In 2015, the United Nations continued to promote health, food and nutrition worldwide. In West Africa, the United Nations Mission for Ebola Emergency Response (UNMEER) continued to coordinate all actors responding to the Ebola virus disease outbreak in accordance with a commonly agreed operational framework under the leadership of the host Governments. UN-system efforts focused on finding people with the disease and following-up with their contacts; treating people with the disease; safe and dignified burials; and community engagement. Early case detection, reinforcement of alerts and surveillance systems and awareness-raising activities became more critical in the push towards zero cases. After fulfilling its core objectives of scaling up the response in Guinea, Liberia and Sierra Leone and establishing the focused coordination of responders, UNMEER closed on 31 July. On 1 August, oversight of the UN-system Ebola emergency response was transferred to the World Health Organization (WHO). Additional response activities included the second WHO high-level meeting on Ebola vaccine access and financing, which focused on efforts to develop and make Ebola vaccines available to affected communities; and the International Ebola Recovery Conference, which focused on targeted investment in the three Ebola-affected countries in a way that contributed to building back better and ensuring greater resilience.

On the occasion of the UN summit for the adoption of the post-2015 development agenda in September, WHO issued the Noncommunicable Diseases Progress Monitor 2015, which reported on the extent to which 194 countries were developing responses to the global burden of non-communicable diseases (NCDs)—namely, cancer, diabetes, and heart and lung disease—subject to the national commitments included in the 2011 UN Political Declaration and the 2014 UN Outcome Document on NCDs. The Monitor was based on the most recent data tracked against 10 indicators developed by WHO to assess progress at the national level in the prevention and control of NCDs.

The 2015 WHO report on the global tobacco epidemic noted that the raising of taxes on tobacco—one of the most effective and cost-effective interventions—was also one of the least implemented tobacco control measures. It called on all Parties to the WHO Framework Convention on Tobacco Control to make specific commitments to implement strong tobacco control policies and protect the health of their people.

On rolling back Malaria, the World Health Assembly adopted in May the WHO Global Technical Strategy for Malaria 2016–2030, and in July, the third International Conference on Financing for Development launched the second edition of the Roll Back Malaria Partnership’s Global Malaria Action Plan, “Action and investment to defeat malaria 2016–2030”. Those two documents provided the framework for achieving a reduction in global malaria incidence and mortality rates by at least 90 per cent by 2030. In September, the General Assembly urged the international community to implement the Global Technical Strategy, including through support for the complementary Action and Investment to Defeat Malaria 2016–2030 plan, in order to achieve the internationally agreed targets on malaria.

On road safety, the Secretary-General appointed a special envoy to mobilize political commitment and raise awareness of the need to reduce road traffic crashes and their consequences on public health and development. For the third UN Global Road Safety Week in May, events took place in at least 105 countries, and the associated #SaveKidsLives campaign generated action to better ensure the safety of children on the world’s roads. In November, the Second Global High-level Conference on Road Safety adopted the “Brasilia Declaration on Road Safety”, which aimed to halve road traffic deaths by 2020—as called for by target 3.6 of the newly adopted Sustainable Development Goals (SDGs).

Concurrent Level 2 and Level 3 emergencies during the year required institution-wide responses from the World Food Programme (WFP) as it continued to reach the world’s most vulnerable people with lifesaving food assistance. Working with over 1,000 non-governmental organizations, WFP directly assisted 76.7 million people—most of them women and children—in 81 countries through 201 projects. WFP responded to severe, complex emergencies in Iraq, South Sudan, Yemen, the Syria region and Ebola-affected West Africa.

According to the Food and Agriculture Organization, the Millennium Development Goal (MDG) commitment to halve the percentage of hungry people had been almost met at the global level. Seventy-two of the 129 countries monitored had reached the MDG target, yet hunger remained an everyday challenge for almost 795 million people worldwide, including 780 million in the developing regions. Regarding the transition from the MDGs to...
the SDGs on food security and nutrition, the Secretary-General reported that reaching SDG 2 (Zero Hunger) and the interlinked targets of at least six other SDGs would be critical to making a shift to resilient, diverse and productive agriculture and food systems that were environmentally, socially and economically sustainable.

In May, the World Health Assembly approved a set of additional core indicators for the global monitoring framework on maternal, infant and young child nutrition and recommended that Member States report on the entire core set of indicators starting in 2016 and that a review of the global nutrition monitoring framework be conducted in 2020.

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**Health**

**AIDS prevention and control**

**Implementation of Declaration of Commitment and Political Declaration**

**Report of Secretary-General.** In April [A/69/856], the Secretary-General submitted a report to the General Assembly on progress made towards achieving the targets outlined in the 2011 Political Declaration on HIV/AIDS [YUN 2011, p. 1135] as well as the Millennium Development Goals (MDGs), and global efforts to end the AIDS epidemic as a public-health threat by 2030. The report noted that the number of new infections and AIDS-related deaths continued to fall globally, and risk-taking behaviour had been reduced in many settings. Between 2001 and 2013, there was a 58 per cent reduction in new infections (to 2.1 million) and between 2005 (the year with the highest number of new infections) and 2013, there was a 35 per cent decline in AIDS-related deaths. Through advocacy for affordable medicines and scaled-up treatment programming, access to lifesaving antiretroviral therapy (ART) had improved dramatically and mother-to-child transmission rates continued to fall. Of the 13.6 million people who received ART by June 2014, 12.1 million were in low- and middle-income countries. In sub-Saharan Africa, some 86 per cent of people living with HIV who knew their status were receiving ART, and about 76 per cent of those enrolled in treatment had achieved viral suppression. Following scaled-up provision of ART for pregnant women living with HIV, there was a 58 per cent decrease globally in new infections among children between 2002 (the year with the highest recorded number) and 2013.

Despite those gains, in some countries and regions the progress was slow or sliding backwards. Gaps in the AIDS response had emerged in the Middle East, Northern Africa and some countries in Eastern Europe, where the most significant increases in new infections had occurred. Specific groups were also being disproportionately affected by HIV in many countries. In sub-Saharan Africa, women constituted 57 per cent of adults (15 years of age or over) living with HIV and acquired HIV between five to seven years earlier than did men.

The Secretary-General recommended that international donors, Governments, civil society, the UN system and other key partners implement a series of joint actions to enhance the AIDS response efforts. He noted that a strong focus on AIDS should continue, to ensure that gains were preserved and built upon, and that linkages with the AIDS response were promoted across the post-2015 sustainable development agenda, particularly in the areas of poverty reduction, employment creation and empowerment of women and girls. Efforts must focus on specific locations and populations that were being left behind, to ensure that resources and programming were targeted to need and grounded in human rights and gender equality. Towards achieving zero discrimination, indicators for measuring reductions in stigmatization, discrimination and human rights violations must be developed and monitored. He also recommended that social protection programmes be scaled up to enhance HIV prevention, treatment, care and support, with a particular focus on cash transfer programmes for young women in countries with a high prevalence of HIV; that resources be used effectively to exert the highest impact on those in need; and that the knowledge, expertise and lessons learned from the global AIDS response be harnessed within the post-2015 era to assist in solving other complex sustainable development challenges.

On 23 December (decision 70/554), the General 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 seventieth (2016) session.

**GENERAL ASSEMBLY ACTION**

On 23 December [meeting 82], the General Assembly adopted resolution 70/228 [draft: A/70/L.38] (Organization of the 2016 high-level meeting on HIV/AIDS) without vote [agenda item 11].

**Joint UN Programme on HIV/AIDS**

Children’s Fund (UNICEF), 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.

**Report of Executive Director.** In response to Economic and Social Council resolution 2013/11 [YUN 2013, p. 1172], the Secretary-General transmitted a January report of the UNAIDS Executive Director [E/2015/8] on progress made in implementing a coordinated response by the UN system to the HIV/AIDS epidemic. The report stated that the number of people newly infected with HIV in 2013 (approximately 2.1 million) was 38 per cent lower than in 2001; the number of AIDS-related deaths (1.5 million) was down 35 per cent from the peak in 2005; and the number of children newly infected with HIV (240,000) represented a 58 per cent decline from 2002. Yet, AIDS remained the sixth biggest cause of death globally, the leading cause of death in sub-Saharan Africa and the leading cause of death worldwide among women of reproductive age. Persistent gaps in the response contributed to the continuing severity of the epidemic. As at December 2013, some 35 million people were living with HIV. As at June 2014, over 60 per cent of all people living with HIV were not receiving antiretroviral therapy, in large part because more than half of those people did not know their HIV status. While declining globally, new HIV infections were rising in some countries, in particular where services were not prioritized for most-affected populations. In many countries, key populations and other vulnerable groups continued to be left behind in the response, while gender inequality, criminalization and other human rights violations remained significant barriers to progress.

