



What would it take to accelerate fertility decline in the least developed countries?

Fast population growth, fueled by high fertility, hinders the reduction of poverty and the achievement of other internationally agreed development goals.¹ While fertility has declined throughout the developing world since the 1970s, most of the least developed countries still have total fertility levels above 5 children per woman. Furthermore, universal access to reproductive health, one of the key goals of the Programme of Action adopted by the International Conference on Population and Development (ICPD) in 1994 and reaffirmed by the World Summit in 2005, is still far from being achieved and unmet need for family planning² in the least developed countries remains high. Thus, particularly in the least developed countries, satisfying the unmet demand for modern family planning methods would reduce fertility, moderate population growth and have several beneficial effects on maternal and child health that would contribute to the achievement of other key Millennium Development Goals.³ Given the synergies between improved access to family planning and other development goals, for every dollar spent in family planning, between 2 and 6 dollars can be saved in

interventions aimed at achieving those other goals.⁴ This policy brief provides an overview of fertility trends and changes in selected indicators of reproductive health in the least developed countries and a discussion of the policies that underpin them.⁵

For purposes of this brief, the *less developed regions* include all the countries and areas of the world except Australia, Canada, Japan, New Zealand, the United States of America and all countries in Europe. The group of *least developed countries* (LDCs) includes the 49 countries designated as such by the General Assembly.⁶ The rest of the countries in the less developed regions, as a group, are designated by the term *developing countries*.

Fertility trends and contraceptive use in the least developed countries

Because most countries in the less developed regions have experienced major reductions in fertility since 1970, high fertility is concentrated today in few countries and is particularly prevalent among the 49 least developed countries, 31 of which had fertility

Table 1. Total fertility, contraceptive prevalence and selected indicators of reproductive health in the less developed regions, 1970-2005

Area	Total Fertility				Adolescent birth rate		Contraceptive prevalence				Unmet need for family planning
	1970	1985	1995	2005	1995	2005	Any method		Modern methods		
							1995	2005	1995	2005		Latest
Less developed regions	5.7	3.9	3.1	2.7	52	47	55	61	49	55	11
<i>Developing countries</i>	5.6	3.6	2.8	2.4	42	37	60	66	54	60	9
<i>Least developed countries (49 countries)</i>	6.5	6.1	5.4	4.8	125	117	21	31	15	24	23
LDCs in Sub-Saharan Africa (31 countries)	6.6	6.7	6.5	5.8	130	129	12	17	6	12	27
Rest of LDCs (18 countries)	6.4	5.2	4.1	3.3	119	100	33	47	27	39	17
LDCs with TF>5 (31 countries)	6.7	7.0	6.7	6.0	137	133	12	18	6	12	28
LDCs with CP (Modern)<10 (17 countries)	6.6	6.5	6.4	5.9	125	156	11	13	4	6	25

Note: The data corresponds to weighted averages of national data closest to the indicated dates.

