Ministry of Rural Rehabilitation and Development(MRRD)
Rural Water Supply, Sanitation and Irrigation Programme (RuWatSIP)

Country Paper/Afghanistan

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The Islamic Republic of Afghanistan is a landlocked country located within South and Central Asia. It has a population of approximately 32 million, making it the 42nd most populous country in the world. This includes roughly 2.7 million Afghan refugees still living in Pakistan and Iran. It is bordered by Pakistan in the south and east; Iran in the west; Turkmenistan, Uzbekistan, and Tajikistan in the north; and China in the far northeast. Its territory covers 652,000 km^2, making it the 41st largest country in the world. Human habitation in Afghanistan dates back to the Middle Paleolithic Era, and the country's strategic location along the Silk Road connected it to the cultures of the Middle East and other parts of Asia.

The largest city with over three million residents is its capital, Kabul. Other large cities in the country are, in order of population size, Kandahar, Herat, Mazar-i-Sharif, Jalalabad, Lashkar Gah, Taloqan, Khost, Sheberghan, and Ghazni. Urban areas are experiencing rapid population growth following the return of over five million expatriates. The percentage of urban population living in slums is almost 74 percent of the total urban population in Afghanistan (5.1 million people). Slum dwellers, as defined by the Millennium Development Goals (MDGs) indicator 7.10, are still a very significant number even if their numbers and proportion have slight decreased in comparison to the 2011-12 ALCS. According to the Population Reference Bureau, the Afghan population is estimated to increase to 82 million by 2050.

Since the fall of the Taliban, the government has struggled to extend its authority beyond the capital and to forge national unity through provision of social services for the communities. Meanwhile, the Afghan government was able to build some democratic structures, and the country changed its name to the Islamic Republic of Afghanistan. Attempts were made, often with the support of foreign donor countries, to improve the country's economy, healthcare, education, transport, and agriculture.

Despite of the existing tremendous mineral resources (1-3 trillion USD), fertile lands, and water sources Afghanistan is still an impoverished least developed country, one of the world's poorest because of decades of war and lack of foreign investment. As of 2014, the nation's Gross Domestic Product (GDP) stands at about $60.58 billion with an exchange rate of $20.31 billion, and the GDP per capita is $1,900. The country's exports totaled $2.7 billion in 2012. Its unemployment rate was reported in 2008 at about 35%. According to a 2009 report, about 42% of the population lives on less than $1 a day. The nation has less than $1.5 billion in external debt. According to the Human Development Index, Afghanistan is the 15th least developed country in the world. The average life expectancy is estimated to be around 60 years for both sexes. The country has one of the highest maternal mortality rate in the world as well as the highest infant mortality rate in the world (deaths of babies under one year), estimated in 2015 to be 115.08 deaths/1,000 live births. Data from 2010 suggested that one in ten children die before they are five years old. The Ministry of Public Health (MoPH) plans to cut the infant mortality rate to 400 for every 100,000 live births before 2020. The country currently has more than 3,000 midwives, with an additional 300 to 400 being trained each year.

Provision of some of life-sustaining services as Water, Sanitation and Hygiene (WASH) particularly sanitation despite recent developments still remains one of the lowest in the world. (% 2.4 in the rural areas and $ 8.3 nationally). Water supply in Afghanistan is characterized by a number of achievements expansion of a community based rural water

supply, expansion of urban water supply in cities such as Heart and Kunduz, such as and challenges, and reform of the institutional framework for urban water supply through the decentralization of service provision from an ineffective national agency to local utilities managed on the basis of commercial principles. Challenges include a tense security situation, dilapidated infrastructure as a result of decades of war and neglect; a high level of non-revenue water estimated at about 40% including water use from illegal connections; inappropriate pipe materials such as asbestos-cement used for older pipes; a lack of qualified personnel; widespread poverty; and traditional social norms especially concerning the role of women. Internally Displaced Persons (IDPs), returnees and disabled people constitute a mix of humanitarian and development challenges, including protection of their human rights and security of their livelihoods.

