Annual Report 2025–2026

AHI received and distributed no charitable donations during 2025-2026. It accepts no funds, holds no assets, and employs no staff. Trustees unanimously view AHI strictly as a campaigning organization.

Standard regulatory frameworks fail to accommodate true altruism. Widespread sanctions, misused funds, and heavy regulatory burdens demonstrate that the current charitable model is broken. Assuming every organization requires external capital forces grassroots initiatives into complex financial oversight and administrative overhead.

Recognizing charities that refuse financial donations directly addresses core issues of capital control and money movement:

- Eliminates Intermediation Risks: Opting out of money removes laundering risks, cross-border transfer fees, regulatory friction, and capital diversion.
- Enforces "Local Stays Local": Without a central intermediary absorbing funds, initiatives rely entirely on mutual aid, direct volunteer labor, and shared local resources. No capital is extracted or redirected.
- Prioritizes Execution Over Grant Allocation: Eliminating money management forces organizations to focus on direct action, capacity building, and peer-to-peer resource sharing.

Creating a dedicated classification for "Non-funded direct action" protects genuine local self-sustaining models from being forced into standard donation workflows. Moreover, with advancements in AI, massive administrative spending by large international charities is indefensible—UK-based bureaucracy consumes a disproportionate share of funds that should serve local action directly.

The fundamental point is about the architecture of philanthropy, financial transparency, and true local autonomy. When systems assume that *every* organization must accept external capital to function, they inadvertently force grassroots entities into financial clearinghouses, administrative overhead, and complex oversight frameworks.

We believe that recognizing the value of charities that do not accept financial donations is a good start to addressing the core challenges of money movement and capital control:

- Elimination of Financial Intermediation Risks: By opting out of receiving monetary funds, an organization bypasses money laundering concerns, cross-border transfer fees, regulatory compliance burdens, and capital diversion. The challenge of "controlling money moving around" is solved by removing money from the equation entirely.
- Radical "Local Money Stays Local" Model: When no central charity absorbs or redistributes funds, local initiatives rely purely on local mutual aid, shared resource pools, direct volunteer labour, or in-kind contributions. Capital never leaves the community because no financial capital is being extracted or redirected by intermediary platforms.
- Focus on Project Execution over Capital Allocation: Traditional platforms default to funding projects through financial grants. Organizations that operate strictly without accepting funds prioritize direct action, local capacity building, and peer-to-peer resource sharing over financial management.

Acknowledging a category for "Does not accept monetary donations / Non-funded direct action" ensures that genuine mutual aid and local self-sustaining models are recognized and valued, rather than forced into standard donation-processing workflows. Furthermore, with the advances in AI technology, the huge spending on administration by large charities should not be acceptable. First, administration staff in the UK do not fill an empty stomach in Africa but benefit those doing administration in the UK. In addition, the bureaucracy to move money around consumes a large proportion of the funds. Finally, and most importantly, it removes the autonomy from the community and places it at a desk in the UK. If one agrees that the community knows their local context best, while the knowledge of the person sitting at the desk tends to be based on averages, the proposed solution may not be accepted by the community.

The AHI strategy is to advocate for “Making Every School a Health Promoting School” through the promotion of Global Standards for Health Promoting Schools (see: https://www.who.int/health-promotingschools/en/). Schools may fundraise for themselves and accept donations to enable the school to run the AHI HPS model. Any money raised locally is managed locally, which may include the construction of low-cost sinks, refurbishment of toilets, and consumables to improve hygiene habits.

The AHI developed an operational HPS model firmly embedded within the broader tradition of health promotion established by the Ottawa Charter (WHO, 1986), which emphasized the need for supportive environments, strengthened community action, and the reorientation of health services toward prevention and equity. These principles were reinforced in the document “Health Promoting Schools Framework,” a WHO/UNESCO 2021 global standards publication, which calls for the integration of health into all aspects of school life, including governance, curriculum, services, and community engagement.

Implementation guidelines and assessment research protocols were developed and are in the public domain for adoption everywhere in the world.

The AHI HPS promotes an intervention addressing the huge global burden of diseases, including oral health, the most prevalent health condition in humankind. Recently, we have launched a campaign titled “Eradicating tooth decay and dental pain in schoolchildren worldwide.” Oral health is part of the set of interventions included in the full model. The oral health component of the AHI HPS model addresses the 74th World Health Assembly resolution recognizing “that oral diseases are highly prevalent, with more than 3.5 billion cases of untreated dental diseases causing suffering in nearly half of the world’s population, and that oral diseases are closely linked to noncommunicable diseases (NCDs), leading to a considerable health, social and economic burden.” The Resolution urges Member States to address key risk factors of oral diseases shared with other noncommunicable diseases, such as high intake of free sugars, and to shift from the traditional curative approach towards a preventive approach that includes the promotion of oral health within the family, schools, and workplaces, and includes timely, comprehensive, and inclusive care within the primary healthcare system.

To our knowledge, the AHI HPS model is the most comprehensive intervention to date that translates the Ottawa Charter into practice by integrating a full suite of interdependent, school-based communicable and non-communicable disease interventions within one coherent framework. Importantly, it incorporates metrics capable of assessing the implementation, the combined impact of all interventions, and the specific contribution of each component individually. This dual-evaluation approach strengthens accountability, enables fine-tuning of programme design, and provides a robust evidence base for policy adoption and scale-up.

We are cautious and ambitious. Trustees unanimously decided on the need to demonstrate the effectiveness of the AHI HPS model before starting to implement it on a large scale. Implementation research methodologies were adopted to test the implementation strategy. Implementation research seeks to identify and address the wide range of challenges associated with translating evidence-based

interventions into practice. It can examine any aspect of implementation, including the factors that facilitate or hinder adoption, the processes through which interventions are introduced, and the strategies required to promote their large-scale use and long-term sustainability. Implementation research is particularly suited to answering what, why, and how interventions work in “real-world” settings and to testing approaches for improving them.

Schools adopting the AHI HPS model are using our public domain protocols to assess the implementation and the impact of the AHI novel school intervention. Results of implementation research and follow-up studies in three different extremely challenging contexts demonstrated that the AHI HPS intervention is appropriate for schools serving low-income communities (appropriateness domain), agreeable to stakeholders (acceptability domain), and adopted at the institutional level (adoption domain). In addition, the follow-up assessment of schools implementing the AHI HPS model confirmed its feasibility and showed very good coverage and retention, demonstrating potential for scaling up as this school-based health promotion intervention can be successfully applied at a large scale. Ongoing yearly follow-up studies will continue assessing the implementation and further adapting the model to operate cross-culturally.