

**Restructuring Family Policies:
Trans-National Organizations and
'Soft Politicking' for Reform**

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Abstract

In recent years, national governments in OECD countries have been pressured from many sources to reform social policies for families with children. This paper, based on research from a portion of my recent book manuscript, focuses on one source of political pressure: trans-national organisations such as the United Nations, the European Union and the International Labour Organisation. Although trans-national organisations develop multilateral agreements in order to urge governments to restructure social policies, these organisations are often forced to focus on ‘soft politicking’ to encourage ‘welfare laggards’ to tow the line. Efforts to restructure three areas of family policies are used to illustrate my argument: the development of parental benefits for employed parents, reproductive concerns, and issues relating to child maltreatment. I show that national politics and existing institutional arrangements of welfare provision present important constraints on trans-national efforts to encourage the harmonization of family policies.

Introduction

Socio-demographic trends relating to family life are beginning to converge in OECD countries but family-related policies and social programs remain divergent. Cross-national variations in policy response have been attributed to differences in the pace of family change, cultural ideas about family and women’s employment, institutional structures, political ideologies, and local lobbying efforts (Baker 1995, Gauthier 1996, Hantrais 2004). In the past few decades, increasing political pressure has come from trans-national organizations that expect national governments to restructure their social policies to fit in with global labour market concerns, neo-liberal ideas and practices, ‘best practices’ in social programs, and issues of human rights.

This paper, which is derived from a larger study of the impact of ‘globalization’ on family trends and policy reform (Baker, forthcoming), investigates the nature of international political pressure and its impact on the restructuring of social programs for families with children in OECD countries. Past and current family policy debates are examined within three policy areas: family planning and

reproductive rights¹, parental benefits for employed parents, and programs related to child maltreatment. These family policy issues, which have been gleaned from international reports, academic studies and the media, shed light on the extent of influence that trans-national organisations have on national policy restructuring.

Family Planning and Reproductive Rights

Reproductive behaviour was once viewed largely as a private matter. However, both the church and state actively disapproved of sex outside of marriage, all states legislated against incest, and most denied certain legal rights to ‘illegitimate’ children born outside marriage. Some states have also restricted access to contraception and abortion both outside and within marriage, viewing them as threatening to religious or cultural values, to the family as an institution, or to state population priorities. In the early 1900s, advocates of greater contraceptive use were met with religious and legal opposition, as opponents argued that the purpose of marriage was procreation. This meant that sex outside marriage, homosexuality, and birth control devices were considered immoral, and were also illegal in countries such as New Zealand, Australia and Canada until the late 1960s (Molloy 1992, Gilding 1997: 67, McLaren and McLaren 1986).

Albanese (2004) demonstrated that several European governments from the 1930s onward either attempted to encourage marital fertility through pronatalist political discourse and social programs, or encouraged women to participate in the labour force and to limit their family size through liberalized access to contraception and abortion. She concluded that as governments become more nationalist, and

¹ Lucy Husbands, my research assistant at the University of Auckland, researched portions of this section for me.

particularly in times of ethnic conflict and unrest, they tend to encourage a more patriarchal family with higher fertility.

Over the last fifty years, reproductive behaviour has become widely accepted as a social policy concern. This includes post-war and more recent attempts to encourage domesticity and higher birth rates, as well as efforts to promote zero population growth and smaller families in countries such as India and China. It also includes recent policy changes to discourage reproduction by women receiving welfare benefits in the United States (Mink 2002).

In 1968, family planning found its way into international human rights discourse with the UN-sponsored International Conference on Human Rights in Teheran. The groundbreaking Proclamation of Teheran stated that

“the protection of the family and of the child remains the concern of the international community. Parents have a basic right to determine freely and responsibly the number and spacing of their children” (United Nations 2003: 14).

This recognition of family planning as a human right coincided with the development of new types of contraceptives, including ‘the pill’ and the intrauterine device (ibid: 14-15). In 1979, the United Nations urged member states in the *Convention on the Elimination of All Forms of Discrimination against Women*, to remove discrimination in the provision of health care services, including access to family planning. The 1993 *Vienna Declaration*, adopted by the World Congress on Human Rights, reaffirmed these basic reproductive rights by declaring a woman’s right to accessible and adequate health care and the widest range of family planning services (United Nations 2000: 59).

The concept of reproductive rights as basic human rights was further strengthened in 1994 at the UN International Conference on Population and Development in Cairo and its five-year review of implementation in 1999.

