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**Fertility Decline and Population Policies  
in the Arab World**

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## Fertility Decline and Population Policies in the Arab World

### Introduction

In the last three decades, a considerable body of research on changing family patterns and demographic issues has become available for the Arab countries. Most of the population information has focused on fertility behavior, including patterns of child bearing and the use of contraception. These data have been gathered through a series of large-scale international survey programs, including the World Fertility Survey (WFS) from 1972 to 1984 and the Contraceptive Prevalence Surveys (CPS) from 1977 to 1985 and the current Demographic and Health Surveys (DHS), which started in 1984, and Pan Arab Project for Child Development (PAPCHILD), which was initiated in 1985.

This paper briefly describes the range of fertility policies in the region, and examines key findings on fertility regulation from the retrospective surveys indicated here. The paper also discusses the changes that have been taking place in fertility behavior in the Arab countries covered by these surveys.

### I. Fertility Policies in the Arab Countries

A national population policy is defined as involving governmental implementation of policies to influence either directly or indirectly the demographic character of the country population such as population growth and age structure, mortality and morbidity, fertility and the family, international migration, urbanization and spatial distribution (United Nations, 1989). In this paper, we will present information on 'fertility policies', that is, on governmental policies concerned with limiting or promoting fertility.

Arab countries can be divided into three main groups according to the nature of their fertility policies as shown in Table 1. The first group of six countries (Algeria, Egypt, Jordan, Morocco, Tunisia and Yemen) views their fertility level and trend as too high. The governments of most of these countries consider rapid population growth as an obstacle to achieving development objectives. In the 1960s, Egypt, Morocco and Tunisia were among the first developing countries to officially adopt policies to reduce fertility and set quantitative targets in terms of contraceptive use, fertility rates and population growth. As a result of high unemployment and serious obstacles to economic growth, Algeria changed its position in the early 1980s (officially at the Second World Population Conference in Mexico in 1984), adopting a policy of direct intervention to modify demographic variables in conjunction with socio-economic restructuring. Before that, Algeria vehemently opposed fertility reduction and considered population control as a Western creation to hide the real reasons of underdevelopment. Yemen has formulated a population policy of direct intervention in 1991 and established targets to reduce fertility and increase the practice of contraception. Since 1986, Jordan has switched from a non-interventionist position to a policy of promoting lower fertility. At the moment, the National Population Commission has proposed a "birth spacing policy" which is under consideration by the government.

With a population of 137 million in 1993, these six countries represent almost 57 percent of the total Arab population estimated to more than 241 million. Two countries of this group are the most populous nations of the region: Egypt (58.3 million) and Morocco (28 million).

TABLE 1 Current Perception of Fertility by the Governments of the Arab Countries and Socio-demographic Indicators, 1993

Status	Number of Countries	Countries	Population (millions)	Percent of Total Population in 1992	Total Fertility Rate 15-49	Infant Mortality Rate (per 1000)	Life Expectancy	Per capita GNP 1991 (\$US)	Percent urban
Fertility is considered to be unsatisfactory because it is too high, and there are policies to reduce it.	6	Algeria	27.3		4.4 a	42 a	66	2 020	50
		Egypt	58.3		3.9 b	56	60	620	44
		Jordan	3.8		5.5	34	71	1 120	70
		Morocco	28.0		4.0 b	57 b	65	1 030	47
		Tunisia	8.6		3.4	43	68	1 510	59
		Yemen	11.3	56.7	7.5	84 b	46	540	29
Fertility level is considered to be satisfactory, and there are no or some intervention to maintain it.	12	Bahrain	0.5		3.9	20	72	6 910	81
		Djibouti	0.5		6.6	47	48	--	81
		Lebanon	3.6		3.7	46	68	--	84
		Libya	4.9		6.4	68	63	--	76
		Mauritania	2.2		5.0 a	83 a	47	510	39
		Oman	1.6		6.7	44	66	5 650	11
		Qatar	0.5		4.3	26	71	15 870 c	90
		Saudia Arabia	17.5	34.6	6.8	65	66	7 070 c	77
		Sudan	27.4		6.5	87	53	408 c	21
		Somalia	9.5		7.0	127	46	--	24
		Syria	13.5		7.1	48	65	1 110	50
U. A. Emirates	2.1		4.9	25	71	19 870 c	81		
Fertility is considered to be unsatisfactory because it is too low, and there are measures to increase it.	2	Iraq	19.2		7.0	79	64	--	70
		Kuwait	1.7		4.4	14	71	16 150 c	96
Total	19		242.0	100.0	4.4	58	63	--	49

