

LOW-FERTILITY  
- THE FUTURE OF EUROPE?



# Entre Nous

THE EUROPEAN MAGAZINE FOR SEXUAL AND REPRODUCTIVE HEALTH



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WHO Regional Office for Europe  
Scherfigsvej 8  
DK-2100 Copenhagen Ø  
Denmark  
Tel: (+45) 3917 1602  
Fax: (+45) 3917 1818  
E-mail: [entrenous@euro.who.int](mailto:entrenous@euro.who.int)  
[www.euro.who.int/entrenous](http://www.euro.who.int/entrenous)

**Chief editor**

Dr Gunta Lazdane

**Editor**

Jacqueline Bryld

**Editorial assistant**

Dominique Gundelach

**Layout**

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Bryld



Gunta  
Lazdane



**More than half of the countries that make up the WHO European Region have fertility levels, which are defined as low or lowest-low. This significant population feature of the European region is in some countries causing concern, due to changes in the structures of the labour market and national economy, or might do so in the future. This issue of *Entre Nous* illustrates that the policy solutions to the 'demographic crises' are complex and context specific.**

The Museum of Contraception presents the history of humankind in trying to plan a family and prevent unwanted pregnancies. Since the discovery of hormonal contraception in the middle of the last century, the research in this field has resulted in providing a significant diversity of choices to couples in order to ensure "ability to have a satisfying and safe sex life and capability to reproduce and the freedom to decide if, when and how often to do so" (Programme of Action (POA) adopted at the International Conference on Population and Development (ICPD), 1994).

During the last 20-30 years the international community has changed the focus of the development goals from reducing the global population growth to ensuring sexual and reproductive health and rights. Several international agreements have set the scene and recommended the way to achieve "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes"

(POA ICPD, 1994). The 57th World Health Assembly in 2004 approved the World Health Organization's first Global Reproductive Health Strategy to accelerate progress towards the attainment of international development goals and targets. Since then many countries have analyzed the reproductive health of their population and developed their national strategies for the further improvement of reproductive health. Parallel to this process the question has been asked: "How important are these international agreements as well as the goal to achieve universal access to reproductive health services for the countries in the European Region of WHO, where more than half of the Member States have low fertility rates and a negative population growth?"

Let us make it clear – these agreements are still of high importance, some might argue now more than ever. Since the ICPD in 1994 and the World Summit in 2000 there have been several attempts to undermine the global commitments to ensure reproductive rights and access to sexual and reproductive health services. As can be read from several of the articles in this issue of *Entre Nous*, upholding the reproductive rights of women and men, also in a European context, can be a challenge and several governments have led pro-natalist policies, which in some cases have been in conflict with ensuring reproductive rights.

The fact that many policy makers in Europe are following the development of the fertility trends closely is signified by the fact that several countries have established high-level national committees to evaluate the possibilities of changing the present demographic trends. For example President Vladimir Putin highlighted the demographic crisis of the Russian Federation in his state-of-the-nation address this year and has made it one of the countries highest priorities: "First a lower death rate; second, an efficient migration policy; and third, a higher birth rate".

This edition of *Entre Nous* is planned to assist policy makers to learn more about the general trends of fertility rates in Europe and the ways some countries

are trying to respond to what by some is discussed as the 'fertility crises' through support to couples with children and to create family friendly environments. We have invited authors, specialist in this field from academic institutions, professional associations and UN agencies to discuss the role of the health care services in increasing the birth rates. The role of social factors is emphasized in many articles, and the national experts in the field present examples of the policies in countries from different parts of the European region.

It is beyond any doubt that all efforts should be made to ensure that health and sexuality education is combined with analysis of human values and responsibilities for every single adolescent. Information and knowledge increases the possibilities of making informed choices and preventing mistakes in reproductive behaviour that may have long lasting consequences. Reproductive health services are to meet the needs of all women and men to fulfil their goals in family planning. The global community is trying to achieve universal access to reproductive health by 2015, in less than 10 years. We are to ensure that reproductive health services are accessible and of high quality in all countries, including those with low fertility rates.

We hope that you will find this issue of *Entre Nous* helpful for your future activities in the area of sexual and reproductive health and rights and beyond.

**Gunta Lazdane**  
[gla@euro.who.int]  
Chief Editor

**Jacqueline Bryld**  
[jbr@euro.who.int]  
Editor

# IS EUROPE TRAPPED IN/BY LOW FERTILITY?

The “Low Fertility Trap”

**Birth rates throughout Europe (a) have declined to very low levels – currently the majority of countries have total fertility rates (TFR) below 1.5 children per woman. Several recent studies have suggested that this level might be a threshold that triggers self-reinforcing mechanisms, which tend to further suppress fertility. Hence, once TFR falls below 1.5, bringing it back up will be more difficult. Lutz (1) termed this the “low fertility trap”(b). Most countries of Southern, Central and Eastern Europe, including the European parts of the former Soviet Union, seem to have fallen in this “trap”:**

Moreover, in a number of these countries TFR is even below 1.3, a level that Kohler, Billari and Ortega (2) refer to as “lowest low fertility”(c) - see Figure 1.

There have been occasions when populations have experienced very low fertility in the past (e.g. the well known example of France during World War I). Until the early 1970s, when former West Germany’s TFR dropped below 1.5, this had occurred only under exceptional circumstances (e.g. wars) and was always followed swiftly by a recovery. Italy and Spain were the first to break through the “lowest-low fertility” barrier in 1993, followed within two years by several Central and East European countries (Bulgaria, the Czech Republic, Latvia and Slovenia). What was East Germany bears the dubious fame of being the first to have a TFR of under 1 in peace time - TFR there was below 1 during the period 1991 to 1996, dropping to as low as 0.77 in 1993 and 1994.

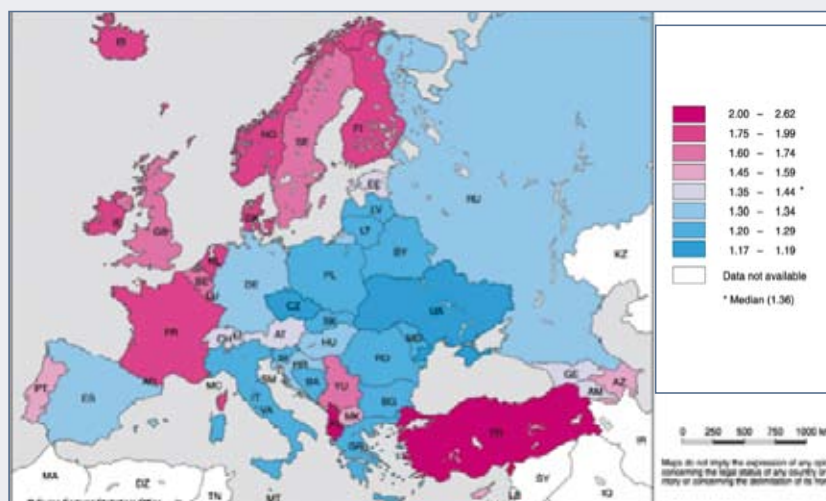
Very low fertility levels are no longer confined to Europe. Several Asian countries have also fallen in the “low fertility trap” – Hong Kong was the first to do so in 1985, and currently along with Macao, the other Special Administrative Region of the People’s Republic of China, has a TFR of below 1. Japan, the Republic of Korea and Singapore also have TFRs below 1.5. In North America, Canada has been close to the “trap” for several

years, and the latest data suggests that in 2002 its TFR was already 1.48 (3). In Latin America, Cuba had a TFR below 1.5 during the mid 1990s, although that country is one of the few examples where that indicator has resurged above the 1.5 threshold.

## Is it “Quantum”, or is it “Tempo”?

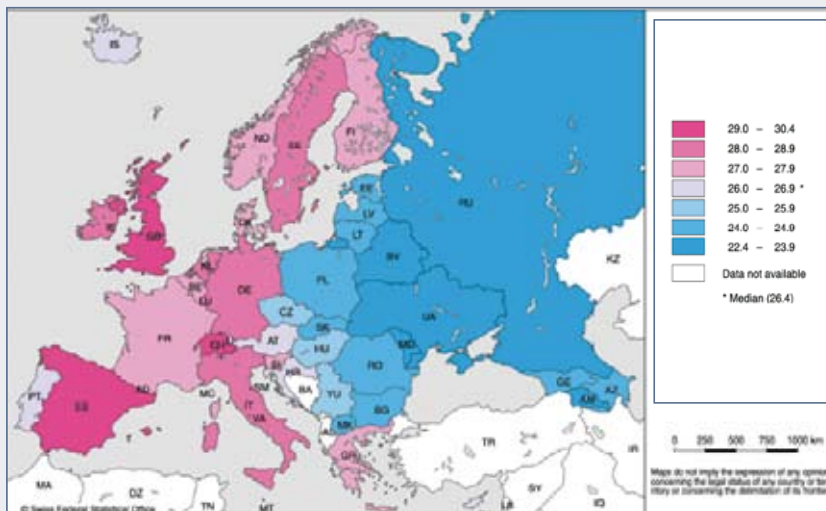
This is the question that experts have been asking themselves when it comes to interpreting the decline in birth rates. This is because the levels and trends of period fertility indicators, like the TFR, could be driven by two mechanisms: changes in the number of children that women have, and changes in the timing of births. The TFR measures the average number of births a woman would have by the time she reaches the end of her reproductive years, if she experiences the age-specific fertility rates observed in a given period. This measure “transposes” a momentary experience over the lifetime of a cohort. The postponement of fertility introduces distortions in that transposition. The completed fertility rate (CFR), on the other hand, presents the actual average number of children that women of a real cohort have by the end of their childbearing years. The changes in completed fertility are often referred to as “quantum” effects, while the changes in timing of childbearing -- as “tempo” effects. The bottom line is that because of

**Figure 1**  
Mean age of women at birth of first child, around 2003





**Figure 2**  
Total fertility rate (TFR) in Europe around 2003 (children per women)



**Table 1**  
Proportion of women aged 18-34 and 55 and over having declared 'none' as ideal number of children (%)

Country	Age group 18-34	Age group 55+	Country	Age group 18-34	Age group 55+
Austria	12.6	6.1	Latvia	1.9	1.8
Belgium	9.4	5.5	Lithuania	2.2	2.2
Bulgaria	0	0.8	Luxembourg	6.2	4.4
Cyprus	1.8	0	Malta	1.9	5.8
Czech Republic	5.2	1.0	Netherlands	12.2	5.7
Denmark	2.0	1.6	Poland	4.1	1.6
Estonia	1.5	4.0	Portugal	3.7	2.3
Finland	4.3	3.3	Romania	3.1	2.1
France	3.7	3.9	Slovakia	2.0	1.3
Germany	16.6	5.0	Slovenia	3.4	1.3
Greece	3.4	0.6	Spain	3.9	3.9
Hungary	4.1	1.4	Sweden	3.1	1.5
Ireland	4.8	3.4	Turkey	0.8	0
Italy	3.8	2.4	United Kingdom	3.5	3.6

Source: Fahey, T. and Z. Spéder (2004). *Fertility and family issues in an enlarged Europe*. Dublin., p. 30

the postponement of births, TFRs underestimate somewhat the completed fertility that will be reached by the cohorts currently in childbearing ages.

The map in figure 2 presents the mean ages of mothers at first birth in Europe around 2003, and shows the extent of postponement in the timing of parenthood. To put these data in perspective -- in 1975 the highest mean age at first birth registered in Europe was 25.7 (in Switzerland), and in the majority of countries that indicator was between 22 and 24 years. Most researchers interpret this as part of the general trend towards postponement of choices that are irreversible or hardly reversible, usually associated with the ideational and other changes linked to the so-called "second demographic transition". Again in line with the predictions of the second demographic transition theory about the importance of individual autonomy and self-expression, the differences between individuals within a population in the timing of parenthood are also increasing (4).

Another of the salient trends underlying low fertility in Europe is the increasing childlessness in many parts of Europe. Motherhood is still nearly universal among the women in most Central and East European countries, where the proportion of women who reach age 50 childless is well below 10 percent and relatively little change has been observed across cohorts. In the rest of Europe, however, that proportion is generally above 10 percent and has been increasing. According to some estimates the childlessness among women born after 1970 might approach 25 percent in countries like Austria, Germany (specifically its western parts), and England and Wales (5). Unexpectedly for many observers, there is increasing evidence that in some West European countries (specifically Austria, Germany, and the Netherlands), childlessness emerges as an ideal life style (4). Data from the 2002 EuroBarometer survey indicate that over one in ten young women (aged 18 to 34) in these countries have declared "none" as the ideal number

of children (see table 1).

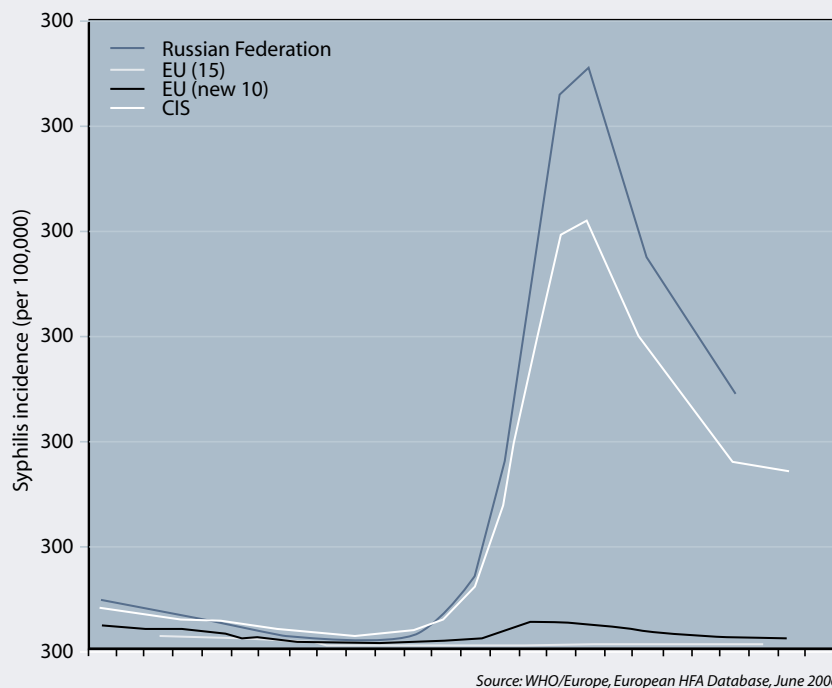
There is evidence that involuntary childlessness is also on the rise. Part of it is driven by factors related to union formation (i.e. the inability to find a suitable partner); another part, by biological factors (infertility). The levels and trends in infertility are difficult to ascertain because of definitional and measurement issues, however, there is evidence that as postponement has pushed births towards the end of a woman's reproductive years, where fecundability is reduced, sterility is higher, and the risk of miscarriage is increasing, more and more women report problems becoming pregnant. In some countries of Eastern Europe and the Commonwealth of Independent States, two other factors are often quoted as contributing to increasing infertility -- the high incidence of repeat abortion, and the spread of sexually transmitted infections (STIs). Figure 3 gives a picture of the dramatic increase in STIs after the collapse of the former Soviet Union (d).

