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Letter dated 12 January 2015 from the Secretary-General addressed to the President of the General Assembly

The present letter on the work of the United Nations in the response to the Ebola outbreak in West Africa covers developments from 1 November 2014 to 1 January 2015, the 90-day mark since the establishment of the United Nations Mission for Ebola Emergency Response (UNMEER). It contains information on activities carried out by my Special Envoy on Ebola and UNMEER, and provides an update on progress made in the Ebola response pursuant to General Assembly resolution 69/1 since my update of 12 November 2014 (A/69/573).

Current situation of the Ebola outbreak

As at 31 December 2014, a total of 20,206 confirmed, probable and suspected cases of Ebola had been reported in five affected countries (Guinea, Liberia, Mali, Sierra Leone and the United Kingdom of Great Britain and Northern Ireland) and four previously affected countries (Nigeria, Senegal, Spain and the United States of America). One confirmed case was reported on 29 December in the United Kingdom. A total of 7,905 deaths have been reported.

In the three most affected countries (Guinea, Liberia and Sierra Leone), significant progress has been made in slowing the spread of the disease. When the General Assembly passed its landmark resolution on 19 September 2014 welcoming my intention to establish UNMEER, the epidemic was spreading at an exponential rate, with new cases doubling every three to four weeks. More than 4,000 people were being infected with the disease each month, with more than half of cases resulting in death, overwhelming the response capacities of local health systems.

The situation with regard to the outbreak in the three most affected countries continues to stabilize, with the average number of newly recorded cases each week remaining at a comparable level since the beginning of October and decreasing slightly in December.

The total figures continue to mask significant differences, however, both among and within countries. The number of new cases reported is fluctuating in Guinea and decreasing in Liberia. In Sierra Leone, the western part of the country is experiencing the highest incidence of transmission, although there are signs that the

increase has slowed. While the weekly numbers remain broadly similar, the disease is now more widely dispersed, creating significant challenges for the response.

The national trend in Guinea has been fluctuating since September and at present there is no discernible upward or downward trend in the country: 144 confirmed cases were reported in the week prior to 31 December, compared with 153 in the week prior to 1 December and 117 in the week prior to 1 November. In the week ending 24 December, Guinea reported 156 confirmed cases, the highest incidence of new cases since the outbreak began. This was largely due to a spike of 54 cases in Kissidougou prefecture, where the incidence of new cases then declined to 14 during the last week of December. The rate of transmission also remained high in the capital, Conakry, where 26 confirmed cases were reported in the week prior to 31 December. Other districts reporting high levels of transmission include Coyah, Forécariah, Macenta and N'zérékoré. The epicentre continues to be in the south-eastern region of Guinée forestière. At the same time, three districts that had previously reported Ebola cases did not report any confirmed or probable cases during that same week. As at 31 December, Guinea accounted for 2,797 cases and 1,709 deaths. Attempts to address the crisis in Guinea have sometimes been hampered by violent resistance to awareness-raising efforts and the continued use of unsafe practices in many remote areas of Guinée forestière region, which shares borders with Liberia, Côte d'Ivoire and Sierra Leone.

In Liberia, case incidence has been decreasing at the national level since mid-November. Thirty-one confirmed cases were reported in the week ending 31 December, in contrast with the rapid spread in mid-September, when more than 450 cases were recorded each week. On 31 December, for the first time in months no new case was recorded in Liberia. Montserrado county, which includes the capital, Monrovia, continues to be the area most affected by Ebola in the country, with 19 confirmed cases reported that week. New cases of transmission also continue to be reported in Grand Cape Mount county. Only two other counties reported cases that same week, while 11 counties did not report any cases. Lofa county, once the epicentre of the outbreak, reported no cases for the eighth consecutive week, highlighting the strength of response efforts in that district. As at 31 December, Liberia had reported a cumulative total of 8,018 cases and 3,423 deaths.

Sierra Leone is currently experiencing the highest rates of transmission of the three most affected countries, with 337 new confirmed cases reported in the week prior to 31 December. During the last week of November, Sierra Leone reported 537 new confirmed cases, accounting for more than 81 per cent of the 657 cases reported that week in all of the three most affected countries. Indeed, with more than 9,446 cases and 2,758 deaths, Sierra Leone now has the highest cumulative number of Ebola victims of all affected countries and has eclipsed overall caseloads in Liberia. Ebola transmission is most prevalent in the western and northern districts of Sierra Leone, but there are signs that the increase in incidence has recently begun to slow down. In the week prior to 31 December, the capital, Freetown, accounted for 44 per cent of the country's new confirmed cases (149), the highest case incidence reported since the start of the outbreak.

On 17 December, the Government of Sierra Leone and the United Nations system, through UNMEER, initiated the "Western Area surge", an operation aimed at intensifying efforts to curb the disease in the western parts of the country,

including Freetown. This targeted surge is expected to bring about an eventual decline in caseloads, even as the number of recorded cases increases as a result of more robust surveillance. Transmission also continues at a high rate in the district of Kono in the east of the country. Districts such as Bo and Tonkolili, however, have seen caseloads decline in recent weeks. Four districts in the country's south and east did not report any new confirmed cases: Bonthe, Kailahun, Kenema and Pujehun.

The recent outbreak of Ebola in Mali provided a stark reminder of the cross-border threat posed by the disease. Mali has seen two index cases of Ebola since 23 October. At the request of the President of Mali, Ibrahim Boubacar Keïta, UNMEER established an office in Bamako to support the Government in containing the Ebola outbreak and bolstering its preparedness. The office, which became operational on 26 November, was led by Dr. Ibrahima Socé Fall of Senegal as its Ebola Crisis Manager for an initial period of two months.

While the first case of Ebola, which was reported on 23 October, did not result in a chain of transmission, a second case, reported on 11 November in Bamako, resulted in six additional cases. Of the eight cases recorded in Mali, six resulted in deaths (including of two health-care workers). On 15 December, Mali marked the end of the 21-day surveillance period for all remaining contacts in the chain of transmission. No further cases have been recorded. The experience shows that the efforts made by the Government since May 2014 to strengthen preparedness have paid off. I would like to congratulate the Government of Mali on this achievement, which highlights the importance of preparedness. When the first case was reported in Mali, the Government diligently implemented the needed response measures and ensured a rapid and robust response, putting in place an emergency operations centre and appointing an Ebola response coordinator with a direct reporting line to the President. The successful containment of these Ebola cases in Mali also benefited from significant efforts on the part of a range of United Nations system entities, under the leadership of the World Health Organization (WHO) and UNMEER.

