Millennium
Development
Goals

ACHIEVING
THE MDGs
IN ASIA:
A CASE FOR
MORE *aid?*

United Nations
E S C A P

Contents

Overview

One of the greatest merits of the Millennium Development Goals (MDGs) is that they provide developing countries and the international development community with a framework for planning policy interventions and monitoring progress in reducing the many dimensions of economic and social poverty. All countries use exact, though mostly relative, targets to achieve their development goals, irrespective of initial conditions.

The Millennium Development Goals Report 2005 published by the United Nations in September 2005, shows in the words of the Secretary-General:

> … how much progress has been made in some areas, and how large an effort is needed to meet the Millennium Development Goals in others. If current trends persist, there is a risk that many of the poorest countries will not be able to meet many of them.

In giving an accounting of progress in achieving the Goals, the report argues that it is especially in countries of sub-Saharan Africa, and to a lesser extent South Asia, where additional effort is needed for the Goals to be reached on time (by 2015). In many cases, efforts must focus on a reversal of negative trends.

A Future Within Reach: Reshaping Institutions in a Region of Disparities to Meet the Millennium Development Goals in Asia and the Pacific, a regional report published by the United Nations Economic and Social Commission for Asia and the Pacific (ESCAP), the United Nations Development Programme (UNDP) and the Asian Development Bank (ADB) around the same time as the Secretary-General's report,

> …finds this region has made rapid progress towards many of the MDGs. But not all the developing countries in Asia and the Pacific are making sufficient progress; indeed none are currently on track to meet all the goals by 2015.

The regional report identifies particular problems in terms of the number of countries that are off-track and the gap that remains to be bridged if the Goals are to be achieved: eliminating extreme poverty and reducing hunger, having children complete primary enrolment, reducing child mortality and providing access to potable water in rural areas. Five of the 55 ESCAP member developing countries, namely: Afghanistan, Timor-Leste, Papua New Guinea, Uzbekistan and Mongolia, are not expected to achieve a single one of their targets for these high-priority indicators. Fourteen others, many located in the subregions (as defined by ESCAP) of South and South-West Asia and North and Central Asia, are off track for achieving more than half of the aforementioned high-priority indicators.

A smaller number of countries have to bridge a large remaining gap in reducing prevalence of the human immunodeficiency virus (HIV), in achieving gender parity at the primary and tertiary education levels in enabling children to reach grade 5 and complete primary school in providing access to water in urban areas and in reducing extreme poverty (people living on less than US$ 1 per day). Smaller gaps remain in reducing maternal mortality in lowering carbon dioxide emissions, in increasing access to sanitation in rural areas and in protecting forest cover; however, few countries are making progress in achieving these indicators. Finally, the Asian and Pacific region has had many successes and relatively small remaining gaps to bridge in reducing the consumption of chlorofluorocarbons (CFCs), in increasing access to sanitation in urban areas, in reaching gender parity at the secondary level of education and in stopping the spread of tuberculosis (TB).

Assessing development on the basis of progress alone, however, is not sufficient. A country that has, for example, slipped back with regard to its access rate to clean water in rural areas from 95 per cent to 94 per cent — perhaps because higher priority is attached to increasing a low primary enrolment rate — would be classified as regressing, while other countries that have much lower access rates for this indicator could be on track.
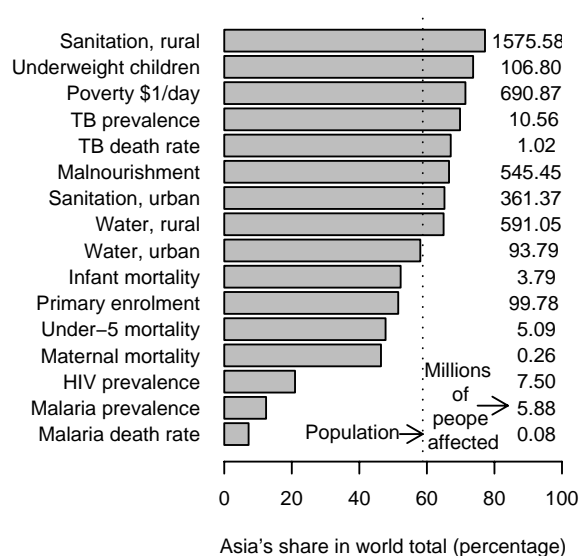
This report attempts to broaden the perspective on performance by highlighting the work that remains to be done in Asia. First, it shows that, despite the progress that many countries in the Asian and the Pacific region are making towards reaching the MDGs, by far the largest number of people affected by the various social and economic dimensions of poverty live in Asia. Second, it demonstrates that, given this large number, Asia is benefiting from relatively small amounts of development aid.

People affected in Asia

Asia is the home of a majority of the world's population; in 2004 Asia accounted for 3.7 billion, or around 60 per cent, of all people globally. The share of Asia in the number of people living in social and economic poverty (as measured by MDG indicators) is in many cases much larger than the Asia's share in the world's population.

Figure 1 shows that Asia accounts for over two thirds of all people living in rural areas without access to sanitation, of underweight children, of people on living less than a dollar a day and of TB cases in the world. It accounts for more than 60 per cent of all malnourished people, people without access to sanitation in urban areas and people without access to water in rural areas.

Figure 1. People living in social and economic poverty in Asia, latest value

Indicator	Value
Sanitation, rural	1575.58
Underweight children	106.80
Poverty $1/day	690.87
TB prevalence	10.56
TB death rate	1.02
Malnourishment	545.45
Sanitation, urban	361.37
Water, rural	591.05
Water, urban	93.79
Infant mortality	3.79
Primary enrolment	99.78
Under–5 mortality	5.09
Maternal mortality	0.26
HIV prevalence	7.50
Malaria prevalence	5.88
Malaria death rate	0.08

Asia's share in world total (percentage)

Note: The unabbreviated indicators are given in annex II.

In which parts of Asia do the affected people live? Table 1 answers this question. The first row of data gives the share of each subregion in the total population of Asia. China and India together account for close to two thirds of the total. In this report and for statistical reasons only China and India are treated as separate subregions. Any reference to East Asia and South Asia in this report, therefore, excludes China and India. The remaining rows indicate the shares of people living in economic and social poverty, as illustrated by the data on various MDG indicators.

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Three quarters of all Asians in rural areas without access to sanitation live in China and India. For China, this reflects the overall situation regarding access to water and sanitation; China's share of the number of people aversely affected consistently exceeds its share in the Asian population. It is only with respect to water and sanitation (in urban areas), however, that China is doing worse than Asia on average. In India, on the other hand, access to water is better, but the country's share in the number of people deprived is larger than its share in Asia's population for almost every indicator. India accounts for 29 per cent of Asia's population, but for over half of its poor and underweight children. With respect to health indicators India is also behind the rest of Asia. India accounts for almost a third of all TB deaths in the region, 38 per cent of all malaria deaths, more than 40 per cent of all child deaths, more than half of all maternal deaths, and over two thirds of all people living with HIV/AIDS (acquired immunodeficiency syndrome).

Table 1. Distribution of affected Asian people across subregions, latest value (percentage)

Indicator	CIS Asia	China	East Asia	India	South Asia	South-East Asia	West Asia
Population	*2.0*	*36.5*	*2.2*	*28.6*	*11.2*	*14.8*	*4.8*
Sanitation, rural	1.3	36.2	0.3	**39.4**	10.8	10.0	1.9
Underweight children	0.4	8.9	0.4	**53.2**	**19.6**	14.3	3.1
Poverty $1/day	1.0	30.8	0.2	**51.3**	10.8	5.3	0.6
TB prevalence	1.0	30.2	1.0	**29.1**	**14.4**	**22.8**	1.4
TB death rate	1.2	22.8	0.9	**32.5**	**17.6**	**23.3**	1.7
Malnourishment	**3.0**	25.9	1.7	**40.7**	**14.7**	12.0	1.9
Sanitation, urban	1.7	**41.8**	1.7	**34.4**	6.8	12.1	1.5
Water, urban	1.5	**41.5**	1.4	12.6	**15.3**	**21.7**	**5.9**
Water, rural	2.0	**43.5**	0.6	23.1	**12.2**	**15.7**	2.8
Infant mortality	**2.5**	13.9	0.6	**43.4**	**22.9**	10.3	**6.5**
Primary enrolment	**2.4**	11.7	0.1	**39.5**	**29.0**	10.1	**7.1**
Under-5 mortality	**2.3**	12.8	0.5	**44.6**	**23.6**	10.2	**6.0**
Maternal mortality	0.5	3.8	0.2	**55.0**	**27.3**	9.5	3.7
HIV prevalence	0.6	9.8	0.4	**66.9**	2.5	**19.1**	0.6
Malaria prevalence	0.4	0.3	1.8	1.3	10.4	**39.3**	**46.6**
Malaria death rate	0.0	0.0	0.0	**38.3**	15.9	**35.8**	**10.1**

Notes: Numbers in bold indicate shares in the number of aversely affected people exceeding shares in population. The unabbreviated indicators are given in annex II.

The situation in other parts of South Asia is broadly similar to that of India. Hunger, expressed in terms of both underweight children and malnourished people is a larger problem than in Asia overall. The subregion's share in child and maternal deaths is more than double its share in the Asian population.

The situation in South-East Asia is similar to that in China. The subregion has smaller shares of people living in deprivation than in the Asian population. Exceptions are causes of illness and disease (HIV/AIDS, malaria and TB) and access to water.

How is Asia doing compared with other regions?

This section analyses by goal the specific parts of Asia and other parts of the world in which the people affected by social and economic poverty live, and the progress that has been made to achieve the MDGs. For each indicator discussed, this report places each subregion into one of four categories:

- ● *Early achiever* — Has already met the target
- ▲ *On track* — Expected to meet the target by 2015
- ■ *Off track – Slow* — Expected to meet the target, but after 2015
- ♦ *Off track – Regressing* — Slipping backwards, or stagnating

The diversity of subregional experience and achievement is summarized in Table 2. Most subregions are early achievers or on track for some indicators, but off track for others. China, for example, is an early achiever for child mortality, but off track for access to clean water. One subregion of the world is uniformly off track for all indicators: sub-Saharan Africa.

Table 2. The world's subregions, on track and off track for achieving MDGs

Goal	1			2	4		5	6			7			
Subregion	Poverty US$ 1	Underweight children	Malnourishment	Primary enrolment	Under-5 mortality	Infant mortality	Maternal mortality	HIV prevalence	TB prevalence	TB death rate	Water, urban	Water, rural	Sanitation, urban	Sanitation, rural
Sub-Sahara Africa	♦	■	■	■	■	■	■	♦	▲	▲	♦	♦	■	■
North Africa	●	■	■	▲	●	▲	▲	▲	▲	▲	●	●	■	♦
Caribbean	●	▲	▲	▲	▲	▲	♦	♦	▲	▲	●	●	▲	▲
Latin America	♦	▲	■	▲	▲	▲	♦	♦	▲	▲	●	●	▲	▲
CIS Asia	▲	●	♦	▲	■	■	■	♦	▲	▲	♦	♦	●	■
China	▲	▲	▲	▲	●	●	■	▲	▲	▲	●	●	♦	■
East Asia	♦	♦	♦	▲	▲	▲	♦	▲	▲	▲	●	●	♦	♦
India	▲	■	♦	♦	■	■	♦	♦	▲	▲	●	●	●	●
South Asia	▲	■	■	▲	■	■	■	♦	▲	▲	●	●	♦	▲
South-East Asia	▲	■	■	■	▲	▲	■	♦	▲	▲	●	●	■	■
West Asia	♦	■	♦	■	■	■	■	♦	▲	▲	●	●	▲	▲
CIS Europe	▲	●	▲	▲	■	■	■	♦	▲	▲	●	●	●	■
Europe in transition	●	●	■	♦	●	●		▲		▲	●	●	●	●
Oceania		●		♦	■	■		♦	▲	▲	●	●	♦	■
Developed regions	●	●	▲	♦	●	●	▲	♦		▲	●	●	●	●
Other											●	●		

Key: ● Early achiever ▲ On track ■ Off track, slow ♦ Off track, regressing

Note: The unabbreviated indicators are given in annex II.

