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Contraceptive Paths of Adolescent Women Undergoing an Abortion in France

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Abstract

Purpose—Although more than 30,000 teenagers had an induced abortion in France in 2007 (14.3% of all abortions), little is known about their abortion experience. We explore young women's decisions related to their abortion and the patterns of abortion care among teenagers in France, and draw particular attention to the contraceptive circumstances surrounding the abortion.

Methods—The data are drawn from the French National Survey of Abortion Patients conducted in 2007, comprising 1,525 women aged 13–19 years.

Results—A majority of French teens (82%) reported their pregnancy was unplanned and took on the responsibility of having an abortion: 45% made the decision alone, 46% shared the decision with their family or partner, and 9% reported the decision was made on their family's or partner's request alone. Sixty-nine percent of teenagers were eligible for both medical and surgical abortions, but only 43% thought they were given a choice of methods. Two-thirds of pregnancies were caused by contraceptive misuse or failure, mostly due to condom slippage or breakage (26%) or inconsistent pill use (20%). In 68% of cases, teenagers were prescribed a more effective method than the one they were using before, although only 11% received a prescription for a long-acting method. One in five teenagers reported not receiving a prescription for contraception.

Conclusions—Our results reveal varying degrees of young women's autonomy in the decisions regarding their abortion. Although most teens switch to more effective methods of contraception after an abortion, only a minority receives a prescription for a long-acting method.

Keywords

Induced abortion; Contraception behavior; Teen pregnancy; Patient-centered care; National survey; France

Abortion rates between 2000 and 2007 have remained rather stable for all women in France (14.7/1,000 women per year in 2007, the last year for which statistical data are available),

but have increased among teenagers (15–19 years), from 14 per 1,000 per year in 2001 to 15.6 per 1,000 per year in 2007 [1]. These figures include all teens and therefore underestimate abortion rates among sexually active teens [2]. The recent increase in teenage abortions partially reflects a higher propensity to resort to abortion over time. Between 2001 and 2007, the teen birth rate in France, relatively low in Europe [3], has slightly decreased from 10.4 to 9.6 per 1,000 women aged 15 to 19 years, whereas the abortion ratio has increased from 1.4 to 1.6 [1,3,4]. Six of 10 teen conceptions (60.9%) ended in abortions, representing >30,000 terminations performed in France in 2007 (14.3% of all abortions) [1].

The recent increase in teen abortions must be viewed in the context of a dramatic decline in teenage pregnancy rates since the early 1980s, which outpaced the overall decline in the fertility rate in the 1980s [5]. In 1980, 28 of 1,000 young girls had given birth by the age of 18 years, and 24 had had an abortion. In 1997, only 12 per 1,000 teenagers had given birth while the proportion having had an abortion remained constant [6].

Despite the sharp decrease, teenage pregnancy has progressively emerged as a public health concern, drawing considerable attention from the healthcare professionals and policy makers. However, beyond the media portrayal of teenage pregnancies extensively covered in the form of distressing personal stories (the type of media coverage in France is similar to that in the United Kingdom [7]), very little is known about teenagers' abortion experience in France. Using the first large nationally representative survey of abortion patients conducted in 2007, we explore teenagers' decisions related to their abortion, including with whom they discussed the abortion in the context of the elimination of the mandatory requirement for parental consent for minors, enacted in the 2001 revision of the French Abortion Law. We also examine the patterns of abortion care in hospital and in physician's private office settings (all surgical abortions are performed in hospitals in France, whereas medical abortions can be performed in both settings since 2004). We draw particular attention to young women's autonomy in the ability to choose the abortion technique among those who were eligible for both techniques. In 2007, medical abortion in France was officially limited to pregnancies <8 weeks since the last menstrual period (LMP), although clinical guidelines indicated its effectiveness and safety for pregnancies up to 9 weeks since LMP. The gestational age was officially extended to 9 weeks since LMP by the National drug safety agency in 2008. The French abortion law requires that women be given the choice of techniques for early abortions. Previous studies have shown that women who express a preference feel strongly about their choice [8,9], and that those who choose the abortion technique they favor are more likely to be satisfied with the procedure than those who are randomized to receive either medical or surgical treatment [8,10]. In the last part of this study, we explore young women's contraceptive circumstances surrounding the abortion and more specifically focus on postabortion uptake of long-acting reversible contraception, as these methods are known to have lower typical-use failure rates [11,12], especially among teens [12]. The use of these methods is typically low among teenagers in France; data from the 2005 National Health Barometer survey, a population-based omnibus survey on health conducted every 5 years, showed that no teenagers aged 15–19 years reported using intrauterine devices (IUDs), and only .8% reported using implants [13].

