Teenage Sexual and Reproductive Behavior in Developed Countries

Country Report For France

Nathalie Bajos
Sandrine Durand

Occasional Report No. 5
November 2001

THE ALAN GUTTMACHER INSTITUTE
NEW YORK & WASHINGTON

Acknowledgments

This report is part of The Alan Guttmacher Institute's cross-national study, *Teenage Sexual and Reproductive Behavior in Developed Countries,* conducted with the support of The Ford Foundation and The Henry J. Kaiser Family Foundation.

The *Country Report for France* was written by Nathalie Bajos and Sandrine Durand of Institut National de la Santé et de la Recherche Médicale (INSERM). Review of the manuscript, copy-editing and formatting were provided by AGI staff.

Other publications in the series, *Teenage Sexual and Reproductive Behavior in Developed Countries* include country reports for *Canada, Great Britain, Sweden* and *The United States*, a report that summarizes and compares the five countries: *Can more Progress be Made?* And an executive summary of this report.

Suggested citation: Bajos N and Durand S, *Teenage Sexual and Reproductive Behavior in Developed Countries: Country Report for France*, Occasional Report, New York: The Alan Guttmacher Institute, 2001, No. 5.

For more information and to order these reports, go to www.guttmacher.org.

© 2001, The Alan Guttmacher Institute, A Not-for-Profit Corporation for Reproductive Health Research, Policy Analysis and Public Education

Table of Contents

Part I. Levels and Trends in Adolescent Sexual and Reproductive Behavior

Birthrates and Abortion Rates

Since the early 1980s, the number of births among minors has been steadily declining in France. The actual number of births to women 15–17 dropped from 6,597 in 1980 to 2,462 in 1995, resulting in a pronounced drop in the birthrate, from 5.1 per 1,000 in 1980 to 2.2 per 1,000 in 1995. A similar trend is found among 18–19-year-olds, whose birthrate fell from 37.2 per 1,000 in 1980 to 14.2 per 1,000 in 1995. The birthrate among women 20–24 also declined, going from 121.5 per 1,000 in 1980 to 56.5 per 1,000 in 1995 (see Appendix A, Table A1).

Age at First Birth

The declining birthrate among young French women is part of an overall rise in the average age at childbirth in recent years. The average age of women giving birth in France has gone from 26.7 years in 1975 to 29.1 in 1996.[1] And according to vital statistics, women's age at first birth has risen from 24.4 years in 1980 to 26 in 1989 and to almost 28 in 1998.[2]

Birthrates and Abortion Rates by Age and Marital Status

Despite this very marked and steady drop in the birthrate among young women, there has been no accompanying increase in the number of adolescent abortions. In 1995, 5,641 abortions were performed among women 15–17, compared with 7,301 in 1980. This decrease in absolute numbers also resulted in a somewhat reduced abortion rate among minors. The abortion rate fell from 5.6 per 1,000 women 15–17 in 1980 to 5.1 per 1,000 in 1985 and 1990, and then to 4.9 per 1,000 in 1995. Among women 18–19, the abortion rate fell from 17.4 per 1,000 in 1980 to 13.0 per 1,000 in 1990. In 1995, it went up again slightly to 14.3 per 1,000—about the same rate as that reported in 1985. A very slight decrease in the abortion rate was also found among 20–24-year-olds, going from 21.2 per 1,000 in 1980 to 18.3 per 1,000 in 1990 and 1995. These data demonstrate that by 1995, the overall pregnancy rate (births plus abortions) among young French women had dropped to almost half its 1980 level among women 18–19 and women 20–24, and had declined by one-third among girls aged 15–17 (see Appendix A, Table A1).

These data cannot be used to study patterns of adolescent reproductive behavior by marital status because we do not have updated census data that would make such an analysis possible (unfortunately the most recently available census in France dates back to 1990).[a] Furthermore, data on the union status of women having an abortion are themselves also often incomplete: 6% of women having abortions in 1995 did not report their legal marital status, and 9% did not report their de facto union status.

Nevertheless, we do know that births to minors are proportionally much higher among the married than among the unmarried simply because there are so few married teenagers at age 15–17. For example, in 1995, the birthrate among married women 15–17 (of whom there were only 531) was 482 per 1,000, while it was only 1.9 per 1,000 among unmarried 15–17-year-olds (of whom there were over 1.1 million). This very high birthrate among married 15–17-year-olds suggests that a small handful of young teenage girls become pregnant each year and marry to legitimize the birth (see Appendix A, Table A2).

The abortion rate is also much higher among 15–17 married women (50.8 per 1,000 in 1995) than among unmarried women (4.5 per 1,000). However, the absolute number of abortions is much higher among unmarried young women (5,150), some of whom are cohabiting, than among married adolescents (27).

[a] As of mid-1999, the results of the 1999 census were not yet available.

In 1994, the government carried out a survey of sexual behavior among a nationally representative sample of young men and women aged 15–18—Analyses des Comportements Sexuels des Jeunes, or ACSJ.[3] Data on birthrates among minors obtained from the 1994 ACSJ may be used to illustrate further some of the changes that have been taking place in age at first birth (for the vast majority of minors, births at 15–17 are first births). These data confirm, as we have already seen, a decline in the birthrate among minors, at least since 1980. However, we do not know whether these trends have affected all social groups in the same way. The 1994 ACSJ shows that 1.3% of all young women 15–18 (1.2% at ages 15–17 and 1.8% at age 18) have ever been pregnant, regardless of outcome. This proportion is 3.3% among adolescent women who have had sexual intercourse. However, among sexually experienced young women 15–18, 2% of those receiving an academic secondary education[b] have been pregnant, compared with 15% of those in vocational training. Among this same age group, 1% and 9%, respectively, have had an abortion.[4]

According to a recent health evaluation of young people 15–19, 6% of sexually active female adolescents have been pregnant and of those, 20% carried the pregnancy to term (that is, 0.5% of all French women).[5] So four out of five pregnant girls had either a miscarriage or an abortion. According to the 1994 ACSJ, the level of adolescent pregnancy and abortion in France is particularly high among students in vocational schools. Six percent of girls who had their first intercourse within the last two years, and more than 10% of those who began having intercourse within the last three years, had an abortion.[6]

Sexual Activity and Contraceptive Use

Age at First Intercourse

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.[7] 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 1922–1935 than among men in that same cohort (a mean of 21.3 years for women, versus 18.4 years for men). The most marked decrease is seen among young men and women whose sexual lives started during the 1960s, a period of dramatically changing social values, when the women's movement was fighting for legal contraception and abortion and the student movement culminating in the May 1968 protests was taking place. 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.[8]

The results of the 1994 ACSJ show that today young people of both sexes have their first sexual intercourse at practically the same age (median age of 17 years 3 months for boys and 17 years 6 months for girls). Overall, there is greater discontinuity in patterns of sexual initiation between successive cohorts of women than among men.

It is noteworthy, nevertheless, as the data in Appendix A, Table A3 reveal, that more than half of adolescents 15–17 have not engaged in sexual intercourse (62% of girls and 56% of boys). Among 18-year-olds, nearly one-third (34% of girls and 30% of boys) are still virgins/sexually inexperienced. Moreover, one in 10 young men and women 15–18 claim never even to have engaged in kissing or any kind of "necking." However, about 52% of girls and 46% of boys in this age group say they have engaged in sexual behaviors that do not involve actual intercourse. Among young people who have had sexual intercourse, nearly 3.5 years separate the median age at first kiss from the median age at first intercourse for both boys and girls.[9]

Despite the pronounced convergence in the timing of sexual initiation for the two sexes, perceptual differences between young men and young women remain significant. The 1992 study of adult sexual behavior in France, Analyse des Comportements Sexuels en France, or ACSF,[10] shows that two-thirds of women 18–49 report that they were very much in love with their first partner. In contrast, only one of every three men 18–49 says he was in love with his first partner. For them, the first sexual encounter is mostly a learning experience in sexual technique, or to build a self-image, rather than a real relationship.[11] These differences in perception are still found in the 1994 ACSJ. The majority of girls 15–18 have their first relationship out of love, while nearly half of the

[b] There are two distinct tracks in France's secondary education system: high schools (lycées), at which students specialize in either general or technical academic subjects; and vocational training (or 'professional') schools. In the school year 1998-1999, according to French Ministry of Education statistics, there were 2.3 million students in French secondary schools. Of these, 34% were in vocational schools and the remainder, in lycées (see www.education.gouv.fr/syst/default.htm).

boys do so because of attraction or physical desire.[12]

In every generation, social factors strongly affect behavioral patterns. Age at first intercourse is always lower among blue-collar groups, regardless of the time period, and increased educational level is associated with a delay in sexual initiation.[13] The 1994 ACSJ shows that young people who are in apprenticeship programs or vocational schools begin their sexual lives earlier than students following academic high school careers (see Appendix A, Table A8).[14] Furthermore, while there has been a general convergence of timing between girls and boys in academic high schools, among students in vocational training the sexual debut of boys precedes that of girls by four to five months.[15]

The 1992 ACSF suggests that whether people have their first sexual relationship at an early or later age tends to foreshadow lasting attitudes toward sexuality, couple relationships and even family life.[16] People who become sexually active at a very young age tend subsequently to lead less "orderly" and more complex personal lives. They have more sexual partners in the course of their lives–first during adolescence, but also during periods when they are in a relationship. Consequently, sexual lifestyles become apparent at quite an early age, and condition behaviors that strongly affect patterns and levels of sexual risk.[17]

Number of Sexual Partners

Almost all adults understand a sexual partner as being a person with whom they have had complete sexual intercourse. For minors, this definition is less straightforward. Some young teenagers consider that a sexual partner is a person with whom they have had any sexual contact, whether or not intercourse occurred. Previously, we said that more than half of young people 15–17 and nearly one-third of 18-year-olds have not had sexual intercourse. Yet studying the number of sexual partners young people have had raises particular problems since the 1994 ACSJ does not clearly distinguish between the sexual partners with whom respondents had complete intercourse and other kinds of "sexual" partners.

The proportion of young people who have had several sexual partners (with or without sexual intercourse) during their lifetime increases from 35% among boys 15 and 16 to 50% among those age 18. Among girls, these percentages are, respectively, 24% and 40%. The proportion of boys who have had five partners or more exceeds 12%. It is 5% for girls. The proportion of young people 15–18 who have had full sexual intercourse with several partners[c] over the past 12 months is estimated to be 40% for boys and 27% for girls. In other words, once they have had intercourse, exposure to the risk involved in acquiring a new partner affects all young people in the same way, regardless of age.[18]

Among young people who had their first intercourse at least one year before the survey, boys report more partners than girls, regardless of age (see Appendix A, Table A4). This is probably not because boys are slightly more sexually precocious than girls, but because their first relationships are briefer.[19] Among boys, multiple partnership is linked to how long they have been sexually active and, to a lesser extent, to the type of secondary education (multiple partnership being more widespread among young boys going to vocational schools than among those in academic high schools). Among girls, multiple partnership is also linked to length of sexual activity, regardless of age. However, unlike boys, girls attending vocational programs are less likely than those in academic high schools to have multiple partners.[20]

The proportion of men and women 18–49 who have not had a sexual partner for the past 12 months (because they have never had sexual relations or have not had a partner recently) decreases with age. Among women it falls until age 39, and then rises slightly (7% of women 45–49 no longer have sexual partners) (see Appendix A, Table A13).

The majority of French men and women report that they have had only one sexual partner over the past twelve months. The number of multiple partnerships (at least two partners within the past 12 months) is always higher among men than among women, a phenomenon found in all surveys. This finding is partially attributable to the fact that men count all of their sexual relations, while women—in line with social norms on female sexuality—are more likely to count only the sexual relationships that were really important to them. Multiple partnership is less common among adults than among minors. It is more frequent among 18–24-year-olds, affecting nearly one in every 10 women and nearly one in every four men. With increasing age, the practice of multiple partnerships then tends to stabilize, at a little more than one woman in every 20 and one man in every 10.

We should point out that multiple partnership is

[c] It is not possible to determine the precise number of partners.

not the same thing for adults as for young people. In fact, one of the features of sexual intercourse among young people is that their relationships are brief and the interval between two relationships is quite long.[21] The older people get, the more serial partnership decreases and is replaced with more overlapping relationships. The change toward concurrent multiple partnership that we find more often among adults occurs progressively.

Frequency of Intercourse

Adolescents appear to have intercourse less frequently than adults (see Appendix A, Table A5). Half the girls and nearly two-thirds of the boys who have ever had sexual relations have intercourse once a week or less. Girls 15–17 and those aged 18, who have engaged in lengthier sexual relationships, have intercourse more frequently than boys.[22] This pattern is also found among young people aged 18 and 19, where girls have intercourse more frequently than boys. For these young adults, the most common frequency is one sexual encounter per week. For adults over age 20, it is four times a week (see Appendix A, Table A14). The trends are the same for both sexes and analysis of responses from French men and women aged 18–69 attests to a great consistency in the responses of men and women, contrary to what we find for the number of partners.[23]

Contraceptive Use at First Intercourse

Among adults, even before the beginning of the AIDS epidemic and before the campaigns promoting condom use (these started in 1987), there were substantial changes in contraception at first intercourse. Seventy-two percent of women born between 1949 and 1953 (aged 40–44 in 1994) did not use any contraceptive method at first intercourse, 14% used the pill and 8% used a condom. However, among women born between 1969 and 1973 (aged 20–24 in 1994), 32% used no contraceptive method at first intercourse, 44% used the pill, 27% used a condom and 1% used the pill and a condom[d,24]

These trends continue and are becoming more pronounced. According to the 1994 ACSJ, 70% of girls 15–18 who had sexual intercourse reported the use of a condom at first intercourse, and 17% used the pill. For boys, these figures are 75% and 20%, respectively. In other words, the reporting of both sexes very much agrees. Most often, a condom was used alone, but nearly one out of five times, it was used in combination with another contraceptive method—most often the pill. It is noteworthy that 10% of girls and 6% of boys used no contraceptive method at first intercourse.

One of the most remarkable findings is the large increase in condom use during recent years. In 1989, 57% of young men and women 15–18 used a condom at first intercourse, and this figure increased to 85% in 1994.[25] Condom use is more common among men who became sexually active at an early age; among girls, no similar relationship appears. The large increase in condom use does not seem to be at the expense of pill use. According to boys' reports, use of the pill at first intercourse increased slightly through 1992; according to girls, it fluctuated, without any marked underlying trend.[26]

Contraceptive use at first intercourse varies by type of secondary schooling. Young men and women enrolled in vocational schools are much more likely to use the pill and less likely to use the condom than students in academic high schools. However, age at first intercourse, as we have seen, also varies by educational track, so it is difficult to talk about a specific educational effect (see Appendix A, Table A9).

Contraceptive Use at Last Intercourse

Young people's contraceptive use at last intercourse differs markedly from their use at first intercourse. In particular, the 1994 ACSJ shows that use of the pill is more widespread at most recent intercourse than at first intercourse (18% vs. 7% among girls 15–18 and 14% vs. 10% among boys) (see Appendix A, Table A7). At the same time, condom use decreases (13% vs. 30% among girls, and 15% vs. 37% among boys). Simultaneous use of a condom and another contraceptive method at first intercourse decreases among girls in all types of school, but not among boys. While condom use at first intercourse is not linked to whether the girl is taking the pill, at last intercourse, in contrast, condom use appears to be very much linked to whether the partner is also taking the pill. The condom is used in 46% of cases when the partner is taking the pill and in 83% of cases when she is not taking the pill, according to boys; these figures are 19% and 79% according to girls.[27] The differences by type of schooling at first intercourse continue to hold true for girls but not for boys, that is, the pill is used more often and the condom less often by young

[d] No data on contraceptive use at first sexual intercourse are available in the 1992 ACSF.

people in vocational school than by academic high school students.

The 1992 ACSF indicates that up until age 35 the most widely used contraceptive method at last intercourse is the pill; at later ages, the IUD becomes the most common method (see Appendix A, Table A15). The condom now occupies a significant place: it is used by 8-18% of women and 11-53% of men. It is often used in combination with a medical method, especially among those under the age of 25. The discrepancy in the responses of men and women on the subject of the condom is found in all surveys. It is partly the result of the difficulty certain women have in reporting the use of a method whose social image remains associated with the high-risk sexual behavior that some term "easy," and which is consequently socially unacceptable. The data on the use of the condom alone without another method lead us to believe that the condom is now an accepted method of contraception in France.

Throughout the 1970s, there were broad social differences in contraceptive practice. However, according to a 1988 national survey, patterns of contraception were becoming more homogeneous, and by that year use of the pill no longer depended on level of education, profession or urban-rural residence. However, IUD use remains higher among the most educated women.[28] The 1992 ACSF found that young women 20–24 from the most privileged social backgrounds (having high levels of education) are somewhat more likely to use the pill and less likely to use the IUD than their less well educated counterparts. However, we cannot speak about a class effect, since both the timing of relationships and family planning patterns differ among the various social groups.

STDs and HIV/AIDS

According to the 1994 ACSJ, 1.4% of boys who have already had sexual intercourse report that they have had a sexually transmitted disease (STD). This is the case for 6% of girls. Fungal infections, which, among women, are not predominantly sexually transmitted, represent 83% of the STDs reported by girls and 24% of those reported by boys. After eliminating fungal infections from consideration, the STD rate is the same for girls and boys—1.1%. This figure increases to 2% for both boys and girls who have been sexually active for more than two years. Among 18–24-year-olds, 4% of heterosexual men and 7% of women report that they had had an STD in the five years preceding the survey. If we exclude fungal infections, these percentages decrease to 2% among men and 1% among women.[29]

Ten percent of sexually active young people are considered to have been at risk of contracting STD/HIV during their last sexual intercourse.[e] Furthermore, 2% of young people who had their first sexual intercourse in the previous two years reported a history of non-fungal STD. This is probably an underestimate because some of those infections were undetected.[30] Furthermore, according to the Gynechla survey, nearly 5% of young women under age 21 seeing a private gynecologist were carriers of Chlamydia trachomatis.[31] However, there are no special prevention and screening protocols for that disease, even though it is recognized as contributing to certain aspects of low fertility in women. According to the 1995 PREVADAV conducted among practitioners in STD clinics, the seropositivity rate among 18–25-year-olds fell by 4% in 1991, 3% in 1992, and 1% in 1993 among patients who were less than 25-years-old.[32]

According to the 1997–1998 Barometer of Young People's Health survey (Baromètre Santé Jeunes) conducted by the French Health Education Committee (Comité Français d'Education pour la Santé), which evaluates the health of young people 15–19, girls are more likely than boys to have undergone HIV testing (12.4% vs 8.5%).[33] This percentage greatly increases with age, particularly, after age 18.

Summary

The quality of birth and abortion reporting has hardly changed since the early 1980s.[f] Trends in France can therefore be characterized by a decline in the birthrate among minors and young adults, stability in the abortion rate among minors, and a slight drop in the abortion rate among women aged 18–24. Overall, the decrease in the birthrate was not accompanied by an increase in the abortion rate among young women. Consequently, in addition to indicating a delay in the timing of the first birth, these data suggest a positive trend in contraceptive behavior.

[e] The definition of at-risk refers to young people with multiple partners who did not use a condom during their last sexual intercourse with a partner who possibly, or certainly, had multiple partners and whose serologic status was unknown.

[f] It is believed that approximately 15% of abortions performed in France are not reported and are therefore not included in these statistics. We cannot know whether underreporting involves particular age or union groups.

Lower pregnancy rates are occurring within the context of a declining age at first intercourse for women. Today, girls begin their sexual life at approximately the same age as boys. However, the perception of that first experience is very different for girls than for boys. First intercourse occurs at a younger age among adolescents from a blue-collar background. Early sexual initiation can foreshadow sexual life styles with adverse impact on patterns of sexually-related health risk. Pregnancy, whether it ends in abortion or childbirth, is more common among young people from less privileged social backgrounds.

Another notable feature of patterns of sexual intercourse among young people is that their relationships tend to be of brief duration, and the interval between relationships to be quite long. Among boys, having multiple sexual partners is associated with the length of time they have been sexually active and is found more often among students in vocational training. Among girls, multiple sexual relationships are rare.

From the perspective of preventive behaviors, the most remarkable phenomenon is the very marked increase in condom use in recent years. Today, in 20% of cases, the condom is used in combination with another method of contraception, most often the pill. This increase in condom use does not seem to be at the expense of the pill, at least in 1995. Moreover, once a relationship becomes stable, the pill tends to supplant the condom as the couple's method of contraception. The available data do not indicate whether there are significant differences by socio-economic status in access to methods of contraception and prevention. This does not mean that those effects do not exist, but considering the number of confounding factors (age at first intercourse, time since first intercourse, type of secondary education), we cannot quantify such effects. They are, however, to be expected, in view of existing differences in abortion levels (that is, in unwanted pregnancies) by young women's socio-economic status.

Part II. Societal Attitudes about Sexuality

General Level of Openness toward Sexuality

In the 1950s, the sexuality of young people had not yet become a topic for discussion in France.[34] Passage of the Neuwirth Law in 1967, legalizing contraception, affirmed the emergence of sexuality as a subject of public debate and marks the beginning of official government involvement in this area. There was almost no public discussion about sexuality among young people until 1973–1974, 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. 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'éducation Familiale, or CPEF). Supported by leftist progressive forces, in 1975, the strong mobilization of the feminist movement promoted passage of the Veil Law, legalizing abortion.

All these legislative changes 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 survey and 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."[35] This trend was reinforced by the discovery of AIDS. Starting with a national campaign launched in 1987, the government and other public authorities intensified HIV prevention activities.

Some opposition to abortion rights and to the provision of information about sexuality is expressed by political groups and by non-governmental organizations representing a relatively small segment of the French public. Though small, these organizations nevertheless manage to challenge abortion rights and to obstruct open access to sex information through such activities as demonstrations by anti-abortion zealots and political pressure on Roussel Uclaf Laboratories to stop manufacturing RU-486.

Aspects of Adolescent Sexual or Reproductive Behavior that are Considered Problematic

In numerous publications, members of the medical community blame unwanted pregnancies and early childbirth among adolescents on society's routine acceptance of sexuality among this group. Some experts believe that such tolerance is responsible for an increasingly earlier age at first intercourse and that it incites young people to engage in "unbridled" sex.[36] However, the author of a 1998 report on early childbearing in France believes that the reality of teenage childbearing for young women is a lot less serious than many medical publications claim. This author stresses the impact of the strong social stigmatization of early childbirth on our knowledge and on our understanding of the actual experience of adolescents.[37]

Nevertheless, the issue of early pregnancy has become a topic of public discussion. Recently, two widely popular television shows, broadcast early in the evening, were devoted to the subject of early childbearing in France. And, the government commissioned a consulting gynecologist working in a Paris area family planning center to write a report on the issue. The resulting Uzan report was published in March 1999.[38] However, this study presents results and analyses that do not always correspond to the available demographic data, which indicate that early childbearing is not as great a problem in France as it is in other European countries.

Society as a whole, but particularly doctors and

other members of the prevention community, tend to view all young people as being at high risk for the transmission of STDs and HIV, even though surveys show that most adolescents' sexual activity is not as risky as claimed. Adolescent sexual relationships are often episodic, or punctuated by periods of abstinence of varying length.[39] And young people frequently use condoms.

The 1994 ACSJ points to a persistent social phenomenon that is at the heart of relationships between boys and girls during adolescence.[40] Girls frequently have their first sexual intercourse with boys who are substantially older, which leads to a limitation on the number of partners available to boys in those age groups. This age difference is puzzling. There is no restriction preventing sexual relationships among peers. Certainly, there are pressures, or older models of behavior, that speak to this pattern, but such models have not prevented a growing trend toward early sexual intercourse, which is bringing sexually active girls closer in age to boys. Nor have these models prevented premarital sex from becoming widespread.

The 1994 ACSJ found that 30% of the first and 35% of the most recent partners of 15-year-old girls are over age 18. Among 18-year-old girls, these proportions are 68% and 81%, respectively. In contrast, among boys aged 15, only 1% of first and 2% of most recent sexual partners are over 18-years-old, while among those aged 18, 19% and 27%, respectively, are themselves over age 18. It seems that the age disparities among partners at first intercourse are partly a result of the girls' decision to choose older partners. This asymmetry plunges boys into a world of partner scarcity and, simultaneously, involves girls in authoritarian relationships—intentionally or not—because of differences in experience and maturity compared to that of their partners.[41]

The 1994 ACSJ revealed a troubling degree of sexual abuse among young people. It shows that 15% of girls and 2% of boys declare that they have already experienced forced sexual intercourse. Students pursuing general educational tracks report being much less frequently subjected to forced sexual intercourse than those in technical or vocational tracks.[42] We do not know whether this finding reflects a real increase in sexual violence, or whether it is now easier than it used to be to reveal this type of abuse. The perpetrators of forced relationships come from varying spheres of young people's lives, but are typically known to the young victim. In more than three-quarters of cases, forcible sexual intercourse is committed by young people, and most often by young people the girls know. Incest with an adult in the family was reported by 5% of girls, and 84% of sexual relations forced on women involve men they know.