Table 2 also gives an early indication of the most difficult areas. Some of the most serious problem indicators are under MDG 1, MDG 5 and MDG 6; two thirds or more of the subregions are off track for malnourishment, maternal mortality and HIV prevalence. The proportion of subregions off track is only slightly smaller for access to safe water and sanitation in rural areas under MDG 7.

Goal 1 – Eradicate extreme poverty and hunger

Achieving the first goal is fundamental to the overall attainment of the MDGs. Poverty and hunger are both causes and consequences of a lack of education, gender discrimination, ill health and the overexploitation of fragile ecosystems. Most parts of Asia have been making good progress towards halving poverty by 2015, but hunger will not be halved on the continuation of recent trends.

Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar per day

Looking at the global picture in Figure 2, it is striking that with the exception of the countries belonging to the Commonwealth of Independent States (CIS) in Europe and the Caribbean, two areas with low numbers of extremely poor people, only Asia has been making good progress towards reaching the target (see the box above for interpreting the left-hand side of the figure).

The relative progress has not been better than in South-East Asia, where the poverty rate decreased by a percentage point per year, while a reduction of less than half a percentage point per year would be sufficient to reach the target by 2015. South-East Asia is helped, however, by the fact that the dollar a day poverty rate was already relatively low (22 per cent) in 1990. The poverty rates of South Asia and China in that year exceeded 30 per cent; in India and sub-Saharan Africa they were well over 40 per cent. Given the larger gaps to bridge, the progress of China has been particularly impressive, while South Asia and India are also well on their way to achieving the target.

Sadly, this is not the case for sub-Saharan Africa. In order to halve the poverty rate to 22 per cent in 2015, it has to come down by 2.3 percentage points a year which is an ambitious target when poverty has actually been increasing slightly since 1990.

Figure 2. Poor people (living on less than US$ 1 a day)

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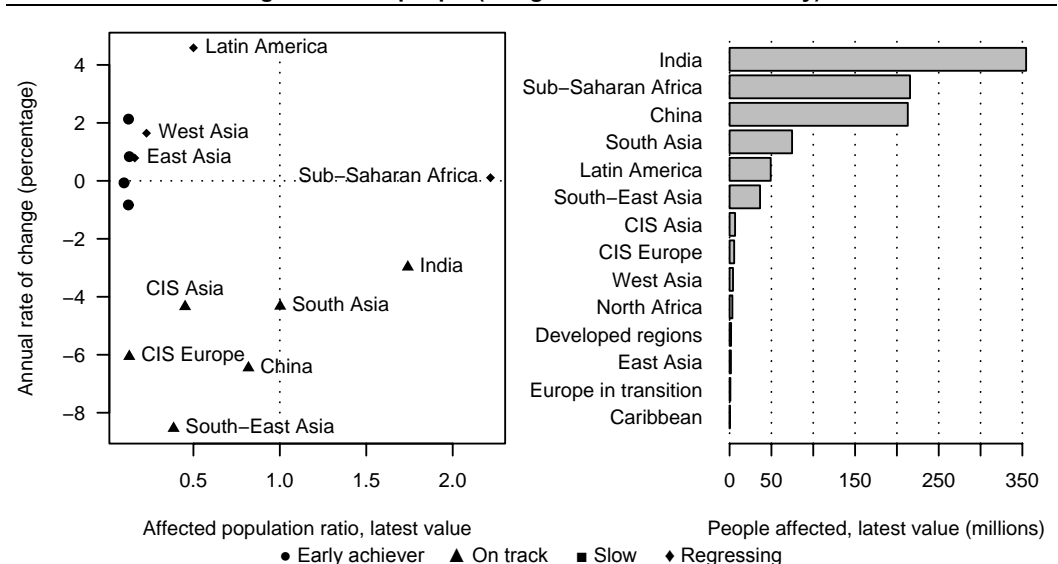
Despite the aforementioned progress, India was still home to 354 million people living on less than US$ 1 per day which is more than of a third of the world's total. This number is 138 million more than in the whole of sub-Saharan Africa. China, with 213 million people still living on less than US$ 1 per day, is third on the list of areas with the largest number of poor people.

Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger

The trend towards reaching the poverty target in most of Asia unfortunately does not translate into proportional decreases in hunger; in fact, most of Asia is likely to miss the targets of halving between 1990 and 2015 the proportion of underweight children and malnourished people.

Figure 3 shows that China is the only subregion in Asia that is on track to reach the target of halving the proportion of children that are underweight by 2015. Apart from East Asia, which has actually been regressing, the rest of Asia has been making progress, but at a too slow a pace.

What explains the remarkable difference in classification of the Asian subregions with regard to US$ 1 per day poverty and underweight children? Part of the reason lies in different starting points. The proportion of children underweight in 1990 was substantially higher than the proportion of the population living on less than US$ 1 per day in all Asian subregions except China; this remained the case around the turn of the millennium. The task of halving the proportion of underweight children is therefore, at least mathematically, more difficult than that of halving poverty. In China and sub-Saharan Africa, in contrast, the proportion of underweight children was substantially lower than the poverty rate in both 1990 and around 2000.

Figure 3. Underweight children
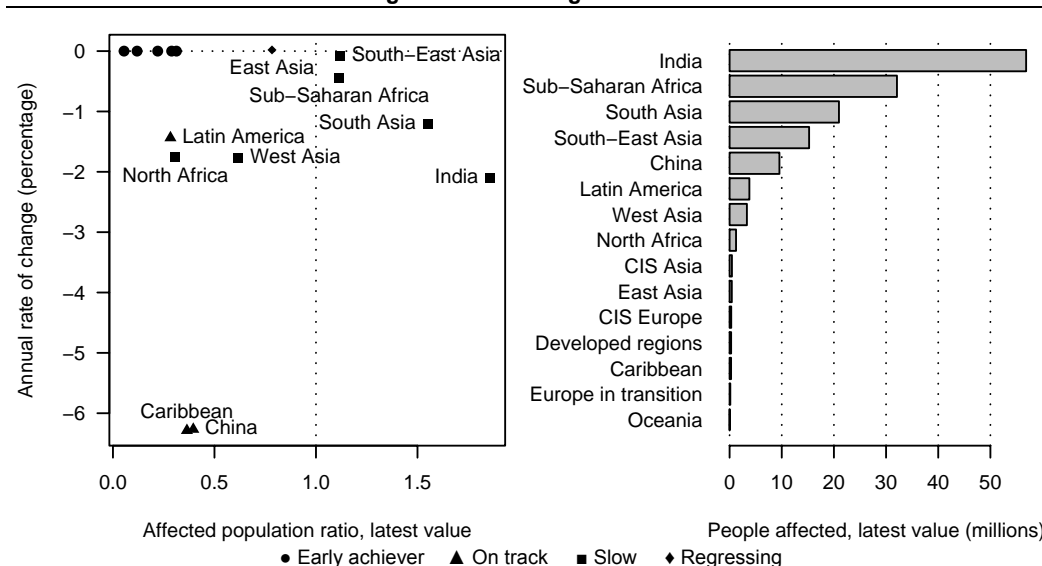
In absolute terms, India is home to 57 million underweight children below age 5, which is 39 per cent of the global total. This is more than one and a half times the number of 32 million for the whole of sub-Saharan Africa at the latest date for which data is available. The subregion with the third largest number of underweight children was South Asia, with 21 million, followed by South-East Asia with 15 million and China with 10 million. West Asia was home to 3 million underweight children.

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Figure 4. Malnourished people
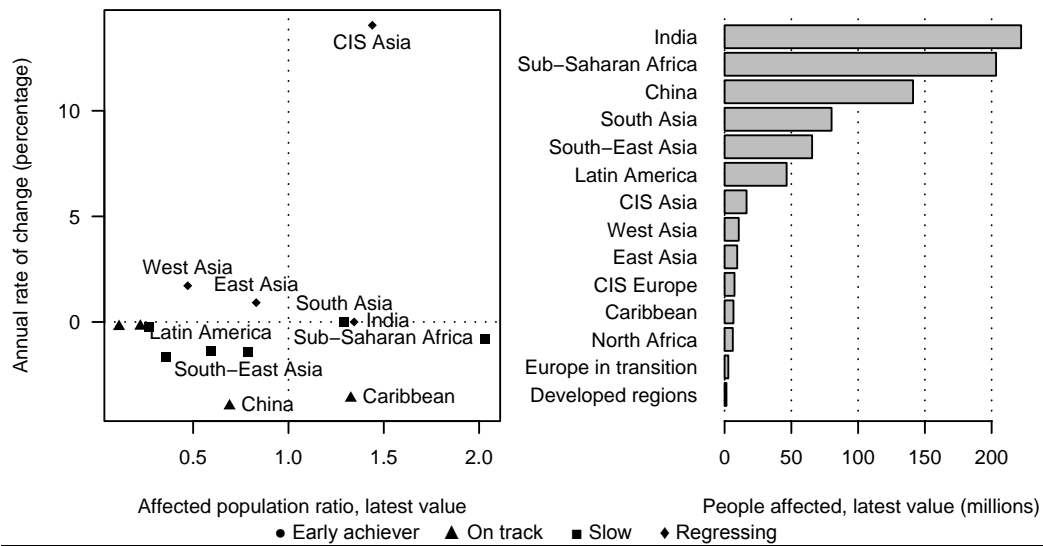
The observations with regard to underweight children in Asia extend to the proportion of malnourished people, as indicated by Figure 4. With the exception of China, no subregion is on track to meet the target by 2015. In fact, India, East Asia and the CIS part of Asia have been regressing from the target, the latter subregion doing so rapidly; its malnutrition rate of 23 per cent is second only to that of sub-Saharan Africa. The reason for the lack of progress, however, differs: malnourishment rates were low compared with poverty rates in 1990 and there has simply not been much progress since.

India (with 222 million) and sub-Saharan Africa, with (203 million) are each home to more than a quarter of all people who daily consume less than the minimum level of dietary energy that humans require. Despite recent progress, China (with 141 million people) is still the subregion with third largest number of malnourished people, followed by South Asia (with 80 million) and South-East Asia (with 66 million).

Goal 2 – Achieve universal primary education

Education is not only a basic right in itself but it also enhances capabilities and it is therefore a critical condition for a person to escape or avoid poverty (Sen, 2000).

Target 3: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling

Three indicators are used to measure this target: the net enrolment rate, the proportion of children starting grade one who reach grade five, and the proportion of children who complete a course of primary education. As the denominator values for the latter two indicators cannot be easily obtained, the following discussion focuses on the enrolment rate.

