Number 646
July-August 2026

Population & Societies

Approximately 1 in 5 women in France will experience miscarriage during their lifetime

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Not all pregnancies result in the birth of a child. Some, such as in the case of miscarriage, are interrupted spontaneously. How do we define miscarriage, and how is its frequency measured within the population? Does miscarriage risk vary by age or education? What is women's experience of the medical care they receive? Drawing on multiple complementary French data sources, the authors address these questions.(1)

Miscarriage, that is, spontaneous early pregnancy loss, is frequent but remains under-researched. A miscarriage can permanently impact the lives of those affected. The medical treatment of these miscarriages is also a topical issue: the French College of Gynecologists and Obstetricians (CNGOF) is currently revising its guidelines on the care of first trimester pregnancy loss. In this article, research by the Social Inequalities in the Risk and Aftermath of Miscarriage team (SOC-MISC) offers new information on the subject.(2)

What is a miscarriage?

In everyday language, 'miscarriage', or '*fausse couche*' in French, refers to the spontaneous, early loss of a pregnancy. The French expression—which translates literally as 'false birth'—has come under scrutiny (Box 1) since it may suggest that the pregnancy is not real or that the sense of loss is unjustified; similarly, the corresponding English term 'miscarriage', if interpreted literally, might imply that the pregnancy was carried incorrectly, or that the mother did something wrong. However, these respective terms are used here because they are the most widely understood forms in each language and encompass the broadest range of experiences. In France, the definition of miscarriage has evolved over time: between 1993 and 2001, spontaneous pregnancy losses occurring up to the 28th week of gestation (counted from the first day of last menstrual period) were considered miscarriages. In 2001, the criteria were adjusted to include only pregnancies ending up to the 22nd week of gestation. After this point, they are referred to as stillbirths (in French, *mort-nés* or *mortinaissances*).

Box 1. Evolution of the French terminology

The terminology used to describe pregnancies that end spontaneously before a viable birth is possible has changed significantly over time in France. As early as the 18th century, medicine distinguished '*faux germes*' (literally, 'false germs')—formless masses with no recognizable embryo—from '*fausses couches*', a term then synonymous with spontaneous abortion. This coexistence still persists, in French as in English: while the expression '*fausse couche*' (miscarriage) is widely used in everyday language, '*avortement spontané*' (spontaneous abortion) remains the standard medical term used in the International Classification of Diseases (ICD-10, category O03). Formulations such as '*perte de grossesse*' (pregnancy loss) or '*arrêt précoce de grossesse*' (literally, early pregnancy ending), have appeared more recently; they reflect an intention, firstly, to be more inclusive of the diversity of clinical situations and experiences and, secondly, to differentiate them from other situations such as voluntary termination of pregnancy (abortion) or termination for medical reasons (TFMR, when the pregnancy is intentionally terminated for reasons associated with viability or maternal-fetal health). These terminology changes testify to shifts in social and medical attitudes towards this reproductive event. In the absence of any scientific or clinical consensus regarding these formulations and to respect the variety of individual experiences, we have chosen here to use the common expression—miscarriage—which also has the advantage of encompassing the greatest diversity of experiences.

(1) Data for the figures are available in Excel format in the 'Related Documents' tab on INED's web page for *Population & Societies*.

(2) Acknowledgements: This research was funded by the European Union (European Research Council, SOC-MISC, Grant Agreement No. 101077594). However, the points of view and opinions expressed are those of the authors and do not necessarily reflect those of the European Union or of the European Research Council Executive Agency. Neither the European Union nor the funding agency can be held liable. The authors are also grateful to the Fondation Solimut Mutuelle de France for its support with the project's qualitative research.

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Since 2008, moreover, a late miscarriage (between 14 and 22 weeks of gestation) may be reported to the civil registry as a stillbirth [1, 2].

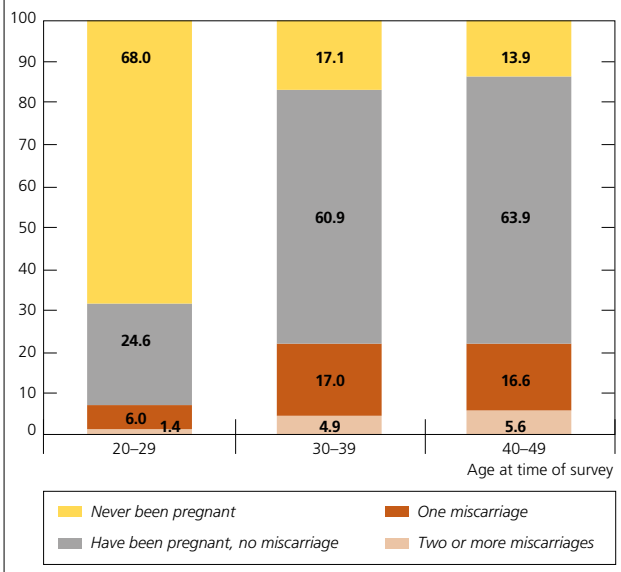
Around 1 in 4 women who have been pregnant report experiencing a miscarriage

