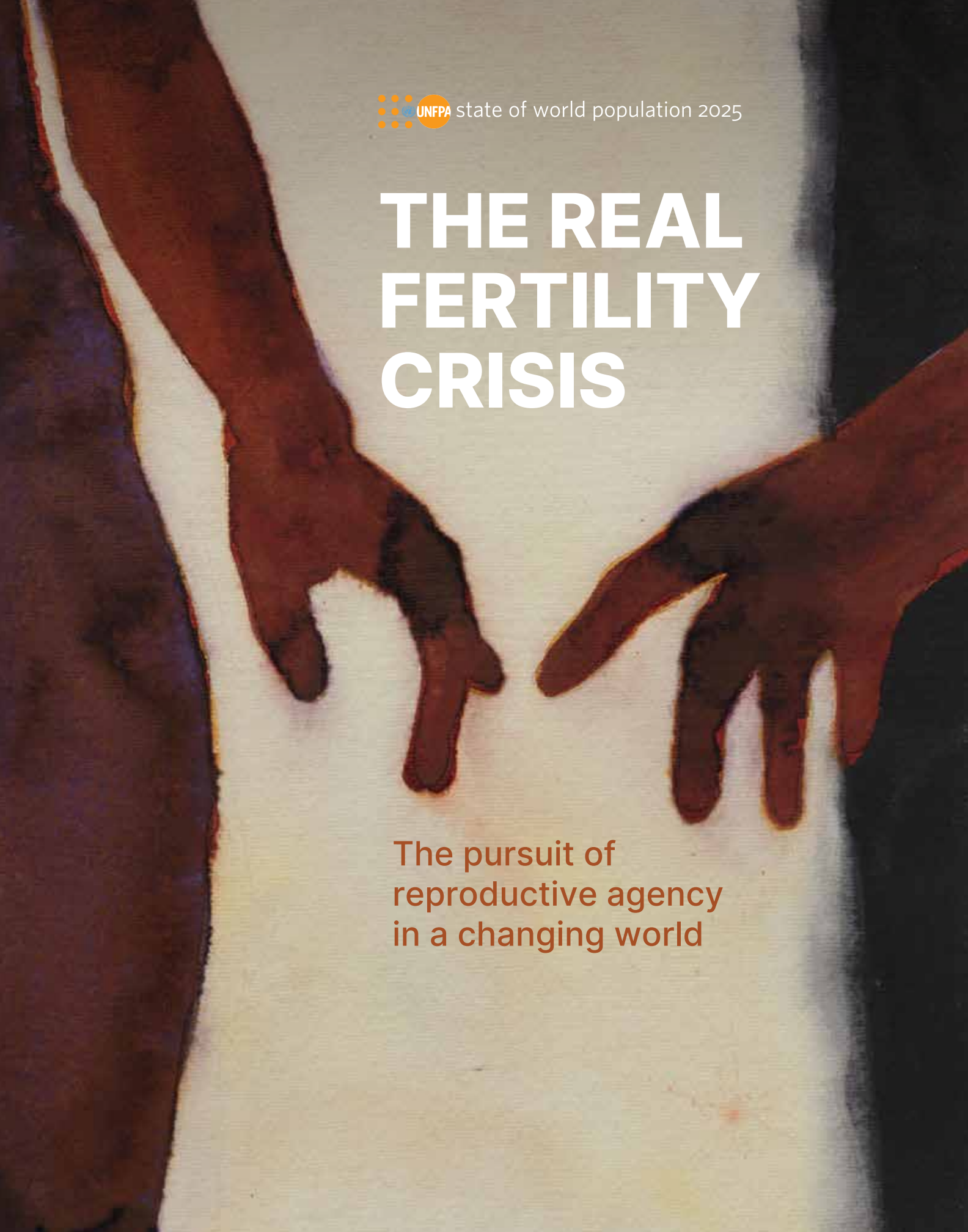

UNFPA state of world population 2025

THE REAL FERTILITY CRISIS

The pursuit of reproductive agency in a changing world

State of World Population 2025

This report was developed under the auspices of the UNFPA Division for External Relations.

EDITOR-IN-CHIEF
Ian McFarlane

EDITORIAL TEAM
Senior editor: Rebecca Zerzan
Production editor/creative direction: Katherine Black
Features editor: Richard Kollodge
Features writers: Leyla Alyanak, Richard Kollodge, Daisy Leoncio
Editorial guidance: Jacqueline Daldin, Lisa Ratcliffe
Digital edition manager: Katherine Black
Digital edition advisers: Enes Champo and Nahema Patwari

SENIOR EXTERNAL ADVISER
Shalini Randeria

RESEARCHERS AND WRITERS
Amanda Chatata, Nyovani Madise, Monika Mynarska, Anita Raj, Agnese Vitali, Rebecca Zerzan

IN FOCUS AUTHORS
Vladimíra Kantorová, Sunhye Kim, Ying-Yi Lin, Michelle O'Brien, Dr. Friday Okonofua, Elizabeth Root, Siqi Wu and Marita Zimmerman

UNFPA LEAD TECHNICAL ADVISERS
Emilie Filmer-Wilson and Elizabeth Wilkins

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The designations employed and the presentation of material in maps do not imply the expression of any opinion whatsoever on the part of UNFPA concerning the legal status of any country, territory, city or area or its authorities, or concerning the delimitation of its frontiers or boundaries.

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A NOTE ON ART
This year's *State of World Population* report incorporates the work of watercolour artists Graham Dean, Marianna Gefen, Cyan Haribhai and Stina Persson. Their layered, fluid visuals capture the ambivalence and uncertainty many people feel when confronting choices about their fertility in today's changing world. The front cover is a piece called *About to Touch* by artist Graham Dean.

UNFPA

Ensuring rights and choices for all


UNFPA state of world population 2025
THE REAL FERTILITY CRISIS
The pursuit of reproductive agency in a changing world

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FOREWORD

With this report, we shine a much-needed light on the individual realities of vast numbers of people who are unable to create the families they want.

We asked people – across 14 countries, which together represent more than a third of the global population – what they actually want for their reproductive lives and futures, and whether they believe they will be able to realize those ambitions. What we find is that too few people are able to exercise true choice when it comes to some of the most intimate and consequential decisions in their lives.

Our human population is the subject of growing interest – and intensifying anxiety. The concerns that draw most attention are declining fertility rates, ageing and workforce shortages, while many still argue that the greatest threat to the planet is overpopulation.

Yet whatever the concern, one factor continues to be largely omitted from the public discourse: what people themselves want for their fertility, families and futures.

It is often assumed or implied that fertility rates are the result of free choice. Unfortunately, that is not the whole picture.

Recent *State of World Population* reports have brought to light a number of concerning findings: that roughly half of all pregnancies are unintended; that public rhetoric around population size and fertility rates is driving fear, which can be, and has been, used to fuel ethnonationalism and undermine reproductive rights; and that, despite significant advances in sexual and reproductive health and rights, the most marginalized people have experienced the fewest gains. Data published by UNFPA over the past five years also show that about one in ten women are unable to decide whether to use contraception. Roughly one quarter of women are unable to make decisions about their own healthcare. And roughly one quarter of women are unable to say no to sex.

Millions and millions of people still, therefore, cannot exercise their reproductive rights and choices. This inability of individuals to realize their desired fertility goals is the real fertility crisis – not overpopulation or underpopulation – and we see it everywhere we look.

The research conducted for this report finds that barriers to avoiding an unintended pregnancy and barriers to starting a family are often ultimately the same: economic precarity, gender discrimination, lack of support from partners and communities, low-quality sexual and reproductive healthcare, lack of access to services like affordable childcare or education, and pessimism about the future.

We find that when we ask the right questions, we can see both the problem and solution clearly. The answer lies in reproductive agency, a person's ability to make free and informed choices about sex, contraception and starting a family – if, when and with whom they want.

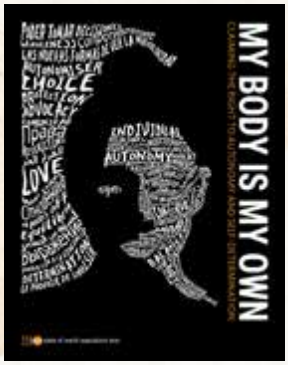
Reproductive agency is more than just freedom from coercion or improved access to services, it is the full range of conditions that enable people to exercise their reproductive rights and ensure true choice, including gender equality, economic stability, decent health and confidence in the future.

These conditions are still out of reach for far too many people. In response, all of us, including policymakers, should ask what people want and need – not as an afterthought, but as the first and most important inquiry when considering population issues. Policies should respond directly to these concerns. This includes ensuring the full range of reproductive health and rights for all people; providing consistent, long-term support to parents and families; and ending gender-based violence and the gender-discriminatory norms that undermine people's fertility ambitions.

Let's create the circumstances where people who deeply want to experience the joys and rewards of parenting can meet their fertility goals, where they have hope for a better tomorrow that is supportive of their choices and protective of their rights, one where their children, and their children's children, can thrive. We hope this report sparks a much-needed discussion and action to advance those rights and choices.

Dr. Natalia Kanem
Executive Director
United Nations Population Fund

Recent UNFPA *State of World Population* reports examine the state of bodily autonomy and reproductive choice across the globe.



GLOSSARY

The language used to speak about fertility trends is often fraught. Policymakers and media should avoid alarmism in their choice of words, particularly in our current age of disinformation. While many of the terms referenced in this report are commonly used, it is important to remember that they do not refer to abstract concepts, but to human lives. This report uses the following terms with the meanings below; these are not always technical terms, and do not always have consistent definitions. The descriptions below are not meant to be prescriptive but to help readers understand the ideas in the report.

Adolescent birth rate: Adolescent birth rate measures the annual number of births to girls or women aged 15–19 per 1,000 women in that age group; it measures the risk of childbearing among women aged 15–19. (Where data are available, adolescent birth rate can and should also be calculated for girls aged 10–14.)

Antinatalist: Policies or practices that encourage a lower birth rate, discourage procreation or promote fewer children (Population Reference Bureau, 2025). "Antinatalism" can also be used as a noun to refer to the belief that having children is morally problematic (Morioka, 2021). This term is avoided where possible in this report, as it is used so variably that it fails to communicate clearly.

Demographic anxiety: Fear or concern, whether founded or unfounded, related to population trends, including population size, population change, migration or fertility rates.

Demographic change: Shifts in a population's size and structure resulting from changes in fertility, mortality and migration patterns.

Demographic diversity: A term used to refer to the diversity of countries' demographic profiles and trends, e.g., the fact that in the world today, some countries have high fertility and their populations are growing whereas others have low fertility and their populations are shrinking.

Demographic resilience: The capacity of a country to anticipate, adapt to and take advantage of demographic changes within a human rights framework.

Fertility aspirations: The reproductive goals or hopes of a given individual, couple or family.

Fertility targets: Fertility measures such as changes in the number of births, birth rates or fertility rates that are the goal of any given population policy. This report uses the term "fertility targets" to refer to state policies and does not recommend such objectives.

Fertility transition: The process by which fertility rates have decreased from high levels to lower levels. This process began in the 19th Century in Europe and in the 20th Century in Asia and Latin America, where demographic transitions are still underway. Population growth continues in Africa, largely due to rapid declines in death rates.

High fertility: In this report, "high fertility" is not used in reference to any fixed fertility rate, but in a comparative sense. United Nations definitions of high fertility have varied based on context, sometimes meaning more than 3.2 children per woman (UN DESA, 2014), more than 3.5 children per woman (UN DESA, 2017) or more than the projected replacement-level fertility rate in a given country.

Low fertility: Similarly, "low fertility" is used in a comparative sense, rather than to refer to a specific fertility rate. In this report, "low fertility" is not used in reference to any fixed fertility rate, but in a comparative sense. Generally, the term is used to describe total fertility rates at or below 2.1 children per woman – rates that do not lead to long-term population growth. The report recognizes that perceptions of what constitutes low fertility are subjective.

Overachieved fertility: A situation in which a person has more children than they desire.

Overpopulation: While there is no agreed technical definition, this term is commonly used to describe population numbers that cannot be supported by available resources. It can be used to express concern about rising birth rates or immigration trends, and often assumes there is an ideal fertility rate or population size, ideas not recommended by this report.

Population control: The practice of intentionally controlling the growth, size or distribution of a human population. The term is often associated with measures that violate human rights.

Population policies: Policies concerning a range of population issues, including population size and growth, reproductive health and family planning, population distribution by age, fertility and marriage, spatial distribution and urbanization, health and mortality, and internal and international migration.

Population targets: Numbers or number ranges of people that are the goal of any given population policy.

Pronatalist: Policies or practices that encourage a higher birth rate (Population Reference Bureau, 2025). "Pronatalist" can also be used to refer to advocates of policies or practices that promote an increased birth rate. Some use this term to specifically refer to "cultural and institutional forces that compel reproduction" (Bajaj and others, 2023). This term is avoided where possible in this report, as it is used so variably that it fails to communicate clearly.

Replacement-level fertility: The benchmark used by demographers to represent the average number of children a woman needs to have to maintain a stable population size – typically around 2.1 children per woman (Population Reference Bureau, 2025). The exact fertility rate that ensures the replacement of a generation varies across countries, as it is also affected by other factors such as the mortality rate, migration and the sex ratio at birth.

Reproductive agency: The capacity to exercise informed, empowered decision-making over one's reproduction. This capacity requires more than an ability to say yes or no; it requires an enabling environment in which individuals and couples can make choices unfettered by legal, political, economic and normative constraints. It is a fundamental aspect of bodily autonomy, self-determination and human rights; international human rights frameworks recognize reproductive agency as essential for gender equality and the empowerment of women and girls.

Reproductive autonomy: The power to make choices about one's own body, sexuality and fertility without fear of violence or coercion.

Reproductive coercion: Any measure or behaviour that interferes with a person's autonomous decision-making over their reproductive health.

Reproductive rights: The internationally recognized basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health (UNFPA, 2014).

Sexual and reproductive health and rights: This encompasses a comprehensive and integrated set of sexual and reproductive health services and information required to attain the highest standards of health and human rights for all people. These interventions include not only prevention of unintended pregnancy, protection against gender-based violence and access to accurate information, but also treatment of infertility and reproductive cancers, counselling and care related to sexual function and satisfaction, care for people irrespective of their sexual orientation or gender identity, and care in all settings, including humanitarian crises (Tedros and Kanem, 2018).

Sub-replacement fertility: A total fertility rate below 2.1, the average number of children per woman needed to maintain a population from one generation to the next – assuming low mortality and no significant migration or skewed sex ratio at birth.

Tempo effect: A demographic term that refers to changes in the timing of childbearing among various demographic groups and the impact of such changes on the (period) total fertility rate (MPIDR, 2025). An overall increase in the age at which women have children, for example, may result in fewer births in the current year, therefore decreasing the total fertility rate for the period even if the number of children that women have during their life course does not change.

Tempo- and parity-adjusted total fertility rate: A variant of the total fertility rate that accounts for the tempo (timing) and parity (the number of pregnancies a woman has carried to at least 20 weeks' gestation) of births. The measure is intended to provide a more nuanced picture of fertility trends over time, particularly as a society's childbearing norms (such as having children later in life) evolve.

Total fertility rate: Unless otherwise stated, the total fertility rate refers to the period total fertility rate – the average number of children a woman would have if she were to live to the end of her reproductive life and give birth to children in alignment with the age-specific fertility rates of a given period (Population Reference Bureau, 2025).

Underachieved fertility: A situation in which a person has fewer children than they desire.

YOUTH TESTIMONIALS*

I want children, but it's becoming more difficult as time passes by. It is impossible to buy or have affordable rent in my city. I also would not like to give birth to a child in war times and worsened planetary conditions if that means the baby would suffer because of it.

– Anonymous, female, 29, Mexico

I have one child but don't plan on having any more. I am unable to do so due to financial instability, precarious employment, unaffordable housing, and the high cost of childcare and education.

– Anonymous, female, 29, Zambia

Bringing a child into the world is only one step. The real challenge is raising them. And for a favourable upbringing, there must be a good environment and adequate infrastructure.

– Anonymous, male, 30, Paraguay

* See technical note on page 143

Artwork by Marianna Gefen

The future feels bleak despite the measures being taken by the government. Moreover, a lot of policies worldwide are against women's healthcare. I feel that this pushes us to stay single and have no children.

– Anonymous, female, 31, Philippines

Finding the right partner is important because I believe that raising a child should be a shared responsibility with emotional and financial support from both parents.

– Anonymous, female, 18, India

Before I bring a child into this world, I have to fight for the right to do so on my own terms – for same-sex marriage, for surrogacy, for adoption rights and parental recognition where I am from. Because this isn't just my fight. It's the fight of billions of young people trapped in systems that deny them the rights and dignity they deserve.

– Roman, male, 26, Azerbaijan

There are enough resources on Earth to sustain everyone and more, they are just distributed terribly, which is something we as a society should be working on extensively. I believe we will be able to do this, which will provide me the privilege of having a child without remorse.

– Ilian Sales Segarra, 24, Belgium

Artwork by Stina Persson

CHAPTER 1

Revealing the real crisis

The world is transforming at a breathtaking scale and pace: Global fertility rates are declining. The human population is projected to reach its crest within the century and then to fall (UN DESA, 2024). One in four people currently live in a country where the population size is estimated to have already peaked. The result will be societies as we have never seen them before: Communities with larger proportions of older persons, smaller shares of young people, and, possibly, smaller workforces.

These tectonic population changes will shape the future of humanity for generations to come – yet they follow another monumental demographic change that occurred within living memory: a spike in the pace of population growth that started in the 20th Century. Annual live births climbed sharply, reaching more than 120 million in the 1970s (UN DESA, 2021), part of a so-called "fertility boom" observed in much of the world (Reher and Requena, 2015). It would be wise to understand today's demographic changes within this recent historical context, which provoked widespread anxiety and led to many policies that resulted in harmful consequences and rights violations (Hartmann, 2016; Ehrlich and Ehrlich, 1968) – outcomes that can and must be avoided this time around.

In fact, our current world is one of great demographic diversity – some countries continue to experience high fertility rates while others have declining fertility, for example; some have high rates of immigration, others high rates of emigration. Diversity of demographic profiles exists within countries as well. Additionally, the world's current configuration is the foreseeable consequence of long-standing trends. "Decades ago, countries had the data to know that their populations would be ageing... There is no reason for population ageing to come as a surprise today," demographers note (UNFPA, 2024). What should be most startling, then, is not the speed at which the world is changing, but our collective resistance to navigating these changes with preparation and circumspection.

Rather than addressing this trend with foresight and nuance, we are seeing echoes of last century's dread. Almost everywhere, headlines are forecasting collapsing pensions systems (Constance, 2024), shrinking electorates (Shankar, 2024), rising ethnic tensions (Rajesh, 2024) and irreversible human "depopulation" (Eberstadt, 2024), even as concerns about "overpopulation" persist (Maynard and Seager, 2022).

Yet new research by UNFPA highlights that there is, in fact, a very real crisis taking place – a crisis that requires urgent action, but often *different* actions than those currently being implemented. It is a crisis in reproductive agency – in the ability of individuals to make their own free, informed and unfettered choices about everything from having sex to using contraception to starting a family.

Reproductive agency requires not just the ability to say yes or no, not just the right to be free of coercion; it requires a full range of conditions that enable people to exercise true choice. By focusing on the enabling political, legal and social environment that empowers individuals to make these decisions, reproductive agency offers a pathway towards the full realization of reproductive rights.

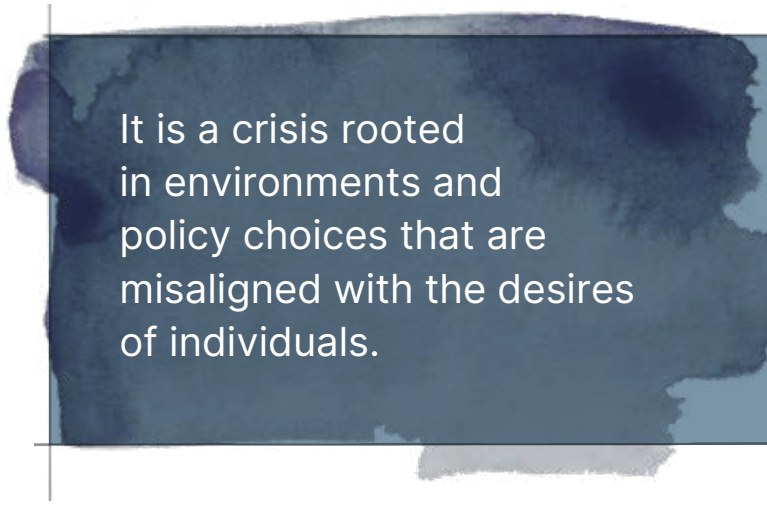
The real crisis

Original research for this report, by UNFPA and the international polling firm YouGov, finds that very high proportions of men and women – in every country surveyed, in every region of the world – are unable to realize their fertility aspirations. Rates of unintended pregnancy are persistently high across regions, as are difficulties having the number of children respondents desire. Both overachieved fertility aspirations, in which people have more children than they believe ideal, *and* underachieved fertility aspirations, in which they have fewer children than they desire, are pervasive.

In other words, conversations, policies and solutions must shift away from alarmism over "population explosion" and "population collapse" and towards the real-world concerns of individuals making profoundly consequential, deeply intimate choices about their bodies, families and futures. This crisis is not rooted in individual reproductive decisions that fail to align with the needs of a state or economy. Rather it is a crisis rooted in environments and policy choices that are misaligned with the desires of individuals, which have failed to create the economic security and personal empowerment that people say are preconditions for realizing their family formation goals – whether that goal is to have many children, few children or none at all.

This crisis does, indeed, require policy interventions – but not policies designed to induce people to use contraception (Hartmann, 2016) or to discourage them from doing so (Tenbarge, 2023), nor policies that promote childbearing (Pavlova and Guy, 2022) or incentivize small families (Hayre, 2024). In fact, policies to decrease fertility rates may do little, and can in extreme cases cause harm (Li and Miller, 2000), while most efforts to boost fertility rates seem to have little long-term impact, and could even backfire (Botev, 2015). Rather, the solution requires a fundamentally different approach: to greatly increase global investments in advancing reproductive autonomy, irrespective of a country's fertility rate. This means enabling all people, men and women, to make these decisions for themselves, and under the enabling conditions they demand.

The fulfillment of individuals' reproductive rights and fertility desires would have far-reaching impacts, most notably for the health and well-being of people and their families. But there would also be significant gains for communities and countries from reducing the economic costs associated with unintended pregnancy, especially among adolescents (see box on page 44), to minimizing the significant health-system costs of unsafe abortion (Sully and others, 2020), to realizing the labour-force participation of future generations born in secure socioeconomic conditions supportive of their families.



Artwork by Stina Persson

How common — or uncommon — are unfulfilled fertility aspirations?

In preparation for this report, UNFPA and YouGov conducted an online survey of more than 14,000 adults, both men and women, across 14 countries that together are home to more than 37 per cent of the global population. The survey sought to learn about the fertility aspirations and achievements of individuals, and to understand the challenges they experienced, if any. The results were eye-opening, not only in how frequently people's fertility aspirations go unfulfilled but also in how often they face barriers to both preventing pregnancy and becoming pregnant.

Across every country, the most common number of children desired was two. But every country surveyed had significant proportions of people who reported having to revise their intended family size during their life course, and those revisions took place in both directions – some changed their plans to accommodate fewer children, and some changed their plans to accommodate more. Almost one fifth of reproductive-age adults (18 per cent) believed they would be unable to have the number of children they desired: 11 per cent believed they would have fewer children than they would ideally choose, while 7 per cent believed they would have more. (Some 37 per cent said they expected to meet their ideal number, and 45 per cent did not know or did not want to say.)

Responses were also collected from people aged 50 and older, whose reproductive lives are assumed to be completed. From these

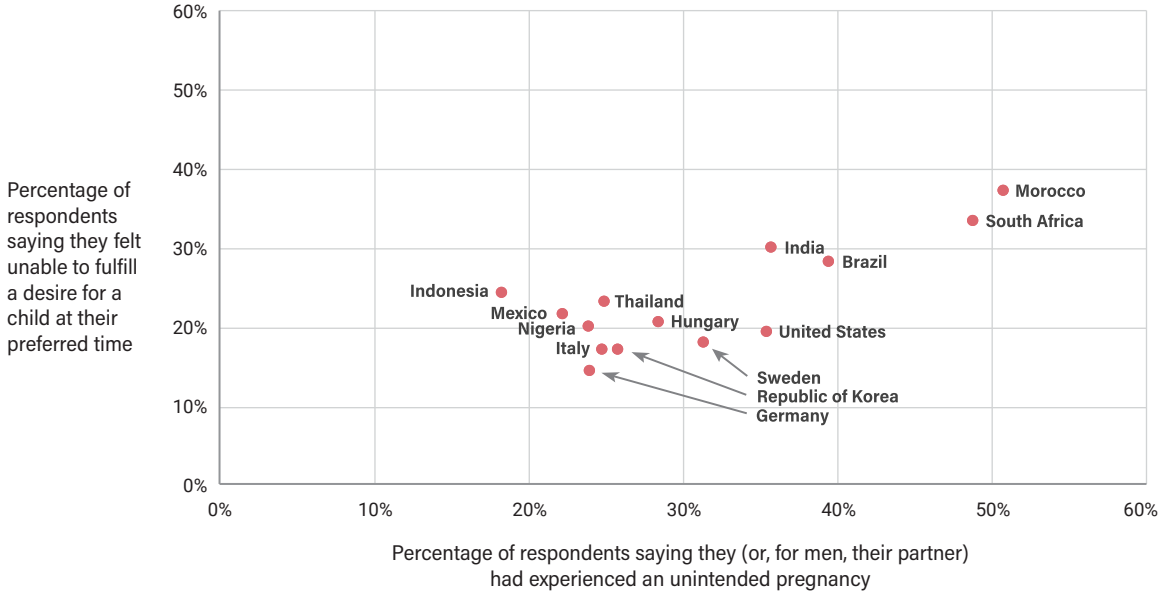
individuals, we see a portrait of people's actual realized fertility – and it commonly does not match their ideals. In this group, 31 per cent reported having fewer children than they ideally would have chosen, and 12 per cent reported having more. (In this age group, 38 per cent said they had achieved their ideal number and 19 per cent said they did not know or did not want to say.)

When asking respondents of all ages about their experiences, nearly 1 in 3 (32 per cent) said they or their partner had experienced an unintended pregnancy. Nearly 1 in 4 respondents (23 per cent) had experienced a time when they desired a child but felt unable to fulfil the desire at the preferred time – and of these, more than 40 per cent said they ultimately had to forgo their desire to have a child. Alarmingly, almost 13 per cent of respondents had experienced *both* an unintended pregnancy *and* barriers to having a desired child (and in some countries this figure was upwards of 20 per cent), indicating systems and environments are failing to support individuals' reproductive decision-making (see Figure 1).

In other words, everywhere we look, people are struggling to freely realize their reproductive aspirations. People who over-realized their desired fertility and people who under-realized it were present in countries with both high and low fertility rates, indicating that barriers to achieving one's ideal family are ubiquitous.

FIGURE 1

Unintended pregnancy and challenges having children



In all countries surveyed by UNFPA/YouGov, respondents experienced difficulty preventing unintended pregnancy and becoming pregnant at the timing they desired.

Source: UNFPA/YouGov Survey

FIGURE 2

Barriers to having children

Survey responses to the question: "In your personal situation, what factors have led or are likely to lead you to have fewer children than you initially desired?"

	Health			Economic			
Countries listed from low to high total fertility	Infertility or difficulty conceiving	Barriers to fertility or pregnancy-related medical care	Poor general health or chronic illnesses	Financial limitations	Housing limitations (e.g., lack of space, high house prices/rent costs)	Lack of sufficient/ quality childcare options	Unemployment/ job insecurity
Republic of Korea	12%	6%	11%	58%	31%	28%	26%
Thailand	19%	10%	17%	51%	21%	17%	33%
Italy	15%	6%	13%	29%	14%	12%	30%
Hungary	10%	4%	8%	34%	20%	11%	16%
Germany	11%	3%	10%	25%	18%	12%	10%
Sweden	10%	3%	9%	19%	6%	3%	5%
Brazil	8%	7%	13%	39%	18%	8%	26%
Mexico	8%	7%	8%	35%	23%	14%	21%
US	16%	8%	12%	38%	15%	12%	17%
India	13%	14%	15%	38%	22%	18%	21%
Indonesia	6%	9%	10%	39%	22%	6%	20%
Morocco	10%	4%	19%	47%	20%	11%	15%
South Africa	15%	8%	13%	53%	17%	9%	33%
Nigeria	14%	11%	13%	32%	14%	17%	16%
All countries average	**12%**	**7%**	**12%**	**39%**	**19%**	**12%**	**21%**

	Desires changed/ influenced		Concerns over future		Other factors		
	Change of heart (deciding I want fewer children)	My partner wanting fewer children	Concerns about political or social situation (e.g., wars, pandemics)	Concerns about climate change or environmental degradation	Lack of a (suitable) partner	Insufficient involvement of my partner in housework/ childcare	Pressure or force from the doctors or health workers resulting in having fewer children
Republic of Korea	14%	13%	8%	8%	10%	19%	3%
Thailand	12%	9%	23%	18%	25%	11%	6%
Italy	7%	11%	19%	11%	17%	8%	1%
Hungary	9%	8%	10%	4%	17%	5%	4%
Germany	11%	11%	13%	9%	15%	8%	2%
Sweden	4%	9%	6%	4%	17%	5%	4%
Brazil	18%	12%	21%	11%	15%	8%	5%
Mexico	12%	8%	21%	14%	16%	8%	5%
US	12%	19%	11%	7%	18%	11%	6%
India	17%	19%	14%	16%	12%	15%	14%
Indonesia	19%	17%	14%	9%	4%	16%	7%
Morocco	8%	17%	8%	4%	9%	13%	4%
South Africa	17%	18%	15%	9%	18%	9%	5%
Nigeria	17%	19%	12%	10%	9%	10%	8%
All countries average	**13%**	**13%**	**14%**	**9%**	**14%**	**11%**	**5%**

The respondents were given 14 possible factors but could also provide their own. A small number of people added additional factors, which included miscarriage or death of a child; inability to have a child after difficult pregnancy; sexual orientation; and God's will (in Indonesia).

Note: This question was not asked of respondents who indicated that their ideal number of children is zero. Because respondents could select multiple factors, the percentages will not sum to 100 per cent. The percentages used elsewhere in this report to describe overall categories of barriers ("health", "economics", "concerns over the future", etc.) have been calculated to avoid double-counting respondents who selected multiple barriers within one category.

Source: UNFPA/YouGov Survey.

Why are survey respondents not having the family sizes they desire? The reasons are wide-ranging, but the greatest barrier by far was economic. Out of 10,000 people who reported having or wanting to have children, 39 per cent reported that financial limitations were a factor that had affected or would affect their ability to realize their desired family size (see Figure 2). The second most commonly reported factor, at 21 per cent, was unemployment or job insecurity.

From "population explosion" to "population collapse"

The last century saw major advances in healthcare and development, propelling the largest population expansion in human history – one broadly viewed as a "population bomb" when it came to people in the Global South. A variety of anxieties took hold, ranging from concerns that overpopulation would stymie development and increase poverty, to the assumption that famine and mass death were unavoidable. Many leaders and advisers, especially those in developed countries, predicted a "race to oblivion" unless measures were implemented to control women's fertility (Ehrlich and Ehrlich, 1968) – too often through practices such as coerced use of contraception and forced sterilization or abortion (Hartmann, 2016).

Hindsight offers a more neutral account of this period and its impacts: The number of people sharing our planet has more than tripled since 1950, while over that same period, the average fertility rate per woman has declined from 5 in 1950 to 2.25 (UN DESA, 2024). It is expected to reach 2.1 – the so-called "replacement rate" (see terms on pages 6–7) – by 2050. Unlike the vertiginous population declines that take place during wars or epidemics, these shifts have been gradual and in many ways deliberate, a result of progress in both life-extending and contraceptive medicine, among other advances.

In fact, not all countries have expressed alarm over fertility rates in the same way. In Latin America, for example, demographic concerns are less related to rising or falling birth rates and more likely to focus on diverse demographic trends within countries, where inequalities and structural barriers can influence whether, when and how people choose to have children.

Still, countries' demands for assistance "in dealing with their population problems" (UNFPA, 1994) – however those problems are defined by each country – have never disappeared. Nor, for that matter, have the ethnonationalist views that drove, and continue to drive, much anxiety around both migration and sexual and reproductive health. Rather than support efforts to engineer population size or composition, UNFPA advocates for demographic resilience, an approach that embeds population policies – including those pertaining to migration and sexual and reproductive health, as well as other issues like human capital development – firmly within a human rights framework. While rights-based migration is a key consideration, this report focuses on the sexual and reproductive health and rights aspects of population issues, which are at the heart of UNFPA's mandate.

The third, at 19 per cent, was housing concerns, such as lack of space or high cost.

When the factors were classified into broad categories – e.g., health issues, economic concerns, fears about the future, and lack of a supportive partner or absence of any partner – more than half the respondents indicated economic barriers were impacting their ability to have the number of children they desired. About 1 in 4 (24 per cent) respondents cited health issues (including difficulty conceiving, barriers to fertility or pregnancy care, and general poor health). Nearly 1 in 5 (19 per cent) said fears about the future – climate change, environmental degradation, wars, pandemics or similar – would lead or had led them to have fewer children than desired.

Partnership issues also played a clear role – 14 per cent of respondents said that the lack of a partner, or a suitable partner, had led or would lead to them having fewer children than desired. More than 10 per cent said their partner's insufficient involvement in housework or childcare had led or would lead to this outcome. Respondents under the age of 40 were more likely than those aged over 40 to cite the unequal division of domestic labour as a factor leading to the underachievement of their fertility goals (12 per cent compared with 9 per cent), perhaps indicating a generational change in expectations, and women were nearly twice as likely as men (13 per cent compared with 8 per cent) to report this as a barrier to reaching their desired number of children. (See Chapter 3 for more on how gender and social norms contribute to fertility aspiration and achievement.)

When respondents were asked what factors had led or would likely lead to their having *more* children than ideally desired, the most common response, 21 per cent, was improvement in economic conditions, followed by one's partner desiring a child (or more children) and change of heart, both 14 per cent. Why would improved economic conditions lead to people having more children than ideally desired? This is open to interpretation; some but not all respondents who said changing economic conditions would lead to overachieving their fertility aspirations *also* indicated they might have a change of heart over the number of children they desire. It's possible that economic improvements could make people more open to having a child or more children; it's also possible that people may experience heightened social or partner pressure to have more children than they desire (or to proceed with unintended pregnancies they might otherwise terminate) if they are unable to use economic conditions as a reason for limiting their family size.

Artwork by Cyan Haribhai

FEATURE

One family, three generations and evolving views about childbearing in India

India is now the world's most populous nation, with nearly 1.5 billion people – a number expected to grow to about 1.7 billion before it begins falling, around 40 years from now (UN DESA, 2024). Behind these numbers are the stories of millions of couples who decided to start or expand their families, as well as the stories of women who had few choices about whether, when or how often they became pregnant.

In 1960, when India's population was about 436 million, the average woman had nearly six children. Back then, women had less control over their bodies and lives than they do today. Fewer than 1 in 4 used some form of contraception (UN DESA, 2024), and fewer than 1 in 2 had attended primary school (World Bank Data, 2020).

But in the years that followed, educational attainment increased, access to reproductive healthcare improved, and more women gained a voice in the decisions that affected their lives. The average woman in India now has about two children (UN DESA, 2024). While women in India, and every other country, have more rights and choices today than their mothers or grandmothers did, they still have a long way to go before they are empowered to have the number of children they want – if any – when they want them.

Three generations of women from the Devi family in Bihar highlight just how much has changed in India over the past 65 years, and how this is affecting fertility aspirations.

Saraswati Devi, age 64

In 1976, Saraswati Devi was married at age 16. By the time she was 30, she had given birth to five sons. All the other women in her village had about that many children. If women had fewer, people thought they were sick, Saraswati recalls.

That was a time when large families were seen as both a blessing and an economic necessity. Having children then was considered "God's gift", she says. "My mother-in-law always said, 'The more children you have, the more hands there are to work in the fields.'"

Conversations around pregnancy spacing or limiting family size were rare. "We didn't know about contraceptives back then," she says. "We didn't know how to delay or prevent pregnancies, and we were too afraid to ask." Pressure from friends, neighbours and especially her mother-in-law had an outsized influence on how many children she had, Saraswati says. "When I wanted to stop having children, my mother-in-law insisted that I continue, and I could not disobey her."

If she could do it all over again, Saraswati says she would have had fewer children.

Anita Devi, age 42

Anita Devi, Saraswati's daughter-in-law, married at 18 in the late 1990s. Unlike her mother-in-law, Anita knew about and could have obtained family planning from the health workers who visited her village. Nevertheless, she ended up having six children; four daughters and two sons. "My husband and mother-in-law wanted more children, especially a son," Anita says. "I felt exhausted, but I had little say in the matter."

She adds, "I initially wanted only one or two children, just one girl and one boy. We are poor, and raising a large family is difficult… But talking about family planning was not easy in my family, and my husband was against contraception."

Today, she reflects, "Despite our struggles, I am happy with my family. All my children have received some education. I divide my time between working in the home and helping my husband on the farm."

Pooja Kumari, age 26

Anita's daughter Pooja Kumari graduated from university before marrying at 22. She had her first child at 23. In the following three years, she used contraceptives provided by Accredited Social Health Activist, a group of frontline health workers in her community. She recently decided to have a second child.

"My husband and I have decided to have only two children," Pooja says. "We want to raise them well, provide them with a good education, and ensure a secure future for our family. With limited financial resources, we believe a small family is best."

Pooja says that after she gives birth, she plans to work and contribute financially to her home. "My husband supports my ambitions, and together, we are planning for a stable future."

Pooja says she learned about reproductive health and rights through Raatri Chaupals, nighttime community assemblies where villagers gather to learn about health and rights through films and discussions. These meetings boosted her confidence to have conversations with her husband about the number and timing of her pregnancies. Women like Pooja, having both contraceptive services and the support of their communities and families, are part of a new generation with the knowledge and power to realize their fertility goals.

Moving away from blame

The UNFPA/YouGov survey shows clearly that men and women face significant barriers to realizing their fertility aspirations. Yet popular rhetoric, and even political discourse (Looker, 2024), continues to assign responsibility for falling marriage and fertility rates to women alone. Media, academics and policymakers continue to presume *both* that fertility decline is an issue of female choice *and* that women are unreliable reporters of their own internal desires. Headlines from around the world blare: "Italian Women are Eschewing Motherhood" (Migliaccio and Bloomberg, 2024), "Japan's Women Opt Out of Marriage" (Rich, 2019), "Dutch Birthrate Falls as More Young Women Say No to Motherhood" (Dutch News, 2023), "Women on Reproductive Strike" (Chamie, 2015), "No Sex, No Babies: S. Korea's Emerging Feminists Reject Marriage" (Reuters, 2020), "India's Women Reject Marriage in their Millions" (Sunder, 2020), "Latin American Women Opt Against Motherhood in Shift from Traditional Gender Roles" (Laguna and Morland, 2025), "The Kenyans Saying No to Motherhood and Yes to Sterilisation" (Kupemba, 2025) and "Any Woman Who Says She's Happy to be Childless is a Liar or a Fool" (Spicer, 2013).

These assumptions are critically flawed, in no small part because men, too, play an essential role in all aspects of reproduction. In fact, research shows that the parenthood aspirations of *both* men and women are changing over time (see Chapter 3, page 76). Furthermore, evidence shows that, in women's everyday lived experiences, they are too seldom able to exercise true, unhindered reproductive choice. While people do, indeed, have more reproductive choice than ever before – thanks to a wide array of modern contraceptive options and international standards for comprehensive sexuality education – that choice remains deeply circumscribed, especially for women and girls.

From the onset of puberty, often as young as age 10 or earlier, girls face shame, harassment (UNFPA, 2021) and diminished freedoms (UNFPA, 2022; Hallmann and others, 2015) for no reason other than their natural reproductive development. Research looking at the experiences of boys and girls in 15 countries across 5 continents finds, "pubertal boys are viewed as predators and girls as potential targets and victims. Messages such as – do not sit like that, do not wear that, do not talk to him, boys will ruin your future – support the gender division of power" (Blum and others, 2017). The study also notes "consequences for girls in many parts of the world include child marriage, early school leaving, pregnancy, HIV and sexually transmitted infection risk, violence exposure, and depression".

Artwork by Cyan Haribhai

Indeed, this is borne out in current data. Globally, nearly 1 in 5 women is married off while still a child (UNFPA, n.d.). Gender-based violence is one of the most pervasive human rights violations in the world, with roughly 1 in 3 women experiencing sexual violence, intimate partner violence or other forms of abuse in her lifetime – a figure that, due to significant rates of unreporting, may be an underestimate (WHO, 2024). According to the latest data from Sustainable Development Goal 5.6.1, across 69 countries, 11 per cent of women are unable to make decisions about contraception (individually or jointly with a partner), 25 per cent are unable to make decisions about their own healthcare, and 24 per cent are unable to say no to sex (UNFPA, 2025). And of 32 countries with time series data, 13 have seen women's experience of bodily autonomy *regress* between 2006 and 2022 (UNFPA, 2024a).

