

Putting Humanitarian Health First: G7 Summit Health Performance, 1975–2020

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Introduction

As July 2020 unfolds, the global toll due to the COVID-19 pandemic has surpassed 11 million cases and half a million deaths. This outbreak, which began in China in late 2019 and then swiftly spread to Europe and the United States, has moved into the developing world in Latin America and Africa and had a second spike in the United States. As the pandemic proliferated, the world looked to the key global summit institutions to cope, starting with the G7 major market democracies at its emergency video summit on March 16, 2020. Yet, after a second G7 emergency video summit a month later, G7 leaders stopped meeting, even as the pandemic escalated into its new epicentres in the developing world and in the United States again.

This highlighted the perennial question: does the G7 govern health for itself and its own, largely affluent citizens at home, or does it govern health for all, including the largely poorer people in the global community as a whole? In particular, does it govern health primarily as a biomedical problem addressing the diseases of the rich through the instruments that rich, developed countries produce, possess and prefer, or does it govern health as a global humanitarian problem focused on saving the lives of poor people in poor countries throughout the developing world from the diseases that harm them most, using the instruments they can afford or internationally secure?

To answer this key question, this study examines G7 summit health commitments and its members' compliance with them from the G7's start in 1975 through to its most recent summit that produced a public communiqué on March 16, 2020. It focuses on the differences between "regular" health commitments focused on issues and instruments in the Global North, such as cancer, anti-microbial resistance, medical staff training, research and development, and best practices, and "humanitarian health" commitments focused on the diseases that overwhelmingly kill poor people in poor countries in the Global South, such as HIV/AIDS, malaria, tuberculosis, polio, neglected tropical diseases and

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Ebola (see Appendix A). As COVID-19 is a disease that kills both, it is categorized according to the instruments identified in the commitments addressing it.

This study finds that over the past 45 years, the standard annual G7 summits produced 431 health commitments (see Appendix B). Of these, the 277 commitments on humanitarian health for the South made up to the 2019 Biarritz Summit were close to double the 154 commitments on regular health for the North. Health commitments rose four times, from 1996 to 1999, from 2000 to 2010, and from 2014 to 2016, culminating in an all-time peak of 85 commitments in 2016, followed by a sharp drop from 2017 to 2019 before a fourth rise in March 2020. These phases were largely driven by G7 performance on the component of humanitarian health commitments. They almost always exceeded those on regular health at each summit, until the great reversal during the four most recent regular summits from 2016 to 2019 and the emergency summit in March 2020.

The most recent G7 summit, held by video conference on March 16, 2020, produced the fourth rise. It made 12 commitments on health, for almost half of its 27 commitments overall. Of the 12, one was on humanitarian health and 11 were on regular health. This reinforced a new focus on regular health commitments since 2016.

Members' compliance with their G7 health commitments shows a similar pattern (see Appendix B). It averaged 74% with surges to high compliance annually averaging 81% from 2000 to 2007 and again to an annual average of 87% from 2013 to 2016. Compliance with regular health commitments averaged 70%, with 79% from 2000 to 2007 and 70% from 2013 to 2016. The humanitarian health commitments had substantially higher average compliance of 75%, with 81% from 2000 to 2007 and 87% from 2013 to 2016. For most summits, compliance with humanitarian health commitments exceeded that of the regular ones.

By member, overall health compliance was led by Canada, the European Union and the United States. Humanitarian health compliance was led by Canada and the United Kingdom, and regular health compliance was led by the EU and Canada.

The G7 has thus primarily been a humanitarian health governor for the world, rather than a regular health governor for itself. It was so from 1975 through to 2016, in both the number of commitments it produced and members' subsequent compliance with them. Its shift from 2016 to 2020 to focus on health commitments for the G7's citizens was accompanied from 2016 to 2019 by a much lower annual average of 60% compliance. However, with the strong compliers of the United States holding the G7 presidency in 2020 and the United Kingdom in 2021, there are some grounds for hope that the G7's historically strong performance on humanitarian health will revive.

A preliminary analysis of how G7 leaders can improve compliance, through the use of inexpensive accountability measures that they control, suggests two ways they can boost their health compliance this year and next. The first is to make more health commitments at each summit. The second is to invoke and support the World Health Organization (WHO) as the central, core international organization governing global health, and especially humanitarian health for all.

G7 Health Commitments

From 1979 to 2019, the G7 regular summits made 431 health governance commitments. Of these, 277 focused on humanitarian health for the poor and 154 on non-humanitarian or regular health for the relatively rich. Many of the humanitarian health commitments mentioned supporting health in Africa, African countries, developing countries, and low- or lower middle-income countries. They also specified ways to combat HIV/AIDS, tuberculosis, malaria, polio, malnutrition and health systems improvement to address humanitarian health issues. When there was a major health crisis,

the G7 addressed it in its health commitments. However, as HIV/AIDS, tuberculosis, malaria, polio, malnutrition and health system improvement in developing countries have not been resolved, the G7 remained focused on humanitarian health year after year.

Since their start in 1979, the number of G7 overall health commitments has spiked several times: in 2000, 2002, 2006 and 2016 (see Appendix C). The years following the spikes of 2002 and 2006 continued to have a high number of commitments. In 2003 at Evian there were 15 commitments and in 2007 at Heiligendamm there were 42. As for 2016 in Ise-Shima, it was the year previous that made many commitments — 61 in 2015 at Elmau. In 2003 at Evian, 14 of the 15 commitments were on humanitarian health. In 2007 at Heiligendamm 31 of the 42 commitments were on humanitarian health. In 2015 at Lough Erne, 35 of the 61 commitments were on humanitarian health. The 2015 commitments continued the efforts of the G7 to fight Ebola and prepare for future pandemics, as well as neglected tropical diseases.

However, since the spike of 85 commitments in 2016, the number of health commitments has dropped below 10 each year. Furthermore, the majority of health commitments made at the 2017, 2018 and 2019 summits did not focus on humanitarian health.

The 2000 Okinawa Summit made 14 commitments on health, none of which was on humanitarian health. These commitments mentioned HIV/AIDS, tuberculosis and malaria. The 2002 Kananaskis Summit made 19 health commitments, eight of which were on humanitarian health. Again, HIV/AIDS, tuberculosis and malaria were mentioned, including the Global Fund to Fight AIDS, Tuberculosis and Malaria, as well as polio. There were explicit mentions of assisting Africa and African countries.

The 2006 St. Petersburg Summit made 60 health commitments, 55 of which were on humanitarian health. The Global Fund was once again mentioned, with many commitments specifically noting HIV/AIDS, tuberculosis malaria and polio, including the Roll Bank Malaria Partnership and specific mentions of supporting humanitarian health in African countries. As well, there was a focus on the avian influenza outbreak, which led to many commitments on epidemic preparedness and fighting infectious diseases, including the WHO Global Outbreak Alert and Response Network (GOARN).

The 2016 Ise-Shima Summit made 85 health commitments. However, only 27 focused on humanitarian health. These commitments were on WHO initiatives, the Global Health Security Agenda, HIV/AIDS, fighting the Zika virus, and supporting humanitarian health efforts in low- and lower middle-income countries. Many of the regular health commitments mentioned anti-microbial resistance, pharmaceutical products and aging populations.

The regular or non-humanitarian health commitments went through several phases since 1979. They focused on nuclear, chemical and biological proliferation in the new Cold War and post-Cold War years from 1980 to 1995. Beginning in 2000, many health commitments began to focus on fundraising, engaging with donors and organizations, and developing health systems. In 2007, there was a new focus on sexual and reproductive health education and producing pharmaceuticals. At the 2010 Muskoka Summit, the spotlight was on maternal, newborn and child health. However this subject had a substantial humanitarian dimensions, as the intended beneficiaries were in the Global South (Kirton, Bracht and Kulik 2014). In 2015 the focus on anti-microbial resistance emerged. In 2016, universal health coverage was promoted. In 2017, mental health made an appearance. The focus on nuclear, chemical and biological proliferation in health commitments ended in 1995, but the main themes of the regular health commitments since 2000 have often been repeated in each following summit.

The March 2020 video conference produced the fourth rise. Its 12 health commitments made up almost half of the total 27 commitments made by the leaders. With 11 commitments on regular health, the video summit reinforced the G7's focus on regular health commitments since 2016. The one humanitarian health commitment was on supporting the global mandate of the WHO to lead on disease outbreaks and emergencies with health consequences, leaving no geographical vacuum.

To be sure, other health commitments made on March 16 could be considered partially humanitarian, with their focus on global health, as well as health within the G7. One was on enhancing efforts to strengthen health systems in G7 members and globally. Another was on increasing coordinated research efforts, including through voluntary support for the global Alliance Coalition for Epidemic Preparedness and Innovation. As well, the G7 committed to making efforts to increase the availability of medical equipment where it was needed most. These three commitments are not strictly humanitarian health commitments, but they are also not exclusively non-humanitarian, regular ones. As the WHO is a leading provider of humanitarian health, the commitment made on supporting the WHO is considered a humanitarian health commitment.

Compliance with Humanitarian Health Commitments

With more than half its health commitments made on humanitarianism health, the G7's implementation of them is more significant than the commitments themselves. Implementation of the humanitarian health commitments contributes to saving the lives of people in developing countries while words alone do not have that power.

Of the 431 health commitments made by the annual G7 summits, 71 (16%) have been assessed for compliance by the G7 Research Group. Of these, 49 (69%) are on humanitarian health and 22 (or 31%) on regular health. The 71 commitments include one from 1983, one from 1997, three from 1998, one from 1999, five from 2000, two from 2001, eight from 2002, six from 2003, two from 2004, six from 2005, five from 2006, six from 2007, four from 2008, three from 2009, four from 2010, one from 2011, one from 2012, one from 2013, three from 2014, three from 2015, three from 2016, one from 2017 and one from 2018. These compliance assessments thus come from every year since 1997, except for 2011 (with four health commitments) and 2017 (with two).

Compliance with the G7's 71 assessed health commitments averaged 74%, or +0.47 on the scientific scale (see Appendix B).¹ Compliance was positive in almost every year (see Appendix D). Compliance with the regular health commitments averaged 70% (+0.40), and compliance with the humanitarian health commitments averaged a substantially higher 75% (+0.49).

By summit, compliance with the overall health commitments made at the Japanese-hosted Okinawa Summit in 2000 was 88% (+0.77), and 93% (+0.86) with its humanitarian health commitments. Overall health compliance with the 2002 commitments dropped to 75% (+0.49), the same for the humanitarian health commitments. Overall health compliance with the 2006 commitments dropped again to 72% (+0.44), with the humanitarian health commitments even lower at 66% (+0.31). For the 2016 commitments, overall health compliance rose to 74% (+0.48) and the humanitarian health compliance to 79% (+0.57).

