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# If only I knew: Fertility policy and family planning in Switzerland

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# 1 About this white paper

This white paper *If I only knew: Fertility policy and family planning in Switzerland* is the result of a cooperation between the Competence Center for Diversity, Disability and Inclusion at the University of St.Gallen and Merck Switzerland. Our aims are a) to understand the current barriers to fertility treatments and family planning in Switzerland from the perspectives of affected individuals, employers, and Swiss federal government and b) to develop actionable recommendations. As outlined in later sections, next to the current legal situation, we focus mostly on the general attitudes and misconceptions that affect people's decision-making when it comes to fertility treatment and family planning.

The multi-faceted analytical approach included a thorough literature and policy review, analyses of HSG Benchmarking data and other secondary data bases (e.g. data from the Swiss Federal Statistical Office), and semi-structured interviews with representatives of each of the three stakeholders.

We would like to thank several experts in the field for sharing their insights. The research was led and written by Dr. Anna Brzykcy and Dr. Nora Keller, and edited by Prof. Dr. Gudrun Sander and Prof. Dr. Brigitte Leeners.

# 2 Management summary

Switzerland has just recorded the lowest birth rate ever: 1.3 children per woman. This is below the EU average of 1.46 live births. 1 in 5 couples in Switzerland is struggling with infertility (i.e. they do not conceive a child after 12 months of regular and unprotected sexual intercourse), and this number is expected to rise. Respectively, an increasing number of couples will be affected by secondary infertility as their age will be even more advanced when planning a second baby. The age at which most individuals start planning their families has shifted to over 31, or even to late 30s for people with higher education levels, which exacerbates age-related infertility.

While this topic affects an increasing number of (young) adults, 57% of them aged 20-26 (Generation Z members) and 27-37 (Millennials) admit that they know little to nothing about factors influencing their own fertility, fertility-related issues such as menstruation or menopause, or common fertility treatments. This is partly because infertility is rarely spoken about and is full of misconceptions.

Few realize that Switzerland – a country often regarded as the progressive and liberal democracy - is badly placed to tackle the delayed family planning and fertility issues. One main reason is that it has one of the most restrictive and discriminatory legal frameworks when it comes to fertility with prohibitively high out-of-pocket costs for fertility treatments: Three rounds of in vitro fertilization (IVF, one of the most common fertility treatments) cost up to 55% of the annual disposable income of Swiss households. At the same time, Switzerland lacks progressive family support policies, which makes starting a family a much more difficult decision than necessary.

In this white paper, we used multi-source data to identify common misconceptions about (in)fertility in Switzerland (e.g. “Infertility does not affect someone like me.”; “In Switzerland, I have access to the best possible medical care.”) and to better understand current barriers to family planning and fertility treatments. Based on this, we developed recommendations for action for people who are or will be affected by infertility, employers, and the federal government. While each of these stakeholders has an important role to play, it is their combined efforts that can make a difference. Legislative change is the way forward, but it requires significant groundwork to raise awareness, fill knowledge gaps, and change mindsets about (in)fertility. In Switzerland, with its direct democracy, individuals and public interest groups play a big political role. Given rising skills shortage, employers are also highly incentivized to better support their employees with fertility issues. In short: A coalition of actors, perhaps even a new social contract, is necessary to tackle the fertility challenge together.

# 3 Why you should care

In 2024, Switzerland had the lowest birth rate ever recorded: 1.3 children per woman. To put this into perspective: In 1876, each woman was expected to have 4.4 children (FSO, 2024h). While the rest of Europe is experiencing falling fertility rates, too, Switzerland lags behind the EU, where the average fertility rate is 1.46 live births (FSO, 2024h). Thus, Switzerland is experiencing what a prominent Swiss newspaper recently called a "turning point in the history of humanity": The advent of the age of "de-population" (Ferber, 2025).

How does this affect people's lives in practice? 1 in 7 couples in Switzerland struggles with infertility. 1,557,500 individuals in Switzerland will experience, are experiencing, or have experienced infertility during their lifetime (WHO, 2023). Even scarier, many (young) people have no idea: 57% of the members of Generation Z and Millennials living in Switzerland have little to no knowledge about factors influencing fertility (Switzerland Report, 2024).

At over 31 years, Switzerland's first-time mothers are among the oldest in Europe. This is partly due to Switzerland's conservative norms around (care) work. Many women (and some men) feel that they have to get their career on track before starting a family. Mothers still carry out the lion's share of care work at home, major career steps happen in the small age window from 31 to 40, and part-time employment can strongly reduce chances for promotion. The government does not guarantee parents the support they need, such as affordable childcare or equitable parental leave. This makes prospective parents in Switzerland to postpone family planning and think twice before having kids.

The higher age partly explains the increasing number of people choosing to undergo fertility treatments. In any given year, between 6000 and 7000 women in Switzerland undergo in vitro fertilization (IVF). Unfortunately, Switzerland is at a huge disadvantage when it comes to finding medical solutions for its falling birth rate, as it has some of the most restrictive fertility policies in Europe (European Atlas of Fertility Treatment Policies, 2024). Switzerland is also the only country in western Europe where no part of IVF is covered by the mandatory health insurance. This precludes many couples who can't afford treatment from getting fertility assistance or forces them to seek more affordable treatment abroad. As a liberal democracy that prides itself in its direct voting system, as a champion of cutting-edge biomedical research and state-of-the art medical care, its restrictive stance on fertility is particularly jarring.

**Most common fertility treatments briefly explained:**

**Intrauterine insemination (IUI)**: The growth of ovarian follicles (i.e. a small, fluid-filled sac in the ovary that contains one immature egg) is supported through injections. Sperm is inserted directly into uterus shortly before ovulation.

In **in vitro fertilization (IVF**), the growth of ovarian follicles is supported through injections. Once they reach an adequate size, a last maturation step is induced, and eggs are retrieved. Mature eggs are fertilized with sperm in a laboratory. Most often one and rarely two embryos are put back into the uterus 2-5 days after egg retrieval (embryos may also be frozen to be used up to ten years later). Pregnancy happens if any of the embryos implant in the lining of the uterus.

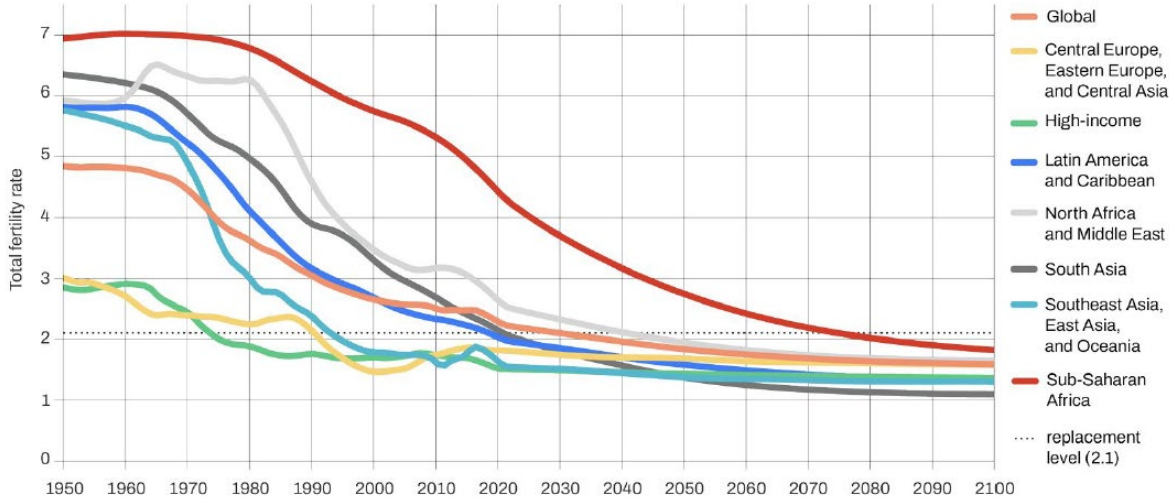
**Intracytoplasmic sperm injection (ICSI)** is a form of IVF that is used when male infertility (e.g. low sperm count or motility) prevents pregnancy. One spermatozoid (motile sperm) is injected into the center of each mature egg to facilitate fertilization.

# 4 Why we need to act now

## 4.1 The consequences of doing nothing

As they say: The personal is political. The consequences of not acting are not just personal but societal, economic, and political. On a personal level, the "fertility gap" will continue to grow: While the majority of people in Switzerland still dreams of the two-child family, for most, this won't become reality. Surveys in Europe tracking ideal fertility preferences over time have shown a steep decline in the intended or expected number of children since the 1960s (The Economist Group, 2024).

Figure 1. Total fertility rate, 1950-2100, by GBD super-region and for the globe

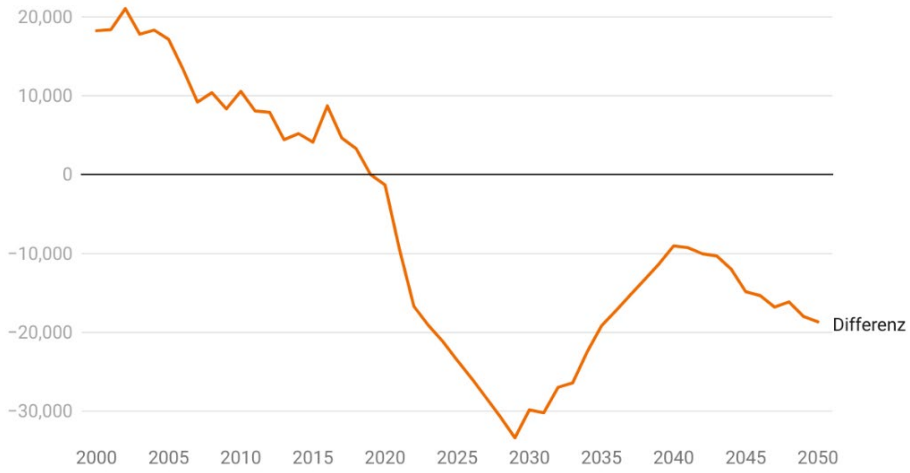



*Source: Bhattacharjee et al. (2024); GBD = Global Burden of Disease*

Politically and societally, it is hard to overstate the seismic implications of this demographic shift. For Western Europe[1], different prognoses illustrate the severity of the issue: The population of Western Europe is expected to decrease by 12% by 2100. Switzerland's neighbors, Italy and Germany, will experience decreases by 41% and 16%, respectively. Switzerland will fall somewhere into this range.

Switzerland is dependent on immigration to "balance out" declining fertility. If we exclude immigration, the working-age population of Switzerland has been steadily declining since 2020 and is expected to continue doing so (Economiesuisse, 2023). The problem: As other European countries are experiencing similar fertility declines, the conditions to remain in one's home country may become more attractive. Europe is projected to reach its peak population size and to begin experiencing population decline in the 2030s.

Figure 2. Annual difference between 65- and 20-year-olds



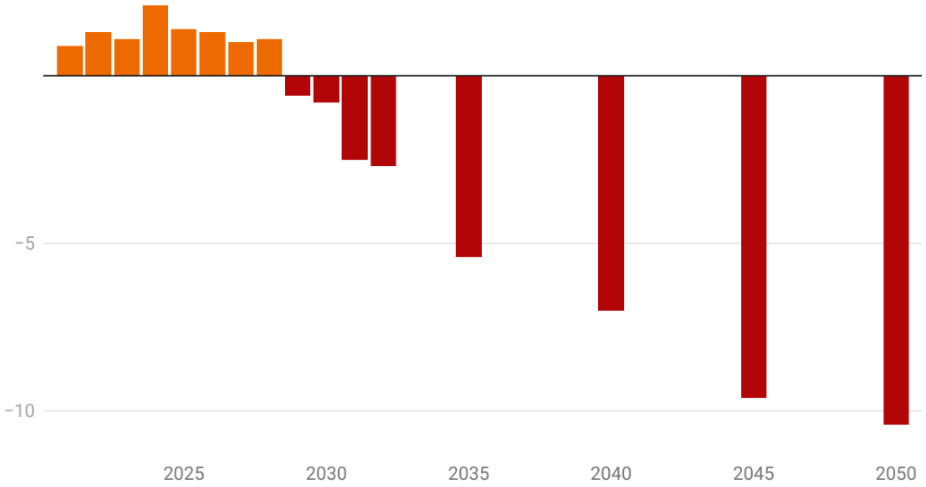

*Source: Economiesuisse (2023)*

This puts significant pressure on both the economy and the provision of public services. In 2029, the number of people reaching retirement age will exceed the number of young people entering the labor market by over 30,000. In the next ten years, the share of retirees will grow by 26%; that of employees, by 2% (Minsch & Saurer, 2024).

