

Contraception

There are several types of contraception available which allow a woman to control when and if she conceives a child. It is important to note that no form of contraception used during sexual intercourse is 100% protective and some have possible side effects. Not all contraceptives suit everyone (medications and allergies can be factors in this) so it is advisable to discuss this issue with a nurse or doctor before making a decision. All forms of contraception are available free on the NHS from family planning clinics and some GPs.

Abstinence

Abstinence involves both partners refraining from sexual intercourse. This method is 100% reliable (if strictly adhered to) and allows partners to explore different ways of showing their love and commitment to each other. This choice must be practised by both partners in a relationship and requires strong communication skills for the happiness of both involved.

Barrier methods

Condoms, diaphragms and caps are all barrier methods. These methods form a physical barrier that prevents sperm from reaching and fertilising the egg.

The Male Condom

The male condom (also referred to as just the condom) is a thin sheath made of rubber (latex) or plastic (polyurethane or tactylon) that is rolled over the erect penis before sexual intercourse. When used properly, condoms are 98% effective yet because they are often put on incorrectly, torn by nails or rings, or made less effective by oil based products, in practice they are generally only around 85-90% effective. If the penis touches the vagina before the condom is put on, the condom slips off or appears torn at any point during sexual intercourse, emergency contraception methods (see below) must be sought to prevent pregnancy. Condoms also protect against STIs and HIV. Some condoms contain

spermicide, a chemical that kills sperm. These are being phased out as research has shown that Nonoxinol 9 (a spermicide) does not protect against STIs and HIV and may even increase the risk of infection. Condoms can be bought at chemists.

The Female Condom

The female condom (sometimes referred to as the Femidom) is made of polyurethane and is inserted into the vagina at any time before sexual intercourse. There is an inner ring, which should be pushed back to rest just above the pubic bone, and an outer ring, which lines the labia, that secures it loosely in place. Like the male condom, it protects against STIs and HIV as well as pregnancy. As it is made from thin polyurethane some believe it offers greater physical stimulation than male condoms. The penis can push the condom out of place or it can slip so it is advised to guide the penis inside the condom to prevent pregnancy. Female condoms are considered 95% effective if used properly, (but again, in practice tend to be only 85% effective) and can be bought at chemists.

The Diaphragm and Cap

The diaphragm is a flexible cup shaped device that covers the cervix inside the vagina. The cap is smaller, fitting well round the base of the cervix. They are made of varying sized silicone or rubber and are used with spermicide coming as a gel or cream. They are reusable (though should be replaced about once a year) and are initially fitted by a doctor or nurse. They can be placed in the vagina any time before sexual intercourse but must be removed before the recommended maximum time (varying between 30 and 48 hours) and remain in place for at least 6 hours after sexual intercourse. Diaphragms (but not caps) can cause cystitis, though ensuring a good fit often helps. Diaphragms and caps do not protect against STIs and HIV and are theoretically 92-96% reliable, but only around 85% in practice. Once a woman knows the size and type she uses they can be bought from chemists.



Hormonal methods

The Combined Pill

The Combined Pill (also referred to as just the pill) is a small tablet containing two hormones, oestrogen and progesterone. It is advisable to take the pill at the same time every day but a 'missed pill' is a pill taken more than 24 hours late. It is necessary to take 21 active pills followed by a 7 day break (where a woman may menstruate) or 7 inactive pills (some brands provide these) to be protected for the 28 day cycle. Taking the pill temporarily stops ovulation meaning that while following the program a woman will not release an egg for fertilisation. It also thickens the mucus around the cervix making it difficult for sperm to penetrate and fertilise an egg. Additionally, it thins the lining of the womb decreasing its ability to accept a fertilized egg. While on the pill, PMS and menstruation may reduce. Research has also shown that the pill decreases the risk of certain cancers (ovarian, womb and colon). Temporary side effects (headaches, mood swings, nausea and breast tenderness) may also develop but are often stopped by changing to a different type of pill. There is a low risk of certain serious side effects but a woman's lifestyle (smoking, obesity, level of fitness) and family medical history are more prominent factors in developing a condition. At consultation about any new health problems, a woman should always mention that she is taking the pill. It is 99% effective against pregnancy but taking pills late, missing pills, vomiting or diarrhoea reduces this and another method of contraception should be used until the programme is regularised.

The Progesterone-Only Pill (POP or the mini-pill)

The POP is taken by women who for medical reasons, preference or lifestyle conditions (breastfeeding etc) cannot take the combined pill. It is necessary to take it at the same time every day; more than 3 hours delay with most types reduces its efficiency. There is one type (Cerazette) which allows a 12 hour delay. Periods tend to become irregular or in some cases stop completely. There is a low risk of ovarian cysts but these are usually not dangerous and disappear without treatment. If a woman becomes pregnant while on the POP, there is a very slightly increased risk of an ectopic pregnancy. However, this increased risk is less than that for women who do not use contraception. The efficacy of the POP depends on age; it is more effective (98%) in women over 30, but (apart from Cerazette) is less effective in younger women.