Source: The information on the current governmental position on a country's fertility is compiled from United Nations, World Population Policies and DNS reports. The socio-demographic indicators are compiled from the 1993 World Population Data Sheet of the Population Reference Bureau, Inc. All figures are taken from the data sheet unless noted as drawn from the following sources:

- a - PAPCHILD Reports
- b - DNS Reports
- c - World Bank (1990)

Note: The Occupied Territories of Gaza and the West Bank, which are part of the League of the Arab States are not included here.

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The second group of 12 countries perceives the current fertility rates as satisfactory. Five countries (Libya, Oman, Qatar, Saudia Arabia and United Arab Emirates) have implemented measures to reduce mortality, maintain their current high level of fertility and reduce dependency on expatriate labor force (United Nations, 1989). With regard to access to modern contraceptive methods, these countries have a policy of little or no support, and there are even major restrictions in Saudia Arabia. The remaining seven countries (Bahrain, Djibouti, Lebanon, Mauritania, Somalia, Sudan and Syria) have no explicit policy to raise fertility; however, they provide limited support to family planning activities, with services provided mainly through local family planning associations affiliated with the International Planned Parenthood Federation (IPPF). This group represents 35 percent of the population in the Arab countries.

The third group of two countries (Iraq and Kuwait) views the present fertility rate as unsatisfactory, because they are too low. The government of Iraq has intervened to increase fertility by means of various pro-natalist measures such as family allowances and benefits, child allowances for salaried workers, and paid maternity leave for working women, including 100 percent of earnings payable at least 10 weeks. Although Iraq had an active national family planning association until 1991, the government has since the mid 1980s limited access to modern methods of contraception. Kuwait has also a policy to boost fertility rates among the national population. The government provides cash benefits by means of child allowances, maternity benefits and housing subsidies to families with a male Kuwaiti in government service. Access to contraception is permitted, but without government support for information or provision of methods. These two countries represent less than 9 percent of the Arab population.

## II. Fertility and Family Planning Indicators

Though reproductive levels remain high in the Arab world, many countries have entered a long-term process of demographic transition with continuing decline in fertility and infant and child mortality. In particular, there has been significant change in fertility and its determinants in the six Arab countries with the most active fertility control policies. This section of the paper first compares the family planning service delivery programs in each of these six countries. The paper then looks at evidence of the major changes that have occurred in these six countries in two of most important and measurable proximate (immediate) determinants of fertility decline—age at marriage and use of modern contraception. The paper highlights declines in fertility in a number of the countries. Finally, consideration is given to broader social changes, particularly increasing education, that have helped to shape the climate in which the changes in fertility behavior and its determinants have been occurring.

### A. Program Discussion

Three countries (Egypt, Morocco and Tunisia) have had national family planning programs for many years, but their approaches to achieving the shared goal of widespread contraceptive practice differ in many respects. The three other countries (Algeria, Jordan and Yemen) are considered newcomers to the task of setting up family planning programs, but the impact on fertility decline of their efforts to increase contraceptive use is already evident in Algeria and Jordan.

## 1. Algeria

Until early 1980s, the government took the position that resolution of population issues lay in social and economic development. The first mention of family planning in an official government statement appeared in the Public Health Code of 1976, where birth spacing by contraception was acknowledged as needed to protect the life and health of mothers and children as well as the well-being of the family. At the Second Population Conference in 1984 in Mexico, Algeria officially recognized the need to for direct intervention to modify demographic variables. Although no quantitative fertility targets have been established, the policy is to reduce fertility by measures such as expanding the family planning program and improving the status of women (increase in the legal age at marriage from age 14 to 16, interdiction of forced marriage and pension and child support for divorced women). Family allowances are limited to those with a maximum of four children. The government provides direct support free of charge for information about, and access to, modern contraception through the MCH centers of the Ministry of Health (Nortman, 1981, United Nations, 1989 and AAPF, 1993).