The highest overall health compliance was 100% (+1.00) for a regular health commitment made in 2012. It was followed by 95% (+0.89) for a 2013 humanitarian health commitment. The lowest health compliance was 25% (-0.50) for a regular health commitment made in 2017 and 45% (-0.11)

¹ Compliance is measured on a three-point scientific scale. A score of +1 (100%) indicates full compliance with a commitment, a score of 0 (50%) indicates partial compliance or a work in progress, and a score of -1 (0%) indicates non-compliance or a failure to comply or action taken that is counter to the commitment.

for a regular health commitment made in 2011. Those were the only two commitments with compliance was below 50% (0). Regular health commitments received scores of 100% (+1.00) for commitments made in 2001, 2003 and 2012. For humanitarian health commitments, the highest scores were 94% (+0.89) for a commitment made in 2013, 93% (+0.86) for 2000 and 92% (+0.83) for 2007.

By G7 member, the highest overall health compliance came from Canada at 90% (+0.79) (see Appendix E). Canada also had the highest compliance on humanitarian health at 92% (+0.83), and the second highest compliance on regular health at 90% (+0.79). The EU stood second on overall health at 89% (+0.78), first on regular health at 91% (+0.81) and fourth on regular health at 78% (+0.55). On humanitarian health, the UK came second at 87% (+0.73), and France third at 79% (+0.58). The US had 82% (+0.63) on overall health compliance, but stood sixth on humanitarian health at 72% (+0.44). Japan, Germany and France stood in the middle in all three areas. Russia and Italy came at the bottom for all three.

Thus, Canada and the UK are the leaders in health compliance. This bodes well for the UK presidency in 2021. The overall health compliance score of 89% (+0.77) for the United States, a close third after the EU's 89% (+0.78) and Canada's 90% (+0.79), also bodes well for the US presidency this year.

Causes of Compliance with Humanitarian Health Commitments

To improve compliance, and thus save many lives, it is important to know what causes compliance with these humanitarian and regular health commitments, and which of these causes are low-cost, previously used, proven “accountability measures” under the direct control of the G7 leaders (Kirton and Larionova 2017). This section begins the task of finding out, guided by the work on G7 health and overall compliance that has gone before (Kirton 2006; Kirton, Roudev and Sunderland 2007; Kirton and Guebert 2010; Kirton, Kulik and Bracht 2014; Kirton, Kulik, Bracht and Guebert 2014; Samuels, Kirton and Guebert 2014; Kirton and Nikolaeva 2019; Byrd 2020; Rapson 2020).

Three such accountability measures are considered here: the number of commitments made at the summit; having a health ministerial meeting the same year; and working with core international organizations, in this case, depending on the specific issue in the commitment, the WHO, UNAIDS and the Global Fund.

Commitment Volume

The first measure, the number of health commitments at the summit, has long aroused a debate among two competing hypotheses. It can go two ways: the more the merrier or the fewer for focus. The “more the merrier” hypothesis asserts that the more health commitments the leaders make at the summit, the higher the compliance with any one or all of them will be. This is because a higher volume signals to the subsequent implementers the leaders’ political will, thus indicating that among all the competing demands, these are the priority commitments they want fulfilled. Moreover, compliance with one health commitment constitutes compliance with other, often closely related, ones. The “fewer for focus” hypothesis asserts that when leaders make only a few commitments, the implementers that work for them can concentrate their fixed, scarce resources on getting them done, rather than spread them thinly among many commitments on health and, by extension, other things.

In the case of G7 summit health commitments and compliance, the evidence suggests very tentatively that the “fewer for focus” hypothesis is more likely to be correct. The 11 summits with average compliance higher than 74% averaged 17 commitments at each summit (see Appendix E). The nine summits with under-average compliance averaged only 15 commitments each.

The number of G7 summit health commitments changed yearly. In the beginning and recently, there were fewer made, and since 2000 it has been sporadic. However, there were several years with between 42 and 85 commitments. The highest compliance scores — 100% in 2012, 95% in 2013 and 94% in 2001 — came in years when only one, two or three commitments were made, respectively. The lowest compliance scores of 25% for 2017 and 45% for 2011 both came when seven commitments were made. The years that made more than 40 commitments had compliance of 72% for 2006, 79% for 2007, 86% for 2015 and 74% for 2016. The years with the most commitments were 2016 with 85 and 2006 with 60.

These results are sensitive to the number of commitments assessed for compliance each year, both absolutely and as a portion of the overall number made. They do not account for the level of ambition or difficulty of the commitment made or assessed. Further research should also assess the number of health commitments made on the same subject and also that number as a portion of the overall commitments on all subjects made.

Ministerial Meetings

The second accountability measure is the occurrence of a meeting of the ministers responsible for the same subject on which the commitment was made during the same presidency. Here one hypothesis holds that a pre-summit ministerial meeting prepares the leaders for making commitments that are professionally appropriate and realistically deliverable, and also secures the ministers' support in advance. A ministerial held after the summit produces fast follow-up on the compliance task. The second hypothesis counters that such meetings let the leaders delegate the hard work of the commitment and compliance to their ministers, and free the leaders to devote their own unique authority to other things.

The accumulating evidence thus far shows that holding a same-subject, same-year ministerial meeting has the strongest positive-improving effect across most subjects in both the G7 and G20 of any accountability measures assessed (Kirton 2006; Rapson 2020; Rapson and Kirton 2020).

G7 health ministers met in 2006, 2016 and 2019. In the first two of these years, their leaders' summits averaged 73 health commitments, which had average compliance of 73%, slightly below the 74% average for health compliance overall. It seems that a health ministerial strongly coincides with more leaders' health commitments, but the relationship to compliance remains uncertain, given that there are only two years with a health ministerial meeting and complete data on leaders' health commitments and compliance. A more detailed look at each of the two years is thus appropriate.

G8 health ministers met for the first time on April 28, 2006, in Moscow, when Russia held the G8 presidency. The WHO, UNAIDS and the Global Fund participated. The meeting discussed measures to address avian influenza, pandemic preparedness and prevention, GOARN and HIV/AIDS (G8 Health Ministers 2006). Partnering with Africa to combat HIV/AIDS, as well as tuberculosis, malaria and polio were also discussed, among other topics. The overall compliance score for their leaders' 60 health commitments that year was 72%, just below the overall health average of 74%. Of the five commitments made at that meeting, four were on humanitarian health. The one assessed regular health commitment scored 78%. The four humanitarian health commitments focused on HIV/AIDS with 75% compliance, tuberculosis with 61%, polio with 72% and health emergency preparedness with 56%, with one above the 74% average.

The G7 health ministers met for the second time on September 11–12, 2016, now in Kobe, Japan, and with the WHO present. The ministers stated that “global health security remains high on the international agenda” under the focus of “Reinforcing the Global Health Architecture for Public Health Emergencies” (G7 Health Ministers 2016). The commitments made under this pillar reaffirmed the G7's support for the WHO, pandemic preparedness and prevention, and the fight

against Ebola. The other pillars of this meeting were “Attaining Universal Health Coverage and Promotion of Health through the Life Course Focusing on Population Ageing,” “Antimicrobial Resistance,” and “Research and Development and Innovation.” On universal health coverage, the ministers recommitted to ending “the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases,” as well as eradicating polio. At the Ise Shima Summit earlier that year in May, G7 leaders made a record high of 85 commitments, which had compliance of 74%. The one assessed regular commitment had 69% compliance, as did the humanitarian health commitment on the Global Health Security Agenda. The other humanitarian health commitment assessed, on ending AIDS, tuberculosis and malaria through working with the Global Fund, had compliance of 88%.

On May 17, 2019, G7 health ministers met for a third time, this time in Paris, France. Once again, the WHO and the Global Fund were among the attendees. Ministers reiterated their commitment to ending AIDS, tuberculosis and malaria, as well as eradicating polio and making progress on global health security and pandemic and emergency preparedness and response (G7 Health Ministers 2019). At the Biarritz Summit in August, G7 leaders made only four health commitments, whose compliance has not yet been assessed.

In 2020, since the COVID-19 pandemic began, the G7 Health Ministers held at least four meetings: on February 3, on March 9, on March 19 and on April 3. Data on their leaders’ health commitments and compliance do not exist, other than identification of the 12 health commitments G7 leaders made on March 16.

Core International Organization Catalyst

The third accountability measure is the presence in a commitment of a reference to the core international organization related to the issue at hand, specifically in the case of health the WHO or, in special circumstances, the Global Fund. Here the first hypothesis is that such a reference alerts the most capable and experienced, fully multilateral organization to activate its formidable resources to assist in implementation. This contrasts with the “organizational more the merrier” hypothesis, which argues that invoking several international organizations makes all feel included and activated and adds the resources of all to work together to help get the commitment implemented. A reference to the core international organizations alone should have a particularly pronounced compliance-enhancing effect for commitments on humanitarian health, given the WHO’s global mandate and governance structure.

The second, competing hypothesis is that of “organizational buck passing,” because invoking several international organizations allows each to leave it to the other to do the job. Another competing hypothesis is that assigning the problem to the WHO alone leaves G7 ministers and officials free of the responsibility to act directly to implement the commitment their leaders have just made.

Subsequent research can explore the impact of references to other international organizations, along with or instead of the relevant core international organization.

Another hypothesis is that of “organizational competitiveness” as each invoked international organization competes to secure additional resources from G7 governments to do the job, and fights to do it according to its distinctive mandate, organizational capacity and culture and expertise. In the field of health, an additional hypothesis could address the larger issue of the effectiveness of centralized global health governance grounded in the WHO since 1948, or fragmented global health governance with many old and new institutions involved in a regime complex to do specific and overlapping things.

At present, a focus on the core international organization of the WHO suggests that its presence in a commitment does indeed catalyze compliance with the G7 commitment where it appears. Of the 71

G7 summit health commitments assessed for compliance, the eight that invoked the WHO averaged compliance of 83%, well above the 74% average for all 71 commitments. The six that invoked the WHO alone averaged 82%. The two that invoked the WHO with one other organization (UNAIDS from 2005 and the Food and Agriculture Organization from 2016) averaged 85%.

A more detailed look at individual summits suggests the compliance-enhancing potency of reference to the core WHO for commitments on humanitarian health. The three humanitarian health commitments assessed for compliance from 2000 all mentioned strengthening partnership with the WHO. All three had compliance of 100%. The one humanitarian health commitment assessed from 2005 that invoked the WHO had 100% compliance.

The invocation of the issue-specific Global Fund as the core international organization had a mixed effect. It generally coincided with high compliance, but never with complete compliance. The one assessed 2001 humanitarian health commitment was on the launch of the Global Fund and had 88% compliance, with all members except the United States having full compliance. Support for the Global Fund was reiterated in 2002, but compliance was only 63%. However, the 2003 commitment on the Global Fund had 95%. The one assessed 2016 humanitarian health commitment, which stated that the G7 would end AIDS, tuberculosis and malaria through working in partnership with the Global Fund and others, had 88% compliance.