In addition to the postponement of parenthood and the increasing childlessness, several other changes are occurring along with the decline of fertility. One of the most salient among them is the weakening link between childbearing and marriage. This has led to the reversal of the relationship between fertility levels and nuptiality, as birth rates are now higher in countries with higher proportions of extramarital births, higher divorce rates, and higher mean age at first marriage (for more details see (4)). The proportion of extramarital births has been increasing throughout Europe. In the northern parts of the continent more than half of the births are extramarital – this proportion is highest in Iceland, where up to 65 percent of children are born out of wedlock. It has to be noted, however, that the vast majority of these take place within cohabiting unions.

#### Pro-natalist Policies: To Be or Not To Be

This Hamletian question has been on the minds of many policy-makers in Europe. Attitudes towards, and traditions

**Figure 3**  
Reported incidence of syphilis per 100,000 population



Source: WHO/Europe, European HFA Database, June 2006

NOTE: The designations used are as follows: EU (15) - the 15 Member States of the European Union prior to 1 May 2004; EU (new 10) - the 10 new Member States of the European Union from 1 May 2004; CIS - the 12 countries of Commonwealth of Independent States;

in interventions to influence birth rates vary across Europe. France, a country that up to the Second World War had the lowest fertility in the world, has had a long-standing pro-natalist policy. A broad consensus across the political spectrum exists there around that policy and around the need for strong family support programmes. The policy in France includes, among other things, relatively generous family allowances, parental leave, tax breaks, and other incentives. According to many, the fact that France currently has one of the highest fertility levels in Europe is due to that policy. In general, however, the evidence about the success of such kind of policies is limited and there is an on-going debate about their efficacy and efficiency.

The communist regimes in Central and Eastern Europe also had a tradition of active pro-natalism. At different times, they used restrictions on abortions, or fiscal and other incentives to increase the

birth rates. This reflected the fact that these regimes were much more likely to perceive policy intervention in private lives acceptable, and people were more likely to tolerate that. As a result, some of these policies created serious problems in the reproductive health field. The case with Ceausescu's policies in the 1960s is probably the best-known example. Nowadays, the concern about low fertility in some countries in Eastern Europe is fueled by nationalist and/or ethno-centric sentiments, and voices are often heard that favour measures to increase the birth rates at the expense of reproductive health and rights, and in detriment to women's status.

In the rest of Europe, governments have been guided by the understanding that it is the right of individuals to determine freely the number of children they have. In addition, objections are raised that pro-natalist measures might jeopardize what has been achieved in



the field of gender equality, as increased fertility could interfere with the educational opportunities and career aspirations of women and might confine them to the traditional family roles. The bitter lessons of history, where pro-natalism is associated with fascism and eugenicism have also often been evoked. In light of the dramatic decline of birth rates, however, more and more governments are reconsidering their position. As the United Nations system for monitoring government perceptions and policies on population have shown, between 1996 and 2003, the proportion of governments in Europe that perceive their fertility levels as too low has increased by one third, and those that perceive their rate of population growth as too low have almost doubled. The proportion of governments that have declared that they are putting in place policies to raise fertility levels and rates of population growth has increased respectively by twenty five, and by over fifty percent (6).

All this raises the issue of finding the most effective and efficient ways and means to react to the dramatic demographic changes in Europe. As pointed out earlier, the debate on that issue is still raging. Several broad points could be highlighted though: (1) policies narrowly focused on increasing birth rates are not likely to be successful; instead, demographic change needs to be addressed through comprehensive population policies (i.e. those that address all underlying processes, not just fertility), which in turn need to be an integral part of modern social policies; (2) two of the elements of these policies have to be programmes focusing on social integration of young people, particularly through youth employment, and on better reconciliation of work and family obligations; (3) consistency and continuity have to be among the primary characteristics of these policies – most observers agree that if French policies are to be considered successful, it is because they have been applied consistently over many decades; (4) these policies also need to be contextual, i.e. the mix of policy tools need to reflect

the specific conditions and circumstances in a country; (5) they certainly need to be non-coercive, to respect the rights of individuals, and to be acceptable across a broad political spectrum; (6) last but not least, the policies need to be financially viable, i.e. they need to be within the fiscal capacity of a country in the long run – making commitments that are not sustainable financially runs the risk of jeopardizing economic growth and further aggravating the population situation in a country.

In a sense the Hamletian question no longer stands in front of the governments – most of them are persuaded that they need to act.

#### ENDNOTES

- (a) Unless stated otherwise, for the purposes of this article we define Europe in the strict geographic sense, and not in the broader senses used by the United Nations, World Health Organization and other international organizations.
- (b) Jean Bourgeois-Pichat was probably the first to assume that a completed fertility of 1.5 children per woman presents a “limiting value”, which European countries might be approaching (7). The notion that once TFR falls below 1.5, fertility will stay low was first suggested by Peter MacDonald (8).
- (c) Fertility settings where TFR is higher than 1.3 but lower than 1.5 Kohler, Billari and Ortega (2) refer to as “very low fertility”. The term “lowest low fertility” is disputable, at least because it precludes “naming” situations of even lower fertility.
- (d) Although the graph shows data for syphilis infections, which are more easily identifiable and better reported, it can also be seen as a marker for chlamydial infection and gonorrhoea, the two STIs most tightly linked to infertility.

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#### Nikolai Botev

[Botev@unfpa.org]

Population and Development  
Adviser

Country Technical Services Team for  
Europe & Central Asia

United Nations Population Fund

# HUMAN RIGHTS CONSIDERATIONS IN ADDRESSING LOW FERTILITY

**Concern about falling fertility rates, in particular where fertility rates are below replacement levels, has often led governments to implement, or to consider implementing, pronatalist policies. This paper will briefly examine a situation where pronatalist policies were implemented and comment on the effectiveness and human rights implications of such policies. It is beyond the scope of this paper to dissect the xenophobic assumptions that often underlie pronatalist policies.**

European countries have experienced dramatic demographic changes in the past thirty years. Fertility rates have declined constantly, in most cases well below the replacement rate of 2.1 children per woman (1). In addition to very low fertility rates, mortality has continued to decline, resulting in the acceleration of demographic ageing. These trends have led to major concerns about the decrease in labour supply and the impact on future economic growth, and the inability of economies to provide pensions and health care for ageing populations.

Fertility rates in the EU15 have been below the population replacement level for three decades and now are only at two thirds of that level. Portugal, Spain, Italy and Greece were among the countries with the highest fertility rates in the mid-1970s. They now have the lowest fertility rate in Europe. Central and Eastern European countries have also experienced significant declines in their fertility rates. With the exception of Albania (more than

2 children per woman) and Macedonia (1.77), all countries have rates below 1.4 (2). Some Eastern European countries have the lowest fertility levels ever recorded worldwide.

Faced with fertility rates below replacement levels, many governments are considering implementing, or have already implemented, pronatalist policies aimed at increasing their country's birth rate. Such policies should be carefully examined from two perspectives to understand their actual effect. Firstly, such policies should not violate the human rights and autonomy of the women and men that they will affect. Secondly, the policies should be closely examined to determine if they would actually be effective in achieving the desired outcomes. Furthermore, pronatalist policies should be considered in conjunction with a country's immigration policies. For, if the desired outcome is to increase the population of the country, an increase in the birth rate is not the only means to achieve this end. A rights based holistic approach to the promotion of population growth would include progressive immigration policies that were developed using an anti-racism framework.

## **The case of Romania and Russia**

From 1966 through 1989, Romania had one of the most repressive population policies in the Warsaw pact countries. Basic rights to reproductive choice and autonomy were disregarded by a government intent on increasing fertility. In 1966, abortion was outlawed and the importation of contraceptives was discontinued. Sexual education was either entirely unavailable, or it took the form of a propaganda campaign that misstated the risks of contraception. The long term effect of the lack of evidence based sexual education during this period of time is that even today, many individuals in Romania are ill informed about matters relating to their sexual health and reproductive choice.<sup>4</sup>

Despite the coercive measures taken by the government, women in Romania struggled to exercise their reproductive

rights. During this time period, with no access to legal abortion and no access to contraception, women resorted to illegal and unsafe abortion as their primary method of fertility control. One of the tragic results of this violation of basic reproductive rights was that Romania had the highest maternal mortality rate in all of Europe, by a factor of ten, and one of the highest infant mortality rates (3).. The pronatalist policy of the government did not increase the fertility rate. It only increased the suffering of the women and families of Romania. It is estimated that almost 20% of women of reproductive age may have become infertile. On average, every woman may have undergone at least five illegal and unsafe abortions by the age of 40 (3). The high maternal mortality rate meant that thousands of orphans were left to suffer from illness and poverty.

In 2003, the Romanian Ministry of Education implemented a sexual education curriculum. Although this is an important step towards lowering the abortion rate in Romania, there are also significant social factors that contribute to the high rate of abortion. The transition from a planned central economy under the communist regime to a market economy has resulted in an increase in poverty levels from 7% in 1989 to 44% in 2000 (4). Added to this are gender inequities that result in women being concentrated in low paying jobs, or being unemployed. This economic reality effectively limits a woman's reproductive rights and makes it virtually impossible for her to afford contraceptives.

The Russian Federation's fertility rate is among the lowest in the world, at a rate of 1.62 lifetime births per woman in 2005 (5). Life expectancy at birth has shown significant declines and is far below European average, at 71.9 for women and 58.9 for men (5). Combined with the decline in fertility, the Russian Federation has one of the fastest growing HIV/AIDS pandemics in the world, which has hit young people the hardest. As a result of these factors, the Russian Federation's population has aged rapidly over the past





decade. Furthermore, unemployment and poverty are widespread, causing further barriers for persons wishing to have children. In May, 2006, Vladimir Putin offered a bonus of 250,000 rubes (about US\$9,200.) to women who have a second child (6). As articulated below, this will likely not be sufficient to reverse the declining fertility rate.

### Policies addressing low-fertility rates

Rather than implementing a coercive approach to increasing fertility rates, governments should understand that there is a strong relationship between social situation and low fertility. High rates of unemployment, or unstable employment, inadequate housing, lack of access to affordable child care, poor health care, and difficulties in balancing career and parental responsibilities, lead individuals to have fewer children than they actually desire. Therefore, government investment in social services would be a more effective way to increase fertility rates.

When a society is organized in such a way that parents can achieve a balance between work and family, the indirect costs associated with parenting fall. This may partly explain why countries with high labour force participation rates for mothers have relatively high rates of fertility and countries with low labour force participation for mothers have low fertility. Similarly, gender equity in the workplace and in society generally is correlated to higher fertility rates. For example, Sweden experienced an increase in fertility rates in the late 1980s. No one factor was responsible for this increase in fertility. Rather, it appears that the combination of the availability of high-quality childcare, extensive equitable parental leave, and a general environment of equality between men and women, worked together to contribute to higher levels of fertility.<sup>8</sup>

A market economy, no matter how successful the market is, will always provide lower benefits to those with children than to those without children.<sup>9</sup> In order to increase fertility rates in a non-coercive manner, changes in social and economic

organization on a wide scale will be required. It will be necessary to recognize children as a social good, not merely as a private optional pleasure. This would include recognition that family benefits, such as maternity and parental leave, and high quality universal childcare, are not merely benefits for the families who use them, but are a benefit to all of society.

For governments that are considering implementing pronatalist policies to counter the effects of falling fertility rates, it is essential that such policies respect human rights, take a holistic approach, ensure measures are designed to promote the advancement of women and consider the special needs of adolescents.

### Conclusion

International consensus agreements, such as the Programme of Action adopted by 179 governments at the 1994 International Conference on Population and Development (ICPD), and the five and ten year reviews, the 1995 United Nations Fourth World Conference on Women in Beijing (Beijing Conference), and the five and ten year reviews, go beyond traditional family planning and are grounded in a human rights and reproductive rights based approach to issues of population. These agreements embrace the necessity of securing women's rights and equality and involving women in the formulation of laws and policies relating to population and development.

These are essential principles to be followed by governments in both the development and implementation of fertility policies. Policies should clearly articulate references to principles of human rights, including free and informed choice, non-discrimination, equal access to reproductive health care and women's rights. Policies should also include an explicit provision covering non-discrimination for minority or indigenous populations.

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### Jane Gauthier

[jane@acpd.ca]

Associate Executive Director  
Action Canada for Population and  
Development

# CURRENT TRENDS OF FERTILITY – AND INFERTILITY- IN EUROPE

**'7.2. All persons have the right of access to reproductive healthcare services including those who are infertile, or whose fertility is jeopardized by sexually transmitted infections' ICPD, POA, 1994 (1)**

**Figure 1**

TOTAL FERTILITY RATES	
COUNTRIES	LAST AVAILABLE DATA
Belarus (2004)	1,2
Bosnia and Herzegovina (2004)	1,2
Italy (2003)	1,2
San Marino (2003)	1,2
Spain (2003)	1,2
Poland (2003)	1,22
Ukraine (2004)	1,22
Czech Republic (2004)	1,23
Latvia (2004)	1,24
Slovenia (2004)	1,25
Lithuania (2004)	1,26
Republic of Moldova (2004)	1,26
Slovakia (2004)	1,26
Andorra (2004)	1,27
Hungary (2004)	1,28
Bulgaria (2004)	1,3
Greece (2003)	1,3
Romania (2004)	1,3
Croatia (2003)	1,33
Russian Federation (2004)	1,34
Malta (2004)	1,37
Armenia (2004)	1,38
Georgia (2003)	1,4
Germany (2004)	1,4
Austria (2004)	1,42
Switzerland (2004)	1,42
Portugal (2003)	1,44
Estonia (2004)	1,47
Cyprus (2004)	1,49
Belgium (2002)	1,53
Serbia and Montenegro (2003)	1,6
Luxembourg (2004)	1,7
United Kingdom (2003)	1,72
Netherlands (2004)	1,73
Monaco (2003)	1,8
Albania (2004)	1,8
Denmark (2004)	1,8
Finland (2004)	1,8
Norway (2004)	1,8
Sweden (2004)	1,8
France (2004)	1,89
Azerbaijan (2003)	1,9
TFYR Macedonia (2003)	1,9
Ireland (2004)	1,95
Iceland (2004)	2,0
Kazakhstan (2004)	2,2
Turkey (2004)	2,21
Uzbekistan (2004)	2,46
Kyrgyzstan (2004)	2,5
Turkmenistan (2003)	2,7
Israel (2004)	2,9
Tajikistan (2003)	3,0

- Lowest-low fertility countries
- Low fertility countries
- Below replacement countries
- Replacement countries

Source: WHO HFA Database

Natural fertility is currently low throughout Europe, much lower than the replacement level - 2.1 children per woman during her lifetime, which is required for a stable population (see Figure 1).

