Family Planning, Declining Fertility and the

Convergence of Family Policies

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Abstract
Over the last fifty years, reproductive behaviour has become widely accepted as a major concern of governments. In the 1960s, governments were urged to strive for ‘zero population growth’ but in 1968, the United Nations began viewing family planning as a human rights issue rather than focusing only on population control and demographics. By the 1990s, UN documents were empowering women in matters of reproduction and urging governments to ensure their access to a wide range of family planning services. Now, widespread use of contraceptives and abortion, and below-replacement fertility rates are beginning to concern some governments, churches and advocacy groups.

Based on a larger research project on the impact of ‘globalization’ on family policies in OECD countries, this paper demonstrates that pressures from international organizations continue to encourage the harmonization of family planning services and practices. Nevertheless, national policies and services are more likely to be influenced by political ideas about the role of the state in family life, concerns about healthcare expenditures, and the politics of choice. Family planning and fertility rates are converging in OECD countries but not necessarily in the direction approved by supra-national organizations, some governments or social conservative groups.

Introduction
In 2004, Pope John Paul II initiated a report asking governments to help women attend to ‘their family duties’ when they enter the labour market (The Guardian 2004). The Vatican appealed to governments to assist women to cope with their ‘maternal vocation’, suggesting that the recent decline in fertility, especially in southern Europe, is symptomatic of a ‘breakdown in values’. Greater selfishness among couples who are ‘more interested in consumer goods than creating life’ was targeted as the cause of fertility decline. This papal warning represents one example of the growing concern about declining fertility and the external pressures on welfare states to seek policy solutions.

Fertility concerns are now widespread in a number of countries. While China and India continue their policies to limit family size, social conservatives in some western countries are
encouraging married couples to reproduce. For example, the Australian Treasurer recently advocated having more children to resolve the ‘problems’ of population aging and low replacement rates when he said: “… you should have one for the father, one for the mother and one for the country…” (Dodson 2004). Despite this advice, it is clear that childbirth decisions are influenced by a variety of economic and social factors, as well as personal choice.

Social research clearly indicates that procreation is considered intrinsic to heterosexual marriage, gender identity and ‘normal’ adult life, and that most adults who marry also become parents (Albury 1999, Baker 2004). Nevertheless, some people are more likely than others to limit their fertility. The costs and benefits of having children vary with gender, educational attainment and employment opportunities. For example, women with postgraduate education and high incomes are less likely to have children than educated men or women with lower levels of schooling and income, because highly educated employed women have more to lose from reducing their commitment to paid work (Beaujot 2000). Fertility rates also vary by culture and ethnicity, partially reflecting social class differences but also indicating the range of cultural values placed marriage, fertility and family.

Young people are justifiably delaying reproduction until they complete their education, find permanent work that pays enough to afford the rising cost of housing and childrearing, and settle into a stable relationship. However, they are not delaying sexual activity. The new contraceptives enable the effective separation of sexuality and reproduction, and permit more individuals to choose permanent solutions such as sterilization (Balakrishnan 1993). In addition, current levels of marriage instability discourage reproduction (Weston et al 2004), as few women would choose to become sole mothers. Marital reproduction is increasingly becoming a choice in
OECD countries, with improvements in contraceptive technology and legalised abortion, and more liberal social attitudes towards non-marital sex and a childfree life.

Based on a larger research project on global influences on family policies, this paper demonstrates that both international and internal pressures encourage governments to harmonize reproductive services. Nevertheless, the provision and availability of these services are influenced by many other factors, including cost concerns, the arguments of powerful lobby groups, prevalent models of family supported by government, and the politics of choice.

**Policies and Services for Contraception**

Reproduction was once viewed as a private matter outside the scope of state involvement, except that the state privileged ‘legitimate’ births within legal marriage by giving these children more legal and social rights. Until the 1960s, both church and state discouraged any sexual behaviour or technological interventions that interfered with marital reproduction. Nevertheless, contraception has been available and used for well over a hundred years.

