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SRHR in France: education, information and access for all

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1. Background and related policy context of France in relation to promoting SRHR

1.1 Outlines of the French SRHR and gender policy goals

The current situation of the French SRHR highlights some strengths with regard to several main goals of the national SRHR[1] (and international[2]) strategy.

France is a leading country regarding **primary health-care access**[3], which is an important SDG; the **contraceptive cover is quite high** (and we can stress the recent decision, in February 2022, to make some methods free of charge for young women under 25); **abortion cares are guaranteed by the law** (since 1975) until 14 weeks of pregnancy (for induced abortion); after 14 weeks, abortions for therapeutic reasons are allowed. The legal frame for induced abortion has been enlarged during the past decades, more recently during the sanitary crisis context, but some **inequalities** and **barriers** remain.

[1] Ministère des affaires sociales et de la santé. Stratégie nationale de santé sexuelle - Agenda 2017 - 2030

[2] For instance, an international Generation Equality Forum was held in 2021 in Paris. The event deeply promoted rights of women and girls, gender equality. Financial external aid is mainly oriented to support sexual and reproductive health and rights and the health of women and girls for the 2021-2025 period, and through the implementation of its national Women, Peace and Security action plan.

[3] The Security Health Insurance system offers wide coverage. The main fund (Caisse Nationale d'Assurance Maladie des Travailleurs Salariés, CNAMTS) covers 92 % of the population; the agricultural fund 7 % and other specific funds 1% . Access to essential care for undocumented migrants can be provided in all territories (excluding Mayotte), under conditions. Those conditions were recently modified by decree; However, non-use of this health coverage is important, and the share of non-use is higher for women than for men (based on a study conducted in two territories, that may not be representative of all undocumented people, but those data are quiet relevant).
https://www.legifrance.gouv.fr/codes/article_lc/LEGIARTI000042485535
https://www.irdes.fr/recherche/questions-d-economie-de-la-sante/245-le-recours-a-l-aide-medicale-de-l-etat-des-personnes-en-situation-irreguliere-en-france-enquete-premiers-pas.pdf

In order to discuss both the strengths and weaknesses of SRHR, this discussion paper focuses on both **"access for all"** and on **specific needs** for the most vulnerable care recipients. Contraception, abortion, sexual education, vulnerabilities, gender-based violence (especially sexual violence) will drive the common thread of the discussion.

Finally, the question of **numeric tools and online services** will be raised.

1.2 French sexual and reproductive background

As pointed out in WHO texts, "*Sexual health needs to be understood within specific social, economic and political contexts*".

The SRHR in France are implemented in a context of **'sustained' fertility level** (regarding to most of EU countries) thanks to significant family policies (figure A.1 in Annex). Fertility mainly occurs between 25 and 35 for women, and fertility rates at the youngest ages are low. Births occurs mainly outside marriage, but the conjugal norm is still very strong. Single parenthood at births is rare. The status of children born inside or outside marriage are equal since 2005.[4]

The **contraceptive cover is high** and the French contraceptive model is driven by the **pill norm**, associated (or not) with condoms for the youngest and then the use of the DIU (figure A.2). This model is driven by a **gender gap in contraceptive use**, contraceptive burden, and contraceptive effects on bodies (especially due to hormonal treatment, which is a female concern).

Abortion was legalised in 1975. After a diminution of abortions in the 1980ies thanks to the diffusion of contraceptive use, the variation of the annual number of abortions since the end of the 1990ies are not significant. Around **220,000 abortions are practiced each year** (figure A.3), **rates at young ages are low**. Regarding the access, several enlargements occurred since the last decades, and very recently during the sanitary crisis: rise of the delay, services provided in non-hospital settings, diversification of the type of practitioners allowed to provide abortion care (general practitioner and more recently midwives), and implementation of telemedicine. But some barriers to access abortion care services remain and depend on services in the area of residence. The private sector is not an actor providing abortion care anymore, while the public sector has to face difficulties, reinforced by the sanitary crisis.