Taken together, the central message seems to be “trust the WHO,” alone or with other subject specific international organizations, to help the G7 comply best with the leaders’ commitments on humanitarian health. In addition, invoking the Global Fund adds value on HIV/AIDS, tuberculosis and malaria. This is an important message as the first half of 2020 ended, as tuberculosis had killed more people around the world than COVID-19 had. But as COVID-19 will quickly surpass tuberculosis as the leading global cause of death in the second half of 2020, the overall message is to trust the WHO above all.

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Appendix A: Methodology

Definition

Humanitarianism, as defined by the International Association of Professionals in Humanitarian Assistance and Protection (n.d.), is “a broad dedication to and belief in the fundamental value of human life. Though lacking an agreed definition, this central ethics of humanitarianism crosses cultures and history. Humanitarianism is also a more specific reference to the (international/Western) crisis response that has evolved from the founding of the Red Cross and first Geneva convention over 150 years ago. As a systemic response to crisis, humanitarianism involves addressing the needs of people affected by conflict, natural disaster, epidemic and famine. In these crises, the focus of humanitarianism is, to varying degrees, placed upon basic or immediate needs of assistance and protection, as distinct from (though increasingly linked to) work more directly aimed at development, peace building, rule of law, etc.”

Given this definition, it helps to look at the humanitarian aid that leading organizations engage in. For example, the United Nations delivers humanitarian aid by several entities: the United Nations Development Programme (UNDP), the United Nations Refugee Agency (UNHCR), the United Nations Children’s Fund (UNICEF) and the World Food Programme (WFP). The UNDP mainly focuses on mitigating, preventing and preparing for natural disasters; the UNHCR works on helping refugees; the UNICEF works to help and protect children; the WFP, as well as the Food and Agriculture Organization of the United Nations, works to ensure that victims of disasters have access to food and nutrition; and the World Health Organization works to ensure that humanitarian health emergencies are addressed by the international community (UN n.d.).

One of the world’s leading teams focusing on humanitarian issues is the Humanitarian Policy Group (n.d.), run by the Overseas Development Institute. This group focuses on five topics of humanitarianism: “principles, politics and the humanitarian system; civilian security and protection; displacement, migration and urbanization; livelihoods and food security in crises; [and] protracted crises and transitions.” The approaches of the Humanitarian Policy Group and the UN to humanitarianism overlap in the areas of displacement, migration and urbanization, and livelihoods and food security in crises. Particularly at a time like 2020 with the COVID-19 pandemic, health is also an important factor of humanitarianism.

For the purposes of this report, humanitarianism is thus defined as a systematic response to crisis that addresses the needs of people affected by conflict, natural disaster, epidemic and other health-related crises and famine with a strong focus on refugees and children.

Search Terms

The following keywords were used to identify G7 commitments related to humanitarian health for this report: humanitarianism, humanitarian, aid, crisis, conflict, natural disaster, epidemic, famine, health, HIV, AIDS, malaria, tuberculosis/TB, polio, United Nations (UN), the United Nations Development Programme (UNDP), the United Nations Refugee Agency (UNHCR), the United Nations Children’s Fund (UNICEF), the World Food Programme (WFP), the World Health Organization (WHO).

The following terms were excluded: development, rule of law, crime, corruption, peace, peacebuilding, peacemaking, peacekeeping, negotiations. General references to development and the development world were also excluded.

The full list of commitments is provided in Appendix H.

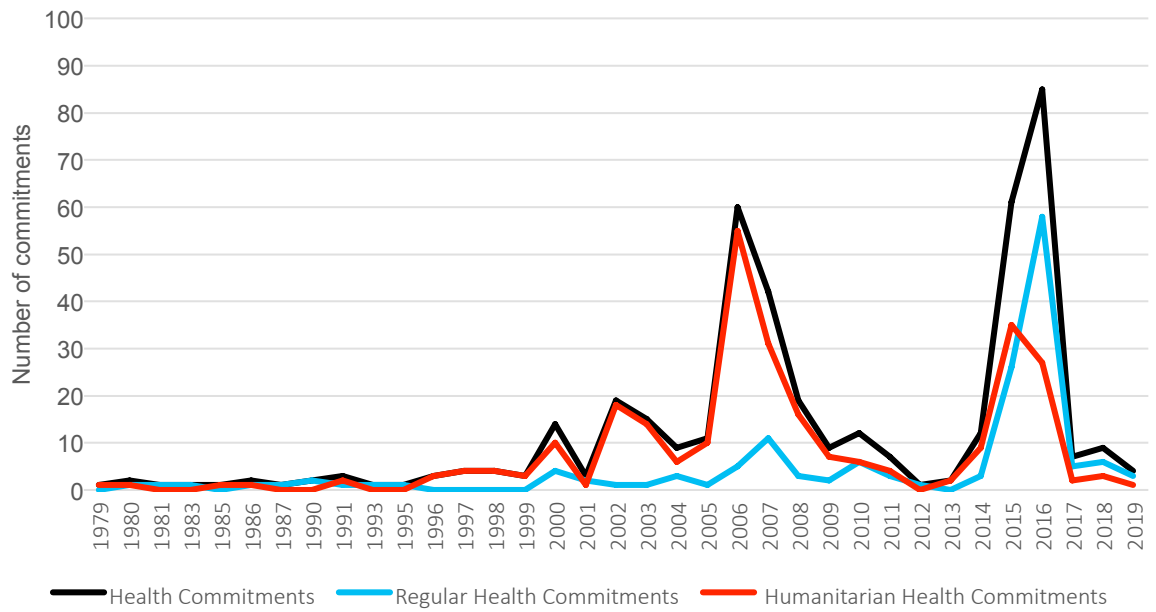
Appendix B: G7 Summit Health Commitment and Compliance, 1979-2020

Year	# health commitments	Health compliance overall	# regular health commitments	Regular health compliance	# humanitarian health commitments	Humanitarian health compliance
1979	1	n/a	0	n/a	1	n/a
1980	2	n/a	1	n/a	1	n/a
1981	1	n/a	1	n/a	0	n/a
1983	1	n/a	1	n/a	0	n/a
1985	1	n/a	0	n/a	1	n/a
1986	2	n/a	1	n/a	1	n/a
1987	1	n/a	1	n/a	0	n/a
1990	2	n/a	2	n/a	0	n/a
1991	3	n/a	1	n/a	2	n/a
1993	1	n/a	1	n/a	0	n/a
1995	1	n/a	1	n/a	0	n/a
1996	3	n/a	0	n/a	3	n/a
1997	4	n/a	0	n/a	4	n/a
1998	4	69%	0	n/a	4	69%
1999	3	50%	0	n/a	3	50%
2000	14	88%	4	84%	10	93%
2001	3	94%	2	100%	1	88%
2002	19	75%	1	50%	18	75%
2003	15	93%	1	100%	14	85%
2004	9	75%	3	72%	6	78%
2005	11	72%	1	n/a	10	72%
2006	60	72%	5	78%	55	66%
2007	42	79%	11	67%	31	92%
2008	19	62%	3	67%	16	56%
2009	9	71%	2	64%	7	78%
2010	12	57%	6	56%	6	59%
2011	7	45%	3	45%	4	n/a
2012	1	100%	1	100%	0	50%
2013	2	95%	0	50%	2	95%
2014	12	92%	3	92%	9	n/a
2015	61	86%	26	n/a	35	86%
2016	85	74%	58	69%	27	79%
2017	7	25%	5	25%	2	n/a
2018	9	75%	6	75%	3	n/a
2019	4	n/a	3	n/a	1	n/a
Subtotal	431	74%	154	70%	277	75%
2020 ^a	12	n/a	11	n/a	1	n/a
Total	443	74%	165	70%	278	75%

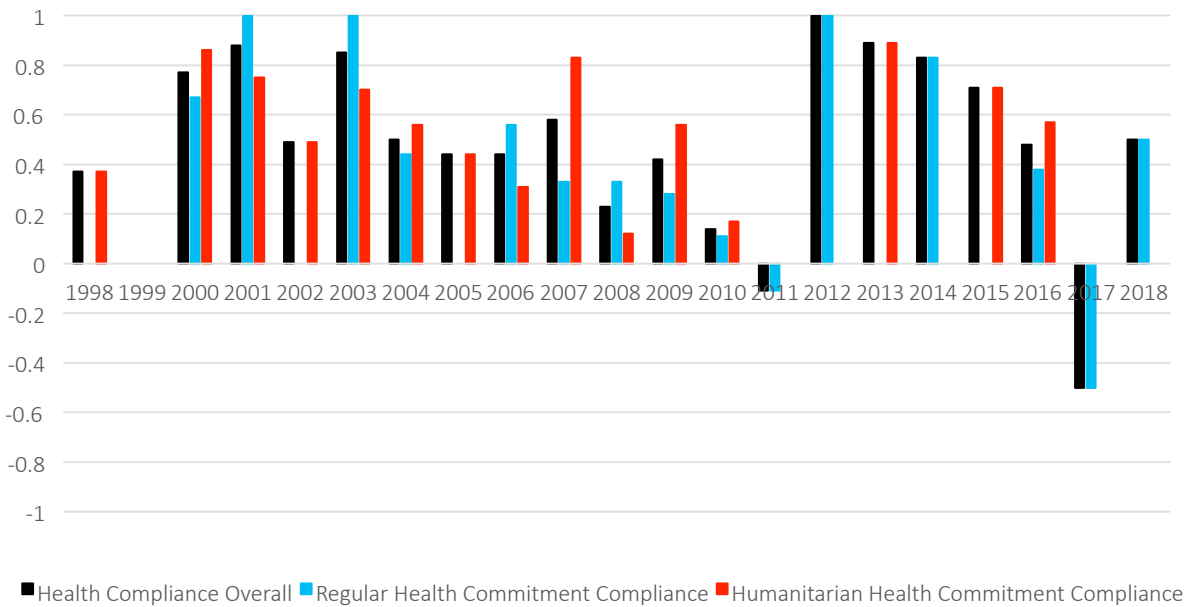
Note: n/a = not available.

^a Commitments made in the G7 Leaders' Statement on COVID-10 issued at the G7 leaders' video summit on March 16, 2020, coded by the Director of Compliance Research for the G7 Research Group. Compliance assessments with these commitments are in progress at the time of writing.

