WORLD HEALTH ORGANIZATION

FIFTY-FIFTH
WORLD HEALTH ASSEMBLY

GENEVA, 13-18 MAY 2002

RESOLUTIONS AND DECISIONS
ANNEXES

GENEVA
2002
## ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

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<tr>
<td>ACHR</td>
<td>Advisory Committee on Health Research</td>
</tr>
<tr>
<td>ASEAN</td>
<td>Association of South East Asian Nations</td>
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<tr>
<td>CEB</td>
<td>United Nations System Chief Executives Board for Coordination [formerly ACC]</td>
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<tr>
<td>CIOMS</td>
<td>Council for International Organizations of Medical Sciences</td>
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<tr>
<td>FAO</td>
<td>Food and Agriculture Organization of the United Nations</td>
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<tr>
<td>IAEA</td>
<td>International Atomic Energy Agency</td>
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<tr>
<td>IARC</td>
<td>International Agency for Research on Cancer</td>
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<tr>
<td>ICAO</td>
<td>International Civil Aviation Organization</td>
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<tr>
<td>IFAD</td>
<td>International Fund for Agricultural Development</td>
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<td>ILO</td>
<td>International Labour Organization (Office)</td>
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<td>IMF</td>
<td>International Monetary Fund</td>
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<td>IMO</td>
<td>International Maritime Organization</td>
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<tr>
<td>ITU</td>
<td>International Telecommunication Union</td>
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<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<tr>
<td>PAHO</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<tr>
<td>UNCTAD</td>
<td>United Nations Conference on Trade and Development</td>
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<tr>
<td>UNDCP</td>
<td>United Nations International Drug Control Programme</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>UNEP</td>
<td>United Nations Environment Programme</td>
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<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNHCR</td>
<td>Office of the United Nations High Commissioner for Refugees</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>UNIDO</td>
<td>United Nations Industrial Development Organization</td>
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<tr>
<td>UNRWA</td>
<td>United Nations Relief and Works Agency for Palestine Refugees in the Near East</td>
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<tr>
<td>WFP</td>
<td>World Food Programme</td>
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<tr>
<td>WIPO</td>
<td>World Intellectual Property Organization</td>
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<tr>
<td>WMO</td>
<td>World Meteorological Organization</td>
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<td>WTO</td>
<td>World Trade Organization</td>
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The designations employed and the presentation of the material in this volume do not imply the expression of any opinion whatsoever on the part of the Secretariat of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Where the designation “country or area” appears in the headings of tables, it covers countries, territories, cities or areas.
The Fifty-fifth World Health Assembly was held at the Palais des Nations, Geneva, from 13 to 18 May 2002, in accordance with the decision of the Executive Board at its 108th session. Its proceedings are issued in three volumes, containing, in addition to other relevant material:

Resolutions and decisions, Annexes – document WHA55/2002/REC/1

Verbatim records of plenary meetings, list of participants – document WHA55/2002/REC/2

Summary records of committees and ministerial round tables, reports of committees – document WHA55/2002/REC/3
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FIFTY-FIFTH WORLD HEALTH ASSEMBLY

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OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES

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Dr J.F. LÓPEZ BELTRÁN (El Salvador)

Vice-Presidents
Mrs J. PHUMAPHI (Botswana)
Professor V.F. MOSKALENKO (Ukraine)
Mr S.S. BHANDARI (Nepal)
Mr B.R. MOOA (Kiribati)
Dr A.J.M. SULEIMAN (Oman)

Secretary
Dr Gro Harlem BRUNDTLAND, Director-General

Committee on Credentials
The Committee on Credentials was composed of delegates of the following Member States: Cyprus, Equatorial Guinea, Estonia, Ethiopia, Fiji, Iceland, Panama, Qatar, Thailand, Togo, Turkey, and Uruguay.

Chairman: Dr F. GRACIA (Panama)
Vice-Chairman: Dr K. AL-JABER (Qatar)
Rapporteur: Mr I. EINARSSON (Iceland)
Secretary: Mr T.S.R. TOPPING, Legal Counsel

Committee on Nominations
The Committee on Nominations was composed of delegates of the following Member States: Angola, Canada, Central African Republic, Chile, China, Ecuador, France, Greece, Guatemala, Indonesia, Iran (Islamic Republic of), Jamaica, Kuwait, Lebanon, Malawi, Maldives, Mauritania, Russian Federation, Samoa, Seychelles, Slovakia, United Kingdom of Great Britain and Northern Ireland, Uzbekistan, Zimbabwe, and Dr Hong Sun Huot, Cambodia (President, Fifty-fourth World Health Assembly, ex officio).

Chairman: Dr J.F. LÓPEZ BELTRÁN (El Salvador)
Secretary: Dr Gro Harlem BRUNDTLAND, Director-General

General Committee
The General Committee was composed of the President and Vice-Presidents of the Health Assembly and the Chairmen of the main committees, together with delegates of the following Member States: Barbados, China, Côte d'Ivoire, Cuba, Democratic People's Republic of Korea, France, Japan, Mexico, Morocco, Russian Federation, Rwanda, Sao Tome and Principe, Sierra Leone, Spain, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, and United States of America.

Chairman: Dr J.F. LÓPEZ BELTRÁN (El Salvador)
Secretary: Dr Gro Harlem BRUNDTLAND, Director-General

MAIN COMMITTEES

Under Rule 35 of the Rules of Procedure of the World Health Assembly, each delegation was entitled to be represented on each main committee by one of its members.

Committee A

Chairman: Dr J. KIELY (Ireland)
Vice-Chairmen: Mrs D. COSTA COITINHO (Brazil) and Dr S.P. AGARWAL (India)
Rapporteur: Dr A. MSA MLIVA (Comoros)
Secretary: Dr S. HOLCK, Director, Health Information Management and Dissemination
Committee B

**Chairman:** Professor A.M. COLL SECK (Senegal)

**Vice-Chairmen:** Mr H. M’BAREK (Tunisia) and Professor PHAM MANH HUNG (Viet Nam)

**Rapporteur:** Dr S. SOEPARAN (Indonesia)

**Secretary:** Dr M.K. BEHBEHANI, Director, Eastern Mediterranean Liaison
RESOLUTIONS

WHA55.1 Centenary of the Pan American Health Organization

The Fifty-fifth World Health Assembly,

Having considered the report on the centenary of the Pan American Health Organization;¹

Bearing in mind that the Pan American Health Organization is the oldest international health organization in existence, since it was founded by the republics of the Americas in December 1902, and has worked uninterruptedly on behalf of the health of their peoples since that time;

Recalling that since 1949 the Pan American Health Organization has served as the Regional Office for the Americas of the World Health Organization;

Considering the role played by the Pan American Health Organization in the past 100 years in the noteworthy improvement that can be seen in health in the Region of the Americas;

Aware of the leadership displayed by the Pan American Health Organization, together with Member States, in the eradication of smallpox and poliomyelitis, and in the significant reduction of measles, which is close to elimination, among other achievements in the Americas in the course of the past 100 years,

RESOLVES:

(1) to congratulate the Pan American Health Organization on attaining the first centenary of its foundation in this year 2002;

(2) to congratulate the Member States of the Americas on the improvements in their peoples' health achieved during the past century;

(3) to encourage the Member States of the Pan American Health Organization to redouble their efforts to achieve equity in health matters, in the spirit of unity that has characterized panamericanism of the Region during the past 100 years;

(4) to thank the Pan American Health Organization and the World Health Organization for their close cooperation, dedication, leadership and contributions to the health of the peoples of the Americas.

(Third plenary meeting, 14 May 2002)

¹ Document A55/4.
WHA55.2 Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine

The Fifty-fifth World Health Assembly,

Mindful of the basic principle established in the WHO Constitution, which affirms that the health of all peoples is fundamental to the attainment of peace and security;

Recalling all its previous resolutions on the health conditions in the occupied Arab territories;

Convinced that the basis of negotiations and of achieving a just and lasting peace should be United Nations Security Council resolutions 242 (1967), 338 (1973), other relevant United Nations resolutions, the principle of the inadmissibility of acquisition of others' territory by force, the need for every State in the area to be able to live in security, and the principle of "land for peace";

Reaffirming the inalienable, permanent and unqualified right of the Palestinian people to self-determination, including their right to establish their sovereign and independent Palestinian State, and looking forward to the early fulfilment of this right;

Expressing deep concern at the deterioration of health conditions as a result of the Israeli military acts against the Palestinian people since 28 September 2000, acts such as firing on civilians and deliberate extrajudicial killing, which caused hundreds of deaths and tens of thousands of injuries among Palestinians, including a large number of children; imposition of siege on Palestinian areas, thus preventing medicines and food from reaching towns, villages and refugee camps; obstruction of ambulances, injuring a number of ambulance crew members; and denial of access of injured people to hospitals, thus condemning them to death;

Gravely concerned at the continued deterioration of the situation in the occupied Palestinian territory and at the gross violations of human rights and international humanitarian law, in particular, acts of extrajudicial killing, closures, collective punishments, persistence in establishing settlements, arbitrary detentions, besieging of Palestinian towns and villages, shelling of Palestinian residential districts using warplanes, tanks and the Israeli war machine, continued incursions into towns and camps and the mass killing of men, women and children living there as happened recently in the camps of Jenin, Balata, Khan Younes, Rafah, Ramallah, Gaza, Nablus, Al-Bireh, Al-Amari, Jabaliya, Bethlehem and Dheisheh;

Gravely concerned at the continued violence which has caused large-scale death and injury among Palestinians, the toll of casualties having reached thousands killed and over 40,000 wounded since 28 September 2000;

Emphasizing the urgent need for full implementation of the Declaration of Principles and subsequent Accords between the Palestine Liberation Organization and the Government of Israel;

Expressing grave concern at the ongoing Israeli settlement policies in the Palestinian occupied territory, including East Jerusalem, and other violations of international law, of the Fourth Geneva Convention (1949) and of relevant United Nations resolutions;

Stressing the integrity of the entire occupied Palestinian territory and the importance of guaranteeing the freedom of movement of persons and goods within the Palestinian territory, including the removal of restrictions of movement into and from East Jerusalem, and the freedom of movement to and from the outside world, bearing in mind the adverse consequences of the continued closure of
the Palestinian territory on the health sector, hindering the vaccination programmes in particular for more than eight months, leading to high risk of infectious diseases and epidemics, whereas vaccination and immunization against infectious diseases constitute a basic right of every child in the world;

Noting with deep anxiety and concern the deterioration resulting from the excessive use of force by the Israeli occupation forces against civilians, including medical teams, and its negative impact on health programmes, especially on mother-and-child-related programmes, vaccination, reproductive health, family planning, epidemic control, school health, control of drinking-water safety, insect control, mental health and health education;

Deeply concerned at the serious deterioration of the economic situation in the Palestinian territory, which has become a serious threat to the Palestinian health system, aggravated by the withholding by Israel of funds due to the Palestinian Authority, including health insurance income;

Affirming the need to increase health support and assistance for Palestinian populations in the regions under the control of the Palestinian Authority and for the Arab populations in the occupied territories, including Palestinians and the population in the occupied Syrian Golan;

Reaffirming the right of Palestinian patients and medical staff to benefit from health facilities available in the Palestinian health institutions in occupied East Jerusalem;

Affirming the need to provide international protection for the Palestinian people and health assistance to the Arab populations in the occupied territories, including the occupied Syrian Golan;

Having considered the reports on health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine,\(^1\)

1. RECOGNIZES that the Israeli occupation is a severe health problem because of the serious threat it poses to the health and lives of Palestinian citizens;

2. STRONGLY CONDEMNS the Israeli military invasion of Palestinian towns and camps, which has resulted so far in the death of hundreds of Palestinian civilians, including women and children;

3. STRONGLY CONDEMNS the aggression of the Israeli army of occupation against hospitals and sick persons and the use of Palestinian citizens as human shields during Israeli incursions into Palestinian areas;

4. STRONGLY CONDEMNS firing on ambulances and paramedical personnel by the Israeli army of occupation, preventing ambulances and cars of the International Committee of the Red Cross from reaching the wounded and the dead in order to transport them to hospitals, thus leaving the wounded bleeding to death in the streets;

5. STRONGLY CONDEMNS the refusal by the Israeli occupation army to allow the burial of Palestinians, thus obliging their families to bury the bodies of their loved ones in available space around their homes and in hospital grounds;

6. AFFIRMS the need to support the efforts of the Palestinian Ministry of Health to continue to provide emergency services, deliver health and disease prevention programmes, receive further

\(^1\) Documents A55/33 and A55/33 Add.1.
casualties in the future, and deal with thousands of cases suffering from physical and mental disabilities;

7. CALLS ON Israel to release all funds due to the Palestinian Authority, including health insurance dues;

8. URGES Member States and intergovernmental, nongovernmental and regional organizations to extend urgent and generous assistance to bring about health development for the Palestinian people and to meet their urgent humanitarian needs;

9. THANKS the Director-General for her efforts, and requests her:

   (1) to visit the occupied Palestinian territories as soon as possible in order to examine the facts related to their health situation;

   (2) to reinstate a fact-finding committee on the deterioration of the health situation in the occupied Palestinian territory, which shall submit annual reports to the Director-General and to the Health Assembly until the end of the Israeli occupation of said territory;

   (3) to take urgent steps in cooperation with Member States to support the Palestinian Ministry of Health in its efforts to overcome the current difficulties, in particular so as to guarantee the free movement of those responsible for health, of patients, of health workers, and of emergency services, and the normal provision of medical goods to Palestinian medical premises, including those in Jerusalem;

   (4) to continue to provide both the necessary technical assistance to support health programmes and projects for the Palestinian people, and emergency humanitarian assistance to meet needs arising from the current crisis;

   (5) to take the necessary steps and make the contacts needed to obtain funding from various sources, including extrabudgetary sources, to meet the urgent health needs of the Palestinian people;

   (6) to continue her efforts to implement the special health assistance programme, taking into consideration the health plan of the Palestinian people, and adapt it to the health needs of the Palestinian people;

   (7) to report on the implementation of this resolution to the Fifty-sixth World Health Assembly.