The Contraceptive Injection

There are two types of contraceptive injection: Depo-Provera that protects for 12 weeks and Noristerat that protects for 8 weeks. Both injections contain progesterone and they work

by preventing ovulation, like the combined pill. The injection is more than 99% reliable as women do not have to remember to take a pill as with other hormonal methods. It is injected into a muscle, normally in the bottom. Like the combined pill, the injection may reduce heavy periods and PMS. It also protects to some extent against pelvic inflammatory disease, endometrial cancer and possibly ovarian cancer. The injection commonly affects a woman's periods by making them irregular and possibly heavy at the beginning, but after a few months they usually become lighter and less frequent, or even stop completely. These changes are not harmful. Fertility also may not return immediately after a woman stops using the injection. The injection increases the appetite and may cause weight gain. As it is a lasting form of contraception, a woman will have to tolerate any possible side effects, until the injection runs out.

Intra-uterine system (IUS)

The IUS is a small T-shaped device that is fitted in the womb releasing progesterone. The IUS works in a similar way to the POP. It lasts for five years and is more than 99% effective as the hormone is released automatically. Periods usually get lighter and less painful, or stop completely and unlike the injection, fertility immediately returns when the device is removed. However, a small number of women experience temporary side effects (headaches, acne, breast tenderness,) and may develop non-dangerous ovarian cysts. The device can be removed if unpleasant side effects persist. The IUS must be fitted by a doctor or nurse and needs a check-up a few weeks after it is fitted to check that all is well. A woman will be taught to feel the threads connected to the device since if it slips out of place (displacement) or is completely pushed out of the womb (expulsion), effectiveness will reduce.

Contraceptive Implants

Also referred to as just the implant, this contraceptive is a small flexible rod (about the size of a hairgrip) that is fitted under the skin (usually on the upper arm), releasing progesterone. It lasts for up to three years, is more than 99% effective and works by stopping ovulation. It is fitted by a trained nurse or doctor under local anaesthetic therefore pain is minimal. Once fitted an initial check up is required in the first three months and from then on once every year until it runs out. Like the IUS temporary side effects may occur as well as non-dangerous ovarian cysts. Periods may become irregular though they will usually settle within the first year.

The Contraceptive Patch (Evra)

The contraceptive patch is a small skin-coloured patch (like a plaster) which releases oestrogen and progesterone. It works

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like the combined pill, is 99% effective against pregnancy and can be applied to most areas of the body apart from the breasts or where there is broken or sensitive skin. The patch is changed every seven days and needs to be worn for three out of four weeks for 28 day protection. Periods are usually lighter or may stop and PMS may reduce. Temporary side effects (headaches, acne) may occur.

Other contraceptive methods

Intra-uterine devices (IUD)

The IUD (also referred to as the coil) is a small device (no longer than a matchstick) made of copper and plastic that is inserted into the womb. It works by preventing the sperm from entering in the cervix, womb or fallopian tubes, by thickening the mucus around the cervix and by thinning the womb's lining making it difficult to accept a fertilised egg. IUDs are 99% effective against pregnancy and last from five to ten years depending on the type used. Fertility returns as soon as the device is removed. Periods may become heavier and more painful though this may ease after the initial few months. There is also a small risk of infection. IUDs must be fitted by a doctor or nurse and require a check up three to six weeks after insertion and from then on once a year. Like the IUS, IUDs can slip out of place or be pushed out of the womb increasing risk of conception. However, a woman will be taught to feel the threads attached to check it is still in place.

Male sterilisation (vasectomy)

Male sterilisation involves an operation performed on the scrotum (usually under local or general anaesthetic) which cuts or blocks the tubes that carry sperm from the testicles to the penis. This means that when a male ejaculates there will be no sperm present in the semen. Approximately 1 in 2000 vasectomies fails and the tubes may rejoin but this is uncommon. Some vasectomies can be reversed (this is expensive and rarely available on the NHS) but it should be considered a permanent form of contraception. After the operation, the scrotum may become bruised, swollen and painful. A small number of men experience bleeding, large swelling or an infection which all require professional advice and treatment as soon as possible. Pain normally disappears within the following weeks but some experience prolonged pain. This usually goes away with anti-inflammatory medicine and rest. Waiting lists for vasectomies on the NHS can be long so patients can also pay for private treatment.

