing and shelling: hell on earth. The next morning, Ms Al Mubaslat felt for the first time that “I had been offered the gift of coming back to life.” Never a religious person, at that moment she was humbled by the power that had offered the opportunity to wake up.

There isn’t much time; what time you do have should be lived to all of its potential.

We should enjoy what we do. The constant in our careers is us, so we must give what we can to our workplaces instead of reshaping ourselves to fit. So how do we bring the joy we hold within us to the workplace, and make it a vessel through which we can channel positive energy and motivation to do something good?

Ms Al Mubaslat’s new job is in a donor organisation. It is a new thing—“not selling stories and begging for funds; now I have the money!” It is a fun place to be for a change, and the challenge is to use that responsibly. Donors often take themselves very seriously; but if they do not create partnerships with respect, they become a burden on their partners. As a manager of a fund, the ethical responsibility is to be a good sponsor, a good donor, to remember how painful it was to adhere to the ridiculous requests she used to receive from donors when the shoe was on the other foot—being truly productive, contributing somehow to positive change somewhere.

She has made some changes: no suits to work (they never wore jeans before); shelves have been put up, and everybody has donated a few books; there are a few plants around the place, a beanbag. These are not dramatic sweeping changes, but sometimes the small, low-cost things are what you need to bring positive ritual and sincerity to a workplace. The fancy brochures have been removed to a "parking lot, where we park our mistakes and go back and celebrate them." You celebrate failure because failure is how you learn to be successful next time.

Ms Al Mubaslat is 48 years old, with two children in their 20s who remind her of the importance of holding on to the playfulness, the joy in life. We must remember the bored child who got frustrated when things took forever; if we enjoy what we do, we can give all of ourselves. We should play with our work, go to our workplaces with a smile, enjoy it and be honest. We must live every minute as if there won't be another; act like we will be responsible for the mistakes we make; do our best and keep trying. To be paid to do something you love is heaven.

Discussion

- Given the huge size and scale of the UN, the practicalities of bringing the integrity of who you are into the workplace must be challenging. The lesson of early attempts at UNAIDS was that "we live out of our fears rather than the reality," putting constraints on ourselves and fearing people's responses to us. The trick is not to change the organisation, but to change yourself: if you start on that level, then those close to you might be inspired. "Start that and it will get infectious." UNAIDS has had to do a great deal of soul searching; this has revealed that many people want to see change within the organisation, but that all are afraid. How is this achieved? Start with individuals, and they speak to others, and you move forward from there.
- Despite the importance of failure, we live in a highly commercialised world where sometimes it is not considered an option, and the system doesn't forgive. How can we transcend these barriers—how do we celebrate failure? Well: the world may not forgive, but it does forget. It is usually not the end result that is the learning point, but the process—and we can go back through our processes and see what changes might have influenced the end result. Process matters, and there is always something in the process from which you can learn. The focus on outcome is a killer.
- We tend to label things good and bad, right and wrong… but sometimes this is just a matter of perspective. All the world's big inventions came from a series of trials and iterations—we can call them failures, or we can call them learning. When children fall while learning to walk, we don't call that failure. It is important that we are kind to ourselves, and distance ourselves from judgement. Failure is important: it generates discovery and new ideas and it is vital for eventual success. Everything in this world comes from this concept: there is good and bad, dark and light, and we cannot have one of these things without the other.
- "Maybe failure is an abstract concept. If you're on a creative process, there's no success or failure, you keep going, some things don't work, at some point you get somewhere you're happy. You cannot be efficient, it's impossible.

There is no deadline - its process." In huge companies failure is a defect, and this is a problem of culture that we have to face. Too much efficiency kills creativity: you need failures and mistakes because they are parts of the process.