(Eighth plenary meeting, 17 May 2002 – Committee B, first report)
WHA55.3 Financial report on the accounts of WHO for 2000-2001; report of the External Auditor, and comments thereon made on behalf of the Executive Board; report of the Internal Auditor

The Fifty-fifth World Health Assembly,

Having examined the Financial report and audited financial statements for the period 1 January 2000 – 31 December 2001 and the Report of the External Auditor to the Health Assembly;¹

Having noted the first report of the Administration, Budget and Finance Committee of the Executive Board to the Fifty-fifth World Health Assembly,²


(Eighth plenary meeting, 17 May 2002 – Committee B, second report)

WHA55.4 Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution

The Fifty-fifth World Health Assembly,

Having considered the second report of the Administration, Budget and Finance Committee of the Executive Board to the Fifty-fifth World Health Assembly on Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution;³

Noting that, at the time of opening of the Fifty-fifth World Health Assembly, the voting rights of Afghanistan, Antigua and Barbuda, Armenia, Azerbaijan, Bosnia and Herzegovina, Central African Republic, Chad, Comoros, Dominican Republic, Georgia, Guinea-Bissau, Iraq, Kazakhstan, Kyrgyzstan, Liberia, Nauru, Niger, Nigeria, Republic of Moldova, Somalia, Tajikistan, Turkmenistan and Ukraine remained suspended, such suspension to continue until the arrears of the Member State concerned have been reduced, at the present or future Health Assemblies, to a level below the amount which would justify invoking Article 7 of the Constitution;

Noting that, in accordance with resolution WHA54.5, the voting privileges of Belarus, Democratic Republic of Congo, Djibouti, Guinea, Suriname and Togo have been suspended as from 13 May 2002 at the opening of the Health Assembly, such suspension to continue until the arrears have been reduced to a level below the amount which would justify invoking Article 7 of the Constitution;

Noting that Argentina, Gabon, Paraguay and Solomon Islands were in arrears at the time of the opening of the Fifty-fifth World Health Assembly to such an extent that it was necessary for the Health Assembly to consider, in accordance with Article 7 of the Constitution, whether or not the

² Document A55/38.
voting privileges of these countries should be suspended at the opening of the Fifty-sixth World Health Assembly;

Having been informed that as Gabon and Solomon Islands had subsequently paid their arrears in full they would no longer be included on the list of Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution,

DECIDES:

(1) that in accordance with the statement of principles in resolution WHA41.7 if, by the time of the opening of the Fifty-sixth World Health Assembly, Argentina and Paraguay are still in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution, their voting privileges shall be suspended as from the said opening;

(2) that any suspension which takes effect as aforesaid shall continue at the Fifty-sixth and subsequent Health Assemblies, until the arrears of Argentina and Paraguay have been reduced to a level below the amount which would justify invoking Article 7 of the Constitution;

(3) that this decision shall be without prejudice to the right of any Member to request restoration of its voting privileges in accordance with Article 7 of the Constitution.

(Eighth plenary meeting, 17 May 2002 – Committee B, second report)

WHASS.5 Arrears in payment of contributions: Azerbaijan

The Fifty-fifth World Health Assembly,

Having considered the second report of the Administration, Budget and Finance Committee of the Executive Board on Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution, with respect to the request of Azerbaijan for the settlement of its outstanding contributions, and the terms of that proposal as set forth in the report of the Director-General to the Administration, Budget and Finance Committee,

1. DECIDES to restore the voting privileges of Azerbaijan at the Fifty-fifth World Health Assembly;

2. ACCEPTS that Azerbaijan shall pay its outstanding contributions, totalling US$ 4 194 273, in 10 annual instalments (with a minimum payment of US$ 100 000 per year) payable in each of the years 2002 to 2011, subject to the provisions of Financial Regulation 6.4, in addition to the annual contributions due during the period;

3. DECIDES that, in accordance with Article 7 of the Constitution, voting privileges shall be automatically suspended again if Azerbaijan does not meet the requirements laid down in paragraph 2 above;

4. REQUESTS the Director-General to report to the Fifty-sixth World Health Assembly on the prevailing situation;

1 Annex 3 of document EBABFC17/2, contained in document A55/26, Annex 1.
5. REQUESTS the Director-General to communicate this resolution to the Government of Azerbaijan.

(Eighth plenary meeting, 17 May 2002 – Committee B, second report)

WHA55.6 Arrears in payment of contributions: Dominican Republic

The Fifty-fifth World Health Assembly,

Having considered the second report of the Administration, Budget and Finance Committee of the Executive Board on Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution, with respect to the request of the Dominican Republic for the settlement of its outstanding contributions, and the terms of that proposal as set forth in the report of the Director-General to the Administration, Budget and Finance Committee,¹

1. DECIDES to restore the voting privileges of the Dominican Republic at the Fifty-fifth World Health Assembly;

2. ACCEPTS that the Dominican Republic should settle its outstanding contributions for the period 1993-2001, totalling US$ 957 988, in 10 annual instalments as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
</tr>
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<tbody>
<tr>
<td>2002</td>
<td>95 788</td>
</tr>
<tr>
<td>2003</td>
<td>95 800</td>
</tr>
<tr>
<td>2004</td>
<td>95 800</td>
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<td>2010</td>
<td>95 800</td>
</tr>
<tr>
<td>2011</td>
<td>95 800</td>
</tr>
<tr>
<td>Total</td>
<td>957 988</td>
</tr>
</tbody>
</table>

payable in each of the years 2002 to 2011, subject to the provisions of Financial Regulation 6.4, in addition to the annual contributions due during the period;

3. DECIDES that, in accordance with Article 7 of the Constitution, voting privileges will automatically remain suspended if the Dominican Republic does not meet the requirements laid down in paragraph 2 above;

4. REQUESTS the Director-General to report to the Fifty-sixth World Health Assembly on the prevailing situation;

5. REQUESTS the Director-General to communicate this resolution to the Government of the Dominican Republic.

(Eighth plenary meeting, 17 May 2002 – Committee B, second report)

WHA55.7 Miscellaneous Income

The Fifty-fifth World Health Assembly,

Having considered the report on Miscellaneous Income,¹

DECIDES that the interest earned in respect of regular budget funds for the year ending 31 December 2001 shall be apportioned among Member States in accordance with the provisions of resolution WHA41.12; however, in lieu of being credited to Member States in the financial period 2004-2005, it shall be applied in like manner in the financial period 2002-2003;

DECIDES further that the total amount to be apportioned among Member States in 2002-2003 shall be US$ 21 976 333.

(Eighth plenary meeting, 17 May 2002 – Committee B, second report)

WHA55.8 Real Estate Fund

The Fifty-fifth World Health Assembly,

Having considered the report of the Director-General on revolving and other long-term funds;²

1. EXPRESSES appreciation to the Swiss Confederation and to the Republic and Canton of Geneva for the continued expression of their hospitality;

2. AUTHORIZES the Director-General to proceed with the construction of a new building at headquarters at a cost currently estimated at CHF 55 000 000, of which WHO’s share is estimated at CHF 27 500 000, on the understanding that if WHO’s share were likely to exceed by more than 10% the aforementioned amount, further authority would be sought from the Health Assembly;

3. APPROVES the use of the Real Estate Fund for the repayment over a 50-year period of WHO’s share of the interest-free loan to be provided by the Swiss authorities with effect from the first year of the completion of the building;

4. NOTES that negotiations are under way with the Swiss authorities with a view to reducing WHO’s share of the loan to be provided by the Swiss authorities by the value of compensation for the demolition of the V building;

¹ Document A55/27.
5. REQUESTS the Director-General to report at appropriate intervals to the Executive Board and the Health Assembly on progress in the construction of the new accommodation at headquarters and on related costs;

6. AUTHORIZES the construction of an extension to Building 2 and the construction of a new four-storey building to provide additional office accommodation and car parking in the Regional Office for the Western Pacific, to be financed from the Real Estate Fund.

(Eighth plenary meeting, 17 May 2002 – Committee B, second report)

**WHA55.9 Revolving Sales Fund**

The Fifty-fifth World Health Assembly,

Noting the proposals on the Revolving Sales Fund contained in the report of the Director-General on revolving and other long-term funds,¹

1. DECIDES that paragraphs 4 and 5 of resolution WHA22.8 shall be superseded by the paragraphs below so that the following conditions shall govern the operations of the Revolving Sales Fund:

4. …

   (i) the Fund shall be used for the purpose of financing the cost of printing and reprinting additional copies of WHO publications for sale, of producing additional copies of WHO films, filmstrips, other visual media, of the production of any other item which the Organization may produce for sale, of sales promotion, of staff exclusively engaged in such sales, and the distribution and mailing costs;

   (ii) proceeds of all such sales shall be credited to the Fund;

   (iii) expenditure incurred in accordance with paragraph 4(i) shall be debited to the Fund;

   (iv) the transactions during the year and the status of the Fund shall be included in each financial report of the Director-General;

5. AUTHORIZES the Director-General, at the end of each financial period, to transfer to Miscellaneous Income any surplus standing to the credit of the Revolving Sales Fund;

2. DECIDES further that the provisions of this resolution shall become effective as from the financial period 2002-2003.

(Eighth plenary meeting, 17 May 2002 – Committee B, second report)

WHA55.10 Mental health: responding to the call for action

The Fifty-fifth World Health Assembly,

Recalling resolutions WHA28.84 and EB61.R28 on the promotion of mental health, resolution WHA29.21 on psychosocial factors and health, resolutions WHA32.40, WHA33.27 and EB69.R9 on alcohol- and drug-related problems, resolution WHA30.38 on mental retardation, resolution WHA39.25 on prevention of mental, neurological and psychosocial disorders, resolution EUR/RC51/R5 on the Athens Declaration on Mental Health, Man-Made Disasters, Stigma and Community Care, and resolution EB109.R8 on strengthening mental health;

Bearing in mind World Health Day 2001, the ministerial round tables at the Fifty-fourth World Health Assembly, The world health report 2001 and the multitude of activities initiated during 2000-2002 related to advocacy, policy and programme development, legislation, and research;

Considering the imperative need to pursue and accelerate such activities worldwide in order to improve the mental-health status of populations, especially the most vulnerable groups;

Welcoming the definition in The world health report 2001 of the activities related to promotion, prevention and care and to protection of the human rights of people with mental illness and their families that all Member States can implement according to their level of priorities and resources in mental health;

Recognizing that the toll of mental health problems is very high and rising worldwide, that such problems cause significant disability, heighten the risk of social exclusion, and increase mortality, that stigmatization and discrimination are major problems obstructing the path to care, and that the human and economic costs are staggering;

Noting the existence of programmes which can prevent the occurrence of a significant proportion of these problems and thus reduce their negative social impact and human suffering;

Further recognizing the need to maintain the momentum on mental health in order to raise public and professional awareness of the real burden of mental disorders, to protect the human rights of people with mental illness as an integral component of mental-health policies, and to implement strategies, programmes and policies as proposed in WHO’s global action programme for mental health,

URGES Member States:

(1) to reaffirm the provisions of resolution EB109.R8;

(2) to provide support to WHO’s global action programme for mental health;

(3) to increase investments in mental health both within countries and in bilateral and multilateral cooperation, as an integral component of the well-being of populations;

(4) to strengthen action to protect children from and in armed conflict.

(Ninth plenary meeting, 18 May 2002 – Committee A, first report)

WHA55.11 Health and sustainable development

The Fifty-fifth World Health Assembly,

Having considered the report on the World Summit on Sustainable Development;¹

Recalling Principle 1 of the Rio Declaration on Environment and Development, namely, “Human beings are at the center of concerns for sustainable development. They are entitled to a healthy and productive life in harmony with nature.” and Chapter 6 on health of Agenda 21, adopted at the United Nations Conference on Environment and Development (Rio de Janeiro, Brazil, 1992);

Welcoming the report of the WHO Commission on Macroeconomics and Health² and noting the references to the resources needed to scale up the coverage of essential interventions to achieve desired health outcomes;

Recognizing that sustainable development aims at improving the quality of life of all the world's present generation, without compromising that of future generations;

Further recognizing that achieving this objective requires integrated action towards economic growth, the assurance that no individual or nation is denied the opportunity to benefit from development, management and conservation of natural resources, protection of the environment, and social development;

Aware that these pillars are mutually supportive, creating synergy for sustainable development and good health;

Bearing in mind the contribution that poverty reduction makes to health, and health to sustainable poverty reduction; that sustainable global and local environments make to health; and that viable health services uniquely make to sustainable development;

Aware of the need for a comprehensive approach to health, and of the intersectoral nature of health problems and solutions;

Noting with concern that, despite much social and economic progress, health continues to be severely compromised in many countries by inadequacies in the implementation of required measures in all areas of sustainable development,

1. URGES Member States:

(1) to address the link between health and sustainable development at the World Summit on Sustainable Development (Johannesburg, South Africa, 2002);

¹ Document A55/7.
(2) to provide timely and effective support to the health programme as envisaged in the New Partnership for Africa’s Development (NEPAD) as a means of achieving sustainable development in Africa, and to similar initiatives in other regions;

(3) to reaffirm internationally agreed development goals, including those contained in the United Nations Millennium Declaration;

(4) to implement the United Nations Declaration of Commitment on HIV/AIDS and internationally and regionally agreed targets for the reduction of the disease burden;

(5) to encourage countries in development to prepare and implement sustainable strategies to reduce poverty and to include in such strategies plans to address the unacceptable burden of communicable and noncommunicable diseases;

(6) to encourage developed countries that have not done so to make concrete efforts towards the target of allocating 0.7% of GNP as official development assistance to developing countries and 0.15% to 0.2% of GNP as official development assistance to least developed countries, as reconfirmed at the Third United Nations Conference on Least Developed Countries (Brussels, 2001); and to encourage developing countries to build on progress made in ensuring that official development assistance is used effectively to help achieve development goals and targets;

(7) to apply the 20:20 principle whereby not less than 20% of official development assistance and not less than 20% of countries’ own budgets are allocated to social-sector spending;

(8) to dedicate funds for health research, particularly for development of new drugs and vaccines for preventing and treating diseases of poverty;

(9) to adopt policies that create healthy workplaces, protect workers’ health and, consistent with national and international law, prevent transfer of hazardous equipment, processes and materials;

2. REQUESTS the Director-General:

(1) to provide support to countries to implement strategies and interventions aimed at achieving the internationally agreed development goals, including those contained in the United Nations Millennium Declaration, and to scale up their efforts in health to the level required;

(2) to provide technical support to countries to frame policies and to implement national commitments and action plans that promote consumption patterns at individual and national levels that are sustainable and health promoting;

(3) to accelerate development of an action plan to address the ethical recruitment and distribution of skilled health-care personnel, and the need for sound national policies and strategies for the training and management of human resources for health;

(4) to provide support to countries further to develop effective disease surveillance and health information systems;

(5) to provide support to countries to establish and strengthen on the basis of a multisectoral approach existing programmes of action, to empower people to protect and promote their health and well-being;
(6) to report to the Fifty-sixth World Health Assembly on the World Summit on Sustainable Development and on progress made in implementing this resolution.