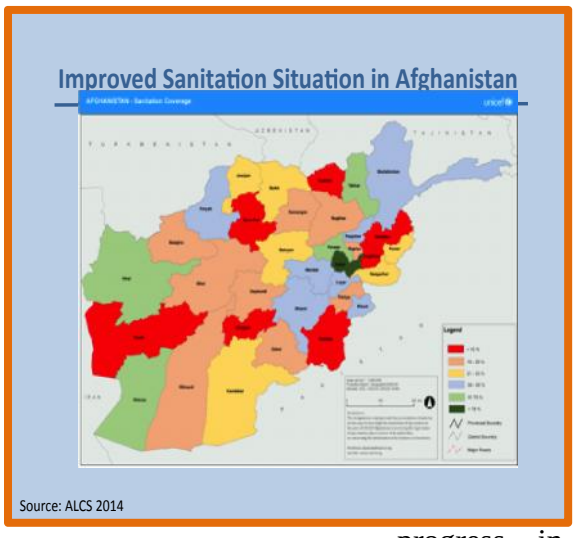
1.1. Development and Planning Framework:

It was in the first time that Afghanistan National Development Strategy (ANDS) 2008-2013) proposes to achieve the MDGs by 2020. The medium-term strategic objectives are set for 5 years, from 2010-2014. For each sector, time specific benchmarks defined. Under the section of Agriculture and Rural Development ANDS highlight that "the Rural Water Supply and Sanitation services will assure that by 2013, 98 percent of villages will have access to safe drinking water and 50 percent of villages will have improved sanitation facilities. This will substantially improve health, hygiene and welfare in rural communities". In line with the ANDS and MDG, MRRD formulated Strategic Intent (2010- 2014). The first paragraph of objective 1 of the strategic intent ends with: All infrastructure projects for potable water supply and sanitation will include training on hygiene and sustainable environmental management.

1.2. Institutional Framework, Legal Instrument:

Since 1950s to 1990s United Nations Children's Fund (UNICEF) as the only support organization helps Afghanistan through the Rural Development Department (RDD) in provision of water supply and small-scale sanitation services for the rural areas. All services were provided through project in ad hoc manner without inclusion of hygiene promotion and large-scale sanitation facilities. To move from project base to programmatic approach, it was in 2003 that the Government of Islamic Republic of Afghanistan (GoIRA) authorized MRRD to lead, through newly established Rural Water Supply and Sanitation Programme (RWSSP), all Rural Water Supply and Sanitation (WATSAN) activities in the country. To do this the rural water supply and sanitation national policy framework was formulated by MRRD with the support of the sector line ministries and stakeholders in September 2004. The policy was revised and renamed as National Rural Water, Sanitation and Hygiene (WASH) Policy in 2010 which provides a roadmap for improving the quality of life of people in rural areas by ensuring access to safe water and improved sanitation and promoting the adoption of hygienic practices at the personal, household and community levels. The policy advocates provision of WASH services in a package with hygiene as the glue in binding water and sanitation together to produce positive health benefits. . Provincial Rural Development Departments PRRDs, District Development Assemblies (DDAs) and Community Development Councils (CDCs) are the respected sector institutions at the provincial, district and village levels respectively. Ministry of Public Health (MoH), Ministry of Education (MoE) and Ministry of Urban Development Affairs (MUDA) are the key sector ministries engaged in WASH services. Sector Internatinal and National Non-Governmental Organizations (I/NGOs), United Nation (UN) agencies, Civil Service Organizations (CSOs) and other support organizations are key sector stakeholders in WASH.

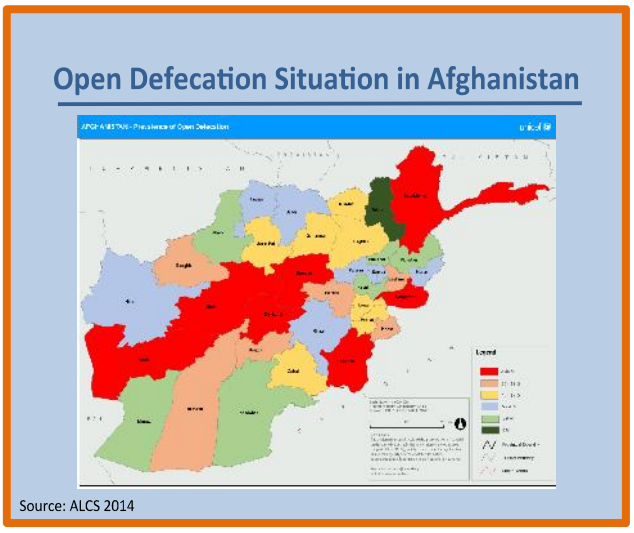
2.1. Coverage Definition:



The 2004/5 National Risk and Vulnerability Analysis (NRVA) survey in Afghanistan reported 7% Improved Sanitation Coverage while NRVA in 2007/8 figured out the same indicator at 5%. The report can hardly explain the decrease in access to improved sanitation comparing NRVA 2004/5 with NRVA 2007/8, although fast population growth and repatriation can be the causes. The Afghan Living Condition Survey (ACLS) 2011-2012 reports this coverage at 8.3 % at national and 2.4% at the rural levels. Recently the ALCS 2014 midyear review report has shown this coverage at 14.9 % and the end year review reported a decrease to 13% which both shows a progress in the improved sanitation. (39% taken into consideration the coverage of population with covered pit latrines. However this category of the latrines is under discussion by the water and sanitation group/WSG whether to be consider as improved sanitation facilities). One of the reasons for this increase could be the new definition of improved and unimproved latrines, which was done by the WSG led by MRRD.

Rapid population growth and unregulated housing development have created serious social and environmental challenges in the urban areas**.**

The common sanitation practice in the country in 2003 had been unimproved raised drop latrines in the east, north-east, center and south where the water table is shallow and the terrain underlain by bed rocks while in the north where the terrain is soft unconsolidated formation and water table is deep, open pit latrines are common.



The above mentioned ACLS also reports 19 % open defecation in 2014 (25 % rural and negligible numbers in urban areas). Open defecation is common is common in 17 provinces.

Mainly central highland and northeast in Badakhshan and Takhar. As far as access to safe drinking water source is concerned ALCS 2014 observed a large increase in the proportion of the population with access to an improved source of drinking water, from 44 percent in 2011-12 to 67 percent in 2014. This implies an unabated continuation of the improvement of the drinking water situation in the country and also implies that the ANDS target of 61.5 percent of the population having access to improved sources has already been achieved six years before the target year of 2020.

2.2. Coverage, (Hygiene Behavioral Change):

Islam does teach privacy, personal and environment hygiene and elite of the religion now and then preach the issues hygiene and privacy in their Friday Prays and other sermons. The high percentage (81%) of Open Defecation Free (ODF) in the country may be accounted for these religious and cultural values. Despite of the high percentage of ODF, the under five mortality rate (U5MR) is estimated 91/1000 (ACLS 2011-2012) the highest in the region. This high figure is accounted for poor sanitation practices as global estimates suggest that interventions aimed at improving hygiene (hand washing) lead to reductions in the frequency of diarrhea by up to 44 percent, which is greater than the reductions achieved through improved water supply alone (25 percent) or sanitation alone (32 percent). Provision of physical infrastructures may look an easy job but changing attitudes of the people prove to be much difficult. In another words without an effort to enhance public awareness about the consequences of poor hygiene and its health implication no sophisticated hardware can sustainably achieve the required solutions.

2.3. Policy/ Strategy, Investment:

Prior to 2010, hygiene promotion had not been spelled out in the policy paper. It was in 2010 that hygiene promotion as an essential part of the services was incorporated into the water supply and sanitation policy framework and renamed as Water Supply, Sanitation and Hygiene (WASH) policy. The WASH policy as a road map was formulated to promote the sector and ensure everyone has gradually access to safe drinking water, uses sanitary latrines, and all the villages are ODF and fully sanitized in the long term , with increased adoption of hygienic behavioral change in households, schools and communities. Afghan Context Community-led Total Sanitation (ACCLTS) as one of the approach and methodology was incorporated in the policy and after contextualization and implementation has shown promise and success as a community mobilization and empowerment strategy. The strategy aimed at behavior change at the community level by creating ODF, and fully sanitized communities through collective local action, and without hardware subsidies to individual households in some parts of the country. While considerable progress has already been made over the last two years, a lot yet remains to be done.