It follows that European populations are presently declining.

There are no strong effects from medical factors behind this. The explanation is rather socio-economic in nature and concerns most of all the status for women in education, economy, working conditions and family life. Less children are being born at a higher age of their mothers (and fathers), the delay in childbearing being very substantial, in several countries three years or more, and in subgroups even much longer. There have been different attempts to increase the fertility of the population in Europe by encouraging women to have the first child earlier in life and to have more than one child per couple. However, it is a very complex issue and there is not one solution. Fertility healthcare is part of it.

The prevalence of infertility, on the other hand, is essentially stable over time at around 10-12%. Some variation occurs following changing life-styles (smoking, stress, overweight and sexually transmitted disease) resulting in the future, possibly, in a moderate increase of infertility problems, as these life-style factors increase in Europe.

The possibility of a thorough and correct medical investigation and diagnosis of a couple's infertility problem is today in Europe excellent, in most areas. There are hormone tests, ultra-sound and x-ray more readily available, whereas 40 years ago there were hardly any of these.

Treatment options for infertility have increased dramatically since some 20 years back, especially now that assisted reproduction techniques, like in-vitro fertilization (IVF), have become available. However, availability to IVF treatments differs substantially between European countries and elsewhere. About three million children have been born after IVF treatment worldwide so far, and 60% of these were born in Europe, since 1978,



when the first IVF child was born (in the UK).

Demand for services related to infertility management comes from the need for treatment in relation to confidence in the treatment methods (efficacy, safety and quality of services), from ethical and cultural considerations and from alternatives available, e.g. adoption.

Availability of services results from a demand in a population met politically with legal regulation and allocation of public funding. Some countries in Europe have a generous attitude towards infertility treatments (e.g. the Nordic countries) while other countries are more restrictive (e.g. Italy).

Fertility healthcare is part of the actions to increase the fertility of the population and consists of prophylactic measures and available and effective infertility treatment. The cost of infertility management is determined by the proportion of the patients seeking infertility treatment (domestic and abroad; on equal terms or only the well-off), its impact in the population and the quality of the treatment (the total cost to the society, multiple pregnancies and births, side effects and health of the children).

Reproductive medicine helps individuals to reach their individual goals for a family. However, the increasing success rates and the better availability in some countries is now reaching the level when the effects of these treatments reach a significant level also for population growth.

In the Nordic countries up to 4 % of all children born come from IVF treatments, another 2-3 % from other forms of infertility treatments summing up to 6-7% of all children born. However, the situation differs in many countries due to number of reasons (Fig.2).

There are two main scenarios in availability and cost of infertility treatment. In many countries of Europe cost of treatment is partially covered by the society. It results in patients seeking treatment soon after infertility diagnosis, they are younger and there is good efficiency of the treatment. If the cost of treatment is paid to a large extent by the couple, patients are saving up money and waiting to seek treatment. Patients in this scenario are older, the efficiency of treatment is lower and often they seek treatment where available resulting in patient tourism.

Infertility is a disability and infertile couples deserve the moral, legal and economic support of the society to attain the highest standard of reproductive health. Investments in infertility research and treatment are profitable both for the individual and for the society.

In Europe one in six couples is affected by unwanted childlessness. In many countries due to the local regulations or the cost of treatment not all patients have the same access to treatment and it is restricted to women and men who can afford it. The Nordic countries have a favourable framework for modern, effective infertility treatment and patients have an

equal access to fertility services. In many ways such a development would be very positive also for many other countries in Europe. Politicians, professional and patient groups need to open a dialogue to reach conclusions of a positive attitude and positive actions to help people achieve their reproductive goals and to stop population decline.

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For additional reading

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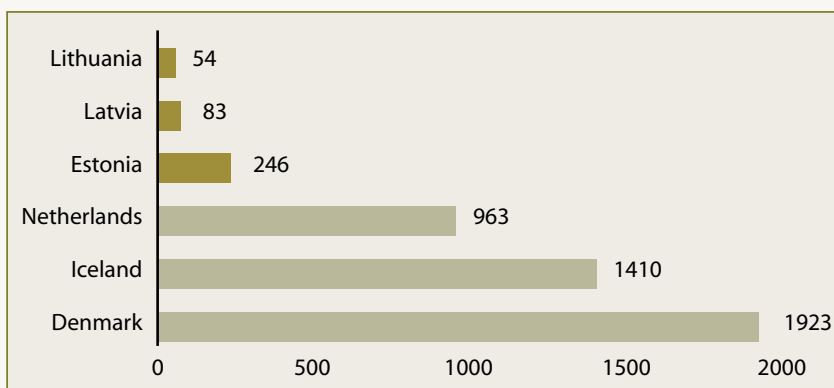
Karl G. Nygren

[karl-gosta.nygren@telia.com]  
Chairman of the European IVF Monitoring Consortium of ESHRE  
European Society for Human Reproduction and Embryology

Gunta Lazdane

[GLA@euro.who.int]  
Regional Adviser  
Reproductive Health and Research  
WHO Regional Office for Europe

Figure 2  
Medically assisted reproduction in Europe  
(N of cycles/per million population, 2001)



# THE DETERMINANTS OF LOW FERTILITY IN EUROPE

**A**s a consequence of below-replacement fertility that has prevailed in many parts of Europe for several decades starting since the 1960s and 1970s, low birthrates have begun to generate negative population momentum, that is, a new force for population shrinkage over the coming decades due to the fact that past below-replacement fertility will soon result in declining numbers of potential parents

The global population is at a turning point as, for the first time, the majority of the world's population is living in countries or regions with below-replacement fertility levels. Several aspects of this trend towards low fertility are striking. First, the spread of below-replacement fertility to formerly high fertility countries has occurred at a remarkably rapid pace and implied a global convergence of fertility indicators that has been quicker than the convergence of many other socioeconomic characteristics. Second, earlier notions that fertility levels may naturally stabilize close to replacement level—that is fertility levels with slightly more than two children per women—have been shattered. Sustained below-replacement fertility has become commonplace, and Europe has been a leader in the trend towards low and very low fertility. While there is considerable variation in the fertility levels across European countries—with TFRs ranging in 2002 from 1.13 in the Czech Republic to almost 2.0 in Ireland—the median total fertility rate, i.e., the TFR level below which 50% of the populations in Europe live, is currently near 1.3. The implications of such low fertility are substantial. For instance, in the absence of migration, sustained TFR levels at or below 1.3 imply a reduction of the annual number of births by 50% and a halving of the population size in less than 45 years. Moreover, as a consequence of below-replacement fertility that has prevailed in many parts of Europe for several decades starting since the 1960s and 1970s, low birthrates have begun to generate negative population momentum, that is, a new force for population shrinkage over the coming decades due to the fact that past below-replacement fertility

will soon result in declining numbers of potential parents (4). A continuation of this trend could substantially exacerbate the future aging of the population, reinforce a future decline in the population size and constrain the effectiveness of policy interventions aimed at increasing the number of births.

## **Social factors contributing to low fertility**

Demographic analyses suggest that the decline in the desire to have at least one child has not been a primary driving force in the emergence of very low fertility in the Southern, Central and Eastern European countries (2; 6). While childlessness is likely to rise, it is projected to remain at relatively modest levels even in very low fertility countries (exceptions, however, include Germany and Austria where already relatively high levels of childlessness are likely to further increase). These findings on childlessness therefore suggest that the biological, social and economic incentives for children are sufficiently strong that most women (or couples) desire to have at least one child (3). Nevertheless, while first births are not necessarily foregone even in very low fertility countries, they are delayed to an increasingly late age. In many low fertility countries, this postponement has been very intense and has led to some of the highest mean ages at first birth worldwide. The reasons underlying this postponement of childbearing are often a rational response to the specific situation of young adults that is characterized by a high level of uncertainty due to high unemployment, uncertain labor market prospects, and rapid socioeconomic change. Young adults thus face an incentive to delay decisions that imply long-term commitments, such as the decision to have children, and prefer to invest in education, human capital and labor market experience.

These rational responses, however, are not a complete explanation of delayed childbearing. In addition, social feedback mechanisms—resulting from changes in the norms about the timing of childbearing, shifts in the attitudes towards fami-

lies, or fierce competition in rigid labor markets—are likely to reinforce delayed childbearing. Postponed childbearing thus originates in individual's responses to new socioeconomic contexts that make late childbearing a rational decision, and this response is exacerbated by social feedbacks that cause large and persistent changes in the mean age at birth at the population level. This widespread transition towards a late pattern of childbearing in Europe, however, implies that the extent to which specific socioeconomic and institutional contexts in different European countries accommodate late childbearing has become an essential determinant of cross-country variation in fertility levels. A striking example in this context is the reversal of the aggregate relationship between female labor force participation and fertility. Conventional economic theory predicts that increases in the wage rate of women lead to increases in women's labor force participation on the one side, and decreases of fertility on the other side due to increased opportunity costs of children in combination with a low income elasticity of the number of children. However, several recent studies have documented that the cross-country correlation between the total fertility level and women's labor force participation (FLFPR) reversed (5): while high levels of fertility in the 1970s were associated with low levels of female labor force participation, high fertility was associated with high female labor force participation in the late 1990s, and the lowest fertility levels in Europe since the mid-1990s are often found in countries with the lowest FLFPR. Moreover, the very low in Southern Europe has occurred in a rigid labor market characterized by a low compatibility of childbearing with woman's labor market participation, which is due to the difficulties in entering and re-entering the labor market and the limited flexibility of working hours.

Very low fertility in Europe is therefore caused by the combination of several factors: (a) Socioeconomic incentives to delay childbearing that make postponed fertility a rational response to high economic uncertainty in early adulthood,



increased returns to education, shortages in the labor market and similar factors. (b) Social feedback effects on the timing of fertility that reinforce the adjustment of individual's desired fertility to socioeconomic changes. (c) Institutional settings, characterized by labor market rigidities, insufficient child-care support and a prevalence of relatively traditional gender roles, favor an overall low quantum of fertility and lead to reductions in completed fertility that are causally related to the delay in childbearing. While each of these factors already contributes to reduced fertility, it is the combination and interaction of these factors that leads to very low fertility.

### U.S. versus European fertility: what explains the difference?

In contrast to the projected population shrinkage due to low fertility and negative population momentum in Europe, the U.S. population continues to be characterized by rapid growth. The majority of this growth in recent years is attributed to natural increase—that is, an excess of birth over deaths—while net immigration accounted for about 40%. The U.S. population is also projected to grow by almost 50% in the coming decades. Why is the U.S. different? One might argue that the U.S. fertility trends simply trails behind Europe and Japan, and that the TFR in the U.S. will fall to historically low levels in future years, as occurred for so many wealthy countries in recent decades. However, the situation of the U.S. compared to most other high-income countries differs in at least two respects. First, population composition favors a higher fertility level, since some of the largest immigrant and minority groups within the U.S. have fertility levels that lie above than the national average. Second, fertility in the U.S. is relatively high for the population as a whole. Notably, the TFR of non-Hispanic White women, falling in a range from 1.77 to 1.87 during 1990–2001, exceeds the national average for most other high-income countries. While the heterogeneity of the U.S. population is therefore one factor that contributes to the relatively high level of fertility in the

United States, it does not constitute the primary explanation. Instead, it appears that an overriding factor is their greater ability to combine work and childbearing, thanks to a variety of institutional factors. In general, women (and couples) are deterred from having children when the economic cost—in the form of lower lifetime wages—is too high. Compared to other high-income countries, this cost is diminished by an American labor market that allows more flexible work hours and makes it easier to leave and then re-enter the labor force. The importance of this situation is reflected in the positive relationship between measures of women's labor force activities and levels of fertility across wealthy countries in recent years. As a result, despite a lack of public financial support for families with children, it appears that the flexibility offered to individuals through the market in the U.S. facilitates integration of work and traditional family life.

### Policy responses

The only viable long-term strategy to limit the extent of population aging and the decline of the population size will be an increase in the level of fertility. The policy options available to European low and very low fertility countries, however, are limited (1). The existing empirical evidence provides mixed conclusions as to the effects of various policies on fertility behavior. On balance, the evidence supports a weak positive relation between reproductive behavior and a variety of policies, but policy measures, which may potentially affect reproductive behavior will manifest their influence only in the long-term. Policy measures that aim to make women's participation in the formal labor force compatible with childrearing are in our opinion among the most promising alternatives. The effectiveness of such measures, however, is likely to be limited due to a negative population momentum that results from decades of below-replacement fertility in many parts of Europe since the 1960s and 1970s. Even if policies are effective in raising women's or couple's fertility, and even if levels of immigration into Europe

increase, a loss of demographic weight within the global population, a decline in the population size during the coming decades and a substantial aging of the population are therefore safe predictions for the Europe of the twenty-first century. It is clear that current social and economic institutions are not sustainable in light of these trends, and individual's life-courses already have been—and will continue to be—transformed in response to reductions in fertility and increases in longevity. Adjusting to the demographic reality of the 21st century will therefore constitute a major challenge for policy makers and companies on the one, and for individuals and families on the other side. Whether the adjustment to these trends can be successful, and whether these trends lead to a reduced well being of individuals if appropriate policies are implemented, is still an open question.

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**Hans-Peter Kohler**  
[hpkohler@pop.upenn.edu]  
Professor of Sociology  
University of Pennsylvania

# EUROPE'S LOOMING POPULATION BUST

While global population continues to increase, with medium or high fertility combined with falling infant and child mortality to produce swelling cohorts of young people, that of Europe is changing in a very different way. Sharp declines in fertility threaten to shrink the region's population, and increasing life expectancy is tilting the demographic balance from young to old, with large potential impacts on living standards.