(Ninth plenary meeting, 18 May 2002 – Committee A, second report)

WHA55.12 Contribution of WHO to the follow-up of the United Nations General Assembly special session on HIV/AIDS

The Fifty-fifth World Health Assembly,

Deeply concerned that the global HIV/AIDS pandemic, through its devastating scale and impact, constitutes a global emergency and one of the most formidable challenges both to human life and dignity and to the effective enjoyment of human rights, and undermines social and economic development throughout the world which affects all levels of society: national, community, family and individual;

Noting with profound concern that HIV continues to spread unabated around the world and that in many countries, in particular in Eastern Europe and Asia, infection rates have risen dramatically during 2001, so that by the end of 2001, 40 million people worldwide were living with HIV/AIDS, 90% of them in developing countries, and 75% in Africa;

Recalling and reaffirming the previous commitments on HIV/AIDS made through the Declaration of Commitment on HIV/AIDS adopted at the special session of the United Nations General Assembly on HIV/AIDS (27 June 2001), the United Nations Millennium Declaration (8 September 2000), and the United Nations Secretary-General’s road map towards its implementation1 as well as resolution WHA54.10 on scaling up the response to HIV/AIDS;

Acknowledging WHO’s special role within the United Nations system to combat and mitigate the effects of HIV/AIDS, and its responsibility in the follow-up of the Declaration of Commitment on HIV/AIDS and as a cosponsor of UNAIDS;

Recognizing the essential role of the health sector in the response to HIV/AIDS and the need to strengthen health systems and make them more effective so that countries and communities may contribute maximally to the fulfilment of the global targets set out in the Declaration of Commitment on HIV/AIDS;

Recognizing that the full realization of human rights and fundamental freedoms for all is an essential element in a global response to the HIV/AIDS pandemic that includes prevention, care, support and treatment, reducing vulnerability to HIV/AIDS, and preventing stigmatization and related discrimination against people living with, or at risk of, HIV/AIDS;

Having considered the report of the Director-General on the global health-sector strategy for HIV/AIDS;2

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1 General Assembly document A/56/326.
Commending the efforts of the Director-General to enhance and strengthen WHO's response to the HIV/AIDS pandemic and further to develop and extend the role of WHO as a key cosponsor of UNAIDS,

1. URGES Member States:

   (1) to act upon the political commitment expressed at the United Nations General Assembly special session on HIV/AIDS, by operationalizing the Declaration of Commitment on HIV/AIDS and by allocating significantly increased resources to the health sector so that it may play an effective role in prevention, care, support and treatment of HIV/AIDS;

   (2) to foster mechanisms to increase global resources for the response to HIV/AIDS;

   (3) to establish and strengthen monitoring and evaluation systems, including epidemiological and behavioural surveillance and assessment of the response of health systems to the epidemics of HIV/AIDS and sexually transmitted infections, to enhance programming of interventions by learning from success and failure and to optimize the allocation of resources;

   (4) to establish or expand counselling services and voluntary, confidential HIV-testing in order to encourage health-seeking behaviour and to act as an entry point for prevention and care;

   (5) to increase access to care, including by making prophylactic and therapeutic drugs affordable according to the availability of resources and assuring that they are safely and effectively used in the proper context of existing systems;

   (6) to build and strengthen partnerships between health-care providers, both public and private, and communities, including nongovernmental organizations, in order to mobilize and empower communities in the response to HIV/AIDS;

   (7) to scale up significantly programmes to increase coverage of interventions intended to reduce the spread of HIV and increase the quality and length of life of those living with HIV/AIDS, on the basis of scientific evidence and lessons learned;

   (8) to advocate the reduction of stigmatization and discrimination against people living with or at risk of HIV/AIDS and to mitigate the impact of HIV/AIDS on vulnerable groups, especially women and children;

2. REQUESTS the Director-General:

   (1) to continue to ensure that WHO plays a key role in providing technical leadership, direction and support to the health system's response to HIV, within the United Nations system-wide response, as a cosponsor of UNAIDS;

   (2) to provide support to countries in order to maximize opportunities for the delivery of all relevant interventions for prevention, care, support and treatment of HIV/AIDS;

   (3) to provide support to countries in order to strengthen the health sector so that it may play a more effective and catalytic role in relation to other relevant sectors with a view to achieving a well-coordinated, multisectoral and sustainable response to the epidemic;
within the framework of strengthening the health system’s response to HIV/AIDS, to provide support to countries, as part of their national strategies, in the areas of prevention, care, support and treatment in order to meet the commitments and goals agreed at the United Nations General Assembly special session on HIV/AIDS, in particular as they:

(a) take effective measures, within a supportive environment, to ensure that people everywhere, particularly young people, have access to the information and services necessary to enable them to protect themselves from HIV;

(b) intensify and expand action to achieve the goal of the special session of lowering the proportion of infants infected with HIV through reduction of HIV transmission in women of reproductive age, access to family-planning information and services for HIV-infected women, and provision of interventions that reduce transmission from mother to child;

(c) develop national strategies and actions on care and support for people living with HIV/AIDS, including prevention and treatment of opportunistic infections and provision of palliative care and psychosocial support;

(5) to continue broad-based consultations with countries and partners on the global health-sector strategy, which will comprise tools and approaches for scaling up effective, feasible and sustainable interventions;

(6) to provide support for research on new technologies and approaches to prevent and treat HIV/AIDS, such as vaccines, microbicides, standard and simplified regimens for antiretroviral treatment and monitoring, and for operational research on service delivery;

(7) to submit a report on WHO’s work on HIV/AIDS, including the global health-sector strategy, to the Executive Board at its 111th session and the Fifty-sixth World Health Assembly.

(Ninth plenary meeting, 18 May 2002 — Committee A, second report)

**WHA55.13 Protection of medical missions during armed conflict**

The Fifty-fifth World Health Assembly,

Recalling and reiterating resolution WHA46.39 entitled “Health and medical services in times of armed conflict”;

Reaffirming the need to promote and ensure respect of the principles and rules of international humanitarian law, and guided in this respect by the relevant provisions of the Geneva Conventions of 1949 and their Additional Protocols of 1977, as applicable;

Aware that, over the years, considerations based on international humanitarian and human-rights law have resulted in improved protection for medical personnel and for their recognized emblems during armed conflict;

Deeply disturbed by recent reports of increasing attacks on medical personnel, establishments and units during armed conflicts;
Alarmed by the extent to which civilian populations are being affected by the lack of medical care as a consequence of attacks directed at health and other humanitarian personnel, and health establishments, during armed conflicts;

Aware of the adverse effects of such conflicts on high-priority public health programmes, such as the Expanded Programme on Immunization and control of malaria and tuberculosis;

Recognizing the benefits of ceasefires brokered for national immunization days as appropriate;

Convinced, in accordance with international law, that it is indispensable to protect against attacks directed at health personnel, hospitals, health facilities and infrastructures, ambulances and other medical vehicles and communication systems used for humanitarian purposes,

1. CALLS on all parties to armed conflicts fully to adhere to and implement the applicable rules of international humanitarian law protecting civilians and combatants who are hors de combat as well as medical, nursing and other health and humanitarian personnel, and to respect provisions that regulate the use of Red Cross and Red Crescent emblems and the protective status they have under international humanitarian law;

2. URGES Member States to condemn all attacks directed at health personnel, especially those that impede ability of such personnel to carry out their humanitarian function during armed conflicts;

3. ALSO URGES Member States, organizations of the United Nations system, other intergovernmental and nongovernmental bodies active in the humanitarian or health fields to promote actions that ensure the safety of health personnel;

4. FURTHER URGES parties to conflict and humanitarian relief organizations to assure that ambulances, other medical vehicles, health facilities or other structures which facilitate the work of health personnel are used for humanitarian purposes only;

5. REQUESTS the Director-General:

   (1) to promote the protection of and respect for health personnel and establishments;

   (2) to liaise closely with the competent organizations of the United Nations system, including UNICEF, the Office for the Coordination of Humanitarian Affairs, the Office of the High Commissioner for Refugees, and the Office of the High Commissioner for Human Rights, together with the International Committee of the Red Cross, the International Federation of Red Cross and Red Crescent Societies and other relevant intergovernmental and nongovernmental bodies in order to promote implementation of this resolution;

   (3) to disseminate this resolution widely.

(Ninth plenary meeting, 18 May 2002 – Committee A, second report)
WHA55.14 Ensuring accessibility of essential medicines

The Fifty-fifth World Health Assembly,

Welcoming adoption of the “Declaration on the TRIPS agreement and public health” at the Fourth WTO Ministerial Conference (Doha, 14 November 2001), supportive of the rights of countries to protect public health and, in particular, to promote access to medicines for all;

Recalling discussions and proposals reported by Member States in their regional meetings before the Fifty-fifth World Health Assembly, mainly at the 53rd session of the Regional Committee for the Americas (September 2001)\(^1\) and the Forty-eighth session of the Regional Committee for the Eastern Mediterranean (October 2001)\(^2\) and, additionally, the thorough discussion of the Executive Board at its 109th session;\(^3\)

Reaffirming resolution WHA54.11, emphasizing WHO’s medicines strategy and its requests to Member States and the Director-General of WHO;

Having considered the report on WHO’s medicines strategy: expanding access to essential drugs;\(^4\)

Aware of the need to assure the continuity of updating WHO’s Model List of Essential Drugs in light of evidence-based, scientific information;

Underlining the feasibility of addressing comprehensively the impact of international trade agreements on equitable access to all drugs, particularly essential drugs;

Conscious of the responsibility of Member States to support solid scientific evidence, excluding any biased information or external pressures that may be detrimental to public health;

1. **URGES** Member States:

    (1) to reaffirm their commitment to increasing access to medicines, and to translate such commitment into specific regulation within countries, especially enactment of national drug policies and establishment of lists of essential medicines based on evidence and with reference to WHO’s Model List, and into actions designed to promote policy for, access to, and quality and rational use of, medicines within national health systems;

    (2) to establish the necessary mechanisms for essential medicines lists that are science-based, independent of external pressures, and subject to regular reviews;

    (3) in addition to health policies and actions, to implement complementary measures to ensure that national lists of essential medicines are supported by standard clinical guidelines, preferably national therapeutic formularies, with the aim of promoting rational prescription;

\(^1\) See document CD53/5.

\(^2\) See resolution EM/RC48/R.2.

\(^3\) See document EB109/2002/REC/2, summary records of the third, fourth and ninth meetings.

\(^4\) Document A55/12.
(4) to reaffirm, within the national drug policies, WHO's concept of essential medicines as those medicines that satisfy the priority health-care needs of the population, reflecting also availability, quality, price and feasibility of delivery, and re-emphasizing the evidence base for overall national discussions;

(5) to continue monitoring the implications on access to medicines of recent patent-protection laws and compliance with WTO's Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS);

2. REQUESTS the Director-General:

(1) to strengthen the Expert Committee on the Use of Essential Drugs, ensuring its independence from external pressures at all times, the use of science-based criteria for revision and updating, and receipt, when appropriate and as required, of the necessary inputs from all relevant stakeholders;

(2) to ensure that WHO's medicines strategy addresses the important issue of the impact of international trade agreements on access to medicines and to reflect, in the relevant reports to WHO's governing bodies, progress in its comprehensive endeavour;

(3) to advocate the necessary action worldwide to promote market-based differential pricing for essential medicines between high-, middle-, and low-income countries, and to provide technical support, especially to developing countries, to establish drug-pricing policies;

(4) to advocate the concept and policies of essential medicines as a tool for implementing rational prescription of medicines;

(5) to continue to work on the methodology for computerized databases on reference prices of essential medicines worldwide;

(6) to pursue all diplomatic and political opportunities aimed at overcoming barriers to access to essential medicines, collaborating with Member States in order to make these medicines accessible and affordable to the people who need them;

(7) to join with and support nongovernmental organizations in the process of implementing initiatives that are compatible with public health priorities.

(Ninth plenary meeting, 18 May 2002 – Committee A, second report)

WHA55.15 Smallpox eradication: destruction of Variola virus stocks

The Fifty-fifth World Health Assembly,

Recalling resolution WHA52.10 on smallpox eradication;

Having considered the report on smallpox eradication;

Noting that the research programme will not be completed by the end of 2002,

1. DECIDES to authorize the further, temporary, retention of the existing stocks of live *Variola virus* at the current locations specified in resolution WHA52.10, for the purpose of enabling further international research, on the understanding that steps should be taken to ensure that all approved research would remain outcome-oriented and time-limited and be periodically reviewed, and that a proposed new date for destruction should be set when research accomplishments and outcomes allow consensus to be reached on the timing of destruction of *Variola virus* stocks;

2. REQUESTS the Director-General:

   (1) to continue the work of the Advisory Committee on Variola Virus Research with respect to the research involving *Variola virus* stocks and to ensure that the research programme is conducted in an open and transparent manner;

   (2) to ensure that regular biosafety inspection of the storage and research facilities is continued in order to confirm the strict containment of existing stocks and to ensure a safe research environment for work with *Variola virus*;

   (3) to ensure that research results and the benefits of this research are made available to all Member States;

   (4) to report annually on progress in the research programme and relevant issues to the Health Assembly, through the Executive Board.