Family planning services are also available in the private sector, including pharmacies and the Algerian Family Planning Association (AAPF) which is affiliated to IPPF. In addition, international assistance has been accepted from the UN Fund for Population Activities, and the World Health Organization.

## 2. Egypt

Egypt has the largest and among the oldest family planning programs in the Arab world. Family planning services were offered as early as the 1950s by nongovernmental social service agencies (including the Egyptian Family Planning Association). In the mid-1960s, the Government of Egypt assumed an active role in providing family planning services, with the establishment of the Supreme Council for Family Planning. For the next 25 years, policy and program coordination was concentrated in the Population and Family Planning Board and its successor, the National Population Council. As further sign of its continuing concern with population, the Egyptian government has very recently established a Ministry of Population and Family Affairs.

The national family planning program in Egypt relies upon both public sector and private sector providers to serve family planning clients. Currently, around two in three users obtains services from private outlets, principally private doctors or clinics and pharmacies.

## 3. Jordan

Although Jordan has no explicit population policy, it recognizes that demographic variables are linked to socio-economic development. The National Population Commission was established in 1973 to plan and promote a national population policy, and since the late 1970s national development have made explicit reference to factors such as high population growth, rural-urban migration, spatial distribution and age structure (Cornelius et al., 1993). At the moment, a "birth spacing policy" is under consideration by the government. The objectives of this policy are to promote childspacing and reduce infant and maternal mortality.

Through the Ministry of Health, the Jordan Family Planning and Protection Association (JFPPA) and agencies concerned with rural, women are receiving information about family health and contraceptive methods and services if they are desired. The private sector is the major provider of family

planning services in the country; it includes private clinics, doctors and pharmacies. The JFPPA which is the leading family planning NGO in Jordan, currently operates eight clinics with financial support of IPPF, USAID and UNFPA.

#### 4. Morocco

Morocco has had a national family planning program since 1966, when both a national High Population Commission and local committees concerned with population issues were established. A major early success was the repeal of the French Law of 1920, which prohibits the advertising, sale and distribution of contraceptives.

The Moroccan family planning program is distinguished by its integration of family planning services with the primary health care delivery system and its strong outreach efforts. The strategy of delivering home-based services was expanded from an experimental effort in one province in the late 1970s to the entire country in 1986. Currently, around two thirds of all users obtain services from public sector providers, with about one-tenth served by outreach efforts.

#### 5. Tunisia

Tunisia has among the most advanced family planning programs in Africa and the Middle East. Since the early 1960s, Tunisia has had a comprehensive population program, which seeks to incorporate demographic variables into socio-economic planning, promote full equality for women, encourage small family size and permit free access to all major methods of family planning, including sterilization. The Office Nationale de la Famille et de la Population (ONFPF), a semi-autonomous agency of the Ministry of Public Health, coordinates governmental efforts to provide family planning services.

Today, in Tunisia, contraceptive services are offered, free of charge, in more than 1,000 public sector facilities throughout the country. Over three-quarters of all current users obtain their methods from these public sector outlets, with the remainder relying on pharmacies or private physicians and nurse-midwives.

#### 6. Yemen

In 1984, a National Committee for Population and Family Planning (NCPFP) was established to strengthen the government capacity to implement a population policy in North Yemen. After the achievement of the Yemeni unity between the two parts in May 1990, the government drafted a national population strategy which, after revision, was adopted as national policy at the National Population Conference in October 1991. Targets to be achieved by the year 2000 are a total fertility rate of 6 children per woman and a prevalence contraceptive rate of 35 percent. The policy commits the government to supporting the provision of contraceptives, the training of family planning volunteers, raising awareness of the right to family planning, and to implementing the policy through the establishment of and support for a National Population Council (United Nations, 1990 and Delargy et al., 1993).