Health-care workers continue to face an acute risk of contracting Ebola. By the end of the reporting period, 678 health-care workers had been infected with Ebola, of whom 380 have died. Liberia accounts for the highest number of cumulative cases, with 369 cases in total, while Sierra Leone has reported 143 cases and Guinea 148. In Liberia and Sierra Leone, the numbers of new infections have, however, declined from their peaks, in spite of the high caseload in Sierra Leone. Infections among health-care workers continue to be of concern, particularly in Guinea, where seven new infections were reported in the week prior to 21 December. Many of these health-care workers contracted Ebola in non-Ebola health facilities, highlighting the importance of strengthening the capacity of regular health systems to control and prevent infection as part of an integrated approach to end Ebola.

As at 31 December, seven confirmed cases of Ebola were reported among United Nations personnel and four among the members of the immediate families of United Nations personnel. There have been five confirmed deaths. Through the generous assistance of Member States and through arrangements with commercial partners, the availability of appropriate Ebola and non-Ebola health-care services and a sustainable medical evacuation process for United Nations, humanitarian and related personnel serving in the affected countries has been ensured.

There remain persistent challenges with regard to the data collection process and the quality of epidemiological data owing to the inaccessibility of remote areas, the unreliability of reported data and perceived underreporting due to the resistance of some communities, notably in Guinea. These challenges are particularly prevalent at the district level. More accurate and timely data is needed to understand the evolution of the epidemic, evaluate the effectiveness of interventions and allocate limited resources effectively. UNMEER is working with key agencies involved in data collection, including Médecins sans frontières (MSF), WHO and the United States Centers for Disease Control and Prevention, to address this challenge through the development of a unified, technology-based reporting system. The deployment of additional information management officers and the training of data managers to support this system will result in progressively more accurate data.

While the overall slowdown in the spread of Ebola in the region is a welcome development, the situation between and within the countries remains variable and the total number of new cases remains high and distributed widely across many districts in the three countries.

Current progress with regard to the operational framework to stop the Ebola outbreak

Overall assessment

Significant progress has been made with regard to the operational framework to stop the Ebola outbreak, which was established at a multi-stakeholder conference convened by UNMEER in October. This operational framework identified four key lines of action: (a) case finding through surveillance, laboratory services and contact tracing; (b) case management in Ebola treatment units and community care centres; (c) safe and dignified burials; and (d) social mobilization and community engagement. Through the implementation of these four lines of action, the concerted efforts of the United Nations system and its partners are contributing to stopping the spread of Ebola in the three most affected countries.

It is also important to recognize that the progress in slowing transmission rates achieved to date is, in great measure, due to the efforts of affected communities. These communities have changed their behaviours and adjusted traditional practices that increased the likelihood of virus transmission, such as the washing of bodies of the deceased prior to burial. In most cases, these behavioural changes were the result of appropriate social mobilization and community awareness-raising efforts made under the proactive leadership of the national Government. While awareness-raising efforts need to be markedly strengthened in several regions, particularly in rural Guinea and in the western districts of Sierra Leone (including Freetown), there are many promising signs of progress.

International efforts have also played a key part in reducing the spread of Ebola. By supporting the establishment of treatment centres and safe and dignified burial teams and by training thousands of contact tracers and social mobilizers, the response has contributed significantly to a reduction in the spread of Ebola, saved hundreds of lives through earlier and better treatment for the sick and prevented higher rates of transmission.

Through the collective efforts of national Governments, affected communities and the United Nations system and its partners, all countries have made significant

progress in the key lines of action, including in case finding and contact tracing, isolation and treatment, safe burials and social mobilization.

Progress towards meeting key targets

While it is difficult to provide exact figures given that not all Ebola-related deaths are reported, at this point it is estimated that over 90 per cent of individuals reported to have died from Ebola receive a safe and dignified burial. Out of precaution, safe burial practices have also been applied to many deaths not clearly attributable to Ebola. Currently, 221 trained safe burial teams are in place and an increase in the number of such teams is planned to provide adequate capacities to ensure safe burials for expected future caseloads. Despite the overall progress, there are still regions where safe burials are not carried out. Improved geographical coverage and greater mobility of safe burial teams are needed. In addition, portions of the population remain sceptical about safe and dignified burials, which leads them to carry out clandestine, unsafe burials. It has been reported that in some households the body of the deceased was washed before the safe burial team was called.

By the 60-day mark, the target of isolating and treating 70 per cent of people with Ebola was achieved in Guinea and Liberia, as well as in many but not all districts of Sierra Leone. In Guinea and Liberia, the rapid build-up of Ebola treatment units and community care centres has been reinforced by community-based initiatives to encourage the self-isolation of individuals identified as having been infected with the virus, resulting in the isolation and treatment of more than 70 per cent of all such individuals.

In Sierra Leone, at the 60-day mark, this target had not been achieved in four districts (Western Area Urban, Western Area Rural, Port Loko and Bombali) where transmission rates continue to be high owing, in large measure, to the shortage of adequate treatment facilities. During a visit to Sierra Leone from 30 November to 2 December, my Special Representative and my Special Envoy met with the President, Ernest Bai Koroma, to discuss solutions to curbing the high rate of transmission in the western and northern areas of Sierra Leone.

The Government of Sierra Leone developed a “Western Area surge” plan with the active support of the United Nations system, through UNMEER, and its partners. On 3 December, the United Nations deployed an emergency surge team to support the National Ebola Response Centre of Sierra Leone in the implementation phase. The operation, which was launched on 17 December, sought to contain the rapid spread of the virus by increasing bed capacity and enhancing support for the achievement of the lines of action. UNMEER mobilized operational partners to provide the capacities to meet critical gaps, such as beds and convalescent centres, and facilitated the transport of additional laboratories from within the region, the airlifting of blood samples and the deployment of laboratory data specialists.

Taking stock at the 90-day mark, the objective was to isolate 100 per cent of all Ebola patients and ensure safe and dignified burials in 100 per cent of Ebola-related deaths. Many affected districts have reached the goals set out by the key performance indicators, while others are still on track to achieving them. All three countries have sufficient net capacity to isolate and treat 100 per cent of confirmed Ebola patients. The aggregate availability of Ebola treatment unit beds exceeds the numbers of reported Ebola patients. Guinea reports an overall availability of

1.9 beds per Ebola patient, Liberia 13.9 and Sierra Leone 3.6. Similarly, there are enough burial teams in place to ensure safe and dignified burials in 100 per cent of all deaths due to Ebola. The reality is, however, that there are still patients with Ebola who do not receive treatment and there are still people who die from Ebola who do not receive a safe and dignified burial.

The capacity to isolate Ebola patients is not uniform across the districts and regions of each country, causing continuing shortages in several districts. Putting in place this capacity takes time, while the disease can quickly spread to new areas. Some affected districts therefore may have more Ebola treatment units or community care centre beds than patients, while, in others, the number of locally available treatment beds is insufficient. Steps are being taken to address these discrepancies, for example by making new beds available in underserved areas and redistributing beds from well-served ones.