In Switzerland, there was an average of 6.5 people of working age for every retiree in 1948; in 2020, this ratio was 3.3:1. By 2050, the "old age dependency ratio" will fall to 2.2. This poses significant challenges for the old-age insurance (OASI or AHV), as the financing of the first pillar is based on the pay-as-you-go system. This means that working individuals continuously fund the pensions of retirees. If immigration follows the (optimistic) projection of the Federal Statistical Office, we will be short 10 billion a year by 2050, barring seismic reforms.

[1] Data-based projections for Switzerland are based on outdated data (pre-Covid) and assume a fertility rate of 1.51. As this is now far from reality, projections from the Federal Statistical Office were not used here (FSO, 2020).

Figure 3. From OASI / AHV Surplus to deficit (in billion francs)




*Source: Economiesuisse (2023)*

Falling fertility rates are exacerbating the skills shortage prevalent on the Swiss labor market over the last few years. There will be a shortfall of around 431,000 people in the labor market by 2040. This is around eight percent of the total working population today (Economiesuisse, 2023). Individuals will feel the economic strain, too: GDP per capita is projected to fall steadily starting in the late 2020s, even though real salaries will rise. By 2050, average household disposable income might be 9% lower, and a whopping 16% by 2080 (Buchmann, 2021).

> *"But if these numbers are falling, schools are going to close. Old age homes will open, villages will close etc. Because when you close a school in a village, the whole village is doomed. And then there's another element that needs to be taken into account, namely the increase in life expectancy, which is the tree that hides the forest. We used to work on a delta, with as many births as deaths. Now, there are fewer births and fewer deaths, except during the COVID period."* Professor of Reproductive Medicine

**In short: What's at stake? Prosperity in Switzerland.**

- **Shrinking workforce and (skilled) labor shortages:** Even if immigration patterns follow optimistic forecasts, there will be a shortfall of around 431,000 people in the labor market by 2040. This is around eight percent of the total working population today.
- **High dependency ratios (fewer young people per elderly person):** By 2050, old-age dependency ratio will fall to 2.2, which could equal as much as 10 billion a year in the old-age insurance OASI (AHV) shortfalls.
- **Rising pressure to increase immigration:** Switzerland will become ever more dependent on immigration in the coming decades. Yet, political sentiment is swinging the other way. The Swiss People's Party has collected the signatures necessary to launch an initiative to cap the resident population at 10 million. In 2024 and the beginning of 2025, far-right parties have made gains in almost all European elections that they contested.
- **Sociopolitical tensions and conflicts:** All of this will likely lead to rising sociopolitical tensions and conflict due to growing economic and financial strains, resentment towards the aging

population, increased pressure on the labor force, and the incompatible political trajectories of the necessity of more immigration and growing anti-immigration sentiment.

## 4.2 Necessary actions for sustainable change

To empower and enable everyone to have the family they want, we need to act in two areas: (1) increase awareness and shift mindsets of the key stakeholders such as people who are or will be affected by infertility, employers, and the federal government, and (2) improve access to fertility treatments. Each of the three stakeholders are integral parts of this seismic transformation.

**Challenging misconceptions:** Even though infertility touches (or will touch) many, many lives, few people in Switzerland have a well-founded understanding of their own fertility, the rise in infertility, or the possibilities and limits of assisted reproductive technology (ART). What are these misconceptions, and how are they misleading and / or plain wrong?

- *Infertility is a women's issue*: In fact, it affects men and women equally.
- *With modern medicine, infertility can be "fixed"*: With success rates that decrease with age, IVF offers opportunities for later family planning but cannot compensate for factors like age. In fact, on average, IVF only leads to a live birth in one in three patients (see the approximate total of persons undergoing IVF treatment each year in Figure 8).
- *Infertility is a private problem*: Keeping one's fertility struggles private can increase stress and lead to potentially deleterious negative psychological effects. It also prevents people affected by infertility from getting the support they need from other persons who had undergone fertility treatments, friends, or others including work colleagues, etc.
- *Infertility affects a small minority:* Infertility struggles affect nearly 20% of people worldwide. Just because people don't talk about it doesn't mean they're not suffering.

Without first changing hearts and minds, no legal or policy changes can have a lasting effect.

**Guaranteeing access:** Switzerland's restrictive legal framework around fertility denies treatment to many people. It's one of the only countries in Europe where egg donation is not yet legal. No part of IVF is covered through either mandatory health insurance or some kind of public fund. The lack of vital family support (e.g. equitable parental leave, affordable childcare) further disincentivizes family planning. Unless the government starts taking its responsibility seriously, the fertility crisis will become ever more dire.

> *"Infertility is a disease like any other, no more and no less. In Europe, for example, there are 40,000,000 infertile people, and worldwide, there are 300,000,000 infertile people. But because it's a disease that touches the intimate, that touches the family, that touches politics, that touches God, nobody talks about it."* Professor of Reproductive Medicine

> *"In Swiss society we are really lacking the awareness and knowledge that infertility is a qualified illness."* Researcher on fertility treatment and care

# 5 Countering common misconceptions about (in)fertility

Why is Switzerland at such a disadvantage when it comes to finding solutions for its falling total fertility rates? A key part of the answer: There are many common misconceptions around (in)fertility and a widespread lack of knowledge about the issue. Because of this, women might not know when it is a good time to preserve their fertility in case they want to start a family later. Couples might not seek the best treatment when it could be most effective. Most people might not know that loved ones are struggling with infertility. Employers might not support their employees in the way they need. Governments might not pass the appropriate legislation. Swiss civil society might not make their political demands for legislative changes heard. After all: Switzerland has a unique popular voting system, where civil society and individuals play an outsized role in affecting legislative change.

Through interviews with experts, employers, politicians and affected individuals, a thorough review of the literature and analysis of recent surveys and other types of data on (in)fertility, we identified five key misconceptions about (in)fertility impeding fertility progress in Switzerland. In what follows, we show how these misconceptions operate in practice and (most importantly) what the government, employers, and individuals can do to support positive change.

**Total fertility rate:** Average number of children born to women during their reproductive years if they were subject to the fertility rates of a given period and if they were to live until the end of their reproductive years.

**Infertility** is a disease of the male or female reproductive system defined by the failure to achieve a pregnancy after 12 months or more of regular unprotected sexual intercourse.

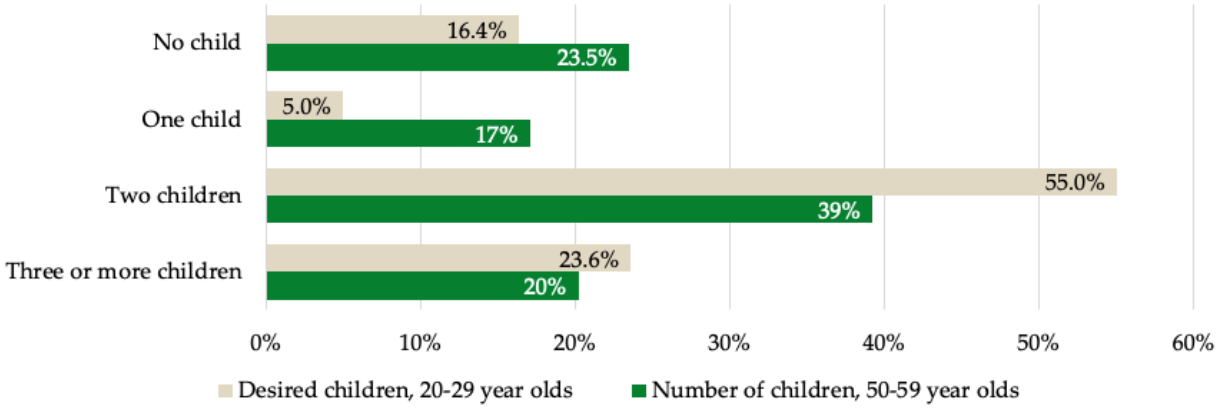
## 5.1 "Infertility does not affect someone like me."

The prevalence numbers of infertility are sobering: 20% of the Swiss population can expect to experience fertility issues at some time point in their lives (Blöchinger & Mertens, 2024). Yet, most people don't realize the high likelihood that infertility could affect them, too.

**When it comes to building a family, dream and reality are far apart**

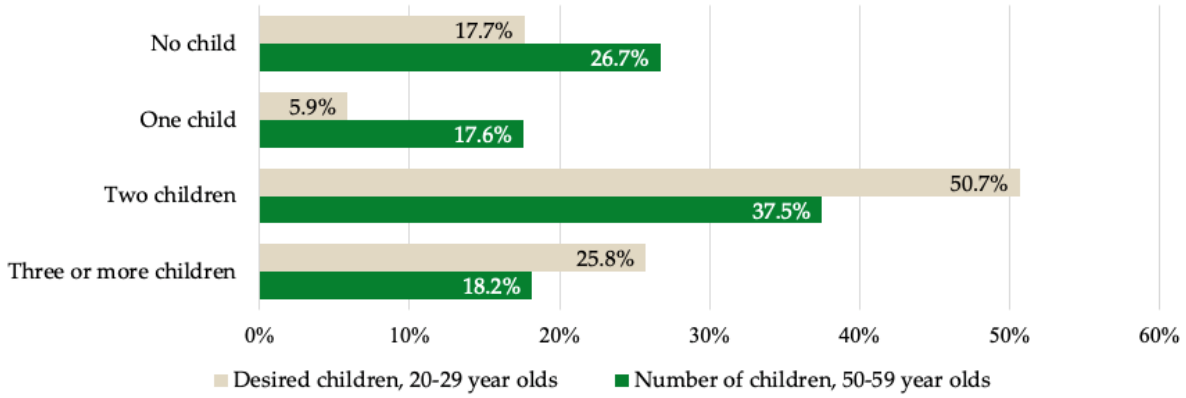
In Switzerland, one in five couples who want to start a family never fulfill their wish for children (USZ, 2024). While over 50% of women and men want two children, only around 38% actually have two children, resulting in a "fertility gap" of around 12% (FSO, 2024a). In other words, it is has become quite common for couples to have fewer children than they would like. Furthermore, just because a couple had conceived a child does not mean that they will not have difficulties conceiving another one. In fact, 6.5% of adults in Europe experience secondary infertility in their lifetime (WHO, 2023).