Full reproductive agency remains elusive even among people who have the resources and empowerment to use contraceptives, seek health services and say no to sex. Accessible and affordable treatments for infertility have not kept pace with the expansion of contraceptive technologies (Haddad and others, 2021), for instance. Furthermore, a wealth of evidence – including the new data described in this report – highlights that family formation is influenced by many complex and interdependent biological, economic, societal and individual factors.

Holding women primarily responsible for fertility rates, therefore, harmfully scapegoats women while failing to recognize the role of men in conception and reproduction, and failing to acknowledge the conditions needed by both men and women to realize their family-formation desires. In fact, such narratives lead to skewed policy choices and, often, negative unintended consequences.

In women's everyday lived experiences, they are too seldom able to exercise true, unhindered reproductive choice.

Coercion leads to unintended consequences

Coercive policies are widely condemned, but there is not always agreement as to what coercion looks like. One commonly understood definition of reproductive coercion is any measure or behaviour that interferes with a person's autonomous decision-making over their reproductive health. This can be state-imposed. At the extreme, for example, some states have engaged in forced sterilization and coerced contraception; others have banned contraception and abortion (Hartmann, 2016). But other measures have historically been used to exert pressure on reproductive choice, as well. Policymakers in the Soviet Union imposed taxes on childlessness (Selezneva, 2016). Viet Nam imposed fines on those who had more children than permitted (Goodkind, 1995).

Importantly, coercion need not be legally mandated to be perpetrated by state actors – or anyone else. Coercive conditions can and do exist when systemic protections are insufficient. For example, the High Court of Namibia found that a state-operated hospital had unlawfully coerced HIV-positive women into sterilization procedures during childbirth (SAFLII, 2012). A 2021 UNFPA assessment in the East and Southern Africa region found that, despite progress in providing access to contraceptives, challenges such as providing an insufficient range of contraceptive options and provider bias continue to undermine fully informed and voluntary choice (UNFPA, 2021a).

No matter the source, coercion has often also triggered unintended consequences as both men and women seek to assert their reproductive autonomy (see more on page 36). In places where abortion is prohibited or inaccessible, women commonly seek unsafe abortions, increasing the rates of maternal disability and mortality. Today, unsafe abortions account for an estimated 45 per cent of all abortions globally, and are one of the leading causes of maternal death (WHO, 2024a).

As another example of unintended consequences, bans on abortion can lead to individuals voluntarily or involuntarily forgoing reproduction. An increasing number of young people sought permanent sterilizations – both tubal ligations and vasectomies – as abortion bans came into effect in the United States in 2022 and 2023 (Strasser and others, 2025), for example. And in low-income countries with limited access to safe abortion, recourse to unsafe abortion is known as a significant contributor to secondary infertility – difficulty becoming pregnant after experiencing a prior pregnancy or birth (Seiz and others, 2023).

Coercive programmes not only violate human rights, but the degree to which they impact fertility in the long term has also been questioned. Even the most coercive policies to *increase* fertility rates have produced results only as long as these measures have been strictly enforced – at great cost. The 1966 ban on abortion and contraception in Romania (Socialist Republic of Romania, 1966) led to an immediate increase in total fertility rate from 1.87 births in 1966 to 3.59 in 1967, but by 1970, the fertility rate had fallen below 3 (UN DESA, 2024), and the country's population never reached its 30 million target. The consequences, meanwhile, were grave: By the time the policy ended in 1989, Romania had the highest maternal mortality rate in Europe, some 87 per cent of which was attributable to unsafe abortion, as well as vast numbers of abandoned children (Hord and others, 1991). The economic consequences were significant as well, with children born in this period experiencing worse educational and labour market outcomes (Pop-Eleches, 2006). When the ban on contraception and abortion was lifted, and people were more able to exercise volition over their reproductive lives, the country saw immediate declines in the fertility rate, to 1.84 in 1990 and reaching a low of 1.27 in 2001 (maternal death rates also sharply declined in this period) (Hord and others, 1991).

Unintended consequences have also followed from efforts to *decrease* fertility. Some people have gone to great lengths to have children in violation of strict fertility caps. Under China's former fertility policy, for example, families

would have incurred a financial penalty for having more children than permitted. As a result, "parents who violated family planning policy often refrained from getting [household registration permits] for their children in order to avoid fines", affecting the children's access to "various social benefits such as medical insurance and access to basic education" (Xinhua, 2016) and skewing civil records (Skalla, 2004). When the policy was rescinded in 2016, unregistered citizens were able to apply for household registration permits (Xinhua, 2016). Furthermore, many countries that have sought to decrease fertility rates, either broadly or among specific communities, have seen negative consequences for the health, welfare and rights of women (WHO and others, 2014) and targeted communities, such as indigenous populations (Lawrence, 2000).

The long-term efficacy of these measures has also been questioned. While birth rates have clearly fallen under coercive schemes, global fertility rates also declined due to rapid economic development and increased access to voluntary family planning, leading some to question whether the same demographic outcome might have occurred anyway without coercive state policies (Li and Miller, 2000).

Building trust through stable, rights-based conditions and policies

Whether the policies are coercive or not, there are real risks to treating fertility rates as a faucet to be turned on or off. Many of the countries that are today seeking to increase fertility have, within the last 40 years, sought to decrease birth rates.

For example, China, Japan, the Republic of Korea, Thailand and Türkiye all reported in 1986 an intention to lower their national fertility rates through policy interventions, deeming their respective fertility rates at that time as "too high". By 2015, however, all five countries had switched to policies designed to *boost* fertility (UN DESA, n.d.). Today all five have total fertility rates below two children per woman (UN DESA, 2024).

In fact, many millions of people have experienced a complete reversal in their governments' fertility objectives – sometimes within very recent memory. Just last year, India's Andhra Pradesh State repealed a law banning candidates with more than two children from seeking elected office; state authorities are now considering a new ban, this time on candidates with fewer than two children (The Hindu, 2025). The persistence of low fertility in these countries may simply reflect changing norms and a broader global trend towards lower fertility. But it may also reflect concerns over the tenuousness of people's reproductive freedoms (Jiang, 2024) and the reliability of programmes that purport to support their fertility aspirations.

Even if states have not wavered in their fertility objectives, efforts to incentivize childbearing are still often ineffective, with fertility rates continuing to trend downward – even as the data in this report show that very large numbers of people desire having more children than they think is feasible under their current circumstances. This suggests that, even when states provide financial incentives or other measures intended to boost fertility, they are not creating the full range of enabling conditions that people say they need to have families.

Some evidence also suggests that current efforts to increase fertility can erode trust in the systems and institutions people rely on as they plan their families and futures. Some women report reconsidering their plans to have more children in the wake of abortion bans that have increased maternal death rates (Presser and others, 2025; Suozzo and others, 2025): "I don't want to die trying to have another baby," said one woman in early 2025. "I don't want to leave my own living child motherless" (Darby, 2024). One young woman in the Philippines told UNFPA, "A lot of policies worldwide are against women's healthcare. I feel that this pushes us to stay single and have no children." (See testimonials from young people on pages 8–9.)

Even arguably benign efforts, such as communications campaigns around low fertility, can produce counterproductive results.

Lawmakers and prominent figures openly contemplate rolling back hard-won gains in gender equality for the purpose of increasing fertility rates.

In Italy, for example, a "Fertility Day" campaign – featuring slogans like "Beauty knows no age, fertility does" and "Hurry up! Don't wait for the stork" (Lavanga, 2016) – provoked criticism that the government was out of touch with what people need to start families, such as decent work. As another example, authorities in the Republic of Korea launched a "birth map" website, showing the distribution of women of childbearing age, to increase public awareness of the country's birth rate. This sparked criticism that people unable or unwilling to have children were being shamed. Though the website was ultimately shut down (Associated Press, 2016), the map is seen as having contributed to the country's "4B Movement", in which participants assert they will not date, have sex, marry or have children (Shamim, 2024).

Distrust is exacerbated when lawmakers and prominent figures openly contemplate rolling back hard-won gains in gender equality for the purpose of increasing fertility rates. Recent responses to fertility declines have included Iran's "Youthful Population and Protection of the Family" law which asserts "any free distribution or subsidies of items related to contraception... are prohibited", "scientific textbooks will be updated to explain the physical and mental harms of abortion and the complications of using contraceptives", and "marriage loan facilities for couples under 25 years of age and women under 23 years of age" will increase in order "to reduce the age of marriage" (Government of the Islamic Republic of Iran, 2021). American academics have recommended the elimination of education subsidies to end young people's "harmful over-consumption of schooling" (Greene and Burke, 2024).

In the Republic of Korea, a state research body recommended policies to enhance young people's "sexual attractiveness and sociability" (Choi, 2024).

Demographic anxiety is also being expressly weaponized to undermine reproductive autonomy. Anti-gender activists in Europe have called on politicians to "use demographic decline as [an] argument" in pursuit of a "legal ban on abortion in all jurisdictions" (Agenda Europe, 2024). Indeed, one recent lawsuit to ban medication abortion, brought by several state attorneys general in the United States, asserts that decreased births due to abortion "is a sovereign injury to the State in itself". It further warns that medication abortion "is depressing expected birth rates for teenaged mothers", and that "a loss of potential population" will result in "diminishment of political representation" and "loss of federal funds" (United States District Court for the Northern District of Texas, Amarillo Division, 2024).

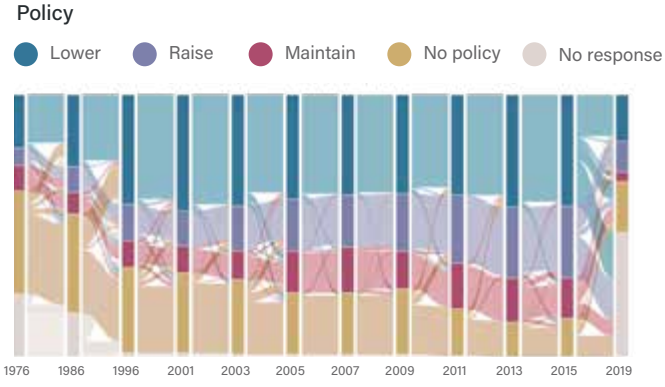
In the end, fear and distrust surrounding state intervention in fertility rates are rooted in historical injustices, concerns about bodily autonomy, the potential for discrimination, scepticism about policy effectiveness, and a fundamental belief that reproductive decisions should remain personal and private. These factors contribute to a strong aversion to policies that are even perceived as coercive or as infringing upon individual rights and choices.

FIGURE 3

Changes in government fertility policies over time

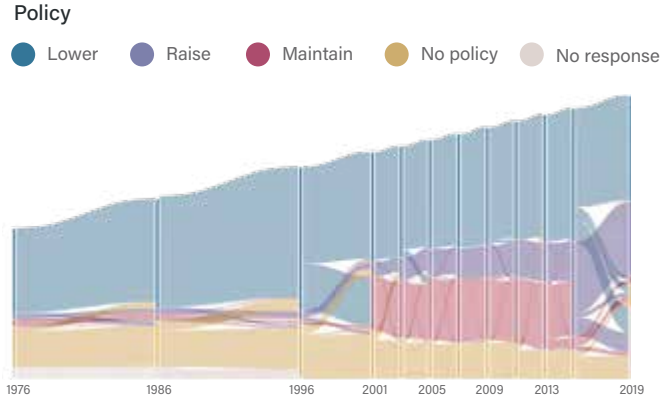
Simplified alluvial plot of reported fertility policies, 1976–2019

Share of countries reporting fertility policies by policy type and inquiry year



Population-weighted alluvial plot, country fertility policies, 1976–2019

Share of people living under government fertility policies by policy type and inquiry year



Source: UNFPA, 2023.

Note: Changes in the self-reported fertility policy objective of United Nations Member States, as collected in the survey Inquiry among Governments on Population and Development, over the past 50 years. The data from 1976 and 1986 contain policy objectives from about 150 Member States; the data for 2019 contain policy objectives from around 100 Member States; for all other years, the data reflect policy objectives for nearly 200 Member States.

FEATURE

Young men redefine their role in family planning

When Thabo speaks to other young men in his community in KwaZulu-Natal, South Africa, he doesn't talk theory – he tells his story.

It begins with a condom breaking, followed by panic. "It was late. The clinic was closed," he recalls. "But I remembered what I heard at the youth health talk: You've got 72 hours."

The next morning Thabo made his way to the Wembezi Clinic, where he'd grown up receiving vaccinations and check-ups, and asked for help. He was tested for HIV, given emergency medication to reduce his risk of infection, and offered something that would shape his future more than he expected: Clear, quality information that was free of judgment.

"They showed me how to use condoms properly. They talked to me about protecting myself, but also about planning for the future. That day changed everything."

Thabo wasn't ready to become a father. But he discovered that he was ready to become a leader. Now 24 years old, he volunteers as a youth mentor, helping other

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young men in his community to navigate sexual health and relationships as part of a growing movement supported by the 2gether 4 SRHR [sexual and reproductive health and rights] programme. The programme brings together services for sexual and reproductive health, HIV prevention and gender-based violence under one roof.

In South Africa, the conversation around family planning has long focused on women. But men, like women, face barriers to making free and informed choices. In South Africa, 17 per cent of people expect to have more children than they want. Another 17 per cent expect to have fewer. These aren't just statistics – they are stories of interrupted dreams and unmet need.

Sometimes the issue isn't just lack of access; it's different standards. Many young men are raised with the idea that pregnancy is a woman's responsibility, that asking questions about sexual health is shameful, or that displaying emotions constitutes weakness. The result? Missed opportunities. Broken communication. Families formed or fractured by silence.

Research from South Africa shows that the issues of high rates of unplanned pregnancy, limited involvement by fathers and economic stress are deeply intertwined. When young people, and especially young men, are left out of the conversation, families bear the consequences.

But Thabo is part of the change. At the Wembezi Clinic, he facilitates men's groups in which young men can talk openly about their reproductive choices, sexual health, fatherhood and all of the emotions these topics bring to the surface. "Some of them didn't even know they could say no. Others didn't know they had the right to wait," he says. "Now they do."

The clinic, with support from the 2gether 4 SRHR programme, doesn't just provide condoms or relationship counselling – it offers a shift in mindset. Young men are welcomed into the conversation. They are encouraged to ask questions. They are heard, without being judged.

"You wouldn't believe how many guys say, 'I didn't know I could ask these questions,'" Thabo says. "We talk about responsibility, but also about dreams. You can plan a family. You can wait. You can say: Not yet."

He adds, "I'm not afraid anymore. I know what I want. And I want other guys to feel that too."

Perceptions matter

Also counterproductive are the overly simplistic ways that policies are popularly described – as being either "pronatalist" or "antinatalist". Firstly, these terms are often simply inaccurate. Policies that improve access to contraception services are not "anti-baby", just as policies that deny access to abortion care and contraception are not "pro-baby". Secondly, the terms are used with vast inconsistency; "antinatalism" is applied as readily to family planning programmes as it is to forced sterilization, and "pronatalism" refers equally to childcare grants and contraception bans.

Artwork by Marianna Gefen

The truth is that both approaches can be used to empower people to make their own informed reproductive choices, just as both approaches can be used to deny people that right. Contraception programmes should be supportive of individual choices, but have also been used as a tool for curtailing childbearing among populations perceived to be "less desirable" (UNFPA, 2024a). "Baby bonuses" can offer critical help to parents struggling with the expenses of child-rearing, but they can also be used as cash inducements to reproduce, stigmatizing those who benefit from them (Garrett and others, 2017). Measures that may seem harmless, such as financial "incentives" for larger or smaller families, can indirectly lead to constraints on reproductive choice by increasing men's and women's vulnerability to coercion from partners, families or in-laws.

Calling policies "pro-" and "antinatalist" can thus colour how they are understood, with impacts on their effectiveness. The view that family-friendly policies are pronatalist, or contraception services are antinatalist, can contribute to the perception that these policies and services are inherently unreliable, context-dependent rather than rights-based, and available only until the objectives of a state change. In fact, a final objection to these terms is their focus on the presumed or express intention of the state rather than their impact on the agency of individuals. Research indicates policies supportive of childbearing can actually have lasting negative impacts on fertility rates simply by being *perceived* as trying to compel a certain reproductive behaviour. By contrast, policies *perceived* as supportive of individual choice may actually facilitate childbearing (Botev, 2015).

What is the alternative to policies seeking to influence fertility rates? Policies that expressly – in letter and spirit – affirm the rights of individual women and men to make their own choices: "Policies should focus on giving parents sufficient autonomy in deciding whether to have children, when, and how many, and on facilitating parenthood rather than on fertility targets" (Botev, 2015).

Unfortunately, global policymaking trends are not moving in this direction: The 2023 *State of World Population* report found, between 1976 and 2015, an increase in the number of governments adopting policies to influence their country's fertility rates (UNFPA, 2023). (See Figure 3.)While efforts to influence fertility can take many forms, and some may indeed have been supportive of human rights and reproductive choice (such as by improving access to contraception and maternal health services), the 2023 report also found signs of diminishing support for families and gender equality in a number of countries. Some "38 countries, between 2015 and 2019, reduced childcare subsidies, lump-sum payments for children, and child or family allowances (policies that not only support children but also help women to remain in, or return to, remunerated employment)," the analysis found. "This raises an important question: if human rights and welfare were a primary incentive for implementing family-supportive policies, would these measures be less subject to abrogation?"

Gender inequality and low fertility

The transition from high mortality and high fertility to low mortality and low fertility has been common to all countries, albeit experienced at different times and for different durations. However, the continuation of fertility decline in countries with already sub-replacement fertility rates (see pages 6–7 on terminology) is linked to persistent gender inequality. In particular, researchers note that the slow increase in men's involvement in caretaking plays a key role in keeping family size small (Goldscheider and others, 2015; McDonald 2013). Chapter 3 of this report explores in detail the impact of gendered caretaking on fertility aspirations.

Women's access to decent work is also a factor, given the importance of economic security to the realization of people's fertility aspirations. Yet women's labour force participation lags significantly behind men's (World Bank, 2022), to the detriment of their economic well-being and status in the family (UNFPA and Equimundo, 2022). Despite these facts, governments and policymakers continue to treat fertility rates as tools for unlocking economic growth (UNFPA, 2023), rather than viewing positive economic and social conditions as prerequisites for people to exercise unfettered reproductive agency – including the desire of many people to have more children than they believe is feasible in today's world.

Measuring what matters

The assumption that human sexuality and fertility should bend to the will of leaders and states was once commonplace, but it no longer holds. Bodily autonomy is increasingly demanded, as well as recognized and codified as a human right. In January 2025, the United Nations Human Rights Committee found that forcing survivors of rape to carry pregnancies to term was "a violation of life with dignity, an act amounting to torture, and a failure to protect some of the most vulnerable" (OHCHR, 2025). That same month, the European Court of Human Rights found that holding a woman liable for divorce if she did not have sex with her husband "took no account whatsoever of consent to sexual relations" (ECHR, 2025).

Still, as shown above, population concerns continue to be framed in public discourse as the harmful consequences of choices made by women, especially young women. As in the past, demographic "problems" and "solutions" are assumed to take the shape of a woman's body. The persistence of these notions is partly the result of deeply rooted patriarchal norms – but that is not the only factor. Another equally important reason is that the metrics currently used to guide demographic thinking are in many ways ill suited to the task.

Too often, for example, the success of family or population policies is determined by whether they have increased a community's or country's total fertility rate or absolute number of births (Lutz and others, 2024). But the success of such policies should lie in their impact on the status and well-being of people, not the total fertility rate. And even if increasing the fertility rate was a reasonable policy goal, total fertility rate is an imperfect measure of fertility change over time. It often gives the false impression that a short-term policy has resulted in increased births, when more nuanced measures, such as tempo- and parity-adjusted total fertility rate or cohort measures, often show the same policy had no such effect. (See more on page 102.)

Furthermore, there are reasons to question whether the ultimate goal of such policies is truly to increase births. Countries reporting an intention to boost fertility rates seldom expand fertility services to same-sex couples or single individuals, and many expressly deny services to these individuals (Hawkins, 2024). Some countries seeking to increase fertility rates prevent immigrant populations from accessing maternity care (Pařízková and others, 2023). Yet expanding access to these services would simply and effectively increase the total number of people able to realize their fertility aspirations. These incongruities cast doubt about the underlying goals of such policies: Are they truly intended to increase fertility rates or do they intend to promote reproduction only among certain groups of people? Measurements that count how many people strive to become parents but face barriers to doing so would help to identify such biases and misalignments.

Total fertility rate is not the only metric unsuited to evaluating the success of policies and programmes. Modern contraceptive prevalence rate, too, has historically been used in overbroad ways when evaluating the success of family planning programmes, but this can encourage programmes to set quotas rather than engaging and listening to women themselves. Newer measures are asking women whether they *want*

to use contraception and whether they are able to satisfy those desires (Lin and others, 2024). (See page 96.)

At the individual level, measures of desired fertility have also been subject to contention. Survey questions about the wantedness of pregnancies and childbirths have been asked for more than 80 years (Bhushan and Hill, 1995), but responses to these inquiries have been open to a variety of interpretations depending upon the exact wording of each question. Answers can also be affected by ex-post rationalization, the tendency to revise earlier preferences to reflect the number of children one has had. Concerns about confidentiality may also affect how people answer these questions (Valente and others, 2024). And, of course, fertility desire can change throughout a person's life as their circumstances evolve. But there has been progress in this area, as well. Evaluating fertility aspirations within a specific timeframe, for example, can improve the predictive power of an individual's stated intentions (Bernardi and others, 2015). Researchers are also developing new ways to measure the impact of shocks and crises (Marteleto and others, 2023), work-life balance (Kurowska and others, 2023) and other factors on fertility intention, for example.

Efforts to measure fertility desires and intentions more systematically across countries are also encouraging. The Generations and Gender Survey measures fertility intention, though primarily in European countries, with a few East Asian and Latin American inclusions, for instance (GGP, n.d.). One of the strongest tools for measuring fertility intention has been the Demographic and Health Survey, though it has been conducted only in developing countries and is currently frozen for funding review (Mandavilli, 2025). Further efforts are also on the horizon. Later this year, for example, UNFPA will be launching a survey of the fertility aspirations of young people, and the barriers to and enablers of these aspirations; the survey will cover all world regions and be informed, in part, by the findings of the UNFPA/YouGov survey (see page 34 for more).

One area where there is a need for more work, however, is in measuring and understanding uncertainty in reproductive goals. In the UNFPA/YouGov survey conducted for this report, 22 per cent of respondents of reproductive age indicated "don't know" or "prefer not to say" when asked their ideal number of children, and 35 per cent were unable to say how many children they expected to have, indicating that the experience of uncertainty is extremely common, yet it is not well researched.

People can express uncertainty not just at the possibility of becoming a parent but also while they or their partner are experiencing a pregnancy. Yet pregnancies are typically divided into binary categories – intended or unintended, wanted or unwanted – when in fact a person's desire to become pregnant can exist nebulously between these terms, and can change over time. New measures are being developed to capture these subtleties (ANSIRH, n.d.). This area of research will be valuable because, while unintended and unwanted pregnancies are associated with significantly worse maternal and child health outcomes (Nelson and others, 2020), the outcomes of pregnancy uncertainty are poorly understood (as are the outcomes of parental regret, another seldom explored topic [Johnson and Pétursdóttir, 2023; Piotrowski, 2021]).

Additionally, there is no standard or comprehensive measure of reproductive agency – but efforts are under way to develop one. The closest international measure has been Sustainable Development Goal 5.6.1 measuring bodily autonomy, which assesses a woman's ability to make decisions about her own healthcare, contraception and ability to say no to sex. And while this measure has been a milestone in the effort to understand sexual autonomy, there are many aspects of reproductive choice that have gone overlooked (see page 115).

Instead of seeking to influence fertility decisions, policymakers would do well to design policies that inquire about, and respond to, the stated preferences of individuals. Policies should also seek to adapt to the expressed desires and expectations of people themselves, which evolve as norms and conditions change. For instance, World Values Surveys conducted from 1981 to 2012 show growing acceptance of same-sex relationships globally, particularly among younger respondents (Roberts, 2019). And of 1.5 million respondents to the 2023 What Young People Want survey – all aged between 10 and 24 – more than 3 per cent declined to identify as either a man or a woman (What Young People Want, n.d.). These trends call into question the wisdom of restricting reproductive services to married, heterosexual couples.

Further surveys to take place

UNFPA will be launching a youth reproductive choices survey in 2025, informed by the results of the UNFPA/YouGov survey described in this report. The youth reproductive choices survey aims to understand the reproductive desires and intentions of young people, as well as barriers and enablers to the realization of these desires, in approximately 50 countries from all world regions. The resulting data will be used to inform policy and programming for our demographically diverse world.

Rethinking reproductive choice

In the end, the most profound reproductive choice a person can make is whether, when and with whom to have a child. UNFPA has long identified that for too many women this is no choice at all: The most comprehensive projections, looking at more than 150 countries, indicate that nearly half of all pregnancies globally are unintended (Bearak and others, 2020). But the ability to prevent an unintended pregnancy is not the only matter affecting a person's ability to affirmatively choose parenthood. To capture real agency over one's fertility, we must also recognize and understand those people who deeply, sometimes desperately, want a child or children, but for whom that dream is out of reach.

Both preventing unintended pregnancies and enabling intended pregnancies are profoundly consequential for people's human rights and welfare. Both require supportive environments, policies and norms. And for both, scholars and policymakers are increasingly looking beyond just women to include men in these measurements, and beyond just heterosexual couples, to include those on the gender continuum and single individuals.

We must look also beyond the total fertility rate when designing policies and recognize that, everywhere we look, significant proportions of adults are overachieving their fertility goals, significant proportions are underachieving their fertility goals, and too many struggle through both experiences at different stages in their lives. In fact, this report finds that the barriers a person faces in seeking to avoid a pregnancy often mirror the barriers they face when wanting to start a family: economic precarity, gender discrimination, partners and communities that fail to support their desires, low-quality sexual and reproductive healthcare, pessimism about the future, and more. *These* are the factors that policymakers can and should address to enable all people to have the families they desire, with the security and empowerment they require.

Artwork by Cyan Haribhai

IN FOCUS

Who decides? Engineering choice and subverting control

Throughout history, governments and societies have sought to influence women's fertility using methods ranging from coercive policies and financial incentives to cultural stigmatization (UNFPA, 2023). Such measures frequently reflect patriarchal and statist assumptions that prioritize national or societal needs over individual agency.

While these dynamics are not new, the recent rise in populist rhetoric and policies has further reinforced attempts to influence women's reproductive autonomy, intensifying the struggles, negotiations and resistance surrounding this issue. In particular, as low fertility rates are increasingly perceived as national crises, governments are implementing policies to increase childbearing – often reinforcing gender unequal norms and provoking concerns about women's bodily and reproductive autonomy.

One direct way in which governments control fertility is through policies related to reproductive medical services. In the Republic of Korea, for example, abortion is not covered by national health insurance, but some local governments offer financial incentives for procedures like reversing vasectomies or tubal ligations (Ables and Yoon, 2024). Some countries criminalize abortion or enforce strict regulations, creating significant obstacles to obtaining safe and timely reproductive care (CRR, n.d.). Others impose barriers to obtaining voluntary sterilization. In Japan, for example, women seeking elective sterilization procedures face stringent conditions, such as needing spousal consent, having children already or proving health risks from pregnancy, making these procedures nearly inaccessible for single, childless women (Rich and Notoya, 2024).

Meanwhile, encouragement to have more children is not applied equally for all people, with middle- and upper-class, heterosexual, married women often prioritized as ideal candidates for motherhood. Single women, LGBTQIA+ individuals and low-income groups are frequently excluded from such benefits (Rich and Notoya, 2024). These policies reinforce gender unequal norms, perpetuating the idea that a woman's primary role is to bear children, while systematically marginalizing diverse family structures and individual aspirations. As a result, the burden of addressing low fertility rates disproportionately falls on specific groups of women, further entrenching inequalities and limiting reproductive agency.

Yet policies to influence fertility, and social norms that undermine choice, are often met by resistance. Individuals and communities facing these challenges have developed strategies to assert autonomy over their reproductive lives. For example, in the Republic of Korea, the so-called "4B Movement" (No Dating, No Sex, No Marriage, No Childbirth) serves as a collective response to entrenched gender norms and reproductive expectations. It also reflects

resistance to pervasive technology-facilitated gender-based violence, including digital sex crimes and online misogyny, which threaten reproductive agency. Similarly, in the United States, the "boysober" movement – where individuals opt for celibacy – acts as a form of resistance against patriarchal and heteronormative expectations around relationships and sexuality. Notably, the boysober movement emerged in the wake of the incel (involuntary celibate) online community, which perpetuates misogynistic views rooted in a sense of entitlement to sex.

Both the 4B and boysober movements are facilitated by social media, illustrating how the rapid transnational flow of ideas helps individuals resist restrictions and societal pressures. Similarly, both real-world and online underground networks have emerged in places where contraception and abortion access are limited, providing clandestine support to those seeking these services. For instance, in many Latin American countries with stringent abortion laws, there is growing reliance on self-managed medication abortions, efforts facilitated by global solidarity networks that share resources and guidance (Berger and Klimentov, 2024).

Cross-border travel for reproductive services is another strategy to resist reproductive restrictions, not only to access abortion but also to access family-formation support. In places where access to assisted reproductive technology is restricted to heterosexual married couples, single women and LGBTQIA+ individuals are increasingly travelling abroad to access health systems with more inclusive policies (Belmonte and others, 2021). However, these options are available only to those with sufficient mobility and financial resources, leaving many others without access.

Rather than work at odds with people's desire for reproductive agency, policies, systems and environments should respect and support their reproductive aspirations.

These resistance strategies highlight how commonly people and collectives seek to restore individual agency over their bodies. Rather than work at odds with people's desire for reproductive agency, policies, systems and environments should respect and support their reproductive aspirations. This requires accessible healthcare, inclusive family policies and comprehensive reproductive education that prioritizes autonomy and informed decision-making.

Text contributed by Kim Sunhye, assistant professor of Women's Studies at Ewha Womans University and co-founder of SHARE (Center for Sexual Rights And Reproductive Justice) in the Republic of Korea

Artwork by Marianna Gefen

CHAPTER 2

Opening a policy window of opportunity

The gap between desired and achieved fertility is present everywhere we look – and in some places this gap is a chasm. Policymakers have focused largely on only one form this gap takes: unintended pregnancies, which for families can mean the difference between carefully budgeting for an intended number of children versus stretching their resources to accommodate more. For a woman, it might mean pregnancy by, and lifelong ties to, an abusive partner (Goli and others, 2020). For both parents, it can mean an education or career path disrupted (Institute of Medicine [US] Committee on Unintended Pregnancy, 1995). For a child born from an unintended pregnancy, it can mean a higher risk of preterm birth, low birth weight and long-term adverse health outcomes (Beumer and others, 2024; Nelson and others, 2020).

But now, as countries around the world transition towards a future with lower fertility rates (UN DESA, 2025a), many are grappling with the opposite concern: People having fewer children than desired. For these individuals, a fertility gap is a void in the family that a child or children were hoped to fill. For those who end up forgoing childbearing entirely, the sense of loss might be compounded by the stigma of being "selfish" or perpetually childlike. At the same time, a growing number of people are voluntarily choosing to remain childfree (Golovina and others, 2024; Hintz and Tucker, 2023), a reproductive choice that can offer alternative paths to happiness and fulfilment (Stahnke and others, 2022), but which can also result in hardship when penalized by society and laws (Tanaka and Johnson, 2014).

Thus far, the policy prescriptions have been treated as categorically distinct: high-fertility contexts are thought to require efforts to prevent unintended pregnancies and to promote girls' education and empowerment; low-fertility contexts are thought to require subsidies for child-rearing and support for parental leave. But treating these as disparate approaches fails to address the far more complex reality that barriers to both pregnancy prevention and family formation exist in all contexts, and the full range of policy solutions is needed *everywhere*.

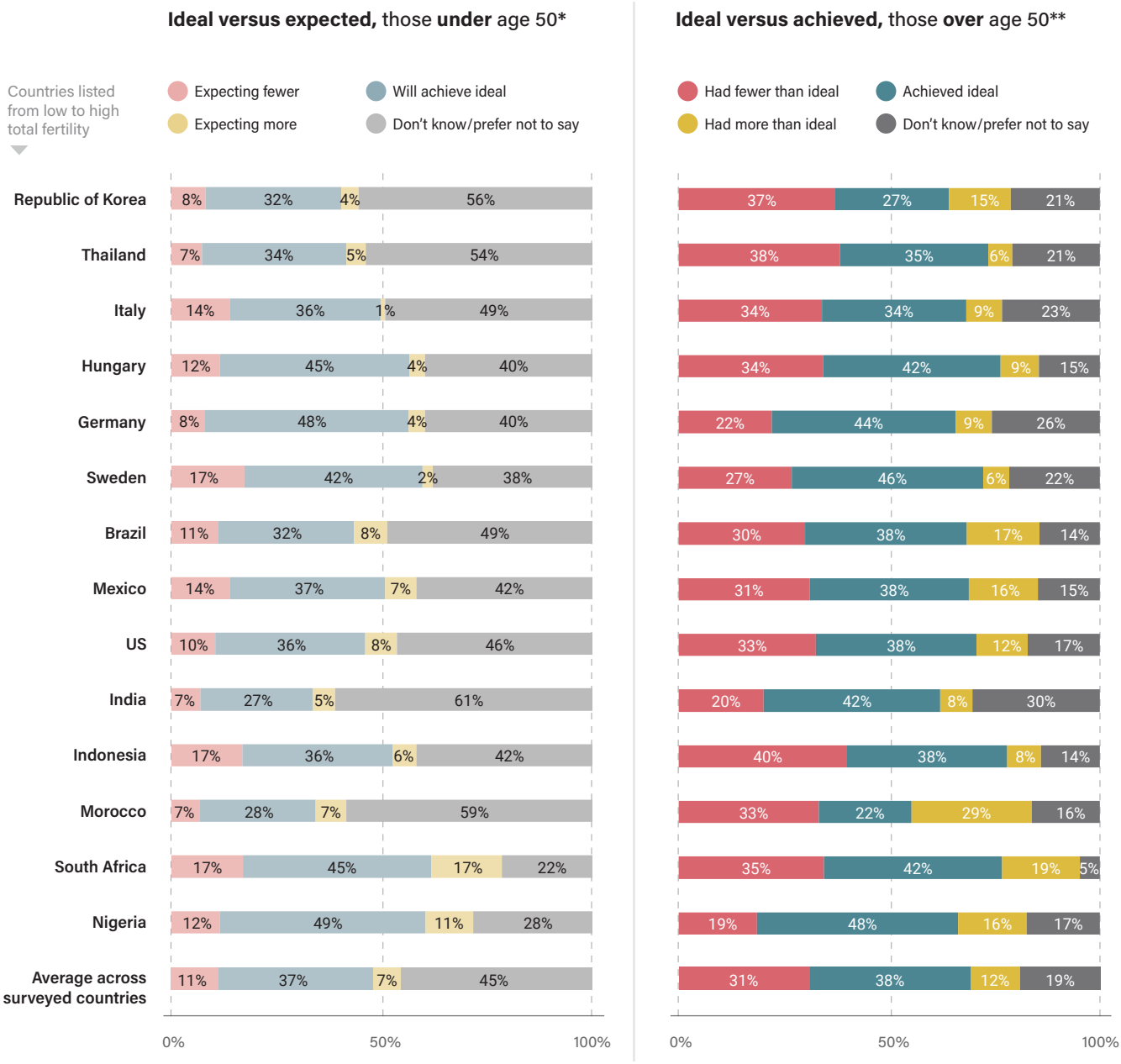
Barriers to reproductive aspirations

Barriers to a person's fertility desires can take many forms, but to understand these barriers, it is important to *ask*. Neglecting to investigate people's desires and challenges can potentially result in inadequate or ill-suited policy interventions.

For example, the UNFPA/YouGov survey found that only 1 per cent of respondents in Italy under age 50 expected to have more children than desired, compared with as many as 14 per cent who reported expecting to have fewer than they would ideally choose (see Figure 4). Without context, this might suggest that resources currently spent on contraception support should be directed instead towards health and social programmes that support family formation. Yet nearly 25 per cent of all Italians surveyed said they, or their partner, had experienced an unintended pregnancy – indicating that services to prevent unintended pregnancy are *also* critically needed (see Figure 1 on page 15).

FIGURE 4

Difference between respondents' ideal and expected/achieved number of children



Respondents were asked about their ideal number of children (see Figure 8). Those under 50 were asked how many children they expect to have; those over age 50 were asked how many children they have. People over- and under-achieving their reproductive aspirations are common in all countries, no matter the total fertility rate.

*Potentially still within their reproductive lives

**Reproductive lives likely complete

Source: UNFPA/YouGov Survey.

Similarly, the country with the highest rate of expected fertility *over*achievement was South Africa, where 17 per cent of survey respondents, men and women, expected to have more children than they ideally desired. One might assume that programmes to support family formation would be less important in this context – yet when asked if they had ever wanted to have a child but felt unable to do so at the time they desired, 34 per cent of South African respondents said yes, indicating that many people also need support for family formation.

Notably, almost 13 per cent of respondents across all 14 countries indicated they had experienced *both* an unintended pregnancy *and* a time when they wanted to have a child but felt unable to (see Figure 5). This finding might be seen as confusing: Why would one person have both experiences? The answer, likely, is that the timing and circumstances

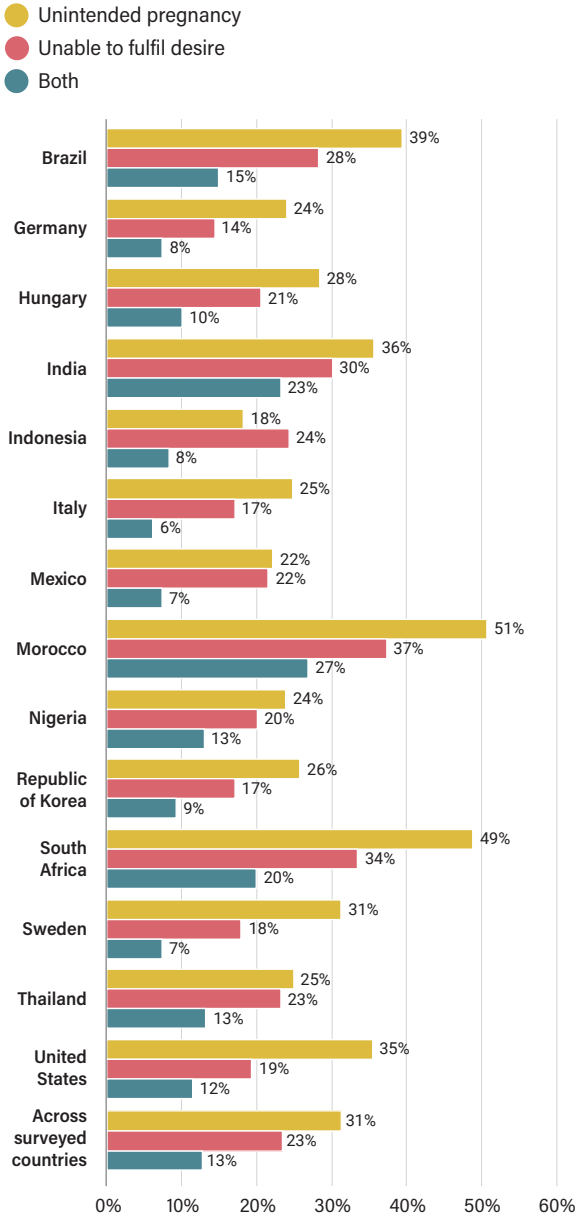
Artwork by Graham Dean

of one's pregnancy matter enormously. For these respondents, a pregnancy under specific conditions – perhaps at a certain age, with a certain partner or with a certain income – was desired, while a pregnancy under other conditions was not. (See text box on page 44.)

What emerges is a concerning picture of obstacles to reproductive agency in every country investigated. Crucially, however, this picture also highlights how many people can be reached with the services and programmes that would help them realize their goals, a significant "policy window of opportunity" (Gauthier, 2007). When designed with a person-centred approach – inclusive, rooted in human rights, dignity and gender equity (Gietel-Basten and others, 2022) – policy interventions can remove at least some of these barriers so that individuals and couples are able to achieve their fertility aspirations, whatever those aspirations may be (Gauthier and Gietel-Basten, 2024). Below, this chapter explores policies that currently pose barriers to the realization of people's fertility aspirations, and also policies that can support this realization, looking at those across health, economic and housing sectors, as well as those aimed at fostering human development and gender equality.

FIGURE 5

Experience of unintended pregnancy and unfulfilled desire for a child



Significant proportions of people have experienced both an unintended pregnancy and a time when they were unable to fulfil their desire for a child.

Source: UNFPA/YouGov Survey.

Unintended pregnancy: Not a solution

Policymakers may be tempted to ask whether unintended pregnancy might be a solution to underachieved fertility on the individual level, or low fertility rates on the macro level. The answer is no.