2.4. Monitoring System in Place, Partnership

Monitoring system is not going beyond, reporting by the contractor with the endorsement by the provincial authorities. In MRRD monitoring and reporting section has been newly established and monitoring format has been developed with WSG support and shared with stakeholders. Through creating close partnership with sector I/NGOs, regular reports have been sent to MRRD for compilation. The Management Information System (MIS) Geographical Information System (GIS) system have been newly established and launched. The system is accessible in MRRD website and relevant sector partner can feed the required information to the system and vice versa can retrieve the required information from the system. The system also has started to collect and disseminate disaggregated data at the regional level. Afghanistan is regularly participating in South Asian Conference on Sanitation (SACOSAN). Furthermore membership of Sanitation and Water for All (SWA) is another partnership of the country at the global level. In both of these partnership a number of commitment have given to the forums and regular progress/reports against the agreed indicators are shared with the SWA secretariat and also presented in the meetings called for this purpose

3.1. Reform, Policy Change

Since 2004, the policy has experienced two round of revision one in 2007 and the second time in 2010 when it was renamed as WASH policy. For the implementation of the revised policy strategic plan for five years has been formulated. The sanitation sector mission in the 2010-2014 WASH policy was to provide access to safe sanitation for 50% of the population by 2014. This requires creating 19,425 villages ODF and fully sanitized by creating 520,000 new household toilets and rehabilitation of 700,000 traditional household toilets into safe ones; and rehabilitating 3,500 old toilets in schools and creating 23,000 new ones in schools which will provide safe sanitation in 80% of schools. The total required budget to implement all initiatives in the sanitation strategic plan is US$ 90.68 million over the five-year period. After elapsing two years in 2012 taking into consideration the existing capacity, lack of sufficient funds and inadequate coordination among the stakeholders, the plan proved to be too ambitious. Thus the need for formulation of sanitation strategy which can translate broad, long-term organizational goals in WASH Policy into a set of strategic operational objectives, measures and initiatives in the context of the six identified Strategic Focus Areas (SFAs):
Focus Area Number-1: Strengthening coordination among stakeholders
Focus Area Number-2: Institutional Capacity Building
Focus Area Number-3: Community Education and Mobilization through Afghan Led CLTS approach
Focus Area Number-4: Construction with no or little subsidy
Focus Area Number-5: Creation of Ownership/Sustainability
Focus Area Number-6: People well being through provision of safe sanitation.
The workability of the strategy in terms of scaling up of the coverage proved to be lower than expectation

3.2. Investment Made

Despite investments of over US $ 200 million and construction of approximately 100,000 water points since 2002, sanitation component can hardly experienced up scaling. While 68 % of households make use of some form of a traditional latrine facility, only 13% of the national population has access to safe and hygienic latrines. Use of demonstration latrines, subsidies for latrine construction and traditional hygiene strategies have not been successful in triggering behavior change and generating demand for sanitary latrines on a large scale. The school sanitation programme has brought positive changes in hygiene practices of children attending schools; who are being increasingly seen as promising catalysts of sanitation behavior change at the household and community levels. For scaling up of sanitation at the community level, USAID supported CLTS $ 50 million project in close coordination with Ru-WatSIP/MRRD was piloted in eight provinces by Sustainable Water Supply and Sanitation (SWSS) (2009-2012) with promising results. The Ru-WatSIP/MRRD with the financial support of UNICEF started replication of the CLTS approach in other provinces and the process is still going on. The CLTS concept was reviewed and adapted to Afghan situation and renamed Afghan Context CLTS with strong sanitation improvement and hygiene education components.

3.3. Good Example (innovations, benefits, reforms etc.)

CLTS approach has been contextualized and seconded by hygiene promotion and latrine

improvement and new construction in such a way to merge social, cultural and religious values which help target communities change their attitudes and take practical steps to ensure ODF villages, upgrade their traditional latrines and construct new latrines. Through establishing Family Health Action Group (FHAG) women were actively engaged in improving sanitation practices. Through this innovation all classes of the communities including CDCs members, elders, children, women and religious leaders were participated in the process sanitization of innermost circle of living environment and beyond.

3.4. Social, Technological Advancement etc.

The CDCs together with FHAG as the community based institutions and assets will remain in the communities after the completion of the projects. Also DDAs and Community Health Workers (CHWs) remain as supporters of these institutions. Familiar with the local cultural context, technology, materials, these institutions can coach the households to develop sanitation process from ensuring ODF up to upgrading sanitation facilities and excreta management. The sector I/NGOs led Ventilated Improved Pit Latrines (VIP) and Ventilated Improved Latrines (VIL) technology have been seen replicated in the villages. If Seminar local market/ outlets developed, definitely, people will promote sanitation even faster without any subsidy

4.1. Coverage


Despite the innovation brought about in creating enabling environment and advocating the sanitation coverage at the national level can hardly go beyond 13 [1] %. at the national level. Understaffing and poor capacity at the sub-national level as well as insufficient donation and inadequate political will are among the most deferring factors in against scaling up of sanitation and ensuring universal coverage. Poor public awareness about the link between sanitation and health is another gap at the community level.

