

Water, Sanitation, and Health Advisory Group, South-East Asia Region

*Report of the First Meeting
New Delhi, 6-8 May 2002*

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ACRONYMS USED

ADB – Asian Development Bank
AIT – Asian Institute of Technology
ASEAN – Association of Southeast Asian Nations
CAH - Child and Adolescent Health
CEHA - Centre for Environmental Health Activities
CEPIS – Centro Panamericano de Ingeniería Sanitaria (PAHO)
DALY – Disability Adjusted Life Years
DANIDA – Danish International Development Assistance
GPE – Global Programme Evidence for Health Policy
HDI – Human Development Index
HLTF – High Level Task Force on Intercountry Cooperation
HPE – Health Promotion and Education
IMCI – Integrated Management of Childhood Illness
NEERI – National Environmental Engineering Research Institute
NGOs – Nongovernmental Organizations
PHE – Protection of Human Environment
PRSP – Poverty Reduction Strategy Paper
PSI – Population Services International
SAARC – South Asia Association for Regional Cooperation
SDE – Sustainable Development and Healthy Environments
SEAR – South-East Asia Region
SEARO – South-East Asia Regional Office
SHP – Sustainable Health Policy

STP- Short Term Professional

NHD – Nutrition for Health and Development and Food Safety

UN – United Nations

UNDP – United Nations Development Programme

UNICEF – United Nations Children Fund

USAID – United States Agency for International Development

UWSS – Urban Water System Surveillance

WB-WSP – World Bank, Water and Sanitation Programme

WHO – World Health Organization

WHO-HQ – World Health Organization - Headquarters

WSH – Water, Sanitation and Health

WSHAG – Water, Sanitation and Health Advisory Group

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1. INTRODUCTION

The first meeting of the Water, Sanitation, and Health Advisory Group, South-East Asia Region, was held from 6 -8 May 2002. The objectives were:

- (1) To establish the Water, Sanitation and Health Advisory Group (WSHAG) for the South -East Asia Region, and
- (2) To make recommendations for the development of the Water, Sanitation, and Health Programme in SEAR at the regional and country levels.

The meeting stressed the importance of safe water, sanitation, and hygiene in reducing the incidence of diarrhoeal diseases and other illnesses related to water, sanitation and hygiene. Improvements in water supply and sanitation are crucial to the process of social and economic development.

The list of participants is at Annex 1.

2. INAUGURATION

Dr Uton Muchtar Rafei, Regional Director of the WHO South-East Asia Regional Office (SEARO) inaugurated the meeting. He outlined the progress made in water and sanitation in the Region from 1990 to 2000, but stressed that additional investments and policy reforms are needed to increase coverage and access to services, to improve efficiency of the sector, and to optimize health benefits. The WSHAG, a group of experts representing different stakeholders, was formed to make recommendations for programme development and to support the Regional Office in mobilizing resources for programmes. For the goal of universal water and sanitation coverage in the Region to be realized by 2025, an investment of US\$2 to 10 billion per year will be required depending on the technologies used. Health authorities should advocate increased investment in the water and sanitation sector, particularly considering that the benefits of such investment accrue to the health sector while the costs are borne by urban and rural development authorities, municipal governments, and other local authorities.

The Regional Director outlined a number of approaches to achieve the year 2025 goal, including the use of innovative, low cost technologies, community development, more applied research, the establishment of interagency coordination mechanisms, and behaviour change intervention strategies, such as social marketing. He expressed his certainty that the WSHAG will have many other suggestions and looked forward to the results of this meeting.

The objectives, agenda, and programme were approved with the reservation that the WSHAG should focus on regional issues in the first meeting, and turn its attention to national issues in the future.

Prof K J Nath was appointed Chairman of the Meeting, and Dr Hening Darpito, Co-Chairman. Dr Robert Quick was named Rapporteur.

3. BACKGROUND

Mr Guy Howard presented WSHAG organizational issues. The objectives of the WSHAG are to advise the SEA Region on policy and programme priorities, country and regional support, and collaborative opportunities. In addition, the WSHAG should facilitate collaboration at regional and national levels and help ensure that water, sanitation, and hygiene remain priorities of the SEA Region.