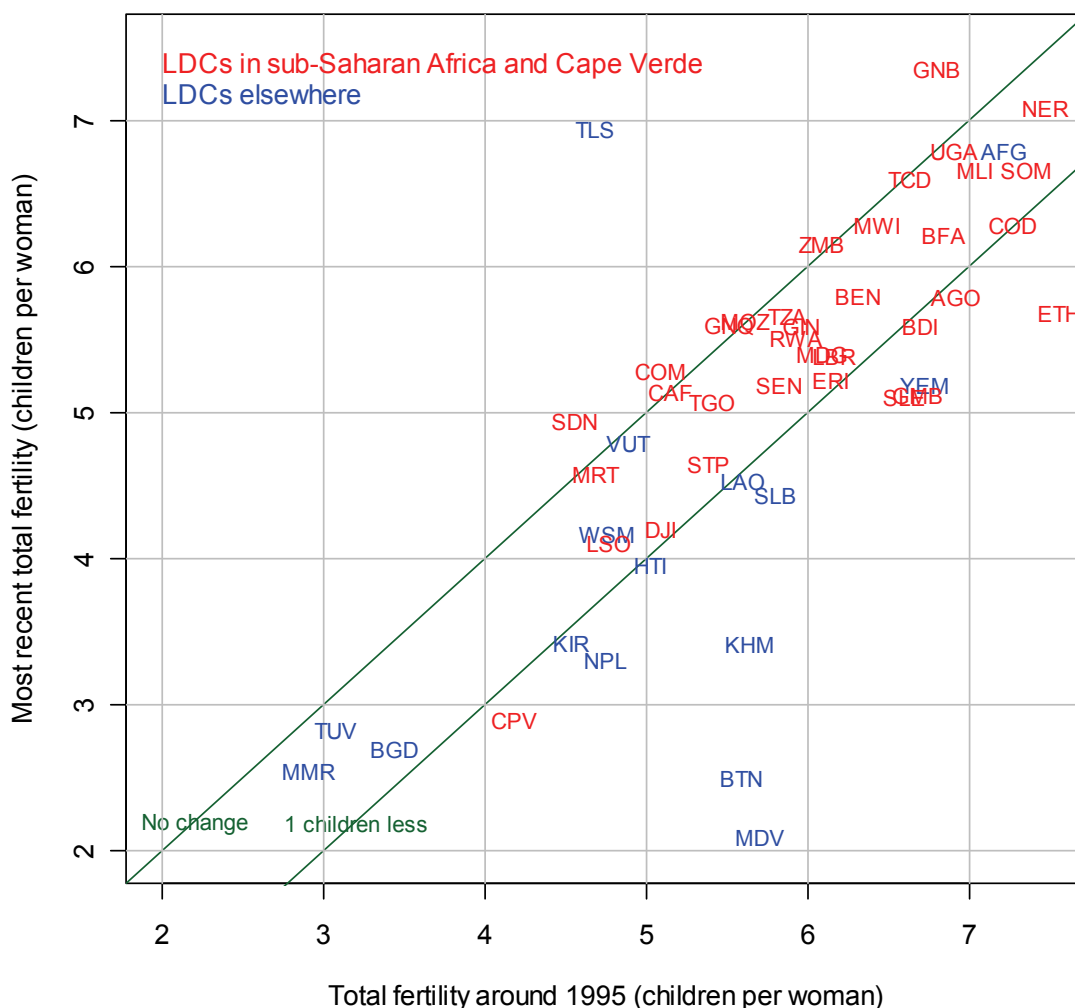
Sources: World Fertility Data 2008 (POP/DB/FFP/Fert/Rev2008) and Millennium Development Goals Indicators.

levels above 5 children per woman around 2005. Among the rest of the countries in the less developed regions, that is, the developing countries, only Cameroon and Nigeria still have such high fertility levels. Furthermore, fertility remains high in the least developed countries as a group. Thus, in 2005, women in the least developed countries had, on average, twice as many children as women in developing countries (4.8 vs. 2.4, as shown in table 1).

The majority of least developed countries have long been characterized by high fertility, although in the 1960s and early 1970s, high fertility was common in most countries of the less developed regions. Yet, even

as early as 1970, total fertility in the least developed countries as a group was nearly one child higher than that in the group of developing countries (6.5 vs. 5.6 children per woman). Moreover, whereas fertility declined rapidly in most developing countries, it has declined very slowly in the majority of the least developed countries. Overall, the fertility of developing countries dropped from 5.6 children per woman in 1970 to 3.6 by 1985 and reached 2.8 children per woman by 1995. In contrast, the fertility of the least developed countries dropped by just 0.4 of a child from 1970 to 1985 (from 6.5 children per woman to 6.1) and was still a high 5.4 children per woman in 1995.

Figure 1: Total fertility in the least developed countries and Cape Verde around 1995 and 2005



Source: World Fertility Data 2008 (POP/DB/FFP/Fert/Rev2008).
For country codes see table 2.

Despite the commitments made by Governments at the time of the 1994 International Conference on Population and Development, fertility in the majority of the least developed countries continued to decline slowly after 1995. Thus, in 27 of the 49 least developed countries, total fertility has dropped by less than one child since 1995 and, in eight, fertility has remained virtually unchanged or has even increased (figure 1). Only in 14 least developed countries has fertility declined by over one child per woman.