And, while three-quarters of the boys reporting forced relationships declare that they have been forced into sex by women they know, coercion exerted by women on boys does not represent a socially accepted power relationship and may have a different meaning than forced relationships reported by young women. When a girl initiates sexual intercourse or when she performs certain acts (e.g., fellatio), boys may have the impression that they have been forced, because they are confronted with something that they believe "should not happen that way." The prevention of sexual abuse during childhood and adolescence is now receiving greater attention by the Ministry of Education.

National Efforts to Change Current Adolescent Sexual and Reproductive Behavior

Government institutions are now playing a more important role and becoming more involved in HIV prevention and information. The government launched its first public HIV prevention campaign in 1987. The French AIDS Prevention Agency (Agence Française de Lutte contre le Sida, or AFLS) was created in 1989, and the AIDS division of the Public Health Administration (Direction Générale de la Santé, or DGS) 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 an effective 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.

Since 1994, the media have focused on young people in their general HIV prevention campaigns. However, the messages rarely focus on a specific age group. Partnerships have been created between the DGS and radio stations having a large audience

among young people (NRJ, FUN RADIO) to disseminate prevention messages and develop programming that focuses on prevention.

In 1988, governmental bodies set up Anonymous Free HIV Screening and Information Centers (Les Centres d'Information et de Dépistage Anonyme et Gratuit, or CIDAGs) across the country. On average, the program receives requests from 280,000 individuals a year.

Advertising to publicize this government HIV screening system is intensifying, targeting young people as well as the doctors and social workers 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 under-developed. The last campaign was in 2000 and the one before that, in 1992. Since publication of the Uzan report, the DGS has been implementing an action research program to prevent unwanted pregnancies among adolescents throughout the country (see below for more details about this program).

Social Attitudes and Norms toward Sexuality

Society looks at early sexuality and motherhood differently for younger than for older women. For centuries, it was very common for girls to marry and have children at age 14 or 16. Even up until the 1970s, it was considered normal to be a mother at age 18 or 19. Today, however, 20 is usually considered the minimum age for childbirth. In fact, nowadays, teenage childbearing is viewed as a social anomaly and a condition laden with possible risks.[43]

Attitudes toward Sexuality

Currently, it is socially accepted that sexual intercourse is one of the first experiences of couple formation. Intercourse usually takes place well before the decision to cohabit and more often coincides with when the partners begin to "go out together."[44] In France, there is a growing disconnect between the timing of transitions into sexual, marital and family life, and increasing variation in couple formation. However, we have no data on what the general public thinks about these trends, or about premarital sex.

In terms of extramarital sex, studies show that 6% of married men and 3% of married women report that they have had other partners. Multiple sexual partners are more common among men (25%) and women (10%) who are not in a union. Furthermore, the higher the educational level and the larger the city, the higher the proportion of multiple partners. The multiple partner rate is highest in the Paris metropolitan area. According to the 1992 ACSF,[45] 42% of men and 30% of women think that it is acceptable for a married man to have an affair; and 39% of men and 26% of women think that it is acceptable for a married woman to have an affair.

Surveys (ACSF 1992, ACSJ 1994) of people who have had sexual intercourse at least once in their life show that 4% of men and 3% of women report that they have had at least one partner of the same sex. In terms of the social approval of homosexuality, 76% of men and 74% of women think it is acceptable for two men to have sexual intercourse, while 75% and 64% respectively think that it is acceptable for two women to have sexual intercourse. Homosexuality was decriminalized in France on June 22, 1991, but, as Michaël Pollak points out, while "homosexuality is no longer automatically considered a punishable offense, even in families that accept the homosexuality of a son or brother, a tacit agreement often makes this an unmentionable subject of conversation."[46]

There have certainly been changes in the kinds of sexual images and practices that are considered socially acceptable. An increase in reports of oral sex suggests that French people now engage in more diverse practices and that these are becoming legitimized. Diverse sexual practices were much less common in 1970—the year of the first sex survey in France.[47] However, by 1992, 75% of women and 79% of men reported that they had experienced cunnilingus at least once; and 76% of men and 66% of women said they had experienced fellatio at least once.[48]

Similarly, French women are reporting increasing satisfaction with their sexual lives, and this seems to be especially linked to their access to effective methods of contraception. However, at the same time, we find an underreporting by women of masturbation and number of sexual partners. This underreporting, revealed by a question incorporated at the end of the questionnaire, makes sense. Today in France, sexual behavior still remains socially determined by a context that attributes differential roles and statuses to each gender. While men tend to value engaging in a range of sexual practices and having multiple partners, women tend to value sexual stability and monogamy, and consider these to be desirable aspects of female sexuality. Thus, attitudes and behaviors that are valued in males may still be strongly stigmatized when adopted by women.

Communication about Sex

According to the 1992 ACSF, 6% of men and 7% of women reported that they had talked about STDs and HIV, and 12% of both men and women said they had discussed contraception with their partner at last intercourse. Men and women talk as much about STDs, HIV and contraception when they are with a cohabiting partner or regular partner as when they are with a new partner. Women report having discussed HIV and contraception with occasional or new partners more often than men do.

The same survey found that among 18 and 19-year-olds, 37% of young men and 29% of young women had found it easy to speak about sex and contraception with their father, and 61% and 52%, respectively, had been able to speak with their mother. At age 20–24, the proportions easily able to talk to their father are 56% for men and 60% for women. The proportions able to talk to their mother are 80% among men and 74% among women. The mother, therefore, remains the preferred conversational partner, and more so for men than for women.

Among the 18–19-year-old age group, 26% of men and 41% of women report that when they were children their families spoke to them "often or very often" about sex. Among French people aged 18–69, these levels are 11% for men and 15% for women, while among those 20–24, they are 22% and 38% respectively. Among survey respondents who are parents, 89% of fathers and 93% of mothers believe that it is important to talk to their children about sex.

Conversations and confidences about sex vary for men and women. The 1992 ACSF shows that 27% of women and 17% of men have a confidant with whom they discuss sexual matters, and that 42% of women and 36% of men have at least two. Men employed in management and the higher intellectual professions and the intermediate professions have fewer confidants than average, while office workers of both sexes have more. Finally, most confidants are female (62%) and 84% of women confide in people of the same sex. Among men, only 63% of confidants are themselves men.

Recent surveys about sexual behavior raise the issue of sexual pleasure. In the 1992 ACSF, orgasm at last sexual intercourse, sexual practices leading to orgasm and the need for simultaneous orgasm were explored by the questionnaire. In the 1994 ACSJ, sexually active adolescents 15–18 were asked if they derived pleasure from their last sexual intercourse.

Concern about Adolescent Sexual and Reproductive Behavior, as Inferred from Legal Regulations

Sex and Marriage

Under French law, the concept of sexual consent is socially recognized for individuals over age 15 and, since 1982, without distinction between homosexual and heterosexual practices. A minor may have sexual intercourse at age 15, but criminal proceedings may be brought against an adult who has sexual intercourse with a person under age 18, on the grounds of sexual molestation or assault, particularly if the adult has authority over the minor. Furthermore, even before age 15, a minor is legally responsible if he/she commits sexual assault.

The law states that "any act of sexual penetration of any nature whatsoever committed on another individual through violence, coercion or surprise, constitutes rape."[49] Rape is the only kind of sexual assault that is a criminal offense. All other types of sexual assault are considered misdemeanors. Rape charges may be brought before the Assizes Court and are punishable by incarceration from 15 years to life with aggravated circumstances.[g] In order for rape to be actually recognized as such, the victim must establish that there was violence, the element that constitutes the crime. Given this requirement, because proof of coercion is difficult to establish, such actions are often called sexual assaults, which are simple misdemeanors.

Over the past 15 years, there has been an increase in the number of complaints filed for rape. This reflects a greater ease in revealing sexual abuse, probably as a result of the wider dissemination of information about sexual violence since the early 1980s. However, without being able to demonstrate this, we believe that the number of rape cases is greater than the number of complaints filed. In the 1980s, we estimated their number by multiplying the number of complaints by a factor of three.[50]

Eighteen is the legal age for marriage without parental consent. At age 15, a minor girl may marry with parental consent or permission from the public prosecutor. Even when emancipated (i.e., no longer under parental authority with respect to administration of property and liability in the event of injury), a minor cannot marry without parental consent. Marriage emancipates a minor, but childbirth does

[g] Vulnerability and age of the victim, committed by a legitimate, natural or adoptive parent, gang rape, threat with a weapon, torture, death.

not. A minor mother has parental authority over her child, but she is still subject to the parental authority of her own parents.

Adolescent Services

Until May 2001, only young women 18 and over could legally obtain an abortion without parental consent. This condition, which was quite difficult to circumvent in practice, was applicable to any surgical procedure (except in the event of a medical emergency). The requirement of parental consent was identified as likely to delay access by minor women to abortion and to explain the overrepresentation of minors among women requesting late abortions. Approximately 12% of minors, compared to about 3% of older women sought abortions more than 12 weeks following their last period, which was the legal limit.

Three non-governmental agencies, the French Family Planning Movement (Mouvement Français pour le Planning Familial, or MFPF), the National Coordination of Associations for the Defense of Abortion and Contraception (Coordination Nationale des Associations de Défense de l'Avortement et de la Contraception, or CADAC) and the National Association of Abortion and Contraception Centers (Association Nationale des Centres d'IVG et de Contraception, or ANCIC) all tried to gain the right for minors to obtain an abortion without parental consent. The Uzan report recommended revising the law to allow adolescents over the age of 16 easier access to abortion.

In 1974, an easing of the Law of 1967 gave minors over 15 access to contraception, and to screening and treatment for STDs without parental consent, as long as they went to the CPEFs, which provide free services. However, other than in the CPEFs, any prescription of drugs administered to a minor is subject to parental consent, a legal condition that currently poses a problem for the care of minors who test positive for HIV.

A new law has been voted in May 2001 which makes abortion legal until 14 weeks (instead of 12 weeks) and allows minors to have an abortion without their parent's authorization, so long as another adult, of the minor's choice, is involved. Furthermore, the delivery of contraception is now legal for every medical doctor. Before the new law, it was only allowed for minors who went to a family planning center. Furthermore, a minor may visit the physician of his/her choice, who is required to maintain doctor-patient privilege.

Attitudes and Norms Related to Sexual and Reproductive Behavior in the Media

Formal and Informal Broadcasting Standards

The spirit of French law in the area of birth control is dominated by the legacy of the laws of 1920 and 1923 (still in effect), under which the Penal Code still considers abortion a misdemeanor.[51] And because of language in the law stating that "all anti-natal advertising is prohibited,"[52] information about contraceptives remains limited. Moreover, information about abortion may be considered an "incitement to abortion." Commercial advertising of contraceptives is subject to the same regulations as all drugs available by prescription, being prohibited except in medical and pharmaceutical journals.

Since 1987, the need for HIV prevention led the legislature to authorize the promotion and advertising of condoms for reasons of public health. However, there has never been any question of repealing the clause banning "anti-natal propaganda" in its entirety. But in fact this ban is not always upheld. In 1997, one company did a great deal of advertising in women's magazines for a new computer-assisted rhythm method, presented as a natural method of contraception. However, the ban was invoked in 1992 by upholders of the moral order protesting against a contraceptive campaign that was about to be undertaken. The contents of the campaign were then modified by the Prime Minister, several days prior to its launch. The TV spot that was to be aired contained the message, "Contraception, so that you can concentrate on love." It was replaced by "Contraception, it's simple when you talk about it."

Condom and Pill Advertising

Women's journals and the mass media, including radio and television, disseminate HIV prevention campaigns and messages promoting condom use. Radio is regularly used for government campaigns against HIV, particularly to reach young people and certain social groups. In the summer campaign of 1999, radio spots were used, but most of the activity relied on the dissemination of "photo romances." However, no prevention message specific to the pill or the morning-after pill is currently being disseminated in the media. In June and July 2001, a national radio campaign on emergency contraception was created, especially directed to young people. The slogan was "The right to make a mistake."

How Sex is Depicted on Television

No study on this subject has been done in France. However, as some professionals point out, "Rare are the hit films or novels that talk about ovulation, spermatozoa and chlamydia."[53]

On-screen female nudity (always partial) is frequently used in advertising, whereas on-screen male nudity is less common. It is particularly pervasive in the written press (more in magazines and weeklies than in the daily press), and in TV commercials. Furthermore, in the promotion of erotic electronic services, Minitel utilizes and displays nudity and suggestive depictions of the female body. Overall, on-screen nudity and erotic scenes are quite well accepted, but genital organs are not shown.

Public Discussion about Coverage of Sexuality in the Media

In several parts of the country, municipal ordinances prohibit public display spaces from advertising erotic messages accessible on-line via Minitel. Some feminist associations, such as the Association Opposed to Violence against Women in the Workplace (Association contre les Violences Faites aux Femmes au Travail, or AVFT), regularly protest commercials that present degrading and stereotypical images of women, or incite violence against women. For example, in 1997, a boycott of Levi's brand jeans was launched by AVFT to protest an advertisement that was particularly ambiguous about rape. However, the audience for this type of action remains relatively small in France. Certain groups in the moral values lobby denounce sex on television and want very strict regulation in this area. For several years, a symbol has appeared at the bottom of the television screen informing viewers if the program in progress contains scenes that are violent or likely to be offensive. But in general, the issue of sex in the media does not arouse much public or governmental action.

Young People's Socialization about Sexuality, Sexual Behavior and Sexual Responsibility

The 1993 ACSJ looked at young people's sources of information about HIV and found that young people rely on various informants and do not have the same degree of confidence in all of them. Like adults, 15–18-year-olds rank groups, such as physicians and scientists as their top sources of reliable information.[54] They have less confidence in educators than do adults. It is possible that this misplaced confidence stems from the fact that adults prefer to delegate the difficult role of sex educator to teachers and so hope they are a reliable source. The young people who are most knowledgeable about HIV have the least confidence in educators. Students in academic high schools are more likely to trust health specialists, whereas those in vocational training institutions are more likely to place their confidence in the family and school. The result is that most young people tend to trust health specialists rather than their teachers and trainers.

The KAPB survey revealed a drop in the perceived legitimacy of the government and the Ministry of Health (probably as a consequence of the contaminated blood affair), but not that of physicians, researchers or private organizations.[55] Furthermore, despite the extensive media blitz about HIV/AIDS in the early 1990s, 32% of young people under the age of 30 thought that there was not enough talk about HIV/AIDS. Information was deemed insufficient on treatments (72%), methods of transmission (43%), screening (44%) and methods of protection (28%).

According to a 1993 survey about the social conditions of young people ages 11–19 attending public schools,[56] peers are important sources of information about sex and HIV-related issues. Furthermore, more than half of adolescent boys and girls say they would like more information about HIV/AIDS, pregnancy and sex.

Sex Education in Schools

National Guidelines Related to Sex Education

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 now 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;
4. Family planning and prevention of sterility.

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 deeply involved in sex education programs.

The topic of sexuality is currently 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[57] and was reinforced in a 1998 memo,[58] which included sex education as part of the health curriculum introduced in 1998. Sex education is also provided in health education workshops, which all students in the first four years of secondary education must attend for 30 to 40 hours, over four 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* (for a detailed description of the sex education curriculum in France schools, see Appendix B).

The programs that have been developed, the approaches taken and the policies issued by the National Education office are applicable throughout the country, in 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. Certain rather 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 CPEF.

Controversy About the Content of Sexuality Education

For several years, some traditional representatives of the Muslim community have been requiring their daughters to wear a headscarf and forbidding them to attend biology classes dealing with sex and reproduction. However, these attitudes, which regularly trigger a great deal of controversy around the concept of secularity in education, involve a relative minority. In addition, the moral values lobby (particularly Catholic family groups) regularly protests sex education in schools. In August 1998, this lobby managed to get the Council of State to rescind (but only temporarily, due to faulty drafting) the 1996 government memo introducing two mandatory hours of sex education in schools. In July 2000, the authorization for school nurses to dispense emergency contraception was annulled by the Council of State, possibly under pressure from Catholic groups. But it was nevertheless re-accepted in January 2001.

Recent Changes in the Provision of Sexuality Education

The first Ministry of Education memo about sex education and information was dated July 23, 1973.[59] It expressed the need to replace an outdated form of protective education with a new formula, based on the mastery of information and on instilling responsibility. Prior to the onset of HIV/AIDS, the memorandum stipulated that sex education should be provided in biology courses and in additional (elective) classes that could be taught by teachers or outside experts.

Since 1995, the Ministry of Education office has instituted a new training program for teachers designed to help them keep up with the new 1996 and 1998 policies introducing two mandatory hours of sex education. The Ministry affirms its desire to mobilize the entire educational community around this issue.

These new approaches, updating sex education in the context of HIV, acknowledge that, until now, sex education in the schools was often not sufficiently broad and that although new teaching modules and appropriate training were needed, these were rarely implemented. Today, it is 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.

Other Sources of Information about Sex and Sexual Behavior

The 1992 ACSF offers several insights into the sexual lives of young people.[60] At ages 18–19, half of French young men have (often or occasionally) seen pornographic films or read pornographic magazines. Young women at that age are not very responsive to either of these forms of entertainment. Finally, in 1992 fewer than 6% of men 20–24 report that they had visited a prostitute, compared with 25% of men 20–29 surveyed in 1970.[61] This decline is corrobo-

rated by the reduction in the number of young men who say their first experience of intercourse was with a prostitute.

Several weekly magazines popular with young adolescent girls (particularly *Girls* and *OK*) regularly discuss the issues and problems young people face in their sexual lives, and a regular column written by a physician gives advice in this area. Furthermore, an FM radio show hosted by a "young and hip" physician (Fun Radio) apparently owes its success to the freedom with which he discusses sex. Many young listeners ask the doctor for advice, and others feel free to express their point of view on any subject. In fact, sex is the central topic raised by most of the listeners.

For several years, the Ministry of Health has been working in partnership with various television and radio stations with large adolescent audiences to broadcast prevention messages and develop educational programs. A number of telephone information services and helplines created in recent years have become sources of information for young people. In 1997, the AIDS Info Services (Sida Info Services) received 400,000 calls at all of its regional centers throughout the country.

Furthermore, the Blue Line (Ligne Azur), created in 1998, offers a helpline for young people dealing with the problem of sexual identity and orientation. More specifically, this service targets young people who might be questioning their sexual desires and attractions. Finally, several years ago, the government implemented Youth Health Line (Fil Santé Jeunes), a free telephone information and helpline about health matters. Analysts estimate that more than half of the calls involve questions about sex.[62]

Interventions on Sexual Behavior and the Socialization of Adolescents About Sex

Overall, government policy in the area of HIV prevention was mainly developed with a view to promoting the most effective method against transmission—the condom. Nevertheless, a government sponsored risk-reduction program targeting women has recently been started. And a number of private agencies have been working for many years with prostitutes and intravenous drug users to increase use of the condom.

Operation "Low price Condoms" (1992–1993)

In the summer of 1992 and winter of 1993, the AFLS and the Ministry of Health conducted a huge awareness campaign, first for young people and then for adults. "Go out covered—1-franc condoms!" and "Youth rate for all—1-franc condoms!" were its slogans. The goal was to encourage people to think of themselves as users and to facilitate access to condoms by reducing the purchase price. A 1993 evaluation of the campaign found that the TV ads and billboard posters were particularly successful. About 83% of the French public reacted positively to the posters and TV ads, and 64% of irregular and nonusers said they had been motivated by the campaign (versus 80% of regular condom users).

The main ideas of the campaign were a low-price condom for adolescents and a partnership with radio stations widely listened to by this population group. However, the campaign was built around a single message that did not particularly target young people or other age groups, and the message was not highly sexualized. The policy of the 1-franc condom was continued for several months after the launch of the campaign.

The Blue Line (Ligne Azur, 1998)

This service was designed in 1998 to support and listen to young people searching for their sexual identity. It was intended to supplement AIDS Info Service's more generalized helpline program. After several months of pre-testing, the service now offers a helpline every day from 5:00 p.m. to 9:00 p.m. No evaluation of the service has yet been published.

New Sex Education Policies for Schools (November, 1998)

Since 1995, the Ministry of Education has organized a national training program, conducted by local school districts using funds specifically earmarked by the DGS. Its purpose is 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 instructs educators how to evaluate needs in this area, how to meet those needs and how to encourage sex education initiatives in every school district. An initial evaluation in May 1997 finds that this training effort has been worthwhile. Twenty-seven out of the country's 28 school districts are now involved in the program, and some 50 resource people have already been trained.

The work of this program provided the basis for the Ministry's revised sex education policies of April 1996 and November 1998. These are aimed at

reducing risky sexual behavior in France, especially among young people. The initiatives represent a turning point in the Ministry's attitudes towards sex and the prevention of sexual risk behaviors. They affirm the importance of the Ministry's role in the transmission of knowledge and in the development of responsible attitudes toward sexuality. The now mandatory nature of the sex education classes in middle schools emphasizes the importance attributed to this subject, which was long believed to have no place in schools. Furthermore, the link between health education and sex education opens up the possibility of discussing risk-taking within a broader perspective.

The March 1999 Uzan Report on the Prevention of Unwanted Pregnancies among Adolescents

In 1998, the government commissioned a gynecologist to prepare a report on pregnancy among adolescents. Published in March 1999, the Uzan report attempts to evaluate the conditions under which unwanted adolescent pregnancies occur, the medical and social consequences and the measures likely to reduce the number of unwanted pregnancies by facilitating access to contraception and abortion. Since the study sample was made up of adolescents with an unwanted pregnancy visiting a family planning center in the Paris region, it was not representative of all adolescents facing this situation.

The study findings are not always in agreement with either currently available national demographic data on contraception and abortion among minors or with a recent sociological study of adolescent childbearing.[63] Notwithstanding, in late March 1999, the conclusions of the Uzan report led the DGS to send out a nationwide request for proposals (RFP) for projects to prevent unwanted pregnancies among adolescents. Two or three regions should be selected to participate in this prevention program.

Overview

The issue of early childbearing seems to arouse strong feelings among government authorities and institutions in charge of prevention programs, even though the extent of the phenomenon is stable in France, and the factors involved in adolescent childbearing have not yet been clearly identified. However, the small increase in abortions among minors reported in 1996 calls for attention to this issue and requires an in-depth analysis of the factors involved. Some of the questions raised are: Should minors have access to abortion without parental consent? This question has been answered with the new law of May 2001. Should school nurses be allowed to dispense the morning-after pill, which was authorized for sale without prescription in June 1999? This question has been answered in January 2001 when nurses finally were authorized to deliver emergency contraception pills at school.

Part III. Reproductive Health Services for Adolescents

Accessibility of Reproductive Health Care to Adolescents

In France, there are a multitude of reproductive health facilities in the public and private sectors that are likely to permit access to preventive services and health care. We distinguish between the facilities specifically intended for adolescents and those that are accessible regardless of age or sex. Some of these only provide information, while others provide a combination of information, prescriptions and health care. In general, we have little reliable data about where adolescents obtain reproductive health care services.

To access information, adolescents who are attending school can turn to the school social worker, nurse or doctor or the University Preventive Medicine services (Médecine Préventive Universitaire, or MPU). In addition, like adults and adolescents who are not attending school, they can contact Information Establishments (Etablissement d'Information, or EI) which provide information and counseling services specifically in the area of sexual health and risk behaviors.

For access to prescriptions and health care, there are specialized facilities offering sexual behavior risk prevention (unwanted pregnancies, STD/HIV, sexual violence) for adolescents, but these are relatively few and were not set up by the government, even though some of them are currently partially financed by public funds.

Specific services providing sex information and contraceptive prescriptions to adolescents are offered on Wednesdays[h] by approximately 60 provincial associations belonging to the French Family Planning Movement, or MFPF. Specific services for adolescents are also offered at two Teen Info Units set up by Mr. Nisand, the author of the report commissioned by the government and published in March 1999 concerning the conditions of access to abortion in France.

Furthermore, there are other medical service facilities or sites that are not specifically intended for adolescents, but that may also meet their reproductive health care needs. Like adults, adolescents may consult:

- a physician in the public or private sector;
- a Family Planning and Education Center, or CPEF;
- or a Center for Voluntary Termination of Pregnancy, or CIVG (for abortion services only).

Finally, with respect to HIV prevention services, Anonymous Free HIV Screening and Information Centers, or CIDAGs, have been established by the government throughout the entire country for men and women of all ages (see Table 1 for summary).

Services Targeting Adolescents

There are two types of facilities in France that provide reproductive health care services especially intended for adolescents in order to give them access to information about sex and contraception.

