

Health, food and nutrition

In 2014, the United Nations continued to promote health, food security and nutrition worldwide. In response to the outbreak of the Ebola virus disease in West Africa, which on 8 August the World Health Organization (WHO) declared a public health emergency of international concern, the Secretary-General appointed the United Nations System Senior Coordinator for Ebola Virus Disease as well as the Deputy Ebola Coordinator and Operation Crisis Manager and announced the formation of the Global Ebola Response Coalition to ensure integrated support to affected countries, while helping prevent the spread of the disease to other countries. The Security Council then convened in September an emergency session on the public health crisis. By resolution 2177(2014), the Council declared the Ebola outbreak a threat to international peace and security and called on Member States and UN entities to respond urgently. In turn, by resolution 69/1, the General Assembly addressed measures to contain and combat the Ebola outbreak. The international response to contain the outbreak, treat the infected, ensure essential services and preserve stability was coordinated by the newly established United Nations Mission for Ebola Emergency Response and the Office of the Special Envoy on Ebola.

In the area of HIV/AIDS, data from the Joint United Nations Programme on HIV/AIDS (UNAIDS) indicated that there had been a decline in new infections globally from 3.4 million in 2001 to 2.1 million in 2013, a decrease of 38 per cent. AIDS-related deaths had decreased by 35 per cent over the past eight years (from a peak of 2.3 million in 2005 to 1.5 million in 2013). In spite of those gains, HIV/AIDS remained a serious challenge. In some regions, new infections continued to rise and AIDS-related deaths continued unabated. UNAIDS urged the international community to prioritize HIV/AIDS in the post-2015 development agenda and aim at ambitious targets.

According to WHO, non-communicable diseases (NCDs) were the leading cause of death and disability worldwide, and progress in combating them remained uneven between developed and developing countries. Eighty per cent of NCD fatalities occurred in developing countries, largely due to inadequate technical capacity and financial resources within those countries.

In April, the United Nations Children's Fund and the World Bank convened the third high-level

meeting of the Sanitation and Water for All global partnership, at which 55 countries, donors and banks made more than 370 new specific commitments towards ensuring adequate water and sanitation for all. As malaria remained a serious global health challenge, WHO rolled out a new global malaria strategy that set new targets in alignment with the post-2015 development agenda. As at the end of 2014, 179 States and the European Union had become parties to the WHO Framework Convention on Tobacco Control, of which 80 per cent had adopted or strengthened tobacco control legislation after ratifying the Convention.

Complex emergencies caused by conflicts and large-scale population displacement continued to have serious implications for food security. The World Food Programme (WFP) concurrently responded to six Level 2 and six Level 3 emergencies, including severe and complex emergencies in the Central African Republic, Iraq, South Sudan and Syria. In total, WFP provided food assistance for 80 million people in 82 countries, most of them women and children. The Programme received its highest-ever level of voluntary contributions, totaling \$5.38 billion, 79 per cent of which was directed to emergencies.

According to the Food and Agriculture Organization of the United Nations (FAO), during the period 2012–14, 805 million people worldwide were chronically undernourished—209 million fewer than in the period 1990–1992. The Millennium Development Goals hunger target of halving the proportion of undernourished people in developing countries by 2015 was within reach; however, the developing world was not on track to achieve the World Food Summit target of halving the number of undernourished people by 2015. Thirty-three countries—26 in Africa and 7 in Asia—remained in need of food assistance owing to conflict, crop failures, high domestic food prices or a combination of those factors.

The Second International Conference on Nutrition, organized by FAO and WHO, resulted in the Rome Declaration on Nutrition committing world leaders to establish national policies for eradicating malnutrition in all its forms and transforming food systems so as to make nutritious diets available to all.

The year 2014 was the International Year of Family Farming, which focused global attention on the significant role of family and smallholder farming in ensuring food security and poverty alleviation.

Health

AIDS prevention and control

Implementation of Declaration of Commitment and Political Declaration

Report of Secretary-General. In April, the Secretary-General submitted a report [A/68/825] to the General Assembly on progress made towards achieving the 2015 targets outlined in the 2011 Political Declaration on HIV/AIDS [YUN 2011, p. 1135]. He noted that new HIV infections and AIDS-related deaths globally were declining. The estimated number of new HIV infections globally dropped from 3.4 million in 2001 to 2.3 million in 2012—a decline of 33 per cent—while the annual number of AIDS-related deaths dropped from 2.3 million in 2005 to 1.6 million in 2012—a decline of 30 per cent. The number of children newly infected with HIV in 2012 was 260,000—a 52 per cent drop compared to 2001 and a 35 per cent drop over the preceding three years. In an encouraging sign of the sustainability of the AIDS response, many Governments, including those in low- and middle-income countries, were taking steps to increase domestic public sector financing for HIV-related activities.

Those positive global trends notwithstanding, not all regions and population groups reported progress. New HIV infections continued to increase in Eastern Europe, Central Asia, the Middle East and North Africa, while the pace of AIDS-related deaths in those regions continued unabated. As at December 2012, an estimated 35.3 million people worldwide were living with HIV. Of the 35.3 million cases, 25.1 million, or 71 per cent, were in sub-Saharan Africa, as were 70 per cent of the cases of new HIV global infections and 75 per cent of AIDS-related global deaths. Women comprised 50 per cent of people living with HIV worldwide, and an estimated 58 per cent in sub-Saharan Africa. Outside sub-Saharan Africa, the largest concentration of people living with HIV was in the Asia-Pacific region with 4.8 million people, of whom 36 per cent were women.

Progress in the HIV response effort continued to be held back by the limited availability of antiretroviral drugs in many regions, as well as by HIV-related stigma, discrimination, and punitive laws and practices. As at December 2012, lifesaving antiretroviral treatment had reached only about one in three eligible people worldwide. Access to HIV treatment remained extremely low in Eastern Europe, Central Asia, the Middle East and North Africa, and was also notably lower in West and Central Africa compared to Eastern and Southern Africa. Children were roughly half as likely as adults to obtain antiretroviral therapy, while HIV-related mortality rates among adolescents increased by 50 per cent since 2005. Surveys conducted in 35 countries through

the People Living with HIV Stigma Index indicated that discriminatory behaviour towards people living with HIV remained relatively common. Punitive legal frameworks also continued to undermine effective action to address the HIV-related needs of key populations. In 2013, 63 countries maintained HIV-specific provisions that allowed for the prosecution of HIV non-disclosure, exposure and/or transmission. Most countries retained laws that criminalized some aspect of sex work, and in some regions, introduced new punitive laws that further criminalized and/or limited the freedom of association and expression of the lesbian, gay, bisexual and transgender populations.

The Secretary-General recommended that Governments, civil society, international donors, the UN system and other key partners implement a series of joint actions to enhance the AIDS response effort. He highlighted the need to expedite progress towards the 2015 targets; ensure equitable and non-discriminatory access to HIV services for all persons; end punitive laws and law enforcement that acted as barriers to health and HIV services and replace them with protective ones; develop new, ambitious targets to end the AIDS epidemic; and integrate the HIV response as a development priority in the post-2015 agenda (see p. 960).

On 30 June (**decision 68/555**), the General Assembly took note of the report of the Secretary-General and the recommendations contained therein as input for consideration in the discussions on formulating the post-2015 development agenda. It decided to convene a high-level meeting on HIV/AIDS in 2016, preferably in the second half of the year, and to undertake the necessary consultations to determine the modalities and organizational arrangements for such a meeting during its seventieth session, but no later than December 2015. On 29 December (**decision 69/554**), the Assembly decided that the item entitled “Implementation of the Declaration of Commitment on HIV/AIDS and the Political Declarations on HIV/AIDS” would remain for consideration during its resumed sixty-ninth (2015) session.

Joint UN Programme on HIV/AIDS

The Joint United Nations Programme on HIV/AIDS (UNAIDS)—the main advocate for global action on HIV/AIDS—had eleven co-sponsors in 2014: the International Labour Organization, the United Nations Development Programme (UNDP), the United Nations Educational, Scientific and Cultural Organization, the United Nations Population Fund (UNFPA), the Office of the United Nations High Commissioner for Refugees (UNHCR), the United Nations Children’s Fund, the United Nations Office on Drugs and Crime, the United Nations Entity for Gender Equality and the Empowerment of Women, the World Food Programme (WFP), the World Health Organization (WHO) and the World Bank.

Programme Coordinating Board

The UNAIDS Programme Coordinating Board (PCB), at its thirty-fourth and thirty-fifth meetings (Geneva, 1–3 July and 9–11 December) [UNAIDS/PCB (33)/13.23; UNAIDS/PCB (34)/14.16.rev.1], considered the report of its Executive Director; the report of the chair of the Committee of Cosponsoring Organizations; and the performance and financial reports for 2012–2013.

At the thirty-fourth meeting, the Executive Director summarized the latest UNAIDS data as featured in the *Global report: UNAIDS report on the global AIDS epidemic 2013*. The data indicated that worldwide there had been a 33 per cent decrease in new HIV infections since 2001, a 30 per cent decrease in AIDS-related mortality since 2005, and a 52 per cent decline in new HIV infections among children since 2001. More than 9.7 million people were accessing HIV treatment at the end of 2012. Significant challenges remained, however: only one out of every three children had access to HIV treatment; just 24 per cent of people living with HIV in sub-Saharan Africa had an undetectable viral load; 50 young women worldwide were infected with HIV every hour; and new infections were on the rise in several regions and countries. The Board further considered, inter alia, an update on the AIDS response in the post-2015 development agenda [UNAIDS/PCB (34)/14.4] and the issue of HIV, adolescents and youth [UNAIDS/PCB (34)/14.5]. At that same meeting, the Board confirmed Australia as Chair and elected Zimbabwe as Vice Chair for the period of 1 January to 31 December 2014. The Board also requested UNAIDS to intensify its coordinated technical support to Governments, civil society and key populations, and to report to the thirty-fifth PCB meeting on concrete actions taken to reduce stigma and discrimination in all its forms, consistent with the United Nations High Level Political Declarations of 2006 [YUN 2006, p. 1411] and 2011 [YUN 2011, p. 1135], as well as the UNAIDS 2011–2015 Strategy: Getting to Zero [YUN 2010, p. 1222].

At the thirty-fifth meeting, the Executive Director reported that notable gains had been made towards the vision of zero HIV/AIDS discrimination and other goals, but that key challenges remained. He highlighted the urgent need to transform HIV/AIDS data collection and analysis processes, and to address the social, political and economic drivers of HIV. Having taken note of the report of the Executive Director, the Board further considered, inter alia, an update on the AIDS response in the post-2015 development agenda [UNAIDS/PCB (35)/14.20] and the issues of universal access [UNAIDS/PCB (35)/14.22]; paediatric HIV treatment, care and support [UNAIDS/PCB (35)/14.23]; and actions to reduce stigma and discrimination [UNAIDS/PCB (35)/14.24 rev.1]. The Board requested UNAIDS to develop the next phase AIDS strategy beginning in 2018, and to hold, before the end of 2014, a financing dialogue to ensure predictable and sustained funding. The Board also took

note of the Report of the Chair of the Committee of Cosponsoring Organizations and its emphasis on responding to HIV among people who injected drugs in Eastern Europe, Central Asia and other regions, as well as on the Committee's partnerships with civil society.

In July, UNDP and UNFPA submitted a joint report [DP/2014/24-DP/FPA/2014/16 & Corr.1] (see p. 1218) that addressed the implementation of decisions and recommendations of the thirty-second and thirty-third PCB meetings that had been held in June and December 2013.

Gap report

In July, UNAIDS released the *Gap report* containing the latest HIV/AIDS data and serving as a follow-up to the 2013 UNAIDS *Global report*. According to the *Gap report*, there were 2.1 million new HIV infections worldwide in 2013—a decline of 38 per cent from the 2001 figure of 3.4 million. In the preceding three years alone, new HIV infections had dropped by 13 per cent. The number of children newly infected with HIV in 2013 stood at 240,000—a 58 per cent decrease from the 2002 peak of 580,000 children. Access to antiretroviral medicines for pregnant women living with HIV had averted more than 900,000 new HIV infections among children since 2009. Globally, there had been a decline in HIV/AIDS related deaths: in 2013, there were 1.5 million deaths—a decrease of 35 per cent from the 2005 peak—and in the preceding three years alone, AIDS-related deaths had fallen by 19 per cent. UNAIDS estimated that \$19.1 billion was invested in the AIDS response in low- and middle-income countries in 2013, an increase of about \$250 million over the amounts invested in 2012. The increase was largely driven by domestic investments by countries themselves after international HIV/AIDS assistance had flattened in the preceding years.

The *Gap report* highlighted several opportunities to address challenges and potentially turn the tide of the AIDS epidemic. New HIV infections continued to rise in some regions; fifteen countries accounted for more than 75 per cent of the 2.1 million new HIV infections that occurred in 2013. Many of those countries were in Eastern Europe and Central Asia, where 0.6 per cent of adults were living with HIV; the Middle East and North Africa, where new infections had increased by 31 per cent since 2001; and Western Europe and North America, where new infections had increased by 6 per cent over that same period. Twenty-two million people, or three in five people living with HIV, were still not accessing antiretroviral therapy.

In order to achieve the 2015 global AIDS targets, UNAIDS recommended identifying and addressing HIV/AIDS medicine stock-outs in real time; tracking HIV treatment policy implementation; and projecting future trends to identify countries that were not on track. The report also outlined eight action points for ending the AIDS epidemic, including protecting human

rights; investing in communities; focusing on local epidemics and populations; decentralizing delivery of HIV services; expanding the choices for HIV prevention and treatment; integrating HIV programmes with other health and development programmes; and innovating and investing in science for a cure and a vaccine.

Non-communicable diseases

Prevention and control of non-communicable diseases

Inter-Agency Task Force. On 7 April, in response to General Assembly resolution 66/2 [YUN 2011, p. 1146] and Economic and Social Council resolution 2013/12 [YUN 2013, p. 1174], the Secretary-General submitted to the Council a report [E/2014/55] by the WHO Director General on progress achieved since July 2013 by the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases (NCDs), as proposed in an earlier report of the Director General [ibid.]. Annexed thereto was the report of the first meeting (Geneva, 2–3 October 2013) of the Task Force to develop draft terms of reference for consideration by Member States at a formal meeting convened by WHO (Geneva, 13–14 November 2013), including a division of tasks and responsibilities for UN funds, programmes and agencies and other international organizations.

At its second meeting on 29 and 30 January 2014, the Task Force designed a joint work plan for the 2014–2015 period to ensure policy coherence and accountability among UN organizations in their implementation of the WHO Global Action Plan for NCDs 2013–2020 [YUN 2013, p. 1174]. The Director General recommended that the Council continue to encourage Member States to implement the Global Action Plan; and that the Council adopt the Inter-Agency Task Force Terms of Reference, taking into account the recommendations of the 134th WHO Executive Board session and the sixty-seventh World Health Assembly (see p. 1366).

GENERAL ASSEMBLY ACTION

On 13 May [meeting 85], the General Assembly adopted **resolution 68/271** [draft: A/68/L.45] without vote [agenda item 118].

Scope and modalities of the comprehensive review and assessment of the progress achieved in the prevention and control of non-communicable diseases

The General Assembly,

Recalling the political declaration of the high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, and in particular paragraph 65, by which it decided to hold a comprehensive review and assessment in 2014 of the progress achieved in the prevention and control of non-communicable diseases,

Recognizing the continued negative impact of non-communicable diseases, including the socioeconomic and

development challenges faced by all countries, in particular low- and middle-income countries, and the need for continued concerted action and a coordinated response, including monitoring of the progress at the national, regional and global levels,

Mindful of the need to maintain strong national, regional and international political commitment towards the prevention and control of non-communicable diseases,

Taking note of the note by the Secretary-General transmitting the report of the Director General of the World Health Organization on the prevention and control of non-communicable diseases,

1. *Decides* to convene a high-level meeting to undertake the comprehensive review and assessment on 10 and 11 July 2014, consisting of an opening plenary meeting on 10 July from 10 a.m. to 11 a.m., followed by plenary meetings from 11 a.m. to 1 p.m. and from 3 p.m. to 6 p.m., and two consecutive round tables on 11 July from 10 a.m. to 1 p.m. and from 3 p.m. to 5 p.m., followed by a closing plenary meeting from 5 p.m. to 6 p.m.;

2. *Also decides* that the comprehensive review and assessment shall take stock of the progress made in implementing the commitments in the political declaration of the high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, identify and address gaps and reaffirm the political commitment in response to the challenge of non-communicable diseases;

3. *Further decides* that the speakers at the opening plenary meeting will be the President of the General Assembly, the Secretary-General, the Director General of the World Health Organization, the Administrator of the United Nations Development Programme and a representative of civil society who will be chosen by the President of the Assembly from among non-governmental organizations in consultative status with the Economic and Social Council and in consultation with Member States;

4. *Decides* that the overall theme of the review will be “Taking stock of progress in implementing the political declaration of the high-level meeting of the General Assembly on the prevention and control of non-communicable diseases and scaling up multi-stakeholder and national multisectoral responses to the prevention and control of non-communicable diseases, including in the context of the post-2015 development agenda”;

5. *Also decides* that the organizational arrangements for the round tables will be as follows:

(a) The specific themes of the round tables will be:

(i) Round table 1: “Strengthening national and regional capacities, including health systems, and effective multisectoral and whole-of-government responses for the prevention and control, including monitoring, of non-communicable diseases”;

(ii) Round table 2: “Fostering and strengthening national, regional and international partnerships and cooperation in support of efforts to address non-communicable diseases”;

(b) Each round table will be co-chaired at the ministerial or high official level, with the co-chairs to be appointed by the President of the General Assembly;

(c) Participation in each round table will include Member States, observers and representatives of entities of the United Nations system, civil society and non-governmental organizations, academic institutions and the private sector;

(d) In order to promote interactive and substantive discussions, there will be no pre-established list of speakers for the round tables;

6. *Requests* the President of the General Assembly to draw up a list of non-governmental organizations in consultative status with the Economic and Social Council that may participate in the high-level meeting, including the round tables;

7. *Also requests* the President of the General Assembly to draw up a list of representatives of other relevant non-governmental organizations, civil society organizations, academic institutions and the private sector who may participate in the round tables, taking into account the principle of transparency and the principle of equitable geographic representation, and to submit the proposed list to Member States for their consideration on a non-objection basis and bring the list to the attention of the Assembly;

8. *Decides* that the closing plenary meeting will comprise the presentation of summaries of the round tables and the adoption of a concise, focused, action-oriented outcome document, requests the President of the General Assembly to produce a draft text and to convene informal consultations as appropriate in order to enable sufficient consideration and agreement by Member States, and also requests the President of the Assembly to appoint, as soon as possible, two co-facilitators for the consultation process;

9. *Notes* the ongoing regional multi-stakeholder consultations of the World Health Organization, regional commissions and other relevant agencies and their contributions to the preparations for the high-level meeting as well as to the meeting itself;

10. *Requests* the President of the General Assembly to organize, no later than June 2014, in consultation with representatives of non-governmental organizations in consultative status with the Economic and Social Council, civil society organizations, the private sector and academia, an informal interactive hearing with non-governmental organizations, civil society organizations, the private sector and academia to provide input to the comprehensive review and assessment;

11. *Also requests* the President of the General Assembly, in consultation with Member States, to finalize the organizational arrangements for the review, including the list of speakers for the plenary meetings to be held on 10 July 2014, the identification of the civil society representative to speak at the opening plenary meeting, and the assignment of participants to the round tables, taking into account the level of representation as well as equitable geographical representation.

ECONOMIC AND SOCIAL COUNCIL ACTION

On 13 June [meeting 24], the Economic and Social Council adopted **resolution 2014/10** [draft: E/2014/L.13] without vote [agenda item 10 (f)].

United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases

The Economic and Social Council,

Recalling its resolution 2013/12 of 22 July 2013 on the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases,

Taking note of General Assembly resolution 68/271 of 13 May 2014 on the scope and modalities of the

comprehensive review and assessment of the progress achieved in the prevention and control of non-communicable diseases to be held on 10 and 11 July 2014,

Having considered the note by the Secretary-General transmitting the report of the Director-General of the World Health Organization on the Task Force,

Acknowledging that the global burden and threat of non-communicable diseases, principally cardiovascular diseases, cancer, chronic respiratory diseases and diabetes, which are linked to four main risk factors, namely, tobacco use, harmful use of alcohol, an unhealthy diet and lack of physical activity, as well as the global burden of mental health issues constitute major challenges for the economic and social development of many Member States and may lead to increasing inequalities within and between countries and populations,

1. *Takes note* of the report of the World Health Organization formal meeting of Member States to complete the work on the terms of reference for the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases, and the recommendation of the World Health Assembly to submit the proposed terms of reference to the Economic and Social Council;

2. *Endorses* the terms of reference for the Task Force, including a division of tasks and responsibilities for United Nations funds, programmes and agencies and other international organizations, as contained in the appendix to the above-mentioned report of the Director-General of the World Health Organization;

3. *Requests* the Secretary-General to report to the Council at its 2015 session on the implementation of its resolution 2013/12, and in this regard decides that, under the agenda item entitled "Coordination, programme and other questions", the title of the sub-item "Tobacco or health" shall be revised to read "Prevention and control of non-communicable diseases".