1.3 Orientation of the SRHR main goals

The global orientations of the national plan strategy focus on several main goals[5]:

[4] Ordinance of 4 July 2005 (effective since the 1 July 2006) reforming filiation: the concepts of "legitimate" filiation and "natural" filiation are abandoned.

[5] http://solidarites-sante.gouv.fr/IMG/pdf/strategie_nationale_sante_sexuelle.pdf
Maternal and child health are not covered by this strategy but are addressed by specific national policies. The report indicates that "*Consistency and Articulation of these policies with this strategy will be ensured*". It would be interesting to see how this articulation is effective.

- Access to human rights, respect for **gender and sexualities**;
- **The promotion of sexual health** through information, education, communication and sexual health training;
- Information on **dysfunctions and sexual disorders**, their prevention, screening and management;
- **Prevention** through HBV and HPV vaccination, screening and management of STIs including HIV and viral hepatitis;
- **Reproductive health promotion** (prevention of infertility related to causes infectious, contraception, abortion and prevention of unwanted/unintended pregnancies);
- **Combating discrimination** based on sex, sexual orientation or identity gender;
- Prevention, treatment of **sexual violence**.

2. Description of the main elements of the policy/initiatives

Numerous initiatives led to significant improvements of SRH services. Succession of laws permitted to enlarge abortion rights and access, to provide better information and recently focused attention on youth needs, by providing young women a free of charge access to contraception.

2.1 The implementation of a Toll-free number

A national toll-free number **"Sexuality, contraception, and abortion"** was implemented in 2015. This platform is coordinated by the Family Planning, with the support and/or coordination of the Ministry of Health and Social Cohesion and the Women's Rights and Equality Ministry and the national agency 'Santé Publique France'. This tool, implemented across all the territories, via the support of territorial organisation of the health system (see figure A.4 that describes the French health system organisation) helps people who seek information or orientation, with accurate response to their situation.

Very recently (since 28/09/2022), A website was implemented in order to provide access to information: https://ivg-contraception-sexualites.org/

In 2023, an online chat will also be implemented in order to answers online questions of people that try to reach them.

2.2 The implementation of EVARS model

The EVARS model: “Espaces Vie Affective, Relationnelle et Sexuelle/Emotional, relational and sexual life spaces” (EVARS), is implemented since 2018 and a total number of 150 EVARS centres are disseminated across regions and departments. About 10 more soon to be opened on the metropolitan and overseas territories. It represents a 4 M. Euros budget in 2022 (regarding data presented during the seminar). Interventions consist to inform, welcome, listen, guide and support the public, on access to rights and services in terms of emotional life and sexual health. They are part of initiatives to spread integral sexual health education and fight against discrimination. They provide information on rights (contraception, abortion, STIs), pre-abortion interviews, education to affective and sexual health sessions, make promotion of gender equality, fight against sexism and discriminations regarding gender identity and sexual orientation, promote respect of the intimacy of the elderly or disabled people as well as every vulnerable person, intervene within conjugal and familial troubles, desire/process of adoption or medically assisted procreation carried to term or interrupted, can provide with information and support for families and people facing difficult situations, for victims of sexual and/or intrafamilial violence. The actual roadmap is guided by the need to guaranteeing an accessible and coordinated offer for sexual and reproductive health everywhere in the country and effectiveness at a territorial level.

More widely than the services afford, it seems that the implementation of EVARS can participate to spread a **common culture** in order to improve **sexual autonomy** and respect, body autonomy and respect and then participate to reduce gender gaps and gender-based violence and reduce stigmatisation of LGBTQI people or people with disabilities.