Figure 4. Desire to have children and the actual number of children among women in Switzerland




*Source: FSO (2024a)*

Figure 5. Desire to have children and the actual number of children among men in Switzerland

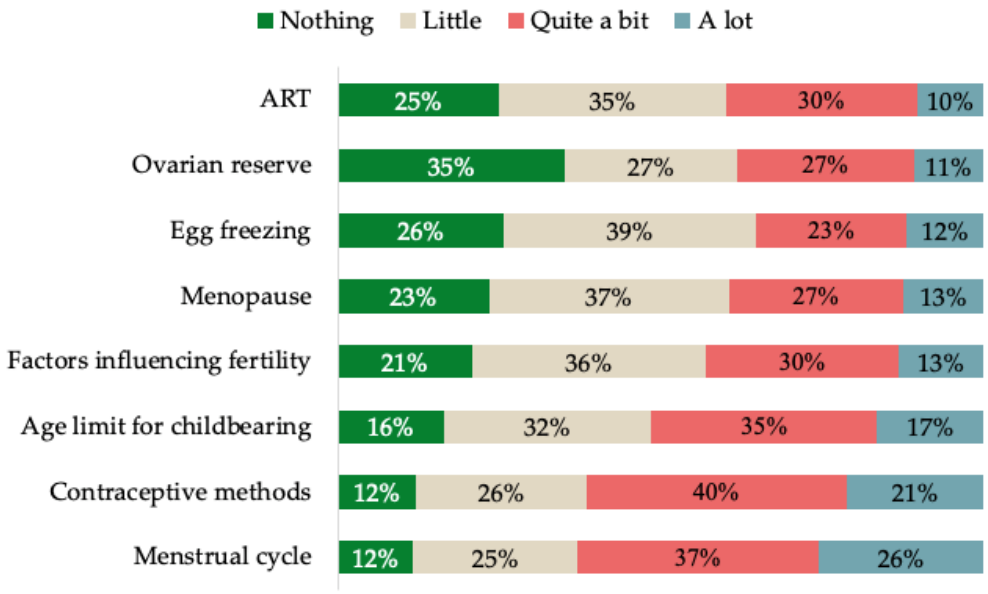



*Source: FSO (2024a)*

Part of the fertility gap can be explained by the "high" age of Swiss first-time mothers: Above 31. The decline of fertility is particularly steep after the age of 35. Pregnancy after the 40th birthday is often very difficult. Above the 45th birthday the genetic material of so many eggs is altered, making a healthy pregnancy a rarity (Leeners et al., 2013).

Most members of Generation Z and Millennials are unaware of the high prevalence of infertility and unwanted childlessness – and have given little thought to their own fertility. A survey of 623 young people living in Switzerland shows that a large portion of them know little to nothing about the decline of fertility with age, about common factors influencing fertility, or the fact that every woman's ovarian reserve is limited (i.e. number of immature eggs with a potential to ovulate) (Switzerland Report, 2024).

Figure 6. How much do you know about the following topics?




*Based on Switzerland Report (2024) including data from 623 members of Generation Z and Millennials living in Switzerland. Refer to Appendix for more detailed information regarding the data base; ART = Assisted reproduction techniques*

This is not surprising, as sex education is Swiss schools focuses almost entirely on the prevention of pregnancy and sexually transmitted diseases (FOPH, 2024a). Students are not taught about the intricacies of their own fertility. In retrospect, many regret their little knowledge and limited focus on own fertility and family planning "at the right time" (e.g. between the age of 25 and 30), so they could have started planning their family earlier or taken measures to preserve their fertility.

> *"There is a lack of awareness in society that infertility is a qualified disease. People think that they can have children later and only then realize that this is more difficult than they thought. They wish they had been informed about it earlier. Between 25 and 30, no one said it could be difficult later."* Researcher on fertility treatment and care

> *"One woman in 6 has problems procreating. But what if we take the woman's age into account? A 30-year-old woman has a 1-in-4 chance of experiencing infertility, and a 1-in-3 chance at the age of 35, and 1-in-2 at age 40."* Professor of Reproductive Medicine

(In)fertility is still a taboo subject, which contributes to the lack of common knowledge. A recent survey study involving 1,564 adults living in Germany suggests that while 46% persons admit to speak openly about sex, only 37% would reveal their fertility struggles (Fertil

ity Survey, 2024). Men are even more uncomfortable talking about these issues than women. For many, being infertile is linked with shame and poses a threat to self-esteem and masculinity.

> *"Fertility is not only a women's issue but also a men's issue. Women are used to having regular check-ups but men much less so. For men, there is also the issue of shame and self-esteem: Am I still a real man? Do I even want to have children under such conditions? I have often experienced in fertility clinics that even if the treatments involve men, it is more likely to be the women who organize the whole thing."* Psychotherapist counseling people undergoing fertility treatment

This extends to the doctors' office: 60% of women rarely or never talk about fertility with their gynecologist. In turn, gynecologists, primary care physicians, or nurses rarely bring up the topic of fertility and family planning to their patients (Lienhard et al., 2024) or give general advice such as *"Just try it for a little longer."*[2]

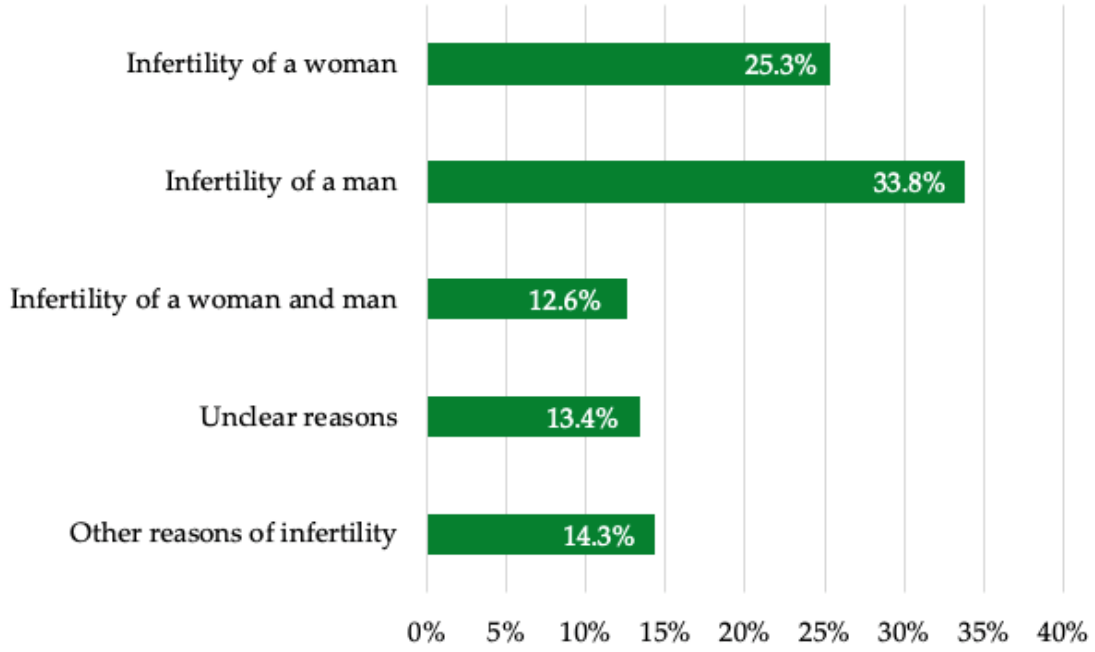
> *"It is important that physicians and family doctors discuss these issues with people and couples. Something like "you are reaching certain age, have you already thought about family planning? Do you want to have kids?"; It is important that people are aware of their declining fertility once they reach certain age to make informed decisions. Doctors should be laying out the different options people have much earlier, including the option to preserve one's fertility."* Former IVF patient

Talking more openly about (in)fertility can create a virtuous cycle, making others think about the limits of fertility and the importance of early action. In fact, people whose friends or family have shared their infertility struggles are considerably more likely to proactively undergo fertility testing, in contrast to people who have no one in their circle with known fertility struggles (Fertility Survey, 2024). Once the latter experience infertility at some point in their lives, they have little knowledge to build on and feel lonely from the start of their "(in)fertility journey".

**Infertility is not just a women's issue**

While infertility is often talked about as a "women's issue", the causes of infertility are as likely to lie with men as women. In fact, male infertility is more likely to be the cause for IVF treatment (USZ, 2024).

Figure 7. Reasons for IVF treatment




*Based on secondary data from the Federal Statistical Office from the period 2007-2022 (refer to Appendix for further details). IVF = in vitro fertilization*

[2] Taken from the interview with an expert on fertility treatment and care.

A growing body of research suggests that men's biological clocks tick, too (Muncey et al., 2025; Ku et al., 2025). The quantity and quality of men's sperm declines over time (Zhang et al., 2022). With increasing age, it takes longer for couples to conceive – due to both partners' declining fertility (Ford et al., 2000). As our interviewee (former IVF patient) put it *"The infertility is never only for one in the couple. The couple is infertile regardless of who has a health condition that is preventing the pregnancy."*

**"If I do not get pregnant, I will just do IVF."**

Many people overestimate what modern medicine can do and are unaware of its limitations when it comes to fertility.

> *"Seeing celebrities who get pregnant in their mid-50s (but don't mention that this required donor eggs) in the press – this creates false expectations and a false image of what's possible. Knowledge about fertility is really limited."* Physician and reproductive medicine researcher

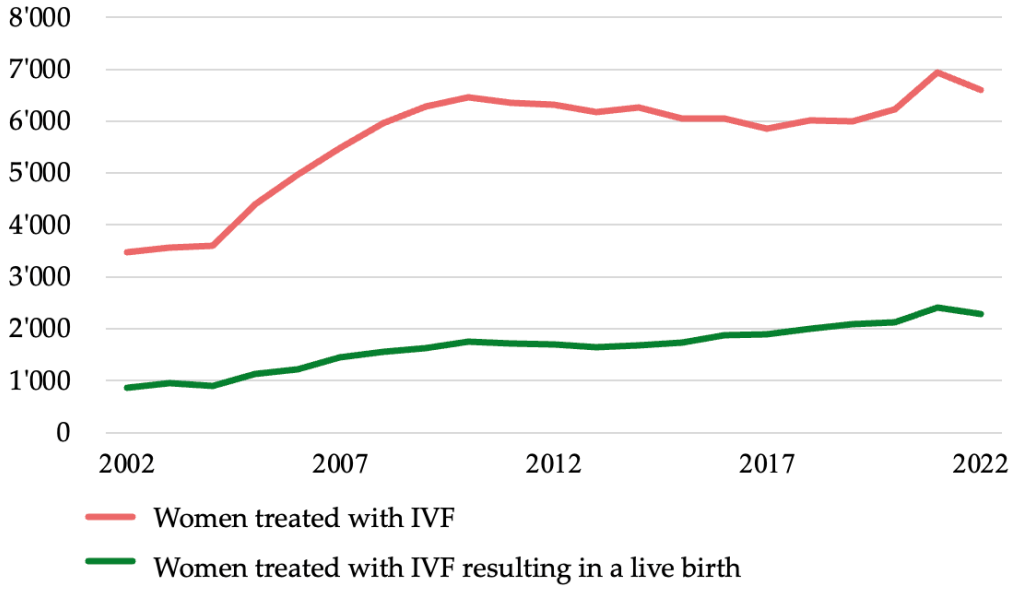
> *"I've spoken to many well-educated women who told me - if it doesn't work, I'll just do IVF. They don't know how often these treatments don't work. That's because we don't talk about all the unsuccessful attempts, just the success stories."* Researcher on fertility treatment and care

Some women consider the IVF treatment to be an easy fix for starting family at a later age. Some associate fertility treatments such as egg freezing or IVF with older and career-oriented women and are unaware that 40% of women who start IVF are 34 years old or younger (FOPH, 2024b). Furthermore, many might think of IVF patients as older in part because they often have to undergo multiple rounds of treatment (during which they get older).

> *"People get older over the course of their treatment. The treatment takes a long time for various reasons: psychological (because you need a break, don't want to do all those shots and needles again), or because it takes time to make hard decisions (moving from hormone therapy to IVF to egg donation, etc.). This creates the false impression that only older women undergo reproductive treatments."* Psychotherapist counseling people undergoing fertility treatment

The reality (for many): Fewer than 1/3 of women, who undergo IVF treatment, actually end up with a baby. Not to mention the high financial costs of the treatment or the psychological strain before, during, and after the treatment. 40% of women who had a failed IVF cycle (i.e. cancelled cycle, negative pregnancy test, or pregnancy ending in miscarriage) are at higher risk of depression (Holley et al., 2012). Women who remain childless after unsuccessful infertility treatment are also more vulnerable to depression later in life (i.e. 20-23 years after the failed IVF treatment) (Vikström et al., 2015).