High-level meeting. In accordance with resolution 68/271 (see p. 1343), the General Assembly held a high-level meeting (New York, 10–11 July) to discuss progress achieved in the prevention and control of NCDs since the Millennium Summit [YUN 2000, p. 47]. The opening plenary included statements by the General Assembly President, the Secretary-General, the WHO Director General and the UNDP Administrator.

The Assembly President stated that developing countries had the political will to prevent and control NCDs, but were unsuccessful in doing so because they lacked the technical and financial resources needed to address the significant health and socioeconomic impact of NCDs. Development assistance dedicated to health amounted to approximately \$31 billion, of which only \$377 million was being directed towards NCDs. Integrating NCDs into bilateral and international development cooperation, as well as into national development agendas and prevention strategies, was critical for achieving better utilization of the billions of dollars in health development assistance. The Under-Secretary-General and Chef de Cabinet for the Executive Office of the Secretary-General delivered a statement on behalf of the Secretary-General,

who identified NCDs as a major and growing challenge to development. During the preceding three years, Governments had instituted more institutional, legal, financial and service arrangements to prevent and control NCDs. The Secretary-General hoped that the high-level meeting would help frame the concrete actions that countries had to take between 2014 and the third high-level meeting on NCDs in 2018.

The Director General of WHO highlighted the steps taken by Governments worldwide to combat NCDs. Of the 172 countries that reported data in 2014, 95 per cent had a unit or department in the Ministry of Health responsible for NCDs, and about half had instituted an integrated NCD operational plan with a dedicated budget. The proportion of countries conducting NCD risk factor surveys jumped from 30 per cent in 2011 to 63 per cent in 2013. The progress was highly uneven, however, as evidenced by a lack of capacity in the developing world, where 85 per cent of premature deaths from NCDs were occurring. NCDs had also overtaken infectious diseases as the world's leading cause of morbidity and mortality. The public health mindset needed a shift in focus from cure to prevention, and a transition to coordinated, multisectoral and multi-stakeholder action.

The UNDP Administrator stated that low- and middle-income countries were bearing the brunt of NCDs. For those countries, the economic cost of the four main NCDs (cardiovascular diseases, cancers, chronic respiratory diseases and diabetes) was predicted to exceed \$7 trillion between 2011 and 2025, roughly equivalent to \$500 billion per year, or 4 per cent of the gross domestic product of low and middle-income countries as measured in 2010. UNDP welcomed ongoing discussions on proposed targets to reduce NCD-related mortality and strengthen the implementation of the WHO Framework Convention on Tobacco Control—the world's first international treaty on a health issue.

GENERAL ASSEMBLY ACTION

On 10 July [meeting 100], the General Assembly adopted **resolution 68/300** [draft: A/68/L.53] without vote [agenda item 118].

Outcome document of the high-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of non-communicable diseases

The General Assembly

Adopts the following outcome document:

Outcome document of the high-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of non-communicable diseases

We, Ministers and representatives of States and Governments and heads of delegations, assembled at the United Nations on 10 and 11 July 2014 to take stock of the pro-

gress made in implementing the commitments set out in the political declaration of the high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, adopted by the General Assembly in its resolution 66/2 of 19 September 2011,

Intensifying our efforts towards a world free of the avoidable burden of non-communicable diseases

1. Reaffirm the political declaration, which has catalysed action and retains great potential for engendering sustainable improved health and human development outcomes;

2. Reaffirm our commitment to address the global burden and threat of non-communicable diseases, which constitute one of the major challenges for development in the twenty-first century, undermine social and economic development throughout the world, threaten the achievement of internationally agreed development goals and may lead to increasing inequalities within and between countries and populations;

3. Reiterate that the most prevalent non-communicable diseases, namely, cardiovascular diseases, cancers, chronic respiratory diseases and diabetes, are primarily linked to four common risk factors, namely, tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity;

4. Reiterate our concern regarding the rising levels of obesity in different regions, particularly among children and youth;

5. Recognize that mental and neurological conditions are an important cause of morbidity and contribute to the global non-communicable disease burden, in respect of which there is a need to provide equitable access to effective programmes and health-care interventions, as described in the comprehensive mental health action plan 2013–2020 of the World Health Organization;

6. Recall the Moscow Declaration, adopted at the first Global Ministerial Conference on Healthy Lifestyles and Non-communicable Disease Control, held in April 2011, as well as all the regional initiatives undertaken on the prevention and control of non-communicable diseases, including the declaration of the Heads of State and Government of the Caribbean Community entitled “Uniting to stop the epidemic of chronic non-communicable diseases”, adopted in September 2007, the Libreville Declaration on Health and Environment in Africa, adopted in August 2008, the statement of the Commonwealth Heads of Government on action to combat non-communicable diseases, adopted in November 2009, the declaration of commitment of the Fifth Summit of the Americas, adopted in June 2009, the Parma Declaration on Environment and Health, adopted by the member States in the European region of the World Health Organization in March 2010, the Dubai Declaration on Diabetes and Chronic Non-communicable Diseases in the Middle East and Northern Africa Region, adopted in December 2010, the European Charter on Counteracting Obesity, adopted in November 2006, the Aruba Call for Action on Obesity of June 2011, and the Honiara Communiqué on addressing non-communicable disease challenges in the Pacific region, adopted in July 2011;

Taking stock: progress achieved since 2011

7. Welcome the development by the World Health Organization, in accordance with paragraph 61 of the political declaration, of the comprehensive global monitoring

framework, including the set of 9 voluntary global targets for achievement by 2025 and a set of 25 indicators to be applied across regional and country settings in order to monitor trends and assess progress made in the implementation of national strategies and plans on non-communicable diseases, and the adoption of the framework by the World Health Assembly;

8. Also welcome the endorsement by the World Health Assembly of the Global Action Plan for the Prevention and Control of Non-communicable Diseases 2013–2020 and its adoption of the nine indicators to inform reporting on progress made in implementing the Global Action Plan;

9. Welcome the establishment of the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases and the endorsement of its terms of reference by the Economic and Social Council on 13 June 2014;

10. Welcome the request that the Director General of the World Health Organization prepare, for consideration during the sixty-eighth World Health Assembly, in consultation with Member States, United Nations organizations and other relevant stakeholders, as appropriate, and within existing resources, a framework for country action, for adaptation to different contexts, taking into account the Helsinki Statement on Health in All Policies, adopted at the Eighth Global Conference on Health Promotion, aimed at supporting national efforts to improve health, ensure health protection, health equity and health system functioning, including through action across sectors on determinants of health and risk factors of non-communicable diseases, based on best available knowledge and evidence;

11. Also welcome the endorsement by the World Health Assembly of the terms of reference for the comprehensive global coordination mechanism for the prevention and control of non-communicable diseases;

12. Recognize the remarkable progress achieved at the national level, since September 2011, including an increase in the number of countries which have an operational national non-communicable disease policy with a budget for implementation, from 32 per cent of countries in 2010 to 50 per cent of countries in 2013;

13. Recognize that progress in the prevention and control of non-communicable diseases has been insufficient and highly uneven, due in part to their complexity and challenging nature, and that continued and increased efforts are essential for achieving a world free of the avoidable burden of non-communicable diseases;

14. Acknowledge that, despite some improvements, commitments to promote, establish or support and strengthen, by 2013, multisectoral national policies and plans for the prevention and control of non-communicable diseases, and to increase and prioritize budgetary allocations for addressing non-communicable diseases, were often not translated into action, owing to a number of factors, including the lack of national capacity;

15. Acknowledge that many countries, in particular developing countries, are struggling to move from commitment to action and, in this regard, reiterate our call upon Member States to consider implementing, as appropriate, within national contexts, policies and evidence-based, affordable, cost-effective, population-wide and multisectoral interventions, including a reduction of modifiable risk factors of non-communicable diseases as described in ap-

pendix 3 to the Global Action Plan for the Prevention and Control of Non-communicable Diseases 2013–2020;

16. Recognize that affordable interventions to reduce environmental and occupational health risks are available and that prioritization and implementation of such interventions in accordance with national conditions can contribute to reducing the burden of non-communicable diseases;

17. Reiterate our call upon Member States to consider implementing, as appropriate, according to national circumstances, policy options and cost-effective, affordable, multisectoral interventions for the prevention and control of non-communicable diseases in order to achieve the nine voluntary global targets for non-communicable diseases by 2025;

Reaffirming our leadership: commitments and actions

18. Reaffirm our commitment to advance the implementation of multisectoral, cost-effective, population-wide interventions in order to reduce the impact of the four common behavioural risk factors for non-communicable diseases, through the implementation of relevant international agreements, strategies, national policies, legislation and development priorities, including educational, regulatory and fiscal measures, without prejudice to the right of sovereign nations to determine and establish their taxation policies and other policies, where appropriate, by involving all relevant sectors, civil society and communities, as appropriate;

19. Recognize that the implementation of the Global Action Plan for the Prevention and Control of Non-communicable Diseases 2013–2020, the Global Strategy on Diet, Physical Activity and Health, the Global Strategy to Reduce the Harmful Use of Alcohol, the Global Strategy for Infant and Young Child Feeding of the World Health Organization and the United Nations Children's Fund, and the World Health Organization Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children, as appropriate, will accelerate efforts to reduce non-communicable diseases, and reiterate our call upon Member States to mobilize political will and financial resources for that purpose;

20. Reiterate our commitment to accelerate the implementation of the World Health Organization Framework Convention on Tobacco Control by States parties, and encourage countries to consider becoming parties to the Convention;

21. Call upon Member States to take steps, including, where appropriate, effective legislation, cross-sectoral structures, processes, methods and resources that enable societal policies which take into account and address the impacts on health determinants, health protection, health equity and health system functioning, and which measure and track economic, social and environmental determinants and disparities in health;

22. Call upon Member States to develop, as appropriate, institutional capacity with adequate knowledge and skills for assessing the impact on health of policy initiatives in all sectors, identifying solutions and negotiating policies across sectors to achieve improved outcomes from the perspective of health, health equity and health system functioning;

23. Recognize the importance of universal health coverage in national health systems, and call upon Member States to strengthen health systems, including health-care

infrastructure, human resources for health, and health and social protection systems, particularly in developing countries, in order to respond effectively and equitably to the health-care needs of people with non-communicable diseases throughout the life cycle;

24. Continue to scale up, where appropriate, a package of proven, cost-effective interventions, including those identified in appendix 3 to the Global Action Plan;

25. Reiterate the importance of increased access to cost-effective cancer screening programmes as determined by national situations, as well as the importance of promoting increased access to cost-effective vaccinations to prevent infections associated with cancer, as part of national immunization schedules;

26. Acknowledge that limited progress has been made in implementing paragraph 44 of the annex to General Assembly resolution 66/2, and although an increased number of private sector entities have started to produce and promote food products consistent with a healthy diet, such products are not always broadly affordable, accessible and available in all communities within countries;

27. Continue to encourage policies that support the production and manufacture of and facilitate access to foods that contribute to a healthy diet and provide greater opportunities for the utilization of healthy local agricultural products and foods, thereby contributing to efforts to cope with the challenges and take advantage of opportunities presented by globalization and to achieve food security and adequate nutrition;

28. Reaffirm the primary role and responsibility of Governments in responding to the challenge of non-communicable diseases, including through engaging non-governmental organizations, the private sector and other sectors of society to generate effective responses for the prevention and control of non-communicable diseases at the global, national and local levels;

29. Recall that effective non-communicable disease prevention and control requires leadership and multisectoral approaches to health at the governmental level, including, as appropriate, health-in-all-policies and whole-of-government approaches across sectors beyond health, while protecting public health policies for the prevention and control of non-communicable diseases from undue influence by any form of real, perceived or potential conflict of interest;

Moving forward: national commitments

30. Commit to addressing non-communicable diseases as a matter of priority in national development plans, as appropriate within national contexts and the international development agenda, and to take the following measures with the engagement of all relevant sectors, including civil society and communities, as appropriate:

(a) Enhance governance:

(i) By 2015, consider setting national targets for 2025 and process indicators based on national situations, taking into account the nine voluntary global targets for non-communicable diseases, building on guidance provided by the World Health Organization, to focus on efforts to address the impacts of non-communicable diseases and to assess the progress made in the prevention and control of non-communicable diseases and their risk factors and determinants;

(ii) By 2015, consider developing or strengthening national multisectoral policies and plans to achieve the national targets by 2025, taking into account the Global Action Plan for the Prevention and Control of Non-communicable Diseases 2013–2020;

(iii) Continue to develop, strengthen and implement, as appropriate, multisectoral public policies and action plans to promote health education and health literacy, with a particular focus on populations with low health awareness and/or literacy;

(iv) Raise awareness about the national public health burden caused by non-communicable diseases and the relationship between non-communicable diseases, poverty and social and economic development;

(v) Integrate measures to address non-communicable diseases into health planning and national development plans and policies, including the design process and implementation of the United Nations Development Assistance Framework;

(vi) Consider establishing, as appropriate to the respective national context, a national multisectoral mechanism, such as a high-level commission, agency or task force for engagement, policy coherence and mutual accountability of different spheres of policymaking that have a bearing on non-communicable diseases, in order to implement health-in-all-policies and whole-of-government and whole-of-society approaches, and to monitor and act on the determinants of non-communicable diseases, including social and environmental determinants;

(vii) Enhance the capacity, mechanisms and mandates, as appropriate, of relevant authorities in facilitating and ensuring action across governmental sectors;

(viii) Strengthen the capacity of ministries of health to exercise a strategic leadership and coordination role in policy development that engages all stakeholders across government, non-governmental organizations, civil society and the private sector, ensuring that issues relating to non-communicable diseases receive an appropriate, coordinated, comprehensive and integrated response;

(ix) Align international cooperation on non-communicable diseases with national plans concerning non-communicable diseases in order to strengthen aid effectiveness and the development impact of external resources in support of non-communicable diseases;

(x) Develop and implement national policies and plans, as relevant, with financial and human resources allocated particularly to addressing non-communicable diseases, in which social determinants are included;

(b) By 2016, as appropriate, reduce risk factors for non-communicable diseases and underlying social determinants through the implementation of interventions and policy options to create health-promoting environments, building on guidance set out in appendix 3 to the Global Action Plan;

(c) By 2016, as appropriate, strengthen and orient health systems to address the prevention and control

of non-communicable diseases and the underlying social determinants through people-centred primary health care and universal health coverage throughout the life cycle, building on guidance set out in appendix 3 to the Global Action Plan;

(d) Consider the possible linkages between non-communicable diseases and some communicable diseases, such as HIV/AIDS, call for the integration, as appropriate, of responses to HIV/AIDS and non-communicable diseases, and in this regard call for attention to be given to people living with HIV/AIDS, especially in countries with a high prevalence of HIV/AIDS, in accordance with national priorities;

(e) Continue to promote the inclusion of prevention and control of non-communicable diseases within programmes for sexual and reproductive health and maternal and child health, especially at the primary health-care level, as well as communicable disease programmes, such as those addressing tuberculosis, as appropriate;

(f) Consider the synergies between major non-communicable diseases and other conditions as described in appendix 1 to the Global Action Plan in order to develop a comprehensive response for the prevention and control of non-communicable diseases that also recognizes the conditions in which people live and work;

(g) Monitor the trends and determinants of non-communicable diseases and evaluate progress in their prevention and control:

- (i) Assess progress towards attaining the voluntary global targets and report on the results using the indicators established in the comprehensive global monitoring framework, according to the agreed timelines, and use results from monitoring of the 25 indicators and 9 voluntary targets and other sources of data to inform and guide policy and programming, aiming to maximize the impact of interventions and investments on non-communicable disease outcomes;
- (ii) Contribute information on trends in non-communicable diseases to the World Health Organization, according to the agreed timelines on progress made in the implementation of national action plans and on the effectiveness of national policies and strategies, coordinating country reporting with global analyses;
- (iii) Develop or strengthen, as appropriate, surveillance systems to track social disparities in non-communicable diseases and their risk factors as a first step to addressing inequalities, and pursue and promote gender-based approaches for the prevention and control of non-communicable diseases on the basis of data disaggregated by sex, age and disability, in an effort to address the critical differences in the risks of morbidity and mortality from non-communicable diseases for women and men;

(h) Continue to strengthen international cooperation in support of national, regional and global plans for the prevention and control of non-communicable diseases, inter alia, through the exchange of best practices in the areas of health promotion, legislation, regulation, strengthening of health systems, training of health-care personnel and the development of appropriate health-care infrastructure and diagnostics and by promoting the development and dissemination of appropriate, affordable and sustainable transfer

of technology on mutually agreed terms for the production of affordable, safe, effective and quality medicines and vaccines, while recognizing the leading role of the World Health Organization as the primary specialized agency for health in that regard;

31. Continue to strengthen international cooperation through North-South, South-South and triangular cooperation in the prevention and control of non-communicable diseases to promote at the national, regional and international levels an enabling environment to facilitate healthy lifestyles and choices, bearing in mind that South-South cooperation is not a substitute for, but rather a complement to, North-South cooperation;

32. Continue to explore the provision of adequate, predictable and sustained resources, through domestic, bilateral, regional and multilateral channels, including traditional and voluntary innovative financing mechanisms;

Moving forward: international commitments

33. Invite the Development Assistance Committee of the Organization for Economic Cooperation and Development to consider developing a purpose code for non-communicable diseases in order to improve the tracking of official development assistance in support of national efforts for the prevention and control of non-communicable diseases;

34. Reiterate our commitment to actively promote national and international investments and strengthen national capacity for quality research and development, in all aspects relating to the prevention and control of non-communicable diseases, in a sustainable and cost-effective manner, while noting the importance of continuing to incentivize innovation in public health, inter alia, as appropriate, through a sound and balanced intellectual property rights system, which is important, inter alia, for the development of new medicines, as recognized in the Doha Declaration on the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) and Public Health;

35. Reaffirm the right to use, to the fullest extent, the provisions contained in the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement), the Doha Declaration on the TRIPS Agreement and Public Health, the decision of the General Council of the World Trade Organization of 30 August 2003 on the implementation of paragraph 6 of the Doha Declaration, and, when formal acceptance procedures are completed, the amendment to article 31 of the TRIPS Agreement, which provide flexibilities for the protection of public health, and in particular to promote access to medicines for all and encourage the provision of assistance to developing countries in this regard;

36. Give due consideration to addressing non-communicable diseases in the elaboration of the post-2015 development agenda, taking into account, in particular, their serious socioeconomic consequences and determinants and their links to poverty;

37. Call upon the World Health Organization, in consultation with Member States, in the context of the comprehensive global coordination mechanism for the prevention and control of non-communicable diseases, while ensuring appropriate protection from vested inter-

ests, to develop, before the end of 2015, an approach that can be used to register and publish contributions of the private sector, philanthropic entities and civil society to the achievement of the nine voluntary targets for non-communicable diseases;

Towards the world we want: follow-up

38. Request the Secretary-General, in collaboration with Member States, the World Health Organization and relevant funds, programmes and specialized agencies of the United Nations system, to submit to the General Assembly, by the end of 2017, for consideration by Member States, a report on the progress achieved in the implementation of the present outcome document and of the political declaration of the high-level meeting of the Assembly on the prevention and control of non-communicable diseases, in preparation for a comprehensive review, in 2018, of the progress achieved in the prevention and control of non-communicable diseases.

Global status report. Following on its first global report on the prevention and control of NCDs [YUN 2010, p. 1223], WHO, in its second global report in 2014, provided the latest estimates on NCD mortality, available as at 2012. As the leading cause of death globally, NCDs were responsible for 38 million (68 per cent) of the world's 56 million deaths. More than 40 per cent of them (16 million) were premature deaths of people under the age of 70 years. Almost three quarters of all NCD deaths (28 million), and the majority of premature deaths (82 per cent), occurred in low- and middle-income countries. The report also noted the status of such voluntary global NCD targets [YUN 2013, p. 1174] as concerned reducing the harmful use of alcohol; insufficient physical activity; reducing salt/sodium intake; reducing tobacco use and hypertension; halting the rise of obesity and diabetes; and improving coverage of treatment for prevention of heart attacks and strokes and access to basic technologies and medicines.