The Fertility, Contraception, and Sexual Dysfunction survey (FECOND, 2009–2011) allows us to reconstruct the pregnancy histories reported by the survey respondents. Among women aged 40–49 at the time of the survey, whether they had ever been pregnant or not, more than 1 in 5 (22%) had experienced at least one miscarriage. More specifically, 17% of them had experienced one miscarriage and 6% had experienced two or more (Figure 1). Only 7% of women aged 20–29 at the time of the survey had experienced at least one miscarriage, but more than half of these respondents (68%) had never been pregnant. Lastly, among women aged 30–39 at the time of the survey, 17% had experienced one miscarriage and 5% had experienced multiple (Figure 1).

Overall, among women aged 40–49 who had ever been pregnant, around one quarter had experienced miscarriage.

Different types of data can be used to measure the prevalence of miscarriage, i.e., the share of pregnancies ending this way. Each data type presents its own advantages and limitations, but by combining them we can better quantify this risk.

Figure 1. Distribution of women by experience of miscarriage, by age group



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Guide: Among women aged 20–29 at the time of the survey, 68% had never been pregnant. Due to rounding, the column totals do not always equal 100%.
Source: FECOND survey (2009–2011).

According to the FECOND survey (Box 2), 14% of pregnancies reported by respondents of all ages ended in miscarriage (Figure 2); this figure is consistent with international literature estimates, which often place this proportion between 12% and 19% [3]. Furthermore, 8% of these miscarriages are late (beyond 14 weeks of gestation), meaning that 0.6% of all reported pregnancies end in late miscarriage. The large majority of miscarriages identified therefore take place during the first trimester of pregnancy.

Administrative data extracted from the National Health Data System (SNDS) for the 2013–2023 period indicate that around 10% of pregnancies ended in miscarriage; this figure is lower than that of the FECOND study and declines slightly over the time period in question. This discrepancy versus the survey results is explained by the fact that these administrative

Box 2. Data sources

a) The *Fécondité, contraception et dysfonctions sexuelles* survey (Fertility, Contraception, and Sexual Dysfunction, FECOND), 2009–2011

The FECOND survey was conducted from 2009 to 2011 by the French Institute of Health and Medical Research (INSERM) and the French Institute for Demographic Studies (INED) among 5,275 women and 3,373 men between 15 and 49 years old. It covers various topics associated with sexual and reproductive health and can be used to trace the full pregnancy histories reported by the respondents. After indicating the number of pregnancies previously experienced, respondents were asked about the outcome of each of these pregnancies, with one of the categories being '*une fausse couche ou un œuf clair*', i.e., miscarriage or blighted ovum (anembryonic pregnancy). The full questionnaire is available at this link:
https://data.ined.fr/index.php/catalog/61

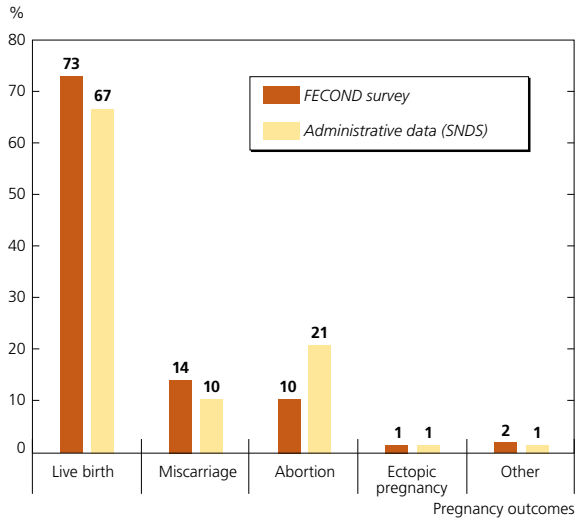
b) Administrative data from the Système national des données de santé (National Health Data System, SNDS), 2013–2023

The SNDS is composed of multiple databases of administrative healthcare records, including the health insurance and hospitals databases (Programme de médicalisation des systèmes d'information [PMSI]). It covers all beneficiaries of the public health insurance system (Assurance Maladie) in France. When a miscarriage results in a hospital stay, it is directly identified in the PMSI using codes from the International Classification of Diseases 10th Revision (ICD-10). Miscarriages that did not result in a hospital stay were indirectly identified by the authors 1) in cases where pregnancy ultrasounds were conducted in the first trimester but not after, and 2) in cases of first trimester pregnancies declared to the health insurance system without resulting in a birth [4]. These data do not, therefore, enable us to identify miscarriages that did not require any medical care. Furthermore, as this information is only available for 2013 onwards, any pregnancy that occurred before that year is not observed. At the time of analysis, data from 2023 are the most recently available.