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Figure 5. Children not enrolled in primary school

Affected population ratio, latest value

People affected, latest value (millions)

● Early achiever ▲ On track ■ Slow ◆ Regressing
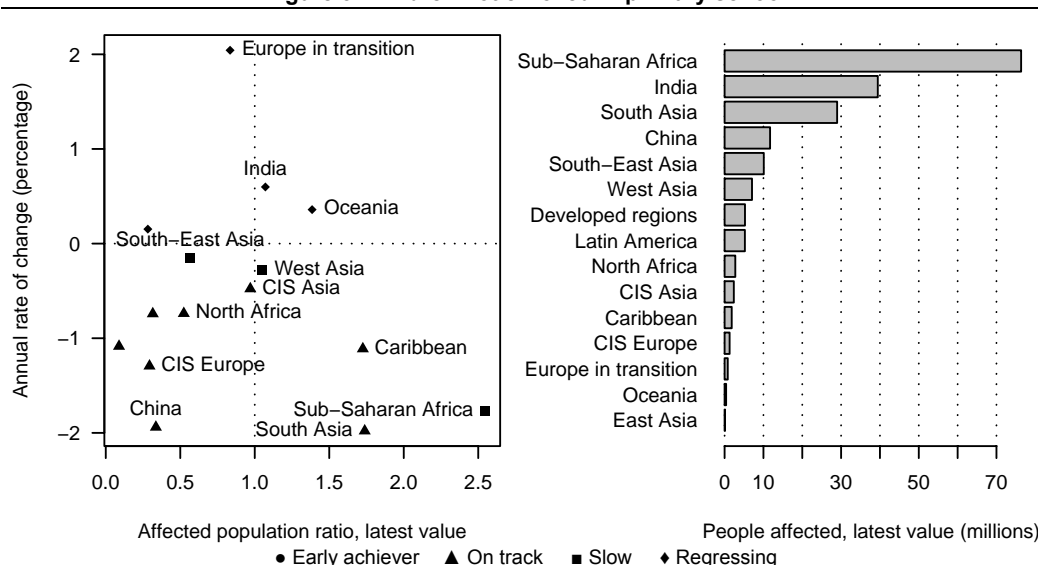
Progress towards an enrolment rate of 95 per cent, the cut-off where the target is considered to be achieved, has been mixed, as shown in Figure 5. While China, South Asia and the CIS countries in Asia have been making good progress towards reaching the target, West Asia, South-East Asia and India have not; the latter two subregions have actually been moving away from the target. Despite its progress, South Asia, after sub-Saharan Africa still has the second lowest enrolment rate: 71 per cent versus 83 per cent for India as a whole.

That India is slipping back is worrying, however, because it is the subregion with the second largest number (39 million) of children not going to school when they should be doing so. This is more than half the number in sub-Saharan Africa (76 million) but that subregion has been making significant progress - in which terms it is only third to South Asia and China - from very high initial non-enrolment rates. It is because of the large gap that sub-Saharan Africa has to bridge that is classified as slow.

Despite the progress noted above, South Asia and China remained the regions with the third and fourth largest number of children not going to primary school, 29 million and 12 million respectively, followed by South-East Asia, 10 million, and West Asia, 7 million.

Goal 3 – Promote gender equality and empower women

The Millennium Summit placed gender equality at the heart of achieving the MDGs. Gender parity entails not only equal access to social services, but also empowerment of women in their families and their communities. The actual target for this goal, however, is restricted to education.

Target 4: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015

Equal participation of women in society and the economy cannot be achieved without gender parity in education, at all levels. Governments can contribute much to the target through generic measures, including legislating and enforcing compulsory education for both boys and girls for as many years as national resources allow, training and employing teachers and providing school facilities.

In countries where resources are lacking, however, girls often lose out when families must choose between sending a girl or a boy to school. Targeted interventions in such settings can go a long way towards getting girls into school and keeping them there. These include providing safe transportation to and from school and separate toilets for girls and boys, and removing gender stereotyping from the classroom (United Nations, 2005).

Figure 6. Illiterate women, 15-24 years old

Excess number of women, 2002 (millions)
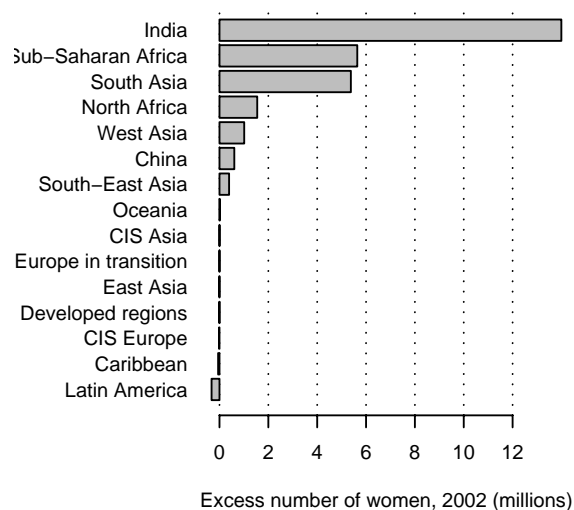
Figure 6 shows that gender inequality in literacy is a particular problem in Asia with the exception of East Asia and Africa. In India 84.2 per cent of all young men were literate in 2002, compared with just 76.4 per cent of all young women. This imbalance resulted in 13 million more young women being illiterate than young men. In Bangladesh, Nepal and Pakistan the male and female young adult literacy rates were 8 to 11 percentage points apart; the subregion had 5.4 million more illiterate young women than young men in 2002.

The literacy rate among young adults in China was around 99 per cent and the gap between the female and male rates was a mere 0.3 percentages point. Because of the sheer size of the country, however, this translated to 607,000 more illiterate young women than young men. The situation in most of South-East Asia was similar. It is in the poorer countries of that subregion, i.e., Cambodia and Lao People's Democratic Republic, where significant gaps (of 4–5 percentage points) remain.

Goal 4 – Reduce child mortality
The perhaps most important indicator of social development is the survival of children beyond the years that they are most likely to succumb to disease and illness.

Target 5: Reduce by two thirds, between 1990 and 2015, the under-5 mortality rate
The two relevant measures for this target are the under-5 mortality rate and infant mortality rate.

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Figure 7. Under-5 deaths

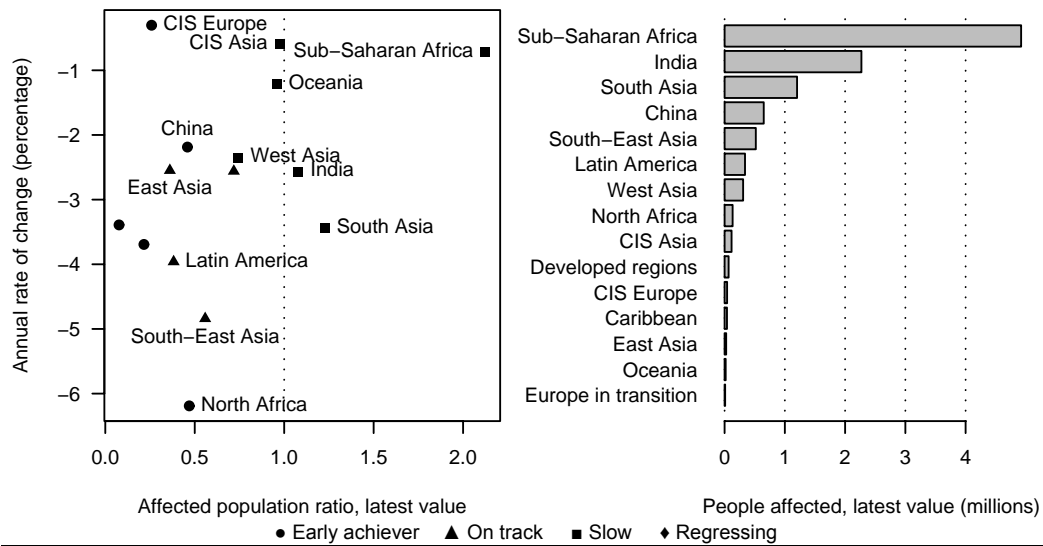Annual rate of change (percentage) vs Affected population ratio, latest value (left); People affected, latest value (millions) (right)

● Early achiever ▲ On track ■ Slow ◆ Regressing

All subregions of the world have been making progress in reducing child mortality over the last three decades; the progress during the last decade and a half is illustrated in Figure 7 and 8. The gains, however, have not been consistent across regions and over time. In sub-Saharan Africa 4.9 million children, the same number as in the entire continent of Asia, die annually before they reach the age of five, accounting for 46 per cent of the world's total of under-5 deaths. This number is more than double the 2.3 million such children who die in India. These regions were followed by South Asia with 1.2 million under -5 deaths, China with 650,000 and South-East Asia with 518,000.

Asia's overall share in under-5 and infant mortality is about half the global total, which is significantly lower than in its 60 per cent share in the global population. Its share of the world's poor and hungry (underweight children and the malnourished), on the other hand, is around two thirds. What explains these differences?

The World Health Organization (WHO, 2003) has established that over half of all child deaths annually are caused by five preventable conditions: diarrhoea, acute respiratory infections, measles, malaria and perinatal conditions. Malnutrition can severely aggravate these conditions; however it is not a leading cause of child mortality in itself.

A major underlying factor of infant and under-5 mortality is HIV/AIDS. The spread of HIV affects children's life expectancy both directly through mother-to-child-transmission, opportunistic infections and the lack of resistance against parasitic disease and indirectly, i.e., the HIV status of adult family members. A child that has lost its mother to AIDS is much more likely to die than a child with a living mother, independently of its own HIV status (see also Figure 9). Moreover, resources utilized to care for family members living with HIV/AIDS are often diverted away from expenditure on children's health. HIV/AIDS is much more prevalent in sub-Saharan Africa than in most of Asia (see Figure 10).

Another factor is that many parts of Asia have improved general health conditions, especially those that help to prevent the spread of communicable infectious disease. Particular progress has been made in the prevention of diarrhoea and measles through increased use of oral rehydration therapy and improved coverage of routine vaccination. As a consequence, many Asian countries are beginning to replicate the cause-of-death patterns found in developed countries, where perinatal conditions rather than infectious diseases

are the leading cause of death. Such a shift has not yet occurred in most of sub-Saharan Africa.

A final important factor in the relatively low contribution of Asia to child mortality globally is a recent shift in demographic patterns. China and India are among the Asian countries where total fertility rates have started to decline in the last decade; declining fertility rates are associated in particular with declining infant mortality rates. This shift has not yet occurred in sub-Saharan Africa. The largest number of infant deaths occurs in sub-Saharan Africa (3 million), India (1.6 million), South Asia (886,000), China (521,000) and South-East Asia (390,000) (WHO, 2003).