2.3 Sexual health education

The Fontanet Circular (23 July 1973) was the first legal initiative on sexual education. Nevertheless, this "information" to sexuality remains optional and refers only to "information" and provides a “biological” approach of reproduction. The 1980ies, in the context of AIDS, led to a significant raise of social awareness. Prevention was extended to schools and became a public health issue. In 1998, Circular No. 98-234 entitled "Sexuality Education and AIDS Prevention" was elaborated. An effective consideration of the importance of sexuality education in schools emerged, leading to its institutionalisation. Since 2001, the legislation requires **three "minimum" annual sessions of two hours,** per "homogeneous age group” (without specifying minimal ages). These sessions of two hours of sexual health were not systematically provided, nor homogeneously implemented (and are still not). The last national strategy pointed out (as a main axis) the relevance of “sexual health promotion, particularly **among youth, in a comprehensive and positive** approach". Nevertheless, the lack of resources and time, generally not allowing personal and institutions to a satisfying implementation has to be pointed out. To do so, the Ministry of Education and the High Council for Gender Equality recently announced measures to ensure the implementation of the application of the 2001 law, by accompanying school directions

and staff (i.e. teachers and stakeholders) to settle sexuality education, disseminating vademecum on sexual education. A training seminar gathering academic direction of the National Education Services and other stakeholders was held on 1 December 2022 (Circular of 30-9-2022).

2.4 Free of charge access to contraception for women under 26

Since 1st January 2022**, young women under the age of 26** can access free of charge contraception (under prescription) in pharmacies without advance of charge. The list of methods includes: **1st or 2nd generation hormonal pills, hormonal contraceptive implant, IUD, hormonal emergency contraception, consultations** (with doctors or midwives), **examinations or medical acts** related to contraception.

These recent modifications of the law may touch a huge number of young people (3 million regarding to the estimations), it could therefore reinforce contraceptive medical norm and the gender gap and exclude various types of publics (trans people, people who cannot have recourse to hormonal methods). In December 2022, a new decision was taken to enlarge free access to condoms. The measure concerning free condoms for 18-25 years old from 1 January 2023 in pharmacies was announced on 8 December 2022 during a territorial session of the National Council for Refoundation (a new council that was implemented in September 2022) dedicated to the health of young people[6]. It was recently extended to minors as well.

3. Results of the policies/initiatives and their impact on achieving gender equality – Key results, challenges, obstacles

Policies and initiatives settled have concrete impacts on the effectiveness of access to SRH. But some challenges remain, to reduce gender gaps and in order to include all the types of the public, especially people who are more on the margins.

The access to **sexual health education** and SRH services is, at some points, **not guaranteed, nor homogeneous** across the country.

There are some inequalities among territories, among generations and among social groups. Some social groups can still be **stigmatised** and can face **barriers to a 'good' access**.

The question of gender violence and especially **sexual violence** has to be more widely included in the policies and be concrete. For the moment, there is a division between sexual education, access to information and services, and structure that work with victims of violence (and perpetrators). This is a great challenge that will

[6] https://www.service-public.fr/particuliers/actualites/A16208

have to be faced, maybe with the support of the national commission on incest and sexual violence.

4. Assessment of the strengths and weaknesses of the policy

Access to abortion, contraception, Sexual health care service.

The global access to health care services is driven by a plurality of services and practitioners, which is a strength of the policy. But **some inequalities remain** and the access for more vulnerable populations is a real concern, as well as inequalities between territories. The overseas territories present some indicators (especially health perinatal indicators showing more difficulties for women in these areas).

Effectiveness of the access to sexual education.

Sexual education programmes are specified in the legal texts, but the concrete effectiveness is not sufficient.

According to a report, published by the High Council for equality, on the basis of a study conducted in the 2014-2015 school year, on a sample of 3,000 public and private institutions interviewed, the sexual education programmes were not sufficient: 25% of elementary schools, 4% of middle schools and 11.3% of high schools declared that nothing was put in place. The number of classes having received at least all three sessions is relatively low: 47% in last level of primary school, less than 12% at upper levels. This is pointed out and this could make the link between sexual education policies and a global plan on **violence against children and teenagers** and **gynaecological and obstetrical violence.**