Three ‘contraceptive revolutions’ have been apparent in industrialized countries over the past century (Dickson et al 1997). The first took place in the late 19th century and involved ineffective barrier methods (such as condoms and diaphragms) used mainly by married couples, while many people remained single and celibate. The second contraceptive revolution took place after the 1960s which involved the more effective hormonal methods (‘the pill’). More effective contraception shifted public attitudes about reproduction and weakened the link between marriage and childbearing. The third contraceptive revolution, in the 1970s, involved sterilization, which is now the most commonly used method of contraception in North America as well as many European nations (Balakrishnan et al 1993).
Three quarters of married women now use some form of contraception, as Table 1 indicates. More effective contraception, combined with secularization and changing patterns of women’s education and employment, have led to changing sexual practices, the greater separation of sex and marriage, and smaller families. However, national governments and conservative lobby groups have sometimes viewed contraception as a threat to religious or cultural values, to the family as an institution, or to state population priorities. In the early 1900s, advocates of greater contraceptive use were met with religious and legal opposition, as opponents were concerned that preventing conception would encourage sex outside marriage. They saw marriage as the only acceptable place for sexual activity and argued that according to the Christian Bible, the purpose of marriage was procreation. This meant that sex outside marriage, homosexuality, and birth control devices were all considered to be immoral or sinful. They were also illegal in countries such as New Zealand, Australia and Canada until the late 1960s (McLaren and McLaren 1986, Molloy 1992, Gilding 1997: 67).

(Place Table 1 about Here)

Throughout the 1950s, legal marriage and the birth rates increased in North America and Australasia, partly in reaction to the years of separation and hardship during World War Two. However, the invention of ‘the pill’ in the 1960s and the broadening of women’s aspirations and opportunities encouraged rapid change in sexual practices and attitudes. Activists for women’s rights demanded more sexual freedom, the eradication of the ‘double standard’ of sexual practices, greater access to contraception and abortion, as well as access to tertiary education and employment equity. In Canada, homosexuality between consenting adults, therapeutic abortions in hospitals, and the advertisement and dissemination of birth control became legal for the first time in 1969 in one all-encompassing bill (McLaren 1999: 173).
In 1968, family planning found its way into international human rights discourse with the UN-sponsored International Conference on Human Rights in Teheran. The groundbreaking Proclamation of Teheran stated that “the protection of the family and of the child remains the concern of the international community. Parents have a basic right to determine freely and responsibly the number and spacing of their children” (United Nations 2003: 14). This recognition of family planning as a human right coincided with the significant progress made in developing new types of contraceptives, including the contraceptive pill and the intrauterine device (ibid: 14-15). In 1979, the United Nations urged member states in the Convention on the Elimination of All Forms of Discrimination against Women, to remove discrimination in the provision of health care services, including access to family planning. The 1993 Vienna Declaration, adopted by the World Congress on Human Rights, reaffirmed these basic reproductive rights by declaring a woman’s right to accessible and adequate health care and the widest range of family planning services (United Nations 2000: 59).

Viewing reproductive rights as basic human rights was further strengthened in 1994 at the UN International Conference on Population and Development in Cairo and its five-year review of implementation in 1999. Governments were urged to ensure universal access to reproductive health care and access to safe, effective and affordable methods of family planning. They were also urged to provide freedom from sexual violence, the elimination of harmful traditional practices (including female ‘genital mutilation’), and freedom from coercion within the family and society (ibid). The 1994 Cairo conference revolutionised the conceptualisation of family planning by empowering women in matters of reproduction (United Nations 1995). Reproductive issues became articulated within the discourse of self-determination and individual
well-being and rights, rather than focusing solely on population control and demographics (United Nations 2003).