Governments were urged to ensure universal access to reproductive health care and access to safe, effective and affordable methods of family planning. They were also urged to provide freedom from sexual violence, the elimination of harmful traditional practices (including female genital ‘mutilation’), and freedom from coercion within the family and society (ibid). The 1994 Cairo conference revolutionised the conceptualisation of family planning by empowering women in matters of reproduction (United Nations 1995). Reproductive issues became articulated within the discourse of self-determination, individual well being and human rights, rather than population control and demographics (United Nations 2003).

This ideological shift was influenced by feminist non-governmental organizations that critiqued the demographic rationale for international population policy as coercive and unethical because it subjected women’s bodies to the attainment of an abstract and quantitative societal goal. Feminists also criticised the inaccessibility of reproductive health services to some women, as well as the lack of respect and privacy often given to women at family planning clinics (Finkle & McIntosh 2002). The Cairo conference promoted the idea that family planning and women’s health services should be integrated as a single package while giving greater attention to women’s rights (United Nations 2003: 17-18). This was not a new practice in countries such as Sweden, where there had been a long history of integrating family planning programs within a broader health care context (Westlander & Stellman 1988).

Women’s right to reproductive health was also a central focus in the United Nations’ Fourth World Conference on Women held in Beijing in 1995. Their platform for action called upon governments to recognize that reproductive health depends partly on available information and services, the prevalence of high-risk sexual

behaviour, discriminatory social practices, and negative attitudes towards females. Governments were also asked to address gaps in the collection and analysis of statistical information on women and health, and to encourage research on these issues (UN 2000).

United Nations statistics reveal that three quarters of married women now use some form of contraception. Table 1 shows the percentage of married women using contraceptives, as well as total fertility rates and teen birth rates in several countries. Three quarters of all countries, either member or non-member states of the United Nations, provide direct support for access to modern contraceptive methods (United Nations 2003: 7). Direct support refers to the provision of family planning services through government-run facilities, such as hospitals, clinics, health posts and health centres and through government fieldworkers (*ibid*). Another 17 per cent of countries support family planning and contraception programs indirectly by supporting non-governmental activities such as those operated by family planning associations. Yet despite sizeable growth in government support over the last 30 years, the demand for contraceptive and family planning services still greatly exceeds supply.

(Place Table 1 about Here)

More effective contraception has contributed to declining birth rates but fertility decline has also influenced contraception policies. Fertility rates have declined substantially in many countries with the rising cost of raising children, the changing role of women, and improvements in fertility control. This decline is causing ‘population aging’ which many governments now see as a looming crisis with higher cost for health care and retirement pensions. While the majority of less developed nations continue to view their fertility rates as ‘too high’, an increasing percentage of wealthier nation’s governments now regard their rates as ‘too low’ (UN

2003: 1). Just over half of wealthier nations now consider their fertility rates to be inadequate compared with 21 percent in 1976 (ibid).

Most countries have shifted their policies within the past thirty years towards increased support for modern contraceptive methods (United Nations 2003). At the same time, a number of OECD countries have reduced direct government support for family planning initiatives² (ibid). This shift may represent an attempt to counteract a trend of below-replacement fertility rates or it may reflect a broader context of privatisation and government withdrawal from centralised health and welfare programs. Possibly both these factors have influenced policy shifts.

In Eastern Europe and Russia, profound economic and political upheaval has not only hastened fertility decline but the development of capitalism and privatization has also led to more restrictive laws relating to contraception and abortion. Several attempts have been made to restrict abortion in Russia and Croatia (Albanese 2004) and the Catholic Church has once again become an influential lobby group in Poland, restricting access to abortion in 1997 (CRRP 2004).

Access to Abortion

For over forty years, access to legal abortion has been controversial but at the same time, there has been widespread agreement that early pregnancy reduces the opportunities of young women. Teenage birth rates have generally declined but some young women still become pregnant before they complete their education, find paid work or establish a household. Especially in those countries where abortion is illegal, young unmarried women are more likely than older married ones to seek abortions

² Austria, Canada, Denmark, France, Japan, Italy and New Zealand provided direct support for contraception in 1996 but changed to indirect support by 2001 (United Nations 2003).

from untrained practitioners, to perform abortions on themselves, and to delay seeking medical treatment if complications arise (United Nations 2000: 58).