- "You can be spiritual in business way"—make a report of lessons identified, outcomes, things that were overcome by alternative solutions.
- One example of a small practical intervention was the Montrose "chat room," an important asset that gives hard-working staff a space in which to cherish people and the atmosphere and the laughter they have together.
- Sometimes we give the worst of ourselves to thoe we love the most. If we go out into the world and save lives, day in, day out, our workplaces see the best of us; but then we come home spent, and the people who look after us, the people we love, only see a defeated version of us. How do we look after ourselves so that our dearest do not just see reduced versions of the selves we've already given to the rest of the world? This happens because we moved away from understanding purpose in our lives, and what a holistic life is meant to be. Work is very important, but it is one aspect of our lives. If we can give the best to our families, when we go to work we are able to give something better. If we have no balance, we crash. Seven out of ten people feel lonely in their lives, one in three people at work suffers from some kind of mental health issue. "We need to be living a whole life, not parts of it."
- The person who raised this question recounted how he was brought up by a phenomenal mother, but because of the opportunities he had, he was away from home a lot; he would return during holidays exhausted. His mother would be excited to tell him everything, and he would be too tired to listen. Now, she has end stage heart disease. He has scheduled time to be with her—and made sure that that time is good time, time where he has energy to be present. This has also made him healthier and happier. There is a lot more we can do, day to day, to structure time with our families, to take time to work at home not because of a crisis, but because it is important. This helps with wellbeing, with work, and with our relationships with those we love.
- Meditation is one solution, as expressed in the sage advice that "you should meditate 20 minutes a day—if you're too busy, you should meditate an hour a day." To demystify what can be a fairly opaque and confusing notion, meditating can be as simple as reconnecting to something you truly love, however that works for you—be it painting, music or something else. If we are in a place where we are in true love with ourselves, working as an act of sharing, giving and contributing of the best of ourselves—as with our relationships with children, where there is so often an overflowing love, all the time—we can be truly effective. Being kind to oneself is about asking: if I loved someone else, would I be as tough on them as I am on myself? Driven by guilt, emotion and a sense of failure, we are too harsh too often.
- It is OK to be defeated, to be tired, with the ones we love; they are the ones who truly give us empathy and forgiveness. We can be our true selves with them, and they will forgive us. But when we are with them, we must make sure we're all there—fully there.

- When we are wronged, forgiving is important. “Anger is a poison we drink hoping that someone else will die.” In forgiveness, we make conscious decisions to let go of the sin; to live with consequences, but not to hold others to them. When you want to fight something bad, you have to respond to it with something good.
- Ngawang Tenzin offered the example of her own family, who—like many other refugees—saw their families killed and their land taken; but Tibetan culture is to try to empathise, to forgive themselves and others. Forgiveness does not mean forgetting, but moving on: it is good in that it allows you to heal, but also allows others to move ahead. Compassion is not about pity; compassion sees everyone as equal. Forgiveness is part of compassion. Buddhism is about improving yourself, and this means putting yourself in others’ shoes. When you face problems with forgiveness, you have to do that. “Even here, as I was talking with my sister form China, I was putting myself in the Chinese President’s shoes… imagining I had billion people to look after and a country to run… how would I feel if I was Chinese? This effort makes me feel connected as a human being.” Sometimes it reduces our pain to understand others.

As the discussion drew to a close, the painting was finished. Describing her work, **Isabelle Wachsmuth** explained how the act of painting is her own meditation space, a space for wellbeing and consciousness of self. The type of painting she had done represents all the stories shared with the forum: the stories of humanity and the infinite spiral of life. The colours echo the environments from which people come, the beauty of Les Pensières and its surroundings, and our need to follow our paths with solidarity, sharing and learning. Life is infinite, with no beginning and no end. Consciousness an evolutionary process, and the deeper you go, the more you discover inside of you, and the fewer limitations you feel.

Conclusion & next steps

Katherine Marshall reflected on another remarkable gathering. Ahimsa gatherings enable us to enjoy a knowledge of a unique mix of people, a richness and an ease that are a kind of alchemy, a certain magic created over time. Fundamental to this is a sense of friendship that leads to trust and curiosity. It is really a distinctive effort, and it is something we must not lose.

Michael Moller was kind to give us his closing perspective after a long career working at very high level. The themes he raised, the sense of a balance of fear, anxiety,

anger, concern and hope that he articulated, are ideas woven through this whole gathering. They point to something fundamental to the notions of the SDGs: everything is connected to everything else. Every problem, every discipline, confronts constantly the intersections of the so-called "5 Ps"—peace, people, planet, prosperity and partnership—that symbolise how every issue and problem is inseparable from the others.

