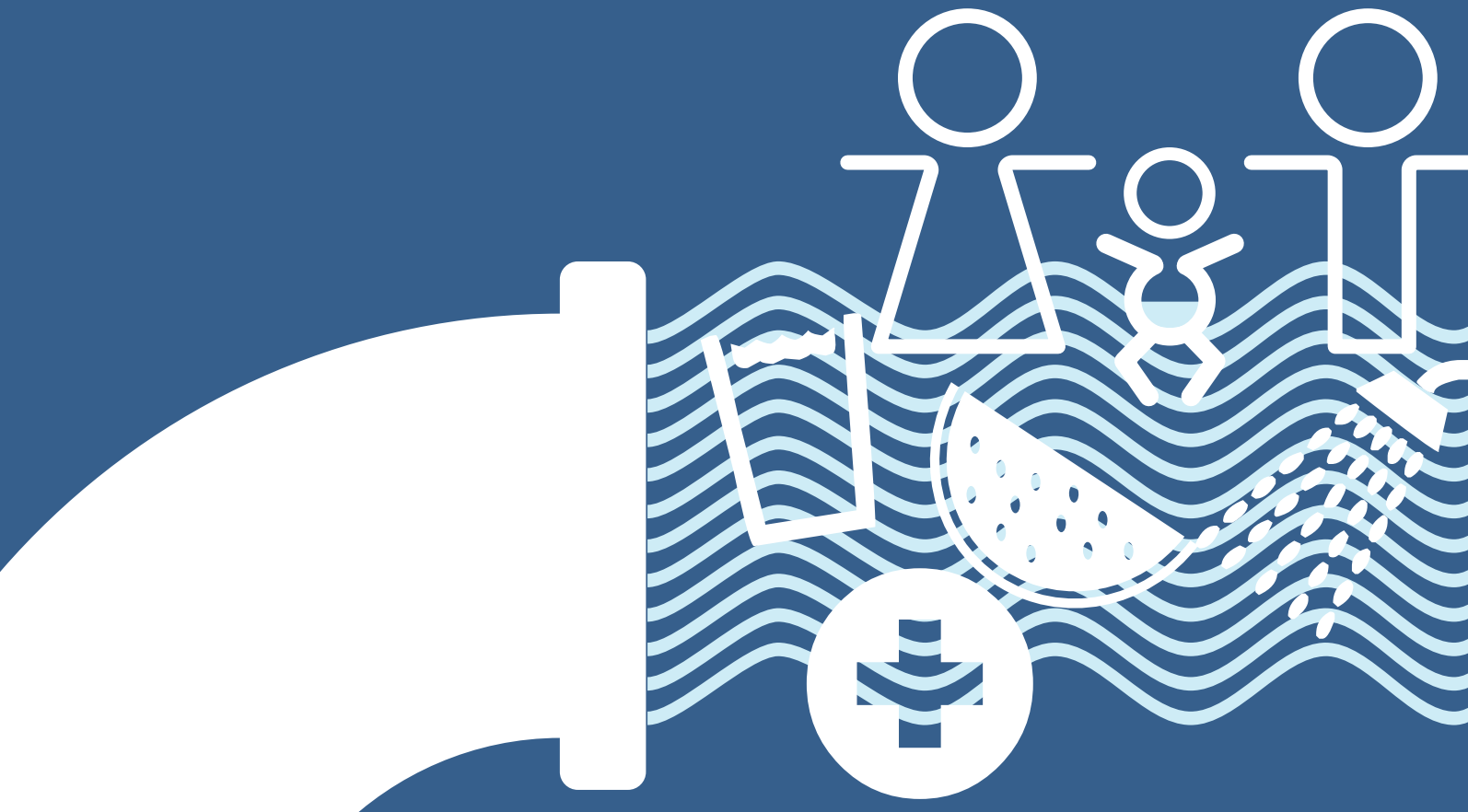
UN WATER

INVESTING IN WATER AND SANITATION: INCREASING ACCESS, REDUCING INEQUALITIES

Special Report for the
Sanitation and Water for All (SWA)
High-Level Meeting (HLM) 2014



glaas

UN-Water Global Analysis and Assessment of Sanitation and Drinking-Water

I. Background

Data from 86 countries[1] are presented in this preliminary analysis, along with information provided by 21 external support agencies (ESAs). The full GLAAS report, scheduled for publication in September 2014, will include an analysis of 90 or more countries and ESA respondents, representing all Millennium Development Goal (MDG) regions and over 90% of official development assistance for sanitation and drinking-water.

The GLAAS process enables countries to discuss and identify national water and sanitation priorities and barriers to service provision, along with promoting a culture of accountability, partnership and shared responsibility. This latest GLAAS information is being used to help governments formulate specific, achievable, measurable, and time-bound commitments in preparation for the Sanitation and Water for All (SWA) High-Level Meeting (HLM). GLAAS provides Finance and Water Sector Ministers, along with Ministers of Development Cooperation, with information that allows them to make more informed investment decisions to extend and sustain service provision. It underscores to Ministries of Health that adopting a primary prevention approach to reduce disease is a cost-effective[2] and equitable approach to improving the lives of millions.

1 2013 GLAAS survey results are based on responses from 86 countries globally: Africa (33), European and Central Asian Region (12), Eastern Mediterranean Region (11), Latin America (16), South-East Asia (6) and the Western Pacific Region (8).

2 WHO (2012) Global costs and benefits of drinking-water supply and sanitation interventions to reach the MDG target and universal coverage. Geneva, World Health Organization. Available at: http://www.who.int/water_sanitation_health/publications/2012/globalcosts.pdf [accessed 31 March 2014].

In many countries, water and sanitation policies, plans and strategies are in place to reach vulnerable groups such as those living in poverty. However, monitoring progress in access and service provision for the poor is carried out in less than half of countries for sanitation and drinking-water. Targeting of finance and measures to reduce disparities between the rich and poor are not being consistently applied. Only 15% of low and middle income countries have established and apply financial measures that are targeted towards reducing inequalities in access to sanitation for the poor and just below a quarter for drinking-water. [TABLE 1]

Table 1 **Measures of inequality for those living in poverty**

	World Bank country classification by income[a]	Number of countries	GOVERNANCE: Universal access policy specifically includes measures for the poor	MONITORING: Monitoring system tracks progress in extending services for the poor	FINANCE: Finance measures to reduce disparity between the rich and poor are consistently applied
SANITATION	Low income	30	80%	40%	13%
	Lower middle income	24	83%	54%	12%
	Upper middle income	24	71%	29%	21%
WATER	Low income	30	80%	43%	23%
	Lower middle income	24	83%	58%	21%
	Upper middle income	24	71%	42%	25%

PERCENTAGE OF COUNTRIES IN THE CATEGORY WITH EQUITY MEASURE IN PLACE

- 80–100%
- 60–79%
- 40–59%
- 0–39%

a Due to a small sample size the category of 'high income countries', including Chile, Estonia, Lithuania, Oman and Uruguay, has been removed from this table. Due to pending revised data, Columbia, Dominican Republic and Guinea Bissau have not been included in these calculations.

