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Why has the number of abortions not declined in France over the past 30 years?

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Abortion is a final resort after contraception has failed. When the Veil Act legalizing abortion in France was passed 30 years ago, the frequency of abortion was expected to decrease as modern contraception methods spread. Though the number of unplanned pregnancies has gone down, the number of abortions has not. As Nathalie Bajos and her colleagues explain, women with unplanned pregnancies more frequently resort to elective abortion.

On 21 December 1974, the French Parliament passed the Veil Act, promulgated on 17 January 1975, authorizing elective abortion under certain conditions. The 1974 Act was reviewed after five years and confirmed by Parliament on 31 December 1979. At the end of 1982, Parliament voted for elective abortion to be reimbursed by the French social security. More recently, the Act of 4 July 2001 relaxed certain provisions (see box).

The 1974 vote reflected the trend of public opinion, which had gradually come round to the idea of a "liberal" law giving women explicit freedom to decide for themselves whether their pregnancy placed them in a "situation of distress". Elective abortion is a medical procedure that raises specific ethical and philosophical issues: the right to life, ownership of one's own body, the relation to motherhood and desired fertility, partner relationships, etc. In return for granting women the right to choose, the Act – exceptionally – gives doctors the right to refuse to undertake the procedure.

Viewing termination as a final resort, the legislator hoped that the simultaneous spread of contraceptive use (legalized by the Neuwirth Act 1967 and made reimbursable just days ahead of the Veil Act) would gradually reduce recourse to abortion. But thirty years on, the frequency of elective termination is as high as at the end of the 1970s (figure).

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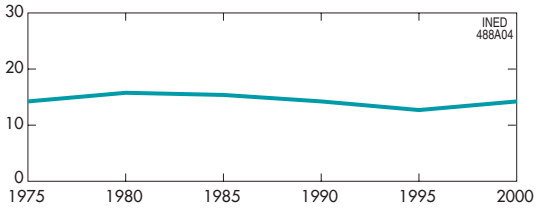
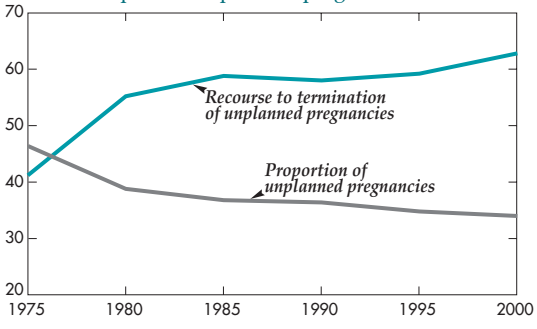
Figure - Frequency of recourse to induced abortion and of unplanned pregnancies in France

a) Annual terminations per 1,000 women aged 15-49



b) Proportion of unplanned pregnancies (per 100 pregnancies) and frequency of recourse to induced abortion (per 100 unplanned pregnancies)



Sources: INED, DREES surveys and yearbooks.

CONTENTS

A paradox: contraception has spread, but the number of abortions has not fallen

So, despite the large-scale spread of medical contraception methods (pill and IUD), the number of terminations has remained surprisingly stable since 1975, with a rate of around 14 abortions per year per 1,000 women aged 15-49, i.e., approximately 200,000 abortions annually (1) (figure). It is estimated that some 40% of women will have recourse to abortion at some time in their life. This overall stability, however, appears to conceal a rise in abortion rates among the under-25s [1]. This does not mean that contraception has no effect on the use of abortion. But it is a complex linkage in which elective termination is the end process in a chain of events, which starts with the woman having sexual intercourse without desiring pregnancy, but failing to contracept, or experiencing contraception failure. Then, if an unplanned pregnancy occurs and she elects for termination, she must access the health care system within the statutory time limit, fulfilling the requirements relating to term of pregnancy, place of termination, etc. In a chain of events like this, stability in the number of terminations may reflect either stability in each link of the chain, or opposing trends that cancel each other out overall.

The number of women exposed to the risk of pregnancy is no higher today than in the 1970s: age at first intercourse has fallen only slightly [2], while the frequency of sexual intercourse and the proportion of childless women have both remained stable. More widespread use of modern contraceptive methods has led to fewer women being exposed to the risk of unplanned pregnancy than a few years ago. In 1978, 52% of at-risk women used a medical method of contraception (pill or IUD), versus 82% today [3]. The result has been a drop in the number of unplanned pregnancies, which accounted for 46% of pregnancies around 1975, 36% fifteen years later, and 33% today (figure) (2).