For women, the costs of unintended pregnancy – even pregnancies that are ultimately embraced and celebrated – often last a lifetime. Girls who become pregnant while still in school may drop out or face expulsion. With an incomplete education, young mothers often face difficulties securing decent employment; one study from the United States found that unplanned births reduce labour force participation by as much as 25 per cent (Nuevo-Chiquero, 2010). Unintended pregnancy also represents a critical challenge for health systems – it is associated with conditions such as post-partum haemorrhage, preterm birth, pre-eclampsia and post-partum pre-eclampsia, and with delays in accessing prenatal care. Women with unintended pregnancies are at significantly higher risk of post-partum depression than women who become pregnant by choice, and children born of unintended pregnancy often experience poorer health outcomes.

Unintended pregnancies can also lead to serious human rights consequences. In some places, women and girls may be at risk of so-called "honour killings" (UNFPA, 2022a), for example, if the pregnancy occurs out of wedlock. Furthermore, unintended pregnancies are often the result of sexual violence. One study from Haiti, Nigeria, Malawi, Uganda and Zambia concluded that, in some cases, more than one third of reported survivors became pregnant from their first or most recent experience of forced or pressured sex (UNFPA, 2022a). Forcing survivors of rape to continue with a pregnancy against their will is considered by the United Nations Human Rights Council to be a violation of human rights that can amount to torture (United Nations General Assembly, 2013).

Additionally, many unintended pregnancies are not necessarily unwanted but are mistimed, with consequences escalating as the discrepancy between the timing of the pregnancy and the mother's desired timing increases. Seriously mistimed births are more likely to result in preterm birth and children with worse education and employment outcomes (Nguyen, 2018; Pulley and others, 2002).

Those inclined to see unintended pregnancy as a solution to low fertility rates may regard adoption as the preferred alternative to preventing or ending an unintended pregnancy (Cooper Davis, 2022). But while adoption can be a happy experience for all parties involved, it is not a possibility for everyone, can sometimes have adverse impacts (Brodzinsky and others, 2021), and does not replace the need for individuals to have agency over their bodies and reproductive lives.

Finally, the UNFPA/YouGov data show that significant proportions of people, in every country surveyed, actually want to have children but lack the enabling conditions and services required. Interventions should therefore seek to support reproductive agency for all people, including those who affirmatively want to become parents.

Health policies

Health policies are some of the most impactful means of supporting and expanding reproductive choice. This has been amply illustrated by the global improvements in women's reproductive autonomy that have taken place over the past 30 years. At the International Conference on Population and Development, held in Cairo in 1994, 179 governments signed a Programme of Action committing to, among other things, the promotion of sexual and reproductive health and reproductive rights (UNFPA, 2024). Since then, there has been an increase in access to family planning and increased legal access to abortion. In that time, 60 countries have revised their abortion laws to remove restrictions (CRR, n.d.), with legalization taking place most recently in Argentina, Colombia, Ireland, Mexico, Portugal and Uruguay (Becquet and others, 2024). Women's "guaranteed freedom" to access abortion became a constitutional right in France in 2024 (CRR, 2024).

Policy progress has not been linear, however. There has been a recent rollback in sexual and reproductive health and rights, including, in some places, growing restrictions on bodily autonomy (UN Women, 2024). In 2021, Poland greatly restricted abortion, banning the procedure even in cases of severe fetal impairment, while in 2022 the United States saw the removal of long-standing protections for abortion rights, leading some states to ban and criminalize abortion. Abortion rates also increased in the United Kingdom, where a recent proliferation of social media misinformation (McEvinney, 2023) has contributed to a shift away from reliable hormonal methods of contraception (McNee and others, 2025).

Today, 8 per cent of all women aged 15–49 worldwide face an unmet need for family planning (UN DESA, 2025), constrained contraceptive autonomy that prevents individuals from making informed, full and free decisions (Yeatman and Sennott, 2024; Senderowicz, 2020). But there are other constraints on bodily autonomy as well: As of 2025, 44 per cent of women and girls worldwide do not have decision-making power or bodily autonomy regarding sexual relations, contraceptive use and reproductive healthcare (UNFPA, 2025).

Clearly, better policies are needed *both* to enable people to prevent unintended pregnancies *and* to have children when they are ready for them. Both needs can be addressed by ensuring that the full range of sexual and reproductive health services are available and, ideally, well integrated into primary health systems. Unfortunately, not all health systems are able to provide the full range of sexual and reproductive health services, whether due to poor integration of these services within healthcare systems, provider bias, insufficient availability of affordable and quality reproductive health commodities (not only contraceptives but also maternal health medicines and treatment for sexually transmitted infections) or other limitations.

Access to and quality of the full range of reproductive care

Quality of care can have a direct impact on fertility intention. The quality of maternal and newborn care a person receives can impact their future fertility aspirations, for example. A traumatic childbirth experience due to obstetric and gynaecological violence, medical procedures performed without prior consent and pressure with breastfeeding are all associated

with reduced intention to have a subsequent pregnancy (Minello and others, 2024). Furthermore, lack of adolescent-friendly health services could lead to higher risk of adolescent pregnancy (Graybill and others, 2024).

Of course, these issues matter not just for enabling people to have the children they desire. Quality and comprehensiveness of care are also essential to ensure the health and well-being of communities. Yet, too often, reproductive and maternal health services are simply unavailable. While poor availability of these services is commonly associated with high-fertility contexts, this is increasingly also the case in low-fertility settings. A lack of obstetric clinicians, leading to "maternity care deserts" and increasing mortality risk (Wallace and others, 2021), is of growing concern in the United States (Howard, 2024), while other countries with low birth rates are seeing the closure of birth departments and the loss of experience in dealing with obstetric complications, with adverse impacts on women and their babies (Hoffmann and others, 2023; Kildea and others, 2015).

This was borne out in the UNFPA/YouGov survey, which found that, globally, nearly 1 in 5 respondents – 18 per cent – had experienced a situation where they were unable to access medical or health services related to contraception or procreation. This ranged from 10 per cent in Germany to 33 per cent in Morocco, an indication that all countries' health systems have considerable room for improvement in meeting the reproductive health needs of their populations.

Care for infertility

Efforts to scale up the availability and quality of family planning programmes, maternal healthcare and safe delivery services have been ongoing for decades, and as a result, there are many well-documented case studies showing how this can be done, from low-income, rural communities to affluent urban centres. What most countries lack, however, is experience in developing and implementing available, affordable and high-quality treatment for – and prevention of – infertility.

Globally, it is estimated that about 1 in 6 people will experience infertility at some point in their lives (WHO, 2023). This number is based on the medical definition of infertility: The absence of conception after one year of unprotected intercourse. However, when we account for fertility intentions (Passet-Wittig and Bujard, 2021) and consider as infertile those individuals who were unable to conceive after one year *of trying*, the UNFPA/YouGov survey found a slightly higher prevalence in the countries surveyed: 1 in 5 (21 per cent). Of the UNFPA/YouGov survey respondents who experienced infertility, more than 60 per cent ultimately managed to have a child (or another child, if they had been experiencing secondary infertility). However, almost 40 per cent said they did not end up succeeding in having a child.

Infertility arises for various reasons, from untreated sexually transmitted infections to malfunctioning of the female or male reproductive systems, to age-related, environmental and lifestyle risk factors. In some cases it is unexplained (WHO, 2024b). High- and low-income countries have broadly similar infertility prevalences, though this varies by

study and measurement; by some measures, such as period infertility prevalence, Africa is the region with the highest rates of infertility (WHO, 2023), even as the continent has some of the highest fertility rates. (See text box on page 95 about infertility in Africa.) Unfortunately, this issue is all too often ignored in low-income countries with above-replacement fertility and the consequent suffering of prospective parents is therefore largely invisible.

Not being able to realise one's desire for children can have far-reaching consequences for individuals' subjective well-being (Goisis and others, 2023; McQuillan and others, 2022; Mirowsky and Ross, 2002). The psychological consequences of infertility are often profound for both men and women. Normal and complicated grief, depression and anxiety are common experiences for those who undergo infertility treatment (Mesquita de Castro and others, 2021); the consequences of infertility can be particularly severe in communities that place a strong value on fecundity and large families. A discordance between desired and actual fertility may represent a disruption of one's expected life course (Hagestad and Call, 2007), and involve a loss of identity and sense of control (McQuillan and others, 2003).

For some, infertility arises when trying to conceive a first child; in such cases, it may lead to involuntary childlessness. For others, it arises with second and higher-order pregnancies and, in less affluent societies, it is frequently the outcome of unsafe abortions and deficits in maternal healthcare (Seiz and others, 2023). Couples can experience female or male infertility, or even both. However, the stigma may not be shared equally. Infertility among men is much less studied (WHO, 2023), and at least one large-scale study in Canada shows sizable gaps in men's knowledge about male-factor infertility (Daumler and others, 2016). Meanwhile, women are more frequently blamed for infertility by their partners, families and communities, increasing their vulnerability to intimate partner violence, according to a meta-analysis of nine low- and middle-income countries (Bourey and Murray, 2022).

Demand for medically assisted reproduction greatly exceeds access and use (Adamson and others, 2023). In vitro fertilization (IVF) is perhaps the most well-known form of assisted reproductive technology, but it is extremely cost-prohibitive, with no robust examples of affordable, accessible and effective IVF programmes in low- and middle-income countries (Chiware and others, 2021). Other technologies, such as intrauterine insemination and ovarian stimulation, can treat people experiencing infertility, typically at lower costs (Cohlen and others, 2018).

Even in low-resource settings where assisted reproductive technologies are unlikely to be adopted by health systems, interventions such as fertility awareness and infertility prevention can and must be expanded.

A trend towards later childbearing

Late childbearing has, throughout human history, characterized third- and higher-order births (Livi-Bacci, 2017), but today, later childbearing is increasingly common among first-time parents (Beaujouan, 2020). Norms around the appropriate ages for having a child have shifted considerably over time, with older parenthood becoming increasingly socially acceptable (Lazzari and others, 2025; Billari and others, 2021; Billari and others, 2011) and, to some extent, desirable (Lebano and Jamieson, 2020). Having a first child at later ages can bring advantages: Older parents tend to have more stable careers and higher disposable income than younger parents, translating into more resources for their offspring (Powell and others, 2006). Children of older parents tend to have better cognitive, behavioural (Trillingsgaard and Sommer, 2018; Goisis, 2015) and health-related outcomes (Sutcliffe and others, 2012).

However, the postponement of childbearing may clash with the onset of infertility, which considerably lowers the chances of conception (Leridon, 2008). Biologically speaking, the reproductive lifespan covers a period of about 35 years for a woman (roughly between the ages of 15 and 49) and a bit more for men, yet human fecundity can decline even in a person's late 20s. The onset of "advanced parental age" is considered to occur at age 35 for women and age 40 for men, after which the chances of conceiving naturally decline considerably (De la Rochebrochard and Thonneau, 2003).

Individuals are often unaware of biological age limits to fertility, overestimate the probability of pregnancy at advanced ages, overestimate the age at which male and female fertility starts to decline (Mac Dougall and others, 2013), and have inadequate fertility knowledge overall (Mohammadi and others, 2023; Hammarberg and others, 2013). This can result in seeking infertility care at an age when the chances of conception are lower and more costly. By promoting early intervention, it may be possible to improve treatment outcomes. Fostering a broader culture of fertility awareness among young adults – not just among women but also men (Ferlin and others, 2022) – to improve understanding of reproductive health, fertility preservation, fecundity and associated risk factors can enable better-informed reproductive decisions (Mburu and others, 2023).

Even in low-resource settings where assisted reproductive technologies are unlikely to be adopted by health systems, interventions such as fertility awareness and infertility prevention can and must be expanded (Norman and Fauser, 2024) (see page 62).

Cost and location lead to unequal impacts on the availability of infertility care for different communities (Lazzari and others, 2022), as do laws and regulations determining who can access medically assisted reproduction, at what age and with what partner, what costs they bear and how many cycles can be subsidized.

The number of fertility clinics per capita varies considerably between and even within countries (Fauser and others, 2024; Seiz and others, 2023). Long waiting lists, linked to shortages of medical personnel, are particularly stark in low-income countries (Weinreb and others, 2024), further reducing access to, and the success of, fertility treatment.

Even when fertility care is widely available at the national level, it is seldom, if ever, available to all people and under the same conditions. In higher-income countries, low-income couples are effectively excluded from costly fertility treatments if these are not publicly subsidized, resulting in broad inequalities across social classes.

Health systems also differ regarding the rights, including eventual compensation, of third parties such as donors of gametes and gestational surrogates – where these technologies and services are permitted at all (Passet-Wittig and Bujard, 2021). Eligibility is generally restricted to married heterosexual couples of reproductive age who have failed to conceive after one year of regular unprotected intercourse. LGBTQIA+ couples and individuals are often excluded, and when they are eligible, they often face gaps in the clinical expertise of healthcare providers and low levels of inclusion in fertility care (He and others, 2024). Single people are also often excluded, and ethnic minorities face disparities in access to, and outcomes of, fertility care (HFEA, 2023). (See more on legal barriers on page 65.) Within this challenge is an opportunity – a chance to equalize access to fertility care for those currently left behind, whether they are ethnic minorities, economically disadvantaged, members of the LGBTQIA+ community or single individuals seeking an unconventional path to parenthood.

Some governments are beginning to subsidize access to fertility care (Made for Families, n.d.; Medical Korea, n.d.). Such efforts can reduce inequalities across socioeconomic groups (Seiz and others, 2023), and in some settings and circumstances they can even be cost-effective (Keller and others, 2023; Vélez and others, 2014). In this respect, publicly subsidizing fertility care can be an equalizer for prospective parents, and as such, it should be pursued. But it must be approached with caution, lest access be manipulated to the detriment of human rights and health. The focus of assisted reproductive technology must remain on addressing infertility, rather than increasing the total fertility rate or reversing population decline.

Furthermore, medically assisted reproduction cannot be the only long-lasting solution to empower people to have the children they want at later ages. The cost of even a single fertility treatment remains considerable, while the success rate of medically assisted conceptions declines as both maternal (Vitagliano and others, 2023) and paternal (Murugesu and others, 2022) age advance. The contribution of assisted reproduction to total fertility rate has been estimated for a limited number of countries such as Australia, the Czech Republic, the Kingdom of the Netherlands and the United States, and was found to range between 0.05 and 0.10 children per woman (Kocourková and others, 2023; Lazzari and others, 2023; Tierney, 2022; Habbema and others, 2009).

And while technology in this sector is growing rapidly – including everything from egg-freezing to CRISPR gene-editing technology – so, too, are the concerns. Serious bioethical questions are unresolved when it comes to the commodification of reproduction, the rights of surrogates, gamete donors and donor-conceived persons, "designer babies", and the interests of the billion-dollar, often unregulated fertility industry (UNFPA, 2024b; Waldby, 2019) – issues that must be managed with care.

From demographic security to demographic resilience

As demographics shift in many parts of the world, concerns have been raised about the potential impact of changing populations on national and international security. Such unease is not new: Fears of dying out or of being overtaken by a population different from one's own have persisted across historical and geographical contexts (UNFPA, 2023). Now, as some fertility rates in Asia and Europe decline, political actors have begun to warn that shifting populations could lead to insecurity or instability. Many of these concerns are related to the size and age structure of the population. Sometimes they are also linked to ethnonationalist sentiment – an ideology which posits that nationality is intrinsic to ethnic identity. In such contexts, individuals may be encouraged, or compelled, to have children not for their own reasons, but out of duty to their nation and its survival (Cordier, 2024). Demographic anxiety is often at the root of extremist, violent movements in countries experiencing demographic shifts, and can even promote sectarian and international conflict (Armitage, 2021).

To counter this, UNFPA works with countries to move away from a framework of demographic security and towards demographic resilience, empowering nations to proactively navigate population shifts. In 2021, UNFPA launched a programme to shift views away from demographic crises to opportunities (UNFPA, n.d.a.). By using reliable population data, promoting rights-based, evidence-driven policies, and leveraging partnerships and technology, countries can mitigate risks while advancing national and global development. The Republic of Moldova, for example, has replaced its earlier National Programme on Demographic Security 2011–2025 with a focus on demographic well-being. Its Concept Vision on Population and Development holistically engages all ministries to address ageing, desired fertility, life expectancy and outmigration of the working-age population. Similar approaches are being implemented across low-fertility countries to address demographic change comprehensively, with evidence and based on human rights.

Economic barriers

Healthcare might seem the most obvious starting point for supporting reproductive choice, but no less important are economic measures.

In high-fertility contexts, for example, leaders often worry about women giving birth to too many dependents; in low-fertility contexts, leaders often worry women are producing too few workers. These views broadly assume that women undertake the work of human reproduction and child-rearing while men engage in work outside the home, despite evidence that women have long been economically active (Long, 1958) and men have long contributed to child-rearing (Sear, 2021).

These assumptions can lead to ill-considered and ineffective approaches that treat domestic birth rates as tools to invigorate flagging economies (Balter, 2006). In fact, large-scale childbirth does not lead to immediate economic growth because it greatly increases the dependency ratio – the proportion of economic dependents to workers – in communities with already growing demands for care in old age. More immediate and effective economic measures to shore up slowing economic growth include increased labour productivity by youth, women, older people and migrants. Of these options, analysis indicates increased participation of women in the workforce might be the most effective (UN DESA, 2023).

Meanwhile, the view of human fertility as a driver of macro-level economic security obscures the fact that micro-level economic security is also one of the chief prerequisites for the realization of desired fertility. In fact, today, economic precarity is widely understood to be a key determinant undermining people's ability to realize the number of children they want (Wilkins, 2019), even as it is still *also* linked to a high incidence of unintended pregnancy, part of a cycle of poverty often experienced by adolescent parents and, especially, adolescent mothers. Low disposable total income or inability to access family resources may prevent access to contraception, leaving adolescents vulnerable to early pregnancy (UNFPA, 2022a), with ultimate negative outcomes at the family, society and country levels.

Economic instability can even lead to both outcomes at the same time: the West and Central Africa region currently has the world's highest rates of adolescent childbearing, followed by the East and Southern Africa region. Yet literature suggests that in sub-Saharan Africa, particularly in urban areas, socioeconomic challenges and high costs of living *also* contribute to the frequent under-realization of couples' fertility desires (Church and others, 2023; Yeboah and others, 2021). A study of low- and middle-income countries describes it this way: "In many countries, women from high wealth quintiles decreased their likelihood of unrealized fertility compared to the lowest quintile… further, women from higher wealth quintiles are better able to mitigate their fertility intentions" (Assaf and Moonzwe Davis, 2021).

What are the economic barriers to reproductive choice? Labour market insecurity, unemployment, low pay, absence of a living wage and overall economic instability (Alderotti and others, 2021; Vignoli and others, 2020).

Barriers can also include the high costs of reproductive healthcare, especially when it comes to infertility treatment, and the overall high costs of raising children. The cost of housing, too, greatly contributes to people's financial burdens (Tocchioni and others, 2021).

This is one reason the fertility gap between desired and actual fertility is more common in contexts with limited welfare support. Globally, the mean age of childbearing – now at 28 years – has been steadily increasing (UN DESA, 2025a) as people delay their transition to parenthood in order to have greater economic stability and resources (see box on the trend towards later childbearing on page 48). In a number of high-income countries, for example, childlessness is now more prevalent among lower-educated men and women, reversing past trends that saw higher-educated women more likely to be childless than lower-educated women (Jalovaara and others, 2018).

Below are some of the policy measures that can relieve economic burdens for prospective parents, making their fertility aspirations more achievable.

Childcare

The work of caregiving is typically either low paid or unpaid – in fact, the value of unpaid care work is estimated to equal between 5 and 9 per cent of global gross domestic product (Van der Gaag and others, 2023; Ervin and others, 2022). The invisible unpaid, or underpaid, labour of women in caregiving roles contributes substantially to women's absence from the workforce and, as shown in this report, to their decision to forgo having children or to have fewer children than they would ideally like.

Artwork by Marianna Gefen

By contrast, available, affordable and quality childcare for dependent children, from infancy to early adolescence, with opening hours aligned with parents' working schedules, is of paramount importance for increasing mothers' labour force participation and work-life balance (Morrissey, 2017). There is also evidence that, at least in some countries, formal childcare can have a positive impact on fertility (Dimai, 2023; Bergsvik and others, 2021; Wood and Neels, 2019; Rindfuss and others, 2010; Baizán, 2009).

There are many forms of childcare, varying by context and cultural norms, but one of the most universal is the support of family members. This is particularly true of countries without a developed welfare state. Grandparental childcare, especially, is a pillar of support for many working parents, as it makes up for the unavailability or unaffordability of public or private childcare services. Literature has shown that grandparental childcare provision increases mothers' labour force participation in some countries (Aassve and others, 2012). The evidence for a link between grandparental childcare and fertility is more mixed, yet for several countries the presence of grandparents and, more generally, the presence of kin, is associated with increased fertility (Rutigliano and Lozano, 2022; Sear, 2018; Aassve and others, 2012a). If grandparents are available, nearby and perceived as supportive, their adult children may have higher chances of transitioning to parenthood and to second- and higher-order births, and they are more likely to express short-term fertility intentions (Pessin and others, 2022; Aassve and others, 2012a). Emotional support from grandparents also may contribute to increasing women's fertility intentions (Tanskanen and Rotkirch, 2014). The role of grandparents is considered to be so relevant that grandparental childcare has been defined as "an emerging reproductive strategy" (Thomese and Liefbroer, 2013).

> The invisible unpaid, or underpaid, labour of women in caregiving roles contributes substantially to women's absence from the workforce and to their decision to forgo having children or to have fewer children than they would ideally like.

Yet it is important that the allocation of childcare tasks does not simply transfer the burden from parents onto other caretakers. Grandparental childcare is often unpaid, increasing the economic precarity of grandparent caregivers – especially women (Birchall and Holt, 2022). Research from Europe, for example, shows that having grandchildren substantially reduces the labour force participation of older women, particularly in countries with little formal childcare (Backhaus and Barsland, 2021). Some governments are providing financial support to family-based care. Sweden and Germany, for example, have offered paid leave for grandparents providing childcare (Olsen, 2024; Connolly, 2008).

Centre-based childcare, such as nurseries and daycare facilities, is often assumed to be culturally inappropriate in many low- and middle-income settings, but studies actually show that uptake of centre-based care is *increasing* in these countries (Evans and others, 2024). Researchers also note that pre-primary school childcare programmes are more associated with economically well-off households in South Asia and Latin America (Chaturvedi, 2019), indicating the barriers to centre-based childcare are likely more related to affordability and accessibility than cultural taboos. One study from an informal urban settlement in Kenya found "mothers eager to send their children" to subsidized early childcare centres; access to subsidized care was also associated with greater employment among mothers (Clark and others, 2017).

Even as these formal childcare services can be costly to parents, the labour of childcare often remains low paid due to the tendency to undervalue both care work and occupations commonly held by women (Gambaro, 2012). Remedies to these concerns can come in the form of subsidies, which may be applied to either centre-based care or to at-home caregivers. Countries such as Colombia and Chile have financed centre-based care through national budgets, while local-level programmes in India have used cooperative and non-profit models. Not only are centre-based programmes associated with increased maternal workforce participation, but programmes in Argentina, Bolivia and Uruguay also saw positive impacts on child outcomes (Chaturvedi, 2019).

Transition to adulthood

As the median age of childbearing rises, young people increasingly regard becoming economically independent from their family of origin and forming a partnership as key prerequisites for parenthood. Yet the actual ages at which young people are able to attain economic independence and parenthood (and, in countries where co-residence between one's partner and parents is uncommon, leave their parental home) are too often older than the age of peak fertility and the age considered ideal by young people themselves (Lazzari and others, 2025; Schwanitz and others, 2024; Billari and others, 2021).

The unaffordability of living independently, the cost of housing and the difficulty in finding decent work are among the top-reported reasons preventing young people from establishing independence from their family of origin (Berrington and Perelli-Harris, 2024). Notably, housing concerns are not linked solely to youth; they can be a barrier to people of all ages. In Belarus, for example, more favourable housing conditions were consistently linked to higher birth rates in both rural and urban settings, throughout a woman's reproductive life, with the most significant impact on second and third births (GGS Belarus, 2017). Even so, housing costs are a particularly critical concern among young people. One study from Brazil found that young adult winners of housing credit lotteries were 32 per cent more likely to have children (Van Doornik and others, 2025), for example, and data from China, the Islamic Republic of Iran and the United States show housing costs impact not only young people's fertility but also their likelihood of marrying (Gao and others, 2022; Gholipour

and Farzanegan, 2015; Bowmaker and Emerson, 2015).

Unemployment, insecure and precarious employment, involuntary part-time employment and perceived economic uncertainty are all barriers to reaching milestones along the transition to adulthood (Matysiak and Vignoli, 2024). This issue is global. For example, more than 1 in 4 young people in Africa – around 72 million – are not in employment, education or training, a study by the International Labour Organization found, with young women facing higher barriers to labour force participation than young men (ILO, 2023).

Youth coming from a low socioeconomic family background, youth of migrant origin and those belonging to sexual minorities are even more disadvantaged in realizing their aspirations throughout the transition to adulthood (Eurofound, 2024; Billari and others, 2019). Economically disadvantaged and lower-educated individuals are less likely to partner (Bellani and others, 2017) and therefore to become parents (Lee and Zeman, 2024; Hwang, 2023; Keizer and others, 2008), and are the most likely to be childless (Wang and Mu, 2025; Ghaznavi and others, 2022; Jalovaara and others, 2018).

Violence and conflict also impact the transition to adulthood. Research in Haiti and Honduras finds that community violence delays youth independence, forcing many to remain in their parental homes for safety, undermining access to education and decent employment, and fuelling a cycle of exclusion (Chávez and Aguilar, 2021).

Artwork by Cyan Haribhai

The inability to realize one's aspirations during young adulthood can even trigger emigration to other countries offering better opportunities, particularly during periods of economic recession, when unemployment increases more for young people than for those of other ages (Aassve and others, 2013), all of which is likely to further depress fertility (Anelli and Balbo, 2021). Moving abroad can further impact fertility aspirations by stretching family support networks that are often the primary source of childcare.

Decent work and adequate pay must be aligned to the cost of living and housing costs – a critical matter for youth employment policies.

Policy efforts should be aimed at empowering young people to achieve the milestones of the transition to adulthood that they wish to experience, at the age that they want, and under the conditions they aspire to (UNFPA, n.d.a.). Policymakers must therefore engage with the specific needs and desires of young people, whose journeys to adulthood will likely vary by country and culture. Research shows that fertility aspirations in China, for example, are influenced by housing security, which plays a role not only in a young person's budgeting but also in their perception of subjective well-being, expectation for intergenerational mobility and expectation of providing eldercare (Zhang, 2024).

By removing economic, labour market and housing uncertainty, young people can be empowered to navigate their transition to adulthood at the time of their choosing and be better supported to realize their fertility aspirations. For many, it can help prevent an unwanted delay that makes medically assisted reproduction the only viable option to achieving their reproductive aspirations.

Family-friendly work policies

Balancing childcare responsibilities with full-time employment remains a significant challenge, especially for women (Thévenon, 2009). Family-friendly workplaces offer a potential remedy, and they are becoming increasingly widespread. In the European Union, for example, family-friendly workplaces are directly supported by the EU Work-Life Balance Directive, which entered into force in 2019. Such programmes have been shown to improve both employees' work-life balance and their overall well-being, and they also increase mothers' continued employment after childbirth (Chung, 2017).

Family-friendly workplace policies can include: flexible work arrangements that allow parents to work adapted hours or off-site; on-site childcare and childcare assistance; parental leave after birth (including both maternity and paternity leave) at full-pay equivalent; healthcare benefits for dependents; nursing breaks; and leave to care for sick children. Yet such policies are available to too few workers globally (UNICEF, n.d.).

Progress has been made in providing access to maternity leave. While most data on parental leave come from high-income countries, one study of 111 developing countries found that maternity leave was positively associated with

female labour supply, especially when the cost of leave was borne by the government (Amin and Islam, 2022). The amount of maternity leave has increased over the last five decades as well, with the greatest increases in Central Asia and Europe.

Unfortunately, leave for fathers remains comparatively rare, and thus the gap between maternity leave and paternity leave has grown over time (Hyland and Shen, 2022). While 186 countries globally provide maternity leave, only 122 provide paternity leave, with the average duration being just 9 days (Van der Gaag and others, 2023). Progress in granting paternity leave has been slowest in the Middle East and North Africa, with an average of 2 days of leave in 2021, and in sub-Saharan Africa, with 2.7 days (Hyland and Shen, 2022). Yet paternity leave has a host of benefits, including better health outcomes for children, as well as better relationships between fathers and their children and between fathers and their partners (Pizarro and Gartzia, 2024). Decreasing the gap between maternity and paternity leave is also shown to increase female labour force participation (Hyland and Shen, 2022).

However, if not implemented carefully, family-friendly policies can be counterproductive by reinforcing negative stereotypes. In India and the United States, women report that making use of family-friendly policies – even medically necessary maternity leave – incurs a reputational cost in the workplace (Bhattacharya, 2024; Bose and Chatterjee, 2024; Hampson, 2019). Workers are often "reluctant to take advantage of these policies under male-centered organizational practices" that regard parents, and especially mothers, as less-ideal workers, one Korean study notes (Kim, 2008).

Artwork by Stina Persson

Discriminatory gender norms influence both men's and women's willingness to make use of family-friendly policies (Kaufman, 2018; Von Hippel and others, 2016). Some research shows that parental leave is associated with negative career repercussions for both men and women, though this varies by country and industry (Krstic and Hideg, 2019). Other research shows that family-leave policies can actually have a disproportionately positive impact on men, reducing their work-life conflicts. Yet women's work-life conflicts broadly do not change unless there are also improvements in gender-equitable norms and attitudes (Hsiao, 2023).

It is imperative, therefore, that government and workplace policies endeavour to ensure that all employees, particularly male employees, make use of the benefits they are entitled to. But this also speaks to the importance of improving work-life balance for all workers – not only parents – in order to mitigate the stigma of using parental leave accommodations. In fact, all workers' family lives suffer under time-intensive work environments. For example, in East Asia and elsewhere, long, inflexible working hours on-site are often required to obtain benefits and promotion, with little consideration for employees' family commitments. These have a clear impact on family welfare and the decision to have children, studies in the Republic of Korea (Kim, 2023) and in some European countries have found (Kurowska and others, 2023).

What are some viable alternatives? One option is to make paternity leave obligatory: In April 2025, Singapore initiated a mandatory two weeks of leave for new fathers to address low uptake and encourage a more balanced division of childcare responsibilities (Tan, 2024). Countries in which paternal leave is non-transferable, with leave policies allotted as individual entitlements for each parent, also see much higher levels of uptake among men (Shand, 2018).

Another option would be the expansion of work-life policies so they are applied irrespective of family status. By providing better work-life accommodations to all workers, the disincentive to recruit and retain women workers is eliminated, and the disinclination to take parental leave could be further reduced among men. Younger workers sceptical that workplace policies will enable them to care for their future children would begin to realize the benefits of flexible leave immediately, building trust in the accommodation of workplaces towards the needs of all workers.

These work-life accommodations should include access to medical leave of all kinds. This would eliminate discrimination against workers seeking accommodations for pregnancy care and infertility treatment – the latter being "reproductive work" (Wilkinson and others, 2023) that requires time for regular hormone intake, frequent doctors' appointments, visits to clinics and even foreign travel for cross-border reproductive healthcare (Wu and others, 2013). Individuals, especially women, may require time off work or flexible work schedules, yet asking for accommodations can be risky in a labour market still rife with pregnancy discrimination and discrimination against working mothers (Kachi and others, 2022). Expanding access

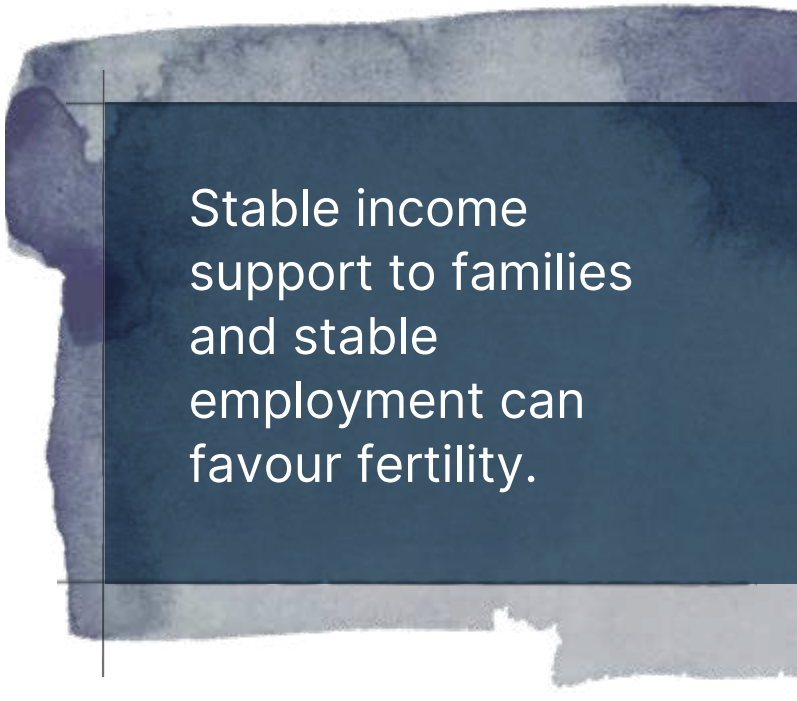
to medical leave for all workers, irrespective of family type, could enable all workers to step into caretaking roles that otherwise tend to fall, by default, to women, including attending medical appointments with children and/or elderly parents or grandparents.

Work-from-home and hybrid work arrangements, which have become more commonplace in recent years, could also theoretically enable better work-life balance for parents. Yet the implementation of such policies is unequal across sectors (Lambert and others, 2023), and the rise of telework more broadly may be increasing worker competition and depressing wages, according to research in Latin America (Kabat, 2025). And while remote work opportunities can, in some cases, help women have a desired child – such as when they would otherwise have a very long commute – it broadly does not result in women having children, studies from Europe show (Kurowska and others, 2023). In fact, because home-based work often has negative impacts on career growth, can increase both workplace and domestic burdens, and fails to address the root issue of gender-unequal care burdens (see page 79 in Chapter 3 for more), women in the UK working from home were actually *less* likely to have a child than women working on-site and unemployed women (Osiewalska and others, 2024). Workplace policies, therefore, should take care to address the gender-unequal impacts of family leave and flexible work policies, as these play important roles in workers' decisions to have children.

Short-term windfalls versus long-term stability

Finally, stable income support to families and stable employment can favour fertility (Alderotti and others, 2024). This may seem obvious, but many policies seeking to support family formation are short-lived or subject to reversal as political winds change. Many policymakers are under pressure to show immediate material improvements in constituents' lives or immediate changes in total fertility rates. Therefore, short-term, one-time or time-limited policies are common.

Lump-sum payments, grants or cash transfers around the time of a baby's birth – a "baby bonus" – have been a common policy approach. Very generous baby bonuses can have an impact, but likely only a temporary one. Such programmes in Australia, Quebec and Spain, for example, resulted in a short-term increase in births, but likely from parents bringing forward the timing of their children (UNFPA, 2019).



FEATURE

The business of care

When Anastasia Aslan, in the Republic of Moldova, found out she was expecting her fourth child, she didn't hesitate. Unlike many working mothers who struggle to balance career and family, Ms. Aslan knew she had a safety net: Her employer, the Panilino bakery company, had flexible hours, a daycare centre and policies that supported parents.

"When planning for the child, we considered several factors, such as whether we could support ourselves during my maternity leave and how I would combine household tasks with work. In this sense, the fact that Panilino offers a daycare centre was a factor that helped us decide to have another child."

Panilino's family-friendly policies are actually core to its business model. With support from UNFPA and the Austrian Development Agency, Panilino opened an in-house childcare centre, encouraging parents to continue working while their children were being cared for.

A business case for family-friendly policies

Throughout south-eastern Europe, shrinking populations and staff shortages are forcing companies to rethink the way they support families. Far from being a financial burden, companies adopting these policies see them as positive. "These practices foster a positive and flexible environment that promotes well-being," says Mergim Cahani, founder and CEO of Gjirafa, one of central Europe's fastest-growing tech companies. "From a human resources perspective, offering these practices helps attract top talent who appreciate these values. Additionally, by improving employee satisfaction and reducing turnover, these practices ultimately contribute to profitability through higher productivity, reduced recruitment costs and a more engaged workforce."

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Gjirafa offers flexible hours, hybrid work, caregiver leave and parental leave for fathers. These are designed to help employees balance their responsibilities at work and at home, especially if they have young children.

"We introduced these practices gradually, responding to needs as they emerged. Rather than implementing them all at once, we adapted over time, recognizing the importance of flexibility and support in creating a more inclusive workplace," Mr. Cahani says.

Beyond baby bonuses: The role of government

For decades, Eastern European countries have experimented with financial incentives – cash bonuses for new babies, tax breaks for larger families, even medals for mothers of multiple children. Increasingly, governments are becoming aware that economic incentives and awards are not meeting the full needs of parents.

Maja Papatolevska, Deputy Head of North Macedonia's Department of Labour at the Ministry of Economy and Labour, says her country has been working to improve workers' rights and their work-life balance – including plans to introduce paid leave for caregiving, expanded maternity and paternity leave, and new parental leave rights, which should help redistribute caregiving responsibilities more equally.

"We also introduce the possibility for an employee who has a child up to the age of 8 to request to work more flexible hours for the purpose of childcare, in the form of part-time work, adaptable working hours or remote work, in accordance with his or her needs for childcare and the work-related needs of the employer," she adds.

The proposed shift extends beyond legal reforms to cultural attitudes. "Pregnancy and the beginning of motherhood are some of the most challenging periods for a woman. However, if she is supported by the state during these processes, ensuring that her experience is as painless as possible in terms of its potential impact on her professional life, the chances of her not giving up on motherhood or her career, but pursuing them in parallel, are significantly greater."

UNFPA is supporting these policies through its Expanding Choices initiative, which works with governments and businesses to create sustainable, gender-responsive approaches to work and family life in the Western Balkans and the Republic of Moldova.

Shifting social norms

Cultural barriers to parenthood are persistent in many parts of the region, where women still bear the brunt of unpaid caregiving, and men are less likely to take parental leave. "If we think about the daily household chores – cleaning, cooking, taking care of the children, school, kindergarten – that routine can become overwhelming for a woman. That's why I encourage mothers to have the courage to return to work as soon as possible," says Ms. Aslan.

For Ms. Aslan, the benefits of her company's policies go beyond convenience. "The opportunity to work remotely, offered by the director, is extremely valuable. I know that I am a valued employee and that there are people waiting for me to return. The daycare provides me with the peace of mind I need, knowing that my child is safe and that I can be with him whenever necessary. I hope that more and more companies will encourage such policies, supporting mothers in planning their future and their families with confidence."

Regular cash transfers show somewhat more impact. For example, regular cash transfers had a small but noticeable impact on period total fertility in studies in Argentina, Hungary, Israel and Spain (UNFPA, 2019). Another example is from Poland, which in 2016 began providing substantial direct cash transfers to families with two or more children – amounting to 2 per cent of the country's gross domestic product. Yet even here the results were limited: A 1.5 percentage point increase in the overall probability of a woman having a child, mostly affecting women aged 31–40. Notably, fertility among women aged 20–30 actually fell in this period, perhaps because women of this age were prioritizing their education and careers in pursuit of even *more* financial stability, or because they "might resist what they perceive as government pressure to have children" (Bokun, 2025).

Other efforts to improve the economic welfare of families have included the Russian maternity capital policy, implemented in 2007, of transferring non-cash capital to mothers, in the form of housing subsidies, mortgage repayments, education grants and pension funds. These transfers were available to mothers of two, three or more children, and were meant to be available until 2016, although the policy was then extended. Period total fertility increased, in part due to parents moving forward the timing of their childbearing, but also due to increased births of second and third children, though notably there is no agreement about how strong these impacts have been (UNFPA, 2019).

The overarching indication is that longer-term financial security – whether through improved earning potential, greater job security or better economic conditions overall – is important for enabling people to realize their fertility goals. While short-term, limited or one-time financial transfers may help with child-related expenses, they may also just encourage parents to bring forward their childbearing plans in anticipation of the assistance disappearing; these parents might still ultimately forgo their desires for additional children (UNFPA, n.d.a).

Education, information

Education policies can go a long way towards improving reproductive health, rights and choices. At the same time, poorly implemented and insufficiently supported education can have grave repercussions for individuals' rights, reproductive lives and long-term welfare.

A robust body of evidence shows that comprehensive sexuality education, for example, leads to improved health outcomes for young people, including reduced rates of adolescent pregnancy and sexually transmitted infections, as well as positive impacts on partner communication, sexual health knowledge and awareness of services (UNESCO, 2016; Constantine and others, 2015; Rohrbach and others, 2015). Comprehensive sexuality education typically includes medically accurate information about human anatomy, contraception, sexually transmitted infections, consent and healthy communication in relationships. When taught to international standards, it is age-appropriate, includes information on human rights and gender equality, and is tailored to cultural contexts with the participation of educators, students, parents and community members (UNFPA, 2018).