CAMBODIA

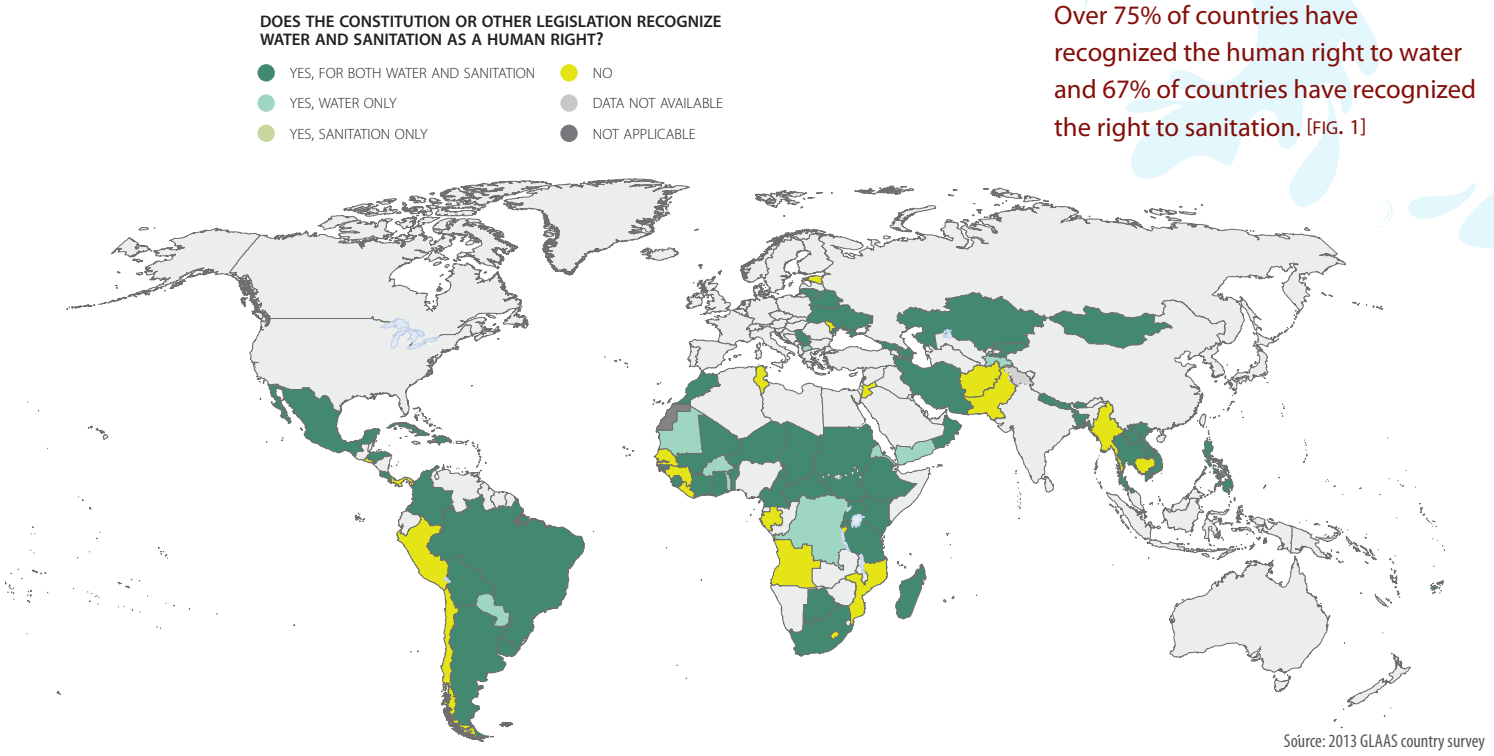
A focus on improving WASH services for the urban poor for better results

Cambodia has achieved remarkable progress in the delivery of urban WASH services in the last 10 years with Phnom Penh Water Supply Authority (PPWSA) highlighted as an example of achievement. PPWSA has won a number of national and international awards for its work, including the Stockholm Industry Water Award in 2010 and the Asian Development Bank Water Prize in 2004. Cambodia has developed effective policies for ensuring water is affordable for poor people especially in urban areas. The result of these efforts is that urban coverage has increased for both drinking water and sanitation among all wealth quintiles. The progress for increasing sanitation coverage for the two lowest urban wealth quintiles is significant: from a low base (0%), to nearly 30% and 70%. In 2012, 7% of the population in urban areas practiced open defecation, down from 28% in 2005.[3] A remaining challenge is to strengthen the delivery of rural water and sanitation services.

3 WHO/UNICEF (2014) Progress on drinking-water and sanitation – 2014 update. Geneva, World Health Organization.

II. Human right to water and sanitation

Fig. 1 **Countries with a constitution or other legislation that recognize water and sanitation as a human right[a]**



Over 75% of countries have recognized the human right to water and 67% of countries have recognized the right to sanitation. [FIG. 1]

Source: 2013 GLAAS country survey

a Some countries may have more broadly defined laws or legislation for incorporating the human right than others.

SOUTH AFRICA

A focus on providing for the poorest leads to more equitable WASH outcomes

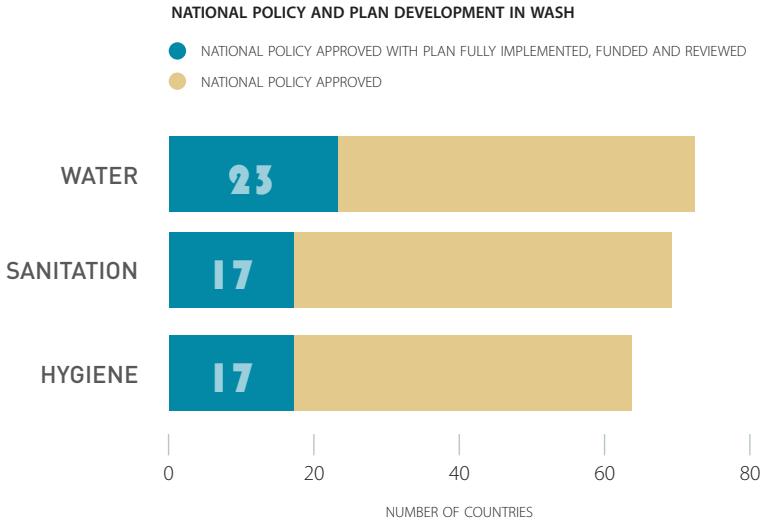
With the ending of apartheid the Government of South Africa prioritized the provision of basic services including, water supply, sanitation and energy services. Ambitious targets were set within a policy framework that included 'free basic water' and 'free basic sanitation' for households with resources below the social grant amount (approximately US$ 1 per day). In 2012, 3.47 million and 1.84 million people benefitted from free services for water and sanitation respectively.[4] Resources were provided to decentralized organizations charged with providing basic WASH services. Strong monitoring frameworks were put in place to track progress against the targets. Although the time-frame for reaching the targets of universal coverage have not been met, major gains in access have been achieved, especially for the poor and those living in rural areas.[5] There remains, however, a major challenge in attracting and retaining professional staff to manage, operate and maintain WASH infrastructure.

