is unlike that in the United States, where IUD use has become very uncommon because of legal liability concerns.) Medical standards in France forbid physicians from prescribing IUDs to childless women, because of the risks of infection and subsequent sterility. (This risk is not higher for childless women, but the consequences are considered more serious for this group.) Because French women have been delaying childbearing, the mean age at which they become “eligible” for IUDs has therefore been increasing.

The number of sterilizations has been declining in France since 1978. Between 1978 and 1988, this decrease was due mainly to a decline in the number of sterilizations for medical purposes only. Between 1988 and 1994, sterilizations for contraceptive purposes also fell, especially among women younger than 40. Vasectomies remain extremely rare in France, and women are sterilized only after the age of 35 or 40—and only if they already have two or more children—because French doctors are reluctant to perform “early” sterilizations.

The motives for prescribing oral contraceptives in France have become more diverse. Doctors usually first prescribe them to young women in order to regulate their hormonal cycles (regardless of sexual activity). Pills are also prescribed to older women in order to prevent troubling menopausal and premenopausal symptoms. Moreover, because minipills or third-generation pills supposedly have fewer side effects, there is less resistance to prescribing oral contraceptives for more than 10 years of use. Consequently, oral contraceptive use has grown steadily through all age groups of French women (Figure 1); IUD use, on the other hand, has remained negligible among younger women, and was prescribed less frequently in 1994 than in 1988 among women younger than 35 (Figure 1).

During the 1970s, use of medical methods (oral contraceptives and IUDs) was higher among socioeconomic groups more familiar with medical prevention, such as more educated women, women living in urban areas and white-collar employees. By 1988, however, contraceptive behavior had become more homogeneous. In particular, the percentage of pill users did not vary by education, profession or place of residence. (IUD use was still more frequent among more educated women.)

In 1994, the percentages of women using IUDs and pills were almost identical within various socioeconomic groups, despite an increase in oral contraceptive prices. Because we do not have any information about the type of pills used by survey respondents, we can only presume that the use of nonreimbursed oral contraceptives did not introduce new differentials in contraceptive behavior patterns.