Few countries deny women an abortion if the continuation of pregnancy endangers her life but vast cross-national variations exist in the degree to which abortions are legally available to women (United Nations 2002). In countries such as Sweden, Norway, the Netherlands, Denmark, France, Belgium, and the United States, abortions are available on request, regardless of the reason sought (CRRP 2003). However, most nations that permit abortion on liberal grounds have established conditions that must be observed for the abortion to become legal. These include limits on gestational age (usually around 12 weeks), the type of medical facility where the abortion must be performed (hospital or licensed clinic), and who can perform it (a licensed medical practitioner).

Some jurisdictions require mandatory waiting periods and counselling, and even third party authorisation, such as spousal consent in Turkey (Rahman, Katzive and Henshaw 1998). Furthermore, even governments permitting abortion on liberal grounds may not fund the procedure in the absence of medical necessity or other extreme circumstances (United Nations 2002). In some countries, such as Sweden, Italy and France, abortion is subsidised to varying degrees by the government, but the United States and Germany will pay for abortions only for women on low incomes who could not otherwise afford the procedure (ibid). Thirty-two American states have declined to use their Medicaid funds to pay for abortions unless life is threatened or pregnancy resulted from rape or incest (Sullivan 2003).

Numerous countries permit abortion on more limited grounds, such as when the continued pregnancy threatens to jeopardise the physical or mental health of the woman, if there is evidence of foetal impairment, or in the case of rape or incest (UN

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

United Nations' conferences in Cairo in 1994 and Beijing in 1995 both urged equality and reproductive autonomy for women. However, the international community remains reluctant to place any substantive pressure on nations to modify or repeal highly restrictive abortion laws (CRRP 2003). Subsequently, international conventions allow nation states considerable cultural and moral autonomy in this area. However, the UN urges member states to grant women access to safe abortion where it is legal and also urges access to quality medical care for women who suffer from post abortion complications regardless of the legality of the abortion itself (UN 1994, Article 8.25; UN 1995, Article 106.k).

The Beijing conference in 1995 also urged governments to "consider reviewing laws containing punitive measures against women who have undergone illegal abortions" (UN 1995, Article 106.k). Women's right to attain the highest standard of sexual and reproductive health and the right to make reproductive decisions free from discrimination, coercion and violence was also stressed (UN 1996). Both the 1994 and 1995 conferences confirmed that these rights are grounded

in and draw from an extensive body of international human rights instruments and international consensus documents³. All these documents stress the human rights aspect of accessibility to quality health care (UN 1996: 39-41).

The European Union law is also reluctant to dictate to national governments about abortion issues. The Maastricht Treaty (*Treaty on the European Union*) may be interpreted as protecting a nation's right to define its own legal parameters with regards to abortion, as it includes a provision which offers protection of national identity and sovereignty (European Union 1992, Article F.1). Furthermore, following the principle of 'subsidiarity', reproductive health policies remain within the jurisdiction of member states (Girvin 1996: 166).

Despite this, the European Parliament voted in 2002 to support a report by the Committee on Women's Rights and Equal Opportunities on the state of women's sexual and reproductive health and rights in the European Community (CRRP 2004). Through the report, the European Parliament urged member states to legalise induced abortion under certain conditions, at least in cases of forced pregnancy, rape, or the endangerment of a woman's health or life. The underlying principle is that the woman herself should make the final decision (European Parliament 2002). It remains to be seen how this will influence the member states with more conservative abortion laws, such as Ireland, Switzerland and more recently Poland⁴. Also, controversies undoubtedly will continue over the tension between women's reproductive rights and men's rights, as well as issues of cultural and religious identity.

³ These include the *Convention on the Elimination of All forms of Discrimination against Women* 1979, the United Nations *International Covenant on Economic, Social and Cultural Rights* 1966, the *European Convention for the Protection of Human Rights and Fundamental Freedoms* 1950 and the *European Social Charter* 1961 and 1996.

⁴ Abortion was legalized in Poland in 1956 but after 1990, it was restricted with consistent lobbying from social groups linked to the Catholic Church. The 1997 law prevents abortion on social grounds.