Figure 8. Success rate of IVF




*Based on secondary data from the Federal Statistical Office from the period 2007-2022 (refer to Appendix for further details). IVF = In vitro fertilization*

**What can we do?**

- ✓ To change course on declining fertility and empower everybody to build the family they want, a concerted effort to understand the causes of delayed family planning and (in)fertility is necessary. To fully get at the societal, economic, and biological levels of the issue and build a broad coalition of supporters (e.g., Federal Office of Public Health, specialized medical societies, educational stakeholders), the federal government needs to spearhead such an effort.
    - This should include additional support and resources for existing research programs studying the Swiss context and a broadening of disciplines and researchers involved. Particular attention should be paid to differences in attitudes, concerns, and challenges between different areas of the country (rural vs. urban, protestant vs. catholic cantons, different language regions). Are there differences in access to medical treatments, childcare, psychological support? Are infertility and ART more stigmatized among some groups than others? How does the access to fertility treatments vary across different social groups (e.g. homosexual vs. heterosexual couples)? How many do not access because of treatment costs?
- ✓ The Federal Office of Public Health should sponsor and support a public awareness campaign that brings together different stakeholders and voices and breaks through the stigma.
    - A key focus should be on making (in)fertility a topic for women *and* men. Talk about the role of age in both women's and men's fertility. Increase visibility of persons who made timely decisions about their family planning and/or preservation of fertility and let them act as role models in the public discussion.
    - Start a public conversation with male and female role-models talking openly about their infertility issues and fertility treatments (with and without happy endings). Ask them to speak openly about the psychological and physical side effects and normalize talking about the sense of shame, loneliness and failure many people struggling with infertility feel.

- Engage credible spokespeople (e.g., reproductive medicine specialists) to provide clear, objective and realistic information about what it means to undergo fertility treatment. Key messages should include: IVF and egg freezing are not "quick fixes" or "insurance policies". Individual risk factors (pre-existing diseases such a coagulation disorders, autoimmune diseases, or mental disorders such as depression) should be considered in the fertility journey.
  The awareness campaign should emphasize the importance of the issue, and that it is not "career women who waited too long" who are the main recipients of IVF: Half of all IVF treatments are due to men's infertility, there is a wide range of medical conditions that makes IVF necessary, infertility affects 1 in 7 couples, etc.

✓ The cantons (or a coalition of cantons) should change the approach to sex education in schools by making scientifically reliable resources easily accessible, in order to provide students of all ages with a holistic understanding of fertility. This includes, for example,…
- …training teachers and school psychologists to deliver accurate and effective information about how to prevent pregnancy and sexually transmitted infections but also the regulation of fertility and how the likelihood of conception and live birth changes over time. Ensure that there are multiple touch points to refresh this knowledge (e.g. vocational training, university).
- …making information about sex, sexuality, fertility, consent, etc. available in an easy-to-access format for young people who might be ashamed to talk about these issues at school or at home. This helps normalize conversations about fertility and age-related decline in fertility, too! This Dutch website (https://sense.info/en) is a great example.
- …using safe sex campaigns to encourage timely reflection on family planning and fertility decline over time (e.g. "Sex is always possible - family planning too?").
- …making scientifically reliable information about fertility treatments easily accessible to everyone including lists of providers, a run-down of the legal framework (and where to get help), counselors specializing in fertility, support groups and peer-to-peer exchange etc. Inform also about the current success rates of various fertility treatments and factors influencing these success rates, as well as individual risk factors (e.g. pre-existing diseases such a coagulation disorders, autoimmune diseases, or mental disorders such as depression), which should be considered in the fertility journey.

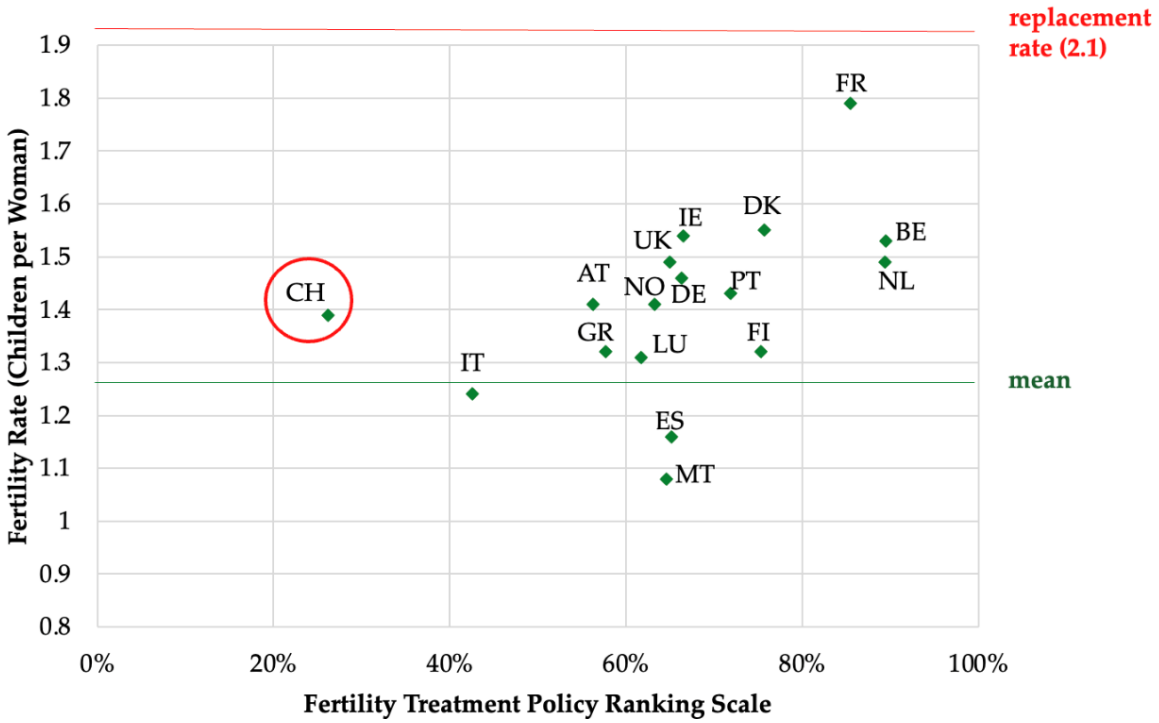
✓ Health professionals can make a difference by encouraging people to think and act on their own family planning - at least ahead of the most critical time points in their biological clocks (e.g. 35 years of age for women). The government is thus well served to train family doctors, gynecologists, and other relevant healthcare professionals on reproductive health and how to…
- … address the topic of family planning and/or the preservation of fertility in their interactions with patients. Inform them about the right time to start a fertility treatment (e.g. egg freezing at the age of 34 results in preserving eggs of much higher quality than when the treatment is done at the age of 38). Make sure they are aware of the current legislation, which allows for a 10-year cryopreservation period (i.e. cooling and storing of eggs) and a realization of pregnancy from these oocytes up to the age of 40.
- … manage expectations and be transparent about current possibilities and limitations of reproductive medicine (e.g. age, cannot be fully compensated for). What matters are informed and timely actions. Integrate early discussions of preventive measures (such as egg freezing) and later, present all treatment options.

## 5.2 "In Switzerland, I have access to the best possible medical care."

Switzerland has not only a below-average fertility rate in Europe but is also badly placed to tackle its fertility issue. It has one of the most restrictive and discriminatory legal frameworks when it comes to fertility, and prohibitively high out-of-pocket costs for fertility treatment, to boot. These factors significantly restrict the ability of prospective parents with fertility issues to access and afford the care and treatment they need.

> *"I feel ashamed that in a country like Switzerland, which is so highly developed and has such a high GDP per capita, we rank so low when it comes to access to fertility treatments."* Former IVF patient

Figure 9. Relationship between the fertility rate and the score on the fertility treatment scale across European countries.




*Scale explanation: 0-30% = exceptionally poor (i.e. access to treatments very limited, no funding); 31-49% = Very poor (i.e. access to treatments limited, funding poor or none); 50-59% = Poor (i.e. access to treatments for selected groups, poor funding); 60-69% = Medium (i.e. access to treatments for selected groups, variable funding); 70-80% = Very good (i.e. quite good regulations, access to treatments to many groups of patients, quite good funding); 81-100% = Excellent (i.e. good regulations, access to treatments for most patients, good funding). Source: Eurostat (2024); Replacement rate = Number of children per women that must be born to replace people that leave because of death.*

**"Switzerland is a progressive, liberal democracy with equal rights for all."**

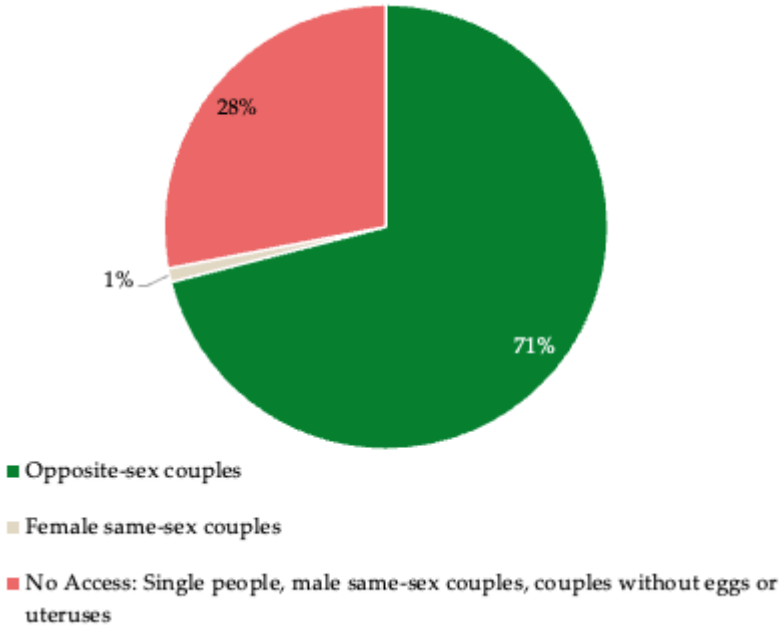
Currently, Switzerland has one of the most restrictive legal frameworks in Europe when it comes to reproductive assistance. For instance, you can't access reproductive assistance if you…
… don't have your own eggs (because egg donation is not legal),
… need donor sperm and aren't married (only married couples have access to donor sperm),
… are a woman without a uterus (because surrogacy is illegal),
… are a gay male couple (because both surrogacy and egg donation is illegal),

… need donor eggs and donor sperm (because egg donation and embryo donation illegal),
… are single (because IUI and IVF are only available to couples, as is donor sperm).

Sure: The Swiss Executive Council has recently decided on a revision of the Federal Act on Medically Assisted Reproduction, which is in force since 2001. The revision will (likely) legalize egg donation and make sperm donation and egg donation available to unmarried couples. Still left out: Women without uteruses, male couples, and single women.

Plus, the proposal for the revision will not be available until 2026, and political parties have already announced that they will ask for a popular referendum. Three years is the bare minimum until any legislative change *might* take place.

