Adolescent Pregnancy in France

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French: abortion · Adolescent pregnancy · Contraception · Double standard of sexuality · First intercourse · Women's liberation movement · Maternal and child health · Sex education · Sexually transmitted infection · Unintended pregnancies

Introduction

Teenage Pregnancy: A Major Public Health Issue?

In France, "teenage pregnancy" refers to pregnancy that occurs before the age of 20. In general, the public perception is that these pregnancies are problematic, regardless of the emotional or social situation of the adolescent girl or boy (Le Den 2012; Le Van 1998). Many French researchers and public health providers use the World Health Organization's (WHO) definition of "adolescence" a person between 10 and 19 years of age. This is a period when adolescents are maturing both physically, emotionally, and socially. There is widespread agreement in France that adolescence is not a good time to become a parent which it is more an adult responsibility (i.e., individuals who have acquired their residential, economic and emotional independence from their family (Galland 1996). Motherhood at a young age is thus seen as a hindrance to the personal development of adolescent girls. Jeannette Bougrab, Secretary of State for Youth, stated in 2012 "Pregnant at 13 or 14 years, this is not normal.[1]" Pregnancy in adolescence is therefore seen as a deviant behavior. This implies that the pregnant or parenting adolescent has not conformed to the standards of French society, thus directly contributing to the stigmatization of pregnant adolescents (Le Den 2012). While teen pregnancy was considered to be a "medical risk" in the 1970s–1980s, adolescent pregnancy today is considered "a psycho-social risk" (Le Van 1998).

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[1] Interview with Jeannette Bougrab: Ados enceintes, Jeannette Bougrab sonne l'alarme, published in lepoint.fr the February, 16th, 2010.

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The media and public officials regularly seize upon this issue and present it as a "major public health issue." To support this position, they qualify as "alarming" the statistics on number of abortion among minors and warn that the number of adolescent abortion is increasing. Roselyne Bachelot-Narquin, Minister of Health, Youth, and Sports in 2010 stated that, "Faced with the worrying resurgence of unwanted adolescent pregnancies, we cannot remain inactive.[2]"

Yet, the demographic indicators show a marked decrease in pregnancies since the 1970s among French adolescents. Births to adolescents 18 years of age and younger decreased by 60 % between 1980 and 1997, and represented about 0.6 % of all live births in 1997 compared with 1.3 % in 1980 (Brouard and Kafé 2000). In 2011, the births to adolescents 18 years of age or younger accounted for only 0.3 % of total live births in France. The prevalence of pregnancies among adolescent girls is in the order of 30 per 1,000, holding steady since the mid-1990s.[3]

At the same time, the number of abortions among girls 15–19 years of age remained relatively stable, somewhere between 15 and 17 abortions per 1,000 adolescents between 1976 and 2009. Adolescent abortions in France were the lowest at the end of the 1980s and early 1990s, averaging 12 abortions per 1,000.

Mariette Le Den notes, ''Teenage pregnancies upset and are a concern among actors in the public sphere even though the numbers are relatively small and have been decreasing for 30 years." The United Nations Children's Fund notes that globally, "Although the number of teenage pregnancies has decreased, the public perception of teenage pregnancy as a social problem has increased" (Adamson et al. 2001).

What precisely is the history of teenage pregnancy in France? Has it always been regarded as a major public health issue? And, what social meaning can be attributed to these adolescent pregnancies? It is these questions that we try to answer in this chapter using demographics, epidemiological, and public health data.

Adolescent pregnancy in France is often characterized as "girls" who become pregnant before the age of 20. This is the definition that we will use throughout this chapter. However, in our analysis, we will make a distinction between minor females (girls who are younger than 18) and those between 18 and 20 years old.

After reviewing the history of fertility among young French women starting in the eighteenth century, we will describe legal developments regarding access to contraception, abortion, and the sexual education provided to adolescents in France. We will also examine the risks linked to unplanned adolescent pregnancies such as sexually transmitted infections STIs and HIV/AIDS transmission. Then, we will discuss developments in contraception use among adolescents and their sexual practices. Finally, we will present the historical trends in rate of adolescent pregnancies, as well as factors that govern the decision to abort or to continue the pregnancy.

Historical Context

In his studies, Louis Henry (1978) explores the demographic behavior of the people of France in the "Ancient Régime" (before the French Revolution of 1789) until the beginning of the twentieth century. His sources of information were the parish registers for the prerevolutionary period, and then, he uses the civil registers after the 1790s. These data, however, are inadequate to provide an estimate of the population at each age (now estimated by the population census), which makes the extent of fertility by age impossible. According to demographers, "out of wedlock births" were more or less common across regions and time, but these births often referred to as "illegitimate" births did not occur in large numbers because of social pressures and religious standards, which allowed having children only in the context of marriage (Blayo 1975). In these

[2] Discourse of Roselyne Bachelot-Narquin, Minister of Health, Youth and Sports for the Women International Day, Mesures en faveur de la prévention et de la prise en charge des grossesses non désirées, Paris, March, 8th, 2010.

[3] Source: Insee, Bilan démographique 2011.

conditions, the average age at first marriage may give an idea of the age at which females have their first child, since the union of the two spouses also meant the entry into sexual and reproductive life.

The average age at first marriage for French women over the last few hundred years has varied by only by a couple of years. It was 24.5 years for the period 1680–1689 and reached the record value of 26.5 years in 1780–1789. The age declined to 23.9 years in the period 1880–1889 and observed a slow progression to reach 24.1 years in 1900–1909.

The average age at first marriage for men followed the same trend with a gap of 2 years, except for the period 1840–1909 where it stabilized at around 28 years of age. The difference in age between the bride and groom on average was fairly stable at 3 years (Houdaille and Henry 1979). The decrease in the average age at marriage for men just after the Revolution (1789) seems to have been due to individual efforts among young men to avoid conscription. The average age for men again became stable in the second half of the nineteenth century, while the average age for women continued to decrease. The increase in the age at the wedding for males appeared to be a gender imbalance caused by the loss of males during the wars (Houdaille and Henry 1979).

Because of the Catholic doctrine stating that a sexual union has to be procreative, birth control practices, essentially coitus interrupts and abortion, were not or seldom used by couples. This is important because age at first marriage and a relatively high rate of permanent celibacy could reduce fertility and thus the growth of the population (Hajnal 1965).

The fertility rate among married women younger than 20 years of age was very high from 1670 to 1819, varying between 200 and 350 births per 1,000 (Henry 1978; Houdaille and Henry 1973). However, the actual number of married adolescents was actually small. Thus, the number of pregnancies and births among adolescent girls was relatively insignificant when compared to all women, regardless of their marital status. Pregnancy at a young age was therefore not a common occurrence in traditional French culture. Moreover, young mothers were not even considered to be deviant individuals.

With the introduction of general and periodic population census starting in 1801, the age structure of the French population was better known. The study of fertility rates in France began in the early twentieth century. Census data show a high rate of stability in terms of fertility over the years. The exception was during the war years. Fertility rates retuned to previous levels and then increased. The "baby boom" period (1945 to the late 1970s) is characterized by an increase in fertility at all ages. From the late 1970s onwards, however, the rate of births in France began a dizzying fall, especially for the 20–24-year-old age-group for which the fertility dropped over 70 % (see Fig. 1a). Among girls 17–19 years of age, their fertility rates dropped almost 80 % during the same period (Fig. 1b).

The decrease in fertility rates of younger women, primarily the 20–24 age-group, and to a lesser extent the 15–19-year-old girls has led to an increase in the average age of childbearing since the 1970s in France.

Apart from the periods of world wars (1914–1918 and 1939–1945), the average age of first motherhood declined between the beginning of the twentieth century to the 1970s—end of "baby-boom"—to reach its lowest point, 23.8 years of age. After this period, the average age of first childbirth increased in France and reached an average age of 28.0 years in 2008 (see Fig. 2). The average age of motherhood (for all births) follows the same trend: its lowest level of 26.5 years in 1977; it reached 30.2 years of age in 2011.