Greater frequency of abortion in cases of unplanned pregnancy

Assuming that the change in conditions of access to termination is demand-neutral, the largely stable abortion rates would appear to reflect an increased propensity to terminate in the event of unplanned pregnancy. Where four in ten (41%) unplanned pregnancies ended in termination in 1975, the proportion is now six in ten (62%) (figure) [3]. The trend appears particularly marked among very young women: despite a significant decrease in conceptions, their frequency of terminations has risen in the past ten years [4].

This changing pattern of termination is taking place against a background of changes in women's status, characterized by sharply rising school enrolment and labour force participation rates. Contraception and, in the event of contraceptive failure, recourse to termination, have given rise to a paradigm shift from unwilling to elective motherhood, thereby helping to redefine both female and male parenthood. Children must now be "scheduled" in a stable emotional context, and at the right moment in the parents' career paths. Moreover, unplanned pregnancies no longer occur in the same circumstances as hitherto. There is a higher frequency of non-conjugal sexual intercourse, while age at first childbirth has risen, averaging 9.5 years after first coitus compared to 5.5 years 25 years ago. Couples are also more often subject to periods of socioeconomic instability, affecting women in particular. A reasonable inference might be that the new reproductive norm and changing socio-emotional experiences have combined to produce an increased propensity to abortion in the event of unplanned pregnancy. This statistically cancels out the effect of the rise in modern contraception methods which has reduced the number of accidental pregnancies.

Box

Main changes introduced by the Act of 4 July 2001

- pre-termination consultation made optional for adult women;
- legal limit extended by 2 weeks (to 12 weeks pregnancy or 14 weeks amenorrhoea);
- prescription of RU486 (abortion pill) by GPs permitted in certain circumstances;
- parental authorization for under-age girls no longer compulsory, a referring adult must be present;
- GPs authorized to prescribe contraception for minors without parental consent.

At-risk women or abortion-risk situations?

The information recorded in termination forms (3) can be used to construct a broad socio-demographic profile of women who have recourse to termination [1]. The rate of recourse to abortion first rises with the woman's age, peaking at 20-24 years (27.4 per 1,000), and declining thereafter. All social status categories are concerned. The (relatively few) women who repeatedly have recourse to termination appear to be experiencing specific emotional, economic and social problems [6].

(1) France is on the European average, below the Scandinavian countries and eastern Europe, but above the western European countries, especially the Netherlands, where the annual rate is 7 per 1,000.

(2) Widespread use of condoms (often without the pill) in the early days of sexual activity might, however, involve more failures in the early months of use [5].

(3) The 1975 Act, which is still in force on this point, requires a form to be completed for each termination, giving a number of socio-demographic and medical particulars.

Table 1 - Women's contraceptive status at the time of the conception resulting in subsequent abortion (around 1998)

Contraceptive status	%
No contraception	28.1
Pill	23.1
IUD	7.0
Condom	19.3
Natural method	19.1
Other method	3.4
Total	***100.0***

Source: Cocon Survey 2000

Note: the Cocon survey was conducted with the support of INSERM, INED and the Wyeth-Lederlé laboratory.

At the time when the unplanned pregnancy which ended in termination occurred, 28% of the women were not using any method of contraception, 22% used a natural method, and 19% condoms (table 1). But failure may occur even with reputedly effective methods: 23% of women were on the pill, although in six in ten cases the failure was attributed to forgetting to take it.

The reasons for contraception failure are varied [3, 5]. Over and above the problems of information and access to contraception for some groups, and uncertainty about whether the pregnancy is wanted, certain women – young girls in particular – are slow to adopt contraceptive practices because of the absence of social recognition of their sexuality. Another cause of failure may be use of a method that is inappropriate to the conditions of the woman's social, emotional and sexual life. The prevailing contraceptive norm in French society is condom use at sexual initiation, followed by the pill once the relationship has become stable. Oral contraception becomes the method of choice once sexual life has become – or is deemed to have become – stable, while the IUD is prescribed only when desired fertility is completed [3]. Far from disappearing, this norm has been further reinforced over the past decade. But the social rationales that govern women's lives do not necessarily square, at a given point on their personal life course, with the demands of this norm. So, the pill – theoretically the most effective of all means of contraception (apart from sterilization and implants) – is not necessarily the most appropriate for women with an irregular sexual life (it is difficult to take daily protection against a non-daily risk), or whose lifestyle is incompatible with the strict daily routine of oral contraception. This raises the question of how lifestyle is taken into account at the time of prescription. Giving women real ownership of their choice of contraception would surely narrow the gap between a method's theoretical and practical effectiveness

Another important point is the fact that one in two women who underwent elective abortion had changed their contraceptive status in the 6 months preceding the intercourse which resulted in the termination. This suggests that special attention should be paid to the phases of contraceptive transition, i.e., the starting, stopping or suspension of a particular mode of contraception. Finally, recourse to emergency contraception after failure of a traditional contraceptive method remains infrequent [3], and it is too soon to tell how its spread will affect recourse to abortion.