In 31 of the 49 least developed countries, total fertility exceeds 5 children per women. Only two developing countries, Cameroon and Nigeria, have similarly high fertility levels

The persistence of high fertility in the majority of the least developed countries and the slow fertility reductions observed among them are associated with high levels of unmet need for family planning. It is estimated that, in the least developed countries as a group, 23 per cent of women of reproductive age who are married or in union have an unmet need for family planning (table 1). This level compares unfavourably with that estimated for the group of developing countries, where unmet need stands at 9 per cent.

The level of unmet need is particularly high in the least developed countries located in sub-Saharan Africa (27 per cent) and in those with total fertility exceeding 5 children per woman (28 per cent). Furthermore, in half of the 34 least developed countries having the requisite data, at least a quarter of all women of reproductive age who are married or in union have an unmet need for family planning. Such high levels of unmet need suggest that the reduction of fertility could be accelerated if effective measures were taken to satisfy the unmet demand for family planning.

Data on contraceptive prevalence corroborate that the use of modern contraceptive methods among women in the least developed countries remains low, with just 24 per cent of women of reproductive age who are married or in union using modern methods. The equivalent proportion in developing countries is 60 per cent. Furthermore, levels of modern method use are particularly low in the least developed countries located in sub-Saharan Africa, where just 12 per cent of women of reproductive age who are married or in union use modern methods. For the rest of the least developed countries, the equivalent figure is 39 per cent.

Increases in the use of modern contraceptive methods have contributed significantly to the rapid reduction of fertility achieved by developing countries since 1970.⁷ Although modern contraceptive use has increased in several least developed countries, such increases have not been sufficient to meet demand. In the least developed countries of sub-Saharan Africa, for instance, the level of modern method use has doubled since 1995, rising from 6 per cent to 12 per cent, but the current level would have to triple by 2015 in order to satisfy existing demand.

Use of modern contraceptive methods in the least developed countries is a low 24 per cent, while in developing countries it is 60 per cent

Among the 17 least developed countries with the lowest levels of modern contraceptive use (below 10 per cent), all except Timor-Leste are located in sub-Saharan Africa and all, except Mauritania, have fertility levels of at least 5 children per woman. Furthermore, in those having the requisite data, unmet need for family planning ranges from 16 per cent to 32 per cent, averaging 25 per cent for the group. These moderate to high levels of unmet need indicate that lack of access to family planning is a significant contributor to the slow pace of fertility decline in the least developed countries.

Unmet need for family planning is high in many least developed countries. The reduction of fertility could be accelerated if effective measures were taken to satisfy the existing unmet need for family planning

The persistence of high adolescent fertility in the least developed countries

Fertility in the least developed countries is not only high, it is also characterized by a very early onset of childbearing. Consequently, the least developed countries display some of the highest adolescent birth rates in the world. Thus, whereas the total fertility of the least developed countries is double that of the developing countries, their adolescent birth rate is more than thrice as high: 117 births per 1000 women aged 15-19 vs. 37 births per 1000. Furthermore, the adolescent birth rate of the least developed countries has remained virtually unchanged since 1995. Given that early

childbearing increases the morbidity and mortality risks of both women and infants, it is urgent to reduce its incidence. Promoting later marriage and the education of girls are two measures conducive to the reduction of early childbearing. Ensuring access to information on contraceptive methods and to family planning for both young women and men would also contribute to promote a later onset of childbearing, especially if supported by efforts to empower women.

Synergies between improved access to family planning and other development goals

Fertility reductions are more likely to occur and be sustained when child mortality is declining because, the lower child mortality, the more certain parents can be that their offspring will survive to adulthood, thus reducing the need to have more children than desired as an insurance against premature death. Consequently, measures to reduce child mortality can also contribute to increase demand for family planning and accelerate fertility reductions. Furthermore, children are more likely to survive when subsequent pregnancies occur at least 24 months and, preferably, 36 months or longer after their birth. In other words, the use of family planning to space pregnancies can increase child survival,⁸ thus setting off a virtuous cycle whereby increased child survival leads to fewer pregnancies over a woman's life, thereby reducing fertility and the lifetime risk of maternal mortality. These synergistic effects of family planning and desirable health outcomes are one major reason for its cost effectiveness.