Appendix C: G7 Health Commitments, 1979–2019



Appendix D: G7 Health Compliance, 1998–2018



Appendix E: Compliance with Health Commitments by Year and Member

	Overall	Humanitarian	Non-Humanitarian	Overall	Humanitarian	Non-Humanitarian	Overall	Humanitarian	Non-Humanitarian
	Canada			France			Germany		
1983	100%		100%	100%		100%			
1997	100%	100%		100%	100%		100%	100%	
1998	100%	100%		100%	100%		17%	17%	
1999	50%	50%		50%	50%		50%	50%	
2000	100%	100%	100%	100%	100%	100%	94%	88%	100%
2001	100%	100%	100%	100%	100%	100%	100%	100%	100%
2002	75%	100%	50%	65%	65%		55%	59%	50%
2003	100%	100%	100%	94%	88%	100%	82%	63%	100%
2004	100%	100%	100%	50%	100%	0%	100%	100%	100%
2005	67%	67%		60%	60%		70%	70%	
2006	94%	88%	100%	82%	63%	100%	44%	38%	50%
2007	100%	100%	100%	100%	100%	100%	70%	90%	50%
2008	67%	84%	50%	75%	50%	100%	50%	50%	50%
2009	88%	100%	75%	88%	100%	75%	50%	50%	50%
2010	100%	100%	100%	50%	50%	50%	88%	75%	100%
2011	100%		100%	0		0	100%		100%
2012	100%		100%	100%		100%	100%		100%
2013	100%	100%		100%	100%		100%	100%	
2014	100%		100%	67%		67%	100%		100%
2015	67%	67%		84%	84%		100%	100%	
2016	100%	100%	100%	38%	75%	0	88%	75%	100%
2017	50%		50%	0		0	0		0
2018	100%		100%	50%		50%	50%		50%
Average	90%	92%	90%	72%	79%	65%	73%	74%	75%
	Italy			Japan			Russia		
1983									
1997									
1998	67%	67%		50%	50%		17%	17%	
1999	50%	50%		50%	50%		50%	50%	
2000	69%	88%	50%	100%	100%	100%	25%	50%	0
2001	100%	100%	100%	75%	50%	100%	100%	100%	100%
2002	67%	67%		63%	75%	50%	42%	42%	
2003	94%	88%	100%	94%	88%	100%	92%	84%	100%
2004	50%	100%	0	25%	0	50%	50%	0	100%
2005	38%	38%		84%	84%		80%	80%	
2006	50%	50%	50%	63%	25%	100%	88%	75%	100%
2007	35%	70%	0	70%	90%	50%	44%	88%	0
2008	50%	50%	50%	75%	50%	100%	92%	17%	0
2009	13%	0	25%	100%	100%	100%	50%	50%	50%
2010	13%	0	25%	50%	50%	50%	38%	50%	25%
2011	0		0	0		0	100%		100%
2012	100%		100%	100%		100%	100%		100%
2013	100%	100%		100%	100%		50%	50%	
2014	84%		84%	84%		84%			
2015	50%	50%		84%	84%				
2016	38%	75%	0%	88%	75%	100%			
2017	0		0	0		0			
2018	100%		100%	50%		50%			
Average	56%	62%	46%	67%	67%	71%	59%	57%	62%

	Overall	Humanitarian	Non-Humanitarian	Overall	Humanitarian	Non-Humanitarian	Overall	Humanitarian	Non-Humanitarian
	United Kingdom			United States			European Union		
1983							100%		100%
1997				100%	100%		100%	100%	
1998	100%	100%		100%	100%		100%	100%	
1999	50%	50%		50%	50%				
2000	100%	100%	100%	94%	88%	100%	100%	100%	100%
2001	100%	100%	100%	75%	50%	100%	100%		100%
2002	63%	75%	50%	68%	86%	50%	67%	67%	
2003	94%	88%	100%	94%	88%	100%	94%	88%	100%
2004	100%	100%	100%	100%	100%	100%	100%	100%	100%
2005	70%	70%		84%	84%		100%	100%	
2006	69%	88%	50%	100%	100%	100%	56%	67%	50%
2007	100%	100%	100%	100%	100%	100%	85%	70%	100%
2008	75%	100%	50%	92%	84%	100%	59%	17%	100%
2009	100%	100%	100%	75%	100%	50%	75%	100%	50%
2010	50%	50%	50%	75%	100%	50%	50%	50%	50%
2011	0		0	0		0	100%		100%
2012	100%		100%	100%		100%	100%		100%
2013	100%	100%		100%	100%		100%	100%	
2014	100%		100%	100%		100%	100%		100%
2015	100%	100%		100%	100%		100%	100%	
2016	88%	75%	100%	75%	100%	50%	75%	50%	100%
2017	50%		50%	0%		0%	100%		100%
2018	100%		100%	50%		50%	100%		100%
Average	82%	87%	78%	79%	89%	72%	89%	78%	81%

Appendix F: Compliance by Number of Commitments

Health compliance overall	Number of commitments	Year
25%	7	2017
45%	7	2011
50%	3	1999
57%	12	2010
63%	19	2008
69%	4	1998
71%	9	2009
72%	11	2005
72%	60	2006
74%	85	2016
75%	19	2002
75%	9	2004
75%	9	2018
79%	42	2007
86%	61	2015
89%	14	2000
92%	12	2014
93%	15	2003
94%	3	2001
95%	2	2013
100%	1	2012
Humanitarian health compliance	Number of commitments	Year
50%	3	1999
56%	16	2008
59%	6	2010
66%	55	2006
69%	4	1998
72%	10	2005
75%	18	2002
78%	6	2004
78%	7	2009
79%	27	2016
85%	14	2003
86%	35	2015
88%	1	2001
92%	31	2007
93%	10	2000
95%	2	2013
Regular health compliance	Number of commitments	Year
25%	5	2017
45%	3	2011
50%	1	2002
56%	6	2010
64%	2	2009
67%	3	2008
67%	11	2007
69%	58	2016
72%	3	2004
85%	6	2018
78%	5	2006
84%	4	2000
92%	3	2014

Appendix G: Compliance by Member

Member	Overall compliance	Member	Humanitarian health compliance	Member	Non-humanitarian health compliance
Canada	90%	Canada	92%	European Union	91%
European Union	89%	United Kingdom	87%	Canada	90%
United States	89%	France	79%	United Kingdom	79%
United Kingdom	83 %	European Union	78%	Germany	75%
Germany	73%	Germany	74%	United States	72%
France	73%	United States	72%	Japan	71%
Japan	67%	Japan	67%	France	65%
Russia	59%	Italy	63%	Russia	62%
Italy	56%	Russia	57%	Italy	46%

Topic	Number of commitments
HIV/AIDS	44
General humanitarian health	44
Health emergency preparedness	27
Infectious Diseases	23
Supporting Africa/African countries	19
Working with the World Health Organization	18
Polio	17
Global Fund to Fight AIDS, Tuberculosis and Malaria	17
Neglected tropical diseases	13
HIV/AIDS, tuberculosis and malaria	12
Malaria	11
Malnutrition	8
Avian Influenza	6
Working with International Organizations	6
Tuberculosis	5
Ebola	2
Measles	2
Severe acute respiratory syndrome	2
Zika	1

Appendix H: Humanitarian Health Commitments, N = 277

1975 Rambouillet, France (0)

No references.

1976 San Juan, Puerto Rico, United States (0)

No references.

1977 London, United Kingdom (0)

No references.

1978 Bonn, Germany (0)

No references.

1979 Tokyo, Japan (1)

27. We will place more emphasis on cooperation with developing countries in overcoming hunger and malnutrition.

1980 Venice, Italy (1)

32. We are deeply conscious that extreme poverty and chronic malnutrition afflict hundreds of millions of people of developing countries. The first requirement in these countries is to improve their ability to feed themselves and reduce their dependence on food imports. We are ready to join with them and the international agencies concerned in their comprehensive long-term strategies to increase food production, and to help improve national as well as international research services.

1981 Montebello, Canada (0)

No references.

1983 Williamsburg, United States (0)

No references.

1984 London II, United Kingdom (0)

No references.

1985 Bonn II, Germany (1)

16. We are deeply concerned about the plight of African peoples who are suffering from famine and drought. We shall continue to supply emergency food aid.

1986 Tokyo II, Japan (1)

38. We pledge ourselves afresh to fight against hunger, disease and poverty, so that developing nations can also play a full part in building a common, bright future.

1987 Venice II, Italy (0)

No references.

1988 Toronto, Canada (0)

No references.

1989 Paris, France (0)

No references.

1990 Houston, United States (0)

No references.

1991 London III, United Kingdom (2)

23. We will provide humanitarian assistance to those parts of Africa facing severe famine and encourage the reform of United Nations structures in order to make this assistance more effective. We will also work to help the countries concerned remove the underlying causes of famine and other emergencies, whether these are natural or provoked by civil strife.
41. In addition to its own domestic efforts, South Africa also needs the help of the international community, especially in those areas where the majority have long suffered deprivation: education, health, housing and social welfare. We will direct our aid for these purposes.

1992 Munich, Germany (0)

No references.

1993 Tokyo III, Japan (0)

No references.

1994 Naples, Italy (0)

No references.

1995 Halifax, Canada (0)

No references.

1996 Lyon, France (3)

95. We draw attention to the measures already undertaken in each of our countries to encourage the scientific community in its search for remedies to these diseases. We pledge to pursue this effort at the national level, while at the same time promoting international cooperation among research teams in this field.
96. Moreover, we will continue to extend various kinds of assistance programs, in particular for the benefit of the countries hardest hit by HIV/AIDS and other infectious diseases.
97. We will continue to work to ensure the availability of safe and effective treatments for these all-too-often fatal diseases.

1997 Denver, United States (4)

24. In the coming year, our governments will promote more effective coordination of international responses to outbreaks; promote development of a global surveillance network, building upon existing national and regional surveillance systems; and help to build public health capacity to prevent, detect and control infectious diseases globally including efforts to explore the use of regional stocks of essential vaccines, therapeutics, diagnostics and other materials.
25. Central to this work will be strengthening and linking existing activities in and among each of our countries, with developing countries, and in other fora, especially the World Health Organization.
26. We will work to provide the resources necessary to accelerate AIDS vaccine research, and together will enhance international scientific cooperation and collaboration.

27. The Joint United Nations Program on HIV/AIDS (UNAIDS) must help expand the scale and quality of the response to HIV/AIDS. As a group and with others, we will work to assure that it has resources adequate to fulfill its mandate.

1998 Birmingham, United Kingdom (4)

21. To enhance mutual cooperation on infectious and parasitic diseases and support the World Health Organisation's efforts in those areas.
22. We support the new initiative to "Roll Back Malaria" to relieve the suffering experienced by hundreds of millions of people, and significantly reduce the death rate from malaria by 2010.
23. We will also continue our efforts to reduce the global scourge of AIDS through vaccine development, preventive programmes and appropriate therapy, and by our continued support for UNAIDS.
24. We welcome the French proposal for a "Therapeutic Solidarity Initiative" and other proposals for the prevention and treatment of AIDS, and request our experts to examine speedily the feasibility of their implementation.