(Ninth plenary meeting, 18 May 2002 – Committee A, second report)

**WHA55.16 Global public health response to natural occurrence, accidental release or deliberate use of biological and chemical agents or radionuclear material that affect health**

The Fifty-fifth World Health Assembly,

Underlining that the focus of the World Health Organization is on the possible public health consequences of an incident involving biological and chemical agents and radionuclear material, regardless of whether it is characterized as a natural occurrence, accidental release or a deliberate act;

Having reviewed the report on the deliberate use of biological and chemical agents to cause harm: public health response;

Seriously concerned about threats against civilian populations, including those caused by natural occurrence or accidental release of biological or chemical agents or radionuclear material as well as their deliberate use to cause illness and death in target populations;

Noting that such agents can be disseminated through a range of mechanisms, including the food- and water-supply chains, thereby threatening the integrity of public health systems;

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Acknowledging that natural occurrence or accidental release of biological, chemical agents and radionuclear material could have serious global public health implications and jeopardize the public health achievements of the past decades;

Acknowledging also that the local release of biological, chemical and radionuclear material designed to cause harm could have serious global public health implications and jeopardize the public health achievements of the past decades;

Recalling resolution WHA54.14 on global health security: epidemic alert and response, which stresses the need for all Member States to work together, with WHO and with other technical partners, in addressing public health emergencies of international concern, and resolution WHA45.32 on the International Programme on Chemical Safety, which emphasized the need to establish or strengthen national and local capacities to respond to chemical incidents;

Recognizing that one of the most effective methods of preparing for deliberately caused disease is to strengthen public health surveillance of and response to naturally or accidentally occurring diseases,

1. URGES Member States:

   (1) to ensure they have in place national disease-surveillance plans which are complementary to regional and global disease-surveillance mechanisms, and to collaborate in the rapid analysis and sharing of surveillance data of international humanitarian concern;

   (2) to collaborate and provide mutual support in order to enhance national capacity in field epidemiology, laboratory diagnoses, toxicology and case management;

   (3) to treat any deliberate use, including local, of biological and chemical agents and radionuclear attack to cause harm also as a threat to global public health, and to respond to such a threat in other countries by sharing expertise, supplies and resources in order rapidly to contain the event and mitigate its effects;

2. REQUESTS the Director-General:

   (1) to continue, in consultation with relevant intergovernmental agencies and other international organizations, to strengthen global surveillance of infectious diseases, water quality, and food safety, and related activities such as revision of the International Health Regulations and development of WHO’s food-safety strategy, by coordinating information gathering on potential health risks and disease outbreaks, data verification, analysis and dissemination, by providing support to laboratory networks, and by making a strong contribution to any international humanitarian response, as required;

   (2) to provide tools and support to Member States, particularly developing countries, for strengthening their national health systems, notably with regard to emergency preparedness and response plans, including disease surveillance and toxicology, risk communication, and psychosocial consequences of emergencies;

   (3) to continue to issue international guidance and technical information on recommended public health measures to deal with the deliberate use of biological and chemical agents to cause harm, and to make this information available on WHO’s web site;
(4) to examine the possible development of new tools, within the mandate of WHO, including modelling of possible scenarios of natural occurrence, accidental release or deliberate use of biological, chemical agents and radionuclear material that affect health, and collective mechanisms concerning the global public health response to contain or mitigate the effects of natural occurrence, accidental release or deliberate use of biological, chemical agents and radionuclear material that affect health.

(Ninth plenary meeting, 18 May 2002 – Committee A, second report)

WHA55.17 Prevention and control of dengue fever and dengue haemorrhagic fever

The Fifty-fifth World Health Assembly,

Having considered the report on prevention and control of dengue;¹

Recalling resolution WHA46.31 and resolutions CD31.R26, CD33.R19 and CD43.R4 of the Directing Council of the Pan American Health Organization on dengue prevention and control;

Concerned that an estimated 50 million dengue infections occur annually and that the geographical spread, incidence, and severity of dengue fever and dengue haemorrhagic fever are increasing in the tropics;

Recognizing the growing burden of disease, particularly among children, and the social and economic impact of dengue epidemics;

Acknowledging the progress made in reducing the case-fatality rates of dengue haemorrhagic fever in some countries;

Appreciating that significant advances have been made in the development of dengue vaccines, although they are not yet available for public health use;

Recognizing that prevention or reduction of dengue viral transmission entirely depends on control of the mosquito vector Aedes aegypti and, to a lesser extent, A. albopictus and other secondary vector species;

Aware that dengue vector-control programmes have had considerable success in the past, but that sustained suppression of vector populations today largely depends on commitment of governments and on community participation in both planning of intervention strategies and implementation of control measures to prevent breeding of A. aegypti;

Further acknowledging that, at the International Conference on Dengue and Dengue Haemorrhagic Fever (Chiang Mai, Thailand, 2000), more than 700 public health specialists from 41 countries recommended that all countries at risk of dengue viral transmission should develop and implement sustainable prevention and control programmes,

¹ Document A55/19.
1. URGES Member States:

(1) to advocate increased commitment and allocation of additional human and other resources for improved and sustained prevention and control efforts and for strengthened research;

(2) to build and strengthen the capacity of health systems for surveillance, prevention, control and management of dengue fever and dengue haemorrhagic fever;

(3) to strengthen the capacity of diagnostic laboratories, taking into account the fundamental importance of laboratory diagnosis to confirm etiology, and to strengthen clinical and epidemiological surveillance of dengue fever and dengue haemorrhagic fever;

(4) to promote active intersectoral partnerships involving international, regional, national and local agencies, nongovernmental organizations, foundations, the private sector, and community and civic organizations;

(5) to pursue, encourage and support research on, and development, application and evaluation of, new and improved tools and strategies for prevention and control of dengue fever and dengue haemorrhagic fever;

(6) to strengthen health measures at borders for vector control, to ensure timely diagnosis and treatment of the disease, and to optimize regional resources;

2. URGES other specialized agencies, bodies and programmes of the United Nations system, bilateral development agencies, nongovernmental organizations and other concerned groups to increase their cooperation in dengue fever prevention and control, through both continued support for general health and social development and specific support to national and international prevention and control programmes, including emergency control;

3. REQUESTS the Director-General:

(1) to develop further and support implementation of the global strategy for prevention and control of dengue fever and dengue haemorrhagic fever through integrated environmental management;

(2) to continue to seek resources for advocacy and research on improved and new tools and methods for dengue fever prevention and control and their application;

(3) to study the need for and feasibility of incorporating the surveillance and research of other arthropod-borne viral infections, such as Japanese encephalitis, West Nile, and other emerging diseases, in the surveillance system for dengue haemorrhagic fever;

(4) to mobilize financial resources to be spent on vector control and research into vaccines.

(Ninth plenary meeting, 18 May 2002 – Committee A, third report)
WHA55.18 Quality of care: patient safety

The Fifty-fifth World Health Assembly,

Having considered the report on quality of care: patient safety;¹

Concerned that the incidence of adverse events is a challenge to quality of care, a significant avoidable cause of human suffering, and a high toll in financial loss and opportunity cost to health services;

Noting that significant enhancement of health systems' performance can be achieved in Member States by preventing adverse events in particular, and improving patient safety and health care quality in general;

Recognizing the need to promote patient safety as a fundamental principle of all health systems,

1. URGES Member States:

   (1) to pay the closest possible attention to the problem of patient safety;

   (2) to establish and strengthen science-based systems, necessary for improving patients' safety and the quality of health care, including the monitoring of drugs, medical equipment and technology;

2. REQUESTS the Director-General, in the context of a quality programme:

   (1) to develop global norms, standards and guidelines for quality of care and patient safety, and the definition, measurement and reporting of adverse events and near misses in health care, by reviewing experiences from existing programmes and seeking inputs from Member States, in order to provide support in developing reporting systems, taking preventive action, and implementing measures to reduce risks;

   (2) to promote framing of evidence-based policies, including global standards that will improve patient care, with particular emphasis on product safety, safe clinical practice in compliance with appropriate guidelines, and safe use of medicinal products and medical devices, taking into consideration the views of policy-makers, administrators, health-care providers and consumers;

   (3) to support the efforts of Member States to promote a culture of safety within health care organizations and to develop mechanisms, for example through accreditation or other means, in accordance with national conditions and requirements, to recognize the characteristics of health care providers that offer a benchmark for excellence in patient safety internationally;

   (4) to encourage research into patient safety, including epidemiological studies of risk factors, effective protective interventions, and assessment of associated costs of damage and protection;

¹ Document A55/13.
(5) to report on progress to the Executive Board at its 113th session and to the Fifty-seventh World Health Assembly.

(Ninth plenary meeting, 18 May 2002 – Committee A, third report)

WHA55.19 WHO's contribution to achievement of the development goals of the United Nations Millennium Declaration

The Fifty-fifth World Health Assembly,

Having considered the note by the Director-General;¹

Recalling the commitments made in the United Nations Millennium Declaration adopted by the United Nations General Assembly in September 2000² and the United Nations Secretary-General's road map towards its implementation;³

Recalling in particular the goals set out in the Millennium Declaration to have reduced, by the year 2015, maternal mortality by three-quarters, and under-five mortality by two-thirds, of their 1990 levels;

Recognizing that increased access to good-quality primary health care information and services, including reproductive health, is critical for attainment of the development goals contained in the United Nations Millennium Declaration;⁴

Recalling and recognizing the Programme of Action adopted at the International Conference on Population and Development, commitments made at the Copenhagen Social Summit and the World Summit for Children, the Beijing Declaration and Platform for Action, and the Declaration on the Elimination of Violence against Women, their recommendations and respective follow-ups and reports;

Mindful of WHO’s functions, as set out in its Constitution, which include to promote maternal and child health and welfare;

Recalling that the Constitution of the World Health Organization states that enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;

Recognizing the equal rights of men and women, and noting that progress towards realization of those rights should involve access to good-quality reproductive-health care, including family planning services that are effective, affordable and acceptable;

¹ Document A55/6.
² United Nations General Assembly Resolution 55/2.
³ General Assembly document A/56/326.
⁴ It is understood that "primary health care services" do not include abortion except when consistent with national and, where applicable, local law, and with full respect for the various religious and ethical values and cultural backgrounds.
Recognizing also the importance of the Convention on the Rights of the Child as a framework for addressing child and adolescent health and development;

Recognizing that maternal, child and adolescent health and development have a major impact on socioeconomic development, and that achievement of the global targets for the coming decades will require renewed political commitment and action;

Concerned that, because of poverty and lack of access to basic health and social services, close to 11 million children under five years of age, nearly four million of them within the first month of life, die every year of preventable diseases and malnutrition, and that complications related to pregnancy and childbirth kill more than half a million women and adolescent girls every year, and injure and disable many more;

Concerned also by global inequities which lead to women dying during pregnancy and childbirth from conditions that are readily preventable and treatable, such as severe bleeding, infections, obstructed labour, hypertensive disorders, as well as from unsafe abortions;

Convinced that concerted action to make pregnancies and childbirth safer will have a beneficial impact on the survival of women and neonates, and will contribute to the health and development of children and adolescents and to the well-being of families;

Welcoming the report of the Commission on Macroeconomics and Health, which provides a useful approach to achievement of the Millennium Development Goals, and other internationally agreed development goals, including those contained in the United Nations Millennium Declaration;

Recognizing, as concluded by the Commission on Macroeconomics and Health, that improvements in maternal and neonatal health and survival are vital contributions to poverty reduction;

Further recognizing that the development goals contained in the United Nations Millennium Declaration cannot be achieved without the renewed commitment of the international community, and aware of the Health Assembly’s leadership in this context;

Reaffirming resolution WHA48.10 on reproductive health: WHO’s role in the global strategy,

1. URGES Member States:

   (1) to strengthen and scale up efforts to achieve the development goals of the Millennium Declaration and other internationally agreed goals and targets;

   (2) to strengthen and expand efforts to meet, in particular, international development goals and targets related to reduction of maternal and child mortality and malnutrition and to improve access to primary health care services, including reproductive health, with special attention to the needs of the poor and underserved populations;

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2 It is understood that “primary health care services” do not include abortion except when consistent with national and, where applicable, local law, and with full respect for the various religious and ethical values and cultural backgrounds.
(3) to continue to advocate as public health priorities safe pregnancy and childbirth; breastfeeding; neonate, child and adolescent health and development; and elimination of violence against women;

(4) to include in efforts to develop health systems, plans of action for making pregnancy safer, based on cost-effective interventions for good-quality maternal and neonatal care;

(5) to ensure that primary health-care facilities strive for full coverage of their neonate, child and adolescent populations with interventions known to be effective, including those that help families and communities care for their children and young people;

(6) to support the negotiations towards an effective framework convention on tobacco control;

(7) to encourage the pharmaceutical industry and other relevant partners and organizations to make essential drugs more widely available and affordable by all who need them in developing countries;

2. ENCOURAGES developed countries that have not done so to make concrete efforts towards the target of allocating 0.7% of GNP as official development assistance to developing countries and 0.15% to 0.2% of GNP as official development assistance to least developed countries, as reconfirmed at the Third United Nations Conference on the Least Developed Countries (Brussels, 2001), and encourages developing countries to build on progress made in ensuring that official development assistance is used effectively to help achieve development goals and targets;

3. CALLS upon the international donor community to increase its assistance to developing countries in the health sector, taking into account the recommendations of the Commission on Macroeconomics and Health;

4. FURTHER CALLS upon countries and other partners in development to increase their investments in the health sector, where appropriate, in line with the recommendations of the Commission on Macroeconomics and Health;

5. REQUESTS the Director-General to lead an international drive to generate resources and investments for research to improve health in developing countries, particularly in relation to neglected diseases, taking into account the recommendations of the Commission on Macroeconomics and Health;

6. URGES the Director-General to facilitate a process to consider, together with Member States, the recommendations of the Commission on Macroeconomics and Health and their follow-up, through intergovernmental, bilateral, national and other mechanisms, recognizing that these recommendations are based on a partnership approach between developed and developing countries, and that actions cannot be undertaken at national level without coordinated and simultaneous action at international level;

7. FURTHER REQUESTS the Director General:

(1) to report to the Executive Board at its 111th session and to the Fifty-sixth World Health Assembly on WHO’s strategy for child and adolescent health and development, together with WHO’s planned follow-up to the United Nations General Assembly special session on children;
(2) to develop a strategy for accelerating progress towards attainment of international development goals and targets related to reproductive health, and to submit a progress report to the Executive Board at its 111th session and to the Fifty-sixth World Health Assembly;

(3) to promote reporting on progress towards internationally agreed goals and targets in the area of reproductive health as part of WHO's contribution to the Secretary-General's report to the United Nations General Assembly on progress towards attainment of the development goals of the Millennium Declaration.