The MFPF opened its first contraception and abortion information and counseling center in 1961 provides. In half of the MFPF facilities with EI certification, adolescents can obtain information and guidance about access to contraception, while in the other half of the facilities—those that are funded as CPEFs—young people can obtain information as well as a contraceptive prescription. In the facilities managed by the MFPF, the services for youth often use various tools such as videos and group techniques to promote the exchange of information about sexuality and all of its associated risks. Furthermore,

[h] In France, school-age adolescents are usually more available on Wednesdays than on other days of the week.

a confidential medical file is established and a gynecological examination is available to adolescents who request one. This exam is explained but rarely carried out at the time of the initial prescription, because the MFPF staff believes that it is preferable not to systematically make this a prior requirement for young people to gain access to contraception. In general, it is carried out after three months of contraceptive use. In 1998, more than 325,000 individuals were seen at MFPF facilities, 15-20% of whom were minors. The MFPFs also work with schools to provide information about where and when their services are available to youth. In 1998, the MFPF reached approximately 56,000 young people attending school and 10,000 young people not attending school through information sessions held at schools and various facilities such as group welfare homes, young worker's residences, discotheques and guidance centers for the unemployed.[64]

Inspired in part by the MFPFs specific targeting of young people, Mr. Nisand created two Teen Info Units that have been in operation since 1993 in Poissy (a Paris suburb) and since 1999 in Strasbourg. According to Mr. Nisand, it is important that the specific service facilities for adolescents not be CPEFs, because they are not suited to that target group, particularly because of their name. Consequently, he created facilities located in hospitals and associated with the obstetrics and gynecology department which are exclusively intended for adolescents. They provide listening and counseling services for adolescents and work regularly with schools to create a bond between the young people and the facility that can provide them with additional information or contraception free of charge.

Because Mr. Nisand believes that the obstacle which gynecological examinations represent for many adolescents is likely to distance them from access to contraception, these are never given at Teen Info Units at the time of the initial prescription. Furthermore, the adolescents who attend these facilities do so anonymously, since no identification is requested. The visit is always free and leaves no paperwork trail. Moreover, no medical record is established. The contraceptive products (condoms and pills) are provided free of charge. Since no information is recorded when an adolescent visits this type of facility, we have no data concerning their activity. They are financed by a full grant from the hospital in which they are located and, according to one estimate, 150,000 adolescents are seen per year. The General Council (Conseil Général) and the Women's Rights Delegation (La Délégation aux Droits des Femmes) are looking at the possibility of funding the Strasbourg unit, which pleases Mr. Nisand, who advocates more sustained government involvement and who believes that services specifically for adolescents rely too heavily on an organizational environment that is very dependent on political power.[i]

Services for Adolescents and Adults

In addition to the facilities that specialize in providing services to young people, adolescents as well as adults have access to reproductive health care through several additional sources, including EI, CPEFs and private physicians.

The EI (created by decree in 1972) provide information, counseling and family guidance, but do not provide health care. However, they do provide appointments for information and counseling about sex, contraception, marriage, STDs/HIV, parenting and spousal abuse. They also provide mandatory pre-abortion interviews and work with the schools. These establishments are all financed by the Provincial Offices of Health and Social Affairs (Directions Départementales Affaires Sanitaires et Sociales), but are often managed by associations (the MFPF is the most commonly represented). An EI may be independent or it may be associated with a CPEF.

The CPEFs (approximately 1,000 now exist) were created in 1974 and are financed by the General Council in each province. Their mission is to provide at least 4 half-days of prenatal examinations and at least 12 half-days of family planning or educational visits per 100,000 inhabitants 15–50-years-old residing in the province. The CPEFs offer information on contraception, prenatal medical care, screening and treatment of STDs, marital counseling visits, abortion and pre-abortion interviews. One of the missions of the CPEFs is to promote access to information about sex and to prevent unwanted pregnancy among minors. Contraceptives and, since 1990, confidential screening and treatment of STDs, are available free of charge to minors and the uninsured. Minors may receive services without

[i] In 1993, the General Council of a northern French province where the majority was very politically unfavorable to the work and objectives of the MFPF, reduced its funding of the local MFPF association by more than 70%, requiring that six planning centers be closed and consequently considerably reducing the health care services provided at the provincial level.

parental consent. In some centers, medical visits for adults who are eligible for Social Security are paid for through the third party insurance system; in other centers, the consultation is free.

The CPEF staff is composed of at least one physician (head of the facility) and one marriage counselor. In most CPEFs, there is also a nurse or midwife and a social worker. The sex information and family planning professionals, particularly the marriage counselors are not full time employees of the establishment, and often work shifts in several establishments. They are paid an hourly rate that is currently fixed at the legal minimum wage (approximately 40 francs gross).

The CPEFs also work with the schools to inform young people about sex, contraception, STDs/HIV and sexual violence. Most CPEFs are set up by the provincial governments, but associations (mainly the MFPF, which manages some thirty CPEFs) may obtain CPEF certification from the provincial General Council if they promise to fulfill certain conditions required for this type of center.[65] We do not have good attendance figures for the CPEFs because, since 1994, the annual report of these facilities is no longer processed and distributed on a national level. According to the 983 CPEFs that reported their activity in 1993, approximately 95,000 minors were seen, representing 14% of the 670,000 clients. While the CPEF facilities are accessible regardless of age or sex, men very infrequently attend these facilities.

Several reports published in 1999[66] point out that adolescents attend CPEFs infrequently, even when they know of their existence, and various proposals have been made to remedy the situation. While access by adolescents to this type of service is very much encouraged in the course of sex information and education sessions held in schools, the Uzan report on unplanned adolescent pregnancy recommends setting up an interface system between the schools and the CPEFs in order to facilitate access by young people to these facilities. Furthermore, the last report by CSIS stresses the need for more awareness of young people's schedules, particularly their school requirements and periods of availability, when scheduling CPEF activities.[j] Finally, according to Mr. Nisand, author of the report on access to abortion in France, the CPEFs are not suited to receiving adolescents. He recommends setting up units specializing in contraceptive information and prescriptions for adolescents like the two Teen Info Units.

Services for Pregnant Adolescents

If an adult or minor woman wants an abortion, she must contact a CIVG, which may be located in a public hospital or a private clinic. The CIVGs are often associated with the obstetrics and gynecology department and, in the public sector, they may be associated with a hospital-based CPEF. These clinics are fully financed by the hospital or are part of the gynecology department budget. In public CIVGs, women are seen for an initial appointment prior to the abortion and are hospitalized for about a half-day for the abortion, which is 80% covered by Social Security (the woman is responsible for approximately 200 to 300 francs for fees in the public sector).

In the private sector, the appointment prior to the abortion is held in a private office and its cost often exceeds the amount reimbursed by Social Security. The CIVGs offer women the choice between medical abortion and surgical abortion as well as a choice of the various forms of anesthesia if she opts for the latter. In practice, women do not always have a choice.[k] If the CIVG employs a social worker or marriage counselor,[l] the mandatory pre-abortion social-work interview may be done on site. If not, the woman is sent to an EI, a CPEF, or her local social worker for the interview. The Nisand report pointed out the difficulties in accessing abortion, particularly for minor women, who were still required to obtain parental consent. He recommended eliminating that specific condition for minor women. This is part of the law passed in May 2001 along with the extension of the legal abortion period (this period has been extended from 12 to 14 weeks of gestation).

Pregnant adolescents who wish to continue their pregnancy do not need their parent's consent and may be housed in mother-child establishments called Maternity Centers (Centres Maternels) if their economic situation is unstable or if they have been rejected by their family. Women may be housed there, regardless of age, from the sixth month of

[j] For example, many of these centers decrease their activities or close during school vacations, particularly during the month of August, when young people are more available.

[k] One of the objectives of the government plan of action for improving women's access to abortion is to allow women to exercise their right to choose the method most suited to them.

[l] Social workers and marital counselors are the two types of professionals allowed to conduct the pre-abortion interview.

pregnancy until the child is three years old; most of the cases involve adolescents and/or unemployed single mothers. In 1997, there were approximately 103 establishments of this type which have approximately 3,700 beds for women and their children, and while nearly half are managed by associations, all are funded by the government in the provinces.[67] On January 1, 1994, 137 minor women were housed in the Maternity Centers, representing 9% of the 1,607 women housed. Depending on their resources, the women may share in the cost of their housing or be housed free of charge. Parenting classes and social-service support are provided to integrate these women into society. However, the particularly rigid educational support that these facilities provide to the women does not always correspond to their aspirations for independence and does not give them the best preparation for meeting that opportunity. The women are treated much like children, for example, they are prohibited from having sexual relationships and there is a rather strict monitoring of outings and visitors, even when this is the child's father.

STD and HIV Services

With respect to HIV prevention and screening, several systems have been implemented by the government. Early in the century, free STD services and facilities were provided particularly to combat syphilis.[m] Consisting of STD dispensaries and offices in a hospital department, some of these facilities were closed, while others have remained. Most of the time, their activities have been redirected to the issue of STDs in general and HIV in particular, especially since 1988, when the government (AIDS Division of the DGS) set up a network of CIDAGs across the entire country. These centers devote much of their time to information, guidance and working in partnership with other medico-social facilities. This system was reinforced in 1992, when separate clinics were set up, among other things, to provide (free and anonymous) HIV screening, but with less extensive informational activity than the CIDAGs. The anonymous free HIV screening facilities are often associated with a hospital. On average, they see 280,000 people and screen 1,500 cases of HIV infection per year.[68] The HIV screening process is voluntary and must be done with the consent of the individual.[n] Appointments prior to the test and following it are mandatory and make it possible to provide advice on prevention and counsel individuals.

In general, we have little reliable data on the numbers and distribution of adolescents who obtain reproductive health care according to the types of facilities visited. In France, there are approximately 1,900,000 women 15–19 and, according to the 1994 ACSJ, 18% of them used the pill (at last sexual intercourse); this amounts to 342,000 young women.[69] Since the CPEFs see fewer than 100,000 adolescents per year, we might assume that a considerable number of adolescents go to private doctors (general practitioners or gynecologists) for prescriptions of oral contraceptives (with the parent's consent). However, no reliable data on this subject are currently available.

Availability of Contraceptive Supplies to Youth

If an adolescent goes to a CPEF for an oral contraceptive prescription, she will receive a three month supply of pills free of charge and confidentially, after which another appointment is scheduled for follow-up gynecological and laboratory tests. Another prescription is then written, generally for 6 to 9 months. However, if she sees a private doctor (general practitioner or gynecologist), she must pay for the visit (at least 115 francs for a general practitioner and at least 150 francs for a gynecologist) and pay for the pills at the pharmacy, expenses that may be partially reimbursed by Social Security. Doctors do not always ask an adolescent for her parent's consent before prescribing contraception, however, because reimbursement of these expenses means that the parents will automatically receive a statement of the treatment obtained by the adolescent, many of them pay for the full cost. Since the third generation pills have come onto the French market, practitioners have a tendency to prescribe these new products to adolescents requesting an oral contraceptive, even though their medical advantage has not been proven and despite a cost approximately 5 times higher than that of the second generation of pills, which are reimbursed by Social Security. In this case, the pill is sometimes provided free of charge by the physician

[m] Until 1996, screening for this disease was mandatory for men and women prior to marriage; currently it is systematically offered during prenuptial examinations, but is now voluntary.

[n] Some physicians recommend mandatory HIV screening, particularly during prenuptial examinations, but currently there is no question of modifying the law in that regard. However, in practice, informed consent is not always required beforehand and this screening tends to be done systematically, particularly for preoperative workups.

for the first 6 to 12 months, because the pharmaceutical laboratories distribute free samples to physicians in order to gain some loyalty for their product. As a result, a young woman must spend approximately 50 francs a month to purchase a third generation pill and 10 francs for a second generation pill, which will then be reimbursed. While condoms are available free of charge at CPEFs and CIDAGs, many young people purchase their own condoms. Ten condoms cost at least 10 francs (the lowest price), particularly in supermarkets. In pharmacies, condoms cost about 50 francs for 10.

Table 1. Summary of reproductive health care services in France

Mission Area		Information	Prescriptions, Screening Health Care	Housing
Sex Contraception	Accessible regardless of age or gender Specific services for adolescents	- Info. Establishment (EIs) - CPEFs (free and anonymous to minors) - In approximately 30 EIs and 30 CPEFs managed by the MFPF, specific services for adolescents on Wednesdays - Teen Info Units	- CPEFs - Physicians (general practitioners /gynecologists) -Pharmacy: Emergency contraception available without a prescription (Norlevo) - Teen Info Unit	
STD	Accessible regardless of age or gender	- CIDAGs	- Physicians (general practitioners / gynecologists - public or private sector) - CPEFs - CIDAGs - Anonymous Free Screening Visits	
AIDS	Specific services for adolescents	- Teen Info Units	- Teen Info Units	
Term pregnancy	Accessible to any woman regardless of age	- CPEFs	- Physicians (general practitioners / gynecologists / obstetricians–public or private) - CPEFs	- Maternity centers
Abortion	Accessible to all women	- Physicians (general practitioners/ gynecologists) - EIs - CPEFs - CIVGs	- CIVGs (public or private)	

EI: Information Establishment

CPEF: Family Planning and Education Center

CIVG: Center for Voluntary Termination of Pregnancy

Societal Messages that Encourage Responsible Preventive Behavior among Adolescents

Overall, the government communicates little about contraception and the locations that make contraceptive services available. The French Health Education Committee (Le Comité Français d'Education pour la Santé, or CFES) founded in 1972, is under the supervision of the Ministry of Health. Its mission is to promote health through information and education. It is financed by the government and the national Social Security fund, which delegate to it the implementation of national campaigns on broad public health topics, particularly contraception and, since 1994, on HIV. The CFES is responsible for HIV/AIDS communication and uses a methodology it developed for other health topics, combining communication at the national level and field initiatives. In addition, the CFES distributes posters, brochures, folders and teaching materials to associations, agencies and individuals. The CFES is supported by a network of 125 regional and provincial health education committees who carry out the national campaigns and conduct local initiatives, based on their knowledge of the local area. In 1982, in conjunction with the Ministry of Youth, the CFES published and disseminated a brochure entitled *I'm Young and Informed* (Jeune, Je m'Informe). This document described the various contraceptive methods and directed young people to contact their Regional Youth Information Centers (Centres Régionaux d'Information Jeunesse, or CRIJ)[o] to obtain a list of resources on this subject. In 1990, a brochure entitled *The First Times* (Les Premières Fois) was published, discussing HIV/AIDS and contraception, and adopting a truly educational approach to sexuality. In 1999, a brochure was published for women on the harmfulness of smoking, particularly in combination with oral contraceptives.

The launch of the contraceptive information campaign, originally scheduled for the fall of 1999, was postponed until 2000. This was the first campaign carried out by the government, which dealt with both contraception and HIV prevention and emphasized condom use. However, the campaign's primary purpose was to provide information about the various contraceptive methods and the locations where contraception is available, particularly for young people. This communication campaign on contraception (details below) was conducted for a year, combining media (TV spots, radio and press messages) and non-media activities (9 million copies of an information brochure and a telephone line accessible for one year). Various relationships and life stages were depicted: an adolescent, a single young woman and a couple with a child. Men were depicted as being involved with contraception. The National Education Department was the main partner in this initiative thereby affirming its involvement in preventing risky sexual behavior. The information brochure is being disseminated in schools during the two mandatory hours of sex education.

The manufacturers of a major brand of menstrual protection products (Tampax) have been participating in sex education sessions in certain schools for approximately two years by providing information about menstruation and the products it manufactures. Boys are not involved in these information sessions, which do not really meet the criteria of the latest National Education Department directives intended to improve the quality of the sexual behavior risk prevention programs in schools. Furthermore, pharmaceutical laboratories (specifically Organon and Wyeth) regularly devise and distribute documents, videos and gadgets (a pill box with alarm) for adolescents, arguing that this helps to facilitate their contraceptive use.

In 1998, Wyeth[p] laboratory developed a kit for educators, containing fact sheets on contraception and a video, entitled *Pleasure of Loving* (Plaisir d'Aimer), which described the various contraceptive methods. The National Education Department was not involved in developing the kit, which was nevertheless intended for use by school nurses and science teachers, and expressed reservations regarding its use in schools. However, 2,000 kits had already been distributed. More than 9,000 schools requested a kit. In general, the contents of the video provide a rather negative image of contraception.[q] Finally, in 1999, an Internet site devoted to information about contraception was created by the Organon laboratory in conjunction with the National College

[o] A CRIJ is a provincial facility for receiving young people who request information about health, lodging, employment and recreation and to guide them toward the facilities likely to be able to satisfy their request.

[p] The MFPF was a partner in this initiative for establishing written media, but did not participate in making the video. It informed the laboratory of its profound disagreement with the contents of the video.

[q] The only two characters in the video are the ovum (Ova) and the spermatozoon (Zoïde) who are trying to meet but who are prevented from doing so by contraceptive methods.

of French Gynecologists and the National Federation of Medical Gynecologists.

The government regularly communicates about HIV prevention and the locations for anonymous free screening, using media campaigns and distributing documents. The Regional HIV Information and Prevention Centers (Centres Régionaux d'Information et de Prévention du Sida, or CRIPS) is particularly involved in the dissemination of information on this issue. The CRIPS provide information sessions in schools, in which they do not use a preestablished and systematic model, but rather respond as much as possible to questions from adolescents, very often about sex. In addition, the CRIPS make information about government policies and services available to health providers and the public at large.

Compared to other European countries, condom use was low before the HIV/AIDS epidemic in France (approximately 5% of couples) and its contraceptive efficacy was greatly disputed, particularly by those involved in preventing unwanted pregnancies. Consequently, it was necessary to promote a new image of the condom and to convince the general public, as well as professionals, of its preventive efficacy and, to a lesser extent, of its contraceptive efficacy. Campaigns to promote condom use often made use of humor to change the public's resistance to this method. The government has launched approximately one public campaign a year in recent years, often during the summer months. TV, press and radio spots are often used to disseminate messages specifically addressed to young people.

In general, many HIV prevention messages in government campaigns depict women as the ones who embody and initiate a preventive stance, while men are often shown as hesitating or refusing to adopt this approach. Making women accountable for contraception tends to be used as an interim strategy in preventing HIV. However, this comes at the risk of appearing to legitimize men's irresponsibility in failing to adopt preventive practices.

Furthermore, the government's HIV prevention policy has long been exclusively based on a goal of "zero risk." However, due to the influence of certain associations working in prevention programs (particularly among drug addicts and/or prostitutes) and the results of some social science research, the government is now stressing risk reduction. Moreover, in 1998, the DGS signed a contract with the MFPF to develop a risk-reduction program for women at risk (details below). This action is part of a comprehensive sexual health education approach. Previously, the prevention of HIV and of unwanted pregnancy have been handled separately, even though a more comprehensive approach to reducing sexual behavior risks and encouraging preventive attitudes would probably help avoid a multiplicity of sometimes contradictory or incompatible messages. For example, the condom is presented as an effective method of preventing HIV, but its contraceptive efficacy is often challenged, particularly by those in charge of preventing unwanted pregnancy among adolescents. These officials often recommend that young people should use the condom in combination with the pill. In the future, there should be greater consistency among the various prevention messages disseminated among young people. The government (particularly the National Education Department) is anxious to work in partnership with the various educational and social institutions dealing with young people and to integrate the HIV prevention policy into a comprehensive educational approach to sexual health.

The AIDS prevention campaign in the summer of 1999 was quite innovative. It depicted various individuals facing difficulties in adopting AIDS prevention behaviors, thus challenging prior communication strategies that tended to remain silent about the obstacles to HIV prevention encountered by many adolescents and adults.[r] A notable exception was the "3000 scenarios against one virus" campaign conducted in 1994. In 1995, there was a change in the tone of the government public information campaigns dealing with HIV which began to talk about risk situations rather than risky behaviors or populations at risk. The campaign conducted during the summer of 1999 underlined that relationships are the determining factor in adopting risk behaviors with respect to HIV. In addition, it combined the promotion of preventive behaviors with solidarity for infected individuals. Until then, information campaigns presented these two messages quite separately.

While many French celebrities have made public statements on AIDS, on the need for prevention and the need for solidarity with HIV-infected individuals, the subject of contraception is not often raised. Many TV shows broach the topics of sex, pregnancy,

[r] For example, "The condom-today everybody says yes!," an earlier message attempts to encourage a new standard of sexual behavior, but does not deal with the types of the resistance and difficulties that are obstacles to behavior modification.

sterility and medically assisted conception techniques, but there is a notable lack of discussion about contraception, except in programs recounting the history of the pill and its legislation, that were broadcast in 1997 for the 30th anniversary of the Neuwirth Act.

Moreover, anti-abortion associations are mobilizing against the use of contraception and generally believe that adolescent sex is unacceptable. They particularly protest against sex education in schools and think that risk prevention messages incite adolescents to engage in early sex and even "sexual debauchery." However, these groups have a rather limited audience among young people. The Survivors (Les Survivants), a new anti-abortion movement of adolescents supported by Pope John Paul II at the World Youth Days in August 1997, distribute flyers to young people at school exits, advising them not to have abortions, to mobilize against the 1975 law authorizing abortion and also not to use contraception.

Policies and Intervention Programs

On July 16, 1999, Martine Aubry, the Minister of Employment and Solidarity, announced a government plan of action to improve the conditions of access to contraception and abortion, particularly for adolescents. Two approaches were planned: one was to improve information about all contraceptive methods by conducting a communication campaign on the issue launched in January 2000, and the second consisted of various measures to improve women's access to abortion services and the quality of those services.

The Communication Campaign about Contraception

The goals of the communication campaign on contraception were to reaffirm the right to contraception and to improve knowledge about all contraceptive methods, particularly in conjunction with the release of the emergency contraceptive in France. Available since March 1999, Tétragynon is an emergency contraceptive dispensed in pharmacies by prescription. Furthermore, the emergency contraceptive is available at pharmacies without a prescription since the release of Norlévo on June 1, 1999. The unrestricted sale of this product in pharmacies, in combination with its lack of contraindications and side effects (even though the package insert lists many), should facilitate access by adolescents to this type of contraceptive. However, the high cost of this method (approximately 60 francs) could represent an obstacle to access by the most destitute, particularly young people. Since October 2001, one can be reimbursed for the emergency contraception if one has a medical prescription.

The information campaign about contraception, in partnership with the National Education Department included initiatives developed in partnership with the media and non-media. Shows focusing on contraception have been scheduled and broadcast in partnership with radio stations for three months. In addition, a low cost telephone line was set up for one year to answer technical questions and to direct young people to locations where contraceptive information and prescriptions can be obtained.

Finally, 9 million copies of an information brochure (the size of a calling card, which unfolds like a road map) were distributed. Its objective was to describe the various methods of contraception and to publicize the telephone line.

The campaign on pregnancy prevention had a 20 million franc budget for development and dissemination. However, no funds were allocated for follow-up of this campaign and for allowing prevention workers to continue it on a broad scale through locally targeted actions. The communication campaign on contraception will be evaluated.

Measures Planned for Improving the Conditions of Access to Abortion

In order to guarantee that women have complete access to abortion, the Ministry of Employment and Solidarity announced various measures. Some of them have been implemented immediately, while others are to be implemented.

• *The immediate measures*. Various measures are intended to improve the conditions for enforcing the 1975 Veil Act at CIVGs. First, public hospitals must incorporate the practice of birth control into their obstetrics and gynecology departments so that this service benefits all patients and staff. Also, hospital directors must verify that future chiefs, prior to appointment, agree to accept and carry out abortions and not to appeal to the conscience clause allowing them not to do so. Second, in order to consolidate abortion services, it was planned that 20 staff physician positions be created in one year. However, this effort is considerably less than what would be needed in order to confer status on all of the temporary physicians who are practicing abortion.

Physicians are reminded that for abortion, as in other medical activities, professionals are required to provide an ongoing public service and are encouraged to work locally in a network with the various CIVGs to achieve that objective. In addition, the CIVGs must offer women a choice of all of the methods of anesthesia and abortion that are currently available, particularly the medical method. Many CIVGs have not yet incorporated non-surgical abortions into their practice and do not offer it to women.

Furthermore, a training effort has been planned for the clinic staff who receive the women requesting an abortion. They will be able to participate in continuing education modules that may be provided by physicians and by associations active in family planning. In addition, at Mr. Nisand's suggestion, theoretical education in birth control and the ethical, legal, social and medical issues it raises will be offered to medical students in the latter years of their initial training.

Finally, the Regional Birth Commissions (Commissions Régionales de la Naissance which report to the Regional Departments of Health and Social Affairs and centralize the perinatal data for each region) are now responsible for verifying the availability and accessibility of contraceptive and abortion information to women. They must also assess the obstacles to abortion access in their region and verify that data are kept to permit evaluation of the need for abortion.

The National Health Evaluation Agency (l'Agence Nationale d'Evaluation en Santé—an agency responsible for hospital department accreditation procedures) will develop a standard protocol for evaluating abortion services. This guide will be widely disseminated to help improve the quality of abortion services, from the reception point until women leave the clinic.

• *Changes to the Veil Abortion Act*. Modification to current legislation now affirms, with the law voted in May 2001, a minor girl's right to an abortion without having to inform her parents (while before this date, parental consent was mandatory) and acceptance of 14 weeks of gestation as a legal limit for the abortion procedure. Even though abortion and contraception rights groups do not think that these legislative changes are sufficient, they still welcome them. The anti-abortion groups launched a protest campaign, in response to the governmental announcement sending petitions and postcards with anti-Semitic overtones to the minister in charge of abortion and to Mr. Nisand.