1999 Köln, Germany (3)

38. We are concerned at the continuing global spread of AIDS. We reaffirm the need to continue efforts to combat AIDS at the national and international level through a combined strategy of prevention, vaccine development and appropriate therapy.
39. We also pledge to continue our national and international efforts in the fight against infectious and parasitic diseases, such as malaria, polio and tuberculosis, and their drug-resistant forms.
40. In particular we will continue to support the endeavors of the World Health Organization and its initiatives "Roll Back Malaria" and "Stop TB."

2000 Okinawa, Japan (10)

23. Implement an ambitious plan on infectious diseases, notably HIV/AIDS, malaria and TB. We therefore commit ourselves to working in strengthened partnership with governments, the World Health Organization (WHO) and other international organizations, industry (notably pharmaceutical companies), academic institutions, NGOs and other relevant actors in civil society to deliver three critical UN targets.
36. 1) Reduce the number of HIV/AIDS-infected young people by 25% by 2010.
37. 2) Reduce TB deaths and the prevalence of the disease by 50% by 2010.
38. 3) Reduce the burden of disease associated with malaria by 50% by 2010.
39. Mobilizing additional resources ourselves and calling on the MDBs to expand their own assistance to the maximum extent possible.
40. Giving priority to the development of equitable and effective health systems, expanded immunization, nutrition and micro-nutrients and the prevention and treatment of infectious diseases.
43. Working to make existing cost-effective interventions, including key drugs, vaccines, treatments and preventive measures more universally available and affordable in developing countries.
45. Strengthening cooperation in the area of basic research and development of new drugs, vaccines and other international public health goods.
47. We will take stock of progress at the Genoa Summit next year and will work with the UN to organize a conference in 2001 focusing on strategies to facilitate access to AIDS treatment and care.

2001 Genoa, Italy (1)

26. To meet that commitment and to respond to the appeal of the UN General Assembly, we have launched with the UN Secretary-General a new Global Fund to fight HIV/AIDS, malaria and

tuberculosis. We are determined to make the Fund operational before the end of the year. We have committed \$1.3 billion

2002 Kananaskis, Canada (18)

11. We underlined the devastating consequences for Africa's development of diseases such as malaria, tuberculosis and HIV/AIDS. In addition to our ongoing commitments to combat these diseases, we committed to provide sufficient resources to eradicate polio by 2005
76. Assisting African producers in meeting product and health standards in export markets; and, improving Health and Confronting HIV/AIDS we commit to: Helping Africa combat the effects of HIV/AIDS – including by:
109. Supporting programmes that help mothers and children infected or affected by HIV/AIDS, including children orphaned by AIDS.
110. Supporting the strengthening of training facilities for the recruiting and training of health professionals.
111. Supporting the development, adoption and implementation of gender-sensitive, multisectoral HIV/AIDS programs for prevention, care, and treatment.
112. Supporting high level political engagement to increase awareness and reduce the stigma associated with HIV/AIDS.
113. Supporting initiatives to improve technical capacity, including disease surveillance.
114. Supporting efforts to develop strong partnerships with employers in increasing HIV/AIDS awareness and in providing support to victims and their families.
115. Supporting efforts that integrate approaches that address both HIV/AIDS and tuberculosis; and
116. Helping to enhance the capacity of Africa to address the challenges that HIV/AIDS poses to peace and security in Africa.
117. Supporting African efforts to build sustainable health systems in order to deliver effective disease interventions – including by: Pressing ahead with current work with the international pharmaceutical industry, affected African countries and civil society to promote the availability of an adequate supply of lifesaving medicines in an affordable and medically effective manner.
118. Supporting African countries in helping to promote more effective, and cost-effective, health interventions to the most vulnerable sectors of society – including reducing maternal and infant mortality and morbidity.
119. Continuing support for the Global Fund to Fight AIDS, Tuberculosis and Malaria, and working to ensure that the Fund continues to increase the effectiveness of its operations and learns from its experience.
120. Supporting African efforts to increase Africa's access to the Global Fund and helping to enhance Africa's capacity to participate in and benefit from the Fund.
122. Supporting and encouraging the twinning of hospitals and other health organizations between G8 and African countries.
123. Providing, on a fair and equitable basis, sufficient resources to eliminate polio by 2005.
124. Supporting relevant public-private partnerships for the immunization of children and the elimination of micro-nutrient deficiencies in Africa.
125. Supporting health research on diseases prevalent in Africa, with a view to narrowing the health research gap, including by expanding health research networks to focus on African health issues, and by making more extensive use of researchers based in Africa.

2003 Evian, France (14)

10. We agreed on measures to strengthen the Global Fund to fight AIDS, Tuberculosis and Malaria and other bilateral and multilateral efforts, notably through our active participation in the donors' and supporters' conference to be hosted in Paris this July.
11. We agreed on measures to improve access to health care, including to drugs and treatments at affordable prices, in poor countries.
12. We agreed on measures to encourage research on diseases mostly affecting developing countries.

13. We agreed on measures to mobilise the extra funding needed to eradicate polio by 2005.
14. We agreed on measures to improve international co-operation against new epidemics such as SARS.
111. We commit, with recipient countries, to fulfil our shared obligations as contained in the Declaration of Commitment on HIV/AIDS for the 2001 United Nations General Assembly Special Session.
112. We reiterate our commitment to fight against AIDS as well as Tuberculosis and Malaria as agreed in Okinawa, through further actions in such areas as institutional building, public-private partnerships, human resource development, research activities and promotion of public health at the community level. We will strengthen our efforts in this fight, both bilaterally and multilaterally.
113. We reaffirm our support for the Global Fund to fight AIDS, Tuberculosis, and Malaria.
115. We will work to develop an integrated approach that will facilitate the availability and take-up of discounted medicines for the poorest in a manner that is fair, efficient and sustainable.
116. We will also work with developing countries to encourage greater uptake of such offers of free and discounted drugs, as are now being made.
117. We will take the steps necessary to prevent the diversion of those medicines away from the countries or regions for which they were intended.
118. We direct our ministers and officials, working urgently with WTO partners, to establish a multilateral solution in the WTO to address the problems faced by these countries, rebuilding the confidence of all parties, before the Cancun Ministerial.
119. In particular we will work with developing countries to increase their own ability to contribute to research and development on these diseases, including to create incentives and the necessary regulatory systems to support ethical and safe clinical trials.
120. Confronting the threat of SARS: We will continue to work closely with the World Health Organisation, to undertake research and investigation at a high level and to develop appropriate means of international co-operation.

2004 Sea Island, United States (6)

166. We endorse this concept and call for the establishment of a Global HIV Vaccine Enterprise.
167. We call on all stakeholders in the Global HIV Vaccine Enterprise to complete the development of this strategic plan by our next Summit.
168. The United States, in its role as president of the G8, will convene later this year a meeting of all interested stakeholders in the Enterprise to encourage their collaborative efforts in HIV vaccine development. This meeting should clarify how the strategic plan is to be implemented.
170. We will take all necessary steps to eradicate polio by 2005.
171. To ensure that polio does not re-emerge, we will work to ensure the full integration of necessary measures in national health strategies and structures in the post-eradication period through 2008.
173. We will also remain engaged with the governments of the six polio-endemic countries and the nine countries in which polio is now spreading to urge them to take stronger steps to contain and destroy the polio virus.

2005 Gleneagles, United Kingdom (10)

5. To boost investment in health and education, and to take action to combat HIV/AIDS, malaria, TB and other killer diseases.
68. Investing in improved health systems in partnership with African governments, by helping Africa train and retain doctors, nurses and community health workers.
69. We will ensure our actions strengthen health systems at national and local level and across all sectors since this is vital for long-term improvements in overall health, and we will encourage donors to help build health capacity.
70. With the aim of an AIDS-free generation in Africa, significantly reducing HIV infections and working with WHO, UNAIDS and other international bodies to develop and implement a

package for HIV prevention, treatment and care, with the aim of as close as possible to universal access to treatment for all those who need it by 2010.

71. We will also work with them to ensure that all children left orphaned or vulnerable by AIDS or other pandemics are given proper support.
72. We will work to meet the financing needs for HIV/AIDS, including through the replenishment this year of the Global Fund to fight AIDS, TB and Malaria; and actively working with local stakeholders to implement the '3 Ones' principles in all countries.
73. We note continuing work to explore establishing an International Centre for Genetic Engineering & Biotechnology centre in Africa to help research into vaccines for the diseases that are afflicting the continent.
74. Supporting the Polio Eradication Initiative for the post eradication period in 2006-8 through continuing or increasing our own contributions toward the \$829 million target and mobilising the support of others.
75. Working with African countries to scale up action against malaria to reach 85% of the vulnerable populations with the key interventions that will save 600,000 children's lives a year by 2015 and reduce the drag on African economies from this preventable and treatable disease.
76. Helping to meet the needs identified by the Stop TB Partnership. We also support the call for a high-level conference of Health Ministers for TB in 2006.

2006 St. Petersburg, Russia (55)

1. Improved international cooperation on the surveillance and monitoring of infectious diseases, including better coordination between the animal and human health communities, building laboratory capacities, and full transparency by all nations in sharing, on a timely basis, virus samples in accordance with national and international regulations and conventions, and other relevant information about the outbreaks of diseases.
2. Intensification of scientific research and exchanges in the area of infectious diseases, with a special attention given to involving scientists from developing countries in international scientific research programs.
3. Support for efforts by the relevant international organizations to respond effectively to outbreaks of avian influenza and to help the global community prepare for a possible human influenza pandemic, including timely implementation of the commitments made at the January 2006 Beijing International Pledging Conference on Avian and Pandemic Influenza.
4. Fulfillment of prior G8 commitments on the major infectious diseases, in particular by mobilizing support for the Global Fund to Fight AIDS, Tuberculosis, and Malaria; continuing to pursue as close as possible to universal access to HIV/AIDS treatment for all who need it by 2010; supporting the Global Plan to Stop TB; providing resources in cooperation with African countries to scale up action against malaria; continuing to expand the Global HIV Vaccine Enterprise; and continuing our support for the Global Polio Eradication Initiative so that the planet can be declared polio-free within the next few years.
5. Improved access to prevention and treatment of diseases for those in need, through assistance programs focused on strengthening the capacity of health systems and the training, deployment, and retention of qualified health workers; and through innovative clinical research programs, private-public partnerships, and other innovative mechanisms.
6. Support for efforts by work with relevant international organizations to mitigate the health consequences of emergencies, including natural and man-made disasters, including through better coordination and capacity building.
7. We support immediate implementation of the provisions of the revised International Health Regulations considered relevant to the risk posed by avian and pandemic influenza.
[International Law: IHR]
9. We will continue to support existing global networks working under World Health Organization (WHO) auspices, such as the Global Outbreak Alert and Response Network (GOARN).