Use of family planning to space pregnancies can increase child survival and start a virtuous cycle whereby lower child mortality reduces desired family size and leads to fewer pregnancies, thereby improving child health and survival

Other factors that have contributed to the decline in fertility in developing countries include the expansion of education and the empowerment of women,⁹ both encompassed by the Millennium Development Goals. However, the least developed countries are lagging behind in the achievement of those goals¹⁰ and, to the extent that progress to attain them accelerates, one likely outcome will be rising demand for family planning as the desired number of children decreases.

Studies indicate that countries with lower fertility spend substantially more in the health and education of children than those with higher fertility. At the household level, children born into large families have fewer opportunities to receive schooling than those born into small families. Furthermore, women with fewer years of schooling tend to have higher fertility than those with higher levels of education. Hence, by improving access to family planning and giving women the possibility of reducing the number of children they bear, another virtuous cycle can be promoted, whereby smaller families lead to better child education thereby improving the education prospects of future generations and reinforcing the desire for fewer children.

Developing countries that have managed to reduce population growth by reducing fertility tend to have higher net enrolment ratios in primary school than those experiencing rapid population growth. The least developed countries are lagging behind in providing primary education to their rapidly growing number of children. Reducing birth rates by meeting the demand for family planning will moderate the growth of the number of children and make it easier to achieve universal primary education.

The role of policy in countries lagging behind

Around 2005, modern contraceptive use was below 10 per cent in 17 least developed countries, often as a result of decades of weak Government commitment to the reduction of fertility. Thus, in 1985, only five of those 17 countries considered their fertility to be too high, whereas the rest thought it was satisfactory or did not express a view. By 1995, only eight had policies to lower fertility. In 2005, four countries with total fertility surpassing 5 children per woman still considered its level to be satisfactory or too low¹¹ (the Central African Republic, the Democratic Republic of Congo, Equatorial Guinea and Somalia) and none had a policy to lower fertility.

Over time, some least developed countries have changed their views on fertility. Mali, for instance, still had in 2004 a total fertility of 6.7 children per woman (figure 2) and modern contraceptive use was a low 7 per cent in 2006. Yet, until the early 1990s, the Government of Mali considered the country's fertility level satisfactory and, although it adopted a population policy in 1991, the policy did not set clear goals regarding fertility or family planning. Yet, by 1993, the Government had changed its view on the level of fertility, reporting it as too high, and by 2003, a new population policy identified "controlling population growth" as an important objective. In addition,