Figure 10. Access to ART in Switzerland




*Sources: FSO (2024e, 2024f, 2024g); Sotomo (2016); ART* = Assisted reproductive technology

**"The highest quality healthcare in Europe"**

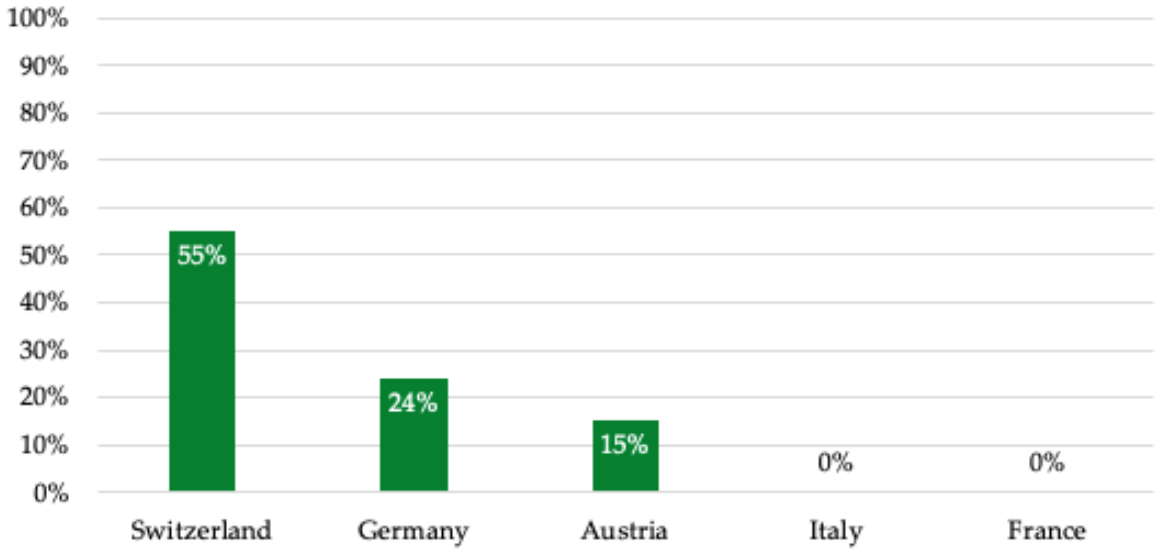
Switzerland is known for its strong pharmaceutical industry, with several global pharmaceutical companies supporting the development of medical treatments headquartered there. Switzerland is generally considered to have a world-class healthcare system (US News & World Report, 2024). The fact that access to reproductive assistance is so restricted is in direct contrast with this reputation and can even hinder research advances.

**Many are priced out of reproductive care**

Access to reproductive assistance is also severely limited by its steep cost. While insurance covers three rounds of IUI (only for heterosexual couples), Switzerland is the only country in Western Europe where no percentage of IVF or ICSI treatment is covered by insurance or public funding. In all other countries, at least three rounds of IVF or ICSI are covered by insurance (save co-pay), with the exception of Austria and Germany, where at least half the cost is covered.

Fertility treatment (3 rounds of IVF) can cost between 40% and 66% of the median Swiss household income. A US study found that insurance coverage plays a large role in driving the demand for IVF, with the rate of IVF falling by half when treatment is not covered (Peipert et al., 2022).

Figure 11. Expected costs of three rounds of IVF and their share of disposable annual income across selected European countries.




*Source*[3]

> *"People who have little money and still start the treatment are under enormous pressure. It has to work in a short time. Afterwards it's finished because there's no more money. I've had women who have broken down. They've had panic attacks."* Psychotherapist counseling people undergoing fertility treatment

[3] Estimates for Switzerland and Germany are based on a review of different fertility clinics. A "typical" fertility clinic at the higher and lower end of estimated costs was selected to construct an average estimate. Switzerland: Kinderwunschzentrum Admira Winterthur (https://www.admira.ch/de/kinderwunsch/kosten/), CPMA Centre Médicale de Fertilité Lausanne (https://www.cpma.ch/en-us/Treatments-and-MAP/Costs-of-treatments). Germany: Kinderwunschärzte Berlin (https://kinderwunsch-arzt.berlin/), Fertility Center Hamburg FCH (https://fertility-center-hh.de/). A legal analysis of insurance coverage in Europe was used to ascertain how much is covered (Seelmann, 2021, https://www.bag.admin.ch/de/fortpflanzungsmedizin-stellungnahmen-gutachten-und-empfehlungen). Austria has legally set price tags for treatments at public and private hospitals. A public fund covers 70% of the cost, under certain conditions, as detailed in BMASGK, 2023 (https://www.sozialministerium.gv.at/Themen/Gesundheit/Eltern-und-Kind/IVF-Fonds.html). Information for Italy and France was taken from the European Atlas of Fertility Policy (2024) (https://fertilityeurope.eu/atlas2024/). Insurance co-pay costs for medical visits and medication are not considered, as these are dependent on individual insurance providers and differ regionally in several countries. Disposable income figures are based on Household net adjusted disposable income estimates from the OECD Better Life Index (OECD, 2024, https://www.oecd.org/en/data/tools/oecd-better-life-index.html).

In every other country in Western Europe, some part of IVF is covered by health insurance or some kind of fund. Why do people with fertility struggles in Switzerland have to pay out of pocket to get the care they need? The Swiss Federal Court decided in 1987 that insurers don't have to pay for "experimental" fertility treatments such as IVF and has since refused to revise its decision. Thus, Swiss legislation about insurance coverage for fertility treatment is based on a state of IVF science almost 40 years out of date (Pärli & Mahrer, 2022).

> *"When it comes to surrogacy, this focus on "preventing women's exploitation" is just paying lip service to the idea. People will just go abroad. You're just exporting a moral dilemma and the risk of exploitation. Precisely because you don't regulate but just prohibit and restrict, surrogacy mostly takes place in countries where there are much weaker protections."* Expert on fertility law

Covering ART would be relatively cheap compared to other types of medical treatments. If 6000 women (approximately the number of women undergoing IVF treatment each year) would each receive financial coverage for three rounds of IVF, this would result in direct medical costs of 126 million (BZ, 2022). In contrast, the consequences of tobacco consumption cause direct medical costs of approximately 3 billion annually (ZHAW, 2019). What is particularly paradoxical is that the long-term medical costs of infertility are significant: According to a Danish study with more than 98.000 participants, the risk of mental illness is around 18% higher among involuntarily childless women than among other patients (Baldur-Felskov et al., 2013). A study in Sweden showed that the partner of a person with diagnosed infertility is also more likely to fill a prescription for mental health drug (Bögl et al., 2024).

The costs of infertility go thus far beyond the costs of the treatment and include various secondary costs such as costs for psychotherapy and psychiatric treatment. Notably, the latter *is* covered by basic health insurance.

**What can we do?**

- ✓ The government in collaboration with insurance companies should make it a key priority to mandate funding (either as part of mandatory health insurance or through some kind of public fund) for all forms of ART.
    - Financial coverage for IUI, IVF and ICSI should be tied to clearly defined, transparent medical criteria (e.g. age, likelihood of treatment success, number of attempts, etc.). It is important that funding for treatment is made available to same-sex couples and single women, as well.
- ✓ Ending discrimination when it comes to treatment access is perhaps *the* key priority. Due to Switzerland's unique direct democracy voting system, this means that action should target law-makers *and* the voting public, and that public interest groups and lobbies can play an important role in driving the issue. This involves the following action areas:
    - Ensuring the necessary political coalitions (across parties from the entire political spectrum) and developing a targeted action plan for implementing the legalization of egg donation. As this will most likely include a public referendum, this requires a broad public awareness campaign about why egg donation is important and has positive long-term effects: and
        - Legalizing it at home would provide safer, regulated options than going abroad to access donor eggs. Explain that ethical egg donation is not exploitation and can be regulated responsibly, especially if it is based on altruistic donations.
        - "This is about equality – sperm donation is legal, so why not egg donation?" – Highlight the gender inequality in Swiss reproductive laws, where men can donate

sperm, but women cannot donate eggs. In fact, a recent representative survey in Switzerland showed that this is a strong political argument: 73% of respondents believe that if sperm donation is legal, egg donation should be too (UZH, 2024).

- Lifting restrictions on egg freezing for non-medical reasons, allowing women to preserve fertility earlier in life. This should be combined with a thorough counseling about when to best freeze eggs (e.g. freezing in mid 20s might not yet be necessary and it might be better to first control/observe fertility over time and do freezing at later age of 32-34; Given the 10-year period of storing eggs, this would ensure that women have high-quality eggs at the time they really need them).
- Making ART accessible for single women.
- Educating politicians and the public about surrogacy, dispel misconceptions, and highlight its ethical, medical, and social aspects, focusing on the lack of legal protections for surrogates abroad. Encourage lawmakers to explore altruistic surrogacy, where surrogates receive compensation only for medical and related expenses. The motto should be: Regulate, don't restrict.

✓ To make sustainable change, the government needs to spearhead systemic strategic action. This should involve an interdisciplinary panel of experts from Switzerland and abroad to develop a longer-term fertility plan for Switzerland (e.g. legal experts, public health experts, reproductive medicine researchers, physicians, sociologists, psychologists, and Swiss politicians). The plan should include priority areas (e.g. equal access to fertility treatments, incentives for early family planning, equal parental leave for men and women, affordable child-care) and policy and implementation recommendations for the federal and/or cantonal governments. France is currently implementing such a fertility plan and can offer some insights from the ongoing implementation process.

## 5.3 "I can put my fertility on ice but not my career."

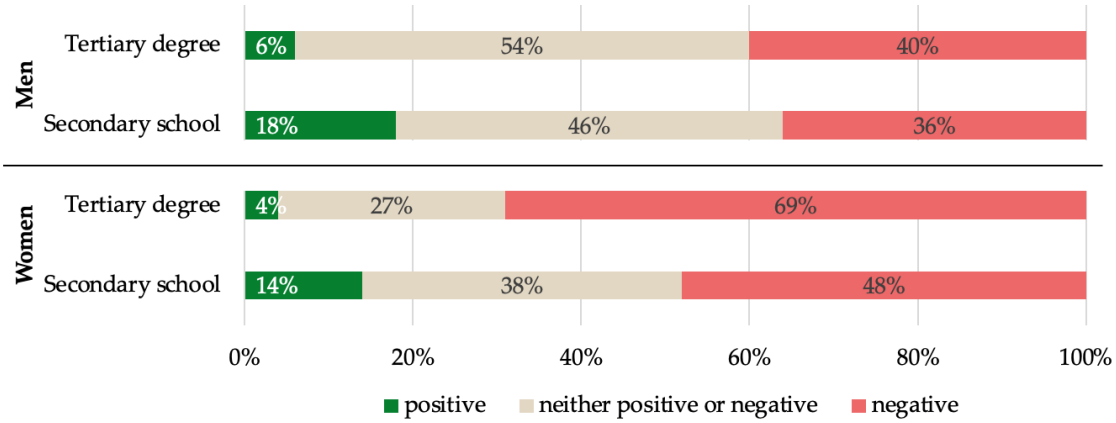
In Switzerland, first-time mothers are among the oldest in Europe at 31.2 years old, a full year and a half older than the EU average (FSO, 2024b). Why? In Switzerland, traditional norms around work and family incentivize many women to get their career on track before starting a family.

> *"It would be better not to wait with having kids until I have my career on track: Have kids first, then focus on your career. But companies would have to have career tracks in place that allow for this and communicate very clearly that they are supportive."* Professor of Sociology

**Key career steps coincide with "family primetime"**

Swiss career norms and (care) work culture incentivize career-oriented women to have babies later and move through key career steps first. In a survey by the Swiss Federal Statistical Office, a staggering 69% of women with tertiary degrees (and 40% of men) expect a child to have negative effects on their career prospects.

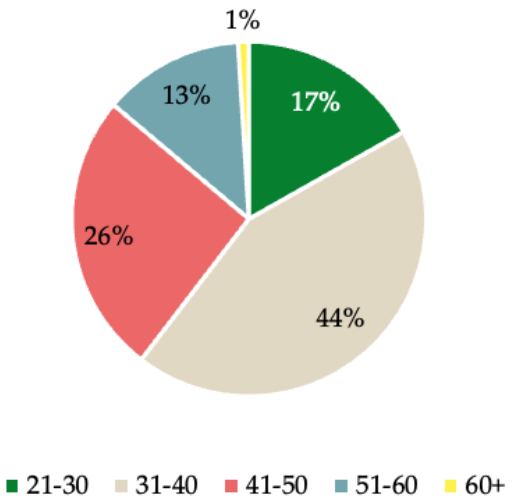
Figure 12. How would the birth of a child affect my career prospects?