10. Enhancing information exchange and encouraging national governments to provide timely and reliable information in an open and transparent manner.
11. Helping developing countries improve the capacity of their national systems for the surveillance and monitoring of infectious diseases, by providing technical assistance and training experts.
12. Building preparedness for future emerging infectious diseases, including through future-oriented scientific and clinical research projects.
13. We will also seek to improve global and regional cooperation among experts to combat illegal wildlife trafficking, which is contributing to the spread of zoonotic diseases.
14. In this effort, we will aim to increase scientific cooperation with developing countries, encourage partnerships between experts and laboratories of developing and developed countries, and increase the scientific potential in countries of all income levels.
15. We will continue to provide full support for their efforts, and for those of the international financial institutions such as the World Bank, the Asian Development Bank, and the International Monetary Fund.
16. We pledge to coordinate our international investments to fight the spread and impact of the disease.
17. Working with the WHO, FAO, and other UN agencies to update global avian influenza and pandemic influenza control strategies and preparedness plans; establish standard operating procedures and logistical arrangements, using existing technical networks; and to encourage robust arrangements for the quickest possible reporting.
18. Supporting efforts to increase worldwide production capacity for, and stockpiling of, antivirals.
19. Working with pharmaceutical companies to examine options for increasing production capacities for vaccines, and encouraging development of next generation influenza vaccines.
20. Supporting capacity building in the most vulnerable countries in disease-surveillance and early warning systems, including enhancement of diagnostic capacity and virus research, by helping them to develop their national plans, build relevant infrastructure, train experts, strengthen veterinary services and laboratories and mitigate the socio-economic impact of control measures.
21. Raising awareness among populations, and enhancing public education programs in all countries at risk.
22. Exchanging timely information and samples, in accordance with national and international regulations and conventions, related to the occurrence of avian influenza in our countries on a timely basis with the international community, and developing and using best practices for influenza preparedness, surveillance and control.
23. Using reference and national laboratories for the timely detection of avian influenza, and encouraging the establishment of additional laboratories in epidemic-prone regions. In this regard, we welcome the Russian proposal to establish the WHO Collaborating Centre on Influenza for Eurasia and Central Asia, subject to meeting all applicable WHO and other international standards, to enhance international capacity to counter the spread of the viruses in the region.
24. We pledge our continued support to the Joint United Nations Programme on HIV/AIDS (UNAIDS), the WHO, the Global Fund to fight AIDS, Tuberculosis and Malaria (the Global Fund), the World Bank and other organizations, initiatives and partnerships actively working to fight these diseases.
25. Further promotion of a comprehensive and well-balanced approach to tackling HIV/AIDS, which includes prevention, treatment and care.
26. Continued involvement of all relevant partners, including civil society, the private sector and people living with HIV/AIDS, in the activities to tackle the HIV/AIDS pandemic and to reduce stigma and discrimination against people with this disease.
27. [In our response to HIV/AIDS, we will adhere to the following principles:] scale up support to address the rising rates of HIV infection among young people, particularly young girls and women.

28. Supporting the continued implementation of comprehensive, evidence-based strategies of prevention, and the development of new and innovative methods of prevention, such as microbicides, and vaccines against the diseases that increase the risk of HIV transmission.
29. Facilitating access to prevention, treatment and care for the most vulnerable segments of the population.
30. Building the capacity of health care systems in poor countries through recruitment, training and deployment of public and private health workers; and raising public awareness of the existing threat in all countries affected.
32. The G8 members will work with governments and technical agencies to support the preparation of high quality, timely proposals for Global Fund AIDS, Tuberculosis and Malaria grants.
33. We reaffirm our partnership with African nations and with the African Union, and will continue to work with them to deliver on the goals of the New Partnership for Africa's Development (NEPAD), to improve health systems overall and to fight infectious diseases.
34. We remain committed to our Sea Island Summit initiative on creation of a Global HIV Vaccine Enterprise, and reaffirm our determination to bring it to fruition.
35. We reaffirm the commitment we made at the Genoa Summit in 2001 to halt the spread of this disease.
36. We will also support the Global Plan to Stop TB, 2006-2015, which aims to cut TB deaths in half by the year 2015 compared to 1990 levels, saving some 14 million lives over ten years, and call upon all donors and stakeholders to contribute to its effective implementation.
37. We reaffirm our commitment to work with African countries to scale up malaria control interventions, reduce the burden of the disease, and eventually defeat malaria on the continent and meet the Abuja target of halving the burden of malaria by 2010.
38. We agree to strengthen malaria control activities and programs in African countries with the objective of achieving significant public health impact.
39. We will collaborate with governments, private sector companies and non-governmental organizations in public-private partnerships to expand malaria interventions and programs.
40. We support the development of new, safe, and effective drugs, creation of a vaccine, and promotion of the widest possible availability of prevention and treatment to people in need.
41. We welcome efforts in the framework of the "Roll Back Malaria Partnership" and support activities of public and private entities to save children from the disease.
42. Finally, we commit ourselves to a regular review of our work in the field of tackling these three pandemics.
43. We urgently call for mobilization of financial support and will continue to work collectively and with bilateral and multilateral donors to close the funding gap for 2007-2008, and will continue to work with others towards securing the resources necessary to finish the program and declare our planet polio-free in the near future.
44. The existing polio monitoring network is a valuable resource. We will work with other donors and stakeholders to maintain this network after polio has been eradicated, with a view to supporting other public health objectives, in particular those related to disease monitoring.
45. We will continue our support for the Measles Initiative launched in 2001 and will work towards a steady decrease in the number of measles-related deaths, progress in halting the spread of measles in regions and countries, and its eventual elimination.
46. We will assist the Global Measles Partnership and encourage the WHO to continue to implement its plans on measles prevention and elimination, as mandated by the World Health Assembly in 2004, and to propose measures donors and national governments should take to reach and maintain a high level of immunity to measles.
47. We agree to continue to support efforts by developing country partners, particularly in Africa, to ensure that initiatives to reduce the burden of disease are built on sustainable health systems.
51. Given the potential for the breakdown of public health services as a result of natural and man-made disasters, we support actions aimed at improving the preparedness and capacity of

healthcare systems to meet health challenges posed by emergencies, especially in developing countries.

52. We commit to strengthen existing networks aimed at mitigating health consequences of natural and man-made disasters, including through effective use of rapid response teams, where appropriate, and helping disaster-prone developing countries build their own capacities in this area.
212. We will work to support cross-sectoral approaches combining investments in education and other key areas such as poverty reduction, health and sanitation, water nutrition and infrastructure to achieve EFA goals, raising HIV/AIDS awareness in education systems. (Health).
310. We will seek to enhance international capacities to monitor and respond to outbreaks of infectious diseases through establishment of new laboratories and strengthening WHO Global Outbreak Alert and Response Network.
311. Aware of the threat posed by avian influenza, we will cooperate closely with each other and with relevant international organizations and other partners in preparing for a possible human influenza pandemic.
312. We reaffirmed our commitments to fight HIV/AIDS, tuberculosis and malaria and agreed to work further with other donors to mobilize resources for the Global Fund to Fight AIDS, Tuberculosis and Malaria and to continuing to pursue as closely as possible to universal access to HIV/AIDS treatment for those who need it by 2010.
313. We also resolved to support the Global Plan to Stop TB aimed to save up to 14 million lives by 2015 and to provide resources in cooperation with African countries to scale up action against malaria.
314. With the aim to monitor the progress in tackling these three major pandemics, we agreed to a regular review of our work in this field.
315. We will also continue to support the Global Polio Eradication Initiative so that the planet can be declared polio-free within the next few years.
316. We will further work through assistance programs focused on strengthening health care systems in developing countries.

2007 Heiligendamm, Germany (31)

225. The G8 countries will scale up their efforts to contributing towards the goal of universal access to comprehensive HIV/AIDS prevention programs, treatment and care and support by 2010 for all, and to developing and strengthening health systems so that health care, especially primary health care, can be provided on a sustainable and equitable basis in order to reduce illness and mortality, with particular attention paid to the needs of those most vulnerable to infection, including adolescent girls, women and children.
226. We recognize that meeting this goal of universal access as well as realizing the Millennium Development Goals for fighting HIV/AIDS, malaria and tuberculosis on a sustainable basis and strengthening of health systems will require substantial resources. We will continue our efforts towards these goals to provide at least a projected US\$ 60 billion over the coming years, and invite other donors to contribute as well.
227. We recognize that the level of demand to the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) will increase substantially in the future as has been projected by the GFATM Board. In this regard, noting the conclusions of the April meeting of the GFATM Board, which estimated an additional demand approximately of US\$ 6 billion by 2010 which might possibly reach US\$ 8 billion, G8 members pledge to work with other donors to replenish the GFATM and to provide long-term predictable funding based on ambitious, but realistic demand-driven targets.
228. G8 partners will work with other stakeholders so that Global Fund resources continue to be used in alignment with existing national priorities and processes.

