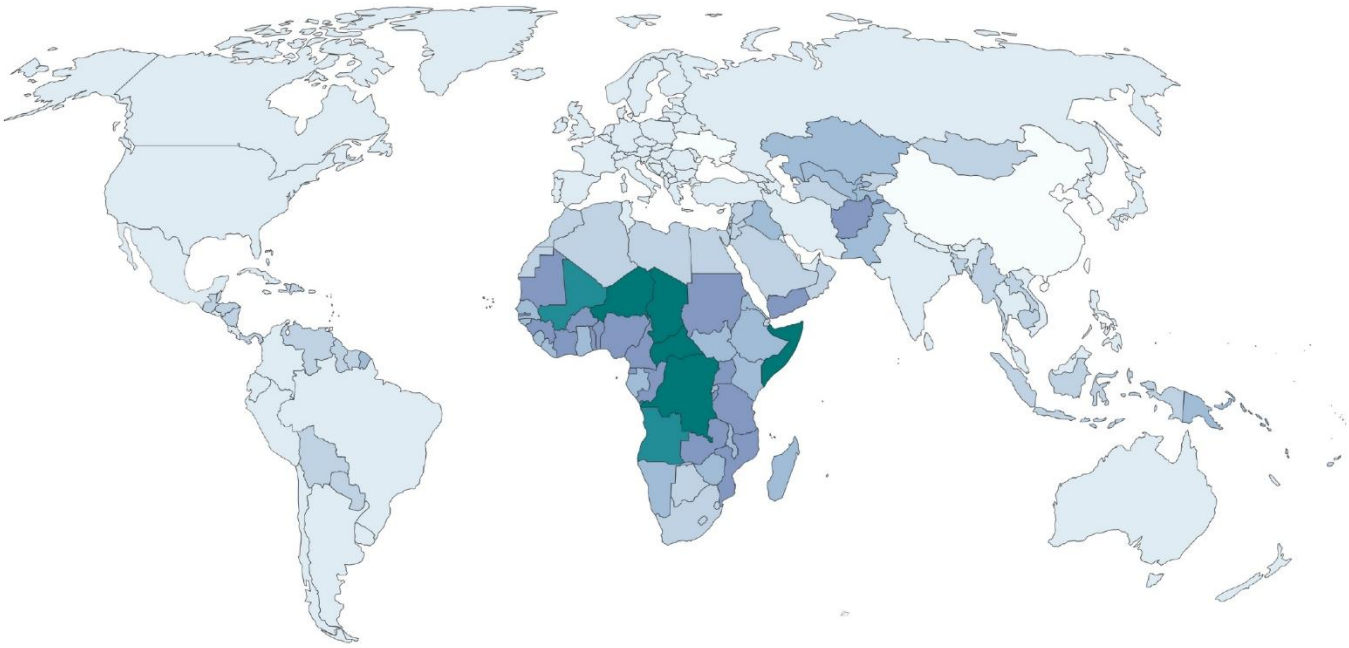

The Wilberforce Society X Cambridge University for Reproductive Rights

From Coercion to Choice:
The Case for Liberal Natalist Policies

January 2025

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The following report was written by students at the University of Cambridge for the Wilberforce Society, the world's oldest student think-tank, and Cambridge University for Reproductive Rights, a forum for students to learn about, discuss, and campaign for reproductive rights. We are grateful to the expert reviewers for voluntarily contributing their time to provide comments for this report. Any shortcomings remain the responsibility of the editor and authors.

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Executive Summary

Declining birth rates in high-income countries and persistently high birth rates in many low-income countries present significant social, economic, and infrastructural challenges worldwide. In countries with falling birth rates, policymakers are already grappling with the economic challenges of an ageing population. On the contrary, high fertility in less developed countries causes severe stress to local infrastructure and compounds financial difficulties.

In response to this demographic challenge, governments across the globe are increasingly intervening in citizens' decisions regarding whether and when to have children. These interventions may include the provision of financial incentives or resources such as contraception – but in some cases, take the form of coerced sterilisation, forced pregnancy or abortion, restricted or mandated contraception, and the suppression of sexual health information. The latter policies compromise women's rights in order to produce more or fewer babies, pitting demographic goals against personal freedoms. These approaches remain in the minority for now, but our age of potential global catastrophe and unprecedented levels of human migration is driving extremist anti- or pro-natalist rhetoric. In Japan, the Conservative Party leader has suggested increasing birth rates by banning women aged over 18 from university and mandating hysterectomies for those still childless by the age of 30.[1] In Kenya and Nigeria, figures discuss whether it is 'Africa's turn' for a two-child limit.[2] We face an increasingly degrading political dialogue where the fundamental human rights of female citizens appear to be up for negotiation.

At this critical juncture, this report makes the case for a liberal and rights-centred approach to natalist policies which balances these competing demands. We introduce a framework for assessing natalist policies, defining a successful policy as one which alters the birth rate in a form that meets underlying economic, infrastructural, or health concerns at play, *and* upholds rather than infringes human rights and individual autonomy.

Smart natalism works for families, not against them. Women in high-income countries are having too few children but *want* more, and women in low-income countries are having many children, but *want* fewer. Therefore, at the heart of truly successful pro- or anti-natalist policy is helping people to have the families they want, when they want. Such policies can balance demographic demands with individual autonomy. Indeed, we demonstrate that the efficacy and long-term sustainability of most natalist policies is *predicated* on their respect for parents' wants, needs, and rights. Analysing case studies from around the world, we outline recommendations relevant to all actors considering the architecture of successful and sustainable natalist interventions.

Pro-natalism

The most successful pro-natalist policies broaden autonomy; heavy-handed interventions only birth new problems. Generally, policies pushing for motherhood within traditional gender roles (which we term 'subsidised patriarchy') are broadly ineffective and can be morally egregious. To productively address the birth gap in developed countries, governments must develop a modern, woman-friendly and family-friendly society. Key lessons include:

- Financial incentives can work (though remain expensive) if designed to promote autonomous and flexible parental decision-making, not to compel women into a narrow model of behaviour.

- Policymakers have treated the provision of parental leave and childcare as silver bullets, but there are merely baby steps with limited effects unless implemented in line with a culture shift – for example, targeting leave towards men.
- Flexible or family-friendly working arrangements; ambitious housebuilding programmes; and promote gender equality (reducing unpaid labour, stigma, and other burdens on working mothers) are part of the cultural and structural shift required to reduce financial and socio-cultural costs to childbearing.

The so-called 'iron law' of fertility – that when wages increase, fertility decreases, should therefore be conceptualised as a horseshoe.[3] Development drives down fertility rates *until* very high levels of development start to facilitate more childbearing.[4] Designing policies to achieve those conditions by reducing the perceived cost of childbearing is the primary task of pro-natalist governments in high-income countries.

Anti-natalism

Coercive anti-natalist policies are also egregious, broadly ineffective, and wholly unnecessary. Choice over contraception, education, and schemes to empower women and girls sustainably reduce high fertility rates in low-income countries: more empowered women in these contexts choose, without external coercion, to have smaller families. Key lessons include:

- Meeting unmet needs for contraception, by promoting comprehensive understanding of and access to a variety of contraceptives, lowers the TFR and improves quality of life. This must be a primary focus for policymakers.
- Where there initially appears to be no birth gap (that is, when women *want* as many as nine children), girls who complete primary and secondary school education scale down their childbearing desires.
- Low-income countries see lower birth rates where girls can access quality education and specific family planning education; schemes to tackle harmful cultural norms; and schemes to access quality jobs.
- Any gender empowerment programmes must focus on holistic cultural change (and not on individual women alone) in order to bear fruit.

It is not a contradiction to say that development and gender equality reduces birth rates in some contexts and raises it in others. Conveniently, most people want 2-3 children. Liberal natalism empowers people to meet this desire, opting for light-touch intervention in cases of individual deviation, to close the stark birth gaps currently present in both high-income and low-income countries.

Natalist policies are one tool in a policymaker's arsenal; governments should concurrently adjust migration, taxation, and other structural policies. However, given that policymakers are already implementing natalist policies, we tailor our recommendations to this context.

Natalism must not be the watchword only of extremist or populist groups, who currently occupy much of the discourse space and whose commitment to women's rights is fundamentally suspect. Our report conceives policies which deliver on natalist goals without infringing on reproductive freedom, evolving us from outdated policies of coercion to progressive policies that nurture choice.

1: Introduction: the case for liberal natalism

1.1: The demographic challenge

A Total Fertility Rate (TFR) of 2.1 is needed to maintain a stable population in the absence of immigration – in other words, each women needs to give birth to an average of 2.1 children. A TFR of 1.3 would be a 'reason for concern', and TFR as 'ultra-low'.[5] In contrast, TFR above 5 is 'high'.[6] Very few countries maintain a TFR of around 2.1; the European average is just 1.46, whereas the African average is 4.16. Therefore, most countries are witnessing their populations either ageing and shrinking, or becoming younger and growing.

In practice, these TFRs cause economic and societal pressures in both contexts. Governments are therefore adopting natalist policies: pro-natalist policies can counter the economic issues associated with an ageing population; anti-natalist policies can respond to severe infrastructural pressures, extreme poverty, and the health impact of high parity births. Overall, natalist policies can improve the ratio between the productive and dependent population, improve the economy, or adjust the population size to available resources.

Low fertility impacts on economy, society, and individuals

Economic impact

The most persuasive justification for pro-natalist policies concerns economic stability. Sub-replacement (each generation being less populous than the previous) can cause numerous economic problems.[7]

- **Workforce decreases, dependency rises:** fewer people (proportionally, or even numerically) remain in the workforce to produce goods and services and pay taxes, resulting in less productivity. Meanwhile, growing numbers of retired, older citizens make greater demands on the state, in turn implicating the social rights of those requiring pensions and social security.
- **Stifling demand:** population growth brings a bigger market in which to sell goods; population decline incentivises people to save for retirement.
- **Undermining innovation:** knowledge and living standards stagnate and productivity declines when a large younger generation does not exist to innovate.[8]

Overall, low fertility rates suppress GDP growth and stretch public finances, burdening national health insurance and social security programs.[9]

The challenge of an ageing population can be addressed through policies looking beyond the birthrate. A 2019 EU report suggested re-evaluating pension ages.[10] The UK-based NGO *Population Matters* have proposed more holistic policies to address an ageing population which do not target fertility rates.[11] However, given that policies generally remain 'focused on one principal demographic driver: increasing birth rates', it is important to outline a vision of effective and rights-respective interventions specifically within this space.[12]

Societal impact

Some propose a moral argument for pro-natalism: to maintain 'social stability' or 'social cohesion'.[13] This can denote a fair intergenerational relationship: in ageing populations, the older generation often have a monopoly on resources, yet burden the taxation system at the

expense of the young working generation. This is a moral extension of the economic argument above. For others, however, 'social stability' is an exclusionary concept regarding the ethnic or cultural makeup of 'the people'. Their concern is that falling birth rates and rising immigration will replace the 'real' population with 'outsiders'.[14] They may also seek to reinscribe the 'traditional purpose' of women in society: to rear children. Such aims are inherently based on exclusion and discrimination. While 'moral panic' may be a powerful political discourse, we do not consider it a justified reasoning for pro-natalist policy.