The decrease in age at motherhood between the end of the Second World War and the beginning of the 1970s can be explained, in part, by the decrease in the age at marriage. Some explain that it was a way for a woman to escape her family, but she becomes dependent both financially and legally to her husband.[4] Another

[4] The Code Napoleon (1804) considers women as minors under the guardianship of their father, then their husband. In 1965 they won the right to manage their property, open a bank account, to practice a profession without the permission of their husband (or father).

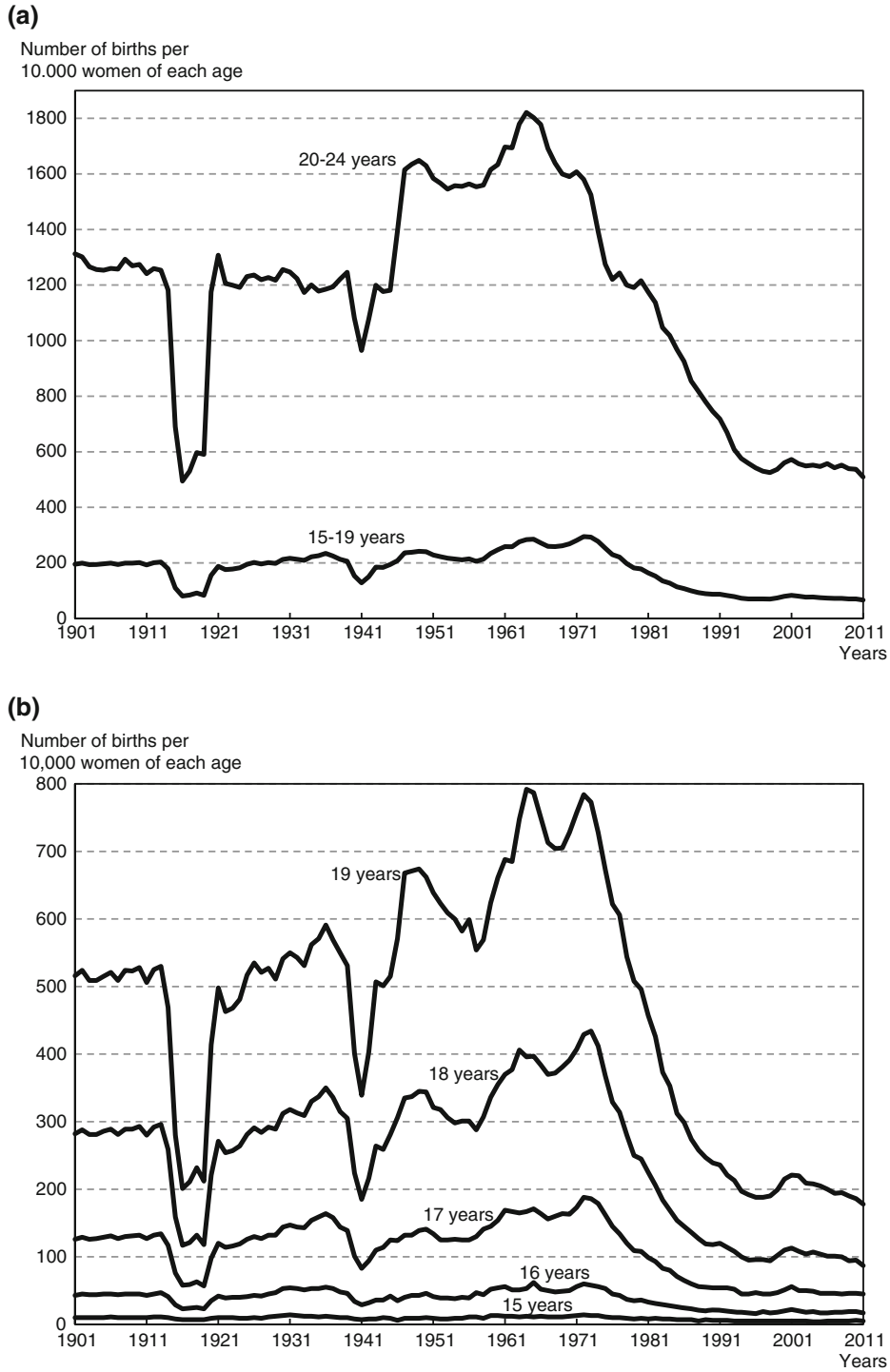

Fig. 1 **a** Trend in fertility rates of 15–19 and 20–24 in France since 1900. *Source INSEE*. **b** Trends in fertility rates of 15–19 in France since 1900. *Sources* Pison (2012), INSEE

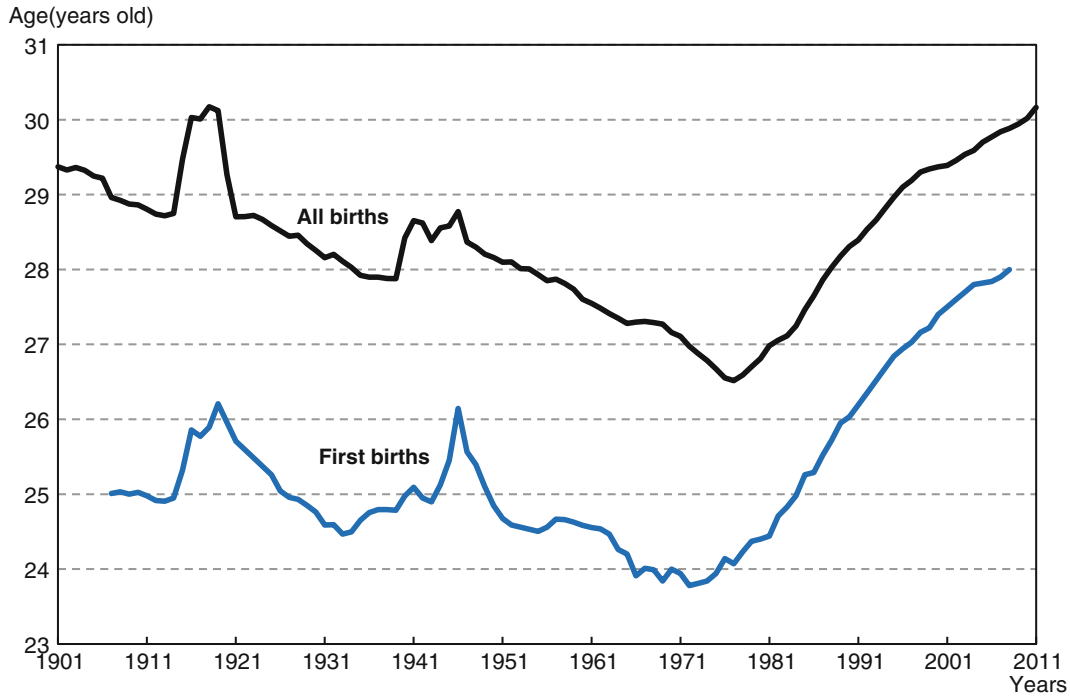

Fig. 2 Trend of average age at childbearing in France since 1900. *Sources* Mazuy et al. (2011), Pison (2010)

explanation was the need to legitimize a birth conceived outside of marriage (Pison 2010). Indeed, during this time, contraceptive practices were essentially limited to coitus interruptus, and if pregnancy did occur, abortion was prohibited and considered to be a crime.

The 1970s is the period when the decline in adolescent motherhood began. It is, therefore, a critical phase that needs careful study to better understand reproductive behavior in France. What are the political and cultural changes that took place to cause or promote changes in reproductive behavior (average age of motherhood in 1977 was 26.5 years and 30.2 years in 2011).