The terms of reference of WSHAG include:

- (1) To conduct a situation review;
- (2) To make recommendations for policy and action plans at the regional and national levels;
- (3) To identify knowledge and information gaps and strategies to meet these;
- (4) To make recommendations for WHO support to countries;
- (5) To identify potential partnerships, and
- (6) To develop benchmarks for monitoring progress.

The composition of WSHAG includes a small number of regional and extraregional experts drawn from the water and sanitation and the health sectors. It is believed that the interdisciplinary nature of WSHAG should aid the effectiveness of its work. The members were nominated by the Director, Sustainable Development and Healthy Environments and appointed by the Regional Director, WHO South-East Asia Regional Office.

WSHAG will have annual meetings rotating among SEAR countries, each member having a term of office of 2-3 years, and a rotating chair for the meetings. The future establishment of links to country level interagency groups is felt to be very important, with the use of existing groups, wherever possible. The WHO Representatives in country offices may facilitate these links.

A number of potential indicators to measure the effectiveness of WSHAG were suggested. These include the following: whether the most pressing water, sanitation and health needs are being addressed; linkages to national committees; dissemination of WSHAG recommendations at the national level; actions taken and resources made available at the national level to meet recommendations; the effect of WSHAG on improved national coordination in WSH; the influence of WSHAG recommendations on policy and best practices; acceptance and actions taken on capacity building recommendations; ongoing monitoring and assessment activities at the country level; identification of priority research needs and strategies developed to meet them; identification of priority regional advocacy and communication initiatives; access to water and sanitation infrastructure; and quality of service (i.e., determined through use levels, reliability of service, cost, and simple observational measures of quality).

Several issues emerged in the ensuing discussion on the organization of WSHAG.

Firstly, a suggestion was raised for WSHAG to consider not only regional aspects, but to link itself with similar work that is occurring internationally, for example WHO's current global initiative for the development of water and sanitation indicators. Other initiatives may also have already developed indicators that could be useful to WSHAG.

Secondly, the point was made that it is important to consider human resource and budgetary limitations facing the WSH programme in the

Regional Office. Several recommendations were made for balancing resource constraints and needs. It was recommended that means to overcome political obstacles to developing water, sanitation and health programmes be considered and strategic partnerships developed. Concern was raised about the operative capacity of the Regional Office in the WSH area of work, and a recommendation was made to take greater advantage of WHO Collaborating Centres, research institutions, and universities to strengthen it.

Thirdly, the meeting requested that the Regional Office officially inform the governments of its Member Countries about the formation of the WSHAG and its membership.

4. LINKAGES BETWEEN THE SEAR WATER, SANITATION AND HEALTH ADVISORY GROUP AND WHO'S GLOBAL STRATEGY

Mr Jose Hueb made a presentation on the WHO Global Strategy on Water, Sanitation and Health. He reviewed the health hazards of poor water supply, sanitation, and water supply and sanitation coverage by region. He outlined the Vision 21 targets of halving the percentage of people not served by 2015 and universal coverage by 2025, but warned that these targets may more easily be reached if 1990 baseline data are used, instead of 2000 baseline data. He then delineated the core and support functions of the global WSH programme, which included the normative function, international legal instruments, water and sanitation in emergencies, global monitoring, policy development and advocacy, technical cooperation, research promotion and orientation, and development of health-oriented knowledge base as a cross-cutting issue.

WHO's mission statement incorporating both concepts of provision of water and sanitation services and improved health was also reviewed. WSH programme targets were described, and guiding principles outlined, including putting health at the centre of its work, taking a leadership role but seeking partnerships, learning to be a better team player, making better use of WHO-wide resources, delivering quality, promoting it effectively, and regulating workload by referencing to targets and likely impact on health.