Efforts by the National Education Department in the Area of Sex Education

Since 1995, the National Education Department has revised its prevention policy involving young people attending school. The entire educational community must be mobilized around HIV prevention and the prevention of unwanted pregnancy and sexual violence should be incorporated into a comprehensive approach to sex and health education. Two hours of sex education have been mandatory in secondary schools since 1996, focusing on prevention before the first sexual experiences. Furthermore, since 1998, 40 hours are also set aside in secondary schools for citizenship and health education. Sex, contraception and HIV are also included in that comprehensive educational approach.

While the National Education Department wants to strengthen the community's involvement in sex education, these new directives are being implemented very progressively and unevenly. Despite the implementation of a training system in 1995, school personnel are still not comfortable with this new mission. In this context, some school nurses and some educators welcome the participation and tools offered by the pharmaceutical laboratories (such as Wyeth) and health-related product companies (such as Tampax). In 1999, the National Education Department sent a letter to school district directors calling for vigilance on the part of the educational community with respect to participation by agents from outside of their institutions. However, no prohibition was clearly stated with respect to the laboratories, even though those who are responsible for prevention believe that such participation is no substitute for a health and sex education program provided to young people by the educational community.

The National Sexual Risk Reduction Program for Women

Since 1996, "mothers/children/HIV" has replaced the title "women and HIV" in its organizational chart of the Ministry of Health's HIV Division. This change reflects a symbolic desire by the government to highlight women as autonomous and as one of its priorities. Epidemiological data show that, in France, in recent years, there has been an increase in the proportion of heterosexual AIDS cases.[70] In this context and considering the specific social and

physiological vulnerability of women, the government has affirmed its involvement in reducing sexual and reproductive risks for women. After a period devoted to building a network of partnerships and awareness, the government has defined a comprehensive action strategy based on a national risk reduction program targeting women. In 1998, a three-year agreement between the government and the MFPF was signed, commissioning the association to implement this preventive health action for women, particularly those in precarious socioeconomic situations.

This initiative is divided into two phases and, at the same time, has been evaluated.[71] In the first phase, 60 MFPF leaders received training on sexual risks, known methods of protection, the latest epidemiological and therapeutic developments regarding HIV infection, group management and counseling techniques. This new prevention premise breaks with the long-time goal of zero risk and is based on risk reduction within the framework of a more comprehensive approach to sexual health. In the second phase, these leaders are charged with forming groups of some 10 women who are experiencing prevention problems or looking for a new method of protection. These groups will specifically teach women about the female condom which is available through the DGS and the MFPF. This initiative is targeted specifically at women, particularly those at highest risk.

These women's groups meet five times and are designed to be a place for discussing the difficulties each one is experiencing acquiring knowledge and developing personal strategies for risk reduction to protect their health. Two additional sessions may be held at the request of the women to guide them in creating community health projects and to assess the difficulties they have encountered or the projects they have begun. One of the expected extensions of this program is the emergence of relay-women in various communities (cultural or neighborhood) likely to initiate prevention and health actions. By the end of the year 2000, 4,800 women should have benefited from this program. The evaluation shows that this type of program is successful in reaching people with extensive social problems and in making them speak about sexual issues, prevention and contraception.

Part IV. Public Policy and Programs for Disadvantaged Groups

Prevalence and Distribution of Economically, Socially or Culturally Disadvantaged Subgroups

According to the French National Institute of Economic and Statistical Information (INSEE), in 1995, one out of every two households had a standard of living of less than 7,500 francs per month per consumption unit.[s] The mean monthly income per consumption unit is 9,545 francs. At the low end, 10% of households have less than 3,823 francs, and at the high end of the scale, 10% have more than 16,559 francs.

The gap between the median standard of living and the standard of living among the higher income group is widening.[t] However, according to the INSEE, the increase in income disparities among households is apparently offset by social services, which target the lower income groups. There have also been changes in government benefits to reduce disparities among retirees.[72]

Since there are various definitions of poverty level,[u] the estimates of the proportion living in poverty vary between 8% (5 million people) and 11% (6.5 million people). The population living below the long-term poverty line tends to be predominantly female and younger than the total population. Poverty mostly affects the elderly (age 75 and over) and people under the age of 25 (excluding students living on their own). Poverty is minimal at around age 30 and age 70. In France, poverty rises and falls with current economic conditions and is strongly linked to unemployment and underemployment, two phenomena that particularly affect young people and women.

Women are more affected by long-term poverty than are men between the ages of 25 and 45 and after age 65. The converse is true before age 25 and between the ages of 55 and 65. There is no perceptible gender difference between the ages of 45 and 55. In theory, with respect to the statistical standard, for couples, living together, the spouses are treated identically. Consequently, the disparity between male and female poverty levels derives from adults who are not living with a partner; in other words, single persons, single parents and young people living with their parents. During their working years, single men are poorer than single women. However, since single women are often part of a single-parent family, this explains the overrepresentation of poor 25–45-year old women. In 1994, 1995 and 1996, along with large families, single-parent families experienced a high rate of long-term poverty and, in nine out of 10 cases, were headed by women. During their working years, women have a higher unemployment rate than men and, when they have a paying job, they work part time more often than men and receive approximately 30% lower pay than men for equal work.

Young people under 25 are mostly poor because their family is poor: 35% of poor young people spent 1994, 1995 and 1996 living in a large family and 11% spent them in a single-parent family. The risk of unemployment is higher among young people at all

[s] Income per consumption unit (CU) is income corrected for the size of the household. A single individual counts as one CU, a couple with no children counts as 1.5 CU, a couple with one child counts as 1.8 CU, a couple with two children counts as 2.1 CU, etc.

[t] The appreciable increase in the income gap, which was especially marked in the early 1990s, is attributable to increases in unemployment and underemployment rather than to an increase in wage differentials, which has been barely perceptible since 1984.

[u] According to INSEE's data, in 1994, just over 9%, i.e., 5.5 million persons, were living below poverty level in France. The poverty level is 3,800 francs a month for an individual or 6,800 francs for a couple with one child. According to the European panel, 8%, i.e., 5 million adults (persons age 17 or older in 1994, with the exception of students living away from home or living on their own) living in ordinary housing in France were considered long-term poor for the period from 1994-1996. The poverty level for that study was about 3,300 francs per month per consumption unit. According to a current definition of relative poverty, 11% of the population is poor, i.e., 6.5 million persons are affected by poverty in France.

education levels, but increases even further for the least qualified young people entering the labor market.[73] Consequently, those with the lowest education are the most affected by problems of social and vocational integration. In France, a plethora of new types of employment contracts are challenging the hegemony of the Employment Contract with Unspecified Time Frame (Contrat à Durée Indéterminée or CDI), which, along with unemployment and various forms of internship programs, constitutes the first phase of entry into working life for a majority of the young people who do not pursue a higher education. Fewer than half of young adults 20–24 (43%) who have completed their education have a stable job, while 53% are in an unstable work situation: unemployment, temporary employment (Employment Contract with Specified Time Frame, Contrat à Durée Déterminée or CDD), part time employment or internship program.[74] Among the unstable employment contracts, some are specifically intended for young people, such as the Jobs for Youth (Emplois Jeunes), while others, such as the CDD, the Solidarity Employment Contract (Contrat Emploi Solidarité, or CES), and the involuntary part-time work contracts do not exclusively affect young people. The young people most affected by problems of integration are immigrants. Finally, the worsening of social and vocational integration problems, particularly among young people, has produced such a high level of exclusion among some youth that they move to another part of the country. However, this phenomenon, which is currently the subject of a study commissioned by the government,[v] is poorly understood in France.

Public Support for Government Assistance

The French population values the country's social security system and rallies to defend it. That was specifically the case in December 1995, when the last Social Security reform plan was presented by Alain Juppé (Prime Minister). This plan triggered a massive mobilization of workers as well as some intellectuals (particularly Pierre Bourdieu (a very well known sociologist), who spearheaded an initiative against the Juppé plan), leading to the withdrawal of the plan, even though it had the support of the leadership of the CFDT.[w]

However, there are also extreme right-wing minority groups who are advocating a revamping of the social security system to specifically exclude immigrants, despite the conditions under which welfare and social services are assessed and granted. Foreigners are often subject to discrimination, particularly with respect to employment and housing. According to a report written in 1998 by the High Council on Integration (Haut Conseil à l'Intégration), the situation is worrisome. With regard to undocumented individuals, there have been a certain number of incidents, including the denunciation of illegal residents who use hospitals and schools.[75] More generally, the facilities intended to aid individuals in difficulty are not always very well accepted in neighborhoods. In Paris, but also in certain provincial cities, inhabitants have been mobilizing to oppose the opening or continued presence of drug rehabilitation centers. However, there have not yet been any studies in France about the Nimby (not in my back yard) syndrome with respect to facilities that aid individuals in great financial and social difficulty.[76]

Finally, the conservative right and the National Union of Family Organizations (l'Union Nationale des Associations Familiales, or UNAF) believe that family policy focuses too strongly on social issues, that it is not pro-family enough and that it is responsible for the decline in the birthrate. In the fall of 1997, these organizations rallied en masse against the Prime Minister's decision to make Family Allowances (Allocations Familiales, or AF) subject to financial need.[x] In June 1998, the government reversed that decision and Family Allowances are once again paid to all families regardless of income.

Summary of Recent Developments in Social Welfare

The government has been extensively involved in social welfare for the most disadvantaged since the passage, in July of 1998, of the Non-Exclusion Act (Loi Contre les Exclusions), which has several sections devoted to housing, employment, health care and indebtedness among people most affected by economic and social disadvantage. However, according to the authors of a study on unstable employment and health care, the national government

[v] The National Monitoring Center for Poverty and Societal Exclusion, is conducting a study on migratory youth that will provide a synthesis of existing studies and a field study based on 40 forty agencies working with populations in difficulty.

[w] The CFDT is one of the major unions in France.

[x] 25,000 francs per household constituted the monthly resource ceiling not to exceed in order to receive these benefits.

should become more involved in covering the most disadvantaged and not limit itself to delegating the task to the local level.[77]

In December 1997 and January 1998, the movement for unemployed and under-employed workers initiated an unprecedented mobilization, even though its constituency was limited with regard to the number of people affected by unemployment and underemployment. For more than two months, various actions (unoccupied housing, food from supermarkets, invitations to major restaurants, etc.) and numerous local and national demonstrations increased the visibility and public awareness of the social impact of unemployment. This mobilization was expanded throughout Europe.[y] In December 1998 and December 1999, the movement for unemployed and under-employed workers mobilized with the same major demands: a 1,500 franc increase in all "social minimums" paid, allocation of a Minimum Integration Income (Revenu Minimum d'Insertion, or RMI) to young people under age 25 with no means of support and a Christmas bonus for the unemployed. Under pressure from the movement, the government decided to grant a one-time year-end bonus to RMI recipients, based on family income.[z] Since the Non-Exclusion Act was passed in 1998, certain unemployed and under-employed workers' associations (particularly Act against Unemployment, AC! Agir Contre le Chômage or AC, and the National Movement of Unemployed and Precariously Employed Workers) are able to represent the unemployed at local offices of the National Agency for Employment (l'Agence Nationale pour l'Emploi, or ANPE), and can assist the unemployed in the procedures they must carry out in order to assert their rights as job seekers.

Despite the benefits allocated by the government to low-income individuals (details below), the most disadvantaged among them often have trouble retaining housing, even in the (public and private) low-rent housing projects, (Habitations à Loyer Modéré, or HLMs). In this context, the Right to Housing organization (Droit Au Logement, or DAL) is rallying to keep low-income families in their housing and, more generally, is challenging the government on the right to housing for all and their commitment to that issue (details below). The spectacular nature of this organization's actions (requisitions, occupation of public places, demonstrations, etc.) and the commitment of numerous celebrities to its cause have promoted strong media coverage of this movement, which has a good deal of public support.

Many people in great financial and social difficulty do not assert their rights and consequently do not take advantage of the social services available to them. Due to the non-use of benefits and services and administrative problems, largely attributable to the French social welfare system's complexity and lack of comprehensibility, the National Monitoring Center for Poverty and Exclusion has scheduled a major study for the near future concerning the difficulties faced by poor and under-employed individuals in obtaining information and the benefits to which they are entitled.

Since 1982, the government has been undergoing a process of decentralization. There are currently centralized government services and decentralized government at the regional (Regional Council) and departmental (French "départements" represent main administrative divisions of the French territory) level (General Council). In the context of increased decentralization, social welfare is largely the responsibility of each department. The Regional Council is more responsible for training, particularly of young people.

Since 1988, the RMI provides a minimum income to people over age 25 living in highly precarious conditions, or to those under age 25 with at least one dependent child. More than 10 years after its introduction, the RMI has become an ever-growing benefit. As of December 31, 1997, there were 1,068,000 recipients, and more than two million eligible dependents (spouse and dependent children). This benefit affects mostly young people 25–29 and the applicants are increasingly younger. One out of every 15 young people 25–29 is living on RMI and the new recipients under age 30 now represent 53% of all those living on RMI.

Furthermore, since 1996[aa] there has been an

[y] December 12 and 13, 1997: European meetings against precarious employment took place in Grenoble, bringing together government officials and politicians, trade unionists, researchers in economics and sociology, and precarious and unemployed workers.

[z] 1,000 francs for an individual, 1,500 francs for a person with one dependent, 1,800 francs for two dependents, 2,200 francs for three dependents, 2,600 francs for four dependents and, beginning with five people, 400 francs per additional person. Furthermore, a 2% revaluation of the RMI and other "social minimums" was undertaken.

[aa] The government expressed an interest to revive family policy by implementing annual family conferences in 1996. Furthermore, since 1998, there has been an interministerial family delegation and a task force on family law set up by the Minister of Justice.

upsurge in family-centered policy-making in France. This approach, normally the prerogative of the right wing, had been pretty much abandoned by the left-wing governments in power since 1981. According to the Prime Minister, family policy has a new mission. It must become an essential force in preventing violence and delinquency, two issues that are presently receiving the support of the public and of the government.

Finally, as a result of the passage of the Non-Exclusion Act, several new measures have been implemented specifically for very socially disadvantaged individuals. Since 1998, the government has introduced the Journey to Employment Access (Trajet d'Accès à l'Emploi) or TRACE program in order to facilitate the vocational integration of the least qualified young people. Starting January 1, 2000, the Universal Health Coverage (Couverture Maladie Universelle, or CMU) system is being progressively put in place to facilitate access to the health care system by the most disadvantaged. This measure falls within the framework of the government's desire to promote access to health care through the common law health care system. Contrary to policies that have been in place for many years, this is no longer solely a matter of developing a health care system specifically for the poor, even though certain initiatives target the most disadvantaged and even the most excluded individuals. This new measure will provide basic and supplemental health insurance for the poorest population. While some people are still excluded from this benefit, it should make the national health insurance system and the conditions for obtaining care more easy to understand.

Details of French Social Welfare Policies

In France, the social welfare system is composed of different measures that are under the jurisdiction of the centralized and decentralized public authorities[bb] (particularly the General Council in each department) and an extensive network of agencies operating in the area of unstable employment and disadvantage. These include benefits and social welfare specifically for expectant parents and families with one or more dependent children, allocations for jobless and low-income individuals, measures intended to facilitate access to health care by disadvantaged individuals and social benefits and measures related to housing.

Social Welfare for Expectant Parents and Families with Dependent Children

There are several types of benefits and allocations for expectant parents and families with dependent children. In order to protect children from abandonment, abuse and infanticide, since 1941 (and with increasing explicitness since the new laws were passed in 1993 and 1996), French law has recognized a woman's right to give birth anonymously, to surrender her child and give it up for adoption. In France, we speak of "anonymous childbirth"[cc] or "secret childbirth."

Child Social Welfare, which is under the jurisdiction of the General Councils, has a mission to protect children and, for that purpose, is able to take temporary or permanent custody of them (by placing them in an institution) if the parents are unable to care for them.

With regard to day care, there are early childhood care programs that are under the jurisdiction of the government (especially at the departmental level), but not exclusively. Day care centers and drop-in centers provide care for children ages 3 months to 3 years. This is one of the most financially advantageous types of care, with a cost that varies according to the family's income (typically costs 10%-12% of family income). Single persons with children and those with social problems have priority access to these programs. However, the number of available places is considerably lower than the number of applicants.[dd]

Many families use other types of day care for their children. These are different forms of in-home day

[bb] In 1998, the General Councils devoted just over 90 billion francs to this budget. This figure reflects a 2.5% increase compared to 1997, which is the lowest rate of increase since 1990. In general, the departmental public authorities are seeking to limit social welfare expenditures (61% of departmental operating expenses), particularly through cutbacks and tighter controls. According to the statistics published in the spring of 1999 by the Decentralized Social Action Monitoring Center, in 1998, child welfare was still the primary area of assistance (23.5 billion) and represented 31% of the direct expenditures by the departments. The second largest expense item was assistance to disabled persons (26%). Finally, medical assistance and RMI comprised 11% and 5%, respectively, of departmental expenditures.

[cc] The law that authorizes this procedure is currently the subject of debate and is being examined by the government, which may lead to its reform. There is talk of doing way with the mother's anonymity in the name of the child's right to know his or her origin, in an environment where this legal procedure is still poorly understood and particularly taboo in France, even among the professionals who assist women in this procedure.

[dd] A report recently released by the government states that there is a shortage of 500,000 places in day care.

care by mother's helpers[ee] certified by the government, or by uncertified individuals (often but not always students). In this context, families may receive an In-home Day Care Allocation (l'Allocation pour la Garde d'Enfant à Domicile, or AGED) consisting of a reduction in payroll taxes for employing a domestic worker. This type of day care is difficult for low-income individuals to afford.

AF are paid to all families with at least two children, regardless of income (from June 1997 to June 1998, they were paid only to families with a monthly income below 25,000 francs) and are based on the number of children. Consequently, regardless of a family's income, a family receives AF if it has at least two dependent children. The amount of the AF is 687 francs for two dependent children and 881 francs per additional child.

A Family Support Allocation (l'Allocation de Soutien Familial, or ASF) is paid by the Family Allocations Fund (Caisses d'Allocations Familiales, or CAF) to single parents raising one or more children without the assistance of the other parent. It pays a monthly amount of 483 francs per dependent child. If the parent without custody of the child is legally required to pay child support, the CAF handles the payment or withholding procedure instead of the woman. In that case, the ASF represents an advance on the child support that is owed.

Other family benefits are available based on income and are specifically intended for people with low or very low incomes. The Single Parent Allocation (l'Allocation de Parent Isolé, or API) was created in 1976 to provide a minimum income for single parents raising dependent children. In the context of the unborn child, a pregnant woman is considered similar to a single parent. The allocation is paid by the CAF until the third birthday of the last child. It is financed by the National Family Benefits Fund managed by the National Family Allocations Fund (Caisse Nationale des Allocations Familiales, or CNAF).

On January 1, 2000, the amount of the API was 3,236 francs for a pregnant woman and 4,315 francs for a single person with a child; this amount is increased by 1,079 francs per additional dependent child. Nearly half of API recipients have two or more dependent children. A large proportion of API recipients are young; more than three out of every five recipients (63% of all recipients), i.e., 93,800 individuals, are under age 30, including 55,500 recipients under the age of 25 (37% of all recipients).[78]

The Allocation for Young Children (l'Allocation Pour Jeune Enfant, or APJE) is paid to families with low and very low incomes by the CAF, from the fourth month of pregnancy until the child is three years old. As of January 1, 2000, its maximum amount was 986 francs per month, but may be less, since it varies based on the family's income. If there are three or more dependent children, when the youngest reaches the age of three, the APJE payment ends and is taken over by the Family Supplement (Complément Familial, or CF) which varies according to income, with a maximum of 895 francs per month (does not vary based on number of children).

The Childrearing Allocation (l'Allocation Parentale d'Education, or APE)[ff] is an allocation paid to a father or, as in 99% of the cases, a mother who decides to entirely or partially leave his/her salaried job in order to devote him/herself to rearing at least two children (eligibility criteria changed in 1994: from three children to two), the youngest of which must be under age 3.

As of January 1, 2000, the monthly amount of the APE was 3,061 francs for full time work, 2,024 francs for no more than half-time work, and 1,531 francs for salaried work between 50% and 80% of full-time. This is neither a "motherhood salary" in that, in order to be eligible, one must have been previously employed, nor a "pure" benefit to compensate for leaving a job, since it may be paid to individuals who have already stopped working. However, for many women, this allocation alleviates their vocational integration problems.[79]

For the individuals and families in the greatest difficulty, there is emergency assistance that may be issued by social workers from Community Social Action Centers (Centres Communaux d'Action Sociale, or CCAS) and those reporting to the General Council in each department.

[ee] There are too few mother's helpers in cities, while there are too many in rural areas in comparison to the demand.

[ff] Since July 1994, approximately 150,000 mothers of two children withdrew from the labor market within the framework of this benefit. Somewhere between family policy and employment policy, this allocation is not exactly part of the social welfare benefits because it is subject to conditions of prior salaried employment. However, receipt of this allocation is largely linked to women's employment precariousness and a recent assessment of this mechanism points out that receiving this allocation only reinforces a woman alienation from the labor market.

Benefits for Jobless and Low-income Individuals

In cases of unemployment (inability to hold a salaried job) or low income from a salaried job, there are several benefits that may be paid to individuals who apply for them, if they meet the eligibility requirements.

There is a compensation system for unemployed people who, under certain conditions, may receive an unemployment allocation. The Decreasing Individual Allocation (l'Allocation Unique Dégressive, or AUD) is available to individuals who held a salaried job for a sufficiently long period, only if they were fired for financial reasons or if they completed a closed-ended work contract. This benefit is proportional to prior compensation and decreases over time. Some recipients whose AUD compensation runs out may receive the Specific Solidarity Allocation (l'Allocation de Solidarité Spécifique, or ASS).

The ASS was instituted in 1984. It is paid by the Association for Employment in Industry and Commerce, or ASSEDIC, to some unemployed individuals[gg] whose AUD unemployment insurance has run out. As of January 1, 2000, the monthly amount of the ASS was 2,522 francs for a single individual with a monthly income of less than 3,363 francs and 6,726 for a couple. Its amount is based on income and is paid if the monthly income is between 3,363 and 5,885 francs for a single individual and between 6,726 and 9,248 francs for a couple.[80]

However, individuals who have voluntarily left a job while under CDI or CDD, and those who have not held a salaried job for a long enough period of time are not eligible for either AUD or ASS. However, some of them may be eligible for other allocations, if they meet certain required criteria.

For all unemployed individuals over age 25, or those under age 25 with one or more dependent children, who are not eligible for unemployment insurance, AUD or ASS, there is the RMI. It is an allocation that may be paid at a full or partial rate, depending on the income of the applicant and/or his/her spouse. As of January 1, 2000, the amount of the RMI was 2,552 francs per month for a single individual, plus 50% (1,276 francs per month) for a two-person household, plus 30% (765 francs per month) for a third person and 40% (1,020 francs per month) per person, starting with the fourth person. RMI recipients must enroll in a vocational integration program; this is a requirement for continuing to receive this allocation. RMI recipients have incomes far below the levels generally considered as constituting poverty.[81]

Furthermore, disabled individuals may receive the Allocation for Disabled Adults (l'Allocation aux Adultes Handicapés, or AAH) and those with a disability acquired on the job may receive the Supplemental Disability Allocation (l'Allocation Supplémentaire d'Invalidité, or ASI). The AAH was instituted in 1975 to provide a minimum income for disabled individuals with no incomes or with low incomes who are not eligible for an old-age or disability benefit or a disability pension.[hh] As of January 1, 2000, the monthly amount was 3,471 francs per month and this allocation is paid every month for one to five years, or even 10 years if the disability is not likely to have a favorable outcome.[82]

The ASI was created in 1930 and is available to individuals under the age of 60 who are receiving a disability pension from a Social Security agency for a permanent disability that has reduced their ability to work by at least two-thirds, when this disability pension is less than a certain amount. The monthly amount of the ASI is based on the recipient's income. It supplements that income with a ceiling of approximately 3,500 francs for a single individual and 6,200 francs for a couple.[83]

Finally, there are allocations for individuals in very specific situations, such as those just released from prison or requesting refugee status (Integration Allocation),[ii] senior citizens with no incomes or very low incomes (Supplemental Old-Age Allocation)[jj] and those with financial difficulties related to the death of a spouse (Widowhood Insurance Allocation).[kk]

[gg] The recipient must show proof of five years of salaried work over the course of the ten years preceding the breach of the work contract that made him/her eligible for compensation under the unemployment insurance.

[hh] The recipient must show proof of at least 80% disability, or 50% in cases where it is shown to be impossible to find a job due to the disability. He/she must be age 20 or older (or age 16 for any child who no longer makes his/her family eligible for Family Allocations).