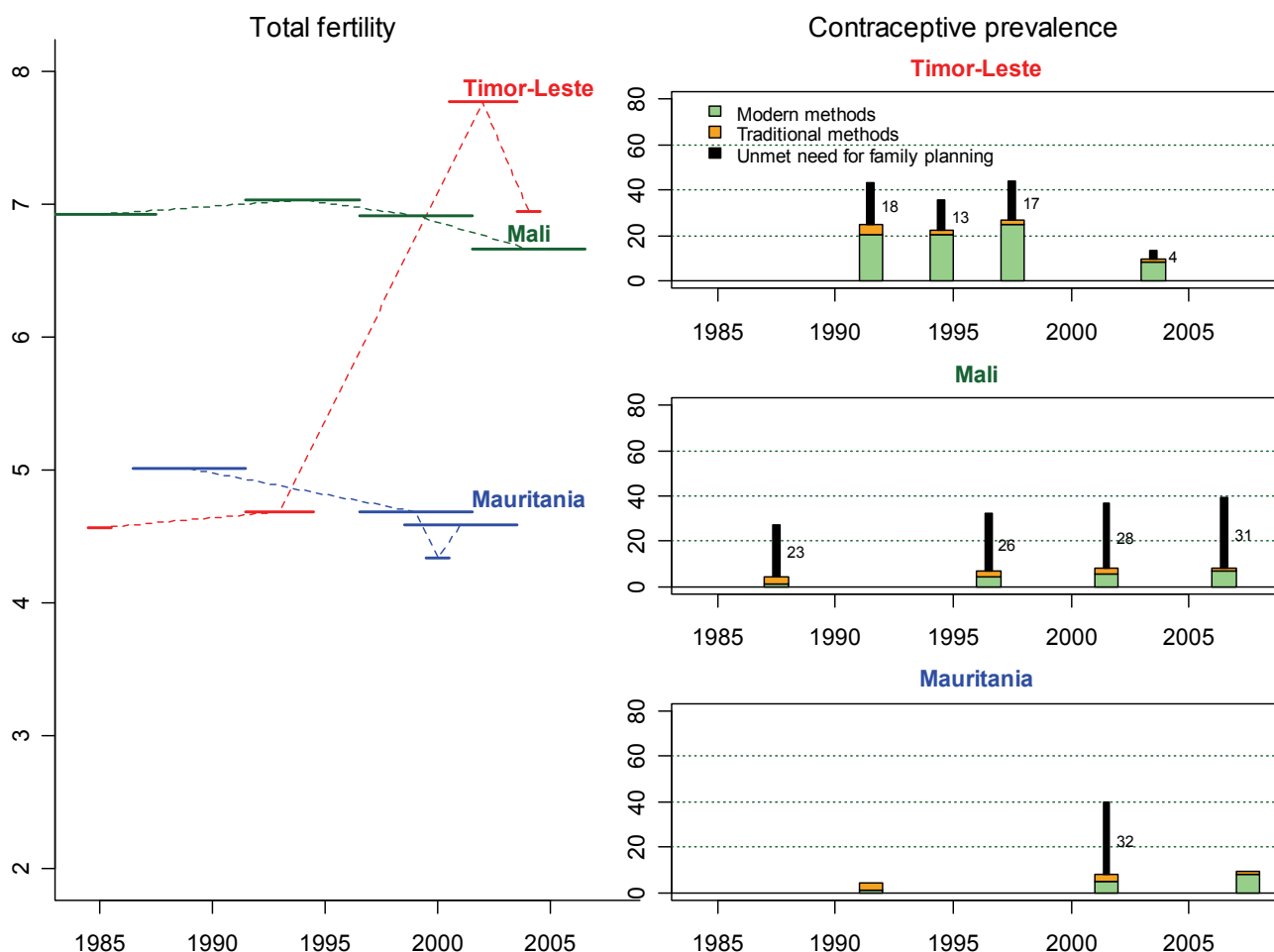
the 2006 Poverty Reduction Strategy Paper expressed concern about population growth and the high unmet need for family planning,¹² which by that time had risen to 31 per cent. Clearly, the time has come to translate this commitment into effective actions to expand access to family planning.

In Mauritania, whose fertility had declined slowly from 5 children per woman in 1990 to 4.6 in 2001 (figure 2), the Government considered its level as satisfactory until 2005 when it first reported the country's fertility as too high. Although the Government adopted a population policy in 1995, that policy lacked clear goals in regard to fertility or contraceptive use.¹³ More recently, the National Reproductive Health Programme 1998-2002¹⁴ aimed at reaching a very modest contraceptive prevalence of

10 per cent by 2002 and the current Poverty Reduction Strategy 2006-2010 seeks to reduce fertility to 4 children per woman by 2015,¹⁵ a very modest decline considering current fertility levels and the high unmet need for family planning prevalent in the country (32 per cent). In Mauritania, therefore, decisive action could well achieve more ambitious goals than those set so far by the Government.

Timor-Leste is an exceptional case because its fertility increased above 7 children per woman after having remained at levels well below 5 children per woman for over a decade (figure 2). Such an increase resulted from the post-independence desire to rebuild a population that had suffered considerable losses during the struggle for independence. Although fertility in Timor-Leste,

Figure 2: Total fertility, contraceptive prevalence and unmet need for family planning in three least developed countries lagging behind



Sources: World Fertility Data 2008 (POP/DB/FFP/Fert/Rev2008) and Millennium Development Goals Indicators.

has dropped somewhat from its peak and was estimated at 7 children per woman in 2004 unmet need for family planning is at an all time low, at just 4 per cent, and the rapid population growth that has ensued is a source of concern for the Government. Consequently, Timor-Leste's National Reproductive Health Strategy for 2004-2015 recognizes that reducing fertility is necessary to eradicate poverty, reduce infant and maternal mortality, and improve maternal and child health.¹⁶ It therefore aims at facilitating access to information about family planning and improving the availability of contraceptive methods so as to raise contraceptive prevalence to 40 per cent by 2015. In this case, the Government seems committed to meet this ambitious goal.

