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Abortion in France 50 years after the Veil Act: Rates and methods that vary across the country

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On 29 November 1974, the French National Assembly voted to decriminalize abortion, a first step in the process leading to the Veil Act on voluntary termination of pregnancy. Fifty years on, this article reviews the changes that have taken place since this historical turning point and examines the conditions of access to abortion, including for medical reasons, in France today, and the methods used.

Promulgated on 17 January 1975,*[(1)] the Veil Act decriminalized abortion[(2)] under two sets of circumstances: first, 'voluntary termination of pregnancy before the end of the 10th week' (elective abortion) in cases of 'distress', and second, 'voluntary termination of pregnancy for medical reasons' (TPMR). Fifty years on, how is abortion practiced in France?

What is the legal framework for abortion in France?

The Veil Act was adopted for a period of 5 years, then prolonged indefinitely in 1979* by the Pelletier Act (Figure 1). Elective abortion was initially authorized up to the 10th week of pregnancy. This limit was extended to 12 weeks in 2001* and to 14 weeks in 2022.* At the outset, elective abortion was not reimbursed, but following the 1982 Roudy Act* the cost was partially covered by the state health insurance system (Assurance Maladie). It became totally free of charge in 2013,* along with all associated procedures from 2016. The waiting period was shortened and has now been abolished, and the obligatory 'psychosocial' interview became voluntary in 2001 for adults over 18. Below age 18, parental consent is no longer required, but the person must still be accompanied by an adult. The 1975 Act gave physicians the right to refuse to perform abortions, and this conscience clause remains in force today.[(3)]

Therapeutic abortion, tolerated in a few rare cases by the Academy of Medicine since 1852, was formally legalized in the 1939 French Family and Natality Code with the aim of curbing recourse to so-called 'criminal' abortions [1]. The 1975 Act authorizes TPRM at any time during pregnancy for reasons linked to the health of the woman or foetus. They are subject to strict rules, however, and the authorization procedure has become increasingly complex. Requests must be validated by two physicians, one of whom must be a member of a multidisciplinary antenatal diagnosis centre (*centre pluridisciplinaire de diagnostic prénatal*, CPDPN). This requirement has been in force since 1994* for requests linked to foetal health and since 2011* for those linked to the woman's health. As of 2001*, all TPMR requests must be examined by a multidisciplinary team (physicians and/or other health or welfare professionals).

Elective abortion: A wider range of methods and professionals

In 1975, all elective abortions had to be performed surgically by a physician in a hospital. Self-managed abortions were not decriminalized until 1993.* Drugs to induce medication abortion became available in 1988, initially administered in hospital settings and, since the 2000s, in physicians' offices, health centres or sexual health centres* (formerly known as family planning and education centres - centre de planification et d'éducation familiale, CPEF). Medication abortions in these settings are authorized up to the end of the 5th week of pregnancy. As of 2016, surgical abortions can also be performed in health centres, and midwives can prescribe medication abortions. During the COVID-19 pandemic in 2020, the legal time limit for a medication abortion was extended to 7 weeks of

(1)* The asterisks (*) in this article refer the reader to the table listing the articles of the law in the Online Appendix.
https://doi.org/10.34847/nkl.da9d5984

(2) Under Article 317 of the 1810 Penal Code, abortion was a criminal offence.

(3) The conscience clause specific to elective abortions complements the existing clause in the Code of Public Health (formerly in the Code of Medical Ethics) for all non-urgent medical procedures. It also applies to midwives.*