[ii] Created in 1984 and managed by the ASSEDIC on behalf of the government. It is paid for no more than one month. As of January 1, 2000, its amount was 1,776 francs for a monthly income below 3,553 francs for a single individual and 8,883 francs for a couple. A partial payment is made if the income is between 3,553 and 5,329 francs for a single individual and between 8,883 and 10,659 francs for a couple .

[jj] Created in 1956, it provides supplemental income to senior citizens over the age of 65 with very low income. It supplements the recipient's income and has a ceiling of approximately 3,500 francs for a single individual and 6,200 francs for a couple.

[kk] Created in 1980, the recipient must be under the age of 55 and must have raised at least one child for 9 years prior to his/her 16th birthday or must be raising at least one child at the time of the

Measures Intended to Facilitate Access to Health Care by Disadvantaged Individuals

To facilitate access to the health care system, there are specific consultation facilities for disadvantaged women and children, various measures for covering health care costs and various measures designed to increase access to health care among those individuals in greatest difficulty.

There are two types of health care facilities that specifically serve socially disadvantaged women and children. For gynecological care, contraceptive prescriptions, prenatal care, screening and treatment for STD/HIV, the CPEF provide free visits and treatment for minors and individuals with no social coverage.[ll] With regard specifically to health care for children under the age of 6, the Mother and Child Protection Centers (under the jurisdiction of the General Councils) provide free office visits. Occasionally, in cooperation with the CPEFs, they make social and medical house-calls to women in particularly disadvantaged situations who are alienated from the health care system.

Since 1945, there has been a medical insurance system available to all salaried workers and their dependents (spouse and children). A portion of the health care costs (varying depending on the service) is reimbursed by Social Security and the rest may be covered by supplemental medical insurance for covered individuals (this is rarely the case for individuals with low incomes or who are in difficulty).

For individuals who have no social protection or who have too little income to meet health care costs not reimbursed by Social Security, there are measures under the jurisdiction of the government that cover these costs. These are the Government Medical Assistance (l'Aide Médicale Etat, or AME) and Hospital Medical Assistance (l'Aide Médicale Hospitalière, or AMH). However, these measures are currently undergoing changes and the configuration of social welfare assistance for access to the health care system has been partially modified.

CMU has been in effect since January 1, 2000 and allows stable and permanent residents to receive social coverage for health care costs. It also allows individuals with incomes below 3,650 francs to benefit from supplemental medical coverage. In this context, a portion of the beneficiaries of AME (or AMH) will be eligible for CMU. In fact, the criteria for access exclude several groups from basic CMU and more frequently from supplemental CMU. Undocumented individuals of foreign nationality residing in France are not eligible for CMU. Individuals with incomes greater than 3,500 francs per month (this is particularly the case for AAH recipients) are also not eligible for supplemental CMU. However, individuals who are partially excluded (no supplemental medical coverage) or totally excluded (no basic medical coverage) from the CMU always have recourse to AME or AMH. All RMI recipients are automatically eligible for supplemental CMU. Young people over the age of 16 may have their own Social Security card and receive supplemental CMU if they have broken the ties with their family.

This measure is intended to widen access to the health care system by disadvantaged groups, including those without social coverage. Other measures are available to facilitate access to health care by the most disadvantaged.

Measures to Facilitate Health Care Access by Individuals in the Greatest Difficulty

Following an experiment carried out in Paris in 1992, since 1994, special programs for the disadvantaged have been set up in 19 public hospitals in the public welfare system in Paris and surrounding areas and in hospitals in the major cities in France. They provide immediate access, for individuals without social coverage (regardless of income, social coverage or legal status), to medical and nursing care and make it possible to incorporate social welfare follow-up into the strictly medical management model.[mm]

Since November 1993 in Paris, and since May 1994 in the Paris region, as well as in the major provincial population centers, approximately forty

widowhood. The recipient must not be living maritally with another person. It is paid for three to five years, with a decreasing benefit, in order to provide a minimum income for the surviving spouse of a person eligible for social security. Its amount is approximately 3,200 francs for the first year, 2,100 francs for the second year and 1,600 francs for the third through fifth years.

[ll] The "undocumented" often fear that using the health care system, because it is under the purview of the public authorities, will result in their being reported to those authorities. In this context, they often turn to the organizational sector when they are seeking health care.

[mm] In general, after meeting with a social worker, individuals entering this program are directed, within the hospital itself, toward the most appropriate department for their health care needs and are given a routing slip for access. Thereafter, these persons are given careful social follow-up, which allows more than 70% of the patients who apply to this program to obtain (or renew) social coverage for one year.

Social SAMUs (rescue squads) have been implemented. The Social SAMU was modeled on the Medical SAMU (Emergency Medical Assistance Service). These provide outreach to individuals who are in such difficulty that they are unable to request help, whether it be health care, housing or any other assistance.[84] However, this type of intervention focuses more on medical management than on social intervention.

Mission France of the organization Doctors of the World has several locations for free office visits and medical care. More than 30 health care centers specifically for individuals in difficulty employ 1,800 volunteers and an organization staff of more than a hundred.[85] This is one of the most active organizations working in the area of health care access to disadvantaged populations.

Created in 1993, the RESO organization, brings together more than 2,000 practitioners in private and hospital practice, who commit to providing health care and medications.[nn] Located throughout France, they are contacted through a coordinating telephone center with a toll free number, staffed by volunteer health care professionals.[86]

Measures Related to Housing

There are social programs for the provision of housing and housing allocations available to low-income individuals. For individuals in great difficulty, there are several social shelter programs.

In France, there are low-rent housing projects, or HLMs, which are managed by public and private agencies. These are specifically for low-income individuals, but the demand for this type of housing quite exceeds the supply. It may take five years (or more) between the application and the assignment of housing. Low-income families, and even the most disadvantaged, are often excluded or cannot manage to keep this type of housing.

Other social benefits specifically for housing include Personalized Housing Assistance (L'Aide Personnalisée au Logement, or APL). This is a benefit paid by the CAF to low income tenants who live in subsidized housing, particularly but not exclusively in the HLMs. The amount is based on the type of housing, the composition of the household and the cost of the rent. It may vary from approximately 100 to 1,300 francs. The Family Housing Allocation (l'Allocation de Logement à Caractère Familial, or ALF) is reserved for individuals not eligible for APL and who have dependent children. The amount is subject to the same requirements and is approximately identical to APL. Finally, the Social Housing Allocation (l'Allocation Logement à caractère Social, or ALS) is an allocation paid by the CAF to low-income individuals who are not eligible for APL or ALF. The amount varies (approximately 100 to 1,200 francs) based on income, composition of the household and the cost of the rent paid by the applicant. Students are eligible for this allocation if they do not live with their parents and have no income or have low income from employment.

For individuals in great difficulty, there are about 1,000 social shelters, which have approximately 33,500 beds for adults and children. Some of them specialize in accommodating mothers and children (4,510 beds), whether minors or adult women, who are in social difficulty or have broken ties with their families and who are pregnant or have one or more dependent children.[87]

Private organizations are widely involved in providing emergency homeless shelters. Homes belonging to Catholic Charities, The Salvation Army, The Emmaus Foundation and Secours Populaire Français, offer services where homeless individuals or those who are disadvantaged economically can obtain clothing free of charge or for a small fee.

In the context of the worsening economic crisis, several types of organizations work with low-income individuals and families to help them obtain or keep rental housing. This is particularly the case for the DAL and the national network of Local Committees for Self-contained Housing for Young People (Comités Locaux pour le Logement Autonome des Jeunes, or CLLAJ) which work specifically with young people to obtain housing, particularly by acting as mediators between landlords (or their agents) and the young people who use their services. They may also assist young people by serving as a guarantor to the landlords and real estate brokers.

[nn] Since it was created, RESO has received more than 40,000 calls, half of them placed by the users themselves, one-third by family and friends, and 16% by social workers.

Table 2. Overview table of social services available to minor and adult young women in financial difficulty

Age	Under age 25				Over age 25			
Pregnant/ or Dependent Child	YES		NO		YES		NO	
Spouse	YES	NO	YES	NO	YES	NO	YES	NO
Available social services	-API then -RMI -ASF (if no support from the father) -APJE (then CF if at least 3 children >3 years) -AF (if at least 2 children) -AL -HS AGED	- RMI -APJE (then CF if at least 3 children >3 years) -AF (if at least 2 children) -AL -HS -AGED	-AL -HS	-AL -HS	-API then -RMI -ASF(if no support from the father) -APJE (then CF if at least 3 children >3 years) -AF (if at least 2 children) -AL -HS AGED	-RMI -APJE (then CF if at least 3 children >3 years) -AF (if at least 2 children) -AL -HS -AGED	-RMI -AL -HS	-RMI -AL -HS

API: "Single Parent Allocation"
APJE: "Young Child Allocation"
CF: "Family Supplement"
AF: "Family Allocations"
AGED: "In-home Day Care Allocation"
ASF: "Family Support Allocation"
AL: Housing Assistance (APL) or Allocations (ALS and ALF)
HS: "Social Shelter"
RMI: "Minimum Integration Income"

Note: For single persons receiving both RMI or API and AL, the amount paid to them is calculated as follows: a housing fee of 306 francs is subtracted from the RMI (then equal to 2,246 francs) and a fee of 295 francs is deducted from the API (then equal to 2,941 francs). Furthermore, API and RMI are not paid simultaneously. The woman receives the allocation with the higher amount.

Examples. A young woman who is a minor, a high school student, pregnant and without income, may receive on a monthly basis: API (- AL fee = 2,941 francs) + APJE (986 francs), therefore at least 3,927 francs in addition to AL (too fluctuating to be calculated here). After the birth of her child, the amount of the API will be 4,315 francs (- AL fee) until the child is three years old. Then, she may receive RMI (3,828 francs – AL fee) and ASF (486 francs) if the father does not pay child support and she lives alone.

A pregnant young woman, age 22, unemployed after one year of salaried employment at a net 6,000 francs per month, with one dependent child, may receive on a monthly basis: AUD (4,800 francs) + APJE (986 francs), therefore, approximately 5,786 francs in addition to AL (too variable to be calculated here) and possibly ASF (486 francs) if the father does not pay child support and she lives alone.

Interventions or Programs that Assist Youth from Disadvantaged Populations

There are different facilities, work contracts, and programs specifically intended for young people, particularly those with difficulty integrating socially and vocationally. The government and Regional Councils share jurisdiction with regard to assistance for training and vocational integration of young people.

Information and Guidance Facilities for Training and Integrating Young People

There are Service, Information and Guidance Facilities (Permanences d'Accueil, d'Information et d'Orientation, or PAIO) and Local Missions (Missions Locales, or ML). In both cases, these are specialized services, information and guidance facilities for young people under the age of 25 with social and/or vocational integration problems. They provide information and guidance to young people about their common law rights and the integration or training programs in which they may enroll. These facilities provide education and guidance in job seeking procedures and offer personalized follow-up. The PAIO and ML constitute referral facilities for Local Employment Agencies (Agences Locale pour l'Emploi, or ALEs (local departments of the ANPE)) and are available only to those under the age of 25. Along with other facilities, they are responsible for implementing the TRACE program, which is the key measure in the employment component of the Non-Exclusion Act, passed in July 1998.

Work Contracts Specifically for Young People

There are various systems for partial exemptions from payroll taxes for employers who hire young people under the age of 25. There are different apprenticeship contracts, combining training and compensated vocational experience. These are available to young individuals between the ages of 15 and 25. The Jobs for Youth, which has been progressively implemented since 1997, currently enrolls 222,000 individuals. The Jobs for Youth must develop new areas for vocational integration to meet the new needs emerging in society. These are predominantly jobs involving leadership, sports, education, security and the development of new technologies. This is a five-year contract and the government pays 80% of the salary to the young person, which must be at least the legal minimum wage (approximately 40 francs per hour, gross), in other words, approximately 5,600 francs per month. Since most of these jobs require training and skills often beyond the baccalaureate level. They are not intended for the least qualified young people, but rather for those who are unable to become vocationally integrated despite their diplomas and/or training.

There is also the CES which is not specifically intended for young people, but which particularly affects them since, like the Jobs for Youth contract, for many young people, this type of hiring contract is used in their first work experience.[88] The CES promotes access to jobs and is partially financed by the government, which pays a portion of the salary. Limited to 20 hours of work per week, the CES is particularly poorly compensated, i.e., approximately 2,400 francs per month (even less than RMI).

Training Programs for the Least Qualified Young People

On the occasion of the mandatory census day in 1990, the French Army, in partnership with National Education, set up a program to screen for reading problems that affect more than 50,000 young people each year (approximately 13% of the young people tested and 4% of an age group) who have not acquired minimum basic reading skills and to guide those identified to several remedial actions. The anti-illiteracy program offers various training programs. However, according to a recent report, this program lacks comprehensibility and accessibility. It should be extensively reformed in the coming months.

The TRACE program, a key measure in the employment component of the Non-Exclusion Act, is a program intended for greatly disadvantaged young people and offers them an individualized track toward lasting vocational integration. It is most particularly intended for young people 16–25 who are the least qualified, the most alienated from employment and the most exposed to the risk of vocational exclusion. Young people with social, personal or family handicaps who feel they have little chance of obtaining a job in the current labor market are also a priority. According to the estimates, the following number of youth were seen: 5,000–10,000 young people in 1998, 25,000–40,000 in 1999 and 45,000–60,000 in 2000 (but no evaluation of this program is yet available). Professionals working in employment, training and integration programs as well as those who work in social centers and organizations are aware of this program and should help identify and guide those young people most likely to

benefit from it. This program, which has a maximum duration of 18 months, offers a personalized integration track composed of several types of interventions. These consist, first, of identifying their difficulties and offering them an appropriate solution and, second, of building an integration strategy with them consisting of assessment, guidance, remobilization, integration and job placement as well as training programs to provide them with basic knowledge or job qualifications. Specialized interventions include literacy programs and ensuring equality between boys and girls as well as gender equality in the workplace. The young people participating in these programs may be compensated, particularly during periods of actual work, and they are covered by medical insurance. When they have no income, the participants in this program may apply for Youth Assistance Funds, or FAJ. The implementation of the TRACE programs relies primarily on the PAIO, ML, ALE and possibly vocational training and integration agencies, homes for young workers and specialized prevention teams. Depending on need, professionals in the health care and social fields may be called upon to participate in the TRACE program.

Finally, through media campaigns (TV and press), the French Army regularly communicates information about its job prospects, particularly but not solely for young people with few or no qualifications.

Programs Focused on Impacting the Sexual or Reproductive Behavior of Disadvantaged Youth

• *Study on reducing unwanted pregnancy.* In March 1999, the DGS requested that the Departmental Health and Social Affairs Bureaus (Directions Départementales des Affaires Sanitaires et Sociales or DDASS) initiate a study on reducing unwanted pregnancy, particularly but not only among adolescents. Although that initiative is not part of the government's action program to improve access to contraception and abortion, it is nevertheless part of a new government mobilization, particularly following the Uzan report on adolescent pregnancy. In all, approximately 22 departments voluntarily applied for this research intervention and three of them (Rhône, Seine Saint-Denis and Somme) were selected. Each of these departments will receive 150,000 francs per year for conducting the intervention defined by the local partners, which will be ongoing for three years. The Regional Health Monitoring Centers (Observatoires Régionaux de Santé, or ORS) which specialize in epidemiological studies at the local level, are in charge of the initial assessment and evaluating the interventions. They also have an advisory role in selecting the interventions to be implemented. For all of this work, each ORS involved has received a budget of 200,000 francs. This program is mobilizing all family planning professionals (particularly those from the CPEF and CIVG), as well as those who work with young people, such as those in National Education. In addition, the Departmental Women's Rights Delegations (Délégations Départementales aux Droits des Femmes, or DDF), hospital obstetrics and gynecology departments, Central Primary Medical Insurance Funds (Caisses Primaires Centrales d'Assurance Maladie, or CPCAM) or MPU departments and local governments may also be recruited for this preventive initiative, which should be supported and implemented by a broad local partnership. Currently, each department is working on the initial phase of the program, i.e. selecting the first studies and/or interventions to be implemented from among the various program components, which were decided upon at the local level. In all of the departments involved, the participants in this program have given priority to the adolescent target population. Many participants are in favor of preventing adolescent pregnancy, without distinguishing between those that are wanted and those that are not. Some professionals believe that these pregnancies present risks, particularly from the medical perspective, but also from the social perspective because adolescent mothers apparently abuse their children more often than other mothers, particularly psychologically. These professionals give little consideration to the possibility of an adolescent wanting to become pregnant at that stage of her life and aim to help women postpone pregnancy. Such professionals tend to consider young women as noncompliant with respect to contraception, because the "adolescent crisis" causes them to adopt compulsive and irrational behavior. But they also acknowledge the need to provide contraceptive information to young people.

• *Project in the Rhône Département.* Priority was placed on reducing unwanted pregnancy among adolescents. Several components are being considered for implementation as part of this initiative. In line with a new measure authorizing school nurses to administer emergency contraception free of charge (and before this measure was discontinued) in the schools and, following the launch of the contracep-

tive information campaign, the Rhône project underwent a few modifications. As a first step, a survey of professionals was done on their opinions about adolescent pregnancy and about young people's opinions on contraception. In light of the results of this study, a video largely depicting the questions and answers of the young people will be made and used as a tool for professionals working on the issue of adolescent sexuality and contraception. As a second step, several other interventions will be undertaken, but their selection and implementation chronology has not yet been established. These may include setting up specific follow-up of adolescent pregnancies from the medical, social and psychological perspective. Adolescents not terminating their pregnancies would be followed-up through the intermediary of one or two pilot CPEFs in order to prevent subsequent unwanted pregnancies or abortions. Adolescents terminating their pregnancies, particularly those requiring an emergency procedure due to the legal time limit, could be managed by a pilot facility (a hospital CIVG) specializing in abortions for very young women. Furthermore, different small intervention programs for young people attending school and young people who had dropped out were considered, particularly in schools and within the framework of the TRACE program. Finally, the last focus concerned facilitating adolescent access to emergency contraception. It would include information in the form of posters and/or booklets intended for young people as well as pharmacists and school medical services. Furthermore, a study in cooperation with the hospitals would make it possible to dispense emergency contraception free of charge in emergency rooms and obstetrics and gynecology departments.

• *Project in the Seine Saint-Denis Department*. This department's project is currently being entirely restructured since it specifically planned to facilitate access to emergency contraception by young people through the intermediary of school nurses by setting up a partnership with National Education. Furthermore, the design of information booklets about contraception will possibly be dropped in favor of other interventions. No information is available concerning the new program that will be developed in this department within the framework of this study.

• *Project in the Somme Department*. The program considered by this department is broken down into three components. The first component is devoted to prevention and information about sex and contraception for young people, particularly those who are attending school. The formation of non-coed groups for the school information sessions is considered an effective method, since each will speak more freely in the absence of the opposite sex. The designing of contraceptive information booklets, which was part of this component, will most likely be dropped due to the dissemination of the information material from the national campaign conducted by the government. The second component is devoted to following-up on contraception in order to "combat repeat abortions and early pregnancies."[89] More generally, this component aims to prevent early pregnancy regardless of whether or not they are wanted. The third component of this program is devoted to providing specific support for those adolescents who wish to terminate their pregnancy and those who do not, as well as pregnant women in great difficulty. Finally, certain interventions could be undertaken for women residing in rural areas. According to the lead researcher for this department's study, this would be a matter of helping adolescents postpone their first pregnancy as well as subsequent pregnancies, the goal being to "have them wait and grow up" before they undergo this experience for the first time, or again.

Part V. Hypotheses Suggested by Various Researchers to Explain Adolescent Pregnancy in France

This section presents the main hypotheses, by various researchers, regarding the most probable explanations for the relatively low adolescent pregnancy rates and birthrates in France as compared to other countries. While they have suggested hypotheses in an attempt to explain this situation, overall, it remains quite enigmatic, even to specialists in sexual and reproductive behavior, particularly in light of the fairly poor quality of information that is provided to young people about sexual risk behaviors.

According to Henri Leridon, demographer at the Institut National des Etudes Démographiques (INED), the French situation with respect to adolescent pregnancy is paradoxical, since the pregnancy rate among minor women is lower than in the United Kingdom and the information provided to young people does not particularly seem to be of better quality in France. As surveys of adolescents have shown, their main sources of information are their peers and the media, far above physicians, family and educators. While there is mother-daughter communication on the issue of menstruation, parents do not easily broach the subject of sex and contraception. In general, due to medically supervised contraceptive distribution, it would seem that adolescents know less about the menstrual cycle and non-medical methods (other than condoms). This could be damaging to the prevention of unwanted pregnancies, particularly between the time of first sexual intercourse, which for the most part occurs with condom use, while the beginning of pill use often does not occur until the relationship stabilizes. Furthermore, there are many adolescents who believe that there is no risk of pregnancy from first sexual intercourse. Consequently, the quality of the information available to adolescents does not explain the lower pregnancy rate among minors in France compared to other countries. However, the stigma attached to unplanned pregnancies, particularly those that occur at young ages, may be involved in the massive recourse to abortion by minors confronted with an unplanned pregnancy. In general, adolescent pregnancies are poorly accepted, since they challenge deeply ingrained social attitudes, particularly on the part of the parents, including those from poor and disadvantaged backgrounds, i.e., the presumption in favor of education and the presumption in favor of choosing the "best" partner. In this context, Henri Leridon points out that parents, even those who would otherwise be opposed to the idea of abortion, tend to favor it when their daughter is confronted with adolescent pregnancy.

According to Michèle Ferrand, sociologist at the Centre National de La Recherche Scientifique, the relatively limited number of adolescent pregnancies and the low birthrate among minors in France is apparently related to the democratization of access to education and the strong support for education by society as a whole, particularly because societal renewal is largely based on educational assets. As in other countries, the age of transition to motherhood was delayed as school enrollment increased. Furthermore, a child is widely considered to be the product of a couple and to need both of its parents. Consequently, there is social recognition of fathers, which is thought to be a barrier to single motherhood among adolescents. This is all the more true in France, where adolescent motherhood is not accompanied by any advantage in terms of acquiring material independence or emancipation from parents. Despite the social benefits available to single parents in difficulty, most of the time, adolescent mothers remain largely dependent on their families.

According to Charlotte Le Van, sociologist and

author of an analysis of early pregnancies in France, the economic, political and cultural revolution of the past three decades gave birth to a new image of women and children, which has contributed to postponing the socially mandated age of first pregnancy.

Widespread and prolonged schooling, as well as generalized access to employment, are actually now encouraging women to delay starting a family. The social image of children has also changed. Gradually stripped of their economic and social value, they are perceived above all as a gratification to their parents. Future mothers want to choose the right time to bear a child, in other words, a time when the child will not create an obstacle to their social fulfillment and when they will be likely to provide the best possible standard of living. The change in the institution of the family has resulted in childbearing patterns affecting consideration of the child's interests and a requirement of "intelligent" parenthood, meaning that a desired child arrives at a time when the couple can provide the space and stability necessary for it.

Extended adolescence is another fact that characterizes our era. If we define that period of life as the age between the onset of physical sexuality and the acquisition of adult social roles, we cannot help but conclude that there has been a notable lengthening of adolescence, due to the deferral of the milestones that mark the entry into adulthood That is why, while pregnancy at a young age is not an unheard-of phenomenon in itself, the recent social and cultural evolution has contributed to rendering it statistically marginal and causing it to emerge as a new social problem.

According to Nadine Lefaucheur, sociologist at the Centre National de La Recherche Scientifique, in France, adolescents leave the family home much later than in England, where they acquire material and financial independence much earlier. This is particularly because the apprenticeship system is more highly developed there. According to this researcher, who is currently working on the draft amendment to the anonymous childbirth law,[oo] cases of infant abandonment as well as the issue of adolescent pregnancy are the subject of alarmist and dramatizing rhetoric that is particularly incompatible with the perspective provided by scientific approach.

[oo] This procedure, which allows a woman to give birth anonymously and to give the child up for adoption, will be legally reviewed. There is a possibility that the woman's anonymity option will be eliminated.

According to Michel Bozon, a sociologist at the Institut National des Etudes Démographiques (INED), strong support for education is the most probable hypothesis to explain the relatively low pregnancy rates and birthrates among adolescents in France. Attitudes in favor of education are strongly held in all social settings and particularly among women. Patterns of secondary and higher education, appear to differ across countries. In Great Britain, there are great discrepancies between the educational levels of men and women, as well as shorter schooling for both sexes in general. France, on the other hand, seems to be one of the few countries in the world where more women than men are enrolled in higher education. There is a strong belief in education, which all social classes perceive as the main vector for social success. In this context, for women and particularly for the youngest women, there is a perceived incompatibility between early motherhood and attitudes in favor of education and career. In France, as in other countries, the age of transition to motherhood increased with the level of women's education and with extended schooling for both sexes. Thus, access to education apparently is a protection from early pregnancy. Furthermore, the context in which the first sexual intercourse occurs may perhaps explain the occurrence of certain pregnancies, particularly when the partner has exerted a degree of pressure. Little explored in the surveys on sex in France (ACSF and ACSJ), is the unexpected nature of first sexual intercourse. This finding suggests that some sexual initiation may occur when pressure is exerted by the partner. While rape is often contrasted to situations of mutual consent as a prerequisite to sexual intercourse, it is more appropriate to take a more nuanced approach to this issue. In particular, the various types of pressures could be situated along a continuum ending in rape, but many of these types of pressures take forms that are less explicit, but just as likely to expose a woman to risk, and particularly the risk of an unwanted pregnancy.