(Ninth plenary meeting, 18 May 2002 – Committee A, third report)

WHA55.20 Salaries of staff in ungraded posts and of the Director-General

The Fifty-fifth World Health Assembly,

Noting the recommendations of the Executive Board with regard to remuneration of staff in ungraded posts and of the Director-General,

1. ESTABLISHES the salary for ungraded posts at US$ 158 353 per annum before staff assessment, resulting in a modified net salary of US$ 108 379 (dependency rate) or US$ 98 141 (single rate);

2. ESTABLISHES the salary for the Director-General at US$ 213 892 per annum before staff assessment, resulting in a modified net salary of US$ 142 813 (dependency rate) or US$ 127 000 (single rate);

3. DECIDES that those adjustments in remuneration shall take effect on 1 March 2002.

(Ninth plenary meeting, 18 May 2002 – Committee B, third report)

WHA55.21 Amendments to the Staff Regulations

The Fifty-fifth World Health Assembly

1. NOTES the amendments to the Staff Rules made by the Director-General and confirmed by the Executive Board at its 109th session concerning, inter alia, contractual reform and the system for performance management and development;¹

2. ADOPTS the amendment proposed to Staff Regulation 4.5 for the purpose of ensuring consistency between the Staff Regulations and the Staff Rules, and that proposed by the Administration, Budget and Finance Committee;²

² See Annex 1.
3. DECIDES that the amendments to Staff Regulation 4.5 shall take effect on 1 July 2002.

(Ninth plenary meeting, 18 May 2002 – Committee B, third report)

WHA55.22 Reimbursement of travel expenses for members of the Executive Board

The Fifty-fifth World Health Assembly,

Recalling resolution WHA30.10,

DECIDES that:

(1) from May 2002 the maximum reimbursement of travel expenses of members of the Executive Board shall be based on WHO travel entitlements as set out in the applicable rules, and restricted to the equivalent of one business class or equivalent return ticket for those members whose travel time between the capital city of the Member State to the place of meeting, including necessary stopovers, exceeds six hours;

(2) all other provisions of paragraphs 1 and 2 of resolution WHA30.10 shall remain applicable, including those for travel of members whose travel time is six hours or less.

(Ninth plenary meeting, 18 May 2002 – Committee B, third report)

WHA55.23 Diet, physical activity and health

The Fifty-fifth World Health Assembly,

Having considered the report on diet, physical activity and health;¹

Recalling resolution WHA53.17 on prevention and control of noncommunicable diseases that reaffirmed that the global strategy for the prevention and control of noncommunicable diseases and the ensuing implementation plan were directed at reducing premature mortality and improving the quality of life;

Recalling *The world health report 2001,*² which indicates that mortality, morbidity and disability attributed to the major noncommunicable diseases currently account for approximately 60% of all deaths and 43% of the global burden of disease, and are expected to rise to 73% of all deaths and 60% of the global burden of disease by 2020;

Noting that already 79% of the deaths attributed to noncommunicable diseases occur in the developing countries;


Alarmed by these rising trends that are a consequence of the demographic and epidemiological transition, including those in diet and physical activity, and the globalization of economic processes;

Recognizing, however, the vast body of knowledge and experience that exists in this domain, and the need to reduce the level of exposure to the major risk factors of unhealthy diets, physical inactivity and tobacco use;

Mindful also that these major behavioural and environmental risk factors are more amenable to modification through implementation of concerted essential public health action, as has been demonstrated in several Member States;

Recognizing the importance of the proposed framework for action on diet and physical activity within the integrated prevention and control of noncommunicable diseases, including support of healthy lifestyles, facilitation of healthier environments, provision of public health services, and the major involvement of the health, nutrition and other relevant professions in improving the lifestyles and health of individuals and communities;

1. **URGES** Member States to collaborate with WHO in developing a global strategy on diet, physical activity and health for the prevention and control of noncommunicable diseases, based on evidence and best practices, with special emphasis on an integrated approach to improving diets and increasing physical activity, in order:

   (1) to promote health and reduce the common risks of chronic noncommunicable diseases that stem from poor diet and physical inactivity by essential public health action and integration of preventive measures in the functions of health services;

   (2) to encourage, as part of health sector reform, incorporation in national plans of action for nutrition as they are updated of strategies for diet, physical activity and health involving all sectors, including civil society and the food industry;

   (3) to monitor scientific data and to support research in a broad spectrum of related areas, including human genetics, nutrition and diet, matters of particular concern to women, and development of human resources for health;

2. **FURTHER URGES** Member States to celebrate a “Move for health” day each year to promote physical activity as essential for health and well-being;

3. **REQUESTS** the Director-General:

   (1) to develop a global strategy on diet, physical activity and health within the framework of the renewed WHO strategy for the prevention and control of noncommunicable diseases and, in consultation with Member States, and with the bodies of the United Nations system and professional organizations concerned, to give priority to providing support to Member States for establishment of corresponding national policies and programmes;

   (2) to support further research on effective implementation of different means leading to healthier lifestyles;

   (3) to ensure that a multidisciplinary and multisectoral approach is a governing idea of the global strategy;
(4) to ensure, while developing the strategy, an effective managerial mechanism for collaboration and technical support involving all programmes concerned at different levels of the Organization and WHO collaborating centres, emphasizing the introduction and strengthening of global and regional demonstration projects;

(5) to strengthen collaboration with other organizations of the United Nations system, and other partners, including the World Bank, international nongovernmental organizations, and the private sector for implementation of plans at global and interregional levels and to promote capacity-building at national level;

(6) to submit a progress report on integrated prevention of noncommunicable diseases to the Executive Board at its 113th session and the Fifty-seventh World Health Assembly.

(Ninth plenary meeting, 18 May 2002 – Committee B, fourth report)

WHA55.24 The need for increased representation of developing countries in the Secretariat and in Expert Advisory Panels and Committees

The Fifty-fifth World Health Assembly,

Guided by the Purposes and Principles of the Charter of the United Nations, in particular the principle of the sovereign equality of its Member States;

Reaffirming the principle of equitable participation of all Members of the Organization in its work, including that of the Secretariat and various committees and bodies;

Bearing in mind Article 35 of the Constitution;

Recalling resolution WHA4.51 adopting the Staff Regulations of the Organization and subsequent resolutions amending these regulations;

Recalling resolution WHA50.15 on recruitment of international staff in WHO: geographical representation;

Further recalling resolution WHA35.10 approving the Regulations for Expert Advisory Panels and Committees and subsequent resolutions amending these regulations;

Concerned that the developing countries are underrepresented in the Secretariat in the professional category, including at headquarters;

Also concerned at the limited representation of developing countries on expert advisory panels and committees,

1. UNDERLINES that the Secretariat of WHO is a common secretariat for all Member States and should therefore reflect the composition of its membership, the majority of which are developing countries;
2. STRESSES, in this context, adherence to the principle of equitable geographical representation and gender balance at all levels in the Secretariat, especially at headquarters, in order to improve its representative character;

3. EMPHASIZES the principles of transparency, fair selection, objectivity, competence and merit in appointments both in the Secretariat and to expert advisory panels and committees;

4. UNDERLINES that country ranges for appointments in the Secretariat should, in principle, be based on membership, equitable geographical representation, population criteria, and balance between developed and developing countries, with less emphasis on financial contributions to the Organization;

5. REQUESTS the Director-General to ensure that the principles of equitable geographical representation, gender balance and a balance of experts from developed and developing countries are respected in making appointments in the Secretariat and in establishing expert advisory panels or expert committees;

6. FURTHER REQUESTS the Director-General to consult with health authorities concerned when appointing experts to advisory panels, to circulate information on all appointments made to these panels to Member States, and to encourage developing countries to send nominations for the panels;

7. DECIDES to amend the Regulations for Expert Advisory Panels and Committees in light of this resolution, as set out in the Annex to this resolution;

8. REQUESTS the Director-General to submit a report to the Fifty-sixth World Health Assembly on implementation of this resolution, including different alternatives to the current representation formula in the Secretariat.

ANNEX

AMENDMENTS TO THE REGULATIONS FOR EXPERT ADVISORY PANELS AND COMMITTEES

Amendment to Regulation 3.1

Add at the end:

Information on all appointments made to the panels shall be circulated to all Member States. The Director-General shall encourage the developing countries to send nominations for the panels.

Amendment to Regulation 3.2

Replace the last sentence with the following:

He/she shall encourage nomination of experts from developing countries and from all regions and shall be helped in this task by Regional Directors.

Amendment to Regulation 4.2

Replace with the following:
As a general rule, the Director-General shall select from one or more expert advisory panels the members of an expert committee on the basis of the principles of equitable geographical representation, gender balance, a balance of experts from developed and developing countries, representation of different trends of thought, approaches and practical experience in various parts of the world, and an appropriate interdisciplinary balance. The membership of expert committees shall not be restricted by consideration of language, within the range of languages of the Organization.

(Ninth plenary meeting, 18 May 2002 – Committee B, third report)

**WHA55.25 Infant and young child nutrition**

The Fifty-fifth World Health Assembly,

Having considered the draft global strategy for infant and young-child feeding;¹

Deeply concerned about the vast numbers of infants and young children who are still inappropriately fed and whose nutritional status, growth and development, health and very survival are thereby compromised;

Conscious that every year as much as 55% of infant deaths from diarrhoeal disease and acute respiratory infections may be the result of inappropriate feeding practices, that less than 35% of infants worldwide are exclusively breastfed for even the first four months of life, and that complementary feeding practices are frequently ill-timed, inappropriate and unsafe;

Alarmed at the degree to which inappropriate infant and young-child feeding practices contribute to the global burden of disease, including malnutrition and its consequences such as blindness and mortality due to vitamin A deficiency, impaired psychomotor development due to iron deficiency and anaemia, irreversible brain damage as a consequence of iodine deficiency, the massive impact on morbidity and mortality of protein-energy malnutrition, and the later-life consequences of childhood obesity;

Recognizing that infant and young-child mortality can be reduced through improved nutritional status of women of reproductive age, especially during pregnancy, and by exclusive breastfeeding for the first six months of life, and with nutritionally adequate and safe complementary feeding through introduction of safe and adequate amounts of indigenous foodstuffs and local foods while breastfeeding continues up to the age of two years or beyond;

Mindful of the challenges posed by the ever-increasing number of people affected by major emergencies, the HIV/AIDS pandemic, and the complexities of modern lifestyles coupled with continued promulgation of inconsistent messages about infant and young-child feeding;

Aware that inappropriate feeding practices and their consequences are major obstacles to sustainable socioeconomic development and poverty reduction;

Reaffirming that mothers and babies form an inseparable biological and social unit, and that the health and nutrition of one cannot be divorced from the health and nutrition of the other;

¹ Annex 2.
Recalling the Health Assembly's endorsement, in their entirety, of the statement and recommendations made by the joint WHO/UNICEF Meeting on Infant and Young Child Feeding (1979) (resolution WHA33.32); its adoption of the International Code of Marketing of Breast-milk Substitutes (resolution WHA34.22), in which it stressed that adoption of and adherence to the Code were a minimum requirement; its welcoming of the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding as a basis for international health policy and action (resolution WHA44.33); its urging encouragement and support for all public and private health facilities providing maternity services so that they become “baby-friendly” (resolution WHA45.34); its urging ratification and implementation of the Convention on the Rights of the Child as a vehicle for family health development (resolution WHA46.27); and its endorsement, in their entirety, of the World Declaration and Plan of Action for Nutrition adopted by the International Conference on Nutrition (Rome, 1992) (resolution WHA46.7);

Recalling also resolutions WHA35.26, WHA37.30, WHA39.28, WHA41.11, WHA43.3, WHA45.34, WHA46.7, WHA47.5, WHA49.15 and WHA54.2 on infant and young-child nutrition, appropriate feeding practices and related questions;

Recognizing the need for comprehensive national policies on infant and young-child feeding, including guidelines on ensuring appropriate feeding of infants and young children in exceptionally difficult circumstances;

Convinced that it is time for governments to renew their commitment to protecting and promoting the optimal feeding of infants and young children,

1. **ENDORSES** the global strategy for infant and young-child feeding;

2. **EXHORTS** Member States, as a matter of urgency:

   (1) to adopt and implement the global strategy, taking into account national circumstances, while respecting positive local traditions and values, as part of their overall nutrition and child-health policies and programmes, in order to ensure optimal feeding for all infants and young children, and to reduce the risks associated with obesity and other forms of malnutrition;

   (2) to strengthen existing, or establish new, structures for implementing the global strategy through the health and other concerned sectors, for monitoring and evaluating its effectiveness, and for guiding resource investment and management to improve infant and young-child feeding;

   (3) to define for this purpose, consistent with national circumstances:

      (a) national goals and objectives,

      (b) a realistic timeline for their achievement,

      (c) measurable process and output indicators that will permit accurate monitoring and evaluation of action taken and a rapid response to identified needs;

   (4) to ensure that the introduction of micronutrient interventions and the marketing of nutritional supplements do not replace, or undermine support for the sustainable practice of, exclusive breastfeeding and optimal complementary feeding;
(5) to mobilize social and economic resources within society and to engage them actively in implementing the global strategy and in achieving its aims and objectives in the spirit of resolution WHA49.15;

3. CALLS UPON other international organizations and bodies, in particular ILO, FAO, UNICEF, UNHCR, UNFPA and UNAIDS, to give high priority, within their respective mandates and programmes and consistent with guidelines on conflict of interest, to provision of support to governments in implementing this global strategy, and invites donors to provide adequate funding for the necessary measures;

4. REQUESTS the Codex Alimentarius Commission to continue to give full consideration, within the framework of its operational mandate, to action it might take to improve the quality standards of processed foods for infants and young children and to promote their safe and proper use at an appropriate age, including through adequate labelling, consistent with the policy of WHO, in particular the International Code of Marketing of Breast-milk Substitutes, resolution WHA54.2, and other relevant resolutions of the Health Assembly;

5. REQUESTS the Director-General:

(1) to provide support to Member States, on request, in implementing this strategy, and in monitoring and evaluating its impact;

(2) to continue, in the light of the scale and frequency of major emergencies worldwide, to generate specific information and develop training materials aimed at ensuring that the feeding requirements of infants and young children in exceptionally difficult circumstances are met;

(3) to strengthen international cooperation with other organizations of the United Nations system and bilateral development agencies in promoting appropriate infant and young-child feeding;

(4) to promote continued cooperation with and among all parties concerned with implementing the global strategy.