Legal Context and Public Policy

Changes in the Legal Context: Access to Contraception and Abortion

The sudden drop in the fertility rate of young people since the 1970s in France seems to be explained by a combination of several factors: the democratization of higher education and the presence of women in the workforce. Employment provides young women the opportunity to acquire a new social status. France is evolving through a phase of high social mobility, a phase that started with the "May 1968" social movement and the formation of the *Mouvement de libération des femmes* (Women's Liberation Movement, MLF). The approval of laws legalizing contraception and abortion was victory of this movement, which enabled women to plan their maternity and families.

Passage of the Neuwirth Law in 1967, legalizing contraception, affirmed the emergence of sexuality as a subject of public debate and marked the beginning of official government involvement in this area. A section of the act specified that underage girls should have parental consent to use a contraceptive (Bajos and Durand 2001).

In 1974, a softening of the 1967 law on contraception gave minors access to contraception without parental consent, but only if they obtained services at government-sponsored

Family Planning and Education Centers (Centres de Planification et d'Education Familiale, or CPEF). Supported by leftist progressive forces, the strong mobilization of the feminist movement promoted passage of the Veil in 1975, legalizing abortion. This law allows all women to have an abortion at a medical center upon request. Like all other legislations, the Chirurgical Act requires that underage girls need to have parental agreement to access to abortion (Bajos and Durand 2001).

The last important modification in 1967's and 1975's laws was made in 2001. The fact that underage girls needed parental consent to obtain an abortion could reduce access for pregnant adolescents, due to the difficulty in confessing to having sexual intercourse to their parents (Bajos and Ferrand 2001). Instead of parental consent, underage girl can now obtain an abortion if they have the consent of any adult of their choosing. On top of that, legal term limit to have an abortion in France was extended from 12 to 14 weeks of amenorrhea.

All legislative changes about contraceptive and abortion contributed to a changing public awareness that sexual behavior has a social dimension. Since then, the sexuality of young people has become the subject of increasingly detailed opinion surveys and is often a common topic of public debate: "The issue has now entered the discourse at meetings and forums where decision makers make choices for society as a whole" (Mossuz-Lavau 1991). This trend was reinforced the advent of the Aids'epidemic. Starting with a national campaign launched in 1987, the government and other public authorities intensified HIV prevention activities (Bajos and Durand 2001).

Sexuality Education in France

In the 1950s, the sexuality of young people had not yet become a topic for discussion in France (Mossuz-Lavau 1991). Moreover, there was almost no public discussion about sexuality among young people until 1974 when the legal age for consensual sex was lowered from age 21 to 18. In that same year, the High Council on Sexual Information, Birth Control and Family Education (Conseil Supérieur de l'Information Sexuelle, de la Régulation des Naissances et de l'Education Familiale, or CSIS) was created as an advisory body. Sex education and information then became part of the school curriculum (Bajos and Durand 2001).

The first Ministry of Education memo about sex education and information was dated July 23, 1973 (Memorandum No. 73-299). It explained the need to replace an outdated form of protective sexual education with a new formula, based on the mastery of information and on instilling responsibility. The memorandum specified that sex education should be provided in biology courses and in additional (elective) classes. These classes could be taught by teachers or outside experts. This was prior to the onset of HIV/AIDS. Finally, in 1995, the Ministry of Education office instituted a new training program for teachers designed to help them follow the new 1996 and 1998 curriculum policies that require two mandatory hours of sex education. The Ministry's efforts were to mobilize the entire educational community around this issue. Until the late 1990s, sex education in French schools was often not sufficiently broad and even though updated to include content on HIV/AIDS, and during that period, these sexual education curriculums were rarely implemented in the schools (Bajos and Durand 2001). In 2011, it was recognized that sex education should adopt a more comprehensive vision of preventing high-risk health behavior and should address the broader education of all citizens.

Since 1995, the Ministry of Education has organized a national training program, conducted by local school districts using funds specifically earmarked to provide sexual education by the Public Health Administration (Direction Générale de la Santé, or DGS). Its purpose was to train physicians, school nurses, social workers and management or supervisory personnel, teachers, and guidance counselors to become more involved in sex education. The program also instructed educators on how to evaluate needs in this area, how to meet those

needs, and how to encourage sex education initiatives in every school district. The work of this program provided the basis for the Ministry's revised sex education policies of April 1996 and November 1998. These were aimed at reducing risky sexual behavior in France, especially among young people. The initiatives represented a turning point in the Ministry's attitudes toward sex and the prevention of sexual risk behaviors. They affirmed the importance of the Ministry's role in the transmission of knowledge and in the development of responsible attitudes toward sexuality (Bajos and Durand 2001).

The CSIS is an advisory body whose analyses contribute to policy at the national level. The commission has reported to the Women's Rights Department (Service des Droits des Femmes) since January 1, 1995. A June 12, 1996 decree redefines the commission's general institutional context, which is under the joint aegis of the ministries in charge of women's rights, the family, and health. Four working commissions have been set up: (1) sex education and information for young people; (2) prevention of sexual violence; (3) child-rearing support for parents; and (4) family planning and prevention of sterility (Bajos and Durand 2001).

In a memo dated November 19, 1998, the Ministry of Education defined new policies for sex education in schools. These policies apply to all public and private institutions under contract to provide elementary and secondary education, but they place the greatest emphasis on the role of the middle (junior high) school in sex and health education. All 12–14-year-olds attend junior high school, and since 1995, these schools have become involved in sex education programs. The topic of sexuality is approached in middle schools through the teaching of reproduction in biology classes and through two hours of *mandatory* sex education. This requirement was implemented in 1996 (Memorandum dated 15 April 1996) and was reinforced in a 1998 memo (Memorandum dated 19 November 1998), which included sex education as part of the health education curricula. Sex education is also provided in health education workshops, which all students in the first 4 years of secondary education must attend for 30–40 h, over 4 years. These workshops also stress the prevention and reduction of violence and sexual abuse. The content of sex education programs is defined in policies issued by the Ministry of Education. In high schools, sex information classes may be held, but they are *optional.* The programs that have been developed, the approaches taken, and the policies issued by the National Education Office are applicable throughout the country. They apply to public schools and certified private institutions. The subject of abstinence is not discussed in France, either in messages targeting the public at large or in prevention messages disseminated at school. Conservative groups might broach the topic of abstinence; however, the concept is used more as an injunction to postpone young people's entry into sexuality (which these participants believe occurs too early) than as one among several prevention strategies adopted in a risk-reduction program. The topic of contraception is discussed in biology courses as well as in sex education and information sessions. In these classes, students are informed about where they can go for services near their school, particularly the Center for Family Planning (Bajos and Durand 2001).

The Act of July 4, 2001 reinforced the role of the school, at all levels, in terms of youth sexuality education. Information and education in sexuality from primary school and throughout the secondary school are required. With curriculum based on the age-group, children and adolescents are to be provided at least three annual sessions of the sexual education a year. These sessions are only taught by teachers of biology but can involve staff contributing to the mission of school health and educational staff as well as external stakeholders such as physicians of the CEPF. This last act confirmed the fundamental role of the school in the sexual education of the youth and its orientation toward structures dedicated to listening to this population about methods of contraception and prevention of risks related to sexuality.

The occurrence of the epidemic of AIDS in the 1980s placed sexuality in a new light. The fear of contamination by HIV pushed the French

State into informing the public of the HIV/AIDS risks associated with sexuality and to provide information as well as preventive measures, to reduce the spread of the epidemic.

The Campaigns of Prevention of Risks: HIV/STIs and Unplanned Pregnancies

Rarely used as a contraceptive method in France, and perceived as more related to prostitution (Paicheler 2002), the condom did not have a very good image in France. This attitude, however, had to change when the nation faced with the AIDS epidemic in the 1980s. Even then it took time, advertising condoms was forbidden until 1987, year of the first public HIV prevention campaign. The focus was that the condom become commonplace. Although the campaign did not focus on the ‘‘most at risk" groups; it was addressed to women, judged more responsible and capable to propose the condom. The French Minister of Health, Claudse Evin, propoted besides "the relevant role of the women" to limit the epidemic (Peicheler 2002).