Overview

In France, adolescent pregnancy rates and birthrates are relatively low compared to other countries. The strong support for education in all social environments seem to be largely at the origin of this situation. Young women apparently perceive early pregnancy as incompatible with pursuing their education and, consequently, often decide to delay

their transition to motherhood. Therefore, when confronted with an unexpected pregnancy at a very young age, most decide to turn to abortion. While adolescent pregnancy is not very widespread in France, it is of concern to the government, as well as those working at preventing unwanted pregnancy and in the media. There is a real discrepancy between the statistical and sociological reality of this phenomenon and the way in which the press and politicians handle it. Contrary to the data available on this issue, the phenomenon is often presented as one of increasing concern, and we regularly see an amalgam of adolescent pregnancies; all of which are presented as unwanted. When it comes to adolescent pregnancy, the notion of wanting a child and intentional conception is completely eclipsed, particularly in the rhetoric of the government.

Recommendations of the Nisand Report to Improve the Availability of Contraception to Adolescents

In a report on the availability of abortion in France, commissioned by the government and published in March 1999, Mr. Nisand discussed various proposals to improve the availability of contraception and abortion to adolescents.

In order to improve the availability of contraception to adolescents, Mr. Nisand proposed a three-pronged strategy. First, he recommended dispensing emergency contraception without a prescription, which was adopted by the government and resulted in the authorization to market the emergency contraceptive Norlevo, which became available in pharmacies without a prescription in June 1999. Anti-abortion and family associations have made requests to the Council of State which for a limited time cancelled the governmental decision since it was in contradiction with the law which specified that every hormonal contraceptive had to be delivered by a physician. In January 2001, a new bill was accepted that again allows nurses to deliver emergency contraception.

Second, he believes that improving the quality of information provided to adolescents about sex and contraception requires greater involvement by the government in this area, which is too often delegated to the private sector. He recommends implementing Teen Info Units, modeled on the two facilities he founded. These would be associated with obstetrics and gynecology departments in hospitals and have the joint mission of providing information and contraceptive prescriptions to adolescents. Information sessions to inform adolescents of the existence of these facilities would be held in schools. Anonymity would be guaranteed and appointments and contraceptives would be free of charge (details in Part III).

Finally, in general, Mr. Nisand recommended taking a new approach to providing information to young people on the issue of sex. He believes that the discourse and messages that target adolescents should avoid teaching a technique, avoid claiming to provide sex education and avoid presenting sex in the form of its associated risks. The information and prevention discusion should be truly humanistic, by placing sexual intercourse in its rightful context of loving relationships, by presenting the differences in the seduction methods used by boys and girls, by emphasizing mutual consent, by representing sexual responsibility as a sign of maturity, and by taking an informative (and even medical) approach to the topics that interest young people, such as homosexuality, masturbation, orgasm, virginity and incest.

In order to improve access to health care by adolescents seeking an abortion, Mr. Nisand advocated eliminating the requirement of parental consent for minors. This proposal was taken into consideration in the new law passed in May 2001 and parental consent is no longer mandatory.

References

1. INED, Vingt septième rapport sur la situation démographique de la France, Paris: INED, 1998.
2. La situation démographique en France, rapport INSEE, 2001.
3. Lagrange H et Lhomond B, eds., *L'Entrée dans la Sexualité, le Comportement des Jeunes dans le Contexte du Sida*, Paris: La Découverte, 1997.
4. Warszwaski J, Comportements sexuels à risque de transmission du VIH, in: Lagrange H and Lhomond B, eds, *L'Entrée dans la Sexualité, le Comportement des Jeunes dans le Contexte du Sida*, Paris: La Découverte, 1997.
5. Arènes J, Janvrin MP and Baudier F, Baromètre Santé Jeunes 1997-1998, Comité Français d'Education pour la Santé, 1999.
6. Lagrange H et Lhomond B, 1997, op. cit. (see reference 3); and Warszwaski J, 1997, op. cit. (see reference 4).
7. Bozon M, L'entrée dans la sexualité adulte: Le premier rapport et ses suites, *Population*, 1993, 48(5):1317-1352.
8. Ibid.
9. Lagrange H et Lhomond B, 1997, op. cit. (see reference 3).
10. Spira A et al., *Les Comportements Sexuels en France*, La Documentation Française, 1993.
11. Bozon M, 1993, op. cit. (see reference 7).
12. Lagrange H et Lhomond B, 1997, op. cit. (see reference 3).
13. Bozon M, 1993, op. cit. (see reference 7).
14. Lagrange H and Lhomond B, 1997, op. cit. (see reference 3).
15. Ibid.
16. Bozon M, 1993, op. cit. (see reference 7).
17. Bajos et al., Sexual risk taking, socio-sexual biographies and sexual interaction: Elements of the French National Survey on Sexual Behaviour, *Social Science and Medicine*, 1997, (44)1:25-40.
18. Lagrange H and Lhomond B, 1997, op. cit. (see reference 3).
19. Levinson S, L'organisation temporelle des premières relations sexuelles, in: Lagrange H and Lhomond B, eds., *L'Entrée dans la Sexualité, le Comportement des Jeunes dans le Contexte du Sida*, Paris: La Découverte, 1997.
20. Warszwaski J, 1997, op. cit. (see reference 4).
21. Lagrange H and Lhomond B, 1997, op. cit. (see reference 3).
22. Ibid.
23. Leridon H, La fréquence des rapports: Données et analyses de cohérence *Population*, 1993, 48(5):1381-1407.
24. INED, 1998, op. cit (see reference 1).
25. Lagrange H and Lhomond B, 1997, op. cit. (see reference 3).
26. Ibid.
27. Ibid.
28. Toulemon L and Leridon H, Vingt années de contraception en France 1968-1988, *Population*, 1992, 6:777-812.
29. Warszwaski J, Apport des enquêtes en population générale pour l'étude des MST, Dissertation, Paris: Université Paris XI, 1998.
30. Lagrange H and Lhomond B, 1997, op. cit. (see reference 3); and Warszwaski J, 1997, op. cit. (see reference 4).
31. Warszawski, J, Meyer L and Weber P, Criteria for selective screening of cervical Chlamydia trachomatis infections in women attending private gynecology practices, *European Journal of Obstetrics and Gynecology and Reproductive Biology*, 1999, 86:5-10.
32. Meyer L et al., Trends in HIV infection among sexually transmitted disease patients in Paris, *AIDS*, 1996, 10:401-405.
33. Arènes J, Janvrin MP and Baudier F, 1999, op. cit. (see reference 5).
34. Mossuz-Lavau J, *Les Lois de L'amour, Les Politiques de la Sexualité en France de 1950 à 1990*, Paris: Payot, 1991.
35. Ibid.
36. Le Van C, *Les Maternités à L'adolescence, Réalités Vécues et Normes Sociales*, Paris: L'Harmattan, 1998
37. Ibid.
38. Uzan M, Rapport sur la prévention et la prise en charge des grossesses des adolescentes, Direction Générale de la Santé, 1999.
39. Lagrange H et Lhomond B, 1997, op. cit. (see reference 3).
40. Ibid.
41. Ibid.
42. Ibid.
43. Deschamps JP, *Grossesse et Maternité Chez L'adolescente*, Paris: Centurion, 1976.
44. Bozon M, La nouvelle place de la sexualité dans la constitution du couple, paper presented at the International Sociology Association Symposium, Madrid, July 1990.
45. Spira A et al., 1993, op. cit. (see reference 10).
46. Pollak M, *Les Homosexuels et le Sida*, Paris: Editions A.M. Métaillé, 1988.
47. Simon P et al., *Rapport sur le Comportement Sexuel des Français*, Paris: Editions Juliard, 1972.
48. Spira A et al., 1993, op. cit. (see reference 10).
49. Article 222-22 of the Penal Code.
50. Mossuz-Lavau J, 1991, op. cit. (see reference 34).
51. Article 234 of the Penal Code.
52. Article 5 of the Neuwirth Laws of 12/28/67 and 12/4/74.
53. Dayan-Lintzer M, Information sexuelle et contraception, *La Semaine des Hôpitaux de Paris*, 1985, 27.
54. Lagrange H and Lhomond B, 1997, op. cit. (see reference 3).
55. Gremy et al., Les connaissances, attitudes, croyances et comportements face au sida: Evolutions 1992-1994-1998, Paris: Rapport ORS/ANRS, 1999.
56. Choquet M and Ledoux S, Adolescents: INSERM survey on health and social conditions of 11 to 19 year-old students, Paris: INSERM, 1994.
57. Memorandum dated 4/15/96.
58. Memorandum dated 11/19/98.
59. Memorandum no. 73-299 dated July 23, 1973.
60. Spira A et al., 1993, op. cit. (see reference 10).
61. Simon P et al., 1972, op. cit. (see reference 47).
62. Brigitte Cadéac and Delphine Viguier, Report on Fil Santé Jeunes, 1998.
63. Le Van C, 1998, op. cit. (see reference 36).
64. Rapport d'activité de 1998 du MFPF, Paris: MFPF, 1998.
65. Decree of August 6, 1992.
66. Uzan M, 1999, op. cit. (see reference 38); Rapport d'étape du groupe de travail, Information, education des jeunes à la sexualité, Paris: Conseil Superieur de l'Information, de la Régulation des Naissances et de l'Education Familiale, Service des Droits des Femmes, 1999; and Nissand I, L'IVG en France: Propositions pour diminuer les difficultés que rencontrent les femmes, Rapport à la Ministre des Affaires Sociales, 1999.

67. Les établissements d'hébergement pour adultes et familles en difficulté sociale-Activité, clientèle et personnel, série chronologique 1985-1996, Documents Statistiques n°279, Service des Statistiques, des Etudes et des Système d'Information, 1997.
68. Ministry of Employment and Solidarity publication on the fight against HIV/AIDS, HIV/AIDS series, 1998.
69. Lagrange H and Lhomond B, 1997, op. cit. (see reference 3).
70. Sida, VIH et MST, Etat des lieux des données en 2000, rapport Institut de Veille Sanitaire (INVS), Paris: INVS, 2000.
71. Mossuz-Lavau J, Une politique de réduction des risques sexuels pour les femmes en difficulté de prévention, Paris: Rapport CNRS/CEVIPOF, 2000.
72. Lollivier S, Inégalités de niveaux de vie et générations, in: *Données Sociales, la Société Fançaise*, Paris: INSEE, 1999.
73. Galland O, *Les Jeunes*, Paris: La découverte, 1999.
74. Legendre N, Les conditions de vie des pauvres, in: *Données Sociales, la Société Fançaise*, Paris: INSEE, 1999, pp. 444-452.
75. Brixi O, Santé et migration, in: Lebas J and Chauvin P, eds., *Précarité et Santé*, Paris: Flammarion, 1999.
76. Marpsat M, Les sans domicile à Paris et aux Etats-Unis, in: *Données Sociales, la Société Fançaise*, Paris: INSEE, 1999, pp. 480-489
77. Mamou J, Entre action humanitaire et solidarité citoyenne, l'exemple de la mission France de Médecins du Monde, in: Lebas J and Chauvin P, eds., *Précarité et Santé*, Paris: Flammarion, 1998.
78. Zoyem JP, Les minimas sociaux: Huit prestations de solidarité dans le sytème de protection sociale, in: *Données Sociales*, la Société Fançaise, Paris: INSEE, 1999, pp. 462-471.
79. Afsa C, L'allocation parentale d'éducation: Entre politique familiale et politique pour l'emploi, in: *Données sociales, la Société Fançaise*, Paris: INSEE, 1999, pp. 413-417.
80. Zoyem JP, 1999, op. cit. (see reference 78).
81. Afsa C and Amira S, Le RMI: Un dispositif en mutation, in: *Données sociales, la Société Fançaise*, Paris: INSEE, 1999, pp. 462-471.
82. Zoyem JP, 1999, op. cit. (see reference 78).
83. Ibid.
84. Emmanuelli X, L'expérience du samu social, in: Lebas J and Chauvin P, eds., *Précarité et Santé*, Paris: Flammarion, 1999.
85. Mamou J, 1999, op. cit. (see reference 77).
86. Kartout, RESO, in: Lebas J and Chauvin P, eds., *Précarité et Santé*, Paris: Flammarion, 1999.
87. DREES, Demailly, Les sorties du RMI: des motifs souvent multiples et imbriqués; Etudes et résultats de la DREES (Direction de la Recherche des Etudes de l'Evaluation et des Statistiques), N°16, 1999,
http://www.sante.gouv.fr/drees/etude-resultat/er-pdf/er016.pdf.
88. Galland O, 1999, op. cit. (see reference 73).
89. Quote from the referral agent for the Somme Département's research project.

Appendix A

Table A1. Birthrates and abortion rates per 1,000 women aged 15-19, 15-17, 18-19 and 20-24 for selected years

Table A2. Birthrates and abortion rates per 1,000 women aged 15-19, 15-17, 18-19 and 20-24 by marital status, 1995

Table A3. Percentage distribution according to the age when respondents first had intercourse by respondent's age at the survey and gender (ACSJ)

Table A4. Percentage distribution according to the number of sexual partners by respondent's age at the survey and gender among those who had their first sexual intercourse in the past year (ACSJ)

Table A5. Percentage distribution according to the frequency of intercourse in the past month by respondent's age at the survey and gender (ACSJ)

Table A6. Percentage distribution according to the contraceptive method used at first sex by age of respondent at the survey and gender (ACSJ)

Table A7. Percentage distribution according to the contraceptive method used at last sex by age of respondent at the survey and gender (ACSJ)

Table A8. Percentage distribution according to the age when respondents first had intercourse by respondent's age at the survey (15-18), gender and socioeconomic variables (ACSJ)

Table A9. Percentage distribution according to the contraceptive method used at first sex by age of respondent at the survey (15-18), gender and socioeconomic variables (ACSJ)

Table A10. Percentage distribution according to the contraceptive method used at last sex by age of respondent at the survey (15-18), gender and socioeconomic variables (ACSJ)

Table A11. Percentage distribution according to socioeconomic measures by age and gender (ACSJ)

Table A12. Percentage distribution according to the age when respondents first had intercourse by respondent's age at the survey and gender (ACSF)

Table A13. Percentage distribution according to the number of sexual partners in the past year by respondent's age at the survey and gender (ACSF)

Table A14. Percentage distribution according to the frequency of intercourse in the past month by respondent's age at the survey and gender (ACSF)

Table A15. Percentage distribution according to the contraceptive method used at last sex by age of respondent at the survey and gender (ACSF)

Table A16. Percentage distribution according to the age when respondents first had intercourse by respondent's age at the survey (15-19 and 20-24), gender and socioeconomic variables (ACSF)

Table A17. Percentage distribution according to the contraceptive method used at last sex by age of respondent at the survey (15-19 and 20-24), gender and socioeconomic variables (ACSF)

Table A1. Birthrates and abortion rates per 1,000 women aged 15-19, 15-17, 18-19 and 20-24 for selected years

Year and Age Group	All Women				
1980	Birth Rate	Abortion Rate	Number of births	Number of Abortions	Population femmes
			(1)	(4)	(3)
15-19	17.8	10.3	38,017	22,039	2,139,021
15-17	5.1	5.6	6,597	7,301	1,293,936
18-19	37.2	17.4	31,420	14,738	845,085
20-24	121.5	21.2	254,398	44,484	2,093,928

1985	Birth Rate	Abortion Rate	Number of births	Number of Abortions	Population femmes
			(1)	(4)	(3)
15-19	11.5	8.7	24,141	18,249	2,104,439
15-17	3.4	5.1	4,319	6,416	1,256,284
18-19	23.4	14.0	19,822	11,833	848,155
20-24	96.6	19.5	207,438	41,811	2,147,269

1990	Birth Rate	Abortion Rate	Number of births	Number of Abortions	Population femmes
			(1)	(4)	(3)
15-19	9.2	8.4	19,035	17,357	2,063,098
15-17	2.9	5.1	3,424	6,031	1,189,418
18-19	17.9	13.0	15,611	11,326	873,680
20-24	74.5	18.4	157,498	38,858	2,114,905

1995	Birth Rate	Abortion Rate	Number of births	Number of Abortions	Population femmes
			(1)	(4)	(3)
15-19	6.9	8.6	12,873	16,164	1,878,068
15-17	2.2	4.9	2,462	5,641	1,143,209
18-19	14.2	14.3	10,411	10,523	734,859
20-24	56.5	18.3	116,722	37,811	2,066,627

Data source(s):

(1) état civil : naissances légitimes, INSEE

(2) estimation d'après l'enquête périnatale 1995 , DREES, INSERM.

(3) population au 1° janvier 1996, évaluation basée sur le recensement de 1990, INSEE

(4) ivg déclarées (bulletins), DREES. non comprises les non-réponses à la situation matrioniale légale. Estimation d'après l'enquête INED 1994, Population et Sociétés, n°293, septembre 1994

Table A2. Birthrates and abortion rates per 1,000 women aged 15-19, 15-17, 18-19 and 20-24 by marital status, 1995

Year and Age Group	Currently Married				
1995	Birth Rate	Abortion Rate	Number of births	Number of Abortions	Population femmes
			(1)	(4)	(3)
15-19	372.5	30.8	2,103	174	5,646
15-17	482.1	50.8	256	27	531
18-19	361.1	28.7	1,847	147	5,115
20-24	234.5	13.8	49,675	2,924	211,820

	Currently Cohabiting					
1995	Birth Rate	Abortion Rate	Number of births	Number of Abortions	Population femmes	Population femmes 1995 tous statuts
			(2)	(4)		(3)
15-19			4,369			1,878,068
15-17			1,055			1,143,209
18-19			3,358			734,859
20-24	94.9	0.0	50,413		531,493	2,066,627

	Not Currently Married or Cohabiting				
1995	Birth Rate	Abortion Rate	Number of births	Number of Abortions	Population femmes
			(2)		
15-19			6,116		
15-17			1,125		
18-19			4,982		
20-24	13.0	0.0	16,006		1,227,576

	Never Married				
1995	Birth Rate	Abortion Rate	Number of births	Number of Abortions	Population femmes
			(2)	(4)	(3)
15-19	5.6	7.9	10,485	14,855	1,872,422
15-17	1.9	4.5	2,181	5,150	1,142,678
18-19	11.4	13.3	8,340	9,705	729,744
20-24	35.8	17.3	66,418	32,076	1,854,807

Data source(s):
(1) état civil : naissances légitimes, INSEE
(2) estimation d'après l'enquête périnatale 1995 , DREES, INSERM.
(3) population au 1° janvier 1996, évaluation basée sur le recensement de 1990, INSEE
(4) ivg déclarées (bulletins), DREES. non comprises les non-réponses à la situation matrioniale légale. Estimation d'après l'enquête INED 1994, Population et Sociétés, n°293, septembre 1994
Legal Marital Status: L'INSEE compte les séparées non divorcées avec les mariées.
Le nombre de non réponses sur la situation matrimoniale de fait (464 chez les 15-17, 671 chez les 18-19 et 2811 chez les 20-24) ne permet pas d'établir des statistiques correspondantes

Table A3. Percentage distribution according to the age when respondents first had intercourse by respondent's age at the survey and gender (ACSJ)

Females

Percent who first had intercourse at age:	Respondent's age at survey		
	15-17	18	15-18
<13	0.5	0.0	0.4
13	1.1	0.0	0.9
14	4.7	5.0	4.8
15	12.5	10.6	12.1
16	13.2	18.0	14.1
17	3.4	22.1	6.9
18	0.0	8.7	1.7
19	0.0	0.0	0.0
20	0.0	0.0	0.0
21 or older	0.0	0.0	0.0
Never had intercourse	62.1	34.5	56.9
Age not reported	2.6	1.0	2.3
Total Percent	100%	100%	100%
Number-weighted (N)	827,135	189,513	1,016,648
Number-unweighted (N)	1,910	928	2,838

Males

Percent who first had intercourse at age:	Respondent's age at survey		
	15-17	18	15-18
<13	0.9	8.8	0.7
13	3.7	10.2	3.0
14	7.6	19.0	7.9
15	12.3	19.7	11.9
16	12.3	9.7	13.7
17	4.5	0.0	7.6
18	0.0	0.0	2.0
19	0.0	0.0	0.0
20	0.0	0.0	0.0
21 or older	0.0	0.0	0.0
Never had intercourse	55.9	30.5	50.6
Age not reported	2.7	2.1	2.6
Total Percent	100%	100%	100%
Number-weighted (N)	852,101	222,625	1,074,726
Number-unweighted (N)	2,277	1,063	3,340

Source(s): ACSJ

Year of survey: 1994

Table A4. Percentage distribution according to the number of sexual partners by respondent's age at the survey and gender among those who had their first sexual intercourse in the past year (ACSJ)

Females

Number of sexual partners in past year	Respondent's age at survey			
	15-16	17	18	15-18
No partners past year	20.3	11.2	6.7	11.2
1 partner	48.2	56.9	68.2	61.3
2 partners or more	31.5	27.8	25.2	27.5
Total Percent	100%	100%	100%	100%
Number-weighted (N)				
Number-unweighted (N)	98	251	372	721

Males

Number of sexual partners in past year	Respondent's age at survey			
	15-16	17	18	15-18
No partners past year	16.3	14.8	11.4	14
1 partner	41.9	46.6	51.3	47
2 partners or more	41.8	38.6	37.3	39
Total Percent	100%	100%	100%	100%
Number-weighted (N)				
Number-unweighted (N)	202	422	521	1145

Source(s): ACSJ
Year of survey: 1994

Table A5. Percentage distribution according to the frequency of intercourse in the past month by respondent's age at the survey and gender (ACSJ)

Females

Frequency of intercourse in past month	Respondent's age at survey		
	15-17	18	Total
Never had sex	62.1	34.5	56.9
0 times in past month	4.5	5.2	4.6
<1/week	18.3	14.8	17.6
1 time/week	3.7	8.8	4.6
2-4 times/week	13.2	30.2	16.3
5+ times/week	1.8	4.6	1.3
Not reported	2.6	5.9	5.0
Total Percent	100%	100%	100%
Number-weighted (N)	222,625	222,625	852,101
Number-unweighted (N)	1,063	3,340	2,277

Males

Frequency of intercourse in past month	Respondent's age at survey		
	15-17	18	Total
Never had sex	55.9	30.5	50.6
0 times in past month	8.9	9.4	9.0
<1/week	19.8	20.2	19.8
1 time/week	3.2	6.8	3.9
2-4 times/week	7.5	23.4	10.8
5+ times/week	1.0	2.4	1.3
Not reported	3.7	7.3	4.6
Total Percent	100%	100%	100%
Number-weighted (N)	852,101	222,625	1,074,726
Number-unweighted (N)	2,277	1,063	3,340

Source(s): ACSJ
Year of survey: 1994

Table A6. Percentage distribution according to the contraceptive method used at first sex by age of respondent at the survey and gender (ACSJ)

Females	**Respondent's age at survey**		
Percent using each method at first intercourse*	*Total*	*15-17*	*18*
Oral contraceptives	7.2	5.1	16.5
Condoms	24.6	22.4	34.0
Foam/jelly/cream/suppository	0.3	0.4	0.2
Withdrawal	1.7	1.5	2.7
Rhythm (periodic abstinence)	0.6	0.5	0.7
Method not reported	4.2	4.2	3.8
No method used	4.5	3.8	7.6
Never had intercourse	56.9	62.1	34.5
Total Percent	100%	100%	100%
Number-weighted (N)	1,016,648	827,135	189,513
Number-unweighted (N)	2,838	1,910	928
Percent using both condoms and selected medical methods**	5.0	4.1	8.9

Males	**Respondent's age at survey**		
Percent using each method at first intercourse *	*Total*	*15-17*	*18*
Oral contraceptives	10.1	8.0	18.3
Condoms	30.2	28.1	38.2
Foam/jelly/cream/suppository	0.3	0.2	0.7
Withdrawal	1.9	1.8	2.5
Rhythm (periodic abstinence)	0.2	0.2	0.4
Method not reported	3.6	3.8	3.5
No method used	2.8	2.0	5.9
Never had intercourse	50.6	55.9	30.5
Total Percent	100%	100%	100%
Number-weighted (N)	1,074,726	222,625	852,101
Number-unweighted (N)	3,340	1,063	2,277
Percent using both condoms and selected medical methods**	7.1	6.5	9.3

* If multiple methods are reported, classify according to the most effective method used. Totals should add to 100%.