229. Recognizing the growing feminization of the AIDS epidemic, the G8 in cooperation with partner governments support a gender-sensitive response by the GFATM, with the goal of ensuring that greater attention and appropriate resources are allocated by the Fund to HIV/AIDS prevention, treatment, and care that addresses the needs of women and girls.
230. In the overall context of scaling up towards the goal of universal access and strengthening of health systems we will contribute substantially with other donors to work towards the goal of providing universal coverage of PMTCT programs by 2010.
231. [The cost to reach this target, as estimated by UNICEF, is USD1.5 billion.] The G8 together with other donors will work towards meeting the needed resources for paediatric treatments in the context of universal access, at a cost of USD1.8 billion till 2010, estimated by UNICEF.
234. The G8 will support the nationwide inclusion of appropriate HIV/AIDS-related information and life-skills information in school curricula, in the context of nationally owned sector plans as well as prevention information with regard to malaria and other relevant health topics.
235. The G8 will support the nationwide inclusion of appropriate HIV/AIDS-related information and life-skills information in school curricula, in the context of nationally owned sector plans as well as prevention information with regard to malaria and other relevant health topics.
237. The G8 will take concrete steps to work toward improving the link between HIV/AIDS activities and sexual and reproductive health and voluntary family planning programs, to improve access to health care, including preventing mother-to-child transmission, and to achieve the Millennium Development Goals by adopting a multisectoral approach and by fostering community involvement and participation.
238. We are committed to working toward further integration of efforts against TB and HIV/AIDS and the integration of DOTS-treatment and other comprehensive approaches necessary to control TB in our programs and activities in order to alleviate the burden of the co-pandemic.
239. The G8 will make utmost efforts in cooperation with international organizations and partners to eradicate polio and will also work with others to close urgent funding shortfalls.
240. As a priority, the G8 are committed to expand significantly their efforts to contributing to meet the Millennium Development Goal of having halted and begun to reverse the scourge of malaria.
241. To this effect, we will work with African governments and donors to strengthen the effectiveness of their malaria control programs in Africa along the three main intervention lines of artemisinin combination therapy, effective case management, effective, tailored vector control strategies and bednets.
242. G8 members, in support of national malaria control programs, using existing and additional funds, will individually and collectively over the next few years work to enable the 30 highest malaria prevalence countries in Africa (contributing to at least 80 percent of the global malaria deaths) reach at least 85 percent coverage of the most vulnerable groups with effective prevention and treatment measures and achieve a 50 percent reduction in malaria related deaths.
244. We will support responding to those African countries that indicate that they require technical assistance and capacity building programmes for advancing their access to affordable, safe, effective and high quality generic and innovative medicines in a manner consistent with the WTO.
245. The G8 reiterate their support for the work of WHO including its prequalification program and for regulatory authorities to help assure the safety, efficacy, and quality of pharmaceutical drugs, including those produced locally, in particular for second-line antiretroviral treatment and for the newly developed more effective treatment for malaria.
246. The G8 reaffirm their commitment to scaling up towards “universal access” to comprehensive HIV prevention, treatment and care by 2010 and recognise the significant progress made by countries on target setting and planning, notably concerning enhanced availability of affordable antiretroviral treatment.
247. We will therefore work with UNAIDS, WHO, WB and the GF to strengthen their efforts and work together with the African Union and African States, the innovative and generic

- pharmaceutical industry, private donors, civil society and other relevant stakeholders to help deliver next steps towards “universal access”.
248. [In particular we will work with: African Governments] to strengthen and finance health systems and make them more efficient with constructive support of donors and the relevant international organizations such as WHO and World Bank.
 249. [In particular we will work with: African Governments] to contribute to the provision of affordable and quality medicines by eliminating or substantially reducing import tariffs and taxes with the aim to exempt price-reduced or subsidised medicines from these levies as soon as possible and examining logistics and governance issues that may hinder access.
 250. [In particular we will work with: African Governments] to strengthen procurement practices, ensuring accountability and transparency and to review the currently existing drug and device registration policies with the aim of facilitating timely access to safe, affordable and effective HIV/AIDS drugs and medical devices,
 251. [In particular we will work with: African Governments] to develop country-led policies that can ensure effective coordination of donor health programs and identify technical assistance needs, with the support of the WHO, World Bank, UNAIDS, GFATM and other agencies.
 252. [In particular we will work with: International Organizations and donors] to support country-led efforts to improve coordination between all relevant stakeholders to develop costed, inclusive, sustainable, credible and evidence-based national AIDS plans which ensure effective links to health system strengthening.
 256. [In particular we will work with: the Pharmaceutical Industry] to continue to explore further initiatives to provide enhanced access to HIV-medicines at affordable prices and to review price policies with regard to second-line antiretroviral drugs.
 257. [In particular we will work with: the Pharmaceutical Industry] to consider supporting local production of HIV/AIDS pharmaceuticals by voluntary licences and laboratory capacities that meet international standards and strengthen regulatory, certification and training institutes.
 259. As an important step to scaling up towards the goal of universal access to HIV/AIDS prevention, treatment, care and support in Africa, G8 members, in support of national HIV/AIDS programs globally, individually and collectively over the next few years will aim to employ existing and additional programs to support life-saving anti-retroviral treatment through bilateral and multilateral efforts for approximately five million people, to prevent twenty-four million new infections, and to care for twenty-four million people, including ten million orphans and vulnerable children.

2008 Hokkaido-Toyako, Japan (16)

17. We reiterate our support to our African partners’ commitment to ensure that by 2015 all children have access to basic health care (free wherever countries choose to provide this).
102. We will work together, and with other countries, in a complementary manner, to address global health priorities and deliver on existing health commitments.
111. G8 members are determined to honor in full their specific commitments to fight infectious diseases, namely malaria, tuberculosis, polio and working towards the goal of universal access to HIV/AIDS prevention, treatment and care by 2010.
112. Building on the Saint Petersburg commitments to fight infectious diseases, the experts’ report sets forth the ‘Toyako Framework for Action’, which includes the principles for action, and actions to be taken on health, drawing on the expertise of international institutions.
114. In view of sustainability we aim at ensuring that disease-specific and health systems approaches are mutually reinforcing.
115. [In view of sustainability we aim at ensuring that disease-specific and health systems approaches] contribute to achieving all of the health MDGs.
116. We emphasize the importance of comprehensive approaches to address the strengthening of health systems including social health protection, the improvement of maternal, newborn and

- child health, the scaling-up of programs to counter infectious diseases and access to essential medicines, vaccines and appropriate health-related products.
118. We reiterate our commitment to continue efforts, to work towards the goals of providing at least a projected US\$ 60 billion over 5 years, to fight infectious diseases and strengthen health.
 119. To achieve quantitative and qualitative improvement of the health workforce, we must work to help train a sufficient number of health workers, including community health workers and to assure an enabling environment for their effective retention in developing countries.
 120. The G8 members will work towards increasing health workforce coverage towards the WHO threshold of 2.3 health workers per 1000 people, initially in partnership with the African countries where we are currently engaged and that are experiencing a critical shortage of health workers.
 121. We will also support efforts by partner countries and relevant stakeholders, such as Global Health Workforce Alliance, in developing robust health workforce plans and establishing specific, country-led milestones as well as for enhanced monitoring and evaluation, especially for formulating effective health policies.
 122. We note that in some developing countries, achieving the MDGs on child mortality and maternal health is seriously off-track, and therefore, in country-led plans, the continuum of prevention and care, including nutrition should include a greater focus on maternal, new born and child health.
 124. The G8 will take concrete steps to work toward improving the link between HIV/AIDS activities and sexual and reproductive health and voluntary family planning programs, to improve access to health care, including preventing mother-to-child transmission, and to achieve the MDGs by adopting a multisectoral approach and by fostering community involvement and participation.
 125. As part of fulfilling our past commitments on malaria, we will continue to expand access to long-lasting insecticide treated nets, with a view to providing 100 million nets through bilateral and multilateral assistance, in partnership with other stakeholders by the end of 2010.
 126. To maintain momentum towards the historical achievement of eradicating polio, we will meet our previous commitments to maintain or increase financial contributions to support the Global Polio Eradication Initiative, and encourage other public and private donors to do the same.
 127. To build on our commitments made on neglected tropical diseases at St Petersburg, we will work to support the control or elimination of diseases listed by the WHO through such measures as research, diagnostics and treatment, prevention, awareness-raising and enhancing access to safe water and sanitation. In this regard, by expanding health system coverage, alleviating poverty and social exclusion as well as promoting adequate integrated public health approaches, including through the mass administration of drugs, we will be able to reach at least 75% of the people affected by certain major neglected tropical diseases in the most affected countries in Africa, Asia, and Latin America, bearing in mind the WHO Plan. With sustained action for 3-5 years, this would enable a very significant reduction of the current burden with the elimination of some of these diseases.

2009 L'Aquila, Italy (7)

147. We reaffirm our commitment to address the scarcity of health workers in developing countries, especially in Africa and we note the 2008 Kampala Declaration and the Agenda for Global Actions launched by the Global Health Workforce Alliance.
148. We will also begin to address substantial gaps in knowledge about how to manage, organize and deliver health care in Sub-Saharan Africa through a variety of strategies, including by developing networks of researchers and by working with our African partners to establish a consortium of interdisciplinary centres of health innovation.
149. As an enabling first step in developing the consortium, we will convene a planning meeting in late 2009 with African partners to establish a roadmap.

152. We will implement further efforts towards universal access to HIV/AIDS prevention, treatment, care and support by 2010, with particular focus on prevention and integration of services for HIV/TB.
153. We will combine this with actions to: combat TB and Malaria; address the spread of Neglected Tropical Diseases and work towards completing the task of polio eradication; improve monitoring of emerging infectious diseases.
154. We commit to counter any form of stigma, discrimination and human rights violation and to promote the rights of persons with disabilities and the elimination of travel restrictions on people living with HIV/AIDS.
155. We reaffirm our existing commitments, including the US\$ 60 billion investment to fight infectious diseases and strengthen health system by 2012.

2010 Muskoka, Canada (6)

7. We reaffirm our strong support to significantly reduce the number of maternal, newborn and under five child deaths as a matter of immediate humanitarian and development concern.
14. We reaffirm our commitment to come as close as possible to universal access to prevention, treatment, care and support with respect to HIV/AIDS.
15. We will support country-led efforts to achieve this objective by making the third voluntary replenishment conference of the Global Fund to Fight AIDS, TB and Malaria in October 2010 a success.
16. We commit to promote integration of HIV and sexual and reproductive health, rights and services within the broader context of strengthening health systems.
17. G8 donors also remain steadfast in their support for polio eradication and remain committed to a polio-free world.
18. We continue to support the control or elimination of high-burden Neglected Tropical Diseases (NTDs).

2011 Deauville, France (4)

62. We will continue to support the Global Fund to Fight AIDS, Tuberculosis and Malaria.
66. We stress our continuing commitment to the eradication of polio which is a reachable objective.
67. We will continue to support the Global Polio Eradication Initiative.
68. We will work, together with major bilateral donors, global health programmes and country coordination initiatives, to improve these funds' implementation of aid effectiveness.

2012 Camp David, United States (0)

No references.

2013 Lough Erne, Northern Ireland, United Kingdom (2)

23. We will accelerate efforts to tackle the under-nutrition that blights millions of lives.
136. We will build on the achievements of the US G8 Presidency by advancing action in four areas: Deepening impact - by ensuring that investments have a measurable impact on [malnutrition, particularly for smallholders and women, and are made responsibly and support the sustainable use of natural resources].

2014 Brussels, Belgium (9)

94. We reaffirm our commitment to an AIDS free generation.
95. [We reaffirm our commitment to] the Global Fund to fight AIDS, Tuberculosis and Malaria to reduce the burden of these three major infectious diseases on eligible countries and regions.
96. [We reaffirm our commitment to] the Global Fund to fight AIDS, Tuberculosis and Malaria to reduce the burden of these three major infectious diseases on eligible countries and regions.