Closing the birth gap

The more persuasive moral justification for a specifically liberal pro-natalism is that we must allow people to have the children they want. Across Europe, both men and women desire more children than they have. The average desired number is around 2.3, just above the population replacement rate of 2.1.[15] The same holds for the US, where the average woman wants 2.5 children, but has 1.7.[16] This 'birth gap' – the gap between the desired versus actual number of children – stems from 'obstacles to private choices', particularly the challenges of reconciling children with other aspects of life.[17] Therefore, the aim of 'liberal pro-natalism' is to respond to this situation by using public policy to help those that want to have children to do so.[18]

Policies intending to close the birth gap must correctly understand its causes. As this report shows, ascribing low fertility to the improved position of women in society and pursuing policies to reinscribe traditional gender roles is not a successful approach. The pro-natalist section sets out recommendations which better tackle the perceived 'costs' and improve the 'benefits' (financial, physical, socio-cultural) of having a child.

High fertility impacts on environment, infrastructure, and individuals

Environment

The global population will reach 10 billion before the end of this century; environmental concerns drive a minority of people (almost exclusively in high-income countries) to live child-free.[19] Some activists lobby international organisations to promote low birth rates to tackle climate change.[20]

However, a link between population growth and environmental degradation is vigorously contested. 'Child-free' proponents usually refer to the calculation by Wynes and Nicholas (2017) that having one fewer child has twenty-five times the environmental impact of living car-free.[21] Yet Wynes and Nicholas overestimate the environmental impact of children by using figures based on 2005 – emissions across developed countries have since declined, and should continue to do so.[22]

Furthermore, the highest carbon emissions are not produced by the sites of greatest population growth. It is the richest 10% of the global population, whose countries have low fertility rates, that produce an estimated 50% of yearly emissions degrading the environment.[23] Mandating a reduction in population growth for citizens in the developing world is at best inefficient, and at worst an immoral displacement of climate responsibility. Some scholars warn that 'overpopulation discourse' shifts pressure onto the world's marginalised, contributes to 'eco-fascism' (the belief that climate change can be solved through purging certain groups of people), and threatens to compromise the rights of women in the Global South.[24]

Anti-natalist policies for developing countries should be based on stronger justifications than contested data and a presumably negligible environmental impact of reducing birth rates in low-emission communities.

Infrastructure, the local environment, and development
More direct is the link between high fertility and stress on local infrastructure and economy. High fertility rates (and resulting young populations) hinder socio-economic development and maintain poverty levels – countries such as Niger, Burundi, Malawi, and Mozambique are all amongst the world's poorest countries, and have some of the world's highest fertility rates.[25] Reducing population growth specifically (as opposed to lowering the population by, e.g., restricting migration) benefits the economy by increasing the average working age, supply of female labour, and output *per capita*.[26] Smaller family size also allows for both the family and state to make greater investments in children's health and education.

Closing the 'birth gap'
Once again, a strong moral justification for liberal anti-natalism is the presence of a 'birth gap'. Across low-income countries, women want far fewer children than they are having.[27] This is in large part because nearly half of all women in developing countries are unable to deny sex, use contraception, or access healthcare – that is, they are unable to make decisions about their own bodies.[28] Even without additional arguments about the wider societal benefits of reducing rates of pregnancy (that more girls will realise their right to education[29] and will be less likely to live in poverty[30]), allowing women to realise their bodily autonomy is an essential justification for liberal anti-natalist policies.

1.2: The human challenge

Women's human and reproductive rights have historically taken a back seat in natalist considerations, their bodies and individual choices subsumed to state policy. In other words, solutions to the demographic challenge can result in a colossal human cost. We condemn such an approach not only because it is immoral, but because it is ineffective. Our primary aim is to draw attention to the *compatibility* of women's rights with natalist goals – as the paper shows, the policies which *expand* women's reproductive choices and help them realise their desires are also the most effective in altering the birth rate. Those which restrict rights and coerce women are, especially in the long-term, also less successful.

Women's human rights must therefore be a primary consideration, not an afterthought. Successful natalist policies must not violate rights to life, health, education, privacy and bodily autonomy, and other rights understood through internationally-recognised conventions, ratified by every country covered in this report.[31] In addition, policies must uphold individuals' 'reproductive rights', which denotes a collective of rights that allow an individual to freely and responsibly decide the number, spacing and timing of children.[32] They include access to abortion;[33] family planning information and resources, including contraceptives; maternal health and sexual and reproductive health services; assisted reproduction; and the discouragement of harmful traditional practices, such as female genital mutilation.

Finally, laws must not be based on gendered stereotypes. Laws which are founded on a 'gender stereotype that understands the exercise of a woman's reproductive capacity as a *duty* rather than a right', and hence privilege stereotypes above an individual's personal choices, legally constitute gender discrimination.[34]

1.3: Conceiving a 'successful' natalist policy

In response to the demographic challenge, 55 nation-state governments have active policies intending to raise fertility; 68 countries to lower it.[35] These pro-natalist and anti-natalist policies (collectively referred to herein as 'natalist policies') span from financial subsidies to forcible surgical procedures, and are primarily measured with reference to their impact on the Total Fertility Rate (TFR).[36] The TFR is not, however, the *only* measure which should be used to evaluate natalist policies.

When designing a natalist intervention, policymakers must balance the competing concerns outlined above: the demographic challenge that fertility rates can pose to society, and the human challenge that natalist policies can present to individuals. This cannot be evaluated by solely using the basic metric of the TFR. Instead, we derive the following framework for evaluating the success of natalist policy.

When designing a natalist intervention, policymakers should always answer the following questions in the affirmative:

- **After considering an alternative approach to tackle the underlying aim, is a natalist policy specifically required?** For example, if the aim is to improve the ratio between the productive and dependent solution, a change to migration policy may prove insufficient. See below for different justifications for pro- or anti-natalist policy.
- **Does the policy lead to a statistically significant change in the TFR?**
- **Does the TFR alteration assist in meeting the underlying aim?** Policies which fail to solve the underlying aim (for example, when more births are offset by rates of emigration) or inadvertently cause other problems or pressures should be immediately re-evaluated.
- **Does the policy avoid violations of human rights and individual autonomy?**

Ultimately, a successful natalist policy serves society by resolving the demographic challenge, while also upholding and even expanding citizens' rights.

The report proceeds by using the above framework to evaluate the efficacy of natalist policies in a number of global case studies. From this, we derive lessons for designing policies which are successful across the board: that is, which change the TFR in accordance to an underlying socio-economic aim while expanding, not restricting, human freedoms. Indeed, we find that policies which protect basic human dignities can be *more* successful in changing the TFR than their rights-violating alternatives. We hope that these lessons can be used to nurture effective policy-making in this crucial space.

2: Pro-natalist policies

Pro-natalist policies are one tool to tackle an ageing population and accompanying economic concerns in high-income societies. A further justification for liberal pro-natalist policies is to close the birth gap – in most of the developed world, women (and men) *want* more children than they are having. Successful pro-natalist policies remove the costs associated with childbearing and allow these couples to realise their desires.

This section shows that women do not respond well to heavy-handed coercive interventions. Poland's approach, which we term 'subsidised patriarchy', only raises the perceived socio-economic cost of childbearing. Successful policies are those which allow parents broader decision-making, especially means of combining their individual career paths with quality family time. Policies like childcare and parental leave can be important, but will remain limited if they are implemented in a way that entrenches rather than tackles gendered norms. As part of broader structural change in the long-term, countries need to strengthen policies on working patterns, gender equality, and housebuilding.

2.1: What do parents want and need?

It is notable that the demographers of 100 years ago, founding the first pro-natalist groups, predicted an irreversible decline in fertility as a result of female emancipation, and subsequent changes to women's work patterns and family structures.[37] They were proven wrong by the Baby Boom: starting in the mid-1930s, fertility rose by as much as 75% across the American and European continents and in all parts of society, even closed, distinct-value groups like the American Amish.[38] Anvar Sarygulov and Phoebe Arslanagić-Little convincingly argue that the Baby Boom had little to do with values: it arose because giving birth became 'cheaper, easier, and safer'. Innovations in domestic technologies, improvements in healthcare, and a rise in homeownership caused the Boom. These innovations increased the birth rate because they reduced the financial, temporal, or physical *cost* of childbearing and parenting.[39] The birth rate declined again as the rate of improvements in these areas slowed.

Today, the average desired number of children per European woman is 2.3.[40] The path to successful, liberal pro-natalist policy is therefore correctly diagnosing potential costs to childbearing. By developing policies to address these costs, would-be parents can be free to realise their desires.

In high-income economies, there is a high opportunity cost to having children. Parents are less likely to sacrifice the time needed to develop their career, and instead tend to invest in a child's 'quality', not 'quantity'.[41] The so-called 'iron law' of wages therefore associates higher standards of living and development with lower birth rates. Nevertheless, this section demonstrates that the historic relationship between fertility and wages can be overcome, as occurred during the Baby Boom, through policies that address the financial, temporal, and physical costs of childbearing.

The first step is to accurately diagnose what would-be parents want and need, as the following case studies illustrate.

2.2: Financial incentives: for a non-ideological approach

In 2022, Poland's then-Prime Minister Kaczyński blamed the country's low birth rate on young women drinking and partying.[42] His education minister, Przemysław Czarnek, believed that feminism had undermined the 'fundamental procreative function of the family', and encouraged women to prioritise motherhood over their careers.[43] Poland's Law and Justice Party implemented a series of policies which strengthened traditional gender stereotypes by essentially paying women to stay at home, in addition to violating their reproductive rights (see box **i**).

Polish women desire more children, regardless of their socio-economic background or educational level, but are put off childbearing primarily by the inability to combine work and family, and due to health concerns.[44] Successful and liberal pro-natalist policies should address these women's concerns, and the shortcomings of a 'dysfunctional' labour market and healthcare system.[45] Yet the PiS government's flagship policies, which focussed on mitigating the *financial* cost of having children, only exacerbated the perceived *socio-cultural* costs of childbearing.

PiS spent at least 1% annual GDP on cash benefits, but failed to shift the TFR. Their financial incentive system failed because it primarily sought to subsidise traditional 'breadwinner' working patterns; women who do not want long career breaks are 'rarely interested' by programmes which pay them to stay at home and compromise personal and career development.[46] Any removal to *financial* cost of childbearing was offset by an increased *socio-cultural* cost. This cultural aspect cannot be measured numerically, but should not be underestimated: the primary concern driving childlessness in Poland is inability to combine work and family life.[47] This holds strong in other high-income countries: in Japan, women are foregoing marriage because strict gender relations would restrict their activities.[48]

Polish women additionally fear the physical impact of pregnancy and childbirth.[49] The government only worsened this perceived healthcare cost with a strict abortion ban, leading to higher numbers of unsafe abortion, higher maternal mortality, and a lower overall quality of reproductive healthcare.[50] High-profile preventable deaths due to medical neglect and rulings from the European Court of Human Rights against the Polish government only aggravated concerns, where investments and improvements in reproductive healthcare could have allayed them.[51] A number of surveys directly link the ban to lower desired fertility, due to concerns over health or a sense of inequality. Polish youth are particularly opposed to 'raising children in a restrictive society'.[52] Finally, abortion bans are also associated with a decline in female productivity, making it an ill-fitting choice to tackle Poland's economic concerns.[53]

The PiS policies, which essentially sought to bribe women into foregoing career aspirations, and intervened in their health and bodily autonomy, did not remove the costs associated with motherhood. Indeed, in many aspects they worsened them, and made it less likely that women would have the children they desired. Poland's 'subsidised patriarchy' approach, with cash bonuses and coercive laws that reinscribed misogyny, is therefore unsuitable as a policy model. It did not raise the TFR, did not meet the underlying goal of improving economic productivity, and did not respect the human rights of its citizens.

i. Poland: subsidised patriarchy

All but one of the world's ten fastest shrinking countries are in central and eastern Europe.[54] Poland's TFR has not reached above 1.5 since 1996; it currently sits at around 1.3.[55] Childlessness is increasing; one in five people born in 1970 are childless.[56] Adding to the demographic woes is the high rate of outmigration to wealthier EU countries (heavily skewed towards young, educated, skilled individuals), which places additional stresses on the size and demographic makeup of the population and workforce.[57]

Mynarska and Brzozowska (2022) researched Polish citizens' intentions to remain childless: they found that while men only considered the scale of benefits when making decisions on parenthood, women considered both benefits and costs. This pattern remained consistent among all socio-economic groups. This study, and others, find that the main perceived costs to motherhood are:[58]

- **Difficulties combining motherhood and paid work:** *including expectations to stay at home and take time off work; unpaid labour at home, exacerbated by shortages in childcare and non-flexible work patterns; pregnancy-based discrimination and the financial 'motherhood penalty'.*
- **Physical burden and hardship of pregnancy**
- **Social factors**, *including having less time for oneself, one's partner, or other activities;*[59] *stress and responsibility related to parenthood.*
- **Economic factors**, *including direct costs of having children; income instability, low incomes, and economic difficulties faced by young people; difficulties obtaining independent housing.*

The Law and Justice Party (*Prawo I Sprawiedliwość*, PiS), while in power from 2015-23, promoted a values-based answer to demographic panic: outlawing abortion, restricting other reproductive rights, and placing a traditional emphasis on the familial role of women.