An increase in laboratories, from 17 to 23, was reported in the three countries, with 4 of the laboratories being located in Guinea, 8 in Liberia and 11 in Sierra Leone. From any affected district, the nearest laboratory can now be accessed within 24 hours. As at 28 December, the daily testing capacity also increased to a total of 1,700 samples, including 190 in Guinea, 760 in Liberia and 750 in Sierra Leone.

The number of beds in Ebola treatment units remained relatively stable in Guinea and Liberia in December, while it increased dramatically in Sierra Leone, especially in the Western Area. The number of operational community care centres also increased in the three countries, from 22 by the end of November to 42 at the end of the reporting period (33 in Sierra Leone and 9 in Liberia); many more such centres are expected to become operational in the coming weeks.

In Guinea, five Ebola treatment units are currently operational, providing 265 beds. A new Ebola treatment unit in Coyah that opened on 30 December will progressively augment its capacity from 15 to 100 beds. The planned construction of 62 community care centres is under way.

In Liberia, 13 Ebola treatment units are currently operational, providing a capacity of 660 beds. That number represents a decrease from 790 at the end of November and is due to the closure of an Ebola treatment unit in Lofa county and the scaling down of other units in line with the decline in new cases. By late December, it was estimated that only 12 per cent of Ebola treatment beds were occupied. Liberia has 103 beds in its community care centres.

Sierra Leone has experienced the greatest increase in bed capacity, with 19 Ebola treatment units operational by the end of December providing a capacity of 896 beds, in addition to the 291 community care centre beds. This capacity almost doubled during December as a result of the Western Area surge; in the Western Area alone there are 620 beds.

There has been continued progress in the area of safe burials as well. By the end of the reporting period 254 burial teams were operational, of which 63 were in Guinea (100 per cent of the target), 89 in Liberia (89 per cent of the target) and 101 in Sierra Leone (89 per cent of the target). In total, it is estimated that approximately 95 per cent of all reported dead bodies are collected within 24 hours for a safe and dignified burial in Liberia and Sierra Leone, while the corresponding estimate for Guinea is 88 per cent.

There has also been considerable progress in social mobilization and community engagement during the reporting period. More than 150 social mobilization groups, comprised of international and national non-governmental organizations, faith-based organizations and community-based organizations, are active in the social mobilization pillar, which is co-chaired by the United Nations Children's Fund (UNICEF) and the Ministry of Health in each country. According to UNICEF, in Guinea 1,465 of the planned 2,935 community watch committees have been established in all 18 Ebola-affected prefectures. Forty-seven communities in Guinea were targeted for awareness-raising efforts in December. In Liberia and Sierra Leone, the percentage of districts where safe burial is promoted by religious and community leaders has reached 100 per cent, while in Guinea it is 72 per cent. Overall, more than 100,000 teachers, religious leaders, traditional chiefs and community watch committee members have received Ebola training in the three countries so that they can raise awareness among their communities.

Challenges to achieving key response targets

A number of challenges must be addressed in order to move forward and ensure that the global response continues to achieve progress in meeting the more ambitious targets.

It is crucial for the response to remain nimble and flexible in adapting to the shifting pattern of the outbreak. As the intensity of the outbreak diminishes but the geographic spread increases, response capabilities must be adapted accordingly. In the current phase of the response, a district-by-district approach to the outbreak has been adopted to enable the effective isolation, diagnosis and treatment of those infected with Ebola, as well as capabilities for disease surveillance, namely community engagement, case-finding and contact tracing. Facilitating the full roll-out of the district-by-district approach will allow for a more calibrated response, one that is tailored to exigencies on the ground and that will make it possible to detect new cases and outbreaks early and respond quickly.

The continuing resistance of some communities to engaging fully in effective preventive measures to stop the transmission of Ebola needs to be addressed. In areas of community resistance, underreporting of deaths, unsafe burials, late reporting and lack of isolation continue to be the main factors driving transmission. These factors still pose significant challenges in some parts of Liberia and in the Western Area of Sierra Leone, as well as in some rural areas of Guinea, where the number of prefectures reporting instances where communities have resisted help from responders increased from 16 in October to 22 by the end of December; in several instances, communities incited violence against responders. Moreover, as a reduction in Ebola incidence is documented in some areas, communities may become complacent in adhering to preventive measures. The response is seeking to address this challenge through increased and improved community engagement, including by enlisting the support of local community leaders and elders. There is also a need to ensure that community awareness-raising efforts continue, even in districts with few or no new infections, to combat complacency and prevent any flare-ups.

Sufficient numbers of trained and experienced international medical responders with the requisite language skills to support national personnel in responding to a large number of widely dispersed disease outbreaks must be

ensured. To respond to the increasing geographical dispersion of the outbreak, it is necessary to establish a large number of basic and more flexibly deployable treatment and surveillance capabilities at the district level.

There is still a need to make the response, including our rapid response capabilities, more mobile, so as to be able to reach Ebola-affected individuals in remote villages. Increased donations of locally adapted vehicles, including motorcycles, increase the mobility of contact tracers and those transporting laboratory samples so that they can reach their destinations. To support the need for rapid response capabilities in strategic locations, like the capitals, to then deploy quickly to remote locations to contain localized outbreaks, the rapid isolation and treatment of Ebola approach was operationalized in December in Liberia. UNMEER and the United Nations Humanitarian Air Service are working together to provide aviation support to equip those implementing the approach with the required mobility.

Update on the operational activities carried out by the United Nations system, through the United Nations Mission for Ebola Emergency Response, and its partners

The Ebola emergency has galvanized a massive global response to assist the efforts of the national Governments of the three most affected countries. An unprecedented number of international entities have provided financial, operational and medical support.

During my recent visit to the region from 18 to 20 December, I was privileged to witness the global response effort. I travelled the region in solidarity with the Governments and the people of the affected countries and conveyed my strong support to the many courageous response workers on the front lines.

United Nations partners

Operational efforts are being carried out by a broad coalition of responders, including Governments, civil society actors, United Nations agencies, funds and programmes and national and international non-governmental organizations, which are managing the Ebola treatment units and fighting Ebola on the front lines.

MSF alone operates seven Ebola treatment units in the three countries. In October, it began distributing anti-malarial drugs in Monrovia, with plans to reach 300,000 people over the next three months. MSF has similar plans for Freetown. The International Federation of Red Cross and Red Crescent Societies has trained and deployed hundreds of teams to carry out safe and dignified burials, which has been critical in reducing the transmission of the virus. Many other non-governmental organizations are providing support in key areas, including communications systems, food assistance and mapping.