But curricula often focus on the immediate sexual and reproductive health concerns of adolescents rather than preparing them for issues that will unfold across the full life course (Littleton, 2012). Researchers point to a need to include fertility awareness in education programmes for youth (Fauser and others, 2024), and some countries, such as the United Kingdom, are exploring models of this kind of learning (Cheshire and others, 2024). Fertility awareness can encompass not only the fact that fertility declines with age for both men and women, but also that factors like smoking and drug use can affect fertility, that all contraceptive methods (including fertility-awareness methods) have failure rates (*BMJ*, 2019), and that unintended pregnancies can take place even through perimenopause (Bakour and others, 2017).

Comprehensive sexuality education is particularly effective when linked with accessible, non-stigmatizing reproductive health services (Mbizvo and others, 2023), and when it is integrated into teacher-training programmes (UNFPA, 2018). Yet the latest evidence shows that, out of 153 countries with data, 28 per cent do not have any enabling laws, regulations or policies on comprehensive sexuality education (UNFPA, 2022b). Further, after decades of near-universal agreement, comprehensive sexuality education has been the subject of recent rollback and opposition (United Nations, 2023). And even when sexual and reproductive health topics are allowed in classrooms, the curricula can be marred by misinformation; this can be seen from the grade school level through to medical school (UNFPA, 2024a).

When sexuality education contains misinformation or incomplete information, or when information is conveyed in a stigmatizing way, it can reinforce harmful stereotypes and impair young people's ability to plan their futures and families. For example, while adults experiencing infertility affirm that they wish they'd received fertility awareness education (Mena and McLindon, 2023), information about age-related fertility decline (the so-called "biological clock") can be delivered in ways that reinforce prejudice against women and censure over their choices (Aldrighi and others, 2016). Unbiased, non-stigmatizing information is also important for adolescent boys and men, as these groups in particular often lack knowledge about infertility prevention (Daumler and others, 2016).

Unbiased, medically accurate information must also be more widely available in out-of-school contexts, including for adults well beyond school age, to address rampant misinformation about sexual and reproductive health. Falsehoods about reproductive health, human anatomy and healthcare are proliferating widely (Pagoto and others, 2023), particularly on social media, sowing distrust of everything from contraceptives (Glennerster and others, 2023) and cervical cancer screens (Johnson and others, 2021) to human papillomavirus vaccines (Massey and others, 2020), abortion (Pagoto and others, 2023) and HIV (Krings, 2024). Anti-gender actors are also launching apps that promote misinformation (Glenza, 2019), programmes that "have gained legitimacy, and are now being integrated into education curricula" (EPF, 2025). As a result, digital comprehensive sexuality education tools and online sources of reliable, accurate reproductive health information are more important than ever.

Other educational policies can also impact the ability of individuals to realize their reproductive goals. Student parents, and especially student mothers, report serious barriers to completing their education while caring for children, often leading to education discontinuation. The difficulty of balancing education and childcare extends to all levels, from adolescent parents still in grade school to university and postgraduate students (Moghadam and others, 2017) and in all cultural and income contexts (Osei Boakye and others, 2021). Measures to support work-life balance for parents should therefore be extended to education, including greater scheduling flexibility and increased availability of childcare services for student parents (Navarro-Cruz and others, 2023).

Finally, the high costs and pressure involved in some educational systems can also influence fertility aspirations. In the Republic of Korea, a highly competitive school system has been linked to later entry into working life, worse mental health and life satisfaction among adolescents, inequality of opportunity and lower fertility (OECD, 2025). The link between high-pressure education and fertility has also been noted in other countries. Individuals in China and Japan have cited the high cost of education as an important factor in decisions about family size (Ogawa and others, 2009), for example.

Education and adolescent pregnancy – a fuller picture

While access to reproductive health services is critical to reducing adolescent pregnancies, education is no less important. It is often the case that as a population's level of education increases, the rate of adolescent pregnancy decreases. But new research from Latin America shows that the timing of education also matters. While researchers have often focused on the value of tertiary education, upper secondary schooling may actually be the most impactful because access to upper secondary is much more widespread than access to university (Garbett and others, 2025). The impact of staying in school is also shaped by other factors, such as poor compensation for women's skilled labour. A girl's vision for what is possible in her future also plays an important role; research finds that adolescent motherhood is linked to an absence of life plans, such as higher education. These insights point to the role that restrictive gender norms continue to play for young women and girls.

Intersecting inequalities – such as discrimination based on ethnicity, income, age and location – can exacerbate these issues. New research from UNFPA shows that, in the Latin America and Caribbean region, Afro-descendent adolescents are 50 per cent more likely to become mothers than their non-Afro-descendent peers. The costs are severe, amounting to more than $15 billion across 15 countries examined, the vast majority of which are borne by the adolescent mothers themselves (UNFPA, 2025a). To tackle the issue, girls must continue to be encouraged to stay in school. But policymakers must also look beyond the classroom to address the underlying factors driving marginalization. When girls can imagine a future outside of early motherhood, they are more likely to realize it.

Legal barriers to childbearing by choice

Finally, there are many legal barriers to parenthood, both direct and indirect. Direct barriers are most often linked to norms about what constitutes "a family". This definition can determine the eligibility criteria for access to medically assisted reproduction, cash benefits for children, access to parental leave, tax deduction and more. Yet parenthood and family formation are increasingly desired by people who fall outside the conventional image of a nuclear family headed by young, heterosexual parents. Today, parenthood is wanted by, and possible for, single people (Volgsten and Schmidt, 2021), LGBTQIA+ couples (Gato and others, 2021; Kolk and Andersson, 2020; Tate and others, 2019) and women once considered too old to become mothers (Ameratunga and others, 2009).

Legal systems often limit access to family-building services, such as adoption and medically assisted reproduction, to married heterosexual couples only. Joint adoption by same-sex partners is permitted in only 36 countries worldwide, while 37 other countries permit second-parent adoption (the adoption of the child of one partner by the other partner) (ILGA World Database, n.d.). Access to assisted reproduction and surrogacy for same-sex partners is permitted in even fewer countries. In Europe, out of 49 countries, only 17 allow medically assisted insemination for couples regardless of their sexual orientation and/or gender identity and 26 countries allow it for single people (ILGA, n.d.).

Legal restriction can also prevent the official recognition of parenthood achieved through cross-border medically assisted reproduction. Examples of this include the removal of non-biological parents from birth certificates of children born to same-sex couples and the criminalization of surrogacy, even if practised in countries where it is legally permitted (Government of Italy, 2024; Kilbride, 2023). There are other legal measures, too, which deny individuals the right to become a parent, such as compulsory sterilization for people undergoing gender-affirming care – a practice condemned by the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (United Nations General Assembly, 2013), and banned by a 2017 European Court of Justice ruling (ECHR, 2017). In 2023 both Finland and Japan ended such requirements (Reuters, 2023; Yamaguchi, 2023).

Unsurprisingly, the share of individuals who expect to realize their parenthood aspirations is considerably lower among those belonging to gender minorities than it is among heterosexuals (Riskind and Tornello, 2017; Baiocco and Laghi, 2013) and the gap between desired and actual fertility is higher among women in same-sex couples than in opposite-sex couples (Boertien and others, 2024).

Legal restrictions seemingly unrelated to reproductive choice can also have an impact on individuals' decision-making. Some research shows that a country's inheritance laws can impact fertility levels, with one study from Namibia suggesting that women may

choose to have more children at an earlier age to counteract the risk of dispossession in widowhood (Sage, 2025). A person's legal status within a country may also influence fertility. In Colombia, undocumented Venezuelan migrants granted amnesty were less likely to have a child due to better access to healthcare services, including family planning, and improved employment opportunities for women (Amuedo-Dorantes and others, 2023). In countries that do not permit women to pass on nationality to their children, such as Lebanon, Qatar and Somalia (UNHCR, n.d.), children may be left stateless if the father is unknown, missing, deceased or stateless himself, or if the child is raised by two mothers. Individuals in these situations may have to decide between forgoing children or subjecting children to statelessness, conditions that "deny individuals the right to have a child, and infringe the right to parent with dignity by forming a family of their own choosing," according to human rights experts (Levine and Peden, 2021).

There are also widespread legal restrictions to accessing the means to prevent a pregnancy, including age barriers for accessing contraception (Wlodarczak-Semczuk and Charlish, 2024) and bans on elective sterilization for those who do not wish to have children (Fedeli and others, 2023). Similarly common are restrictions on ending an unwanted pregnancy; approximately 40 per cent of women of reproductive age, 753 million, live in places with restrictive abortion laws (CRR, n.d.), and in 95 countries, women can be criminally charged for obtaining an illegal abortion (UNFPA, 2025b).

Artwork by Cyan Haribhai

Other laws specifically curb the reproductive decision-making power of women or adolescents. According to the latest data from the Sustainable Development Goals database, 7 per cent of countries reporting that they have laws guaranteeing access to maternity care actually make this care available on the condition that recipients are married. Twelve per cent of countries reporting they protect access to contraceptive services actually have plural legal systems that undermine access. A third of reporting countries have minimum age requirements to access contraceptive services. One fifth of countries require women and adolescents to obtain third-party authorization to access contraceptive services (UNFPA, 2022).

Finally, there are laws that insufficiently protect people from sexual violence and reproductive coercion, or even criminalize survivors of rape (Vafa and Epstein, 2023), even though approximately 1 in 4 women report being unable to say no to sex, and even though sexual violence contributes significantly to the global incidence of unintended pregnancy (UNFPA, 2022a).

In pursuit of a better world

Around the world, we see that women and men are postponing or forgoing desired childbearing because they face significant barriers to parenthood.

As shown in Chapter 1, across all countries surveyed by UNFPA/YouGov, nearly 1 in 5 respondents (18 per cent) believed they would be unable to have the number of children they wanted. Nineteen per cent of respondents said fears about the future, such as climate change, war and environmental destruction, would lead to the under-realization of their fertility goals. Fifty-four per cent felt that economic factors, from housing limitations to childcare availability to job security, would lead to the underachievement of their desired family size.

At the same time, millions continue to experience unintended pregnancies. And too many people are experiencing both. All of this points to a policy environment that is hostile to the dreams and aspirations of young people, leading to pregnancies many did not want to have, while creating a world they are unwilling to bring life into. But this policy landscape can – and must – change. By listening to young people, we can create a better future for them, and for their children.

IN FOCUS

How much fertility decline can be attributed to reductions in adolescent childbearing?

While many policymakers are deeply concerned about declining birth rates, these changes can be an indication of successful human rights and development initiatives seeking to reduce adolescent childbearing. A review of the evidence finds that in some countries and regions, recent declines in total fertility rates to low and very low levels are intricately linked to rapid reductions in birth rates among adolescents and young women (aged 15–24 years), caused by a postponement of childbearing.

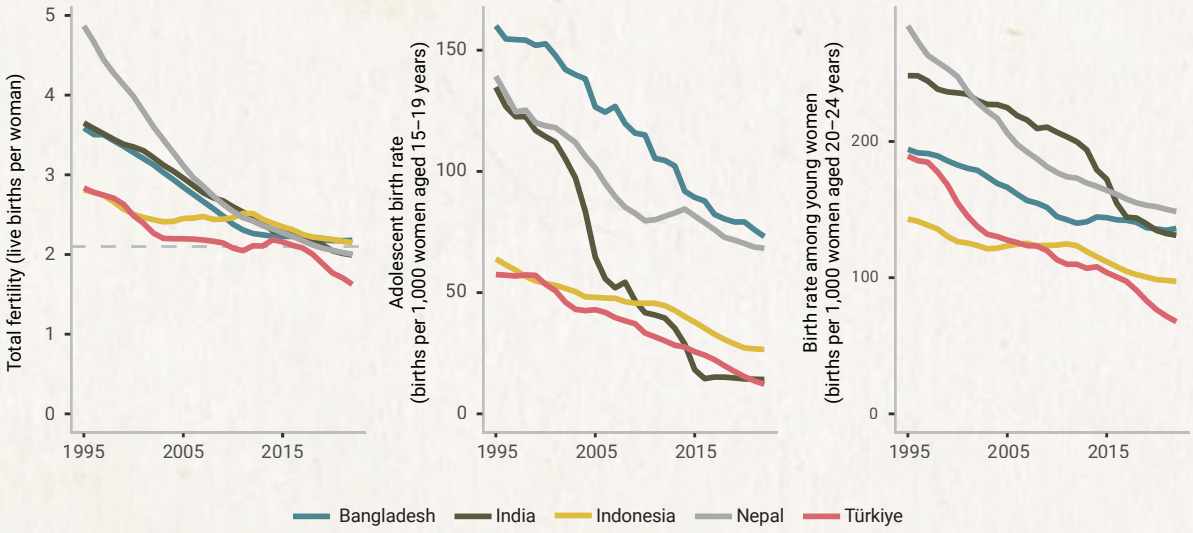
The substantial drop in adolescent birth rates stands out as one of the major success stories in public health over the past three decades.

Figures 6a and 6b present total fertility and birth rates among women aged 15–19 and 20–24 across selected countries in Asia and Latin America and the Caribbean. These countries have experienced a steady decline in total fertility over the past two decades, with several reaching or approaching replacement-level fertility (2.1 births per woman) and some experiencing an acceleration of fertility decline to very low levels in recent years. At the same time, a sharp decline in adolescent birth rates among girls and young women aged 15–19 years has been observed.

Argentina has seen a substantial 60 per cent decline in the adolescent birth rate, dropping from 64 births per 1,000 girls and young women aged 15–19 in 2015 to 25 in 2022. A similar trend was observed in Uruguay, where the adolescent birth rate declined by 53 per cent in the same period. Though more studies and data are needed, the evidence shows that the decline in total fertility in recent years is associated primarily with the postponement of first births among adolescents and young women, supported by government programmes promoting access to family planning services and information among adolescents and young women (Pardo and others, 2025; Cabella and others, 2024).

FIGURE 6a

Total fertility rate (left), adolescent birth rate, 15–19 years (middle), and birth rate among young women, 20–24 years (right), in selected countries in the Asia Pacific region and Eastern European and Central Asia region (1995–2022)

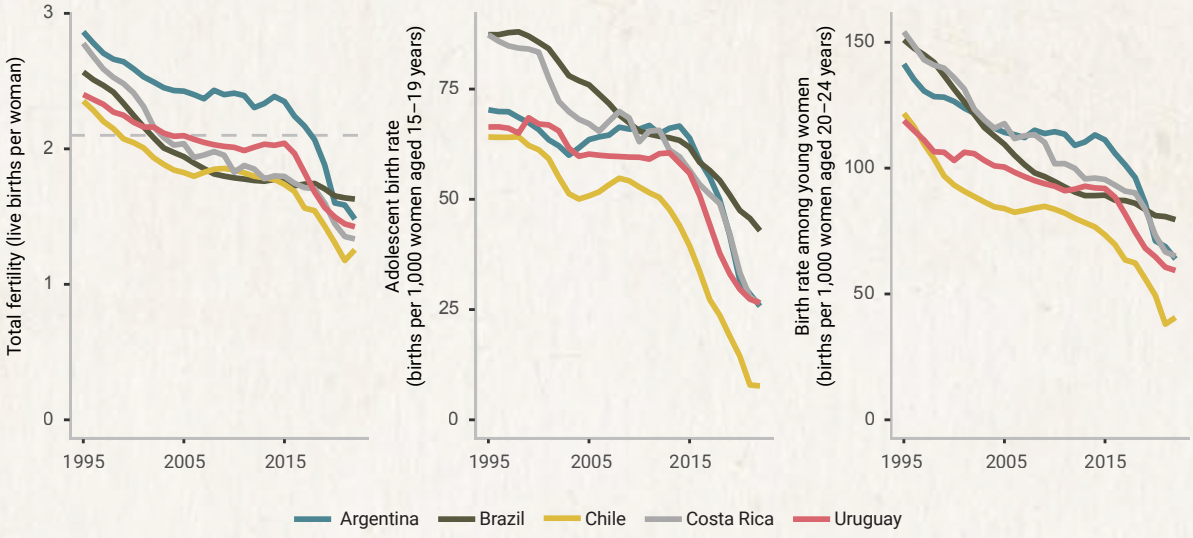


Source: UN DESA, 2024.

Note: The dashed grey horizontal line in the first panel indicates the level of replacement fertility.

FIGURE 6b

Total fertility rate (left), adolescent birth rate, 15–19 years (middle), and birth rate among young women, 20–24 years (right), in selected countries in Latin America and the Caribbean (1995–2022)



Source: UN DESA, 2024.

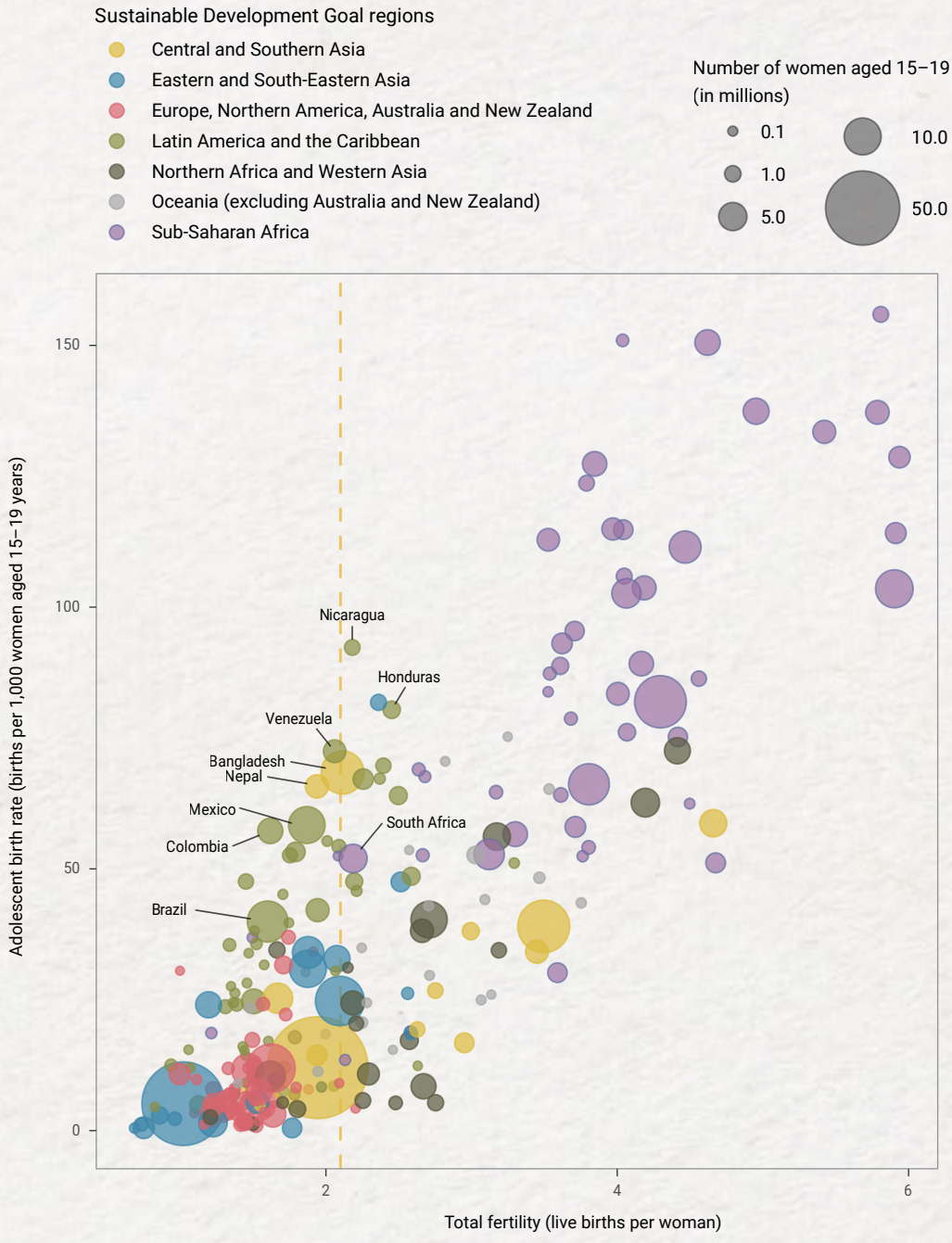
Note: The dashed grey horizontal line in the first panel indicates the level of replacement fertility.

Similar declining trends in adolescent childbearing are also observed in countries in Asia. The substantial drop in adolescent birth rates stands out as one of the major success stories in public health over the past three decades, allowing more young women and girls to complete their schooling and avoid health complications from early pregnancies.

Additionally, the significant decline in birth rates among young women aged 20–24 years signals a trend towards delayed childbearing, as recent cohorts of women entering reproductive age have fewer children early in life. These trends indicate that decreasing childbearing among adolescents and young women has played a key role in the overall fertility declines in both regions. Based on historical experience in other low-fertility countries, there is the potential for recuperation of childbearing at later ages, as women who do not start childbearing as adolescents or in their early 20s eventually have children at an older age. For example, the declines in total fertility to very low levels observed in the 1990s in Eastern European countries were linked to the postponement of childbearing (Sobotka, 2005) and eventually total fertility recuperated to slightly higher levels. Yet how much of the postponed childbearing will be realized in women of older ages will depend also on the existence of socioeconomic conditions and family policies favourable to childbearing (UN DESA, 2025a).

Moreover, some countries with low total fertility still report relatively high adolescent birth rates, exceeding 50 births per 1,000 girls and young women aged 15–19 (Figure 7). These countries, primarily in Latin America and the Caribbean – such as Colombia, Mexico and the Bolivarian Republic of Venezuela – as well as a few in Central and Southern Asia – such as Bangladesh and Nepal – will hopefully experience rapid declines in adolescent childbearing in the near future. This will in turn contribute to further reductions in total fertility (see UN DESA, 2025a, for scenarios depicting the impact of adolescent fertility declines). However, as demonstrated in previous contexts, this initial decline may be eventually followed by a slight recuperation of fertility rates among women aged 25 and older. This highlights the importance of looking beyond the total fertility measure and examining age-specific fertility patterns to uncover the underlying factors that shape fertility trends.

FIGURE 7 **Adolescent birth rates (15–19 years) by total fertility, by region, 2025**



Notes: Countries and areas with at least 90,000 inhabitants in 2025 are represented in the figure. The size of the bubbles is determined by the number of women aged 15–19 years in 2025. The country label of Venezuela (Bolivarian Republic of) has been abbreviated as Venezuela. The dashed orange vertical line indicates the level of replacement fertility.

Source: UN DESA, 2024.

Text contributed by Vladimíra Kantorová and Siqi Wu of UN DESA.

Artwork by Graham Dean

CHAPTER 3

Gender equality and dividends for all

The year 2025 marks the 30th anniversary of the Beijing Declaration and Platform for Action, a landmark international agreement that affirmed "women's rights are human rights". Building on the 1994 International Conference on Population and Development, it further declared, "The explicit recognition and reaffirmation of the rights of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment" (UN Women, 2014).

The intervening years have seen major advances for women and girls, not only in the policy arena but also in the attitudes and social norms that underlie policies. For example, surveys asking if it is ever acceptable for a man to beat his wife show declining agreement over time across countries, an indication people are increasingly rejecting intimate partner violence and other forms of gender-based violence (Vartanova and others, 2023; Birdsall and Oroxom, 2018); this trend has been accompanied by the adoption of some 1,583 laws against gender-based violence across 193 countries, up from only 12 countries in 1995 (UN Women, 2025).

The world has also grown more accepting of women's participation in decision-making at the highest levels. Between 1997 and 2025, the proportion of women serving in national parliaments increased from around 12 per cent to around 27 per cent (IPU Parline, n.d.). In fact, research into values finds that across a variety of measures, "for every country group, in any year of the survey, the younger the cohort, the more gender-egalitarian the attitudes" (Biolcati and Ladini, 2022).

Yet these gains remain tenuous, and are too easily subject to reversal. The Gender Social Norms Index, which investigates gender biases across a variety of measures, finds gains in attitudes towards women and girls stalling in the last decade: Across 38 countries "the share of people with at least one bias decreased modestly, from 86.9 per cent to 84.6 per cent" (UNDP, 2023). While trend data on bodily autonomy, available for 32 countries between 2006 and 2022, show improvements in 19 countries, 13 have seen women's experience of bodily autonomy *regress* (UNFPA, 2024a).

Some of this may be due to the growing strength of the anti-gender (also called the "anti-gender ideology") movement, which "mobilized first in Europe and then in Latin America" and "formed various national and transnational alliances with shared strategies and objectives", according to a recent Human Rights Council guidance document. "Women human rights defenders who work in these areas, in particular those defending sexual and reproductive rights, have also increasingly been subjected to hostilities by anti-gender movements" (OHCHR, 2024).

Public rhetoric at times expressly blames gender equality for declining fertility rates. Indeed, a correlation between women's empowerment and declining fertility rates has been observed for decades (Schmelz, 1976), and though the nature of this correlation is now being questioned (see box on gender inequality and low fertility, on page 31), it has nonetheless resulted in the promotion of feminism as a tool by which to reduce birth rates: "Promoting gender equality and feminism may be the best way of increasing demand for birth

control in high fertility countries," said a 2019 newsletter of the now-defunct organization Negative Population Growth, Inc (Rubenstein, 2019). This treatment of gender equality as a mechanism by which to achieve a demographic end, rather than a human rights goal in itself, has likely contributed to the view that reversing women's empowerment (by reducing access to education, for example) would trigger increased fertility rates (Greene and Burke, 2024). But even if such measures were not adamantly contrary to human rights principles, there is little evidence that this would work.

This treatment of gender equality as a mechanism by which to achieve a demographic end, rather than a human rights goal in itself, has likely contributed to the view that reversing women's empowerment would trigger increased fertility rates.

Still, fertility desires do interact, and often in complex ways, with evolving gender norms and attitudes. For men, fertility may symbolize legacy and social status, while for women, it is often tied to caregiving roles and societal pressures to bear children. This may explain the long-observed gender gap in how many children are desired, with men often reporting wanting more children than women (Boonaert and others, 2025; Myong and others, 2021; Westhoff, 2010). This was borne out in the UNFPA/YouGov survey: On average, across all 14 countries, 56 per cent of men and 45 per cent of women indicated that "to preserve name and assets" is an important reason to have a child, with men finding this reason more important than women in every country but one.

Son preference, another manifestation of gender inequality, can also play an important role, especially in South Asia, East Asia and the South Caucasus. The preference for sons can lead to gender-biased sex selection, which can even skew sex ratios across entire populations (WHO, 2011; Guilmoto, 2009). Where gender-biased sex selection does *not* take place, the preference for sons can lead to couples having more children than ideally desired, as parents of daughters try again for sons (Chaudhuri, 2012; Seidl, 1995). Indeed, the UNFPA/YouGov survey found that the preference for a son was stronger among men than among women (49 per cent versus 40 per cent) across nearly all countries.

Such factors can lead to differences between men and women in the desired number of children. According to data from Demographic and Health Surveys conducted between 2000 and 2023 and analysed by STATcompiler, women's mean ideal number of children in sub-Saharan Africa was roughly 4.8 while for men it was 5.7. Similarly, in South-East Asia and South Asia, the mean ideal number of children for women was 3 and for men it was 3.3.

In Latin America and the Caribbean, the gender difference is much smaller, with women desiring an average of 2.9 children while men desire 3.

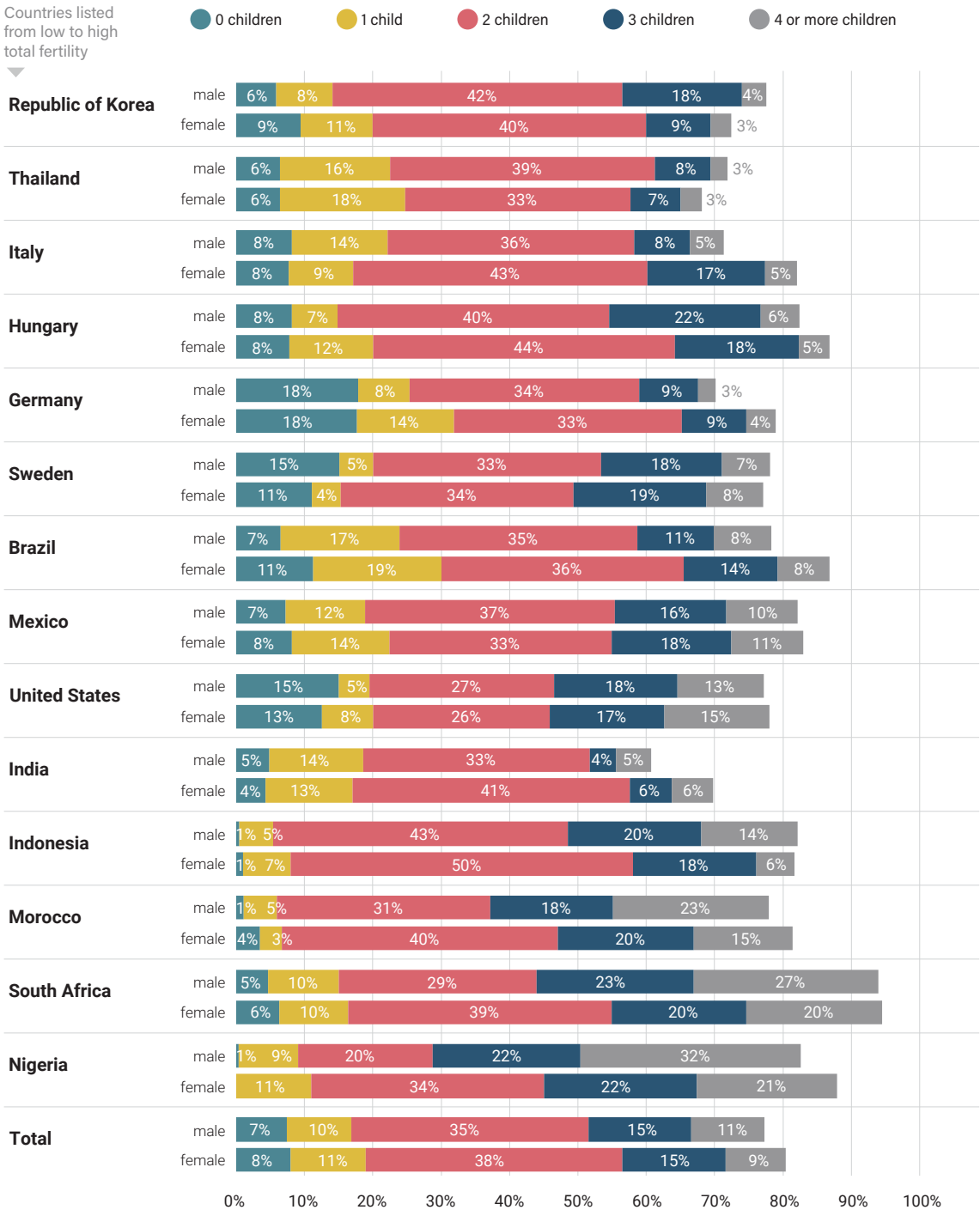
Still, these are broad generalizations. In some contexts, women can also find it prestigious to have a lot of children because of the status it carries (Church and others, 2023; Thoma and others, 2021), and women in a handful of countries report desiring more children than men (Buss and others, 2000) (see Figure 8).

Fertility desires also change over time in response to life conditions such as age, health, economic stability and changes in partnership. For example, improving economic conditions may lead couples to revise their fertility plans upwards, while health challenges or changes in marital status can reduce the desired family size. This, too, was seen in the UNFPA/YouGov survey, with 21 per cent of survey respondents stating they would likely have more children than initially or ideally desired if their economic conditions improved (whether this indicates they would be open to having more children or they are more likely to succumb to pressure to do so is unclear).

Artwork by Marianna Gefen

FIGURE 8

Respondents' ideal number of children, by country



Respondents without children were asked "If you could choose the exact number of children you would like to have in your lifetime, how many would you ideally have?" Respondents with children were asked "If you could go back to the time when you had no children and choose the exact number of children you would like to have in your lifetime, how many would you have ideally chosen?" Blank space represents respondents who said they don't know/prefer not to say.

Source: UNFPA/YouGov Survey.

Gender in the family and at work

Gender roles and the distribution of labour – especially caretaking labour – also play a role in fertility aspirations and realized fertility. These roles, often shaped by cultural, economic and policy contexts, determine how responsibilities are shared between partners and can significantly impact decisions about having children.

Despite considerable progress towards parity between women and men in the public sphere of life – in education, work and political participation – less has changed in the private sphere, where women remain primarily responsible for housework and care of dependent family members (both children and the elderly) (Esping-Andersen and Billari, 2015; Goldscheider and others, 2015). Women are estimated to perform between three and ten times as much unpaid care and domestic work as men, a discrepancy considered "one of the single largest drivers of women's curtailed educational opportunities, careers and leisure time" (UNFPA and Equimundo, 2022). Although men now devote considerably more time to housework and childcare than in the past, 50 years of data from across 19 Western countries (Altintas and Sullivan, 2016) show that cultural norms still overwhelmingly prescribe that men exhibit "good" fathering by being breadwinners for their families (Townsend, 2002). Women, on the other hand, are encouraged to prioritize their children over other spheres of life, regardless of their labour force participation (ILO, 2024).

The division of labour is not exclusively the result of cultural pressures. For instance, the allocation of paid and unpaid work among partners may depend on which partner earns more money (Lundberg and Pollack, 1996) or which partner has a more flexible job (Presser, 1994). Still, salary, flexible working arrangements and other factors are themselves informed by, and perpetuate, gender norms (Chung, 2023). Women are more likely to occupy low-paid jobs (Van der Gaag and others, 2023), and female-dominated industries are less likely to offer flexibility (Jacobi and others, 2025) – factors that can weigh in favour of women leaving the workforce to take on unpaid care. Meanwhile, because holding a paid job is shown to greatly increase women's role in household decision-making (UNFPA and Equimundo, 2022), the factors that push women into unpaid care work can also contribute to a cycle of disempowerment.

Regardless of the driving force behind gendered divisions of labour, this division is known to affect childbearing aspirations, with many women opting to have fewer children to balance their professional and domestic responsibilities (Raybould and Sear, 2020; Channon and Harper, 2019). Even if women desire having more children, childcare responsibilities often make it difficult for them to pursue career advancement, maintain full-time employment or engage in professional development opportunities (Torres and others, 2024; Parker, 2015). Men often feel less pressure to modify their work trajectories to accommodate family needs (Barbar and others, 2024). Research suggests that partners who equitably share domestic chores tend to have higher fertility relative to those in "unequal-sharing" households where domestic roles are fulfilled more by one specific partner while the other is

solely a breadwinner (Raybould and Sear, 2020; Riederer and others, 2019; Mencarini and Tanturri, 2004).

Theories on gender equity and fertility generally suggest that, in high-income societies, the lowest fertility rates are likely to occur among women who experience a "double burden" of balancing paid work and unpaid domestic responsibilities. However, these theories also predict that fertility rates may rise when male partners actively participate in and share household and caregiving duties. This suggests a U-shaped relationship, where both conventional male breadwinner–female homemaker couples and fully egalitarian dual-earner couples may exhibit higher fertility (Raybould and Sear, 2020). Today, many experts predict that fertility will be low until gender equality is achieved in both the private and the public spheres (Esping-Andersen and Billari, 2015).

Importantly, gender roles in the workplace and at home are in flux, particularly with the rise in hybrid and virtual work arrangements, which have reshaped the relationship between employment and childbearing for many women (Minhas, 2024). While hybrid and remote work can make paid work and childbearing more compatible for women, it can also reinforce gender unequal norms if caregiving responsibilities continue to fall primarily on them. For example, research indicates that home-based work can blur the boundaries between work and family life, potentially increasing work-family conflict, and it can have negative repercussions on women's careers, thereby reducing their fertility rates (Osiewalska and others, 2024) (see page 59 on family-friendly work policies).

Greater engagement of fathers

Similarly, norms around paternal involvement in childcare are also evolving, gradually reshaping family dynamics. Greater engagement from fathers in childcare and household responsibilities can ease the burden on women, influencing their fertility choices positively and enabling more equitable partnerships (Leocádio and others, 2024; Fanelli and Profeta, 2021). More egalitarian attitudes are contributing to these shifts. For instance, research finds that parents with egalitarian gender attitudes who view child-rearing as a shared responsibility tend to have higher-quality parental involvement, which positively impacts children's social behaviour (Wang and Cheung, 2023). Likewise, the combination of mothers working outside the home and fathers being very involved as caregivers led to the greatest transmission of gender-equitable attitudes to their children (UNFPA and Equimundo, 2022).

But these changes are gradual. In the 2022 analysis of the International Men and Gender Equality Survey, both men and women were asked about their fathers' participation in caretaking work, which is associated with a son's future participation in care work. The responses showed only modest increases in fathers' domestic contributions over time. When asked about their own contributions to housework, across 21 countries women's participation in this work was near universal, while across 32 countries fewer than half of men said they had undertaken some of these responsibilities – and 28 per cent said they never had (UNFPA and Equimundo, 2022).

These trends extend to childcare, too. Across 18 countries surveyed, majorities of respondents reported that routine childcare is "always or usually" done by women. There are also disparities in the types of childcare fathers report engaging in: Fathers were much more likely to report having ever played with their children than to report having ever bathed their children. There is also a large disparity between men and women who perceive routine childcare as being shared equally between partners – in every country, significantly larger proportions of men than women reported sharing these responsibilities equally (UNFPA and Equimundo, 2022).

Yet there are signs that men are very invested in care work. According to the 2023 *State of the World's Fathers* report, almost 90 per cent of men across 15 countries "feel as responsible for care work" as their partner. Both men and women reported that taking care of children brought them a sense of well-being. Parents who reported being satisfied with their level of parental involvement were 1.5 times more likely to agree that "I am the person I always wanted to be". A majority of men and women – more than 80 per cent in most countries – believed that boys should be encouraged to learn caretaking skills (Van der Gaag and others, 2023).

Artwork by Stina Persson

Why have children?

Just as norms around men's and women's roles in the family are changing, so too are norms around children and the reasons people report for having them. Researchers have long noted trade-offs between the quantity of children one has and the quality of investment that can be made in each child. In societies with very high mortality rates, high fertility rates can be advantageous, in that they ensure the survival of at least some children (even though higher fertility rates are attended by higher maternal and infant death rates). In the absence of high mortality rates, lower fertility becomes more advantageous, allowing greater investment in each child (Page and others, 2016).

The number of children desired can also be linked to the support parents expect to require in older age. The balance can shift towards more children where children's labour is essential and when there are inadequate pension and social security systems (ILO and UNICEF, 2022). Couples may also weigh the substantial investment needed to ensure a higher quality of life and therefore opt for fewer children (Church and others, 2023).

This framing, though, suggests that the reason to have a child is primarily utilitarian, and of course there are many more reasons to have a child, or to not have one. The UNFPA/YouGov survey asked more than 14,000 respondents to rate the importance of various reasons for and against having children. Significant variation was found between countries when it came to most reasons. Indeed, respondents in some countries, such as Indonesia and Nigeria, rated preserving one's family name and assets for future generations, and supporting parents in old age, quite highly. Respondents in Indonesia, Morocco and Nigeria also indicated religious and social obligations are significant reasons to have children; respondents in Germany and Sweden, by comparison, found religious and social obligations to be half as important.

But across the board, respondents in every country reported joy – the lifelong joy a child brings and the satisfaction that comes from raising a child – as being the most important reason to have a child. Similarly, there was widespread agreement that the costs associated with child-rearing ("raising a child is too expensive" and "raising a child requires too much time and energy") are one of the most significant reasons to weigh against having children.

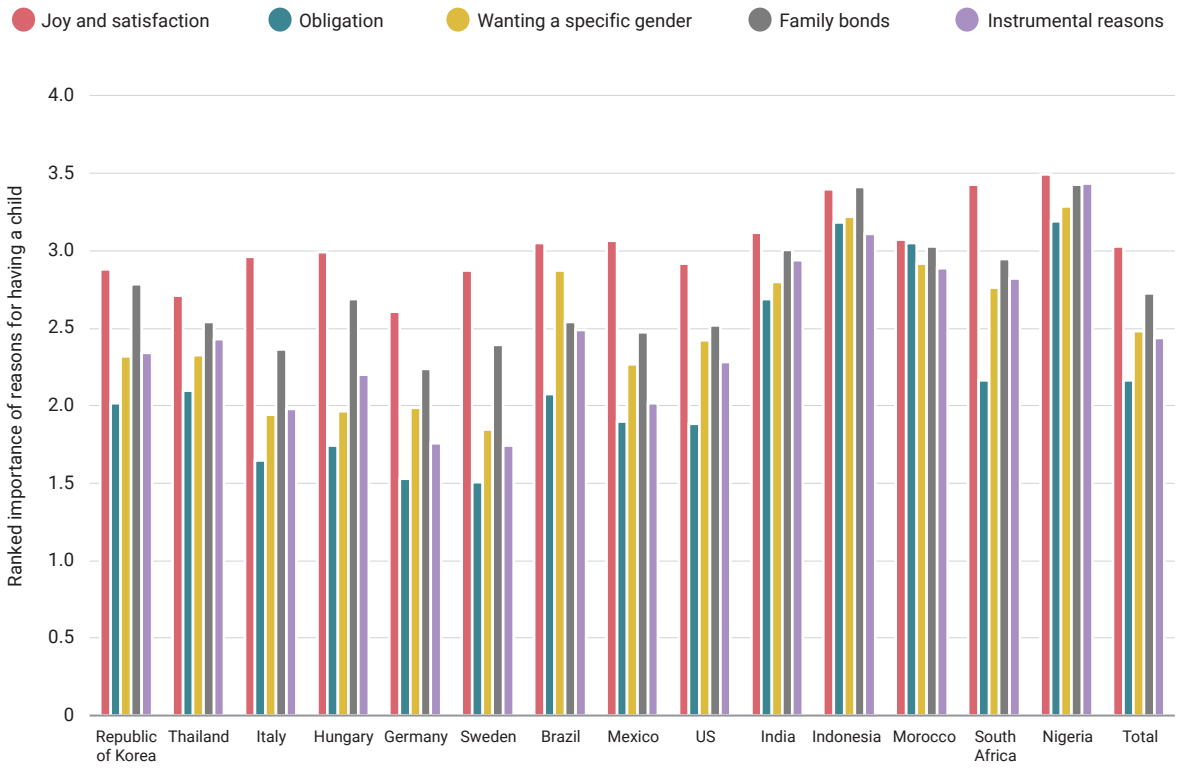
The fact that children are universally valued for bringing joy to their parents, and the fact that this is widely considered more important than other factors, calls into question the utilitarian arguments often employed by policymakers to encourage childbearing. Rather than being motivated by financial, eldercare or status-related incentives, people seem more inclined to consider factors such as whether the world offers an environment where children can thrive and whether conditions will allow people to enjoy raising their children.