This ideological shift can be largely traced to the influence of feminist non-governmental organizations that critiqued the demographic rationale for international population policy, saying that it was coercive, unethical and subjected women’s bodies to the attainment of an abstract and quantitative societal goal. Feminists were also critical of the inaccessibility of reproductive health services to some women, as well as the lack of respect and privacy that service providers often showed women at family planning clinics (Finkle and McIntosh 2002). The Cairo conference pushed the notion that family planning and women’s health services should be integrated as a single package while giving greater attention to the rights of women (United Nations 2003: 17-18). This was not a new idea in Sweden, which had a long history of integrating family planning programs within the broader health care context (Westlander and Stellman 1988).

Women’s right to reproductive health was also a central focus in the United Nations’ Fourth World Conference on Women held in Beijing in 1995. Their platform for action called upon governments to recognize that reproductive health depends partly on available information and services, the prevalence of high-risk sexual behaviour, discriminatory social practices, and negative attitudes towards females. Governments were also asked to address the gaps in the collection and analysis of statistical information on women and health, and to encourage research on these issues (United Nations 2000).

Three quarters of all countries, either member states of the United Nations or non-members, now provide direct support for access to modern contraceptive methods (United Nations 2003: 7). Direct support entails the provision of family planning services through
government-run facilities, such as hospitals, clinics, health centres or government fieldworkers. Another 17 per cent of countries support family planning programs and contraceptives indirectly, through support of non-governmental activities such as those operated by family planning associations (ibid). However, despite sizeable growth in government support over the last 30 years, the demand for contraceptive and family planning services still greatly exceeds supply.

In recent years, declining birth rates have influenced perceptions about contraceptive use. The majority of less developed nations continue to view fertility levels as too high and consequently sponsor family planning activities. At the same time, an increasing percentage of wealthier nation’s governments have come to regard national fertility levels as too low (United Nations 2003: 1). Just over half of wealthier nations now consider their fertility rates to be inadequate compared with 21 percent in 1976 (ibid). Both the changing role of women and the increasing fertility control afforded by modern contraceptive methods have substantively reduced fertility rates. This has caused population aging, which many governments (such as Australia) see as a looming crisis.

Nearly all countries have shifted their policies within the past thirty years towards increased support for modern contraceptive methods (United Nations 2003). At the same time, a number of OECD countries have reduced direct government support for family planning initiatives (ibid). It is difficult to ascertain whether or not this shift represents an attempt to counteract below-replacement fertility rates or if it reflects a broader context of privatization and government withdrawal from centralised health and welfare programs. Quite possibly both these factors have influenced the policy shifts. In Eastern Europe, profound economic and political upheaval has not only hastened the decline in fertility but the development of capitalism and

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1 Austria, Canada, Denmark, France, Japan, Italy and New Zealand provided direct support for contraception in 1996 but changed to indirect support by 2001 (United Nations 2003).
privatization has also led to more restrictive laws relating to contraception and abortion. This is especially the case in Poland, where the Catholic Church has once again become an influential lobby group (Hantrais 2004).

Some citizens are still fighting for access to contraception while others seem reluctant to use it. In many western countries, sexuality has become a marketable commodity that is romanticised in the media and sold in the consumer-oriented economy as fantasies and pleasures (McDaniel and Tepperman 2000: 132). Prevalent representations of sex help to explain why some young people fail to use contraception even when it is available and they have participated in sex education programs. The rational and clinical aspects of birth control contrast vividly with the romantic and glamorous images of love and sex. Furthermore, sex education often focuses on the mechanics of sex without dealing with values and feelings about sexuality.

In addition, religious opposition remains strong to contraception and especially to abortion. In the United States, for example, the fundamentalist Christian lobby has ensured that state-funded sex education programs focus on celibacy before marriage as the most effective form of birth control. Open discussions about contraceptives are discouraged by these groups because they are assumed to promote premarital sex (Sullivan 2003). The Catholic Church remains staunchly opposed to most forms of contraception as well as to abortion. Controversies continue in many countries about the nature of sex education and its role in the schools, as well as access to contraception and abortion.