Efforts to increase treatment capacity have been greatly assisted by the deployment of international medical responders. This broad coalition of responders includes African medical personnel made available to national Governments through the African Union Support to the Ebola Outbreak in West Africa. Since it was launched in September, the African Union has deployed hundreds of health experts to Guinea, Liberia and Sierra Leone. By the end of the reporting period, the African Union had initiated the deployment of 550 personnel, including 81 from the

Democratic Republic of the Congo, 187 from Ethiopia and 196 from Nigeria, to serve as epidemiologists and health-care and clinical workers. One Ebola treatment unit in Liberia (Congo Town) and one in Sierra Leone (Bombali) are already run by African Union experts, in conjunction with the national ministries of health. I would like to commend the African Union for the deployment of skilled volunteers under the African Union Support to the Ebola Outbreak in West Africa.

The West African Health Association deployed personnel to support Ebola facilities in Guinea and Liberia. The Economic Community of West African States (ECOWAS) has identified hundreds of African doctors for training and deployment to the affected countries. Meanwhile, the Mano River Union is supporting cross-border cooperation in the response.

The response is also being supported by foreign medical teams from Australia, China, Cuba, Germany, Kenya, the Republic of Korea, the Russian Federation, South Africa, Sweden and Uganda, as well as by national and foreign defence forces, particularly from France, the United States and the United Kingdom, which have played critical enabling roles in Guinea, Liberia and Sierra Leone, respectively. The coordination of military efforts with civilian-led activities is ensured by UNMEER civil-military liaison officers and fully integrated into the national and UNMEER coordination mechanisms.

The private sector has also mobilized to provide support to the Ebola response. Companies in the affected countries, primarily from the mining sector, have provided equipment and warehouse space. The commitment of some companies to continue operations during the Ebola outbreak has helped preserve hundreds of thousands of jobs, as well as prospects for economic recovery. Transport industry companies have supported the international delivery of assistance through free air and sea transportation services, as well as advocacy against harmful air travel restrictions. The information technology sector has contributed data analysis services to responders and donated mobile phones to support epidemiological data collection and to help Ebola patients keep in touch with their families. The African Union Commission, in collaboration with mobile telecommunications operators and others, has launched an SMS campaign to mobilize resources in support of the operations of the African Union Support to the Ebola Outbreak in West Africa. Pharmaceutical companies have provided personal protective equipment and medical supplies to responders and are working on the development and trials of vaccines in partnership with WHO. Private sector organizations have established an Ebola private sector mobilization group to better coordinate their contributions to the response in West Africa, with a commitment to ensure the safety of their employees and to provide a lifeline for continued economic activity.

United Nations system

In the three most affected countries, UNMEER supports national Ebola response plans and seeks to ensure that all responses are coherent and effective. Reporting directly to me, UNMEER works in close collaboration with the national Governments and United Nations agencies, funds and programmes to align all entities involved in the response on a commonly agreed operational framework under the leadership of the host Government. It provides assistance to the Governments in managing the crisis response both at the national and the district levels, and identifies challenges and response gaps, directing resources to fill them.

Its regional mandate also allows UNMEER to take a broader view of the outbreak and the required response efforts, including by supporting cross-border collaboration and redeploying assets across borders as needed.

UNMEER has provided support to the host Governments for the operationalization of national crisis management structures, including through the deployment of staff to support the National Ebola Response Cell in Guinea, staffing and communications support to the National Ebola Response Centre in Sierra Leone, planning support to the incident management system in Liberia, and the roll-out of the response's district-by-district approach, including through support to identify the needs and gaps at the district level in line with national plans. UNMEER has also facilitated the transport of national health officials and responders to districts of concern and facilitated the transport of rapid response supplies and blood samples to laboratories. Together with the World Food Programme (WFP) and the United Nations Humanitarian Air Service, UNMEER has facilitated the deployment of the rapid isolation and treatment of Ebola teams.

UNMEER has worked to strengthen cross-border cooperation in the prevention and control of Ebola, including through the organization of a technical meeting on 9 December hosted by the Government of Liberia on this subject. The meeting was attended by government delegations from Liberia, Sierra Leone, Mali and Nigeria, representatives from the Mano River Union, the African Union and ECOWAS, and United Nations and international partners. Participants agreed on the need for a regional, rather than multi-country, approach to the response. The subsequent transfer of the European Union-sponsored testing laboratory from Liberia (Foya, Lofa county) to Sierra Leone (Freetown) provided a concrete example of cross-border collaboration resulting from the meeting. Additionally, UNMEER has facilitated meetings between delegations from affected countries, such as Guinea and Mali, on cross-border issues.

UNMEER has also mobilized significant logistical and human resources to facilitate the response. It has established operational offices in four countries and headquarters in a fifth. An UNMEER liaison capacity is being established in Dakar to support coordination with United Nations agencies, funds and programmes on the restoration of essential services and to plan for early recovery. As at 31 December, 211 staff and personnel with specific crisis coordination and other relevant experience had been deployed, including 126 (59 per cent) in the affected countries. That included 21 field crisis managers stationed at the district level to support response coordination; UNMEER is also facilitating the installation of mobile data collectors to support them.

To ensure the prompt mobilization of vetted coordination experts, UNMEER also leveraged the surge mechanisms of the Office for the Coordination of Humanitarian Affairs. To help national Governments and UNMEER establish coordination structures, the Office also deployed United Nations Disaster Assessment and Coordination teams to UNMEER headquarters in Ghana, to Liberia and to Mali.

To date, 176 organizations are operating emergency programmes across the three countries most affected by Ebola. In Liberia, the eight humanitarian clusters, which are all co-chaired by a government counterpart and have reporting lines to the Resident Coordinator and to UNMEER, have allowed for a particularly integrative approach to the response. Humanitarian clusters were activated for the coordination

of logistics; health, including nutrition; water, sanitation and hygiene; food security; protection, including child protection; early recovery; and education. The health and logistics clusters are also integrated into the UNMEER operational framework. In addition, an inter-cluster coordination mechanism was established.

WHO has continued to undertake training for substantial numbers of health-care personnel and communities, including 160 national epidemiologists, 84 Guinean Red Cross officers and 400 village committee members in Guinea; 1,500 health-care workers, 800 social mobilization volunteers in Montserrado and 20 women's community groups in Liberia; and 722 health-care workers in Sierra Leone. In Guinea and Liberia, WHO has deployed infection prevention and control specialist teams to train health-care workers in the use of personal protective equipment; develop plans to undertake facility evaluations; investigate health-care worker infections; and implement infection prevention and control assessment tools in Ebola facilities. In Sierra Leone, WHO conducted infection prevention and control assessments at 34 Ebola treatment facilities.