5. WATER, SANITATION AND HEALTH IN THE WHO SOUTH-EAST ASIA REGION

The talk by Ms. Sharon Khan reviewed the water supply, sanitation and hygiene situation in SEAR, and showed comparative infectious disease mortality data by category. An inverse relationship between sanitation coverage and childhood mortality by country and the direct relationship between sanitation coverage and the Human Development Index (HDI) by country were demonstrated on line graphs. There was apparently no consistent relationship between improved water supply coverage and HDI by country, although these data are problematic because water supplies termed as “improved” are not necessarily safe for human consumption. Globally, 5.3% of all deaths and 6.8% of DALYs are lost due to poor water supply, sanitation, and hygiene, while in SEAR, 6.6% of all deaths and 7.2% of DALYs are lost due to diarrhoeal diseases. Some inherent difficulties in assessing the water-related disease burden were described, and the need for better epidemiological evaluation stressed.

The conclusion reached by Esrey in his 1991 paper that sanitation interventions are more effective than hygiene interventions, followed by water quantity interventions, and finally water quality interventions was reviewed, but then evidence was presented from a number of studies that suggested that targeted point-of-use water quality interventions have a diarrhoea-preventive effect that is equal to or greater than the effect of sanitation. Conclusions from the WHO Commission on Macroeconomics and Health that hand-washing interventions can lead to substantial reductions in disease were presented, and the point was made that if hygienic practices became ingrained in cultures, they would reduce the need for repeated public health interventions.

Vision 21 targets for year 2015 were reviewed next and the cost to achieve the targets in SEAR was estimated at US\$1.6 to US\$9.6 billion per year depending on the technologies used. The health savings that would result from such investment was estimated to be approximately US\$2.25 to US\$6.3 billion per year. Other considerations that would improve the cost effectiveness analyses, such as health benefits, avoided medical expenses, productivity gains, time savings, and new investment benefits were also discussed.

The presentation concluded that health authorities in SEAR countries should be strong advocates of increased investment and policy reform in the water supply and sanitation sector, particularly since the benefits of such investment accrue to the health sector while the costs do not. If health authorities are to become effective advocates in this regard, they will need to strengthen research, surveillance, information management and communications programmes. Recommendation was also made that health authorities should develop capacity as promoters of low cost interventions that may mitigate the health consequences of deficiencies in water supply and sanitation services, and poor hygiene.

In discussion, it was felt that the talk on WHO's global WSH strategy was timely for the WSHAG initiative. However, the data collection and analysis methods used to collect data for the *Global Water Supply and Sanitation Assessment 2000* were questioned, because in some countries the percentages of populations with access to improved water supply seemed elevated. It was explained that the relatively high coverage found in some countries results from a methodology that estimates coverage by "improved" water supplies as opposed to "safe" water supplies, since a methodology for the latter is currently lacking. WHO has recognized this deficiency and is working to improve the methodology.

A second concern expressed by the meeting regarding the *Assessment 2000* report was the lack of discussion of specific national problems such as the arsenic problem in Bangladesh. It was explained that no global report could effectively discuss the broad range of individual national problems, but that currently WHO and UNICEF were supporting the preparation of national reports as follow-up to the global *Assessment 2000* report. Specific national issues would be treated in detail in the national reports.

Referring to the presentation of water, sanitation and health in the SEA Region, a concern was expressed about recommending the use of interim measures in water and sanitation because they may hinder the definitive resolution of the problem of lack of services in the long term. It was suggested that the term "interim" may not correctly reflect WHO's intention and that the term "incremental" may be preferable, because it implies continued effort to upgrade services. Low cost, alternative, incremental services are needed to protect the health of at-risk populations as efforts are made to reach the year 2015 and 2025 targets. A caution was given that behaviour change should not

be considered as an interim measure and infrastructure interventions as long-term measures. Behavioural changes should be permanent, not interim, and as such may be considered to be an incremental measure.

The observation was made that relevant to the cost benefit discussion, the cost of continuing inadequate water supply, sanitation, and hygiene services and practices (i.e., the “do nothing” option) may be higher than the cost of actually implementing these interventions.

Two problems that were not addressed adequately in the preceding presentations, and that perhaps should be contemplated, were solid waste and the relationship of nutrition to health problems under consideration.