The French AIDS Prevention Agency (Agence Française de Lutte contre le Sida, or AFLS) was created in 1989. The AIDS division of the Public Health Administration and an interministerial committee were both established in 1994. The Ministry of Education office has entered into several partnership agreements with HIV coordinators at the Ministry of Health to work toward prevention strategies among young people. Since 1996, the Ministry of Education has expressed interest in playing a major role to prevent sexual risk behaviors by implementing two mandatory hours of sex education in schools. Policy directives on the prevention of health and sexual risk behaviors focus specifically on sexual abuse and violence. However, there has been certain reluctance by school principals to install condom dispensers in high schools (Bajos and Durand 2001).

In 1997, following the arrival of triple-drug therapy for the treatment for HIV/AIDS (1996), the focus was on the early support and treatment of the disease; therefore, regular screening was encouraged. This included initiatives focused on youth, such as awareness campaigns against HIV at sports events, music festivals, all cultural gatherings where there are young people that can be reached with advertising. The 2003 campaign again tried to trivialize the use of condoms designating them a consumer product and allowing them to be sold. The "National Plan for combating HIV/AIDS and the IST 2010–2014" provided by the Ministry of Health and Sports in 2010 focused particularly on young people, women, and persons with disabilities (Ministry of Health and Sports 2010).

Advertising to publicize this government HIV screening program intensified. It was targeting young people as well as the doctors and social workers who were likely to be serving this age-group. However, government advertising on the prevention of unwanted pregnancies and the use of contraception is quite sporadic and relatively underdeveloped (Bajos and Durand 2001).

The first Government contraception campaign began in France in 1982. Supported by Yvette Roudy, then Minister of Women's Rights, it was aimed at the female audience and was intended to reaffirm the right to contraception, still frowned upon by public opinion. A special section was also presented in colleges and high schools. In 1992, a second campaign, particularly addressing adolescents, was developed by a team from the Secretary of State for the rights of the women of the time, Véronique Neiertz. The issue was to talk about sexuality without shocking the parents. A first version of the TV spot had to be abandoned; the Prime Minister at the time sought a "less direct" version of the campaign deemed too suggestive. In 2000, a new campaign encouraged talking about sexuality and to choose its contraception. Emphasis was placed on the morning-after pill. In 2009, the campaign focused on women and men between 18 and 30 years of age. The message encouraged them to talk about contraception and promoted the diversity of contraceptive that are available.

The last campaign promoting contraception in 2012–2013 used media (TV, Internet, press, radio, etc.) and was titled, "the best contraception

is that one chooses," and it aimed at the entire population and focused on the different contraceptive methods available to women. The theme was to encourage women to choose contraception that best fits into their sexual and emotional life. This program was based on the results of the research, which showed that contraceptive failures were more frequent among women who were using a method of contraception that did not meet their emotional, sexual, and social needs (Bajos et al. 2003). One component of this campaign is particularly aimed at young people. Entitled "If boys could get pregnant would we be more interested in contraception?" And, it depicted young men who are "pregnant" and are therefore faced with the management of an unplanned pregnancy.

All these posts seem to reach their target as 99.7 % of youth 15–19 years of age in 2010 reported having had information about contraception (FECOND-Inserm/Ined 2010 survey). However, their sources of information appear to vary somewhat by sex. Some 91 % said that they learned about contraception in school. For young women, their mother was their second source of information (60.4 % compared to 34.0 % for their male counterparts, in fourth position). Young men turn more to the media (i.e., television, radio, newspapers). These sources of information were cited by 1 out of every 2 adolescents (54.8 % for boys and 53.4 % for girls). National Education therefore plays the role of providing the first information on sexual education of the population. The campaigns of information, cited by 1 out of every 2 adolescents (54.1 %), also have an important role in providing access to sexual information.

Sexual and Contraceptive Practices

Adolescent Sexuality

Over the past few decades, age at first intercourse has fallen among both French men and French women. The decline has been moderate for men and more pronounced for women (Bozon 1993). The difference in the pace of decline by gender is essentially due to the fact that average age at first intercourse was much higher to begin with among women born in 1936–1940 than among men in that same cohort (a mean of 20.6 years for women versus that of 18.8 years for men). The most marked decrease was seen among young men and women whose sexual lives started during the 1960s. This was a period of dramatically changing social values in France. During this period, the women's movement was fighting for legal contraception and abortion. The student movement culminated in massive protest and demonstrations in May 1968. However, in the 1970s and 1980s, age at first intercourse stabilized somewhat for men and women, at just over 17 for young men and 18 for young women (Bozon 2008). The results of the 2010 FECOND survey show that young people of both sexes have had their first sexual intercourse at practically the same age (median age of 17 years and 1 month for boys and that of 17 years and 6 months for girls) (see Fig. 4).

Although the age at sexual debut may have converged, female and male experiences of this event remain very different. For example, more women than men still have their first sexual experience with a partner who has already had sexual intercourse and who is at least 5 years older. However, it is noteworthy that with successive generations, women are increasingly likely to experience their sexual debut as something expected and planned for (Bozon 2008).

A Double Standard of Sexuality

Today in France, sexual behavior still remains socially determined by a context that attributes differential roles and statuses to each gender. While having multiple partners remains associated to men's sexuality, sexual stability and monogamy are seen as desirable aspects of women's sexuality. Thus, attitudes and behaviors that are valued in males may still be stigmatized when adopted by women (Bajos and Durand 2001).

The fact that the behaviour of young people is no longer so strongly controlled by their families does not mean that the differences between

women and men in socialization of sexuality have disappeared or decreased Bozon (2008). Through initiation to masturbation during pre-adolescence, one can say that men continue to serve an early apprenticeship in individual desire, backed by cultural representations, rather than in relationships. By contrast, young women are still educated, for the most part, to consider sexual debut as an experience which has to do with feelings and relationships. It may be that this representation of sexual initiation for women is linked to the responsibility which is still socially attributed to them, than that of trying to engage men in a monogamous relationship, even if this is only an end result (Bozon 2008).

While 1 out of 2 women (54.1 %) aged 15–19 in 2010 reported that their relationship with their first partner lasted 6 months or more, only 1/3 of men (29.9 %) reported the same. On the contrary, 8.5 % of men said their first sexual experience was a "one night stand." Only 1.3 % of women reported that their first sexual experience was a "one night stand" (Enquête FECOND-Inserm/Ined 2010). Thus, the obligation to remain a virgin until marriage has been less important for women since the 1960s. The expectation of women today is that sex is appropriate in a loving relationship (Bozon 2008).

So while some differences by sex and social group are tending to decrease over the generations, this stage of life is still very different for the two sexes. Sexual development during adolescence is a period of apprenticeship in conjugal sexuality for women, while it is more of a personal experience for men (Bozon 2008).

Another striking feature of changing sexual debut is that sexual initiation signifies less and less the beginning of an official conjugal history, a change that is particularly notable for women. Fifty years ago, two-thirds of women and a third of men had their first experience of sex with their future conjugal partner. Today, this is true for only one individual in ten (for both women and men). At the same time, age at first union, and even more at the birth of the first child, has risen markedly (Prioux 2003). So in France, as in many countries of the North and South (Wellings et al. 2006), the first sex now ushers in a non-reproductive sexuality between adolescence and parenthood for both sexes but one which is still lived out differently depending on whether one is a woman or a man (Bozon 2008).

So for women, the phase of their active sexual life before the first union has doubled in time in the space of a few decades, from 2 years for women of the cohorts of 1936 to 1945, to 4 years for those born between 1971 and 1980. This change has been much less significant for men over the same period: from 5.5 to 6 years, respectively (Toulemon 2008).