FIGURE 9

Reasons for having children

Respondents ranked, on a scale of 1 to 5, the importance of various reasons for having a child. The reasons were classified into the following categories:

1. "To bring me lifelong joy" and "To derive satisfaction from guiding a child's development and teaching them" were classified as "Joy and satisfaction".
2. "To fulfil religious values related to family" and "Having a child is an obligation to society" were classified as "Obligations".
3. "Wanting to have a son" and "Wanting to have a daughter" were classified as "Wanting a specific gender".
4. "To strengthen the bond with my partner" and "To have a sibling for my existing child/children" were classified as "Family bonds".
5. "To preserve the family name and assets for future generations" and "To have a child providing (practical or economic) support when I am old" were classified as "Instrumental reasons".



Note: Countries listed from low to high total fertility

Source: UNFPA/YouGov Survey

The intensification of parenting

Parenting burdens are also increasing, and not simply along gendered lines but overall for both mothers and fathers. Much of this can be understood as a positive development, a response to new evidence that parental investment in children's emotional and cognitive development is critical for child welfare and future success. But the demands are intense, and they are seldom alleviated by reduced burdens elsewhere: Studies in Europe and the United States, for example, find that the time women spend interacting with their children has increased even as labour force participation has also increased (UNFPA, 2019). This intensification of parenting demands is contributing to mental health burdens on caregivers (Office of the U.S. Surgeon General, 2024; Faircloth, 2023), not just in the Global North or Western countries but everywhere (Faircloth and others, 2013).

While 9 in 10 parents report that caring for children is "one of the most enjoyable things in their lives", the benefits do not always outweigh the strains, finds Equimundo in its *State of the World's Fathers* report (Van der Gaag and others, 2023). That report found that 17 per cent of parents have no support in caring for their children. Low-income families were more likely to report having no support.

Parents who say they lack support are more likely to agree that "caring for my children is more exhausting than enjoyable". Of all respondents surveyed by Equimundo, 29 per cent of fathers and 32 per cent of mothers said this (Van der Gaag and others, 2023), indicating that, while mothers are somewhat more affected, fathers are also experiencing hardships and burdens related to childcare.

The COVID-19 pandemic is widely acknowledged as increasing the level of care parents provided to children (Van der Gaag and others, 2023), but the trend towards intensified parenting – and growing strain – was already well under way by that time. An advisory by the United States Surgeon General notes that the proportion of parents who reported coping "very well" with the stresses of parenting declined between 2016 and 2019, before pandemic lockdowns took place. By 2023, 48 per cent of American parents said that most days their stress was completely overwhelming, compared with 26 per cent of other adults (Office of the U.S. Surgeon General, 2024).

Some research finds exposure to the hardships of parenting is linked to lower fertility rates. For instance, some women raised in large families have expressed lower intended fertility aspirations because they understood how taxing it is to shoulder caregiving responsibilities (Bimha and Chadwick, 2016). Similarly, people in environments with highly competitive educational systems report devoting so much time and resources into their children's academic success that it can even disincentivize having more children (Mackenzie, 2024) (see more on page 64).

The need for childcare support has clear policy implications (as described in Chapter 2), but here we also see the social dimensions of this need: Even families with two involved parents can be exhausted by the demands of modern parenting, particularly if compounded by the stresses of economic precarity. Solutions, then, must focus on relieving some of these burdens, better enabling caretakers to experience the rewards of parenting.

FEATURE

Grandparents step in

When Carina Persson first heard she could use her daughter's parental leave to help care for her grandson, it was an unexpected gift. "It gives me the opportunity to spend valuable time with my grandson, just the two of us, and at the same time, it feels good to be able to unburden my daughter and her husband, who both have full-time jobs," she says.

Ms. Persson, a senior adviser in the public sector, belongs to a growing number of Swedish grandparents taking advantage of an innovative 2024 law that lets parents transfer up to 90 days of paid leave to close relatives, including grandparents, or even family friends. In a couple, each parent can transfer up to 45 days, while a single mother or father can transfer the full 90 days, providing far greater flexibility for parents who work. In Ms. Persson's case, she could take time away from her own work, and 80 per cent of her salary would be covered by the Swedish Social Insurance Agency.

A system built on flexibility and equality

Progressive family policies are nothing new in Sweden, which has long promoted gender equality and supported different family structures. The country has one of the most generous parental leave policies in the world, with up to 480 days of paid leave per child.

Trude Warner, who wrote an interim report on the new law, says childcare needs are changing. "One of the aims of the reform is to make it easier for different family structures to use parental benefits, and it seems to have had some effect in that regard, at least for single parents, who are overrepresented among those who have used this opportunity."

The report shows that most transferred leave days go to grandparents, especially maternal grandmothers, but parents can decide for themselves: "The law does not dictate how families should use the policy. It merely provides options," says Ms. Warner, an analyst at Försäkringskassan, the Swedish Social Insurance Agency.

Many Swedish families, especially single mothers, have welcomed the law, and the business community, already accustomed to flexible work arrangements and family-friendly policies, has also adapted easily. "My employer has been very supportive," says Ms. Persson. "So far, we have not come across any challenges."

A Nordic approach to family support

Sweden's latest parental leave reform is part of a broader Nordic trend that supports reproductive intentions. In Norway, parents receive 12 months of leave, and there are quotas for each parent to ensure responsibilities are shared (Norden, n.d.). In Iceland, a 2000 law granted both parents an equal three-month quota, and an additional three months to split between them, significantly increasing paternal participation in childcare. And in Denmark, free

fertility treatment was extended in 2024 to those having a second child (Danish Ministry of the Interior and Health, 2024), confirming a well-established Nordic approach that allows citizens to make their own reproductive decisions.

The Nordic countries are known for their low-cost childcare (Richardson, 2012). This makes it possible for both parents to work without spending excessively on caring for their children, and helps more women enter and stay in the workforce, with Iceland leading the way.

Access to fertility treatments has also expanded in this region, allowing a more diverse range of families to have children and realize their reproductive aspirations. State-funded IVF for the first child has been available in Denmark since 1986, and was expanded to free IVF treatment for the second child in 2024 (Anderson, 2021). In 2005, Sweden's public healthcare system began offering state-funded IVF and donor insemination to same-sex female couples, giving them the same access as heterosexual couples. These benefits were expanded to single women a few years later. In 2019, Sweden further widened access for those facing fertility challenges by allowing embryo donation and the use of both donated sperm and eggs.

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Looking ahead

Today, Sweden – like much of Europe – faces a declining birth rate. Policymakers hope that these and other initiatives will make life easier for families. And indeed, the recent World Fertility Report finds that, among countries with a long history of low fertility, those "with a higher level of public spending on families and good progress achieving gender equality, such as France, Norway and Sweden, tend to have higher levels of fertility than those not doing so" (UN DESA, 2025a).

For now, families and grandparents like Carina Persson are embracing the changes. "It is a great privilege to be able to take grandparental leave with my grandchild," she says.

And this latest reform represents something more than previous progressive family policies: It is an acknowledgment that modern families rely on more than just parents to raise children. By allowing shared leave with trusted relatives, the system mirrors today's society, helping make sure reproductive intentions actually become reality.

Childfree by choice

The changing norms and reasons for starting a family are reflected, as well, in the growing number of people voluntarily choosing not to have children. In some places, a majority of people who say they do not expect to become parents state that it is simply because they do not want children (Brown, 2021). This lifestyle choice appears to be increasing, as is the growing tolerance of childlessness as a legitimate choice (Ibisomi and Mudege, 2014; Noordhuizen and others, 2010). Despite this increasing acceptance of diverse life choices, both women and men who choose to remain childless continue to face significant societal stigma, the stereotype of being selfish, immature or unnatural (Mandujano-Salazar, 2019), as well as pressures linked to cultural and family expectations.

The reasons for choosing to be childfree are complex, and not necessarily reflective of an aversion to children. Research shows that many women identify parenting norms and unequal gender norms as contributing to the decision to forgo having children (Salgado and Magalhães, 2024). Others identify concerns about the future as being instrumental in their decision (Helm and others, 2021). These facts raise questions about the degree to which remaining childless is always an unconstrained choice. If conditions enabled people to have the children they desired without fears of sacrificing planetary health, personal career goals and individual happiness, would they all still choose to go without children? At the same time, it is also true that a great number of individuals know from an early age that they do not desire children (Neal and Watling Neal, 2022), and in later ages voluntarily childless women report high levels of well-being and low levels of regret (though studies are limited and broadly from Europe and the United States) (Jeffries and Konnert, 2002).

In some contexts, the share of young men and women saying they never want children is increasing (Golovina and others, 2024). And there do appear to be cultural norms that encourage having fewer children or no children at all. Persistently low fertility rates, for example, are thought to eventually change norms towards a preference for smaller families: "The fewer the children belonging to the environment that young people experience, the lower the number of children that will be part of their normative system in terms of what is a desirable life" (Lutz and others, 2006). This may be happening in places with very low fertility rates. "No-kid zones" are common in restaurants and other spaces in the Republic of Korea, the country with the lowest fertility rate in the world (Lau and others, 2023). The preference for child-free spaces requires that caretakers – usually women – exempt themselves from such places at least some of the time, which could further reinforce women's decision to forgo children.

What is clear, however, is that the choice to refrain from parenthood is intimately tied to reproductive autonomy, and that childbearing under coercion produces net harm to individuals and families. Unfortunately, some policymakers are seeking to de-legitimize the choice to forgo childbearing, such as by criminalizing "childfree propaganda" (Euronews with AP, 2024). As noted elsewhere in this report, efforts to constrain reproductive decision-making are often ineffective or even counterproductive.

Family structure and fertility aspirations

Family structures can also significantly shape fertility aspirations, with nuclear, extended and blended family systems influencing childbearing decisions in distinct ways. Yet there is often reluctance by policymakers to account for the complex dynamics of family structures as they exist in the world, as doing so can invite bitter ideological disputes over what qualifies as "a family" (Sanders, 2018).

Nevertheless, it is important to recognize that family structures are diverse, and that they have always been so: "In different cultural, political and social systems, various forms of the family exist," states Principle 9 of the International Conference on Population and Development Programme of Action, which was adopted by consensus in 1994 (UNFPA, 2014). One critical reason to recognize differences in family composition is because some family structures, including "single parent-headed households, child-headed households, families with members with disabilities and intergenerational households might be particularly vulnerable to poverty and social exclusion", states a resolution of the Human Rights Council (Human Rights Council, 2017).

The fertility desires of individuals – and the ability of individuals to exercise decision-making over their fertility – can be powerfully influenced by family composition, and by the support available to different forms of the family. A two-parent nuclear family, for example, often concentrates childcare and household responsibilities on parents. Such arrangements can shift fertility planning towards a "quality over quantity" model, with fewer children and greater investments per child. In high-income countries like Denmark, Finland, Germany, Norway and Sweden, access to high-quality childcare and education, as well as generous parental leaves (UNICEF, 2019; Rostgaard, 2014), enables parents to focus resources on fewer children (Melhuish, 2016).

By contrast, low-income countries often lack comprehensive childcare systems, leading to higher reliance on extended family networks for caregiving. In fact, the most common household type globally is the extended family, accounting for 38 per cent of the world's population (Kramer and others, 2019). Extended families and mixed-generation households may actually encourage larger families by distributing caregiving roles and viewing children as contributors to household support systems.

Polygamous marriages also influence fertility decisions. Women in such unions tend to have higher fertility desires than those in monogamous marriages, especially in West Africa, where larger families are prized (Millogo and others, 2022; Bahari and others, 2021). In polygamous situations, men's high fertility desires can be satisfied by having more than one wife. The presence of polygamous marriages may even impact the fertility choices of monogamous couples: Some literature suggests that women in these communities may try for more children to avoid their spouse seeking out another wife (Church and others, 2023).

Blended families, formed through remarriages, also interact with people's fertility aspirations in complex ways. The complexities of integrating

children from different households can discourage blended families from having more children. However, some literature suggests that women who remarry actually tend to have higher fertility aspirations, because they want to have children with their new spouse (Assaf and Moonzwe Davis, 2022; Myong and others, 2021; Vohra, 2014).

Crucial, then, are policies that recognize that many family structures can, do and always have existed to facilitate childcare and parental support. Some family structures, such as intergenerational households, may offer additional support to prospective parents but have added or more complex needs, such as eldercare considerations. Other families must be recognized as highly vulnerable and as warranting additional support, such as female-headed households, which are more inclined to experience poverty (Human Rights Council, 2017).

Partnering norms and the "loneliness epidemic"

Much has been said about declining partnership formation, falling marriage rates and a growing so-called "loneliness epidemic" (King, 2018), cultural and social conditions that are linked to declining fertility aspirations (Karsit, 2023). Some of this is a conflation of various independent factors. For instance, cohabitation is on the rise as an alternative to marriage (UN DESA, 2016) – mostly concentrated in Organisation for Economic Co-operation and Development (OECD) countries, where 42 per cent of births now take place outside of marriage (OECD, 2022) – and when less stigma is attached to childbearing outside of marriage, cohabiting women are just as likely as married women to intend to become pregnant (Guzzo and Hayford, 2012). Furthermore, many marriages, especially in lower-income countries, are not formally registered, making global marriage trends challenging to evaluate.

Still, data do show that in many countries, changing partnership patterns are affecting fertility intention and people's ability to realize their fertility desires. In East Asia, for example, where marriage and childbearing are closely correlated (Kramer and others, 2019), there are declining rates of marriage, which is linked to declining fertility rates. In Japan, fertility among married couples remains around two children, and non-marital childbearing is rare (Raymo and others, 2021). Other regions are seeing an increase in singlehood. In the European Union, the number of single-person households without children increased by 21 per cent between 2013 and 2023 (Eurostat, 2024). In some regions, researchers have also noted a decline in sexual activity across all ages (Jing and others, 2023; Willingham, 2022).

In response, many have blamed women for "opting out" of marriage or partnerships (Rich, 2019), and still others blame young people for "failure to launch" (Fry, 2023). The reality is likely more nuanced and less deserving of censure. While shifting gender roles are affecting marriage patterns globally, and while resistance to conventional family structures is contributing to a rise in singlehood and delayed family formation (Miettinen and others, 2015; Raymo and others, 2015), *both* men *and* women largely report that they are not choosing to be unpartnered. Research from Japan, for example, finds most adults feel

adrift, without strong motivations to marry or remain single. Others say they desire marriage but that it simply hasn't happened. Only a minority decisively refuse to marry (Raymo and others, 2021).

Why are people not finding long-term partners? Economic and educational factors play a clear role: In many countries, unpartnered adults – and especially unpartnered men – are more likely to have a low income and be less educated (Fry, 2025; Raymo and Park, 2020). It is often assumed that women's increasing levels of education and economic independence contribute to higher rates of singlehood among both lower-educated men and higher-educated women, and there is some indication that this can be the case (Raymo and Park, 2020; Raymo and Iwasawa, 2005).

It is important, though, that women's educational achievement and empowerment not be treated as threats to fertility– in fact, persistent gender inequality likely plays a significant role in negative partnering trends among lower-educated and lower-income men.

Evidence from across European countries shows partnership formation suffers when advances in gender equality stall (Bellani and others, 2017). This research also counters conventional views of the so-called "marriage market", in which low-income men are expected to become less desirable as women gain education and income.

Education and fertility

In sub-Saharan Africa, literature highlights how higher education attainment among women is correlated with delayed or lower fertility (MPIDR, 2024), particularly in societies that lack robust support systems for balancing work and family life (Channon and Harper, 2019). Although the relationship between women's education and fertility differs contextually, some evidence shows that women pursuing higher education and professional aspirations face the challenge of aligning these goals with their reproductive intentions. Interestingly, evidence from low-fertility settings highlights a paradox: Highly educated women often express higher intended fertility than their less-educated counterparts, yet they struggle to realize their fertility ideals simply because they start childbearing later, and the desire to advance in one's career usually leads to fewer births even if higher fertility was initially intended (Beaujouan and Berghammer, 2019; Testa and Stephany, 2017).

The 2023 *State of World Population* report underlines this finding, suggesting that the gap between desired and actual fertility may be influenced by inadequate policies that fail to support women's dual roles as professionals and parents. This issue becomes even more urgent in the light of claims that higher education is to blame for low fertility (Greene and Burke, 2024). Education remains a critical factor for empowering all people to find economic security, professional fulfilment and improved status. Work environments and higher education must now respond to accommodate the growing population of highly skilled women, and all parents, in the workforce.

FEATURE

Nigeria's family planning providers helping couples realize their fertility intentions

More than 1 in 10 Nigerian women and men have more children than they desire, according to the UNFPA/YouGov survey. Most of these respondents say that social pressures or limited access to reproductive health services, particularly family planning, were to blame for "overachieving" their fertility goals. In Nigeria and elsewhere around the world, family planning is often unavailable or inaccessible to people who are living in poverty. But in a number of Abuja's poorest communities, service providers are mobilizing to help women obtain the contraceptive methods of their choice and exercise their right to have the number of children they want, when they want them.

"I have three children," says Hawa. After giving birth to her second child, Hawa used oral contraceptives but missed some doses and became pregnant a third time. "Originally my husband wanted two. We have reached our limit." She says she is now using a long-acting injectable contraceptive, which she receives from the family planning clinic at the nearby Kuje General Hospital.

Talatu Yakubu, a healthcare provider at Kuje General Hospital, says family planning services are becoming more available, not only in Abuja but across the country. "Every community has a health centre or clinic with people trained on family planning," she says. "So no community is left behind."

But Ms. Yakubu says that while the number of women who use family planning is growing, there are still many others who would like to prevent or delay a pregnancy but are not using a modern contraceptive, either because they are confused about how to use it safely or because their husbands or partners forbid it. In Nigeria, about 16 per cent of all women between the ages of 15 and 49 are using a modern method of contraception, compared with the global average of 44 per cent (UN DESA, 2025).

"There are many misconceptions," Ms. Yakubu says. Some women believe, for example, that using a three-month injectable contraceptive will result in permanent infertility. Other women believe that they are not supposed to start using family planning before they have had three or four children.

Men need to be part of the solution, Ms. Yakubu says. "They need to start coming with their wives for counselling." And if they tell other men about what they have learned, even more people will know how family planning works. "Information is power, and what you know can be acted upon quickly." Women in Nigeria have five children on average. But the largest share of respondents to the YouGov survey indicated an ideal family size of two children. Family planning providers should do more advocacy in communities and religious centres, Ms. Yakubu adds. "Some faith organisations will tell you it is evil. More advocacy to them will ensure acceptance."

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It finds instead that gender equality is associated with *higher* levels of partnering for low-income men, likely because "societies may prioritize characteristics of potential partners other than their breadwinning capacity" (Bellani and others, 2017). That is, when men are valued for more than their economic contributions, and when women are valued for more than their childbearing and domestic contributions, partnerships can be formed and sustained around other qualities and interests. "Women may be more inclined to value men in terms of the degree to which they adhere to gender egalitarianism," the researchers say.

In other words, when women's empowerment grows but full gender equality remains out of reach, lifelong singlehood is more likely. Indeed, women's empowerment means marriage and childbearing are less often required as an economic survival strategy for women and girls (though it does remain the case in many conflict and fragile settings [Madsen and Finlay, n.d.]).

The decline in partnerships in some contexts may also be explained by research showing that gender expectations are changing more rapidly for young women than for young men. The International Men and Gender Equality Survey looked at the attitudes of young men and young women when it comes to power, gender roles and tolerance of gender-based violence, asking if they agreed that "a man should have the final word about decisions in his home", "a woman's most important role is to take care of her home and cook for her family", and "a woman should tolerate violence in order to keep her family together". Younger women consistently held significantly more equitable views than older women – rejecting gendered power dynamics, household gender roles and tolerance of violence – while younger men rarely had more gender-equitable attitudes than older men (UNFPA and Equimundo, 2022).

Partnership formation suffers when advances in gender equality stall.

In fact, the youngest cohort of men surveyed had attitudes more similar to the oldest men surveyed, while men in their early 30s were found to have slightly more egalitarian views. Study authors theorize that younger men are exposed to anti-feminist and male supremacist messages, particularly online, and that many in this group have not yet partnered and therefore are projecting hypothetical ideas about relationships uninformed by real experience.

Given that single parenthood remains stigmatized in much of the world, any decline in partnership formation is likely to have a significant impact on fertility intention and people's ability to realize their ideal family size: Around 14 per cent of people who wanted children said they had fewer children than desired, or would likely have fewer children than desired, because they lacked a partner or lacked a suitable partner, according to the UNFPA/YouGov survey.

Violence, coercion and fertility aspirations

Gender-based violence, both within and outside the household, significantly shapes women's fertility choices. Whether perpetrated by intimate partners, family or community members, healthcare workers or states themselves, gender-based violence – and reproductive violence more specifically – affects women's ability to exercise decision-making over their fertility.

Studies indicate that intimate partner violence is associated with higher rates of unintended pregnancy and reduced contraceptive use (Han and others, 2024; Castro Lopes and others, 2022). Women who experience abuse, whether physical, emotional, sexual and/or psychological, have less autonomy and reproductive choice (Aboagye and others, 2024). For example, women may feel pressured to conform to their partner's fertility preferences – whether having more or fewer children – out of fear of violence. Reproductive coercion is often a way in which abusive partners and family members exercise power and control over women and girls, by using violent tactics to control their reproductive autonomy and fertility decisions, including whether or not to get pregnant, use contraceptives or have an abortion. Additionally, abusive relationships often create instability, further complicating fertility decisions and limiting women's autonomy over their reproductive choices.

Gender-based violence can also discourage partnership formation, thereby contributing to unrealized desire for children. For example, technology-facilitated gender-based violence, such as online harassment, cyberstalking and the non-consensual sharing of intimate images, can discourage women from participating in online spaces (UNFPA, 2025c), where social support networks are often found and where increasingly large proportions of partnerships are started (Hogan and others, 2011). A significant proportion of women report being exposed to harassment and threats of violence in online dating platforms (Anderson and others, 2020).

As illustrated elsewhere in this report, states can and do perpetrate violence that directly impacts women's fertility intentions, including forced sterilizations, forced abortions and criminal penalties on abortion care. But coercive social norms also shape and drive fertility aspirations and limit reproductive agency. Norms around motherhood, gender roles and the value of children in society can be reinforced coercively; for example, through parents or older members of the community dictating how young people and couples should behave. In many sub-Saharan African societies, women may face family and societal pressure to have many children as a demonstration of their value. Collective gender and fertility norms can substantially limit contraceptive use (Riese and others, 2023). In India and other countries, son preference has led to pressure to continue childbearing until a male child is born (Watts, 2024).

In the UNFPA/YouGov survey, social pressures – including expectations of one's religion, community and, to a smaller extent, doctors or health workers – were identified by 11 per cent of respondents

as reasons why they expected to, or did, have more children than desired. In some countries, these pressures were much more pronounced: 20 per cent of respondents in Morocco, 22 per cent in India and 35 per cent in Nigeria said that these pressures were likely to lead, or had led, to them overachieving their fertility goals. Pressure from health workers was also found to have an impact on underachievement of fertility goals, with 5 per cent of respondents saying this had led, or was likely to lead, to the underachievement of their desired fertility. This was seen most markedly in India, where 14 per cent of respondents said pressure from doctors or health workers had led, or would lead, to them having fewer children than they wanted.

Disadvantaged and marginalized groups, including ethnic minorities, economically disadvantaged populations, individuals facing discrimination due to sexual orientation or gender identity, and people with disabilities, have a higher risk of experiencing both sexual violence and reproductive coercion. LGBTQIA+ people and persons with disabilities are more likely to face sexual violence and barriers to contraception, as well as judgment and stigma from health systems, contributing to unintended pregnancies, for example (UNFPA, 2022a), even as they *also* experience exclusion from assisted reproductive technology and adoption systems (He and others, 2024; IGLA World Database, n.d.), limiting their ability to have the children they desire.

The masculinity crisis and the gender-equity dividend

At a time when advances in gender equality are being rolled back in many countries, manhood is also being increasingly politicized and weaponized, in part due to systemic failures to include men and boys in the realization of gender equality. The reality is that gender equality benefits *both* men *and* women, and the persistence of gender unequal norms is harming men as well as women. As research into adolescence in 15 countries, across 5 continents, highlights, "boys are not unscathed" by prevailing myths about gender (Blum and others, 2017).

For decades, for example, OECD countries have noted an achievement gap between boys and girls at almost every level of schooling (Cappon, 2011). Women now outnumber men in university enrolment in 75 per cent of middle-income countries and 95 per cent of higher-income countries, and exceed men in university graduation by significant margins

The persistence of gender unequal norms is harming men as well as women.

(Welmond and Gregory, 2021). But not all boys are affected by this gender gap; typically it is boys who experience one or more forms of disadvantage, such as poverty, discrimination on the basis of ethnicity or other forms of marginalization. Why? One reason identified by World Bank researchers is that social norms devalue the importance of education for lower-income men and boys, and that jobs that do not require an education are more available to men and boys than to women and girls (Welmond and Gregory, 2021).

Conventional gender norms also discourage men from health-seeking behaviours, as observed across a range of health fields, from sexual and reproductive health to mental health, findings that are supported by studies across regions and cultures (Chitando, 2024; Narasimhan and others, 2021; Gough and Novikova, 2020; Leichliter and others, 2011). Globally, men and boys are 2.3 times more likely than women and girls to die by suicide (WHO, 2021). They are four times more likely to die by homicide (UNODC, 2019). They are nine times more likely than women and girls to be the perpetrator of a homicide (UNODC, 2019). Gender equality, achieved for all people, would abolish the norms that treat violence and health neglect as masculine virtues. It would address gender-unequal labour markets, education systems, divisions of labour and forms of self-expression, lifting all people up rather than leaving so many behind.

The World Health Organization, for example, finds that living in a country with better gender equality improves a man's health, halves his chance of being depressed, reduces his likelihood of suicide and reduces by 40 per cent his risk of violent death (WHO, 2018). These gains are often referred to as the "gender-equity dividend", with men reaping benefits such as equitable partnerships and workplaces that allow them to experience the rewards of caregiving; the gender-equity dividend could also lead to increased fertility in low-fertility, high-income countries over time, researchers say (Anderson and Kohler, 2015).

Unfortunately, too many communities are moving in the opposite direction: Angry, misogynistic attitudes – in online communities and the real world – are encouraging many disadvantaged young men to see gender equality as advancing women at the expense of men (UN Women, 2025a). Policies, too, are often knowingly or unknowingly informed by societal norms, and even policies with the best of intentions – like generous maternity leave – can have wildly unequal impacts if they do not account for norms and cultural practices as they exist within communities.

Regulations alone are unlikely to empower people to realize their fertility aspirations without simultaneous efforts to embrace the values and norms that are internationally agreed goals for the world: Gender equality, an end to discrimination of all kinds and the attainment of dignity and rights for all people. These aspirations cannot be met by returning to a largely mythical past of breadwinning men and child-rearing women. The only reasonable direction is forward.

IN FOCUS

Infertility stigma and treatment in sub-Saharan Africa

The World Health Organization estimates that sub-Saharan African countries have the highest period prevalence of infertility as compared with other world regions (WHO, 2023). Paradoxically, sub-Saharan Africa has also been identified as the region with the highest rate of fertility (UN DESA, 2024). But the co-existence of high rates of fertility with infertility should not be unexpected, and in fact there may be a common cause in poor access to, and use of, sexual and reproductive health services and commodities. The use of contraception in Africa, at 25.4 per cent, is lower than the global average of 65 per cent, due to incorrect perceptions that contraceptive use promotes infertility (Sedlander and others, 2021; Sedlander and others, 2018). At the same time, long-standing data indicate that infertility on the continent is largely attributable to genital tract infections in men and women (WHO, 1987).

Consequently, Africa's reproductive health practitioners have repeatedly argued that the tendency for population policies and programmes to focus exclusively on fertility control in Africa without addressing the equal challenge of infertility is highly problematic. Additionally, experts note that approaches focusing on the prevention of infections (sexually transmitted infections, puerperal infections, post-abortion infections, etc.) would be more effective at scale in reducing the prevalence of infertility. In fact, infertility is the most common reason for gynaecological consultations in many African countries. Yet there has been limited use of the primary preventative, root-cause approach in the design of policies and programmes for tackling infertility in many African countries. Instead, many infertility treatment programmes in Africa focus on secondary treatment with conventional and high-cost reproductive technology such as IVF and embryo transfer (Okonofua, 2003). Given the often inadequate healthcare systems in many parts of Africa, with limited provision for infertility management, only a restricted number of infertile couples (fewer than 2 per cent) are able to obtain effective treatment. This has been described as a human rights and social equity issue, as the families with infertility are predominantly poor and unable to access high-cost infertility treatments (Okonofua, 1996).

The consequence has been that most infertile couples in Africa delay treatment (Dierickx and others, 2019). This results in a large proportion of couples who remain infertile at the end of their reproductive lives. The social consequence of infertility is also a major challenge in sub-Saharan Africa, one which has been largely underreported. Available evidence indicates that infertile women (and, to a lesser extent, infertile men) suffer considerable stigma and retribution as a result of their infertility. While infertility can be roughly equally attributed to men and women, women suffer the greatest stigma when infertility results in divorce, gender-based violence, separation and societal denials (Dimka and Dein, 2013; Okonofua and others, 1997).

Given the above, policy approaches in sub-Saharan Africa that give equal importance to the prevention and management of fertility and infertility will be more effective in addressing population needs than the current emphasis on prevention of unintended pregnancy and secondary treatment of infertility.

Text contributed by Dr. Friday Okonofua, emeritus professor of obstetrics and gynecology and reproductive health at the University of Benin, Benin City, Nigeria.

IN FOCUS

Believe women: Measuring what matters in family planning

For decades, several metrics have dominated global family planning: modern contraceptive prevalence rate (mCPR), which should tell us how many women are using a modern contraceptive method; unmet need for contraception, which should identify women who aren't using contraception but need it; and demand satisfied, which combines the previous measures to show what percentage of women with unmet need are using contraception. These measures are widely used by governments, donors and global health organizations to measure progress and set targets. Unfortunately, these metrics do not actually reflect what women want and need.

In particular, mCPR focuses on usage, not autonomy. It tells us nothing about whether a woman wants to be using contraception, has adequate method choice or is able to access her preferred option. Unmet need doesn't ask women if they want to use contraception – it infers need using a complex algorithm based on factors like marital status, desire for more children and (in)fertility. Demand satisfied assumes who should be using contraception; it doesn't directly ask women whether they are satisfied with the contraceptive choices they've made.

These measures make assumptions about deeply personal, dynamic reproductive behaviours. In doing so, they risk misrepresenting women's needs, overstating demand and even reinforcing coercive approaches in the name of "meeting targets".

A simple, powerful idea: Ask women about their intentions

A growing body of research suggests a better way is possible (Holt, 2023; Sarnak and others, 2023; Rothschild and others, 2023; Senderowicz, 2020) and starts by asking women a simple question: Do you intend to use contraception in the near future?

Rather than centring efforts solely on increasing mCPR or demand satisfied, we can better serve women's needs by aligning with their stated intentions and supporting them in carrying those out. To maximize impact and respect women's autonomy, family planning programmes can prioritize those who clearly express an intention to use contraception. Directing resources towards women who are ready and willing to use contraception ensures more effective, demand-driven programming and avoids misallocating efforts towards those who currently have no intention to use.

Recent analyses by the Institute for Disease Modeling (IDM) at the Gates Foundation (Lin and others, 2024), using data from over 38,000 women in 10 low- and middle-income countries, show how a woman's stated intention to use contraception within 12 months – known as intent to use (ITU) – provides deeper insight into who wants to use contraception and how programmes can better support them. It can also track whether women are able to act on their intentions over time. ITU reflects a woman's voice – in her own words, on her own timeline. IDM's research

uncovered several findings that challenge conventional thinking:

- **Intention predicts action –** Women who intended to use contraception within a year were more likely to start using a method than those labelled as having unmet need.

- **"Unmet need" mislabels women –** About 25 per cent of women in the study were assigned a status that did not match their actual intentions. Some were marked as having unmet need despite having no plans to use contraception, others were overlooked despite wanting to use a method soon. Since unmet need is used to calculate demand satisfied, this also overestimates how many women want to use contraception but are not doing so.

- **Women's contraceptive needs are dynamic –** Nearly 60 per cent of women changed their behaviours or intentions during the follow-up period. These shifts were influenced by changing desires, cultural and social norms, access barriers and perceived need.

- **Barriers to use are not determined by demographics –** Women who intended to use contraception within a year but didn't ("aspiring users") were not fundamentally different from those who did ("actualized users"). This highlights a key limitation of metrics like unmet need, which rely on demographics to classify women.

From measurement to meaning

If we want to build family planning programmes that support rights, autonomy and access, we must start by asking women what they want – and we must believe them when they reply. Intention-based metrics like ITU offer more accurate, meaningful insights. These should be paired with questions asking women why they are not using contraception if they express a desire to do so and what challenges they face in accessing a preferred method, ensuring that programmes respond to real barriers and lived experiences.

Incorporating ITU into national and global monitoring systems would allow us to redefine programme success as enabling women to achieve their stated contraceptive and fertility goals rather than maximizing contraceptive use. It would avoid over- or underestimating programme success based solely on usage statistics. And by recognizing the real barriers identified by women and the fact that reproductive needs change, it would enable the design of programmes that support women in making the choices they want to make, when they want to make them.

As we shape future global development goals, we have the opportunity to modernize how we measure progress in family planning. Traditional indicators like mCPR and unmet need, while useful, are limited. A more nuanced, woman-centred approach – grounded in agency, intention and access – offers a more effective, equitable approach. This shift requires us to directly ask women about their intentions, believe their stated preferences, and value both those who say "yes" to contraception and those who say "not right now".

Text contributed by Michelle O'Brien, Ying-Yi Lin, Marita Zimmerman and Elisabeth Root, from the Institute for Disease Modeling, Gates Foundation

Artwork by Stina Persson

CHAPTER 4

The lessons of history – and hope

The evidence is clear: We are moving from a world of rapid population expansion, in the mid-20th Century, to a period of declining fertility rates. Our current world is one of great demographic diversity. Yet, as in the past, narratives and rhetoric are taking on a catastrophic tone, with birth rate declines fuelling fears of economic collapse and "demographic suicide" (Pritchett and Viarengo, 2013), even as many nations remain concerned about "unchecked population growth", largely in low- and middle-income nations where fertility rates remain relatively high (Modebadze, 2021). These worries, too often, are framed in terms that scapegoat the poorest and most marginalized people (UNFPA, 2023).

All countries and regions, no matter their total fertility rate, have significant prevalences of *both* unintended pregnancy and unrealized desire for children.

It is hard to escape the conclusion that these concerns – which certainly both warrant policy responses – are rooted in outdated notions around who should be reproducing and why, and the notion that the achievement of a country's preferred birth rate will ensure economic and political security. Yet dividing the world into high- and low-fertility zones results in bifurcated approaches that neglect the fact that *all* countries and regions, no matter their total fertility rate, have significant prevalences of *both* unintended pregnancy and unrealized desire for children. As argued throughout this report, there is a genuine crisis at hand: One of conditions, environments and policy choices that are failing, everywhere, to facilitate individuals' and couples' ability to realize their family formation goals, whatever those goals may be.

Without holistic and inclusive policies addressing the full range of individuals' needs, policymakers may convey the impression, rightly or wrongly, that they prioritize the fertility goals of the state over the fertility goals of the individual.

Below, this chapter recaps many of the findings and recommendations that can be found in Chapter 1 on the UNFPA/YouGov survey findings, Chapter 2 on the policy barriers and solutions to reproductive choice, and Chapter 3 on the social and gender norms that can support healthier and happier families and lives. And, finally, this chapter takes a deep look at the complex but critical issue of reproductive agency and how policymakers, civil society and all people can measure, evaluate, sustain and promote it.

Demographic dissonance: A mismatch in how we think about population

No matter the direction of change in fertility rate, demographic trends have tended to be described in apocalyptic language, often sounding the alarm over low birth rates among one's own national or ethnic group, while fearmongering about the high fertility of others. More than five decades ago, influential authors warned of an imminent "population bomb" exploding in the developing world (Ehrlich and Ehrlich, 1968). This led to efforts to reduce total fertility rates, measures that at times violated human rights, including through forced sterilization schemes and targeted family planning programmes among vulnerable and marginalized populations (UNFPA, 2023). The "population bomb" prediction failed to materialize, and over the intervening decades even nations with the highest total fertility rates and the fewest resources have seen improvements in health, nutrition and survival (Lam, 2023; Lam, 2011). Unfortunately, fears of imminent overpopulation persist – alongside emerging and equally pessimistic warnings that declining fertility rates will cause the "mass extinction of entire nations" (Musk, 2024).

When the global population reached 8 billion, headlines proclaimed that the world was teetering into overpopulation and also that countries were collapsing from depopulation. The 2023 *State of World Population* report examined just how confusing this moment has been for policymakers, academics and the general public alike. In surveys conducted across eight countries, the most commonly held view among everyday citizens was that the world's population was too large, and in six of those countries, the most common view was that the global fertility rate was too high. Yet respondents in half of the surveyed countries viewed their own country's domestic population size and fertility rate as either too low or just right. Interestingly, men were more inclined than women to see fertility rates as a problem (UNFPA, 2023). Countries' own views – as reported by the Inquiry Among Governments on Population and Development, a United Nations survey of government policies – reveal similar unease regarding fertility rates. A comparison of Inquiry survey responses from 1976 to 2015 found a notable uptick in countries adopting fertility policies with an express purpose to raise, lower or maintain fertility rates; yet countries with no expressed intention to influence fertility rates were found to have, on average, higher levels of democracy, human freedom and human development.

The 2023 report also found, based on countries' self-reporting in the 2021 Inquiry, that adolescents were facing increasing restrictions to contraceptive access over time, and that countries with restrictions in contraception access also tended to have more restrictions in access to, and provision of, maternity care. Taken together, the analysis suggests that demographic anxiety is fuelling a tendency to treat fertility rates as tools to "fix" population trends, even if such efforts are often unsuccessful in their aims and are also, broadly, correlated with reduced rights, freedoms and health for both women and men.

Artwork by Stina Persson

Better fertility measures

As discussed in Chapter 1, too many governments measure the success or failure of their policies by whether fertility rates are going up or down or remaining stable. From slogans like "One is fun" (Kumar, 2001) to "Demographic rearmament" (France24, 2024), leaders have made it amply clear they wish to influence the fertility of their countries and constituents. Whatever the direction they intend for their national fertility rate, policymakers often benchmark these goals against the so-called "replacement" total fertility rate of 2.1 children per woman. Yet this practice is problematic.

The presumption that 2.1 births per woman will result in population stability (itself a dubious goal) actually assumes zero migration (either immigration or emigration), low infant mortality and natural sex ratios at birth. Few, if any, countries can meet all these conditions. In fact, Australia, Canada, France, Luxembourg, New Zealand, Sweden, the United Kingdom and the United States have long had fertility rates below 2.1 yet their populations are still expected to grow beyond 2054 due to immigration (UN DESA, 2025a).

Even if not aiming at a 2.1 fertility rate, total fertility rate is often a suboptimal tool for capturing the number of births a woman will have in her lifetime. (For this, one must look at the total number of live births a woman has had by the time her reproductive life is complete.) Unfortunately, policymakers often look for short-term impacts – perhaps even impacts that can be highlighted ahead of their next election – rather than wait for stronger

data. Research finds that, often, women are actually changing the timing of their births, not the overall number of children they have over their lives (Lutz and others, 2024).