This article discusses Europe's demographic prospects and their implications for population growth and age structure (a). It then assesses the possible effects of population change on Europe's economies and societies, before concluding with a discussion of the policies used by countries to halt fertility decline and mitigate the impacts of aging populations.

## The future of Europe's population

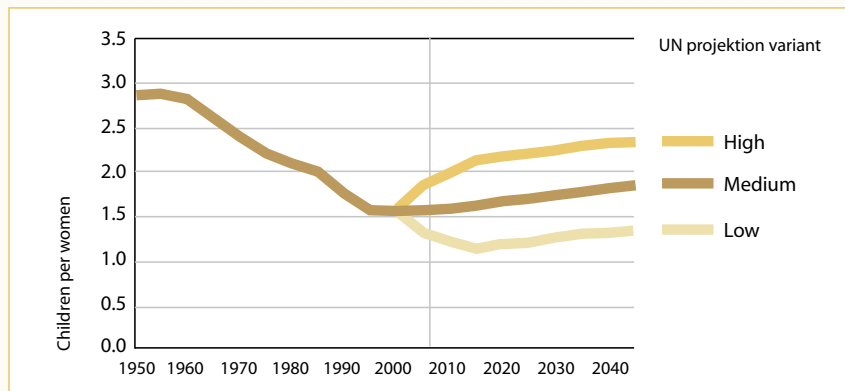
Since 1950 Europe has experienced rapid demographic change. The region's fertility rate has fallen steadily and to a very low level, the population growth rate is slowing and will likely turn negative in the next few decades, and the ratio of working-age to non-working age people is about to plummet as the proportion of elderly mushrooms.

Halfway through the last century, Europe's total fertility rate stood at almost 2.9 children per woman (1). Today women have an average of less than 1.6 children (see Figure 1), well below the replacement rate of 2.1. In the next 40 years, the United Nations projects a small increase in fertility under its medium variant scenario, although with a possible range between 1.33 and 2.33 children per woman by 2045, much uncertainty clouds this forecast.

Europe's age structure is also likely to change markedly. As fertility has fallen, life expectancy in most parts of the region has increased. Since 1950, life expectancy at birth has risen from 66 to 73 years (2). This would be still higher if it were not held down by Russia, where male life expectancy is just 59 years. As a result, the proportion of Europeans aged 65 and over is expected to increase from 16% to 24% between 2000 and 2030 (3).

This aging of the European population will lead to a large shift in the ratio of people of working age to those not of

Figure 1 Total Fertility Rate



Source: United Nations, World Population Prospects 2004

working age. There are currently more than two people aged 15-64 for every individual outside that age bracket. As the proportion of elderly grows and that of young people falls, this ratio will plummet to below 1.5 people of working age per dependent by 2050. This will be a lower ratio than at any other time between 1950 and 2050.

## The consequences of change

The possible consequences of these demographic changes encompass the economic, the social, and the political. The combination of low birth rates and a large elderly generation may leave Europe with a shortage of workers to support elderly dependents. For the former, supporting the pension payments and health and social security costs of large elderly cohorts may prove a burdensome task. Tax rates may need to rise for economies to cope. Some have forecast dire consequences, with the Economist arguing that, "the political and economic renaissance of Europe that was predicted at the European convention [of July 2003] is likely to be stillborn" (4).

A lower ratio of workers to dependents will, other things equal, tend to reduce per capita gross domestic product, but economies and individuals will naturally adjust to mitigate these impacts. Adopting capital-rather than labor-intensive technologies could mitigate a fall in GDP per capita in the medium term. As people live longer and remain healthy longer, some will choose to work beyond retirement age, thereby reducing the fiscal pressure on younger workers. (In some countries laws may need to be changed to accommodate such desires.)

Rising life expectancy means that those who choose to retire will need to save more

in order to maintain a comfortable standard of living. Increased savings will mean that more funds are available for investment for businesses. With fewer children, moreover, parents will be inclined to invest more in the health and education of each child. In countries where health and various levels of education are free, this will not matter; but where they are not, the increased incentive to invest in children could strengthen human capital.

Even if GDP per capita does not decrease dramatically, however, the absolute size of economies may contract. The president of the Russian Federation, Vladimir Putin, has described population decline as "the most acute problem" facing the country. Shrinking economies and shrinking populations may cede political and economic power to countries whose demographic and economic trends are moving in the opposite direction.

## Responses to change

Many European countries have taken steps to halt population decline and mitigate the effects of aging. In a 2005 United Nations survey, 32 European governments viewed their countries' fertility as too low. Twenty-seven of these had implemented policies to increase it (5).

Measures to encourage couples to have more children vary across countries. They range from reducing support for contraception to making life more painless for working parents. In developed regions as a whole, the proportion of governments providing direct support for contraception fell from 62% in 1976 to 38% in 2005 (5). Some countries, such as Italy and Poland, provide one-time payments to couples that

David E. Bloom



David Canning

have children (in Italy's case this starts with the second child), while in others parents receive income tax benefits depending on the number of children they produce.

Once they have persuaded couples to have children, governments then endeavor to make parenthood easier. Countries including France and the United Kingdom give monthly allowances to couples with children. In France this allowance increases for families with three children. Mothers and sometimes fathers receive paid maternity leave – Spanish mothers' 16 weeks of paid leave and Norwegian mothers' 10 months are fully funded by the state. When they return to work, parents benefit from state-funded child-care – France provides fee day care at crèches to younger children, and Italy gives free places at nurseries (6).

The efficacy of these policies is unclear. France, whose family-promoting (or pro-natalist) policies are among the most comprehensive in the world, has a high fertility rate for Europe, at 1.9 children per woman (1). A number of studies have found that policies that promote childbearing reduce the costs of childrearing, enable parents to work, and involve fathers in parenting help increase fertility (7-12).

On the other hand, the benefits of pro-natalist policies in Singapore, which include tax credits, one-time payments to parents, and priority housing for families with three or more children, were short-lived, with fertility rising briefly after implementation in the early 1980s before falling off to 1.42 children per woman by 2001 (13). This may in part be due to limited uptake or implementation of some policies. The European Union's public opinion Eurobarometer found that 84 per cent of men surveyed had not taken or did not intend to take parental leave because, for example, either such leave did not exist, they could not afford it, they perceived such leave as being mainly for women, or their wife or partner did not work (14).

Governments may also choose to tackle the fiscal burden of an aging population by encouraging people to work for longer. Raising the retirement age, ensuring that individuals receive (and know that they will receive) all pension benefits to which they are entitled, and encouraging workers to save more for their retirement are among the measures already being considered in

countries such as the UK.

### Conclusion

As described above, European countries grappling with demographic change potentially have three broad policy measures at their disposal: pro-natalist policies, increased immigration, and encouraging people to work longer and save more. None will be easy to sell to electorates, however, and the effectiveness of each is unproven. Both more rigorous research and clearer advocacy by governments may help convince societies that such policies are needed and likely to work. The challenges posed by Europe's looming population bust are not insurmountable but there is no time to dawdle: Pro-natalist policies cannot produce new workers in less than a generation; immigration can surely not increase quickly, and as the share of the elderly population increases, its political power may make other changes hard to bring about. Given the scale of the challenges, policy-makers would be well advised to act sooner rather than later.

### Endnotes

a) By 'Europe' we refer to those countries defined by the World Health Organization as making up the European region – see <http://www.euro.who.int/AboutWHO/About/MH> for the full list of countries.

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### David E. Bloom

[dbloom@hsph.harvard.edu]  
Clarence James Gamble Professor of Economics and Demography  
Department of Population and International Health  
Harvard School of Public Health

### David Canning

[dcanning@hsph.harvard.edu]  
Professor of Economics and International Health  
Harvard School of Public Health

# LOW FERTILITY, LOW MODERN CONTRACEPTIVE PREVALANCE, HIGH NUMBER OF ABORTIONS

– The case of Serbia

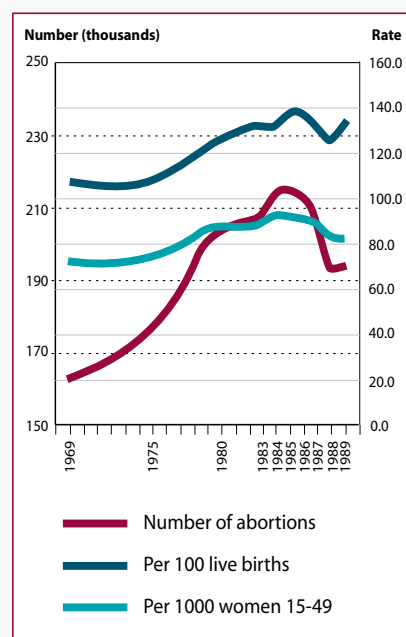
**Transition in fertility in Serbia (excluding Kosovo and Metohija) began during the closing decades of the nineteenth century. Total fertility rate of about 2,1 was measured as early as in the mid-1950s. As soon as in 1971 the rate was about 20% lower than the population replacement level. The rate was more or less stabilized over the next two decades. There is an obvious decline in the number of births across low fertility regions of Serbia in the 1990s. Between 1991 and 1999, total fertility rate in Serbia declined from 1,73 to 1,41. In 2000 and 2001 total fertility rate slightly increased, and in the period 2001-2004 remained stable at the level of about 1.50.**

Parallel, the transition from traditional birth control to modern contraceptive use did not take place in Serbia. The method of coitus interruptus was not replaced by hormonal oral contraception or intrauterine device. Although official statistical contraceptive base has not been established, according to the results of several investigations in this domain about 10% of women in reproductive age have any experience with modern and effective contraception. Precisely, the results of the last study show that 11.2% of women in reproductive age use combined oral contraception, intrauterine device or

condoms (1). The consequence of the conservative birth control model is the huge number of induced abortions.

The data on abortions are deemed complete as from 1969 to 1989 (figure 1). The number of abortions kept growing continuously until 1985, from 167,383 in 1969 to 222,573 in 1985, meaning that it went up by a third. In 1986, 1987 and 1988, the absolute number of abortions was decreasing, so that in 1989, with level of 201,660 it was the same as that in the preceding year. The estimated number of induced abortions today is about 200,000 abortions per a year or 90.5 abortions per 1,000 women in the age 15-44 (2).

**Figure 1**  
Number of abortions in Serbia, 1969-1989



Source: Official health and vital statistics data

In 1989, last year with complete statistical data, the structure of the women who have had an abortion, shows that majority of them were aged between 20 and 39 years (90%), married (92.1%), with one or two living children (75.8%). Mention worthy is also the fact that 22% woman subjected to abortion had already had four or more abortions in the history.

Research findings discovered a complex array of factors linked to conservative birth control model with resulting huge

number of abortions in Serbia. The main are insufficient knowledge of contraception and abortion, a belief that modern contraceptive methods are harmful to health, and a number of psychological barriers, also those arising from relationships with partners (3). Additionally, there are few organized efforts to promote sex education and information on contraception, as well as limitations in the family planning programme. It should be stressed out that liberalization of the abortion law occurred at a time of decrease birth rate and very modest presence of modern contraceptive methods.

Namely, socio-medical indications were accepted as grounds for abortion from 1952. In 1969 the law was further liberalized. Abortion was permitted at a woman's request up to the tenth week of pregnancy and, beyond ten weeks, with the approval of a medical commission. Age limit was 18 years, but from 1995 abortion is available on request for women aged 16 or more years.

The high prevalence of induced abortions is the main reproductive health problem in Serbia, having in mind the cost of this procedure for fertility and quality of women's lives. The incidence of early complications following induced abortion in Serbia can be assessed as high. The result of representative survey implied that the rate of early complications is 21.3% (4). However, severe early complications of abortion were found to be rare, but the risk of their occurrence is higher compared to the developed countries.

The reasons for the high incidence of complications of induced abortion are considered to be the huge number of these procedures conducted in abortion services per day, inadequate pre-operative measures, as well as the predominant use of conventional abortion techniques.

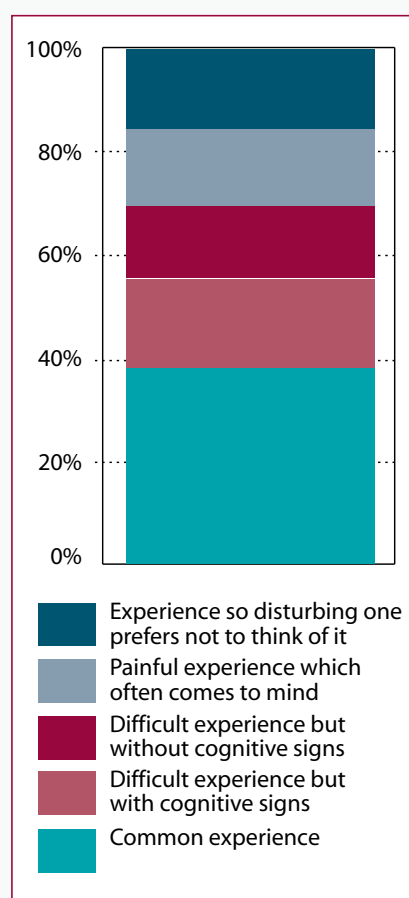
Results of the survey on the psychological consequences of abortion (3) have confirmed that women assess this procedure as a complex and difficult experience. About 45% of women show unexplained emotional reactions towards abortion even two months after the





intervention (figure 2). The psychological trauma varies in degree. In retrospect, abortion is felt as a hard experience but without cognitive signs (14%), painful experience which often comes to mind (14.6%), or an experience which is so disturbing that one prefers not to think of it (15.9%).

**Figure 2**  
Women's experience of abortion



Source: Rašević M. *Towards an Understanding of the Abortion in Serbia*. Institute of Social Sciences, Belgrade (1993).

Two actions in reproductive health sphere promotion have been carried out in Serbia from the end of 1990s. First action has been related to network developing of reproductive health counseling centers for young people and the aim of the second action was activating schools for maintaining and promoting reproductive health for young people.

Development of the youth friendly reproductive health counseling service model was based on the principle of

providing an integral program for young persons and not just isolated rendering of services for their various problems. Implementation of these principles assumes uniting the existing prevention and curative measures of health services, namely establishing reproductive health counseling services for young people within primary health centers, above all as an activity of the school-age unit. According to this model, youth friendly reproductive health care services have been opened in a quarter of municipalities in Serbia.