Methods

The data for this study are part of a nationally representative survey of 8,245 women having an elective abortion in France between April and September 2007. The study received the approval of the relevant French government oversight agency (the Commission Nationale de l'Informatique et des Libertés). The sample was selected using a multistep procedure. First, a sample of 184 public or private hospitals was randomly selected after stratification by region and by caseload, based on the 2006 National hospital abortion statistics. All women

who presented for an abortion in the selected facilities or in a physician's private practice affiliated with the selected facilities during the study period (1 or 2 months depending on women's age and study region) were invited to participate, and were enrolled in the study after giving oral consent. Women aged <18 years (the age when an individual is legally considered an adult in France) were oversampled in regions in which the study period was 1, by extending the enrollment period to 2 months. An estimated 66% of the hospital-based abortions performed in the sampled hospitals during the study period are represented in the data set.

At the time of abortion, 1,573 women (15.7% of the initial sample) were <20 years of age. After excluding women who reported their pregnancy was terminated for medical reasons (n = 48), our study population comprised 1,525 women aged 13 to 19 years.

The National Survey of Abortion Patients was designed to explore the sociodemographic characteristics of women having an abortion, their use of contraception before and after the procedure, and the patterns of access for abortion care in France. Data were collected by two questionnaires at the time of the procedure. The physician or midwife who performed the abortion collected medical information on women's medical and reproductive histories, on the date of the LMP and gestational age at the time of the abortion, and on the medical protocol. Women completed a self-administered questionnaire collected at the time of the abortion (after the aspiration or after they received mifepristone), providing information on their sociodemographic background and the circumstances surrounding the decision to have an abortion (including whom they had talked to and who had made the decision about terminating the pregnancy). More specifically, they were asked "Did you make the decision to terminate the pregnancy (*multiple choices*): at your partner's request/at your family's request/as a couple/because you decided it yourself." We defined a hierarchical variable using the following algorithm: women who stated they made the decision on their own with no other responses were considered in a specific category, those who made the decision on their own but also stated that it was a couple's decision or the decision was made on their family or partner's request were considered to have shared the decision, and women who did not participate in the decision (either alone or as a couple) were categorized either as having made the decision on their partner's request alone or on their family's request alone.

Women were also asked about their contraceptive use at the time of conception and the type of prescription they received during the course of abortion care. More specifically, they described the last form of contraception they had used before finding out they were pregnant, if and when they had stopped using the method in the month they became pregnant. Further information included reasons why they thought they had become pregnant. Response items included missed pills, condom breakage or slippage, IUD failure, emergency contraception failure, method (condom, spermicides) not used at that act of intercourse, and so forth. Women were also asked in a separate question whether they had used emergency contraception to try to avoid the current pregnancy. Postabortion contraceptive prescription was assessed by asking women whether they were prescribed a method of contraception, and what form of contraception they had been prescribed. In another section of the survey, women were asked to describe the patterns of access to the abortion facility. A common anonymous identifier for each woman linked the medical and the patient questionnaires.

After describing the sociodemographic characteristics of the study population, we explore the patterns of access to abortion care, including choice of abortion technique. Data on eligibility for both abortion techniques based on gestational age at first contact (medical abortions in France in 2007 were performed before 8 weeks since LMP) were available for 82% of women in the study who provided the date of the LMP and the date of the first

medical contact. We also evaluated the delay between first medical contact and the abortion procedure by type of abortion technique, in the context of a mandatory 8-day waiting period required in France. We finally examined the use of contraception before and after the procedure by women's sociodemographic characteristics using χ^2 tests and studied the predictors of use of highly effective contraceptives after the abortion, using a multivariate logistic regression model. In case of dual method use in the month of conception (14%) or postabortion contraceptive prescription/recommendation of multiple methods (6.3%), we selected the method that was the most effective, based on typical-use failure rates [8]. Our definition of highly effective contraceptives included the IUD and the implant, alone or in combination with other methods (injectables are hardly ever used in France). Although very effective, we did not consider the pill in this category, as typical-use failure rates are twice as high among teenagers as compared with pill failures rates among women aged 30 years [8].