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

Abortion remains controversial for several reasons. First, some religious groups firmly believe that it is a form of murder. Second, not all hospitals provide abortions, requiring some women to travel to other regions or countries, at greater expense, to obtain these services. This opens the jurisdiction to accusations of inequalities in access to health services, but also encourages illegal abortions. Third, some fathers' rights activists and individual fathers believe that they should have more say in whether or not 'their child' is aborted or has the right to life. In Canada, the courts have generally confirmed that women and their physicians have the right to decide if the pregnancy should continue, leaving the male partner with few options especially if he is no longer living with the woman (O'Connor, Orloff & Shaver 1999). Fourth, rising health care costs and restructuring in the health sector have encouraged hospital administrators to make judgements about state funding for

particular services, and abortions become vulnerable to cuts especially when they are seen as controversial procedures.

Fertility concerns are now widespread in a number of countries, especially those that remain ambivalent about full-time maternal employment and reject higher immigration as a solution to population increase. In Australia, for example, considerable public discourse among social conservatives deals with how to encourage women to have more children. In the May 2004 budget, the Australian Treasurer advocated having more children to resolve declining fertility, low replacement rates and the aging population ‘problem’ when he said: “... you should have one for the father, one for the mother and one for the country...” (Dodson 2004). Expanding subsidised childcare spaces and enhancing the maternity payment were also policy solutions from the 2004 Australian budget.

In 2004, Pope John Paul II initiated a report that asked governments to help women attend to ‘their family duties’ when they enter the labour market (*The Guardian* 2004). The Vatican rejected feminism and appealed to governments to assist women to cope with their ‘maternal vocation’, suggesting that the recent decline in fertility, especially in southern Europe, is symptomatic of a ‘breakdown in values’. Greater selfishness among couples who are ‘more interested in consumer goods than creating life’ was targeted as the cause of fertility decline. This papal warning is one of many examples of the growing external pressure on welfare states to reform family policy, as women’s employment increases and birth rates fall throughout the world. Combining paid work and childbearing is clearly challenging for many women, requiring special leave provisions.

Maternity/Parental Benefits for Employed Parents

About a hundred years ago, Bismarck established cash maternity benefits for employed women in Germany and by World War I, several European countries, including France, Italy and Britain, had legislated some form of national maternity insurance for working women. The first and most influential international standard that recognized the needs of working mothers emerged from the 1919 *International Labour Organisation Maternity Protection Convention*. This convention laid down such basic principles as a woman's right to maternity leave, nursing breaks, wage compensation, and job protection for its member unions (Heitlinger 1993: 190).

In 1952, the ILO Convention was revised to include a 12-week minimum leave period, including six weeks after the birth. Additional leave was to be provided in cases of pregnancy-related illness, and medical benefits were to be provided by qualified midwives or medical practitioners. Employers could not give notice of dismissal during maternity leave and nursing mothers had to be given work breaks for breastfeeding. The Convention was amended again in 2000 to include 14 weeks leave but the ILO continues to lobby for 18 weeks (ILO 2000b). The European Union Social Charter also provides requires signatory states to provide a minimum of 14 weeks paid maternity leave or social security benefits (Council of Europe 1996, Article 8).

The rationale behind maternity leave arose partially from concern over the health and well-being of children whose mothers were employed. The development of a cash benefit program within the social insurance system reflects the view that maternity contributes to the needs of society as well as those of individual parents and their families. In addition, social insurance for maternity supports the idea that income

loss at maternity is a social risk and that society as a whole should provide protection against such loss (Kammerman and Kahn 1989).

Gender-specific maternal leave policies assume that childbirth is a physical ordeal requiring preparation and recuperation for women. Protective legislation is needed to prevent risks to the unborn foetus and to the health and well-being of the pregnant woman. In addition, maternity benefits are often viewed as a form of employment equity, to allow women equal opportunity in the workforce rather than penalizing them when they become pregnant. Finally, maternity leave and benefits can be used as an inducement to reproduce by ensuring that employed women do not respond to the difficulties of combining work and childrearing by choosing to remain childless.

Gender-neutral parental benefits incorporate some concerns about childbirth but also emphasize the processes of nurturing and bonding. The philosophy behind parental leave is that fathers should be encouraged to be present during childbirth, to bond with their newborn infants, and to participate in their daily care. Childbirth leave and benefits directed only to mothers could discourage employers from hiring women of childbearing age, discourage gender equality, and discriminate against men who want to care for their newborn infants. Political pressure, especially from legal reformers and fathers' rights groups, has required many jurisdictions to ensure that program eligibility is gender-neutral. In Canada, for example, the right to parental leave and benefits was fought on the principle of gender equality or equal rights for biological and adoptive fathers (Baker and Tippin 1999).