WFP is providing a common services platform for the Ebola response that includes aviation, the building of treatment centres, "last-mile" transportation and logistics coordination. Its extensive logistics network for the response in all three countries includes a main logistics base, 11 forward logistics bases, three staging areas, three main hubs and three regional staging areas to provide intermediate storage facilities for more than 40 implementing partners. WFP has also managed the construction of eight Ebola treatment units in Guinea and Liberia, including the new Ebola treatment unit in Coyah, Guinea, which opened on 30 December. Since the onset of Ebola response operations, the logistics cluster has transported 5,186 tons of humanitarian supplies and more than 22,000 cubic metres of cargo on behalf of more than 25 partners to Ebola health-care facilities and warehouses. The air coordination cell in Copenhagen, put in place by the logistics cluster and jointly overseen by WFP and UNICEF, has not only carried out regional strategic airlifts but also coordinated 95 inter-agency and fully funded flights carrying 4,548 tons of cargo for partners to the affected countries since September. In December alone, at least 742 tons were flown into the West African region on 30 flights, including strategic and regional airlifts.

Personnel from the United Nations Mission in Liberia have provided logistics and engineering support to the response in that country. Meanwhile, the United Nations Multidimensional Integrated Stabilization Mission in Mali supported the response by contributing personnel, logistics and material assistance to the national coordination structure and provided support for the Government's tracking exercise.

UNICEF, in partnership with Governments, civil society organizations and non-governmental organizations, significantly scaled up its efforts to establish community care centres, which provide basic supportive care, testing and a range of prevention services. UNICEF has also reached more than 2 million people with awareness-raising messaging, is supporting national authorities by establishing protocols to facilitate school reopenings and providing technical assistance for remote schooling options such as radio education, and has provided more than 1,800 children with child protection services.

UNICEF has, in partnership with Governments, community-based organizations and non-governmental organizations, significantly scaled up its efforts to establish community care centres, engage communities through social

mobilization, ensure child protection, provide critical water, sanitation and hygiene services and to procure key critical commodities such as personal protective equipment. UNICEF also supports the maintenance and strengthening of non-Ebola health-care and education services, including radio education. For example, in Sierra Leone, 36 community care centres are now functional and in Liberia 10 rapid isolation and treatment of Ebola teams are fully equipped. In Guinea, 1,290 village watch committees are engaging in social mobilization and more than 200 cars and 700 motorcycles are being used in support of contact tracing, the transportation of patients and blood samples and safe burials. In Liberia, UNICEF has helped a network of district social mobilizers engage 175,000 households through house-to-house visits and town hall meetings on prevention practices, rapid reporting, isolation of the infected and addressing stigma. In Sierra Leone, more than 4,300 health-care workers and 2,600 support staff received training in infection prevention and control. The UNICEF supply division delivered more than 4,000 tons of supplies in support of all critical services.

Under the United Nations Development Programme (UNDP) cash payment scheme for Ebola care workers, which is helping to ensure uninterrupted health services, case tracing and safe burials, over 97 per cent of registered Ebola workers are linked to payment mechanisms and 90 per cent of registered Ebola workers have been paid on time. With UNDP support, the United Nations was able to facilitate two payments by the Government in Sierra Leone, on 14 November and 5 December, which resulted in the payment of more than 14,000 Ebola workers per payout. UNDP is providing technical support to national Governments in the design and implementation of the payment systems.

The United Nations Population Fund (UNFPA) has continued to train contact tracers in Sierra Leone. In December, 1,803 contact tracers were trained in partnership with the Ministry of Health and Sanitation, bringing the total number of trained contact tracers to 5,030. UNFPA also worked with the ministries of health of the States members of the Mano River Union to develop a midwifery project aimed at providing reproductive, maternal and infant health services. More than 500 midwives, doctors and support staff are currently being recruited in the framework of the project, to open and equip at least 20 midwifery facilities in each of the three most affected countries.

The Office of the United Nations High Commissioner for Human Rights, together with the Guinean authorities and partners, has organized a series of events in Conakry and Nzérékoré on human rights perspectives in the Ebola outbreak.

The World Bank and the African Development Bank have provided significant support to national government efforts to stop Ebola transmission and treat infected individuals, including funds for different United Nations system entities that provide support to Governments for a system to bring international medical responders to the region and for support to national budgets so that Governments can continue to provide essential services in a range of sectors.

Activities of the Special Envoy on Ebola and the Global Ebola Response Coalition

Following extensive engagement at the global level in October and November on behalf of the Governments of the three most affected countries, my Special Envoy on Ebola returned to the region from 25 November to 3 December. He visited

UNMEER headquarters in Accra and met with national Governments and response partners in Guinea, Sierra Leone, Liberia and Mali. In all four affected countries, my Special Envoy noted strong political engagement at the highest level, as well as functioning robust coordination mechanisms.

The Global Ebola Response Coalition, chaired by my Special Envoy, continues to serve a convening and information-sharing role between actors in the response both in the affected countries and in capitals around the world. The Coalition continues to expand with the objective of ensuring that a well-connected network of partners can continue to collectively identify bottlenecks and develop new global strategies under the leadership of national Governments.

At my request, my Special Envoy has also spearheaded the establishment of a global information centre on Ebola. The centre, based at United Nations Headquarters, brings together communications experts from across the United Nations system with partners from the private sector to develop clear and robust messages on the Ebola outbreak. The centre will develop messaging and a proactive strategy to engage media and other communications partners and it will work closely with the Governments of the affected countries to catalyse greater global support for their efforts.

My Special Envoy will continue to lead efforts within the Coalition, in coordination with the Office for the Coordination of Humanitarian Affairs, the World Bank, the European Union and the international campaigning and advocacy organization ONE, to increase clarity on funding requirements and disbursements related to the response by continuing to report up-to-date information. As at 31 December, the Ebola Response Multi-Partner Trust Fund had total pledges and deposits amounting to $141 million. Between 1 November and 1 January, it disbursed over $105.5 million to address critical unfunded gaps in the three most affected countries. The largest disbursement, of $34 million, was made to fund WFP logistics operations, while other disbursements have been made to fund epidemiological surveillance in the three most affected countries, to support 10 community care centres in Guinea, to protect Ebola-affected children in Liberia and to provide support to NERC and the rapid response and stabilization teams in Sierra Leone, among other priorities.

In an effort to create further transparency and greater clarity on gaps and resourcing needs, I asked my Special Envoy to publish a “resources-for-results” report on 22 December. The report provided a thorough overview of affected countries’ needs, as highlighted by Governments, including available resources, disbursements to date and remaining gaps. Country-tailored reports were made available to the Governments of the three most affected countries; the reports provided specific figures in terms of available resources allocated by the major United Nations entities as well as funds disbursed, mapped against countries’ estimated and projected needs.