Female sterilisation (tubal occlusion)

Female sterilisation involves one of two types of operation (laparoscopy or mini-laparoscopy, performed under a local

or general anaesthetic) which cut or block the fallopian tubes. A woman who has been sterilised will still release an egg every month but it will be absorbed naturally by her body with no risk of conception. Female sterilisation is 99% effective though as with vasectomies, the tubes can rejoin. Some methods of sterilisation can be reversed (this is expensive and rarely available on the NHS) but it should be considered a permanent form of contraception. The operation is more intrusive (it is performed between the navel and bikini line) than a vasectomy, creating a small risk of complications such as internal bleeding or infection. As with vasectomies the NHS waiting lists can be lengthy so private treatment can also be paid for.

Natural family planning (fertility awareness)

Natural family planning involves observing and recording a woman's natural signs (or fertility indicators) on each day of her menstrual cycle. The main signs recorded are body temperature, cervical secretions (mucus) and the cycle length. Changes in these factors can enable a woman to identify her fertile time (approximately 8 days) and therefore not have sex (or use another method of contraception) during that period to prevent pregnancy. However, because sperm can survive five (or even six) days, in practice, for many couples, the 'unsafe period' will last around two weeks. If correctly taught by a fertility awareness specialist and adhered to strictly, this method is 98% effective. To correctly calculate a woman's fertile time may require observations recorded every day for up to 6 months. If a woman becomes tired, stressed, ill or uses hormonal methods of contraception this will affect her cycle making the signs difficult to interpret and reduce its reliability. GPs and family planning clinics do not often provide fertility awareness teachers so a woman would normally need to find her own (see the Natural Family Planning Methods website for lists) and some charge a fee. The FPA website supplies guidelines on how to record fertility. Fertility monitoring devices (available from chemists) measure hormonal changes to predict a woman's fertile time. Brands differ in reliability. Breastfeeding can also be used as a natural family planning method providing that a woman is either fully or nearly fully breastfeeding and that the baby is less than six months old. If guidelines are carefully followed, breastfeeding can be up to 98% effective against pregnancy.

Emergency Contraception

Emergency contraception can be used if a woman has had unprotected sex or if a form of contraception has failed (a condom split or a pill missed). There are two forms: the emergency contraceptive pill or the emergency intrauterine device (IUD).

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Emergency contraceptive pill

The emergency pill can be taken up to 72 hours after sex but it is more effective in the first 24 hours (95% effective in the first 24 hours, 58% if left for up to 72 hours). It contains progestogen and works by stopping ovulation, preventing fertilisation and stopping an egg implanting itself in the womb. After taking the pill a woman may feel sick. A very small number vomit (if this is within two hours of taking the emergency pill another pill will need to be taken or an IUD could be fitted) and it commonly disrupts a woman's period. It is recommended to do a pregnancy test after taking the emergency contraceptive pill especially if her next period is more than a week late. In addition to family planning centres and GPs, the pills are available free from most NHS walk-in centres and minor injuries units, some hospital A&E departments and some chemists. They can also be bought for approximately £26 at other chemists (if aged over 16) and some privately run clinics.

Emergency intrauterine device (IUD)

An IUD (as described above) can be fitted as an emergency contraceptive method up to five days after unprotected sex or up to five days after the earliest predicted date of ovulation (i.e. day 19 of a regular 28 day cycle). It is over 99% effective at whatever stage it is fitted in the process and can be removed by a trained doctor or nurse at a woman's next period if this is what she wants. Even if a woman does not want the IUD to be removed it is advised to see a doctor or nurse 3 to 4 weeks after it is fitted to check that she is not pregnant and discuss any problems.

Useful contacts**British Pregnancy Advisory Service**

For appointments, call 08457 30 40 30
(Mon-Fri 8am-9pm, Sat 8.30am-6pm, Sun 9.30am-2.30pm)

Website: www.bpas.org

Brook Advisory Centres

Helpline: 0800 0185 023 (Mon-Fri 9am-5pm)

Website: www.brook.org.uk

Family Planning Association (FPA)

Helplines: 0845 122 8690 (Mon-Fri 9am-6pm),
028 90 325 488 (Mon-Thur 9am-5pm Fri 9am-4.30pm,
Northern Ireland unplanned Pregnancy)

Website: www.fpa.org.uk

Marie Stopes International

Helpline: 0845 300 8090 (24 hours)

Website: www.mariestopes.org.uk

National Health Service Direct

Tel: 0845 4647 (24 hours)

Website: www.nhsdirect.nhs.uk

Natural Family Planning Methods

Email: admin@fertilityuk.org

Website: www.fertilityuk.org

Sources**Brook**

www.brook.org.uk [accessed July 2007]

FPA information leaflets

www.fpa.org.uk/information/leaflets [accessed July 2007]

NetDoctor.co.uk

www.netdoctor.co.uk [accessed July 2007]

NHS Direct

www.nhsdirect.nhs.uk [accessed July 2007]

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