*Based on secondary data from the Federal Statistical Office (FSO, 2024c)*

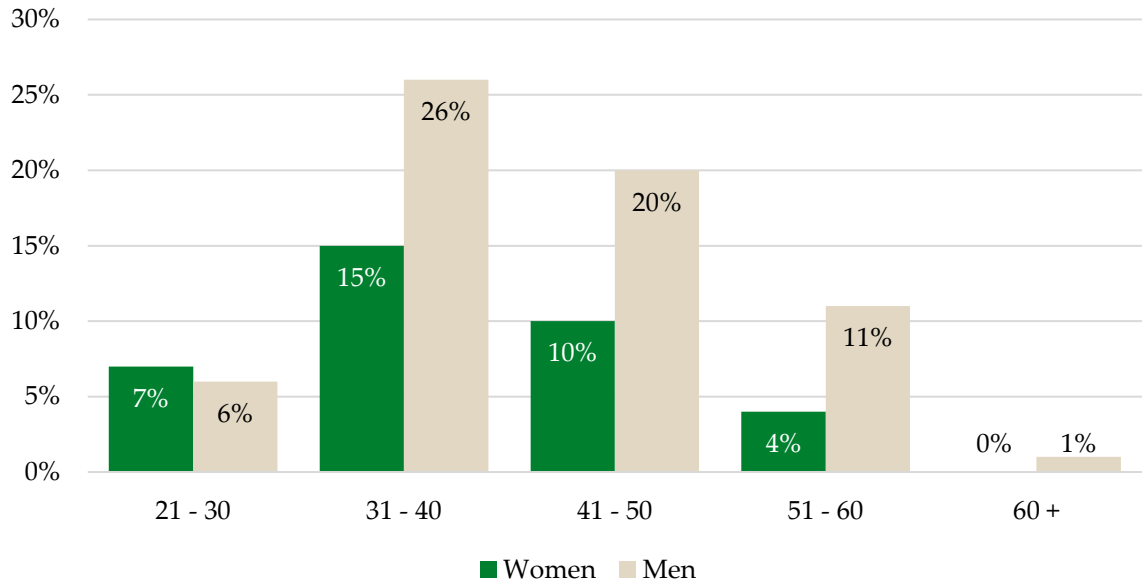
These fears are well-founded: According to our unique dataset containing the anonymized HR data of 370,000 employees in 90 public and private Swiss organizations, nearly half of all promotions go to employees aged 31 to 40 (see Figure 13). The message is clear: Those "family primetime" years are also the time to advance your career. In fact, if one does not move into upper management before 40, this is unlikely to happen later. While women have lower chances of entering power positions then men (i.e. positions with personnel responsibility), their chances are best between 31 and 40. That is, while 15% of power position go to women aged 31-40, it is only 10% at age 41-50 and 4% at age 51-60 (see Figure 14). Men are far better off regardless of the age group they are in. This puts women in Switzerland into a unique bind.

Figure 13. Share of promotions by age - all employees




*Based on HSG Benchmarking Data 2024 from over 90 companies in Switzerland. Refer to Appendix for more detailed information regarding the data base and data analyses.*

Figure 14. Share of promotions to power positions across age and gender groups



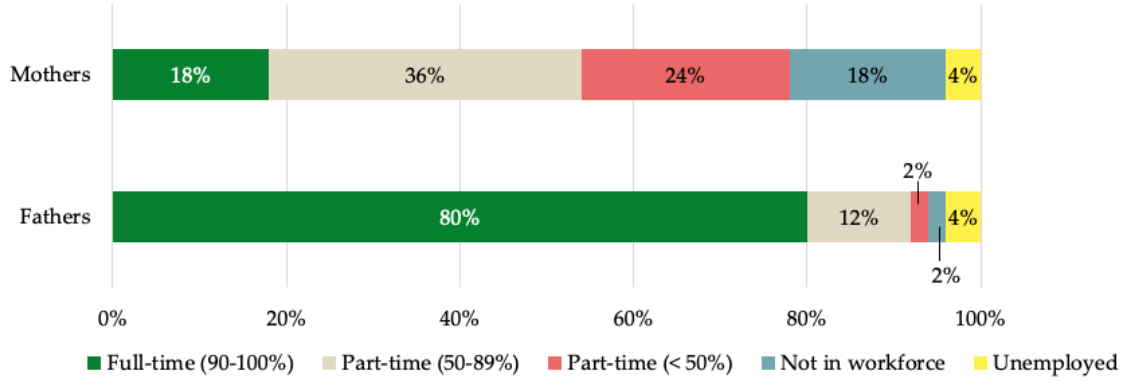

*Based on HSG Benchmarking Data 2024. Refer to Appendix to more detailed information regarding the data base and data analyses.*

**Parenthood upends women's (but not men's) careers**

Traditional care work norms are still deeply entrenched in Swiss society. This explains partly the high maternal age in Switzerland, especially among well-educated women. Once kids are in the picture, Switzerland's mothers do the lioness's share of care work: In 56% of households, mothers do most of the care work; fathers take on the majority of care responsibilities in only 3% of households (FSO, 2023).

Accordingly, it comes as little surprise that many women reduce their paid work percentage once they have kids: Only 18% of mothers with kids 12 and under work full-time, compared to 79% of fathers. 46% of mothers work less than 50% or don't work at all, compared to 9% of fathers (FSO, 2024d). Unfortunately, in Switzerland, part-time work is still a career killer. Employees who work less than 80% make up 12% of all employees, but their share in promotions is at only 5%. Additionally, the mindset, that women still have to choose between career and family, has a negative impact on having children early.

Figure 15. Employment situation of parents with children under the age of 12




*Based on secondary data from the Federal Statistical Office (FSO, 2024d)*

**"Egg freezing is for career women"**

Contrary to what most people think, it is usually not professional reasons that drive women into egg freezing. The most common include (a) lack of the right partner, and (b) desire for conventional parenthood and a genetic relationship to the child (Faas-Fehervary & Busser Weiss, 2024; Schmid et al, 2025). Many overlook that there are other (non-social) reasons for egg freezing. Medical freezing is another term and refers to egg freezing recommended to women before they start their cancer treatment (this is because chemotherapy can negatively alter the oocytes).

Also, most people do not realize that egg freezing may not be a suitable solution for women who've put off dealing with their fertility for most of their 30s. Women's fertility is best around the age of 25, and since the quality of oocytes persists on a high level till the early 30ies, fertility for later family planning should ideally be preserved around 33 years of age. The elder women get, the higher is the number of oocytes (eggs) that are genetically abnormal. The current legal limitation of cryopreservation (i.e., freezing and storing eggs) for 10 years should also be taken into account when deciding for fertility preservation. As maternal and fetal risks strongly increase after age 46, pregnancy should ideally be realized before (Sheen et al, 2018).

In short, we should empower women to plan their fertility journey proactively in the way that is best for them. The government and employers play a key role in bringing this reality about.

**What can we do?**

- ✓ Employers can only benefit from broadening the career window beyond the "family prime time", making promotion optionable for men and women of all age groups. The following actions can help make it a corporate reality:
  - Analyze what promising diverse talent you lose by restricting key career steps to employees in their 30s, in order to make the business case for change. Support equal parental leave for all employees, regardless of gender.
  - Set diversity targets for promotions over 40. Encourage women (and men) who reduced their employment percentage because of the family prime time to increase it again at later age (e.g. around 40) and combine it with a promotion perspective based on concrete performance criteria.
  - Utilize all possible communication platforms to make diverse career paths visible. Identify and increase visibility of role models across hierarchy levels that share their best-practices at the work-family interface

- Offer flexible, lifecycle-oriented career paths that fit the diverse needs of employees, including employees undergoing fertility struggles. E.g.: opportunities for sabbaticals, temporary reductions in employment percentage, lateral internal moves, etc.
- Position family planning and parenthood as a normal part of men's and women's careers by…
    - … actively encouraging men to take their full parental leave and to take on an equal share of care responsibilities.
    - … actively managing parenthood and fertility, sensitizing and training your HR and line managers to support parents on their team.
    - … offering women and men in the rush hours of life the chance to keep key positions in job-sharing models or to remain in the company with a lower employment percentage for a time, while remaining in the talent pool. Encourage them to play an active role in this process through, for example, task crafting (e.g. temporarily dropping, adding or changing the nature of current tasks and responsibilities from the job description).

✓ The government needs to create incentives for employers (especially for small and medium sized businesses) to offer solutions for their employees (e.g. longer parental leave for men, paid time for fertility treatments, a fertility allowance that similar to the already existing maternity allowance could ease the burden on smaller employers and to empower them to support their employees the best they can).

✓ Last but not least, the public should push for the necessary legislative changes described above to provide legal protection and support for parents and the growing number of people undergoing fertility treatment.

## 5.4 "We already provide our employees with the flexibility they need."

Employees with fertility struggles take on considerable "reproductive work" alongside the demands of paid employment. Challenges are varied, complex, and highly dependent on individual circumstances, but range from the physical and psychological, the logistical, to the social and financial. Employers can support their affected employees or make their life even more stressful (Wilkinson et al., 2023). Yet, few employers in Switzerland have fertility policies or provide any other kind of direct support to employees who struggle with infertility. There are also no legal support structures protecting people undergoing fertility struggles from discrimination at work.

**Family-friendly policies apply after the child is born, but not before**

Very few companies in Switzerland offer specific support to their employees undergoing fertility struggles. To our best knowledge, 2 companies in Switzerland offer financial fertility benefits (e.g. reimbursement of fertility treatments up to 40.000 CHF), and a small handful offers other forms of support, such as webinars on fertility, counselling, or specialist consultations. In contrast, most companies offer support for pregnant employees or new parents. This is supported by our annual survey study involving 90 D&I and HR professionals from major companies and organizations in Switzerland, which shows that 65% of employers support childcare for their employees (e.g. subsidize daycare or even offer their own childcare facility), 53% offer support for parents (e.g., coaching or the ability to reduce responsibilities and / or worktime for a certain amount of time), and a third have employee resource groups or

networks for parents (Implemented D&I Measures Questionnaire, 2024). Legally, pregnant employees are protected from termination and have the right to 14 weeks paid maternity leave.

Employers who offer financial support observe positive reactions from their employees (e.g. *"Just fantastic! I hope the program will be progressively extended to some more countries. Proud to be part of this company!"*).[4] In times of unprecedented skills shortage in the Swiss labor market, more companies should consider taking action when it comes to fertility support.

But: Not all fertility support policies are created equal. In the last ten years, companies like Google or Meta made headlines by offering to pay for their female employees to freeze their eggs. This can incentivize employees to further delay family planning and undergo a painful medical procedure that might simply not be medically necessary.[5] Paying for employees' egg freezing also does not address any of the underlying structural causes for why so many women delay having children. Company leaders we interviewed emphasize the importance of approaching fertility and family planning holistically:

- ✓ Promote an organizational culture that supports starting a family (e.g. through measures that reduce stress)
- ✓ Adapt career paths to different life phases: For example, enable employees to temporarily reduce their employment percentage or relinquish some of their responsibilities for a certain amount of time. This could be attractive for new parents or employees struggling with family planning.
- ✓ Widen the career window and empower employees under 30 and over 40 to take significant steps.

> *"Employers and managers have a responsibility to offer the right family friendly framework conditions. Right now, there is barely any active support for employees when it comes to family planning. The role of the manager is to be close to the employee, provide support even in difficult life situations, enable a proper work-life balance, re-entry after pregnancy."* Company leader

**Existing flex work options are insufficient**

You might be tempted to think: Flex work is the new normal in the Swiss workplace, and that should be enough to meet the needs of employees struggling with fertility. And yes: at least on paper, flexible work *is* the norm in Swiss workplaces: All companies included in our HSG Benchmarking sample offer the option of at least some remote work. 93% offer flexible working hours. 44% provide the possibility to purchase additional holidays.