The Coalition will also continue its efforts to ensure that early recovery and revival efforts are fully integrated into the Ebola response. This will involve supporting the development of a unified risk, recovery and revival agenda across health systems, economies and societies across West Africa. Recovery efforts will be led from within countries with country-specific agendas, with the Coalition helping to ensure a smooth transition from the Ebola response to post-Ebola revival.

Moving forward

The success of the global Ebola response also depends on those activities that fall outside of the UNMEER operational framework but within the purview of the mandates of United Nations agencies, funds and programmes as part of the broader strategy designed by my Special Envoy on Ebola. For example, in addition to activities aimed at stopping the outbreak and treating the infected, the broader strategy includes providing essential services, preserving stability and preventing outbreaks in non-affected countries. United Nations agencies, funds and programmes and their partners have been coordinating efforts to begin to address the cross-sectoral impacts of the outbreak under the leadership of the Resident Coordinators in Guinea, Liberia and Sierra Leone.

Stopping the outbreak and treating the infected

To contain the Ebola outbreak, it is necessary to further tailor the response in terms of the location and spread pattern of the disease. The initial emphasis was on containing the spread by finding and isolating infected individuals in the epicentres of the outbreak; now, it has shifted to eliminating transmission of the virus wherever it appears, including through greater focus on contact tracing and surveillance. As smaller, more localized outbreaks of Ebola appear across a broader geographical area, the response must adapt correspondingly from a country-level to a district-level approach. With this in mind, Governments, partners and the United Nations system are focusing on tailored responses in each of the 62 districts of the three most affected countries (33 districts in Guinea, 15 districts in Liberia and 14 districts in Sierra Leone).

In a district-by-district approach, districts are categorized according to two criteria: the nature of the transmission and the nature of the district. The intensity of the transmission (high, low or none) is the primary determinant of which lines of action become the focus of the response, but the scale and tactics used to operationalize the response are also influenced by the geographic nature of the district (urban, rural or border). An analysis of each district based on these criteria allows for the responses to be tailored to the needs so as to maximize the effectiveness of the interventions and the efficiency with which resources are allocated.

In districts with high rates of transmission, the response will focus on treatment capacity and safe burials, while in districts with no cases the focus will be on surveillance measures. Urban and rural areas differ in terms of the types of treatment facilities available and the number of teams needed. Border districts, especially districts bordering non-affected countries, require special measures, including for the prevention of the cross-border spread of the disease through strong surveillance and for ensuring cross-border cooperation, information-sharing and resource mobilization.

The district-by-district approach will be complemented by a rapid response capacity that can be deployed in cases of sudden flare-ups of the disease that are beyond the capacities in place at the district level.

The district-by-district approach will also require ensuring that surveillance and contact-tracing capacities are present in all districts, including those with no current cases, to allow for early responses to new outbreaks, preventing the disease

from spreading, using fewer resources than would be required if the response were delayed. The district-level approach will also build basic capacity for monitoring of infectious diseases, a capacity that will form part of the UNMEER exit strategy and will need to outlast Ebola and the current response.

Reflective of this district-level approach, the United Nations system, through UNMEER, is increasing its focus on ensuring that all persons newly infected with Ebola come from lists of known Ebola contacts. This indicator provides a key measure of the level of control achieved over the spread of the disease.

With the support of the United Nations system, through UNMEER, and its partners, national Governments in the three most affected countries have made preliminary progress in rolling out the district-by-district approach. On 20 December, NERC convened all district coordinators and district medical officers in Sierra Leone to prepare district response plans that will form the basis of a consolidated needs document to appeal for donor support. In Guinea, the United Nations system, through UNMEER, has supported the Government's strategy to decentralize coordination of the response to the prefecture level, with the appointment of a prefectural coordinator in each of the country's 18 affected prefectures. UNMEER field crisis managers have been deployed to six field locations, covering 11 of these prefectures. In Liberia, meanwhile, UNMEER field crisis managers help to facilitate the activities of county health teams on the ground.

Providing essential services and preserving stability

Taking note of the impact that the Ebola outbreak has had on essential services in the affected countries, I have requested my Special Envoy on Ebola to assume a leadership role in ensuring that the immediate and safe provision of essential services receives the necessary attention as part of the integrated Ebola response. In each of the affected countries, UNMEER and the Resident Coordinators will ensure that this immediate response is guided by national priorities, underpinned by a support strategy and implemented in a coordinated manner. To present an up-to-date overarching regional strategic framework for the immediate response, the Office for the Coordination of Humanitarian Affairs, together with my Special Envoy and WHO, is leading a revision of the overview of needs and requirements for the Ebola response that will be published in mid-January 2015. This strategic review will also pave the way for a reflection on how to ensure a seamless transition from the immediate response to the post-crisis recovery phase.

At the same time, to strengthen the operational link between UNMEER and the United Nations agencies, funds and programmes involved in the restoration of essential services and early recovery, UNMEER has established a liaison office in Dakar to facilitate co-location with the regional offices of most United Nations agencies, funds and programmes. I am grateful to the Government of Senegal for its agreement to host this office.

Non-Ebola health care

Fear of transmission, shortages of health-care workers and a lack of available personal protective equipment and triage mechanisms to ensure infection prevention and control have had a devastating impact on the availability of non-Ebola health-care facilities. In Liberia, the Ministry of Health estimates that less than 45 per cent of public health-care facilities were functional as at the end of the reporting period.

Cases of malaria, pneumonia, tuberculosis and typhoid often go untreated and HIV/AIDS treatments and maternal health options have been rendered unavailable. Maternal health requires special attention: UNFPA reports that in 2015 some 100,000 births in the affected countries are expected to entail life-threatening complications. Since May, the Ebola outbreak has also disrupted regular vaccination programmes owing to concerns over convening crowds.

Apart from the urgency of strengthening non-Ebola health-care facilities to address routine needs, ending the Ebola outbreak will also depend on strengthened health systems in the affected countries to facilitate the early detection of cases through strong disease surveillance. It will become vital to ensure that non-Ebola health-care facilities are capable of providing basic health services, while protecting health-care workers and patients against Ebola infection. The safe reopening of health-care clinics also means that patients who may possibly be infected with Ebola can safely seek treatment in their own communities, thus reducing the risk of the spreading the disease to unaffected areas.

To encourage clinics to reopen and accept patients, WHO has developed a set of "no-touch" guidelines for community health workers operating in small clinics. MSF has also started establishing triage facilities in Monrovia to enable the safe resumption of basic health-care service provision. The three most affected countries have a health sector redevelopment plan in place. In Liberia, WHO, together with partners, is supporting the Government in undertaking a review of the impact of the Ebola outbreak on its health services with the intent of accelerating the restoration of essential services while building a more resilient health-care system.