Tobacco

WHO Framework Convention on Tobacco Control

The WHO Framework Convention on Tobacco Control (FCTC) was adopted by the World Health Assembly in 2003 [YUN 2003, p. 1251] and entered into force in 2005 [YUN 2005, p. 1328]. It facilitated an internationally coordinated response to combating the tobacco epidemic, and set out specific steps for Governments to take. At the end of 2014, 179 States and the European Union were parties to the Convention.

Global progress report. The 2014 FCTC global progress report provided an overview of the status of implementation of the Convention, based on information submitted by the Parties in the 2014 reporting cycle. Overall, 80 per cent of the Parties strengthened their existing or adopted new tobacco

control legislation after ratifying the Convention, and over two thirds reported recent development, adoption and implementation of national tobacco control programmes, a significant increase over the previous reporting period. The average implementation rate for substantive Articles of the Convention stood at almost 60 per cent, compared with just over 50 per cent in 2010. The proportion of countries levying tobacco excise taxes increased to 92 per cent, up from 67 per cent in 2010 and 85 per cent in 2012. Overall, more than two thirds of Parties increased tobacco tax rates since 2012.

Progress was uneven when it came to the implementation rate for other Articles. For example, the average implementation rate for the Article 5 provisions (General obligations) was 65 per cent, while the average implementation rate for Article 22 (International cooperation) was 37 per cent, and for Article 19 (Liability) only 14 per cent. One third of the Parties were yet to put in place legislative measures in line with the requirements of the Convention; many Parties were also yet to designate a national tobacco control focal point and increase full-time capacity in tobacco control. Strengthening of national capacity and legislation for tobacco control, as well as strengthening of the national coordination mechanism and international cooperation were necessary steps that would have an overarching impact on the Convention's implementation.

Water and sanitation

The United Nations Children's Fund and the World Bank convened the third high-level meeting (Washington, D.C., 11 April) of Sanitation and Water for All (swA), a global partnership of Governments, donors, civil society organizations, the private sector, community-based organizations, research and learning institutions, and several UN agencies working together to achieve universal access to clean water and adequate sanitation, in line with the water and sanitation targets of the Millennium Development Goals [YUN 2000, p. 49]. The meeting was attended by 21 ministers of finance and 35 ministers responsible for water and sanitation, as well as several ministers of health. Other attendees included donors and development banks along with senior representatives of civil society and the United Nations. At the meeting, 55 swA partner countries, donors and banks made some 370 new commitments for increasing and improving the use of financial resources, reducing inequality in access, building the capacity of institutions charged with delivering water and sanitation services, and coordinating resources more effectively.

On 19 December, the General Assembly adopted **resolution 69/215** on the International Decade for Action, "Water for Life", 2005–2015, and further efforts to achieve the sustainable development of water resources (see p. 1166).

Malaria

Roll Back Malaria initiative

On 25 April, the Secretary-General transmitted to the General Assembly a report [A/68/854] of the WHO Director General submitted in accordance with Assembly resolution 67/299 [YUN 2013, p. 1178] on consolidating gains and accelerating efforts to control and eliminate malaria, particularly in Africa, by 2015. Using data received from malaria-endemic countries and a range of organizations, the Director General reviewed progress made in the implementation of resolution 67/299; detailed the adoption and scaling-up of interventions recommended by the WHO for malaria-endemic countries; assessed progress towards the 2015 global malaria targets, including Millennium Development Goal 6; and provided recommendations for ensuring that progress was accelerated up to and beyond 2015.

Malaria continued to pose a serious challenge to global health. In 2012, there were an estimated 207 million cases worldwide. Of those, 627,000 involved fatalities affecting mostly children under the age of five in sub-Saharan Africa. Malaria remained concentrated in 17 countries where some 80 per cent of the fatalities occurred. The Democratic Republic of the Congo and Nigeria accounted for approximately 40 per cent of malaria mortality worldwide. The South East Asia region—the second most-affected part of the world—India bore the highest malaria burden, followed by Indonesia and Myanmar.

There had been some notable progress in the fight against malaria. Between 2000 and 2012, a substantial scale-up of malaria interventions led to a 42 per cent decline in malaria mortality rates globally, saving an estimated 3.3 million lives. About 90 per cent or three million of those saved were children under five in Africa. The mortality rate among children under the age of five declined by 54 per cent in Africa and 25 per cent globally. In November 2014, 18 heads of State at the East Asia Summit made a commitment to eliminating the disease from the Asia-Pacific region by 2030. Between 2008 and 2012, Argentina, Egypt, Georgia, Iraq, Kyrgyzstan, the Russian Federation, the Syrian Arab Republic and Uzbekistan reduced their local malaria transmission to zero cases, while Armenia, Morocco and Turkmenistan were certified free of malaria. In the WHO European region, local transmission was confined to three countries in 2012: Azerbaijan, Tajikistan and Turkey; the region was otherwise generally on track to reduce local malaria transmission cases to zero by 2015.

Between 2004 and 2013, international financial disbursements for fighting malaria had expanded tenfold, however, available funding was still substantially less than the \$5.1 billion required to achieve universal coverage of malaria interventions. The Director

General urged Member States to step up malaria control and elimination efforts; address the priority actions highlighted in resolution 67/299; and develop both traditional and innovative financing tools to alleviate suffering in the 17 highest-burden countries. In 2013, WHO began developing a new global malaria strategy to provide countries with evidence-based technical guidance for the 2016–2025 period and set new targets in alignment with the post-2015 development agenda.

GENERAL ASSEMBLY ACTION

On 10 September [meeting 108], the General Assembly adopted **resolution 68/308** [draft: A/68/L.60 & Add.1] without vote [agenda item 13].

Consolidating gains and accelerating efforts to control and eliminate malaria in developing countries, particularly in Africa, by 2015

The General Assembly,

Recalling that the period 2001–2010 was proclaimed by the General Assembly as the Decade to Roll Back Malaria in Developing Countries, Particularly in Africa, and that combating HIV/AIDS, malaria, tuberculosis and other diseases is included in the internationally agreed development goals, including the Millennium Development Goals,

Recalling also the malaria-related goals and commitments in the outcome document of the high-level plenary meeting of the General Assembly on the Millennium Development Goals,

Recalling further its resolution 67/299 of 16 September 2013 and all previous resolutions concerning the struggle against malaria in developing countries, particularly in Africa,

Recalling World Health Assembly resolutions 60.18 of 23 May 2007 and 64.17 of 24 May 2011, urging a broad range of national and international actions to scale up malaria control programmes, and resolution 61.18 of 24 May 2008 on monitoring the achievement of health-related Millennium Development Goals,

Recalling also the commitment made by African leaders to end the epidemic of malaria by ensuring universal and equitable access to quality health care and by improving health systems and health financing, contained in the African Common Position on the post-2015 development agenda,

Bearing in mind the relevant resolutions of the Economic and Social Council relating to the struggle against malaria and diarrhoeal diseases, in particular resolution 1998/36 of 30 July 1998,

Taking note of all declarations and decisions on health issues, in particular those related to malaria, adopted by the Organization of African Unity and the African Union, including the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, containing the pledge to allocate at least 15 per cent of national budgets to the health sector, the Abuja call for accelerated action towards universal access to HIV and AIDS, tuberculosis and malaria services in Africa, issued by the Heads of State and Government of the African Union at the special summit of the African Union on HIV and AIDS, tuberculosis and malaria, held in Abuja from 2 to 4 May 2006, the decision of the Assembly of the African Union at its fifteenth ordinary session, held in Kam-

pala from 25 to 27 July 2010, to extend the Abuja call to 2015 to coincide with the Millennium Development Goals, and the declaration of the special summit of the African Union on HIV/AIDS, tuberculosis and malaria, held in Abuja from 12 to 16 July 2013,

Recognizing the leadership provided by the African Leaders Malaria Alliance and the continued commitment to help to achieve the 2015 targets, and encouraging the members of the Alliance to continue to provide political leadership at the highest level in the fight against malaria in Africa,

Welcoming the creation of the Asia Pacific Leaders Malaria Alliance, recognizing the leadership and commitment of the Alliance to achieve the 2015 targets, and encouraging the members of the Alliance to continue to provide political leadership at the highest level in the fight against malaria in the Asia-Pacific region,

Taking note of the World Health Organization framework for action for an emergency response to artemisinin resistance in the Greater Mekong subregion of South-East Asia, launched in April 2013,

Welcoming the selection by the Secretary-General of malaria as one of the top priorities of his second mandate and his commitment to develop new partnerships and improve existing ones and to scale up high-impact interventions aimed at significantly reducing the number of deaths from malaria,

Recognizing the linkages among efforts being made to reach the targets set at the Extraordinary Summit of Heads of State and Government of the Organization of African Unity, held in Abuja on 24 and 25 April 2000, as necessary and important for the attainment of the "Roll Back Malaria" goal and the targets of the Millennium Development Goals by 2010 and 2015, respectively, and welcoming in this regard the commitment of Member States to respond to the specific needs of Africa,

Recognizing also that malaria-related ill health and deaths throughout the world can be substantially reduced with political commitment and commensurate resources if the public is educated and sensitized about malaria and appropriate health services are made available, particularly in countries where the disease is endemic,

Recognizing further that malaria control interventions have a positive impact on overall child and maternal mortality rates and could help African countries and other malaria-endemic countries to reach Millennium Development Goals 4 and 5 of reducing child mortality and improving maternal health, respectively, by 2015,

Acknowledging the progress made in parts of Africa in reversing the high burden of malaria through political engagement and sustainable national malaria control programmes, as well as the progress being made towards achieving by 2015 the goals concerning malaria control set by the World Health Assembly and the Roll Back Malaria Partnership,

Recognizing that, despite the fact that increased global and national investments in malaria control have yielded significant results in decreasing the burden of malaria in many countries and that some countries are moving towards the elimination of malaria, many countries continue to have unacceptably high burdens of malaria and in order to reach internationally agreed development goals, including the health-related Millennium Development Goals, must rap-

idly increase malaria prevention and control efforts, which rely heavily on medicines and insecticides whose utility is continuously threatened by the development of resistance in humans to antimalarial agents, as well as resistance of mosquitoes to insecticides,

Aware that recent successes in prevention and control are fragile and can be maintained only with sufficient and sustained national and international investment to fund global malaria control efforts fully,

Recognizing the serious challenges relating to substandard, falsified and counterfeit drugs, as well as poor malaria diagnostics,

Expressing concern about the continued morbidity, mortality and debility attributed to malaria, and recalling that more efforts are needed if the Abuja malaria targets and the malaria and Millennium Development Goal targets for 2015 are to be reached on time,

Emphasizing the importance of strengthening health systems to effectively sustain malaria control and elimination,

Commending the efforts of the World Health Organization, the United Nations Children's Fund, the Roll Back Malaria Partnership, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank and other partners to fight malaria over the years,

Taking note with appreciation of the Global Malaria Action Plan developed by the Roll Back Malaria Partnership,

1. *Welcomes* the report prepared by the World Health Organization, and calls for support for the implementation of the recommendations contained therein;

2. *Calls for* increased support for the implementation of international commitments and goals pertaining to the fight to eliminate malaria as stipulated in the internationally agreed development goals, including the Millennium Development Goals;

3. *Encourages* Member States, relevant organizations of the United Nations system, international institutions, non-governmental organizations, the private sector and civil society to continue to observe World Malaria Day on 25 April in order to raise public awareness of and knowledge about the prevention, control and treatment of malaria as well as the importance of meeting the Millennium Development Goals, and stresses the importance of engaging local communities in this regard;

4. *Encourages* the Special Envoy of the Secretary-General for Malaria to continue raising issues relating to malaria in collaboration with other United Nations organizations already working on those issues in the context of the international political and development agendas and to work with national and global leaders to intensify efforts to secure the political commitment, partnerships and funds to drastically reduce malaria deaths by 2015 through increased access to prevention, diagnosis and treatment, especially in Africa;

5. *Welcomes* the increased funding, while recognizing the need for additional funding, for malaria interventions and for research and development of preventive, diagnostic and control tools from the international community, through funding from multilateral and bilateral sources and from the private sector, as well as by making predictable financing available through appropriate and effective aid modalities and in-country health financing mechanisms aligned with national priorities, which are key to strength-

ening health systems, including malaria surveillance, and promoting universal and equitable access to high-quality malaria prevention, diagnostic and treatment services, and noting in this regard that a high level of external assistance per person at risk for malaria is associated with a decrease in the incidence of the disease;

6. *Urges* the international community, United Nations agencies and private organizations and foundations to support the implementation of the Global Malaria Action Plan, including through support for programmes and activities at the country level in order to achieve internationally agreed targets on malaria;

7. *Calls upon* the international community to continue to support the secretariat of the Roll Back Malaria Partnership and partner organizations, including the World Health Organization, the World Bank and the United Nations Children's Fund, as vital complementary sources of support for the efforts of malaria-endemic countries to combat the disease;

8. *Urges* the international community to work in a spirit of cooperation towards effective, increased, harmonized, predictable and sustained bilateral and multilateral assistance and research to combat malaria, including support for the Global Fund to Fight AIDS, Tuberculosis and Malaria, in order to assist States, in particular malaria-endemic countries, to implement sound national plans, in particular health plans and sanitation plans, including malaria control and elimination strategies which may include evidence-based, cost-effective and context-appropriate environmental management solutions, and integrated management of childhood illnesses, in a sustained and equitable way that, inter alia, contributes to strengthening health system development approaches at the district level;

9. *Appeals* to the malaria partners to resolve the financial, supply chain and delivery bottlenecks that are responsible for stock-outs of long-lasting insecticide-treated nets, rapid diagnostic tests and artemisinin-based combination therapies at the national level, whenever they occur, including through the strengthening of malaria programme management at the country level;

10. *Welcomes* the contribution to the mobilization of additional and predictable resources for development by voluntary innovative financing initiatives taken by groups of Member States, and in this regard notes the International Drug Purchase Facility, UNITAID, the International Finance Facility for Immunization, the advance market commitments for vaccines, the GAVI Alliance and the Affordable Medicines Facility for Malaria pilot, and expresses support for the work of the Leading Group on Innovative Financing for Development and its special task force on innovative financing for health;

11. *Urges* malaria-endemic countries to work towards financial sustainability, to increase, to the extent possible, national resources allocated to malaria control and to create favourable conditions for working with the private sector in order to improve access to good-quality malaria services;

12. *Urges* Member States to assess and respond to the needs for integrated human resources at all levels of the health system in order to achieve the targets of the Abuja Declaration on Roll Back Malaria in Africa and the internationally agreed development goals, including the Millennium Development Goals, to take action, as appropriate, to effectively govern the recruitment, training and

retention of skilled health personnel, and to give particular focus to the availability of skilled personnel at all levels to meet technical and operational needs as increased funding for malaria control programmes becomes available;

13. *Urges* the international community, inter alia, to support the Global Fund to Fight AIDS, Tuberculosis and Malaria to enable it to meet its financial needs and, through country-led initiatives with adequate international support, to intensify access to affordable, safe and effective antimalarial treatments, including artemisinin-based combination therapies, intermittent preventive therapies for pregnant women, children under 5 and infants, adequate diagnostic facilities, long-lasting insecticide-treated mosquito nets, including, where appropriate, through the free distribution of such nets and, where appropriate, to insecticides for indoor residual spraying for malaria control, taking into account relevant international rules, including the Stockholm Convention on Persistent Organic Pollutants standards and guidelines;

14. *Requests* relevant international organizations, in particular the World Health Organization and the United Nations Children's Fund, to assist the efforts of national Governments to provide universal access to malaria control interventions to address all at-risk populations, in particular young children and pregnant women, in malaria-endemic countries, particularly in Africa, as rapidly as possible, with due regard to ensuring the proper use of those interventions, including long-lasting insecticide-treated nets, and sustainability through full community participation and implementation through the health system;

15. *Calls upon* Member States, in particular malaria-endemic countries, with the support of the international community, to establish and/or strengthen national policies, operational plans and research, with a view to scaling up efforts to achieve internationally agreed malaria targets for 2015, in accordance with the technical recommendations of the World Health Organization;

16. *Commends* those African countries that have implemented the recommendations of the Abuja Summit in 2000 to reduce or waive taxes and tariffs for nets and other products needed for malaria control, and encourages other countries to do the same;

17. *Calls upon* United Nations agencies and their partners to continue to provide the technical support necessary to build and enhance the capacity of Member States to implement the Global Malaria Action Plan and meet the internationally agreed goals, including the Millennium Development Goals, and looks forward to the timely completion of the second edition of the Global Malaria Action Plan;

18. *Expresses deep concern* about emerging drug and insecticide resistance in several regions of the world, calls upon Member States, with support from the World Health Organization and other partners, to implement the Global Plan for Artemisinin Resistance Containment and the Global Plan for Insecticide Resistance Management in Malaria Vectors and to strengthen and implement surveillance systems for monitoring and assessing changing patterns of drug and insecticide resistance, calls upon the World Health Organization to support Member States in the development of their national insecticide resistance management strategies and to coordinate support at the international level for countries to ensure that drug efficacy and insecticide resistance testing is fully operational in order to enhance the use of artemisinin-based combination thera-

pies and insecticides, and stresses that the data gathered should be utilized for further research and development of safe and effective therapies and vector control tools;

19. *Urges* all Member States to prohibit the marketing and use of oral artemisinin-based monotherapies and to replace them with oral artemisinin-based combination therapies, as recommended by the World Health Organization, and to develop the financial, legislative and regulatory mechanisms necessary to introduce artemisinin combination therapies at affordable prices in both public and private facilities;

20. *Recognizes* the importance of the development of safe and cost-effective vaccines and new medicines to prevent and treat malaria and the need for further and accelerated research, including into safe, effective and high-quality therapies, using rigorous standards, including by providing support to the Special Programme for Research and Training in Tropical Diseases, through effective global partnerships, such as the various malaria vaccine initiatives and the Medicines for Malaria Venture, where necessary stimulated by new incentives to secure their development, and through effective and timely support for the pre-qualification of new antimalarials and their combinations;

21. *Calls upon* the international community, including through existing partnerships, to increase investment in and efforts towards research to optimize current tools, develop and validate new, safe and affordable malaria-related medicines, products and technologies, such as vaccines, rapid diagnostic tests, insecticides and their delivery modes, to prevent and treat malaria, especially for at-risk children and pregnant women, and testing opportunities for integration in order to enhance effectiveness and delay the onset of resistance;

22. *Calls upon* malaria-endemic countries to assure favourable conditions for research institutions, including the allocation of adequate resources and the development of national policies and legal frameworks, where appropriate, with a view to, inter alia, informing policy formulation and strategic interventions on malaria;

23. *Reaffirms* the right to use, to the fullest extent, the provisions contained in the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement), the Doha Declaration on the TRIPS Agreement and Public Health, the decision of the General Council of the World Trade Organization of 30 August 2003 on the implementation of paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health, and, when formal acceptance procedures are completed, the amendment to article 31 of the Agreement, which provide flexibilities for the protection of public health, and in particular to promote access to medicines for all and to encourage the provision of assistance to developing countries in this regard, and calls for the broad and timely acceptance of the amendment to article 31 of the Agreement, as proposed by the General Council of the World Trade Organization in its decision of 6 December 2005;

24. *Recognizes* the importance, in the struggle against malaria, of the World Health Organization Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property, adopted by the World Health Assembly on 24 May 2008;

25. *Calls upon* malaria-endemic countries, development partners and the international community to support

the timely replacement of long-lasting insecticide-treated nets in accordance with the recommendations of the World Health Organization on the service lives of such nets, in order to prevent the risk of malaria resurgence and a reversal of the gains made to date;

26. *Calls upon* the international community to support ways to expand access to affordable, effective and safe products and treatments, such as vector control measures, including indoor residual spraying, long-lasting insecticide-treated nets, including through the free distribution of such nets, adequate diagnostic facilities, intermittent preventive therapies for pregnant women, children under 5 and infants, and artemisinin-based combination therapy for populations at risk of falciparum malaria infection in endemic countries, particularly in Africa, including through additional funds and innovative mechanisms, inter alia, for the financing and scaling up of artemisinin production and procurement, as appropriate, to meet the increased need;

27. *Recognizes* the impact of the Roll Back Malaria Partnership, and welcomes the increased level of public-private partnerships for malaria control and prevention, including the financial and in-kind contributions of private sector partners and companies operating in Africa, as well as the increased engagement of non-governmental service providers;