**Access to Abortion**

The state’s role in facilitating legal or therapeutic abortion has been controversial for over forty years. Increasingly, early pregnancy is seen as a health and socioeconomic risk to women but
birth rates in OECD countries have generally declined among teenage women (OECD 2005). Nevertheless, some young women still become pregnant before they complete their education and many have abortions, sometimes requiring parental permission. Especially in those countries where abortion is illegal, young unmarried women are more likely than older married ones to seek abortions from untrained practitioners, to perform abortions on themselves, and to delay seeking medical treatment if complications arise (United Nations 2000: 58). Therapeutic abortion rates vary cross-nationally but have increased in the liberal welfare states\(^2\) between the 1970s and 1990s, as Table 2 indicates.

(Place Table 2 About Here)

Few countries deny women an abortion if the continuation of pregnancy endangers her life but vast cross-national variations exist in the legal availability (United Nations 2002). In Sweden, Norway, the Netherlands, Denmark, France, Belgium, the United States and the Russian Federation (amongst others), abortions are available on request, regardless of the reason sought (Centre of Reproductive Rights and Policy 2003). However, most nations that permit abortion on liberal grounds have established conditions that must be met before the abortion becomes legal. These include the type of medical facility where the abortion must be performed (hospital or licensed clinic), who can perform it (a licensed medical practitioner), and limits on gestational age (usually before 12 weeks). The limits on gestational age remain contentious. As more accurate prenatal imaging is developed, age-old controversies flare up about when a foetus becomes a human being or a legal ‘person’ with human rights.

Obtaining an abortion is not seen as an ordinary health service in most countries. Some jurisdictions require mandatory waiting periods and counselling before abortion, and even third

\(^2\) Canada and the English-speaking countries have been called ‘liberal’ welfare states (Esping-Andersen 1990) because they focus on individual responsibility for well-being, they tend to target social benefits to those with low income and provide relatively ungenerous social benefits.
party authorisation, such as spousal consent in Turkey (Rahman, Katzive and Henshaw 1998). Furthermore, governments that permit abortion on liberal grounds may not fund the procedure in the absence of medical necessity or other extreme circumstances (United Nations 2002).

Abortion is subsidized by the state to varying degrees in Sweden, Italy and France, but the United States and Germany will pay for abortions only for low-income women who could not otherwise afford the procedure (ibid). Thirty-two American states have declined to use their Medicaid funds to pay for abortions in the absence of extreme circumstances, such as a life threatening pregnancy or one resulting from rape or incest (Sullivan 2003).

Numerous countries allow abortion on limited grounds, such as when continuation of the pregnancy threatens to jeopardise the physical or mental health of the woman, if there is evidence of foetal impairment, or in the case of rape or incest (United Nations 2002). In the Republic of Ireland, abortion is legal only when the pregnancy endangers the woman’s life (Mahon 2001).

Access sometimes varies considerably among regions of the same country (United Nations 2001: 73-5). In federal states such as the United States, Canada and Australia, state variations are apparent in access, creating a situation of ‘abortion tourism’ as women travel to those states where the procedures are more readily available (Sullivan 2003). Even where laws converge across states or regions, substantial differences in accessibility may still exist in practice (United Nations 2002). In Italy, for example, abortion is legally available on request but the lack of hospital facilities and the high number of gynaecologists who are conscientious objectors create barriers for women seeking abortions, especially in the south.

Both the UN Cairo conference in 1994 and the Beijing conference in 1995 urged reproductive autonomy for women. However, the international community remains reluctant to
place any substantive pressure on nations to modify or repeal highly restrictive abortion laws and international conventions allow nation states considerable cultural and moral autonomy (Centre of Reproductive Rights and Policy 2003). The United Nations urges member states to give women access to safe abortion “where it is legal”, and urges access to quality medical care for women who suffer from post abortion complications regardless of the legality of the abortion itself (UN 1994 Article 8.25, UN 1995 Article 106.k). This requirement clearly seeks to address the vast numbers of women who die during unsafe illegal abortions, particularly in poorer nations (United Nations 1996).