Each woman was assigned a sampling weight that was inversely proportional to the probability of the facility being selected in the sample and to the duration of the study period. A further adjustment was introduced to reflect the characteristics of women having an abortion in France (age, abortion technique, and type of facility), based on national abortion statistics provided by hospital records. All analyses are weighted to take the complex sampling design into account. Analyses were performed using Stata software version 11 SE (StataCorp, College Station, TX).

Results

A majority of young women (59%) were aged 18 years (Table 1). Three-quarters were still living with their parents, and two-thirds were students. Only a minority had given birth before (10%), or were living in a couple (12%). Twelve percent reported they had experienced a prior abortion.

Circumstances surrounding the decision to terminate the pregnancy

A majority of young women (74%) had talked to their partner about the decision to terminate the pregnancy, 41% discussed it with their mother, 30% with friends, 13% with their father, and 21% with another member of the family. Overall, 42.2% of teens had discussed having the abortion with at least one parent. Minors were more likely than older teens to have talked to a parent (48% vs. 38%, $p = .01$). Only 2% of young women had not discussed the issue with anyone. Most teens (61%) stated they had made the decision themselves, 39% declared it was the couple's decision, 10% stated they had made the decision on their family's request, and 12% on their partner's request (sum >100% because multiple responses were allowed). When recategorized in a single hierarchy, 45% reported the decision was theirs alone, 46% shared the decision with their partner or family, and 9% declared the decision was made on their family's or partner's request alone.

When asked about the timing of the pregnancy, 82% of teens reported they had not planned to become pregnant, 7% had planned to become pregnant later, 6% had never thought about it, and 3% did not know. The remaining 2% had planned to become pregnant at that time. This latter group of young women was more likely to state that the decision to terminate the pregnancy was taken on their family's or partner's request alone (33.9% vs. 8.7% for other women, $p < .0035$). Women who contributed to the decision (alone or with their partner or family) were more likely to declare that the pregnancy was not planned at all (83.9% vs. 62.3% for women who terminated the pregnancy at their partner's or family's request alone, $p < .001$) (Table 2). Conversely, those who stated the decision was made on their family's or partner's request alone were more likely to report the pregnancy was planned (8% vs. 1.6%).

Patterns of abortion care

Two-thirds of teenagers (69%) knew where to go to have the abortion at the time they decided to terminate the pregnancy. Half of them contacted a private practitioner first (27% a general practitioner and 20% a gynecologist), 36% a family planning facility, and 13% a private or public hospital.

Sixty-nine percent of teenagers were theoretically eligible for both abortion techniques (medical and surgical), as their first medical contact took place before 8 weeks since LMP, and 8% with no information on the date of first contact had a medical procedure. These women reported they had been given the choice of abortion techniques in 42.8% and 53.4% of cases, respectively.

Forty-seven percent of teenagers had a medical abortion, on average 11.6 days (95% confidence interval [CI]: 10.5–12.7 days) after their first medical contact for the abortion, whereas those who had a surgical procedure waited on average 17.8 days (95% CI: 16.3–19.2 days). The proportion having medical abortions increased to 68% among women eligible for both techniques, and to 81% among eligible women who had been given a choice of abortion procedure. Eligible women who believed they had not been given a choice had a medical abortion in 57.3% of cases. The mean gestational age at the time of the abortion was 8.2 weeks since LMP (7.9–8.4), with a 3-week difference according to the type of procedure: medical abortions were performed on average at 6.4 weeks since LMP (95% CI: 6.2–6.5) and surgical abortions at 9.8 weeks since LMP (95% CI: 9.5–10.1). Eighty-four percent of young women had their abortion in a public hospital, whereas only a minority had a medical abortion in a physician's private office (allowed only for women aged 18 years); among those aged 18–19 years who had a medical abortion, 5% had the abortion in a private physician's office.