4 2013 GLAAS country survey: South Africa.

5 WHO/UNICEF (2014) Progress on drinking-water and sanitation – 2014 update. Geneva, World Health Organization.

III. National policies, implementation and monitoring

Fig. 2 **Status of national policy and plan development in WASH**



Source: 2013 GLAAS country survey

Countries are struggling to fully implement national WASH plans. While most countries have developed WASH policies, less than 30% of countries report having plans that are costed, funded, implemented and regularly reviewed. [FIG. 2]

ETHIOPIA

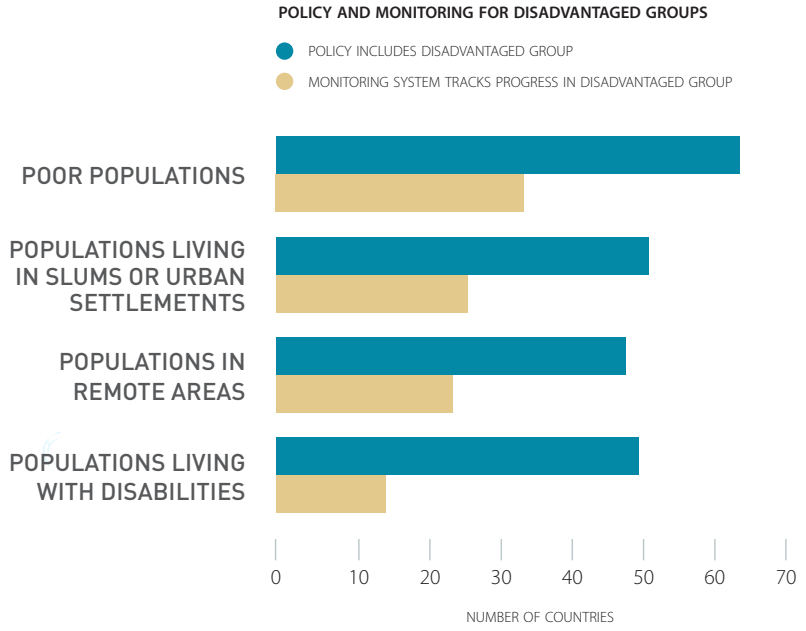
Clear plans and coordinated action by the different ministries responsible for WASH outcomes accelerates progress

Under its Universal Access Plan (UAP)[6] in 2005, the Government of Ethiopia set ambitious long-term objectives to meet the WASH MDG targets and to move towards universal access. It followed this with a clear strategy to coordinate its WASH efforts across different Ministries (Water Resources, Health, Education) civil society and ESAs. Significant financial and human resources were made available and the UAP was updated in 2011. The result: major increases in access to drinking water, sanitation and hygiene promotion within both urban and rural populations by all wealth quintiles.

6 Moriarty P, Jeths M, Abebe H and Deneke I (2009) Synthesis Paper: Reaching Universal Access: Ethiopia's Universal Access Plan in the Southern Nations, Nationalities and People's Region (SNNPR). Research-inspired Policy and Practice Learning in Ethiopia and the Nile Region (RiPPLe), Governance and Planning Team. Addis Ababa, Ethiopia.

Fig. 3 Policy and monitoring for disadvantaged groups in water and sanitation[a]

Countries are progressively establishing policies for disadvantaged groups, but a gap remains in their capacity to track and report progress in access for disadvantaged groups. [FIG. 3]



Source: 2013 GLAAS country survey

a The following countries have been excluded from analysis pending revised data, Columbia, Dominican Republic and Guinea Bissau.

- Only 31% of countries have and use available data for resource allocation in the sanitation sector.
- By contrast, in the health sector, data-based decision making is used by 65% of countries to respond to water and sanitation related disease outbreaks.
- More than half of countries undertook a national joint sector review for sanitation in the last two years, involving on average six to nine ministries and institutions (Fig. 4).

Few countries collect and analyse data AND use this information to make funding decisions on sanitation. [FIG. 4]

Fig. 4 Institutional leadership and coordination in sanitation and existence of a national joint sector review[a]

NUMBER OF MINISTRIES AND NATIONAL INSTITUTIONS	DATE OF LAST NATIONAL JOINT SECTOR REVIEW (FROM JANUARY 2014)			
	<1 YEAR	1 –<2 YEARS	2–4 YEARS	>4 YEARS/ UNSPECIFIED/ NO NATIONAL ASSESSMENT
≤5	Guinea, Iran (Islamic Republic of), Kenya, Macedonia, Mozambique, Senegal, Chad, United Republic of Tanzania	Afghanistan, Jordan, Lithuania, Republic of Moldova, Pakistan	Argentina, Madagascar, Myanmar, Nepal, Sudan,Tajikistan, Viet Nam	Central African Republic, Estonia, Haiti, Oman, Paraguay
6–9	Azerbaijan, Burundi, Benin, Burkina Faso, Belarus, Gabon, Liberia, Lesotho, Mali, Mongolia, Panama, El Salvador, Serbia, South Sudan, Tonga, Uganda, Ukraine	Bangladesh, Bolivia, Eritrea, Kazakhstan, Cambodia, Mexico, Niger, West Bank and Gaza Strip, South Africa	Brazil, Bhutan, Cuba, Ethiopia, Ghana, Lao PDR, Philippines, Timor Leste	Angola, Botswana, Cook Islands, Georgia, Gambia, Lebanon, Peru, Thailand, Yemen
≥10	Costa Rica, Fiji, Sierra Leone, Uruguay	Côte d'Ivoire, Democratic Republic of the Congo, Mauritania, Rwanda	Cameroon, Honduras, Kyrgyzstan, Togo	Morocco, Tunisia

a The following countries were not included in the analysis due to pending revised data: Columbia, Chile, Dominican Republic & Guinea Bissau The number of Ministries or national Institutions reported by countries in this figure does not reflect any level of coordination or lack thereof.