28. *Encourages* the producers of long-lasting insecticide-treated nets to continue to accelerate technology transfer to developing countries, and invites the World Bank and regional development funds to consider supporting malaria-endemic countries in establishing factories to scale up production of long-lasting insecticide-treated nets;

29. *Calls upon* Member States and the international community, especially malaria-endemic countries, in accordance with existing guidelines and recommendations of the World Health Organization and the requirements of the Stockholm Convention related to the use of DDT, to become fully knowledgeable about the technical policies and strategies of the World Health Organization and the provisions of the Stockholm Convention, including for indoor residual spraying, long-lasting insecticide-treated nets and case management, intermittent preventive therapies for pregnant women, children under 5 and infants and monitoring of in vivo resistance studies to artemisinin-based combination therapies, as well as to increase capacity for the safe, effective and judicious use of indoor residual spraying and other forms of vector control, including quality control measures, in accordance with international rules, standards and guidelines;

30. *Requests* the World Health Organization, the United Nations Children's Fund and donor agencies to provide support to those countries that choose to use DDT for indoor residual spraying so as to ensure that it is implemented in accordance with international rules, standards and guidelines, and to provide all possible support to malaria-endemic countries to manage the intervention effectively and prevent the contamination, in particular, of agricultural products with DDT and other insecticides used for indoor residual spraying;

31. *Encourages* the World Health Organization and its member States, with the support of the parties to the Stockholm Convention, to continue to explore possible alternatives to DDT as a vector control agent;

32. *Recognizes* the importance of a multisectoral strategy to advance global control efforts, invites malaria-

endemic countries to consider adopting and implementing the Multisectoral Action Framework for Malaria developed by the Roll Back Malaria Partnership and the United Nations Development Programme, and encourages regional and intersectoral collaboration, both public and private, at all levels, especially in education, health, agriculture, economic development and the environment, to advance malaria control objectives;

33. *Also recognizes* the need to strengthen malaria surveillance and data quality in all endemic regions to enable Member States to direct financial resources to the populations most in need and to respond effectively to disease outbreaks;

34. *Calls upon* Member States and the international community to strengthen mechanisms for country-based coordination of technical assistance to achieve alignment of the best approaches to implement World Health Organization technical guidance and to mobilize support for the sharing and analysis of best practices to address urgent programmatic challenges, to improve monitoring and evaluation and to conduct regular financial planning and gap analysis;

35. *Encourages* sharing, across regions, of knowledge, experience and lessons learned with regard to the control and elimination of malaria, particularly between the Africa, Asia-Pacific and Latin America regions;

36. *Calls upon* the international community to support the strengthening of health systems, national pharmaceutical policies and national drug regulatory authorities, to monitor and fight against the trade in counterfeit and sub-standard antimalarial medicines and prevent their distribution and use, and to support coordinated efforts, *inter alia*, by providing technical assistance to improve surveillance, monitoring and evaluation systems and their alignment with national plans and systems so as to better track and report changes in coverage, the need for scaling up recommended interventions and the subsequent reductions in the burden of malaria;

37. *Urges* Member States, the international community and all relevant actors, including the private sector, to promote the coordinated implementation and enhance the quality of malaria-related activities, including through the Roll Back Malaria Partnership, in accordance with national policies and operational plans that are consistent with the technical recommendations of the World Health Organization and recent efforts and initiatives, including, where appropriate, the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, adopted at the Third High-level Forum on Aid Effectiveness, held in Accra from 2 to 4 September 2008;

38. *Recognizes* the need for political commitment and financial support beyond 2015 to sustain and expand the achievements in the struggle against malaria and to meet the international malaria targets through prevention and malaria control efforts to end the epidemic, while acknowledging the remarkable progress in combating malaria to date;

39. *Requests* the Secretary-General, in close collaboration with the Director General of the World Health Organization and in consultation with Member States, to report to the General Assembly at its sixty-ninth session on the implementation of the present resolution, and specifically on progress towards achieving the 2015 targets of the Abuja Declaration and those of the Global Malaria Action Plan and Millennium Development Goal 6, including iden-

tification of best practices and successes and specific challenges limiting the achievement of the targets and, taking these into account, to provide recommendations to ensure that the targets are reached by 2015.

On 29 December (**decision 69/554**), the General Assembly decided that agenda item “2001–2010: Decade to Roll Back Malaria in Developing Countries, Particularly in Africa” would remain for consideration during its resumed sixty-ninth (2015) session.

Ebola outbreak in West Africa

In a May report [S/2014/342] to the Security Council on the United Nations Operation in Côte d’Ivoire (see p. 258), the Secretary-General said that an outbreak of the Ebola virus had been confirmed on 22 March in the Guinée Forestière area near Guinea’s border with Liberia and, subsequently, in Conakry. Following an alert from the World Health Organization (who) urging heightened surveillance for illnesses consistent with viral haemorrhagic fever, the countries neighbouring Guinea instituted measures along the land borders to protect those at risk and prevent the virus from spreading. Suspected cases of infection had been ruled out in Mali, while in Guinea and Liberia, 143 and 11 related fatalities were recorded, respectively, as at 1 May. No cases of Ebola virus infection had been reported in Côte d’Ivoire.

In an August report [S/2014/598] to the Security Council on the United Nations Mission in Liberia (UNMIL) (see p. 261), the Secretary-General stated that by 30 July, a total of 383 cases of Ebola virus disease had been reported in Liberia, resulting in 216 deaths, including of health-care workers. The Government of Liberia, supported by the United Nations, had initiated an awareness-raising campaign, including messages in local languages on UNMIL Radio, and revised its national response plan with support from who. Tradition, denial and community resistance, however, proved difficult to surmount. WHO and the United Nations Children’s Fund (UNICEF) had received \$617,000 from the United Nations Central Emergency Response Fund on 14 July.

Subsequently, in an August letter [S/2014/644] to the Security Council President recommending a technical rollover of the mandate of UNMIL (see p. 262) due to the ensuing exceptional circumstances in Liberia, the Secretary-General reported that the Ebola virus disease outbreak in West Africa had escalated so drastically in just a matter of weeks that, on 8 August, who had declared it a public health emergency of international concern. To facilitate a coordinated international response, on 12 August, he had appointed Dr. David Nabarro (United Kingdom) to serve as the United Nations System Senior Coordinator for Ebola Virus Disease. Dr. Nabarro had been in Liberia from 21 to 23 August as part of a regional visit to assess the situation and make rec-

ommendations for the response going forward. Ebola was having a devastating impact on Liberia, with the Ministry of Health recording, as at 24 August, a cumulative total of 1,378 cases, resulting in 743 deaths. While the Ebola outbreak began primarily as a medical emergency, it had become more complex, with significant political, security and humanitarian implications. Its long-term effects on the people and the economy of Liberia were likely to be considerable. Earlier, on 6 August, President Ellen Johnson Sirleaf had declared a 90-day state of emergency, noting that the scale and scope of the epidemic exceeded the response capacity of national institutions, requiring extraordinary measures in order to save lives, including the suspension of certain constitutionally guaranteed rights and privileges, for example, by restricting movement and freedom of assembly. The Legislature had endorsed that decision.

Additional measures announced by the President included a moratorium on official travel for government officials and the deployment of the Armed Forces of Liberia and the Liberia National Police to enforce the isolation of the areas of the country most affected by Ebola. Meanwhile, the Government had also established mechanisms to coordinate the national and international response, and allocated emergency funding. On the recommendation of the National Elections Commission, the judiciary was considering the constitutionality of postponing the senatorial elections scheduled for October. Notwithstanding the efforts of the Government to contain the Ebola virus, it continued to spread, fuelled by fear, denial, tradition and lack of public trust in national institutions. Compounding the medical emergency was the surging cost of food, water and other basic goods, particularly in cordoned-off areas.

Meanwhile, the country was becoming increasingly isolated as a result of the decision of some airline companies to cease servicing countries affected by Ebola, which had implications for the humanitarian response. On 20 August, further measures announced by the President to contain the disease, including a nationwide curfew, went into effect. The escalating crisis was having such a profound impact that it would be necessary for all of the international partners of Liberia, including the United Nations, to fully mobilize all resources behind the fight against the epidemic.

Global Ebola Response Coalition. On 1 September, the Secretary-General announced the formation of the Global Ebola Response Coalition, which included the Governments of affected countries and neighbouring countries, African regional and subregional bodies, development partners, non-governmental organizations (NGOs) and businesses, along with UN system entities. The coordination mechanism was intended to ensure integrated support to affected countries, while helping prevent the spread of the Ebola virus disease to other countries.

Appointment. On 8 September, the Secretary-General appointed Anthony Banbury (United States) as Deputy Ebola Coordinator and Operation Crisis Manager. Mr. Banbury, who along with the UN System Senior Coordinator for Ebola Virus Disease would work closely with WHO in managing the overall response to the Ebola crisis, would coordinate the operational work of the UN system, Member States, NGOs and other stakeholders under a single platform, working closely with the various response actors in the region.

Establishment of United Nations Mission for Ebola Emergency Response

Communication. In a 15 September letter [S/2014/669] to the Security Council President, the Secretary-General transmitted a joint letter dated 29 August from Alpha Condé, President of Guinea; Ellen Johnson Sirleaf, President of Liberia; and Ernest Bai Koroma, President of Sierra Leone, that detailed the impact of the Ebola virus disease in their countries and its implications for West Africa and beyond. Presidents Condé, Johnson Sirleaf and Koroma requested a UN resolution on a comprehensive response to the Ebola virus disease outbreak that would include a coordinated international response to end the outbreak; strategic guidance from WHO for overall response and the restoration of basic health service; a coordinated international response to support the societies and economies of affected countries during the outbreak; maintaining trade and transportation links with reasonable precautions; and an international public education campaign.

(For more information on the political and security situation in Guinea, Liberia and Sierra Leone, see PART ONE, Chapter II.)

Security Council action. On 15 September, by **resolution 2176(2014)** (see p. 262), the Security Council expressed appreciation for the appointments of the UN System Senior Coordinator for Ebola Virus Disease and the Deputy Ebola Coordinator and Operation Crisis Manager operating from the United Nations Operations and Crisis Centre, in order to assist Governments in the region to address the Ebola outbreak, and urged the international community to respond swiftly to the shortage of qualified medical professionals and appropriate equipment and preventive measures necessary to address the Ebola outbreak in West Africa.

Letter of Secretary-General. In identical letters of 17 September [A/69/389-S/2014/679] to the Presidents of the General Assembly and the Security Council, the Secretary-General asserted that the Ebola virus disease crisis was no longer just a public health crisis, but had become multidimensional, with significant political, social, economic, humanitarian, logistical and security dimensions. WHO had reported nearly

5,000 cases, resulting in over 2,500 deaths. Owing to difficulties in monitoring and reporting, the total number of cases and deaths was likely to be much higher. International experts assessed that Ebola was spreading at an exponential rate, with the number of cases doubling approximately every three weeks. The Governments of Guinea, Liberia and Sierra Leone were determined to respond effectively, but, as expressed in their letter of 29 August (see p. 1356), requested assistance and support.

In view of the rapid spread of the Ebola virus disease, the Secretary-General stated that he had decided to establish a UN mission to harness the capabilities and competencies of all the relevant UN actors under a unified operational structure. The singular strategic objective and purpose of the mission would be to work with others to stop the Ebola outbreak. The strategic priorities of the mission would be to stop the spread of the disease; treat the infected; ensure essential services; preserve stability; and prevent the spread to countries currently unaffected. The mission, through its presence in the affected States, would provide needed field-level support to the Governments and peoples of West Africa. At the operational level, the intended United Nations Mission for Ebola Emergency Response (UNMEER) would be headed by a Special Representative of the Secretary-General—appointed following consultation with the WHO Director General—who would report directly to the Secretary-General.

The Secretary-General requested the support of the Security Council, the General Assembly and all Member States to address the crisis. A detailed report outlining required resources would be submitted for the approval and consideration of the Assembly and a trust fund to mobilize voluntary contributions would be established to address any gaps in the activities of UN system partners.

Security Council consideration. On 18 September [S/PV.7268], the Security Council held an emergency session to discuss the Ebola virus disease outbreak in West Africa. The emergency session was the third in the Council's history to examine the security implications of a public health issue. The session featured a statement from the Secretary-General and briefings from Dr. David Nabarro; Dr. Margaret Chan; and Mr. Jackson Niamah, a team leader at a Médecins Sans Frontières treatment centre in Monrovia, Liberia.

The Secretary-General said that the unprecedented scope of the Ebola outbreak required a level of international action unprecedented for an emergency. He articulated his intention to establish UNMEER with its five priorities: stopping the Ebola outbreak, treating the infected, ensuring essential services, preserving stability and preventing further outbreaks. UNMEER would draw on the capacities of many partners and

work closely with regional organizations. There was, however, a need to scale up the response effort in order to fulfil critical needs totalling almost \$1 billion.

Dr. Nabarro stated that the Ebola response was lagging because the outbreak was advancing at an exponential pace. There was a need for international assistance to go beyond health and fill gaps in areas such as food and supplies, whose delivery had been interrupted in the affected countries. Dr. Chan called on Member States and other partners to support the WHO Ebola Response Roadmap, in which the most urgent needs were outlined along with 12 critical actions. Mr. Niamah called for greater capacity-building support for the Ebola response effort and, in particular, for more specialized care centres, beds and expert personnel, training for medical staff, helicopters, and basic sanitation needs such as soap and buckets.

SECURITY COUNCIL ACTION

On 18 September [meeting 7268], the Security Council unanimously adopted **resolution 2177(2014)**. The draft [S/2014/673] was submitted by 134 Member States.

The Security Council,

Recalling its resolution 2176(2014), adopted on 15 September 2014, concerning the situation in Liberia and its statement to the press of 9 July 2014,

Recalling also its primary responsibility for the maintenance of international peace and security,

Expressing grave concern about the outbreak of the Ebola virus in, and its impact on, West Africa, in particular Liberia, Guinea and Sierra Leone, as well as Nigeria and beyond,

Recognizing that the peacebuilding and development gains of the most affected countries concerned could be reversed in the light of the Ebola outbreak, and underlining that the outbreak is undermining the stability of the most affected countries concerned and, unless contained, may lead to further instances of civil unrest, social tensions and a deterioration of the political and security climate,

Determining that the unprecedented extent of the Ebola outbreak in Africa constitutes a threat to international peace and security,

Expressing concern about the particular impact of the Ebola outbreak on women,

Welcoming the convening of the Mano River Union Extraordinary Summit, held in Guinea on 1 August 2014, and the commitments expressed by the Heads of State of Côte d'Ivoire, Guinea, Liberia and Sierra Leone to combat the Ebola outbreak in the region, including by strengthening treatment services and measures to prevent the outbreak spreading across borders,

Taking note of the measures taken by the Member States of the region, especially Liberia, Guinea and Sierra Leone, as well as Nigeria, Côte d'Ivoire and Senegal, in response to the Ebola outbreak, and recognizing that the outbreak may exceed the capacity of the Governments concerned to respond,

Taking note also of the letter dated 29 August 2014 from the Presidents of Liberia, Sierra Leone and Guinea to the

Secretary-General, requesting a comprehensive response to the Ebola outbreak, including a coordinated international response to end the outbreak and to support the societies and economies affected by restrictions on trade and transportation during the outbreak,

Recognizing the measures taken by the Member States of the region, in particular Côte d'Ivoire, Cabo Verde, Ghana, Mali and Senegal, to facilitate the delivery of humanitarian assistance to the most affected countries,

Emphasizing the key role of Member States, including through the Global Health Security Agenda where applicable, to provide adequate public health services to detect, prevent, respond to and mitigate outbreaks of major infectious diseases through sustainable, well-functioning and responsive public health mechanisms,

Recalling the International Health Regulations (2005), which are contributing to global public health security by providing a framework for the coordination of the management of events that may constitute a public health emergency of international concern, and aim to improve the capacity of all countries to detect, assess, notify and respond to public health threats, and underscoring the importance of States members of the World Health Organization abiding by these commitments,

Underscoring that the control of outbreaks of major infectious diseases requires urgent action and greater national, regional and international collaboration, and in this regard stressing the crucial and immediate need for a coordinated international response to the Ebola outbreak,

Commending Member States, bilateral partners and multilateral organizations for the crucial assistance, including financial commitments and in-kind donations, provided to and identified for the affected people and Governments of the region to support the scaling-up of emergency efforts to contain the Ebola outbreak in West Africa and interrupt transmission of the virus, including by providing flexible funds to relevant United Nations agencies and international organizations involved in the response to enable them and national Governments to purchase supplies and enhance emergency operations in the affected countries, as well as by collaborating with public and private sector partners to accelerate development of therapies, vaccines and diagnostics to treat patients and limit or prevent further infection or transmission of the Ebola virus disease,

Expressing deep appreciation to the first-line responders to the Ebola outbreak in West Africa, including national and international health and humanitarian relief workers contributed by the Member States of diverse regions and non-governmental organizations such as Médecins sans frontières and the International Federation of Red Cross and Red Crescent Societies, and also expressing appreciation to the United Nations Humanitarian Air Service for transporting humanitarian personnel and medical supplies and equipment, especially to remote locations in Guinea, Liberia and Sierra Leone, during the outbreak,

Welcoming the efforts of the African Union, in coordination with bilateral partners and multilateral organizations, to craft a united, comprehensive and collective African response to the outbreak, including through the deployment of health-care workers to the region, and also the efforts of the Economic Community of West African States to support steps to contain the spread of the Ebola virus, including through the support of the defence forces of its member States,

Expressing concern about the impact, including on food security, of general travel and trade restrictions in the region, and taking note of the call by the African Union upon its member States to lift travel restrictions to enable the free movement of people and trade to the affected countries,

Emphasizing the role of all relevant United Nations system entities, in particular the General Assembly, the Economic and Social Council and the Peacebuilding Commission, in supporting the national, regional and international efforts to respond to the Ebola outbreak, and recognizing in this regard the central role of the World Health Organization, which designated the Ebola outbreak a public health emergency of international concern,

Stressing the need for coordinated efforts of all relevant United Nations system entities to address the Ebola outbreak in line with their respective mandates and to assist, wherever possible, national, regional and international efforts in this regard,

Taking note of the World Health Organization Ebola response road map of 28 August 2014 which aims to stop transmission of the Ebola virus disease worldwide, while managing the consequences of any further international spread, and taking note also of the 12 mission-critical actions, including infection control, community mobilization and recovery, to resolve the Ebola outbreak,

Taking note also of the World Health Organization protocols to prevent the transmission of the Ebola virus disease between individuals, organizations and populations, underlining that the Ebola outbreak can be contained, including through the implementation of established safety and health protocols and other preventive measures that have proven effective, and commending the efforts of the United Nations Mission in Liberia to communicate, including through UNMIL Radio, such protocols and preventive measures to the Liberian public,

Reiterating its appreciation for the appointments by the Secretary-General of Dr. David Nabarro as the United Nations System Senior Coordinator for Ebola Virus Disease and of Mr. Anthony Banbury as the Deputy Ebola Coordinator and Operation Crisis Manager operating from the crisis response mechanism of the United Nations, which was activated on 8 September 2014 and which aims to consolidate the operational work of the United Nations system, Member States, non-governmental organizations and other partners focused on providing assistance to the affected countries in response to the Ebola outbreak, as well as to ensure United Nations system assistance to developing, leading and implementing an effective response to the broader dimensions of the outbreak that include food security and access to basic health services,

Welcoming the intention of the Secretary-General to convene a high-level meeting on the margins of the sixty-ninth session of the General Assembly to urge an exceptional and vigorous response to the Ebola outbreak,

1. *Encourages* the Governments of Liberia, Sierra Leone and Guinea to accelerate the establishment of national mechanisms to provide for the rapid diagnosis and isolation of suspected cases of infection, treatment measures, effective medical services for responders, credible and transparent public education campaigns, and strengthened preventive and preparedness measures to detect, mitigate and respond to Ebola exposure, as well as to coordinate the rapid delivery and utilization of international assistance, including health workers and humanitarian relief supplies,

as well as to coordinate their efforts to address the transnational dimension of the Ebola outbreak, including the management of their shared borders, and with the support of bilateral partners, multilateral organizations and the private sector;

2. *Also encourages* the Governments of Liberia, Sierra Leone and Guinea to continue efforts to resolve and mitigate the wider political, security, socioeconomic and humanitarian dimensions of the Ebola outbreak, as well as to provide sustainable, well-functioning and responsive public health mechanisms, emphasizes that responses to the Ebola outbreak should address the specific needs of women, and stresses the importance of their full and effective engagement in the development of such responses;

3. *Expresses concern* about the detrimental effect of the isolation of the affected countries as a result of trade and travel restrictions imposed on and to the affected countries;