A more recent report published in July 2021 by a mission of the General Inspectorate of Education, Sport and Research, points to the complexity of the devices and the lack of effectiveness. The mission proposes thirty-five recommendations, following its findings and analyses. These recommendations are grouped around eight themes: Better understand sexuality education; Clarify the legislative and regulatory framework; Better integrate sexuality education into education policy at national and territorial levels; Make sexuality education more readable; Encourage schools to develop the implementation of sexuality education; Consolidate the administrative and operational framework for external interventions; Implement a monitoring and evaluation approach; Strengthen the training of actors. The Minister of National Education, Youth and Sports, the Minister Delegate to the Prime Minister, Minister for Gender Equality, Diversity and Equal Opportunities and the Secretary of State for Children and Families entrusted the General Inspectorate of Education, Sport and Research (IGÉSR) and the General Inspectorate of Social Affairs (IGAS) a mission relating to the evaluation of sexuality education, in application of the plan to fight violence against children 2019-2022. Measure 2 of this plan does provide for an "evaluation of public policy", particularly sexuality education, starting in 2020, to study its impact, and if necessary, improve its content and effective deployment. **For the**

moment, there is no clear link between the implementation of policies on sexual violence and policies on sexual health and rights.

Some existing structures could have a key role to coordinate pluri-sectorial actions. For instance, the INJEP, the EVARS, the planning, specialised NGOs, practitioners' representatives, CIIVISE, HCE, Santé Publique France, and ministers concerned.

Youth, Sexual education and disabilities

Women and men, and especially youth with disabilities have emotional, sexual and reproductive needs. However, many receive poor or no formal sexual health education. Agreement or core recommendations for sexual health support, education, and promotion have to be disseminated. An instruction of 5 July 2021 (published on 31 August 2021) for social and medico-social institutions (ESMS), beyond respect, intimacy and residents' choices about their love lives and sexual and reproductive rights, aims to prevent all violence by putting in place educational and support measures. It requires the establishment of information and awareness-raising sessions for women with disabilities on their right to control their bodies, the notion of consent, to fight against any phenomenon of control. This programme deploys in each region a resource centre "Intimate, sexual life and parenting support" for women with disabilities, their relatives and professionals. Already deployed in 9 regions since 2021. It's supposed to be generalised in all regions in 2022 and after.

There is also the 'Handigynéco' approach led by the Île-de-France regional health agency: midwives intervene with women with disabilities within ESMS (gynaecological consultations) and raise their awareness of all forms of violence; They also carry out preventive actions with professionals in the health and social sectors. This action is being generalised in the whole region and in other two regions in 2022.

Research and experimentations on the topic have to be improved in order to provide specific tools and interventions the adapted to the needs and to the kind of limitations youth can encounter.

Links between researchers, NGOs and policy makers could be reinforced (see HANDISEX research project).

Finally, the question of **numeric tools and online services** has been raised. On the one hand, they can contribute to spread information (Chat, social media, specific app.) and enlarge access to services (with telemedicine), on the other hand, they can also generate or reinforce age inequalities and between social groups and reinforce gender gaps, because of an inequal access to electronic tools (numeric fracture).

5. Recommendations

- Gender equality programmes and sexuality education should be developed **more efficiently, maybe with the support of the dissemination of EVARS interventions, vademecum dissemination, and a big training plan.**
- At school, a **peer to peer approach** could be promoted, under supervision of professionals and stakeholders. Students are the recipients and actors of the implementation of sexual health promotion in their institutions. The involvement of students in sex education projects should be promoted (see SEXPAIRS project, which is a population health intervention research project for adolescents and young adults in the general population seeking to evaluate the effectiveness of an online participatory community).
- In parallel to the educational sector, a **training plan on gender equality and sexual health** targeted at health professionals, the sports and culture sector, social workers etc. could be established.
- **Reducing geographical inequalities** in access to **abortion** is an important goal to challenge: financial re-evaluation of abortion care could incite more practitioners. The emergence of **midwives** in abortion and contraception cares and services is notable and has to be encouraged.
- The question of the **respect of the choice of the method** (for contraception and abortion) has to be documented.
- It seems highly relevant to support multi-annual **plans against violence against children**, and to **document the gynaecological and obstetrical violence** (by supporting research, in order to produce a national diagnosis). Each year, nearly one billion of patients give birth or have an abortion, so exposure to specific violence during obstetric and orthogenic care is a major concern.
- Make a diagnosis on the relevance of the adaptation of the tools to the use of new media (chat, social networks, promotion of (web) TV series on sexual and reproductive health).
- The **most vulnerable groups**: children and youth, people with disabilities, LGBT people, and victims of gender-based violence have to be more effectively taken into account and actions have to be evaluated.