The Beijing conference in 1995 urged governments to “consider reviewing laws containing punitive measures against women who have undergone illegal abortions” (UN 1995 Article 106.k). Women’s right to attain the highest standard of sexual and reproductive health and the right to make reproductive decisions free from discrimination, coercion and violence was also stressed. Both the 1994 and 1995 conferences confirmed that these rights are grounded in and draw from an extensive body of international human rights instruments and international consensus documents. All these documents emphasize the human rights aspect of accessibility to quality health care (United Nations 1996: 39-41).

European law remains ambivalent about abortion. The Maastricht Treaty (Treaty on the European Union) may be interpreted as protecting a nation’s right to define its own legal parameters with regards to abortion, as it includes a provision offering protection of national identity and sovereignty (European Union 1992, Article F.1). Furthermore, following the principle of ‘subsidiarity’, reproductive health policies remain clearly within the jurisdiction of member states (Girvin 1996: 166). Nevertheless, the European Parliament voted in 2002 to

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support a report by the Committee on Women’s Rights and Equal Opportunities on the state of women’s sexual and reproductive health and rights (Centre for Reproductive Rights 2004). Through the report, the European Parliament urged member states to legalise induced abortion under certain conditions, at least in cases of forced pregnancy, rape, or the endangerment of a woman’s health or life. The underlying principle is that the woman herself should make the final decision (European Parliament 2002). It remains to be seen how this will influence the member states with more conservative abortion laws, such as Ireland, Switzerland and more recently Poland. Undoubtedly, controversies will continue considering the tension among women’s reproductive rights, men’s rights, and issues of cultural and religious identity.

Other European laws have also been applied to further women’s right to abortion. For example, the Maastricht Treaty supports the rights of thousands of Irish women who travel to England each year to obtain abortions. This is not because it explicitly protects their reproductive rights but rather because it asserts their rights as EU citizens to travel freely between member states (Mahon 2001). The right of access to information is also protected under Article 10 of the Convention for the Protection of Human Rights and Fundamental Freedoms 1950. This right was enforced in the early 1990s by the Council of Europe in a challenge to the Supreme Court of Ireland’s denial of the right to provide information on abortion (United Nations 2001: 68). Despite these small gains for Irish women, abortion is by no means freely accessible, as the cost of travelling to England alongside accommodation and medical costs are substantial (Mahon 2001: 178).

The legality of abortion remains controversial for several reasons. Firstly, some religious groups firmly believe that the foetus is a ‘child’ with a right to life and that abortion is a form of

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4 Abortion was legalized in Poland in 1956 but after 1990, it was restricted with consistent lobbying from social groups linked to the Catholic Church. The 1997 law prevents abortion on social grounds.
murder. Secondly, some hospitals do not provide abortions, largely for religious reasons, which forces women to travel to other places at greater expense to obtain these services. This situation encourages illegal abortions and also opens the jurisdiction to accusations of inequalities in access to health services. Thirdly, some fathers’ rights activists and individual fathers believe that they should have more say in whether or not ‘their child’ is aborted or has the right to life. In Canada, the courts have generally confirmed that women and their physicians retain the right to decide if the pregnancy should continue, leaving the male partner with few options especially if he is no longer living with the pregnant woman (Boyd 2003). Fourth, rising health care costs and restructuring in the health sector have encouraged hospital administrators to make judgements about state funding for particular services, and abortions become vulnerable to cuts especially when they are seen as controversial procedures (Armstrong et al 2002). Finally, some policy makers want to ensure that abortion is used as a last resort, that it is not overused, and does not threaten the nation’s population stability or growth.