c) The *Fausses couches et inégalités sociales* survey (Miscarriages and Social Inequalities, FISO), 2025

The FISO survey is a qualitative survey administered in 2025 via semi-structured interviews by members of the SOC-MISC team (INED). It was used to collect 41 interviews with women who had experienced a miscarriage during the last 5 years within metropolitan France. The interviewees were recruited through a call for testimonies publicized in hospital waiting rooms across four departments of France (n = 20), through an advertisement on social media (n = 15), and via the snowball effect (n = 6). This survey aimed to document the diversity of miscarriage experiences in France. It was particularly focused on the individual perceptions and definitions of miscarriage held by those concerned, with the aim of improving miscarriage follow-up in epidemiological studies; on the experience of medical care in order to gain a better understanding of care pathways within the French system; and, lastly, on the consequences of miscarriage on mental health and its medium- and long-term effects.

Figure 2. Distribution of pregnancies by outcome



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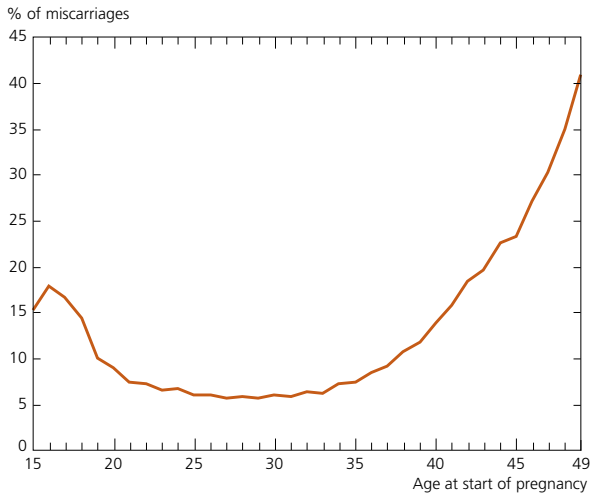
Guide: According to the FECOND survey, 73% of all pregnancies reported resulted in a live birth.

Note: Only one outcome per pregnancy is recorded. The category 'Other' includes terminations of pregnancy for medical reasons (TFMR), molar pregnancies (abnormal egg with proliferative degeneration of the placenta), and stillbirths.

Scope: All pregnancies in women aged 15–49.

Sources: FECOND survey (2009–2011) and National Health Data System (SNDS), 2013–2023.

Figure 3. Percentage of pregnancies ending in miscarriage, by age



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Guide: Nearly 15% of pregnancies in women 15 years of age result in miscarriage, as opposed to any other pregnancy outcome (live birth, abortion, ectopic pregnancy, stillbirth, termination for medical reasons, or other loss of pregnancy).

Source: National Health Data System (SNDS), 2013–2023.

data are less accurate when it comes to identifying miscarriages (see Box 2) but are more accurate at recording abortions than surveys (in which the latter tend to be under-reported) [5]. These two effects result in a lower proportion of miscarriages being observed among total pregnancies in the administrative data than in the survey data.

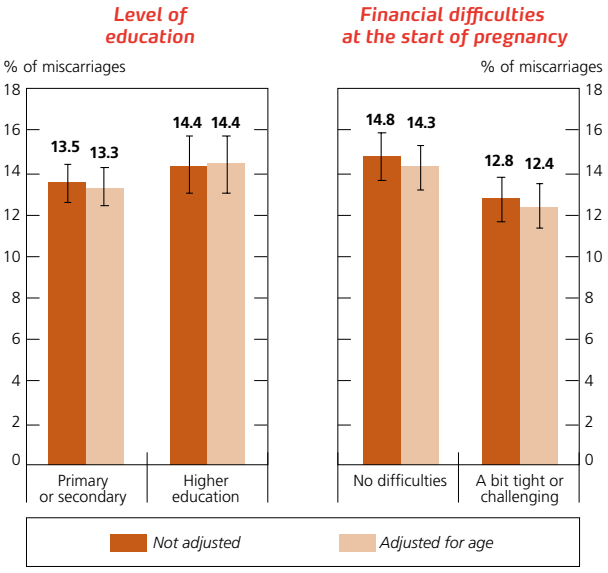
Higher risk of miscarriage before the age of 20 and particularly over the age of 34

Age is the primary risk factor for miscarriage. For this analysis we use the administrative data only, since the population numbers by precise age at start of pregnancy in the survey data are too small. The probability that a pregnancy will end in miscarriage is relatively high in women under the age of 20, reaching over 10% before declining; it then increases again from the age of 34 (Figure 3). This J-curve is consistent with the findings of international literature [3]. Thus, in pregnant women aged 35, 8% of pregnancies identified in the administrative data result in a miscarriage. This proportion reaches 14% of pregnancies at the age of 40, 23% at age 45, and more at older ages.