Source: 2013 GLAAS country survey

Sector coordination mechanisms are contributing to coherence of aid programmes, particularly in countries where a large number of ESAs operate. [TABLE 2]

Table 2 **ESA finance compared to implementation of financing plans and sector-wide coordination (eight countries receiving 20 percent or more WASH financing from external sources)**

COUNTRY	ESA FINANCE (AS % OF WASH FINANCE)	NUMBER OF ESAS (OVER US$ 100 000 PER YEAR)	SECTOR-WIDE COORDINATION THAT IS BASED ON SECTORAL FRAMEWORK IMPLEMENTED	FINANCING PLAN	PLAN IMPLEMENTATION STATUS
Bangladesh	**36**	**17**	**Yes**	**Agreed**	**Partial**
Burkina Faso	**55**	**12**	**Yes**	**Agreed**	**Full**
Ghana	**90**	**17**	**Yes**	**Agreed**	**Partial**
Lesotho	**45**	**8**	**Yes**	**In development**	**—**
Madagascar	**23**	**12**	**Yes**	**Agreed**	**Partial**
Morocco	**22**	**12**	**Yes**	**Agreed[a]**	**Full[a]**
Nepal	**26**	**10**	**Yes**	**Agreed[b]**	**Full[b]**
Panama	**72**	**3**	**Yes**	**Agreed**	**Full (urban) Partial (rural)**
Tunisia	**24**	**10**	**No**	**Agreed**	**Full**

a Except for financial plan for rural sanitation in development.
b Except for urban sanitation which is not fully implemented.

Source: OECD-CRS, 2014 and 2013 GLAAS country survey

IV. FINANCING

a. Sufficiency, revenue sources, and expenditures at country level

Many countries that require investment to extend WASH service provision have the capacity to absorb funds and implement programmes. [FIG. 5]

Fig. 5 **Sufficiency of funds versus human resource and financial planning capacity, and funding absorption (urban sanitation) based on responses from 77 countries**

INDEX OF CAPACITY TO INVEST AND ABSORB FUNDS[a]	SUFFICIENCY OF FUNDS TO MEET MDG TARGETS		
	<50% OF FUNDS NEEDED	50–75% OF FUNDS NEEDED	>75% OF FUNDS NEEDED
High	Belarus, Benin, Bhutan, Ethiopia, Fiji[b], Gambia, Georgia, Lesotho, Mauritania, Pakistan, Republic of Moldova, Senegal, Tajikistan, Uganda, United Republic of Tanzania	Ghana, Rwanda	Azerbaijan[b], Burkino Faso, Cambodia, Estonia, Iran (Islamic Republic of)[b], Morocco, Tunisia[b], Viet Nam[b]
Medium	Bangladesh, Burundi, Central African Republic, Cook Islands, Côte d'Ivoire, Guinea, Honduras[b], Lebanon, Liberia, Madagascar, Mali, Mozambique, Nepal, West Bank and Gaza Strip[b], Paraguay[b], Serbia, Timor-Leste, Togo, Ukraine	Eritrea, Jordan, Kenya, Niger, Panama	Chad, El Salvador, Oman, Peru, South Africa, Tonga
Low	Argentina[b], Cameroon, Costa Rica, Democratic Republic of the Congo, Gabon, Haiti, Kyrgyzstan, Lao PDR[b], Mongolia, Philippines, Sierra Leone,South Sudan, Yemen	Afghanistan, Angola, Mexico[b], Myanmar[b], Sudan	Bolivia, Brazil, Kazakhstan, Thailand[b]

a Index is based on a total score of five questions, including:
1. Are human resources a limiting factor in national or local WASH planning, construction of facilites, or financial planning and expenditures?
2. Has the government defined a financing plan/budget for the WASH sector, clearly assessing the available sources of finance and strategies for financing future need?
3. Are expenditure reports available that allow actual spending on WASH to be compared with committed funding?
4. What is the estimated percentage of domestic commitments for WASH utilized?
5. What is the percentage of offical donor capital commitments for WASH utilized?

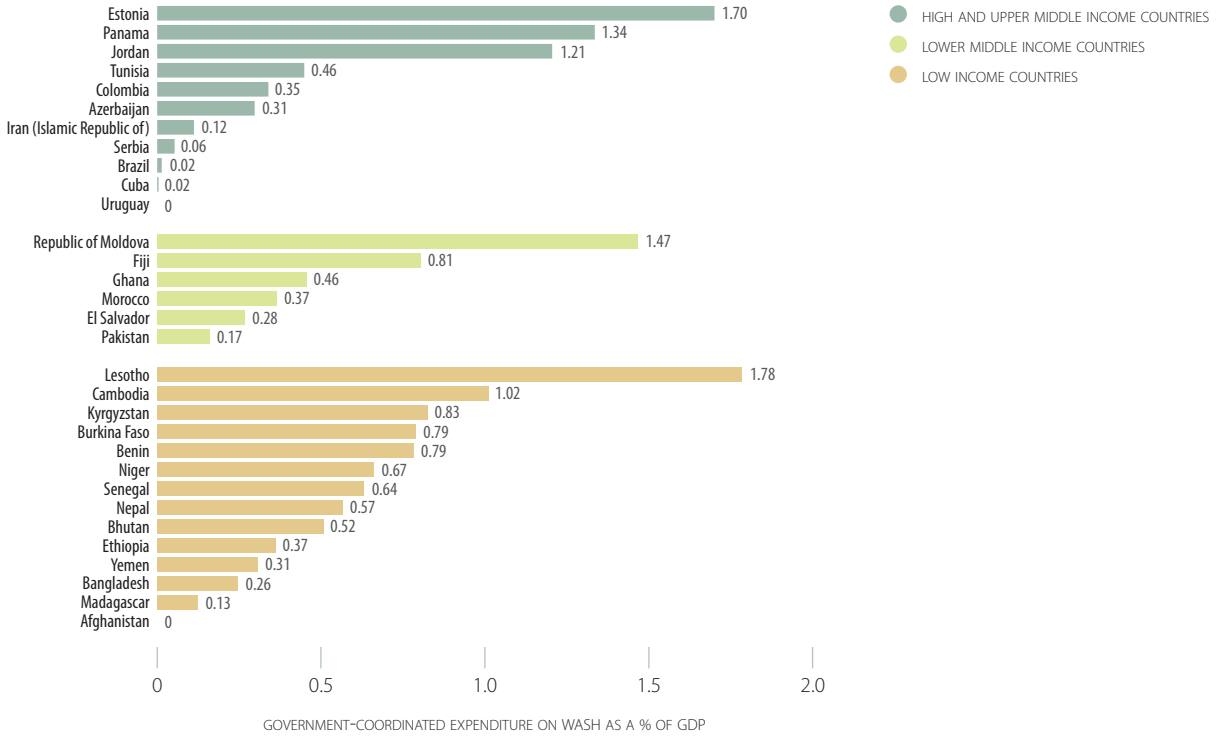
b Indicates that this country has reached the MDG target for sanitation. Reported insufficiency of funding may be based on national targets that go beyond MDG goals, based on funds needed to sustain coverage levels due to recurring capital maintenance or additional needs due to population growth.

Source: 2013 GLAAS country survey; WHO/UNICEF 2014

The overall median public WASH expenditure is reported at 0.46% of GDP.