4. *Calls upon* Member States, including of the region, to lift general travel and border restrictions, imposed as a result of the Ebola outbreak, and that contribute to the further isolation of the affected countries and undermine their efforts to respond to the Ebola outbreak, and also calls upon airlines and shipping companies to maintain trade and transport links with the affected countries and the wider region;

5. *Calls upon* Member States, especially of the region, to facilitate the delivery of assistance, including qualified, specialized and trained personnel and supplies, in response to the Ebola outbreak to the affected countries, and in this regard expresses deep appreciation to the Government of Ghana for allowing the resumption of the air shuttle of the United Nations Mission in Liberia from Monrovia to Accra, which will transport international health workers and other responders to areas affected by the Ebola outbreak in Liberia;

6. *Calls upon* Member States, especially of the region, and all relevant actors providing assistance in response to the Ebola outbreak to enhance efforts to communicate to the public, as well as to implement, the established safety and health protocols and preventive measures to mitigate against misinformation and undue alarm about the transmission and extent of the outbreak among and between individuals and communities, and in this regard requests the Secretary-General to develop a strategic communication platform using existing United Nations system resources and facilities in the affected countries, as necessary and available, including to assist Governments and other relevant partners;

7. *Calls upon* Member States to provide urgent resources and assistance, including deployable medical capabilities such as field hospitals with qualified and sufficient expertise, staff and supplies, laboratory services, logistical, transport and construction support capabilities, airlift and other aviation support and aeromedical services and dedicated clinical services in Ebola treatment units and isolation units, to support the affected countries in intensifying preventive and response activities and strengthening national capacities in response to the Ebola outbreak and to allot adequate capacity to prevent future outbreaks;

8. *Urges* Member States, as well as bilateral partners and multilateral organizations, including the African Union, the Economic Community of West African States and the European Union, to mobilize and provide immediately technical expertise and additional medical

capacity, including for rapid diagnosis and training of health workers at the national and international levels, to the affected countries and those providing assistance to the affected countries, and to continue to exchange expertise, lessons learned and best practices, as well as to maximize synergies to respond effectively and immediately to the Ebola outbreak, to provide essential resources, supplies and coordinated assistance to the affected countries and implementing partners, and calls upon all relevant actors to cooperate closely with the Secretary-General on response assistance efforts;

9. *Urges* Member States to implement relevant temporary recommendations issued under the International Health Regulations (2005) regarding the 2014 Ebola outbreak in West Africa, and lead the organization, coordination and implementation of national preparedness and response activities, including, where and when relevant, in collaboration with international development and humanitarian partners;

10. *Commends* the continued contribution and commitment of international health and humanitarian relief workers to respond urgently to the Ebola outbreak, and calls upon all relevant actors to put in place the necessary repatriation and financial arrangements, including medical evacuation capacities and treatment and transport provisions, to facilitate their immediate and unhindered deployment to the affected countries;

11. *Requests* the Secretary-General to help to ensure that all relevant United Nations system entities, including the World Health Organization and the United Nations Humanitarian Air Service, in accordance with their respective mandates, accelerate their response to the Ebola outbreak, including by supporting the development and implementation of preparedness and operational plans and liaison and collaboration with Governments of the region and those providing assistance;

12. *Encourages* the World Health Organization to continue to strengthen its technical leadership and operational support to Governments and partners, monitor Ebola transmission, assist in identifying existing response needs and partners to meet those needs to facilitate the availability of essential data and hasten the development and implementation of therapies and vaccines according to best clinical and ethical practices, and also encourages Member States to provide all necessary support in this regard, including the sharing of data in accordance with applicable law;

13. *Decides* to remain seized of the matter.

General Assembly consideration. On 19 September, at its third plenary meeting [A/69/PV.3], the General Assembly addressed the Ebola virus disease outbreak in West Africa. The President of the Assembly said that the outbreak was no longer merely a subregional or regional calamity, but rather an international crisis. Women, as primary caregivers, community leaders and front-line health workers, were particularly at risk. Introducing the draft resolution on the establishment of UNMEER, which aimed to bring the UN system competencies into a single, unified structure for a rapid response to the outbreak and provide coherent support to national, regional

and international efforts, the President implored the Assembly to add its voice to that of the Security Council in calling on the international community to take immediate steps to support the countries affected by the deadly virus. While a high price had already been paid, the cost of inaction could reach unimaginable proportions.

The Secretary-General stated that the crisis had significant economic, social, humanitarian, political and security dimensions. While WHO had reported that of the nearly 5,000 people infected by the Ebola virus, about 2,500 had died so far, the actual number of casualties was probably higher, due to shortfalls in reporting and monitoring. Cases were doubling every three weeks. The Secretary-General said that WHO had developed a response roadmap and was working with Guinea, Liberia and Sierra Leone to identify the best possible epidemiological ways to address the outbreak, including through Ebola treatment centres and community care centres. He outlined the five priorities of UNMEER: to stop the outbreak; treat the infected; provide essential services; preserve stability; and prevent outbreaks in non-affected countries. The Mission would also support national efforts, reinforce government leadership and emphasize community outreach and training. Its headquarters would be located in Accra, Ghana, and that country's international airport would be used for a vital air bridge.

GENERAL ASSEMBLY ACTION

On 19 September [meeting 3], the General Assembly adopted **resolution 69/1** [draft: A/69/L.2, as orally revised] without vote [agenda item 124].

Measures to contain and combat the recent Ebola outbreak in West Africa

The General Assembly,

Expressing grave concern at the recent Ebola outbreak in West Africa and its unprecedented nature and scope,

Expressing grave concern also at the rapid deterioration of the situation, in particular in Guinea, Liberia and Sierra Leone, and the threat that this poses to their post-conflict recovery,

Expressing deep concern about the potential reversal of the gains made by the affected countries in peacebuilding, political stability and the reconstruction of socioeconomic infrastructure in recent years,

Underscoring the urgent need to contain this public health crisis owing to its possible grave humanitarian, economic and social consequences,

Underlining its strong commitment to responding to this emergency in a timely, effective and coordinated manner,

Recognizing the central role being played by the World Health Organization in leading worldwide support for the courageous responses of countries whose people are affected by, and at risk of, Ebola,

Welcoming all national, regional and international efforts aimed at ending the crisis, and reaffirming the important role of regional and subregional organizations

in this regard, in particular, the African Union and the Economic Community of West African States,

Expressing appreciation for the appointment by the Secretary-General of a United Nations System Senior Coordinator for Ebola Virus Disease and a Deputy Ebola Coordinator and Emergency Crisis Manager, in order to assist Governments in the region to address the Ebola outbreak,

Noting the adoption by the Security Council of resolution 2176(2014) of 15 September 2014 and resolution 2177(2014) of 18 September 2014,

1. *Welcomes* the intention of the Secretary-General to establish the United Nations Mission for Ebola Emergency Response;

2. *Requests* the Secretary-General to take such measures as may be necessary for the prompt execution of his intention and to submit a detailed report thereon for consideration by the General Assembly at its sixty-ninth session;

3. *Calls upon* all Member States, relevant United Nations bodies and the United Nations system to provide their full support to the United Nations Mission for Ebola Emergency Response.

Appointments. On 23 September, the Secretary-General announced the appointment of Dr. David Nabarro (United Kingdom) as his Special Envoy on Ebola and Anthony Banbury as his Special Representative and Head of UNMEER. The appointments were made following close consultations with the WHO Director General. The Special Envoy on Ebola would provide strategic and policy direction for a greatly enhanced international response and galvanize essential support for affected communities and countries. The Special Representative and Head of UNMEER would provide the operational framework and unity of purpose to ensure the rapid, effective and coherent action necessary to stop the Ebola outbreak, to treat the infected, to ensure essential services, to preserve stability and to prevent the spread to countries currently unaffected.

Further developments

Report of Secretary-General. On 24 September [A/69/404], in response to resolution 69/1 (see above), the Secretary-General submitted a report to the General Assembly on UNMEER and the Office of the Special Envoy on Ebola. The report, which contained estimated preliminary resource requirements for UNMEER and the Office of the Special Envoy on Ebola, outlined five strategic priorities, six guiding principles and resourcing assumptions for UNMEER. The strategic priorities included stopping the spread of disease; treating the infected; ensuring essential services; preserving stability; and preventing the spread of the disease to unaffected countries. The six guiding principles included reinforcing government leadership; delivering a rapid impact on the ground; coordinating and collaborating with actors outside the United Nations; tailoring responses to the needs of different countries; reaffirming WHO leadership on all health issues; and identifying benchmarks for transition post-emergency and ensuring that all actions strengthen systems.

The Special Representative of the Secretary-General would head the Mission and be tasked with building and maintaining a regional operational platform that ensured the rapid delivery of international assistance. The Mission's headquarters, to be established in Accra, Ghana, would have four pillars, including a medical response; operational coordination and planning; essential services response; and an in-country crisis response team in the three affected countries of Guinea, Liberia and Sierra Leone.

The Secretary-General, pending submission of a detailed revised programme budget, requested that the General Assembly approve estimated preliminary requirements for UNMEER and the Office of the Special Envoy on Ebola amounting to \$49,943,600 (net of staff assessment) for the period from 19 September to 31 December 2014. He also proposed that the Assembly authorize him to enter into commitments in an amount not exceeding \$49,943,600, pending submission of a detailed revised programme budget during the latter part of the main part of the sixty-ninth (2014) session.

High-level meeting. On 25 September, the Secretary-General convened a high-level meeting on the response to the Ebola virus disease outbreak. Speaking via teleconference were Presidents of Guinea, Liberia and Sierra Leone. The Secretary-General noted that the crisis had highlighted the need to strengthen early identification systems and action and suggested that a stand-by "white coats" corps of medical professionals be formed. While there had been a concerted response from the international communities and organizations, increased contributions were still required. International financial institutions and national Governments announced further pledges at the meeting.

ACABQ report. In a 30 September report [A/69/408], the Advisory Committee on Administrative and Budgetary Questions (ACABQ) conveyed its having been informed that due to the urgency of establishing initial capability on the ground in the countries concerned following the establishment of UNMEER on 19 September, as well as the ongoing planning process, the Secretariat had been unable to conduct a thorough analysis and provide full details to support the request for resources for the Mission and the Office of the Special Envoy on Ebola for the period of 19 September to 31 December. Inasmuch as UNMEER was the first emergency health mission established by the Organization, the Committee emphasized the need for close coordination and cooperation among all partners in order to ensure the effective and efficient operation of the Mission in light of the involvement of multiple senior officials in leadership roles.

ACABQ recommended that the General Assembly request the Secretary-General to provide in his detailed budget submission comprehensive information

on the UN system's response and the specific functions and tasks of UNMEER and partners. The Secretary-General should detail the Mission's operational targets, benchmarks, indicators of achievement and expected time frames. In addition, there needed to be a rigorous assessment of the envisaged structure and staffing, with the grade levels of the proposed positions closely aligned with their respective functions and responsibilities. The Secretary-General should provide detailed justifications for non-post categories of expenditure, taking into account the total resources made available through the multi-partner trust fund, Member States and other partners, along with any in-kind contributions; and he should make every effort to seek contributions to that multi-partner trust fund.

The Committee recommended that the General Assembly authorize the Secretary-General to enter into commitments in an amount not exceeding \$49,943,600 for the Mission for the period from 19 September to 31 December. It emphasized that recommendation was without prejudice to any recommendation it might make to the General Assembly when it considered the detailed budget submission for the Mission or any decision that the Assembly might take with regard to the Mission's organizational structure, staffing and operational requirements.

GENERAL ASSEMBLY ACTION

On 9 October [meeting 22], the General Assembly, on the recommendation of the Fifth (Administrative and Budgetary) Committee [A/69/422], adopted **resolution 69/3** without vote [agenda item 132].

United Nations Mission for Ebola Emergency Response

The General Assembly,

Having considered the report of the Secretary-General on the United Nations Mission for Ebola Emergency Response and the Office of the Special Envoy on Ebola and the related report of the Advisory Committee on Administrative and Budgetary Questions,

1. *Takes note* of the report of the Secretary-General;
2. *Endorses* the conclusions and recommendations contained in the report of the Advisory Committee on Administrative and Budgetary Questions;
3. *Recalls* paragraph 24 of the report of the Advisory Committee, and emphasizes that the adoption of the present resolution is without prejudice to any subsequent review of the United Nations Mission for Ebola Emergency Response by the General Assembly and any decision it may take with regard to the budgetary arrangements, organizational structure, staffing and operational requirements of the Mission, when it considers the detailed budget submission by the Secretary-General.

High-level meeting. On 23 October, WHO convened a high-level meeting on Ebola Vaccines Access and Financing. More than 90 participants, including scientists, representatives of drug regulatory

authorities, NGOs, funding agencies and foundations, the GAVI alliance for childhood immunization and development banks, took part in examining the complex policy issues surrounding access to experimental Ebola vaccines and discussing ways to ensure the fair distribution and financing of such vaccines.

Letter of Secretary-General. In a 12 November letter [A/69/573] to the President of the General Assembly, the Secretary-General reviewed the activities from 19 September to 31 October that had been carried out by the Special Envoy on Ebola and UNMEER in pursuance of Assembly resolution 69/1 (see p. 1360). The letter reviewed the background of the Ebola virus disease outbreak and the development of the global response; the current situation; the Mission's activities and progress; and outstanding issues that needed to be addressed in order to move forward.

As the first-ever UN emergency health mission, UNMEER combined the technical expertise of WHO with the operational capabilities of other UN agencies, funds and programmes to lead international efforts that supported, reinforced and responded to the national plans of the affected countries of Guinea, Liberia and Sierra Leone. The outbreak called for a massive, proportionate and well-organized global response that could support those Governments, guided by six principles of commitment: to the affected countries' ownership, sovereignty in decision-making and final authority; to reflecting the interests of people affected by the outbreak, by working in ways consistent with their social structures and national interests; to a differentiated but disciplined approach, aligned to a set of objectives ensuring consistency across geographies and situations to the extent feasible; to a dynamically adaptive approach, tailoring resource deployment to supply at any given time and to the scale of the outbreak in specific locations, and recognizing gaps as they existed or might exist; to working on essential systems beyond Ebola and not only to stopping the outbreak, but also to minimizing the impact on health care structures, food security and social and economic situations at local and national levels; and to building for the long term by strengthening health infrastructure in affected countries in the medium term. Furthermore, the Government of Ghana was hosting UNMEER headquarters in Accra to coordinate deliveries of aid to the affected countries.

As at 31 October, a total of 13,567 confirmed, probable and suspected cases of Ebola had been reported in six affected countries (Guinea, Liberia, Mali, Sierra Leone, Spain, United States) and two previously affected countries (Nigeria, Senegal). A total of 4,951 deaths had been reported. The outbreak impacted access to basic health care, food, livelihood and education, with vulnerable groups such as pregnant women, children and elderly persons disproportionately affected. The fragile economies of Guinea,

Liberia and Sierra Leone had also experienced rising prices, lower household incomes and greater poverty.

The World Bank estimated that the short-term growth rate of gross domestic product in 2014 had decreased from 4.5 per cent to 2.4 per cent in Guinea; from 5.9 per cent to 2.5 per cent in Liberia; and from 11.3 per cent to 8 per cent in Sierra Leone.

On 10 October, the Global Ebola Response Coalition (see p. 1356) adopted a response framework with near-term objectives over the following 30, 60 and 90 days. In the first 30 days, starting 1 October, the Mission was to establish its presence in the four countries and deploy personnel, aircraft, vehicles, communications and logistical capabilities. At the 60-day mark, the goal was to achieve 70 per cent isolation and 70 per cent safe burials, which would require a high-capacity scale-up of Ebola treatment units and community care centres. The 90-day mark aimed to achieve 100 per cent case isolation and 100 per cent safe burials, along with declining infection rates.

After establishing the Mission, the United Nations had deployed advance teams to Ghana, Guinea, Liberia and Sierra Leone to prepare for operations and engage with key partners in the region. The Mission also held an operational planning conference (Accra, Ghana, 15–18 October) with UN actors and international partners to produce an operational framework. The Mission's line of action in support of containment included case finding, laboratories and contact tracing; case management; safe dignified burials; and community engagement and social mobilization.

The World Food Programme provided dedicated services for the Ebola response; all staging areas and main hubs in Accra and in the three affected countries were operational. Regional operational staging areas were also established in Accra, Dakar, and Las Palmas, Spain. Eight forward logistics bases across Guinea, Liberia and Sierra Leone had become operational. Work was also underway to establish 16 additional satellite hubs in the field to facilitate access to both community care and district health centres.

Air operations with dedicated staff and assets were deployed to Guinea, Sierra Leone, Accra and Dakar. Six helicopters and four fixed-wing aircraft were positioned in the region. An air coordination cell at the Copenhagen office of UNICEF was established. Since 19 September, 3,001 tons of ambulances, medical and operational support supplies, water, sanitation and health supplies on 47 UN-coordinated flights were flown into the region. The United Nations Humanitarian Air Service had been providing dedicated common air transport service since August and a humanitarian air corridor opened in Dakar to the affected countries on 25 September. In addition, several Governments provided air and maritime support, including Germany with two C-160 cargo planes

operating supply runs from Accra to the three affected countries, Luxembourg with airlift capacity for vital supplies and Denmark committing to maritime sealift support.

By 31 October, gap analyses and planning showed the total revised financial requirement for critical lines of action and enabling functions amounted to \$1.5 billion—an increase from the initially foreseen \$988 million—for the support of the activities of the UN system and international partners. The increase reflected the changes and scaling up of responses to stop and treat the virus and deliver on community mobilization. The Office for the Coordination of Humanitarian Affairs noted that \$799 million had been received, committed or pledged to date; and efforts were aimed at ensuring funds received were translated quickly into demonstrable impact within villages, towns and cities. Overall costs related to immediate needs and beyond were estimated to be in the region of \$4 billion, depending on the international and national communities mobilizing and deploying the necessary resources as well as how quickly the crisis could be brought under control.

Despite the deployments and pledges, an additional 14 foreign medical teams were urgently needed. An entire information management system was also needed to develop an effective data management mechanism, including mobile data collection. While efforts were focused on achieving the 60-day goal (see p. 1362), the critical needs of abandoned orphans and people affected by diseases other than Ebola (particularly malaria) also had to be addressed; and the United Nations and NGOs needed staff and resources to do so.

Work was being done to increase the preparedness of all countries, with special attention to those in Africa, particularly 15 States that bordered countries with widespread and intense transmission, or that had strong trade and travel ties with such countries. Those States were prioritized for technical assistance on preparedness from WHO teams and partners. Teams had already been deployed to Côte d'Ivoire and Mali and were working with health authorities there. Urging Member States not to resort to travel restrictions or close their borders, as such was already obstructing response efforts, the Secretary-General maintained that the Ebola virus disease could only be stopped at its source by deploying the essential human resources to contain the outbreak. It was encouraging that, within 30 days, UNMEER had been deployed to four countries, mobilized significant human resource and logistical assets, set up operational capabilities in record time and developed a detailed operational plan in collaboration with the Governments of Guinea, Liberia and Sierra Leone and relevant UN partners and NGOs. Remaining gaps and medical and social challenges, however, needed to be addressed in order to begin containing the disease.

Security Council consideration. On 21 November, the Security Council held a meeting [S/PPV.7318] on peace and security in Africa, focusing on the engagement of the Council on the Ebola virus disease outbreak, which it had declared to be a threat to international peace and security (see p. 1357). Addressing the Council, Dr. Nabarro, Special Envoy of the Secretary-General on Ebola, said that where the response strategy was being implemented fully, transmission was decreasing, although results were uneven in different countries. Anthony Banbury, Special Representative of the Secretary-General and Head of UNMEER, told the meeting that while the financial needs were increasing, government revenues of the affected countries were decreasing.

SECURITY COUNCIL ACTION

On 21 November [meeting 7318], following consultations among Security Council members, the President made statement **S/PRST/2014/24** on behalf of the Council:

The Security Council reiterates its grave concern about the unprecedented extent of the Ebola outbreak in Africa, which constitutes a threat to international peace and security, and the impact of the Ebola virus on West Africa, in particular Liberia, Guinea and Sierra Leone. The Council expresses its appreciation for the crucial contributions and commitments made by the Member States of the region to continue to lead the ground-level response against the Ebola outbreak, as well as to address the wider political, security, socioeconomic and humanitarian impact, including on food security, of the Ebola outbreak on communities and the need to plan for the longer-term recovery in the region, including with the support of the Peacebuilding Commission. The Council underscores the continued need for robust contact tracing, social mobilization and community-level engagement efforts, especially outside of major urban areas in the most affected countries.