Lack of Government commitment is at the root of low contraceptive prevalence. Among the 17 least developed countries with very low recent levels of modern contraceptive use, just five considered fertility to be too high in 1985 and just 8 had policies to reduce fertility by 1995

In sum, in instances where fertility has remained high, lack of Government concern about high fertility and rapid population growth is at the root of the limited access that the population has to family planning and the high levels of unmet need for contraception. Yet, as the case of Timor-Leste suggests, there are also cases where the Government is taking the lead in influencing population trends by setting ambitious family planning goals.

The success stories

Despite their similarities, the least developed countries are not homogeneous and some provide examples of successful implementation of policies to strengthen family planning programmes. Cape Verde, a country that graduated in 2007 out of least developed status, provides one such example. Its Government began reporting its level of fertility as too high in 1989, at a time when total fertility in the country was close to 6 children per woman. Since then, family planning services expanded and rising contraceptive prevalence led to rapid reductions in fertility, which dropped to 2.9 children per woman by 2003 while modern contraceptive use reached 57 per cent by 2005. This success generated added demand for contraception as the small family norm took hold. Consequently, by 2005, still 17 per cent of married women of

reproductive age had an unmet need for family planning and the Government continued to be committed to satisfy that demand.

Cambodia, just as Timor-Leste, also experienced an increase of fertility after the demise of the 1970s Khmer Rouge regime, with fertility reaching 6 children per woman in the 1980s.¹⁷ Concerned about the rapid population growth that ensued, the Government of Cambodia adopted in 1994 the National Birth Spacing Policy and established the National Reproductive Health Programme. In 1997, those initiatives were buttressed by the National Safe Motherhood Policy, which was instrumental in making family planning available throughout the country. In 2003, the Government's new National Population Policy acknowledged the negative consequences of fast population growth on health, the environment and the fight against poverty, and reinforced the commitment to improve access to family planning services.¹⁸ Government commitment has therefore contributed to the decline in fertility, which started before any policy was enacted but has kept a rapid pace since then. Contraceptive prevalence reached 40 per cent in 2005 but just 27 per cent of women of reproductive age who were married or in union were using modern contraceptive methods and an additional 25 per cent had an unmet need for family planning. Aware that more needs to be done to meet the demand for modern contraception, the Government has adopted the *National Strategic Development Plan 2006-2010*, which has the ambitious goal of increasing modern contraceptive use to 44 per cent by 2010 and 60 per cent by 2015.¹⁹

On a per capita basis, donor funding for family planning declined by more than 50 per cent over the past decade in 42 of the 49 least developed countries

In several of the least developed countries located in Asia the use of modern contraceptives has increased markedly since 1994 (by at least one percentage point per year). These countries include Bangladesh, Bhutan, Cambodia, Myanmar and Nepal. As a result, the group of least developed countries outside Africa experienced a reduction of fertility from 4.1 children per woman in 1995 to 3.3 in 2005, while modern contraceptive use rose from 27 per cent to 39 per cent. Nevertheless, unmet need in this group of countries remains moderately high, at 17 per cent, and is very high in Haiti (38 per cent) and the Lao Peoples' Democratic Republic (40 per cent).

Donor funding to support the expansion of access to family planning is particularly important for the least developed countries where unmet need is substantial. However, over the past decade per capita donor funding for family planning has dropped by over 50 per cent in 42 of the 49 least developed countries. Mobilization of resources in combination with government commitment are necessary conditions to develop and sustain the family planning programmes that can respond efficiently to satisfy the existing demand for effective contraception.