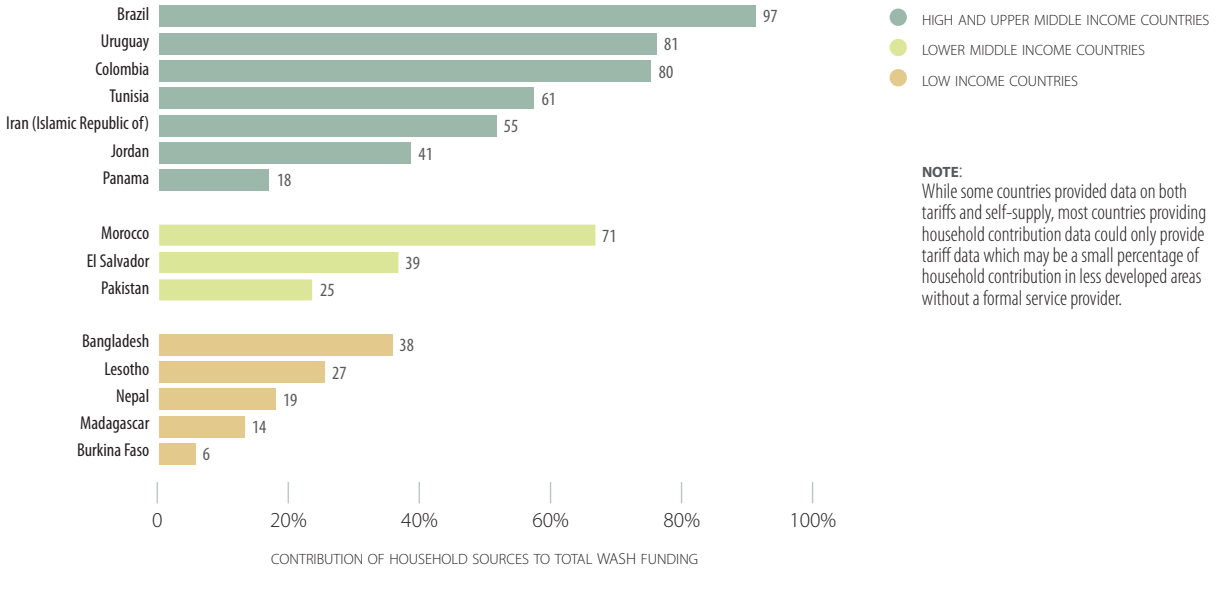
- Public expenditure for WASH varies widely across countries, however low income countries spend proportionally more government funds on WASH than higher income countries (Fig. 6).
- Household contributions are reported to be between 6% and 97% of WASH financing (Fig. 7).
- 77% of countries indicate WASH financing is insufficient (<75% of funds needed) to reach coverage targets for sanitation and 66% of countries indicate insufficient financing to reach coverage targets for drinking-water.

Fig. 6 **Comparison of public expenditure contributions by country income groups**



Source: 2013 GLAAS country survey

Fig. 7 **Comparison of household contributions by country income groups**



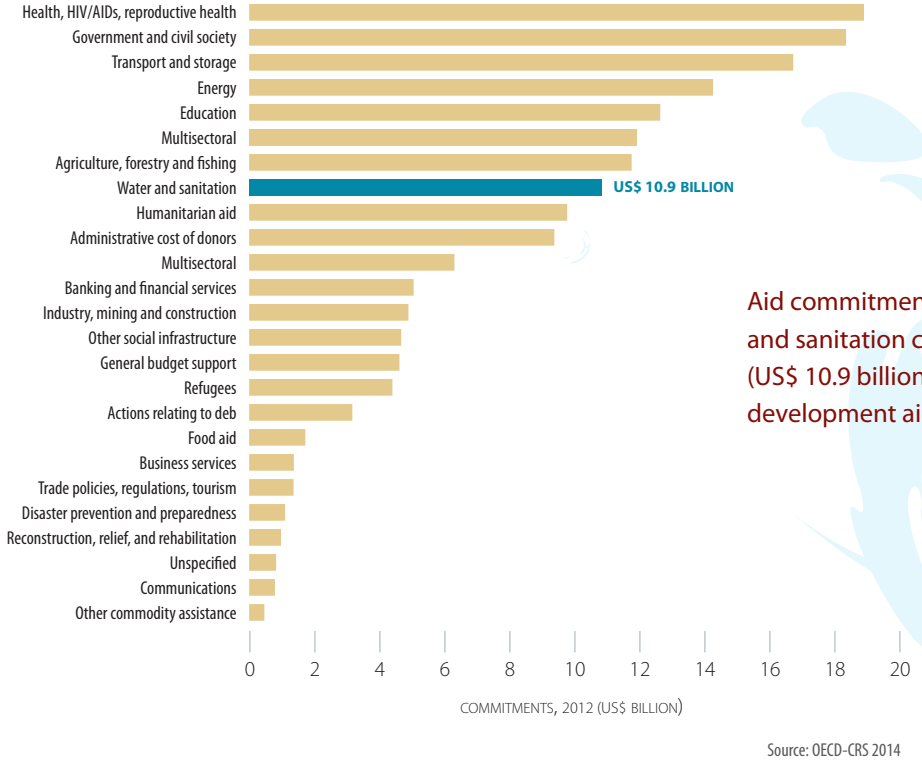
Source: 2013 GLAAS country survey

NOTE:
While some countries provided data on both tariffs and self-supply, most countries providing household contribution data could only provide tariff data which may be a small percentage of household contribution in less developed areas without a formal service provider.

b. Aid policy prioritization, commitments and disbursements

- The total amount of development aid[7] for sanitation and drinking-water increased to over US$ 10.9 billion in 2012, from US$ 8.0 billion in 2008.

Fig. 8 **Comparison of WASH development aid in 2012 relative to other sectors**

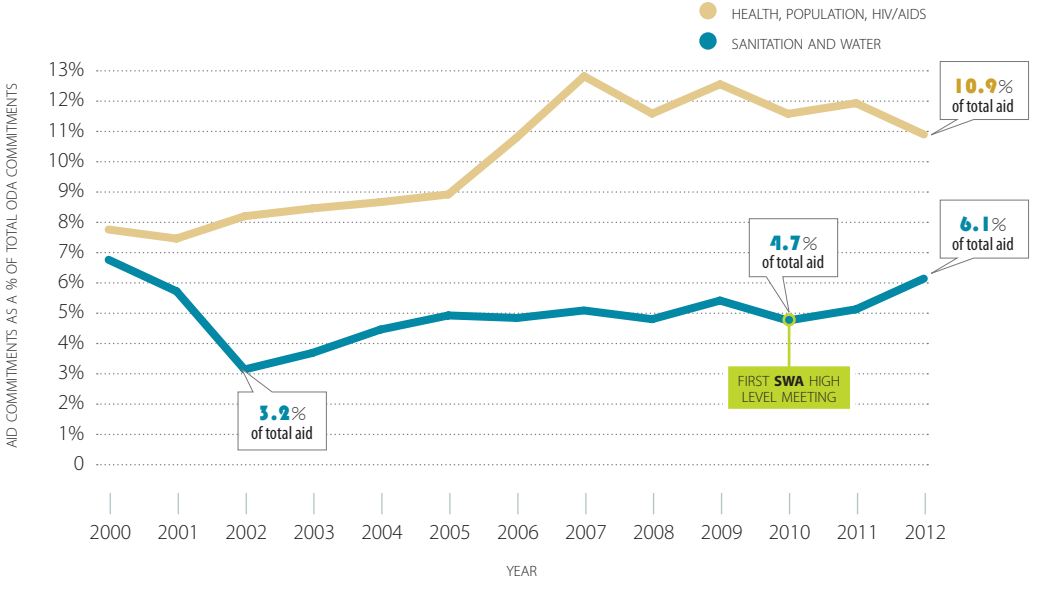


Aid commitments to water and sanitation comprised 6.1% (US$ 10.9 billion) of total reported development aid in 2012. [FIG. 8]

Source: OECD-CRS 2014

- Aid disbursements have not increased proportionally with commitments, and have remained flat over the past three years.