Nearly six out of every ten users of modern methods in Yemen are supplied by the public sector, while the private serves four in ten. In the private sector, pharmacies are the major source of contraceptive methods. The role of the Yemen Family Planning Association (YFPA), an IPPF affiliate is still limited regarding the provision of contraceptive services, although the Association provides

training and information.

## B. Proximate Determinants of Fertility

### Changes in Marriage Patterns

Marriage is a primary determinant of women's exposure to the risk of pregnancy, especially in countries like those in the Arab world where childbearing is confined to marital unions. Fertility levels tend to be higher in countries in which women marry at a young age because women who marry early are exposed to the risk of childbearing for a longer duration than women who delay marriage. Table 2 presents the proportion of women who are still unmarried and the singulate mean age at marriage at two points in time for the countries studied in this paper.

TABLE 2 Percentage of Women Never Married by Age and Singulate Mean Age at Marriage (SMAM) in Five Arab Countries, Censuses, WFS and DHS Surveys

Age	Algeria		Egypt		Jordan		Morocco		Tunisia		Yemen (N)	
	1977	1987	1980	1988	1976	1990	1979/80	1992	1978	1988	1979	1991/92
	Census	Census	WFS	DHS	WFS	DHS	WFS	DHS	WFS	DHS	WFS	DHS
15-19	54	72	78	85	80	89	79	88	94	96	39	76
20-24	21	38	36	40	36	55	36	56	57	64	7	28
25-29	7	16	14	16	13	26	12	34	20	30	3	9
30-34	3	7	4	5	5	11	3	14	6	11	2	3
35-39	2	3	2	2	2	5	1	7	2	5	0	1
40-44	1	4	2	2	2	3	1	3	2	3	2	0
45-49	1	2	2	2	2	2	0	0	1	8	1	0
SMAM	21.1	24.0	21.3	22.0	21.6	24.0	21.3	25.	23.9	25.0*	16.9	20.9

Note: The singulate mean age at marriage can be interpreted as the average number of years lived as single among women who ultimately marry.  
 \*SMAM was calculated for age 15-44  
 Sources: WFS data are from United Nations (1987), DHS data for Egypt and Tunisia are from Adlekh et al (1991), DHS data for Jordan, Morocco and Yemen are from unpublished tabulations and DHS reports and census figures for Algeria are from Kouacouci (1992).

The rapid change that has occurred over the past 15 years in the age at marriage is evident from both these indicators. The proportion who remain single clearly increased among women under age 30 in all of the countries. In addition, significant increases are observed in the proportion remaining single in the 30-34 cohort in Jordan, Morocco and Tunisia; currently more than one in ten women age 30-34 in these three countries has not yet married.

The increasing tendency to delay marriage also is reflected in the increases in the singulate mean at marriage for all countries. The singulate mean age at marriage is defined as the average number of years lived as single for women who will eventually marry. The singulate mean age at marriage exceeded 20 years in all six countries and was 25 years or more in Tunisia and Morocco.

## Changes in Contraceptive Use

Another principal determinant of fertility levels is contraceptive use levels. Table 3 shows five of the six Arab countries have moderately high contraceptive use levels (Table 3); around one in two married women were reported as using in Algeria and Tunisia (at the time of the latest survey), 47 percent were using in Egypt, 42 percent in Morocco and 35 percent in Jordan. North Yemen—with only 6 percent of married women reported as currently practicing family planning—clearly lags behind the other five countries.