4.2. Technology

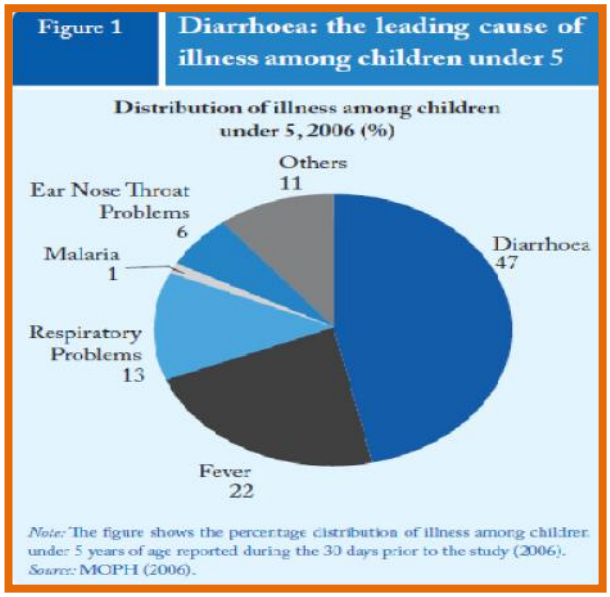
Raised drop single vault and open pit latrines, depending on the types of terrains and groundwater locations, are among the most common traditional latrines that are being used by rural communities. 68 % of rural communities are using these kinds of latrines.

Double vault composting latrines, echosan latrines, VIP and VIL are among the improved latrines which are largely being used in the rural communities as well as urban areas. Further to social factors, lack of sanitation marketing (SanMark) in which private sector can play a much greater role in providing sustained access to improved sanitation to low-income households is the technological gap to be addressed. SanMark invests strategic support to help private sector, through sustain supply chain, to sell more affordable, desirable products including concrete or squatting slabs, manhole covers, ventilation pipes, and other elements to traditionally un-served consumers. Despite of the known economic value of the compost to the farming communities, poor excreta management is still a common practice both in semi- urban, urban and rural communities.

[1] ACLS

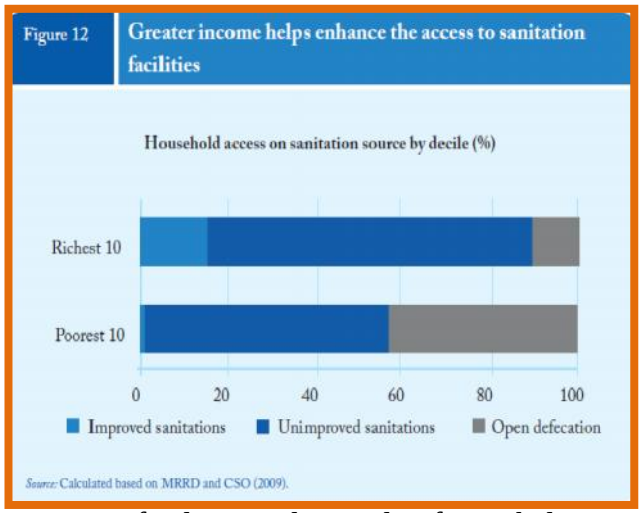
4.3. Health

MRU5 is estimated 91/1000, which is unacceptable, and the highest in the region and 23% of the mortality is accounted for the poor sanitation practices. This means that, every hour, three to four children under 5 die because of the effects of diarrhea. Analysis of health management information system data reveals that an average of 43 percent (ranging from 22 to 51 percent) of the admissions of children aged 0–59 months across 70 hospitals were due to diarrhea, including dehydration, bloody diarrhea and other complicated cases of diarrhea. On average, Afghan children undergo six episodes of diarrheal disease each year. Repeated bouts of diarrhea contribute to an increase in the occurrence of persistent diarrhea, which is considered a cause of malnutrition. Forty-two per cent of young children in Afghanistan are stunted, a result of being malnourished and having been exposed regularly to pathogens of fecal origin due to lack of safe drinking water, sanitation and poor hygiene behavior. Limited hygiene education and the lack of awareness campaigns that link sanitation and health, mean that Afghans are not demanding that government leaders provide basic services.