Differences between women and men in age at sexual debut and in number of partners during this young initiation period are becoming blurred. A pre-conjugal model for women is characterized by more long-lasting relationships. A non conjugal model for males is a succession of partners and where periods without sexual activity are more frequent (Bozon 2008).

In the Simon Survey (1970), young people's sexual attitudes were found to be radically different from those of previous generations. This was no longer the case in 2006; attitudes were fairly stable and no longer evolving. This phenomenon also was observable in other domains, for example in politics and in values in general (Galland 2004). Young people were no longer rebelling against unrealistic sexual sanctions because they were adolescents. Marriage was no longer the main passageway into adulthood. The right to a sexual life before first union or marriage is rarely contested even for teenagers. More generally, the attitudes of young people are the same as "adults" for the most part. In the CSF survey (2006), for example, a majority of young people believed that, "by nature men have more sexual needs than women." There were issues, however, where adolescents were more open-minded about sex than their elders; for example, they were more acceptant of homosexuality. Surprisingly, there also was a significant proportion of young men (a fifth of those between 18 and 24) who showed no interest in either sexuality or living together in a long-term relationship (Bozon and Le Van 2008). Moreover, since the age at first childbirth,

after first coitus, rose for females from 5.5 years 25 years ago (Bajos et al. 2004) to 9.5 years in 2009, the period of non-reproductive sexual activity has almost doubled during the last decades.

Changes in Contraceptive Practices

By the mid-1970s, over half (51 %) of girls between 15 and 19 years of age used some form of contraception during their first sexual intercourse. By 2009, over 90 % of girls in the same age-group used some form of contraception during their first sexual intercourse (see Fig. 3a). Among boys between 15 and 19 years of age, slightly over 50 % used contraception during the first sexual intercourse. By 2009, over 95 % of boys used some form of contraception during their first sexual intercourse (Fig. 3b). Among French adolescents today, initiation of sexual intercourse is associated with a powerful obligation to protect you and your partner (Bozon 2009b). To avoid HIV infection, adolescents use mostly condoms (92.3 %) and 15.9 % used both a condom and the contraceptive pill (see Table 1) (FECOND-Inserm/Ined 2010 survey). The "success" of condom use among young people in the 1990s is attributable to the condom being used to protect from sexually transmitted infections. By adopting a "responsible" behavior, as a viable part in the ritual of the first reported sexual intercourse, condom use may also be a way for partners to adapt to the uncertainty of these initial phases of sexual life and relationships (Bozon 2009b).

Young women, however, continue to be more concerned than men by unplanned pregnancies, although they reported that they used a condom as many as men. Support for sexual and reproductive health issues is thus primarily the responsibility the adolescent girl during the phase of sexual initiation. Young women have internalized the need to be responsible for themselves and their partner (Bozon 2009b).

The spread of contraceptive in France since its liberalization in 1967 was fast. Pill is the most widely used contraceptive, and the IUD (intra-uterine device) is the second most used one (Bajos et al. 2012).

However today, contraceptive standards may vary according to the age and the type of sexual relationship. With the outbreak of the AIDS epidemic, condom promotion campaigns strongly contributed to the dissemination of the current model. All sexual relationships start with a condom, which is succeeded by the pill as soon as the relationship stabilizes and the sexual life is assumed to be stable. Finally, when the desired number of children is reached, most women move to the IUD (Bajos and Ferrand 2001).

Today in France, approximately 70 % of 15-19 adolescent girls who were having sex and did not want to be pregnant use a medical method of contraception (pill, implant, patch, vaginal ring) and 26 % used a condom (FECOND-Inserm/Ined 2010 survey). The pill was the most widely used contraceptive (69 %) in this age-group, and 20 % of the girls used two forms of contraception, one being a condom. Young women aged 15–17 use more condoms as their main method of contraception than their older counterparts (respectively, 44.7 % and 16.5 %). This raises the question of reimbursement of this method in contexts where social acceptance of youth sexuality is limited. Financial barriers may also restrict access to other contraceptive methods requiring medical care.

What best describes sex among adolescents is its episodic nature. Typically, there are long periods without a sexual partner (Bozon 2008). Under these conditions, adolescent females often report that it is difficult to use contraception (such as the pill) that must be taken daily.

Contraception Failures

Among the 70 % of teenage girls who reported a reason for not using contraception at the time of conception, 31 % thought that they were not at risk of becoming pregnant and 23 % had not planned on having sex (FECOND 2010 Inserm/Ined survey). Other reasons included problems with contraceptive methods in the past (20 %), not thinking about contraception (14 %), partner

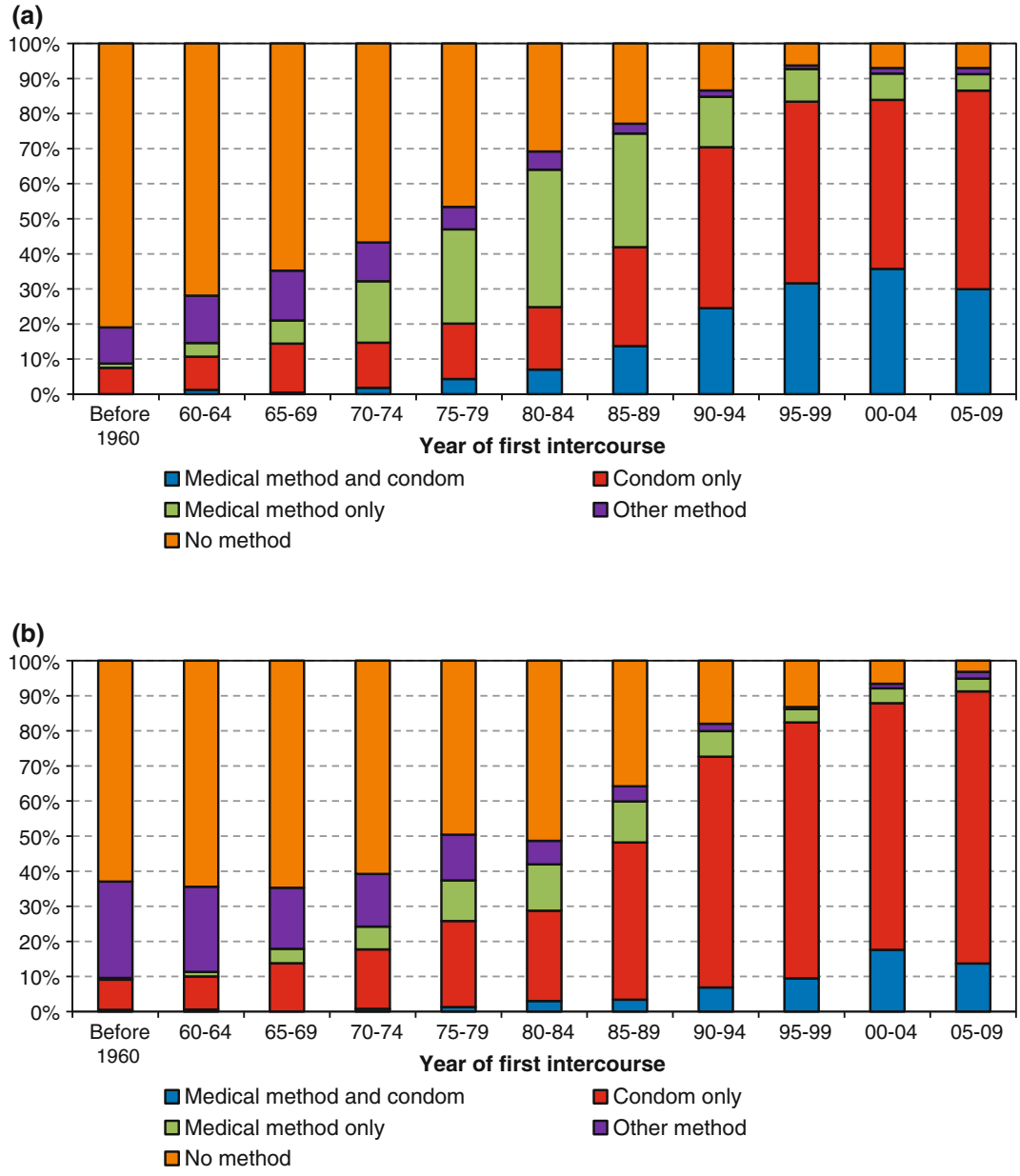

Fig. 3 **a** Contraceptive use at first intercourse for women. **b** Contraceptive use at first intercourse for men. *Sources* Beltzer and Bajos (2008), Fecond Survey (2010)

unwilling to use contraception or wanting a pregnancy (7 %), cost (5 %), and not wanting parents to know about their contraceptive practices (5 %) (Moreau et al. 2010a).