Yet the monitoring of population trends is indeed imperative for policymakers. Understanding demographic changes is critical for everything from hospital funding to infrastructure development to pension planning and the recruitment of teachers. No sector goes untouched by the changes wrought by population change, and "virtually nothing in the social sciences can be projected with such a great degree of confidence, for so many decades in advance, as demographic change", experts note (UNFPA, 2024).

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The answer is to consider other macro-level measures of fertility. There is parity- and tempo-adjusted total fertility rate, for example, and completed cohort fertility. Additionally, proposed measures such as current migration replacement total fertility rate can be used with both mortality and net migration figures to anticipate population change; when this measure is applied to 22 countries, all with sub-2.1 fertility rates, it predicts population increase in more than half (Parr, 2020).

And, importantly, these metrics must be complemented with new and emerging micro-level evidence of the desires, intentions and empowerment of individuals. For this, we need more systematic collection of data on fertility desires, follow-up research to assess the extent to which these desires are realized and measures of the barriers to and enablers of achieving these desires. We will also need a better understanding of reproductive agency itself (see page 112).

Finally, and most crucially, fertility targets are themselves ill-advised and often produce harmful unintended consequences. As the 1994 International Conference on Population and Development Programme of Action stated clearly, and by consensus, "governmental goals for family planning should be defined in terms of unmet needs for information and services" rather than "imposed on family-planning providers in the form of targets or quotas" (UNFPA, 2014). This language has been the subject of three decades of sustained global agreement, in no small part because of the horrors that can unfold when lower fertility targets are pursued. These include not only population control schemes, forced sterilization and forced abortion, but also coercive pressures and stigma applied to men and women alike.

The same must now be said about government goals for higher birth rates. These, too, must not be imposed in the form of targets or quotas, and instead should be defined in terms of the intention and desire of the couples and individuals giving birth. Are the births wanted? Are they safe? And are the parents able to raise their child or children with the security, standard of care and personal well-being they desire? And to guard against the possibility of future rights violations, these goals must be as inclusive as possible, facilitating both pregnancy prevention and family formation for all people, no matter their ethnicity, migration status, gender or sexual orientation.

Artwork by Cyan Haribhai

Better policies

Sadly, the world is entering "an era of misogynistic backlash", according to a recent UN Women report (UN Women, 2025a), in which "almost one quarter of countries reported that backlash on gender equality is hampering implementation of the Beijing Platform for Action". These trends are coalescing with fears over depopulation. Gender equality and feminism are being explicitly blamed for some countries' declining birth rates (Wilkins and others, 2025).

Yet the UNFPA/YouGov survey results presented in this report, and corroborating research, show that most people actually do want children (UN DESA, 2025a; OECD, 2016), and the most commonly expressed reason is because children bring joy and satisfaction. Some people do not want children, a choice that is deeply personal, entirely valid and may be growing (Gouni and others, 2022). At the same time, research cited in Chapters 2 and 3 shows an array of factors that limit many people's ability to realize their dreams of family formation and family size, whatever those dreams may be.

Economic burdens are one of the most common barriers on the road to parenthood. An intensification of parenting engagement is expected from both parents – but mothers especially. And while fathers desire more engagement, social and occupational expectations have not advanced to facilitate more equal labour distribution or time for fatherhood. In both high-income countries broadly and urbanizing low-income contexts, nuclear families are becoming more common,

and extended family support is less available (Reyes, 2018). Formal childcare can be very expensive or hard to access, and management of occupational and domestic labour is highly onerous, especially for women, who generally carry a greater domestic burden.

Meanwhile, there remains much unfinished work towards ending unintended pregnancy and empowering people to choose whether, when and with whom to have a child or children. The UNFPA/YouGov survey's finding that 31 per cent of respondents had experienced an unintended pregnancy supports the ample research showing that unintended pregnancy is not only widespread but often ends in abortion, regardless of the legality of that procedure. In fact, the best global estimates hold that nearly half of all pregnancies are unintended, 61 per cent of which end in abortion (Bearak and others, 2020).

But these facts are not cause for despair. Rather, they represent a window of opportunity for creating better policies that address all of these issues in a holistic, rights-affirming way. While many specific policy barriers and remedies are elaborated in Chapter 2, below we highlight select policy areas that warrant specific attention in order to support the reproductive choices of men and women everywhere.

Ensure sexual and reproductive health and rights for all

High-quality, comprehensive sexual and reproductive health services must be accessible and affordable within community health settings, ideally integrated into existing health services. Assurance of clinical reproductive and maternal healthcare needs to be prioritized. Healthcare providers need to be available in lower-income and low-population areas. Investments must be made into services reaching populations at higher risk for sexual and reproductive health concerns, including maternal morbidity and mortality.

That means abandoning – no matter the total fertility rate – policies that restrict providers from reaching populations in need or that impede the provision of the full range of sexual and reproductive health services. This includes family planning counselling, maternal care, safe delivery services, making safe abortion care accessible to the full extent of the law, and post-partum and newborn care, as well as

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prevention and treatment of infertility. It also means ending barriers to such services, which persist in the form of age restrictions, spousal and parental consent laws, and denial of elective sterilization for informed, consenting adults.

A fully inclusive approach must also be guaranteed, given the past and current struggles of groups of people pushed into, or prevented from, having children. This is not simply because ending discrimination in healthcare provision is ethically sound and a human rights mandate. It is also because, as discussed in Chapter 1, distrust of the motivations behind, and long-term reliability of, state policies can undermine people's choices as they decide when and whether to have children.

Yet even as these critical services must be in place for everyone, the programmes and policies themselves cannot assume a one-size-fits-all approach. Data show that impediments to family formation and barriers to pregnancy prevention have many community- and client-specific factors. After all, reproductive coercion can take place on the intimate partner level, the family level, the health service level and the legislative level (Silverman and Raj, 2014), each with its own unique manifestation.

There are promising developments in this area, particularly in the effort to secure equitable access to prevention, diagnosis and treatment of infertility. In Europe just last year, the Coalition for Fertility was launched, bringing together a broad range of civil society actors, medical associations and reproductive rights groups to recommend comprehensive, inclusive and rights-affirming policies (Coalition for Fertility, n.d.).

Comprehensive sexuality education

It is important that comprehensive sexuality education be made available in school systems. Chapter 2 of this report highlights the benefits of incorporating a full life-course perspective into comprehensive sexuality education curricula, including non-stigmatizing information about fertility awareness. Accurate fertility awareness information can help adolescents safeguard against preventable causes of infertility and understand both the benefits and drawbacks of fertility postponement, an increasing trend globally (Beaujouan, 2020).

Unfortunately, accurate sexual health information is being undermined, both at the governance level (United Nations, 2023) and in the growing proliferation of misinformation (Pagoto and others, 2023). This is a concerning trend, one that policymakers can and must address.

Strengthen social and economic security for all

And yet policies are indeed needed across a variety of domains to support men's and women's reproductive aspirations – whatever those aspirations may be. Many such policies are discussed in detail in Chapter 2, but they warrant repeating briefly here.

Supporting high-quality, accessible and affordable childcare is essential. There are many ways this can be implemented, with examples across countries of all income levels, from government-subsidized care facilities and support to family caretakers to community-based cooperative and non-profit models (Chaturvedi, 2019).

More equitable family leave policies, which encourage or require paternity leave to be taken in amounts similar to maternity leave, can greatly improve women's workforce participation and men's involvement in caretaking, with significant benefits for both (Van der Gaag and others, 2023; Sobotka and others, 2019). Expanding the same flexibility and support to non-parent workers, too, could support the family aspirations of younger people, whose parental aspirations are too often hindered by demanding work cultures (Kim, 2023).

Efforts to end gender-based violence, including domestic and intimate partner violence and sexual violence, are urgently needed, as is recognition of the many ways that violence undermines reproductive choice and fertility. Sexual violence and coercion lead to vast and unacceptable numbers of unintended pregnancies, greatly compounding the trauma and violation of rape (UNFPA, 2022a). Intimate partner violence is also linked to lower contraception use by women, often the result of coercion by an abusive partner (Oni and others, 2021).

Violence can undermine people's fertility goals in other ways, too. For example, research in Honduras shows that women who experience physical intimate partner violence are less likely to desire more children (Kuhlmann and others, 2019).

Programmes that alleviate poverty and economic precarity are critically important. This means labour market reforms and adjustments (in some cases moderate, in other cases radical) in pension systems and social security.

To address flagging economic productivity and workforce shortages, reforms must also include increasing women's and young people's access to decent work and, though it may be unpopular, greater immigration (UNFPA, 2019). How such adjustments are implemented will vary from country to country, but there are a growing number of tools available to policymakers, from national transfer accounts in ageing populations (UNFPA, n.d.b.) to housing market reforms (UNFPA, 2019).

This policymaking must be inclusive – created with the involvement of the people who will be affected. That means involving working women in employment policy design, involving caretaking fathers in paternity leave planning, and involving young people in discussions around housing reform. While the composition of decision makers will vary by context, it will remain critical to include representatives across different communities, from single mothers to ethnic minorities to LGBTQIA+ persons, to ensure that benefits accrue to all.

Finally, policies need not, and should not, be restricted to the national level. In fact, regional, subnational and employer-level policies greatly influence the conditions in which people make their family-formation choices. Barriers to sexual and reproductive health and access to childcare support vary greatly between rural and urban areas, affecting everything from the number of children born, to voluntary sterilization rates (Clark and Levy, 2025). Family-friendly policies are tailored and implemented at the regional level in Italy (Horowitz and Pianigiani, 2024) and the Republic of Korea (Yoon, 2023).

Protection against coercive policies is also needed at the subnational level: Politicians in southern India have called attention to the impact of lower fertility rates on parliamentary representation (Chauhan, 2024), leading some states to propose fertility minimums for those seeking local office (The Hindu, 2025). The criminalization of abortion, as well, varies significantly between states in Mexico and the United States (CRR, n.d.).

Indeed, efforts to monitor all kinds of policies for their impact on reproductive agency are warranted. As this report highlights, reproductive choice can be constrained even by policies not intended to be coercive, and even by policies not obviously linked to reproduction – such as gendered inheritance laws (Sage, 2025) and nationality laws (Levine and Peden, 2021). The absence of good policies can also make people highly vulnerable to reproductive coercion. Policies and regulations that expose people to coercion or deplete their reproductive agency should therefore be not only identified but also monitored to ensure they are remedied. While sexual and reproductive health policies are increasingly monitored by civil society (CRR, n.d.; EPF, n.d.; Fertility Europe, n.d.) and international actors (Sustainable Development Solutions Network, 2024), vigilance is required to identify harmful laws introduced across other domains.

Finally, employer practices are a critical complement to government policies, as these can facilitate or disrupt people's family-formation decisions – sometimes more than laws themselves. Demanding hours and gender discrimination in hiring and leave policies often push people to delay or even forgo childbearing, as Chapter 2 shows. Employer influence can work in the other direction, as well: One company recently threatened to fire employees if they did not "get married and start a family within three quarters" (Wang, 2025).

At the same time, positive employer policies are being implemented by businesses around the world. The UNFPA-led Coalition for Reproductive Justice in Business, for example, is engaging companies to invest in sexual and reproductive health and rights programmes in their workplaces and supply chains, using a scorecard of metrics for companies to track progress on key workplace issues including maternity leave, fertility treatments and sexual harassment protocols (UNFPA, 2024c).

Transforming social norms

Policy changes are necessary but not sufficient – and perhaps not possible – without attendant changes in social norms, as Chapter 3 demonstrates. Responsibility for declines in marriage and childbearing is overwhelmingly attributed to women, often without consideration of the greater burdens women bear in both. As the UNFPA/YouGov survey shows, about 1 in 8 women (13 per cent) say that they will have fewer children than they want because their male partner is not sufficiently contributing to the added domestic labour children bring to a household.

Yet men and boys – particularly the most disadvantaged – are also ill-served by gender-unequal social norms. Growing numbers of

men plainly state they desire more involvement in care work, either for themselves or their sons (Van der Gaag and others, 2023), but societal norms and pressures continue to stand in the way. Worse still, there is an active backlash against progress in this area, for both men and women, with ever-louder and coordinated proponents of regressive norms, which claim to support marriage and family but actually restrict the rights, choices, health and welfare of families and individuals (EPF, 2021).

To spur norms change, boys must be taught the value of care from a young age. This means promoting role models who advocate for gender equality. It means providing opportunities for boys to practise empathy. As they grow older, young men must continue to be taught the value of non-violent relationships in which responsibilities are shared. While we know that men are participating in care work at higher rates than in the past, much more is needed to level the playing field (Van der Gaag and others, 2023).

While promoting healthier social norms can be challenging, models of positive normative change exist. Male action groups in Ethiopia and Uganda, for example, have helped to shift gender norms, increase male engagement in family planning, improve couple communication and reduce gender-based violence (UNFPA, 2021a).

And while it is neither new nor inaccurate to observe that family formation is complex and changing, restrictive norms regarding the requirements for a family and what a family looks like continue to alienate and harm those uninterested, unwilling or unable to adhere to these norms – from LGBTQIA+ individuals to female-headed households to single parents raising children alone.

Also needed are *cultural* shifts away from workplace norms that are demonstrably detrimental to employees' family lives. This would benefit not just working mothers but all people, including those who are not parents but might like to be. Similarly, the cost and intensity of parenting are overwhelming for many – a clear disincentive for those desiring a child or more children.

And, finally, it would be remiss if this report did not note that the focus on fertility rates, especially for specific subpopulations, is often rooted in ethnonationalism, whereby the goal of the state is not simply to facilitate certain birth rates but to apply these to certain kinds of people. The inclusion of immigrants and other marginalized populations is needed not just in policies but in efforts to promote more positive, inclusive, rights-affirming norms for all.

FEATURE

Breaking the teen pregnancy cycle

For many girls in Estebanía, a rural town in the Dominican Republic, early motherhood is an expectation, not a surprise. Anlli's mother was 16 when she had her, and Anlli, now 18, does not want history to repeat itself.

"I want to study. I want to work and have a career. I want to be financially stable," she says. "I don't want to look back and wonder what I could have been." Anlli may achieve her dream because she has what her mother did not: choices.

Without needing adult consent, she took control of her reproductive health and, with her boyfriend, sought out information and guidance.

Casa Clave: A safe space

Evelyn Sánchez, a local nurse and community leader, has turned her home into a Casa Clave, part of a broader initiative promoted by UNFPA to provide adolescents in the Dominican Republic with tools to prevent unplanned pregnancies and early unions. A neighbourhood house that is more haven than health centre, the Casa Clave welcomes Anlli and her friends to talk, without being judged, about anything from family planning to relationships to life projects. "We can talk to Evelyn here and it's confidential, it's something that will not leave this place," Anlli says.

Ms. Sánchez encourages hesitant girls to cross the threshold, knowing that even if they don't ask for contraception the first time, curiosity will bring them back.

"My house is a second home for them. They say they come to see my dogs, but really, they come because they need someone to talk to," Ms. Sánchez says. "They ask me everything. I explain the [contraceptive] methods available, but I never make the decision for them."

"Many of these girls are afraid of being found out," says Dr. Lainer Calderón, who runs the Unidad de Atención Primaria (UNAP), a local healthcare clinic in Estebanía that works in partnership with the Casa Clave. "They worry that their parents or someone from the community will see them and judge them. That fear keeps some from seeking help until it's too late."

He has seen the same cycle repeat itself in too many young lives. "We used to see 24 teenage pregnancies a year in our local healthcare clinic, here in Estebanía" he says. "Now, we have two or three. But even one is too many."

Even within the clinic, challenges arise. Dr. Calderón recalls a father who came to confront him after discovering his 15-year-old daughter had received an implant. "He was furious," he remembers. "I asked him, 'Would you rather find out she is three months pregnant instead?' That conversation changed his mind. He left thanking me."

The battle against cultural norms

The Dominican Republic has been making efforts and investing more to reduce adolescent pregnancy. The adolescent fertility rate dropped from 90 births per 1,000 girls to 77 births from 2013 to 2019. For 2024, the United Nations predicted the fertility rate would be lower.

Casa Clave and similar projects exist to help girls who have already decided they don't want children yet. "It's not about telling girls what to do with their lives, it is about giving them information so they can make their own decisions," says Dr. Calderón. From the pill to injectables and implants, adolescents are given options and information at both the clinic and the Casa Clave.

UNFPA proposed the Casa Clave model in its work alongside the Dominican Ministry of Health and the National Health Service to expand access to contraception and reproductive health education. Today, more than 50 of these safe spaces exist across the country, supplied with contraceptives by the Ministry.

The organization has also trained healthcare workers, like Dr. Calderón and Ms. Sánchez, to provide confidential, quality care services. "Adolescents have the right to access sexual and reproductive health information and education, enabling them to realize their full potential and shape their life's path," says Mario Serrano, UNFPA's representative in the Dominican Republic. "It's not just about preventing pregnancy – it's about protecting and promoting girls' futures."

A changing future

Not only are pregnancy rates starting to decline in Estebanía, but some of the first girls who came to Casa Clave have moved on to university, defying expectations. "A few of my first girls are professionals, a few have even studied medicine. Others are now mothers, but because they wanted to, not because life forced them to," says Ms. Sánchez.

Yet barriers remain. While access to contraception has improved, sex education in schools is still limited. Many girls simply don't know where to go. Others fear repercussions from their families or communities. The fight isn't just about contraception – it's about shifting mindsets.

Ms. Sánchez remembers the early days when people whispered about her work. "At first, people said, 'Why are you talking to them about this?' But they saw the change."

The Casa Clave has changed Anlli's life. Now in her first year at university, she looks forward to having children someday, when she's ready.

Her life is already different from her mother's: "My mom always told me, 'I don't want you to go through what I did.' And I know that if I have children before finishing my education, I won't be able to give them the life they deserve."

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A new goal for all: Reproductive agency

Emphasis on the need for monitoring and ensuring reproductive agency is a hallmark of this report. Just as new measures must be embraced to nuance total fertility rate and to verify the success of population policies, so too are new measures needed to understand reproductive agency for all – but especially for women and girls, whose bodies and futures remain most significantly impacted by childbearing.

It must be noted that both men and women experience serious abrogations of their reproductive rights. While data on men are slim compared with the data on women, the UNFPA/YouGov survey found that they, too, commonly experience pressure and coercion that undermines their exercise of reproductive agency. Eighteen per cent of respondents had, at some point in their lives, experienced pressure to become pregnant or have a child when they did not want to, with broadly similar results for men and women, though with great variation across countries. And in about half of the surveyed countries, more men than women reported feeling this pressure, findings that warrant further investigation.

Pressure also works in the other direction: 15 per cent of respondents across all countries reported experiencing pressure to use contraception or otherwise prevent a pregnancy when they actually wanted to have a child. Men and women were again almost equally likely to say they had experienced this pressure.

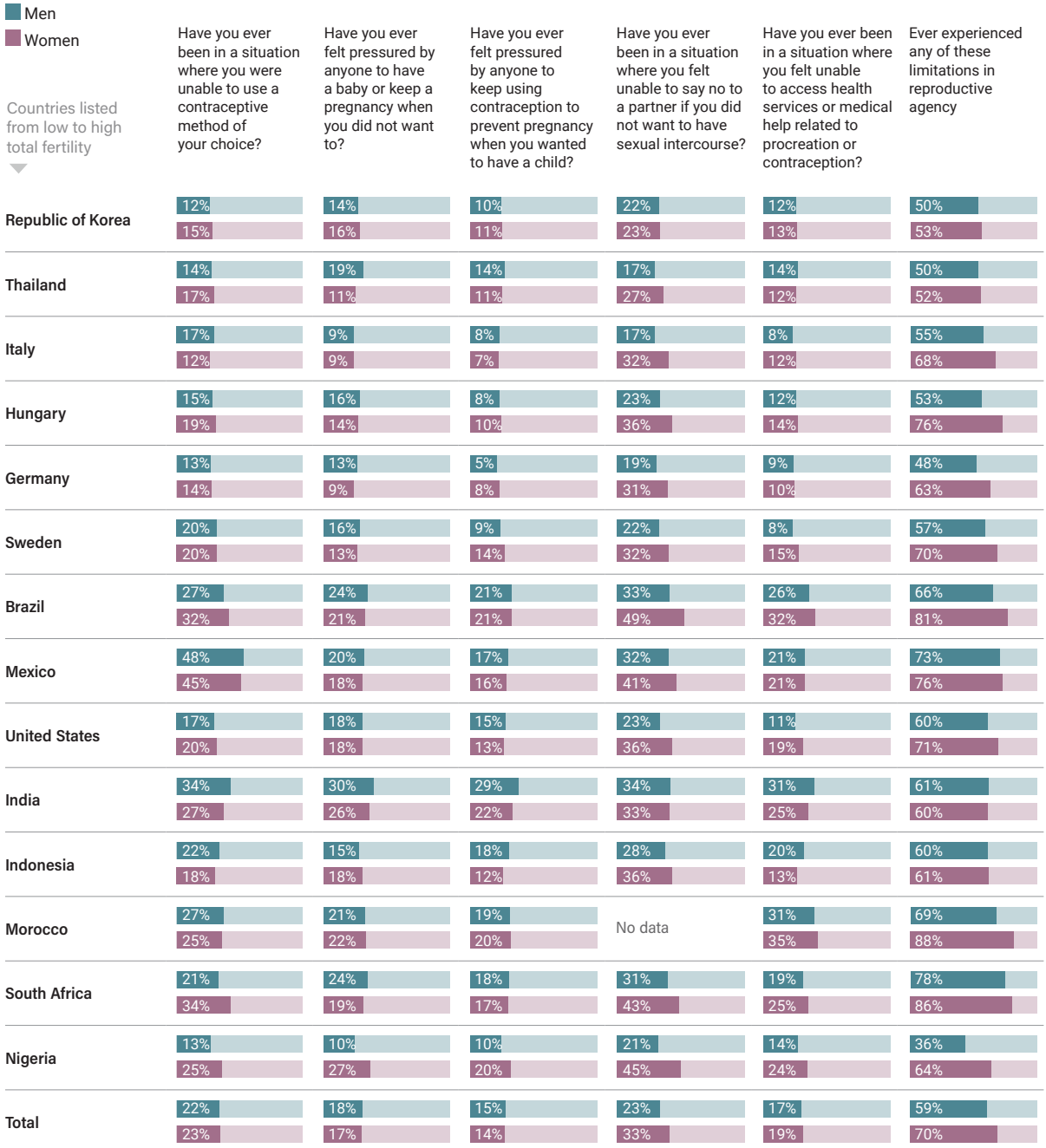
When asked if they had ever been in a situation where they felt unable to say no to sexual intercourse, many more women than men responded yes: 33 per cent of women compared with 23 per cent of men. In no country was the figure lower than 17 per cent (17 per cent being the prevalence among men in Thailand), and it reached up to 49 per cent among women in Brazil. This finding, among both women and men, should be a call to action for all policymakers and advocates, a clear indication that sexual coercion is unacceptably commonplace for both men and women.

Men and women were also similarly likely to respond affirmatively to the question "Have you ever been in a situation where you felt unable to access health services or medical help related to procreation or contraception?" (17 per cent for men, 19 per cent for women), and to the question "Have you ever been in a situation where you were unable to use a contraceptive method of your choice?" (22 per cent for men and 23 per cent for women).

Indeed, men even face some unique disadvantages when it comes to reproductive choice – namely, their contraceptive options are few and far between. Condoms and vasectomy are the two most common male-oriented options, which, like all contraceptives, have drawbacks and failure rates for users. As the 2022 *State of World Population* report noted, "male contraceptive pills, long-acting reversible gels (that block sperm), and injectables are perennially in clinical trials but have not been launched commercially", reflecting the decision-making of investors and policymakers (UNFPA, 2022a). Indeed, policymaking around contraceptives has been deeply

FIGURE 10

Limitations in reproductive agency



Large proportions of both men and women have experienced limitations in their reproductive agency.

Note: The question about saying no to sex could not be asked in all countries.

Source: UNFPA/YouGov Survey.

informed by existing gender norms, resulting in a disproportionate focus on women's bodies as the problem and solution to unintended pregnancy. Today, a growing movement is demanding more and better contraceptive options for men, which would both improve men's choice and support shared responsibility over family planning.

Even so, women's bodies and lives are more directly affected by pregnancy and childbirth (which could, and too often does, kill them), and it is more typically women's labour that is engaged for childcare and related domestic tasks. This is why existing metrics of violence, coercion and decision-making have been developed, tested and refined for women. Given the unequal health consequences and greater exposure to sexual violence borne by women and girls, devising and deploying a woman-focused measure of reproductive agency must be a global public health priority – which in no way contradicts the importance of, and need for, studying reproductive agency among men.

History of reproductive agency metrics

Measures of reproductive behaviours, such as contraceptive use, have been employed for decades. These tools, while critically important in identifying gaps in women's needs, have not necessarily yielded good data on choice and agency (Bhan and Raj, 2021). Since the 2000s, global efforts have sought to support women's empowerment through rights-based programming and policies on sexual and reproductive health, but the practices, targets and indicators have remained entrenched in traditional public health and economic arguments. These measurements often primarily advance the needs and desires of the state over those of individuals. In other words, we have not been sufficiently focused on person-centred reproductive agency.

The most recent global framework for development, the United Nations Sustainable Development Goals (SDGs), includes two goals with specific indicators focused on sexual and reproductive health. Under Goal 3 – the goal to achieve good health and well-being – target 3.7 aims to ensure "universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes". Meanwhile, under Goal 5 – the goal to achieve gender equality and empowerment for all women and girls – target 5.6 calls for ensuring "access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action".

The combination of these targets represents a modest step forward. Together, they emphasize the importance of comprehensive sexual and reproductive healthcare services for all women, and they call for a gender-equality and human rights-based approach to this service delivery. They recognize bodily integrity (i.e., self-determination over one's own body) as central to sexual and reproductive health. And these indicators have been the impetus for collecting vital data across a number of reproductive health and rights areas.

Yet as these targets and indicators have been researched and used, it has become apparent that there are significant gaps in what they

cover. Target 3.7 indicators measure only behaviours and services that can prevent or delay a pregnancy. There is an absence of national focus on sexual behaviour and reproduction more broadly, including fertility desires and the achievement of fertility goals in contexts of infertility. Further, indicator 3.7.1 on "proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods" could stigmatize or disadvantage women who require or prefer other options (see pages 96–97 for more). Indicator 3.7.2 on "adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group" does not capture data on adolescent choice and circumstance. This is important because not all adolescent pregnancies are unintended, particularly in conditions where girls face major gender inequalities and restricted opportunities (Azevedo and others, 2012).

Target 5.6 has similar gaps that demand remedying, even though its indicators, together, offer far greater insight into women's sexual and reproductive agency than has existed before. Indicator 5.6.1 measures the "proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive healthcare". These decisions are defined as whether they can say no to their husband or partner if they do not want to have sex; if they are able, either individually or jointly, to make decisions over contraception; and who makes their healthcare decisions – themselves, their partner or both. Indicator 5.6.2, looks at the "number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive healthcare, information and education".

Since data became available for target 5.6, the world has had, for the first time, a view into women's access to bodily autonomy – revealing widespread constraints in women's ability to make some of their most intimate and consequential decisions. Yet this target is by no means comprehensive. For example, indicator 5.6.1 does not capture whether women are able to have children at the time and with the partner of their choosing, and indicator 5.6.2 does not investigate the non-health system constraints that women face while making reproductive decisions.

There is now a growing global push to recognize the limitations of these existing measures and create new tools with which to better understand reproductive agency in all its nuances. Only with more comprehensive data can we ensure policies are supportive of real, meaningful choice (UNFPA, n.d.c.).

The future of measuring reproductive choice

A number of cross-national surveys have employed or explored measures that can help us articulate new indicators with greater quality and specificity.

As noted above, current indicators of sexual agency focus on the ability to refuse sex in one's intimate relationships, with this being asked only of women currently married or in a union. However, additional indicators could also be useful to help assess women's and girls' sexual safety outside of intimate relationships. For example, the Demographic and Health Survey (DHS) (see box on page 117) also includes

questions on non-partner sexual violence and the age at which a woman or girl was "forced to have sex or perform any sex acts they did not want to", the latter allowing for assessment of child sexual abuse. These, too, can be indicators of sexual safety at the national level.

When the 2022 DHS in Ghana collected these data, for example, the survey showed 6 per cent of women had a history of non-partner sexual violence, and 3 per cent (thought to be a conservative estimate) had experienced forced sex before the age of 15 (GSS and The DHS Program, 2024). Indeed, cross-national data reveal that sexual safety in public spaces is a concern, as demonstrated by the high prevalence of sexual harassment in public spaces seen across national settings (Ranganathan and others, 2021; Kearl, 2010).

Similarly, sexual harassment in the workplace is a major concern for women, reducing their likelihood of entering the labour force, affecting job performance and productivity, and harming mental health (León-Perez and others, 2021; Ranganathan and others, 2021). Importantly, indicators of non-partner sexual violence and child sexual abuse can be used to justify restrictions to women's and girls' freedom of movement, as a means of ensuring their sexual safety but costing them agency and opportunity (Hallmann and others, 2015). Researchers, policymakers and advocates must pay close attention to ensure this does not happen.

One might argue that these issues are covered by research into gender-based violence – and indeed this is an essential area of investigation – but these matters are no less an issue of sexual safety, bodily integrity and sexual well-being, and must be captured and addressed as such. Existing measures of sexual agency, seen in cross-national surveys, tend to be more indicative of sexual control and violence, or the lack thereof, rather than assessing positive sexual engagement for women. While it is important for women to be able to refuse sex when they do not want it, it is equally important for women to be able to initiate consensual sex when they *do* want it.

Neglect of this position maintains outdated norms in which women are viewed as sexual gatekeepers in ways that negate their sexual desire and normalize men's sexual aggression. Assessing women's initiation of and satisfaction with sex in consensual engagement with their partners can help support more positive sexual relationships – an issue that warrants attention given the trends in involuntary singleness and declines in partnership formation seen in some places (see page 88). And while there remains considerable cultural and social reluctance to embrace such assessments, even for married women, these concerns were once expressed about partner violence, which is now a cornerstone of global indicators on gender equality and empowerment.

Additionally, while data on sexual health most typically focus on sexually transmitted infections (STIs), only HIV is directly addressed in the current SDGs framework, under target 3.3. Other STIs are nested under the umbrella of "communicable diseases". Greater attention can and should be paid to monitoring the range of STIs, which are health concerns in themselves that also compromise reproductive and maternal health (Van Gerwen and others, 2022; Otu and others, 2021), and

can undermine people's ability to realize their ultimate family formation goals.

The DHS has important indicators that could be used to this effect, including asking women whether they had a recent STI diagnosis or STI symptoms, and whether they could ask their husband to use a condom. There are additionally two questions that together capture norms regarding a woman's agency or ability to protect herself from STIs if she thinks her husband poses a risk. These are: "If a wife knows her husband has a disease that she can get during sexual intercourse, is she justified in asking that they use a condom when they have sex?" and "Is a wife justified in refusing to have sex with her husband when she knows he has sex with other women?"

Finally, systematic collection of global evidence on reproductive agency, fertility aspirations and the challenges to both must be a priority for the international community. Ideally, future data collection efforts should not only be rooted in the needs, desires, agency and empowerment of young people, but also be longitudinal, following subjects to the end of their reproductive lifespan to assess whether systems and circumstances enabled them to realize their goals.

Funding for data in support of reproductive health and rights

Historically, the international community has relied heavily on the Demographic and Health Survey (DHS) to assess sexual and reproductive behaviours across 90 low- and middle-income nations. The DHS, in place since the 1990s, has been a vital public health and policy tool supported by a number of governments, international and United Nations agencies, and civil society partners. Unfortunately, global funding commitments from the United States, the primary funder of this survey, were lost as of February 2025; the programme is now halted for a funding review. Invaluable monitoring data on contraceptive agency, reproductive health, gender-based violence and many other areas of research could be lost if the DHS is unable to obtain new funding. However, international donors and researchers are working to explore other avenues, in case the DHS is not revived. The smaller Generations and Gender Survey, currently implemented in 24 countries, and the Performance Monitoring for Action Survey both collect family planning data, and could be expanded to a broader array of nations.

The UNFPA/YouGov survey conducted for this report also served as a pilot exercise for the development of a large, cross-national survey that UNFPA will be launching later in 2025. This global survey will explore young people's reproductive choices and partnership aspirations and the barriers and enablers to their fulfilment.

FEATURE

Meeting the needs of ageing populations

The world's oldest person, Brazilian nun and soccer fan Sister Inah Canabarro, died in May 2025, a few weeks shy of her 117th birthday. Few of us will be lucky enough to join the supercentenarian set, but most of us today can expect to live, on average, about 25 per cent longer than our parents and grandparents. About 50 years ago, life expectancy worldwide was about 59 years. Today, it is about 73 years (UN DESA, 2024).

Better healthcare and overall better living conditions have contributed to this dramatic increase in longevity, which, in turn, is contributing to an ever-growing population of older people. The number of people aged 65 years or older worldwide is projected to double from 809 million in 2023 to 1.6 billion in 2050, and to reach 2.4 billion by the end of the century (UN DESA, 2024).

Yet some governments see population ageing primarily as a problem to be solved, as burgeoning older populations add pressure to social security systems and healthcare and declining birth rates mean a smaller future base of workers and taxpayers. This view risks missing out on the enormous economic potential of older people and the businesses that serve them, according to *Longevity Hubs: Regional Innovation for Global Aging*, by the Massachusetts Institute of Technology's AgeLab.

"In terms of both productivity and spending, older people are complete, complex economic players, whose already sizeable impact is posted to expand markedly in the coming years," says Luke Yoquinto, one of the editors of *Longevity Hubs*. It's a mistake to treat them as "takers, hoovering up the rest of society's resources", he adds.

In 2020, for example, spending by people aged 50 years or older on goods and services supported about 1 billion jobs around the world, generating $23 trillion in labour income. That same year, the 50-plus population contributed $45 trillion to global GDP (AARP, 2022).

In a number of cities around the world, the private sector, research institutions and elder-service providers are coming together to develop products and provide services needed in a greying society because they recognize the need for – and economic benefits of – working with and for older populations.

The Boston metropolitan area is well-positioned to become one such "longevity hub", Mr. Yoquinto says. The city has a highly educated labour force, cutting-edge research institutions and top-rated healthcare. Boston could become, as Inc. magazine put it, the "Silicon Valley of the octogenarian set".

There are at least eight longevity hubs emerging around the world, Mr. Yoquinto explains. Businesses in Milan, for example, are responding to the growing demand for senior housing and assisted living services. Milan's financial services firms are starting to offer investment advice customized to older people or are investing in industries that meet the needs of Italy's older populations. Today, about 1 in 4 Italians is aged 65 or older.

In São Paulo, more than 250 representatives from the private sector, academia, healthcare and government have formed a network to respond to Brazil's rapidly ageing population. The network, Envelhecimento 2.0, has become the main channel for exchanging ideas and information about the "longevity ecosystem", and is the place where many of the country's biggest age-related initiatives begin, according to *Longevity Hubs*.

And in cities south-east of Bangkok, in Thailand's Eastern Economic Corridor, private healthcare and eldercare services are booming as an increasing number of retirees from other countries are choosing to relocate to Thailand for its warm climate, affordability, natural beauty and quality of life.

Each longevity hub has something unique to offer and is striving to meet the expressed needs of older people. In the past, Mr. Yoquinto explains, businesses might have provided some tokenistic good or service based on what young people imagined older people should want. All that is changing as researchers, industry and older people are increasingly working together to find solutions that improve lives and are good for the bottom line.

"Innovating for the world's older population – domestic and global – results in a profound competitive advantage," Mr. Yoquinto says. "If you don't do it, somebody else will."

Learning from the lessons of history

In sum, as the world continues to experience growing demographic diversity, with more countries expected to experience rapidly declining fertility rates, alongside ethnonationalist impulses and "overpopulation" concerns in places with persistently high fertility rates, we must exercise maximum caution – and maximum optimism.

Leaders would be wise to keep the last 60 years of history in mind as they deliberate policies that might, if poorly designed, be ineffective or yield unintended consequences, with only temporary impacts but potentially terrible human rights costs. They must also recognize the legitimate concerns of young people, who need not only conditions enabling them to make free, informed reproductive choices, but also hope for a future in which those choices are supported (Gessen, 2014).

Young people overwhelmingly report worries and uncertainty about their futures. Many expect to experience worse outcomes than their parents did. Their concerns about climate change, economic instability and rising global conflicts will be reflected in the choices they make about raising families. It is not uncommon for young people to feel cheated – to believe that their futures have been robbed from them by policymakers impervious to their lived realities. In many countries, the growing percentage of older persons skews electoral influence in their favour, often at the expense of young people. As a result, "political leaders bound by the time horizon of an election cycle tend to serve an older clientele, rather than focus on reforms that are necessary for the younger and future generations" (UNFPA, 2025d).

Leaders concerned about population trends would be wise to listen to these voices and to pursue policies centred on the concept of intergenerational fairness. This requires fostering solidarity between generations and embracing a life-course approach, which can ensure young people are empowered to meaningfully participate in their communities while also meeting the growing needs of ageing persons. One promising example is the Y-ACT initiative in Kenya, which has empowered young people to shape sexual and reproductive health and rights policy and budgeting decisions at the county level, leading to increased investment in adolescent-friendly health services and meaningful youth participation in governance (UNFPA, 2023a).

Young people who feel hopeful about the future are more likely to pursue the lives they want for themselves and their families. As one youth activist, responding to a UNFPA questionnaire, shared, "Young people are not just thinking about their future children – they are thinking about the world those children will inherit" (see more on pages 8–9).

History also offers a clear remedy: The Programme of Action of the International Conference on Population and Development. A close read of this important document actually highlights solutions to many of the challenges facing the world today: It called for "family-sensitive policies in the field of housing, work, health, social security and education in order to create an environment supportive of the family". It insisted upon "the equal participation of women and men in all areas of family and household responsibilities, including family planning, child-rearing and housework". It called for "family leave for men and women so that they may have more choice regarding the balance of their domestic and public responsibilities" (UNFPA, 2014).

That 30-year-old agreement even foresaw many of the issues that are today regarded as novel: The ageing of society and the need to help "families to take care of elderly people", the importance of laws and policies that reflect the "plurality of forms" the family can take, and the need for greater "assistance from third parties" to help parents reconcile their work and family lives.

And, most memorably, it forged a global consensus that couples and individuals should have the information and the means to decide freely and responsibly on the number, spacing and timing of their children. This must remain our goal, regardless of a nation's fertility rate, for all people, everywhere.