Fig. 9 **Comparison of WASH development aid and health, population and HIV/AIDS over time**



Development aid for water and sanitation has risen from 4.7% to 6.1% of total development aid from 2010 to 2012, and nearly doubled as a proportion of total aid since 2002, rising more rapidly since the first Sanitation and Water for All (SWA) High-Level Meeting in 2010. [FIG. 9]

Source: OECD-CRS 2014

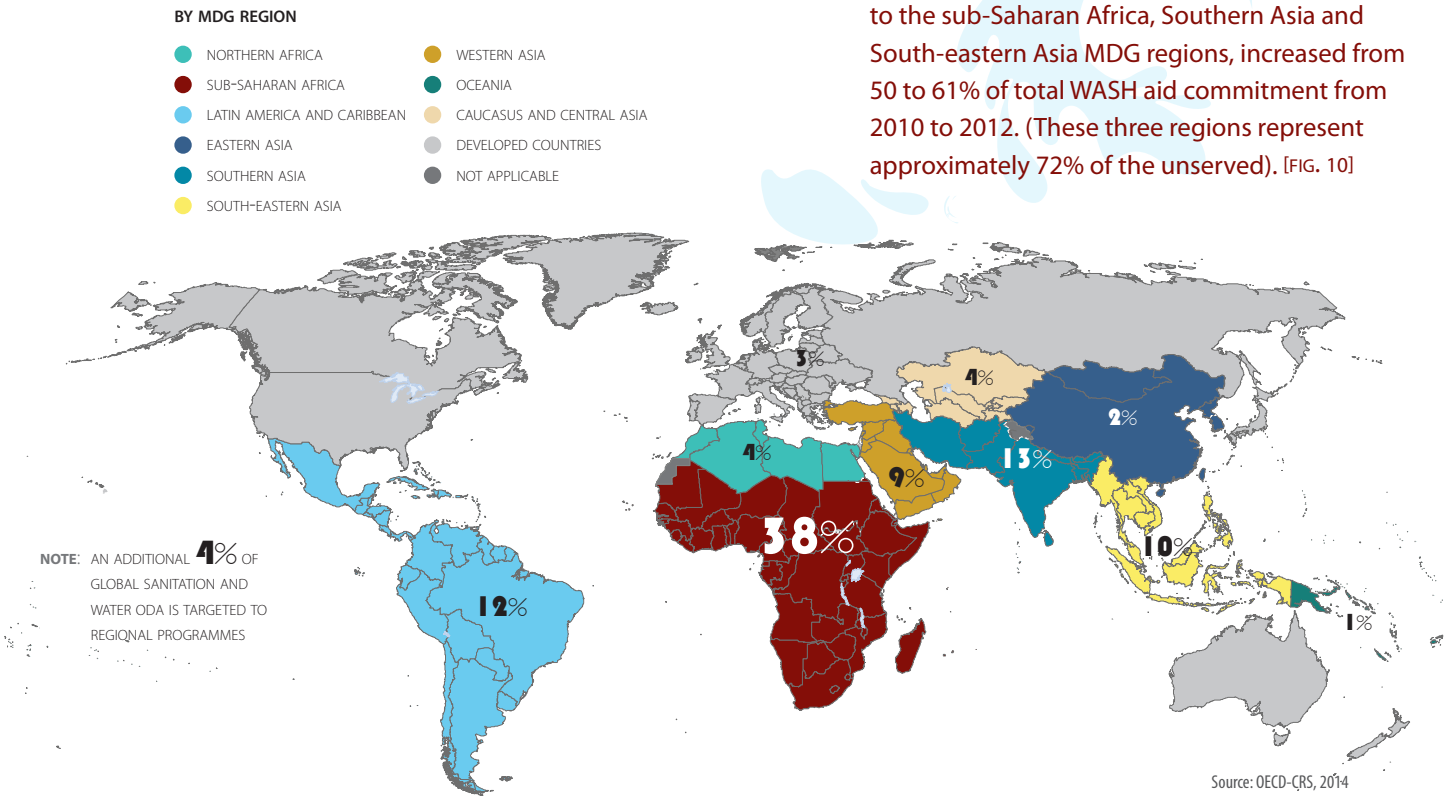
7 Development aid that meets official development assistance (ODA) criteria defined by the Organisation for Economic Co-operation and Development (OECD).

c. Aid targeting

- Over 50% of the unserved populations for both sanitation and drinking-water live in middle income countries.
- The distribution of WASH aid among country income groups broadly aligns with where unserved populations live.
- Development aid for sanitation and drinking-water to fragile and conflict-affected states doubled from US$ 600 million to over US$ 1.2 billion from 2007 to 2012.

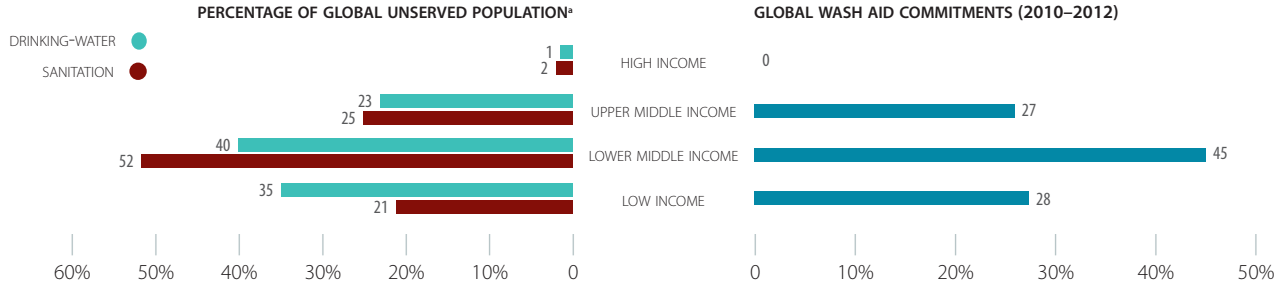
Fig. 10 **Global water and sanitation aid commitments by MDG region, 2012**

Sanitation and drinking-water aid targeted to the sub-Saharan Africa, Southern Asia and South-eastern Asia MDG regions, increased from 50 to 61% of total WASH aid commitment from 2010 to 2012. (These three regions represent approximately 72% of the unserved). [FIG. 10]



Source: OECD-CRS, 2014

Fig. 11 **Comparison of percentage of unserved population and WASH aid by income categories**



a Percentages are based on the number of persons without access to improved sanitation (or drinking-water from an improved source) in each country income category versus the total (global) number of persons without access.