**Declining Fertility and the State**

Governments usually encourage their citizens to marry and reproduce because heterosexual marriage and parenthood are assumed to promote personal and community stability and provide the future generation of workers, taxpayers and consumers. In Europe, concern about fertility decline was prevalent in the 1930s, as the sagging economy, high unemployment and currency devaluation encouraged people to postpone marriage and childbirth. Both Hitler and Mussolini saw declining fertility as a social problem and encouraged married women to devote themselves to child rearing and homemaking (Albanese 2004). However in the same era, France and Sweden found different solutions to declining fertility by creating income tax concessions for each child.
and income support programs to assist parents to raise their children while earning a living (Baker 1995).

The Canadian province of Quebec attempted to raise fertility rates in 1988 when they introduced financial incentives to parents, which became very lucrative for the third child (Baker 1994). These ‘baby bonuses’ were controversial because they were introduced with nationalist Quebecois rhetoric about the importance of raising the ‘francophone’ birth rate in ‘anglophone’ North America. Not surprisingly, the policy failed to produce more babies among French-speaking couples and was quietly abolished in 1996. In 2001, an inexpensive childcare system (costing parents no more than $5.00 per day) was established in Quebec, to better enable women to maintain employment while having a family (Baker forthcoming).

In recent decades, fertility rates have declined considerably in most OECD countries, as Table 3 indicates. Demographers estimate that if couples produced about 2.1 children each, population stability would be maintained and countries could replace their deaths with new births. However, the total fertility rates (or the average number of children per woman who has completed childbearing) are currently below replacement in all OECD countries except Mexico and Turkey (OECD 2005: 28). In 2002, the total fertility rate was 1.75 in Australia and 1.52 in Canada, well below the replacement rate (ibid). The rate in Korea has plummeted even further to 1.17 in 2002 (ibid). Even the southern European countries now experience low fertility rates. Both Italy and Greece had total fertility rates of 2.4 in 1970 but by 2002 their rates had declined to 1.26 in Italy and 1.25 in Greece (OECD 2005: 29). The recent figures in southern Europe diminish any previous statistical association between high fertility, Catholicism and traditional family values (Castles 2002).

(Place Table 3 About Here)
Low fertility rates worry some policy makers because they could lead to ‘population aging’ and insufficient taxpayers to finance the needs of more seniors in the population. Yet fertility decline is not a recent phenomenon. Rates have been declining since the late 1800s, influenced by industrialization, urbanization and modernisation (Beaujot 2000). The benefits of a large number of children per family gradually declined as children could no longer be taken out of school to help support the family. In addition, fewer parents needed to rely on their children to care for them in their old age when old age security programs were developed. As infant mortality rates fell, couples began producing fewer children because more were expected to reach maturity (Chesnais 1992). The cost of raising children also increased but this is now calculated in terms of women’s lost earnings and the need for more spacious accommodation in better school zones or safer areas, as well as the direct costs of children’s food, clothing, care and education. Declining fertility is also related to improvements in contraception, access to legal abortion, personal choices for smaller families, and the difficulty mothers experience combining employment with child rearing (Hakim 2000, McDonald 2000, Weston and Parker 2002).

Employment trends in OECD countries suggest that most women cannot afford or no longer wish to refrain from paid work in order to raise large families but fertility trends can be influenced by social policies (Castles 2002). Fertility rates remain moderately high in countries such as France and Sweden with formal care provisions for preschool children and flexible workplace arrangements for their parents. Rates are also relatively high where birth control is less acceptable and costly but care arrangements for children are relatively inexpensive and informal, such as in the United States. Women tend to have fewer children when they must struggle to earn a living, such as through low wages and job discrimination, when they lack
access to affordable childcare services, or are faced with public discourse that makes them feel guilty about ‘neglecting’ their children while at work.

Fertility has also declined because women are now bearing their first child later in life, now around 28 to 30 years old (OECD 2001: 25). The growing tendency to postpone childbirth has some advantages for women, who are able to complete their education and find paid work before childbirth. A period of continuous full-time employment is often required before women are eligible for maternity benefits. However, postponing motherhood until later in life makes conception more difficult, pregnancy riskier, and contributes to lower fertility rates at the national level. This suggests that delayed fertility may be beneficial to women but also perceived as a looming economic problem for nations.