The report summarized progress achieved towards ten key targets based on the 2011 Political Declaration [YUN 2011, p. 1135], with a specific focus on contributions by UNAIDS. It also discussed AIDS response in the context of the post-2015 development agenda and made recommendations towards ending the epidemic as a public health threat by 2030.

**ECONOMIC AND SOCIAL COUNCIL ACTION**

On 8 April [meeting 22], the Economic and Social Council adopted resolution 2015/2 [draft: E/2015/1.5] (Joint United Nations Programme on HIV/AIDS) without vote [agenda item 12 (g)].

**Programme Coordinating Board**

The UNAIDS Programme Coordinating Board (PCB), at its thirty-sixth meeting (Geneva, 30 June–2 July) [UNAIDS/PCB (36)/15.14], took note of the update on the AIDS response in the post-2015 development agenda [UNAIDS/PCB (36)/15.4] and encouraged the Joint United Nations Programme on HIV/AIDS to advocate for the multisectoral approach of the AIDS response to be reflected in the HIV-relevant target indicators for the proposed Sustainable Development Goals (SDGs). The Board welcomed the report on the multi-stakeholder consultative process to update and extend the UNAIDS Strategy 2011–2015 through the fast-track period 2016–2021 [UNAIDS/PCB (36)/15.5] and took note of the draft UNAIDS Strategy 2016–2021, which would be updated and presented for consideration at the thirty-seventh PCB meeting. The Board also took note of the report on the UNAIDS Unified Budget, Results and Accountability Framework 2012–2015 [UNAIDS/PCB (36)/15.6] and looked forward to the presentation of the 2016–2021 Framework for adoption at its thirty-seventh meeting.

At its thirty-seventh meeting (Geneva, 26–28 October) [UNAIDS/PCB (37)/15.26], the Board adopted the UNAIDS Strategy 2016–2021 [UNAIDS/PCB (37)/15.18. rev1]; and approved the Unified Budget, Results and Accountability Framework 2016–2021 [UNAIDS/PCB (37)/15.19], as well as a core budget for 2016–2017 of $485 million. It also considered an update on the AIDS response in the post-2015 development agenda [UNAIDS/PCB (37)/15.17] and a report on HIV in prisons and other closed settings [UNAIDS/PCB (37)/15.21].

**Non-communicable diseases**

**Prevention and control of non-communicable diseases**

**Inter-Agency Task Force.** On 25 March, in response to Economic and Social Council resolution 2014/10 [YUN 2014, p. 1345], the Secretary-General submitted to the Council a report [E/2015/53] by the WHO Director General on progress achieved since June 2014 by the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases. The work of the Task Force focused on the implementation of the six objectives set out in its terms of reference, and in line with the 2014 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 (NCDs) [YUN 2014, p. 1346], the WHO Global Action Plan for the Prevention and Control of NCDs 2013–2020 [YUN 2013, p. 1174] and the WHO global coordination mechanism on the prevention and control of NCDs. The Task Force workplan covering the period 2014–2015 consisted of 43 actions in support of its six objectives. To complete those actions—each of which had a lead agency—members of the Task Force worked in partnership, including through the alignment of policies and resources. The Task Force prioritized the provision of assistance to world leaders in fulfilling their commitments on NCDs at the country level, but among UN country teams, progress was insufficient.
and uneven in meeting the demand for technical assistance from developing countries to set national targets for 2025; in developing national multisectoral policies and plans on NCDs to achieve the national targets by 2025; and in strengthening national capacities to assess progress and monitor results. Bolder measures were needed to equip country teams with the expertise to support national efforts to address NCDs and mitigate their impacts. The report concluded that country teams had an opportunity, in the context of the post-2015 development agenda, to bring about a paradigm shift by working together to raise awareness about the national public health burden of NCDs and the relationship between NCDs, poverty and social and economic development.

**ECONOMIC AND SOCIAL COUNCIL ACTION**

On 9 June [meeting 33], the Economic and Social Council adopted resolution 2015/8 (United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases) without vote [agenda item 12 (f)].

**Global status report.** On the occasion of the UN summit for the adoption of the post-2015 development agenda (see p. 000), WHO issued the Noncommunicable Diseases Progress Monitor 2015, which tracked the extent to which 194 countries were developing responses to the global burden of non-communicable diseases (NCDs), subject to the national commitments included in the 2011 UN Political Declaration [YUN 2011, p. 1146] and the 2014 UN Outcome Document on NCDs [YUN 2014, p. 1346]. The Monitor presented the achievements and challenges faced by each country as they sought to combat cancer, diabetes, and heart and lung disease. Its findings were based on the most recent data tracked against 10 indicators developed by WHO to assess progress at the national level in the prevention and control of NCDs. The country profiles also included information on the respective population, percentage and number of deaths from NCDs, and the probability of premature mortality from NCDs. Issues covered by the report included the setting of overall NCD reduction targets; measures to reduce tobacco consumption; harmful use of alcohol; unhealthy diets and physical inactivity; and measures to strengthen treatment and care for people with NCDs. It noted that each year, 16 million people died prematurely before the age of 70 from NCDs. With 4 out of 5 of those deaths occurring in developing countries, NCDs presented one of the major development challenges of the twenty-first century. The successful inclusion of NCDs in the post-2015 development agenda gave important positive momentum to the next phase in reducing premature deaths from NCDs, which would culminate in September 2018 with the third High-level Meeting of the UN General Assembly on the prevention and control of NCDs.

**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 2015, 179 States and the European Union were parties to the Convention.

**Global progress report.** The WHO Report on the Global Tobacco Epidemic, 2015: Raising taxes on tobacco stated that there had been steady progress in global tobacco control in the decade since the Framework Convention came into force and seven years after the introduction of the MPower measures, which corresponded to one or more articles of the Framework Convention to help reduce the demand for tobacco at the country level and assist Parties in meeting their FCTC obligations. More than half of the world’s countries-helping to protect 40 per cent of the world’s population (2.8 billion people)—had implemented at least one MPower measure, at the highest level of achievement. That progress more than doubled the number of countries and nearly tripled the number of people covered since 2007. A total of 49 countries with nearly 20 per cent of the world’s population were covered by two or more MPower measures at the highest level, tripling the number of people protected by at least two fully implemented tobacco control measures to 1.4 billion people since 2007. Seven countries, five of which were low- and middle-income, had implemented four or more MPower measures at the highest level. Six of those countries (four of which were low- and middle-income countries with more than 4 per cent of the world’s population—more than 300 million people) were only one step away from having all MPower measures in place at the highest level. The raising of taxes on tobacco to more than 75 per cent of the retail price—one of the most effective and cost-effective tobacco control interventions—was, however, the least implemented MPower measure. Only 1 in 10 of the world’s people lived in the 33 countries that levied taxes to best practice level. There were still many countries with extremely low tobacco tax rates, and some countries that did not levy any tobacco taxes at all. The report noted that it could be difficult to generate sufficient political will to overcome opposition—including from the tobacco industry—to raising tobacco taxes, but because they were generally better accepted than other types of taxes, it was possible to achieve widespread public support, even among tobacco users, especially if at least some of the new tax revenues were used for tobacco control, health...
promotion and other public health programmes. The report called on all countries to fulfil their obligation to protect the health of their people, and all Parties to Framework Convention to make specific commitments to implement strong tobacco control policies as an important means of providing that protection.