UHC is an overarching theme for all of this. 11% of global GDP is spent on health, and every human being faces common health issues. UHC is the only equitable solution to this, leaving no one behind and keeping an eye constantly on the most vulnerable, the communities too often forgotten.

Youth today offer a glimmer of hope: they have the nativist skill with technology that you would expect, but also a new and unusual sense of urgency.

One theme of the Forum down the years has been the constant and varied divisions between the worlds of technology, business, NGOs and FIOs, and 2019 was no different. Making the most of the diversity and force of these players in the global health is our key challenge. We have models that are thriving, nationally and globally, and with the combination of what faith and professionalism can bring, there is the potential to make huge differences in the world. But in the meantime, many organisations are facing serious crises, the future is not clear, and old trade models are under severe threat. Finding new business models is a real issue.

The search for these models is underpinned by the conflict between compassion and charity and the self-sustaining driving processes that are the ideals of the world of business. Charity is not about pity: it is about caring and compassion, but it can move in damaging directions. The enormous central challenge that drives us all is that of finding ways to link faith and charity with sustainability, resilience, respect and true understanding that every person alive has a right to a standard of health care of which anyone would be proud.

Recognising this, we are left with the challenge of the political. This challenge in some sense adds to the alliance that we are building, but it also raises questions of power and accountability that drive a sense of schizophrenia and uncertainty in our group as we consider: what are the responsibilities of the public sector in health? What about regulation and oversight? How reasonably can we think of different models for governments to react to the religious private sector? How do we deal with egos and individuals and the complexity of the partnerships we need to build? The answers must come back again to the unifying force of an ethical drive, of caring not because we have good hearts, but because it is right and possible, and because it is our duty and our responsibility.

JF de Lavison suggested that the role of Ahimsa might be to present a "prophetic voice"—being neutral, trying to facilitate these difficult discussions. He described Ahimsa in acrostic form, thus:

- **Accelerator:** Time is short. We talk a lot, but we need to be concrete, to show success stories in the field.

- **Home maker:** Experiences show us that we don't have solutions for all markets. We need to work with others, to listen to culture, and Ahimsa must facilitate that.
- **Incubator** and…
- **…matchmaker:** Ahimsa brings people together. Even during the course of this Forum a number of projects came together. Ahimsa will work to link together more, and build long lasting partnerships.
- **Sense-maker:** We strive to bring sense to our lives.
- **Advisor:** Ahimsa wants to accompany people and facilitate their work. "We want to be the quiet strength of serenity, bringing happiness, wellness and smiles into the conversation. We can unify people with smiles—we can really look for and reach that serenity."

The paradox in all of this is that we must stop opposing people. If we want to reduce inequality we have to work together and all of us—rich and poor—must accept working with others. Profit and charity must be merged. Profit is a delicate concept: it is not always financial; it can come from taking a value, investing in that value, and developing it. "For me, the best value we have for profit is the human being. If we don't invest in the people, in the poor and the marginalised, where there is fantastic manpower, we won't be profitable." We must therefore reinvest financial profit with the unique objective of fighting inequalities and empowering the bottom of the pyramid—because we have to.

Finally, we must achieve a better balance in our professional and personal lives. Mr de Lavison took this moment to thank his family—including his son Sebastien, installed on the board of the Ahimsa Fund. "What I can do with Ahimsa, I can do it, because I have family behind me."

Next steps

The conclusion of the forum is my conviction that solutions for access to healthcare for the world's most disadvantaged populations, via a network of faith-inspired communities around the world, in an inspiring working environment, is possible. Let's show it.

The next steps for Ahimsa must be concrete achievements. "We need at least two or three pragmatic solutions that have been shown to work and which can be successfully applied in the field. If we start to do that from the bottom up, we can be successful."

For the young people: we need leaders. We expect too much from others; instead, we should ask of ourselves what we can do *for* others. To quote John F Kennedy: "ask not what your country can do for you, but ask what you can do for your country". It is true for each of us.

Ahimsa will be the prophetic voice, and together we will try to make this mission a success.

These closing remarks, and the nascent plans for the fourth Ahimsa Forum in 2021, are expanded upon in JF de Lavison's introduction to this report.

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