6. SITUATION ANALYSIS OF DRINKING WATER QUALITY IN THE SEA REGION

Mr Guy Howard presented a situation analysis commissioned by SEARO that indicated that progress with establishing national water quality surveillance programmes remains poor. No SEAR country has a comprehensive programme; water from urban piped sources, home storage containers, and rural sources are rarely tested; and links between data and action are rare. In the international development assistance community, however, water quality is becoming a higher priority.

The SEAR Action Plan for the Development of National Drinking Water Quality Surveillance (1996) has had limited impact to date. In the Intercountry Consultation on Quality Assurance in Water Supply (Bangkok, January 2001) the plan was simplified from 20 action points to seven principles. The seven principles are: establishment of a national task force, evaluation of the legal system, development of a national surveillance plan, identification of priorities for action, and development of an action plan (including research), development of an information system, and evolution of a system of regular reporting. Legislation and standards development are ongoing, though guidelines are often more appropriate than standards, particularly because any regulation is only as good as the enforcement.

A key point is that government ministries that are assigned water quality surveillance responsibility often lack the necessary capacity. It was also found

that best practices and innovation are more likely to be encountered in other organizations such as NGOs. Laboratory capacity exists in many countries, but more attention should be paid to sanitary inspection and low cost testing as alternatives.

Water quality issues are complex, and include microbial contamination of water stored in homes and contamination with arsenic, fluoride, nitrates, heavy metals, and toxic cyanobacteria.

A variety of surveillance indicators were outlined, including quality from source to point of consumption, continuity of service, cost, quantity, access, use patterns, and coverage.

National policy requirements were spelt out. A framework for implementation was reviewed, issues related to regulation discussed, and suggestions for developing surveillance programmes outlined. Suggestions for implementation of a surveillance system, advocacy and dissemination of data, promotion of ideas and best practices, and developing pilot programmes were provided. Suggested focus areas for surveillance included community-based monitoring, urban surveillance targeting the poor, drinking water safety plans, and linkage to household-focused interventions. The presentation concluded with strategies for programme implementation.

It was stated that water quality surveillance should be developed through multiple sectors and the role of the central government should be diminished. Because the impact of water quality is at the local level, the role of the local government is important. Technical support may be available through university or research institutions, and the private sector should have a role. Coordination of different sectors is important and WHO could encourage governments to improve coordination.

The need for indicators of water quality for rural sectors was discussed. For rural areas, it was noted that a smaller number of indicators were preferable, and that communities should be supported to better monitor their supplies. WHO could assist with the institutional set up for regular rural water quality surveillance.

The importance of not testing every supply was stressed. Surveillance was about lessons learnt and that sampling rather than comprehensive testing

was more rational and cost-effective. An important consideration is what is possible in the context of local institutions and infrastructure. Another key consideration is to not abandon water quality testing, but to develop more cost-effective approaches through a well-designed sampling framework. It was also noted that better microbiologic indicators that give a more specific indication of disease risk would be desirable.

The increasingly important problem of bacterially contaminated boreholes and tubewells was noted.

A suggestion was also made to link water surveillance data to waterborne disease data as an advocacy tool for action.

7. SUGGESTIONS FOR RESTRUCTURING SEARO'S WATER, SANITATION AND HEALTH PROGRAMME

SEARO's current WSH programme covers 10 countries. Recent drinking water quality activities have included the development of a regional action plan to strengthen national drinking water quality surveillance programmes, that has had uneven progress; a situation analysis on drinking water quality surveillance; promotion of urban water system surveillance (UWSS); development of guidance on monitoring chemicals in drinking water, and a demonstration project on point-of-use treatment and safe storage of drinking water. Monitoring and assessment activities include participation in the global *Assessment 2000* and preparation of country-level assessments as follow-up to the global exercise. A draft research agenda on water and health in the SEA Region has also been developed. Finally, a programme of water supply and sanitation in emergencies is under development, spurred on by WHO's rapid response to the Gujarat earthquake which resulted in substantial donor funding.