Reproductive health education in Serbia has never been a component of a school curriculum. By updating the school law in 2003, the legal assumptions enabled carrying out actions of activating elementary schools in maintaining and promoting youth reproductive health. In that sense, a handbook for teachers of various subjects as well as for expert associates of elementary schools was first made, due to a lack of adequate educational material, for work with pupils of the final three grades. Focus was given on concrete work with pupils. The following themes were elaborated: puberty, emotional life of young persons, reproduction physiology, adolescent pregnancy, communication skills, risky behavior, contraception, sexually transmitted infections including HIV and significance of family and children. Publishing of the handbook is underway.

Enabling young people to make right, responsible and healthy choices regarding sexual life is very important. Especially because advancement of reproductive health, apart from direct health effects, achieves a range of other benefits. It increases the level of health and sexual culture of a couple, prevention and healthy life becomes a style of living and a way of thinking and personal responsibility for one's own health is promoted. But, it is only one step in diminishing the abortion problem.

Namely, the conservative birth control model in Serbia is complex, serious and asks for many solutions. It supposes the promotion of knowledge, the network of family planning services, the access to all

kinds of modern contraceptive methods, widening the categories of health care workers who are involved in offering a contraceptive advice, increasing public information and advertising of contraceptives, stressing out the importance of post abortion counseling, involvement of males in taking over responsibility for birth control. Also, very important is to establish a legal basis for voluntary sterilization, as accessibility to this birth control method clearly correlates with the reduction of repeat abortions.

Results are not likely to be achieved quickly. Duration of prevalence of induced abortions indicates that underlying causes of frequency are numerous and stable over time. Considering this, and the slowness of any spontaneous change, it may be expected that the problem of abortions will be present in the years to come. However, duration of abortion prevalence will depend, to a large extent, on the ability and willingness to cope with this issue.

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**Mirjana Rašević**  
[mrasevic@eunet.yu]  
Principal Research Fellow  
Director of Institute of Social Sciences (Belgrade)  
University of Belgrade

**Katarina Sedlecki**  
[ksedlec@eunet.yu]  
Specialist of gynecology and obstetrics  
Director of the Family Planning Centre  
Mother and Child Health Care Institute of Serbia  
Belgrade, Serbia

# DEFENDING THE FAMILY: THE LATVIAN EXPERIENCE

## **The demographic and family situation in Latvia**

In many countries in Europe there are problems of low birth rates and ageing populations. This often results in a demographic crisis. This is also the case in Latvia, where we are speaking of a demographic crisis and a crisis of the family as a value. Since 1989 our population has decreased by 13%, from 2.6 million in 1989 to fewer than 2.3 million in 2005. In 2005 Latvia had a fertility rate of 1.29, which has decreased from 2.0 in 1990 and increased from 1.21 in 2001.

The divorce rate is one of the highest in Europe with more than 51% of marriages ending in divorce. There is high number of abortions: in 2003 of every 1000 pregnancies there were 691 induced abortions, and in 2004 of every 1000 pregnancies there were 674 induced abortions (1). One of the reasons for the high abortion rate is the fact that there are insufficient preventive measures for abortion, among them poor knowledge of contraceptives and other information regarding sexual and reproductive health.

## **Main reasons behind the critical demographic situation**

The main reasons for the decrease in the demographic curve on a whole are insufficient state support for families with children providing opportunities for the parents as need arises to be together with their child at the same time not harming their career, and the presently ruling system of values in the society, which brings forward as priority the increase of the standard of welfare instead of starting a family and bringing up children.

As a consequence of the declining fertility rate, the number of children and youth has decreased and the proportion of persons in the old age has risen (the aging of the population has sped up also by the extension of the lifespan during the last decade). The number of children and juveniles up to the age of 14 since the year 2000 has decreased to 99,500. At the same time the number of people older than 65 has increased by 32,200. Therefore the low birth rate is one of the

factors that influence the increase of the demographic load of Latvia, which means that the society in general and the local governments shall have to divert more resources for social needs.

## **Means of solving the critical demographic situation**

Since 2003 the Latvian government has officially recognized the task to overcome the demographic crisis and to develop a family friendly environment as a top political priority. The Declaration of the Cabinet of Ministers clearly defines the family as a priority (2). Consequently, the government has put on the political agenda measures necessary for satisfying the needs of families and children. In order to develop a family friendly environment, to provide effective protection of the rights of the child and to improve the situation of the child, family and youth it was concluded that it is necessary to establish a special institution to address matters related to family, children and youth. Therefore in May 2004 the Ministry for Children and Family Affairs, the leading state administration institution responsible for drafting and implementation of children rights protection, state youth policy and state family policy, was established.

## **Increasing the allowance for childcare and child birth grant**

The main achievements since 2004 are substantial increases of allowance for childcare as well as a huge increase in the amount of the childbirth grant. In 2005 the allowance for child care was increased – the amount for a person who cares for a child until the age of one year if the person is employed and is on parental leave now is 70 percent of the person's average insurance premium salary but no less than 56 LVL (80 EUR) per month and not more than 392 LVL (565 EUR) per month for an unemployed person the amount of the allowance is 50 LVL (71 EUR) (3).

From the year 2006 the amount of the childbirth grant is 296 LVL (421 EUR) – 100% of the value of the layette in the meaning of money. For the birth of the

first child additionally to the grant 100 LVL (142 EUR) are paid, for the birth of the second child respectively 150 LVL (213 EUR) are paid additionally but for the third and coming children – 200 LVL (285 EUR). This is an increase compared to 2005 when the amount of the childbirth grant was 98 LVL (139 EUR).

## **Support for incomplete families**

In 2003 there were 11400 minors who did not receive maintenance (child support) in a sufficient amount from their parents. Maintenance means the expenses of supporting a child, which each parent has the responsibility to provide to his or her child irrespective of his or her financial condition. In 2004, in order to improve the situation, the Maintenance Guarantee Fund was established. The principal objective of the Maintenance Guarantee Fund is to guarantee the rights of the child to social security, guaranteeing the minimal amount of child support for children, who are being maintained only by one of the parents because the other parent does not fulfill a court adjudication regarding the recovery of child support. The fund provides maintenance for children in a minimal amount set by the Cabinet of Ministers but not more than is set according to the court decision. This is only awarded if the bailiff has admitted that collection of maintenance from the child's parent is impossible or the parent does not pay full amount of the maintenance set by the court decision.

## **Out-of-family care**

Children, who are left without parental care, depending on the age and state of health receive social care services at three different types of childcare and educational institutions. In order to provide a family-oriented environment for children left without parental care and to diminish the number of children placed in childcare institutions, a complex set of activities is being implemented in the field of out-of-family care system coordination and methodical support for foster families, guardians, adopters and specialists working for the local govern-



ments. As a result in May 2006 the number of foster families was 204 comparing with the years 2003 and 2004 when the respective number was 15 and 47. In 2003 there were 15 children adopted domestically and 62 children adopted through inter-country adoptions. In the year 2005 there were already 88 domestically adopted children and 111 children adopted through inter-country adoption. The number of children in out-of-family care institutions continues to decrease. Comparing to the last year when there were registered 3093 children in out-of-family care institutions, on 1st January, 2006 this number was 2881.

By providing an opportunity of wholesome development for orphans and children left without parental care in families the state will promote the possibility for the children to participate actively in the development of the civic society and after reaching the respective age to participate successfully in the labor market and be able to live independently (social inclusion).

### Rights of the child

By analyzing complaints received at the Ministry for children and Family Affairs about violations in the field of the protection of the rights of the child, it has been concluded that the number of cases of emotional and physical abuse in families and educational institutions is increasing. It was realized also that parents, employees at out-of-family care institutions, pedagogues of preschool educational institutions and primary schools lack understanding about matters related to children's rights. Taking into consideration the above mentioned conditions on the 1st of December 2005 a special state institution Inspectorate for the Protection of the Children's Rights was established with the aim of providing recognition of the rights of the child in Latvia and to implement a single system of protection of the rights of the child.

### Hotline for children and youth

In the first half of 2005 the State Inspectors for the Protection of the rights of the

Child initiated an inquiry in educational institutions to find out how children are informed about hotlines. It was concluded that children are not sufficiently informed about hotlines: the responding children could not name hotline telephone numbers. Considering the actual operation of the hotlines as well as the number of complaints about possible violations of the rights of the child in Latvia, from the February 2006 Inspectorate's free of charge hotline for children and teenagers has begun its work in order to provide support in hard and difficult life situations, psychological and practical help in problem solving.

The hotline is a mechanism by which, it is possible to find and readjust the failures in the state administration thus providing better support among others for families and children, improving the environment of the family.

### Action plan for the realization of the conception "State Family Policy"

In order to create favorable conditions for the family in the year 2004, the Cabinet of Ministers accepted the action plan for the realization of the conception "State Family Policy" for the period 2004-2013 (4). The most significant activities of the Action Plan are:

- to develop a state system for the promotion of employment by creating a network of information of the professions demanded; these measures will provide the unemployed with effective re-qualification opportunities;
- to develop a concept for a complex solving of the family lodging problem;
- to reconsider the amount of state family allowance;
- to enlarge the proportion of the skills for family life that have to be acquired in the educational program of social studies for pupils studying in grades 5 to 12;
- to increase the number of regional centers that offer a complex aid in situations of crisis (inter alia provide short-term stay for mothers with children in situations of crisis);

- to create a network of state co-financed family support centers in the municipalities.

Due to the aging of the Latvian population it is possible that until the year 2050 the population of Latvia, especially the number of the able-bodied will swiftly decrease, which could also influence Latvia's fiscal situation negatively. According to the data provided by international credit rating agency Standart & Poors the able-bodied population from 2005 to 2050 could decrease from 69 percent to 59 percent. The agency also forecasts a decrease in the total number of population in Latvia from 2.3 million in 2005 to 1.9 million in 2050, which will be followed by continued and increasing pressure on the State budget. In order to improve the demographic situation it is necessary to continue to increase the State support for families, creating adequate conditions such as providing financial support and services for families to create an enabling environment for families to grow.

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### Linda Andersone

[[linda.andersone@bm.gov.lv](mailto:linda.andersone@bm.gov.lv)]  
Deputy Director of Department of Children and Family Policy Ministry for Children and Family Affairs

# SEXUAL AND REPRODUCTIVE HEALTH IN LOW FERTILITY COUNTRIES

*- the Bulgarian example of policies that have been initiated against low-fertility*

**F**rom a demographic point of view Bulgaria is not a very promising country. Bulgaria's population is among the fastest shrinking in Europe and has been reduced by 908,000 from 1990 till 2004, according to data from the National Strategy for Bulgaria's Demographic Development 2006-2020 (1). By the end of 2004, 7,761,049 were permanently residing in Bulgaria and of these every fourth Bulgarian was over 60 years of age. The population went down by 337 000 in the period between the two latest censuses, which were conducted in 1992 and 2001. The demographic trends suggest low birth rates and some of Europe's highest death rates. Considering that this is happening in combination with the constant migration, mainly consisting of people in the reproductive age, makes the outlook for the future rather negative.

In the light of these demographic trends, which are not surprising considering the demographic development in the rest of Europe, the questions are: "What is done?" and "What should be done?" The debate about the demographic crisis, the ageing of the nation, migration, the newcomers to the country mainly from developing countries, the disparities in demographic trends for different ethnicities started with little voices few years ago and are becoming deeper and broader. Unfortunately and not surprisingly, in some political aspects they are following the already tried Balkan model, as shown below.

## **What leads to the low-fertility levels?**

What stops people in reproductive age from reproduction? Migration, on the one hand – young people of reproductive age, the majority with a high educational status, prefer to realize their reproductive rights abroad, where they feel economically more secure. According to different sources, over one and a half million Bulgarians live abroad and the majority have settled down. Another part of the migration wave consists of people living half of the year (mainly in neighboring countries), and then return for the other

half of the year. Seasonal workers, with considerably lower levels of education, are mostly using illegal channels, which increases their vulnerability to trafficking and are difficult to include in the statistics. This type of immigration leads to a change in the typical family model, which includes grandparents, children and parents. The youngest generation usually remains in country with a member close to the narrow family circle.

Without speaking about migrants, what stops those that are still remaining in the country from reproduction? On the one hand, economic issues – low economic status, instability, insecurity, lack of relevant investments in social programs and one of the lowest standards of living in Europe. Additionally, the family model is changing and is following the Western European tendency, where the majority of the young people and a large share of all people of reproductive age live as cohabitants, without formalizing their relations (in Bulgaria the law doesn't give opportunity for treating such partnerships as "legal" couples and the father has to formally and officially "recognize" the child).

Another big issue linked to fertility is infertility. In Bulgaria there are over 240 000 infertile couples (the total number for all the cases with primary and secondary infertility). The percentage of cases of male and female infertility is relatively equal. The main reason for secondary infertility is a history of reproductive tract infection among adolescents – mainly due to lack of or inappropriate health and sexuality education, which provides inadequate preparation for adolescents' sexual life. It is important to underline that despite all the efforts of the NGO community, UN agencies in the country, and even after gaining the strong support of the Ministry of Health in recent years, the Ministry of Education still shows resistance and delays the inclusion of health and sexuality education in the school curriculum. Actually, young people can choose sexuality education as a discipline in some high schools in selected municipalities and receive interactive trainings,

peer education and life skills education from NGOs and UNFPA. The perspectives regarding the inclusion of health and sexuality education as a separate discipline are not very promising.

## **Addressing low-fertility**

The health reform, and its main instrument - the Health Insurance System, that started in 1998-1999, is advancing slowly and is facing serious problems. The introduction of the figure of the General Practitioner, the private health units, as well as the corruption mechanisms in hospital and the traditionally modest state health budget has led to several crisis: hospitals going bankrupt, lack of systematic prophylactic programs directly affecting the reproductive status (no screening and prophylaxis for breast and cervical cancer), over one million people outside of the Health Insurance System. At the moment the health insurance does not cover the cost of contraception or the treatment of endometriosis, and till the end of 2005 it was not covering expenses related to treatment of infertility. Since 2006, a small step in this direction was made, which, hopefully, is a good sign for the future development. The Health Insurance Fund now covers one IVF (in vitro fertilization) cycle per annum for women under 40. This is insufficient, especially considering that the coverage is partial – only for the materials and consumables, in the light of cycles per annum funded in most of EU countries, but it is a good beginning and a sign of changing attitudes.