Propositions:

- **Support and develop existing tools: EVARS and Toll-free number.**
- In parallel with a national policy: encourage the development of effective **local networks for abortion** (between hospital and city network), relying on health regional agencies and on Planification centres.

- In hospital settings, **specialised units for abortion care** should be encouraged. In order to guarantee the access at all periods (especially during summer and school holidays period, when professionals are not in sufficient number to exercise) and to ensure patient choice, especially between general and local anaesthesia (95% of surgical abortions are under general anaesthesia).
- For non-hospital settings, especially for **midwives**, the delays between the abortion training and the administrative allowance to practice abortions seem to too long. Efforts should be made to strengthen links between hospital and non-hospital settings.
- The question of **male access to contraception** methods could reduce gender gaps regarding mental load and contraceptive 'everyday management'.
- Make a **constitutional law for abortion**, in order to strengthen the abortion right and access.
- **Undocumented migrants and vulnerable people**: access to care for the most vulnerable has to be reinforced, maybe on the support of the "PASS" networks.
- **LGBTQI:** The stigmatisation of LGBT populations in their follow-up on contraception, pregnancy and abortion (especially for trans people). The EVARS model can be a tool to a better offer.
- **Support the actions and productions of the CIIVISE** (independent commission on incest and sexual violence against children), provide financial and institutional support, in order to analyse the huge data collected by the platform. Four months after the launch of the call for Testimonials on 21 September 2021, more than 10,000 testimonials were collected. Those data have to be valorised.
- **Create a national observatory of violence against children**, on the results of CIIVISE, that would work in conjunction with regional and departmental observatories of violence against women, and with the national observatory of childhood protection (ONPE) and **Disseminate the Vademecum** on sexual violence within the family, to professionals who work with children and youth[7].
- **Telemedicine[8], Online App, audio/video/social media/specialised websites:** The recent and fast developments of electronic tools have to be pointed out. These developments have strong impact on every life, regarding care access. The impact on SRH is certainly significant and should be explored more in depth.

[7] A vademecum entitled "sexual violence within the family: understanding, preventing, identifying and acting" has been developed as part of the government's action plan to address and fight sexual violence within the family area. Intended for all staff, three main objectives are expected: improve the knowledge and understanding of domestic sexual violence among professionals; equip staff to promote the freedom of speech and the identification of student victims; strengthen prevention actions, particularly in sexual health education.

[8] For more details, see the report on https://www.who.int/europe/publications/i/item/EUR-RC72-5

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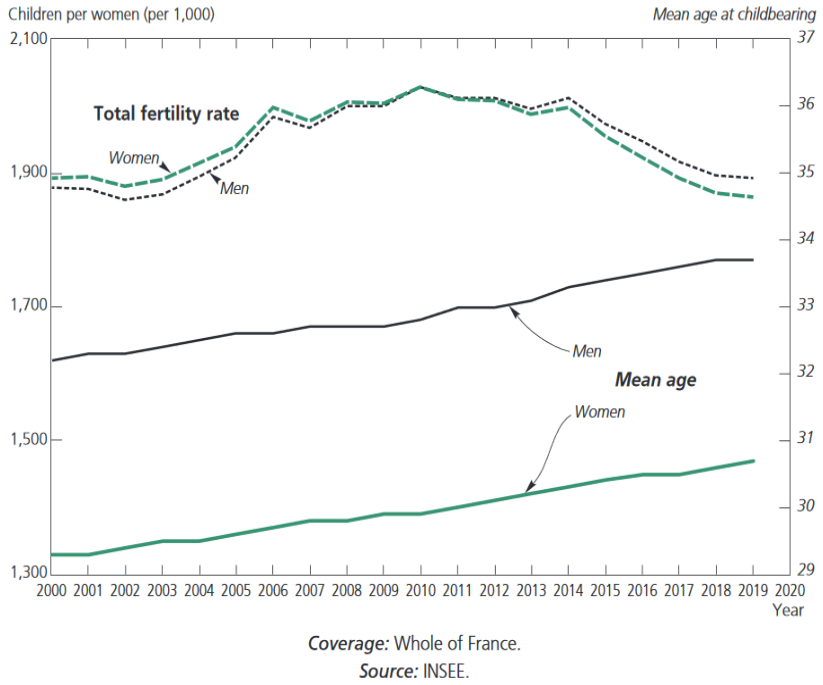
Annex