For the 20.6 % of women that used the pill, 93 % said that the conception is due to an inconsistent or incorrect use of it. For the 31.3 % of those who used a condom, 84 % reported that the condom slipped or broke (Moreau et al. 2010a).

After an abortion, 68 % of teenagers were given a prescription for a more effective method of birth control than the one they were using before the abortion. However, more than half the

Table 1 Principal contraceptive use in 2010 for 15–19-year-old girls

Percentage	Age at 1 January 2011		
	15–17 years	18–19 years	15–19 years
Pill	16.4	47.3	32.1
IUD	0.0	0.0	0.0
Others hormonal methods	0.1	0.6	0.3
Condom	14.1	10.0	12.0
Others[a]	0.7	1.3	1.0
Sterilization[b]	0.0	0.0	0.0
Sterile[c]	0.0	0.0	0.0
Pregnant	0.0	1.5	0.8
Without partner	68.3	36.3	52.0
Want to be pregnant	0.0	1.6	0.8
No contraception	0.3	1.3	0.8
Total	100	100	100
Observations	310	292	602

Hierarchic classification if the respondent uses more than one contraceptive at the same time (sterilization, implant, pill, IUD, injections, patch, vaginal ring, condom, and others)

[a] Other methods are local female methods, withdrawal, periodic abstinence, day after pill, no answer

[b] Contraceptive sterilization only

[c] Medical sterilization and sterile

Sources Inserm-Ined, Fecond 2010

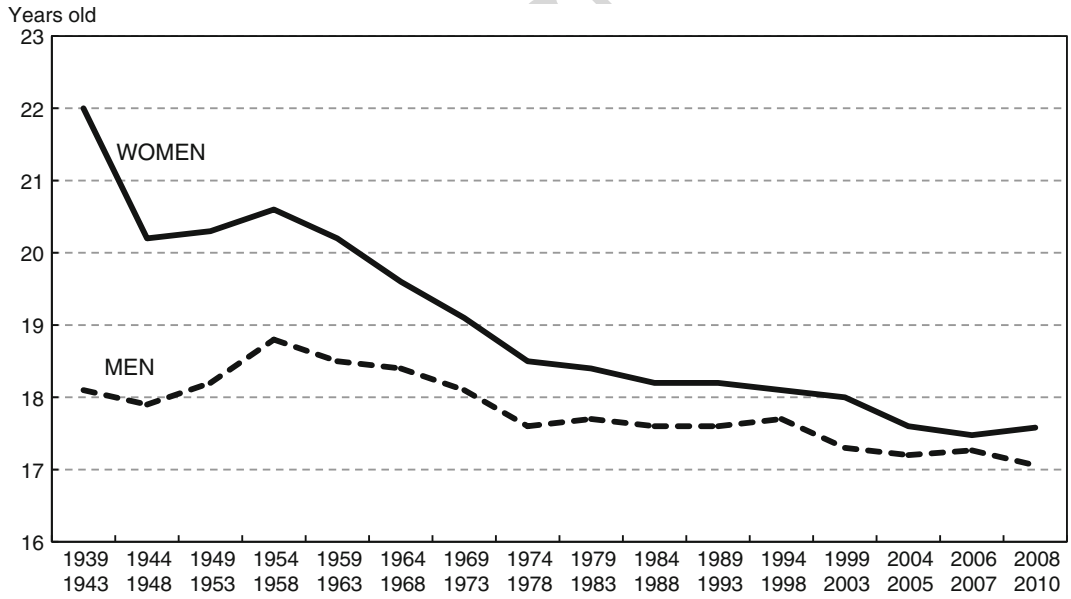

Fig. 4 Median age at first sexual intercourse, by gender and generation (during 18 years old). *Sources* Bozon (2008), Baromètre Santé Survey (2010)

women who described a pill failure (53 %) were prescribed the pill after the abortion. Conversely, 5 % of women who were using hormonal methods received no prescription for a method of contraception after the abortion (Moreau et al. 2010a).

Evolution of the Conceptions, Births and Abortions Since the 1970s

From 1976 to 2009, the rate of conception among adolescent girls in France dropped over 50 % (see Box 1 with the methodology used to calculate rate of conception). This strong decrease in the rate of conception is in part a reflection of the massive dissemination of modern methods of contraception among French girls and women.

Box 1: Methodology

We dispose of data about abortions in France since 1976. If we add fertility rates at 15-19 years old and abortion rates at the same age, we obtain conception rates. We assume that the proportion of unwanted pregnancy is the same for miscarriages than for other pregnancies.

The average length of a pregnancy, when the outcome is an abortion, is 8.6 week after amenorrhea, while pregnancy that results in a birth lasts on average 40.3 weeks after amenorrhea. Thus, two women can be the same age at the time of conception, but one who chooses abortion and the other who chooses to give birth will not have the same age in the statistical databases. This flaw for example makes it look as if younger girls tend to opt for abortion more than older girls. To correct this bias, we transformed the fertility rate into a conception rate by reducing the age of adolescents who gave birth by 0.61 years.

In France, fertility rates follow the same trend as that of conception rates. What these rates show is that since 1976, fewer girls became mothers before the age of 20. Additionally, there was an increase in the average age at first pregnancy when the pregnancy ended in childbirth (see Fig. 2). This is explained by the additional years added to secondary school and to some extent by the precarious economic prospects. Young people in France have difficulties finding stable employment and thus difficulties accessing individual housing. Under these circumstances, the age of first union is increased (Prioux 2003), which delays the age of maternity.

At the same time, the abortion rate remained relatively stable between 1976 and 2009 (approximately 15 abortions per 1,000 women aged 15–19) and in fact reflects an increase in the probability of abortion from 29 abortions for 100 conceptions in 1976 to 53 today (Fig. 5a) for girls found pregnant between the ages of 15 and 19. For girls aged 15–17, the likelihood of resorting to an abortion if pregnant has increased by more than 80 % over the last 30 years. Among adolescent girls between 18 and 19 years of age, the probability to have an abortion if pregnant by 70 %. The younger the girl, the more likely she is to choose abortion than girls 18–19 years of age (respectively, 64 and 47 abortions for 100 conceptions in 2009—see Fig. 5b) although they become pregnant less often than older teens (16 conceptions per 1,000 girls aged 15–17 against 47 for 18–19-year-olds in 2009).