Source: OECD-CRS, 2014; World Bank, 2014; WHO/UNICEF, 2014

Low and lower middle income countries receive 73% of total WASH aid, which is also where many unserved populations live with 73% and 75% coverage for sanitation and drinking-water respectively. [FIG. 11]

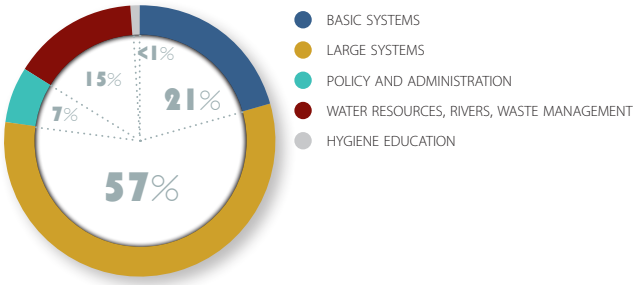
Aid for basic WASH services has declined as a proportion of overall aid for water and sanitation. [FIG. 12]

- The European Commission, Australia, Switzerland, and the Netherlands target a significant proportion of aid for basic sanitation and drinking-water services, as well as providing most aid in the form of grants. Other important contributors, in terms of aid amounts to basic services, include Japan, Germany, the World Bank, and the Asian Development Bank.

Fig. 12 **Breakdown of sanitation and water aid commitments by purpose types, 2012**

BASIC/LARGE: Aid for basic sanitation and drinking-water services decreased from 26% to 21% of overall sanitation and water aid commitments between 2010 and 2012.

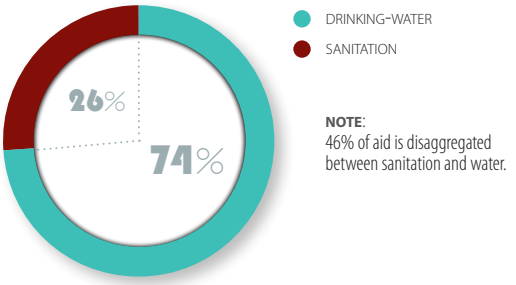
BREAKDOWN OF SANITATION AND WATER AID COMMITMENTS BY PURPOSE TYPES, 2012



Source: OECD-CRS, 2014

WATER/SANITATION: Aid commitments for sanitation comprised one-fourth of water and sanitation ODA in 2012, as compared to one-third in 2010.

COMPARISON OF DONOR COMMITMENTS FOR SANITATION WITH DONOR COMMITMENTS FOR DRINKING-WATER, 2012 (US$ 3.8 BILLION)



NOTE:
46% of aid is disaggregated between sanitation and water.

Source: OECD-CRS, 2014

WHAT ARE BASIC SYSTEMS?

Basic drinking-water systems include rural water supply schemes using handpumps, spring catchments, gravity-fed systems, rainwater collection and fog harvesting, storage tanks, and small distribution systems typically with shared connections/points of use; and urban schemes using handpumps and local neighbourhood networks, including those with shared connections.

Basic sanitation systems are defined as latrines, on-site disposal and alternative sanitation systems, including the promotion of household and community investments in the construction of these facilities.

Source: OECD, 2012

RWANDA

Prioritizing basic services has helped to eliminate open defecation and increase access to improved sanitation, especially in rural areas

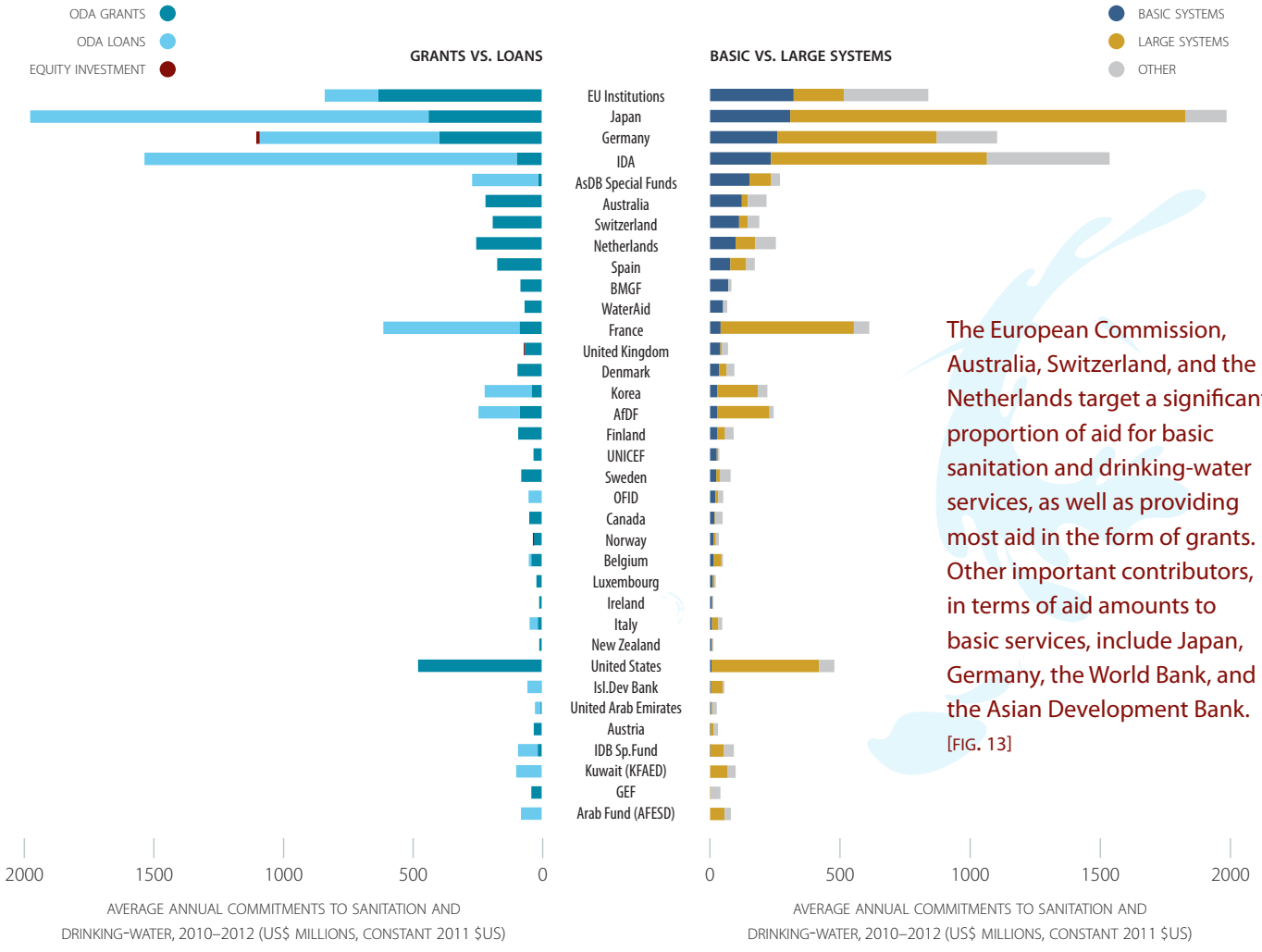
The Rwanda National Water Supply and Sanitation Policy and Strategic Plan[8] published in 2010 set ambitious targets of achieving 85% of the population having access to drinking water and 65% to improved sanitation by 2015 with universal coverage to be achieved by 2020. The time-frame for universal coverage was brought forward to 2017 in a policy update in 2012. The policy also promotes prioritization of basic services ('some for all' rather than 'all for some'), decentralization of service provision, participation by communities, cost recovery and financial sustainability, preferential treatment of vulnerable groups, and a strong framework for monitoring results including the development of a WASH Management Information System. At over 4% of the national budget (and almost 1% of GDP) allocations to WASH were relatively high in 2008, but they have since declined. The result of the policies and actions of the Government of Rwanda and other stakeholders in the sector have been relatively successful for sanitation, with open defecation almost eliminated and access to improved sanitation increased for all wealth quintiles for both urban and rural populations. Overall in rural areas, there has been an increase in improved sanitation from 53% in 2005 to 64% in 2012.[9] However, there has been a general decline in access to improved drinking water in urban areas with 81% of urban populations having access in 2012 compared to 84% in 2005.[9] Increasing coverage for drinking water is a major challenge, given the relatively high cost of operating water systems in both urban and rural environments due to the poor quality of the raw water and the mountainous terrain that increases the cost of treatment and pumping respectively.