Water and sanitation

UN-Water activities. Throughout the year, UN-Water geared its work—issuing reports and policy briefs, and engaging with global campaigns and stakeholder dialogues—towards drawing attention to the role of water and sanitation in an interconnected 2030 Agenda for Sustainable Development; providing input to the Sustainable Development Goals (sdgs) process; and ensuring the creation of a strong, integrated framework for post-2015 monitoring and reporting on water and sanitation, particularly with regard to indicators for sdg 6 (Clean water and sanitation for all). On 30 March in New York, UN-Water supported the organization of a high-level interactive dialogue to celebrate achievements of the International Decade for Action, “Water for Life”, 2005–2015 (see p. 000), which was proclaimed by the General Assembly in 2003 [YUN 2003, p. 1034], and to discuss how lessons learned from the Decade could translate into actions for the 2030 Agenda. On 29 September, during the opening week of the seventieth UN General Assembly, UN-Water co-organized a high-level side event on “Making it happen: ending inequalities and ensuring sanitation, water and hygiene for all as a basis for achieving the sdgs”, which focused on the planned commitments of countries and organizations to achieve sdg 6 and other water-related targets. For World Toilet Day on 19 November, UN-Water coordinated a high-level event in New York to raise the profile of sanitation-related issues and launch a publication by WHO, UNICEF and the United States Agency for International Development entitled Improving nutrition outcomes with better water, sanitation and hygiene: Practical solutions for policies and programmes.

WHO/UNICEF report. In June, the 2015 report of the WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP) was released, providing a definitive analysis of the achievement of the mdg targets on drinking water and basic sanitation. Regarding drinking water, the global mdg target was met in 2010, with 91 per cent of the global population using an improved drinking water source at the time of assessment. In 2015, however, an estimated 663 million people still lacked access to improved drinking water sources. On sanitation, although 2.1 billion people gained access to an improved sanitation facility between 1990 and 2015, JMP estimated that in 2015, 2.4 billion, or 32 per cent of the global population, still lacked access to improved sanitation facilities. In both areas of assessment, urban populations were better served than rural populations. By focusing on inequalities and presenting new ideas for progress, the report underlined the challenge of achieving universal access post-2015.


Malaria

Roll Back Malaria initiative

On 27 May, the Secretary-General transmitted to the General Assembly the report [A/69/916] of the WHO Director General submitted in accordance with Assembly resolution 68/308 [YUN 2014, p. 1351] on consolidating gains and accelerating efforts to control and eliminate malaria in developing countries, particularly in Africa, by 2015. Using the latest available data from malaria-endemic countries and a range of organizations, the Director General reviewed progress made in the implementation of resolution 68/308; the adoption and scaling-up of interventions recommended by WHO for malaria-endemic countries; and assessed progress towards the 2015 global malaria targets, including Millennium Development Goal 6. Between 2000 and 2013, an expansion of malaria interventions had helped reduce malaria mortality rates by 47 per cent worldwide, averting an estimated 4.3 million deaths. The malaria mortality rate in the under-5 age group in Africa declined by 54 per cent during that period. Global case incidence was reduced by 30 per cent. A 2014 analysis revealed that the number of people who carried the malaria parasite in sub-Saharan Africa (i.e., both symptomatic and asymptomatic malaria infections) was reduced from an estimated 173 million in 2000 to 128 million in 2013, notwithstanding an increase of 43 per cent in population levels in malaria-endemic countries of Africa. Based on the data, overall, the world was on track to achieve the mdg target for malaria, but the disease remained concentrated in 16 countries where about 80 per cent of global malaria deaths occurred. Africa bore the world’s highest malaria burden, with two countries—the Democratic Republic of the Congo and Nigeria—accounting for about 39 per cent of malaria mortality worldwide. In South-East Asia, the second most affected part of the world, India had the highest malaria burden. Overall, progress in reducing the malaria burden had been swifter in countries that had lower rates of transmission in the year 2000.

On the development of a new global malaria strategy, the Director General reported that WHO began the work in 2013 to provide countries with
On 11 September [meeting 103], the General Assembly adopted resolution 69/325 [draft: A/69/L.91 & Add.1] (Consolidating gains and accelerating efforts to control and eliminate malaria in developing countries, particularly in Africa, by 2015 and beyond) without vote [agenda item 12].

On 23 December (decision 70/554), 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 seventieth (2016) session.

**Ebola outbreak in West Africa**

**World Health Organization**

**High-level meeting.** The second WHO high-level meeting on Ebola vaccine access and financing (Geneva, 8 January) took stock of efforts to develop and make Ebola vaccines available to communities that had been ravaged by the disease. Progress had come at an unprecedented pace in the context of vaccine development, and participants focused on technical issues pertinent to policymakers, with an emphasis on maintaining the momentum that had been built since the first meeting [YUN 2014, p. 1361]. More than 90 participants were in attendance, including representatives of national and university research institutions, government health agencies, ministries of health and foreign affairs, national security councils and several offices of Prime Ministers and Presidents. Also present were national and regional drug regulatory authorities, the medical charity Médecins Sans Frontières, funding agencies and foundations (the Wellcome Trust) and Gavi, the Vaccine Alliance.

**Special session of Executive Board.** In response to the Ebola virus disease outbreak, the Director General convened a special session of the Executive Board (Geneva, 25 January 2015) [EBSS/3/2015/REC/1], which focused on the current context and challenges; ending the epidemic; preparedness in non-affected countries and regions; and strengthening WHO capacity to prepare for and respond to future large-scale and sustained outbreaks and emergencies. The Board adopted a resolution with 57 operative paragraphs dealing with, inter alia, leadership and coordination; health systems; medical assistance; information and communication; preparedness; therapeutic medicines and vaccines; WHO structure and capacity; research and development; evaluation; and resources, including the agreement in principle to the establishment of a contingency fund. The resolution called on Member States—and, where applicable, regional economic integration organizations—to strengthen capacities to recruit, develop, train and retain the health workforce in developing countries, particularly in the most affected and highly at-risk countries. It also requested the Director General to commission an interim assessment, by a panel of outside independent experts, on all aspects of the WHO response from the onset of the outbreak of Ebola virus disease, to be presented to the sixty-eighth (2015) session of the World Health Assembly.

**World Health Assembly.** The sixty-eighth session of the World Health Assembly (Geneva,
18–26 May) (see p. 000) had before it a report by the who Secretariat on the 2014 Ebola virus disease outbreak: current context and challenges, stopping the epidemic, and preparedness in non-affected countries and regions [A68/24]; the first report of Ebola Interim Assessment Panel [A68/25]; and a report by the Director General on the 2014 Ebola virus disease outbreak and follow-up to the special session of the Executive Board on Ebola: options for a contingency fund to support WHO emergency response capacity [A68/26]. On 26 May, the Assembly adopted decision WHA68(10) on the 2014 Ebola virus disease outbreak and follow-up to the Special Session of the Executive Board on the Ebola Emergency, which requested the Director General to establish a Review Committee under the International Health Regulations (2005) to examine the role of the International Health Regulations (2005) in the Ebola outbreak and response— with the objective of assessing their effectiveness and recommending steps to improve their functioning, transparency and efficiency to strengthen preparedness for future emergencies with health consequences—and to report on its progress to the sixty-ninth (2016) World Health Assembly. Through decision WHA68(10), the Assembly also created a specific, replenishable contingency fund to rapidly scale up the WHO initial response to outbreaks and emergencies with health consequences. The fund would merge the existing two who funds with a target capitalization of $100 million fully funded by voluntary contributions; be flexible within the fund’s scope; and be under the authority of the Director General. The Assembly requested the Director General to report on the performance of the contingency fund to the sixty-ninth World Health Assembly.

International Ebola Recovery Conference

The Secretary-General hosted an International Ebola Recovery Conference (New York, 9–10 July 2015) to ensure that recovery efforts for Guinea, Liberia and Sierra Leone went beyond redressing direct development losses and also contributed to building back better and ensuring greater resilience. The Conference focused on the need for targeted investments to support recovery priorities over a 24-month time frame. Such investments considered the broader risk landscape that included health, governance and peacebuilding within those three countries and the Mano River subregion. Participants discussed country-based and regional anti-Ebola strategies, and the Conference provided a platform to secure pledges that could complement African Union-led efforts and fill technical and resource gaps. An estimated $5.2 billion in pledges were recorded at the Conference, comprising an estimated $3.4 billion announced on 10 July and $1.8 billion in previously committed resources.