The Decision to Continue or to Terminate her Pregnancy

As already noted, two major changes after the 1970s related to French women's sexual behavior: (1) The legalization of contraception and abortion (1967 and 1975) on the one hand, (2) the democratization of higher education providing girls and women more opportunity, and greater access to employment, on the other. Access to modern contraception and abortion gave women more control over unwanted pregnancy and motherhood. Contraception also helped redefine the sexual responsibility between male and female parenting. Women acquire the ability to choose the moment that

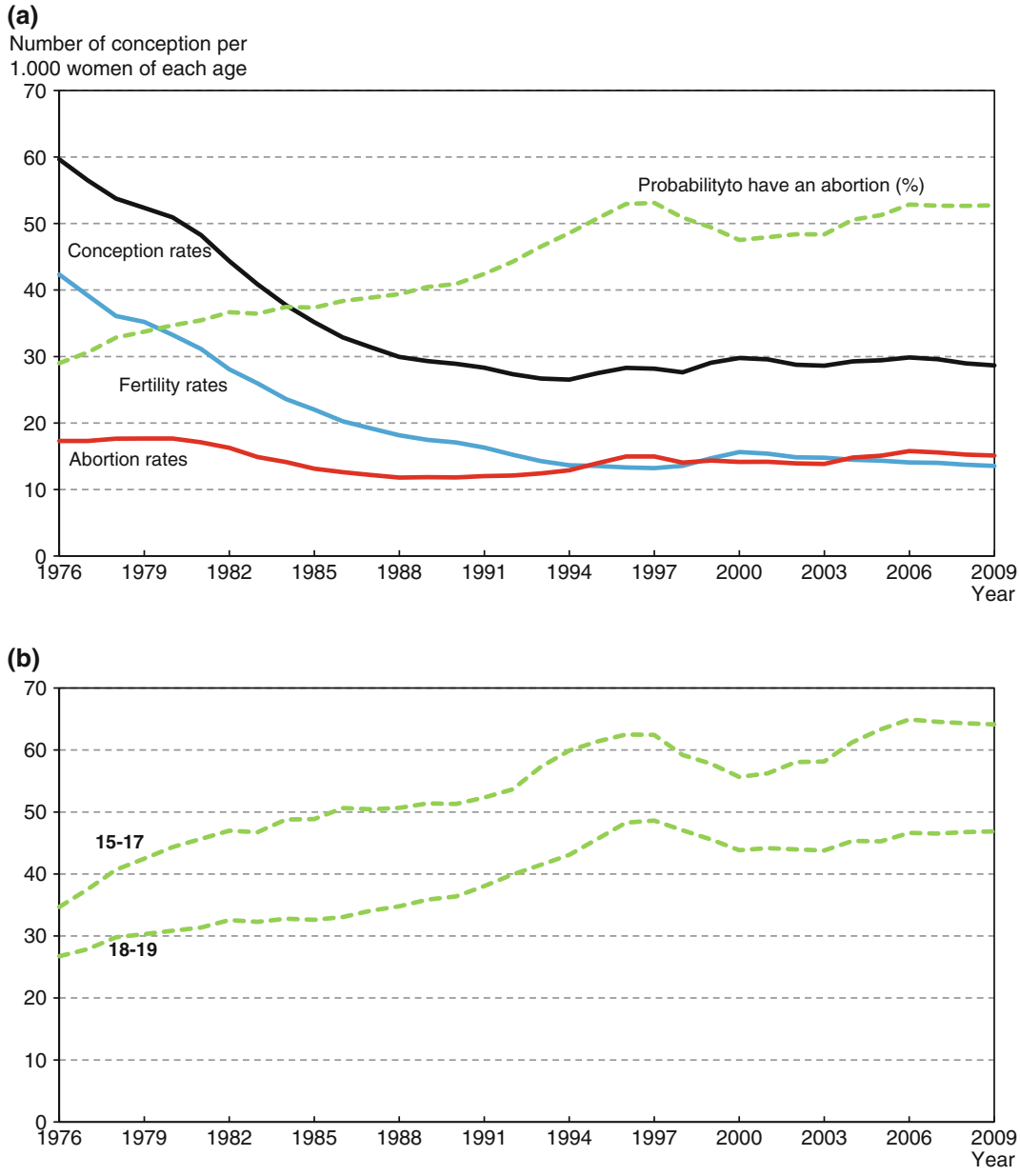

Fig. 5 **a** Trends in conception rates 15–19 since 1976. **b** Trends in the probability to have an abortion for 15–17 and 18–19 since 1976 [per 100 conceptions (births and abortions)]. *Sources* Blayo (1995), Rossier and Pirus (2007), Rossier et al. (2009), Vilain (2011)

they thought was appropriate to have a child ("a child if I want, when I want"). In addition to the need to be in a stable relationship, new conditions for giving birth to a child also were formalized. The new conditions included financial and material resources and independent housing for the family. Consequently, with access to higher education for women, and the emergence of the idea of career planning for women outside of domestic life (to which in the past they were often consigned), many young women made the decision to postpone pregnancy and childbirth

until they could afford to raise a family (Leridon 1998).

Conceptions have not increased among young women in France, but in case of pregnancy they decide more often to have an abortion (Prioux and Mazuy 2009). The average age at motherhood also echoes the access of women to a new status and the redefinition of their role in the public sphere, and this also may explain the increase in abortions in this age-group. Judging pregnancy as inappropriate during adolescence is the result of an interiorized norm that standardize the behavior of individuals without taking into account differences in personal stories of people. However, teenage pregnancies reflect multiple realities that are essential to our understanding the decision to have an abortion or to choose to become a parent.

The Different Types of Teen Pregnancy

Charlotte Le Van (1998), in her qualitative study on teen pregnancy, identifies five profiles of young women who became pregnant before they were 20 years of age.

1. Pregnancy as a "rite of passage." These young women have a strong desire to become pregnant and give birth to a child. It is a thoughtful decision on their part that facilitates the passage from adolescence to adulthood. It also is strong evidence of their love for their partner.
2. Pregnancy as an "S.O.S." In these cases, pregnancy is a "cry for help." The young woman is letting the adults in her world know that she is in distress. She is letting her family and those around her know that she is experiencing a period in her life where physical and social changes seem out of control. Because of the strong social stigma against "early" pregnancy, as soon as the young woman's pregnancy is known she becomes the center of attention and her "cry for help" is heard. Much like an attempted suicide by a child, the announcement of a pregnancy causes shock and excitement among her family and peers. These pregnant young women do not really want a child; they want the shock value that comes with getting pregnant.
3. Pregnancy "insertion." These young women are characterized by the young woman's desire for social recognition. Durand and colleagues (2002) prefers the term, "pregnancy adaptation," because many young women from disadvantaged communities know that they can increase their value as a person by becoming a mother. For many of these young women, where educational opportunities are limited or non-existent, motherhood may improve their quality of life and provide for their future. These young women adapt and make their decisions about motherhood based on the barriers they encounter during adolescence (Durand et al. 2002).
4. Pregnancy related to the young woman's "identity." Among these young women, pregnancy reinforces their view of themselves as competent caretakers of young children and infants. These young women most often have been in contact with children and infants since a young age (younger brothers and sisters, or other children staying in their home). These young women feel confident in their ability to deal with care for children younger than themselves. These young women also know that motherhood is a passage to adulthood, but also wish to further demonstrate their ability and their expertise caring for young children. They want the status and autonomy associated with maternity in their community.
5. "Accidental pregnancy." Unlike young women in the other four categories, pregnancies in these cases appear to have been caused by a failure of contraception. These young women are not expecting to get pregnant; they are surprised by the diagnosis. Without a real desire to be a mother, these young women often choose an abortion.

There is no an adolescent pregnancy, but many adolescent pregnancies. Although, in general, they are perceived as "unwanted", young women wanted to get pregnant. The other women can choose between keeping the pregnancy or have an abortion.

Continue or terminate her pregnancy: building decision

The decision-making process that results in an abortion or continuing the pregnancy must be made in a very short period of time (Donati et al. 2002). Determinants for parenthood is based on reproductive standard which include a stable relationship, adequate material and financial resources, and parents with an adequate trade or education. The complexity of the decision is such, however, that the life experience of each woman and her perception of things at the time of the pregnancy.

Several qualitative and quantitative studies (Berthoud and Robson 2001; Le Van 1998; Sihvo et al. 2003) show that in France, girls who carry their pregnancies to term are often from disadvantaged backgrounds (see Box 2).