But: Do the available flexibility policies meet the needs of employees undergoing fertility treatments such as IVF? In days prior to egg retrieval, medical appointments are frequent and often impossible to plan in advance: *"The hospital gives you a time and you cannot say no and get another time slot"*.[6] During the

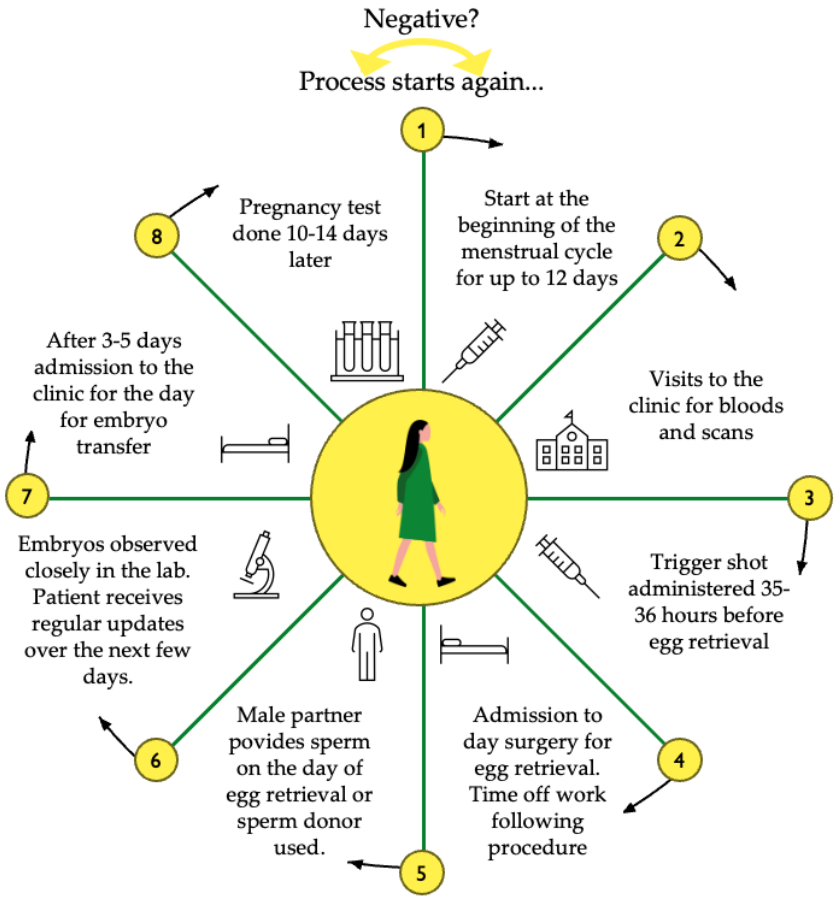
[4] Based on employee responses to an employers' social media posts about financial support for fertility treatments.

[5] As Switzerland limits the length of time to store frozen eggs to ten years, some women are freezing their eggs too early to meaningfully extend their "fertile window."

[6] Taken from the interview with a former IVF patient

preparatory phase of the fertility treatment women might experience moodiness. The preparatory phase is followed by a 9-13 day long stimulation phase, where each evening medications to support follicular maturation are injected. During this time side effects are few. Overall, the effects of medication increase up to the egg retrieval and may cause presenteeism (going to work when you feel sick) and lower productivity if the patient must continue working without any accommodations. After the egg retrieval, women receive regular updates on the egg or embryo development. At some point, they also receive the most stressful and eagerly awaited update about the pregnancy status, all of which is psychologically very challenging. Pregnancy news will reach 35-40% of women who started treatment. Of those, around 20-30% experience miscarriage. This implies that about 28-32% of women who started treatment become mothers. The longer-term effects of failed IVF attempts are especially costly including higher risk of depression and marital problems (Filetto & Makuch, 2005). These are particularly strong when no sufficient support is provided before, during, and after the treatment.

Figure 16. Process of a typical IVF cycle




*Based on Fertility Matters at Work (https://fertilitymattersatwork.com) and expert interviews conducted for the purpose of this white paper. Please note that this is a one possible scenario for an IVF cycle and that it may vary depending on the individual, the medical team, the country in which treatment is conducted etc.*

Fertility treatments such as IVF require full flexibility to choose and plan a working day during a treatment cycle of about 2 weeks (with limited or no business travelling). Increased flexibility is critical to stress management during the treatment. 19% of women who have undergone IVF say that the most

difficult aspect of balancing IVF treatment with work is being forced to take time off for appointments (Zurich UK, 2022).

A large-scale survey in the UK revealed the following forms of support as particularly helpful (CIPD, 2023):

- ✓ Paid time off to attend appointments
- ✓ Understanding from your manager that it can be a challenging time
- ✓ Paid compassionate or other special leave
- ✓ Flexibility of working hours
- ✓ The option to work from home when needed.

Of course, an employee embarking on their fertility treatment journey may not know yet how they will feel, and what they will need at what point. Ideally, according to an interviewee who underwent IVF treatment while working, you would *"leave people to decide how much they work depending on how they feel,"*; *"there might be last-minute changes in work ability," and during some parts of treatment, employees might need "full flexibility in the two weeks of the cycle."*[7] And remember: The legal status of infertility in Switzerland is not clear-cut. Many employees undergo these processes while very much doubting whether their employer considers their ordeal a legitimate medical issue.

**Presenteeism, performance, and attrition**

From a business perspective, it is in companies' best interest to take fertility seriously. If employees undergoing fertility struggles are not supported, this will have negative effects on employee absence, presenteeism, performance, engagement and retention. For example: A 2023 survey in the UK found that 18% of people undergoing fertility treatment ended up leaving their jobs because of the impact of fertility treatment (Kearns et al., 2024). In the Fertifa and Fertility Network UK (2003) survey, 75% of respondents said that their productivity at work was strongly impacted by fertility challenges, and yet more than a third said they received little to no support from their employer. 63% of participants in a staff survey on women's health in the workplace (also in the UK) also highlighted productivity issues, saying they struggled to focus, concentrate or prioritize tasks at work whilst undergoing fertility treatment (Wilkinson et al., 2023).

> *"Employers should support employees who have children, want children, make it conducive to have children. Reproductive leaves would give support and visibility, and stops it being seen as a private matter."* Scholar of fertility law

**A legal framework is necessary to create a fair playing field**

Currently, only three countries (Malta, Korea, and Japan), offer paid leave and/or protection from discrimination for at least some workers (Kearns et al., 2024). Leaving support to the discretion of individual employers is problematic and could well contribute to increasing levels of "reproductive stratification where some people are empowered to nurture and reproduce, while others are disempowered purely based on where they work (Wilkinson et al., 2023).

[7] Taken from the interview with a former IVF patient

*"I think the state should take the responsibility for supporting people who are in undergoing fertility treatment. If the right to fertility leave or reproductive leave is given directly by employers, you would have the state not taking the active role that it's supposed to take, and you would also have differential treatment. So you would have a stratified access to this kind of leaves or to assisted reproduction, because depending on where you work, you might have access to it, or not. That's unfair."* Scholar of fertility law

**What can we do?**

- ✓ Employers or employer associations should develop a formal family and fertility policy so that employees know immediately what support is available. It should be possible to take advantage of these options without line manager or others at work knowing. The policy could cover selected or all points below:
    - Accurate and effective information about fertility and fertility treatments that can be accessed anonymously (e.g. online webinar that can be joined live and/or downloaded later). Combine it with other fertility-related topics like menopause.
    - External counselors and/or medical services that can be contacted anonymously and spoken to under confidentiality. For example, these could be the medical services to which a) employees disclose their infertility issues and treatment and b) contact line managers to inform them of employees needs for more work flexibility because of medical treatments. It should be up to the employee to decide whether the type of the treatment is shared.
    - Unpaid leave for persons with fertility issues (including severe side effects of menstruation and menopause) and/or undergoing fertility treatment. It is important that this option is also available after the treatment (particularly in case of a failed treatment).
    - Flexible working options (e.g. full flexibility in planning a workday, home-office, and limited or no business traveling during the treatment; let people decide how much they want to work on certain days of fertility treatment).
    - Flexible career planning (e.g. shared leadership positions, job crafting).
    - Financial support for child-care.
    - Financial support for fertility treatments: Support egg freezing when oocyte quality is high and educate why egg freezing before the age of 35 is relevant and why doing this in the mid-20s might be too early (mostly because of the current 10-year freezing and storage period). In case of the latter, inform about alternative options (e.g. fertility check and early consultation with medical services).
- ✓ Supplementary processes and policy measures should be in place to increase the actual take-up of available fertility support, such as:
    - Employees' performance gets measured based on output and clear goals rather than physical presence and the number of hours worked.
    - There are processes in place to track output, progress, and performance when working remotely or flexibly.
    - Line managers are trained in how to effectively communicate with employees working remotely or flexibly. It is important that they "check in'" with employees rather than "check up" on them.
    - Role models who challenge outdated work norms, such as fathers in leadership positions taking equitable parental leave or working part-time, are made visible. This helps to create a narrative for employees to connect to; makes the issue feel like a legitimate issue to raise at work; and will raise awareness in line managers and colleagues. In the longer-term, it will help to create a culture of understanding and caring and peer-to-peer support.

- If work is organized in shifts, there needs to be a flex pool, that is, a group of flexible, deployable internal and/or external employees who can jump in when needed. For example, in case of a temporary leave due to treatment or temporary reduction of the employment percentage.

✓ The federal government needs to level the playing field for all employees as much as possible. This includes the following action areas:

- Legislative change to mirror provisions for maternity in the workplace
- Clarifying the legal status of infertility vis-à-vis illness / pregnancy so that there is no question about the right of paid time off for doctors' visits and other reasonable workplace accommodations.
- Explicit protection from discrimination due to fertility struggles.

*"The problem is, even if you introduce a type of leave, if workplace culture doesn't change and the person who has the right to take the leave doesn't feel that it will be safe for them to take the leave because there would be negative repercussions at work … then we'd be back at step one."* Scholar of fertility law

## 5.5 "Infertility is something I would rather not talk about (at work)."

Miscarriage and unfulfilled desire to have children are taboo subjects that few people talk about, to the point where the stigma attached to them is even stronger than to sex or menstruation (Fertility Survey, 2024). This extends to the workplace: A survey conducted on behalf of a fertility center in Germany shows that more than 50% of their clients cannot (or choose not to) talk openly with their employer about their wish to have children or fertility issues (Family Forward, 2024). In a recent survey in the UK, less than a half of those who are undergoing fertility treatment revealed this to their boss and believed this was a taboo topic in the workplace (CIPD, 2023).

**To disclose or not to disclose?**

There are many reasons why women and men would not want to disclose that they are undergoing fertility treatment. Pregnancy and having young children are still a "career killer" in many Swiss companies. Research has long shown that mothers are penalized in promotion processes and recruitment for management positions (Heilman & Okimoto, 2008). The "maybe baby" bias affects even women without children: Women in their early 30s are viewed as a riskier choice and a potential (pregnancy) "inconvenience". Men are hired more often as the "safer option" (Gloor et al., 2018; Peterson Gloor, 2022). Consequently, childless women between the ages of 25–39 are more likely to receive temporary contracts, shorter job tenure, and / or rejections for long-term, permanent positions with good benefits.

A survey in the UK asked 131 women who chose not to disclose their fertility struggles at work why they didn't. The most common reason cited was a desire for privacy, with 64% preferring not to share the matter. Additionally, 30% of individuals were apprehensive about having to disclose an unsuccessful fertility treatment. Meanwhile, 27% felt there was too much stigma surrounding the topic, and 26% expressed concerns about its potential impact on their career (CIPD, 2023).