The party's **2040 Demographic Strategy** proposed to increase the working population almost solely by motivating Polish women to have more children. There was little mention of men, and expressly no planned role for immigration.[60] Instead, 'strengthening of the family' was the primary approach of the Demographic Strategy. PiS' three flagship pro-natalist policies were: cash bonuses; work-life arrangements; and the restriction of reproductive rights.

Cash for Kids

The 2016 **Family 500+ Policy** offered parents a tax-free monthly benefit of PLN 500 (then EUR 120, or 12% of Poland's average gross wage) for their second and any consecutive child aged below 18. Under certain conditions (e.g. low family income, disabled child) a first child would also qualify for the benefit. In 2019 the policy extended to include all first children. In 2022, a new benefit scheme targeted at young people entitled parents to PLN 12,000 (EUR 2,610) for each child after their firstborn aged between 12 and 36 months.[61]

This was an expensive policy: in 2019-21, Poland spent over £7.5 billion per annum in monthly payments to parents, around 1% of its entire GDP.[62] Yet it produced, at best, only mixed results.[63] After an initial boost (peaking in December 2017), birth rates steadily declined and did

not pick up again even as the schemes expanded. The most significant effect was reduction of child poverty, not an increased birth rate.[64] Within one year of being introduced, the 500+ program also caused a drop in mothers' labour force participation of 2.5-3%, particularly affecting women with lower education.[65] Even the initial boost in births following the scheme's introduction is doubtful: a study on Canada found that a cash-benefit-induced TFR boost followed by a decline to pre-scheme levels was simply caused by people bringing childbearing forward, and not increasing the total number of babies overall. The decision to have children sooner temporarily skewed the TFR.[66]

Work-life balance

Poland suffers an endemic 'care gap' due to a lack of care places for children under 3, leaving unfulfilled a crucial point after parental leave ends, but before institutionalised care begins.[67] The **'parental care capital' programme** offered parents a generous allowance during this time, effectively paying one parent (almost always the mother) not to work during this time to provide care.

Restricting reproductive rights

The redesigned **'Preparation for Family Living' curriculum**, written by a Catholic theologian, placed a clear emphasis on traditional values: it mentioned the word 'family' 170 times, and the word 'sex' just once.[68] Regulations in 2017 limited emergency contraception by requiring a prescription (and by delaying its administration, reducing its efficacy). The government furthermore strengthened the right of doctors to refuse provision of contraception on moral grounds.[69] As a result, Poland had the worst contraception access in the EU, falling far behind the next worst offenders (Russia, Bosnia and Herzegovina, and Belarus).[70]

PiS notably implemented one of the world's **strictest abortion laws**. The Constitutional Court ruling of 2020 (PiS had removed several pro-choice judges prior to the decision in a procedure 'tainted by serious irregularities')[71] prohibited abortion on the grounds of foetal abnormality, one of only three grounds permitted in the already-restrictive law. The new law allowed only victims of rape or incest, or women whose pregnancy to access their life, to access abortion. High-profile cases illustrated the meaningless nature of these exemptions. Rape victims were required to file a criminal complaint, obtain a conviction and present a certified letter from a public prosecutor to prove their status within 12 weeks.[72] In 2021-23, at least 3 pregnant Polish women died of sepsis because medical staff refused to treat pregnancy complications with an abortion.[73]

Outcome

Despite these policies, 2022 saw the lowest number of births in Poland since the Second World War.[74] PiS were defeated in October 2023 parliamentary elections.

When implemented differently, financial incentive programmes *can* successfully raises fertility rates. The expansive bonus system operating in France (see box **ii**) is a prime example. France has one of the highest birth rates in Europe. Some have described this 'Gallic success' as 'something of a mystery'[75], but it can be explained as a result of policies which enhance would-be parents' autonomous decision-making.

France's policies mitigate the financial cost of childbearing without forcing restrictions onto the lives and choices of (mostly) female citizens, and therefore do not increase the socio-cultural cost of having children in the way Poland's approach did. Crucially, they offer something for everybody: numerous bonuses are universal. Others are means-tested for specific situations: benefits for those in low-income careers encourage childbearing at an earlier career stage, and support the continuation of work. Deductions to income tax meanwhile offer financial incentives to high-income couples.

The demographer Lyman Stone, in a recent report, compared Spain and France to reach a similar conclusion: 'France's policies are universal and offer a range of benefits. Spain's family policies have traditionally been more targeted either just to dependents of male breadwinners, or to the economically needy.' He concludes: 'France's policies [are] more forthrightly pro-natal (rather than anti-poverty or promoting traditional gender roles), and thus offer greater agency and choice to parents in managing work and family life'.[76]

Unfortunately, this remains a staggeringly expensive policy, accounting until recently for 4% of GDP. In 2015, the French government adopted some cost-cutting measures; the birth rate immediately fell below 2.[77] Therefore, it remains important to evaluate which societal conditions or structurally-targeted schemes are the most productive and cost-effective, and if any have a more sustained impact on the TFR.

ii. France: something for everyone

France's TFR of 1.68 is one of the highest in Europe – and even this is a temporary decline from a TFR of 2 which it held steady for around ten years until 2014.[78] The increase was not caused by immigration, but by a high fertility rate among native-born French women.[79]

France's ***Caisse d'allocations familiales*** **(Family Allocations Office, CAF)** was formalised in 1945. Today, it provides both universal and means-tested services and benefits to parents and would-be parents – including those who are employed, self-employed, or unemployed. The four main services are:

- Services for young children
- Family allowances
- Housing benefits
- Benefits for special purposes

Services for young children
The **PAJE (*Prestations d'accueil de jeune enfant*)** is available to all families expecting or adopting a baby.[80] It includes:

- A pre-birth/pre-adoption **payment**, with the amount tied to income.
- A basic, means-tested **allowance** every month until the third birthday.
- Paid **parental leave** (PreParE) for parents who wish to care for children under three years of age, open to all but adjusted based on income.
- Subsidies for **childcare** (CMG), tied to income but covering up to 85% of costs for registered child minders, home carers, or a registered creche for children under 6.

Family allowances
Allocations Familiales are an allowance for families with a minimum of two children, which disproportionately rises for the number of children. There is no employment requirement, but net income is taken into account. There are additional means-tested schemes for low-income families (*complement familial*) and single or unsupported parents (*allocation de soutien familial*).

Housing benefits
The various benefits on offer include a **family housing allowance** (ALF) for couples who have been married for less than five years, or who have or are expecting a child. Another measure, the **house move bonus** (*la prime de déménagement*), is targeted at large families who move house when their household grows. It requires a household to have three dependent children and to move house before their youngest child is aged two.

Benefits for special purposes
Additional benefits are available for households affected by **disabilities**, including education allowances for a disabled child (AEEH), disabled adult (AAH), or disabled parent (AJPP).

A number of benefits target **low-income** households. The employment incentive (*prime d'activité*), determined by household income and makeup, supplements the income of low-wage salaried or self-employed workers, including students or apprentices receiving an income. School grants (*allocation de rentrée scolaire*) are another means-tested and yearly benefit paid to families for any child aged 6 to 18 enrolled in school.

Bonus: the Quotient System
In addition to these benefits, France's quotient system (in operation since 1945) reduces income tax bills for parents in line with the number of children they have.[81]

Outcome: Taken together, France's spending on family benefits is very high – around 4% of GDP.[82] The policies have resulted in approximately 0.1-0.3 additional children being born to every woman.[83]

2.3: Structural incentives: the role and limits of childcare and parental leave

Numerous studies and policymakers emphasise the importance of parental leave and childcare in allowing parents (particularly women) to balance work and family life. One 2010 study argued that childcare rollout in Norway between 1970-90s resulted in 0.5 extra children per woman.[84] Another found that increasing parental leave entitlement in Austria from 12 to 24 months significantly improved birthrates.[85] In Sweden, Norway, and Denmark, whose fertility ratings are higher than the European average (though still below the 2.1 replenishing rate), over half of children under the age of two are enrolled in nurseries (well above the EU average of 30%).[86] Sweden has the lowest nursery fees of the developed world, and its TFR hovers at around 1.9.

However, policymakers should be cautious. When implemented without careful consideration, these schemes can carry a large price tag, while failing to give parents what they really want.

The cases of Singapore and Hong Kong (see box **iii**) show both the role and the limits of parental leave and childcare. These policies have failed to shift the TFR because they have not engendered the broader pro-family and gender-egalitarian cultural shift required.

iii. Singapore and Hong Kong: when policies fall short

Fertility rates in Singapore and Hong Kong stand at historic lows of 1.0 and 0.8, respectively.[87] In both countries, the declining birth rate and ageing population increases financial burdens on the government and lowering labour force productivity – a significant problem for two international financial.