Take-away messages

- *The least developed countries as a group and in their majority are lagging behind in the transition to low fertility and have rapidly growing populations.*
- *Lack of access to family planning and, in particular, to modern methods of contraception is a major cause of the persistence of high fertility as indicated by the high levels of unmet need for family planning prevalent in most least developed countries having the requisite data.*
- *Expansion of access to family planning requires government commitment and effective action to disseminate information about contraceptive methods and the benefits of smaller families.*
- *Strengthening and expanding family planning services requires adequate funding and access to supplies. Increases in donor funding for family planning would make a major contribution in this regard given that, since the mid-1990s, most least developed countries have experienced a per capita decrease in donor funding for family planning.*
- *Investments in family planning are cost effective because of the strong synergistic effects of longer inter-birth intervals and lower fertility with other development goals. For every dollar spent in family planning, between 2 and 6 dollars can be saved in interventions aimed at achieving other development goals.*

¹ World population monitoring, focusing on the contribution of the Programme of Action of the International Conference on Population and Development to the internationally agreed development goals, including the Millennium Development Goals. Report of the Secretary-General (E/CN.9/2009/3).

² “Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child. The concept of unmet need points to the gap between women’s reproductive intentions and their contraceptive behaviour” (Millennium Development Goals Indicators metadata, Indicator: 5.6 Unmet need for family planning, <http://mdgs.un.org/unsd/mdg/Metadata.aspx>). For MDG monitoring it is expressed as a percentage of women married and in union aged 15 to 49.

³ PATH and United Nations Population Fund, *Meeting the Need: Strengthening Family Planning Programs* (Seattle, PATH/UNFPA, 2006) and UN Millennium Project, *Public choices, private decisions: Sexual and reproductive health and the Millennium Development Goals* (2006).

⁴ Moreland, Scott and Sandra Talbird (2006). *Achieving the Millennium Development Goals: The contribution of fulfilling the unmet need for family planning*. Washington D. C.: USAID, 2006.

⁵ The data on fertility comes from *World Fertility Data 2008* (POP/DB/FFP/Fert/Rev2008). The data on contraception and unmet need for family planning is from the *Millennium Development Goals Indicators* database.

⁶ See table 2 for the list of countries. Cape Verde graduated from the LDCs at the end of 2007. It is therefore not included in the regional averages, but it is analyzed for illustrative purposes precisely because of its graduation.

⁷ Guengant, Jean-Pierre (2007) “La démographie africaine, entre convergences et divergences”. In *L’Afrique face à ses défis démographiques, un avenir incertain*, Benoît Ferry (dir.), Karthala – CEPEID- AFD, Paris, 2007.

⁸ E/CN.9/2009/3, pp. 28.

⁹ Bulatao, Rodolfo A. and John B. Casterline, Eds, *Global fertility transition. Completing the fertility transition* (ESA/P/WP.172/Rev.1), A supplement to *Population and Development Review*, Vol. 27, 2001.

¹⁰ United Nations (2008). *The Millennium Development Goals Report 2008* (United Nations Publication, Sales No. E.08.I.18).

¹¹ United Nations (2007). *World Population Policies 2007* (United Nations Publication, Sales No. E.08.XIII.8).

¹² IMF Country Report No. 08/121.

¹³ For Mali, see Justine Tantchou and Ellen Wilson, “Politiques et programmes de santé reproductive après le Caire : Une étude de cinq pays de l’Afrique francophone”, *POLICY Project Occasional Paper*, No. 7, Futures Group, August 2000, and UN *CCA-Bilan Commun de Pays Mali 2001* (UNDP, 2001). For Mauritania, *Programme National de Santé de la Reproduction 1998-2002. Résumé*. Ministère de la Santé et des Affaires Sociales. Direction de la Protection Sanitaire. République Islamique de Mauritanie, 1998.

¹⁴ *Programme National de Santé de la Reproduction 1998-2002. Résumé*. Ministère de la Santé et des Affaires Sociales. Direction de la Protection Sanitaire. République Islamique de Mauritanie, 1998.

¹⁵ *Cadre Stratégique de Lutte contre la Pauvreté. Plan d’Action 2006-2010*. République Islamique de Mauritanie, 2006. Available in <http://www.cslp.mr>.

¹⁶ *National Reproductive Health Strategy 2004-2015* (Dili, Ministry of Health Timor-Leste, 2004).

¹⁷ Heuveline, Patrick and Bunnak Poch, (2007). “The Phoenix Population: Demographic Crisis and Rebound in Cambodia”, *Demography*, Vol. 44, No. 2, 2007.