United Nations Mission for Ebola Emergency Response

Letters of Secretary-General. In a 10 February letter [A69/759] to the President of the General Assembly, the Secretary-General reviewed the activities from 1 January to 1 February that had been carried out by the Special Envoy on Ebola and the United Nations Mission for Ebola Emergency Response (UNMEER) in pursuance of General Assembly resolution 69/1 [YUN 2014, p. 1360] and since his previous update [YUN 2014, p. 1364]. He reported that as at 1 February, a total of 22,495 confirmed, probable and suspected cases of Ebola had been reported in four affected countries (Guinea, Liberia, Sierra Leone, United Kingdom of Great Britain and Northern Ireland) and five previously affected countries (Mali, Nigeria, Senegal, Spain, United States of America). A total of 8,981 people had died of Ebola as of the reporting period. There were 124 new confirmed cases reported in the week to 1 February, including 39 in Guinea, 5 in Liberia and 80 in Sierra Leone. Mali was declared Ebola free on 18 January after a period of 42 days without registering a new case. That success in containing the outbreak was largely due to the Government’s early and robust efforts in prevention and preparedness, its timely response once cases were reported, and the proactive technical and financial support of numerous international partners. Overall, health-care workers continued to face an acute risk of infection, with a total of 822 confirmed health-care worker infections reported and 488 deaths reported across Guinea, Liberia and Sierra Leone.

UNMEER continued to collaborate with the national Governments and UN agencies, funds and programmes to align all response actors on a commonly agreed operational framework under the leadership of the host Government to support implementation of national plans. In all three affected countries, UNMEER supported the national crisis management centres and deployed field crisis managers to district-level coordination offices (18 in Sierra Leone, 15 in Liberia and 8 in Guinea). To improve the quality of reporting and information, UNMEER supported the standardization of reporting practices at the national and district levels and facilitated data collection through the deployment of over 30 United Nations Volunteers information management officers in field locations and the provision of mobile devices. Who deployed epidemiologists in all 63 districts across the three affected countries, as well as in nine districts in Mali. Under the coordination of UNMEER, UN organizations and partners contributed their expertise to the Ebola response. Who led the overall health response strategy, working closely with Ministries of Health in the affected countries. As the technical lead, who carried out training for health-care workers, including on infection prevention and control. It
also supported social mobilization activities through monitoring and evaluation and provided mental health and psychosocial support training to Ebola treatment unit workers. More than 8,400 health-care workers were trained in Sierra Leone, and more than 1,600 in Liberia. The World Food Programme (WFP) provided food and nutrition support to almost 2.8 million people in Guinea, Liberia and Sierra Leone. With funding from the Ebola Response Multi-Partner Trust Fund, UNDP supported the national authorities, together with partners, to ensure that all Ebola workers were paid correctly and on time. Since 1 January, UNFPA had trained and deployed 5,039 contact tracers in Sierra Leone, who had collectively followed up a total of 75,325 Ebola contacts. There were also 58 foreign medical teams from over 40 organizations and national Governments or militaries supporting the operational response.

In a letter [A/69/812] dated 12 March covering developments from 1 February to 1 March, the Secretary-General reported that after a sharp decline in cases, to a low of 99 confirmed cases in the week prior to 25 January, the month of February had seen a plateauing of the number of cases at between 100 and 150 cases per week. The outbreak had also become more localized, with 94 per cent of all confirmed cases in the week prior to 1 March located in an arc covering the coastal area of western Guinea and the coastal and western areas of Sierra Leone. Since mid-December 2014, Guinea had experienced a steep decline to an average of 45 confirmed cases per week for the first three weeks of January 2015. Sierra Leone was continuing to experience the highest number of new confirmed cases among the three countries, reporting 81 confirmed cases in the week prior to 1 March. In Liberia, case incidence declined significantly to single digits per week nationally since the beginning of January. The progress in Liberia could be attributed to several factors, including community engagement in the response, coordination among responders and integration of the lines of actions (case finding, case management, safe and dignified burials and community engagement) at the community level. In each of the three affected countries, infrastructure inputs and clinical capacities, such as Ebola treatment units, laboratories and safe burial teams, were in place as at 1 March 2015, and all three countries had sufficient capacity to isolate and treat 100 per cent of confirmed Ebola patients. There were also sufficient burial teams in place to ensure safe and dignified burials for 100 per cent of all deaths due to Ebola. On 19 February, who held a two-day meeting attended by 160 participants representing the 40 organizations contributing to the 58 foreign medical teams supporting the frontline response efforts. The purpose of the meeting was to agree on best practices in Ebola care and discuss how the teams could best contribute to achieving zero Ebola cases and the reactivation of essential health services. UNICEF continued to lead the social mobilization pillar and the community care centre approach. Social mobilization activities had involved supporting networks of more than 50,000 people across the three affected countries.

In the letter [A/69/871] dated 16 April covering the period from 1 March to 1 April, the Secretary-General reported that although transmission was confined to a relatively narrow geographic corridor, the populations in and around the affected areas of Conakry and Freetown were highly mobile. Therefore, there was a strong focus on enhancing community detection and alert systems through active surveillance in all districts throughout the three affected countries, including Ebola-free districts. The WHO Integrated Disease Surveillance and Response system was being used as a framework to improve existing systems and would enable the investigation and testing of suspected Ebola cases at the county, district and commune levels. Rigorous case investigation and contact tracing were crucial to further curb the spread of Ebola and ensure that new cases stemmed only from registered contacts. In March, 96 per cent of registered contacts, with an average of 2,383 contacts under follow-up, were traced daily. In view of community resistance in Guinea, UNMEER facilitated a Government-led eight-day campaign—“Ebola ça suffit” (Enough Ebola)—funded by the Ebola Response Multi-Partner Trust Fund to reinforce social mobilization efforts, enhance community participation and reduce stigmatization of Ebola survivors. UNMEER, in collaboration with the United Nations Office for West Africa, also facilitated a stakeholders’ forum bringing together political and religious leaders, media, syndicate representatives and civil society actors who declared their collective commitment to the fight against Ebola as a national priority.

In a letter [A/69/908] dated 22 May covering developments from 1 April to 1 May, the Secretary-General reported that as at 3 May, a combined total of 26,628 confirmed, probable and suspected cases of Ebola had been reported in the three affected countries of Guinea, Liberia and Sierra Leone, and in the six previously affected countries (Mali, Nigeria, Senegal, Spain, United Kingdom, United States). There had been a cumulative total of 11,020 confirmed, probable and suspected deaths. In Guinea, Liberia and Sierra Leone, the average weekly case incidence declined from some 110 cases per week in March to an average of 30 cases in April. In Guinea, the weekly incidence decreased to 9 confirmed cases in the week ending 3 May. In Sierra Leone, the incidence in April fluctuated between 9 and 12 weekly cases, with no discernible trend. Liberia did not report a single case in April, and on 9 May, who declared Liberia Ebola free. The geographical area of active transmission had more than halved since February 2015, and almost
all remaining transmission was taking place near the west coast of Guinea and Sierra Leone. The overall Ebola response continued to be centred on four main lines of action: finding people with the disease and following-up with their contacts; treating people with the disease; safe and dignified burials; and community engagement. Early case detection, reinforcement of alerts and surveillance systems and awareness-raising activities had become more critical in the final push towards zero cases.

In a letter [A/69/939] dated 16 June covering developments from 1 May to 1 June, the Secretary-General reported that there was continued, notable progress in efforts to combat Ebola during the reporting period. In May, the combined weekly incidence of new infections fluctuated between 9 and 35 cases in Guinea and Sierra Leone. In Liberia, where the Ebola outbreak had been declared over, the country had entered a three-month period of heightened vigilance. With declining case incidence and a shrinking area of transmission, treatment capacity exceeded demand. Accordingly, ministries of health and partners, in coordination with WHO, proceeded with the decommissioning of surplus Ebola treatment centres. Each country would retain a core capacity of centres strategically located to ensure full geographic coverage, with additional rapid-response capacity in reserve—7 core centres would be retained in Guinea, 5 in Liberia and 12 in Sierra Leone. Surplus facilities would be closed down when a nearby district health facility could safely assume responsibility for triage and isolation or referral of cases. In Sierra Leone, UNICEF, in coordination with the national authorities, closed 29 community care centres, leaving 17 operational across four districts. In Guinea, three of six centres remained functional. In Liberia, the equipment and commodities to implement 16 rapid isolation and treatment facilities remained pre-positioned. UNICEF also continued to work with communities to promote behavioural change to stop transmission, particularly in the remaining hotspots. In Sierra Leone and Guinea, UNICEF and partners had reached 1,332,017 and 1,221,437 households, respectively, with Ebola prevention messages. Educational talks, mass awareness-raising sessions and door-to-door visits, as well as the distribution of hygiene supplies, remained important parts of the community outreach strategy.