Causes of low fertility

Anti-natalist legacies: Both governments promoted a two-child campaign in the 1970s in the face of rapid population growth and (for Hong Kong) the influx of refugees. The Singaporean government's 'Stop-at-Two' policy used advertisements, reduced the cost of contraception, and gave top school choices to the children of parents who had been sterilised before the age of 40. In 1973, a law on persons married to Singaporean citizens required one member of the couple to undergo sterilisation after having two children, or else risk the loss of social benefits or expulsion of the alien spouse.[88] When the government switched to pro-natalism in the 1980s, a mindset of 'quality over quantity' had already been deeply inscribed. The social disincentives for larger families during the 1970s were effective measures in changing behaviours, and are now difficult to undo.[89] The Hong Kong government never mandated a two-child policy by law, but the national Family Planning Association's 'Two Is Enough' campaign and other informal initiatives had a similar effect on the birthrate.[90]

Financial cost: Singapore has the highest cost of living in the world, and Hong Kong is the most expensive place worldwide to purchase property.[91]

'Achievement-oriented' culture: In a society where educational credentialism thrives, parents are expected to wage an 'education arms race' and push for an exceptional level of education, extra-curricular activity, and competitive success in their children. This leads to exceptionally high household on pre-tertiary education. In Singapore, the majority of married couples have children, but stop at 1-2 due to the energy and ability required to help children compete.[92]

(Gendered) opportunity cost: The achievement-oriented culture affects would-be parents, too. Most adults at prime childbearing age are still focussed on success in the workplace.[93] A large proportion of Singaporean singles hope to marry, but prioritise their education or career over dating.[94] This opportunity cost is especially high for women, who shoulder a disproportionately larger share of domestic childcare duties.[95] Cultural stigmas also disparage working mothers – in Hong Kong, fewer than 50% of employers are willing to hire women with children.[96]

Delayed childbirth: All of this results in a high average age of childbearing. Singaporean women aged 20-24 are only as likely to give birth as women age 40-44, usually due to career reasons.[97] The birth rate decline among women in their twenties is not sufficiently compensated by an increase in fertility at later ages: women have less time to reach the same number of children, and assisted reproductive technologies such as IVF (which the Singaporean government subsidises) are not effective enough.[98]

Existing policies

Cash for kids: Singapore's **2001 Marriage and Parenthood Package** first introduced baby bonus cash payments, which have since increased to S$8,000 for a first or second child, and S$10,000 for a third or subsequent child.[99] The Working Mother's Child Relief policy provides an additional tax deduction on up to 25% of a woman's earned income, to encourage working mothers to have children and stay in the workforce.[100] In 2023, Hong Kong announced a payment of HK$ 20,000 (£2000) to the parents of every baby born before 2026.[101] Would-be recipients complain that these incentives are still insufficient to offset the financial cost of raising a child, and the bonuses have had a relatively insignificant effect on the birth rate.[102]

Parental leave: Hong Kong's paid maternity was in 2020 extended from 10 to 14 weeks, still behind Singapore's 16 weeks. Paternity leave in Hong Kong is capped at just five days, compared to Singapore's four weeks (since 1 January 2024), which can be supplemented with two weeks from shared parental leave.[103] Singaporean parents can also claim limited time off work after the initial period of leave – six days of childcare leave per year for children aged below seven.[104] Some leading private firms in Hong Kong have implemented longer paid paternity leave.[105]

Childcare services: A priority for both governments. **Singapore** has affordable and accessible childcare.[106] Working mothers receive subsidies of S$3,000 (£1800) per month for formal childcare, with lower-income families receiving even more.[107] Parents of children at licensed childcare centres receive subsidies of up to S$600 (£350) per month for infant care and up to S$300 (£175) per month for daycare.[108] Families also hire low-cost domestic workers from neighbouring countries, such as Indonesia and the Philippines.[109] Finally, the Integrated Childcare Programme (ICCP) allows children with special educational needs to learn alongside their regular peers, offering additional relief for parents. **Hong Kong** also has an array of childcare services and subsidises non-governmental organisations for childcare for under-threes.[110] However, access is hampered by the uneven distribution of resources to wealthier districts.[111] Pledges to build hundreds of additional childcare facilities are sabotaged by extreme land shortages.[112]

Housing: In Singapore, the Housing and Development Board (HDB) runs priority public housing schemes for parents and families with a third child.[113] Eligible first-time home buyers who are married can also qualify for generous housing grants.[114] Hong Kong suffers extreme land shortage, affecting housebuilding programmes.

Alternative measures: The Singaporean government is also exploring technologies and caring arrangements to address population ageing, which may be a 'blueprint' for other countries.[115] The country's Prime Minister, Lee Hsien Loong, has publicly stated the intention for Singapore to reach the more modest TFR target of 1.4, and meet the country's other needs through immigration.[116] In contrast, low fertility in Hong Kong has been exacerbated by emigration due to political turmoil and the 2013 'zero quota policy' which prevented non-residents (usually mainland Chinese mothers) from giving birth in Hong Kong and thus receiving right to abode for their babies.[117]

Once again, it is vital to consider what would-be and current parents want and need. In one survey of married couples in Singapore, the three most popular policies were paternity leave, shared parental leave, and baby bonuses.[118] In other words, parents wanted to spend more time with their children. The men surveyed emphasised paternity leave, shared parental leave, and extended childcare leave. The women favoured baby bonuses, healthcare grants for reproductive and maternity assistance, and paternity leave. In other words, women favoured policies that would not leave them alone in the home.

Schemes for **shared parental leave** sound good on paper, but introducing this policy into an inegalitarian context does not work in practice, because they do not meet these wants. In Singapore and Hong Kong, working mothers shoulder disproportionately more unpaid work in childcare and domestic tasks.[119] If mothers are culturally expected to take more parental leave and take on a higher domestic burden, the perceived cost of childbearing remains. One study comparing Sweden and South Korea found that parental leave had a greater impact on fertility rates in the more gender-equal Sweden.[120] Parental leave schemes are therefore most successful when provisions encourage men to take it up. 'Use it or lose it' mechanisms, for example, reserve part of the leave provision as an individual right for a mother and father without possibility of transfer. Some schemes also make the length of leave available to mothers dependent on the length of leave taken by fathers.[121]

High availability and low cost of formal **childcare** have a positive impact on the birth rate, particularly in a modern society where traditional kinship communities are often fragmented by nuclear family models, migration, or even architecture.[122] But the cases of Singapore and Hong Kong show the limits of childcare. Despite its availability, subsidised childcare is not raising the birthrate. This is because 'quality parenting cannot be fully outsourced'.[123] In part, the achievement-oriented culture demands parental involvement for holistic personal growth. But beyond that, parents simply want quality time with their children.[124] Another factor is, again, that household chores beyond childcare still increase with each child, and are still disproportionately shouldered by women. Childcare does not fully remove this cost of unpaid labour.

Put simply, outsourcing all parenting is unsatisfactory, because parents want to be involved with their children. Yet, as already seen, long-term leave usually taken by mothers is also unsatisfactory, because the opportunity cost breeds a reluctance to have children. This pressure of balancing a career with investing time in children is fundamental to the low fertility rate across the developed world. It may be a fear not necessarily rooted in reality – in some contexts, employment and earnings do not decrease in the long run after extended parental leave.[125] Nevertheless, to allay it businesses and governments must provide opportunities for parents to involve themselves with their children.

2.4: Shifting culture: gender equality and work-life balance

Gender equality

In high-income countries, women who drop out of work following marriage and children are the exception rather than the norm; most women, like most men, want both.[126] Rather than denying women these opportunities, policies can support higher fertility by reducing the gendered costs of childbearing.

The cases of Singapore, Hong Kong, and Poland, all highlight the power of gendered costs in discouraging women from having the children they desire. The 'motherhood penalty' is a direct **financial cost** resulting from childbirth, where mothers are disadvantaged in pay or perceived competence. In Singapore and Hong Kong, decades of previous anti-natalist policies and messaging have combined with existing gender inequalities to produce entrenched stigma of working mothers. In Hong Kong, fewer than 50% of employers are willing to hire women with children.[127] Many women cite pregnancy-related workplace discrimination, loss of life opportunities and unpaid labour as barriers to having children.[128] Similarly, most women in China (which has now replaced its longstanding anti-natalist one-child policy with a pro-natalist three-child policy) do not desire more than one child: the legacy of 'extensive state propaganda that encouraged women – but not men – to stay at home and raise children' means that in one survey of Chinese women, nearly half reported negative employment repercussions after pregnancy. A third reported income loss, and one in ten reported being fired or demoted.[129] In the UK, the gender wage gap (the difference between the average figure earnt by British women to British men) already exists immediately when women enter the workplace. It rises dramatically after childbearing; by the time the child is 20, the average mother's hourly wages are a third below the average male's.[130]

Crudely comparing gender pay gaps across European and high-income countries suggests that removing the motherhood penalty could improve the birthrate. The 2022 average TFR of the five countries with the smallest gender gaps (Iceland, Norway, Finland, New Zealand, Sweden) is 1.868. Meanwhile, European countries placing between 60-100 in the global gender pay gap rankings (including Poland, Slovakia, Montenegro, Italy, and Greece) have an average TFR of 1.495.[131]

Another key determinant in improving fertility is the reduction of women's **unpaid labour**. Introducing gender-blind policies into a gender-unequal context does nothing to remove sexist penalties: parental leave disproportionately taken by women hardly reduces unpaid labour. Similarly, well-developed childcare services still only provide limited support, given that women are saddled with other additional household chores.

Encouraging male involvement tackles the unpaid care burden while improving the quality time parents get with children. Doepke and Kindermann (2019) show that fertility is higher in countries where fathers engage more in childcare and housework, reducing the burden on women.[132] In France, the ratio of time spent on caring by men to women is 1:1.7, and the fertility rate is close to 2. In South Korea, the time spent is 1:4.5, and the fertility rate is less than 1.[133] A more gender-egalitarian context breeds better pro-natalist results.

Governments must therefore encourage a cultural shift to support working mothers; broad cultural shifts are difficult to engender with one single policy, but as a starting point governments and private companies should:

- Support working mothers with strict enforcement of anti-discrimination employment policies.
- Introduce legislation on the mandatory measuring and reporting of gender pay gaps, with a focus on potential motherhood penalties. Large companies should also be obliged to produce an 'action plan' on addressing discrepancies.
- Develop age-sensitive policies to younger women and support them in having children at an earlier stage of their career.

- Arrange parental leave provisions so that men can and do take it up (such as 'use it or lose it' mechanisms).
- Promote male uptake of unpaid care by encouraging male employees to show hands-on involvement with their families.
- Produce awareness-raising campaigns on the concept of unpaid work, giving statistics on its estimated prevalence in their country.
- Strengthen legislation to support women's rights in general, such as full compliance with the Convention on Elimination of Discrimination Against Women.

Work-life balance

As seen above, childcare provisions should not aim to 'outsource' parental involvement altogether. A bold pro-natalist policy should prioritise flexible working which last throughout the entire period of childrearing and which do not leave traditional and disproportionate burdens on women. Greater workplace flexibility enables parents meaningful engagement with their children throughout childhood, not just immediately after birth. In a number of developed countries, including the UK, employers are devoting increasing attention to four-day-week proposals. One UK survey suggests that four-day weeks bring numerous benefits to working parents, both in providing childcare and in resting and having time to oneself.[134] In Singapore, Minister of State Gan Siow Huang previously encouraged private and public sectors to try different types of flexible work arrangements, including the four-day week.[135]

One crucial element of this is, again, men. Fathers are more likely to have requests for flexible working denied, or fear that it will more negatively impact their career than female peers.[136] Governments and businesses must foster more positive attitudes to flexible working patterns across the board, ensuring that flexible working opportunities are not only taken up by women. The flexible work proposals indicated above should be gender-sensitive; any gender-blind policy introduced into a starkly gender-inegalitarian context will only ever have a limited impact. At its simplest level, this could mean listing 'to care for children as a mother, *father* or carer' (rather than the non-gendered 'parent', to which one might automatically picture a woman) in internal guidelines for requesting flexible work.

At the very least, we need more data on four-week pilot projects which focus on the impact of family and perceptions of fertility. Further data on pilot projects would indicate whether this could be a sustainable solution to allow parents to balance both work and childrearing, removing opportunity costs and allowing for quality time with children without prolonged career breaks.