4.4. Equity and Rights

Access to water is not only a basic human right and an intrinsically important indicator of human progress. It also gives substance to other human rights; it is a precondition for the attainment of wider human development goals. In Afghanistan, overall access to improved sanitation facilities are lower in rural in comparison to urban areas across the country, though differences exist in the types of sanitation facilities used. Alongside rural-urban coverage ratio, the difference between rich and poor households in terms of access to sanitation facilities is conspicuous. The difference between rich and poor households in terms of access to sanitation facilities is depicted in figure below.



The richest 10 percent (the top decile) in the population is16 times[2] more likely than the poorest decile to have access to improved sanitation facilities. While income status certainly contributes to this outcome among the poor, lack of awareness and low demand for improved sanitation also contribute.

[2] NHDR 2011

5.1. Sanitation beyond MDG,

In reference with the gaps and challenges narrated, Afghanistan could hardly meet MDG in sanitation perspective because of the reasons highlighted in the previous sections. In the light of experiences gained through regional SACOSAN and global SWA partnership and field evidence, WASH sector will experience paradigm shift both in improving the enabling environment and process, which lead to up scaling sanitation coverage. The revised WASH policy through the taskforce committee represented by key stakeholders including government sector ministries, sector INGOs and support organization is an example of the strengthening of the sector working environment. The revised policy paper focus, specifically, on sanitation promotion through ACCLTS a well-tested approach. In respect of process improvement and scaling up of sanitation coverage a five days Logical Framework Analysis (LFA) workshop on acceleration of rural sanitation in Afghanistan with the technical and financial support of UNICEF has been conducted (13-17th June 2015) . The workshop brought together 22 participants, including policy makers, mangers and practitioners from key sector ministries (MoPH, MRRD), sector INGOs and UNICEF. The overall objectives of the event was to use LFA as a tool to create common understanding among the partners regarding what the problem is (context analysis), service providers-end users (stakeholders analysis), result- activities-indicators-assumption (what matrix analysis), and how it will happen (management analysis). Based on the LFA workshop outcome, a 10 years sanitation specific plan as part of WASH strategic plan is in the process of formulation that will be included in the revised WASH policy as an annexure.

The LFA workshop is in line with the MRRD concept note on Reformed and Refreshed Ministry in 2015 which defines social development as communities' well-being in terms of people's physical health, a clean living environment, and access to basic services. Based on this concept, MRRD will address services that other ministries do not provide, such as clean drinking water and sanitation. The concept is clearly reflected in the revised WASH Policy. Similarly the workshop is in tune with the UN Sustainable Development Goal (UNSDG) number 6 section 2 of Open Working Group (OWG) proposal for Sustainable Development Goal (SDG) which says" By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations" will be utilized to integrate internal and external sources to ensure sustainability, overcoming the challenges and marching towards universal coverage and improving the service level. Focused effort will be made on upgrading the traditional latrines, which secure 68 % of the sanitation practice scenario.

In the World Bank (WB) supported Program for Result (P-for-R) 100 million $ which is in pipeline 10% is allotted for hygiene and sanitation. This five year initiative is based on deep study report commissioned by WB was planned to be implemented from 2015-2018 in priority areas with the lowermost sanitation and water supply coverage.

5.2. Sustainability

The process of LFA workshop was going on in completely participatory way. After ensuring common understanding among the participants regarding low sanitation coverage, the main factor of high mortality rate of children under five MU5, as the problem and sanitation promotion/CLTS as one of the mean for ensuring behavior change, good sanitation practice and subsequently reduced MU5 as an objective/purpose, the LFA has been utilized. Through this approach and in the context of sanitation, the concept of objective, outcome/impact,

outputs/activities, indicators and assumption was thoroughly discussed. The process was accompanied by drafting 10 years plan (scope of activities). Similarly social marketing, hygiene promotion and public awareness campaigns through media and CLTS approach will enlighten the link between sanitation and health at the grass root level. Also enhancing of coordination among the key stakeholders through regular monthly coordination meeting-sanitation Technical Working Group (STWG) and reporting process in line with the defined responsibility in WASH policy will help ensure sustainability. Also involvement of the community structures and private sector is also a strategy for more sustainable sanitation interventions. Newly established GIS/MIS system will be utilized as monitoring tool for the delivered services.