** Selected medical methods include sterilization, oral contraceptives, IUD, Norplant and Depo Provera.

Source(s): ACSJ

Year of survey: 1994

Table A7. Percentage distribution according to the contraceptive method used at last sex by age of respondent at the survey and gender (ACSJ)

Females Percent using each method at last intercourse *	Respondent's age at survey		
	Total	*15-17*	*18*
Oral contraceptives	17.6	13.1	37.1
Condoms	13.0	12.9	13.6
Foam/jelly/cream/suppository	0.1	0.0	0.3
Withdrawal	0.1	0.0	0.2
Rhythm (periodic abstinence)	0.4	0.4	0.6
Method not reported	9.7	9.4	11.3
No method used	2.2	2.1	2.4
Never had intercourse	56.9	62.1	34.5
Total Percent	100%	100%	100%
Number-weighted (N)	1,016,648	189,513	827,135
Number-unweighted (N)	3,766	928	2,838

Males Percent using each method at last intercourse *	Respondent's age at survey		
	Total	*15-17*	*18*
Oral contraceptives	13.6	9.3	30.1
Condoms	14.6	13.3	19.6
Foam/jelly/cream/suppository	0.3	0.2	1.0
Withdrawal	0.2	0.3	0.0
Rhythm (periodic abstinence)	0.4	0.4	0.7
Method not reported	18.6	18.8	16.8
No method used	1.7	1.8	1.3
Never had intercourse	50.6	55.9	30.5
Total Percent	100%	100%	100%
Number-weighted (N)	1,297,351	222,625	1,519,976
Number-unweighted (N)	4,403	1,063	3,340

* If multiple methods are reported, classify according to the most effective method used. Totals should add to 100%.

Source(s): ACSJ
Year of survey: 1994

Table A8. Percentage distribution according to the age when respondents first had intercourse by respondent's age at the survey (15-18), gender and socioeconomic variables (ACSJ)

Females	**Variable name:** type of residence of the school			
Percent who first had intercourse at age:	<20,000inh	20,000-200,000	200,000-900,000	Paris
<13	0.0	1.6	0.7	0.6
13	0.6	4.2	0.5	1.2
14	4.3	17.8	5.9	4.4
15	11.8	19.1	9.6	10.9
16	16.5	5.7	12.1	9.3
17	6.2	1.3	8.1	7.1
18	2.6	0.0	1.1	1.7
19	0.0	0.0	0.0	0.0
20	0.0	0.0	0.0	0.0
21 or older	0.0	0.0	0.0	0.0
Never had intercourse	55.5	49.9	59.0	62.1
Age not reported	2.6	0.6	3.1	2.7
Total Percent	100%	100%	100%	100%
Number-weighted (N)	270,436	208,768	309,118	228,326
Number-unweighted (N)	476	469	818	1,075

Males	**Variable name:** type of residence of the school			
Percent who first had intercourse at age:	<20,000inh	20,000-200,000	200,000-900,000	Paris
<13	0.8	0.1	0.7	1.3
13	2.9	4.5	2.8	1.8
14	6.1	7.0	8.5	10.3
15	9.6	8.9	14.7	13.1
16	13.8	16.6	13.7	10.7
17	9.3	7.2	7.3	6.0
18	1.5	3.3	1.6	2.1
19	0.0	0.0	0.0	0.0
20	0.0	0.0	0.0	0.0
21 or older	0.0	0.0	0.0	0.0
Never had intercourse	54.5	50.2	47.1	52.0
Age not reported	1.5	2.1	3.6	2.6
Total Percent	100%	100%	100%	100%
Number-weighted (N)	307,142	201,271	366,527	199,785
Number-unweighted (N)	784	500	986	1,070

Table A8. Age at first intercourse, continued

Females	**Variable name:**	type of school	
Percent who first had intercourse at age:	Regular schools	Professionnal cycle	Vocational training centres
<13	0.3	0.4	0.9
13	0.8	0.7	2.6
14	4.0	7.0	7.7
15	11.7	13.5	14.0
16	12.9	17.4	18.5
17	6.1	8.2	12.9
18	1.4	2.9	1.5
19	0.0	0.0	0.0
20	0.0	0.0	0.0
21 or older	0.0	0.0	0.0
Never had intercourse	60.6	47.5	40.1
Age not reported	2.3	2.4	1.6
Total Percent	100%	100%	100%
Number-weighted (N)	764,207	192,802	59,639
Number-unweighted (N)	1,863	554	421

Males	**Variable name:**	type of school	
Percent who first had intercourse at age:	Regular schools	Professionnal cycle	Vocational training centres
<13	0.6	0.9	0.9
13	1.5	5.0	5.3
14	4.9	11.0	14.2
15	11.0	11.7	15.6
16	11.8	16.8	15.8
17	7.3	7.8	8.9
18	1.6	3.1	1.6
19	0.0	0.0	0.0
20	0.0	0.0	0.0
21 or older	0.0	0.0	0.0
Never had intercourse	57.9	42.3	36.0
Age not reported	3.4	1.4	1.8
Total Percent	100%	100%	100%
Number-weighted (N)	634,067	291,037	149,621
Number-unweighted (N)	1,622	731	987

Source(s): ACSJ
Year of survey: 1994

Table A9. Percentage distribution according to the contraceptive method usec at first sex by age of respondent at the survey (15-18), gender and socioeconomic variables (ACSJ)

Females	**Variable name:** type of residence of the school			
Percent using each method at first intercourse*	<20,000inh	20,000-200,000	200,000-900,000	Paris
Oral contraceptives	8.1	6.0	7.6	6.7
Condoms	25.6	33.3	20.8	20.6
Foam/jelly/cream/suppository	0.6	0.5	0.0	0.4
Withdrawal	1.1	2.4	1.8	1.6
Rhythm (periodic abstinence)	0.5	0.0	0.9	0.6
Method not reported	5.2	2.7	4.8	4.4
No method used	3.4	6.2	5.1	3.6
Never had intercourse	55.5	49.9	59.0	62.1
Total Percent	100%	100%	100%	100%
Number-weighted (N)	270,436	208,768	309,118	228,326
Number-unweighted (N)	476	469	818	1,075
Percent using both condoms and selected medical methods**	6.1	4.8	5.1	3.8

Males	**Variable name:** type of residence of the school			
Percent using each method at first intercourse*	<20,000inh	20,000-200,000	200,000-900,000	Paris
Oral contraceptives	8.3	10.8	11.5	9.7
Condoms	29.2	30.1	31.6	29.0
Foam/jelly/cream/suppository	0.3	0.3	0.2	0.4
Withdrawal	1.3	3.0	1.5	2.6
Rhythm (periodic abstinence)	0.3	0.2	0.1	0.3
Method not reported	3.5	3.6	5.1	2.2
No method used	2.6	1.8	2.9	3.8
Never had intercourse	54.5	50.2	47.1	52.0
Total Percent	100%	100%	100%	100%
Number-weighted (N)	307,142	201,271	366,527	199,785
Number-unweighted (N)	784	500	986	1,070
Percent using both condoms and selected medical methods**	5.7	8.5	6.8	8.2

Table A9. Contraceptive method used at first sex, continued

Females	**Variable name:** type of school		
Percent using each method at first intercourse*	Regular schools	Professionnal cycle	Vocational training
Oral contraceptives	5.4	10.2	20.8
Condoms	23.6	27.7	27.4
Foam/jelly/cream/suppository	0.2	0.8	0.5
Withdrawal	1.4	2.8	2.7
Rhythm (periodic abstinence)	0.5	0.7	0.9
Method not reported	4.3	4.0	1.6
No method used	4.0	6.3	6.0
Never had intercourse	60.6	47.5	40.1
Total Percent	100%	100%	100%
Number-weighted (N)	764,207	192,802	59,639
Number-unweighted (N)	1,863	554	421
Percent using both condoms and selected medical methods**	3.7	8.3	11.7

Males	**Variable name:** type of school		
Percent using each method at first intercourse*	Regular schools	Professionnal cycle	Vocational training
Oral contraceptives	7.8	11.9	16.8
Condoms	26.3	36.8	33.4
Foam/jelly/cream/suppository	0.2	0.5	0.4
Withdrawal	1.7	1.9	2.7
Rhythm (periodic abstinence)	0.3	0.2	0.2
Method not reported	3.6	3.9	4.6
No method used	2.2	2.5	5.9
Never had intercourse	57.9	42.3	36.0
Total Percent	100%	100%	100%
Number-weighted (N)	634,067	291,037	149,621
Number-unweighted (N)	1,622	731	987
Percent using both condoms and selected medical methods**	5.5	9.3	9.6

* If multiple methods are reported, classify according to the most effective method used. Totals should add to 100%.
** Selected medical methods include sterilization, oral contraceptives, IUD, Norplant and Depo Provera.

Source(s): ACSJ
Year of survey: 1994

Table A10. Percentage distribution according to the contraceptive method used at last sex by age of respondent at the survey (15-18), gender and socioeconomic variables (ACSJ)

Females	**Variable name:** type of residence of the school			
Percent using each method at last intercourse*	<20,000inh	20,000-200,000	200,000-900,000	Paris
Oral contraceptives	17.1	20.7	17.6	15.3
Condoms	14.9	16.9	10.2	11.0
Foam/jelly/cream/suppository	0.0	0.2	0.1	0.2
Withdrawal	0.0	0.0	0.1	0.2
Rhythm (periodic abstinence)	0.2	0.4	0.7	0.3
Method not reported	11.0	8.6	10.1	8.8
No method used	1.3	3.3	2.2	2.1
Never had intercourse	55.5	49.9	59.0	62.1
Total Percent	100%	100%	100%	100%
Number-weighted (N)	270,436	208,768	309,118	228,326
Number-unweighted (N)	476	469	818	1,075
Percent using both condoms and selected medical methods***	3.2	4.8	3.2	2.9

Males	**Variable name:** type of residence of the school			
Percent using each method at last intercourse*	<20,000inh	20,000-200,000	200,000-900,000	Paris
Oral contraceptives	12.3	14.8	13.9	13.9
Condoms	13.3	13.8	16.3	14.1
Foam/jelly/cream/suppository	0.4	0.6	0.2	0.2
Withdrawal	0.0	0.5	0.1	0.4
Rhythm (periodic abstinence)	0.5	1.1	0.3	0.9
Method not reported	17.2	17.5	20.5	16.7
No method used	1.8	1.5	1.6	1.8
Never had intercourse	54.5	50.2	47.1	52.0
Total Percent	100%	100%	100%	100%
Number-weighted (N)	307,142	201,271	366,527	199,785
Number-unweighted (N)	784	500	986	1,070
Percent using both condoms and selected medical methods***	6.3	6.5	7.0	7.6

Table A10. Contraceptive method at last sex, continued

Females	**Variable name:**	type of school	
Percent using each method at last intercourse*	Regular schools	Professionnal cycle	Vocational training
Oral contraceptives	14.4	23.8	38.5
Condoms	13.0	14.5	8.3
Foam/jelly/cream/suppository	0.1	0.0	0.1
Withdrawal	0.1	0.1	0.0
Rhythm (periodic abstinence)	0.5	0.2	0.6
Method not reported	9.2	11.4	9.9
No method used	2.1	2.5	2.5
Never had intercourse	60.6	47.5	40.1
Total Percent	100%	100%	100%
Number-weighted (N)	764,207	192,802	59,639
Number-unweighted (N)	1,863	554	421
Percent using both condoms and selected medical methods***	2.8	5.5	5.6

Females	**Variable name:**	type of school	
Percent using each method at last intercourse*	Regular schools	Professionnal cycle	Vocational training
Oral contraceptives	11.4	13.7	23.0
Condoms	11.3	20.7	16.4
Foam/jelly/cream/suppository	0.3	0.5	0.3
Withdrawal	0.2	0.0	0.0
Rhythm (periodic abstinence)	0.3	0.5	0.7
Method not reported	17.3	20.7	20.4
No method used	1.3	1.6	3.2
Never had intercourse	57.9	42.3	36.0
Total Percent	100%	100%	100%
Number-weighted (N)	634,067	291,037	149,621
Number-unweighted (N)	1,622	731	987
Percent using both condoms and selected medical methods***	6.1	6.9	9.5

* If multiple methods are reported, classify according to the most effective method used. Totals should add to 100%.

** No risk because respondent currently pregnant, postpartum, trying to get pregnant, infecund or sterile.

*** Other medical methods include sterilization, oral contraceptives, IUD, Norplant and Depo Provera.

Source(s): ACSJ

Year of survey: 1994

Table A11. Percentage distribution according to socioeconomic measures by age and gender (ACSJ)

Age	Social class/parent's occupation							Total Percent	Number (n)
	Farmers	Artisan, tradespeople	Executive, intellectual professsions	Intermediary	Employee	Worker	Inactive and else		
Youth aged 15-18	3.0	11.8	17.7	19.5	13.3	27.6	7.2	100%	6,178

Age and gender	School status			Total Percent	Number (n)
	Regular school	Professional cycle	Training center		
Youth aged 15-18	66.9	23.1	10.0	100%	
males	59.0	27.1	14.9	100%	
females	75.1	19.0	5.9	100%	

Source(s): ACSJ
Year of survey: 1994

Table A12. Percentage distribution according to the age when respondents first had intercourse by respondent's age at the survey and gender (ACSF)

Females

Percent who first had intercourse at age:	Respondent's age at survey						
	18-19	20-24	25-29	30-34	35-39	40-44	45-49
<13	0.0	0.2	0.8	0.2	0.6	0.0	0.8
13	0.1	2.1	1.0	2.2	0.9	0.2	0.0
14	4.7	5.1	2.8	1.8	3.0	0.0	0.3
15	2.8	6.7	5.2	5.4	5.2	1.9	1.2
16	19.0	15.1	8.5	14.3	13.1	7.4	6.0
17	24.5	20.9	24.5	20.3	15.1	10.1	22.6
18	13.4	21.3	19.9	26.0	22.7	28.5	9.5
19	2.7	11.1	14.5	10.3	12.1	15.7	15.0
20	0.0	5.1	10.9	9.2	15.2	12.0	12.0
21 or older	0.0	3.3	7.2	9.9	11.3	23.3	32.0
Never had intercourse	32.9	9.1	4.8	0.4	0.2	0.0	0.0
Age not reported	0.0	0.0	0.0	0.0	0.6	1.1	0.6
Total Percent	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	102.3	297.2	255.2	319.0	228.6	285.0	194.5
Number-unweighted (N)	159	471	386	324	236	202	139

Males

Percent who first had intercourse at age:	Respondent's age at survey						
	18-19	20-24	25-29	30-34	35-39	40-44	45-49
<13	0.0	2.5	2.7	1.0	1.5	2.2	1.6
13	5.6	1.7	3.0	2.6	2.5	2.4	0.6
14	7.8	5.7	7.9	10.3	3.9	6.4	6.0
15	14.7	13.1	7.8	10.5	5.9	7.0	16.0
16	31.9	17.0	19.2	17.7	16.3	12.5	10.7
17	22.3	20.4	22.3	18.7	29.1	16.6	15.0
18	4.3	21.9	16.1	20.7	15.8	21.1	17.0
19	0.8	6.2	8.2	8.9	7.6	8.3	3.5
20	0.0	3.2	7.4	2.8	8.1	9.0	15.4
21 or older	0.0	1.0	4.0	6.4	7.9	12.7	14.0
Never had intercourse	12.6	5.5	1.5	0.6	0.0	0.5	0.0
Age not reported	0.0	1.7	0.0	0.0	1.4	1.4	0.3
Total Percent	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	104.7	292.6	268.4	266.0	275.6	315.0	174.2
Number-unweighted (N)	150	539	502	347	332	283	149

Source(s): ACSF (France)

Year of survey: 1992

Table A13. Percentage distribution according to the number of sexual partners in the past year by respondent's age at the survey and gender (ACSF)

Females

Number of sexual partners in past year	Respondent's age at survey						
	18-19	20-24	25-29	30-34	35-39	40-44	45-49
Never had sex	32.9	9.1	4.8	0.4	0.2	0.0	0.0
No partners past year	2.6	2.1	5.8	2.3	2.3	3.9	7.3
1 partner	56.1	79.3	83.2	91.5	90.5	91.6	87.1
2 partners	5.6	6.7	4.4	4.8	4.9	3.8	4.2
3 or more partners	2.6	2.6	1.9	1.1	1.9	0.7	1.3
Don't know	0.3	0.2	0.0	0.0	0.2	0.0	0.0
Total Percent	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	102.3	297.2	255.2	319.0	228.6	285.1	194.5
Number-unweighted (N)	159	471	386	324	236	202	139

Males

Number of sexual partners in past year	Respondent's age at survey						
	18-19	20-24	25-29	30-34	35-39	40-44	45-49
Never had sex	12.6	5.5	1.5	0.6	0.0	0.5	0.0
No partners past year	0.4	4.4	5.2	1.4	1.9	1.3	1.9
1 partner	61.5	66.3	79.4	86.2	87.0	87.5	85.0
2 partners	12.7	12.9	7.6	5.8	6.9	6.8	6.9
3 or more partners	12.2	10.5	5.9	6.1	3.7	3.0	3.8
Don't know	0.6	0.5	0.3	0.0	0.6	0.9	2.5
Total Percent	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	104.7	292.6	268.4	266.0	275.6	315.0	174.2
Number-unweighted (N)	150	539	502	347	332	283	149

Source(s): ACSF (France)
Year of survey: 1992

Table A14. Percentage distribution according to the frequency of intercourse in the past month by respondent's age at the survey and gender (ACSF)

Females

Frequency of intercourse in past month	Respondent's age at survey						
	18-19	20-24	25-29	30-34	35-39	40-44	45-49
Never had sex	32.9	9.1	4.8	0.4	0.2	0.0	0.0
0 times in past month	15.3	16.1	13.1	8.1	8.3	8.6	11.8
<1/week	11.3	11.6	18.0	9.4	8.2	14.6	14.6
1 time/week	17.7	20.9	25.3	24.5	32.1	22.9	26.0
2-4 times/week	14.0	30.8	25.7	45.5	40.9	42.1	27.4
5+ times/week	8.4	9.7	10.2	10.4	7.3	7.6	14.6
Don't know	0.5	1.8	3.0	1.6	2.9	4.4	5.6
Total Percent	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	102.3	297.2	255.2	319.0	228.6	285.1	194.5
Number-unweighted (N)	159	471	386	324	236	202	139

Males

Frequency of intercourse in past month	Respondent's age at survey						
	18-19	20-24	25-29	30-34	35-39	40-44	45-49
Never had sex	12.6	5.5	1.5	0.6	0.0	0.5	0.0
0 times in past month	16.4	17.2	12.4	8.8	6.5	5.4	4.0
<1/week	18.3	16.9	9.4	7.3	9.5	11.9	11.5
1 time/week	29.4	23.2	25.2	24.2	24.6	26.0	29.6
2-4 times/week	18.3	23.5	38.0	42.9	48.4	41.9	42.8
5+ times/week	0.7	11.8	12.2	13.0	9.4	12.5	8.2
Don't know	4.4	1.9	1.4	3.2	1.7	1.8	4.0
Total Percent	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	104.7	292.6	268.4	266.0	275.6	315.0	174.2
Number-unweighted (N)	150	539	502	347	332	283	149

Source(s): ACSF (France)
Year of survey: 1992

Table A15. Percentage distribution according to the contraceptive method used at last sex by age of respondent at the survey and gender (ACSF)

Females	**Respondent's age at survey**					
Percent using each method at last intercourse *	18-19	20-24	25-29	30-34	35-39	40-44
Oral contraceptives	41.8	66.5	49.4	42.2	31.3	20.8
IUD	0.0	1.6	9.6	26.0	30.1	28.7
Condoms	10.2	6.7	5.0	7.7	4.2	6.5
Diaphragm/Cap/f.condom	0.0	0.1	0.5	0.2	0.6	0.0
Foam/jelly/cream/suppository	0.0	0.8	1.8	0.5	0.6	0.7
Withdrawal	0.0	0.4	0.7	0.0	0.3	0.6
Rhythm (periodic abstinence)	0.0	0.0	0.0	0.0	0.1	0.2
Other	0.0	0.6	0.0	0.7	3.0	2.2
Method not reported	2.7	2.6	3.0	3.2	3.2	5.8
No method used	9.2	11.1	22.9	18.0	24.5	33.2
No intercourse-past 3 mths	3.2	0.5	2.4	1.1	2.0	1.3
Never had intercourse	32.9	9.1	4.8	0.4	0.2	0.0
Total Percent	100%	100%	100%	100%	100%	100%
Number-weighted (N)	102.3	297.2	255.2	319.0	228.6	285.0
Number-unweighted (N)	159	471	386	324	236	202
Percent using both condoms and selected medical method***	6.4	11.3	3.1	6.3	4.2	3.6

Males	**Respondent's age at survey**					
Percent using each method at last intercourse *	18-19	20-24	25-29	30-34	35-39	40-44
Oral contraceptives	43.8	55.9	56.9	36.7	27.5	20.4
IUD	0.0	0.8	6.1	19.1	24.0	32.4
Condoms	34.7	19.7	8.5	10.1	12.5	6.0
Diaphragm/Cap/f.condom	0.0	0.5	0.2	0.2	0.2	1.1
Foam/jelly/cream/suppository	0.0	0.0	0.2	1.6	1.1	1.0
Withdrawal	0.0	0.1	0.0	0.7	1.1	0.3
Rhythm (periodic abstinence)	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.4	0.0	0.5	2.1	1.7
Method not reported	2.0	5.0	4.1	3.8	2.6	4.4
No method used	6.7	9.8	20.7	26.1	28.1	31.2
No intercourse-past 3 mths	0.1	2.2	1.7	0.6	0.9	1.0
Never had intercourse	12.6	5.5	1.5	0.6	0.0	0.5
Total Percent	100%	100%	100%	100%	100%	100%
Number-weighted (N)	104.7	292.6	268.4	266.0	275.6	315.0
Number-unweighted (N)	150	539	502	347	332	283
Percent using both condoms and selected medical methods***	18.3	11.0	7.0	1.3	5.1	5.5

* If multiple methods are reported, classify according to the most effective method used. Totals should add to 100%.
** Not at risk because currently pregnant, postpartum, seeking pregnancy, infecund or sterile.
*** Selected medical methods include sterilization, oral contraceptives, IUD, Norplant and Depo Provera.