2.5: Shifting structures: housebuilding

Growing numbers of studies highlight an intimate relationship between independent household formation and fertility rates.[137] Parental proximity can be a bonus for couples who already have children, and benefit from free childcare and domestic labour. However, persons or couples who lived with or close to parents when *childless*, usually due to youth underemployment and an unaffordable housing market, are associated with *lower* later rates of fertility.[138] In Mediterranean countries, young adults move out of their parents' home later in life – a cultural trend now aggravated by youth unemployment and depressed economies – and women have their first child, on average, aged 31.[139] In Singapore, the 'no-flat, no-child' norm leads rising public flat prices to directly reduce the TFR.[140] Housing subsidies are the only notably effective

cash-bonus policy introduced by Singapore (see box **iii**). Lyman Stone argues that limited housing stock leads couples to reduce not only the number of children they *have*, but the number of children they *desire*.[141]

Couples who *can* afford independent households still have less money to start a family. UK millennials spend nearly a quarter of their income on housing, far more than previous generations.[142] In Poland, young couples face Europe's fastest increasing house prices, long social housing waitlists, and a deficit of over 2 million homes (2023).[143] Even if economic support is offered to families, high prices and low availability of housing harms perceptions of security and stability.[144] Economic uncertainty and perceived instability make couples less keen to start a family.

France (see box) is an outlier in its high rates of home ownership and independent house formation. Various housing benefits encourage new couples to have children, and encourage existing families to grow. Given house size can limit family size, one benefit helps families move to larger properties as their family grows.[145] The impact is clear: over 70% of men are household reference persons (or married to that person); only 13% of French women aged 20-40 co-reside with parents.[146] The proportion of 25-to-34-year-olds owning a home in France is just 3% lower than in 1990 – in the UK, the drop is 22%.[147] And, of course, France's fertility rate is among Europe's highest.

There are two pieces of good news for policymakers. First, house price changes can have an immediate impact, unlike cultural shifts which could take a generation to bear fruit. For instance, the Bank of England's 2009 interest cut, reducing adjustable-rate mortgage payments by 42%, is credited with raising the birthrate by 7.5%[148] Second, a 2016 study found that in contexts with affordable house prices, female fertility rises *in line* with female wages.[149] This once again revises the outdated 'iron law' negatively associating development and fertility. Housebuilding programmes and housing subsidies are a form of development which supports fertility without compromising on wages or societal growth.

2.6: Conclusions: lessons for pro-natalist policy

Taking as a given the 'iron law' between wages and fertility – that higher wages decrease fertility– would offer little hope for an uptick in fertility rates in high-income countries without heavy-handed intervention. Fortunately, this section has suggested that the opposite is true. Development does reduce fertility, but *very high* levels of development (HDI over 0.85 or 0.9) see the association reversed: further development sees *increasing* fertility once again.[150] This was first observed as early as 2009; more recent literature further supports the hypothesis. Another 'iron law', the negative relationship between female education or employment, and fertility, is also weakening in highly-developed contexts.[151] In sum, the 'iron law' is a horseshoe, not a line. Development drives down fertility, until a point where it facilitates more childbearing. Implementing those conditions through policy is the primary task for pro-natalist governments.

'Subsidised patriarchy' does not work: rather than paying women to stay home, it is more effective to 'make it easier to *combine* work and family'.[152] The French case shows that autonomy-focussed cash benefits *can* work, albeit at significant cost. To remove opportunity costs on women posed by childbearing, governments should carefully implement policies that enhance autonomous decision-making and promote a broader pro-family cultural shift. Childcare provisions and parental leave should go hand-in-glove with the encouragement of

greater male involvement in parenting and flexible work, the reporting and addressing of gender pay gaps, and strengthening anti-discrimination laws and support for working women. Finally, a structural shift must provide affordable housing to the generation of reproductive age. These policies additionally guarantee rights to non-discrimination and improve development and productivity across the board.

In short, to engender Baby Boom 2.0, policymakers must set aside 'moral panic' over female emancipation and design progress-driven policies which account for modern societies. Women generally seek what men have always had: fulfilling lives, long careers, *and* children.

3: Anti-natalist policies

Most of the world's population growth occurs in poor, developing nations – 240 babies are born every minute in lower-income countries, compared to 25 per minute in higher-income countries.[153] The ten countries with the fastest-growing populations by birth are all in Sub-Saharan Africa.[154] High fertility in these contexts impacts the environment, infrastructure, and individual rights. In all cases covered below, populations have been at recent risk of famine, environmental degradation, and mass unemployment caused or compounded by high fertility, rapid population growth, and young populations. Anti-natalist policies are a tool that can respond to these pressures – and, crucially, ensure that women who want fewer children have the bodily autonomy to do so.

The approach proposed in this section is essentially the same as in the previous section, but leads to very different outcomes. Given that the vast majority of women in low-income nations desire fewer children, liberal anti-natalist policies should address these needs. The primary unmet need is for contraception; women need both information and access. In addition, policies must improve health prospects for women, end harmful customs such as child marriage, and provide quality education to every girl. These are non-coercive policies which focus on providing women with greater autonomous decision-making, and also decrease the birthrate.

3.1: Coercive contraception policies: lessons from India

More than 250 million women in developing countries have an unmet need for contraception (meaning they do not wish to become pregnant, but are not using safe and effective contraception).[155] Where unmet needs are high, the average number of children per woman is high.[156] The unmet need for contraceptives is a medical emergency as well as a moral one: pregnancies are more likely to be unplanned, high-parity, or child pregnancies, all of which carry additional risk to both mother and baby in countries which already have high rates of maternal mortality.[157]

Providing contraception should be the primary policy to lower fertility rates in low-income countries. India's NPP2000 plan (see box **iv**) included provision of contraception as a key aim, and overall displays many positive attitudes and strategies. In its implementation, however, India's anti-natalist policies fail to tackle root causes of high fertility, opting for coercive measures instead. The original aims of the NPP2000 plan, particularly to provide meaningful choice surrounding contraception, are left unfulfilled as states focus on quota-driven sterilisation and punitive two-child norms. These violate women's rights to health, private life, and civil and political rights. To add insult to (sometimes physical) injury, neither policy is particularly effective.[158] As covered in further detail below, the states with the best results are those which prioritised alternative measures.

India is therefore a clear example of the value in defining anti-natalist 'success' more holistically than merely an altered TFR. The first country in the world to adopt a population policy in 1952,[159] India has succeeded in bringing the TFR to below-replacement levels – but it could have been lowered in a more sustainable, more effective, and more rights-oriented manner.

iv. India: a misplaced focus

India's TFR has fallen in recent years (reaching 2 in 2023), but population control remains a live political issue.[160] Prime Minister Modi links population control to better health, education, and prosperity.[161]

India's **National Population Policy (NPP 2000)** set centralised goals for reducing fertility to 2.1 by 2010,[162] while leaving responsibility at the state level.[163] It noted key drivers of high fertility as unmet need for contraception, high infant mortality, and early marriage (over 50% of girls married before the age of 18).[164]

Contraception and sterilisation

India's unmet need for contraception was 9.4% in 2020, but with far higher rates remaining in Meghalaha (26.9%), Mizoram (18.9%), Bihar (13.6%) and Uttar Pradesh (12.9%).[165] Women in urban slums, rural villages and the northern states continue to experience above-average fertility due to lack of access to contraception and persistent taboos. [166]

The National Rural Health Mission (NRHM) provides the majority of reproductive services to these marginalised communities via its Accredited Social Health Activists (ASHAs), community health workers who advise on and supply contraceptives.[167] Some states engage in additional outreach efforts on family planning.[168]

Sterilisation is the most common form of contraception: over a third of reproductive-age women have undergone sterilisation procedures.[169] Women account for 93.1% of sterilisations, as vasectomies are considered to undermine masculinity and social status.[170] Crucially, almost all sterilisations are accessed via public sector initiatives (ASHAs and other programmes), while the majority of non-permanent contraception is obtained through private channels.[171]

ASHAs have been found to discourage reversible contraception and promote female sterilisation due to monetary incentives attached to sterilisation targets.[172] Sterilisation quotas were first adopted in 1966 (the Fourth Five-Year Plan, 1966-74); between 1969-79, over 27.5 million people were sterilised, a jump from 5.9 million people between 1951-69.[173] Sterilisation rates peaked during the Emergency (1975-77) and waned with the change of government in 1977. Sterilisation targets were substantially reduced – but not removed.[174] Today, many states have reverted the 'Target-Free Approach' adopted at the government level in 1996, and have reinstated target-oriented approaches in state-level programmes.[175]

A 2016 Supreme Court case highlighted that mass (female) sterilisations have, due to inadequate national oversight and high state quotas, frequently been carried out in unacceptable medical settings. Women suffer pain, medical complications, psychological trauma, and even death (at least three per week between 2003-2012).[176] These procedures are also carried out without meeting the legal requirement that patients make an 'informed and voluntary decision': approximately one in three women undergoing the procedure is unaware that it is permanent; more than two in three are not informed about the risks and side effects; and most are not offered alternative contraceptive options.[177] Even where individuals are literate, consent forms are often unavailable in local languages.[178] The Court instructed that 'sterilisation camps' be closed, but media reports suggest they remain common practice.[179]

There is little evidence that mass sterilisation programmes have been the main contributor to India's declining TFR.[180] Furthermore, a focus on sterilisation does not meet the NPP2000 goal of addressing unmet needs for contraception (as women do not have a meaningful choice) and improving healthcare outcomes.[181]

The two-child norm

The NPP2000 also promotes a 'small family norm'; some states have additional legislation to prevent individuals with more than two children from contesting elections, holding public office, being employed by the government, or accessing social welfare schemes.[182]

There is no evidence that the two-child norm effectively lowers the TFR.[183] The average woman in India already does not desire to have more than two children. Those who do are often poorer, from more marginalised social groups, and have experienced higher infant mortality rates – none of which are solved by a punitive two-child policy.[184] Indeed, the states that have been most successful in reducing TFR and achieving beneficial social outcomes (such as Kerala – see below) have not implemented two-child policies.[185]

Kerala: a success story

The southwestern state of Kerala has India's lowest rate of population growth. It also achieved India's most significant fertility transition, reaching below-replacement fertility rates already in the 1990s (when other states faced medium or high TFRs).[186] Key to this transition were a **decline in infant morality** and the **empowerment of women**. Continuous government investment in education and health sinc ethe 1970s kept girls in school and raised the average age of first pregnancy. Improvements in infant healthcare also mean that mothers expect every child to survive, and have fewer.[187] By 2006, Kerala saw the lowest rates of infant mortality in India, the highest female (and general) literacy rates in India – and the lowest birthrate.[188]

Some studies argue that Kerala has traditionally had more gender-equitable culture than other Indian states – but the present-day government decisions have proved equally impactful. Kerala is not so unique that other Indian states could not engender a similar climate.[189]

3.2: Effective contraception programs: lessons from Ethiopia

Sustainable and effective anti-natalist policies can go hand-in-glove with broadening rather than restricting human rights. The policies adopted by Ethiopia (see box **v**) are successful because they acknowledge that high fertility rates are usually not a product of choice. They resolve this by seeking to promote choice, providing women in low-income countries with the resources to make informed choices about themselves and their bodies. This lowers fertility rates while also increasing health and wellbeing.

The Ethiopian government stunned observers with a 'remarkable' TFR shift from 7.7 in 1993 to 4.0 in 2015.[190] During this time, the contraceptive prevalence rate increased from just 4% to 44%, and later shot up to 66%.[191]

Policymakers should note that increasing contraceptive use is a multi-stage process. Improving direct access to different forms of contraception is, of course, a first step. This includes removing barriers to advertising, providing or selling contraception, removing taxation on

contraception, and developing initiatives specifically to target rural and adolescent populations, such as by providing contraception at key meeting points like schools.