Periabortion use of contraception

A small minority of teens (3.4%) had never used contraception before the abortion. Two-thirds (66.5%) reported they were using contraception in the month they became pregnant (Table 3). A quarter of teenagers reported the pregnancy was due to condom slippage or breakage (26%) (representing 84% of the 31% of young women who were condom users), and 19% stated the pregnancy was the result of inconsistent or incorrect use of the pill (representing 93% of the 21% of teens who reported they were using the pill). There were no differences in the proportion of teens reporting no contraceptive use before the abortion, according to young women's age, social, and demographic characteristics (results not shown). However, the percentage of young women using effective methods in the month of conception (mostly the pill) increased with age (from 9% among girls aged < 15 years to 28% among those who were aged 19 years at the time of the abortion). Conversely, the proportion of teens using condoms decreased from 59% among the youngest girls to 37% among 19-year-old girls. Further results of preabortion contraceptive use by age-group are presented in Table 3.

Among the 70% of teenagers who reported a reason for not using contraception at the time of conception, 31% thought they were not at risk of becoming pregnant and 23% had not planned to have sex. Other reasons included problems with contraceptive methods in the past (20%), not thinking about contraception (14%), partner unwilling to use contraception or wanting a pregnancy (7%), cost (5%), and not wanting parents to know about their contraceptive practices (5%). This latter proportion was significantly higher among minors than among their older counterparts (10% vs. 2.3%, $p < .001$).

A minority of teens (12%) had used emergency contraception to try to avoid becoming pregnant, with no significant difference between those who reported using another form of contraception at the time of conception and others (13.2% vs. 9.0%, $p = .07$).

Two-thirds of teenagers walked out of the abortion facility with a prescription for the pill whereas 12% were prescribed a highly effective long-acting reversible method (3.3% the IUD and 8.8% the implant) (Table 4). Although this proportion seemed to increase with age (7.9% among girls <17 years, 11.2% among 17 year olds, 12.6% among 18 year olds, and 14% among 19 year olds), the difference was not statistically significant ($p = .21$). One in five young women reported not receiving a prescription for contraception.

Results from the logistic regression model show greater use of highly effective methods among teenagers living in a couple (odds ratio [OR] = 3.0 [1.8–5.0]), teenagers with children (OR = 3.3 [1.8–6.1]), and those who had had a previous abortion (OR = 2.0 [1.0–4.0]). Young women who had a surgical abortion were also more likely to receive a prescription for a highly effective method than those who had a medical abortion (OR = 1.7 [1.1–2.8]). There was no difference in the rate of IUD prescriptions, however, which was low for all teenagers regardless of the abortion technique (2.4% received a prescription for an IUD after a medical abortion vs. 3.4% after a surgical abortion, $p = .46$). More detailed results of postabortion contraceptive use are provided in Table 5.

In 68% of cases, teenagers received a prescription for a more effective method than the one they were using before the abortion. However, more than half the women who described a pill failure (53%) were prescribed the pill after the abortion, whereas only 20% received a prescription for a highly effective method (Table 4). Conversely, 5% of women who were using hormonal methods received no prescription for a method of contraception after the procedure.

Discussion

Our results provide insights on the realities of teenage abortions in France, revealing varying degrees of young women's autonomy in the decisions related to their abortion. A vast majority of French teens reported their pregnancy was unplanned and took on the responsibility of having an abortion. Such results reflect the prevailing social norm to postpone childbearing. These findings are consistent with the conclusions of a qualitative Swedish study of teens having an abortion, who in many cases viewed abortion as the “natural choice” to avoid social exclusion, although our study did not directly assess young women's reasons for having a pregnancy termination [14]. As maternal age at childbearing increases (age at first childbearing was 28 years in France in 2008 [15]), a strong consensus in Western and Northern Europe, including France, generally views childbearing as belonging to adulthood [14]. Teenage motherhood is generally no longer considered a responsible option, the norm strongly favoring abortion as a path toward greater social opportunities for women. Although our results are consistent with this line of reasoning, we also found that a small minority of teenagers became pregnant accidentally (8%) or intentionally (1%) and may have felt pressured to terminate their pregnancy, as they themselves were little involved in the decision to have an abortion. These results are likely to relate to the “feelings of powerlessness,” expressed by ambivalent teenagers in the Swedish qualitative study providing a more in-depth analysis of this particular topic [14], which raise concern for young women's freedom of reproductive choices. As social pressure to shape women's decisions about pregnancy termination limits their fundamental rights to choose, whether it be to pursue or to terminate the pregnancy depending on the prevailing social norms, professionals and peers should take a more neutral approach in supporting these young women in their decision regarding their reproductive options [14,16]. A vast