Current human resources in the WSH programme are insufficient at the regional level, limited to one international adviser and one secretary. A national consultant is presently assigned to the WSH unit, but his terms of reference are specifically limited to supporting the UN Inter-Agency Working Group on Water and Environmental Sanitation in India. Three WHO country offices have international advisers responsible for the WSH area of work in

addition to other areas of work related to sustainable development and environment. Two additional WHO country offices have a national professional officer or a project officer working in this capacity. Technical resources available to the WSH programme include the expertise of the regional and country staff members, WHO publications, WHO HQ staff (whose number has decreased from 8 to 4 in recent years) and the WHO Collaborating Centres. Financial resources have decreased steadily over the past decade. The High Level Task Force for Intercountry Collaboration did not identify WSH as priority area of work in the current biennium and, as a consequence, the budget for WSH intercountry activities has been reduced to zero. WHO country offices in the Region typically have budgets for WSH activities ranging from tens of thousands to hundreds of thousands of dollars per biennium, although this too has been declining. For example, WHO-India reduced its budget for environmental health by 50 percent in the current biennium as compared to the previous one.

Suggested objectives for the future WSH programme include capacity building of health authorities to advocate for increased investment, sector reform, and intersectoral coordination, research, information management, and promotion of incremental measures. Near and long-term activities were suggested, and human, technical, and financial resources needs were described as a basis for discussion in the working groups.

In discussion, it was noted that the World Health Assembly of 1997 passed a major resolution recommending that water and sanitation interventions should be targeted to areas of high disease risk and WHO is pursuing this by developing methodologies and demonstration projects. It was suggested that WSHAG should advocate this approach.

The fact that the HLTF has decreased funding for WSH to zero demonstrates that water and sanitation is a low priority for ministries of health in SEAR countries. This trend needs to be reversed and WHO advocacy could be an important factor in accomplishing this. Ministries of health should take an active role in advocating increased investment in water and sanitation, and improved efficiency through sector reform. WHO can help to develop capacities of health ministries to perform that function.

It was noted that 40 to 50 years ago, most water and sanitation funding was in the health sector, but in most countries of the Region, that has changed

and now it is typically in other sectors. During the International Water Supply and Sanitation Decade of the 1980s, WHO played a key role, even though most investments were outside of the health sector. WHO remains effective in this role and should expand its scope to interact with the water supply and sanitation sectors and not only the ministries of health.

8. FIELD TRIP

WSHAG participants took a field trip on 7 May to visit the future site of the implementation of the Safe Water System in the West Delhi slums. This project was considered to be a good example of an incremental measure that health authorities should promote in future in order to mitigate the health consequences arising from deficiencies in water supply and sanitation services, and poor hygiene.

The project is a collaborative effort between SEARO, PSI, and Sulabh International. Community toilets constructed by Sulabh and run by the community were visited. A meeting was held with community volunteers who will be the community-based sales agents for "Safewat" disinfectant solution and 20 litre vessels with taps that will be socially marketed by PSI. The field trip offered an opportunity for WSHAG members to observe severely compromised environmental conditions in the slums and ask community members about those conditions and their opinions about the safe water project.

9. CONCLUSIONS AND RECOMMENDATIONS

9.1 Conclusions

The members of the WSHAG concluded that health ministries in Member Countries of the SEA Region need to strengthen their programmes in applied research, information management, and communications in order to better fulfil their role as advocates for water and sanitation for health. The WSHAG members also endorsed the priorities for the regional programme that emerged from the situation analysis and concept paper. These include capacity building, promotion and advocacy, and technical support to Member States.

The WSHAG discussed the adequacy of the areas of emphasis; identified a series of actions to be prioritized by the Regional Office; indicated the role of the Regional Office in implementing them, outlined implementation strategies; defined a set of indicators for measuring progress in carrying out the actions; recommended how the water, sanitation, and health programme could be strengthened in order to make the implementation of the actions possible; and made suggestions for efficiently exchanging information among members of WSHAG. The recommendations of the WSHAG are reported below, but *an overriding concern of the group was that, in order for the Regional Office to successfully undertake the recommended actions, it will need substantial support in terms of financial and human resources.* The erosion of financial support for the water, sanitation, and health programme, and the concomitant severe reduction in staff size that has taken place in recent years, greatly compromise its ability to address the myriad serious and complex deficiencies in water, sanitation and hygiene that confront Member Countries and that result in millions of episodes of disease and hundreds of thousands of deaths every year.