Figure 8. Infant deaths

Affected population ratio, latest value
● Early achiever   ▲ On track   ■ Slow   ♦ Regressing

People affected, latest value (millions)
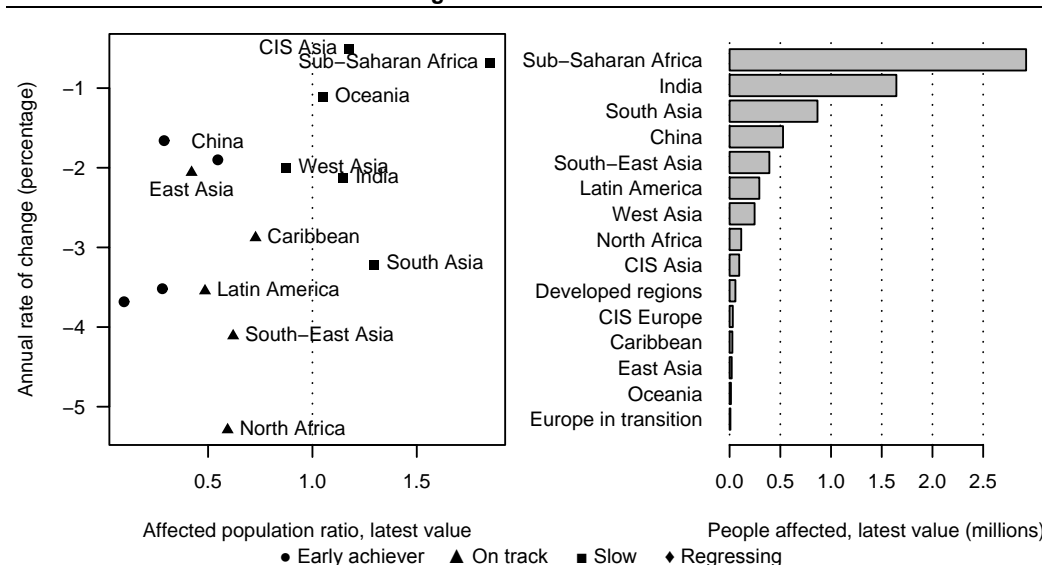
Despite the gains, many Asian subregions are not expected to reach the target by 2015; India, the rest of South Asia, the CIS countries in Asia and West Asia have been progressing too slowly. Worryingly, it is precisely in these subregions where, with the exception of West Asia, child mortality is highest. China, on the other hand, has already reached the cut-off of 45 deaths per 1,000 live births to be classified in this analysis as an early achiever; South-East Asia is hovering around the cut-off rate.

Goal 5 – Improve maternal health

One of the most shameful consequences of the low priority that many countries attach to the health of women is that almost 600,000 women die annually as a result of pregnancy and childbirth; over a quarter of a million of these mostly preventable deaths occurs in Asia (WHO, 2005a).

Target 5: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

The maternal death ratio is one of the more difficult MDG indicators to measure.[1] In the countries where maternal mortality is most prevalent, vital registration systems are often very poor. Data on maternal deaths therefore often have to come from household and other surveys.[2] Since maternal death is less common than other forms of death, a large sample size is needed to estimate the phenomenon accurately. Varying and changing

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[1] See <www.who.int/reproductive-health/publications/maternal_mortality_2000/challenge.html>.
[2] Including decennial population censuses.

definitions of maternal mortality are other reasons for caution against drawing firm conclusions from comparisons over time and across countries.

Figure 9. Maternal deaths
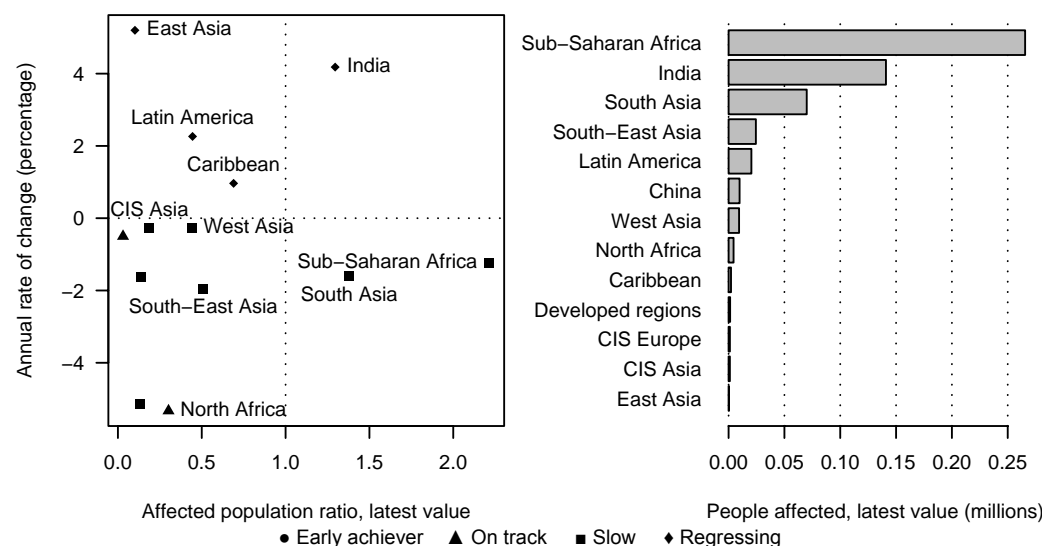
Keeping these limitations in mind, maternal mortality and infant mortality are strongly linked; measures and practices that reduce the one often also reduce the other (World Bank, 2005). This is illustrated by comparing the right-hand charts of Figure 8 and 9: the largest numbers of deaths occurred in 2000, in the same order, in sub-Saharan Africa (266,000 maternal deaths, almost half the global total), India (141,000 maternal deaths) and the rest of South Asia (70,000 maternal deaths). The death of a baby in its first months of life is often a consequence of the poor health and nutritional status of the mother, inadequate care before, during and after delivery, the lack of assistance of a person with midwifery skills during the childbirth and the immediate postpartum period, and the lack of a few critical interventions for the newborn during the first days of life (WHO, 2005a). Asia's overall share in maternal deaths, 47 per cent, is somewhat a bit better than its share in infant mortality (51 per cent).

If monitoring of maternal mortality over time were possible, Figure 9 presents a worrying picture. Several parts of the world, including India and East Asia, have been moving away from the ambitious MDG target. Since India has already one of the highest maternal mortality ratios of all subregions, its situation is particularly disturbing, but not unique to its part of the world. Afghanistan in particular but also Nepal and Pakistan have extremely high maternal mortality ratios. The rest of Asia has been making too slow progress to expect the target to be reached by 2015.

Goal 6 – Combat HIV/AIDS, malaria and other diseases

The aim is simply to reduce the prevalence of diseases and deaths resulting from them; no explicit quantitative targets have been formulated.

Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS

HIV infection rates in Asia remain low compared with those in sub-Saharan Africa; prevalence exceeds 1 per cent only in Thailand, Cambodia and Myanmar. The number of people in Asia living with HIV/AIDS, i.e.; 7.5 million between the ages 15 and 49 (5.0 million of them being from India alone) compared with 23.3 million in sub-Saharan Africa, is far from insignificant.

Figure 10. People aged 15-49 living with HIV/AIDS
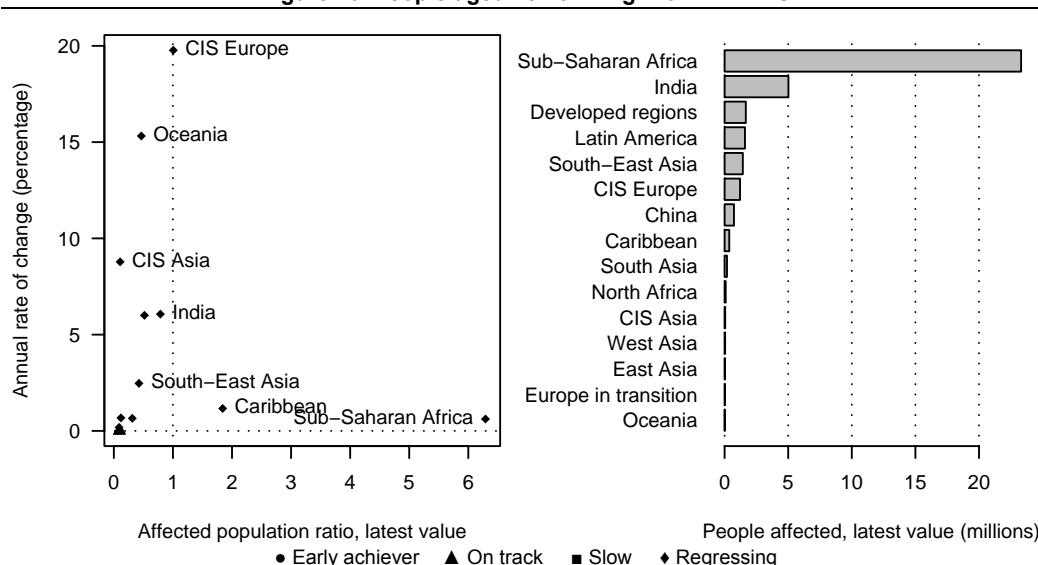
Moreover, HIV/AIDS has been rapidly spreading in some parts of Asia, in particular the CIS countries and India, and more slowly in South-East Asia and West Asia, as shown in Figure 10. Worrying also is the speed at which HIV has been spreading through Oceania. In China and East Asia, on the other hand, prevalence among those aged 15 to 49 has been fairly stable.

The relatively minor contribution, 21 per cent, of Asia to the world's number of people living with HIV/AIDS is due mostly to the huge size of the problem in sub-Saharan Africa. Asia has so far avoided the African numbers for three reasons. First, the onset of the epidemic in parts of Asia occurred in the late 1980s, almost a decade later than in sub-Saharan Africa. Second, with few exceptions, HIV infections in Asia stayed confined to specific population groups: sex workers, intravenous drug users and men having sex with men. Third, many Asian Governments are quite stable compared with African ones, facilitating the implementation of policies and access to resources to combat the epidemic effectively (Brown, 2003).

Target 8: Have halted and reversed by 2015 the incidence of malaria and other major diseases

Progress on halting and reversing malaria is difficult to assess because data on prevalence and death rates are available only for 2000 (see Figure 11). It is clear, however, that the problem is far greater in sub-Saharan Africa; the subregion accounted for 85 per cent of the 52 million malaria cases and 92 per cent of the 1.2 million deaths caused by the disease in 2000. The only other subregions where malaria prevalence, which was 6.2 per cent in sub-Saharan Africa, exceeded 1 per cent are West Asia (1.8 per cent) and Oceania (2.7 per cent). However, because of their larger populations, India, South-East Asia and South Asia accounted for 3, 2 and 1 per cent respectively of all malaria deaths in 2000.