majority of teens in our study talked about the abortion decision with someone, most likely their partner followed by family or friends. However, they were much more likely to discuss the issue than to share the decision to have an abortion. Our results also suggest that the elimination of the mandatory requirement for parental consent for minors has lifted a burden from many young women who do not wish to discuss their decision with a parent. Half of women aged <18 years in our study talked about the issue with a parent when they considered having an abortion, but only a minority shared the decision with their family.

Although a vast majority of teenagers were actively engaged in the decision to have an abortion, less than half thought they had participated in the choice of abortion technique. As found in other countries, teenagers were less likely to be eligible for medical abortion than all abortion patients in France (69% vs. 76% [17]), due to delay in the timing of first consultation [17,18]. Eligible teens were also less likely than all eligible abortion patients to consider they had been given a choice of procedure (42% vs. 50% [17]), which reflects the difficulties in shifting from a paternalistic to a more patient-centered approach to abortion counseling, especially for teenage patients. Empowering young women to make their own informed decisions regarding abortion care is key in improving their overall abortion experience, as shown in previous studies reporting higher levels of short- and long-term satisfaction with the procedure when women participated in the choice of abortion technique [9,10].

As with most abortions in France, a majority of teen abortions were the result of contraceptive misuse or failures, although teenagers were more likely to report condom failures and less likely to describe pill failures compared with their older counterparts [19]. The higher proportion of condom failures as age decreases was also evident in our study showing girls aged <16 years were more likely to report condom use in the month they conceived than their older counterparts. These differences reflect the changes in contraceptive practices over the life course, with younger women favoring condom use over more effective methods at sexual initiation due to HIV and STI concerns [13,20]. As condom failures are common (18.4% within the first year of use according to the latest National Survey of Family Growth estimates), it is critical to anticipate errors of use by promoting dual method use or the use of emergency contraception to prevent unintended pregnancies at sexual debut [12]. However, the promotion of more effective long-term reversible methods may have greater public health impact, as they are not dependent on user compliance [12]. In line with other studies of abortion patients in Europe or in the United States, teenagers were prescribed more effective methods after the abortion than before the procedure. Although postabortion prescription of contraception imperfectly reflects actual use, a prescription is a prerequisite for use of hormonal or other highly effective forms of contraception. Therefore, the small proportion of women who received a prescription for highly effective contraceptives reflects the remaining obstacles in promoting use of these methods, especially IUDs, among young women despite the fact they are the second most popular method of contraception in France [13]. Barriers to use result from health-care providers' reluctance to prescribe IUDs for young women because they are at higher risks for STIs, although the World Health Organization evidence-based medical guidelines for contraceptive use and the French guidelines recommend use of IUDs as a safe and highly effective option for all women, including adolescents and nulliparous women [21,22]. An additional barrier is young women's lack of knowledge or misconceptions about these contraceptive options. Finally, obstacles to postabortion IUD insertion may involve a preference for delayed over immediate insertion (in the case of surgical abortion) due to higher rates of perforation or expulsion [23]. However, recent studies have challenged this view by showing that the benefits of immediate postabortal IUD insertion over delayed insertion, which women favor [24], outweigh the risks because the continuation rate is higher [25] and the risk of repeat abortion is lower [25]. Moreover, the mandatory 8-day

waiting period in France between the first medical visit and the day of the abortion provides an opportunity to screen for and treat STIs before women undergo the abortion, reducing their risks of postabortal [26,27] and post-IUD infection [28]. Expanding young women's contraceptive options and facilitating their access to highly effective methods that do not require daily or coital adherence are critical steps in helping young women gain control over their own fertility.

This main methodological limitation of this study is the 34% nonresponse rate. However, a substantial proportion of nonresponse is likely due to nonparticipation of providers rather than to the refusal of women, as 40% of health professionals did not respond to the survey at the start of the study. Poststratification on the type of facility, geographical location, women's age, and abortion technique was applied to correct for potential nonresponse bias related to these issues. Other limitations are the lack of data exploring women's reasons for having the abortion and the absence of longitudinal data assessing actual use of contraception after the abortion.