TABLE 3 Percentage of Currently Married Women 15-49 Using Specific Contraceptive Methods in Six Arab Arab Countries, WFS, DHS and PAPCHILD Surveys

Method	Algeria		Egypt			Jordan		Morocco		Tunisia		Yemen (N)	
	1986	1992	1980	1988	1992	1976	1990	1979/80	1992	1978	1988	1979	1991/92
	FS	PAPCHILD	WFS	DHS	DHS	WFS	DHS	WFS	DHS	WFS	DHS	WFS	DHS
Any method	35.5	50.8	24.1	37.8	47.1	25.2	35.0	19.4	41.5	31.4	49.8	1.1	5.9
Any modern	NA	43.0	22.7	35.4	44.8	17.8	26.9	16.4	35.5	24.8	40.4	1.1	5.1
Pill	26.4	38.7	16.5	15.3	12.9	11.9	4.6	13.7	28.1	6.5	8.8	0.6	2.2
IUD	2.4	2.4	4.0	15.7	27.9	2.0	15.3	0.8	3.2	8.7	17.0	0.1	1.3
Fem. st.	1.0	1.5	0.7	1.5	1.1	1.8	5.6	1.6	3.0	7.5	11.5	0.1	0.8
Other	NA	0.7	1.5	2.9	2.9	2.1	1.4	0.3	1.2	2.1	3.1	0.3	0.8
Any trad.	NA	7.8	1.4	2.6	2.3	5.8	8.1	2.8	6.0	6.6	9.4	0.0	0.8
Per. abst.	NA	NA	0.5	0.6	0.7	2.1	3.9	1.0	3.0	3.8	6.3	0.0	0.3
Withdrawal	NA	NA	0.4	0.5	0.7	3.3	4.0	1.0	2.6	2.0	2.4	0.0	0.3
Other	NA	NA	0.5	1.3	1.0	0.4	0.2	0.8	0.4	0.8	0.7	0.0	0.2

Source: Unpublished tabulations, United Nations (1987) and DHS and PAPCHILD reports

All six of the countries experienced increases in contraceptive prevalence during the 1980s and early 1990s, although the increase in Yemen was much more modest than in the other countries. In Morocco, the proportion of married women using family planning more than doubled during the period 1979/80 and 1992, from 19 percent to 41 percent, and, in Egypt, contraceptive prevalence nearly doubled during roughly the same period, from 24 percent to 47 percent.

The mix of methods adopted by users varies widely across the six countries. Although Tunisia has the most balanced mix, the IUD is the predominate method among users. The IUD also is by far the most widely used in Jordan and Egypt, while, in Morocco and Algeria, the majority of current users rely on pills.

### C. Fertility Trends

Recent fertility trends have been sharply downward in five of the six Arab countries, which have strong fertility control policies. Yemen with a TFR of more than eight births per woman has recorded only a small decline during the period between the survey dates shown in Table 4. Jordan registered a decline of 2.1 births in the TFR since the mid-1970s; however, the TFR in Jordan remains high (5.6

births per woman. Algeria, Morocco, Tunisia and Egypt also have experienced large declines in fertility since the late 1970s or early 1980s. At the time of the most recent fertility survey in Tunisia and Algeria, the TFR was 4.4 births per woman in each country, in Morocco, the TFR was 4.0 births per woman, and, in Egypt, the TFR was 3.9 births per woman.

**TABLE 4 Total Fertility Rates, WFS, DHS and PAPCHILD Surveys, Women 15-49**

Country	WFS		DHS/PAPCHILD		Percent Decline	
	Year	TFR <sup>a</sup>	Year	TFR <sup>b</sup>	Decline between Surveys	Yearly Decline
Algeria	1986	5.4	1992	4.4	18.5	3.1
Egypt	1980	5.3	1992	3.9	26.4	2.0
Jordan	1976	7.7	1990	5.6	27.2	1.8
Morocco	1979/80	5.9	1992	4.0	32.2	2.5
Tunisia	1978	5.8	1988	4.4	24.1	2.2
Yemen (N)	1979	8.5	1991/92	8.2	3.5	0.3

Source: WFS, DHS and PAPCHILD reports  
<sup>a</sup> Rates are for five-year periods  
<sup>b</sup> Rates are for three-year periods

Fertility levels have not only fallen, but there is clear evidence that many women in these countries are interested in continuing to limit childbearing. According to the most recent fertility surveys in these countries, almost two-thirds of the married women in Egypt and more than half of the married women in Jordan, Morocco and Tunisia do not want more children. Only, in Yemen, do the majority of married women continue to want another birth.