The fundamental, overriding concern of the group was that the High Level Task Force on Intercountry Cooperation did not adequately consider health risks due to water, sanitation and hygiene when identifying the 14 priority areas for budget allocations in the 2002-2003 biennium. A related concern was that the ministries responsible for water supply and sanitation are separate from the ministries of health in most SEAR countries, which results in a fragmented approach to water supply and sanitation needs, a lack of advocacy for addressing deficiencies in water and sanitation, and inadequate linkage of these deficiencies to the extraordinarily high resultant burden of disease.

9.2 Recommendations

For the development of the WSH in SEARO

- (1) The highest priority activity recommended by the working group is for WHO to convene an interministerial conference to include ministers of health and ministers responsible for water supply and sanitation, and others.

- (2) The WSH unit in the Regional Office should have access to a broader range of technical expertise to support the intercountry programme, including not only sanitary engineering but also environmental epidemiology and health economics.
- (3) The regional WSH programme should link to other specific WHO health and disease control programmes, which could include the polio eradication programme, IMCI, women's health, healthy settings, vector control, control of diarrhoeal diseases and others with a clear relationship to water, sanitation and hygiene.
- (4) The Regional Office should sponsor and/or advocate pilot projects that demonstrate low-cost, incremental water and sanitation interventions that can be rapidly implemented.
- (5) The Regional Office should identify areas of critical need for water and sanitation services in the Region and communicate these to national governments.
- (6) A regional water, sanitation and health research agenda should be developed.
- (7) A plan for responding to disasters and emergencies with water and sanitation interventions should be developed.

For resource mobilization and partnerships

- (1) Strategies for mobilizing resources in support of the intercountry WSH programme should be developed, and ad hoc approaches for fund raising should not be used.
- (2) As the basis for building partnerships with allied health programmes, international development partners, and donors, WHO should develop strong advocacy positions.
- (3) Collaboration with neighbouring WHO Regional Offices, particularly in the Mekong River Basin should be intensified.
- (4) SEARO should strengthen its technical resource base by expanding and developing its network of WHO Collaborating Centres in the WSH area of work, and should consider establishing an environmental health technical centre modelled after CEPIS and CEHA.

10. PRESENTATION OF RECOMMENDATIONS TO REGIONAL DIRECTOR

Recommendations of the working groups were presented to Dr. Uton Muchtar Rafei, Regional Director of SEARO. The Regional Director expressed his satisfaction with the outputs of this, the first meeting of the WSHAG, thanked the members for their contributions, and promised to consider carefully their recommendations.

A Note for Record is appended to the present report at Annex 2.

11. IMPLEMENTATION AND FOLLOW UP

WHO/SEARO will follow up on the group's recommendations and will attempt to mobilize internal and external resources to implement related activities. The vision for WSHAG is to have annual meetings, with the next one envisaged to occur immediately following the interministerial conference in 2003, with the objectives of reviewing progress of WSH in meeting the recommendations of WSHAG, and to make recommendations for the ensuing year.

The Chairman, Prof. Nath, thanked the members of the group for their contributions and closed the meeting, stating that a stronger WHO is in everyone's interest.

Annex 1

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Annex 2

BRIEFING OF REGIONAL DIRECTOR ON THE RECOMMENDATIONS OF THE SEAR WATER, SANITATION AND HEALTH ADVISORY GROUP

SEARO **Regional Director (RD)** was briefed in his office at 02:35 p.m. on 08 May 2002 on the recommendations made by the first meeting of the SEAR Water, Sanitation and Health Advisory Group (New Delhi, 06-08 May 2002).

The SEAR Water, Sanitation and Health Advisory Group (WSHAG) was established by RD with the terms of reference:

- To analyse the water, sanitation and health situation in SEAR and to make recommendations to SEARO for development of the inter-country WSH programme; and
- To support SEARO in the mobilization of resources for specific WSH programmes, projects, and activities.