¹⁸ *National Population Policy* (Phnom Penh, Royal Government of Cambodia, 15 August 2003).

¹⁹ *National Strategic Development Plan 2006-2010* (Phnom Penh, Royal Government of Cambodia, 27 January 2006).

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Table 2. Selected indicators of fertility and contraceptive prevalence for least developed countries, most recent data available

Country code	Country name	Total fertility		Contraceptive prevalence		Unmet need for family planning	
		Year	Value	Year	Any method		Modern methods
Least developed countries in sub-Saharan Africa and Cape Verde							
AGO	Angola	2005	5.8	2001	6	5	..
BEN	Benin	2004	5.8	2006	17	6	30
BFA	Burkina Faso	2001	6.2	2003	14	9	29
BDI	Burundi	2001	5.6	2002	20	9	29
CPV	Cape Verde	2003	2.9	2005	61	57	17
CAF	Central African Republic	2003	5.2	2006	19	9	16 ^a
TCD	Chad	2002	6.6	2004	3	2	23
COM	Comoros	2003	5.3	2000	26	19	35 ^b
COD	Dem. Rep. of the Congo	2006	6.3	2007	21	6	24
DJI	Djibouti	2000	4.2	2006	18	17	..
GNQ	Equatorial Guinea	2001	5.6	..	..	..	..
ERI	Eritrea	2000	5.2	2002	8	5	27
ETH	Ethiopia	2003	5.7	2005	15	14	34
GMB	Gambia	2003	5.1	2001	18	13	..
GIN	Guinea	2003	5.6	2005	9	6	21
GNB	Guinea-Bissau	2000	7.4	2006	10	6	..
LSO	Lesotho	2003	4.1	2004	37	35	31
LBR	Liberia	2004	5.4	2007	11	10	21
MDG	Madagascar	2001	5.4	2004	27	17	24
MWI	Malawi	2005	6.3	2006	42	39	28 ^c
MLI	Mali	2004	6.7	2006	8	7	31
MRT	Mauritania	2001	4.6	2007	9	8	32 ^d
MOZ	Mozambique	2001	5.6	2003	17	12	18
NER	Niger	2004	7.1	2006	11	5	16
RWA	Rwanda	2006	5.5	2005	17	10	38
STP	São Tomé and Príncipe	2001	4.7	2000	29	27	..
SEN	Senegal	2003	5.2	2005	12	10	32
SLE	Sierra Leone	2007	5.1	2008	8	7	..
SOM	Somalia	2005	6.7	2006	15	1	..
SDN	Sudan	1997	5.0	2006	8	6	26 ^e
TGO	Togo	2003	5.1	2006	17	11	32 ^f
UGA	Uganda	2004	6.8	2006	24	18	41
TZA	United Republic of Tanzania	2003	5.7	2005	26	20	22
ZMB	Zambia	2006	6.2	2002	34	23	27
Rest of least developed countries							
AFG	Afghanistan	2001	6.8	2006	19	16	..
BGD	Bangladesh	2005	2.7	2004	58	47	11
BTN	Bhutan	2005	2.5	2000	31	31	..
KHM	Cambodia	2003	3.4	2005	40	27	25
HTI	Haiti	2003	4.0	2006	32	25	38
KIR	Kiribati	2005	3.4	2000	36	31	..
LAO	Lao People's Dem. Republic	2005	4.6	2000	32	29	40
MDV	Maldives	2006	2.1	2004	39	34	..
MMR	Myanmar	1999	2.6	2001	37	33	19
NPL	Nepal	2004	3.3	2006	48	44	25
WSM	Samoa	2006	4.2	1998	25	20	..
SLB	Solomon Islands	1999	4.5	..	..	..	..
TLS	Timor-Leste	2004	7.0	2003	10	9	4
TUV	Tuvalu	2005	2.8	..	..	..	..
VUT	Vanuatu	1999	4.8	1995	39	28	..
YEM	Yemen	2005	5.2	2003	23	13	39

Notes: ^a 1995; ^b 1996; ^c 2004; ^d 2001; ^e 1993; ^f 1998.

Sources: *World Fertility Data 2008* (POP/DB/FFP/Fert/Rev2008) and *Millennium Development Goals Indicators*.