(Ninth plenary meeting, 18 May 2002 – Committee B, fifth report)
DECISIONS

WHA55(1) Composition of the Committee on Credentials

The Fifty-fifth World Health Assembly appointed a Committee on Credentials consisting of delegates of the following 12 Member States: Cyprus, Equatorial Guinea, Estonia, Ethiopia, Fiji, Iceland, Panama, Qatar, Thailand, Togo, Turkey, Uruguay.

(First plenary meeting, 13 May 2002)

WHA55(2) Composition of the Committee on Nominations

The Fifty-fifth World Health Assembly elected a Committee on Nominations consisting of delegates of the following Member States: Angola, Canada, Central African Republic, Chile, China, Ecuador, France, Greece, Guatemala, Indonesia, Iran (Islamic Republic of), Jamaica, Kuwait, Lebanon, Malawi, Maldives, Mauritania, Russian Federation, Samoa, Seychelles, Slovakia, United Kingdom of Great Britain and Northern Ireland, Uzbekistan, Zimbabwe, and Dr Hong Sun Huot, Cambodia (President, Fifty-fourth World Health Assembly, ex officio)

(First plenary meeting, 13 May 2002)

WHA55(3) Election of officers of the Fifty-fifth World Health Assembly

The Fifty-fifth World Health Assembly, after considering the recommendations of the Committee on Nominations, elected the following officers:

President: Dr J.F. López Beltrán (El Salvador)

Vice-Presidents: Mrs J. Phumaphi (Botswana)
Professor V.F. Moskalenko (Ukraine)
Mr S.S. Bhandari (Nepal)
Mr B.R. Muaa (Kiribati)
Dr A.J.M. Suleiman (Oman)

(First plenary meeting, 13 May 2002)
WHA55(4) Election of officers of the main committees

The Fifty-fifth World Health Assembly, after considering the recommendations of the Committee on Nominations, elected the following officers of the main committees:

Committee A: Chairman Dr J. Kiely (Ireland)
Committee B: Chairman Professor A.M. Coll Seck (Senegal)

(First plenary meeting, 13 May 2002)

The main committees subsequently elected the following officers:

Committee A: Vice-Chairmen Ms D. Costa Coitinho (Brazil)
Dr S.P. Agarwal (India)
Rapporteur Dr A. Msa Mliva (Comoros)
Committee B: Vice-Chairmen Mr H. M’barek (Tunisia)
Professor Pham Manh Hung (Viet Nam)
Rapporteur Dr S. Soeparan (Indonesia)

(First meetings of Committees A and B, 14 and 15 May 2002)

WHA55(5) Establishment of the General Committee

The Fifty-fifth World Health Assembly, after considering the recommendations of the Committee on Nominations, elected the delegates of the following 17 countries as members of the General Committee: Barbados, China, Côte d’Ivoire, Cuba, Democratic People’s Republic of Korea, France, Japan, Mexico, Morocco, Russian Federation, Rwanda, Sao Tome and Principe, Sierra Leone, Spain, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, United States of America.

(First plenary meeting, 13 May 2002)

WHA55(6) Adoption of the agenda

The Fifty-fifth World Health Assembly adopted the provisional agenda prepared by the Executive Board at its 109th session with the deletion of one item and two subitems and the renaming of one item.

(Second plenary meeting, 13 May 2002)
WHA55(7) Verification of credentials

The Fifty-fifth World Health Assembly recognized the validity of the credentials of the following delegations: Afghanistan; Albania; Algeria; Andorra; Angola; Antigua and Barbuda; Argentina; Armenia; Australia; Austria; Azerbaijan; Bahamas; Bahrain; Bangladesh; Barbados; Belarus; Belgium; Belize; Benin; Bhutan; Bolivia; Bosnia and Herzegovina; Botswana; Brazil; Brunei Darussalam; Bulgaria; Burkina Faso; Burundi; Cambodia; Cameroon; Canada; Cape Verde; Central African Republic; Chad; Chile; China; Colombia; Comoros; Congo; Cook Islands; Costa Rica; Côte d’Ivoire; Croatia; Cuba; Cyprus; Czech Republic; Democratic People’s Republic of Korea; Democratic Republic of the Congo; Denmark; Djibouti;1 Dominica; Dominican Republic; Ecuador; Egypt; El Salvador; Eritrea; Estonia; Ethiopia; Fiji; Finland; France; Gabon; Gambia; Georgia; Germany; Ghana; Greece; Grenada; Guatemala; Guinea; Guinea-Bissau; Guyana; Haiti; Honduras; Hungary; Iceland; India; Indonesia; Iran (Islamic Republic of); Iraq; Ireland; Israel; Italy; Jamaica; Japan; Jordan; Kazakhstan; Kenya; Kiribati; Kuwait; Lao People’s Democratic Republic; Latvia; Lebanon; Lesotho; Liberia; Libyan Arab Jamahiriya; Lithuania; Luxembourg; Madagascar; Malawi; Malaysia; Maldives; Mali; Malta; Marshall Islands; Mauritania; Mauritius; Mexico; Micronesia (Federated States of);1 Monaco; Mongolia; Morocco; Mozambique; Myanmar; Namibia; Nepal; Netherlands; New Zealand; Nicaragua; Niger; Nigeria; Norway; Oman; Pakistan; Palau; Panama; Papua New Guinea; Paraguay; Peru; Philippines; Poland; Portugal; Qatar; Republic of Korea; Republic of Moldova; Romania; Russian Federation; Rwanda; Saint Kitts and Nevis; Saint Lucia; Saint Vincent and the Grenadines; Samoa; San Marino; Sao Tome and Principe; Saudi Arabia; Senegal; Seychelles; Sierra Leone; Singapore; Slovakia; Slovenia; Solomon Islands; Somalia; South Africa; Spain; Sri Lanka; Sudan; Swaziland; Sweden; Switzerland; Syrian Arab Republic; Tajikistan; Thailand; The former Yugoslav Republic of Macedonia; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkey; Tuvalu; Uganda; Ukraine; United Arab Emirates; United Kingdom of Great Britain and Northern Ireland; United Republic of Tanzania; United States of America; Uruguay; Uzbekistan; Vanuatu; Venezuela; Viet Nam; Yemen; Yugoslavia; Zambia; Zimbabwe.

(Fourth and eighth plenary meetings, 15 and 17 May 2002)

WHA55(8) Election of Members entitled to designate a person to serve on the Executive Board

The Fifty-fifth World Health Assembly, after considering the recommendations of the General Committee,2 elected the following as Members entitled to designate a person to serve on the Executive Board: China, Gabon, Gambia, Ghana, Guinea, Kuwait, Maldives, Russian Federation, Spain, United States of America.

(Eighth plenary meeting, 17 May 2002)

1 Credentials provisionally accepted.
2 Document A55/44.
WHA55(9) Scale of assessments 2004-2005

The Fifty-fifth World Health Assembly decided to request the Executive Board to review at its 111th session the scale of assessments for 2004-2005 and to report to the Fifty-sixth World Health Assembly with its recommendations.

(Eighth plenary meeting, 17 May 2002)

WHA55(10) United Nations Joint Staff Pension Fund: appointment of representatives to the WHO Staff Pension Committee

The Fifty-fifth World Health Assembly reappointed Mr L. Rokovada, delegate of Fiji, as member of the WHO Staff Pension Committee, and Mr M. Chakalisa, delegate of Botswana, as alternate member, the appointments being for a three-year period.

(Ninth plenary meeting, 18 May 2002)

WHA55(11) Reports of the Executive Board on its 108th and 109th sessions

The Fifty-fifth World Health Assembly, after reviewing the Executive Board’s reports on its 108th1 and 109th2 sessions, approved the reports; commended the work the Board had performed; and expressed its appreciation of the dedication with which the Board had carried out the tasks entrusted to it. It requested the President to convey the thanks of the Health Assembly in particular to those members of the Board who would be completing their terms of office immediately after closure of the Assembly.

(Ninth plenary meeting, 18 May 2002)

WHA55(12) Selection of the country in which the Fifty-sixth World Health Assembly would be held

The Fifty-fifth World Health Assembly, in accordance with Article 14 of the Constitution, decided that the Fifty-sixth World Health Assembly would be held in Switzerland.

(Ninth plenary meeting, 18 May 2002)

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ANNEXES
ANNEX 1

Amendment to the Staff Regulations

Report by the Secretariat

[A55/36 – 23 March 2002]

2. In order to ensure consistency between the Staff Regulations and the Staff Rules, and to include reference in the Staff Regulations to conditions concerning eligibility of Regional Directors for reappointment, the Executive Board also proposed an amendment to Staff Regulation 4.5.2

3. The amended text is contained in the Appendix.

Appendix

TEXT OF AMENDED STAFF REGULATION

IV. APPOINTMENT AND PROMOTION

4.5 Appointments of the Deputy Director-General, Assistant Directors-General and Regional Directors shall be for a period not to exceed five years, subject to renewal, and in accordance with conditions determined by the Executive Board concerning eligibility of Regional Directors for reappointment. Other staff members shall be granted appointments of a duration, and under such terms and conditions, consistent with these regulations, as the Director-General may prescribe.

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1 See resolution WHA55.21.
DEFINING THE CHALLENGE

1. Malnutrition has been responsible, directly or indirectly, for 60% of the 10.9 million deaths annually among children under five. Well over two-thirds of these deaths, which are often associated with inappropriate feeding practices, occur during the first year of life. No more than 35% of infants worldwide are exclusively breastfed during the first four months of life; complementary feeding frequently begins too early or too late, and foods are often nutritionally inadequate and unsafe. Malnourished children who survive are more frequently sick and suffer the life-long consequences of impaired development. Rising incidences of overweight and obesity in children are also a matter of serious concern. Because poor feeding practices are a major threat to social and economic development, they are among the most serious obstacles to attaining and maintaining health that face this age group.

2. The health and nutritional status of mothers and children are intimately linked. Improved infant and young child feeding begins with ensuring the health and nutritional status of women, in their own right, throughout all stages of life and continues with women as providers for their children and families. Mothers and infants form a biological and social unit; they also share problems of malnutrition and ill-health. Whatever is done to solve these problems concerns both mothers and children together.

3. The global strategy for infant and young child feeding is based on respect, protection, facilitation and fulfilment of accepted human rights principles. Nutrition is a crucial, universally recognized component of the child’s right to the enjoyment of the highest attainable standard of health as stated in the Convention on the Rights of the Child. Children have the right to adequate nutrition and access to safe and nutritious food, and both are essential for fulfilling their right to the highest attainable standard of health. Women, in turn, have the right to proper nutrition, to decide how to feed their children, and to full information and appropriate conditions that will enable them to carry out their decisions. These rights are not yet realized in many environments.

4. Rapid social and economic change only intensifies the difficulties that families face in properly feeding and caring for their children. Expanding urbanization results in more families that depend on informal or intermittent employment with uncertain incomes and few or no maternity benefits. Both self-employed and nominally employed rural women face heavy workloads, usually with no maternity protection. Meanwhile, traditional family and community support structures are being eroded, resources devoted to supporting health- and, especially, nutrition-related, services are dwindling, accurate information on optimal feeding practices is lacking, and the number of food-insecure rural and urban households is on the rise.

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1 See resolution WHA55.25.
5. The HIV pandemic and the risk of mother-to-child transmission of HIV through breastfeeding pose unique challenges to the promotion of breastfeeding, even among unaffected families. Complex emergencies, which are often characterized by population displacement, food insecurity and armed conflict, are increasing in number and intensity, further compromising the care and feeding of infants and young children the world over. Refugees and internally displaced persons alone currently number more than 40 million, including 5.5 million under-five children.

DETERMINING THE AIM AND OBJECTIVES

6. The aim of this strategy is to improve – through optimal feeding – the nutritional status, growth and development, health, and thus the survival of infants and young children.

7. The strategy's specific objectives are:
   • to raise awareness of the main problems affecting infant and young child feeding, identify approaches to their solution, and provide a framework of essential interventions;
   • to increase the commitment of governments, international organizations and other concerned parties\(^1\) for optimal feeding practices for infants and young children;
   • to create an environment that will enable mothers, families and other caregivers in all circumstances to make – and implement – informed choices about optimal feeding practices for infants and young children.