In a letter [A/69/992] dated 24 July covering developments from 1 June to 1 July, the Secretary-General reported that as at 1 July, there had been a total of 27,550 confirmed, probable and suspected cases and an accumulative total of 11,235 confirmed, probable and suspected deaths as a result of the Ebola outbreak in West Africa. In June, the combined weekly incidence fluctuated between 20 and 27 cases in Guinea and Sierra Leone. In Guinea, the incidence remained between 10 and 12 confirmed cases. In Sierra Leone, the incidence decreased from 15 confirmed cases reported in the week to 7 June, to 8 cases reported in each of the two weeks to 28 June. On 29 June, routine surveillance detected a confirmed case of Ebola in Margibi County, Liberia—the first new confirmed case in the country since 20 March. The identification of that first confirmed case in three months in Liberia demonstrated the importance of heightened surveillance and the need for continued vigilance, and WHO was working with partners in Liberia to trace all contacts, identify the source of infection and assess levels of risk. In areas of continuing transmission, community engagement, safe burials, case finding, targeted active surveillance and contact tracing were being strengthened to ensure that remaining chains of transmission were detected, contained and stopped. Community engagement remained of particular importance because resistance to the response continued to be a concern. Communities were and would continue to be the driving force of the response as efforts to identify and uproot the triggers of transmission in the remaining affected localities continued. The leadership, technical expertise and coordination of WHO in reaching and remaining at zero cases were increasingly critical. With a view to strengthening efforts on the ground and addressing remaining hotspots, Operation Northern Push in Sierra Leone and a campaign of reinforced surveillance in Guinea were being implemented. In Sierra Leone, the UNMEER transition process had been completed and its operational functions were handed over to national partners and UN Nations agencies, funds and programmes on 30 June. In Guinea, UNMEER would hand over all operations by 31 July.

**UNMEER closure.** In a letter [A/69/1014] dated 1 September covering developments from 1 to 31 July, the Secretary-General reported that he had announced the closure of UNMEER on 31 July, marking an important milestone in the global Ebola response. The Mission had contributed to scaling up the response in the affected countries and established focused coordination of responders, thus fulfilling its core objectives. On 1 August, oversight of the UN system's Ebola emergency response was fully transferred from UNMEER to WHO, under the direct authority of the WHO Director General. The response continued to require a high level of intensified inter-agency collaboration and support for Governments in order to end the outbreak. To maintain the high-level, dedicated UN leadership needed to reach zero cases, the Secretary-General determined that Ebola crisis managers would remain in the affected countries beyond the Mission's lifespan under WHO oversight, with the support of the resident coordinators and UN country teams, until the end of December 2015 and possibly beyond, subject to a reassessment of exigencies on the ground. In another development, WHO announced on 31 July that a vaccine trial in Guinea had yielded
promising results. The vaccine had yet to be licensed or recommended outside clinical trial settings, but once approved it would be an additional tool to combat the virus in the event of future outbreaks. In the meantime, all contacts of new cases in Guinea would be offered immediate vaccination. Discussions had been initiated regarding a possible expansion of the trial to Sierra Leone.

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

Communication. In a 5 August letter [S/2015/600] addressed to the Secretary-General, the Permanent Representative of Nigeria to the United Nations forwarded the concept note for the Security Council briefing on the global response to the 2013 Ebola virus disease outbreak, scheduled for 13 August 2015.

Security Council consideration. On 13 August, the Security Council held a meeting [S/PV.7502] on peace and security in Africa, focusing on the global response to the 2013 Ebola virus disease outbreak, which included briefings by Dr. David Nabarro, Special Envoy of the Secretary-General on Ebola, and Dr. Margaret Chan, who Director General.

Dr. Chan pointed out that much had changed since she briefed the Security Council on the Ebola outbreak in September 2014 [YUN 2014, p. 1357]. New cases in Liberia had again stopped, and Guinea and Sierra Leone had together reported only three cases during each of the previous two weeks, representing the lowest numbers seen in over a year. At the same time, she cautioned against a false sense of security, saying all it took was a single undetected case in a health facility, one infected contact fleeing the monitoring system, or one unsafe burial to ignite a flare-up of cases. In reference to preparedness measures to prevent the future occurrence of similar or worse outbreaks, she drew attention to the importance of regional arrangements, which improved vigilance and increased the surge capacity for rapid response. She also noted that who was putting together a blueprint for the rapid development of new medical products for any future outbreak.

Dr. Nabarro focused on three components of the Ebola response: the impact of decisive and powerful leadership; the importance of community ownership of the response; and the value of working together in long-term solidarity. He stressed that the response worked best when it was owned by the affected communities. Implementation of the response had gone well when people whose health was at risk had felt in control of their own lives, as well as their deaths, and when community leaders took part. Under those circumstances, people’s concerns and fears were more easily addressed; important cultural practices could be made safe and dignified; transmission chains were identified more quickly; and contacts were traced more readily. Yet even with recognition that community ownership was an essential ingredient, it had not been consistently prioritized in the response, and going forward, Dr. Nabarro urged technical, operational and financial solidarity with the affected counties, and an all-of-society response in the face of new disease outbreaks.

Financing

Report of Secretary-General. A 27 March report [A/69/842] 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. It was estimated that additional resources in the amount of $88,094,000 (net of staff assessment) would be required for the biennium. The report proposed a reconfiguration of staffing structure with personnel relocated/redeployed from UNMEER headquarters in Accra to UNMEER country offices in Guinea, Liberia and Sierra Leone to tackle the Ebola outbreak at the district level. It also proposed positions at Headquarters for back-stopping; operational costs under various sections of the programme budget; and some positions at the Regional Service Centre at Entebbe to provide service delivery.

ACABQ report. In a 15 May letter [A/69/903] on the Office of the Special Envoy on Ebola and UNMEER, the Advisory Committee on Administrative and Budgetary Questions (ACABQ) recommended that the General Assembly approve and appropriate additional resources in the amount of $86,431,000 (net of staff assessment) from the programme budget for the biennium 2014–2015; and appropriate an additional amount of $2,695,000 under section 36, Staff assessment, to be offset by an equivalent amount under income section 1, income from staff assessment.

General Assembly action. On 25 June, by resolution 69/274 B (see p. 000), the General Assembly endorsed the ACABQ conclusions and recommendations and decided to appropriate an amount of $87,839,700 (net of staff assessment) of the programme budget for the biennium 2014–2015. The Assembly noted that the liquidation of UNMEER was planned to be completed by 30 September 2015 and that the activities of the Office of the Special Envoy were planned to be finalized by 31 December 2015. It requested the Secretary-General to ensure a smooth and timely transition from the Mission and the Office to the UN country teams and other actors as a matter of priority; to provide, at the first part of the resumed seventeenth (2016) session of the General Assembly, detailed information, in the context of his lessons learned exercise, on the coordination activities of the Mission and the Office with the wider UN system, the Governments of the most affected countries and other actors; and to include therein the results of his review of the
organizational, administrative and planning aspects, and operation on the ground, as well as information on the final performance, including the liquidation and the disposal of the assets, of the Mission and the Office of the Special Envoy.

Global public health

The sixty-eighth session of the World Health Assembly (Geneva, 18–26 May) [WHA68/2015/REC/1] discussed public health issues such as the global technical strategy and targets for malaria 2016–2030; poliomyelitis; yellow fever risk mapping and recommended vaccination for travellers; the global vaccine action plan; the global action plan on antimicrobial resistance; the health impact of air pollution; strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage; the need for coordinated action at the country level to address the global burden of epilepsy; development of the core set of indicators on maternal, infant and young child development; and the 2014 Ebola virus disease outbreak and follow-up to the Special Session of the Executive Board on the Ebola Emergency (see p. 000). It adopted a series of resolutions and decisions on those and other topics, including resolution WHA68.7 of 26 May, which contained a global action plan on antimicrobial resistance and requested the WHO Director General to elaborate, in consultation with the UN Secretary-General, options for the conduct of a high-level meeting in 2016, on the margins of the General Assembly, including potential deliverables, and to report thereon to the sixty-ninth (2016) World Health Assembly.