5.3. Overcome the Barriers

Low capacity at the sub-national level, donor fatigues, weak political commitment and public unawareness about the link between sanitation and health as well as security that results in inability to monitor seems to be the main barriers in front of marching towards universal sanitation coverage. To overcome the narrated challenges focused efforts are required to be made in different aspects from strategic issues down to the process. The LFA workshop thoroughly highlighted the barriers and gives us a synoptic view about the problems poor sanitation practices, existing capacity at the national, sub-national and grassroots levels and adapted Afghan CLTS as a tool for behavior change. In another words LFA workshop was able to create common understanding among the partners regarding what the barriers are (context analysis), service providers-end users (stakeholders analysis), result-activities-indicators-assumption (what matrix analysis), and how it will happen (management analysis).

5.4. Universal Coverage and Improving the Service Level

Field evidence revealed that WASH Policy targets for Sanitation (2010-2014) would not go beyond aspiration. The Afghan Living Condition Survey (ACLS) 2011-2012 reports this coverage at 8.3 % at national and 2.4% at the rural levels. Recently the ALCS 2014 midyear review report has shown this coverage at 14.9 % and the end year review reported a decrease to 13% which both shows a progress in the improved sanitation. For scaling up the coverage, in the back drop of the aforementioned MRRD led taskforce committee WSG started and finalized the revision of the Policy. The revised product recommends the replication of the nationally well tested ACCLTS approach, taking into consideration the field evidence and hence accompanied by strategic action plan. Based on the above mentioned 10 years drafted sanitation plan, 15,500 villages with more or less 3,500,000 people in 17 provinces will become ODF and subsequently fully sanitized with no subsidy. To do this, 150 CLTS teams with five persons each will be hired and trained. The Plan considers the population distribution in the country and advocates targeting interventions in accordance with the high rate of OD, polio prevalence and stunting revealed in MoPH nutrition survey. All the activities will be managed and coordinated by a competent responsible project management unit/ PMU. Similarly WSG members will synergize its activities with Initiative for Hygiene, Sanitation and Nutrition project (IHSAN) will be fully benefitting from the synergies and inter-linked benefits of having access to sufficient quantities of safe drinking water, the use of an improved latrine or toilet and appropriate hygiene behavior – including washing hands with water and soap and safe handling and disposal of (child-) feces and addressing menstrual hygiene for girls. In WB supported P-for-R 100 million $ which is in pipeline 10% is allotted for hygiene and sanitation. This five year initiative is based on deep study report commissioned by WB was planned to be implemented from 2015-2018 in priority areas with the lowermost sanitation and water supply coverage.

Based on the field evidence, identified gaps and challenges both in strategy and process, Ru-WatSIP/MRRD and sector stakeholders including support organizations started improving enabling environment wherein the role and responsibility of all stakeholders will be defined. Similarly the sector partners in a joint effort undertook the process of discussing and agreeing on common definition and criteria for improved and unimproved sanitation facilities. The finalized definitions had been submitted to Central Statistic Organization (CSO) that is also part of the process. After ensuring common understanding among the participants regarding low sanitation coverage, the main factor of high mortality rate of children under five MU5, as the problem and sanitation promotion/ACCLTS as one of the mean for ensuring reduced MU5 as an objective/purpose, the LFA has been utilized. Through this approach and in the context of sanitation, the concept of objective, outcome/impact, outputs/activities, indicators and assumption was thoroughly discussed. The process was accompanied by drafting 10 years plan (scope of activities). Similarly social marketing, hygiene promotion and public awareness campaigns through media and CLTS approach will enlighten the link between sanitation and health at the grass root level. Also sector ministries and sector I/NGOs started feeding sector data into the newly established GIS/MIS system. This will definitely increase accessibility by different stakeholders to relevant WASH sector information through assembling, analyzing and disseminating available sector data. Replicating contextualized CLTS approach will be a giant step towards universal coverage in sanitation facilities. Regional (SACOSAN) and global (SWA) partnership and given commitment in the relevant events (conferences and meetings) together with agreed indicators will be utilized as roadmap for scaling up sanitation coverage at community, schools and health centers. In emergencies sanitation intervention is also part of the humanitarian WASH cluster that in the long term will merge with development sanitation with considerable funding from humanitarian donors.