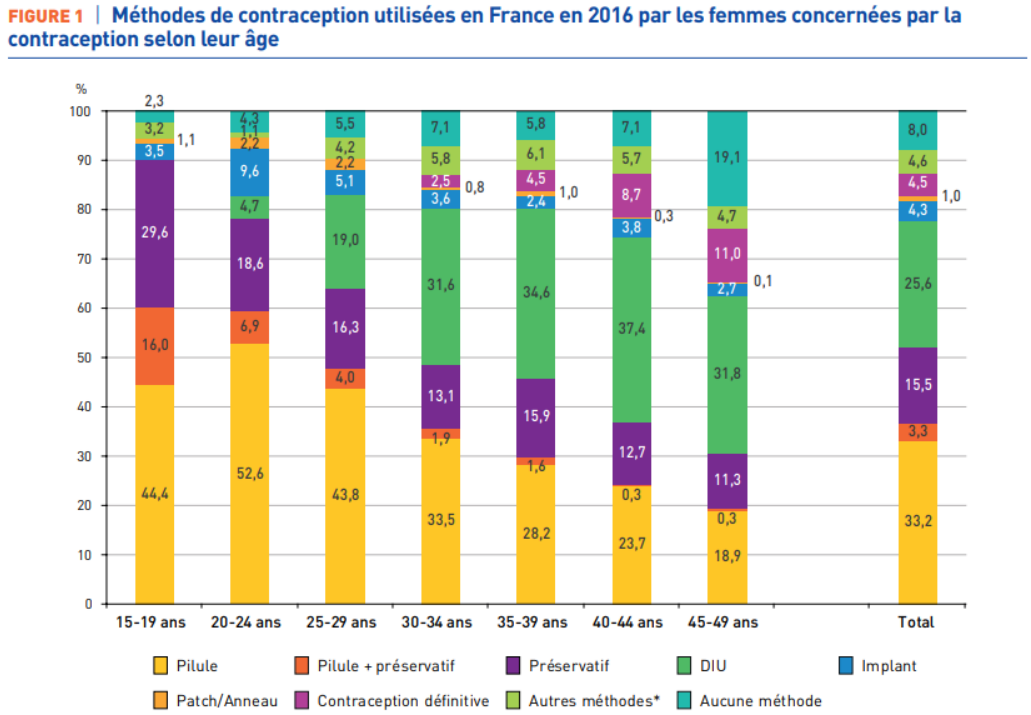
Figure A.1:



Coverage: Whole of France.
Source: INSEE.