With growing unemployment rates, some jurisdictions have also extended unpaid parental and childrearing leave as a way of reducing unemployment, sharing jobs, and creating temporary positions for unemployed workers. However, lone

mothers and low-income parents can seldom afford to take advantage of unpaid leave or leave on half wages. Furthermore, fathers are far less likely than mothers to take parental leave even when wages are replaced (Haas 1990, Beaujot 2000), suggesting that long-term leave (whether paid or not) could perpetuate a gendered division of labour.

Some states continue to view pregnancy and childbirth as a private family matter that is of little concern to either employers or the state. Proponents of this laissez-faire view argue that asking employers to share the expense of childbirth leave and benefits would be too costly and would encourage discrimination against female employees. Employed women might also increase their fertility and work hours simply to take advantage of access to maternity benefits, causing extra expenses and disruptions for employers. If the state were to provide such benefits, taxes would rise significantly. Such arguments have prevailed in the United States where, despite high levels of lone parent households, high fertility rates, and moderately high female employment rates, the federal government has created no national program of maternity or parental benefits. Instead, unpaid leave is provided by the 1993 *Family and Medical Leave Act* and individual states, employers, professional associations and trade unions are left to decide whether or not to offer paid leave (Baker 1995: 179). Similar arguments prevented paid parental benefits from being established earlier in New Zealand (Baker 2001).

Shelley Phipps (2000) examined Canadian micro data from 1988 to 1990 to test some of the assumptions behind the laissez-faire position and to address concerns about the 1997 changes in eligibility rules for Employment Insurance. Until 1997, applicants for Canadian maternity/parental benefits under the Unemployment Insurance Program required 20 weeks of paid employment with at least 15 hours per

week or minimum weekly wages. The switch to Employment Insurance means that applicants now require 700 hours of paid employment with no minimum earnings. She concluded that fertility behaviour was not significantly influenced by the availability of maternity and parental benefits. Second, there is no evidence that women adjusted their labour supply behaviour in order to gain access to such benefits. Furthermore, teenage mothers, women with little education, and those experiencing difficulty in the labour market are less likely to be eligible for these benefits. She used these conclusions to argue that governments should ease access to maternity and parental benefits.

Supra-national organisations such as the International Labour Organisation and the European Union have tried to encourage member states to develop minimum standards of employment benefits, including maternity and parental benefits (Hantrais 2000). Table 2 presents leave and benefits entitlements in a number of OECD countries, showing that some countries do not guarantee any paid leave at childbirth (USA) while others offer nearly a year and a half (Sweden). Of those that offer paid leave, some provide a low-level flat rate benefit while others replace the entire wage or salary. Furthermore, the underlying structure of the legislation in many countries has remained essentially patriarchal, assuming male work characteristics as the norm. Entitlement is sometimes based on a lengthy work record in standard employment even though many women work on temporary contracts or in part-time positions with fewer than the required hours to qualify (Baker 1995, Chaykowski & Powell 1999, Bashevkin 2002).

(Place Table 2 About Here)

Despite pressure from trans-national organisations, the motivating philosophy behind maternity and parental leave and benefit programs varies considerably among

countries. Various lobby groups and national governments have seen such benefits as a maternal and child health issue, a form of employment equity for women, an inducement to reproduction, a citizenship right for every employee, an expense and aggravation to employers, or as a deterrent to hiring women. The model chosen seems to depend mainly on the political ideology of the government in power and the strength of various advocacy groups, especially feminist groups (Heitlinger 1993, Baker 1997). Despite years of efforts by ILO, some countries such as the United States continue to offer employees no statutory right to social benefits at childbirth.

Child Maltreatment

Another family policy area involving international pressure is the need to protect vulnerable family members. Trans-national organizations such as United Nations have been instrumental in pressuring national governments to clarify the rights and duties of parents, to protect children from abuse and neglect, to offer public education on these issues, and to provide interventions for families in need of assistance. Some of the measures designed to prevent and control child abuse include the appointment of children's ombudspersons, the establishment of children's help-lines, the integration of home visiting services, and closer monitoring of children considered to be at risk. The Council of Europe has launched a campaign to combat all forms of violence and the United Nations Committee on the Rights of the Child provides regular reports on child protection measures within industrialized countries.