Protection

UNICEF has provided more than 25,000 children with child protection services, supported the establishment of interim care centres to support children who have come into contact with Ebola, provided psychosocial support in and out of treatment units, as well as family tracing and reunification and interim or alternative care, including cash support to caregivers and Ebola survivors.

Meanwhile, the International Organization for Migration has developed a strategy to support the provision of migrant-friendly prevention, psychosocial and care services to migrant communities, in particular in remote and border areas, in view of the population displacement induced by the epidemic.

Education

An estimated 10,000 schools remain closed in the three most affected countries, preventing some 5 million children aged between 3 and 17 years from obtaining much-needed knowledge and skills. Ministries of education in Guinea, Liberia and Sierra Leone have been eager to see schools reopened as a way to reassure communities and create a sense of stability. In order to ensure that schools can function as safe and protective spaces for learning, however, appropriate protocols must first be established and adequate infection, prevention and control measures put in place. If this is done, measures to support the restoration of education can complement ongoing efforts to stop the Ebola outbreak. For example, schools can serve as an important enabler of community awareness-raising, contact tracing and monitoring.

While schools remain closed, UNICEF and other education partners are supporting the roll-out of the response plans of the ministries of education in each of the three most affected countries. Teachers are being trained in community social mobilization efforts to help stop the spread of the virus. Distance and self-directed learning programmes, including radio education, are helping to ensure continuity of learning at the national level. Alternative education programmes will continue once schools have reopened to reach out-of-school and the most disadvantaged children in the countries.

Food security

According to a recent study by the Food and Agriculture Organization of the United Nations (FAO) and its partners, travel, movement and grouping restrictions along with border closures have had a significant, negative impact on food security and nutrition by lowering food production, food availability and food access, disrupting markets and cross-border trade, decreasing agriculture farm-gate prices and lowering household incomes and purchasing power in the most affected countries.

Since August, WFP and its partners have provided food assistance to nearly 1.9 million people living in the most affected areas of high transmission countries. Food security assessments have been carried out in the three most affected countries by FAO, WFP and Action contre la faim.

Water, sanitation and hygiene

UNICEF, WHO and their implementing partners are providing water, sanitation and hygiene support in two main areas. First, in the health sector, water, sanitation and hygiene interventions are being scaled up to stop virus transmission by ensuring that water is available in quarantine sites, treatment units and referral centres, and that adequate sanitation and hygiene measures are being implemented at these locations, as well as in affected households. To date, an estimated 86 per cent of Ebola treatment units and community care centres in the three most affected countries have functional water, sanitation and hygiene facilities. Second, at the community level, water, sanitation and hygiene interventions contribute to preventing the further spread of the disease and reducing the risk of such spread by ensuring that the population has access to safe water, sanitation and hygiene commodities. For example, UNICEF provided more than 160,000 households with water, sanitation and hygiene kits and support.

Economic impact, livelihoods and early recovery planning

The Ebola outbreak has had an adverse economic impact on the affected countries, reversing development gains and positive economic growth. Agricultural fieldwork has been disrupted in many areas, threatening livelihoods and food security. It is the restriction on the movement of goods and people, however, as well as the closure of markets, that is leaving thousands without access to their livelihoods and sources of income. Major international private companies, particularly in the mining and forestry sectors, have slowed down or stopped their activities. The closure of banks has restricted access to financial resources for investment and consumer activities. Mining and tourism, two main sources of formal employment and revenue, have reduced operations.

According to recent studies by UNDP and the Economic Commission for Africa study *Socioeconomic Impacts of the Ebola Virus Disease on Africa*, the prices of vegetable oil, rice and potatoes have increased by 20-30 per cent in some rural areas of Liberia and the price of rice has increased by at least 30 per cent in Sierra Leone. The negative impact of the Ebola outbreak on the economies of the affected countries is compounded by the suspension of activities of many foreign investors and the collapse of cross-border trade due to border closures. Household incomes in affected countries have suffered, plummeting from around 12 per cent in Guinea to 35 per cent in Liberia and posing a potential threat to peace and stability. Compared with 2013, job losses linked to the outbreak have increased by an average of 3 per cent in the transportation sector, 6.8 per cent in the telecommunications sector, 8.6 per cent in the hospitality and tourism sectors, and 22.9 per cent in the building and public works sectors.

Complementing the individual country economic impact studies conducted in collaboration with national Governments, UNDP has completed the socioeconomic assessment report *Assessing the Socioeconomic Impacts of Ebola Virus Disease in Guinea, Liberia and Sierra Leone: the Road to Recovery*. In the assessment, UNDP highlights that the short-term fiscal impacts are $93 million (4.7 per cent of the gross domestic product (GDP)) for Liberia, $79 million (1.8 per cent of GDP) for Sierra Leone and $120 million (1.8 per cent of GDP) for Guinea.

Social safety net cash transfer programmes, which combine incentives for educational development, adult literacy, livelihoods support and essential cash assistance, are being provided for people who have lost their livelihoods as a result of the crisis. With the support of UNDP, social safety net initiatives started in Liberia on 2 December, with support to bush meat traders affected by the preventive ban on bush meat. A similar programme for the most impoverished, vulnerable people in the affected countries targeting 15,000 households will commence in January. In Sierra Leone, 5,000 vulnerable households and 1,250 youth are being targeted through cash-for-work and skill-building for alternative livelihood programmes. UNDP is also working with trade unions and the private sector to develop Ebola safety standards and procedures for select groups of traders to enable them to attract business.

In terms of next steps in recovery planning, on 12 December, at my request, the Deputy Secretary-General tasked UNDP with leading the United Nations system effort on Ebola-related recovery. Within the framework of the 2008 tripartite agreement between the United Nations, the World Bank and the European Union, UNDP has advocated for the implementation of a joint Ebola recovery assessment to identify the critical areas for recovery interventions and to design integrated, multisectoral national and regional recovery plans. A number of consultations have been held in preparation for an Ebola recovery assessment mission to the region, which is slated for mid-January 2015.

Preventing outbreaks in non-affected countries

The United Nations system, through UNMEER, will work to foster increased cross-border cooperation on Ebola response efforts between the affected countries and neighbouring States that go beyond ensuring effective border control measures and include cooperation on contact tracing, laboratory testing and treatment options.

The 9 December technical meeting on cross-border cooperation in Liberia was a first positive step in that direction.