Figure 11. People affected by malaria

Malaria cases, 2000 (millions)

Malaria deaths, 2000 (millions)
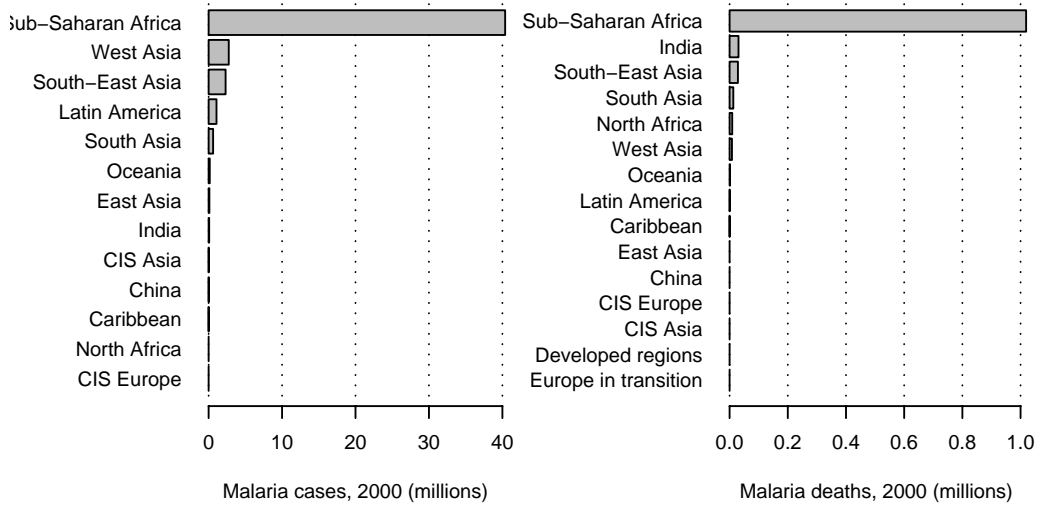
Asia as a whole has been making good progress in bringing TB under control, as indicated by Figure 12 and 13. It is only in the CIS countries of Asia where, together with sub-Saharan Africa, TB prevalence and deaths have continued to rise.

Despite their progress, China and India, with 3.2 million and 3.1 million cases of TB per year respectively, each account for still roughly a fifth of all TB cases. Sub-Saharan Africa, with 3.5 million cases has the largest number of affected people. The share of the number of people dying from TB in sub-Saharan Africa (389,000 deaths) and India (332,000 deaths) is roughly equal to their shares in the number of people living with the disease. In China, however, with 233,000 deaths, TB causes much less mortality. In South-East Asia (238,000 deaths) and South Asia (180,000 deaths); on the other hand, TB is the cause of relatively more mortality than in other parts of the world.

Figure 12. Tuberculosis cases

Affected population ratio, latest value

People affected, latest value (millions)

● Early achiever   ▲ On track   ■ Slow   ♦ Regressing
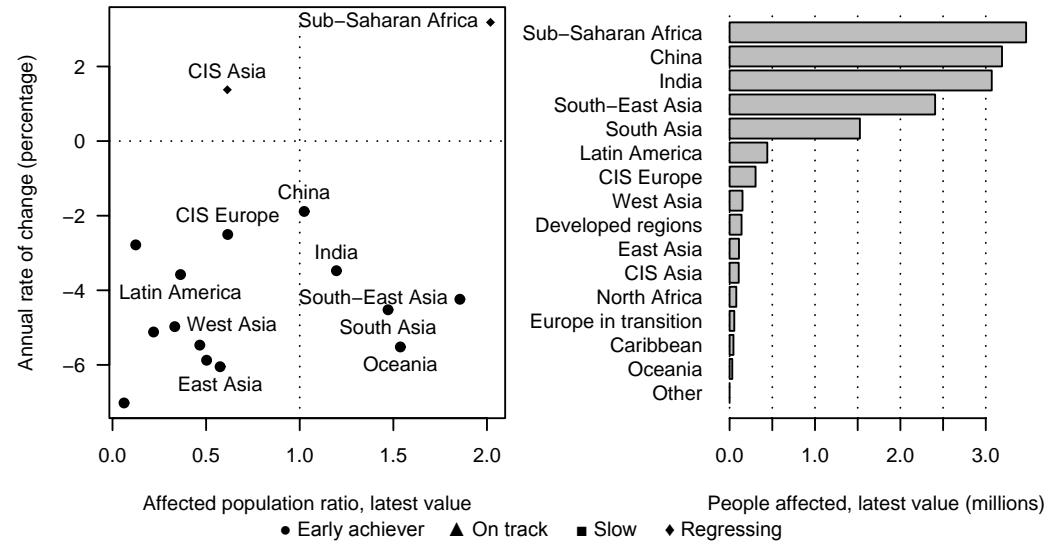
Asia as a whole accounts for more than two thirds of the world's TB cases and deaths, significantly more than its 60 per cent share in the population. What are the factors contributing to this disproportionate share?

First, it should be realized that the health systems of many countries do not cater adequately to case detection. As a consequence, the incidence, prevalence and death rates of many countries are surrounded with uncertainty, which in turn makes control and treatment difficult. It also leads to a lack of monitoring to assure the regularity of drug-taking and the prescription of wrong treatment regimens. Together with an unreliable drug supply, these factors in turn contribute to a high degree of drug resistance (WHO, 2005b).

A second factor is the demographic changes of the last few decades. TB is a contagious disease that spreads through the air, especially in densely populated, unhygienic areas, of which there are many in Asia. TB is common in overcrowded, poorly ventilated slums (World Resources Institute and others, 1998).

Finally, TB is associated with HIV and smoking. TB is a common opportunistic infection in HIV patients; co-infection is particularly common in Thailand, Myanmar, Nepal, Indonesia and India. Smoking increases the risk of TB infection significantly. Tobacco consumption is on the rise in many Asian developing countries, in particular in China, where it was an almost unknown practice until the 1950s (*Time*, 2005). Over half of the TB deaths in Asia are provoked by smoking (Gajalaks and others, 2003).

Figure 13. Tuberculosis deaths
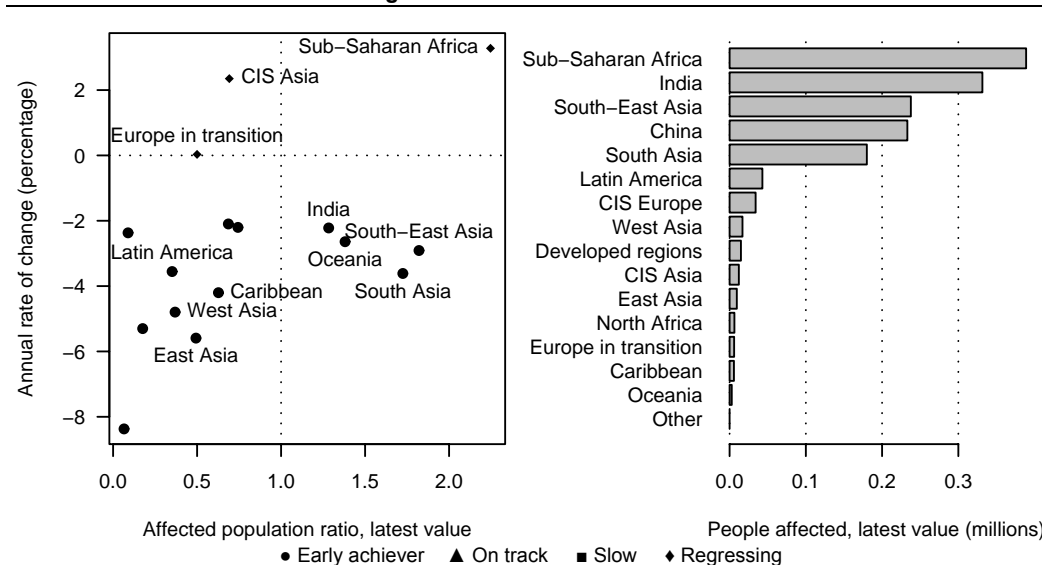
Goal 7 – Ensure environmental sustainability

This goal addresses the important relationship between people and their environment. It consists of two targets. The first target is concerned with conserving and developing countries environmental resources in order to maintain people's livelihoods. Since the target is not expressed in terms of a reference population, it falls outside the scope of this report. The other target assesses access to safe water supplies and sanitation, a key element in the fight against infection and pollution.

Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and sanitation

The world has been making insufficient progress to reach the safe drinking water access target by 2015, as illustrated by Figure 14 and 15. Progress in rural areas has been better than in urban areas and it should be. The number of people without access in rural areas is much larger than in urban areas.

Figure 14. People without access to improved water sources, urban areas

Affected population ratio, latest value

People affected, latest value (millions)

● Early achiever ▲ On track ■ Slow ♦ Regressing
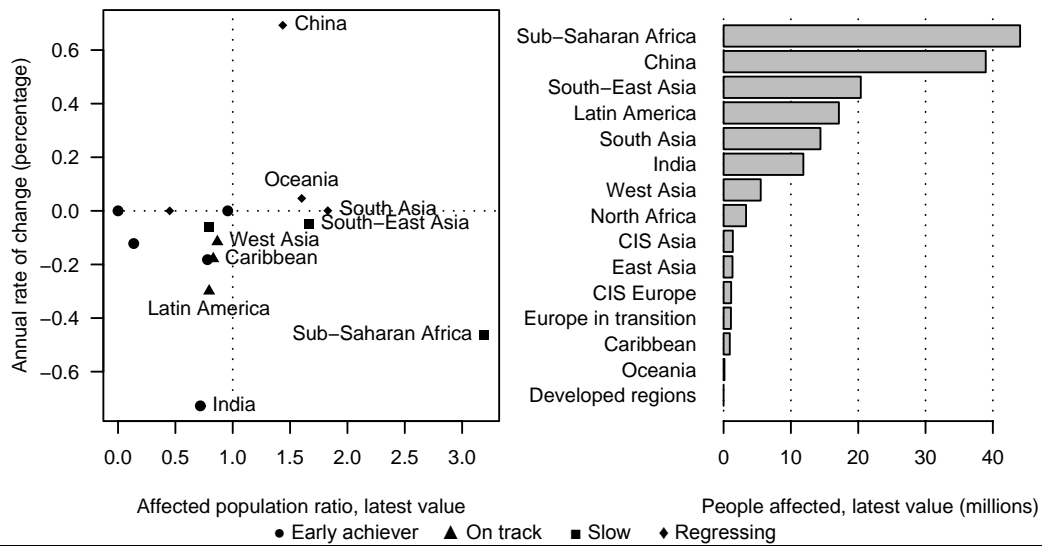
India is a positive exception; it is the only Asian subregion that has already reached the target in both urban and rural areas. In China, by contrast, access to safe water in urban areas has been decreasing, while progress in rural areas has been too slow. Progress has been too slow in both urban and rural areas of South-East Asia. South Asia has been closing the gap in rural areas, but regressing from the target in urban areas.

Together, sub-Saharan Africa, with 295 million, and China, with 296 million, account for well over half of all people without access to an improved water source. The problem is largely a rural phenomenon, in both sub-Saharan Africa and China with more than 87 per cent and 85 per cent respectively of those affected living in the countryside.

The rural-urban divide is even more pronounced in India; 92 per cent of the 148 million people who struggle daily to obtain safe drinking water live in rural areas. This divide is only slightly less wide in South-East Asia, where 82 per cent of the 113 million without clean water live in rural areas, and in South Asia, where 83 per cent of the 87 million people affected live in the countryside.