Few social conservatives would argue that the decline in teenage birthrates is a problem. These rates have declined in OECD countries from an average of 34 births per 1,000 women aged 15-19 in 1980 to 16 in 2002 (OECD 2005: 86). However, cross-national differences are very apparent in teenage birth rates. The 2002 rate in Australia was 18.4 compared to 51.1 in Mexico and 2.7 in Korea (OECD 2005: 87). Cross-national variations in teenage birth rates are influenced by differences in poverty rates, trends in sexual activity, access to contraception, women’s roles, and the percentage of poor and deprived groups in the population (OECD 2005: 86). Teen fertility rates remain relatively high in countries with large percentages of ‘visible minorities’ with low household incomes (such as in the US), few employment opportunities, and lack of access to contraception. These disadvantaged minorities tend to cohabit and marry at younger ages, and to place a higher value on parenthood as an indicator of adult status and love between partners (Edin 2003, Mink 1998). Many studies have found a strong correlation between
teenage pregnancy, early family formation and poor life chances for both parents (especially mothers) and their children (Hobcraft and Kiernan 2001).

(Place Table 4 About Here)

Researchers, policy makers and social conservatives generally agree that the decline in teenage birthrates is beneficial but not everyone acknowledges the family and social benefits of fertility decline among other parents. Large families often require state income supplements, so fewer children per family would help ensure that parents are able to support their children on their own earnings. Having fewer children also enables women to pursue their educational goals and retain paid employment, which usually raises the household living standards as well as providing more income tax revenue to the state. Theoretically, fewer children per family would also enable each child to receive more parental attention.

As total fertility rates continue to decline, governments tend to focus on the economic consequences to the nation rather than the potential advantages to families and women. At the same time, many developing countries continue to struggle with overpopulation, urban growth and poverty among large families by developing family planning strategies.

**Discussion and Conclusion**

Individuals and couples tend to limit their fertility in times of economic hardship, political upheaval or problems combining employment with family responsibilities. Government reactions to fertility issues are also influenced by broader political and economic issues, such as social program restructuring and sensitivity to strong political lobbying. Cutbacks to reproductive services are sometimes part of a larger strategy of neo-liberal restructuring that reduces access to a number of other health and social services at the same time. For example, the changing
political economy of Eastern Europe illustrates this point well as the upheavals related to the
development of capitalism, neo-liberal restructuring and privatisation not only hastened fertility
decline. It also encouraged governments to reduce services such as universal childcare and
enabled the Catholic Church to successfully restrict access to contraception and abortion in
Poland (Albanese 2004, Hantrais 2004). Another example relates to neo-liberal cuts to welfare in
the United States, which prevented welfare mothers from obtaining additional benefits for new
children born, but at the same time eroded access to contraception, abortion and sterilization
operations (Mink 1998).

It is ironical that concerns about declining fertility have been expressed so loudly in
Australia, as total fertility rates here remain much higher than other places such as Canada.
Clearly, Australian concerns are imbedded in a number of other political issues. The centre right
may be worried about population aging and the decline of the working-age population because
they see increased immigration as an undesirable solution to maintaining population growth or
stability. In addition, declining fertility is often associated (rightly or wrongly) with rising rates
of maternal employment, and more women in the labour force could increase national
unemployment rates. More maternal employment will undoubtedly require improvements in
public childcare services, which will be costly to governments. Generally, the political right has
supported the male breadwinner family and opposed increased state spending if it would raise
income taxes.

In the United States, the Christian Right has become a powerful lobby group influencing
public policy. Both Catholic and fundamentalist Christian groups continue to oppose premarital
sexual activity, interventionist forms of contraception, and therapeutic abortion for social or
economic reasons. In places where the Christian Right is politically influential, in the United
States and elsewhere, access to reproductive services has been limited and public funding curtailed. The lobbying efforts of pro-life groups have been persistent and vocal, discouraging some healthcare professionals from performing abortions. As a result, conservative policy makers have had an easier time restricting entitlement and funding to those reproductive procedures that are seen as controversial.