Box 2: Regional Disparities

Contraceptive practices and fertility among adolescents in the overseas departments of France are very different from those of girls living in metropolitan France. As of March 2011, the overseas departments of France were the following: French Guiana in South America, Guadeloupe in North America (located in the Caribbean), Martinique in North America (located in the Caribbean), Réunion in Africa (located on the Indian Ocean), and the Mayotte in Africa (located on the Indian Ocean). It is obvious when examining the causes of adolescent pregnancy and early motherhood that the socioeconomic disparities that exist between these "two Frances" have a great influence on adolescent female sexual behavior and fertility.

Between 1994 and 2011, the fertility rates for females 15–19 in the French Overseas Departments (FOD) were still higher than those of metropolitan France. One reason for the difference is that women in the overseas departments give birth at a younger age than their French counterparts. These high fertility rates also come with high abortion rates among girls from FODs (Mazuy et al. 2011; Vilain 2011). The abortion rate before the age of 20 is two times higher than in metropolitan France and almost four times higher among girls 14 years of age and younger (Mazuy et al. 2011). While the conception rate among adolescent girls in FODs is significantly higher, the proportion of pregnancies terminated before 20 years is lower than in metropolitan France.

Higher abortion rates in the FODs are explained by a lack of inadequate contraception in these regions (Halfen et al. 2006), difficulties of accessing adequate contraception, and inappropriate information leading to more contraception failures (Moreau et al. 2010b). High fertility rates at 15–19 also can be explained by the fact that teen pregnancies are less stigmatized in FODs than in metropolitan France (Mazuy et al. 2011) and the timing of fertility is therefore more flexible.

The socioeconomic conditions are also very different in these regions. While only 18 % of the metropolitan women (18–34-year-olds) in 2007 did not have a secondary education, the proportion was 37 % in the FODs (Temporal et al. 2011). Similarly, while the unemployment rate was 23.7 % for the 15–24 age-group in metropolitan France in 2009, unemployment was more than 50 % for their counterpart in FOD and as high as 56.2 % in Réunion.

Much like in metropolitan France where the least educated girls, living in the most disadvantaged areas, are the adolescents who become mothers, in FODs there are a greater proportion of these girls. These numbers alone explain, to a large extent, the higher rate of fertility among girls living in FOD.

In light of this knowledge, it is clear that the material and financial constraints are rarely alone in determining the choice these girls make. Even in the case of a couple that are involved in a relationship, the length of time that the young people have been involved in a relationship before the pregnancy plays a major role in the decision to carry the pregnancy to term or not. A casual partner, for instance, does not have the same influence in the decision-making process as a boyfriend of several months. Most of the time the casual partner is informed of the pregnancy (Donati et al. 2002; Durand et al. 2002; Le Van 1998). The opinion of the partner is sometimes respected sometimes not. In cases where there is a disagreement on whether or not the girl should continue the pregnancy, a girl with a family with social, economic, and cultural resources is the one who makes the final decision (Donati et al. 2002).

Young women choose the partner that they consider ideal for starting a family: a partner who will be able to take on the responsibilities that goes with raising a family. As important, in France, having a child without a father is as socially unacceptable in adolescence as it is at any other age. In addition, the stigma of single motherhood and the anticipation of the material and financial difficulties involved in raising a child as a single parent may in many cases discourage the continuation of the pregnancy.

The second set of players in this decision process is the family (Donati et al. 2002; Montgomery and Casterline 1996). The categorical rejection of the pregnancy and motherhood for their daughter by the parents can create a difficult and frightening situation for the adolescent. On the contrary, when the idea of pregnancy and motherhood is "accepted early on" by the parents, the idea of continuing the pregnancy may seem less scary to the girl. Moreover, as it happens, mothers who support young girls and their desire to carry through with the pregnancy were themselves mothers at a young age. It is a family pattern of reproduction. This does not mean that the teen pregnancy will be better accepted because some mothers do not want their adolescent daughter "repeat the mistake they committed." That said, the reaction of the family at the announcement of the pregnancy—rejection or acceptance and assistance (for instance, the willingness of the family to share the burden of motherhood) especially of girls whose partner refuses to take on the role as father—plays a major role in the decision to continue a pregnancy (Donati et al. 2002).

The idea that peer group influence shapes behavior is often brought up as soon as one speaks of adolescences (Montgomery and Casterline 1996). Among these girls, pregnancy can appear as a means of emancipation from the family (Bozon 2009a; Galland 2004). Indeed, having the same experience at the same age tends to create strong bonds. In these cases, friends often play the role of first confidant when a girl finds herself pregnant. Knowing that statistically less educated girls become mothers sooner than their more educated counterpart illustrates the difference in the perception of pregnancy at a young age among the two groups. If a girl from a privileged social class becomes pregnant, her peer group will more often view her pregnancy as a major problem that will be harmful to her future. However, for pregnant girls from disadvantaged social groups, motherhood may have more advantages than disadvantages.

Peer groups have a strong influence on individual adolescent behavior. The reaction to friends faced with the announcement of a pregnancy can take many forms. Peers can initiate a move to an abortion or support a friend continuing her pregnancy. In these cases, friends can react with acceptance or rejection when a girl tells them of their pregnancy. Depending on the reaction of her peer group, a girl may reinterpret her pregnancy and the meaning of her pregnancy.

The last set of actors are healthcare professionals (i.e., school nurses, doctors of family planning or abortion center) that the girl must interact with before, during, and after the diagnosis of pregnancy. If the conditions of access to health care systems are not well known, moralizing and guilty attitudes from medical actors were reported by some young women who have had an abortion (Bajos et al. 2002).

All of these actors are themselves influenced by social norms.

In fact, in France, few studies on the disadvantages of being a teen mother have been conducted. By what means can we then consider that teenage pregnancies are necessarily correlated with social and economic difficulty throughout the life of the mother? Without more rigorous outcome studies, how can we say with any degree of accuracy that teenage pregnancies are the main factor for social immobility? Such a conclusion seems to be too hasty and reflect or justify cultural norms, which reject out of hand the idea of pregnancy and motherhood at an early age.

Conclusion

Since the 1970s, adolescent pregnancy has decreased in France. Even as the numbers fall, however, adolescent pregnancy is still attracting the interest of politicians and the media. Among these claims makers, adolescent pregnancy is defined as a "major public health issue." The "unwanted" character that we attribute systematically to the adolescent pregnancies seems to reflect their socially "undesirable" character (Durand et al. 2002). Such attitudes are not based on what is best for the adolescent but are based on a distorted view that adolescent girls who become pregnant are not complying with the accepted reproductive norms of French society (Le Den 2012).

The decline in age at childbearing and the fact that each life stage (e.g., graduation, professional career debut, parenting, ...) must be completed within a age group increasingly restricted have not made desirable teen pregnancies in our societies. The argument most often presented against adolescent pregnancies is adolescent pregnancy disrupts or ends an adolescent girl's education. As a mother, she would experience socioeconomic insecurity due to barriers preventing her from gaining adequate employment, and she would experience difficulties caring for a child. However, no data or research can actually be presented that justifies these assumptions or explain the influences of the social environment on precocious pregnancy. Often we do focus on the living conditions of these young women as they enter into motherhood based on the premise that they will need child-related care and services as they raise their child(ren). While it is true that the socioeconomic issue among women who have children later in life is the determining factor in childbearing, this is not the case for teenage mothers. The observation that socioeconomic stability is important to older women when they become mothers may not hold true for adolescent girls, since their life course is quite different at the time they become pregnant. The fact remains that adolescents who carry their pregnancy to term are a very specific group. They are profoundly affected by issues related to disadvantaged environments, their level of interest in obtaining an education and employment, and their perception of limited future prospects. For some of these girls, the birth of a child is a way for them to acquire social status.

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