WHO and other United Nations system agencies will also work to strengthen Ebola prevention and preparedness capacity in the non-affected priority countries of Africa. International Ebola preparedness missions have so far assessed the level of Ebola prevention and preparedness capacities in 14 of the 15 priority countries in Africa originally identified by WHO: Benin, Burkina Faso, Cameroon, Central African Republic, Côte d'Ivoire, Ethiopia, Gambia, Ghana, Guinea-Bissau, Mali, Mauritania, Niger, Senegal and Togo. On the basis of the WHO consolidated Ebola virus disease preparedness checklist, the missions recommended that the countries establish functional rapid response teams, identify Ebola isolation facilities and train health-care workers in Ebola case management, contact tracing and infection prevention and control. In addition, the United Nations system, through UNMEER, provided technical advice on the revision of the Ebola prevention and preparedness plan of Ghana and helped improve the capacity of the Ebola treatment unit that the country had established in the port city of Tema. Similar support is planned for all immediate at-risk countries visited to date.

On 11 and 12 December 2014, WHO convened a high-level meeting in Geneva on strengthening health systems and resilience in the three most affected countries. The meeting brought together health and finance ministers, non-State actors, donors and international technical agencies with the aim of laying the foundation for stronger health systems in the medium-to-long term in the Ebola-affected countries. It identified the main constraints and challenges faced by countries in rebuilding and developing more resilient health systems; the medium-to-long-term solutions on how to best build and invest in national and subnational systems that deliver basic, essential and good-quality health services that can also respond adequately to future emergencies and crises; and, based on the comparative advantage of each entity, the roles and responsibilities of all the stakeholder groups on their contribution to building resilient health systems in countries, in a coordinated manner under country leadership. At the meeting it was agreed that the three most affected countries, in cooperation with partners, including WHO, would prepare national and regional plans and present them to a meeting hosted by the World Bank in April 2015.

Conclusions

The global response to the Ebola outbreak has made a difference, yet we must not be complacent. The outbreak is still a public health emergency of international concern. The United Nations system will continue to scale up its efforts and we count on all of our partners for greater and more robust support so that, together, we may stop the outbreak.

At the same time, we must also start to think about addressing the broader early recovery needs of the three most affected countries, especially in the health and education sectors, and building longer-term resilience so that countries have the capacity to address future disease outbreaks. Where it is possible to do so without compromising speed and efficacy in containing the virus, the Ebola response must strive to assist in building resilience and stronger health-care systems in the affected countries.

Early recovery efforts must begin now and should be integrated into the response strategy through an increased focus on the provision of essential services.

Any Ebola-related stigma and discrimination must be identified and addressed. Social protection that responds to the needs of survivors, affected households and communities must also be part of early recovery responses that aim to rebuild livelihoods and market activity in the affected countries.

Containing the outbreak will require continued support and engagement of the international community. The second phase of the response, focused on hunting the virus in every district, will have additional resource implications. The cost of continued global risks of outbreaks is significantly higher, however. I call upon Member States to continue to prioritize the response to maintain the tremendous momentum achieved.

To date, more than $1.16 billion has been received, committed or pledged by donors to fund the revised overview of needs and requirements for the Ebola outbreak in West Africa. The Ebola Response Multi-Partner Trust Fund has received $141 million in commitments, pledges and deposits. I thank all those who have contributed. The amounts committed, however, still fall short of the required $1.5 billion and the Ebola Response Multi-Partner Trust Fund is aiming to raise $500 million before March 2015. I therefore call upon all countries in a position to do so to contribute or to contribute more.

While the response needs additional financial resources, it is in even greater need of qualified and experienced staff in critical areas such as epidemiology, social mobilization, infection prevention and control, and logistics. As the focus of the response shifts to early detection and rapid response at the district level, we need qualified field staff on the ground to carry out core response tasks and train national health personnel, thereby building local capacity. This will not only be crucial in containing the outbreak, but also strengthen the local health systems after the end of the Ebola crisis.

As I have said from the early stages of this crisis, the needs go beyond financial resources. Given the centrality of finding every case and every contact to stop transmission, we must scale up our capacities and field presence in areas with high caseloads to further strengthen and expand contact tracing. More community mobilizers need to be recruited and trained to increase awareness of Ebola transmission, prevention, treatment and safe burial practices. Governments need adequate numbers of well-distributed facilities where national personnel receive training and support to provide clinical care, laboratory services and crisis management. Logistics bottlenecks must also be overcome in order to ensure timely food and health assistance to quarantined communities. Stronger and more reliable transportation networks to connect isolation and care centres to laboratories are needed, for which donations of motorcycles are essential.

Skilled international personnel are needed to establish and sustain district-level Ebola treatment units. Insufficient laboratory capacity results in treatment delays due to backlogs of Ebola test samples, increasing risks of transmission to others in the community from undiagnosed Ebola patients. There is also a need to ensure that Ebola-related medical waste, which can be a strong purveyor of the virus, is managed safely and in environmentally sustainable ways.

The focus on a district-level approach requires greater and more dispersed resources. Field crisis managers and the district response teams they lead will be pivotal in enabling broad geographical coverage, while ensuring a high level of

operational effectiveness. Technical health experts, such as epidemiologists and infection prevention and control experts, are needed to track the disease and train and empower local staff involved in case finding, contact tracing and surveillance teams. In addition, rapid response capacities are required at the national and regional levels to enable the rapid deployment of resources to respond to sudden flare-ups of the disease.

Ebola still places a heavy burden on the people of the most affected countries, and we have much more work to do to contain it. At the same time, tremendous progress has been achieved in the fight against Ebola during the past 90 days. As long as one case remains, there remains a risk of retransmission and the possibility of the outbreak restarting.

We must not let that happen. The United Nations is committed to doing everything possible, in solidarity with the people of Guinea, Liberia, Mali and Sierra Leone, and in service of all the people of the world, to end the Ebola crisis.

I commend the Governments of Guinea, Liberia, Mali and Sierra Leone for their leadership. I thank the thousands of national and international medical responders serving on the front lines of the response.

I extend my thanks to all Member States, regional organizations and donors who have contributed to this fight. I applaud your contributions and ask you to be ready to give more. I express my appreciation for the United Nations staff, non-governmental organizations and civil society actors who are playing an instrumental enabling role in the response.

On 3 January, my new Special Representative and Head of UNMEER, Ismail Ould Cheikh Ahmed, assumed his functions. I ask you to extend to him your support and continued cooperation as he moves into this role. I thank Anthony Banbury for his service during the critical start-up phase of UNMEER and for his excellent work in getting the Mission operational on the ground.

Finally, on behalf of the United Nations family, I wish to recognize the sacrifice and honourable service of Marcel Rudasingwa, the Ebola Crisis Manager for Guinea who sadly passed away on 18 November, and I extend my condolences to his family.

I would be grateful if you could bring the present letter to the attention of the members of the General Assembly.

(*Signed*) **BAN** Ki-moon