However, there are three other important steps. Firstly, providing accurate information on the existence, availability and types of contraception, including tackling myths (the primary reason for non-use is the false belief that contraception causes infertility).[192] Secondly, promoting self-efficacy: women who can practise and build confidence in using contraception are more likely to continue using it. Thirdly, promoting gender equality and tackling harmful customs: willingness to use contraception also depends on male support, female empowerment, and freedom from traditional forms. The Ethiopian government has introduced schemes seeking to tackle all three of these considerations.

The provision of contraception is *the* most significant factor driving Ethiopia's TFR decline. Contraceptive use continues to rise as a result of: increased knowledge about contraception; increased understanding of and confidence in using contraception; and increased access. The government continues to resolve ongoing difficulties, particularly in reaching rural areas or adolescent communities, but its policies overall offer a fantastic example for peer countries to follow. The staggering increase in usage rates has been achieved without coercive measures, making it a successful anti-natalist policy that guarantees rather than violates women's rights.

v. Ethiopia: finding and funding an effective approach

In 1990, Ethiopia's high fertility rate was driving an annual growth rate of 3%, with nearly half the population aged under 15. This caused productivity decline and infrastructural stress, exacerbating political turmoil and hostile weather conditions, and leading to food insecurity and famine, land shortages, unemployment, and poor health.[193]

The **1993 National Population Policy (NPP)** intended to 'harmonise' population growth with economic growth and improve quality of life. Key goals included reducing the TFR from 7.7 in 1993 to 4.05 by 2015; increasing contraceptive prevalence from 4% in 1993 to 44% in 2015 (a target later increased to 66%); reducing maternal and infant mortality; and discouraging harmful gendered customs.[194]

Meeting unmet needs for contraception

In 1993, 'not a single' government health facility provided family planning services; the NPP mandated all facilities to provide this service, proposed establishing teenage and youth reproductive health counselling centres, and integrated family planning into medical and nursing curricula to increase capacity.[195] In 2007, the government improved contraceptive supplies by removing the tax levied on imported contraceptives and empowering the Ethiopian Pharmaceutical Supply Agency to procure and distribute them.[196] It also increased the domestic resources allocated to the family planning programme.[197]

Difficulties remain: 36% of Ethiopian women aged 15-49 have an unmet need for contraception.[198] This is lower (22%) in urban areas, and higher (39%) in rural areas.[199] Supply cannot keep pace with demand: there are frequent shortages.[200] Part of the problem is continued dependence on external resources, as Ethiopia imports rather than manufactured the vast majority of its contraceptives.[201]

Encouraging contraceptive uptake requires more than simply providing access to contraception. The NPP also encourages take-up by:

- **Providing accurate information.** In 1990, just 63% of women of childbearing age knew of a family planning method; by 2011, this stood at 97.2%. Yet in 2019 still only 40.5% of married women of reproductive age used contraception.[202] Myths about contraception hinder further uptake: the primary reason for non-use is the false belief that contraception causes infertility.[203] Promisingly, studies observe that contact with family planning providers or exposure to information campaigns reduce this belief.[204]

- **Promoting self-efficacy.** Ethiopian women are more likely to use contraception if they believe they are capable of using it correctly. Family planning programmes are most successful when they provide opportunities for women to learn and practice how to communicate with their spouses.[205]

- **Promoting gender equality and tackling harmful customs.** Across Ethiopia, particularly in rural areas, men dominate healthcare-related decisions within the family; therefore, the NPP proposed that healthcare facilities engage and involve men in family planning.[206] Nevertheless, cultural and religious norms continue to influence women's decision-making. In rural areas with strong religious and cultural leaders, even education (usually a good overall predictor on intention to use contraceptives) does not yield higher contraceptive use. Hence in 2005, the rural TFR was 6.0, and the urban TFR just 2.4.[207] The primary factors determining contraceptive use are gender-equitable norms, higher self-efficacy, and weekly exposure to the radio.[208]

Engaging children and adolescents

- **Reducing infant mortality.** As Ethiopia's TFR has fallen, infant mortality has more than halved in twenty years (from 114 deaths per 1,000 live births in 1990-95, to just 50 per 1,000 in 2010-15).[209] Lower rates of infant mortality mean parents feel a lesser need to have more children as 'insurance'.

- **Education and economic empowerment:** Boys and girls who stay in school are less likely to marry during adolescence and early adulthood. Having high career expectations has an even stronger effect in delaying sexual activity and marriage.[210] The NPP hence amended all laws 'impeding' women's access to social, economic and cultural resources and implemented career counselling services in public schools.

However, difficulties remain:

- **Reducing child marriage:** Ethiopia raised the minimum age of marriage of girls from 15 to 18 years – nevertheless, it continues to have one of the world's highest adolescent early marriage rates, with a 2023 study finding that 17% of girls are married before the age of 15.[211]

- **Limitations in capacity:** Ethiopia has the second-largest youth population in Africa – yet many programmes are failing to adequately target adolescents and provide for their specific needs.[212] One commentator argues that adolescent- and youth-related interventions are 'fragmented under various ministries, uncoordinated, *underfunded*'.[213]

Liberalising abortion

Ethiopia had, until 2005, one of the highest maternal mortality rates in the world – a third of which were a result of unsafe abortion.[214] In 2005, the strict ban was liberalised to allow abortions in the case of rape, incest, foetal impairment, if the woman is a minor, or if she has physical or mental disabilities.[215] Importantly, a woman's stated age or declaration of rape is considered sufficient evidence – in other countries, the requirement to obtain certificates or undertake criminal proceedings render the exceptions unusable.[216] The proportion of maternal deaths attributable to unsafe abortion today accounts for only 1% of all maternal deaths in Ethiopia, significantly helping to halve rates of maternal mortality.[217] Liberalising the abortion law has not increased rates of abortion, and is therefore not an explicitly anti-natalist policy, but does improve the underlying goal of improving quality of life.[218]

Reliance on external funding

Meeting sexual and reproductive health needs in Ethiopia requires an estimated investment of $12.91 per capita per annum, totalling $1.4 billion.[219] Relatively low domestic resource mobilisation for sexual and reproductive health means that the Ethiopian government heavily relies on international funding to finance population programmes, and on non-governmental organisations to deliver them.[220] From 2004-08, Ethiopia received more than $105 million from UNFPA, the US and Germany for family planning purposes.[221]

Outcome

By 2015, the Ethiopian government achieved its ambitious TFR target, halving fertility rates down to 4.0, and making 'substantial progress' towards targets on infant and maternal mortality.[222] Observers describe this phenomenon as 'continuous and remarkable progress'.[223] Continuing difficulties in Ethiopia are due to issues with implementation and funding, and not with the design and fundamental approach itself.

3.3: Shifting fertility desires where there is no unmet need for contraception

If India demonstrates a government failing to properly address unmet needs for contraception, and Ethiopia demonstrates a government which has successfully addressed that need, it is worth considering countries where there is *no* birth gap and low unmet need: that is, where women appear not to want to use contraception, and where women *do* desire as many (or even more) children as they are having.

In a number of low-income countries in Central and Western Africa, such as Niger and Chad (see box **vi**), women are having six or seven children, but wanting eight or nine. Despite the increase in contraception availability, family planning services and improvements in child mortality, birth rates remain high.

This should not be dismissed as intractable 'African exceptionalism'; it is predominately the outcome of gender-inegalitarian cultural norms.[224] Women conform to emulate the fertility preferences of their husbands and family members to 'avoid criticism', use a higher number of children to enhance their 'value' to husbands, and report that family disapproval puts them off

accessing family planning services (see box). Women who challenge these oppressive 'cultural norms' face 'disapproval' and 'stigmatisation'.[225]

Many are rightfully wary of policies which seek to *change* women's desired fertility. The historic coercion of women, such as apartheid South Africa's family planning programmes to reduce the growth of the Black population, means that some see fertility control as 'part and parcel of the colonial legacy'.[226]

Fortunately, these violations need not be repeated: mechanisms which promote informed choice, not set quotas on bodies, result in decreased desired fertility. The socio-cultural pressures in Chad and Niger are founded on the notion that women are second-class citizens, ascribed reproductive functions due to their sex without respect to their individuality. This constitutes gender discrimination.[227] Under international human rights conventions, women are guaranteed the right to 'take part in cultural life', but also to not to.[228] Culture is not monolithic nor unchanging – it must be respected, but not prioritised over the rights of individuals.[229]

The Convention on Eliminating Discrimination Against Women (CEDAW) specifically leaves no place for 'custom' as justification for gender discrimination, including with regard to reproductive autonomy.[230] When the Ethiopian government took direct aim at the 'restrictions' that 'traditional life' places upon women in their population plan, they were acting on their commitment in CEDAW Article 2(f) to 'modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women'. In 2003, the pan-African Maputo Protocol again mandated the removal of harmful practices, including the denial of education, decision-making or bodily autonomy on the basis of gendered non-therapeutic customs. It is clear that the removal of harmful customs has a rights-based and universal mandate.[231]

Changing women's desires requires a light-touch approach centred on guaranteeing the capability of women to choose. The liberal philosopher Martha Nussbaum explains this 'capabilities' approach: programmes 'should not push citizens into acting in certain valued ways', but rather must ensure that all have the necessary resources and conditions for acting in that way *should they wish*. If a woman, 'on due consideration, with all the capabilities at her disposal' chooses to adopt or disregard a certain cultural norm, her choice must be respected.[232] A rare example where this approach requires compulsion is in mandating primary and secondary education, given the role that education plays in opening other choices in life.

3.4: Empowering women: education and autonomy to shift family desires

Policies relating to the empowerment of girls and women to make informed choices are a fundamental second subset of successful anti-natalist policies. These include guaranteeing general education; targeting youth with specific family planning education; and ending child marriage. For example, the 1978 Child Marriage Restraint Act raised the legal age of marriage to eighteen for women (and twenty-one for men) and has been more significant than any other family policy – including mass sterilisation – in reducing the TFR.[233] Girls delay having children until adulthood and marriage, and therefore have fewer overall – and, in the meantime, have increased opportunities to stay in school.

The challenge posed by Niger and Chad – contexts where women espouse a desire to have very high numbers of children – is also solved in a non-coercive manner through the provision of

education. Across sub-Saharan Africa, women's education is the strongest indicator of fertility desires – stronger than household wealth, or area of residence. High levels of reported desired family size in rural parts of Sub-Saharan Africa are mainly a consequence of relatively lower levels of education, with one study finding that women in educated communities report a 21% lower desired number of children to those in the least educated communities.[234] Notably, the study only accounted for 'no education', 'primary', and 'secondary and further'. In other words, general education on any and all topics (such as literacy and numeracy) impacts future fertility desires. This is particularly relevant for countries like Niger and Chad, where education levels are staggeringly low (see box **vi**).

In addition to general education, specific education on family planning can actually *decrease* desired fertility, not just help meet it. High-quality programs in Ethiopia, Malawi, and Rwanda have brought substantial declines in *desired* fertility, although the precise mechanism causing this remains unclear.[235] In short, high-quality contraception schemes which provide women with comprehensive knowledge and a feeling of self-efficacy go beyond meeting unmet needs for contraception and can in fact change desires. When receiving a full understanding of contraception, it seems more women want to use it.