But: Keeping silent at work comes at a real cost in terms of stress, unexplained decreased productivity / quality of work, and a feeling of isolation from colleagues to name just a few (ibid). The infertility disclosure dilemma may well become more pressing throughout the IVF treatment cycle. As patients

advance through the cycle (see the process of a typical IVF cycle above), the compatibility between work and private life becomes challenging to almost impossible. Non-disclosure has significant costs and risks for the employer, too: As previously elaborated, conducting "business as usual" while undergoing fertility treatment can lead to presenteeism and high turnover rates, among other negatives.

Disclosing fertility struggles to your employer requires a safe space and a culture of trust. Women can be at a career disadvantage simply because their employer suspects that they might want to have children in the near future (Peterson Gloor et al., 2022). In fact, one third of women who have recently undergone IVF treatment in the UK believe that disclosing their fertility treatment would put their job at risk. 26% believe that their commitment to the job would be questioned. 16% are worried to be sidelined for work project. 23% anticipate negative consequences on their career advancement (Zurich UK, 2022). A prominent recent UK survey found that 24% of people who told their boss they were going through fertility treatment experienced unfair treatment as a result (Pregnant then Screwed, 2023). Consequently, many feel they have no choice but to keep their (in)fertility status a secret. The recent decision of a Swiss insurance company to provide extra time off for fertility treatment and after the miscarriage must thus have met with a very positive response of both persons affected and their spouses (Tages Anzeiger, 2025).

Opening up to an unreceptive, unsupportive manager can exacerbate stress levels and feelings of isolation. Disclosing fertility struggles to an employer is a complex decision and for some might simply not be an option. In short: Lonely fertility journeys benefit neither employer nor employee, but far too few workplaces create the kinds of cultures of trust and structures that might empower their employees to be fully transparent without fear of negative repercussions.

> *"It's a really difficult subject to talk about even with your own family. Imagine how hard it is to talk to your employer about it."* Swiss parliamentarian
> *"Leaders should know that people undergoing the treatment are busy with constant checking the medication, being in a very frequent contact with the clinic; there is a lot of emotional things going on (thoughts like "are my eggs growing? Oh – there are not so many eggs"); From the employer perspective, you can help "solve" these issues with more flexibility and time off."* Former IVF patient
> *«Reducing stigma and creating more awareness; Prevent lonely journeys; Failed attempts are something that we do not talk much about; This all is needed to prevent lonely (in)fertility journeys."* Company leader

**Leaders lack knowledge about (in)fertility**

Yes, it is hard for employees to open up to their managers about their fertility struggles, but it is also really hard to find the proper words and actions in response to such a sensitive disclosure. Only 35% of people with lived experience of fertility treatment felt their manager understood how to support them and only 7% felt that HR had a good understanding of fertility journeys and understood what they could do to help (Wilkinson et al, 2023).

Leaders, like most people, have little knowledge about (in)fertility and fertility treatments, making it difficult to respond constructively to fertility disclosures in one-on-one meetings with their subordinates. It is a great shame as a constructive response to disclosure is key to developing effective solutions together.

> *"People undergoing treatment have a higher risk of psychological problems. Employers have a responsibility to support their employees in such situation (also because they don't want any long-term consequences).*

> *However, this assumes that the employer knows that their employee is undergoing treatment; the latter does not have to be the case, however, because it is up to the employee whether he/she informs the employer. Ideally, employers say: We support you and want to keep you: This is an illness like any other and our support is there (compatibility between work and private life; further support similar to other illnesses where people are undergoing treatment).*" Researcher on fertility treatment and care

Leader responses may vary depending on how they perceive their leadership role. Is it part of my job to talk about these issues and offer working arrangements that go beyond of what we already offer in terms of remote workplace and flexible working hours? Most employers in Switzerland answer the latter with "no" which explains why their family-friendly policies apply after the child is born and not before (D&I Measures Questionnaire, 2024).

Companies need to work on framework conditions that can empower their employees undergoing fertility treatments and on supporting their managers to support their affected employees. Then, there are creative solutions, too: A former IVF patient and company leader suggest a scenario in which employees can disclose their (fertility-treatment related) needs to a third party within their company (e.g. medical professional) who then communicate with the line manager without disclosing the underlying issue.

> *"Role of leaders during fertility journey; Awareness (should be done through the organization); Topics like how you support women or couples going through fertility treatments in terms of understanding (doctor appointments, being under effect of strong medication/hormones which really affects people under treatment, the necessity to take time off, not being able to work 100% even in the time when you are present); This understanding is more likely to be given for women with small children ("my kind is sick and nobody questions this") but it is not that obvious for women undergoing a fertility treatment; A lot more can be done to support people throughout the treatment and making it less painful and difficult."* Former IVF patient

**What can we do?**

- ✓ In addition to building public awareness for infertility and working towards breaking the taboo, managers greatly affect the well-being of their subordinates planning a family and/or undergoing fertility treatment. This starts at the top: Leaders should communicate clearly that they recognize that family planning and fertility treatments are major life events that are likely to impact employees' well-being and work performance.
- ✓ Employers should empower employees to disclose fertility challenges, if they feel safe to do so. How might this look in practice?
    - Introduce a tool to help employees decide whether or not to disclose their fertility issues at work and, if so, to whom. By considering certain statements such as "My manager is very aware of how other people are feeling" or "In my organization, people with health impairments receive a fair assessment of their work performance", they might be in a better position to weigh factors for and against disclosure. The tool could also inform about resources inside and outside the organization that might be relevant regardless of the disclosure status. In addition to fertility treatments, the tool could be used for several other topics that people may feel uncomfortable talking about (e.g. mental health issues). A similar tool is currently being launched by the Competence Center for Diversity, Disability and Inclusion at the University of St.Gallen. More information can be found on this website.
    - For employees that feel uncomfortable sharing with their manager, organizations should have mechanisms in place to get help and advice anonymously, for instance, through a designated ombuds office or external partner.

- ✓ Employers should clearly define expectations how and to what extent support for employees with sensitive (medical, psychological…) issues is part of leadership. Formal leadership principles can provide guidance and signal that this is a priority for the organization. To ensure sustainable change (for instance, with regards to fertility issues), the following actions could be taken:
    - Offer leaders trainings where they learn the skills necessary to have sensitive conversations with their employees (e.g. leading effective one-on-one meetings; showing constructive reactions to disclosure messages).
    - Educate managers on fertility issues, especially as they pertain to the workplace: Leaders should be aware of the prevalence of infertility issues and treatments, how they impact well-being and work performance, what it implies to go through a fertility treatment, and what services are available within and outside the company.
    - Employers should hold their leaders accountable for creating a culture of psychological safety (e.g., everyone feels safe to disclose and share private information with high impact on work performance and does not fear of their career development) (Edmondson & Lei, 2014).
- ✓ Creating safe and inclusive work climate involves all employees. Everyone in the organization should be encouraged and empowered to make a positive contribution. To support this, employers could offer trainings that foster peer-to-peer support. This could look similar to the mental health first aid trainings for all organizational members that provide some basic practical knowledge and skills to support a person who may be experiencing a decline in their mental well-being (MHFA, 2025).

# 6 What would happen if…?

To make fertility treatments accessible to all who need it, provide them with the necessary support and create widespread awareness of the issue, will require action to be taken by employers, the government, and individuals, like you. To inspire you to get involved, imagine what it would look like if...

- … Switzerland had a comprehensive longer-term fertility plan?
- … both sexual and reproductive health were taught at schools and universities?
- … most women in Switzerland gave birth for the first time at the age of 25?
- … the career window was open to people outside the age range of 31-40?
- … parents and families were given the support they need to care for their children?
- … fertility treatments (e.g. 4 cycles of IVF) were covered by insurance?
- … employees were legally guaranteed the flexibility they needed while undergoing fertility treatment and felt safe to disclose their fertility treatment at work?

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# Appendix

## Data base

This section outlines our data base and analytical approaches for analyses. The data base is a combination of quantitative data and qualitative interview data. The table below summarizes the data base and study samples in more detail.

| **Quantitative data** | |
|---|---|
| HSG Benchmarking Data 2024 | • Anonymized HR data of 370,000 employees from 90 companies and organizations in Switzerland (7% of the Swiss workforce) collected annually by the Competence Centre for Diversity, Disability, and Inclusion at the University of St.Gallen.<br>• 138,000 of the employees are in management positions.<br>• In accordance with Swiss data protection regulations, organizations can collect employee data based on the dimensions gender, age, education, nationality, and language. Data corresponded to the status on December 31, 2023. |
| D&I Measures Questionnaire 2024 | • Questionnaire data from 89 D&I heads or HR professionals from companies and organizations in Switzerland collected annually by the Competence Centre for Diversity, Disability, and Inclusion at the University of St.Gallen. Each specialist reported on e.g. company's DE&I measures that are already being taken or are planned in the future.<br>• Data collected in February and March 2024 |
| Data from Swiss Federal Statistical Office | • Data collected in 2023 as part of "families and generations survey" involving 10,000 people living in Switzerland.<br>• Data on medical practice in reproductive medicine is collected yearly all over Switzerland and is sourced from organizations like FIVNAT, the FOPH, and the EAZW, with monitoring conducted through direct surveys.<br>• 71.6% of women and 73.1% of all Swiss residents are in a relationship, with 71.4% in heterosexual relationships<br>• 2.4% identify as homosexual (based on an online survey by Sotomo between 29.07.2016 and 28.08.2016 with 29,350 recipients). |
| Switzerland Report 2024 | • 623 members of the Generation Z and Millennials living in Switzerland |

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|---|---|
| | • 35% Generation Z (aged 20-26), 65% Millennials (aged 27-37)<br>• 51% women, 49% men<br>• 46% University degree, 38% Secondary education degree, 16% Primary or basic education degree<br>• Data collected via online survey in March and April 2024 by a market research provider on behalf of Merck Switzerland |
| Fertility Survey 2024 | • 1.564 persons living in Germany<br>• 787 women, 777 men<br>• 25-30 years old = 33%, 31-35 years old = 34%, 36-40 years old = 33%<br>• 54% University degree, 28.5% Vocational education degree<br>• Data collected via online survey in May 2025 by a market research provider on behalf of Merck Germany |
| **Interview data** | |
| | 18 interview partners in 14 interviews:<br>• 3 affected persons (former ART patients)<br>• 5 company leaders from various industry sectors such as insurance, IT, finance, biotech.<br>• 2 members of Swiss parliament<br>• 2 physicians (focus: reproductive medicine)<br>• 6 experts (researchers from the fields of gynecology, sociology, psychology, human reproduction, women's health, and legal framework)<br>• Interviews conducted online between November 2024 and January 2025 |

# Approach for analyses

The goal of this white paper was two-fold: First, we sought to identify major misconceptions and attitudes of the three stakeholder groups (i.e. affected persons, employers/leaders, Swiss government) towards (in)fertility and family planning in Switzerland. Second, our aim was to formulate concrete recommendations for action for all three stakeholders. To this end, we have employed a mixed-methods approach for analyses, integrating quantitative and qualitative methods to triangulate results and enhance the robustness of conclusions.

First, in terms of qualitative methods, we conducted 14 semi-structured interviews with 18 individuals from various backgrounds and areas of expertise to capture as wide range of perspectives as possible. The interview data were then coded using a qualitative data analysis software ATLAS.ti (2023, version 23.2.1) and analyzed for common themes. While some of the coding categories were developed prior to the analyses, much of the analyses was inductive in nature and aimed at (a) exploring the data and (b) validating the misconceptions about (in)fertility and family planning that we had identified in a detailed literature review. Overall, we found that most of the misconceptions derived from the literature were addressed by the interviewees. The data and the exchange with the experts helped us better understand some particularities of these misconceptions in the Swiss context.

Second, we conducted descriptive analyses of quantitative data and focused primarily on indicators of central tendency (e.g. mean, median, frequencies) and variability (e.g. range, standard deviation).