Other approaches towards improving low-fertility statistics in the medical sphere are: to reduce infant mortality (including perinatal mortality), improve and optimize prophylactic programs and treatment of diseases of social relevance such as cardiovascular diseases, obesity, respiratory tract diseases, put efforts and emphasis on treatment of sexually transmitted infections (STI) and ensure nationwide options for voluntary counseling and testing (VCT) for HIV/AIDS and other STIs, including hepatitis B and C. The program funded by the Global

**Radosveta  
Stamenkova**



**Todor  
Chernev**



Fund against AIDS, Tuberculosis and Malaria (GFATM) in Bulgaria, implemented by the Ministry of Health and many other NGO and Government partners covers an amount of 16 million USD for the period 2004-2008. The network of service delivery points, providing VCT, is established under this program. Besides mainstream young people, special attention is put on vulnerable and underserved groups – Roma ethnic minority, intravenous drug users (IDUs), commercial sexual workers (CSW) and people living with HIV/AIDS (PLWHA). Prevention and educational programs, trainings and raising awareness are among the main strategies aiming to improve the reproductive status of the nation as a whole together with the main goal of HIV/AIDS prevention. The integration of AIDS and SRHR is an important step in the right direction. Improving the reproductive health situation in Bulgaria is among the main priorities of the Ministry of Health, UNFPA and various NGOs, among which the most prominent efforts and expertise is in the Bulgarian Family Planning and Sexual Health Association (BFPA). Besides prevention and health promotion, maternal and child health, including early diagnosis and screenings during pregnancy, are a priority. In the National Health Strategy 2007 – 2012 some of the main goals are targeted towards coping with the low-fertility situation, without being directly pro-natalist. Strategic goal1: “Improving the health of the nation”, is having among its objectives raising public awareness of healthy lifestyle and the threats to health and optimization of public health protection work; introduction of a system of national monitoring of the health of schoolchildren and improvement of the conditions at children’s medical and social care institutions.

### **Economic measures**

What about economic measures? The National Health strategy in its goal 8 is focused on: “Guaranteeing the financial stability and sustainability of the national healthcare system.” This will be achieved by increasing the share of the GDP al-

located to healthcare, optimizing the system of collecting revenues and through searching for donors and investors within the EU funds coming to country. The National Healthcare Strategy provides for an increase in public funds for healthcare to 5.5% of the GDP as of next year and for a gradual increase to 8% of the GDP by 2012. It is the hope that it will not just be another document without implementation. Because for the time being the direct economic incentives for the potential parents are very limited: fully paid maternity leave is 5 months (however, positively, it should be noted that it can be used both by the mother and the father or other relatives). Currently there is a bill in parliament to prolong maternity leave to 12 months. Unemployed mothers for the same period receive the minimum salary (75 Euro). After the end of the maternity leave the monthly allowance for one child in socially deprived families is only about 10 Euro. In comparison even with the three years maternity leave before 1989, it cannot be considered as widely promoted by the government policy on retaining young people in country and stimulating them to raise children in Bulgaria. A good step is the proposal to give a lump sum for every newborn child to help the family in the first months. The amount is to be negotiated – the increase in this investment should be considerable and it should affect the labor market as well to include interesting places of employment which are compatible to the European standards salaries in order to make young people feel economically secure and to motivate them to stay in the country.

### **The future response**

Government, politicians and society have started to listen to scientists and demographers in the last two years and the demographic crisis is an issue, which is now discussed in the public sphere. Actually almost every political formation and social movement has a policy or attitude to the demographic crisis. The President, ministers, heads of parties and various stakeholders urge that something should be done, but there is no realistic strategy,

and statements are more emotional and populist than structured and competent. This brings serious potential problems: on the one hand, to use the demographic slogan and to try to harm the reproductive rights of people (pretending that abortion regulations are too liberal, which could guide us to the dark side of unsafe abortion and tensions and debates). The chance for this is not so big, but the other problem to be highlighted is more frightening: the attempt of some politicians to give to the demographic situation an ethnic face (emphasizing that the Roma community has better population data than other ethnic groups, or not willing to understand the migration waves that sooner or later will hit us from the other parts of the world). This scenario has to be avoided, mainly by installing favorable economic and health conditions for work and reproduction for the young generation. It is for our common European future.

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### **Todor Chernev**

[[tchernev@safesex.bg](mailto:tchernev@safesex.bg)]  
Member of the Board of Directors  
University Maternity Hospital  
“Maichin Dom” of Sofia  
Hon.President of BFPA

### **Radosveta Stamenkova**

[[rstamenkova@safesex.bg](mailto:rstamenkova@safesex.bg)]  
Executive Director  
Bulgarian Family Planning and  
Sexual Health Association (BFPA)

# BETWEEN POLICY-MAKER AWARENESS AND POLICY RESPONSES: LOWEST-LOW FERTILITY IN ITALY

A pervasive stereotypical view describes the typical Italian family as large. On the contrary, Italians have been the “champions” of low fertility since the early 1990s. The total fertility rate (TFR) fell below 1.3 children per woman—the threshold of so-called “lowest-low” fertility—in the year 1993 and reached a minimum level of 1.18 in 1995. Total fertility has thereafter increased, attaining a level of 1.34 in 2005 (estimation by the Italian National Statistical Institute). To what extent and since when has lowest-low fertility been perceived as a policy issue? Have policy changes, and in particular cash benefits and childcare services, had a role in the recent increase in Italian fertility? In what follows we try to discuss these issues and, if possible, to answer the questions.

## A family-unfriendly and child-unfriendly society

Competing explanations have been put forward in the scientific literature on why Italian fertility attained lowest-low levels. There is however a general agreement that both national-level institutional and policy environments cannot be characterised as family-friendly nor as child-friendly. On the contrary, the Italian society is largely seen as family-unfriendly and child-unfriendly.

According to Eurostat data from 2003, the average level of public spending for welfare in favour of families and children is 2.2% of the GDP within the EU15. In Italy, this level is 1%, with OECD reconstructions showing a fairly constant level since 1980, oscillating from 0.8% to 1.3% at most. Neither is this picture changed by tax relief policies: OECD recently estimated “net social expenditure”, i.e. social expenditure taking into account the effects of the tax system and of private voluntary social expenditures. For net social expenditure, Italy is ranked as 19th out of 23 countries, with 1% of the GDP against 2.1% for the OECD average.

Why this? A possible reason is that Italian policy-makers have not perceived fertility levels as being too low until very recently. The periodic UN survey on

government views and policies tells an interesting story: still in 1996, i.e. when Italy was already top of the world league in low fertility and indicators were publicly available, the fertility level was perceived by the government as “satisfactory”, with policies aiming at no intervention. In 2003 the Italian government started perceiving fertility as “too low”, but still no intervention was regarded as necessary; the government then published a “White Paper on Welfare State” emphasising low fertility as a key societal problem (1). The “White Paper” includes statements such as “an increase in the rate of births keeps on being a necessary presupposition, if we are to restore in Italy a context of generational renovation consistent with the preservation of social cohesion and economic development. In fact, as previously pointed out, even though the decision whether to have children or not keeps on being made by the individual couple, it is unquestionable that everything becomes much more difficult if there are no suitable family-supporting policies” (1). Finally, in the 2005 UN survey, the Government declared that policies should aim at raising fertility levels.

In May 2006, power shifted from the Centre-Right to the Centre-Left coalition, but also the new government stated that fertility is too low and that higher levels would be desirable. Interestingly, this is one of the few issues for which there is a clear agreement between the two main coalitions of Italian politics. Much less agreement within Italian politics (and society) can be found concerning issues of reproductive health and rights, i.e. especially on the basic right to choose freely and responsibly the timing and the number of children. The Centre-Right government during the period 2001-2006, backed by the Catholic Church, passed laws forbidding the use of abortive pills on the one hand, and the use of various artificial insemination techniques (such as artificial insemination by donor) on the other hand. These issues have hardly been connected to the debate on low fertility, which indicates a general scarcity of reflection on reproductive rights. In

what follows, we focus on cash benefits and services.

## Cash benefits linked to children: new attempts

The recent increase in TFR (a difference of 0.16 between 2005 estimates and 1995) is probably also connected to some measurement issues connected to TFR, which is a problematic indicator when (such as in Italy) the mean age at childbearing is not constant. However, we here focus on policy changes during this period and explore their potential effect on fertility.

In Italy, a traditional family allowance for workers was introduced first in the 1930s. After extensions in the following decades, it became income-tested in 1983. Self-employed and non-employed were excluded from the allowance. Indeed, contributions to the family allowance funds have since then been regularly shifted to the payment of old-age pensions. Paid maternal leave for working mothers was extended to 5 months. Did these policies change after the emergence of lowest-low fertility level and with the new policy-maker awareness?

The answer is positive. A new policy was introduced, mostly with anti-poverty aims, in January 1999, together with other minor tax changes; this policy is still in place as of July 2006. The policy has two components. First, a sizable cash benefit for households with at least three co-resident children under 18 and low (household) income levels: 118 Euros per month in 2005, i.e. approximately 7% of the yearly income at the level of the testing threshold. The share of households receiving this transfer has been particularly sizeable for larger households, especially in the less wealthy part of the country, i.e. Southern Italy, where in the year 2000 64.2% of households with three or more children received the benefit. Second, a benefit to households in which one of the partners (typically the woman) is not employed, with relatively mild restrictions on income levels, for 5 months (284 Euros per month in 2005). The benefit is designed to target mothers who were not eligible for standard maternal leave



benefits. A first analysis of the effect of such policy shows a mild but statistically significant impact on the progression to third birth, and a drop in the abortion ratio of mothers with two children that are potentially eligible (2).

In September 2003, another cash benefit was introduced subsequently to the presentation of the “White Paper”, with limited validity for 2003 (retrospectively) and 2004. The benefit amounted to a one-shot transfer of 1000 Euros immediately after the birth of each child. First births and births born from mothers with non-EU citizenship were excluded (the total share of children from parents with foreign citizenship was 8.7% in 2004, the vast majority from mothers with non-EU citizenship). This measure was not renovated, but then subsequently reiterated at the end of 2005, with retrospective validity also for 2005 and first births, but still excluding newborns from non-EU mothers. This benefit could be added on top of the benefits previously described. The retrospective and one-shot nature of the benefit, not planned as a constant measure, together with its size make it unlikely as a measure to influence fertility. The exclusion of newborns in Italy from non-EU mothers also includes a discrimination towards children that is hardly justifiable.

### **An increasing share of children aged 0-2 in childcare centres: does it matter?**

The scientific literature has shown that—at least in the Western world—fertility levels are higher in countries where female labour force participation is higher, i.e., that the cross-country correlation between fertility and female labour force participation has become positive. In Italy, according to recent Eurostat data related to 2005, the total female employment rate is 57.6%, against an average for the EU15 of 65.2%. The ability to combine paid work, childbearing and child-rearing is the main explanation for the emerging compatibility of relatively high fertility and female labour force participation. Childcare services are fundamental

with respect to this, even in a country where traditionally mothers and (usually female) relatives helped in providing childcare. As mothers and other relatives progressively enter the labour market and are increasingly less able or willing to provide support, compatibility is strictly linked to meeting childcare needs (2).

Childcare centres (known as *nidi*, public and/or private, usually open from 8 am to 6 pm) are the main publicly regulated and solicited instrument in Italy for children aged 0-2. The number of *nidi* has been increasing (at the national level) from 2,180 in the year 1992 to 4,885 for the latest available data (usually referring to the year 2004 or 2005). Consequently, the proportion of children aged 0-2 in *nidi* has increased from 5.8% in 1992 to 9.9% for 2004/05, with the population aged 0-2 practically constant across the period.

To what extent is the increase in fertility over about the last 10 years connected to the increased childcare availability? The scientific literature has yet to provide an answer. Regions are responsible for policies concerning *nidi*, with municipalities or other institutions managing the centres. Huge regional variation emerged as a consequence. The recent fertility increase has been most prominent in regions of Northern and Central Italy, where both female labour force participation and *nidi* are more widespread.

An additional but related issue is whether the increase in childcare provision is sufficient to meet the needs of parents. There is a clear signal that unmet needs for childcare do indeed exist: at the national level, in the year 2000, only 68.1% of the eligible applicants to *nidi* could actually be accepted. For more recent years, data for specific regions indicate the persistence of an unmet need.

### **Concluding remarks: public budget and political economy**

Italy faces its fertility problems in a period of serious budgetary restrictions, with public debt approaching 108% of the GDP. If social expenditure towards families and children is to reach EU15

average, more than 1% of the GDP needs to be dedicated to this. This is unlikely to be the case, also because of “political economics” reason: the median voter in the 2006 elections was approximately 47 years old, which makes problematic for any future Italian government both the redistribution of social expenditure from other categories to families and children, and a new attention on reproductive rights—for instance, a 2005 referendum that aimed at the abolition of restrictions on artificial insemination was invalid because of too low voters attendance.

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**Francesco C. Billari**  
[francesco.billari@unibocconi.it]  
Director  
Carlo F. Dondena Research Center  
on Social Dynamics  
Università Bocconi.

# BEHIND THE SURPRISING STABILITY OF ROMANIAN FERTILITY

**The drastic fertility decrease in Romania after 1989 is not an unusual trend in the European context, it is part of the general decreasing movement recorded in the Central and Eastern European countries undergoing economical and social transition after the fall of communism.**

Surprisingly enough, though it started from relatively different levels at the end of the 1980s, the fertility trends were similar in different political, economical and social contexts in the 1990s, resulting in a homogeneous level, with total fertility rates almost identical and stable after the year 2000 of 1.2 to 1.3 births/woman (1). The fertility decrease in the 1990s in the countries undergoing economic and social transition was not determined and maintained by immediate economic factors. The causes were different, mainly non-economic, emerging from the deep changes those post-communist societies went through and which influenced the attitude of the young couple regarding marriage, family and the place of children in the hierarchy of priorities and decisions (2).

Romania's case cannot be analyzed apart from this general picture. There is, although, one important particularity: Before 1990, Romania had a forced and brutal pronatalist policy (with severe restrictions upon access to contraception and abortion) and the total fertility rate was slightly higher than in the other European communist countries (2.2 – 2.3 children/woman). It was obvious that the level of fertility in Romania was artificially maintained at this level and we expected the decrease in the 1990s to be higher, once the restrictive regulations on abortion and contraception were abolished at the end of 1989. Moreover, the economic crisis and the dramatic reduction of the living standards should have amplified the fertility decline to a higher level compared with the other countries where the deterioration of the living standards was only moderate and temporary (Czech Republic, Slovakia, Poland and Hungary). There is, indeed, a higher decrease of fertility in Romania. The particularity of this trend is not the magnitude of the decrease, but the concentration of the decrease in only 3-4 years instead of a spread over a larger period of time, like in the other countries. The already mentioned feature of the Romanian fertility before 1990, can explain this particularity.