A decision that takes account of the emotional and material context

When the unplanned pregnancy occurs within a stable emotional relationship, the woman almost always informs her partner (97% of cases), and eight times in ten the partner agrees with the decision to be taken. In the event of an unstable relationship or relationship breakdown, 17% of partners are not informed. When they are, there is agreement in 56% of cases, and where there is disagreement, it is more often the woman who wants the termination.

The social rationales underlying the termination decision depend on the life-cycle stage. For women under 25 for example, being in formal education is a decisive factor. This conclusion is borne out by many other research findings which show that in industrialized countries, early motherhood is an impediment to further education, and hence to a successful future entry into working life. Conversely, where remaining in education is not a profitable investment, the choice of early motherhood may be a way of acquiring social status and identity; the same holds true with regard to the partner's educational level. Likewise, termination may be a way of deferring unduly early motherhood for women at the start of their career. At ages 25-34 – the usual age of childbearing – the emotional factor appears decisive; for mothers of two or more children, termination is clearly the way to avoid a "surplus" birth; finally, among women aged 35 and over, the career factor seems to be as decisive as the emotional context.

Finally, the abortion decision reflects not so much "selfishness" – the woman terminating her pregnancy merely because it occurs at an inconvenient time – as a concern for the conditions into which the child will be born. It is therefore about women's and men's ability to engage with parenthood in a context where the relational and material factors enable them to confront the uncertainties of life.

A health care system that offers far from satisfactory service

For the medical profession, pregnancy termination is a procedure that brings little job satisfaction.

Whatever the technique used (surgical, and even more so drug-induced), the procedure itself is seen as presenting no particular scientific or technical challenges, and is mostly entrusted to non-tenured doctors. The difficulty of recruiting medical and paramedical staff is not simply the consequence of falling numbers of obstetric gynaecology specialists. It reflect the failings of the system for handling terminations in France, recently highlighted through an analysis of care provision [7]. The problems faced by some women due to inadequate provision are compounded by a lack of support: the access pathways to the care system can be excessively complex. General practitioners faced with a request for termination appear to be less well-informed than specialists about the administrative procedures involved [3]. But the problems some women meet cannot simply be put down to ill-informed professionals, because their response also reflects their perception of the legitimacy of the women' requests [5]. Women are still too often made to feel guilty by health professionals.

Before the Act of July 2001 came into force, several thousand women each year were forced to go abroad for terminations after the legal deadline of 12 weeks (now 14) of amenorrhoea. These women were acutely aware of the stigma of going away to a country where abortion is legal, to have done something that was illegal in their own country, and felt the situation to be unjust. The official procedures, and for some women, the cost, added to the difficulties of the termination experience [5]. It is not yet known exactly how the situation has changed since 2001, but the reactions of some health professionals when the bill was voted in Parliament do not bode well. It is also not known whether allowing GPs to provide non-surgical abortions, authorized since July 2004, will alleviate hospital bottlenecks for surgical terminations.

* * *

The legalization of abortion in France, as in other countries, has substantially improved the health care conditions in which termination is performed, producing an impressive reduction in serious complications and deaths: there is now less than one abortion-related death a year in France (0.3 deaths per 100,000 terminations) [8].

Furthermore, legalizing abortion has had no demographic impact. French fertility dropped sharply from 1964 to 1976. But in the past 30 years, the desired number of children, and the number of children per woman, have remained unchanged.

While public opinion is very largely in favour of legalizing abortion, the conditions of application of certain provisions of the law still call for ongoing support. Anti-abortion movements are active in France, and even more so in other countries (the United States, in particular), though their violent methods have been punishable by law since 1992. For these minorities, the moral case against the principle of termination brooks no argument, and their aim is to throw liberal laws into question. Some doctors are also ambivalent, either on principle or with regard to specific statutory provisions. On balance, however, the real fear is not the abolition of the right to abortion but rather a steady decline in care provision for women wishing to terminate pregnancy.

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