Global health and foreign policy

On 17 December [A/70/PV.80], the General Assembly considered the item on global health and foreign policy, for which it had before it a note [A/70/389] by the Secretary-General transmitting the report of the WHO Director General on the protection of health workers, submitted by the Secretary-General in response to resolution 69/132 [YUN 2014, p. 1367]. The report compiled and analysed the experiences of Member States and provided recommendations for action to promote the safety of medical and health personnel, their means of transport and installations and respect for their professional codes of ethics, particularly with regard to violence in armed conflicts and emergency situations; violence at the workplace in the health sector; the safety of hospitals and health facilities; the role of the International Health Regulations (2005) in enhancing national and global public health security; the heavy toll on health-care workers in responding to the outbreak of the Ebola virus disease in West Africa; and building resilient national health systems and capacities through the health workforce.

At the same meeting, the Assembly considered a draft resolution entitled “Global health and foreign policy: strengthening the management of international health crises” (see below), which called for the development by Member States of resilient and sustainable health systems capable of responding effectively to outbreaks and emergencies, and of implementing effective responses to the broader dimensions of outbreaks and emergencies, including food security and access to basic health services. The resolution also decided that a high-level meeting on antimicrobial resistance would be held in 2016, and requested that the Secretary-General, in collaboration with the WHO Director General and Member States, determine options and modalities for the conduct of that meeting, including potential deliverables.

GENERAL ASSEMBLY ACTION

On 17 December [meeting 80], the General Assembly adopted resolution 70/183 [draft: A/70/L.32 & Add.1] (Global health and foreign policy: strengthening the management of international health crises) without vote [agenda item 125].

On 23 December (decision 70/554), the General Assembly decided that agenda item “Global health and foreign policy” would remain for consideration during its resumed seventieth (2016) session.

Road safety

WHO report. In September [A/70/386], the Secretary-General submitted a report on improving global road safety, prepared by WHO, in consultation with the UN regional commissions and other partners of the United Nations Road Safety Collaboration, and covering the period from September 2013 to August 2015. The report gave an update on the implementation of General Assembly resolution 68/269 [YUN 2014, p. 1370] and described the activities of the global road safety community in pursuance of the objectives of the Decade of Action for Road Safety 2011–2020 [YUN 2010, p. 1233] since the previous report [YUN 2013, p. 1184]. It also included recommendations to the Assembly for achieving the goals of the Decade of Action, which aimed to stabilize and reduce the forecasted level of road traffic deaths in the world through its five pillars of technical support and collaboration: road safety management; safer roads and mobility; safer vehicles; safer road users; and post-crash response.

Several high-profile events and actions had raised awareness on the issue of road safety around the world and the solutions that Governments and other stakeholders needed to implement to reduce road traffic crashes and their consequences on public health and development. On 29 April, the Secretary-General appointed a special envoy for road safety to mobilize
Food, agriculture and nutrition

Food aid

World Food Programme

The Executive Board of the World Food Programme (WFP) held its 2015 sessions [E/2016/36]—the first regular (9–10 February), annual (25–28 May) and second regular (9–12 November)—in Rome, during which it made decisions and recommendations on various organizational and programme matters. It approved several projects and policies, including protracted relief and recovery operations in Burkina Faso, Colombia, the Democratic Republic of the Congo, Ethiopia, Kenya, Nepal, Pakistan, the Philippines, Somalia, the Sudan and Uganda. On 12 November, the Board approved its 2016–2017 biennial programme of work [WFP/EB.2/2015/11].

The Economic and Social Council, by decision 2015/219 of 29 June, took note of the report [E/2015/36] of the WFP Executive Board on its first and second regular sessions and annual session of 2014.

WFP activities

According to a later WFP annual performance report for 2015 [E/2016/14], concurrent Level 2 and Level 3 emergencies during the year required institution-wide responses from WFP as it continued to reach the world’s most vulnerable people with lifesaving food assistance. Working with over 1,000 non-governmental organizations, WFP directly assisted 76.7 million people—most of them women and children—in 81 countries through 201 projects. A further 1.6 million people were reached with programmes funded through trust funds, mostly supported by host governments. In 2015, WFP received the second highest annual level of voluntary contributions—some $4.8 billion. Seventy-nine per cent of expenditure was directed to emergencies. WFP responded to severe, complex emergencies in Iraq (see p. 000), South Sudan (see p. 000), Yemen (see p. 000), the Syria region (see p. 000) and Ebola-affected West Africa (see p. 000); and to major emergencies in the Central African Republic, the Democratic Republic of the Congo, the Horn of Africa, Libya, Mali, Nepal and Ukraine. WFP and its partners also sustained responses to protracted crises in in Afghanistan, Chad, Colombia, Somalia, the State of Palestine and the Sudan, which were brought about by conflict, economic shocks and significant disruptions in food systems.

The humanitarian crisis in the Syrian Arab Republic increased hardship and privation, particularly for those trapped in besieged and hard-to-reach areas. Consistent donor support enabled WFP operations to reach every month about 4 million people inside Syria and more than 4 million refugees in Egypt, Iraq, Jordan, sustained political commitment by promoting adherence to and raising awareness about the UN legal instruments on road safety; sharing good practices through participation in global and regional conferences; and generating funds for advocacy efforts. For the third UN Global Road Safety Week (4–10 May), events took place in at least 105 countries involving governments, international agencies, civil society organizations and private companies. The associated #SaveKidsLives campaign highlighted the plight of children on the world’s roads to generate action to better ensure their safety, including through the release of a WHO communications package containing 10 strategies for keeping children safe on the road. On 26 May, the World Health Assembly adopted resolution WHA68.15 on strengthening emergency surgical care and anaesthesia as a component of universal health coverage, which highlighted the importance of expanding access and improving the quality and safety of emergency and rehabilitation services, including for victims of road-traffic injuries; strengthening the surgical workforce; improving data collection, monitoring and evaluation; ensuring access to safe anaesthetics; and fostering global collaboration and partnerships. Access to emergency and essential services was extremely limited in many parts of the world, which resulted in treatable road traffic injuries leading to death or disability, and resolution WHA68.15 could help countries adopt and implement policies to integrate quality and cost-effective surgical care into their health systems.

On 18–19 November, 2,200 delegates from more than 110 countries convened in Brasilia, Brazil for the Second Global High-level Conference on Road Safety. The Conference adopted the “Brasilia Declaration on Road Safety”, which contained actions to halve road traffic deaths by 2020—as called for by target 3.6 of the newly adopted SDGs. The Conference followed the release in October 2015 of the WHO Global status report on road safety 2015, which reflected information from 180 countries and indicated that despite improvements in road safety, some 1.25 million people died each year on the world’s roads, with the highest road traffic fatality rates in low-income countries. In the previous three years, 17 countries had aligned from 180 countries and indicated that despite improvements in road safety, some 1.25 million people died each year on the world’s roads, with the highest road traffic fatality rates in low-income countries. In the previous three years, 17 countries had aligned at least one of their laws with best practice on seat belts, drink-driving, speed, motorcycle helmets or child restraints. The report noted that the number of road traffic deaths was stabilizing—despite a rapid increase in the number of motor vehicles worldwide and a growing population—but the pace of change was too slow and urgent action was needed to achieve the road safety target reflected in the 2030 Agenda for Sustainable Development (see p. 000).

On 23 December (decision 70/554), the General Assembly decided that agenda item “Improving global road safety” would remain for consideration during its resumed seventieth (2016) session.
Chapter XIII: Health, food and nutrition

Lebanon and Turkey. Funding shortfalls late in the year and large amounts of earmarked funding resulted in reduced assistance, including cuts in ration sizes. WFP was critical to the system-wide response to the Ebola virus disease outbreak in West Africa (see p. 000), assisting 3.7 million people with food, cash and nutrition support and providing logistics support for the wider humanitarian community. Looking forward, WFP started working with WHO, national governments and the private sector to develop a pandemic supply-chain preparedness and response framework for future emergencies.