Figure 15. People without access to improved water sources, rural areas

Affected population ratio, latest value

People affected, latest value (millions)

● Early achiever ▲ On track ■ Slow ♦ Regressing

16
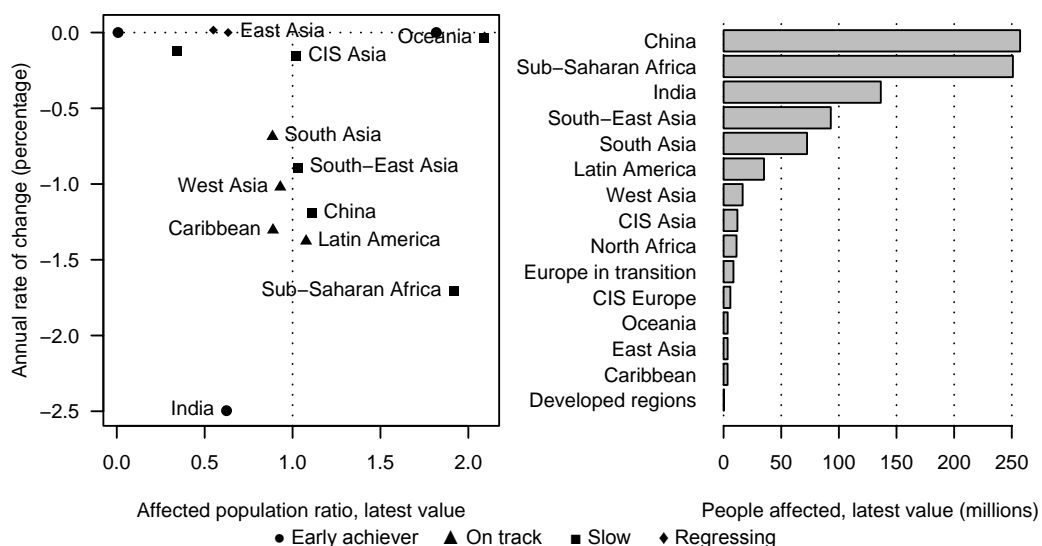
Whereas China is already facing an enormous challenge to provide safe drinking water to its population, the number of people without access to sanitation, 722 million is more than double the number of people without safe water (see Figure 16 and Figure 17). That the urban-rural divide is slightly smaller with regard to sanitation is of little consolation. Worryingly, where China managed to reduce the proportion of the population without access to safe water in urban areas, the proportion without access to sanitation has been increasing in both urban and rural areas.

Figure 16. People without access to improved sanitation, urban areas
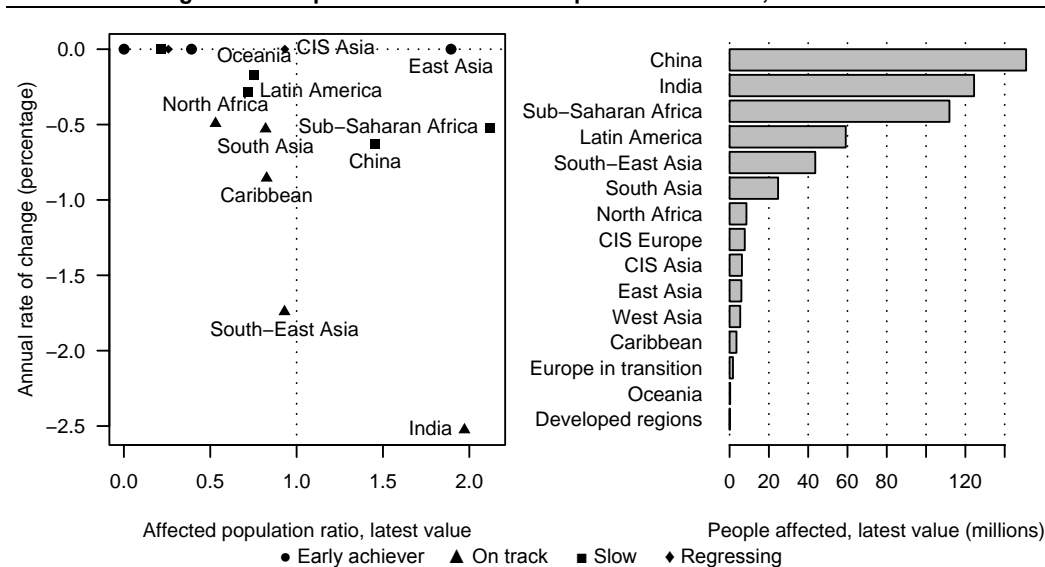
The number of people without access to sanitation in India is with 746 million which is even larger than in China. As with the lack of access to water, the phenomenon is largely a rural one; 83 per cent of those affected live in the countryside.

Sub-Saharan Africa was the subregion with the third largest number of people (449 million) without access to sanitation. The problem here is also largely rural (75 per cent of those affected).

Figure 17. People without access to improved sanitation, rural areas
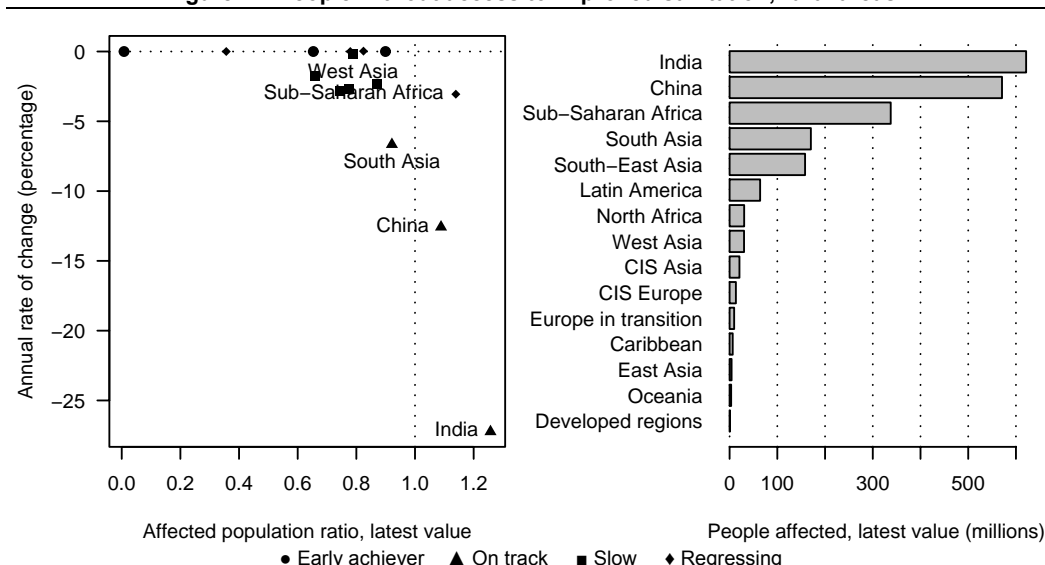
South-East Asia and South Asia were home to 202 million and 195 million people respectively without access to sanitation. The rural character of the problem is nowhere more pronounced than in South Asia (87 per cent of those affected).

Regional distribution of aid inflows

The previous section has shown that Asia is home to a majority of people affected by economic and social poverty for 11 out of 16 of the indicators examined; for eight indicators the share of Asians in the total number of people affected exceeds their share in the world population. Much work therefore remains to be done.

This is primarily, of course, the responsibility of the region itself. The countries that are off track for many of the MDGs can often do much more in terms of mobilizing domestic resources, prioritizing national budges towards MDG sectors, expanding and improving the quality and efficiency of service delivery and removing access barriers to social services.[3] There is, furthermore, much scope for increasing regional cooperation.[4]

Stepped-up regional efforts do, however, have to be complemented by support from the international community. This includes the removal of trade barriers, greater private foreign investment, and allowing for easier movement of skilled personnel. Moreover, as this section will show, many parts of Asia deserve more attention from aid donors.

Figure 18. Aid by subregion, 2004
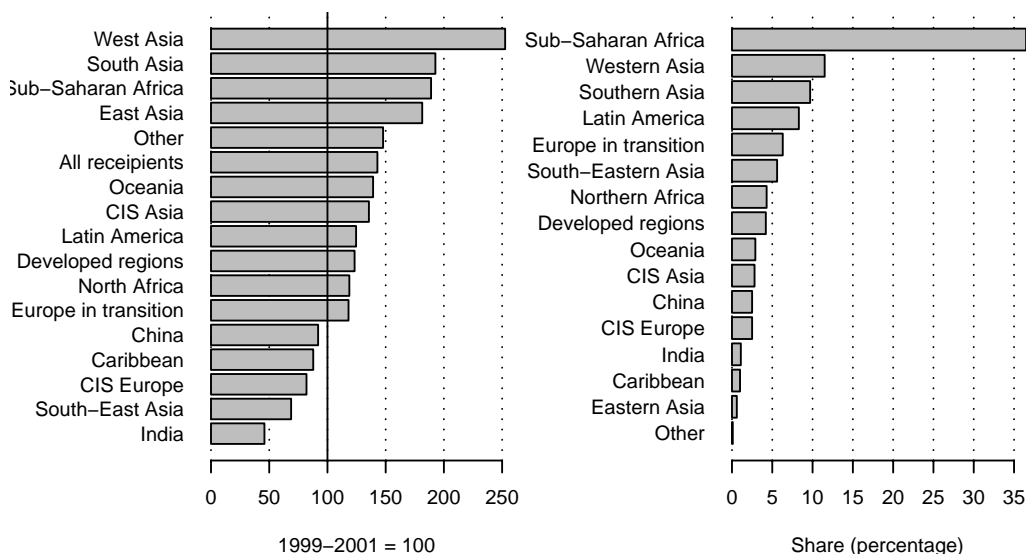
Global aid flows remained relatively stable during the 1990s,[5] but have increased markedly in recent years. Total aid flows increased by 42.9 per cent in 2004 in comparison to the average for the period 1999–2001. This increase is in line with commitments formu-

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[3] See chapter 2 of *A Future Within Reach.*

[4] See chapter 3 of *A Future Within Reach.*

[5] Between 1990 and about 2001, net Official Development Assistance and Official Assistance from Development Assistance Committee countries floated around an average value of US$ 55 billion per year <www.oecd.org/dataoecd.org/43/24/1894385.xls>. Expressed in real terms, aid declined during that period. In this report aid data are analysed from 1999 onward, as it seems that since that year under-reporting of aid flows was systematically reduced.

lated under MDG 8, which is to boost aid and development assistance as well as to reduce the debt burden on developing countries, and particularly the least developed countries.

Despite this increase, only five (Denmark, Luxembourg, the Netherlands, Norway and Sweden) of the 22 member countries of the Development Assistance Committee of the Organisation for Economic Co-operation and Development (OECD) spent at least 0.7 per cent of their gross national income (GNI) on official development assistance, i.e., grants and concessionary loans to promote economic development and welfare.[6] The two largest donors in dollar terms, the United States and Japan committed less than 0.2 per cent of their GNI to ODA. Worryingly, Japan was one of the four DAC countries that reduced real ODA in terms of real GNI from 2003 to 2004.[7] Over two thirds of all commitments by donor countries go directly to the recipients and only 30 per cent transit through multilateral institutions (2.9 per cent through regional development banks). A substantial share of aid is not sector-allocable; of the remaining part the component that addresses basic social services is relatively low, a bit less than 16 per cent both for bilateral and multilateral donors.

Not all subregions have benefited equally from the increase in aid flow over the last few years. The left-hand chart of Figure 18 shows that aid flows to China, the Caribbean, European countries in the Commonwealth of Independent States, South-East Asia and India decreased relative to the period 1999-2001. Aid flows to South Asia, sub-Saharan Africa, East Asia and in particular West Asia,[8] on the other hand, increased by more than the average across subregions.