This is the regional context in which

the Romanian fertility is situated, analyzed at an aggregate level. When analyzed at a deeper level, regionally, by urban/rural areas, age groups and socio-economical characteristics of the woman, we can identify important particularities, different dynamics and structural changes. Moreover, the effects of the economic measures taken by the government in 2003 to stimulate birth rates, offer today some interesting and relevant observations and conclusions.

The birth rate and the total fertility rate have been remarkably stable starting in the mid 1990s, at 10 per 1000 people and 1.3 children per woman. Behind this stability, structural and other types of changes can be noted, that we could define as signs of the modernization of the Romanian fertility. The early Eastern European model of fertility is still well defined, both by the curve of fertility rates by age and by the mean age of the women giving birth. Even if the mean age of women at the birth of the first child increased with two years (from 23 to 25 years), it is still situated at a net lower value compared with the one from the developed European countries. Co-habitation and living in consensual unions is not very frequent, but there are evident signs of expansion of this lifestyle among youth, and it is expected that the phenomenon will be wider in the future. Despite the family planning programmes launched immediately after 1989 by the government with support from non-governmental organizations (NGOs) and international organizations, at a time when the education of the population regarding contraception was still bearing the consequences of the old forced pronatalist policy, modern contraceptive use is still reduced and the number of abortions is extremely high, with all the consequences and risks for the mother's and children's health. The number of abortions is, especially for the last years, underreported, an increasing number of abortions being performed in private clinics whose statistical reports are incomplete. The Reproductive Health Survey from 2004 (3) indicated a total abortion rate of 84/100



**Table 1 Live births and fertility in urban and rural areas, 2002-2005**

Year	Urban				Rural			
	Live births - thousands	Change from previous year - thousands	Crude birth rate - per 1000	Total fertility rate - per woman	Live births - thousands	Change from previous year - thousands	Crude birth rate - per 1000	Total fertility rate - per woman
2002	98.2	-4.2	8.5	.99	112.3	-5.6	11.0	1.60
2003	100.9	+2.7	8.7	1.03	111.5	-0.8	11.0	1.61
2004	111.3	+10.4	9.4	1.11	104.9	-6.6	10.7	1.57
2005	117.8	+6.5	9.9	1.17	103.2	-1.7	10.6	1.55

Source: National Institute of Statistics, 2001b, 2002, 2003; 2004; 2005; 2006a, Bucharest

women aged 15-44 for the period of the three years before the survey. The comparison between the official abortion data and the ones provided by the subjects of the survey indicate an underreporting of 25 – 30%. The same survey indicates a modern contraception prevalence of 45% for women and 34% for men, while the prevalence of the traditional methods is still high of 17% and 24% respectively. As a consequence, the unmet need for modern contraception is also high, 28% of all women and 40% of the married women. Romania had and still has a low urbanization level (55% of its population) and there have always been big economical, social, cultural and demographic differences between the two social environments. It is important to note that, especially after the year 2000, there is a reduction of the difference between the birth rate and fertility rate in urban and rural areas, as result of an opposite trend of the birth rate in the last years – a decrease in rural area and a slight increase in the urban area (see Table 1).

Only the urban area registered a positive trend in the birth rate, determined by the economic measures taken by the government to assist employed women with children. We believe that the examination of the characteristics of this reaction to economic incentives is interesting and useful (see table 2). The government policies initiated in 2003, and improved in 2004, state the possibility for the mother to benefit from a 24-months maternal leave for raising her baby. The monthly subsidy received for that period of time is very high compared with the income level in Romania. It represents 85% of the

gross average income, considerably higher than the average net income of employed women. Since most employed women live in urban areas, it is not surprising that the positive effects of this measure are visible in the increased number of children born in urban areas. The changes in the birth rate trend in urban area in the last three years are extremely significant and relevant to the influence of the economic factors on the birth rate.

If we analyze the dynamic of the births during 2003-2005 by mother's occupational status (see Table 2), there is an evident predominance of the birth distribution among the employed women, who took advantage and will continue to benefit of the economical measures taken by the government. The positive effects are definitely higher in the years 2004 and 2005, with the dissemination of the information and increased awareness regarding the financial benefits emerging from the legislation adopted in 2003 and improved in 2004. In 2005, there was a moderate reduction of the number of births from employed women and the development in 2006 is yet to be determined.

The birth rate decrease in Romania in the 1990s was the result of giving up having a second child or more, as well as of postponing the first birth or refusing to have children. As seen in the above table, in 2003 and 2004, the birth rate increased predominantly based for the first order births, showing that the financial incentives were the most effective on employed women who had no children. There is however a very interesting change that occurred in 2004 and was consolidated in

2005. In the first year there is a significant increase of the second order births and in 2005 that increase is more important than the one for the first order births. If we consider the information from the media, the dynamics for the second order births in 2004 and 2005 has a very clear significance: a number of women who had their first child and took advantage of the mentioned economical measures, decided to have their second child and have another 24 months of well-paid maternity leave. It is admitted that this attitude is well established and will be confirmed by the future trends.

The moderate increase of the birth rate among employed urban women has another positive side, being registered mainly among the women with the highest education level – post-high and university, which should have a positive effect on quality of children. The share of births from women with post-high and university level education is still reduced – only 16% in 2005. This proves not only the well-known lower fertility of women with higher level of education, but also the general education level of the Romanian population. The percentage of births from women having a high level of education was even lower before the moderate birth rate increase after 2002 (9% in 2000).

The Romanian fertility is in a process of rapid structural changes through the reduction in the proportion of fertility at younger ages and the increase in the proportion of fertility after the age of 30. It is a modernization of the fertility, getting closer to the structure from the developed countries. The increase of the fertility of

**Table 2 Annual change in number of births by employment status of mother, live births order, education level and age of mother, 2003-2005**

	2003 / 2002	2004 / 2003	2005 / 2004
<b>BY MOTHER'S EMPLOYMENT STATUS</b>			
- employer	+1	+4	-64
- employee	+2850	+7560	+7311
- housekeeper	+898	+872	-2066
- unemployed	-1221	-96	-205
- self-employed	-153	+277	-341
- other	+350	+1816	+1797
<b>BY LIVE BIRTHS ORDER</b>			
- order 1	+2011	+6963	+2646
- order 2	+751	+2546	+3554
- order 3	-24	+381	+410
- order 4 and more	-13	+543	-178
<b>BY MOTHER'S LEVEL OF EDUCATION</b>			
- primary	+308	+146	+193
- secondary	-742	+1979	-7
- vocational	-25	+1033	+463
- high school	-84	+2187	+263
- post college and university	+3035	+3431	+3317
- other	+233	+1657	+2203
<b>FERTILITY RATES BY AGE – IN %</b>			
15-19	+4.4	+8.4	+1.9
20-24	-2.3	+2.2	-3.4
25-29	+3.6	+5.1	+5.5
30-34	+11.0	+17.5	+17.4
35-39	+12.6	+17.5	+9.5
40-49	+4.5	+13.0	+11.5
<b>MEAN AGE OF MOTHER (YEARS) AT</b>			
- birth of first child	25.7	26.0	26.3
- at childbearing	27.1	27.3	27.6

Source: National Institute of Statistics, 2001b, 2002, 2003; 2004; 2005; 2006a, Bucharest

employed urban women confirms this structural change, the most important increases being recorded after age 30.

A few final remarks on the measures taken by the Romanian government in 2003 and their effects. We are witnessing the positive effects of financial incentives on the women and on couples. The effects are modest, but the decrease of birth rate was thus stopped, even if its present level remains a low one - 10 per thousand. There are two more important

observations to draw. We have mentioned that the adopted measures determined a number of women to give birth to two children. There is a risk that after four years of maternal leave, with a higher subsidy compared with the salary that the women had before the leave and will have after the leave, a number of families will have a lower average income/family member. The living standards of these families will be reduced and the difficulties of raising their children will increase.

In these circumstances, will we witness an increase of the children abandonment, of adoptions or placements in maternal care centers (public or belonging to NGOs)? It is difficult to give a straight answer and only the developments in the following years will show if the respective policies will have such adverse effects. It will be an extremely useful experience for the government in development of future policies to increase the birth rate.

Finally, without minimizing the importance of the measures taken, we need to keep in mind that they are addressing only the employed women who contributed to the social insurance system. They targeted thus only a narrow segment of the total female fertile population, who can have only a moderate contribution in recovering the Romanian fertility. However, we believe that the experience provided by these measures will be useful, when the financial resources of the country will allow it, to formulate and implement national policies to increase the birth rate.

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## Vasile Ghetau

[vasile.ghetau@digicom.ro]

Director

Population Research Center of the Romanian Academy

## Laurian Arghisan

[laurian@unfpa.ro]

Program Officer Reproductive Health, Population and Development  
UNFPA Romania

# RECENT CHANGES IN FAMILY POLICIES IN AUSTRIA AND GERMANY

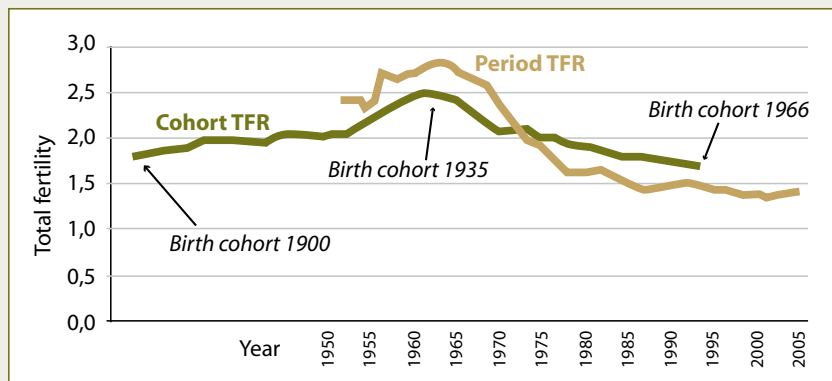
- A response to very low fertility

Long-term trends in Austrian and West German fertility (Figure 1a and Figure 1b) have evolved in parallel with the trends in western and northern European countries. After a marked rise in fertility during the period of economic and social recovery after World War II that culminated in the early 1960s, a substantial drop in fertility took place between the mid-1960s and the mid-1980s (early 1970s in the case of Germany). The period total fertility rate (TFR) continued to decline after 1980, although less rapidly than before, and for both countries the TFR has hovered around the level of 1.4-1.5 in the last two decades. Completed fertility has gradually declined among women born after 1935 for Austria (1933 for Germany), dropping to a value of 1.7 and 1.5, respectively, among women born after 1965 for Austria and Germany.

Low fertility levels combined with increasing survival and rather modest migration flows contribute to population ageing—in particular also to ageing of the labour force—both in Austria and in Germany. As a consequence, family policies aimed to increase fertility, have recently been implemented in both countries. Since differences in fertility levels between countries can be attributed to difference in demographic and socio-economic factors (Neyer 2003), family policies should be aiming to influence both of these factors. A key demographic factor leading to low birth rates, and hence should be subject to targeted family policies, is the postponement of childbearing. Among the socio-economic factors the increase in female labour force participation since the 1970s has put the focus on employment-related fertility policies.

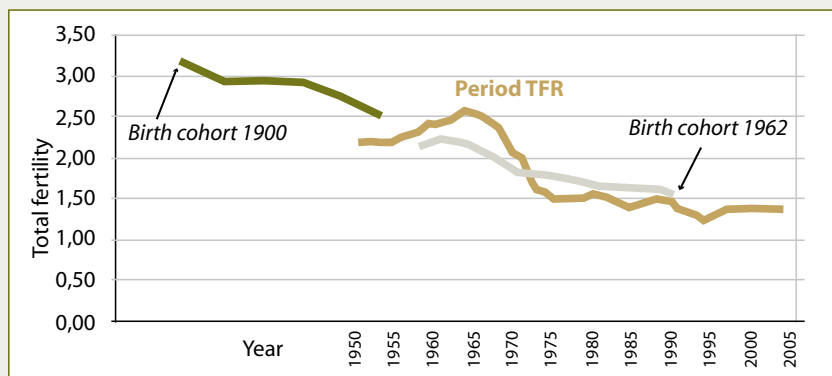
Within the typology of family policies developed by Gauthier (1) Austria and Germany correspond mainly to the 'conservative' regime, which is characterised by a system of state support for families that tends to vary according to the parents' employment status, and that also tends to be driven by a more traditional view of the gender division of labour. The level of cash support is medium to high.

**Figure 1.a** Period (1951-2005) and cohort (1900-1966) fertility indicators, Austria



Source: Sobotka (2005)

**Figure 1.b** Period (1951-2005) and cohort (1900-1962) fertility indicators, Germany (East and West Germany combined)



Source: Federal Statistical Office, Federal Institute for Population Research (2006)

Both countries provide quite generous tax deductions and tax credits to families. The support of working parents is at a medium level. There are relatively long parental and childcare leaves, but more limited childcare facilities (in particular at ages below 3 years). Social policies in Germany and Austria encourage mothers to exit from the labour force and support men as the family breadwinners. For further details see Table 1 and Neyer (2).

It needs to be mentioned that family policies in the former German Democratic Republic were quite different from those in West Germany and were explicitly pro-natalist since 1972. In the East, continuous full employment of both men and women was seen as the main foundation of gender equity. Extensive and inexpensive public childcare, including after-school clubs and crèches for very young children, as well as other social support measures allowed women

to remain in the workforce even during childbearing years. The institutional arrangement in West Germany differed from the East German one particularly in the way in which women were integrated into the labour market. While full-time employment was universal in former East Germany, in West Germany caring for one's child was considered a highly legitimate reason for withdrawing from the labour market. Moreover, a 'housewife bonus' in the tax and transfer system assured that this family model was economically feasible. On the other hand, full labour participation was supposed to be both 'right and duty' by East German constitution and women did not have a real choice not to participate in employment. In addition, combining full-time employment with childcare and household 'obligations' was difficult for many women due to underdeveloped service sector.