The Council stresses the importance for the United Nations Mission for Ebola Emergency Response to continue to strengthen coordination with the Governments of Guinea, Liberia and Sierra Leone and all national, regional and international actors, including bilateral partners and multilateral organizations, including the Mano River Union, the African Union, the Economic Community of West African States, the European Union, the World Bank Group and the United Nations system, in order to more readily identify gaps in the response effort and to utilize all Ebola response assistance more fully and efficiently, particularly at the local level. In this regard, the Council requests that the Secretary-General accelerate efforts to scale up the presence and activities of the Mission at the district and prefecture level outside of the capital cities.

The Council expresses its concern about the recent reported Ebola infections in Mali. The Council recognizes the important steps taken by the Government of Mali, including by appointing an Ebola incident coordinator to lead a whole-of-government response. The Council affirms the importance of preparedness

by all Member States to detect, prevent, respond to, isolate and mitigate suspected cases of Ebola within and across borders and of bolstering the preparedness of all countries in the region. The Council recalls the International Health Regulations (2005), which aim to improve the capacity of all countries to detect, assess, notify and respond to all public health threats.

The Council welcomes the efforts undertaken by the Mission to provide overall leadership and direction to the operational work of the United Nations system, as mandated by the General Assembly. The Council underscores the need for relevant United Nations system entities, including the United Nations peacekeeping operations and special political missions in West Africa, in close collaboration with the Mission and within their existing mandates and capacities, to provide immediate assistance to the Governments of the most affected countries.

The Council lauds the critical, heroic and selfless efforts of the first-line responders to the Ebola outbreak in West Africa, including national health and humanitarian relief workers, educators and burial team members, as well as international health and humanitarian relief workers contributed by the Member States of diverse regions and non-governmental and intergovernmental organizations. The Council expresses its condolences to the families of the victims of the Ebola outbreak, including national and international first-line responders. The Council urges all Member States, non-governmental, intergovernmental and regional organizations to continue to respond to the outstanding need for medical personnel, as well as related critical gap areas such as personnel with expertise in sanitation and hygiene.

The Council underscores the critical importance of putting in place essential arrangements, including medical evacuation capacities and treatment and transport provisions, to facilitate the immediate, unhindered and sustainable deployment of health and humanitarian relief workers to the affected countries. The Council welcomes the steps announced by Member States and regional organizations to provide medical evacuation capacities for health and humanitarian relief workers, as well as other treatment options in situ.

The Council notes the considerable efforts of the international community to scale up its coordinated response to the Ebola outbreak and the important progress on the ground as a result of these contributions. In this regard, the Council commends those Member States, which, in concert with other actors on the ground, have opened Ebola treatment units and provided other crucial support in the affected countries. The Council urges all Member States, bilateral partners and multilateral organizations to expedite the provision of resources and financial assistance, as well as mobile laboratories; field hospitals to provide non-Ebola related medical care; dedicated and trained clinical personnel and services in Ebola treatment units and isolation units; therapies, vaccines and diagnostics to treat patients and limit or prevent further Ebola infection or transmission; and personal protective equipment for first-line responders. The Council calls upon Member States, especially in the region, to facilitate immediately the delivery of such assistance to the most affected countries.

The Council emphasizes that the dynamic needs on the ground in the most affected countries require that the response of the international community response remain flexible, in order to adapt to changing requirements and rapidly respond to new outbreaks.

The Council strongly urges Member States, as well as airlines and shipping companies, while applying appropriate public health protocols, to maintain trade and transport links with the most affected countries to enable the timely utilization of all efforts aimed at containing the Ebola outbreak within and across borders of the region. While recognizing the important role that appropriate screening measures can play in stopping the spread of the outbreak, the Council expresses its continued concern about the detrimental effect of the isolation of the affected countries as a result of trade and travel restrictions imposed on and to the affected countries, as well as acts of discrimination against the nationals of Guinea, Liberia, Mali and Sierra Leone, including Ebola survivors and their families or those infected with the disease.

Appointment. In identical letters of 9 December [A/69/662-S/2014/877], the Secretary-General informed the Presidents of the General Assembly and the Security Council of his intention to appoint Ismail Ould Cheikh Ahmed (Mauritania) as his Special Representative for UNMEER succeeding Anthony Banbury (United States).

Year-end developments. In a later letter [A/69/720] to the General Assembly President, the Secretary-General gave an overview of developments from 1 November 2014 to 1 January 2015 on progress made in the Ebola virus disease response pursuant to General Assembly resolution 69/1 (see p. 1360) since his letter of 12 November 2014 (see p. 1362). He covered the status of the Ebola outbreak; progress of the operational framework to stop the outbreak, including progress towards meeting key targets and challenges to achieving key response targets; an update on the operational activities carried out by the UN system through UNMEER and its partners, as well as his visit to the region (18–20 December); and activities of the Special Envoy on Ebola and the Global Ebola Response Coalition.

The Secretary-General reviewed efforts on moving forward, including stopping the outbreak and treating the infected; providing essential services and preserving stability; non-Ebola health care; protection; education; food security; water, sanitation and hygiene; economic impact, livelihoods and early recovery planning; and preventing outbreaks in non-affected countries.

As at 31 December, 20,206 deaths confirmed, probable and suspected cases of Ebola were reported in five affected countries (Guinea, Liberia, Mali, Sierra Leone, United Kingdom) and four previously affected countries (Nigeria, Senegal, Spain, United States). While the three most-affected countries (Guinea, Liberia, Sierra Leone) showed significant progress in slowing down the spread of the disease, within each

country, statistics illustrated significant differences. The number of new cases reported was fluctuating in Guinea and decreasing in Liberia, while the western part of Sierra Leone was experiencing the highest incidence of transmission. Although the weekly numbers remained similar, the disease was now more widely dispersed, creating challenges for the response.

Because of cross-border outbreaks in Mali, its Government requested that UNMEER establish an office in Bamako that became operational on 26 November. While the first case of Ebola had not resulted in a chain of transmission, a second case had resulted in six additional cases. Of the eight cases recorded in Mali, six resulted in death, including that of two health-care workers. Completing the 21-day surveillance period that began on 15 December, no further cases had been recorded, demonstrating the success of the Government's efforts to strengthen preparedness in Mali.

Within the reporting period, of the 678 health-care workers who had become infected, 380 had died. Data collection and epidemiological data were still impacted by the inaccessibility of remote areas, unreliable reporting and underreporting by resistant communities. UNMEER was working with international partners and NGOs to address data collection and develop a unified, technology-based reporting system. The operational framework established at a multi-stakeholder conference convened by UNMEER in October resulted in significant progress. The collective efforts of national Governments, affected communities, and the UN system and its partners had resulted in reducing the spread of Ebola through establishing treatment centres and burial teams, and training thousands of contract tracers and social mobilizers in affected countries, which helped communities change their behaviour and traditional practices to prevent transmission.

With 221 trained burial teams, over 90 per cent of individuals reported to have died from Ebola received a safe and dignified burial. In some regions, portions of the population were still carrying out clandestine, unsafe burials, including the washing of the body before the safe burial team was called. Improved geographical coverage and greater mobility of safe burial teams were needed. By the 60-day mark, 70 per cent of people with Ebola in Guinea and Liberia had been isolated and treated. Ebola treatment units and community care centres were reinforced by community-based initiatives.

In Sierra Leone, at the 60-day mark, the target of isolating and treating 70 per cent of people infected with the virus was not reached in four districts, in part due to the shortage of adequate treatment facilities. The Government and UNMEER initiated the "Western Area surge" plan which intensified efforts to curb the disease in that region. The Mission mobilized operational partners to meet critical gaps, such

as beds and convalescent centres, and help transport additional laboratories from within the region, airlift blood samples and deploy laboratory data specialists.

All three affected countries had the net capacity to reach the 90-day objective of isolating 100 per cent of all Ebola patients and ensuring safe and dignified burials in 100 per cent of Ebola-related deaths. Because capacity was not uniform across the districts and regions of each country, discrepancies were addressed by increasing laboratories, opening treatment units, increasing bed capacity and continuing safe burials. More than 100,000 teachers, religious leaders, traditional chiefs and community watch committee members received Ebola training in the three countries. In Liberia and Sierra Leone, the percentage of districts where safe burial was promoted by religious and community leaders had reached 100 per cent. Still needed were trained and experienced international medical responders with the requisite language skills to support national personnel. To respond to the increasing geographical dispersion of the outbreak, a large number of basic and more flexible deployable treatment and surveillance capabilities at the district level were needed as well.

As at 31 December, the Ebola Response Multi-Partner Trust Fund had pledges and deposits totalling \$141 million, with \$105.5 million disbursed to address critical unfunded gaps in the three most affected countries. Amounts committed still fell short of the required \$1.5 billion. The Special Envoy's report on "resources-for-results" provided a thorough overview of the needs of affected countries. Country-tailored reports were made available to the Governments of the three most affected countries and provided specific figures of available resources allocated by the major UN entities, as well as funds disbursed.

To contain the Ebola virus disease outbreak, the response needed to be further tailored to the location and spread pattern of the disease. The initial emphasis on containing the spread by finding and isolating infected individuals was now shifting to eliminating transmission wherever it appeared. The response also needed to shift from a country-level approach to a district-level approach. Governments, partners and the UN system were focusing on tailored responses in the 33 districts of Guinea, 15 districts in Liberia and 14 districts in Sierra Leone. The district-by-district approach would be complemented by a rapid response capacity that could be deployed in cases of sudden flare-ups that were beyond the district-level capacity.

To address the impact on essential services, the Mission and resident coordinators of the affected countries were working to ensure a response guided by national priorities. A revision of the overview of needs and requirements for the Ebola response would be published in January 2015. To strengthen the operational link between the Mission and United Nations agencies, funds and programmes involved in the res-

toration of essential services, UNMEER established a liaison office in Dakar. An estimated 86 per cent of Ebola treatment units and community care centres in the affected countries had functional water, sanitation and hygiene facilities. To help reduce further spread of the disease, UNICEF provided more than 160,000 households with safe water, sanitation and hygiene kits and support.

According to a study by the United Nations Development Programme and the Economic Commission for Africa, prices increased on vegetable oil, rice and potatoes by 20 to 30 per cent in some rural areas of Liberia and the price of rice had increased by at least 30 per cent in Sierra Leone. Foreign investors suspended activities and cross-border trade collapsed due to border closures. Household incomes suffered across all three countries, along with an increase in job loss. In response, social safety net cash transfer programmes were being provided for people who had lost their livelihoods, including in Liberia to bush meat traders affected by the preventive ban on bush meat. In Sierra Leone, 5,000 vulnerable households and 1,250 youth were being targeted through cash-for-work and skill-building for alternative livelihood programmes. In addition, a high-level meeting convened by WHO (Geneva, 11–12 December) on strengthening health systems and resilience in Guinea, Liberia and Sierra Leone aimed to lay the foundation for stronger health systems and identified main constraints and challenges in rebuilding and developing more resilient health systems, among other goals.

The Ebola outbreak was still a public health emergency of international concern and the UN system would continue scaling up its efforts. More than \$1.16 billion had been received, committed or pledged by donors to fund the revised overview of needs and requirements for the outbreak. The Ebola Response Multi-Partner Trust Fund had received \$141 million in commitments, pledges and deposits. Nonetheless, the amounts committed still fell short of the required \$1.5 billion. Skilled international personnel were needed to establish and sustain district-level Ebola treatment units, as well as epidemiologists and infection prevention and control experts. Although tremendous progress had been achieved the risk of retransmission and the possibility of another outbreak was present as long as there were active cases.

Financing of UNMEER

Report of Secretary-General. A 17 November report [A/69/590 & Corr.1] of the Secretary-General on the Office of the Special Envoy on Ebola and UNMEER contained proposals for revised estimates of the programme budget for the biennium 2014–2015. Three mechanisms were identified as funding sources: direct funding from the regular assessed budget for the Office of the Special Envoy and UNMEER for lead-

ership, coordination and facilitation of the overall response to the outbreak; direct voluntary funding provided to agencies, funds and programmes implementing the global strategic response plan in the affected countries; and the Ebola Response Multi-Partner Trust Fund for the allocation of funds to meet priority needs, encourage early donor contributions and allow a rapid response to unforeseen requirements. Additional resources needed were estimated to be in the amount of \$189,593,900 (net of staff assessment) for 376 positions in the Office of the Special Envoy and UNMEER, and 20 positions in 2014 and 9 positions in 2015 at Headquarters for backstopping and operational costs.

Emergency operational response activities were estimated at \$1.5 billion, to be funded through voluntary contributions received by the agencies, funds and programmes, including the Trust Fund. The total estimated resource requirements for the immediate response by the UN system were some \$1.7 billion. From the emergency response phase to the development and recovery phase, the wider UN system intervention in the affected countries was estimated at \$4.2 billion.

ACABQ report. In its 16 December report [A/69/660], ACABQ noted that it had not received the requested update on the status of expenditures as at 30 November 2014 and asked that such information be provided to the General Assembly. The Committee was concerned that the Secretary-General's report lacked clarity and/or detail in many elements and recommended that the Assembly request the Secretary-General to submit a more detailed budget proposal at the second part of the resumed sixty-ninth (2015) session. ACABQ recommended that the Assembly establish a separate and distinct special account for income and expenditures related to the Office of the Special Envoy and UNMEER, and authorize the Secretary-General to enter into commitments in the amount of \$104,582,400, inclusive of the amount of \$49,943,600 authorized in resolution 69/3 (see p. 1361) for the Office of the Special Envoy and UNMEER for the period from 19 September 2014 to 30 June 2015, pending the submission of the more detailed budget. The Committee emphasized that the recommendations were made without prejudice to any recommendation it might make to the Assembly when considering the detailed budget submission or any decision by the Assembly regarding the Mission's organizational structure, staffing and operational requirements.

Global public health

The sixty-seventh session of the World Health Assembly (Geneva, 19–24 May) [WHA67/2013/REC/1] discussed public health issues such as tuberculosis, viral hepatitis, psoriasis, exposure to mercury and mercury compounds, traditional medicine, access

to essential medicines, antimicrobial resistance and the World Health Organization (WHO) global disability action plan 2014–2021. It adopted a series of resolutions and decisions on those and other topics. The WHO Secretariat also submitted a report on the prevention and control of non-communicable diseases (NCDs). The report included the final progress report in implementing the 2008–2013 action plan for the global strategy for the prevention and control of NCDs; progress in developing the terms of reference for the global coordination mechanism on the prevention and control of NCDs as well as those for the United Nations Inter-Agency Task Force on the Prevention and Control of Non-Communicable Diseases (see p. 1344); progress in developing a limited set of action plan indicators for the 2013–2020 WHO global action plan for the prevention and control of NCDs; and the role of WHO in the preparation, implementation and follow-up to the UN General Assembly comprehensive review and assessment in 2014 of the progress achieved in the prevention and control of NCDs (*ibid.*).

Global health and foreign policy

On 26 September, pursuant to General Assembly resolution 68/98 [YUN 2013, p. 1182], the Secretary-General transmitted a report [A/69/405] by the WHO Director General focusing on global health partnerships that were helping to advance collectively agreed health priorities for obtaining better health outcomes and ensuring universal health coverage.

The Director General emphasized that forging new global partnerships was one of the major transformative shifts necessary to drive the post-2015 agenda. Global public health partnerships could support Member States' efforts in attaining better health outcomes; accelerating the transition towards universal health coverage; fostering North-South, South-South and triangular cooperation, including the transfer of technologies; preparing for and responding to emergencies and disasters, including minimizing their impact on public health. The Director General recommended that the future efforts of multi-stakeholder partnerships address critical needs that were connected to the six WHO leadership priorities agreed upon by all WHO member States: advancing universal health coverage; health-related Millennium Development Goals; addressing the challenge of NCDs; implementing the provisions of the International Health Regulations (2005) [YUN 2005, p. 1331]; increasing access to essential, high-quality and affordable medical products; and addressing the social, economic and environmental determinants of health. She also urged greater efforts to align the work of health partnerships with national health policies, strategies and plans, while ensuring country ownership and recognizing that a "one-size-fits-all" approach was not appropriate.

GENERAL ASSEMBLY ACTION

On 11 December [meeting 69], the General Assembly adopted **resolution 69/132** [draft: A/69/L.35 & Add.1] without vote [agenda item 124].

Global health and foreign policy

The General Assembly,

Recalling its resolutions 63/33 of 26 November 2008, 64/108 of 10 December 2009, 65/95 of 9 December 2010, 66/115 of 12 December 2011, 67/81 of 12 December 2012 and 68/98 of 11 December 2013, and reaffirming the outcomes of the major United Nations conferences and summits which have contributed to the advancement of the global health agenda as noted in these resolutions,

Recalling also the Universal Declaration of Human Rights, international humanitarian law, the International Covenant on Economic, Social and Cultural Rights and the Constitution of the World Health Organization,

Reaffirming the right of every human being, without distinction of any kind, to the enjoyment of the highest attainable standard of physical and mental health and to a standard of living adequate for the health and well-being of oneself and one's family, including adequate food, clothing and housing, and to the continuous improvement of living conditions,

Underscoring the responsibility of Member States to build resilient national health systems and strengthen national capacities through attention to, inter alia, service delivery, health systems financing, including appropriate budgetary allocations, the health workforce, health information systems, the procurement and distribution of medicines, vaccines and technologies, sexual and reproductive health-care services and political will in leadership and governance, and recognizing the value and importance of universal health coverage in providing access to quality health services, while ensuring that the use of these services does not expose the users to financial hardship, with a special emphasis on the members of the poor, vulnerable and marginalized segments of the population,

Recognizing that health is a precondition for and an outcome and indicator of all three dimensions of sustainable development and that, despite progress made, challenges in global health, including major inequities and vulnerabilities within and among countries, regions and populations, still remain and demand persistent attention,

Noting the role of the Foreign Policy and Global Health Initiative in promoting synergy between foreign policy and global health and that health inequities within and between countries cannot only be addressed within the health sector by technical measures, or only at the national level, but also require global engagement for health, which is rooted in global solidarity and shared responsibility,

Reaffirming the commitment to the achievement of all the Millennium Development Goals, welcoming progress made in the areas of the Goals that concern health, which are key to achieving all the Goals, and stressing the need to further support initiatives aimed at accelerating progress for their achievement,

Recalling its resolution 68/309 of 10 September 2014, in which it welcomed the report of the Open Working Group on Sustainable Development Goals and decided that the proposal of the Open Working Group contained in the

report shall be the main basis for integrating sustainable development goals into the post-2015 development agenda, while recognizing that other inputs will also be considered, in the intergovernmental negotiation process at the sixty-ninth session of the General Assembly,

Underscoring the importance of enhanced international cooperation to support the efforts of Member States to achieve health goals, implement universal access to health services and address health challenges while taking into account different national realities and capacities and respecting national policies and priorities,

Noting the important role that well-coordinated, multi-stakeholder partnerships with a broad range of actors, including national Governments, local authorities, international institutions, business, civil society organizations, foundations, philanthropists and social impact investors, scientists and academics and individuals, can play in development, supporting public health priorities that contribute to better health outcomes,

Reaffirming the right to use, to the fullest extent, the provisions contained in the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement), the Doha Declaration on the TRIPS Agreement and Public Health, the decision of the General Council of the World Trade Organization of 30 August 2003 on the implementation of paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health and, when formal acceptance procedures are completed, the amendment to article 31 of the TRIPS Agreement, as proposed by the General Council of the World Trade Organization in its decision of 6 December 2005, which provide flexibilities for the protection of public health, and in particular to promote access to medicines for all, and to encourage the provision of assistance to developing countries in this regard, and calling for broad and timely acceptance of the amendment to article 31 of the TRIPS Agreement,

Recognizing that the protection of intellectual property can be important in the development of new medicines,

Recognizing also that attacks upon medical and health personnel result in long-lasting impacts, including the loss of life and human suffering, weaken the ability of health systems to deliver essential life-saving services and produce setbacks for health development, and recalling in that regard General Assembly resolution 68/101 of 13 December 2013 on the safety and security of humanitarian personnel and protection of United Nations personnel, as well as World Health Assembly resolution 65.20 of 26 May 2012,

Noting that attacking, threatening or otherwise preventing medical and health personnel from fulfilling their medical duties undermines their physical safety and the integrity of their professional codes of ethics, and that this impedes the attainment of the right to the enjoyment of the highest attainable standard of health, as well as being a barrier to universal access to health services,

Reaffirming that Member States are responsible for ensuring the protection of the health, safety and welfare of their people and the resilience and self-reliance of the health system and access to health services, which is critical for minimizing health hazards and vulnerabilities and delivering effective prevention, response and recovery in emergencies and disasters,