The report noted that in 2015, with the adoption in September by the General Assembly of the 2030 Agenda for Sustainable Development and its 17 SDGs (see p. 000), a commitment was made to end hunger by 2030. SDG 2 (Zero Hunger) addressed the various dimensions of food security and nutrition. Its four targets on access, malnutrition, agricultural productivity and food systems reflected complementary areas for action. The broader scale and diversity of the new goals and food systems reflected complementary areas for action. The broader scale and diversity of the new goals.

The Food and Agriculture Organization of the United Nations (FAO) continued to address global food insecurity. The 2015 edition of the FAO report The State of Food Insecurity in the World stated that the target, 29 of which had also reached the more ambitious World Food Summit [YUN 1996, p. 1129] goal of at least halving the number of chronically undernourished people—namely, to reach Millennium Development Goal (MDG) Target 1C—had been almost met at the global level. Seventy-two of the 129 countries monitored for progress had reached the target, 29 of which had also reached the more ambitious World Food Summit [YUN 1996, p. 1129] goal of at least halving the number of chronically undernourished people within their populations. Marked differences in progress occurred not only among individual countries, but also across regions and subregions. The prevalence of hunger had been reduced rapidly in Central, Eastern and South-Eastern Asia as well as in Latin America. In Northern Africa, a low level had been maintained throughout the MDG and World Food Summit monitoring periods. Other regions, including the Caribbean, Oceania and Western Asia, saw some overall progress, but at a slower pace. In two regions—Southern Asia and sub-Saharan Africa—progress had been slow overall, despite many success stories at country and subregional levels. In many countries that had achieved modest progress, factors such as war, civil unrest and the displacement of refugees had often frustrated efforts to reduce hunger and sometimes even raised the ranks of the hungry.

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 2015 edition of the FAO report The State of Food Insecurity in the World stated that the overall, the commitment to halve the percentage of chronically undernourished people—namely, to reach Millennium Development Goal (MDG) Target 1C—had been almost met at the global level. Seventy-two of the 129 countries monitored for progress had reached the target, 29 of which had also reached the more ambitious World Food Summit [YUN 1996, p. 1129] goal of at least halving the number of chronically undernourished people within their populations. Marked differences in progress occurred not only among individual countries, but also across regions and subregions. The prevalence of hunger had been reduced rapidly in Central, Eastern and South-Eastern Asia as well as in Latin America. In Northern Africa, a low level had been maintained throughout the MDG and World Food Summit monitoring periods. Other regions, including the Caribbean, Oceania and Western Asia, saw some overall progress, but at a slower pace. In two regions—Southern Asia and sub-Saharan Africa—progress had been slow overall, despite many success stories at country and subregional levels. In many countries that had achieved modest progress, factors such as war, civil unrest and the displacement of refugees had often frustrated efforts to reduce hunger and sometimes even raised the ranks of the hungry.
Hunger remained a daily challenge for about 795 million people worldwide—just over one in nine people—including 780 million in the developing regions. That total number of undernourished people represented a reduction of 167 million over the previous decade, and 216 million less than in 1990–1992. The decline was more pronounced in developing regions, despite significant population growth. For the developing regions as a whole, the two indicators of MDG Target 1C—the prevalence of undernourishment and the proportion of underweight children under 5 years of age—had both declined. In some regions, including Western Africa, South-Eastern Asia and South America, undernourishment declined faster than the rate for underweight children, which suggested room for improving the quality of diets, hygiene conditions and access to clean water—factors that affected people’s ability to derive sound nutrition from the food they consumed—particularly for poorer population groups.

The report identified key factors that determined success in reaching MDG Target 1C and provided guidance on policies to emphasize in the future. It noted that inclusive growth provided opportunities for those with limited assets and skills, and improved the livelihoods and incomes of the poor, especially in agriculture. It was therefore among the most effective tools for fighting hunger and food insecurity, and for attaining sustainable progress. Enhancing the productivity of resources held by smallholder family farmers, fisherfolk and forest communities, and promoting their rural economic integration through well-functioning markets, were essential elements of inclusive growth. Social protection also contributed directly to the reduction of hunger and malnutrition. By increasing human capacities and promoting income security, it fostered local economic development and the ability of the poor to secure decent employment and partake of economic growth. There were numerous positive situations to be found linking family farming and social protection, including institutional purchases from local farmers to supply school meals and government programmes, and cash transfers or cash-for-work programmes that allowed communities to buy locally produced food. In countries experiencing protracted crises due to conflicts, political instability or natural disasters, there was increased vulnerability to food insecurity and malnutrition. Those challenges called for strong political commitment and effective measures to protect vulnerable population groups and their livelihoods.

**Agriculture development, food security and nutrition**

**Report of Secretary-General.** In response to General Assembly resolution 69/240 [YUN 2014, p. 1376], the Secretary-General submitted an August report [A/70/333] on agriculture development, food security and nutrition. The report examined the progress made and the challenges that remained in achieving food security and nutrition, sustainably increasing agricultural production and reducing food losses and waste, in accordance with the Secretary General’s Zero Hunger Challenge [YUN 2012, p. 1170]. It also provided recommendations on how to carry forward the work of eradicating hunger and malnutrition, as central to the 2030 Agenda for Sustainable Development and a catalyst for other SDGs.

The Secretary-General noted that since 1990–1992, 216 million people had been lifted out of hunger and the prevalence of undernourishment in the developing world had fallen from 23.3 to 12.9 per cent. Seventytwo out of the 129 developing countries monitored by FAO—more than half the total—had reached the MDG hunger target of halving the prevalence of undernourishment between 1990 and 2015. Extreme poverty in low- and middle-income countries also fell globally between 1981 and 2011, and the MDG poverty target had been met. Overall progress in reducing hunger, however, had been highly uneven. Almost 795 million people—one in nine worldwide—remained chronically hungry, lacking sufficient food for conducting an active and healthy life. Over 1 billion people were extremely poor, living on less than $1.25 per day. In many of the countries that had failed to achieve the international hunger targets, natural and human-induced disasters or political instability had resulted in protracted crises, with increased vulnerability and food insecurity subsisting among large segments of the population. While sub-Saharan Africa had the highest share of the chronically hungry—almost one in four people—South Asia had the highest number, with over half a billion undernourished. Western Asia alone had seen an actual rise in the share of the hungry compared with 1991, while progress in sub-Saharan Africa, South Asia and Oceania had not been sufficient to meet the MDG hunger target by 2015.

The Secretary-General discussed the move from the MDGs to the SDGs on food security and nutrition, noting that world leaders were prepared to renew their efforts through SDG target 2.1, which was to end hunger and ensure access by all people, in particular the poor and people in vulnerable situations, including infants, to safe, nutritious and sufficient food all year round by 2030; and SDG target 2.2, which was to end all forms of malnutrition, including by achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and addressing the nutritional needs of adolescent girls, pregnant and lactating women and older persons by 2030. The latter reflected the set of global nutrition targets set in the WHO Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition [YUN 2012, p. 1175], as endorsed by the sixty-fifth (2012) World Health Assembly in resolution WHA65.6. The SDGs also comprised at least six goals
that addressed the basic and immediate causes of malnutrition, with an additional 18 targets that were directly or indirectly related to nutrition outcomes. Reaching sdg 2 (Zero Hunger) and the interlinked targets of other goals would be critical to achieving a shift to resilient, diverse and productive agriculture and food systems that were environmentally, socially and economically sustainable. While people in rural areas constituted the largest proportion of those living in extreme poverty, investment in agriculture had been shown to be twice as effective in reducing poverty as investment in any other sector. To deliver on the promise of the 2030 Agenda, food systems that not only fed and nourished people, but also delivered increased income and rural livelihoods, were needed.

The Secretary-General recommended that strategies for promoting food security and nutrition incorporate elements such as pro-poor investment; political commitment; social participation, especially including smallholder and women farmers; and the combination of productive support and social protection, and linkages between programmes and actions across different sectors. He emphasized the importance of cooperation among nations, in particular the exchange of experiences through South-South cooperation, as many developing countries faced similar agricultural development challenges, and existing solutions could inspire positive developments with respect to sustainable development challenges, and existing solutions could inspire positive developments with respect to sustainability increasing agricultural yields, ensuring food security and promoting good nutrition.