Female empowerment within the family (that is, reduced inequalities between male and female opportunity) leads to fewer desired children.[236] However, 'female empowerment' programs pursued without regard to local contexts can be completely ineffective. A fascinating 2023 study on Chad demonstrates that individuals with the same level of decision-making may make different decisions based on their context. The study found that women with high decisional autonomy who lived in 'highly inegalitarian socio-cultural groups' have a very similar desired fertility rate (8.92) to those with no decisional autonomy (9.03). This suggests that the former group of women decided to 'adopt behaviours that bring societal benefits [...] even if their personal wish was for a smaller family'. This is because a greater number of children may give them greater rights and autonomy. Women of the same decision-making capabilities in more gender-equal contexts were far more likely to adopt behaviours that favoured lower fertility, with the desired rate falling to 7.42. Of course, that is still far above the TFR 2.1 needed for stable growth, but must be set against the context of mass non-education, underdevelopment, significant unmet contraception needs (affecting 30% of women) and broadly unequal gender relations.[237] The important point here is that empowerment programs need to generate *holistic* cultural change, and not simply empower *individual* women.

vi. Niger and Chad: changing desired fertility

Chad and Niger have some of the highest fertility rates in the world – in Chad, 6.3; in Niger, 6.89 (2021-23 rates).[238] The high birth rate is causing infrastructural pressures, driving poverty, famine, political instability, and violence.[239]

The birthrate cannot be (wholly) explained by **unmet contraception need**. The percentage of married women aged 15-49 with an unmet need for contraception is 19.7% in Niger and 30.2% in Chad. Yet comparable countries with similar rates of unmet contraception needs still have a far lower birthrate.[240] The lack of contraception needs to be addressed, but is not the sole or primary reason for high fertility.

The **desired number of children** in Chad and Niger is exceptionally high, with only a small gap between actual and wanted fertility.[241] Chad and Niger stand out as the only two African countries where actual fertility undershoots desired fertility by one or more children.[242] This is not a phenomenon specific to the region or level of development: neighbouring countries, both with higher and lower GDP per capita rates, all show lower fertility rates.[243] Instead, the high desired fertility is driven by the **socio-cultural context**, particularly strong gender inegalitarian setting. Children are often seen as a measure of prestige.[244] Many women only find success through the framework of having children. Muslim women in polyamorous marriages report using children to enhance their bargaining power and 'value'.[245] Individuals often imitate the reproductive behaviours prevalent in their community 'to gain acceptance and avoid criticism', which is particularly important in societies where informal support networks (rather than a welfare state) represent the main form of insurance.[246]

Women report that unequal gender relations, family disapproval and the prevalent conservative strain of Islam prevent them from accessing family planning services.[247] Women do not have the autonomy or freedom to manage childbearing.[248]

Education rates are low in both Niger and Chad. In 2007, only 15% of women in Niger had *any* primary education; only 1% had completed primary school. Investment in education struggles to keep school enrolment at pace with population growth.[249] In Chad, 68.4% of women have no education, 21.7% have primary education, and just 9.9% have secondary or higher education. In the most gender-inegalitarian societies, 88.9% of women have absolutely no education – and, also, desire more children than their educated peers.[250]

Family planning education is also lacking. In 2012, 90% of women knew of a modern method of contraception – but only 40% were aware of possible side effects.[251] Even if women are knowledgeable about their fertile period, various method options, or possible side effects, and wish to use contraception, available services and locations tend to be limited or costly.

3.5: Funding anti-natalist policies

All this – improving healthcare systems, increasing knowledge of and access to contraception, guaranteeing education and implementing programs to provide women with greater opportunities – requires vast investments. Yet African countries are currently experiencing a colossal debt crisis, and the majority of countries currently spend more on repaying external debts than on their entire healthcare budget.[252] Countries such as Ethiopia primarily rely on international aid to finance their anti-natalist programs.

This reliance leaves the Ethiopian government struggling when geopolitical shifts result in cuts to funding. The United States is one of Ethiopia's largest global health donors.[253] Yet its longstanding **Helms Amendment** (1973) prohibits the federal government from using foreign aid to pay for 'abortion as a method of family planning'. In other words, no US funding to foreign NGOs can be used for abortion-related services – even where abortion is legal.[254] Given the liberalising trend in abortion laws since 1973, the Helms Amendment now hinders over 80% of the countries receiving US assistance from implementing their own laws.[255]

More damaging is the **'Protecting Life in Global Health Assistance' policy** (Global Gag Rule/ Mexico City Policy), additionally implemented by every Republican administration since 1984. This conditions *any* funding to foreign NGOs on their pledge not to perform or 'promote' abortions.[256] NGOs cannot use their own, non-US funds to provide abortion services, information, referrals, counselling, or advocacy without losing US funding across the board, even for unrelated international development projects such as on water or sanitation.

The 2017-21 Trump administration implemented the Global Gag Rule and devastated healthcare provisions across Ethiopia. In a country where NGOs remain a crucial partner of the government in delivering family planning, limits to their funding cut deep. The NGO Marie Stopes International and the Family Guidance Association of Ethiopia could no longer access US funding and closed clinics across the country.[257] Harder-to-reach rural, youth and marginalised communities, which are usually engaged by NGOs rather than government actors, were hardest hit by lack of access. Clinics which did continue to operate cut abortion services, leaving populations in key rural areas unable to access healthcare to which they have a legal right under domestic law. The policy affected 'compliant' and 'noncompliant' clinics alike, as the Global Gag Rule dismantled partnerships between the two and reduced efficient coverage across the country.[258]

Until 2005, Ethiopia had some of the world's highest maternal mortality rates, and unsafe abortions contributed to a third of all maternal deaths in the country.[259] Liberalising the abortion law lowered the proportion of maternal deaths attributable to unsafe abortion, from 32% to less than 10% by 2017.[260] Today, deaths from unsafe abortion only account for 1% of all maternal deaths in Ethiopia.[261]

Provision of abortion is therefore fundamental to Ethiopia's aim of improving citizens' wellbeing and reducing maternal mortality. Yet, the government's ability to implement domestic policy is, to a large extent, conditional on the US electorate. This demonstrates the importance of securing domestic funding for family planning by the Ethiopian government; but should also motivate rather than absolve the international community's commitments. Long-term, unfettered international development programmes provided by international organisations such as UNFPA have tremendous impact. Therefore, rights-respecting states should recognise the importance of this funding and advocate for their allies to remove conservative conditions on healthcare funding.

3.6: Conclusions: lessons for anti-natalist policy

The vast majority of women in low-income countries do not control their fertility; lack of access to contraception and subjugation to patriarchal control are the primary drivers of this crisis. India's infamous, heavy-handed intervention focussed on target-driven sterilisation should not be considered successful, because its misplaced focus does not address these two underlying problems, and violates rights along the way. Instead, programmes that focus on the empowerment of women are a double-win. As shown by Kerala and Ethiopia, these lower the TFR faster and more sustainably, and while guaranteeing, not violating, human rights.

The question remains as to how to proceed when women espouse that they do, in fact, desire very high numbers of children. Here, education and gender empowerment make all the difference. As shown by Niger and Chad: when given information and greater autonomous

decision-making to lessen gender-inegalitarian contexts, women in low-income countries revise their desires and want fewer children.

Family planning may have been previously weaponised by colonial actors to place limitations on women of colour – but that does not mean that independent decision-making over fertility is not something Global South women want and need, or that their rights to education, information and reproductive rights should now be left unrealised. Anti-natalist policies should always focus on expanding choice, not restricting it – a capabilities-based approach which, as shown here, breeds fruit.

The key stumbling block here is funding. Investments would be returned through normalised age stratification and resulting greater work productivity, but in the short term most low-income countries find the price tag an insurmountable one. Rights-respecting high-income states, recognising the moral, infrastructural, and thus geopolitical need to assist low-income states in their anti-natalist policies, should support and fund international organisations such as the WHO and UNFPA. Their own international development programmes should include girls' education, provision of all sexual and reproductive health services, and gender equality; they might also provide interest-free loans for low-income countries to use specifically on family planning policy.

4: Overall Conclusions and Recommendations

Our final recommendations, summarised below, gather indicators likely to help policymakers design justified, successful, and liberal anti-natalist or pro-natalist policy.

Two limitations should be noted. First, cross-contextual comparisons are often helpful, but have limits. Culture can play a role in reducing the relevance of two examples to each other: for example, parents in France seem to spend far less time on parenting than in other countries, which might mean a successful policy in France is less well-suited to the culture of Hong Kong.[262] The fertility context of any given country could also affect the efficacy of new policies: for example, an existing legacy of rights-violating policies can bring complications for any new policies. The whiplash created by China's reversal of its extreme one-child policy and implementation of a three-child policy is one such example; the entrenched and violent legacy of the one-child policy is difficult to shake. In Peru, the traumatic legacy of mass sterilisation under President Fujimori has led to a backlash against all forms of modern contraception, but women instead suffer from criminalised and unsafe abortions.[263]

This first limitation leads us to re-emphasise that natalist policies should always, as a first step, gather data. Drawing on country-specific data, they should address costs, and increase benefits. Our suggestions are key indicators which seem the most promising approaches across different country contexts. However, local actors should always consider these suggestions alongside survey data, and acknowledge there is always a risk of limited impact.

The second limitation is a key assumption in this report: that the ideal number of children reported by women is around 2-3, which would conveniently bring us to the TFR rate for replenishment. Closing the birth gap would therefore mean realising desires, *and* would stabilise the fertility rate at around 2.1 without the stark regional divides of today. This begs the question: what happens when this no longer becomes the case? If, across the globe, women's desires shift to be significantly smaller or higher than around 2.1, is more extreme intervention necessary?

Our answer is threefold. Firstly, we are not yet at a stage where this is a strong consideration: thus far, ample evidence suggests that our assumption holds and will continue to hold. Secondly, we would in such a situation also consider radical changes to migration policy, restructuring of elderly care, or other realms of political intervention. Thirdly, this report shows that, as a general rule of thumb, the most successful long-term policies are as non-interventionist as possible. Our case studies suggest that in any future context, the least coercive policies are also the most likely to be the most successful.

Pro-natalist recommendations

- **Financial incentives** can work if designed to promote autonomous and flexible parental decision-making. Financial incentive schemes should not fall prey to moral panic and seek to reinscribe traditional patriarchal models of breadwinner and housewife. Instead, schemes should be flexible enough to provide something for everyone. Benefits which help low-income families to stay in work can encourage childbearing at an earlier career stage; benefits which give tax deductions to high-income families reduce the high cost of childbearing in a high-income society. Governments should nevertheless be aware that financial incentive systems will carry a substantial price tag.

- Provision of **parental leave** is important, but its effects are limited if they are not targeted towards men. 'Use it or lose it' mechanisms and periods of maternal leave dependent upon paternal leave can encourage take-up.
- Provision of **high-quality and low-cost childcare** is also vital, but governments should be cognisant that parents do not want to fully outsource caring.
- A more **gender-egalitarian context** breeds better pro-natalist results; the level of inhibition posed by socio-cultural and gendered penalties should not be underestimated. Governments can support mothers with:
    - Investments into maternal healthcare and reproductive rights (such as access to information and services, including contraception and abortion), to allay healthcare fears and promote confidence in the healthcare system;
    - Strict enforcement of anti-discrimination employment policies;
    - Legislation on the mandatory measuring and reporting of gender pay gaps, with a focus on potential motherhood penalties;
    - Awareness campaigns on the concept of unpaid care, the ability for fathers to take parental leave, and the normalisation of family time;
    - Financial grants to gather data and run pilot projects for four-day weeks and other work arrangements which would give parents (*both* mothers and fathers) long-term engagement with their children.
- Governments must **increase rates of independent household formation** by couples or individuals of reproductive age, whether by housebuilding or by enhanced first-time buyer schemes and other subsidies. For those who do have an independent household, governments should also introduce a subsidy to assist them in upscaling in line with family desires.