Source : Breton et al. 2021

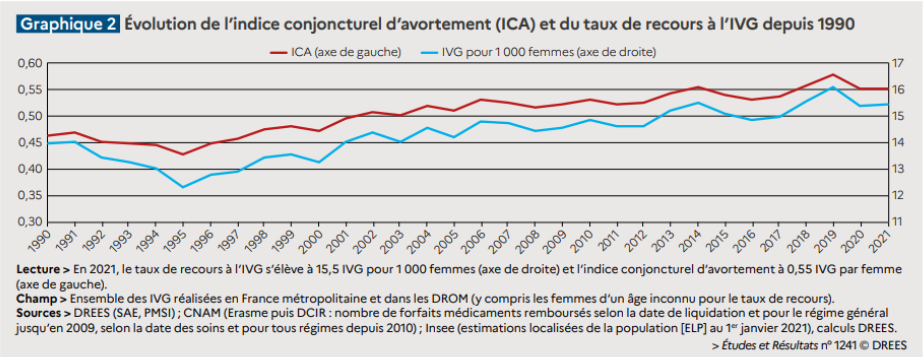
Figure A.2: contraception

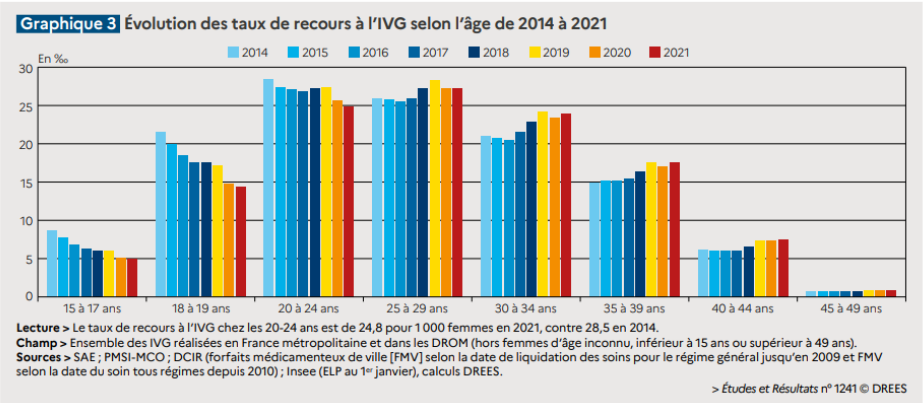


Source : Rahib, Le Guen, Lydie, 2017 *https://www.santepubliquefrance.fr/determinants-de-sante/sante-sexuelle/documents/enquetes-etudes/barometre-sante-2016-contraception-quatre-ans-apres-la-crise-de-la-pilule-les-evolutions-se-poursuivent*

For more details on French demographic trends: see Demographic annual reports (National Statistics Office and National Institute for Demographic Research, Drees), online:
https://www.insee.fr/fr/statistiques/6024136?sommaire=6036447
http://www.journal-population.com/the-demographic-situation-in-france/

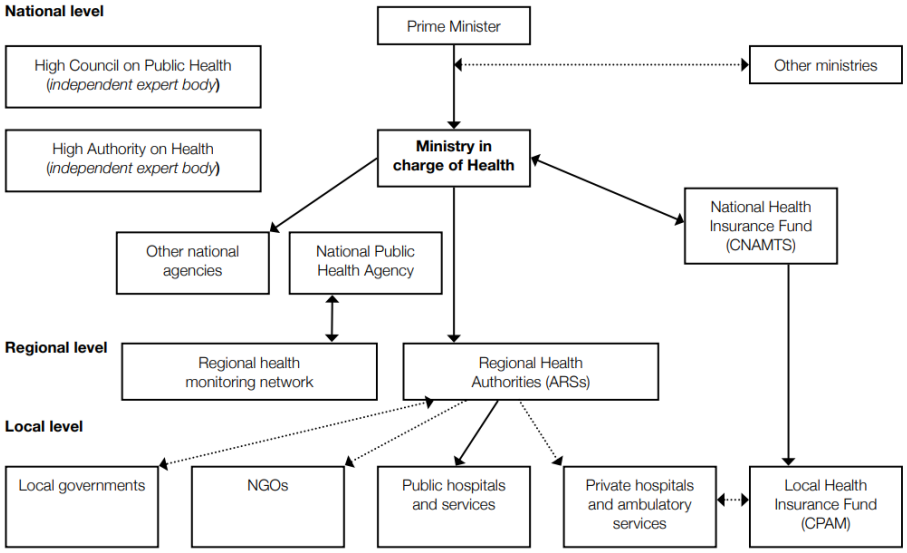
Figure A.3: abortion





https://drees.solidarites-sante.gouv.fr/sites/default/files/2022-09/er1241.pdf

Figure A.4: organisation of the French medical system (type of actors)



Source : Chambaud, Hernandez-Quevedo, 2018, "Organization and financing of public health services in Europe" (who.int)