8. The strategy is intended as a guide for action; it is based on accumulated evidence of the significance of the early months and years of life for child growth and development and it identifies interventions with a proven positive impact during this period. Moreover to remain dynamic, successful strategy implementation will rely on keeping pace with developments, while new clinical and population-based research is stimulated and behavioural concerns are investigated.

9. No single intervention or group can succeed in meeting the challenge; implementing the strategy thus calls for increased political will, public investment, awareness among health workers, involvement of families and communities, and collaboration between governments, international organizations and other concerned parties that will ultimately ensure that all necessary action is taken.

PROMOTING APPROPRIATE FEEDING FOR INFANTS AND YOUNG CHILDREN

10. Breastfeeding is an unequalled way of providing ideal food for the healthy growth and development of infants; it is also an integral part of the reproductive process with important implications for the health of mothers. As a global public health recommendation, infants should be exclusively breastfed for the first six months of life to achieve optimal growth, development and

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\(^1\) For the purposes of this strategy, other concerned parties include professional bodies, training institutions, industrial and commercial enterprises and their associations, nongovernmental organizations whether or not formally registered, religious and charitable organizations and citizens' associations such as community-based breastfeeding support networks and consumer groups.
health.\(^1\) Thereafter, to meet their evolving nutritional requirements, infants should receive nutritionally adequate and safe complementary foods while breastfeeding continues for up to two years of age or beyond. Exclusive breastfeeding from birth is possible except for a few medical conditions, and unrestricted exclusive breastfeeding results in ample milk production.

11. Even though it is a natural act, breastfeeding is also a learned behaviour. Virtually all mothers can breastfeed provided they have accurate information, and support within their families and communities and from the health care system. They should also have access to skilled practical help from, for example, trained health workers, lay and peer counsellors, and certified lactation consultants, who can help to build mothers' confidence, improve feeding technique, and prevent or resolve breastfeeding problems.

12. Women in paid employment can be helped to continue breastfeeding by being provided with minimum enabling conditions, for example paid maternity leave, part-time work arrangements, on-site crèches, facilities for expressing and storing breast milk, and breastfeeding breaks (see paragraph 28).

13. Infants are particularly vulnerable during the transition period when complementary feeding begins. Ensuring that their nutritional needs are met thus requires that complementary foods be:

- **timely** – meaning that they are introduced when the need for energy and nutrients exceeds what can be provided through exclusive and frequent breastfeeding;

- **adequate** – meaning that they provide sufficient energy, protein and micronutrients to meet a growing child's nutritional needs;

- **safe** – meaning that they are hygienically stored and prepared, and fed with clean hands using clean utensils and not bottles and teats;

- **properly fed** – meaning that they are given consistent with a child's signals of appetite and satiety, and that meal frequency and feeding method – actively encouraging the child, even during illness to consume sufficient food using fingers, spoon or self-feeding – are suitable for age.

14. Appropriate complementary feeding depends on accurate *information* and skilled support from the family, community and health care system. Inadequate knowledge about appropriate foods and feeding practices is often a greater determinant of malnutrition than the lack of food. Moreover, diversified approaches are required to ensure access to foods that will adequately meet energy and nutrient needs of growing children, for example use of home- and community-based technologies to enhance nutrient density, bioavailability and the micronutrient content of local foods.

15. Providing sound and culture-specific nutrition counselling to mothers of young children and recommending the widest possible use of indigenous foodstuffs will help ensure that *local foods* are prepared and fed safely in the home. The agriculture sector has a particularly important role to play in ensuring that suitable foods for use in complementary feeding are produced, readily available and affordable.

\(^1\) As formulated in the conclusions and recommendations of the expert consultation (Geneva, 28-30 March 2001) that completed the systematic review of the optimal duration of exclusive breastfeeding (see document A54/INF.DOC./4). See also resolution WHA54.2.
16. In addition, *low-cost complementary foods*, prepared with locally available ingredients using suitable small-scale production technologies in community settings, can help to meet the nutritional needs of older infants and young children. *Industrially processed complementary foods* also provide an option for some mothers who have the means to buy them and the knowledge and facilities to prepare and feed them safely. Processed-food products for infants and young children should, when sold or otherwise distributed, meet applicable standards recommended by the Codex Alimentarius Commission and also the Codex Code of Hygienic Practice for Foods for Infants and Children.

17. *Food fortification* and universal or targeted *nutrient supplementation* may also help to ensure that older infants and young children receive adequate amounts of micronutrients.

**EXERCISING OTHER FEEDING OPTIONS**

18. The vast majority of mothers can and should breastfeed, just as the vast majority of infants can and should be breastfed. Only under exceptional circumstances can a mother’s milk be considered unsuitable for her infant. For those few health situations where infants cannot, or should not, be breastfed, the choice of the best alternative – expressed breast milk from an infant’s own mother, breast milk from a healthy wet-nurse or a human-milk bank, or a breast-milk substitute fed with a cup, which is a safer method than a feeding bottle and teat – depends on individual circumstances.

19. For infants who do not receive breast milk, feeding with a suitable breast-milk substitute – for example an infant formula prepared in accordance with applicable Codex Alimentarius standards, or a home-prepared formula with micronutrient supplements – should be demonstrated only by health workers, or other community workers if necessary, and only to the mothers and other family members who need to use it; and the information given should include adequate instructions for appropriate preparation and the health hazards of inappropriate preparation and use. Infants who are not breastfed, for whatever reason, should receive special attention from the health and social welfare system since they constitute a risk group.

**FEEDING IN EXCEPTIONALLY DIFFICULT CIRCUMSTANCES**

20. Families in *difficult situations* require special attention and practical support to be able to feed their children adequately. In such cases the likelihood of not breastfeeding increases, as do the dangers of artificial feeding and inappropriate complementary feeding. Wherever possible, mothers and babies should remain together and be provided the support they need to exercise the most appropriate feeding option under the circumstances.

21. Infants and young children who are *malnourished* are most often found in environments where improving the quality and quantity of food intake is particularly problematic. To prevent a recurrence and to overcome the effects of chronic malnutrition, these children need extra attention both during the early rehabilitation phase and over the longer term. Nutritionally adequate and safe complementary foods may be particularly difficult to obtain and dietary supplements may be required for these children. Continued frequent breastfeeding and, when necessary, relactation are important preventive steps since malnutrition often has its origin in inadequate or disrupted breastfeeding.

22. The proportion of infants with *low birth weight* varies from 6% to more than 28% depending on the setting. Most are born at or near term and can breastfeed within the first hour after birth. Breast milk is particularly important for preterm infants and the small proportion of term infants with very low birth weight; they are at increased risk of infection, long-term ill-health and death.
23. Infants and children are among the most vulnerable victims of natural or human-induced emergencies. Interrupted breastfeeding and inappropriate complementary feeding heighten the risk of malnutrition, illness and mortality. Uncontrolled distribution of breast-milk substitutes, for example in refugee settings, can lead to early and unnecessary cessation of breastfeeding. For the vast majority of infants emphasis should be on protecting, promoting and supporting breastfeeding and ensuring timely, safe and appropriate complementary feeding. There will always be a small number of infants who have to be fed on breast-milk substitutes. Suitable substitutes, procured, distributed and fed safely as part of the regular inventory of foods and medicines, should be provided.

24. An estimated 1.6 million children are born to HIV-infected women each year, mainly in low-income countries. The absolute risk of HIV transmission through breastfeeding for more than one year – globally between 10% and 20% – needs to be balanced against the increased risk of morbidity and mortality when infants are not breastfed. All HIV-infected mothers should receive counselling, which includes provision of general information about meeting their own nutritional requirements and about the risks and benefits of various feeding options, and specific guidance in selecting the option most likely to be suitable for their situation. Adequate replacement feeding is needed for infants born to HIV-positive mothers who choose not to breastfeed. It requires a suitable breast-milk substitute, for example an infant formula prepared in accordance with applicable Codex Alimentarius standards, or a home-prepared formula with micronutrient supplements. Heat-treated breast milk, or breast milk provided by an HIV-negative donor mother, may be an option in some cases. To reduce the risk of interfering with the promotion of breastfeeding for the great majority, providing a breast-milk substitute for these infants should be consistent with the principles and aim of the International Code of Marketing of Breast-milk Substitutes (see paragraph 19). For mothers who test negative for HIV, or who are untested, exclusive breastfeeding remains the recommended feeding option (see paragraph 10).

25. Children living in special circumstances also require extra attention – for example, orphans and children in foster care, and children born to adolescent mothers, mothers suffering from physical or mental disabilities, drug- or alcohol-dependence, or mothers who are imprisoned or part of disadvantaged or otherwise marginalized populations.

IMPROVING FEEDING PRACTICES

26. Mothers, fathers and other caregivers should have access to objective, consistent and complete information about appropriate feeding practices, free from commercial influence. In particular, they need to know about the recommended period of exclusive and continued breastfeeding; the timing of the introduction of complementary foods; what types of food to give, how much and how often; and how to feed these foods safely.

27. Mothers should have access to skilled support to help them initiate and sustain appropriate feeding practices, and to prevent difficulties and overcome them when they occur. Knowledgeable health workers are well placed to provide this support, which should be a routine part not only of regular prenatal, delivery and postnatal care but also of services provided for the well baby and sick child. Community-based networks offering mother-to-mother support, and trained breastfeeding counsellors working within, or closely with, the health care system, also have an important role to play in this regard. Where fathers are concerned, research shows that breastfeeding is enhanced by the support and companionship they provide as family providers and caregivers.

28. Mothers should also be able to continue breastfeeding and caring for their children after they return to paid employment. This can be accomplished by implementing maternity protection legislation and related measures consistent with ILO Maternity Protection Convention, 2000 No. 183
and Maternity Protection Recommendation, 2000 No. 191. Maternity leave, day-care facilities and paid breastfeeding breaks should be available for all women employed outside the home.


ACHIEVING THE STRATEGY’S OBJECTIVES

30. A first step to achieving the objectives of this strategy is to reaffirm the relevance – indeed the urgency – of the four operational targets of the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding:

1. appointing a national breastfeeding coordinator with appropriate authority, and establishing a multisectoral national breastfeeding committee composed of representatives from relevant government departments, nongovernmental organizations, and health professional associations;

2. ensuring that every facility providing maternity services fully practices all the “Ten steps to successful breastfeeding” set out in the WHO/UNICEF statement on breastfeeding and maternity services;

3. giving effect to the principles and aim of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant Health Assembly resolutions in their entirety;

4. enacting imaginative legislation protecting the breastfeeding rights of working women and establishing means for its enforcement.

31. Many governments have taken important steps towards realizing these targets and much has been achieved as a result, notably through the Baby-friendly Hospital Initiative and the legislation and other measures that have been adopted with regard to the marketing of breast-milk substitutes. Achievements are far from uniform, however, and there are signs of weakened commitment, for example in the face of the HIV/AIDS pandemic and the number and gravity of complex emergencies affecting infants and young children. Moreover, the Innocenti Declaration focuses uniquely on breastfeeding. Thus, additional targets are needed to reflect a comprehensive approach to meeting care and feeding requirements during the first three years of life through a wide range of interrelated actions.

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1 Meeting in Florence, Italy, in July 1990, government policy-makers from more than 30 countries adopted the Innocenti Declaration. The Forty-fourth World Health Assembly, in 1991, welcomed the Declaration as “a basis for international health policy and action” and requested the Director-General to monitor achievement of its targets (resolution WHA44.33).

32. In the light of accumulated scientific evidence, and policy and programme experience, the time is right for governments, with the support of international organizations and other concerned parties:

- to reconsider how best to ensure the appropriate feeding of infants and young children and to renew their collective commitment to meeting this challenge;

- to constitute effective broad-based bodies to lead the implementation of this strategy as a coordinated multisectoral national response by all concerned parties to the multiple challenges of infant and young child feeding; and

- to establish a system to monitor regularly feeding practices, assess trends using sex-disaggregated data and evaluate the impact of interventions.

33. With these considerations in mind, the global strategy includes as a priority for all governments the achievement of the following additional operational targets:

- to develop, implement, monitor and evaluate a comprehensive policy on infant and young child feeding, in the context of national policies and programmes for nutrition, child and reproductive health, and poverty reduction;

- to ensure that the health and other relevant sectors protect, promote and support exclusive breastfeeding for six months and continued breastfeeding up to two years of age or beyond, while providing women access to the support they require — in the family, community and workplace — to achieve this goal;

- to promote timely, adequate, safe and appropriate complementary feeding with continued breastfeeding;

- to provide guidance on feeding infants and young children in exceptionally difficult circumstances, and on the related support required by mothers, families and other caregivers;

- to consider what new legislation or other suitable measures may be required, as part of a comprehensive policy on infant and young child feeding, to give effect to the principles and aim of the International Code of Marketing of Breast-milk Substitutes and to subsequent relevant Health Assembly resolutions.

IMPLEMENTING HIGH-PRIORITY ACTION

34. A comprehensive national policy, based on a thorough needs assessment, should foster an environment that protects, promotes and supports appropriate infant and young child feeding practices. An effective feeding policy consistent with efforts to promote overall household food security requires the following critical interventions:

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1 Consistent with the first target of the Innocenti Declaration, more than 100 countries have already appointed a national breastfeeding coordinator and established a multisectoral national committee. These arrangements could form the basis for the creation of the new body called for here.