Expressing deep concern over the current outbreak of the Ebola virus disease, which demonstrates the urgency of having strong health systems capable of implementing the International Health Regulations, pandemic preparedness and universal health coverage that promotes universal access to health services, which would assist in the prevention and detection of possible outbreaks, as well as of having motivated, well-trained and appropriately equipped health workers, and emphasizing the need for Member States and other relevant institutions to extend urgently all possible means of support to the affected countries to end the Ebola outbreak, while noting the importance of evidence-based responses to prevent fear, stigma and discrimination,

Taking note of multisectoral efforts, including the Global Health Security Agenda, to strengthen global capacity to prevent, detect and respond to infectious diseases, in particular by promoting sustainable and resilient national health systems, surveillance systems and response protocols,

Stressing that the right to the enjoyment of the highest attainable standard of physical and mental health, the development of resilient health systems and advancement of the attainment of universal health coverage are enhanced by the respect of Member States, non-State actors and private individuals for the integrity and safety of medical and health personnel in carrying out their duties and of their means of transport and installations,

Acknowledging the need to prevent and address the exposure of health workers to hazardous working environments and violent incidents and the consequent trauma suffered by them in various forms, through, for example, improved specific training in public health administration and services, patient management and other health-worker support mechanisms, so as to ensure the safety, productivity and efficiency of the workforce and improved access to health-care services,

Stressing that medical and health personnel have a duty to provide competent medical service in full professional and moral independence, with compassion and respect for human dignity, and always to bear in mind human life and to act in the patient's best interest under their respective professional codes of ethics,

Reaffirming the rules and principles of international humanitarian law, including the provisions of the four Geneva Conventions of 1949 and the Additional Protocols thereto of 1977 and 2005, as applicable, as well as international customary law concerned with the protection of medical personnel and humanitarian personnel exclusively engaged in medical duties, their means of transport and equipment, hospitals and other medical facilities,

Reaffirming also the principles of humanity, neutrality, impartiality and independence in the provision of humanitarian assistance and the need for all actors engaged in the provision of humanitarian assistance in situations of humanitarian emergencies, armed conflicts and natural disasters to promote and fully respect these principles,

Deploring acts of violence or threats of violence against medical and health personnel worldwide in armed conflict and emergency situations, and stressing that such acts are detrimental to the development of sustainable health systems and the integrity of the professional codes of ethics of medical and health personnel,

Noting that locally recruited humanitarian personnel and health-care personnel are particularly vulnerable to

attacks and account for the majority of casualties among humanitarian and health-care workers,

Recognizing that one of the most serious threats to medical and health personnel is posed by armed conflicts, acknowledging the risk to such personnel in situations that do not constitute armed conflict, and noting that it is the responsibility of national Governments to carry out appropriate preventive and remedial measures,

Reaffirming the role of the World Health Organization as the directing and coordinating authority on international health work in accordance with its Constitution, and acknowledging the key role of the Organization and other relevant international organizations in providing support to Member States, as appropriate and upon request, in the development and implementation of preventive measures to promote the safety of medical and health personnel, their means of transport and installations and respect for their respective professional codes of ethics,

1. *Takes note with appreciation* of the note by the Secretary-General transmitting the report of the Director General of the World Health Organization on global health and foreign policy;

2. *Urges* Member States to protect, promote and respect the right to the enjoyment of the highest attainable standard of physical and mental health and to consider health in a holistic manner, including by considering health issues in the formulation of foreign policy;

3. *Calls upon* Member States to promote adequate incentives and an enabling and safe working environment for the effective retention and equitable distribution of the health workforce and to implement the World Health Organization Global Code of Practice on the International Recruitment of Health Personnel as a guide to strengthen health systems through sustainable access to qualified personnel;

4. *Invites* the World Health Organization to provide technical support to Member States upon request in order to strengthen their capacity to deal with public health emergencies and the implementation of the International Health Regulations, with particular focus on developing countries, in order to build capacity, strengthen health systems and promote financial sustainability, training, recruitment and retention of human resources for health and technology transfer on mutually agreed terms;

5. *Calls for* the development and attainment by Member States of resilient and sustainable health systems that accelerate the transition towards universal health coverage in such a way as to ensure uninterrupted and accessible services for their populations, and stresses that medical and health personnel should be able to offer appropriate assistance without obstruction, threat or physical attack and in line with their respective professional codes of ethics and scope of practice;

6. *Calls for* all Member States and all stakeholders to respect the integrity of medical and health personnel in carrying out their duties in line with their respective professional codes of ethics and scope of practice;

7. *Recalls* World Health Assembly resolution 65.20, which calls for leadership to be provided at the global level in developing methods for systematic collection of data on attacks on health facilities, health workers, health vehicles and patients in complex humanitarian emergencies, in coordination with relevant United Nations bodies, other rel-

evant actors and intergovernmental and non-governmental organizations, avoiding duplication of efforts;

8. *Strongly condemns* all attacks on medical and health personnel, their means of transport and equipment, as well as hospitals and other medical facilities, and deplores the long-term consequences of such attacks for the population and health-care systems of the countries concerned;

9. *Urges* full respect for the rules and principles of international humanitarian law, including the provisions of the four Geneva Conventions of 1949 and the Additional Protocols thereto of 1977 and 2005, as applicable, stresses the obligation, in accordance with international humanitarian law and applicable national laws and regulations, to respect and protect medical personnel and humanitarian personnel exclusively engaged in medical duties, their means of transport and equipment, as well as hospitals and other medical facilities, in all circumstances, notes in this regard the role of domestic legal frameworks and other appropriate measures in promoting the safety and protection of such personnel, and urges States to develop effective measures to prevent and address violence against such personnel;

10. *Urges* Member States, in accordance with obligations under relevant provisions of international human rights law, including the right to the enjoyment of the highest attainable standard of physical and mental health, to promote equal access to health services and to respect and protect medical and health personnel from obstruction, threats and physical attacks;

11. *Invites* the World Health Organization and other relevant international organizations to develop their capacity to assist Member States, including through the promotion of research, and, upon request and through technical cooperation and other means, to develop appropriate preventive measures to enhance and promote the safety and protection of medical and health personnel, their means of transport and installations, to improve the resilience of health systems and to promote the effective implementation of universal health coverage;

12. *Notes* that challenges in global health still remain and demand persistent attention, and that this urgently requires the fulfilment of commitments to strengthen the global partnership for development, emphasizing in particular in this regard North-South cooperation, as well as the importance of South-South and triangular cooperation and the exchange of best practices, as well as capacity-building and the transfer of technology on mutually agreed terms, to address health inequities in the context of poverty eradication and sustainable development, in line with national priorities;

13. *Urges* Member States, in cooperation, as appropriate, with relevant international organizations and relevant non-State actors, to develop effective preventive measures to enhance and promote the safety and protection of medical and health personnel, as well as respect for their respective professional codes of ethics, including but not restricted to:

(a) Clear and universally recognized definitions and norms for the identification and marking of medical and health personnel, their means of transport and installations;

(b) Specific and appropriate educational measures for medical and health personnel, State employees and the general population;

(c) Appropriate measures for the physical protection of medical and health personnel, their means of transport and installations;

(d) Other appropriate measures, such as national legal frameworks where warranted, to effectively address violence against medical and health personnel;

(e) Collection of data on obstruction, threats and physical attacks on health workers;

14. *Requests* the Secretary-General, in close collaboration with the Director General of the World Health Organization, to submit a report on the protection of health workers, which compiles and analyses the experiences of Member States and presents recommendations for action to be taken by relevant stakeholders, including appropriate preventive measures.

On 29 December (**decision 69/554**), the General Assembly decided that agenda item “Global health and foreign policy” would remain for consideration during its resumed sixty-ninth (2015) session.

International Day of Yoga

On 11 December, the General Assembly considered a draft resolution, introduced by India and co-sponsored by 175 Member States, proposing an International Day of Yoga to raise global awareness of the many health benefits of practicing yoga.

GENERAL ASSEMBLY ACTION

On 11 December [meeting 69], the General Assembly adopted **resolution 69/131** [draft: A/69/L.17 & Add.1] without vote [agenda item 124].

International Day of Yoga

The General Assembly,

Recalling its resolutions 66/2 of 19 September 2011 on the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and 68/98 of 11 December 2013 on global health and foreign policy,

Reaffirming General Assembly resolutions 53/199 of 15 December 1998 and 61/185 of 20 December 2006 on the proclamation of international years, and Economic and Social Council resolution 1980/67 of 25 July 1980 on international years and anniversaries,

Noting the importance of individuals and populations making healthier choices and following lifestyle patterns that foster good health,

Underscoring the fact that global health is a long-term development objective that requires closer international cooperation through the exchange of best practices aimed at building better individual lifestyles devoid of excesses of all kinds,

Recognizing that yoga provides a holistic approach to health and well-being,

Recognizing also that wider dissemination of information about the benefits of practising yoga would be beneficial for the health of the world population,

1. *Decides* to proclaim 21 June the International Day of Yoga;

2. *Invites* all Member and observer States, the organizations of the United Nations system and other international and regional organizations, as well as civil society, including non-governmental organizations and individuals, to observe the International Day of Yoga, in an appropriate manner and in accordance with national priorities, in order to raise awareness of the benefits of practising yoga;

3. *Stresses* that the cost of all activities that may arise from the implementation of the present resolution should be met from voluntary contributions;

4. *Requests* the Secretary-General to bring the present resolution to the attention of all Member and observer States and the organizations of the United Nations system.

Road safety

On 10 April, the General Assembly, in follow-up on resolution 66/260 [YUN 2012, p. 1166] and in consideration of an earlier report [YUN 2013, p. 1184] on improving global road safety, prepared by WHO, in consultation with the UN regional commissions and other partners of the UN Road Safety Collaboration [YUN 2005, p. 1334], called on Member States to implement road safety activities from the Global Plan for the Decade of Action for Road Safety 2011–2020 [YUN 2010, p. 1233].

GENERAL ASSEMBLY ACTION

On 10 April [meeting 82], the General Assembly adopted **resolution 68/269** [draft: A/68/L.40 & Add.1] without vote [agenda item 12].

Improving global road safety

The General Assembly,

Recalling its resolutions 57/309 of 22 May 2003, 58/9 of 5 November 2003, 58/289 of 14 April 2004, 60/5 of 26 October 2005, 62/244 of 31 March 2008, 64/255 of 2 March 2010 and 66/260 of 19 April 2012 on improving global road safety,

Recalling also the United Nations Conference on Sustainable Development, held in Rio de Janeiro, Brazil, from 20 to 22 June 2012, and its outcome document, entitled “The future we want”, in which Member States took into account road safety as part of their efforts to achieve sustainable development,

Recalling further the special event to follow up efforts made towards achieving the Millennium Development Goals, convened by the President of the General Assembly on 25 September 2013, and its outcome document,

Having considered the note by the Secretary-General transmitting the report on improving global road safety and the recommendations contained therein,

Noting that road traffic injuries are a major public health and development problem that has a broad range of social and economic consequences which, if unaddressed, may affect the sustainable development of countries and hinder progress towards the Millennium Development Goals,

Expressing its concern that the number of road traffic deaths still remains unacceptably high, with an estimated 1.24 million lives lost in 2010, and that only 7 per cent of the world’s population is covered by adequate laws that address

all behavioural risk factors, including the non-use of helmets, safety belts and child restraints, driving under the influence of alcohol and drugs, inappropriate and excessive speed and the inappropriate use of cellular telephones, including texting, while driving,

Expressing its concern also that half of all road traffic deaths worldwide involve pedestrians, motorcyclists and cyclists and that some developing countries have inadequate infrastructure and insufficient policies in place to protect these vulnerable road users,

Recognizing the role of the first Global Ministerial Conference on Road Safety, held in Moscow on 19 and 20 November 2009, which culminated in a declaration inviting the General Assembly to declare a decade of action for road safety,

Noting with satisfaction that targeted steps to reduce road traffic injuries undertaken by the United Nations, including in the framework of the Decade of Action for Road Safety, have yielded positive results, and recognizing in this regard that more than 100 Member States, United Nations organizations, non-governmental organizations and civil society representatives organized pedestrian safety activities during the second United Nations Global Road Safety Week, held from 6 to 12 May 2013,

Commending the Governments of Brazil, Mozambique, Romania and Thailand and the World Health Organization for the successful launch, in May 2013, in the context of the sixty-sixth World Health Assembly, of the Global Alliance for Care of the Injured,

Acknowledging the role of Oman in drawing the attention of the international community to global road safety and in preparing the first United Nations Global Road Safety Week, held from 23 to 29 April 2007, during the sixth meeting of the United Nations Road Safety Collaboration, held in Muscat on 27 and 28 February 2007,

Commending the World Health Organization for its role in implementing the mandate conferred upon it by the General Assembly to coordinate road safety issues within the United Nations system, in close cooperation with the United Nations regional commissions, in providing support for the implementation of the Decade of Action and in preparing the Global Status Report on Road Safety 2013 and publishing a pedestrian safety manual, which provides information for use in developing and implementing comprehensive measures to improve pedestrian safety, and commending also the progress of the United Nations Road Safety Collaboration,

Recognizing the work of the United Nations regional commissions in increasing road safety activities and advocating increased political commitment to road safety, in elaborating global road safety-related legal instruments, including international conventions and agreements, technical standards, resolutions and recommendations, and in working towards setting regional and national road traffic casualty reduction targets,

Commending the Economic Commission for Europe for its plan to implement the Decade of Action, which includes actions, initiatives and measures for the Working Parties of the Commission in the areas of road infrastructure, traffic rules, dangerous goods and vehicle regulations, noting with satisfaction the establishment by the Commission of the two new groups of experts, namely on road signs and signals and on improving safety at level crossings, recognizing the continuous work of the World Forum for Harmonization of Vehicle Regulations to modify vehicle regulations to

increase safety performance, and further commending the Commission for organizing special events in May 2013 in the framework of the second United Nations Global Road Safety Week, as well as for servicing 57 legal instruments that provide a commonly accepted legal and technical framework for the development of international road, rail, inland water and combined transport,

Acknowledging the important interregional efforts of the Economic Commission for Europe and the Economic and Social Commission for Asia and the Pacific in organizing the Europe-Asia Road Safety Forum to promote the implementation of United Nations road safety conventions and to facilitate the exchange of experiences in this field among European and Asian countries,

Commending the road safety initiatives of the Economic and Social Commission for Asia and the Pacific, including the organization of the regional Expert Group Meeting on Progress in Road Safety Improvement in Asia and the Pacific, which was held in Seoul from 8 to 10 May 2013, during the second United Nations Global Road Safety Week, and which adopted a joint statement on improving road safety in Asia and the Pacific, and the technical assistance provided to member countries to develop and refine national road safety goals, targets and indicators in support of the Decade of Action,

Commending also the efforts of the Economic Commission for Africa in strengthening the road safety initiative in Africa, including the adoption of the African Action Plan for the Decade of Action for Road Safety as a guiding document that addressed the continent's specificities and targeted a reduction in road traffic crashes by 50 per cent by 2020,

Commending further the efforts of the Economic Commission for Latin America and the Caribbean to advocate and improve road safety in the Latin American and Caribbean region through studies and the dissemination of best practices among national Governments, the private sector, academia and multilateral regional institutions and to include road safety in comprehensive and regionally coordinated transport policies, including the efforts to establish the Mesoamerican Road Safety Plan, and strengthening the capacity of the road safety agency of Chile by enhancing its road safety data collection system as a tool for designing and monitoring effective policies,

Commending the efforts of the Economic and Social Commission for Western Asia on enhancing road safety in the Arab region, including the organization of regional training workshops to accelerate the implementation of the Decade of Action and related recommendations included in the conclusions of the yearly intergovernmental meetings on transport, such as the fourteenth session of the intergovernmental Committee on Transport,

Acknowledging a number of other important international efforts on road safety, including the development by the International Road Transport Union of harmonized and internationally recognized standards for the vocational training of road transport professionals,

Taking note of the report of the Commission for Global Road Safety on safe roads for all as part of a post-2015 agenda for health and development,

Acknowledging the continued efforts of the Road Safety Initiative of the multilateral development banks, coordinated by the Global Road Safety Facility of the World Bank, and their collective actions to scale up road safety management capacity and infrastructure safety, improve

safety performance measures and scale up resources through the development of systematic country projects in low- and middle-income countries,

Commending Member States that have acceded to the United Nations international legal instruments on road safety and that have adopted comprehensive legislation on major risk factors, including disregard for road signs and signals, the non-use of helmets, safety belts and child restraints, driving under the influence of alcohol and drugs, inappropriate and excessive speed and the inappropriate use of cellular telephones, including texting, while driving,

Recognizing Member States and civil society for their continued commitment to road safety by observing the World Day of Remembrance for Road Traffic Victims on the third Sunday of November every year,

Recognizing also the efforts made by some countries to implement best practices, to set ambitious targets and to monitor road traffic fatalities and serious injuries,

Taking into account the importance of strengthening capacity and continuing international cooperation to further support efforts to improve road safety, particularly in developing countries, including least developed countries and middle-income countries, and providing, as appropriate, financial and technical support and knowledge to meet the goals of the Decade of Action,

Recognizing that a solution to the global road safety crisis can be achieved only through multisectoral collaboration, private and public funding mechanisms and partnerships involving the public and private sectors, as well as civil society, including national Red Cross and Red Crescent Societies, academia, professional associations, non-governmental organizations, victims' organizations, youth organizations and the media,

1. *Recognizes* the importance of the efficient movement of people and goods and access to environmentally sound, safe and affordable transportation as a means to improve social equity, health, the resilience of cities, urban-rural linkages and the productivity of rural areas, and in this regard takes into account road safety as part of the effort to achieve sustainable development;

2. *Commends* Member States that have developed national plans that are in line with the Global Plan for the Decade of Action for Road Safety 2011–2020, and encourages Member States that have not yet developed such plans to do so, paying special attention to the needs of all road users, in particular pedestrians, cyclists and other vulnerable road users, as well as issues related to sustainable mobility;

3. *Invites* Member States that have not yet done so to nominate, as appropriate, national focal points for the Decade of Action for Road Safety to coordinate and facilitate national activities for the Decade;

4. *Also invites* Member States that have not yet done so to address road safety holistically, starting with the implementation or continuation of a road safety management system, including, as appropriate, interdepartmental cooperation, the development of national road safety plans in line with the Global Plan for the Decade of Action, improvement of the quality of road safety statistics and data disaggregated by sex and age, collected through the standardization of definitions and reporting practices, and investments in multisectoral road traffic crash surveillance and analysis;

5. *Encourages* Member States that have not yet done so to consider enacting comprehensive legislation on key

risk factors for road traffic injuries, including disregard for road signs and signals, the non-use of helmets, safety belts and child restraints, driving under the influence of alcohol and drugs, inappropriate and excessive speed and the inappropriate use of cellular telephones, including texting, while driving, in order to increase the proportion of countries with comprehensive legislation to 50 per cent by the end of the Decade of Action, and encourages Member States to strengthen their enforcement of existing road safety legislation on the risk factors;

6. *Encourages* the implementation of new car assessment programmes in all regions of the world in order to improve the availability of consumer information about the safety performance of motor vehicles;

7. *Invites* Member States to continue to improve, where appropriate, their road management systems and to introduce both road safety audits for new construction projects and road safety assessment programmes for the existing networks;

8. *Also invites* Member States to develop and implement comprehensive policies on post-crash care and to consider enacting legislation to legally protect bystanders who in good faith provide care to those injured in a crash;

9. *Further invites* Member States to raise awareness of serious road traffic injuries, in particular brain and spinal cord injuries, and to encourage investment in scientific research aimed at effectively treating such injuries;

10. *Encourages* Member States to continue to improve and strengthen pre-hospital, trauma and rehabilitation care through the adoption of a national emergency medical system telephone number, capacity-building and the provision of adequate and appropriate equipment;

11. *Reaffirms* the importance of addressing global road safety issues through international cooperation and by strengthening collaboration between Member States and civil society to build capacity and raise awareness in the field of road safety and to continue to raise awareness through the World Day of Remembrance for Road Traffic Victims on the third Sunday of November every year;

12. *Also reaffirms* the role and importance of the United Nations legal instruments on road safety, such as the 1949 Convention on Road Traffic, the 1968 Convention on Road Traffic, the 1968 Convention on Road Signs and Signals and the 1958 and 1998 agreements of the World Forum for Harmonization of Vehicle Regulations, in facilitating road safety at the global, regional and national levels, and encourages Member States that have not yet done so to consider becoming contracting parties and, beyond accession, applying, implementing and promoting their provisions or safety regulations, as well as adhering to the Convention on the Rights of Persons with Disabilities;

13. *Requests* the World Health Organization and the United Nations regional commissions, in cooperation with other partners in the United Nations Road Safety Collaboration and other stakeholders, to continue the activities aimed at supporting the implementation of the objectives of the Decade of Action;

14. *Also requests* the World Health Organization and the United Nations regional commissions to facilitate the organization of activities during 2015 for the third United Nations Global Road Safety Week, with a focus on improving the safety of children in traffic;

15. *Invites* the World Health Organization to continue to monitor, through its global status reports, progress

towards the attainment of the goal of the Decade of Action to stabilize and reduce road traffic deaths by 2020, and in this regard notes the importance of targets and indicators against which progress can be systematically measured;

16. *Invites* the Secretary-General to continue to promote effective international cooperation on road safety issues, including in the broader context of sustainable transport, and in this regard encourages further efforts, as appropriate, to strengthen the coordination of the work of the United Nations system on sustainable transport, while taking into account the need to adequately address road safety issues;

17. *Reiterates its invitation* to Governments to take a leading role in implementing the activities of the Decade of Action, while fostering multisectoral collaboration that includes the efforts of academia, the private sector, professional associations, non-governmental organizations, civil society, including national Red Cross and Red Crescent Societies, victims' organizations, youth organizations and the media;

18. *Invites* Member States, international organizations, development banks and funding agencies, foundations, professional associations and private sector companies to consider providing adequate and additional funding to activities relating to the Decade of Action, including through contributions to the Road Safety Fund established by the World Health Organization and the FIA Foundation for the Automobile and Society;

19. *Invites* all interested relevant stakeholders to explore new and innovative funding modalities to support and collaborate in national efforts to implement the Global Plan for the Decade of Action, particularly in developing countries, including least developed countries and middle-income countries;

20. *Encourages* Member States and the international community to take road safety into due consideration in the elaboration of the post-2015 development agenda, while recognizing the importance of a holistic and integrated approach to sustainable transport;

21. *Welcomes* the offer by the Government of Brazil to host the second high-level global conference on road safety, to be held in 2015, to bring together delegations of ministers and representatives dealing with transport, health, education, safety and related traffic law enforcement issues, to review progress in implementing the Global Plan for the Decade of Action and in meeting the goal of the Decade of Action and to provide an opportunity for Member States to exchange information and best practices;

22. *Decides* to include in the provisional agenda of its seventieth session an item entitled "Improving global road safety", and requests the Secretary-General to report to the General Assembly at that session on the progress made in the attainment of the objectives of the Decade of Action.