This first meeting of the WSHAG was financed by an allocation from regional savings approved by RD in 2001.

Chairman of the WSHAG Meeting, **Prof K J Nath**, ex-Director of All India Institute of Hygiene and Public Health and President, Institution of Public Health Engineers, thanked RD for his support for WSHAG while expressing his concern that the High Level Task Force on Inter-country Collaboration had not identified WSH as one of SEARO's fourteen priority programmes. He said that water, sanitation and hygiene risk factors were major causes of disease in SEAR, and that there was an urgent need to mobilize political support and financial resources to strengthen this area of SEARO's work.

Rapporteur of the WSHAG Meeting, **Dr Robert Quick**, Medical Epidemiologist, U.S. Centres for Disease Control and Prevention, advised RD that the first WSHAG meeting had recommended that SEAR urgently develop

two parallel strategies: (1) *strengthening the role of ministries of health in the area of water, sanitation and hygiene*, and (2) *promoting low-cost, rapid interventions that mitigate the health consequences of deficiencies in water supply and sanitation services, and poor hygienic practices*. **The overriding recommendations of the WSHAG meeting were:**

- (1) SEARO should convene a meeting of ministers of health and ministers responsible for water supply and sanitation in order to identify the role of health authorities in water supply, sanitation and hygiene, and to gain political support and commitment for strengthening health ministries to fulfil that role.
- (2) SEARO should develop projects to promote low-cost, rapid interventions such as point-of-use disinfection and safe storage of water, handwashing, sanitation for high-risk communities, and others.

In order for SEARO to effectively pursue these strategies, it would be necessary in the long run to strengthen the WSH unit in SEARO with respect to human, technical and financial resources.

Dr Hening Darpito, Director of Water and Sanitation, Ministry of Health, Indonesia, confirmed the WSHAG's recommendations noting that many SEAR countries do not even have a water and sanitation unit within the ministry of health. In a few countries that do have such a unit, such as Indonesia, there exists an urgent need for strengthening the unit.

Dr Jose Hueb, WSH/PHE/SDE/HQ, agreed with the remarks of Dr. Quick and Dr Darpito, and also highlighted the recommendation of the WSHAG meeting that SEARO should build effective partnerships intersectorally at national level, and with other international development partners that may facilitate resource mobilization.

Mr Kesang Wangdi, Director of South Asia Association for Regional Cooperation (SAARC), congratulated RD for his initiative in creating the SEAR Water, Sanitation and Health Advisory Group, and noted the importance of regional cooperation in South Asia in the area of water, sanitation and hygiene programmes. He expressed the desire for continued cooperation between SAARC and SEARO in this regard.

RD recognized that poor drinking water quality, low sanitation coverage, and poor hygiene were important determinants of ill health in SEAR, and he expressed his satisfaction with the recommendations of the WSHAG. RD spoke of his own experiences in promoting sanitation and hygiene in Indonesia, and referred to important experiences that he had observed in several SEAR countries such as Bhutan and Myanmar. RD said that it would be important to link WSH activities to community development programmes such as healthy districts and other health programmes in order to achieve more efficiency and effectiveness. He also agreed that there was a need to develop innovative strategies such as social marketing. **RD observed that RA-WSH should be allocated extrabudgetary funds in order to begin implementing immediately the WSHAG's recommendation on development of projects on low-cost and rapid interventions.** The ministerial level meeting, as recommended by WSHAG, would need proper planning and a longer timeframe for planning. Funds for such a meeting could be mobilized later in the biennium from overall savings etc. and from donors.

Mr B S Lamba, Ag. Director of Sustainable Development and Healthy Environments, SEARO, noted the importance of water, sanitation and hygiene for poverty alleviation. He felt that water supply and sanitation should be appropriately integrated in the emerging PRSP process. He also said that the report of the Commission on Macroeconomics and Health could be used for advocacy for water, sanitation and health. In the end, Mr. Lamba thanked RD for giving his time to receive the briefing.

Mr Terrence Thompson, Regional Adviser WSH/SEARO, thanked **RD** for the meeting..

The briefing ended at 03:05 p.m.