The recent trends in aid flows have partially reshaped the shares of aid received by each subregion; the shares as they were in 2004 are shown in the right-hand chart of Figure 18. At 36.5 per cent (25.6 per cent of total aid in 1999) sub-Saharan Africa has consolidated its status as the largest aid recipient in 2004. This is consistent with the special attention paid to Africa in the Millennium Declaration and subsequent global conferences, and the difficulties sub-Saharan Africa is facing in achieving the MDGs. Apart from West Asia (11.5 per cent) and South Asia (9.7 per cent), other subregions in Asia are receiving relatively small shares of the total amount of global aid. These trends and shares do not, however, reflect an allocation proportional to the "size" of the problem. Different measures can be used to weight the total aid received by each subregion. One possibility is to relate ODA[9] to the population size in order to obtain the ODA per capita (column 1 of Table 3).

India, the subregion with the largest number of poor people, underweight children, malnourished people and rural people without access to sanitation, received just about a dollar per head of ODA in 2004. China received a similar amount. It should be noted, however, that both countries are not actively seeking assistance from the international donor community.

The amounts received by India and China are in complete contrast with those received by Oceania (US$ 190 per head) and the European countries in transition (US$ 87 per head), two regions whose shares in the world population are negligible and the contributions to the number of the global economically and socially poor are relatively small.

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[6] See <www.oecd.org/dataoecd/52/9/1893143.xls>.

[7] Belgium recorded the sharpest decrease, a reduction of 30 percent.

[8] In the case of West Asia, the explanation for the increase in aid is related to the aid for the reconstruction efforts in Iraq.

[9] References to ODA, which in the definition of the OECD is extended to developing countries, in this section includes official assistance or aid flows to economies in transition.

ODA per capita receipts for sub-Saharan Africa, the CIS countries of Asia, West Asia and the Caribbean ranged from US$ 21 to US$ 26. South Asia and South-East Asia also received less aid than the number of the economically and socially poor in these regions would justify, i.e.; US$ 11 and US$ 10 per head respectively.

The ODA per capita indicator does not account for the different development needs of subregions. The lack of progress towards achieving the MDGs is of course an expression of these needs, so that linking MDG goals and targets to aid disbursement would be an obvious way to assess to what extent aid is going to the countries and subregions that are most in need of it , and to what extent aid is contributing to progress. Establishing such a link between the MDGs and aid is, however, not feasible for several reasons.

Table 3. Regional distribution of aid inflows

Region	ODA* per capita, 2004 (US$)	ODA* share / underweight children share, 2004	ODA* / GNI, 2004 (percentage)
Sub-Sahara Africa	26.0	1.38	4.0
North Africa	17.5	5.12	1.0
Caribbean	20.6	7.00	1.9
Latin America	10.0	3.38	0.3
CIS Asia	23.2	9.74	2.2
China	1.4	0.53	0.1
East Asia	3.5	1.75	0.0
India	1.3	0.06	0.2
South Asia	11.3	0.58	1.4
South-East Asia	9.7	0.87	0.7
West Asia	25.7	3.34	0.7
CIS Europe	10.0	18.58	0.3
Europe in transition	87.0	86.56	3.7
Oceania	190.1	566.59	21.5
Developed regions	2.6	21.75	0.0
Other	1,362.0		

*: average for 1999–2004.

First, the information on aid received by the individual recipient countries is incomplete. Second, it is difficult to link specific MDG goals and targets to the different categories of aid. General support to the health sector, for example, could help to achieve all health-related goals (MDGs 4, 5 and 6). Finally, progress towards the achievement of one goal often has spill-over effects on the achievement of others: the extent of access to clean water, for example, correlates strongly (negatively) with child mortality rates.[10] It is therefore difficult to trace progress on a particular goal back to a specific aid category.

As an alternative, aid might be expressed in terms of one single MDG indicator that is more or less representative of the overall underlying construct of social and economic deprivation. One such indicator is ODA received per poor person, (i.e., someone living on less than US$ 1 per day). The problem with this indicator, however, is that US$ 1 per day poverty data are not available for all countries.

Data on the prevalence of underweight children, on the other hand, are available for many countries, and the indicator is also "reasonably" representative of deprivation.[11] The second column of Table 3 therefore compares the share of each subregion in global aid receipts with its share in the global total number of underweight children.

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[10] See also *A Future within Reach*, p. 24.
[11] A forthcoming ESCAP/ADB technical background paper will address this issue in detail.

Oceania's share in ODA is 567 times its contribution to the world total number of underweight children. The shares of the European countries in transition, developed countries, and the CIS countries in Europe in ODA receipts are also many times higher than their contributions to the number of underweight children; to a lesser extent this applies also to the CIS countries in Asia. What these subregions, at least those in transition, have in common is that most of the aid they receive is not aimed at poverty alleviation, but at developing the private sector and strengthening institutional capacity.

The comparison between aid shares and contributions to the number of underweight children is quite different for most of Asia. There are, in fact, just four subregions where shares in the total number of underweight children exceed aid shares and they are all in Asia: China, India, South Asia and South-East Asia.

A measure that relates aid to the size of the economy is the contribution of ODA to GNI. On this measure, Oceania scored with 21.5 per cent, again much higher than any other region. The share of ODA in GNI is substantial in sub-Saharan Africa (4.0 per cent) and again Europe in transition (3.7 per cent). With the exception of the CIS countries in the region, in no part of Asia was the contribution of ODA to GNI more than 2 per cent in 2004.

The allocation of aid over subregions, countries and sectors is of course an outcome of policies and decisions of individual donors. The priorities of each donor might reflect needs, but often they do not. The "Sachs report"[12] argues that the international aid system is ill equipped to provide support to national strategies for achieving the MDGs "… because of a shortage of supportive rules, effective institutional arrangements, and above all resolve to translate commitments to action." The report also notes that donors "… have not encouraged the countries to take the Millennium Development Goals seriously as operational objectives."

The report provides 10 recommendations to fix the international aid system. Among the key points are a call for country-level MDG-based poverty reduction strategies to provide the anchoring process for development support, based on needs, and for donors to evaluate their development (and other foreign) policies in terms of supporting the MDGs.

The Country Policy and Institutional Assessment (CPIA) framework of the International Development Association is an example of an aid allocation mechanism in which MDG-related criteria play an important role. In addition to assessing the economic management, the structural policies and the accountability and public sector management of recipient countries, CPIA takes account of policies for social inclusion. Such policies include those that promote gender equality, equality of public resource use, the building of human resources, social protection and labour and institutions for environmental sustainability.

Conclusions

Asia is making rapid progress towards achieving many of the MDGs. However, some countries are lagging behind, or moving away from the targets. No country is currently on track to achieve all the MDGs by 2015.

Asia is virtually the only region that has been making good progress towards eradicating extreme poverty. The progress has been particularly impressive in South-East Asia and China.

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[12] *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals* (New York, Millennium Project, 2005).

However, Asia still has by far the largest number of poor people. India was home to 354 million people living on less than US$ 1 per day, that is, more than a third of the world's total. This is 128 million more than in the whole of sub-Saharan Africa. Notwithstanding its impressive performance, China still had 213 million poor people.

In contrast to poverty, hunger will not be halved by 2015 if recent trends continue. The proportion of children underweight in 1990 was substantially higher than the proportion of the population living on less than US$ 1 per day in all Asian subregions except China; this also remained the case around 2000. The exception to this was China, which is the only subregion in Asia that is on track to reach the target of halving by 2015 the proportion of children underweight.

Far too many children die from preventable causes in Asia, and much work remains to remedy this situation. The progress towards achieving the child mortality target in India, South Asia, CIS Asia, West Asia and Oceania is too slow for the target to be achieved by 2015. Asia's share in global child mortality, however, is about half, significantly lower than its 60 per cent share of the global population. Better handling of diarrhoea and measles, slower spread of HIV/AIDS, better general health conditions and lower fertility rates partly explain why the problem is less acute in Asia.

Asia as a whole has been making good progress in bringing TB under control. It is only in the CIS countries of Asia where, together with sub-Saharan Africa, TB prevalence and deaths have continued to rise. Despite that progress, the region still accounted for more than two thirds of the world's TB cases and deaths in 2003; China and India combined contributed around 40 per cent. Malaria, in contrast, is less of an Asian problem than an African one.

Asia is well endowed with water resources, yet over two thirds of the population in rural areas and over 60 per cent in urban areas are without access to safe drinking water. Insufficient progress has been made in urban areas, which is at least partly due to rapid urbanization, especially in China and South-East Asia. The proportion of people without access to sanitation in Asia, at nearly 80 per cent in the countryside and 65 per cent in cities, is even higher. It is critical that people be convinced of the value of sanitary latrines. Even the poorest households should be able to afford a basic system.

India stands out within Asia. It has larger numbers of poor people, underweight children, malnourished people and rural people without access to sanitation than any other subregion of the world. South Asia is in a similar position; its share in adversely affected people exceeds its share in global population for the majority of MDG indicators, of which many are the same as for India. Yet, India received just about a dollar of ODA per capita in 2004 and South Asia, not more than US$ 11 per capita. India, as China, are however not actively seeking donor support.

Global aid was declining in real terms during the 1990s, but it has increased markedly since. This increase is in line with commitments formulated under the Millennium Declaration, which calls for a boost in aid and development assistance, as well as for a reduction of the debt burden on developing countries, particularly the least developed countries. Despite this increase, most donors are still far away from the 0.7 per cent ODA of the GNI target.

Moreover, not all subregions have benefited equally from the increase in aid flow over the last few years. Asia, in general, has received far less aid than other regions of the world. This is true in comparison to the size of the population, the level of income and the number of poor people.

The share of ODA in GNI is substantial for sub-Saharan Africa (4.0 per cent) and also for Europe in transition (3.7 per cent). Oceania with 21.5 per cent is an outlier (small populations). In contrast, with the exception of the Asian CIS countries, in no part of Asia was the contribution of ODA to GNI more than 2 per cent in 2004. China and India received only around US$ 1 ODA per person, which is a mere 0.1 per cent and 0.2 per cent of their GNI, respectively.

Annex I: Methods and data sources

MDG indicator progress

The classification of subregions on progress towards achieving the MDGs, presented in Table 2 and from Figure 2 to Figure 17, is based on the methods delineated on p. 44 of the publication entitled *A Future Within Reach: Reshaping Institution in a Region of Disparities to Meet the Millennium Development Goals in Asia and the Pacific*. Indicator values have been obtained from the database maintained by the United Nations Department of Economic and Social Affairs, which is continuously evolving; the data used include updates until 31 March 2005.

A historical annual rate of change is estimated for each indicator and for each country by fitting a least-squares equation of the form:

$$\ln X_t = a + bt,$$

where X is the value of the indicator, t is time and a and b are the parameters to be estimated. The estimated rate of change r is then obtained as:

$$r = \exp(\hat{b}) - 1,$$

where $\hat{b}$ is the estimate of b.

The regression equation is run twice: once on all the available data from 1990 onward, and then on all the available observations from that year except the first year. When the signs of $\hat{b}$ differ, the value generated by the second run is used to calculate r. The reason for the dual run is that the first observation is often an outlier that reverts the sign of the rate of change of recent years.

The indicators on poverty, enrolment rates, mortality rates and access to water and sanitation are expressed in explicit quantitative targets. For these indicators and for countries that have not yet met the target in the year of the latest observation, the required rate of change r^* is calculated as:

$$r^* = \left(\frac{X^*}{X_T}\right)^{1/(2015-T)} - 1,$$

where X^* is the target value and T is the year of the last observation. For countries that have already met the target in the year of the latest observation $r^* = 0$.