8 Republic of Rwanda (2010) National Policy and Strategy for Water Supply and Sanitation Services. Ministry of Infrastructure, Kigali, Republic of Rwanda. Available at: http://www.rura.rw/fileadmin/docs/Board_Decisions/WATSAN_Policy_Strategy.pdf [accessed 31 March 2014].

9 WHO/UNICEF (2014) Progress on drinking-water and sanitation – 2014 update. Geneva, World Health Organization.

d. Aid allocation by ESAs

Fig. 13 **Breakdown in aid commitments to sanitation and drinking-water, among grants and loans, and purpose types, 2010–2012 annual average**



Source: OECD-CRS, 2014

AfDF, African Development Fund, African Development Bank; AFESD, Arab Fund for Economic and Social Development; ADB, Asian Development Bank; BMGF, Bill & Melinda Gates Foundation; EU, European Union; IDA, International Development Association, World Bank; IDB, Inter-American Development Bank; OFID, OPEC Fund for International Development; OPEC, Organization of the Petroleum Exporting Countries; UNICEF, United Nations Children's Fund; USA, United States of America.

The European Commission, Australia, Switzerland, and the Netherlands target a significant proportion of aid for basic sanitation and drinking-water services, as well as providing most aid in the form of grants. Other important contributors, in terms of aid amounts to basic services, include Japan, Germany, the World Bank, and the Asian Development Bank. [FIG. 13]

Most ESAs target funding towards improving health outcomes and welfare of the poorest. Some agencies report they specifically monitor impacts of WASH aid directed to marginalized and vulnerable groups.

- The Netherlands and Switzerland indicate a focus on slums, or poor, rural communities.
- Twelve ESAs disaggregate WASH aid between urban and rural areas – nine out of the 12 are donor countries or multi-laterals, while three are NGOs or foundations (Asian Development Bank, African Development Bank, BRAC, Canada, France, Bill and Melinda Gates foundation, Inter-American Development Bank, the Netherlands, Switzerland, United Kingdom, UNDP and WaterAid).
- The World Bank indicates future plans include improved gender monitoring.

e. Targets and future focus

Every year, ESAs help on average nearly 100 million people gain access to improved drinking-water and over 125 million people gain access to improved sanitation. [TABLE 3]

Table 3 **ESA targets and timeframe**

EXTERNAL SUPPORT AGENCY	POPULATION WITH INCREASED SERVICES (DRINKING-WATER)	POPULATION WITH INCREASED SERVICES (SANITATION)	FUNDING TARGETS	TIME-FRAME
African Development Bank	155 million	226 million		2008–2015 (Rural Water Supply and Sanitation Initiative)
Asian Development Bank	500 million		Sanitation investments to increase at least 25% of total WASH lending	2011–2020 (Water Financing Program)
Australia	8.5 million	5 million		2012–2013
Bill and Melinda Gates Foundation	—	—	US$ 80 million	2010–2015 (annual)
France	1.5 million per year	1 million per year		Annual targets
Netherlands	25 million	25 million		2010–2015 (sanitation) 2010–2018 (drinking-water)
Sweden	—	—	SEK 410 million	2014–2016 (annual)
Switzerland	—	—	CHF 150 million	2014–2016 (annual)
United Kingdom	60 million first time access to water, sanitation and/or hygiene			end-2015
USA	10 million (first-time access)	6 million (first-time access)		2013–2018
World Bank (WSP)	—	50 million		2011–2015

Source: OECD-CRS, 2014 and 2013 GLAAS country survey

"In Kenya, GLAAS results have helped re-define the national WASH indicators which will now be incorporated into the Kenyan national indicator core set monitored on a regular basis. The framework is in progress at the moment."

Benjamin Murkomen
WASH-CLTS Hub M & E
Sanitation & Hygiene Unit
Division of Environmental Health
Ministry of Health
Kenya

"In Madagascar, all key WASH stakeholders, including national and international NGOs, UNICEF, WaterAid and government officials from a number of Ministries are actively engaged in implementing GLAAS."

Solphi Joli Hamelo
Direction du Développement du Partenariat (DDP)
Ministère de L'Eau
Madagascar

This report was developed and coordinated by the GLAAS team in the Water, Sanitation, Hygiene and Health (WSH) Unit at the World Health Organization (WHO) in preparation for the Sanitation and Water for All (SWA) High-Level Meeting (HLM), April 2014. It contains compiled information from 86 countries and 21 external support agencies (ESAs),and does not necessarily represent the decisions or policies of the World Health Organization. These results have been compiled based on the 2013 GLAAS Country and ESA Surveys submitted by participating countries, combined with data from the Organisation for Economic Development and Cooperation (OECD) Creditor Reporting System (CRS) and feedback from interviews conducted with donor representatives at World Water Week in Stockholm, September 2013. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part 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. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

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(Note: Additional countries, e.g. India, Nigeria, Sri Lanka and Zimbabwe will be included in the analysis of the full GLAAS report to be published in September 2014)

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