The UNICEF Report (2003) on child maltreatment argues that the problem of child abuse and neglect needs to be made more public but should not focus only on children considered to be 'at risk'. The report notes that effective strategies include home visits to all families with young children by a variety of qualified health,

education and social service staff. Finally, UNICEF urges governments to consider that child abuse strategies must address the economic circumstances of parents, as those living in impoverished and stressed conditions are more likely to abuse their children (ibid: 21).

Considerable debate continues about whether the new interventions put in place to deal with child maltreatment have actually reduced it. The UNICEF Report shows that rates of child death from maltreatment have fallen in 14 out of 23 countries but the rate has remained stable in four countries and has actually increased in five countries (UNICEF 2003:9). For non-fatal child abuse, a trend is more difficult to establish because new reporting requirements and intervention programs have increased the visibility of abuse. Some programs might prevent serious maltreatment but others may bring to light maltreatment that was previously covered up or not apparent to officials. The Report concludes that the general decline in child deaths through maltreatment and ‘of undetermined intent’ might suggest that general levels of child abuse have declined in most countries, despite increased reporting. However, the alternative explanation is that advances in emergency and medical services have reduced the child death rate but serious abuse and neglect continues (UNICEF 2003:10).

(Place Table 3 about Here)

Child death rates through maltreatment correlate well with the adult homicide rate and reflect the level of violence prevalent in a society (UNICEF 2003: 11). The report compares child deaths through maltreatment and child deaths through injuries, and finds a weaker correlation but suggest that these are two different measures of care and protection that societies afford to their children. Countries such as the United States and Portugal have high rates on both measures (ibid: 11).

The causes of child maltreatment are difficult to determine but it is clear that most adults who are abused as children do not turn out to be child abusers. However, various factors in people's circumstances accumulate to augment the risk. Child maltreatment is heightened by parents who abuse alcohol and drugs and who live in impoverished and violent homes. Maltreatment contributes to depression, anxiety and hostility in children, as well as certain types of behaviour such as physical inactivity, smoking, alcoholism, drug abuse, risky sexual practices and suicide (UNICEF 2003:19). There is clear evidence of growing concern across industrialised countries about the cost of such behaviours to individuals, families, employers and taxpayers.

Developing a culture of non-violence seems to be an important factor in preventing and reducing child maltreatment. Consequently, some states (such as Sweden in 1979) have banned all physical punishment of children, including by parents, and initiated educational campaigns about alternative forms of punishment. A 1999 Swedish study found that physical punishment and public support for physical punishment have both declined substantially since the 1970s. The reporting of child abuse has increased (as in other countries), but youth drug and alcohol abuse rates and youth crime rates are down. However, these figures have been disputed and challenged by other researchers, indicating the difficulty of measuring the effect of legislation (UNICEF 2003: 24).

Although some welfare states have been proactive and focus on the prevention of family poverty, disharmony, and children's behavioural concerns, others have been content to deal with family-related problems after they are drawn to the attention of authorities. The liberal welfare states generally fit into the second category, where contrary to UN pressure, services are targeted to 'at risk' families who have come to the attention of school teachers, social workers, the police or welfare officers (Baker

1995, Krane 2003). Despite continuing rhetoric about family values and importance of children to the future of the nation, these states continue to promote a residual welfare state.

Discussion and Conclusion

Over the years, trans-national organizations such as the United Nations and the World Health Organisation have consistently pressured national governments to carry out research related to health and family well-being, and to gather basic statistics. In addition, these organizations have encouraged member states to sign international agreements granting citizens access to reproductive and maternal health services, childbirth leave from paid work without jeopardizing job security and income, and children's right to be protected from maltreatment. Some 'rich' countries have refused to sign international conventions on social issues, arguing that it would be too costly to create the necessary institutional infrastructure to ensure that the commitments are kept. Others have signed the agreements but allocated insufficient resources to service delivery or enforcement, and therefore failed to promote family well-being.

As we have seen from these three family policy areas, international conventions and agreements may encourage the convergence of social policies but always leave room for national governments to develop their own initiatives. Identical programs are not the goal but even if it were, enforcement would be difficult. Trans-national lobby groups and organizations exert some influence over national governments in their program reform but the impact of this pressure has been uneven. These organizations have tried to encourage the development of certain family-related policies and programs, especially in those states that are 'welfare laggards', but often with limited success.