**D. Differentials by Residence and Education**

Although fertility behavior is changing in all six Arab countries, there remain sharp differences by urban-rural residence and education in key indicators. For example, the level of current use of contraception among married women is uniformly higher in urban than rural areas. Urban-rural differences are particularly striking in North Yemen, where use levels are seven times higher among urban than rural women. Among the other five countries, Tunisia had the urban-rural largest differential (26 percentage points) and Algeria, the smallest (13 percentage points).

**TABLE 5 Percentage of Currently Married Women Who Want No More Children in Selected Arab Countries, DHS Surveys**

Country	Percent Wanting No More Children
Egypt, 1988	66
Jordan, 1990	53
Morocco, 1992	52
Tunisia, 1987	57
Yemen (N), 1991/92	37

Source: DHS reports

**TABLE 7** Percent of Married Women Currently Using a Contraceptive Method by Urban-Rural Residence and Level of Education in Six Arab Countries, DHS Surveys

Residence and Educational Level	Algeria	Egypt	Jordan	Morocco	Tunisia	Yemen (N)
	1992	1992	1990	1992	1988	1991/92
Residence						
Urban	57.5	57.0	41.3	54.5	60.5	20.7
Rural	44.1	38.4	22.3	31.6	34.6	3.3
Educational Level						
No education	NA	37.5	26.0	35.7	42.3	4.8
Primary	NA	54.4	38.3	57.0	56.8	17.2
Secondary +	NA	58.0	37.3	64.9	66.5	25.9

Source: Unpublished tabulations and DHS reports

As also shown in Table 6, current use levels typically vary positively with a woman's educational level. The differentials again are greatest in the case of North Yemen, where only 5 percent of women with no education are using compared to 26 percent of women with secondary schooling or higher.

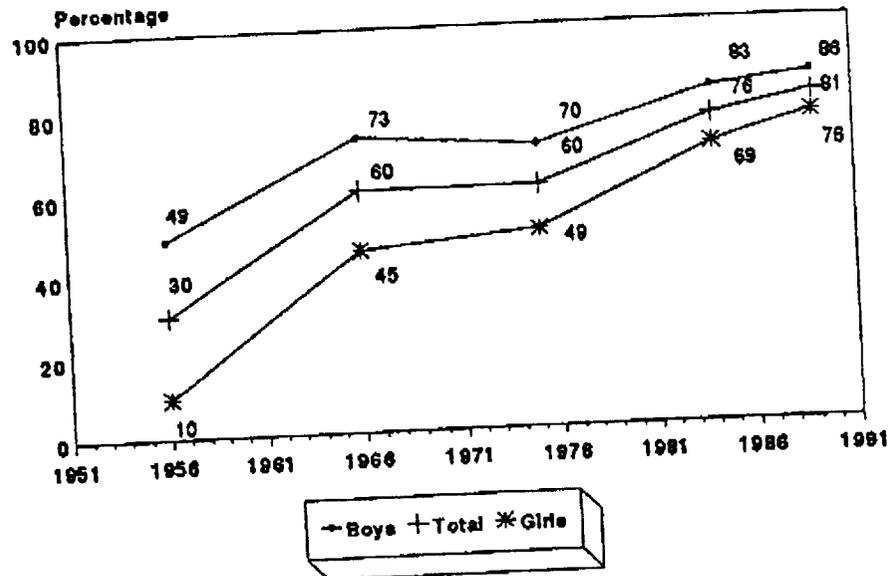
The relatively high use levels observed for women at both the primary and secondary levels are encouraging signs for the future, since female educational levels are rising rapidly in these countries. Figure 1 shows that school enrollment for girls has increased in Tunisia from only 10 percent in the 1950s to 76 percent in the late 1980s. The gap between the enrollment of boys and girls narrowed significantly in the same period. In Jordan, Figure 2 shows the enrollment gap between boys and girls has virtually disappeared. Both Yemen and Morocco continue to have significant gaps in male-female enrollment. The overall level of enrollment of children is also much lower in these two countries than in Tunisia and Morocco.