**Table 1: Family policies in Germany and Austria**

MATERNITY PROVISIONS, 1999-2001	duration in weeks	wage compensation in %	paternity leave
Austria	16	100	none
Germany	14	100	none

PARENTAL LEAVE, 1999-2002	duration	benefit	max. age of child (year)	part-time	father
Austria	2 years	flat rate (30 months+ 6 months for father)	3; 3 months unpaid until child is 7	yes	6 months 'use or loose
Germany	3 years	flat rate 2 years means-tested,	3; 1 year paid until child is 8	yes	yes

CHILDREN IN PUBLICLY FUNDED CHILDCARE IN EUROPE, 1993/1994 AND 1998/2000							
	children (under 3) in publicly funded childcare		guaranteed childcare (under 3)	children (3-6) in publicly funded childcare		guaranteed childcare (3-6)	children (6-10) in publicly funded after-school care
	1993/94	1998/2000		1993/94	1998/2000		1993/94
	Austria	3%	4%	no	75%	79%	no
Germany	2%	10%	no	85%	78%	yes	5% (Germany West) 34% (Germany East)

CHILD BENEFITS 2000-2002	basic principle		by number of children		by age	
Austria	universal		yes		yes	
Germany	universal		yes		no	

Source: Neyer (2003)

**Austria**

In Austria, frequent changes in parental leave regulations during the last years created incentives for parents to space their second and subsequent children in a way that they can receive continuous payments of parental allowance while staying at home with their children. Moreover recent changes in family policies promoted greater compatibility of work and childbearing.

In 1990 and 2002 policy changes were enacted that extended parental leave periods and thereby increased the incentive for mothers to have additional children more quickly. As of July 1990 paid parental leave was extended from the first until the second birthday of a child and even until the third birthday in the case of part-time parental leave (see (2) for more detailed descriptions of parental leave changes). This period was reduced again in July 1996 to a maximum of 18 months following childbirth if only one parent takes the leave, making a 'targeted' spacing behaviour more difficult.

The study by Lalive and Zweimüller (3) reports an increase in the probability of having another child by 15 percent

(4.9 percentage points) within 36 months following the first child, which can be attributed to the new leave regulations introduced in 1990. Part of this increase was due to more rapid child spacing, but some positive effect (3.9 percentage points) remained even ten years after the first childbirth. Focusing on third births, Hoem et al. (4) suggest that many women spaced their third births shortly after the second one in order to qualify for an uninterrupted period of parental leave. For second births Prskawetz and Zagaglia (5) did not find a similar spacing effect.

As of January 2002 parental leave is no longer linked to previous work experience and parents can take parental leave for up to 30 months<sup>2</sup>. More flexibility has allowed to combine parental leave with part-time work more easily, letting each person who receives a parental allowance earn a gross income of up to EUR 14,600 per year. This earning level is usually exceeded by mothers employed full-time with the consequence that they lose their right to these social benefits. Instead of facilitating women's employment opportunities by providing services, the government gave preference to extended

leave for childcare which allows mothers to stay at home with their young children. Preliminary analyses indicate that the positive labour market incentives (by increasing the exemption limit) are outweighed by the negative ones caused by the extension of parental leave.

Combining work and family is difficult for Austrian women due to the insufficiency of public and private childcare as well as inconvenient school hours and opening times of many day-care institutions. In 1998/2000, only 4% of children under age three and 79% aged 3 to mandatory school age were benefiting from any publicly funded formal childcare arrangement (Table 1). When also including private childcare facilities, this number increases to 10%.

As of July 2004 there is a legal right for mothers employed full-time to reduce their working hours after the birth—if the company has more than 20 employees and the mother has been employed at least three years before pregnancy. Unfortunately, only few mothers fulfil these conditions. Generally, part-time jobs are rare in Austria. In 1999, the employment rate of mothers with children under age



6 in two-parent families was 66% and for single mothers 76% (5).

### Germany

A clear distinction between the Austrian and German family policies lies in the taxation system. While most European countries introduced individual taxation by the beginning of the 1990s, in Germany—even today—employed spouses have joint taxation and the family benefits gained through the family taxation system are greater for one wage earner than in families with two wage earners. The system of income splitting provides substantial tax relieves for traditional family forms and imposes “severe penalties on a working wife”.

In order to encourage women to re-enter the labour market, the right to part-time work has been made a legal one in 2001. Another important aspect in easing the combination of work and family is the provision of day-care. Since 1996 children older than three have been legally entitled to a place in a public centre, but this entitlement in fact only guarantees a place in a relatively costly part-time centre offering inflexible opening hours and no lunch so that parents have to organise private day-care in the afternoon.

There is empirical evidence regarding the impact of policy measures on fertility in Germany. Monetary child benefits of all kinds have a significant impact on fertility. The number of places in day-care facilities was found to have a significant effect for having a first child in the East (6), whereas it has not been possible to demonstrate that the local availability of institutional childcare services exerts a positive effect on birth rates in the West.

In June 2006 a new law was passed by the German government that will (starting in 2007) replace the current family allowance of 300 Euro per month by an income-dependent family allowance as already practiced in Nordic countries. This newly established family allowance payment is targeted to replace 67% of previous individual earnings up to a maximum of 1,800 Euro per month and will be granted for 12 months (with an extension for two additional months if

the father takes leave for this period). Parents who space their children closely will obtain a further bonus on top of the family allowances.

To sum up, family policies in Austria and Germany are mainly directed towards financial incentives helping young mothers to retreat from the labour market and much less to structural incentives that would support the compatibility of childrearing and employment.

In both countries, however, there is a clear tendency to increase the availability of childcare, partly also strengthened by the EU’s goal of increasing female employment rates to 60% by 2010. The fact that childcare services are currently being decentralised, marketised or moved to private initiatives could, however, increase social and economic inequality in their accessibility and affordability as pointed out in Neyer (2). Existing studies on effects of family policies on fertility suggest that policy effects are usually stronger with respect to fertility timing, often inducing short-term swings in period fertility and in the number of births, but there is much less clear-cut evidence for lasting changes in fertility quantum. For family policies to have an influence on fertility it is indispensable to also integrate measures in labour market policies, care policies and gender policies (2).

### Endnotes

1. Gauthier’s (2002) definition of family policy encompasses cash and in-kind benefits such as direct cash transfers to families, tax reliefs for families with children, maternity and parental leave, childcare facilities and subsidies, as well as certain provisions in family law.
2. If both parents participate in the parental leave, they are entitled to six additional months of paid leave since 1996; i.e. three years in total since 2002. However, as parental leave continues to be taken almost exclusively by women (in 2004 men constituted only two percent of parental leave users; cf. Gisser and Fliegenschnee 2004), only few couples take advantage of this possible prolongation.

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### Alexia Prskawetz

[[alexia.fuemkranz-prskawetz@oeaw.ac.at](mailto:alexia.fuemkranz-prskawetz@oeaw.ac.at)]  
Deputy Director and Research Group Leader  
Vienna Institute of Demography  
Austrian Academy of Sciences

### Isabella Buber

[[isabella.buber@oeaw.ac.at](mailto:isabella.buber@oeaw.ac.at)]  
Vienna Institute of Demography  
Austrian Academy of Sciences

### Tomáš Sobotka

[[tomas.sobotka@oeaw.ac.at](mailto:tomas.sobotka@oeaw.ac.at)]  
Research Scientist  
Vienna Institute of Demography  
Austrian Academy of Sciences

### Henriette Engelhardt

[[henriette.engelhardt-woelfler@sowi.uni-bamberg.de](mailto:henriette.engelhardt-woelfler@sowi.uni-bamberg.de)]  
Professor for Population Sciences  
Department of Demography  
University of Bamberg, Germany

## Relevant reports

**Federal Institute for Population Research and Robert Bosch Foundation (Eds.): 'The Demographic Future of Europe – Facts, Figures, Policies - Results of the Population Policy Acceptance Study (PPAS)', Stuttgart, 2005.**

This report summarizes the results of an international comparative research project studying the attitudes of the population to demographic change and population-relevant policies. The report analyses what the population in fourteen European countries thinks about family, children, partnership, equity and ageing. The report can be downloaded at:

[http://www.bib-demographie.de/ppa/PPAS\\_brochure\\_en.pdf](http://www.bib-demographie.de/ppa/PPAS_brochure_en.pdf)

**Kohler, H.-P. et al: 'Low fertility in Europe: Causes, Implications and Policy Options' In F.R. Harris (Ed.): The Baby Bust: Who will do the Work? Who will Pay the Taxes?, Lanham, MD: Rowman & Littlefield Publishers, 48-109, 2006.**

This recently published paper presents an up-to-date picture of the European fertility patterns and provides an analysis about the causes and implications of, and potential policy responses to, low and lowest-low fertility in Europe. The paper can be downloaded at:

<http://www.ssc.upenn.edu/~hpkohler/papers/Low-fertility-in-Europe-final.pdf>

**Neyer G.: 'Family Policies and Fertility in Europe: Fertility Policies at the intersection of gender policies, employment policies and care policies', MPIDR Working Paper WP 2006-010, Max Planck Institute for Demographic Research, Rostock, 2006.**

This working paper explores the relationship between family policies, fertility, employment and care. It suggests that similar family policies are likely to exert different effects in different contexts. It argues that a proper assessment of effects of family policies needs to take the combined spectrum of gender relations, welfare-state structures, and labor-market development into account. The paper can be downloaded from:

<http://www.demogr.mpg.de/papers/working/wp-2006-010.pdf>

## Recent WHO publications



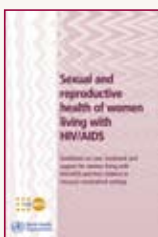
**Accelerating progress towards the attainment of international reproductive health goals – A framework for implementing the WHO Global Reproductive Health Strategy, WHO, Geneva, 2006.**

This document provides a framework for implementing the Reproductive Health Strategy developed in 2004. It focuses on the five action areas to improve sexual and reproductive health defined in the strategy. For each of the key action areas, detailed actions are suggested for implementation at policy and programme levels. These are followed by the role WHO (with its partners) can play in supporting countries in that action area. A range of health-care and health status indicators relating to the five core elements of reproductive health are also provided to facilitate monitoring and evaluation of progress.



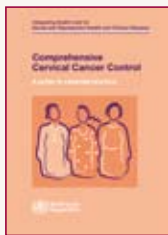
**Global strategy for the prevention and control of sexually transmitted infections: 2006–2015, WHO, Geneva.**

This document was developed to complement the reproductive health strategy developed in 2004. The strategy offers four fundamental benefits of investing in STI control, namely: (i) reduction in STI-related morbidity and mortality; (ii) prevention of HIV through a cost-effective intervention; (iii) prevention of long-term sequelae of STIs, such as cancers, especially in women; and (iv) reduction in adverse outcomes of pregnancy (in women infected with STIs). The strategy highlights opportunities for scaling up an effective response to STI prevention and control and proposes feasible evidence-based interventions for implementation at country level.



**Sexual and reproductive health of women living with HIV/AIDS – Guidelines on care, treatment and support for women living with HIV/AIDS and their children in resource-constrained settings, Published by WHO and co-produced by UNFPA, Geneva, 2006.**

This publication addresses the specific sexual and reproductive health needs of women living with HIV/AIDS and contains recommendations for counselling, antiretroviral therapy, care and other interventions.



**Comprehensive Cervical Cancer Control - A guide to essential practice, WHO, Geneva, 2006.**

This guide is intended to help those responsible for providing services aimed at reducing the burden posed by cervical cancer for women, communities and health systems. It focuses on the knowledge and skills needed by health care providers, at different levels of care, in order to offer quality services for prevention, screening, treatment and palliation of cervical cancer. The Guide presents guidelines and up-to-date, evidence-based recommendations covering the full continuum of care.



**Reproductive Health Indicators - Guidelines for their generation, interpretation and analysis for global monitoring, WHO, Geneva, 2006.**

This document is intended for national public health administrators and health programme managers. It briefly reviews theoretical and practical considerations of indicators, followed by a discussion of the definition, data sources, collection methods, periodicity of collection, disaggregation, use, limitations and common pitfalls for each of the shortlisted indicators. It is hoped that the document will contribute towards a consistent global monitoring and evaluation of reproductive health.

**Important upcoming events**



**23rd Annual Meeting of the European Society of Human Reproduction and Embryology**

1– 4 July, 2007, Lyon, France. For more information regarding registration and programme please visit <http://www.eshre.com/emc.asp?pagelId=206>



**9th European Society of Contraception Seminar: 'From Abortion to Contraception', 21-22 September 2007, Bucharest, Romania.**

For more information please visit [http://www.contraception-esc.com/future\\_esc\\_events.htm](http://www.contraception-esc.com/future_esc_events.htm)



**10th ESC Congress: 'Non-contraceptive impact of contraception and family planning', 30 April – 3 May, 2008, Prague, Czech Republic.**

For more information please visit [http://www.contraception-esc.com/future\\_esc\\_events.htm](http://www.contraception-esc.com/future_esc_events.htm)

**"Youth Sex Education in a Multicultural Europe", BZgA-WHO meeting in November**

14-16 November 2006, Cologne, Germany. The German Federal Centre for Health Education, BZgA Cologne, a WHO Collaborating Centre for Reproductive and Sexual Health, is organizing an international conference on "Youth Sex Education in a Multicultural Europe". The conference will create a forum for technical experts from both governmental and non-governmental organisations to assess the present state of the art of sex education for youth in Europe. In particular, issues and dimensions of a multicultural approach to sex education and the question of quality management in youth sex education will be explored. The aim is to share experiences and best practices, identify challenges and promote partnerships and collaboration at the regional level. Participation at the conference is on invitation only.

**Family Community Health meeting in Malaga**

25-28 September 2006, Malaga, Spain. The Family and Community Health Section at the WHO Regional Office for Europe is holding a meeting for focal points. The meeting will review and discuss the challenges, achievements and developments with national counterparts and other partners in Child and Adolescent Health, Making Pregnancy Safer, Reproductive Health and Research and gender Mainstreaming. Information on proceedings of the meeting and recommendations will be available in English and Russian on the web page of the WHO Regional office for Europe <http://www.euro.who.int/>.

## *Entre Nous*

*The European Magazine  
for Sexual and Reproductive Health*

WHO Regional Office for Europe

Reproductive Health and Research Programme

Scherfigsvej 8

DK-2100 Copenhagen Ø

Denmark

Tel: (+45) 3917 1602 or 1451

Fax: (+45) 3917 1818

[[entrenous@euro.who.int](mailto:entrenous@euro.who.int).]

[www.euro.who.int/entrenous](http://www.euro.who.int/entrenous)



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