Artwork by Marianna Gefen

Artwork by Stina Persson

INDICATORS

Sexual and reproductive health

	Maternal mortality ratio (MMR) (deaths per 100,000 live births)[a]	Range of MMR uncertainty (UI 80%), lower estimate[a]	Range of MMR uncertainty (UI 80%), upper estimate[a]	Births attended by skilled health personnel, per cent	Number of new HIV infections, all ages, per 1,000 uninfected population	Contraceptive prevalence rate, women aged 15–49, per cent				Unmet need for family planning, women aged 15–49, per cent		Proportion of demand satisfied with modern methods, all women aged 15–49	Laws and regulations that guarantee access to sexual and reproductive healthcare, information and education, per cent	Universal health coverage (UHC) service coverage index
						Any method		Modern method						
						All	Married or in union	All	Married or in union	All	Married or in union			
World and regional areas	2023	2023	2023	2024	2023	2025		2025		2025		2025	2022	2021
World	**197**	**174**	**234**	**87**	**0.17**	**49**	**64**	**44**	**58**	**8**	**11**	**77**	**76**	**68**
More developed regions	–	–	–	99	0.14	58	71	52	63	7	8	81	87	84
Less developed regions	–	–	–	82	0.17	50	68	46	61	7	9	80	72	64
Least developed countries	313	277	368	69	0.30	32	43	28	37	15	19	60	71	44
UNFPA regions														
Arab States	133	98	184	84	0.05	33	53	28	45	10	15	65	65	61
Asia and the Pacific	102	89	120	87	0.07	52	70	47	63	6	9	81	74	68
Eastern Europe and Central Asia	18	15	22	99	0.10	43	63	34	49	8	12	67	84	74
Latin America and the Caribbean	77	68	88	92	0.20	58	75	55	71	8	10	83	75	76
East and Southern Africa	276	233	352	74	0.73	35	44	32	40	15	20	64	72	46
West and Central Africa	669	538	920	62	0.34	22	25	19	21	16	21	49	70	40
Countries, territories, other areas	2023	2023	2023	2004–2024	2023	2025		2025		2025		2025	2022	2021
Afghanistan	521	339	942	68	0.04	21	30	18	26	15	23	51	56	41
Albania	7	3	13	100	0.03	47	64	20	26	10	13	36	79	64
Algeria	62	46	87	99	0.05	33	60	28	52	7	11	72	–	74
Angola	183	117	286	50	0.44	18	19	16	17	26	34	38	62	37
Antigua and Barbuda	35	19	55	99	–	41	62	39	59	10	13	76	–	76
Argentina	33	26	41	99	0.09	58	71	56	68	10	11	83	92	79
Armenia	19	15	30	100	0.19	37	60	21	33	7	12	47	87	68
Aruba	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Australia	2	2	3	99	–	58	67	56	64	7	10	86	–	87
Austria	6	4	11	98	–	66	73	63	70	5	7	89	–	85
Azerbaijan	18	12	29	100	0.05	35	58	15	25	8	13	36	–	66
Bahamas	76	50	130	99	0.16	45	65	43	64	10	12	78	–	77
Bahrain	17	12	25	98	–	37	63	27	45	7	12	60	73	76
Bangladesh	115	82	167	70	0.01	54	65	46	56	8	10	75	–	52
Barbados	35	18	56	98	0.14	50	63	47	60	12	14	75	44	77
Belarus	1	1	2	100	0.10	52	62	45	53	11	11	73	83	79
Belgium	4	3	5	–	–	61	67	60	66	6	8	91	–	86
Belize	67	39	111	95	0.39	44	58	41	54	13	17	72	43	68
Benin	518	393	740	81	0.10	20	23	16	19	21	29	39	91	38
Bhutan	47	30	69	99	0.10	40	62	39	60	8	12	81	83	60
Bolivia (Plurinational State of)	146	98	243	72	0.16	45	68	34	51	10	15	62	94	65
Bosnia and Herzegovina	6	3	10	100	0.02	39	51	20	23	9	13	43	70	66
Botswana	155	96	268	100	1.90	58	70	57	69	8	10	87	64	55
Brazil	67	52	88	98	0.24	67	80	65	78	6	7	90	–	80
Brunei Darussalam	36	25	52	100	–	–	–	–	–	–	–	–	41	78
Bulgaria	6	3	9	94	0.03	66	80	52	60	5	7	73	62	73
Burkina Faso	242	155	367	96	0.08	33	37	31	35	13	16	67	81	40
Burundi	392	251	611	75	0.12	21	35	19	31	16	26	52	65	41
Cabo Verde	40	22	65	97	0.52	45	59	44	58	12	15	78	84	71
Cambodia	137	96	239	99	0.07	43	64	32	47	8	11	63	98	58
Cameroon	258	196	359	69	–	25	25	21	19	15	21	52	–	44

Sexual and reproductive health

Countries, territories, other areas	Maternal mortality ratio (MMR) (deaths per 100,000 live births)[a]	Range of MMR uncertainty (UI 80%), lower estimate[a]	Range of MMR uncertainty (UI 80%), upper estimate[a]	Births attended by skilled health personnel, per cent	Number of new HIV infections, all ages, per 1,000 uninfected population	Contraceptive prevalence rate, women aged 15–49, per cent				Unmet need for family planning, women aged 15–49, per cent		Proportion of demand satisfied with modern methods, all women aged 15–49	Laws and regulations that guarantee access to sexual and reproductive healthcare, information and education, per cent	Universal health coverage (UHC) service coverage index
						Any method		Modern method						
						All	Married or in union	All	Married or in union	All	Married or in union			
	2023	2023	2023	2004–2024	2023	2025		2025		2025		2025	2022	2021
Canada	12	8	18	98	–	73	82	70	80	3	4	93	–	91
Central African Republic	692	333	1299	40	–	22	24	17	19	21	26	40	77	32
Chad	748	493	1248	47	0.25	8	9	7	8	19	25	27	59	29
Chile	10	7	13	100	0.18	66	78	61	72	6	8	86	–	82
China	16	11	21	100	–	67	85	65	83	3	3	92	–	81
China, Hong Kong Special Administrative Region	–	–	–	–	–	50	70	47	68	7	10	84	–	–
China, Macao Special Administrative Region	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Colombia	59	45	76	98	0.25	64	82	60	77	5	6	87	96	80
Comoros	179	103	308	97	0.01	13	17	10	13	22	32	28	–	48
Congo	241	144	453	94	1.70	43	46	31	30	14	18	54	55	41
Costa Rica	24	19	28	99	0.17	55	74	53	72	9	10	84	84	81
Côte d'Ivoire	359	237	568	84	0.35	29	29	25	25	17	21	54	64	43
Croatia	3	2	4	100	0.01	46	71	33	47	4	8	66	98	80
Cuba	35	29	42	100	0.18	63	62	62	61	10	13	84	–	83
Curaçao	–	–	–	–	–	39	46	36	43	15	21	67	–	–
Cyprus	14	8	25	100	–	–	–	–	–	–	–	–	72	81
Czechia	3	2	4	100	0.02	63	84	57	76	4	4	84	79	84
Democratic People's Republic of Korea	67	38	114	100	–	62	75	59	72	7	8	86	83	68
Democratic Republic of the Congo	427	283	775	85	0.17	27	31	17	18	20	25	37	–	42
Denmark	4	3	5	96	0.01	63	77	59	73	5	6	88	87	82
Djibouti	162	80	337	87	0.29	16	32	16	31	13	25	54	–	44
Dominica	36	22	61	100	–	48	63	46	61	11	13	78	–	49
Dominican Republic	124	86	185	99	0.36	57	73	54	70	8	10	84	–	77
Ecuador	55	48	66	96	0.12	54	80	49	73	7	6	81	92	77
Egypt	17	11	23	97	0.07	42	62	40	60	8	11	81	–	70
El Salvador	39	25	63	98	0.13	52	74	49	69	8	10	82	92	78
Equatorial Guinea	174	103	309	68	–	19	19	16	16	22	31	40	–	46
Eritrea	291	176	483	34	0.06	9	15	9	14	16	28	35	–	45
Estonia	5	3	9	99	0.08	63	75	52	63	5	7	77	98	79
Eswatini	118	72	209	93	4.20	47	62	46	61	12	16	79	98	56
Ethiopia	195	128	332	50	0.07	28	39	28	38	15	21	64	73	35
Fiji	30	20	47	100	0.40	25	38	22	33	15	23	55	–	58
Finland	8	5	14	100	–	79	82	74	78	3	4	91	98	86
France	7	6	10	98	0.09	67	78	64	75	4	4	91	–	85
French Guiana	–	–	–	–	–	–	–	–	–	–	–	–	–	–
French Polynesia	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Gabon	233	134	424	95	0.79	26	28	20	19	21	28	43	58	49
Gambia	354	245	504	84	0.53	15	22	14	20	15	24	46	–	46
Georgia	20	13	27	100	0.14	32	49	23	35	12	18	53	94	68
Germany	4	3	5	96	–	55	68	54	67	6	9	88	87	88
Ghana	234	155	344	88	0.56	31	37	24	30	14	22	53	66	48
Greece	5	3	8	100	0.05	50	74	37	52	4	7	68	72	77
Grenada	48	29	95	100	–	45	65	42	60	10	12	76	–	70

Sexual and reproductive health

Countries, territories, other areas	Maternal mortality ratio (MMR) (deaths per 100,000 live births)[a]	Range of MMR uncertainty (UI 80%), lower estimate[a]	Range of MMR uncertainty (UI 80%), upper estimate[a]	Births attended by skilled health personnel, per cent	Number of new HIV infections, all ages, per 1,000 uninfected population	Contraceptive prevalence rate, women aged 15–49, per cent				Unmet need for family planning, women aged 15–49, per cent		Proportion of demand satisfied with modern methods, all women aged 15–49	Laws and regulations that guarantee access to sexual and reproductive healthcare, information and education, per cent	Universal health coverage (UHC) service coverage index
						Any method		Modern method						
						All	Married or in union	All	Married or in union	All	Married or in union			
	2023	2023	2023	2004–2024	2023	2025		2025		2025		2025	2022	2021
Guadeloupe	–	–	–	–	–	40	58	36	51	11	15	72	–	–
Guam	–	–	–	–	–	37	66	33	56	7	10	75	–	–
Guatemala	94	82	106	70	0.09	43	65	37	55	8	12	72	–	59
Guinea	494	337	764	55	0.33	15	15	14	14	18	23	44	79	40
Guinea-Bissau	505	313	851	54	0.53	33	25	31	24	16	19	64	80	37
Guyana	75	59	103	98	0.73	30	39	28	38	19	28	58	87	76
Haiti	328	218	569	42	0.48	30	40	27	37	23	32	52	65	54
Honduras	47	37	62	94	0.05	50	73	47	67	8	10	80	80	64
Hungary	12	8	18	100	–	50	70	45	63	7	9	80	93	79
Iceland	3	1	6	97	0.03	–	–	–	–	–	–	–	–	89
India	80	73	87	89	0.05	51	68	45	59	7	9	78	74	63
Indonesia	140	93	235	97	0.10	38	54	38	53	10	14	78	77	55
Iran (Islamic Republic of)	16	10	22	99	0.03	57	82	46	66	3	4	76	63	74
Iraq	66	41	116	96	–	39	57	28	41	8	12	60	59	59
Ireland	4	3	5	100	0.04	65	70	63	67	5	9	89	–	83
Israel	2	1	4	100	0.03	40	73	31	56	5	8	69	–	85
Italy	6	5	9	99	0.03	59	67	49	52	5	9	77	–	84
Jamaica	130	96	175	100	0.42	37	66	34	60	9	10	73	76	74
Japan	3	2	4	100	–	51	59	46	52	9	15	76	85	83
Jordan	31	24	41	100	0.00	33	60	23	41	6	11	58	56	65
Kazakhstan	10	7	14	100	0.12	43	54	41	51	10	14	77	65	80
Kenya	379	267	547	89	0.31	46	64	43	61	6	9	82	48	53
Kiribati	80	34	152	92	–	24	33	20	27	16	22	50	–	48
Kuwait	8	5	12	99	0.04	36	60	30	50	8	13	68	–	78
Kyrgyzstan	42	33	55	100	0.11	26	43	25	41	10	17	68	73	69
Lao People's Democratic Republic	112	75	182	80	0.18	40	62	35	55	9	13	73	96	52
Latvia	19	13	28	98	0.15	58	72	52	62	6	9	81	70	75
Lebanon	15	11	21	98	0.05	32	62	25	47	7	12	64	–	73
Lesotho	478	298	725	89	3.00	50	67	49	67	9	13	83	–	53
Liberia	628	436	913	84	0.15	29	29	28	28	24	30	52	–	45
Libya	59	23	154	100	–	16	41	11	27	10	25	42	–	62
Lithuania	8	5	12	100	0.06	47	71	39	58	6	8	73	87	75
Luxembourg	12	7	19	100	0.08	–	–	–	–	–	–	–	–	83
Madagascar	445	326	652	46	–	42	52	36	46	12	14	68	–	35
Malawi	225	153	352	96	0.61	50	67	49	66	12	14	79	79	48
Malaysia	26	24	34	100	0.09	30	50	23	37	12	19	54	83	76
Maldives	32	22	50	100	–	17	25	14	20	20	29	37	93	61
Mali	367	268	498	66	0.24	20	22	19	22	20	23	48	–	41
Malta	8	4	14	100	0.09	54	80	43	63	3	5	76	–	85
Martinique	–	–	–	–	–	40	60	37	54	10	15	73	–	–
Mauritania	381	263	561	70	0.06	12	17	11	15	21	30	34	65	40
Mauritius	66	44	105	100	0.86	36	67	26	46	7	9	59	75	66
Mexico	42	32	50	88	0.15	53	73	51	69	9	11	82	86	75
Micronesia (Federated States of)	129	56	302	100	–	–	–	–	–	–	–	–	–	48

Sexual and reproductive health

Countries, territories, other areas	Maternal mortality ratio (MMR) (deaths per 100,000 live births)[a]	Range of MMR uncertainty (UI 80%), lower estimate[a]	Range of MMR uncertainty (UI 80%), upper estimate[a]	Births attended by skilled health personnel, per cent	Number of new HIV infections, all ages, per 1,000 uninfected population	Contraceptive prevalence rate, women aged 15–49, per cent				Unmet need for family planning, women aged 15–49, per cent		Proportion of demand satisfied with modern methods, all women aged 15–49	Laws and regulations that guarantee access to sexual and reproductive healthcare, information and education, per cent	Universal health coverage (UHC) service coverage index
						Any method		Modern method						
						All	Married or in union	All	Married or in union	All	Married or in union			
	2023	2023	2023	2004–2024	2023	2025		2025		2025		2025	2022	2021
Mongolia	41	27	58	100	0.01	41	58	38	53	12	15	71	–	65
Montenegro	6	3	10	99	0.04	23	27	17	17	14	22	44	52	72
Morocco	70	51	94	87	0.03	41	71	35	62	7	10	75	–	69
Mozambique	82	60	113	68	2.60	28	29	27	28	21	25	55	–	44
Myanmar	185	124	311	60	0.19	35	60	34	58	8	13	80	91	52
Namibia	139	91	223	88	2.20	53	62	53	61	10	14	83	88	63
Nepal	142	99	234	80	0.02	43	56	36	47	15	20	61	48	54
Netherlands (Kingdom of the)	4	3	6	–	–	63	73	60	70	5	7	88	100	85
New Caledonia	–	–	–	–	–	–	–	–	–	–	–	–	–	–
New Zealand	7	4	9	96	0.01	64	81	60	75	4	5	88	95	85
Nicaragua[1]	60	45	77	94	0.10	59	82	57	79	5	6	88	75	70
Niger	350	227	563	44	0.05	12	15	12	14	16	20	41	–	35
Nigeria	993	718	1540	51	0.34	20	24	16	19	15	19	46	–	38
North Macedonia	3	1	5	100	0.02	44	54	22	22	9	13	41	–	74
Norway	1	1	2	99	–	68	85	63	80	3	4	89	100	87
Oman	13	9	19	100	0.02	22	39	15	27	13	24	44	70	70
Pakistan	155	107	241	68	–	27	41	21	32	11	16	55	69	45
Panama	37	30	43	93	0.35	47	60	45	57	13	17	74	72	78
Papua New Guinea	189	119	307	56	0.65	29	40	24	33	17	24	52	–	30
Paraguay	58	42	81	91	0.20	58	73	55	68	8	8	83	76	72
Peru	51	40	62	95	0.19	54	78	42	60	5	7	72	85	71
Philippines	84	64	119	90	0.24	35	59	26	44	8	12	61	80	58
Poland	2	1	3	100	–	54	74	44	59	6	8	73	89	82
Portugal	15	9	24	97	0.05	58	74	50	63	4	7	80	95	88
Puerto Rico	11	7	19	–	–	52	82	47	74	7	4	80	–	–
Qatar	4	2	6	100	0.04	33	50	28	42	9	14	66	71	76
Republic of Korea	4	3	5	100	–	51	83	45	70	4	6	82	–	89
Republic of Moldova	19	13	27	100	0.30	48	59	39	47	12	15	65	–	71
Réunion	–	–	–	–	–	51	72	50	70	8	9	84	–	–
Romania	12	7	18	98	0.02	53	71	45	59	6	8	76	98	78
Russian Federation	9	6	15	100	–	49	68	43	58	7	9	76	70	79
Rwanda	229	158	373	94	0.24	40	67	37	62	9	12	76	82	49
Saint Kitts and Nevis	74	36	118	100	0.32	48	60	45	56	12	14	75	–	79
Saint Lucia	44	26	77	100	0.14	49	61	46	57	12	14	75	33	77
Saint Vincent and the Grenadines	56	32	87	99	–	48	66	46	63	10	12	78	81	69
Samoa	101	46	233	89	–	14	22	13	20	27	42	32	22	55
San Marino	8	3	16	–	–	–	–	–	–	–	–	–	–	77
Sao Tome and Principe	75	42	138	97	–	38	52	36	48	19	24	62	46	59
Saudi Arabia	7	5	11	100	0.04	23	41	19	34	11	21	55	–	74
Senegal	237	173	365	94	0.16	21	29	20	28	13	19	58	75	50
Serbia	11	8	16	100	0.03	47	59	30	30	6	11	56	99	72
Seychelles	42	26	64	100	–	–	–	–	–	–	–	–	–	75
Sierra Leone	354	249	537	87	0.39	29	28	29	28	19	23	60	65	41
Singapore	6	4	11	100	0.03	34	68	30	60	5	10	78	46	89

Sexual and reproductive health

Countries, territories, other areas	Maternal mortality ratio (MMR) (deaths per 100,000 live births)[a]	Range of MMR uncertainty (UI 80%), lower estimate[a]	Range of MMR uncertainty (UI 80%), upper estimate[a]	Births attended by skilled health personnel, per cent	Number of new HIV infections, all ages, per 1,000 uninfected population	Contraceptive prevalence rate, women aged 15–49, per cent				Unmet need for family planning, women aged 15–49, per cent		Proportion of demand satisfied with modern methods, all women aged 15–49	Laws and regulations that guarantee access to sexual and reproductive healthcare, information and education, per cent	Universal health coverage (UHC) service coverage index
						Any method		Modern method						
						All	Married or in union	All	Married or in union	All	Married or in union			
	2023	2023	2023	2004–2024	2023	2025		2025		2025		2025	2022	2021
Sint Maarten (Dutch part)	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Slovakia	4	3	7	97	0.02	55	79	48	67	5	6	79	86	82
Slovenia	3	2	6	100	–	49	79	41	67	3	5	80	–	84
Solomon Islands	123	65	231	86	–	24	33	20	27	14	18	53	–	47
Somalia	563	244	1089	32	–	8	11	2	3	17	26	10	–	27
South Africa	118	92	137	97	2.70	51	59	51	59	10	14	83	95	71
South Sudan	692	400	1254	40	0.56	7	9	7	8	22	29	23	16	34
Spain	3	2	4	100	0.05	64	68	62	66	5	11	89	–	85
Sri Lanka	18	15	25	100	0.01	46	68	37	56	5	7	74	86	67
State of Palestine[2]	16	9	26	100	–	39	62	30	47	7	10	65	68	–
Sudan	256	159	415	78	0.11	12	18	11	16	17	27	37	57	44
Suriname	84	54	121	100	0.83	35	49	35	48	14	21	70	–	63
Sweden	4	3	6	–	–	59	70	56	68	6	8	87	100	85
Switzerland	5	4	8	–	0.02	73	73	68	68	4	7	89	94	86
Syrian Arab Republic	20	11	38	96	0.00	35	62	26	47	7	12	63	81	64
Tajikistan	14	8	25	98	0.03	24	34	22	32	15	21	57	–	67
Thailand	34	26	49	100	0.13	41	76	40	74	4	7	89	–	82
Timor-Leste	192	125	288	69	0.08	21	36	19	32	13	22	56	–	52
Togo	349	219	526	69	0.26	26	29	23	27	22	29	50	–	44
Tonga	67	30	156	98	–	18	34	16	29	13	25	50	–	57
Trinidad and Tobago	54	40	69	99	–	32	42	26	37	17	22	54	27	75
Tunisia	36	23	53	98	0.07	31	57	27	50	8	14	69	–	67
Türkiye	15	11	22	97	–	43	72	30	50	6	9	63	78	76
Turkmenistan	5	2	8	100	–	36	54	34	51	8	12	77	94	75
Turks and Caicos Islands	–	–	–	100	–	37	40	36	39	18	22	64	–	–
Tuvalu	170	75	409	100	–	20	27	18	24	19	27	46	–	52
Uganda	170	116	298	88	0.86	41	52	36	47	15	20	65	–	49
Ukraine	15	9	25	100	–	53	69	45	56	6	9	76	95	76
United Arab Emirates	3	2	4	100	–	37	53	30	42	11	16	62	–	82
United Kingdom of Great Britain and Northern Ireland	8	6	12	–	–	71	76	65	69	5	7	86	96	88
United Republic of Tanzania	276	192	429	85	0.85	33	40	28	34	16	20	57	–	43
United States of America	17	13	21	99	–	60	76	53	67	5	6	80	–	86
United States Virgin Islands	–	–	–	–	–	53	75	49	70	8	8	80	–	–
Uruguay	15	11	20	100	0.24	57	79	55	77	6	7	87	97	82
Uzbekistan	26	18	40	99	0.10	47	62	45	59	8	11	81	92	75
Vanuatu	100	38	265	91	–	38	49	33	42	15	19	61	–	47
Venezuela (Bolivarian Republic of)[3]	227	148	371	99	0.27	54	76	51	72	7	9	82	–	75
Viet Nam	48	31	69	98	0.06	58	79	48	66	4	6	78	54	68
Western Sahara	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Yemen	118	71	212	61	0.05	31	48	23	35	14	21	52	65	42
Zambia	85	61	126	94	1.20	38	55	37	53	14	17	70	91	56
Zimbabwe	358	236	484	86	0.98	51	69	50	69	8	9	86	73	55

NOTES

– Data not available.

[a] The MMR has been rounded according to the following scheme: <100, rounded to nearest 1; 100-999, rounded to nearest 1; and ≥1000, rounded to nearest 10.

[1] The Government of Nicaragua reports the strengthening of its maternal and neonatal health services and a progressive decrease in the Maternal Mortality Rate, officially publishing a rate of 31.4 per 100,000 live births for the year 2021.

[2] On 29 November 2012, the United Nations General Assembly passed Resolution 67/19, which accorded Palestine "non-member observer State status in the United Nations..."

[3] The figure presented for Venezuela reflects the global estimate produced by the UN Maternal Mortality Estimation Inter-Agency Group (MMEIG), based on data that marked a peak in maternal mortality, before the Government's accelerated plan to reduce maternal mortality developed with technical support from the United Nations. The Government of the Bolivarian Republic of Venezuela reports a progressive decline, officially communicating a national estimate of 65.56 per 100,000 live births for 2024.

DEFINITIONS OF THE INDICATORS

Maternal mortality ratio: Number of maternal deaths during a given time period per 100,000 live births during the same time period (SDG indicator 3.1.1).

Births attended by skilled health personnel: Percentage of births attended by skilled health personnel (doctor, nurse or midwife) (SDG indicator 3.1.2).

Number of new HIV infections, all ages, per 1,000 uninfected population: Number of new HIV infections per 1,000 person-years among the uninfected population (SDG indicator 3.3.1).

Contraceptive prevalence rate: Percentage of women aged 15 to 49 years who are currently using any method of contraception.

Contraceptive prevalence rate, modern method: Percentage of women aged 15 to 49 years who are currently using any modern method of contraception.

Unmet need for family planning: Percentage of women aged 15 to 49 years who want to stop or delay childbearing but are not using a method of contraception.

Proportion of demand satisfied with modern methods: Percentage of total demand for family planning among women aged 15 to 49 years that is satisfied by the use of modern contraception (SDG indicator 3.7.1).

Laws and regulations that guarantee access to sexual and reproductive healthcare, information and education: The extent to which countries have national laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive healthcare, information and education (SDG indicator 5.6.2).

Universal health coverage (UHC) service coverage index: Average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population (SDG indicator 3.8.1).

MAIN DATA SOURCES

Maternal mortality ratio: United Nations Maternal Mortality Estimation Inter-agency Group (WHO, UNICEF, UNFPA, The World Bank, and the United Nations Population Division), 2025.

Births attended by skilled health personnel: Joint global database on skilled attendance at birth, 2025, United Nations Children's Fund (UNICEF) and World Health Organisation (WHO). Regional aggregates calculated by UNFPA based on data from the joint global database.

Number of new HIV infections, all ages, per 1,000 uninfected population: UNAIDS 2024 HIV Estimates.

Contraceptive prevalence rate: United Nations Population Division, 2025.

Contraceptive prevalence rate, modern method: United Nations Population Division, 2025.

Unmet need for family planning: United Nations Population Division, 2025.

Proportion of demand satisfied with modern methods: United Nations Population Division, 2025.

Laws and regulations that guarantee access to sexual and reproductive healthcare, information and education: UNFPA, 2022.

Universal health coverage (UHC) service coverage index: WHO, 2023.

Gender, rights and human capital

World and regional areas	Adolescent birth rate per 1,000 girls aged 15–19	Child marriage by age 18, per cent	Female genital mutilation prevalence among women aged 15–49, per cent	Intimate partner violence, past 12 months, per cent	Decision-making on sexual and reproductive health and reproductive rights, per cent	Decision-making on women's own healthcare, per cent	Decision-making on contraceptive use, per cent	Decision-making on sexual intercourse, per cent	Total net enrolment rate, lower secondary education, per cent	Gender parity index, total net enrolment rate, lower secondary education	Total net enrolment rate, upper secondary education, per cent	Gender parity index, total net enrolment rate, upper secondary education
	2025	2024	2023	2018	2024	2024	2024	2024	2023	2023	2023	2023
World	**38**	**19**	**–**	**13**	**56**	**75**	**88**	**75**	**84.35**	**0.99**	**67.14**	**0.99**
More developed regions	8	–	–	–	87	98	96	92	–	–	–	–
Less developed countries	41	–	–	–	56	74	88	75	–	–	–	–
Least developed countries	88	36	–	22	46	68	86	68	–	–	–	–
UNFPA regions												
Arab States	42	17	54	15	58	92	91	67	–	–	–	–
Asia and the Pacific	24	18	–	13	63	79	91	81	–	–	–	–
Eastern Europe and Central Asia	18	10	–	9	70	89	91	81	–	–	–	–
Latin America and the Caribbean	51	21	–	8	72	86	91	90	–	–	–	–
East and Southern Africa	92	30	–	24	48	76	88	67	–	–	–	–
West and Central Africa	101	33	18	15	26	44	80	55	–	–	–	–
Countries, territories, other areas	2001–2024	2006–2024	2004–2023	2018	2007–2024	2007–2024	2007–2024	2007–2024	2017–2024	2017–2024	2017–2024	2017–2024
Afghanistan	62	29	–	35	–	–	–	–	–	–	45	0.55
Albania	10	12	–	6	62	92	83	77	95	0.93	89	0.99
Algeria	11	4	–	–	–	–	–	–	97	1.00	80	1.10
Angola	163	30	–	25	39	75	74	63	–	–	–	–
Antigua and Barbuda	33	–	–	–	–	–	–	–	99	–	91	0.99
Argentina	26	16	–	5	92	98	95	99	99	–	95	1.09
Armenia	11	5	–	5	62	96	83	76	94	0.97	89	1.04
Aruba	12	–	–	–	–	–	–	–	–	–	–	–
Australia	7	–	–	3	–	–	–	–	98	1.00	94	1.05
Austria	4	–	–	4	96	99	99	98	99	1.00	92	1.02
Azerbaijan	37	15	–	5	–	–	–	–	91	0.99	84	1.05
Bahamas	28	–	–	–	–	–	–	–	90	–	81	1.15
Bahrain	7	–	–	–	87	93	92	79	100	–	98	–
Bangladesh	71	51	–	23	64	77	94	86	76	1.32	75	1.02
Barbados	48	29	–	–	–	–	–	–	99	0.99	92	1.03
Belarus	12	5	–	6	–	–	–	–	96	1.00	95	1.04
Belgium	4	0	–	5	–	–	–	–	99	1.00	98	1.00
Belize	52	34	–	8	–	–	–	–	94	0.99	72	1.08
Benin	77	28	9	15	32	52	66	59	53	0.91	32	0.79
Bhutan	6	26	–	9	–	–	–	–	90	1.19	79	1.25
Bolivia (Plurinational State of)	71	20	–	18	–	–	–	–	93	1.00	81	1.01
Bosnia and Herzegovina	9	4	–	3	–	–	–	–	98	–	77	1.09
Botswana	48	–	–	17	–	–	–	–	91	1.01	69	1.08
Brazil	40	26	–	7	–	–	–	–	96	1.03	92	1.02
Brunei Darussalam	9	–	–	–	–	–	–	–	99	–	74	1.10
Bulgaria	37	–	–	6	–	–	–	–	94	1.00	89	0.97
Burkina Faso	93	51	56	11	12	33	56	41	44	1.17	24	1.23
Burundi	58	19	–	22	40	72	88	60	65	1.10	37	1.16
Cabo Verde	50	8	–	11	–	–	–	–	92	1.04	83	1.15
Cambodia	48	18	–	9	80	92	93	91	86	0.86	50	1.29
Cameroon	98	30	1	22	35	55	74	67	53	0.93	35	0.87

Gender, rights and human capital

Countries, territories, other areas	Adolescent birth rate per 1,000 girls aged 15–19	Child marriage by age 18, per cent	Female genital mutilation prevalence among women aged 15–49, per cent	Intimate partner violence, past 12 months, per cent	Decision-making on sexual and reproductive health and reproductive rights, per cent	Decision-making on women's own healthcare, per cent	Decision-making on contraceptive use, per cent	Decision-making on sexual intercourse, per cent	Total net enrolment rate, lower secondary education, per cent	Gender parity index, total net enrolment rate, lower secondary education	Total net enrolment rate, upper secondary education, per cent	Gender parity index, total net enrolment rate, upper secondary education
	2001–2024	2006–2024	2004–2023	2018	2007–2024	2007–2024	2007–2024	2007–2024	2017–2024	2017–2024	2017–2024	2017–2024
Canada	5	–	–	3	–	–	–	–	99	–	85	1.00
Central African Republic	184	61	22	21	–	–	–	–	45	0.69	17	0.60
Chad	138	61	34	16	27	47	81	63	41	0.76	26	0.65
Chile	6	–	–	6	–	–	–	–	99	–	99	0.99
China	6	3	–	8	–	–	–	–	–	–	–	–
China, Hong Kong Special Administrative Region	1	–	–	3	84	96	88	98	–	1.00	76	0.99
China, Macao Special Administrative Region	0	–	–	–	–	–	–	–	90	0.97	86	1.05
Colombia	39	23	–	12	–	–	–	–	96	1.02	87	1.03
Comoros	74	21	–	8	21	47	71	47	66	1.01	40	1.06
Congo	111	27	–	–	27	41	87	71	–	–	–	–
Costa Rica	25	17	–	7	–	–	–	–	94	1.00	89	1.02
Côte d'Ivoire	96	26	37	16	19	43	53	47	68	1.00	52	1.00
Croatia	7	–	–	4	95	100	97	98	–	–	94	1.06
Cuba	49	29	–	5	–	–	–	–	94	0.99	78	1.04
Curaçao	20	–	–	–	–	–	–	–	100	–	95	1.00
Cyprus	8	–	–	3	–	–	–	–	100	–	99	0.99
Czechia	7	–	–	4	95	99	98	98	100	–	96	1.00
Democratic People's Republic of Korea	1	0	–	–	–	–	–	–	–	–	–	–
Democratic Republic of the Congo	109	29	–	36	31	47	85	74	–	–	–	–
Denmark	1	1	–	3	95	99	97	99	99	1.00	91	1.01
Djibouti	21	7	90	–	–	–	–	–	–	–	–	–
Dominica	49	–	–	–	–	–	–	–	93	0.90	89	0.97
Dominican Republic	77	32	–	10	77	88	92	93	90	1.01	65	1.11
Ecuador	50	22	–	8	87	100	92	95	86	1.02	88	1.04
Egypt	37	16	87	15	–	–	–	–	92	1.00	70	0.94
El Salvador	50	20	–	6	–	–	–	–	78	1.05	56	1.09
Equatorial Guinea	176	30	–	29	–	–	–	–	–	–	–	–
Eritrea	76	41	83	–	–	–	–	–	63	0.85	56	0.82
Estonia	5	–	–	4	–	–	–	–	98	1.00	91	1.01
Eswatini	87	2	–	18	73	95	94	79	–	–	–	–
Ethiopia	72	40	65	27	38	82	91	46	–	–	30	1.01
Fiji	31	4	–	23	62	86	84	77	97	–	78	1.12
Finland	3	0	–	8	–	–	–	–	99	1.00	95	1.01
France	3	–	–	5	–	–	–	–	100	1.00	96	1.02
French Guiana	50	–	–	–	–	–	–	–	–	–	–	–
French Polynesia	24	–	–	–	–	–	–	–	–	–	–	–
Gabon	100	13	–	22	48	60	90	86	64	1.03	53	1.05
Gambia	65	23	73	10	20	49	87	45	86	1.22	58	1.33
Georgia	22	9	–	3	65	95	79	84	98	–	98	0.99
Germany	6	–	–	–	–	–	–	–	98	1.01	88	0.99
Ghana	63	16	2	10	52	76	84	72	92	0.99	66	0.94
Greece	7	–	–	5	–	–	–	–	99	1.00	97	1.00

Gender, rights and human capital

Countries, territories, other areas	Adolescent birth rate per 1,000 girls aged 15–19	Child marriage by age 18, per cent	Female genital mutilation prevalence among women aged 15–49, per cent	Intimate partner violence, past 12 months, per cent	Decision-making on sexual and reproductive health and reproductive rights, per cent	Decision-making on women's own healthcare, per cent	Decision-making on contraceptive use, per cent	Decision-making on sexual intercourse, per cent	Total net enrolment rate, lower secondary education, per cent	Gender parity index, total net enrolment rate, lower secondary education	Total net enrolment rate, upper secondary education, per cent	Gender parity index, total net enrolment rate, upper secondary education
	2001–2024	2006–2024	2004–2023	2018	2007–2024	2007–2024	2007–2024	2007–2024	2017–2024	2017–2024	2017–2024	2017–2024
Grenada	31	–	–	8	–	–	–	–	96	–	90	0.96
Guadeloupe	10	–	–	–	–	–	–	–	–	–	–	–
Guam	26	–	–	–	–	–	–	–	–	–	–	–
Guatemala	58	30	–	7	65	77	91	89	63	0.96	37	1.06
Guinea	128	47	95	21	15	41	76	40	46	0.78	27	0.67
Guinea-Bissau	84	26	52	–	–	–	–	–	–	–	–	–
Guyana	65	32	–	11	71	92	90	83	73	0.96	63	1.09
Haiti	55	15	–	12	57	77	93	79	–	–	–	–
Honduras	97	34	–	7	70	84	88	94	57	1.08	39	1.22
Hungary	17	–	–	6	–	–	–	–	97	1.00	90	1.01
Iceland	3	–	–	3	–	–	–	–	99	1.00	83	1.02
India	11	23	–	18	66	82	92	83	85	1.01	57	1.03
Indonesia	36	16	51	9	–	–	–	–	95	1.06	76	0.99
Iran (Islamic Republic of)	23	17	–	18	–	–	–	–	93	0.99	79	1.00
Iraq	70	28	7	–	–	–	–	–	–	–	–	–
Ireland	3	–	–	3	–	–	–	–	100	–	99	1.02
Israel	6	1	–	6	–	–	–	–	97	1.00	96	1.02
Italy	3	–	–	4	–	–	–	–	98	1.00	94	1.00
Jamaica	35	27	–	7	–	–	–	–	79	1.02	81	0.99
Japan	2	–	–	4	–	–	–	–	100	–	98	1.02
Jordan	17	10	–	14	76	94	96	83	95	0.98	83	1.13
Kazakhstan	17	7	–	6	–	–	–	–	96	0.99	99	1.00
Kenya	46	13	15	23	65	87	92	77	–	–	–	–
Kiribati	51	18	–	25	–	–	–	–	92	1.00	90	1.18
Kuwait	0	–	–	–	–	–	–	–	–	–	–	–
Kyrgyzstan	29	9	–	13	77	94	95	85	92	1.01	63	0.89
Lao People's Democratic Republic	89	31	–	8	–	–	–	–	64	1.01	36	0.92
Latvia	9	–	–	6	–	–	–	–	98	1.00	92	1.03
Lebanon	17	6	–	–	–	–	–	–	67	1.06	45	1.34
Lesotho	53	13	–	17	69	94	94	76	68	1.13	41	1.20
Liberia	131	25	32	27	59	79	84	82	56	1.04	54	1.00
Libya	11	–	–	–	–	–	–	–	–	–	–	–
Lithuania	6	0	–	5	–	–	–	–	99	–	99	1.02
Luxembourg	3	–	–	4	–	–	–	–	98	1.01	86	1.04
Madagascar	143	39	–	–	72	87	93	88	61	1.05	31	1.00
Malawi	136	38	–	17	45	68	91	69	77	0.99	30	0.63
Malaysia	6	–	–	–	–	–	–	–	83	1.06	64	1.14
Maldives	8	2	13	6	54	89	84	70	96	–	68	1.18
Mali	145	54	89	18	5	20	66	26	–	–	–	–
Malta	10	–	–	4	–	–	–	–	98	1.00	90	1.04
Martinique	8	–	–	–	–	–	–	–	–	–	–	–
Mauritania	90	37	64	–	25	63	79	44	67	1.03	38	1.04
Mauritius	21	–	–	–	–	–	–	–	–	–	–	–
Mexico	40	18	–	10	–	–	–	–	92	1.03	69	1.13

Gender, rights and human capital

Countries, territories, other areas	Adolescent birth rate per 1,000 girls aged 15–19	Child marriage by age 18, per cent	Female genital mutilation prevalence among women aged 15–49, per cent	Intimate partner violence, past 12 months, per cent	Decision-making on sexual and reproductive health and reproductive rights, per cent	Decision-making on women's own healthcare, per cent	Decision-making on contraceptive use, per cent	Decision-making on sexual intercourse, per cent	Total net enrolment rate, lower secondary education, per cent	Gender parity index, total net enrolment rate, lower secondary education	Total net enrolment rate, upper secondary education, per cent	Gender parity index, total net enrolment rate, upper secondary education
	2001–2024	2006–2024	2004–2023	2018	2007–2024	2007–2024	2007–2024	2007–2024	2017–2024	2017–2024	2017–2024	2017–2024
Micronesia (Federated States of)	33	–	–	21	–	–	–	–	78	1.02	65	1.06
Mongolia	17	8	–	12	63	85	84	80	94	1.03	95	–
Montenegro	9	6	–	4	–	–	–	–	100	–	87	1.05
Morocco	22	14	–	11	–	–	–	–	95	0.99	77	1.01
Mozambique	158	48	–	16	31	70	67	47	59	0.93	43	0.88
Myanmar	36	16	–	11	68	85	98	81	89	1.07	64	1.21
Namibia	22	7	–	16	71	91	83	94	98	–	80	1.01
Nepal	71	35	–	11	63	72	91	91	95	1.00	80	1.01
Netherlands	2	–	–	5	98	99	99	99	100	1.00	95	0.99
New Caledonia	10	–	–	–	–	–	–	–	–	–	–	–
New Zealand	11	–	–	4	–	–	–	–	98	1.00	93	1.01
Nicaragua	71	35	–	6	–	–	–	–	83	0.90	63	0.99
Niger	150	76	2	13	7	21	77	35	26	0.96	12	0.83
Nigeria	75	30	15	13	29	46	81	56	–	–	–	–
North Macedonia	14	8	–	4	88	98	99	90	–	–	–	–
Norway	1	0	–	4	–	–	–	–	99	1.00	93	1.01
Oman	5	4	–	–	–	–	–	–	86	1.01	76	0.99
Pakistan	41	18	–	16	32	52	85	55	68	0.84	50	0.86
Panama	52	26	–	8	79	94	89	95	–	–	–	–
Papua New Guinea	68	27	–	31	57	86	84	76	69	0.94	43	0.84
Paraguay	72	22	–	6	–	–	–	–	84	1.01	74	1.04
Peru	29	19	–	11	–	–	–	–	–	–	91	1.01
Philippines	27	9	–	6	82	95	91	92	89	1.00	80	1.04
Poland	6	–	–	3	–	–	–	–	100	1.00	99	1.01
Portugal	6	–	–	4	–	–	–	–	100	–	99	–
Puerto Rico	12	–	–	–	–	–	–	–	85	1.03	75	1.03
Qatar	4	2	–	–	–	–	–	–	95	1.02	87	1.06
Republic of Korea	0	–	–	8	–	–	–	–	100	1.00	96	0.99
Republic of Moldova	23	12	–	9	72	97	97	77	100	–	–	1.05
Réunion	17	–	–	–	–	–	–	–	–	–	–	–
Romania	31	7	–	7	–	–	–	–	84	1.00	73	1.02
Russian Federation	13	6	–	–	–	–	–	–	100	–	55	0.94
Rwanda	24	6	–	24	61	83	95	76	95	1.03	62	1.06
Saint Kitts and Nevis	74	–	–	–	–	–	–	–	–	–	81	1.56
Saint Lucia	24	24	–	–	–	–	–	–	85	1.11	80	0.98
Saint Vincent and the Grenadines	38	–	–	–	–	–	–	–	–	–	98	1.02
Samoa	55	7	–	18	–	–	–	–	99	–	78	1.20
San Marino	1	–	–	–	–	–	–	–	91	0.99	40	0.89
Sao Tome and Principe	86	28	–	18	46	69	78	79	94	0.99	73	1.03
Saudi Arabia	8	3	–	–	–	–	–	–	99	1.00	99	1.00
Senegal	67	30	20	12	8	35	62	22	35	1.31	17	1.31
Serbia	14	6	–	4	84	100	86	98	100	–	88	1.04
Seychelles	49	–	–	–	–	–	–	–	98	0.98	82	1.09
Sierra Leone	102	30	83	20	28	44	78	68	91	1.16	73	1.07

Gender, rights and human capital

Countries, territories, other areas	Adolescent birth rate per 1,000 girls aged 15–19	Child marriage by age 18, per cent	Female genital mutilation prevalence among women aged 15–49, per cent	Intimate partner violence, past 12 months, per cent	Decision-making on sexual and reproductive health and reproductive rights, per cent	Decision-making on women's own healthcare, per cent	Decision-making on contraceptive use, per cent	Decision-making on sexual intercourse, per cent	Total net enrolment rate, lower secondary education, per cent	Gender parity index, total net enrolment rate, lower secondary education	Total net enrolment rate, upper secondary education, per cent	Gender parity index, total net enrolment rate, upper secondary education
	2001–2024	2006–2024	2004–2023	2018	2007–2024	2007–2024	2007–2024	2007–2024	2017–2024	2017–2024	2017–2024	2017–2024
Singapore	2	0	–	2	–	–	–	–	100	–	98	0.99
Sint Maarten (Dutch part)	–	–	–	–	–	–	–	–	–	–	–	–
Slovakia	25	–	–	6	–	–	–	–	98	1.00	92	1.00
Slovenia	3	–	–	3	–	–	–	–	99	1.00	97	1.01
Solomon Islands	49	21	–	28	–	–	–	–	77	1.04	64	1.08
Somalia	116	45	99	–	–	–	–	–	–	–	–	–
South Africa	40	4	–	13	61	94	85	72	97	0.98	–	–
South Sudan	158	52	–	27	–	–	–	–	–	–	–	–
Spain	5	–	–	3	–	–	–	–	98	1.00	94	1.01
Sri Lanka	16	10	–	4	–	–	–	–	93	1.02	78	1.05
State of Palestine[1]	43	13	–	19	–	–	–	–	94	1.01	76	1.18
Sudan	87	34	87	17	–	–	–	–	65	0.94	33	1.09
Suriname	40	36	–	8	–	–	–	–	–	–	–	–
Sweden	2	–	–	6	–	–	–	–	100	1.00	97	1.00
Switzerland	1	–	–	2	–	–	–	–	100	–	92	0.99
Syrian Arab Republic	54	13	–	–	–	–	–	–	49	1.12	27	1.24
Tajikistan	39	9	–	14	27	48	79	54	–	–	–	–
Thailand	18	17	–	9	–	–	–	–	100	–	83	1.15
Timor-Leste	42	15	–	28	36	93	92	40	87	1.06	73	1.08
Togo	79	25	3	13	30	47	84	75	73	0.95	45	0.82
Tonga	30	10	–	17	–	–	–	–	99	–	67	1.33
Trinidad and Tobago	36	4	–	8	–	–	–	–	72	1.04	96	–
Tunisia	4	2	–	10	–	–	–	–	–	–	–	–
Türkiye	12	15	–	12	–	–	–	–	100	–	94	0.99
Turkmenistan	22	6	–	–	43	86	68	65	–	–	–	–
Turks and Caicos Islands	13	23	–	–	–	–	–	–	90	–	94	0.78
Tuvalu	36	2	–	20	–	–	–	–	–	–	58	1.41
Uganda	111	34	0	26	59	74	88	86	51	0.98	25	0.83
Ukraine	13	9	–	9	81	98	95	86	89	1.01	78	1.07
United Arab Emirates	3	–	–	–	–	–	–	–	100	–	100	1.00
United Kingdom of Great Britain and Northern Ireland	9	0	–	4	–	–	–	–	99	1.00	95	1.02
United Republic of Tanzania	112	29	8	24	50	74	85	68	50	1.10	15	0.85
United States of America	14	–	–	6	–	–	–	–	99	1.01	95	1.03
United States Virgin Islands	25	–	–	–	–	–	–	–	–	–	–	–
Uruguay	23	25	–	4	92	99	96	97	100	1.00	91	1.06
Uzbekistan	37	3	–	–	70	89	90	85	97	1.00	94	1.00
Vanuatu	81	21	–	29	63	83	82	77	83	0.97	91	0.97
Venezuela (Bolivarian Republic of)	76	–	–	9	–	–	–	–	–	–	78	1.09
Viet Nam	29	15	–	10	–	–	–	–	97	0.96	67	1.13
Western Sahara	–	–	–	–	–	–	–	–	–	–	–	–
Yemen	77	30	19	–	–	–	–	–	–	–	–	–
Zambia	135	29	–	28	47	81	87	64	–	–	–	–
Zimbabwe	87	34	–	18	60	87	93	72	86	1.03	51	0.99

NOTES

– Data not available.