#### IV. Conclusions

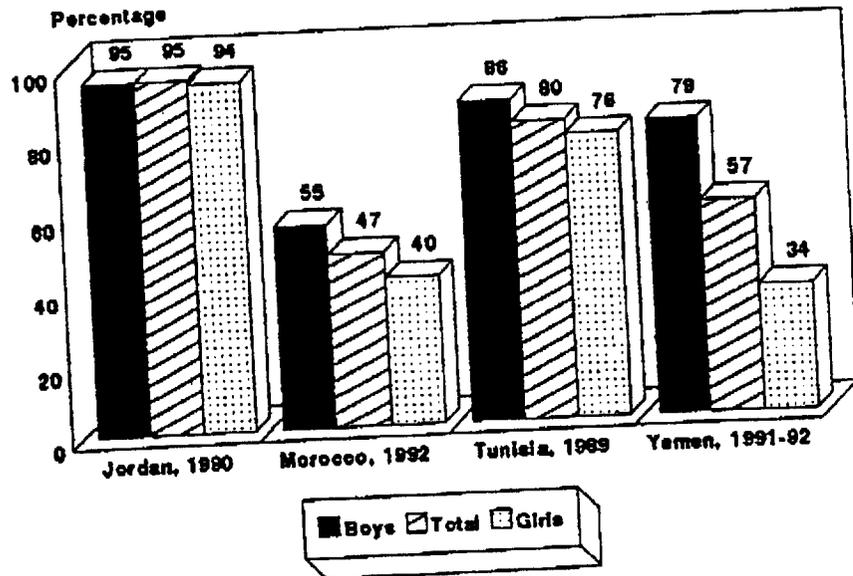
Long-term sustained fertility decline is occurring in most of the Arab countries, which have adopted policies seeking to lower population growth rates. Only in North Yemen do levels remain high; however, Yemen has only recently focused attention on fertility issues and it is probably too soon to assess its progress.

This paper suggests that the path to fertility decline in all cases has involved both changes in that age at marriage and in contraceptive use levels. The five Arab countries in which sustained declines are observed vary significantly in a number of key family planning program indicators, including the method mix and the nature of their contraceptive service delivery infrastructure. With regard to methods, users in Egypt and Jordan rely principally upon the IUD, while, in Algeria and Morocco, pills predominate. Only Tunisia has a balanced method mix.

**Figure 1**  
Trends of School Enrollment  
for Children Age 6-15 in Tunisia



**Figure 2**  
School Enrollment for Children  
Age 6-15 in Selected Arab Countries



The programs also vary in the extent of their reliance on private sector providers and their use of outreach workers. Private doctors and clinics and pharmacies are the primary source for contraceptive services in Egypt and Jordan, while public facilities provide the majority of users with contraceptive methods in Algeria, Tunisia and Morocco. Morocco has the largest outreach effort.

The family planning programs in the successful programs face significant future challenges, particularly the need to motivate and serve an increasing proportion of rural, less educated women if they are to continue to expand the use of contraception. They will be aided in the future by the fact that female educational levels are advancing rapidly but they must work in the present with a female population that is not highly educated.

The fertility changes occurring in Algeria, Egypt, Jordan, Morocco, and Tunisia have taken place against a backdrop of varying socio-economic levels. In Morocco, there have been large fertility declines although socio-economic indicators remain relatively weak. This pattern clearly would not have occurred in the absence of Morocco's relatively strong family planning program. In Jordan, fertility decline has been slower, although the country has relatively strong socio-economic indicators. This may be a result of the fact that Jordan's fertility policies and its family planning program have been relatively weak until recently. However, other factors also have supported high fertility.

This review of fertility change in six countries in the Middle East suggests that socio-economic changes—particularly rapidly advancing educational levels for both men and women—will bring about fertility decline in all Arab countries. This decline will occur whether or not countries adopt strong policies. However, it is clear from the examples of Morocco and Egypt that strong governmental support for family planning can accelerate the inevitable process of fertility change.

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