Generally, social conservatives promote premarital chastity, encourage only natural methods of contraception within marriage, and see childless couples as selfish and even unpatriotic. At the same time, social reformers on the left usually expect the state to reduce the financial constraints to childbearing by providing universal child allowances and resolving the problems of work/family balance through paid parental leave, flexible hours, more paid leave for family responsibilities, and state subsidized childcare. They also argue that fewer children per family could raise the quality of childcare by parents, increase family income because wives would be more likely to be employed, and reduce the need for state income support. Others simply argue that no one should be pressured to marry or reproduce because these should be personal choices.

Zero-population growth and improved access to family planning services were important goals for United Nations in the 1960s and 1970s, and women’s access to contraception and abortion continue to be UN goals today. However, politicians in OECD countries are once again expressing concern that middle class couples are not having enough children. Usually this concern is expressed in terms of the high cost of an aging population, although there are many ways of resolving those policy issues besides encouraging women to have more children. The policy options to remedy declining fertility remain diverse but are influenced by political sensitivities, economic concerns and religious beliefs.
Some people still dream of a home full of happy children but large middle-class families are becoming romanticized memories available to fewer couples. More competitive job markets, rising housing costs, childcare dilemmas, concerns about gender equity, and marriage instability are encouraging more people in OECD countries to use birth control, to delay marriage and to limit their family size. These economic and social pressures shape people’s personal choices about reproduction. Patterns of family planning use and fertility rates do seem to be converging in OECD countries but not necessarily in the direction approved by the Christian Right, the Vatican or some conservative governments.
Table 1: Contraception Statistics for Selected Countries, 1995-2002

<table>
<thead>
<tr>
<th>Country</th>
<th>% of Married Women using Contraceptives</th>
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<tbody>
<tr>
<td>Canada</td>
<td>75</td>
</tr>
<tr>
<td>Australia</td>
<td>76</td>
</tr>
<tr>
<td>New Zealand</td>
<td>75</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>82</td>
</tr>
<tr>
<td>United States</td>
<td>74</td>
</tr>
<tr>
<td>Netherlands</td>
<td>79</td>
</tr>
</tbody>
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* % of women of reproductive age (15-49) reporting contraceptive use by themselves or their partner

Table 2: Induced Abortion Rates in Selected Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Rate of Induced Abortions per 1,000 Women 15-44</th>
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<tbody>
<tr>
<td></td>
<td>1975</td>
</tr>
<tr>
<td>Canada</td>
<td>10.5</td>
</tr>
<tr>
<td>Australia</td>
<td>n.a.</td>
</tr>
<tr>
<td>New Zealand</td>
<td>8.6</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>11.2</td>
</tr>
<tr>
<td>United States</td>
<td>21.7</td>
</tr>
<tr>
<td>Sweden</td>
<td>20.2</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>5.2</td>
</tr>
</tbody>
</table>

Sources: Henshaw 1999.
Table 3: Fertility Rates in OECD Countries, 1970 and 2002

(Births per Woman)

<table>
<thead>
<tr>
<th>Country</th>
<th>1970</th>
<th>2002</th>
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<tbody>
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<td>Australia</td>
<td>2.9</td>
<td>1.75</td>
</tr>
<tr>
<td>Canada</td>
<td>2.0</td>
<td>1.52</td>
</tr>
<tr>
<td>Denmark</td>
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<td>1.72</td>
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*1976 figure

Source: OECD 2005: 29 (selected from data chart G3.1)
Table 4: Teenage Birth Rates in 2002
(Births to Mothers Aged 15-19 per 1,000 women aged 15-19)

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Source: Extracted from OECD 2005: 86
References