97. [To address the threat posed by infectious diseases, we] commit to working with partner countries to strengthen compliance with the World Health Organisation's (WHO) International Health Regulations [International Law: IHR]
98. [To address the threat posed by infectious diseases, we commit to working with partner countries to] enhance health security around the world.
99. We commit to working across sectors to prevent [infectious diseases, whether naturally occurring, accidental, or the result of a deliberate act by a state or non-state actor].
100. [We commit to working across sectors to] detect [infectious diseases, whether naturally occurring, accidental, or the result of a deliberate act by a state or non-state actor].
101. [We commit to working across sectors to] respond to infectious diseases, whether naturally occurring, accidental, or the result of a deliberate act by a state or non-state actor.
102. [We commit to] building global capacity so that we are better prepared for threats such as the recent Ebola outbreak in West Africa.

2015 Elmau, Germany (35)

145. We commit to preventing future outbreaks from becoming epidemics by assisting countries to implement the World Health Organization's International Health Regulations (IHR), including through Global Health Security Agenda and its common targets and other multilateral initiatives. [International Law: IHR]
146. We will offer to assist at least 60 countries, including the countries of West Africa, over the next five years, building on countries' expertise and existing partnerships.
147. We are strongly committed to getting the Ebola cases down to zero.
148. We support the ongoing process to reform and strengthen the WHO's capacity to prepare for and respond to complex health crises while reaffirming the central role of the WHO for international health security.
149. We will coordinate to fight future epidemics.
150. [We] will set up or strengthen mechanisms for rapid deployment of multidisciplinary teams of experts coordinated through a common platform.
151. We will implement those mechanisms in close cooperation with the WHO and national authorities of affected countries.
152. We will develop or review [our national action plans].
153. [We will] effectively implement our national action plans.
154. [We will] support other countries as they develop their own national action plans.
155. We will foster the prudent use of antibiotics.
156. [We] will engage in stimulating basic research.
157. [We will engage in] research on epidemiology.
158. [We will engage in] infection prevention.
159. [We will engage in infection] control.
160. [We will engage in] the development of new antibiotics.
161. [We will engage in the development of] alternative therapies.
162. [We will engage in the development of] vaccines.
163. [We will engage in the development of] vaccines.
166. We commit ourselves to the fight against neglected tropical diseases (NTDs).
167. We will work collaboratively with key partners, including the WHO Global Observatory on Health Research and Development.
168. We will contribute to coordinating research and development (R&D) efforts.
169. [We will] make our data available.
170. We will build on efforts to map current R&D activities, which will help facilitate improved coordination in R&D and contribute to better addressing the issue of NTDs.
171. We commit to supporting NTD-related research, focusing notably on areas of most urgent need.
172. We will stimulate both basic research on prevention.

173. [We will stimulate both basic research on] control.
174. [We will stimulate both basic research on] treatment.
175. [We will stimulate] research focused on faster and targeted development of easily usable and affordable drugs.
176. [We will stimulate research focused on faster and targeted development of easily usable and affordable] vaccines.
177. [We will stimulate] research focused on faster and targeted development of easily usable and affordable point-of-care technologies.
178. As part of our health system strengthening efforts we will continue to advocate accessible, affordable, quality and essential health services for all.
179. We will invest in the prevention [of NTDs in order to achieve 2020 elimination goals].
180. [We will invest in the] control of NTDs in order to achieve 2020 elimination goals.
325. [We remain strongly committed to the eradication of] malnutrition.

2016 Ise-Shima, Japan (27)

70. Reinforcing of the Global Health Architecture to strengthen response to public health emergencies Recognizing the Ebola outbreak turned into a major epidemic partly due to the lack of swift and coordinated actions among relevant stakeholders, we commit to take leadership in reinforcing the Global Health Architecture, relying on strengthening existing organizations
71. We reaffirm the WHO's central role in that architecture to enable and support more swift, effective and coordinated responses to public health emergencies.
72. In this light, we urge and support the WHO to implement its emergency and wider reforms, including its One WHO approach across the three levels of the Organization, namely its headquarters, regional and country offices, in a timely manner, recognizing its resource needs.
73. [Recent outbreaks of Ebola and Zika underscore the imperative to improve prevention of, detection of and response to public health emergencies, whether naturally occurring, deliberate or accidental.] In that respect, we remain committed to advancing compliance with the WHO's IHR objectives including through the Global Health Security Agenda (GHSA). [International Law: IHR]
74. [Recent outbreaks of Ebola and Zika underscore the imperative to improve prevention of, detection of and response to public health emergencies, whether naturally occurring, deliberate or accidental] In that respect, we remain committed to advancing compliance with the WHO's IHR objectives including through the Global Health Security Agenda (GHSA). [International Law: IHR]
79. Meanwhile, taking into consideration the pressing need for HSS in Low Income Countries (LICs) and Lower Middle Income Countries (LMICs) where health systems are especially weak, we are also committed to support country-led HSS in collaboration with relevant partners including the WHO.
80. We are committed to ending AIDS, tuberculosis and malaria, working in partnership with the Global Fund (GF) and others.
196. At the G7 Ise-Shima Summit, we, the G7 leaders, commit to take the following concrete actions for advancing global health. Reinforcing the Global Health Architecture to strengthen responses to public health emergencies -WHO reform for outbreaks and public health emergencies.
197. In addition to its wider reform agenda, urge and support the WHO to implement its reforms for outbreaks and health emergencies, in a timely manner, recognizing also its resource needs, with the understanding that the WHO should continue to play the central role in global public health crisis preparedness and response.
205. [Continue to encourage and support the earliest possible establishment of the partnership in consultation with countries] to leverage support for health system strengthening in the most vulnerable countries.

206. Reaffirm our commitment to the SDGs, to leave no one behind, and to ensure equity by focusing on the needs of vulnerable segments of society, including the poorest and most marginalized populations.
207. With this in mind and recognizing the pressing need for strong, resilient and sustainable health systems in Low Income Countries(LICs) and Lower Middle Income Countries(LMICs) with limited resources and increased vulnerability to public health threats such as epidemic and other severe events, commit to support country-led HSS with greater use of enhanced coordination of country-level actions toward HSS, based on the IHP+ principles, including through the Country Coordination Mechanism of the Global Fund, as well as the GHSA.
208. Support LICs/LMICs's nationally driven and owned efforts toward HSS which might include the following key contributors for the achievement of UHC with better preparedness for and prevention against emergencies; (i) helping the development/adjustment of medium-term national health plans.
209. [Support LICs/LMICs's nationally driven and owned efforts toward HSS which might include the following key contributors for the achievement of UHC with better preparedness for and prevention against emergencies] (ii) strengthening policy making and management capacity for disease prevention and health promotion.
210. [Support LICs/LMICs's nationally driven and owned efforts toward HSS which might include the following key contributors for the achievement of UHC with better preparedness for and prevention against emergencies] (iii) improving access to affordable, safe, effective, and quality assured, essential medicines, vaccines and technologies to prevent, diagnose and treat medical problems.
211. [Support LICs/LMICs's nationally driven and owned efforts toward HSS which might include the following key contributors for the achievement of UHC with better preparedness for and prevention against emergencies] (iv) building a sufficient capacity of motivated and adequately trained health workers.
212. [Support LICs/LMICs's nationally driven and owned efforts toward HSS which might include the following key contributors for the achievement of UHC with better preparedness for and prevention against emergencies] (v) improving and strengthening the quality and use of health statistics and information systems including civil registration and vital statistics;
213. [Support LICs/LMICs's nationally driven and owned efforts toward HSS which might include the following key contributors for the achievement of UHC with better preparedness for and prevention against emergencies] (vi) promoting access to health services and providing technical support to design health financing strategies to provide financial protection against catastrophic out-of-pocket health expenditures, particularly among the poor.
214. [Support LICs/LMICs's nationally driven and owned efforts toward HSS which might include the following key contributors for the achievement of UHC with better preparedness for and prevention against emergencies] (vii) assisting LICs/LMICs' mobilization of their domestic resources, through both public and private sectors, and more efficient health spending as a backbone of sustainable national health system.
215. [Support LICs/LMICs's nationally driven and owned efforts toward HSS which might include the following key contributors for the achievement of UHC with better preparedness for and prevention against emergencies] (viii) monitoring progress towards UHC with measurable indicators and share best practices.
222. [Recognizing the value of taking needs-based responses to health issues for women of all ages, including newborns, children, adolescents, as well as those in fragile and conflict-affected states and humanitarian settings, commit to:] (iii) strengthening the cooperation among the G7's relevant organizations, making the most of their disaster response experiences and drawing upon the Sendai Framework on Disaster Risk Reduction 2015-2030.
223. Reaffirm the importance of immunization as one of key cost-effective measures to prevent the spread of infectious disease and address emerging pandemics and to this end: (i) continue global efforts to achieve the targets established in the Global Vaccine Action Plan.

225. [Reaffirm the importance of immunization as one of key cost-effective measures to prevent the spread of infectious disease and address emerging pandemics and to this end:] (iii) recognize the tremendous progress achieved towards polio eradication where global eradication is now within reach, and reaffirm our commitment to achieve polio eradication targets laid out in the GPEI Endgame Strategic Plan, and recognize the significant contribution that the polio related assets, resources and infrastructure will have on strengthening health systems and advancing UHC.
228. Work together with WHO and other relevant international actors in the global efforts to prevent the spread and reduce the impact of Zika virus, taking account scientific consensus that Zika is a cause of microcephaly and other severe fetal brain defects in newborns and is associated with an increase in Guillain-Barre syndrome and other neurological disorders.
229. Support the work of global partnerships such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, Gavi the Vaccine Alliance, the Global Alliance for Chronic Diseases, and UHC 2030 building upon IHP+, as well as global initiatives such as the implementation of the Global Strategy for Women’s, Children’s and Adolescents’ Health and the GFF as appropriate.
247. Support Infection Prevention and Control such as good hygiene - in particular but not only in LICs and LMICs to reduce healthcare - associated infections and health burden of AMR through appropriate training and technologies, and bilateral or multilateral arrangement.
257. Explore the feasibility of partnerships such as the Vaccine Innovation for Pandemic Preparedness Partnership to conduct a coordinated vaccine research and development.

2017 Taormina, Italy (2)

71. [We remain committed to strengthening] preparedness for public health emergencies and long-term challenges.
72. [We remain committed to strengthening] a prompt, effective and coordinated response to public health emergencies and long-term challenges.

2018 Charlevoix, Canada (3)

24. We will accelerate our efforts to end tuberculosis, and its resistant forms.
25. We reconfirm our resolve to work with partners to eradicate polio and effectively manage the post-polio transition.
26. We affirm our support for a successful replenishment of the Global Fund in 2019.

2019 Biarritz, France (1)

24. We reaffirm our commitment to end the epidemics of AIDS, tuberculosis and malaria.

16 March 2020 G7 Leaders’ Statement

We fully support the World Health Organization in its global mandate to lead on disease outbreaks and emergencies with health consequences, leaving no geographical vacuum.²

² Tentatively drafted by the Director of Compliance for the G7 Research Group.