The estimated actual and required country rates of changes are then weighted by the average reference population (see below) in 1990 and the latest year for which data are available to obtain subregional historical and required rates of change. Because of missing data, these rates of change should be regarded as approximations of unknown subregional average rates.

The subregions are then classified into four groups:

- Early achievers: subregions that have already met the target in the year of the latest observation, so that the required rate of change equals zero;
- On track: subregions for which the (absolute) estimated rate of progress is larger than or equal to the (absolute) required rate of change;
- Slow progress: subregions for which the (absolute) estimated rate of progress is smaller than or equal to the (absolute) required rate of change;

- Retrogressive: the sign of the estimated rate of progress is the opposite of the sign of the required rate of change.

For the remaining indicators, there is no explicit quantitative target, so that no required rate of change can be calculated. The classification of subregions is then based on the estimated rate of change alone:

- Early achievers: subregions for which the rate of change is positive (negative in case the target is to reduce from the baseline value);
- On track: subregions for which the rate of change equals zero;
- Retrogressive: subregions for which the rate of change is negative (positive if the target is to reduce from the baseline value).

Many of the MDGs require reducing an indicator value by a certain proportion. However, for the purpose of the analysis in this report the goal is also treated as achieved if the country has reached a certain absolute value. In the case of primary school enrolment, for example, this is 95 per cent, and for the poverty rate 5 per cent. The "cut-offs" for each indicator are presented below.

Indicators	MDG target	Cut-off
Proportion of population below US$ 1	Reduce by half	5%
Prevalence of underweight children	Reduce by half	5%
Proportion of population undernourished	Reduce by half	5%
Primary enrolment ratio	100	95%t
Child mortality rate	Reduce by 2/3	45 per 1,000 live births
Infant mortality ratio	Reduce by 2/3	35 per 1,000 live births
Maternal mortality rate	Reduce by 3/4	25 per 100,000 live births
HIV prevalence	Reverse prevalence	decrease
TB prevalence	Reverse prevalence	decrease
TB death rate	Reverse incidence	decrease
Percentage of population. without access to water – urban areas	Reduce by half	5%
Percentage of population without access to water – rural areas	Reduce by half	5%
Percentage of population. without access to sanitation – urban areas	Reduce by half	5%
Percentage of population. without access to sanitation – rural areas	Reduce by half	5%

Reference populations

Aversely affected subregional populations are calculated by aggregating country products of the last available indicator value and the reference population for the same year. The reference populations, i.e.; MDG indicator denominator values, have been obtained from *World Population Prospects: the 2004 Revision* (United Nations, forthcoming). The missing data disclaimer mentioned in the previous subsection also applies to subregional affected population aggregates, and they should therefore be treated with the same circumspection. The reference populations applied to the various indicators are the following:

- US$ 1 per day poverty, malnourishment, and TB and malaria prevalence and death rates: total population;
- Underweight children: population of both sexes in the 0 to 4 age group;
- Primary enrolment: population of both sexes in the age group 5 to 14;[13]

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[13] This reference population is probably larger than the actual indicator denominator value in many countries.

- Under-5 mortality, infant mortality and maternal mortality: number of births in relevant five-year period divided by 5;
- HIV prevalence: population of both sexes in the age group 15 to 49;
- Water and sanitation access in urban and rural areas: urban and rural population at five-year intervals, interpolated for non-interval years.

Aid inflows

The ODA and OA data have been obtained from DAC online, an OECD database containing annual aggregates of aid and other resource flows from bilateral and multilateral donors to developing countries and countries in transition. The data are consistent with those collected and disseminated by the OECD/DAC secretariat.[14] The figures differ, however, from those published in international aid statistics for a number of reasons. First, this report uses different subregions (see Annex III) than those used by the OECD/DAC secretariat. Second, this report covers all aid flows, irrespective of source. Therefore, it includes aid originating from DAC member countries, bilateral aid from non-DAC countries, as well as multilateral aid. The latter category includes aid from United Nations agencies, programmes and funds, and also from several international financial institutions, such as regional development banks. Wherever possible, aid amounts from multilateral institutions were directly allocated to the appropriate subregion. In those cases when this was not possible, but the receiving region was known (aid to "Asia unspecified", for example), the aid amount was allocated to subregions in proportion to the subtotals they received. Amounts in records without any geographical indication at all remained unallocated.

Thus, the following distribution of "Total Net ODA/OA" was obtained:

Annex table 1. Total net ODA/OA, all donors (millions of United States dollars)

Subregion	1999	2000	2001	2002	2003	2004
Sub-Saharan Africa	13 531.10	14 236.96	14 820.33	19 788.70	25 332.62	26 829.57
North Africa	2 898.98	2 496.46	2 583.81	2 499.01	2 293.37	3 159.01
Caribbean	980.13	839.27	752.31	784.31	696.45	752.33
Latin America	5 095.50	4 311.72	5 308.79	4 518.70	5 561.47	6 109.77
CIS in Asia	1 542.61	1 401.46	1 564.26	1 880.25	1 777.07	2 038.13
China	2 603.08	1 891.08	1 575.20	1 595.09	1 426.71	1 861.57
East Asia[a]	419.20	119.47	250.18	438.99	-25.55	477.03
India	1 662.88	1 638.05	1 843.15	1 592.18	1 006.71	786.31
South Asia	3 304.66	3 180.25	4 592.77	5 748.18	5 986.19	7 117.16
South-East Asia	6 752.05	6 204.85	5 114.68	5 004.93	4 840.95	4 142.60
West Asia	3 317.23	3 658.91	3 059.93	5 118.98	6 388.62	8 449.86
CIS in Europe	2 661.43	2 268.25	1 792.63	1 966.39	1 740.72	1 837.31
Europe in transition	4 139.47	3 881.88	3 817.30	5 042.49	4 114.89	4 661.18
Oceania	1 461.94	1 607.43	1 468.72	1 470.92	1 805.15	2 105.52
Developed regions	2 501.07	2 601.31	2 406.72	1 813.43	2 630.18	3 085.04
Other	64.21	70.85	66.23	66.66	73.51	99.20
Total	**52 935.54**	**50 408.20**	**51 017.01**	**59 329.21**	**65 649.07**	**73 511.60**

a) The negative value of -25.55 for East Asia in 2003 is due to the Republic of Korea. The Republic of Korea recorded negative flows of net ODA for all years, which is consistent with its donor status, as well as with repayments of loans. In 2003, the Republic of Korea's net ODA flows peaked at -457.73, making the overall total for East Asia negative.

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[14] The data were downloaded on 7 February 2006 from Table 2a of the online DAC database, available at <www.oecd.org/dac/stats/idsonline>. Although all types of flows were extracted for review, the data presented here only include records for "ODA (OA) Total Net" and from "All Donors, Total", which is the sum of aid flows records of "DAC Countries, Total", "Non-DAC Bilateral Donors, Total" and "Multilateral, Total".

Annex II: MDG indicators discussed in this report

No.	Indicator	Short name
1	Proportion of population below US$ 1 (PPP) per day	Poverty US$ 1 per day
4	Prevalence of underweight children under 5 years of age	Underweight children
5	Proportion of population below minimum level of dietary energy consumption	Malnourishment
6	Net enrolment ratio in primary education	Primary enrolment
10	Ratio of literate women to men, 15–24 years old	
13	Under-5 mortality rate	Under-5 mortality
14	Infant mortality rate	Infant mortality
16	Maternal mortality ratio	Maternal mortality
18	HIV prevalence among pregnant women aged 15-24 years	HIV prevalence, aged 15-49 years (replacement indicator because of data availability problems)
21	Prevalence and death rates associated with malaria	Malaria prevalence
		Malaria death rate
23	Prevalence and death rates associated with tuberculosis	TB prevalence
		TB death rate
30	Proportion of population with access to an improved water source, urban and rural	Water, urban
		Water, rural
31	Proportion of population with access to an improved sanitation, urban and rural	Sanitation, urban
		Sanitation, rural

Annex III: Subregions as defined in this report

Sub-Saharan Africa

Angola
Benin
Botswana
Burkina Faso
Burundi
Cameroon
Cape Verde
Central African Republic
Chad
Comoros
Congo
Dem. Rep. of the Congo
Côte d'Ivoire
Djibouti
Equatorial Guinea
Eritrea
Ethiopia
Gabon
Gambia
Ghana
Guinea
Guinea-Bissau
Kenya
Lesotho
Liberia
Madagascar
Malawi
Mali
Mauritania
Mauritius
Mayotte
Mozambique
Namibia
Niger
Nigeria
Rwanda
Sao Tome and Principe
Senegal
Seychelles
Sierra Leone
Somalia
South Africa
Sudan
Swaziland
Togo
Uganda
United Republic of Tanzania
Zambia
Zimbabwe

North Africa

Algeria
Egypt
Libyan Arab Jamahiriya
Morocco
Tunisia

Caribbean

Anguilla
Antigua and Barbuda
Aruba
Bahamas
Barbados
British Virgin Islands
Cayman Islands
Cuba
Dominica
Dominican Republic
Grenada
Haiti
Jamaica
Montserrat
Netherlands Antilles
St. Kitts and Nevis
St. Lucia
St. Vincent and Grenadine
Trinidad and Tobago
Turks and Calicos Islands
British Virgin Islands

Latin America

Argentina
Belize
Bolivia
Brazil
Chile
Colombia
Costa Rica
Ecuador
El Salvador
Falkland Islands (Malvinas)
Guatemala
Guyana
Honduras
Mexico
Nicaragua
Panama
Paraguay
Peru
Suriname
Uruguay
Venezuela

CIS Asia

Armenia
Azerbaijan
Georgia
Kazakhstan
Kyrgyzstan
Tajikistan
Turkmenistan

East Asia

Democratic People's Republic of Korea
Hong Kong, China
Macao, China
Mongolia
Republic of Korea
Taiwan Province of China

South Asia

Afghanistan
Bangladesh
Bhutan
Iran (Islamic Republic of)
Maldives
Nepal
Pakistan
Sri Lanka

South-East Asia

Brunei Darussalam
Cambodia
Indonesia
Lao People's Democratic Republic
Malaysia
Myanmar
Philippines
Singapore
Thailand
Timor-Leste
Viet Nam

West Asia

Bahrain
Cyprus
Iraq
Israel
Jordan
Kuwait
Lebanon
Oman
Palestinian Territory
Qatar
Saudi Arabia
Syrian Arab Republic
Turkey
United Arab Emirates

Yemen

CIS Europe

Belarus
Republic of Moldova
Russian Federation
Ukraine

Europe in transition

Albania
Bosnia and Herzegovina
Bulgaria
Europe Unspecified
TFYR Macedonia
Romania
Serbia and Montenegro

Oceania

Cook Islands
Fiji
French Polynesia
Kiribati
Marshall Islands
Micronesia (Fed. States of)
Nauru
New Caledonia
Niue
Northern Marianas Islands
Palau
Papua New Guinea
Samoa
Solomon Islands
Tokelau
Tonga
Tuvalu
Vanuatu

Developed regions

Bermuda
Croatia
Czech Republic
Estonia
Hungary
Latvia
Lithuania
Malta
Poland
Slovakia Republic
Slovenia

Other

Gibraltar
St. Helena
Wallis and Fortuna Islands

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