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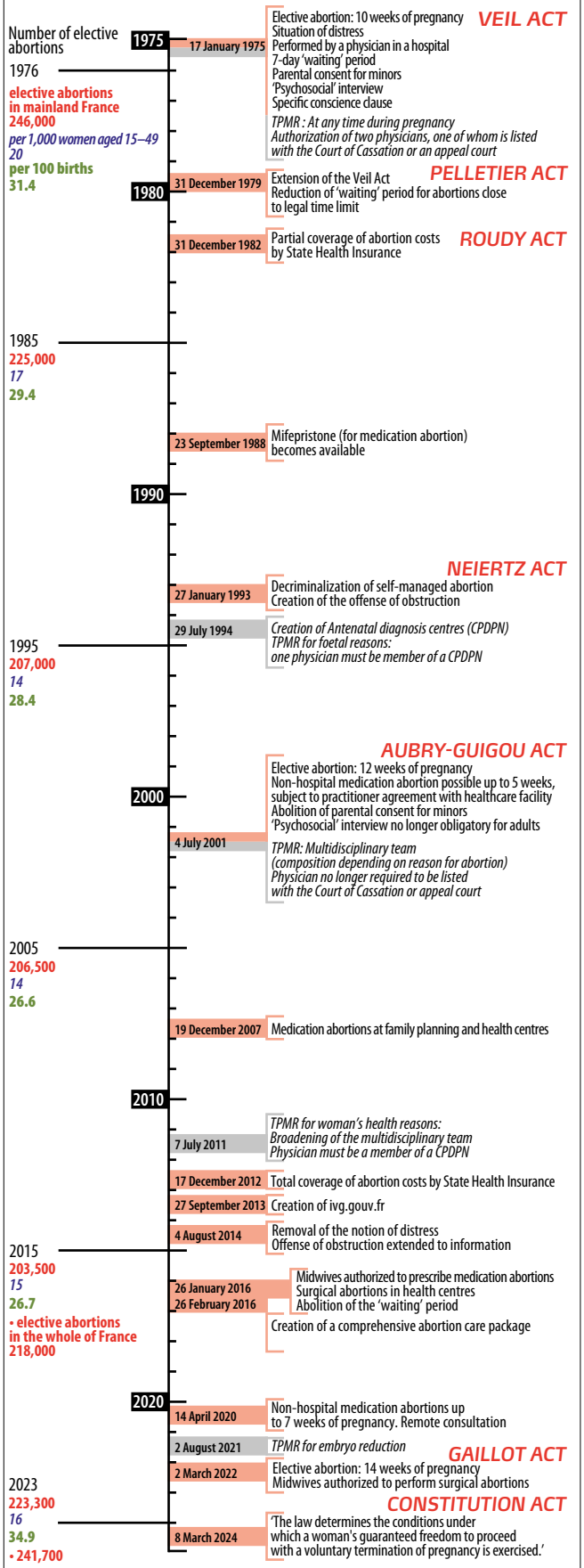
Figure 1. The legal framework of abortion since 1975



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Source: [2]; SNDS, authors' calculations.

pregnancy, and remote consultations were authorized.* In 2022, the Gaillot Act* extended the deadline for elective abortion to 14 weeks and authorized midwives to perform surgical abortions. How frequent is abortion today? How have these less restrictive rules been applied across the country?

Long-term stability and a recent increase

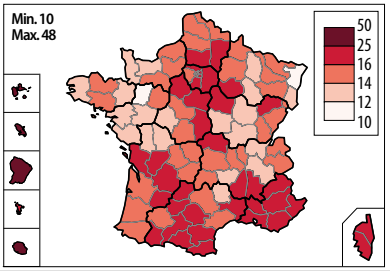
With the spread of contraception, the number of abortions fell until the 1990s, then stabilized at around 220,000 per year [3] for 3 decades. It began rising sharply in the early 2020s, reaching 241,700 in 2023, of which 223,300 in mainland France (Figure 1). Note that the extension of the legal time limit for elective abortion in 2022 only marginally contributed to this increase [4].

Over the last 3 decades, the ratio of elective abortions to births was around 1 in 4, but by 2023 it was close to 1 in 3. This means that for the same number of pregnancies, the decision to terminate has become more frequent, perhaps in response to greater social and economic insecurity and increasing uncertainty about the future. It is too early to say whether the persons concerned are simply postponing future births.

Elective abortion rates vary across the country

In 2023, in France as a whole, there were 17 elective abortions (16 in mainland France) per 1,000 women aged 15–49, but this rate varied substantially between departments (Figure 2), even after taking account of the female age structure and the frequency of pregnancy. The geographical differences observed in 2023 are generally similar to those of the past (Figure 1 in the Online Appendix). Between 2014 and 2023, rates increased in most departments.

Figure 2. Elective abortion rates per 1,000 women aged 15–49, by department of residence, 2023



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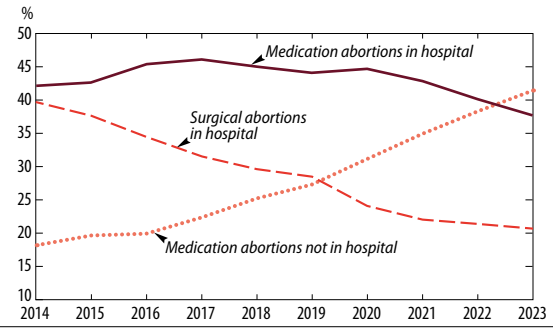
Source: SNDS; authors' calculations.