2 Governments should set a realistic date for achievement of all the global strategy's targets and define measurable indicators to assess their progress in this regard.
For protection

- adopting and monitoring application of a policy of maternity entitlements, consistent with the ILO Maternity Protection Convention and Recommendation, in order to facilitate breastfeeding by women in paid employment, including those whom the standards describe as engaging in atypical forms of dependent work, for example part-time, domestic and intermittent employment;

- ensuring that processed complementary foods are marketed for use at an appropriate age, and that they are safe, culturally acceptable, affordable and nutritionally adequate, in accordance with relevant Codex Alimentarius standards;

- implementing and monitoring existing measures to give effect to the International Code of Marketing of Breast-milk Substitutes and to subsequent relevant Health Assembly resolutions, and, where appropriate, strengthening them or adopting new measures;

For promotion

- ensuring that all who are responsible for communicating with the general public, including educational and media authorities, provide accurate and complete information about appropriate infant and young child feeding practices, taking into account prevailing social, cultural and environmental circumstances;

For support through the health care system

- providing skilled counselling and help for infant and young child feeding, for instance at well-baby clinics, during immunization sessions, and in in- and out-patient services for sick children, nutrition services, and reproductive health and maternity services;

- ensuring that hospital routines and procedures remain fully supportive of the successful initiation and establishment of breastfeeding through implementation of the Baby-friendly Hospital Initiative, monitoring and reassessing already designated facilities, and expanding the Initiative to include clinics, health centres and paediatric hospitals;

- increasing access to antenatal care and education about breastfeeding, to delivery practices which support breastfeeding and to follow-up care which help to ensure continued breastfeeding;

- promoting good nutrition for pregnant and lactating women;

- monitoring the growth and development of infants and young children as a routine nutrition intervention, with particular attention to low-birth-weight and sick infants and those born to HIV-positive mothers, and ensuring that mothers and families receive appropriate counselling;

- providing guidance on appropriate complementary feeding with emphasis on the use of suitable locally available foods which are prepared and fed safely;

- promoting adequate intake of essential nutrients through access to suitable – including fortified – local foods and, when necessary, micronutrient supplements;
• enabling mothers to remain with their hospitalized children to ensure continued breastfeeding and adequate complementary feeding and, where feasible, allow breastfed children to stay with their hospitalized mothers;

• ensuring effective therapeutic feeding of sick and malnourished children, including the provision of skilled breastfeeding support when required;

• training health workers who care for mothers, children and families with regard to:
  - counselling and assistance skills needed for breastfeeding, complementary feeding, HIV and infant feeding and, when necessary, feeding with a breast-milk substitute,
  - feeding during illness,
  - health workers' responsibilities under the International Code of Marketing of Breast-milk Substitutes;

• revising and reforming pre-service curricula for all health workers, nutritionists and allied professionals to provide appropriate information and advice on infant and young child feeding for use by families and those involved in the field of infant and young child nutrition;

For support in the community

• promoting development of community-based support networks to help ensure appropriate infant and young child feeding, for example mother-to-mother support groups and peer or lay counsellors, to which hospitals and clinics can refer mothers on discharge;

• ensuring that community-based support networks not only are welcome within the health care system but also participate actively in the planning and provision of services;

For support for feeding infants and young children in exceptionally difficult circumstances

• ensuring that health workers have accurate and up-to-date information about infant feeding policies and practices, and that they have the specific knowledge and skills required to support caregivers and children in all aspects of infant and young child feeding in exceptionally difficult circumstances;

• creating conditions that will facilitate exclusive breastfeeding, by provision, for example, of appropriate maternity care, extra food rations and drinking-water for pregnant and lactating women, and staff who have breastfeeding counselling skills;

• ensuring that suitable - preferably locally available - complementary foods are selected and fed, consistent with the age and nutritional needs of older infants and young children;

• searching actively for malnourished infants and young children so that their condition can be identified and treated, they can be appropriately fed, and their caregivers can be supported;

• giving guidance for identifying infants who have to be fed on breast-milk substitutes, ensuring that a suitable substitute is provided and fed safely for as long as needed by the infants concerned, and preventing any "spillover effect" of artificial feeding into the general population;
• ensuring that health workers with knowledge and experience in all aspects of breastfeeding and replacement feeding are available to counsel HIV-positive women;

• adapting the Baby-friendly Hospital Initiative by taking account of HIV/AIDS and by ensuring that those responsible for emergency preparedness are well trained to support appropriate feeding practices consistent with the Initiative's universal principles;

• ensuring that whenever breast-milk substitutes are required for social or medical reasons, for example for orphans or in the case of HIV-positive mothers, they are provided for as long as the infants concerned need them.

OBLIGATIONS AND RESPONSIBILITIES

35. Governments, international organizations and other concerned parties share responsibility for ensuring the fulfilment of the right of children to the highest attainable standard of health and the right of women to full and unbiased information, and adequate health care and nutrition. Each partner should acknowledge and embrace its responsibilities for improving the feeding of infants and young children and for mobilizing required resources. All partners should work together to achieve fully this strategy’s aim and objectives, including by forming fully transparent innovative alliances and partnerships consistent with accepted principles for avoiding conflict of interest.

Governments

36. The primary obligation of governments is to formulate, implement, monitor and evaluate a comprehensive national policy on infant and young child feeding. In addition to political commitment at the highest level, a successful policy depends on effective national coordination to ensure full collaboration of all concerned government agencies, international organizations and other concerned parties. This implies continual collection and evaluation of relevant information on feeding policies and practices. Regional and local governments also have an important role to play in implementing this strategy.

37. A detailed action plan should accompany the comprehensive policy, including defined goals and objectives, a timeline for their achievement, allocation of responsibilities for the plan's implementation and measurable indicators for its monitoring and evaluation. For this purpose, governments should seek, when appropriate, the cooperation of appropriate international organizations and other agencies, including global and regional lending institutions. The plan should be compatible with, and form an integral part of, all other activities designed to contribute to optimal infant and young child nutrition.

38. Adequate resources – human, financial and organizational – will have to be identified and allocated to ensure the plan’s timely successful implementation. Constructive dialogue and active collaboration with appropriate groups working for the protection, promotion and support of appropriate feeding practices will be particularly important in this connection. Support for epidemiological and operational research is also a crucial component.

Other concerned parties

39. Identifying specific responsibilities within society – crucial complementary and mutually reinforcing roles – for protecting, promoting and supporting appropriate feeding practices is something of a new departure. Groups that have an important role in advocating the rights of women and children
and in creating a supportive environment on their behalf can work singly, together and with governments and international organizations to improve the situation by helping to remove both cultural and practical barriers to appropriate infant and young child feeding practices.

**Health professional bodies**

40. Health professional bodies, which include medical faculties, schools of public health, public and private institutions for training health workers (including midwives, nurses, nutritionists and dietitians), and professional associations, should have the following main responsibilities towards their students or membership:

- ensuring that basic education and training for all health workers cover lactation physiology, exclusive and continued breastfeeding, complementary feeding, feeding in difficult circumstances, meeting the nutritional needs of infants who have to be fed on breast-milk substitutes, and the International Code of Marketing of Breast-milk Substitutes and the legislation and other measures adopted to give effect to it and to subsequent relevant Health Assembly resolutions;

- training in how to provide skilled support for exclusive and continued breastfeeding, and appropriate complementary feeding in all neonatal, paediatric, reproductive health, nutritional and community health services;

- promoting achievement and maintenance of “baby-friendly” status by maternity hospitals, wards and clinics, consistent with the “Ten steps to successful breastfeeding”\(^1\) and the principle of not accepting free or low-cost supplies of breast-milk substitutes, feeding bottles and teats;

- observing, in their entirety, their responsibilities under the International Code of Marketing of Breast-milk Substitutes and subsequent relevant Health Assembly resolutions, and national measures adopted to give effect to both;

- encouraging the establishment and recognition of community support groups and referring mothers to them.

**Nongovernmental organizations including community-based support groups**

41. The aims and objectives of a wide variety of nongovernmental organizations operating locally, nationally and internationally include promoting the adequate food and nutrition needs of young children and families. For example, charitable and religious organizations, consumer associations, mother-to-mother support groups, family clubs, and child-care cooperatives all have multiple opportunities to contribute to the implementation of this strategy through, for example:

- providing their members accurate, up-to-date information about infant and young child feeding;

- integrating skilled support for infant and young child feeding in community-based interventions and ensuring effective linkages with the health care system;

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• contributing to the creation of mother- and child-friendly communities and workplaces that routinely support appropriate infant and young child feeding;

• working for full implementation of the principles and aim of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant Health Assembly resolutions.

42. Parents and other caregivers are most directly responsible for feeding children. Ever keen to ensure that they have accurate information to make appropriate feeding choices, parents nevertheless are limited by their immediate environment. Since they may have only infrequent contact with the health care system during a child's first two years of life, it is not unusual for caregivers to be more influenced by community attitudes than by the advice of health workers.

43. Additional sources of information and support are found in a variety of formal and informal groups, including breastfeeding-support and child-care networks, clubs and religious associations. Community-based support, including that provided by other mothers, lay and peer breastfeeding counsellors and certified lactation consultants, can effectively enable women to feed their children appropriately. Most communities have self-help traditions that could readily serve as a base for building or expanding suitable support systems to help families in this regard.

Commercial enterprises

44. Manufacturers and distributors of industrially processed foods intended for infants and young children also have a constructive role to play in achieving the aim of this strategy. They should ensure that processed food products for infants and children, when sold, meet applicable Codex Alimentarius standards and the Codex Code of Hygienic Practice for Foods for Infants and Children. In addition, all manufacturers and distributors of products within the scope of the International Code of Marketing of Breast-milk Substitutes, including feeding bottles and teats, are responsible for monitoring their marketing practices according to the principles and aim of the Code. They should ensure that their conduct at every level conforms to the Code, subsequent relevant Health Assembly resolutions, and national measures that have been adopted to give effect to both.

The social partners

45. Employers should ensure that maternity entitlements of all women in paid employment are met, including breastfeeding breaks or other workplace arrangements – for example facilities for expressing and storing breast milk for later feeding by a caregiver – in order to facilitate breast-milk feeding once paid maternity leave is over. Trade unions have a direct role in negotiating adequate maternity entitlements and security of employment for women of reproductive age (see paragraphs 28 and 34).

Other groups

46. Many other components of society have potentially influential roles in promoting good feeding practices. These elements include:

• education authorities, which help to shape the attitudes of children and adolescents about infant and young child feeding – accurate information should be provided through schools and other educational channels to promote greater awareness and positive perceptions;

• mass media, which influence popular attitudes towards parenting, child care and products within the scope of the International Code of Marketing of Breast-milk Substitutes – their information on the subject and, just as important, the way they portray parenting, childcare
and products should be accurate, up to date, objective, and consistent with the Code’s principles and aim;

- **child-care facilities**, which permit working mothers to care for their infants and young children, should support and facilitate continued breastfeeding and breast-milk feeding.

**International organizations**

47. International organizations, including global and regional lending institutions, should place infant and young child feeding high on the global public health agenda in recognition of its central significance for realizing the rights of children and women; they should serve as advocates for increased human, financial and institutional resources for the universal implementation of this strategy; and, to the extent possible, they should provide additional resources for this purpose.

48. Specific contributions of international organizations to facilitate the work of governments include the following:

*Developing norms and standards*

- developing evidence-based guidelines to facilitate achievement of the strategy’s operational targets;

- supporting epidemiological and operational research;

- promoting the consistent use of common global indicators for monitoring and evaluating child-feeding trends;

- developing new indicators, for example concerning adequate complementary feeding;

- improving the quality and availability of sex-disaggregated global, regional and national data;

*Supporting national capacity-building*

- sensitizing and training health policy-makers and health service administrators;

- improving health worker skills in support of optimal infant and young child feeding;

- revising related pre-service curricula for doctors, nurses, midwives, nutritionists, dietitians, auxiliary health workers and other groups as necessary;

- planning and monitoring the Baby-friendly Hospital Initiative and expanding it beyond the maternity-care setting;

- helping to ensure sufficient resources for this purpose, especially in highly indebted countries;
Supporting policy development and promotion

- supporting social-mobilization activities, for example using the mass media to promote appropriate infant feeding practices and educating media representatives;

- advocating ratification of ILO Maternity Protection Convention 2000 No. 183 and application of Recommendation 2000 No. 191, including for women in atypical forms of dependent work;

- urging implementation of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant Health Assembly resolutions, and providing related technical support on request;

- ensuring that all Codex Alimentarius standards and related texts dealing with foods for infants and young children give full consideration to WHO policy concerning appropriate marketing and distribution, recommended age of use, and safe preparation and feeding, including as reflected in the International Code of Marketing of Breast-milk Substitutes and subsequent relevant Health Assembly resolutions;

- ensuring that the International Code of Marketing of Breast-milk Substitutes and subsequent relevant Health Assembly resolutions are given full consideration in trade policies and negotiations;

- supporting research on marketing practices and the International Code.

CONCLUSION

49. This strategy describes essential interventions to protect, promote and support appropriate infant and young child feeding. It focuses on the importance of investing in this crucial area to ensure that children develop to their full potential, free from the adverse consequences of compromised nutritional status and preventable illnesses. It concentrates on the roles of critical partners – governments, international organizations and other concerned parties – and assigns specific responsibilities for each to ensure that the sum of their collective action will contribute to the full attainment of the strategy’s aim and objectives. It builds on existing approaches, extended where necessary, and provides a framework for linking synergistically the contributions of multiple programme areas, including nutrition, child health and development, and maternal and reproductive health. The strategy now needs to be translated into action.

50. There is convincing evidence from around the world that governments, with the support of the international community and other concerned parties, are taking seriously their commitments to protect and promote the health and nutritional well-being of infants, young children, and pregnant and lactating women. One of the enduring tangible results of the International Conference on Nutrition, namely the World Declaration on Nutrition, offers a challenging vision of a world transformed. Meanwhile, its Plan of Action for Nutrition charts a credible course for achieving this transformation.

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1 Document A55/14.

51. In the decade since its adoption, 159 Member States (83%) have demonstrated their determination to act by preparing or strengthening their national nutrition policies and plans. More than half (59%) have included specific strategies to improve infant and young child feeding practices. This encouraging result needs to be consolidated, and expanded to include all Member States, even as it is reviewed and updated to ensure that it takes full account of the present comprehensive agenda. Clearly, however, much more is required if the aim and objectives of this strategy – and present and future feeding challenges – are to be met.

52. This global strategy provides governments and society’s other main agents with both a valuable opportunity and a practical instrument for rededicating themselves, individually and collectively, to protecting, promoting and supporting safe and adequate feeding for infants and young children everywhere.