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Table 1

Characteristics of teenagers undergoing an abortion in France in 2007

Total	n = 1,525	%
Age	15 or less	8.0
	16	13.7
	17	19.2
	18	28.1
	19	31.1
Living in a couple	Yes	12.3
	No	87.7
Type of residence	Independent housing	16.4
	Lives with parents	74.7
	Other situation (student housing, lives at friends' house...)	8.9
Number of children ^a	0	79.9
	1	6.2
	2 or more	2.4
	Missing	11.5
Prior induced abortion ^a	Yes	10.2
	No	78.2
	Missing	11.6
Country of birth	France	91
	Sub-Saharan Africa	4.4
	Northern Africa	1.3
	Western Europe/North America/Australia	1.0
	Other	2.3
Level of education	Less than high school	71.8
	High school graduation professional training	9.4
	High school graduation	14.6
	More than high school graduation	4.0
Professional situation	Work	8.9
	Unemployed	10.7
	Student	66.2
	Other	14.2
Health insurance	No insurance or government aid	7.8
	Own social security	11.2
	Parents' social security	24.0
	Own social security and private insurance	24.0
	Parents' social security and private insurance	33.0
Abortion care		%
Medical facility	Public hospital	84.1
	Private hospital	12.8
	Physician's private practice	3.1

Total	n = 1,525	%
Abortion technique	Medical	47.1
	Surgical	52.9

^aInformation on prior abortion and number of children was collected from the physician questionnaire that was missing for 180 young girls.

Table 2

Decision-making process according to pregnancy intendedness

Decision-making category	Planned at that time	Planned later	Not at all planned	Did not think about it	Do not know	Total
Own decision alone	2.1%	3.6%	86.8%	4.9%	2.7%	100.1%
Shared decision with partner or parents	1.1%	8.0%	81.0%	5.5%	4.3%	99.9%
Decision on parents' or partner's request alone	8.0%	18.9%	62.3%	8.8%	2.0%	100.0%

$p < .001$.

Table 3

Contraceptive methods in the month of conception

Contraception at the time of conception	Total %	<18 years %	18–19 years %	p^a %
No contraception	33.5	30.3	35.7	<.001
IUD, implant	.5	.0	.8	
Patch/vaginal ring	.5	.4	.6	
Pill	20.6	14.0	25.1	
Condom	31.3	42.8	23.3	
Other barrier methods	12.0	10.9	12.9	
Emergency contraception	1.7	1.7	1.7	

^aThe χ^2 test by age-group was performed using a three category preabortion contraceptive variable (no contraception/barrier-natural or EC use/hormonal or IUD use).

Table 4

Postabortion contraception prescription/recommendation according to contraceptive use before the procedure

Prescription/recommendation (in the case of barrier or natural methods) of contraception after the abortion	Contraception before the abortion				Total
	No contraception	Patch-vaginal ring	Pill	Condom/barrier or natural methods	
No contraception	6.7%	.1%	5.1%	7.6%	19.6%
IUD	.7%	.1%	1.3%	.6%	2.8%
Implant	3.3%	0	2.6%	2.8%	8.8%
Patch-vaginal ring	.9%	0	.3%	1.1%	2.3%
Pill	21.6%	.7%	10.7%	33.1%	66.0%
Condom/barrier or natural methods	.2%	0	0	.20%	.4%
Total	33.5%	.9%	20.1%	45.4%	100%

Table 5

Contraceptive prescription/recommendation after the abortion

Contraceptive prescription/recommendation after the abortion	Total %	<18 years %	18–19 years %	<i>p</i> ^a %
No prescription	19.5	17.5	20.9	.41
Implant	8.8	1.1	4.2	
IUD	2.9	8.4	9.2	
Patch/vaginal ring	2.3	2.3	2.4	
Pill	66	70.3	63	
Condom	.4	.5	.3	

^aThe χ^2 test by age-group was performed using a three category postabortion contraceptive prescription/recommendation variable (no contraception/barrier-natural or EC use/hormonal or IUD use).