Miscarriage risk varies little by education or financial situation

According to the FECOND survey, the rate of miscarriage remains at around 14% regardless of women's level of education [6]. Furthermore, pregnancies in women who report facing no financial difficulties at the time of conception have a slightly higher risk of miscarriage than pregnancies in women who did face them, but these differences are not significant. These results are similar whether we take age into account or not (Figure 4).

Figure 4. Probability that a pregnancy will end in miscarriage, by level of education and financial situation



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Guide: Among women with primary or secondary education, 13.5% experience miscarriage. Adjusting for age, the rate for this same category is 13.3%. The bars represent 95% confidence intervals.

Scope: All pregnancies in women aged 15–49.

Source: FECOND survey (2009–2011).

Miscarriage care

International medical standards define three possible approaches to a non-viable pregnancy: expectant (no intervention), medical treatment (primarily with misoprostol), and surgical treatment (aspiration). A miscarriage may also be complete by

the time of the medical consultation. In this event, no treatment is necessary and medical examination can confirm the miscarriage diagnosis.

In France, whether the miscarriage results in hospitalization or treatment by a physician elsewhere, it is covered by the social security system. In practice, very few miscarriages are managed only outside hospital: individuals either go directly to the emergency room or they are sent there by a community-based doctor for confirmation of the diagnosis and/or so that any necessary treatment can be initiated.

Furthermore, the proportion of miscarriages resulting in hospitalization is decreasing. This is not only the case in France but also across other European countries [4], possibly reflecting an increasing preference for the expectant approach or medical treatment, rather than for surgical intervention. The first two options are less invasive and do not require a hospital stay.

Some miscarriages also occur without any medical consultation, but the proportion they represent is difficult to quantify due to lack of data. The qualitative survey Miscarriages and Social Inequalities (*Fausses couches et inégalités sociales*, FISO), conducted in 2025 (see Box 2), shows that some women choose not to seek medical care if the miscarriage occurs very early in the gestation, if they have no doubts about what they are experiencing, or if they attribute the event to a 'natural process' that does not require medical treatment.

Towards better medical care: the beginnings of change

Emergency gynecological care for miscarriage is often considered inadequate by those who experience it. For the very large majority of the 41 women interviewed in the FISO survey, there was a discrepancy between their needs and expectations and the care they received in hospital. For example, they waited in a space shared with pregnant women or women in labour; there was a lack of information about the treatment process and what to expect afterwards—especially during the expulsion of the embryo or fetus—; and no sick leave or referral for psychological support was offered. Finally, clumsy or even hurtful language was used by practitioners, and there was a lack of medical follow-up after the miscarriage.

These findings highlight the need to reassess the care provided in the event of early pregnancy loss. Changes are already underway, both at institutional level and in clinical practice. Since September 2024, a period of sick leave exempt from an initial waiting period (i.e., compensated from the first day of leave) is available to women who have had a miscarriage, but many healthcare professionals remain unaware of this scheme. Furthermore, forthcoming new clinical practice guidelines for miscarriage management, which have been developed with the involvement of the SOC-MISC team, may help to improve the care experience of individuals affected. Lastly, experiencing a miscarriage can have repercussions on subsequent fertility behaviours and intentions, as well as on mental and physical health. These are issues that merit future research.

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Abstract

In France, more than 1 in 5 women aged 40–49 have experienced a miscarriage, that is, 1 in 4 women who have ever been pregnant. Between 10% and 14% of pregnancies therefore end in miscarriage. The risk increases with age from around 34 years but is unrelated to education or financial situation. The emergency medical care provided by hospital gynecology departments is often experienced as inadequate by patients. Recent changes (immediate sick leave) and imminent adjustments (new guidelines for medical practice) mark the beginning of a necessary shift.

Keywords

miscarriage, France, early pregnancy loss, reproductive health, SNDS, FECOND survey, medical care

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INED: 9, cours des Humanités • CS 50004 • 93322 Aubervilliers Cedex • France
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Translator: Beatrice van Hoorn Alkema
Layout: Isabelle Brianchon
Printer: Mérico Delta Print, Bozouls, France
D.L. 3nd quarter 2026 • ISSN 0184 77 83

Population & Societies • No. 646 • July-August 2026
DOI: 10.3917/popsoc.646.0001
Monthly bulletin of the French Institute for Demographic Studies
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