Four in five elective abortions are now medication-induced

In 2023, 4 in 5 elective abortions were medication-induced, and just one in five were surgical (half as many as 10 years previously), most often performed under general anaesthetic (70% of cases). The share of non-hospital medication abortions has increased sharply and now represents half of all abortions of this type. The share of hospital abortions was relatively stable until 2019 but has fallen since the 2020 COVID-19 pandemic (Figure 3). With the generalization of medication abortion, the monopoly of a single private pharmaceutical laboratory (Nordic Pharma) raises questions about the risks of shortages, supply or pressure on prices of

abortion pills.[4] With this monopoly, access to abortion might become difficult. Despite the growing number of non-hospital abortions, public hospitals are still the main abortion providers, with very few private clinics now offering services of this kind.

Figure 3. Relative proportions of elective abortions by method and setting, 2014–2023 (%)



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Coverage: Whole of France.
Source: SNDS; authors' calculations.

Methods that vary across settings: a sign of inequality?

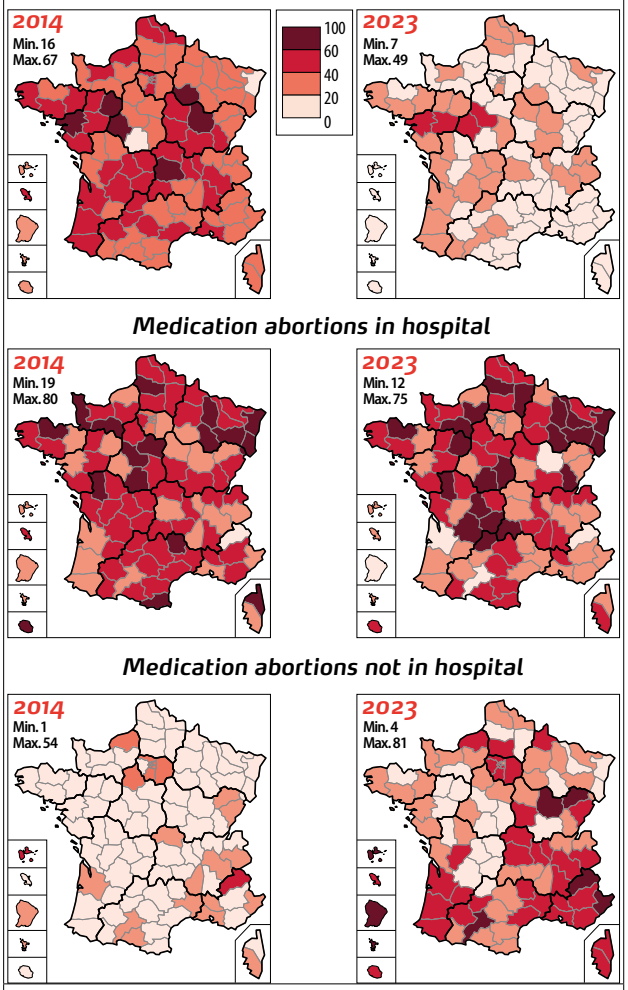
The relative shares of the three types of elective abortions (by setting and method) already varied substantially between departments in 2014 (Figure 4) and have evolved in different ways. The proportion of non-hospital medication abortions has continued to rise in departments where they were already widely practiced in 2014 (excepting Hautes-Alpes and Ardèche), most notably in the overseas territories and in Corsica. Their share of the total remains very unequal, however: in 2023, it ranged from 4% to 81% across the French departments. Surgical abortions in a hospital have become less frequent practically everywhere although they still represented between 40% and 49% of the total in the Maine-et-Loire, Loire-Atlantique, Loir-et-Cher and Indre-et-Loire departments in 2023. Last, medication abortions in a hospital have maintained or acquired a dominant position in several geographical areas, while losing ground in others. In 2023, they accounted for more than 60% of elective abortions in 20 departments and less than 20% in seven others.

These geographical differences do not appear to be linked to disparities in abortion rates (Figure 2) but rather to practices that reflect varying sexual and reproductive health norms and local medical cultures. They may indicate access difficulties and/or a lack of choice in certain locations, depending on the existing medical infrastructure: presence of health facilities (more dispersed in rural areas), degree of coordination between hospitals and other abortion providers, etc.

One in five elective abortions by midwives

Midwives managed more than 45,000 abortions in 2023, i.e. almost 20% of the total and 46% of those outside a hospital. The share of midwife-led abortions varied substantially across France: in 21 departments they managed more than three-quarters of non-hospital abortions, while in 21 others they managed less than one-third (Figure A2 in the online Appendix). Now that midwives are qualified to perform a wider range of medical acts (gynaecological follow-up since 2009, medication abortions since 2016 and surgical abortions since 2022), they have become key providers of 'abortion work' [4], a domain previously reserved for physicians under the Veil Act.