The problem is that many other factors influence the reform of family policies and programs besides pressure from trans-national organizations. Neo-liberal restructuring, including the reduction of income taxes, has reduced revenue for family services and income support in some states since the 1990s. Funding decisions have also become decentralised through block grants from higher to lower levels of government, but in some cases this has reduced federal funding to the provinces⁵. Receiving less public money has encouraged local governments to form partnerships with non-government organizations to deliver social services. Although these partnerships could be very effective, they often operate with fewer state resources and rely on voluntary organizations and unpaid family members to provide more complicated services. Furthermore, these new decentralised arrangements are seldom evaluated for their effectiveness.

Labour market restructuring associated with globalisation has augmented the gap between the rich and the poor in many countries, requiring more social services for those edged out of job security. Particularly parents need state assistance when they cannot earn enough income to support their children, which is increasingly the case under neo-liberal labour market conditions. In addition, decentralization shifts responsibilities further downward, under the guise of democratic accountability. As more states privatize caring activities for children, persons with disabilities and the frail elderly, women are expected to perform more unpaid caring work within their families, and this work becomes further devalued. Individual responsibility is stressed, with punishments for parental neglect or lack of supervision (McDaniel 2002).

⁵ When the Canada Assistance Plan ended in 1996, the Canadian government did not continue cost sharing with the provincial governments but rather moved to block funding for social services, health care and tertiary education. This allowed them to reduce federal expenditures (Baker & Tippin 1999).

Governments develop and modify social policies primarily by amending existing laws and programs while keeping in mind their party's political beliefs and responding to domestic political interests. Advocacy groups representing the entire political spectrum lobby for family policy reform. Some argue that changes in family demography require policy reform, or that equity or human rights concerns will be violated without specific policy amendments. Others believe that the state and business interests need to curb the rising costs of social programs and maintain a residual state.

The restructuring of family policies is negotiated within welfare regimes that include well-developed institutional structures and vested interests. Because social policy is typically restructured through incremental changes rather than dramatic reforms, the existing social welfare system establishes the baseline for further restructuring. This augments the challenges of transplanting social programs from one place to another, even with international pressure, unless the jurisdictions involved share similar political culture, social values, and institutional structures. 'Welfare laggards' can successfully resist international pressures by focusing on their right to national autonomy but also by emphasising the differences between their institutions, legal structures and social programs and those of the reformers.

**Table 1:
Fertility and Contraception Statistics for Selected Countries, 1995-
2002**

Country	Total Fertility Rate (1995-2000)	Teenage Births (per women aged 15-19)	% of Married Women using Contraceptives
Canada	1.6	20.2	75
Australia	1.8	18.4	76
New Zealand	2.0	29.8	75
United Kingdom	1.7	30.8	82
United States	2.0	43.0 (2002)	74
Sweden	1.6	6.5	Na
Netherlands	1.5	6.2	79

* % of women of reproductive age (15-49) reporting contraceptive use by themselves or their partner

Sources: Henshaw et al 1999, UN 2000, OECD 2003, US Dept of Health & Human Services 2003.

Table 2:
Maternity Leave Benefits in Selected OECD Countries

Country	Length of Maternity/Parental Leave	Percentage of Wages Paid in Covered Period	Provider of Coverage
Australia	1 year	0	--
Canada (2004)	15 weeks maternity + 35 weeks parental	55% to a ceiling	Social insurance (employment insurance)
Denmark	18 weeks maternity and 10 additional weeks parental	100% to a ceiling	Social security
France	16-26 weeks	100%	Social security
Germany	14 weeks	100%	Social security to ceiling and employer pays difference
Japan	14 weeks	60%	Social security or health insurance
New Zealand (2004)	12 weeks parental	Flat rate	Social security
Norway	18 weeks maternity + 26 weeks parental	100%	Social security
Sweden	450 days parental	360 days at 100% and 90 days at flat rate	Social security
United Kingdom	14-18 weeks	90% for 6 weeks, flat rate thereafter	Social Security
United States	12 weeks	0	--

Source: Updated version of United Nations. 2000. *The World's Women 2000*. NY: United Nations. P. 142-3.

Table 3
Child Maltreatment Deaths for Selected Countries

Country	Average # of Deaths over 5 Year Period Per 100,00 Children under 15 years
Spain	0.1
Italy	0.2
Norway	0.3
Sweden	0.6
Australia	0.8
Denmark	0.8
United Kingdom	0.9
Canada	1.0
New Zealand	1.3
United States	2.4
Portugal	3.7

Source: UNICEF. 2003. *A League Table of Child Maltreatment Deaths in Rich Nations*. Innocenti Report Card #5. Florence: UNICEF: 4.

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