Committee on World Food Security. In response to Economic and Social Council decision 2011/217 (YUN 2011, p. 1162), the Secretary-General transmitted to the General Assembly and the Economic and Social Council a report [A/70/92-E/2015/82] on the main decisions and policy recommendations of the Committee on World Food Security, as well as the results achieved so far in the area of food security and nutrition. The report described the outcomes of the Committee’s forty-first session (Rome, Italy, 13–17 October 2014), and provided updates on follow-up actions. Topics addressed by the Committee, including through the work of its High-level Panel of Experts on Food Security and Nutrition, were food losses and waste in the context of sustainable food systems; sustainable fisheries and aquaculture for food security and nutrition; the Principles for Responsible Investment in Agriculture and Food Systems; and the development of a framework for action for food security and nutrition in protracted crises. The Committee endorsed the third version of the Global Strategic Framework for Food Security and Nutrition, which included policy recommendations for biofuels and food security; and investment in smallholder agriculture for food security and nutrition. The Committee also discussed the preparation of its multi-year programme of work for the biennium 2016–2017, for which it considered a note produced by the High-level Panel of Experts on Food Security and Nutrition on critical and emerging issues for food security and nutrition.

The forty-second session of the Committee on World Food Security (Rome, 12–15 October 2015) [A/71/89-E/2016/69] endorsed the Framework for Action for Food Security and Nutrition in Protracted Crises, which was intended to guide the development, implementation and monitoring of policies and actions to improve food security and nutrition in protracted crisis situations in a way that responded to the specific challenges of those situations; avoided exacerbating underlying causes; and, where possible, contributed to resolving them. The Committee requested that the General Assembly, through the Economic and Social Council, endorse and ensure the wide dissemination of the Framework for Action to all relevant UN organizations and agencies. The Committee adopted its Multi-Year Programme of Work for the biennium 2016–2017, and endorsed the fourth version of the Global Strategic Framework for Food Security and Nutrition, which included policy recommendations for sustainable fisheries and aquaculture for food security; and nutrition and food losses and waste in the context of sustainable food systems. It also requested that an external evaluation be carried out in 2016 to assess the effectiveness of the Committee since its reform in 2009.

On 22 December (decision 70/547), the General Assembly, on the recommendation of the Second (Economic and Financial) Committee, took note of the note by the Secretary-General transmitting the report on main decisions and policy recommendations of the Committee on World Food Security.

GENERAL ASSEMBLY ACTION

On 22 December [meeting 81], the General Assembly, on the recommendation of the Second Committee [A/70/478], adopted resolution 70/223 (Agriculture development, food security and nutrition) without vote [agenda item 26].

Nutrition

Scaling Up Nutrition. The Scaling Up Nutrition (sun) Movement Annual Progress Report for 2015 noted that the Movement had marked its fifth year, and now had a total of 55 sun countries after Botswana joined in April. In the course of 2014–2015, the Movement saw significant progress in reducing stunting, including in Benin, Cambodia, Ethiopia, Ghana, Guinea-Bissau, Kenya, Kyrgyzstan, Malawi, Tanzania, Zambia and Zimbabwe. There was progress in relation to the Movement’s four strategic objectives, which were to sustain political commitment; endorse national nutrition policies that incorporated best practices; align actions across sectors and among stakeholders; and increase resources for nutrition and demonstrating results. Advocacy in support of effective, evidence-based national policies and legislation surged in 2015,
as did efforts to disseminate and better operationalize policies and plans at the country level. Those efforts were amplified by social mobilization, advocacy and communication strategies, which were in place in 20 countries of the SUN Movement. To galvanize action, high-level nutrition champions from all walks of life, including members of parliament, thought leaders, presidents, prime ministers, celebrities and high-profile advocates, had been nominated by and were supporting the Movement in 30 SUN countries. In addition to updating their nutrition policies, SUN countries focused on integrating nutrition-sensitive outcomes into multisectoral policies and legal and institutional processes. SUN countries were also increasingly track, scale up and align their resources in 2015. The Movement had improved their ability to assess, track, scale up and align their resources in 2015.

The report noted that women played a decisive role in the food security, health and nutrition of their families, and identified improvements to policy, legislation and planning that would empower women and girls as agents of change for improved nutrition in SUN countries. Those included sustained commitment at all levels of government to address the structural problems that prevented women and girls from realizing their human rights; translation of that commitment into legal and policy frameworks that upheld the rights of women and girls at the national level, including on protection from early and forced marriage, access to universal education, access to drinking water, the right to non-discrimination and the right to a life free from violence; and strong funding frameworks and accountability mechanisms to bring services mandated by national legislation and policy to scale, including through the use of disaggregated data by gender and age. Twenty-two SUN countries had identified nutrition-sensitive budget lines focusing on the empowerment of women, and 21 SUN civil society alliances were working on women’s empowerment issues, but more needed to be done across the Movement.

The report noted that in November 2014, the principals of the technical group of the UN Network for SUN—namely, FAO, WHO, UNICEF, the International Fund for Agricultural Development and WFP—agreed that the UN Partnership for Renewed Efforts Against Child Hunger and Nutrition (UN REACH) would serve as the secretariat and coordinating body on nutrition in SUN countries. UN Network members collaborated on the maintenance and updating of global data for tracking the World Health Assembly targets and informing the Global Nutrition Report; development of a global monitoring framework on maternal infant and young child nutrition; harmonized tools and a database platform for tracking the food-based food security indicators; and the convening of the Second International Conference on Nutrition [YUN 2014, p. 1377]. Consultations jointly organized by UN REACH and the United Nations System Standing Committee on Nutrition resulted in the June 2015 release of the United Nations Global Nutrition Agenda, a framework for aligning the work of the UN agencies in support of global and national nutrition goals over a period of five years. Those global and country-level consultations also helped agencies discuss and decide how to move forward in a way that made the UN Network fit for the post-2015 era and the next phase of the SUN Movement.

Follow-up to the Second International Conference on Nutrition

The Second International Conference on Nutrition [YUN 2014, p. 1377] endorsed the Rome Declaration on Nutrition and the Framework for Action, which provided a set of voluntary policy options and strategies for use by Governments, as appropriate, in accordance with national plans, to eradicate malnutrition in all its forms and transform food systems towards making nutritious diets available to all. In May, the sixty-eighth World Health Assembly (see p. 000) considered a report [A68/8] by the Director General on the outcome of the Second International Conference on Nutrition, and, by resolution WHA68.19, endorsed the Rome Declaration on Nutrition and the Framework for Action and requested the Director General to prepare a biennial report on the status of its implementation. The General Assembly welcomed the Rome Declaration and the Framework for Action in July, inviting Governments to implement the Framework in a coordinated manner.

GENERAL ASSEMBLY ACTION

On 6 July [meeting 98], the General Assembly adopted resolution 69/310 [draft: A/69/L.50/Rev.1 & Add.1, as orally revised] (Follow-up to the Second International Conference on Nutrition) without vote [agenda item 13 (a)].

Maternal, infant and young child nutrition

Who issued a May report [A68/9] that contained a table of proposed additional core indicators for the
global monitoring framework on maternal, infant and young child nutrition. The draft indicators were in support of the goals of the WHO Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition [YUN 2012, p. 1175], which called for the global monitoring framework to provide accountability for actions implemented, including through the design of in-country nutrition surveillance systems based on indicators that would facilitate reporting on malnutrition and shape policies and programmes towards achieving the global nutrition targets. The report noted that the global monitoring framework would comprise two sets of indicators: a core set, to be reported on by all countries; and an extended set, from which countries would select those indicators that suited their specific epidemiological patterns and the actions to be implemented in response to their priority nutrition challenges. The report included 14 draft indicators: five on intermediate outcomes, six on process and three on policy environment and capacity. In addition to the seven outcome indicators already approved, the additions made a total of 21 indicators that would constitute the core set.

On 26 May 2015, through decision WHA68(14), the sixty-eighth World Health Assembly approved the additional core indicators for the global monitoring framework on maternal, infant and young child nutrition; recommended that Member States report on the entire core set of indicators starting in 2016; requested the Director General to provide additional operational guidance on how to generate the necessary data for indicators in different country contexts; requested the Director General to review the indicators for the extended set and provide details of the definitions of those indicators, the availability of data and the criteria for their applicability to different country contexts; and recommended a review of the global nutrition monitoring framework in 2020.