[1] On 29 November 2012, the United Nations General Assembly passed Resolution 67/19, which accorded Palestine "non-member observer State status in the United Nations..."

DEFINITIONS OF THE INDICATORS

Adolescent birth rate: Number of births per 1,000 adolescent girls aged 15 to 19 (SDG indicator 3.7.2).

Child marriage by age 18: Proportion of women aged 20 to 24 years who were married or in a union before age 18 (SDG indicator 5.3.1).

Female genital mutilation prevalence among women aged 15–49: Proportion of women aged 15 to 49 years who have undergone female genital mutilation (SDG indicator 5.3.2).

Intimate partner violence, past 12 months: Percentage of ever-partnered women and girls aged 15 to 49 years who have experienced physical and/or sexual partner violence in the previous 12 months (SDG indicator 5.2.1).

Decision-making on sexual and reproductive health and reproductive rights: Percentage of women aged 15 to 49 years who are married (or in a union), who make their own decisions on three areas – their healthcare, use of contraception, and sexual intercourse with their partners (SDG indicator 5.6.1).

Decision-making on women's own healthcare: Percentage of women aged 15 to 49 years who are married (or in a union), who make their own decisions on their healthcare (SDG indicator 5.6.1).

Decision-making on contraceptive use: Percentage of women aged 15 to 49 years who are married (or in a union), who make their own decisions on use of contraception (SDG indicator 5.6.1).

Decision-making on sexual intercourse: Percentage of women aged 15 to 49 years who are married (or in a union), who make their own decisions on sexual intercourse with their partners (SDG indicator 5.6.1).

Total net enrolment rate, lower secondary education: Total number of students of the official age group for lower secondary education who are enrolled in any level of education, expressed as a percentage of the corresponding population.

Gender parity index, total net enrolment rate, lower secondary education: Ratio of female to male values of total net enrolment rate for lower secondary education.

Total net enrolment rate, upper secondary education: Total number of students of the official age group for upper secondary education who are enrolled in any level of education, expressed as a percentage of the corresponding population.

Gender parity index, total net enrolment rate, upper secondary education: Ratio of female to male values of total net enrolment rate for upper secondary education.

MAIN DATA SOURCES

Adolescent birth rate: United Nations Population Division, 2025. Regional aggregates are from World Population Prospects 2024 revision. United Nations Population Division, 2024.

Child marriage by age 18: UNICEF, 2025.

Female genital mutilation prevalence among girls aged 15-49: UNICEF, 2025.

Intimate partner violence, past 12 months: Violence Against Women Inter-Agency Group on Estimation and Data (WHO, UN Women, UNICEF, UNSD, UNODC, and UNFPA), 2021.

Decision making on sexual and reproductive health and reproductive rights: UNFPA, 2025.

Decision making on women's own healthcare: UNFPA, 2025.

Decision making on contraceptive use: UNFPA, 2025.

Decision making on sexual intercourse: UNFPA, 2025.

Total net enrolment rate, primary education: UNESCO Institute for Statistics, 2025.

Gender parity index, total net enrolment rate, primary education: UNESCO Institute for Statistics, 2025.

Total net enrolment rate, lower secondary education: UNESCO Institute for Statistics, 2025.

Gender parity index, total net enrolment rate, lower secondary education: UNESCO Institute for Statistics, 2025.

Toal net enrolment rate, upper secondary education: UNESCO Institute for Statistics, 2025.

Gender parity index, total net enrolment rate, upper secondary education: UNESCO Institute for Statistics, 2025.

Demographic indicators

	POPULATION	POPULATION CHANGE	POPULATION COMPOSITION					FERTILITY	LIFE EXPECTANCY	
	Total population, millions	Population annual doubling time, years	Population aged 0–14, per cent	Population aged 10–19, per cent	Population aged 10–24, per cent	Population aged 15–64, per cent	Population aged 65 and older, per cent	Total fertility rate, per woman	Life expectancy at birth, years, 2025	
World and regional areas	2025	2025	2025	2025	2025	2025	2025	2025	male	female
World	**8,232**	**82**	**24**	**16**	**24**	**65**	**10**	**2.2**	**71**	**76**
More developed regions	1,287	–	15	11	17	64	21	1.5	77	83
Less developed regions	6,944	71	26	17	25	65	8	2.4	70	75
Least developed countries	1,216	30	38	22	31	58	4	3.8	64	69
UNFPA regions										
Arab States	439	36	33	20	29	62	5	3.2	70	74
Asia and the Pacific	4,239	128	22	16	23	68	10	1.8	72	77
Eastern Europe and Central Asia	254	63	23	15	21	66	12	2.1	72	79
Latin America and the Caribbean	664	106	22	16	24	68	10	1.8	73	79
East and Southern Africa	716	28	40	23	32	57	3	4.0	63	68
West and Central Africa	534	31	41	24	33	56	3	4.3	58	60
Countries, territories, other areas	2025	2025	2025	2025	2025	2025	2025	2025	male	female
Afghanistan	43.8	26	43	24	34	55	2	4.7	65	68
Albania	2.8	–	17	12	19	66	18	1.3	78	82
Algeria	47.4	54	30	18	24	63	7	2.7	75	78
Angola	39.0	23	44	24	32	53	3	5.0	62	68
Antigua and Barbuda	0.1	–	17	13	20	70	12	1.6	75	81
Argentina	45.9	–	21	16	24	66	13	1.5	75	80
Armenia	3.0	–	19	13	19	67	14	1.7	72	80
Aruba[1]	0.1	–	17	13	19	66	18	1.6	74	79
Australia[2]	27.0	72	18	12	18	64	18	1.6	82	86
Austria	9.1	–	14	10	15	65	21	1.3	80	85
Azerbaijan[3]	10.4	123	21	16	22	70	9	1.7	72	77
Bahamas	0.4	–	18	14	21	70	12	1.4	71	78
Bahrain	1.6	33	18	12	18	78	4	1.8	81	82
Bangladesh	175.7	57	28	19	28	66	7	2.1	74	77
Barbados	0.3	–	17	12	19	66	17	1.7	74	79
Belarus	9.0	–	16	12	17	66	18	1.2	70	79
Belgium	11.8	–	16	12	17	63	21	1.4	80	85
Belize	0.4	51	26	18	27	69	5	2.0	71	77
Benin	14.8	29	41	23	32	56	3	4.4	60	63
Bhutan	0.8	101	20	16	25	73	7	1.4	72	76
Bolivia (Plurinational State of)	12.6	52	29	19	28	65	6	2.5	66	72
Bosnia and Herzegovina	3.1	–	13	10	15	64	23	1.5	75	81
Botswana	2.6	44	32	19	29	64	4	2.7	67	72
Brazil	212.8	–	19	14	21	69	11	1.6	73	79
Brunei Darussalam	0.5	92	21	14	21	72	7	1.7	74	78
Bulgaria	6.7	–	14	10	15	63	22	1.7	73	80
Burkina Faso	24.1	32	41	25	34	56	3	4.0	59	64
Burundi	14.4	29	44	26	35	53	3	4.7	62	66
Cabo Verde	0.5	–	25	19	27	68	7	1.5	73	80
Cambodia	17.9	60	30	19	27	64	6	2.5	68	74
Cameroon	29.9	27	41	23	32	56	3	4.2	62	67

Demographic indicators

	POPULATION	POPULATION CHANGE	POPULATION COMPOSITION					FERTILITY	LIFE EXPECTANCY	
	Total population, millions	Population annual doubling time, years	Population aged 0–14, per cent	Population aged 10–19, per cent	Population aged 10–24, per cent	Population aged 15–64, per cent	Population aged 65 and older, per cent	Total fertility rate, per woman	Life expectancy at birth, years, 2025	
Countries, territories, other areas	2025	2025	2025	2025	2025	2025	2025	2025	male	female
Canada	40.1	77	15	11	17	65	20	1.3	81	85
Central African Republic	5.5	21	49	27	37	49	2	5.8	56	60
Chad	21.0	26	46	24	33	52	2	5.9	54	57
Chile	19.9	–	17	12	19	69	15	1.1	80	83
China[4]	1,416.1	–	15	12	18	70	15	1.0	76	81
China, Hong Kong Special Administrative Region[5]	7.4	–	10	8	11	66	24	0.7	83	88
China, Macao Special Administrative Region[6]	0.7	–	14	9	14	71	15	0.7	81	85
Colombia	53.4	71	20	14	22	70	10	1.6	75	81
Comoros	0.9	38	37	22	31	59	4	3.8	65	69
Congo	6.5	30	40	24	32	57	3	4.1	65	68
Costa Rica	5.2	–	18	14	21	69	13	1.3	79	84
Côte d'Ivoire	32.7	29	40	23	32	57	3	4.2	60	64
Croatia	3.9	–	14	10	15	63	24	1.5	76	82
Cuba	10.9	–	15	11	17	68	17	1.5	76	81
Curaçao[1]	0.2	–	15	12	18	68	17	1.1	73	81
Cyprus[7]	1.4	79	16	10	16	69	15	1.4	80	84
Czechia	10.6	–	15	11	16	64	21	1.5	77	83
Democratic People's Republic of Korea	26.6	–	19	12	19	68	13	1.8	72	76
Democratic Republic of the Congo	112.8	22	46	23	32	51	3	5.9	60	64
Denmark[8]	6.0	–	16	11	17	63	21	1.5	80	84
Djibouti	1.2	55	29	19	29	66	5	2.6	64	69
Dominica	0.1	–	18	13	20	69	13	1.5	68	75
Dominican Republic	11.5	88	26	17	26	66	8	2.2	71	77
Ecuador	18.3	82	24	17	26	68	9	1.8	75	80
Egypt	118.4	47	32	20	29	63	5	2.7	70	74
El Salvador	6.4	–	24	17	27	67	8	1.8	68	77
Equatorial Guinea	1.9	29	37	21	29	59	4	4.0	62	66
Eritrea	3.6	33	38	24	35	58	4	3.6	67	71
Estonia	1.3	–	15	11	16	63	22	1.4	75	83
Eswatini	1.3	64	33	21	31	63	4	2.7	61	67
Ethiopia	135.5	28	39	22	32	58	3	3.8	65	71
Fiji	0.9	–	27	18	26	67	7	2.3	66	70
Finland[9]	5.6	–	14	11	17	61	24	1.3	80	85
France[10]	66.7	–	16	12	18	61	23	1.6	81	86
French Guiana[11]	0.3	42	31	19	27	62	7	3.3	75	80
French Polynesia[11]	0.3	–	18	15	22	70	12	1.5	82	87
Gabon	2.6	33	36	21	29	60	4	3.5	66	71
Gambia	2.8	32	40	24	33	57	3	3.8	65	68
Georgia[12]	3.8	–	20	14	19	64	16	1.8	70	79
Germany	84.1	–	14	9	14	62	24	1.5	79	84
Ghana	35.1	38	35	22	31	61	4	3.3	63	68
Greece	9.9	–	13	10	15	63	24	1.3	80	85
Grenada	0.1	–	19	15	22	68	13	1.5	73	79

Demographic indicators

	POPULATION	POPULATION CHANGE	POPULATION COMPOSITION					FERTILITY	LIFE EXPECTANCY	
	Total population, millions	Population annual doubling time, years	Population aged 0–14, per cent	Population aged 10–19, per cent	Population aged 10–24, per cent	Population aged 15–64, per cent	Population aged 65 and older, per cent	Total fertility rate, per woman	Life expectancy at birth, years, 2025	
Countries, territories, other areas	2025	2025	2025	2025	2025	2025	2025	2025	male	female
Guadeloupe[11]	0.4	–	16	12	18	59	25	2.1	79	86
Guam[13]	0.2	98	26	16	23	61	13	2.7	74	82
Guatemala	18.7	46	31	21	31	64	5	2.3	71	75
Guinea	15.1	30	41	23	32	56	3	4.0	60	62
Guinea-Bissau	2.3	32	38	23	33	58	3	3.7	62	67
Guyana	0.8	118	29	18	27	64	7	2.4	67	74
Haiti	11.9	62	31	20	29	64	5	2.6	62	69
Honduras	11.0	42	30	19	29	65	5	2.5	71	76
Hungary	9.6	–	14	10	15	64	21	1.5	74	80
Iceland	0.4	62	18	12	19	67	16	1.5	82	85
India	1,463.9	79	24	17	26	68	7	1.9	71	74
Indonesia	285.7	90	24	17	24	68	8	2.1	69	74
Iran (Islamic Republic of)	92.4	81	22	15	21	69	9	1.7	76	80
Iraq	47.0	33	36	23	32	61	3	3.2	71	74
Ireland	5.3	72	18	14	20	66	16	1.6	81	85
Israel	9.5	51	27	17	24	60	13	2.8	81	85
Italy	59.2	–	12	9	15	63	25	1.2	82	86
Jamaica	2.8	–	18	14	22	73	9	1.3	69	74
Japan	123.1	–	11	9	14	59	30	1.2	82	88
Jordan	11.5	–	30	21	29	65	5	2.6	76	80
Kazakhstan	20.8	59	29	17	23	62	9	3.0	70	79
Kenya	57.5	36	36	23	33	61	3	3.1	62	66
Kiribati	0.1	48	34	21	28	61	4	3.1	65	68
Kuwait	5.0	42	18	12	17	79	3	1.5	80	82
Kyrgyzstan	7.3	47	32	19	27	62	6	2.8	68	76
Lao People's Democratic Republic	7.9	53	30	19	28	65	5	2.4	67	72
Latvia	1.9	–	15	11	16	63	22	1.4	72	81
Lebanon	5.9	87	26	19	27	64	10	2.2	76	80
Lesotho	2.4	63	34	22	31	62	4	2.6	55	61
Liberia	5.7	34	39	24	33	58	3	3.8	61	64
Libya	7.5	66	27	19	27	68	5	2.3	71	75
Lithuania	2.8	–	15	10	15	65	21	1.2	72	81
Luxembourg	0.7	66	16	11	16	68	16	1.4	81	84
Madagascar	32.7	29	39	22	32	58	3	3.9	62	66
Malawi	22.2	27	40	25	34	57	3	3.5	64	71
Malaysia[14]	36.0	60	21	16	24	71	8	1.5	75	80
Maldives	0.5	–	19	14	20	76	5	1.6	80	83
Mali	25.2	24	46	25	34	52	2	5.4	59	62
Malta	0.6	73	13	9	13	67	21	1.1	82	86
Martinique[11]	0.3	–	15	11	16	59	26	2.0	80	86
Mauritania	5.3	25	42	24	33	54	3	4.6	67	71
Mauritius[15]	1.3	–	15	12	19	71	14	1.2	72	79
Mexico	132.0	86	24	17	25	67	9	1.9	73	78
Micronesia (Federated States of)	0.1	–	31	21	30	62	6	2.7	64	71

Demographic indicators

	POPULATION	POPULATION CHANGE	POPULATION COMPOSITION					FERTILITY	LIFE EXPECTANCY	
	Total population, millions	Population annual doubling time, years	Population aged 0–14, per cent	Population aged 10–19, per cent	Population aged 10–24, per cent	Population aged 15–64, per cent	Population aged 65 and older, per cent	Total fertility rate, per woman	Life expectancy at birth, years, 2025	
Countries, territories, other areas	2025	2025	2025	2025	2025	2025	2025	2025	male	female
Mongolia	3.5	60	32	20	26	63	5	2.6	68	77
Montenegro	0.6	–	18	13	19	64	18	1.8	74	81
Morocco	38.4	79	25	17	25	66	8	2.2	74	78
Mozambique	35.6	25	44	24	33	53	3	4.6	61	67
Myanmar	54.9	111	24	16	24	68	8	2.1	64	71
Namibia	3.1	35	37	20	29	60	4	3.2	64	72
Nepal	29.6	–	28	19	29	65	7	1.9	69	72
Netherlands (Kingdom of the)[16]	18.4	116	15	11	17	64	21	1.4	81	84
New Caledonia[11]	0.3	77	21	14	22	67	12	2.0	77	82
New Zealand[17]	5.3	99	18	13	19	65	18	1.7	81	84
Nicaragua	7.0	54	28	19	28	66	6	2.2	73	78
Niger	27.9	22	46	25	34	51	3	5.8	61	63
Nigeria	237.5	34	41	24	34	56	3	4.3	54	55
North Macedonia	1.8	–	17	12	17	65	19	1.5	75	80
Norway[18]	5.6	100	16	12	18	65	19	1.4	82	85
Oman	5.5	20	24	13	21	73	3	2.5	79	82
Pakistan	255.2	44	36	22	32	59	4	3.5	66	70
Panama	4.6	58	25	17	24	66	10	2.1	77	83
Papua New Guinea	10.8	40	33	20	30	63	4	3.0	64	69
Paraguay	7.0	58	28	18	26	65	7	2.4	71	77
Peru	34.6	68	24	16	25	67	9	1.9	76	80
Philippines	116.8	86	27	20	29	67	6	1.9	67	73
Poland	38.1	–	14	11	15	65	21	1.3	75	83
Portugal	10.4	–	13	9	15	62	25	1.5	80	85
Puerto Rico[13]	3.2	–	11	10	17	63	25	0.9	79	86
Qatar	3.1	34	15	9	14	83	2	1.7	82	84
Republic of Korea	51.7	–	10	9	14	69	20	0.8	81	87
Republic of Moldova[19]	3.0	–	20	14	19	64	17	1.7	67	76
Réunion[11]	0.9	–	20	15	21	63	16	2.1	81	87
Romania	18.9	–	16	11	16	64	20	1.7	73	80
Russian Federation	144.0	–	17	12	17	65	18	1.5	68	79
Rwanda	14.6	31	37	22	32	59	4	3.6	66	70
Saint Kitts and Nevis	0.1	–	18	12	19	70	12	1.5	69	76
Saint Lucia	0.2	–	17	13	20	73	10	1.4	70	77
Saint Vincent and the Grenadines	0.1	–	21	15	22	67	12	1.8	69	75
Samoa	0.2	125	38	23	31	56	6	3.8	70	74
San Marino	0.03	–	12	10	15	65	23	1.2	84	87
Sao Tome and Principe	0.2	35	37	24	33	59	4	3.5	67	74
Saudi Arabia	34.6	40	24	15	23	73	3	2.3	78	82
Senegal	18.9	30	38	23	33	59	4	3.7	67	71
Serbia[20]	6.7	–	14	10	15	63	23	1.5	74	80
Seychelles	0.1	40	20	13	19	71	9	2.1	70	77
Sierra Leone	8.8	34	38	23	32	59	3	3.6	60	64
Singapore	5.9	110	12	9	18	74	14	1.0	82	86

Demographic indicators

	POPULATION	POPULATION CHANGE	POPULATION COMPOSITION					FERTILITY	LIFE EXPECTANCY	
	Total population, millions	Population annual doubling time, years	Population aged 0–14, per cent	Population aged 10–19, per cent	Population aged 10–24, per cent	Population aged 15–64, per cent	Population aged 65 and older, per cent	Total fertility rate, per woman	Life expectancy at birth, years, 2025	
Countries, territories, other areas	2025	2025	2025	2025	2025	2025	2025	2025	male	female
Sint Maarten (Dutch part)[1]	0.0	55	15	12	18	71	14	1.4	74	80
Slovakia	5.5	–	16	11	15	65	19	1.6	75	82
Slovenia	2.1	–	14	11	15	63	22	1.6	79	85
Solomon Islands	0.8	30	37	22	31	60	4	3.5	69	72
Somalia	19.7	21	47	23	32	51	3	5.9	57	62
South Africa	64.8	62	26	17	24	67	7	2.2	63	70
South Sudan	12.2	35	38	26	37	59	3	3.7	55	61
Spain[21]	47.9	–	13	10	16	66	22	1.2	81	87
Sri Lanka	23.2	133	22	15	23	66	12	1.9	75	81
State of Palestine[22]	5.6	39	38	22	31	59	4	3.2	70	77
Sudan	51.7	22	40	23	32	56	3	4.2	64	70
Suriname	0.6	81	25	17	26	66	8	2.2	71	77
Sweden	10.7	–	17	12	18	62	21	1.4	82	85
Switzerland	9.0	–	15	10	15	65	20	1.4	82	86
Syrian Arab Republic	25.6	20	28	22	33	67	5	2.7	71	75
Tajikistan	10.8	39	36	21	28	60	4	3.0	70	74
Thailand	71.6	–	14	11	18	70	16	1.2	73	81
Timor-Leste	1.4	55	33	22	32	62	5	2.6	66	70
Togo	9.7	33	39	23	32	58	3	4.1	63	63
Tonga	0.1	–	35	24	33	58	7	3.1	70	77
Trinidad and Tobago	1.5	–	17	13	19	70	13	1.5	71	77
Tunisia	12.4	124	24	16	22	67	10	1.8	74	80
Türkiye	87.7	–	21	15	22	68	11	1.6	75	81
Turkmenistan	7.6	44	31	18	24	64	5	2.6	67	73
Turks and Caicos Islands[23]	0.1	104	16	11	16	72	12	1.4	76	81
Tuvalu	0.0	–	33	20	27	60	7	3.1	64	71
Uganda	51.4	26	43	24	34	55	2	4.1	66	72
Ukraine[24]	39.0	19	14	11	16	67	19	1.0	70	80
United Arab Emirates	11.4	30	16	10	18	82	2	1.2	82	84
United Kingdom of Great Britain and Northern Ireland[25]	69.6	122	17	12	18	63	20	1.5	80	83
United Republic of Tanzania[26]	70.6	24	42	23	32	55	3	4.5	65	70
United States of America[27]	347.3	133	17	13	19	65	18	1.6	77	82
United States Virgin Islands[13]	0.1	–	16	11	17	60	23	2.1	71	82
Uruguay	3.4	–	18	14	21	66	16	1.4	75	82
Uzbekistan	37.1	38	31	17	23	63	6	3.5	70	76
Vanuatu	0.3	31	38	22	30	58	4	3.5	70	74
Venezuela (Bolivarian Republic of)	28.5	–	25	19	27	65	10	2.1	69	77
Viet Nam	101.6	118	23	16	22	68	9	1.9	70	79
Western Sahara	0.6	41	23	15	22	70	7	2.2	70	74
Yemen	41.8	24	41	22	31	56	3	4.4	67	72
Zambia	21.9	25	41	24	33	57	2	4.0	64	69
Zimbabwe	17.0	37	40	25	35	56	4	3.6	61	66

NOTES

– Data not available.

[1] For statistical purposes, the data for Netherlands do not include this area.

[2] Including Christmas Island, Cocos (Keeling) Islands and Norfolk Island.

[3] Including Nagorno-Karabakh.

[4] For statistical purposes, the data for China do not include Hong Kong and Macao, Special Administrative Regions (SAR) of China, and Taiwan Province of China.

[5] As of 1 July 1997, Hong Kong became a Special Administrative Region (SAR) of China. For statistical purposes, the data for China do not include this area.

[6] As of 20 December 1999, Macao became a Special Administrative Region (SAR) of China. For statistical purposes, the data for China do not include this area.

[7] Refers to the whole country.

[8] For statistical purposes, the data for Denmark do not include Faroe Islands, and Greenland.

[9] Including Åland Islands.

[10] For statistical purposes, the data for France do not include French Guiana, French Polynesia, Guadeloupe, Martinique, Mayotte, New Caledonia, Réunion, Saint Pierre and Miquelon, Saint Barthélemy, Saint Martin (French part), Wallis and Futuna Islands.

[11] For statistical purposes, the data for France do not include this area.

[12] Including Abkhazia and South Ossetia.

[13] For statistical purposes, the data for United States of America do not include this area.

[14] Including Sabah and Sarawak.

[15] Including Agalega, Rodrigues and Saint Brandon.

[16] For statistical purposes, the data for Netherlands do not include Aruba, Bonaire, Sint Eustatius and Saba, Curaçao, and Sint Maarten (Dutch part).

[17] For statistical purposes, the data for New Zealand do not include Cook Islands, Niue, and Tokelau.

[18] Including Svalbard and Jan Mayen Islands.

[19] Including Transnistria.

[20] For statistical purposes, the data for Serbia do not include Kosovo (United Nations administered region under security council resolution 1244).

[21] Including Canary Islands, Ceuta and Melilla.

[22] Including East Jerusalem.

[23] For statistical purposes, the data for United Kingdom do not include this area.

[24] Including Crimea.

[25] Refers to the United Kingdom of Great Britain and Northern Ireland. For statistical purposes, the data for United Kingdom do not include Anguilla, Bermuda, British Virgin Islands, Cayman Islands, Falkland Islands (Malvinas), Gibraltar, Guernsey, Isle of Man, Jersey, Montserrat, Saint Helena, Turks and Caicos Islands.

[26] Including Zanzibar.

[27] For statistical purposes, the data for United States of America do not include American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and United States Virgin Islands.

[28] More developed regions comprise Europe, Northern America, Australia/ New Zealand and Japan.

[29] Less developed regions comprise all regions of Africa, Asia (except Japan), Latin America and the Caribbean plus Melanesia, Micronesia and Polynesia.

DEFINITIONS OF THE INDICATORS

Total population: Estimated size of national populations at mid-year.

Population annual doubling time, years: The number of years required for the total population to double in size if the annual rate of population change would remain constant. It is calculated as ln(2)/r where r is the annual population growth rate. Doubling time is computed only for fast growing populations with growth rates exceeding 0.5 per cent.

Population aged 0–14, per cent: Proportion of the population between age 0 and age 14.

Population aged 10–19, per cent: Proportion of the population between age 10 and age 19.

Population aged 10–24, per cent: Proportion of the population between age 10 and age 24.

Population aged 15–64, per cent: Proportion of the population between age 15 and age 64.

Population aged 65 and older, per cent: Proportion of the population aged 65 and older.

Total fertility rate: Number of children who would be born per woman if she lived to the end of her childbearing years and bore children at each age in accordance with prevailing age-specific fertility rates.

Life expectancy at birth: Number of years newborn children would live if subject to the mortality risks prevailing for the cross section of population at the time of their birth.

MAIN DATA SOURCES

Total population: World Population Prospects 2024 revision. United Nations Population Division, 2024.

Population Annual Doubling Time, years: World Population Prospects 2024 revision. United Nations Population Division, 2024.

Population aged 0–14, percent: UNFPA calculation based on data from World Population Prospects 2024 revision. United Nations Population Division, 2024.

Population aged 10–19, percent: UNFPA calculation based on data from World Population Prospects 2024 revision. United Nations Population Division, 2024.

Population aged 10–24, percent: UNFPA calculation based on data from World Population Prospects 2024 revision. United Nations Population Division, 2024.

Population aged 15–64, percent: UNFPA calculation based on data from World Population Prospects 2024 revision. United Nations Population Division, 2024.

Population aged 65 and older, percent: UNFPA calculation based on data from World Population Prospects 2024 revision. United Nations Population Division, 2024.

Total fertility rate: World Population Prospects 2024 revision. United Nations Population Division, 2024.

Life expectancy at birth: World Population Prospects 2024 revision. United Nations Population Division, 2024.

Technical notes

The statistical tables in the *State of World Population* 2025 include indicators that track progress toward the goals of the Framework of Actions for the follow-up to the Programme of Action of the International Conference on Population and Development (ICPD), and the Sustainable Development Goals (SDGs) in the areas of maternal health, access to education, reproductive and sexual health. In addition, these tables include a variety of demographic indicators. The statistical tables support UNFPA's focus on progress and results towards delivering a world where every pregnancy is wanted, every birth is safe, and every young person's potential is fulfilled.

Different national authorities and international organizations may employ different methodologies in gathering, extrapolating or analyzing data. To facilitate the international comparability of data, UNFPA relies on the standard methodologies employed by the main sources of data. In some instances, therefore, the data in these tables differ from those generated by national authorities. Data presented in the tables are not comparable to the data in previous the *State of World Population* due to regional classifications updates, methodological updates, and revisions of time series data.

The statistical tables draw on nationally representative household surveys such as Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS), United Nations organizations estimates, and inter-agency estimates. They also include the latest population estimates and projections from World Population Prospects: The 2024 revision, and Model-based Estimates and Projections of Family Planning Indicators 2024 (United Nations Department of Economic and Social Affairs, Population Division). Data are accompanied by definitions, sources and notes. The statistical tables in the *State of World Population* 2025 generally reflect information available as of April 2025.

Regional classifications

UNFPA regional aggregates presented at the start of the statistical tables are calculated using data from countries and areas as classified below.

Arab States Region: Algeria; Djibouti; Egypt; Iraq; Jordan; Lebanon; Libya; Morocco; Oman; Palestine; Somalia; Sudan; Syrian Arab Republic; Tunisia; Yemen

Asia and Pacific Region: Afghanistan; Bangladesh; Bhutan; Cambodia; China; Cook Islands; Fiji; India; Indonesia; Iran (Islamic Republic of); Kiribati; Korea, Democratic People's Republic of; Lao People's Democratic Republic; Malaysia; Maldives; Marshall Islands; Micronesia (Federated States of); Mongolia; Myanmar; Nauru; Nepal; Niue; Pakistan; Palau; Papua New Guinea; Philippines; Samoa; Solomon Islands; Sri Lanka; Thailand; Timor-Leste; Tokelau; Tonga; Tuvalu; Vanuatu; Viet Nam

East and Southern Africa Region: Angola; Botswana; Burundi; Comoros; Democratic Republic of the Congo; Eritrea; Eswatini; Ethiopia; Kenya; Lesotho; Madagascar; Malawi; Mauritius; Mozambique; Namibia; Rwanda; South Africa; South Sudan; United Republic of Tanzania; Uganda; Zambia; Zimbabwe

Eastern Europe and Central Asia Region: Albania; Armenia; Azerbaijan; Belarus; Bosnia and Herzegovina; Georgia; Kazakhstan; Kyrgyzstan; North Macedonia; Republic of Moldova; Serbia; Tajikistan; Türkiye; Turkmenistan; Ukraine; Uzbekistan.

Latin American and the Caribbean Region: Anguilla; Antigua and Barbuda; Argentina; Aruba; Bahamas; Barbados; Belize; Bermuda; Bolivia (Plurinational State of); Brazil; British Virgin Islands; Cayman Islands; Chile; Colombia; Costa Rica; Cuba; Curaçao; Dominica; Dominican Republic; Ecuador; El Salvador; Grenada; Guatemala; Guyana; Haiti; Honduras; Jamaica; Mexico; Montserrat; Nicaragua; Panama; Paraguay; Peru; Saint Kitts and Nevis; Saint Lucia; Saint Vincent and the Grenadines; Sint Maarten; Suriname; Trinidad and Tobago; Turks and Caicos Islands; Uruguay; Venezuela (Bolivarian Republic of)

West and Central Africa Region: Benin; Burkina Faso; Cameroon; Cape Verde; Central African Republic; Chad; Congo; Côte d'Ivoire; Equatorial Guinea; Gabon; Gambia; Ghana; Guinea; Guinea-Bissau; Liberia; Mali; Mauritania; Niger; Nigeria; Sao Tome and Principe; Senegal; Sierra Leone; Togo

More developed regions are intended for statistical purposes and do not express a judgment about the stage reached by a particular country or area in the development process, comprising UNPD regions Europe, Northern America, Australia/New Zealand and Japan.

Less developed regions are intended for statistical purposes and do not express a judgment about the stage reached by a particular country or area in the development process, comprising all UNPD regions of Africa, Asia (except Japan), Latin America and the Caribbean plus Melanesia, Micronesia and Polynesia.

The least developed countries, as defined by the United Nations General Assembly in its resolutions (59/209, 59/210, 60/33, 62/97, 64/L.55, 67/L.43, 64/295 and 68/18) included 44 countries (as of December 2024): Afghanistan, Angola, Bangladesh, Benin, Burkina Faso, Burundi, Cambodia, Central African Republic, Chad, Comoros, Democratic Republic of the Congo, Djibouti, Eritrea, Ethiopia, Gambia, Guinea, Guinea-Bissau, Haiti, Kiribati, Lao People's Democratic Republic, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Myanmar, Nepal, Niger, Rwanda, Senegal, Sierra Leone, Solomon Islands, Somalia, South Sudan, Sudan, Timor-Leste, Togo, Tuvalu, Uganda, United Republic of Tanzania, Yemen and Zambia. These countries are also included in the less developed regions. Further information is available at un.org/development/desa/dpad/wp-content/uploads/sites/45/publication/ldc_list.pdf.

Notes on specific indicators

Maternal mortality ratio. This indicator presents the number of maternal deaths during a given time period per 100,000 live births during the same time period. The estimates are produced by the Maternal Mortality Estimation Inter-agency Group (MMEIG) using data from vital registration systems, household surveys and population censuses. Estimates and methodologies are reviewed regularly by MMEIG and other agencies and academic institutions and are revised where necessary, as part of the ongoing process of improving maternal mortality data. Estimates should not be compared with previous inter-agency estimates.

Births attended by skilled health personnel. Percentage of births attended by skilled health personnel (doctors, nurses or midwives) is the percentage of deliveries attended by health personnel trained in providing life-saving obstetric care, including giving the necessary supervision, care and advice to women during pregnancy, labour and the post-partum period; conducting deliveries on their own; and caring for newborns. Traditional birth attendants, even if they receive a short training course, are not included.

Adolescent birth rate. The adolescent birth rate represents the risk of childbearing among adolescent women 15 to 19 years of age. For civil registration, rates are subject to limitations which depend on the completeness of birth registration, the treatment of infants born alive but dead before registration or within the first 24 hours of life, the quality of the reported information relating to age of the mother, and the inclusion of births from previous periods. The population estimates may suffer from limitations connected to age misreporting and coverage. For survey and census data, both the numerator and denominator come from the same population. The main limitations concern age misreporting, birth omissions, misreporting the date of birth of the child, and sampling variability in the case of surveys.

Contraceptive prevalence, any method and any modern method. Model-based estimates are based on data that are derived from sample survey reports. Survey data estimate the proportion of all women of reproductive age, and married women (including women in consensual unions), currently using, respectively, any method or modern methods of contraception. Modern methods of contraception include female and male sterilization, the intra-uterine device (IUD), the implant, injectables, oral contraceptive pills, male and female condoms, vaginal barrier methods (including the diaphragm, cervical cap and spermicidal foam, jelly, cream and sponge), lactational amenorrhea method (LAM), emergency contraception and other modern methods not reported separately (e.g., the contraceptive patch or vaginal ring).

Unmet need for family planning (any method). Model-based estimates are based on data that are derived from sample survey reports. Women who are using a traditional method of contraception are not considered as having an unmet need for family planning. All women or all married and in union women are assumed to be sexually active and at risk of pregnancy. The assumption of universal exposure to possible pregnancy among all women or all married or in union women may lead to lower estimates compared to the actual risks among the exposed. It might be possible, in particular at low levels of contraceptive prevalence that, when contraceptive prevalence increases, unmet need for family planning also increase. Both indicators, therefore, need to be interpreted together.

Proportion of demand satisfied, any modern method. Modern contraceptive prevalence divided by total demand for family planning. Total demand for family planning is the sum of contraceptive prevalence and unmet need for family planning.

Note on youth testimonials on pages 8–9

"Youth" and "young people" is defined variably in international documents, and within the United Nations typically refers to those aged 15 to 24. These testimonials were collected from a questionnaire shared with select youth leaders around the world. It uses the more expansive definition of "young people" included in the African Youth Charter, broadly referring to people between the ages 15 to 35.

Note on UNFPA/YouGov survey

The surveys were conducted by YouGov, an international online research and analytics technology group with one of the world's largest research networks. This online survey was undertaken in part as a pilot exercise to inform further in-depth research, which will expand on the findings noted in this report. As with all surveys, this exercise had a number of limitations, as noted below, which should be considered when interpreting the findings. A summary of the YouGov survey results can be found on their website at the following web address: ygo-assets-websites-editorial-emea.yougov.net/documents/UNFPA_Fertility_Tabs_Dec25_W.pdf

The selection of countries was based on availability of an YouGov panel or YouGov partner panel, and the need for representation across a variety of fertility, country and regional contexts. Information on YouGov's sampling method, weights and representativeness can be found at yougov.co.uk/about/panel-methodology. Fieldwork was conducted from 15 November to 5 December 2024. The target population of the study was defined as men and women aged 18 or older. The following sample sizes were used in the survey: 1,053 adults in Brazil; 1,066 adults in Germany; 1,039 adults in Hungary; 1,048 adults in India; 1,050 adults in Indonesia; 1,010 adults in Italy; 1,123 adults in Mexico; 1,117 married adults in Morocco; 528 adults in Nigeria; 1,057 adults in Republic of Korea; 1,033 adults in South Africa; 1,009 adults in Sweden; 1,076 adults in Thailand; and 1,054 adults in the United States.

Data limitations

In most cases, the surveys are nationally representative, but surveys in Indonesia, Morocco, Nigeria and Thailand were only "online representative", meaning representative of the population using the Internet. A smaller sample size was used in Nigeria. In Morocco, only married adult respondents could participate as it was not possible to ask single women about procreation-related topics, and questions related to abortion and sexual autonomy could not be asked. Samples have an urban bias in Nigeria and South Africa and, to a smaller degree, Brazil, India and Mexico. Following data inspection, the total sample size was 14,256 respondents aged 18–88.

Due to the format of the survey, the question about respondents' existent number of children resulted in a meaningful proportion of missing data, which required additional verification. Consequently, no analyses were carried out separately for parents and childless respondents, as this could have introduced bias. Most analyses were conducted separately for women and men, but in some cases this distinction was not feasible – in particular, when analyses focused specifically on respondents in reproductive versus post-reproductive age groups.

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Tel. +1 212-297-5000
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