Food, agriculture and nutrition

Food aid

World Food Programme

The Executive Board of the World Food Programme (WFP) held its 2014 sessions [E/2015/36] in Rome: first (10–11 February), annual (3–6 June) and second (10–13 November), during which it made decisions

and recommendations on various organizational and programme matters. It also approved several projects and policies, including protracted relief and recovery operations in Burundi, Chad, Ethiopia, Haiti, Malawi, Mali, Mauritania, Senegal, Yemen and the State of Palestine. On 13 November, the Board approved its 2015–2016 biennial programme of work.

The Economic and Social Council, by **decision 2014/228** of 14 July, took note of the report [E/2014/36] of the WFP Executive Board on its first and second regular sessions and annual session of 2013, as well as of the WFP annual report for 2013 [E/2014/14].

WFP activities

According to a later WFP annual performance report [E/2015/14], unprecedented humanitarian crises made 2014 a challenging year in which WFP provided vital aviation, logistics, telecommunications and other common services to the humanitarian and development community. WFP work was dominated by responses to concurrent Level 3 and Level 2 emergencies that stretched the organization's capacities beyond their expected limits. Four of the emergencies were triggered during 2014: Iraq (see p. 1073), Libya (see p. 383), Ukraine (see p. 1074) and the Ebola crisis in West Africa (see p. 1069). WFP and its partners also continued their responses to protracted emergencies in Afghanistan, the Democratic Republic of the Congo, Myanmar, the State of Palestine, Somalia and the Sudan that involved conflict, natural disasters, economic shocks and significant disruptions to food systems. The concurrent emergency responses required high levels of staff commitment: 2,900 WFP staff—roughly 20 per cent of the total—worked on one or more of the Level 3 emergencies; 600 employees were temporarily deployed, often at short notice.

In 2014, WFP received its highest-ever level of voluntary contributions in the amount of \$5.38 billion, 79 per cent of which was directed to the emergency response effort. In total, direct food assistance was provided for 80 million people in 82 countries, most of whom were women and children, compared with the estimated 75.9 million people anticipated in its management plan. The use of cash and voucher transfers increased to 18 per cent of the year-end budget, compared with 14 per cent in the previous financial period, primarily because that was the main modality used to assist Syrian refugees in Egypt, Iraq, Jordan, Lebanon and Turkey. Cash and voucher transfers assisted 8.9 million people during 2014, 13 per cent more than in 2013. The Ebola virus disease outbreak response required extraordinary efforts, innovative ways of working and new inter-sectoral partnerships. To prevent some health crises from becoming food crises, WFP and its partners rapidly reached affected communities in Guinea, Liberia and Sierra Leone, and restored essential transport, logistics and telecom-

munications services necessary to operationalize the wider response throughout the region.

Looking ahead, the annual performance urged a redoubling of efforts to tackle the harmful effects of hunger and malnutrition on those people left behind by the Millennium Development Goals (MDGs). The Programme's mission to end hunger would continue to be guided by the five pillars of the Secretary-General's Zero Hunger Challenge [YUN 2012, p. 1170], namely: eliminating stunting among children under two; guaranteeing universal access to adequate and nutritious food; ensuring that food systems were sustainable; increasing the productivity and incomes of smallholder farmers by 100 per cent; and eliminating loss or waste of food.

Food Assistance Convention

The Food Assistance Convention (FAC), which came into force on 1 January 2013 [YUN 2013, p. 1185], saw its membership increase with the accession of six countries: Australia, Luxembourg, the Russian Federation, Slovenia, Spain and Sweden, bringing the total membership at the end of 2014 to 14. FAC expanded the traditional focus of previous Food Aid Conventions which centred exclusively on commitments of in-kind food aid for direct consumption. It also incorporated a broader toolbox of eligible activities and food assistance products, including cash, vouchers and products intended for protecting livelihoods, a greater focus on nutrition, and a commitment to improved transparency and accountability. Parties to the Convention were making their commitments in monetary value as opposed to the metric wheat tonne equivalent, sharing information and best practices in food assistance delivery, and meeting twice annually to discuss the most efficient and effective means of delivery of food assistance.

Annual FAC financial commitments to improving the food security and nutritional status of vulnerable populations amounted to over \$2.7 billion dollars in 2014. FAC members responded to humanitarian crises throughout the world, with the Syrian regional conflict constituting the largest single response. Other notable responses included the Ebola virus disease outbreak in West Africa and the crises in South Sudan and Ukraine. In 2014, all members fulfilled their financial commitments, and some exceeded their commitments substantially. Food assistance operations were provided bilaterally, through intergovernmental or other international organizations including WFP.

Food security

Food and Agriculture Organization of the United Nations

The Food and Agriculture Organization of the United Nations (FAO) continued to address global

food insecurity. The 2014 edition of the organization's report *The State of Food Insecurity in the World*, which focused on strengthening the enabling environment for food security and nutrition, stated that 805 million people—or one in nine people—were chronically undernourished in 2012–14: an amount 100 million lower than the previous decade, and 209 million lower than in 1990–92. The vast majority of those undernourished people lived in developing countries, where an estimated 791 million were chronically hungry. The developing world, however, accounted for most of the improvements over the previous two decades, with an overall reduction of 203 million undernourished people since 1990–92. The MDGs hunger target of reducing by half the proportion of undernourished people by 2015 was within reach if appropriate and immediate efforts were stepped up.

Despite the overall progress, the developing world was not on track to achieve the 1996 World Food Summit [YUN 1996, p. 1129] target of halving the number of undernourished people by 2015. Marked differences also persisted across regions. Sub-Saharan Africa had the highest prevalence rate of undernourishment, having made only modest progress in preceding years; around one in four people in the region remained undernourished. Asia, the most populous region in the world, still had the highest number of undernourished. Latin America and the Caribbean, as a whole, met the MDG hunger target as well as the more stringent World Food Summit target.

Key messages outlined in the report included the need for sustained political commitment at the highest level as a prerequisite for hunger eradication; an integrated hunger reduction approach that would include public and private investments to raise agricultural productivity; better access to inputs, land, services, technologies and markets; social protection for the most vulnerable, including strengthening their resilience to conflicts and natural disasters; and specific nutrition programmes, especially to address micronutrient deficiencies in mothers and children under five.

Agriculture development, food security and nutrition

Malabo Declaration. At the twenty-third ordinary session of the African Union (Malabo, Equatorial Guinea, 26–27 June), which also marked the tenth anniversary of the adoption of the Comprehensive Africa Agriculture Development Programme (CAADP) of the New Partnership for Africa's Development [YUN 2009, p. 1234], African leaders adopted the Malabo Declaration on Accelerated Agricultural Growth and Transformation for Shared Prosperity and Improved Livelihoods, reaffirming Africa's strong commitment to using growth in agricultural productivity to spur economic growth, boost the food and income security

of rural households and reduce extreme poverty and hunger. The CAADP aimed at eliminating hunger and reducing poverty through agriculture by increasing public investment in agriculture and raising agricultural productivity. The Malabo Declaration represented a recommitment by Heads of State to the key principles and values of the Programme, particularly mutual accountability on actions and results.

Report of Secretary-General. In response to General Assembly resolution 68/233 [YUN 2013, p. 1187], the Secretary-General submitted an August report [A/69/279] on agriculture development, food security and nutrition. The report examined progress and challenges in achieving food security and nutrition, sustainably increasing agricultural production, and reducing agricultural losses and waste in accordance with the Zero Hunger Challenge [YUN 2012, p. 1170] and international agreements. The Secretary-General also made recommendations on how to maintain momentum beyond the achievement of the 2015 targets through the incorporation of food security, nutrition and sustainable agriculture in the post-2015 development agenda (see p. 960).

The Secretary-General stated that developing regions as a whole had registered significant progress towards meeting the MDG hunger target, but that 33 countries—26 in Africa and 7 in Asia—remained in need of external assistance for food owing to conflict, crop failures and high domestic food prices, or a combination of those factors. From 2000 to 2012, the global prevalence of stunting among children under 5 years of age had declined from one in three to one in four—with the number of children affected falling from 197 million to 162 million, 90 per cent of whom were in Africa and Asia. Worldwide in 2012, 51 million children under 5 years of age were wasted (dangerously thin for one's height), and 17 million were severely wasted—prevalence rates of almost 8 per cent and just under 3 per cent, respectively. Approximately 71 per cent of all severely wasted children lived in Asia and 28 per cent in Africa, with similar figures for wasted children of 69 per cent and 28 per cent, respectively.

As the report also set forth, the International Year of Family Farming, 2014—whose implementation the General Assembly had invited FAO to facilitate in its resolution 66/222 [YUN 2011, p. 1168] declaring the Year—was officially launched on 22 November 2013 at UN Headquarters in New York. Events included five regional dialogues that engaged family farmers and representatives from governments, the scientific community, civil society organizations and the private sector. The dialogues aimed to identify the main challenges and opportunities for family farming in each region, and the main tenets of an enabling policy environment for family farming as a central component for achieving food and nutrition security, and effectively eradicating hunger and rural poverty. At the request of the International Steering Committee

of the Year, the 2014 FAO regional conferences provided forums for constructive dialogue among those stakeholders, and further defined the scope of the work and priorities of FAO in support of family farming at the regional level.

The Secretary-General emphasized that eliminating hunger, ensuring food security and adequate nutrition, and making agriculture and food systems sustainable would require a more integrated approach across many sectors. He referenced an emerging consensus that food security in the post-2015 development agenda had to be aligned with the Istanbul Declaration and the Programme of Action for the Least Developed Countries [YUN 2011, p. 828], which was designed to lift the poorest countries out of poverty. Targets on nutrition in the post-2015 development agenda had also to take into account the 2012 World Health Assembly targets [YUN 2012, p. 1175], which touched upon all dimensions of malnutrition.

The Secretary-General recommended that countries be enabled to determine their own nationally articulated food security strategies developed through consultation with all key stakeholders; Governments undertake research and make other investments to support the capacity of smallholder farmers to adapt to climate change; and continued efforts be made towards improving the food security and nutritional status of the poor, including through strengthened social protection and safety nets.

Committee on World Food Security. By a note [A/69/91-E/2014/84] of 3 September the Secretary-General transmitted to the General Assembly and the Economic and Social Council a report on the main decisions and policy recommendations of the Committee on World Food Security. The report, submitted in response to Council decision 2011/217 [YUN 2011, p. 1162], provided a brief description of the outcomes and decisions taken by the Committee at its fortieth session in October 2013, and, where appropriate, updates on follow-up actions.

Among its principal actions, the Committee endorsed the second version of the Global Strategic Framework that included policy recommendations previously endorsed at its thirty-ninth session in 2012 [YUN 2013, p. 1186]. It also endorsed the next steps of the Communication Strategy for the Framework, and requested that an implementation plan including the budget be developed. The Committee further endorsed the terms of reference, qualifications and selection procedure for the new Committee Secretary, and the modalities and requirements for the inclusion in its Secretariat of other UN system entities that were directly involved in food security and nutrition.

At the session, the High-Level Panel of Experts on Food Security and Nutrition presented two reports: "Biofuels and Food Security" and "Investing in Smallholder Agriculture for Food Security" that were used

as the basis for discussions at two policy round tables. Other topics addressed by the Committee included food security in protracted crises; the Multi-Year Programme of Work; and the work of the High-Level Panel of Experts on Food Security and Nutrition.

On 17 November (**decision 2014/250**), the Economic and Social Council took note of the note transmitting the report on the main decisions and policy recommendations of the Committee on World Food Security.

GENERAL ASSEMBLY ACTION

On 19 December [meeting 75], the General Assembly, on the recommendation of the Second (Economic and Financial) Committee [A/69/474], adopted **resolution 69/240** without vote [agenda item 25].

Agriculture development, food security and nutrition

The General Assembly,

Recalling its resolutions 65/178 of 20 December 2010, 66/220 of 22 December 2011, 67/228 of 21 December 2012 and 68/233 of 20 December 2013,

Recalling also the Declaration of the World Summit on Food Security, particularly the Five Rome Principles for Sustainable Global Food Security, and noting the Rome Declaration on Nutrition, as well as the Framework for Action, which provides a set of voluntary policy options and strategies for use by Governments, as appropriate, adopted at the Second International Conference on Nutrition, held in Rome from 19 to 21 November 2014,

Recalling further the Rio Declaration on Environment and Development, Agenda 21, the Programme for the Further Implementation of Agenda 21, the Johannesburg Declaration on Sustainable Development and the Plan of Implementation of the World Summit on Sustainable Development (Johannesburg Plan of Implementation), the Monterrey Consensus of the International Conference on Financing for Development, the 2005 World Summit Outcome, the Doha Declaration on Financing for Development: outcome document of the Follow-up International Conference on Financing for Development to Review the Implementation of the Monterrey Consensus, the outcome document of the 2010 high-level plenary meeting of the General Assembly on the Millennium Development Goals, the Programme of Action for the Least Developed Countries for the Decade 2011–2020 and the outcome document of the special event to follow up efforts made towards achieving the Millennium Development Goals, convened by the President of the General Assembly on 25 September 2013,

Recalling the outcome document of the United Nations Conference on Sustainable Development, held in Rio de Janeiro, Brazil, from 20 to 22 June 2012, entitled “The future we want”,

Recalling also its resolution 68/309 of 12 September 2014, in which it welcomed the report of the Open Working Group on Sustainable Development Goals and decided that the proposal of the Open Working Group contained in the report shall be the main basis for integrating sustainable development goals into the post-2015 development agenda, while recognizing that other inputs will also be considered,

in the intergovernmental negotiation process at the sixty-ninth session of the General Assembly,

Welcoming the implementation of the International Year of Family Farming, 2014, which raised the profile of the role of family farming and smallholder farming in contributing to the achievement of food security and improved nutrition, looking forward to the implementation of the International Year of Soils, 2015, and World Soil Day, 5 December, and also looking forward to the participation of the United Nations in Expo Milano 2015, “Feeding the Planet, Energy for Life”, which will focus on the theme “The Zero Hunger Challenge—United for a Sustainable World”,

Welcoming also the outcome of the forty-first session of the Committee on World Food Security, held in Rome from 13 to 18 October 2014,

Noting the adoption by the Heads of State and Government of the African Union, at its twenty-third ordinary session, held in Malabo on 26 and 27 June 2014, of the Malabo Declaration on Accelerated Agricultural Growth and Transformation for Shared Prosperity and Improved Livelihoods, which also marked the tenth anniversary of the adoption of the Comprehensive Africa Agriculture Development Programme of the New Partnership for Africa's Development,

1. *Takes note* of the report of the Secretary-General;
2. *Reaffirms* the commitments to making every effort to achieve the Millennium Development Goals by 2015 in support of developing countries, in particular those countries that are lagging most behind and those Goals where progress is most off track, thus improving the lives of the poorest people;
3. *Stresses* the importance of continued consideration of the issue of agriculture development, food security and nutrition, and further encourages Member States and all stakeholders to give due consideration to this issue in the elaboration of the post-2015 development agenda;
4. *Requests* the Secretary-General to report to the General Assembly at its seventieth session on new developments related to the issues highlighted in its resolution 68/233 and in the present resolution;
5. *Decides* to include in the provisional agenda of its seventieth session the item entitled “Agriculture development, food security and nutrition”.

Nutrition

Scaling up nutrition. In 2014, the Scaling Up Nutrition (SUN) movement saw the introduction of self-assessments, undertaken by 37 SUN countries and involving all stakeholders assessing their performance and confirming the ownership by governments and their partners. During the year, an additional 13 countries joined the SUN movement taking the total to 54 countries. Substantial progress was noted in relation to SUN Movement Strategic Objectives 1 and 2, on creating an enabling political environment and establishing best practices for scaling up proven interventions, respectively. In relation to Strategic Objective 3 on aligning in-country actors around a common results framework, it was not an easy task and required continuous efforts by all concerned. In relation to Strategic Objective 4 on increasing resources, there

were early signs that as countries progressed in relation to the first two strategic objectives, they started to see an increase in the resources available for nutrition.

The technical group of the SUN UN System Network (UN Network), built around FAO, WHO, WFP, UNICEF and the International Fund for Agricultural Development, held a face-to-face meeting to help articulate a joint UN vision and discuss necessary institutional arrangements required to promote improved harmonized approaches within the United Nations. The UN Network provided direct support to governments in 14 countries. It also hosted side events aimed at raising the profile of nutrition, including during the fortieth session of the Committee on World Food Security in October 2013 (see p. 1375) and the preparatory technical meetings in November 2013 [YUN 2013, p. 1194] for the Second International Conference on Nutrition (see below).

Second International Conference on Nutrition.

As set forth in a later report [A/70/333], the Second International Conference on Nutrition, co-organized by FAO and WHO, was held at FAO headquarters (Rome, 19–21 November 2014). The high-level intergovernmental conference focused global attention on malnutrition in all its forms—undernourishment, undernutrition, including micronutrient deficiencies, and overweight and obesity. The Conference brought together a total of 164 members of FAO and WHO. More than 2,200 individuals participated, including Heads of State and Government, experts and representatives of civil society and the private sector.

The Conference was convened to review progress made since the 1992 International Conference on Nutrition [YUN 1992, p. 830], respond to new challenges and opportunities, and identify policy options for improving nutrition; bring food, agriculture, health and other sectors together to enable them to align their sectoral policies for improving nutrition in a sustainable manner; propose adaptable policy options and institutional frameworks that could adequately address major nutrition challenges in the foreseeable future; encourage greater political and policy coherence, alignment, coordination and cooperation among food, agriculture, health and other sectors; mobilize the political will and resources needed to improve nutrition; and identify priorities for international cooperation on nutrition in the near and medium terms.

The political Rome Declaration on Nutrition and the Framework for Action, a voluntary technical guide of 60 recommendations on how to implement the Declaration, were the two outcome documents endorsed by participating Governments at the Conference, committing world leaders to establish national policies for eradicating malnutrition in all its forms and transforming food systems so as to make nutritious diets available to all. In the Rome Declaration, ministers and representatives of the members of FAO and WHO also recommended that the General Assembly “consider declaring a decade of action on nutrition from 2016 to 2025 within existing structures and available resources”.