Anti-natalist recommendations

- Governments should urgently pass and enforce legislation to end violations of reproductive rights, notably quota-driven sterilisation. A very high bar should be set before governments offer financial incentives for female sterilisation, a non-reversible contraceptive method: there must be a sufficient climate of knowledge of and access to other contraceptive methods, and the financial incentive should not be sufficiently high to be relied on as a form of temporary income.
- Punitive measures relating to family size should also cease immediately, given they do not address the root causes of high fertility. Civil and political rights cannot be held hostage as an incentive for small family norms.
- **Investments in healthcare** to improve the quality of life of women and children meets overall aims of improving wellbeing, while parents see no need to have more children as 'insurance'.
- **Increasing contraceptive use** is a multi-stage process, requiring:
    - Education as to the existence, availability, and types of contraception;

  - Further education to promote self-efficacy; to tackle infertility myths and cultural taboos; to work with men and religious or community leaders to normalise use;
  - Capacity building and access, including the removal of barriers to advertising, providing, or selling contraception; removal of taxes on importing contraception; developing domestic production of contraception;
  - Developing initiatives specifically to target rural and adolescent populations; for example, providing contraception at key meeting places such as schools or markets.

- Incentivising the enrolment of girls into **primary, secondary and tertiary education** can prevent child marriage and improve women's career aspirations, both of which significantly reduce fertility rates in low-income contexts. General primary and secondary education is one of the greatest indicators of reduced desired fertility levels, even when accounting for wealth and location.
- Specifically, quality **family planning education** can also reduce desired fertility, with women changing their minds after receiving a full understanding of their options.
- Policymakers must acknowledge where gender-unequal cultural traditions drive fertility patterns, and not shy away from **addressing harmful customs against women**. Governments should work to outlaw child marriage, guarantee education for girls, and empower women to access family planning on their own terms. Advocates should focus not on telling local actors to do, but rather on empowering and supporting the work of those already starting conversations and adjusting harmful customs. **Gender empowerment schemes** should at a society holistically, rather than producing highly autonomous women within still-gender unequal situations.
- Low-income countries need **more funding** for successful and sustainable anti-natalist policies. Governments should partner with **non-governmental organisations**, which are particularly useful in reaching rural communities or earning trust among vulnerable populations; but **external funding** can be piecemeal and political. High-income countries must support and fund international organisations such as UNFPA and WHO, and include girls' education, provision of all sexual and reproductive health services, and gender equality as a significant part of their **international development programmes**, as well as providing interest-free loans for low-income countries to use specifically on family planning policy.

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[217] Decline in maternal mortality ratio from 871 to 401 women per 100,000 live births between 2000-2017. Ibid, and DeMaria et al, 'Sexual and reproductive health in Ethiopia'.
[218] On average, the percentage of women aged 15-49 in Ethiopia who have an abortion has remained between 2.2-2.7% since 1990. Indeed, the highest proportion of 2.7% was in 1995-1999, before the law was liberalised. The share of unintended pregnancies ending in abortion has risen from 19% to 31%, but only because the share of unintended pregnancies has declined (from 118 in every 1,000 women in 1990, to 79 in every 1,000 women in 2015-2019. This correlates to only a slight increase in the actual rates of abortion, in line with Ethiopia's population growth. See Ethiopia's country profile on the Guttmacher website.
[219] To be precise, an investment of $12.91 per capita per year to meet sexual and reproductive health needs – a total estimated investment of $1.4 billion. See Ethiopia's country profile on the Guttmacher website.
[220] Ibid.
[221] Arowolo, 'Country Case Study: Ethiopia', p. 14.
[222] Hailemariam, 'Implementation of the Population Policy of Ethiopia'
[223] DeMaria et al, 'Sexual and reproductive health in Ethiopia', p. 3.
[224] The quotation is from John Bongaarts and John Casterline, 'Fertility Transition: Is sub-Saharan Africa Different?', *Population and Development Review* 28 (2012); Endale Kebede, Erich Striessnig, Anne Goujon, 'The relative importance of women's education on fertility desires in sub-Saharan Africa: A multilevel analysis', *Population Studies* 76:1 (2022).
[225] Anne Bakilana and Rifit Hasan, 'The complex factors involved in family fertility decisions', *World Bank Blogs* (2 May 2016).
[226] Monica Bahati Kuumba, 'Perpetuating Neo-Colonialism through Population Control: South Africa and the United States', *Africa Today* 40:3 (1993); Annabel Sowemimo, '#Decolonising Contraception: how reproductive medicine has been used to oppress people of colour', *CORTH Blog University of Sussex* (14 September 2018).
[227] CEDAW LC v Peru – similar statements in rulings by HRC Mellet v Ireland. See also, for example, Malkin v Russia for how the ECHR dismisses stereotypes as reasoning for discrimination.
[228] 2001 Universal Declaration on Cultural Diversity; Article 15(a) ICESCR; Farida Shaheed, 'Cultural Rights: what are these and why are they important for women's right to development?' OHCHR (2008), p. 5.
[229] For an example on how younger generations are already making different cultural choices relating to fertility to their ancestors, see Kebede et al, 'The relative importance of women's education on fertility desires in sub-Saharan Africa' on the Sahel.
[230] CEDAW Article 16(e) enshrined the right to 'decide freely and responsibly' on the number and spacing of children, with 'access to the information, education and means' necessary to exercise this right. Furthermore, CEDAW Article 2(f) commits all States 'to take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women'.
[231] Even the earliest measures for women's rights at the United Nations, in the early 1950s, were pioneered by women of the Global South. The 1954 UN Resolution 843 establishing the supremacy of the Universal Declaration of Human Rights over traditional practices that violate the human rights of women, 1962 Convention on consent and minimum age for marriage, and other actions establishing the universality of human rights over harmful cultural practices were piloted by coalitions of Latin American, Arab, and African states. The fascinating coalition of actors included Peng-Chun Chang, Bedia Afnan, Lakshmi Menon, Begum Rana Liaquat Ali Khan, Mahmud Azmi, Minerva Bernardino, and others. In particualr, Afnan (Iraq), Begum Rana (Pakistan) and Bernardino (Dominican Republic) were among the most passionate and interesting delegates. CEDAW, meanwhile, was primarily drafted by a delegate from the Philippines, heavily shaped by a delegate from Ghana, and influenced by a global consultative process. See Rebecca Adami and Dan Plesch, *Women and the UN: A New History of Women's International Human Rights* (Routledge: 2022).
[232] Martha Nussbaum, *Sex and Social Justice* (Oxford University Press, 1999), p. 46.
[233] Sandhya Agrawal, 'India's National Population Policy (2000): An Evaluation' (2019), pp. 13, 33-4.
[234] Kebede et al, 'The relative importance of women's education on fertility desires in sub-Saharan Africa'.
[235] John Bongaarts, 'Trends in fertility and fertility preferences in sub-Saharan Africa: the roles of education and family planning programs', *Genus: Journal of Population Sciences* 76 (2020).
[236] Esso-Hanam Atake and Pitaloumani Gnakou Ali, 'Women's empowerment and fertility preferences in high-fertility countries in Sub-Saharan Africa', *BMC Women's Health* 19 (2019).
[237] 'Fertility rate vs. unmet need for contraception, 2021' via *OurWorldInData* (Niger highlighted).
[238] In 2021-2023, Chad's fertility rate was around 6.3-6.4. In 2021, Niger was 6.89, having dipped slightly. Ibid; Georges Tagang, Jean-Robert M. Rwenge, 'Women's autonomy and fertility in Chad', *African Journal of Reproductive Health* 27:11 (2023).
[239] Jill Filipovic, 'Why have four children when you could have seven? Family planning in Niger', *The Guardian* (15 March 2017).
[240] Zambia at 4.54, Ethiopia at 4.24, Kyrgyzstan at 3.3 for around 20% unmet need. Burundi at 5.48, Guyana at 2.42 for around 30%. 'Fertility rate vs. unmet need for contraception, 2021' via *OurWorldInData* (Niger highlighted).
[241] Bakilana and Hasan, 'The complex factors involved in family fertility decisions'.
[242] Lyman Stone, 'The Global Fertility Gap', *Institute for Family Studies Blog* (25 February 2019).
[243] Chad's 2023 TFR of 6.4 stood in contrast to TFRs of no more than 5.5 in neighbouring countries Cameroon and Central African Republic, which have respectively higher and lower GDP per capita rates. See also Malcolm Potts et al, 'Niger: Too Little, Too Late', *International Perspectives on Sexual and Reproductive Health* 37:2 (2011).
[244] Bakilana and Hasan, 'The complex factors involved in family fertility decisions'.
[245] Bright Opoku Ahinkorah et al, 'Socio-economic and demographic factors associated with fertility preferences among women of reproductive age in Ghana: evidence from the 2014 Demographic and Health Survey', *Reproductive Health* 18 (2021); Filipovic, 'Why have four children when you could have seven? Family planning in Niger'; Tagang and Rwenge, 'Women's autonomy and fertility in Chad'.

[246] Kebede et al, 'The relative importance of women's education on fertility desires in sub-Saharan Africa', citing Caldwell and Caldwell (1990) and Kravdal (2002).
[247] Bakilana and Hasan, 'The complex factors involved in family fertility decisions'; Bongaarts, 'Trends in fertility and fertility preferences in sub-Saharan Africa: the roles of education and family planning programs', p. 19.
[248] Potts et al, 'Niger: Too Little, Too Late'.
[249] Ibid, p. 95-6.
[250] Tagang and Rwenge, 'Women's autonomy and fertility in Chad'.
[251] Bakliana and Hasan, 'The complex factors involved in family fertility decisions'.
[252] Jennifer Larbie and Tim Jones, Between life and debt, Christian Aid (2024).
[253] Jamie M. Vernaelde, 'The U.S. Global Gag Rule in Ethiopia: a foreign policy challenging domestic sexual and reproductive health and rights gains', *Reproductive Health* 19 (2022).
[254] Ibid.
[255] Anu Kumar, 'Abortions are legal in Ethiopia. But half of these clinics won't provide them.' *New York Times* (18 October 2022).
[256] Feyssa and Gebru, 'Liberalizing abortion to reduce maternal mortality: expanding access to all Ethiopians'; Kumar, 'Abortions are legal in Ethiopia'; Vernaelde, 'The U.S. Global Gag Rule in Ethiopia: a foreign policy challenging domestic sexual and reproductive health and rights gains'.
[257] Ibid.
[258] Ibid.
[259]Dessalegn, 'What Ethiopia can teach the US about abortion rights', *Al Jazeera* (28 September 2022); Feyssa and Gebru, 'Liberalizing abortion to reduce maternal mortality: expanding access to all Ethiopians'; Kumar, 'Abortions are legal in Ethiopia'.
[260] DeMaria et al, 'Sexual and reproductive health in Ethiopia', p. 1; Feyssa and Gebru, 'Liberalizing abortion to reduce maternal mortality: expanding access to all Ethiopians'; Kumar, 'Abortions are legal in Ethiopia'.
[261] Dessalegn, 'What Ethiopia can teach the US about abortion rights'.
[262] 'Parents now spend twice as much time with their children as 50 years ago – except in France', *The Economist* (27 November 2017).
[263] C Ewig, 'Hijacking global feminism: Feminists, the catholic church, and the family planning debacle in Peru', Feminist Studies 32:3 (2006), p. 633; A Taype-Rondan and N Merino-Garcia, 'Hospital admissions and deaths due to clandestine abortion in Peru: what do the numbers reveal?' *Revista Peruana de Medicina Experimental y Salud Pública* 33:4 (2016).