Figure 4. Distribution of elective abortions by method and setting across departments of residence, 2014 and 2023 (%)



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Interpretation: In 2014, 32% of elective abortions in southern Corsica were surgical, versus 18% in 2023.
Source: SNDS; authors' calculations.

Pregnancy terminations for medical reasons: the importance of antenatal diagnosis centres

In 2023, there were 8,400 pregnancy terminations for medical reasons in France, (5 per 10,000 women aged 15–49), and the number has remained relatively stable over the last 4 years. Over the period 2021–2023, TPMR rates varied between departments of realisation (Figure A3a in the Online Appendix). Over the period 2021–2023, 77% of all TPMRs took place in the 38 departments with at least one multidisciplinary antenatal diagnosis centre (CPDPN), as the medical team that examines requests must include a CPDPN member (i.e. a

(4) See the warning and recommendations of the High Council on Gender Equality (HCE) in 2020: https://haut-conseil-egalite.gouv.fr/sante-droits-sexuels-et-reproductifs/actualites/article/penurie-de-medicaments-un-risque-d-atteinte-aux-droits-sexuels-et-reproductifs

Box 1. Health data on abortions

Abortion data are included in the national health data system (SNDS). They are based on medical and administrative abortion data from public hospitals and private clinics, and from the National Health Insurance Fund (Caisse nationale d'assurance maladie, CNAM) for non-hospital abortions [2].

concentration much higher than that observed for births and elective abortions). In 2023, almost 6 in 10 departments, including the outlying departments of Mayotte, Guadeloupe, French Guiana and Corsica, had no CPDPN.

However, the concentration of TPMRs in departments with these centres does not mean that they cannot be performed elsewhere, as shown by the TPMR rates by department of residence (Figure 5). The geographical disparities—that go beyond the female age structure[5] and the frequency of pregnancy—point up inequalities in access to abortion services linked to the distance that must be travelled to reach them.

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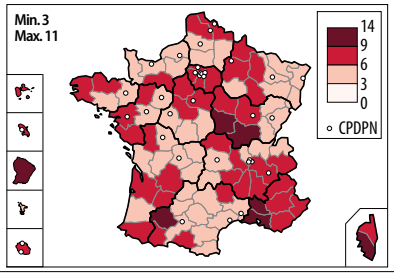
Fifty years after the Veil Act, the way of obtaining elective abortions has changed. A large majority of these abortions are medication-induced and now take place outside a hospital, especially since the COVID-19 pandemic. Under the legal framework in France, abortions can be performed in a range of settings, by both physicians and midwives and using various methods, depending on the reason for termination (medical or not) and duration of pregnancy. The availability of these different alternatives varies across the country, however, sometimes preventing women from choosing their preferred option. At a time when abortion rights and access are being eroded in many countries, the enshrinement of a woman's 'guaranteed freedom' to access abortion in the French Constitution in 2024 is of particular symbolic importance. However, the notion of 'guaranteed freedom' remains vague, and the conditions applicable are laid down by the legislature, so the content of the law and its implementation cannot be guaranteed [6]. Beyond legal considerations, abortion choices may also be constrained by factors such as shortages of abortion pills, practitioners invoking the conscience clause, etc. Conversely, access can be simplified by a broad and stable system of abortion provision, by effective coordination between hospitals and other actors, and a guaranteed choice of method.[6]

(5) TPMR concern older people than elective abortions as high-risk pregnancies are more frequent at older ages.

(6) On these questions, see the report by the Senate Social Affairs Committee dated 16 October 2024 (including 10 recommendations): 'IVG : une 'liberté garantie' mais un accès fragile', https://www.senat.fr/rap/r24-045/r24-045-syn.pdf

Figure 5. TPMR rates per 10,000 women aged 15–49, by department of residence, 2021–2023



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Source : SNDS ; authors' calculations.

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Abstract

Following the decriminalization of abortion in January 1975 under the Veil Act, the framework of abortion provision in France has evolved considerably. The rules governing elective abortion have been relaxed, with an extension of the legal time limit, the diffusion of medication abortion and a broader range of authorized practitioners. For termination of pregnancy for medical reasons (TPMR), on the other hand, the regulations have become more complex. There are large disparities across the French departments in the frequency of, and the methods used for, elective abortions as well as the ease of access to TPMR.

Keywords

abortion, elective abortion, termination of pregnancy for medical reasons, Veil Act, midwife, medication method, surgical method, abortion rate, geographical disparities, France

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