Source(s): ACSF (France)
Year of survey: 1992

Table A16. Percentage distribution according to the age when respondents first had intercourse by respondent's age at the survey (15-19 and 20-24), gender and socioeconomic variables (ACSF)

Females	**Variable name: education level**							
Percent who first	brevet		cap		bac		superieur	
had intercourse	*Age at survey*		*Age at survey*		*Age at survey*		*Age at survey*	
at age:	18-19	20-24	18-19	20-24	18-19	20-24	18-19	20-24
<13	0.0	0.6	0.0	0.6	0.0	0.0	0.0	0.2
13	0.0	4.3	0.5	5.0	0.0	1.8	0.0	0.0
14	6.4	4.6	12.1	6.0	1.0	6.7	0.0	0.8
15	2.9	7.1	0.0	14.1	3.0	5.2	0.0	6.1
16	19.5	30.1	33.7	12.4	11.0	14.8	76.8	7.9
17	29.3	20.4	1.9	27.3	29.6	18.8	11.7	22.5
18	14.9	20.0	7.6	16.1	15.2	23.8	2.6	19.4
19	0.0	2.3	0.0	12.3	6.5	7.7	0.0	23.4
20	0.0	5.4	0.0	1.7	0.0	4.0	0.0	9.4
21 or older	0.0	0.2	0.0	0.0	0.0	3.9	0.0	5.6
Never had intercourse	26.9	5.1	44.3	4.5	33.7	13.3	8.9	4.8
Age not reported	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	40.5	41.8	14.9	35.2	42.6	151.5	2.4	68.3
Number-unweighted (N)	43	52	15	47	91	225	8	145

Table A16. Age at first intercourse, continued

Males	**Variable name: education level**							
Percent who first had intercourse at age:	brevet		cap		bac		superieur	
	Age at survey		*Age at survey*		*Age at survey*		*Age at survey*	
	18-19	20-24	18-19	20-24	18-19	20-24	18-19	20-24
<13	0.0	8.3	0.0	2.4	0.0	1.7		0.0
13	5.2	4.0	28.8	3.0	0.0	0.6		0.5
14	13.0	8.3	2.3	4.4	3.0	4.7		6.8
15	13.9	6.7	3.2	15.5	18.7	17.6		6.9
16	38.6	22.2	19.8	11.8	27.1	15.4		22.6
17	13.2	22.0	40.9	23.0	28.3	19.4		18.6
18	1.5	14.7	4.0	16.6	7.7	27.7		22.8
19	0.0	4.6	0.0	3.5	2.1	7.7		7.9
20	0.0	1.9	0.0	0.8	0.0	2.9		5.8
21 or older	0.0	0.0	0.0	2.3	0.0	0.7		1.1
Never had intercourse	14.6	5.8	0.9	16.6	13.2	1.1		1.1
Age not reported	0.0	1.4	0.0	0.2	0.0	0.5		5.9
Total Percent	100%	100%	100%	100%	100%	100%		100%
Number-weighted (N)	50.9	45.6	11.0	69.4	42.7	115.7		60.7
Number-unweighted (N)	64	68	15	97	71	214		157

Table A16. Age at first intercourse, continued

Females	**Variable name: income**							
Percent who first had intercourse at age:	<8,000 Francs		8-15,000 Francs		15-30,000 Francs		>30,000 Francs	
	Age at survey		*Age at survey*		*Age at survey*		*Age at survey*	
	18-19	20-24	18-19	20-24	18-19	20-24	18-19	20-24
<13	0.0	0.4	0.0	0.1	0.0	0.0	0.0	0.0
13	0.1	1.0	0.0	2.8	0.0	5.2	0.0	0.0
14	6.7	6.7	2.3	2.5	0.0	9.2	0.0	0.0
15	2.9	6.9	1.4	4.1	0.0	12.0	0.0	26.6
16	20.2	12.4	21.7	20.5	15.6	13.3	16.3	0.0
17	23.2	21.6	36.7	19.2	18.8	19.0	0.0	15.5
18	20.2	20.5	1.9	24.0	7.1	20.6	0.0	54.4
19	0.0	11.3	0.0	9.4	0.0	16.2	83.8	0.0
20	0.0	5.8	0.0	3.2	0.0	4.4	0.0	3.5
21 or older	0.0	5.1	0.0	2.9	0.0	0.0	0.0	0.0
Never had intercourse	26.6	8.3	36.0	11.4	58.6	0.2	0.0	0.0
Age not reported	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	58.4	131.5	22.3	104.9	13.0	38.1	3.3	5.5
Number-unweighted (N)	93	240	21	130	12	48	2	8

Table A16. Age at first intercourse, continued

Males	**Variable name: income**							
Percent who first had intercourse at age:	<8,000 Francs		8-15,000 Francs		15-30,000 Francs		>30,000 Francs	
	Age at survey		*Age at survey*		*Age at survey*		*Age at survey*	
	18-19	20-24	18-19	20-24	18-19	20-24	18-19	20-24
<13	0.0	3.7	0.0	1.2	0.0	2.1	0.0	0.0
13	6.7	0.6	0.0	2.6	13.8	3.8	0.0	0.0
14	5.2	4.8	8.6	5.7	9.6	8.3	0.0	25.5
15	16.9	12.0	17.6	14.5	7.8	14.6	0.0	0.0
16	16.2	11.9	32.8	28.8	47.3	13.9	30.7	34.4
17	26.3	21.8	23.0	21.3	19.5	23.6	0.0	12.9
18	6.5	24.5	3.5	13.2	2.0	25.4	0.0	13.0
19	0.5	7.2	1.7	1.4	0.0	7.6	0.0	0.0
20	0.0	1.9	0.0	4.5	0.0	0.0	0.0	14.1
21 or older	0.0	0.7	0.0	2.5	0.0	0.0	0.0	0.0
Never had intercourse	21.7	8.0	12.9	3.3	0.0	0.7	69.3	0.0
Age not reported	0.0	3.1	0.0	1.1	0.0	0.0	0.0	0.0
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	31.1	131.9	43.2	80.2	23.6	53.9	1.2	3.1
Number-unweighted (N)	55	275	48	144	29	71	2	9

Table A16. Age at first intercourse, continued

Females	**Variable name: job**											
Percent who first had intercourse at age:	student		agric-indep		manager		clerk		workers		inactive	
	Age at survey		*Age at survey*		*Age at survey*		*Age at survey*		*Age at survey*		*Age at survey*	
	18-19	20-24	18-19	20-24	18-19	20-24	18-19	20-24	18-19	20-24	18-19	20-24
<13	0.0	0.2		0.0		0.0	0.0	0.1	0.0	0.0	0.0	0.7
13	0.1	0.0		0.0		0.0	0.0	2.2	0.0	0.0	0.0	13.2
14	3.6	0.6		100.0		0.0	3.3	5.4	100.0	10.7	0.0	15.2
15	3.1	7.1		0.0		0.0	0.0	8.4	0.0	3.5	4.3	0.8
16	16.6	8.5		0.0		25.3	38.8	18.3	0.0	14.6	17.1	24.0
17	21.0	24.5		0.0		10.5	35.5	17.9	0.0	20.5	41.4	25.2
18	14.5	21.9		0.0		18.0	1.7	23.7	0.0	25.0	20.6	1.4
19	3.5	13.8		0.0		13.2	0.0	8.6	0.0	16.4	0.0	6.8
20	0.0	8.3		0.0		22.0	0.0	3.1	0.0	2.4	0.0	3.9
21 or older	0.0	2.4		0.0		0.0	0.0	5.3	0.0	0.0	0.0	0.8
Never had intercourse	37.6	12.7		0.0		11.0	20.7	7.1	0.0	6.9	16.6	8.0
Age not reported	0.0	0.1		0.0			0.0	0.0	0.0	0.0	0.0	0.0
Total Percent	100%	100%		100%		100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	78.3	101.7		0.2		4.4	12.0	136.5	1.6	30.1	10.4	24.4
Number-unweighted (N)	133	182		1		12	12	206	1	30	13	40

Table A16. Age at first intercourse, continued

Males	**Variable name: job**											
Percent who first had intercourse at age:	student		agric-indep		manager		clerk		workers		inactive	
	Age at survey		*Age at survey*		*Age at survey*		*Age at survey*		*Age at survey*		*Age at survey*	
	18-19	20-24	18-19	20-24	18-19	20-24	18-19	20-24	18-19	20-24	18-19	20-24
<13	0.0	1.7		0.0	0.0	0.0	0.0	5.1	0.0	2.5	0.0	1.4
13	3.8	0.7		0.0	100.0	0.0	0.0	3.7	15.5	2.1	0.0	0.0
14	9.3	3.0		0.0	0.0	12.8	7.2	13.4	6.9	4.7	1.2	3.4
15	14.7	8.4		0.0	0.0	10.2	39.4	11.1	3.2	16.5	22.4	22.0
16	29.1	19.8		72.6	0.0	31.2	47.0	14.3	44.2	13.7	18.4	21.6
17	23.2	20.9		27.4	0.0	2.6	6.4	14.2	24.9	26.2	20.9	11.5
18	4.5	20.3		0.0	0.0	21.3	0.0	26.3	5.4	21.0	3.5	23.1
19	1.3	9.2		0.0	0.0	9.3	0.0	8.5	0.0	3.3	0.0	2.0
20	0.0	4.7		0.0	0.0	0.0	0.0	3.0	0.0	1.3	0.0	5.3
21 or older	0.0	0.8		0.0	0.0	12.7	0.0	0.2	0.0	1.5	0.0	0.8
Never had intercourse	14.1	7.0		0.0	0.0	0.0	0.0	0.0	0.0	6.2	33.6	9.0
Age not reported	0.0	3.4		0.0	0.0	0.0	0.0	0.2	0.0	1.1	0.0	0.0
Total Percent	100%	100%		100%	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	66.9	99.9		0.5	0.1	3.5	6.1	54.9	20.5	104.7	11.1	29.0
Number-unweighted (N)	108	200		2	1	18	8	122	19	148	14	49

Source(s): ACSF (France)
Year of survey: 1992

Table A17. Percentage distribution according to the contraceptive method used at last sex by age of respondent at the survey (15-19 and 20-24), gender and socioeconomic variables (ACSF)

Females	**Variable name: education level**							
	brevet		cap		bac		sup	
Percent using each method	*Age at survey*		*Age at survey*		*Age at survey*		*Age at survey*	
at last intercourse*	18-19	20-24	18-19	20-24	18-19	20-24	18-19	20-24
Oral contraceptives	48.4	57.4	24.6	46.4	40.9	68.9	91.1	77.3
IUD	0.0	4.8	0.0	6.0	0.0	0.4	0.0	0.2
Condoms	5.5	7.6	7.6	8.6	16.7	4.5	0.0	10.3
Diaphragm/Cap/f.condom	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.3
Foam/jelly/cream/suppository	0.0	0.0	0.0	1.5	0.0	1.1	0.0	0.0
Withdrawal	0.0	2.6	0.0	0.0	0.0	0.0	0.0	0.1
Rhythm (periodic abstinence)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.5
Method not reported	0.0	9.8	11.4	4.2	2.4	1.1	0.0	0.8
No method used	16.6	11.3	12.1	28.8	1.1	10.6	0.0	3.1
Not at risk for unintended preg.**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
No intercourse-past 3 mths	2.6	1.3	0.0	0.0	5.1	0.3	0.0	0.7
Never had intercourse	26.9	5.1	44.3	4.5	33.7	13.3	8.9	4.8
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	40.5	41.8	14.9	35.2	42.6	151.5	2.4	68.3
Number-unweighted (N)	43	52	15	47	91	225	8	145
Percent using both condoms and selected medical methods***	3.1	18.6	0.0	13.1	12.6	7.7	0.0	14.1

Table A17. Contraceptive method used at last intercourse, continued

Males	**Variable name: education level**							
	brevet		cap		bac		sup	
Percent using each method	*Age at survey*		*Age at survey*		*Age at survey*		*Age at survey*	
at last intercourse*	18-19	20-24	18-19	20-24	18-19	20-24	18-19	20-24
Oral contraceptives	50.8	41.6	47.8	55.4	34.5	60.1		58.8
IUD	0.0	2.3	0.0	0.0	0.0	0.6		1.2
Condoms	25.1	27.7	51.3	13.0	41.8	22.0		17.4
Diaphragm/Cap/f.condom	0.0	0.0	0.0	0.9	0.0	0.7		0.0
Foam/jelly/cream/suppository	0.0	0.0	0.0	0.0	0.0	0.0		0.2
Withdrawal	0.0	0.0	0.0	0.0	0.0	0.0		0.2
Rhythm (periodic abstinence)	0.0	0.0	0.0	0.0	0.0	0.1		0.0
Other	0.0	0.0	0.0	0.4	0.0	0.0		1.4
Method not reported	2.6	1.3	0.0	4.7	2.0	6.6		5.3
No method used	6.9	20.2	0.0	9.2	8.3	8.5		5.5
Not at risk for unintended preg.**	0.0	0.0	0.0	0.0	0.0	0.0		0.0
No intercourse-past 3 mths	0.0	1.1	0.0	0.0	0.3	0.4		9.1
Never had intercourse	14.6	5.8	0.9	16.6	13.2	1.1		1.0
Total Percent	100%	100%	100%	100%	100%	100%		100%
Number-weighted (N)	50.9	45.6	11.0	69.4	42.8	115.7		60.7
Number-unweighted (N)	64	68	15	97	71	214		157
Percent using both condoms and selected medical methods***	25.7	6.1	5.6	7.1	12.8	17.0		7.7

Table A17. Contraceptive method used at last intercourse, continued

Females	**Variable name: income**							
	<8,000 Francs		8-15,000 Francs		15-30,000 Francs		>30,000 Francs	
Percent using each method	*Age at survey*		*Age at survey*		*Age at survey*		*Age at survey*	
at last intercourse*	18-19	20-24	18-19	20-24	18-19	20-24	18-19	20-24
Oral contraceptives	43.0	64.5	46.5	67.1	41.4	83.8	16.3	68.0
IUD	0.0	1.1	0.0	3.2	0.0	0.0	0.0	0.0
Condoms	6.4	6.2	13.8	6.1	0.0	3.2	83.8	1.9
Diaphragm/Cap/f.condom	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.0
Foam/jelly/cream/suppository	0.0	0.6	0.0	1.5	0.0	0.0	0.0	0.0
Withdrawal	0.0	0.1	0.0	1.0	0.0	0.0	0.0	0.0
Rhythm (periodic abstinence)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	1.3	0.0	0.0	0.0	0.0	0.0	0.0
Method not reported	3.1	5.0	2.8	0.7	0.0	1.0	0.0	0.0
No method used	15.8	11.8	0.9	8.8	0.0	11.9	0.0	30.1
Not at risk for unintended preg.**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
No intercourse-past 3 mths	5.1	1.1	0.0	0.0	0.0	0.0	0.0	0.0
Never had intercourse	26.6	8.3	36.0	11.4	58.6	0.2	0.0	0.0
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	58.5	131.5	22.3	104.9	13.0	38.1	3.3	5.5
Number-unweighted (N)	93	240	21	130	12	48	2	8
Percent using both condoms and selected medical methods***	6.8	10.6	0	12.1	17	13.7	0	12.6

Table A17. Contraceptive method used at last intercourse, continued

Males	**Variable name: income**							
	<8,000 Francs		8-15,000 Francs		15-30,000 Francs		>30,000 Francs	
Percent using each method	*Age at survey*		*Age at survey*		*Age at survey*		*Age at survey*	
at last intercourse*	18-19	20-24	18-19	20-24	18-19	20-24	18-19	20-24
Oral contraceptives	23.3	44.9	58.9	61.8	39.2	67.8	0.0	43.0
IUD	0.0	1.7	0.0	0.2	0.0	0.0	0.0	0.0
Condoms	36.1	23.2	23.7	17.5	56.0	16.2	30.7	35.4
Diaphragm/Cap/f.condom	0.0	0.6	0.0	0.7	0.0	0.0	0.0	0.0
Foam/jelly/cream/suppository	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0
Withdrawal	0.0	0.1	0.0	0.3	0.0	0.0	0.0	0.0
Rhythm (periodic abstinence)	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0
Other	0.0	0.2	0.0	0.0	0.0	1.1	0.0	8.7
Method not reported	1.2	7.3	1.9	4.0	2.5	3.4	0.0	0.0
No method used	17.4	11.3	2.6	10.7	2.3	9.4	0.0	0.0
Not at risk for unintended preg.**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
No intercourse-past 3 mths	0.5	2.9	0.0	1.2	0.0	1.5	0.0	12.9
Never had intercourse	21.7	8.0	12.9	3.3	0.0	0.7	69.3	0.0
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	31.1	131.9	43.2	80.2	23.6	53.9	1.2	3.1
Number-unweighted (N)	55	275	48	144	29	71	2	9
Percent using both condoms and selected medical methods***	5.4	6.7	28.1	13.6	14.5	16.9	0.0	4.3

Table A17. Contraceptive method used at last intercourse, continued

Females	**Variable name: job**											
	student		agric-indep		manager		clerk		workers		inactive	
Percent using each method	*Age at survey*		*Age at survey*		*Age at survey*		*Age at survey*		*Age at survey*		*Age at survey*	
at last intercourse*	18-19	20-24	18-19	20-24	18-19	20-24	18-19	20-24	18-19	20-24	18-19	20-24
Oral contraceptives	46.7	74.4		100.0		69.0	42.1	64.5	0.0	58.4	12.0	54.1
IUD	0.0	0.3		0.0		0.0	0.0	2.0	0.0	0.0	0.0	7.4
Condoms	10.8	9.3		0.0		9.0	16.2	6.0	0.0	5.9	0.6	0.6
Diaphragm/Cap/f.condom	0.0	0.0		0.0		0.0	0.0	0.1	0.0	0.0	0.0	0.2
Foam/jelly/cream/suppository	0.0	0.0		0.0		0.0	0.0	0.5	0.0	5.3	0.0	0.0
Withdrawal	0.0	0.1		0.0		0.0	0.0	0.8	0.0	0.0	0.0	0.0
Rhythm (periodic abstinence)	0.0	0.0		0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.4		0.0		0.0	0.0	1.0	0.0	0.0	0.0	0.0
Method not reported	3.5	1.0		0.0		0.0	0.0	2.0	0.0	6.3	0.0	8.4
No method used	1.0	1.3		0.0		11.0	1.7	15.8	100.0	15.4	65.8	20.8
Not at risk for unintended preg.**	0.0	0.0		0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0
No intercourse-past 3 mths	0.5	0.4				0.0	19.4	0.3	0.0	1.8	5.0	0.5
Never had intercourse	37.6	12.7				11.0	20.7	7.1	0.0	6.9	16.6	8.0
Total Percent	100%	100%		100%		100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	78.3	101.7		0.2		4.4	12.0	136.4	1.6	30.1	10.4	24.4
Number-unweighted (N)	133	182		1		12	12	206	1	30	13	40
Percent using both condoms and selected medical methods***	8.4	13.1		100.0		0.0	0.0	7.9	0.0	16.1	0.0	18.2

Table A17. Contraceptive method used at last intercourse, continued

Males	**Variable name: job**											
	student		agric-indep		manager		clerk		workers		inactive	
Percent using each method	*Age at survey*		*Age at survey*		*Age at survey*		*Age at survey*		*Age at survey*		*Age at survey*	
at last intercourse*	18-19	20-24	18-19	20-24	18-19	20-24	18-19	20-24	18-19	20-24	18-19	20-24
Oral contraceptives	42.3	54.6		100.0	100.0	45.6	51.9	58.8	58.6	54.6	21.1	59.9
IUD	0.0	0.7		0.0	0.0	5.1	0.0	1.6	0.0	0.6	0.0	0.0
Condoms	34.3	24.6		0.0	0.0	34.3	48.1	12.1	41.5	19.1	17.6	18.0
Diaphragm/Cap/f.condom	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	1.3	0.0	0.0
Foam/jelly/cream/suppository	0.0	0.0		0.0	0.0	2.5	0.0	0.0	0.0	0.0	0.0	0.0
Withdrawal	0.0	0.0		0.0	0.0	0.0	0.0	0.2	0.0	0.3	0.0	0.0
Rhythm (periodic abstinence)	0.0	0.0		0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.0
Other	0.0	0.0		0.0	0.0	7.7	0.0	1.1	0.0	0.3	0.0	0.0
Method not reported	2.3	4.8		0.0	0.0	0.0	0.0	5.2	0.0	6.1	5.3	2.5
No method used	6.8	3.1		0.0	0.0	4.8	0.0	19.5	0.0	11.6	22.4	9.0
Not at risk for unintended preg.**	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
No intercourse-past 3 mths	0.2	5.2		0.0	0.0	0.0	0.0	1.3	0.0	0.1	0.0	1.6
Never had intercourse	14.1	7.0		0.0	0.0	0.0	0.0	0.0	0.0	6.2	33.6	9.0
Total Percent	100%	100%		100%	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	66.9	99.9		0.5	0.1	3.5	6.1	54.9	20.5	104.7	11.1	29.0
Number-unweighted (N)	108	200		2	1	18	8	122	19	148	14	49
Percent using both condoms and selected medical methods***	13.9	12.4		0.0	0.0	14.2	6.9	8.5	37.6	9.1	15.6	17.2

* If multiple methods are reported, classify according to the most effective method used. Totals should add to 100%.

** No risk because respondent currently pregnant, postpartum, trying to get pregnant, infecund or sterile.

*** Other medical methods include sterilization, oral contraceptives, IUD, Norplant and Depo Provera.

Source(s): ACSF (France)

Year of survey: 1992

Table A18. Percentage distribution according to socioeconomic measures by age and gender

Age and gender	Marital/cohabitation status				Total Percent	Number (n)
	Currently Married	Currently Cohabitating	Formerly married/ cohabiting	Never married/ cohabited		
Youth aged 18-19	1.0	3.2	16.5	79.3	100%	309
males	0.0	2.1	22.7	75.2	100%	150
females	2.1	4.3	10.2	83.5	100%	159
Youth aged 20-24	9.2	16.5	19.0	55.3	100%	1010
males	3.8	13.1	22.2	60.9	100%	539
females	14.5	19.8	15.9	49.8	100%	471

Age	Family income/poverty status				Total Percent	Number (n)
	<8,000 Francs	8-15,000 Francs	15-30,000 Francs	>30,000 Francs		
Youth aged 18-19	45.7	33.4	18.7	2.3	100%	262
Youth aged 20-24	48.0	33.7	16.8	1.6	100%	925

Age	Education level				Total Percent	Number (n)
	brevet	cap	bac	superieur		
Youth aged 18-19	44.6	12.6	41.6	1.2	100%	307
Youth aged 20-24	14.9	17.8	45.4	21.9	100%	1,005

Age	No of inhabitants in the town				Total Percent	Number (n)
	<5,000	5-50,000	50-200,000	>200,000		
Youth aged 18-19	30.2	19.8	10.1	39.9	100%	309
Youth aged 20-24	22.1	16.5	15.5	45.9	100%	1,010

Age	Immigrant status		Total Percent	Number (n)
	Native born	Foreign born		
Youth aged 18-19	90.8	9.2	100%	309
Youth aged 20-24	93.4	6.6	100%	1009

Age and gender	School status			Total Percent	Number (n)
	In School	Employed	Inactive		
Youth aged 18-19	70.1	19.5	10.4	100%	309
males	63.9	25.5	10.6	100%	150
females	76.5	13.3	10.2	100%	159
Youth aged 20-24	34.2	56.7	9.1	100%	1010
males	34.2	55.9	9.9	100%	539
females	34.2	57.6	8.2	100%	471

Source(s): ACSF (France)
Year of survey: 1992

Appendix B

France's Sex Education Curriculum

In France, teaching about sexual and reproductive health does not really begin until middle school, in the 7th grade, which students enter at the age of 12, and continues into the 7th, 8th and 9th grades. These subjects are taught in the context of the "life and earth sciences" program.

A. Biology classes

1. In 7th or 8th grade (ages 12–14): "the transmission of human life"

Suggested duration: 11 hours.

Objectives: To provide a simple basis for understanding the puberty and procreation and to provide a general understanding of reproduction.

Consequently, this comes under the advancement of sex education provided by circular memo no. 96-100 dated April 15, 1996. The study of these phenomena, in and of itself as well as through the discussions that it prompts, should constitute an essential contribution to sex education.

Supplement: Depending on the age, maturity and expectations of the students, the teacher may extend this teaching of human reproduction with basic information about family planning and STDs including HIV/AIDS, in cooperation with the school health personnel. For purposes of consistency, the information sessions on contraception and STD must take place, insofar as possible, in the presence of the teacher.

Concepts taught:

- Human beings become capable of reproduction at puberty, secondary sexual characteristics appear, the personality changes.
- As of puberty, the production of gametes is continuous in men and cyclical in women until menopause.
- The human embryo derives from a zygote, resulting from internal fertilization following sexual intercourse.
- The embryo is implanted and develops in the uterus. The human species is viviparous.

Target skills:

- To connect the physical, physiologic and behavioral changes of puberty with the acquisition of the ability to transmit life.
- To connect the male and female genital organs with their respective roles, verbally or using a diagram.
- To explain the anatomic and functional relationship between the fetus and the maternal organism.

Excluded concepts:

- Histologic study of the organs, study of follicle development, study of the formation of gametes.
- Existence of hormones and hormonal mechanisms.
- Embryogenesis, systematic study of fetal stages of development.
- Detailed study of the various stages of labor.
- Psychoaffective and relational aspects

2. Sexual reproduction

Recommended duration: 3 hours

Objective: To achieve a general knowledge of reproductive function

Concepts taught:

- All sexual reproduction comprises the union of the male gamete and the female gamete;
- fertilization results in a zygote, which is the origin of a new individual.

Target skills:

- To recognize that sexual reproduction results from fertilization.

3. In 9th grade: "human responsibility, health and environment" (age 14 -15):

Suggested duration: approximately 3 hours

Objectives: To provide in-depth understanding of procreation by adding to the previous teaching, in the context of sex education. To discuss the prevention of infectious diseases, including HIV.

Concepts taught:

- Community measures make it possible to avoid infectious diseases (definition of the concepts of epidemic, endemic disease and vaccination).
- Prevention of STD's
- Methods of contraception that rely on knowledge of procreation make it possible to choose the appropriate time to have a child.
- Techniques and methods that allow couples to choose whether or not to have a child.
- Techniques of assisted reproduction, such as artificial insemination and in vitro fertilization, give sterile couples the possibility of transmitting life.
- Under certain conditions, a voluntary interruption of pregnancy (abortion) may be done under medical supervision.

Target skills:

- To connect a method of contraception with a phase of reproduction.
- To recognize, based on biological data, the reasons that could lead a couple to use a method of contraception, human-assisted reproduction or abortion.

B. Mandatory sex education sessions (2 hours per year for all middle school students, with emphasis on 13 to 15 year-olds)

Objectives:

- To provide students with the possibility of knowing and understanding the various aspects of sexuality while respecting conscience and the right to privacy.
- To make young people better able to confront the plethora of media and societal messages related to sexuality
- To develop true education about sex and responsibility.
- To encourage evolution in the basic attitudes that are the source of high risk behavior.

Content:

- Sex education should provide information and stimulate thinking about:
- self image
- dimensions of human sexuality (biologic, emotional, psychological, legal, social and ethical)
- relationships (individual and social aspects, accurate knowledge about gender)
- right to sexuality and respect of one's partner (variety of sexual behaviors)
- exercising critical judgment (with respect to sexual stereotypes, idealized, irrational and sexist images)
- preventive attitude (preventive behaviors against sexual abuse, STD, AIDS, and unwanted pregnancy; identification of resource locations and systems in the area of risk prevention), education toward responsibility

Hours:

Sex education sessions: minimum of 2 hours during the school year

Health education workshops: 30 to 40 hours over the four years of middle school