Contraception

Welcome to the contraception guide

"Where can I get contraception?" "Which method of contraception suits me?" "I'm under 16 – can I get contraception?"

Whatever questions you have about getting and using contraception, this guide can help. It aims to give practical information to everyone who wants to know more about contraception, including teenagers; women in their 20s, 30s and 40s; and anyone with a question about the method they use or are thinking about using.

You can find out about the methods that are available.

You can start by finding out about the methods of contraception you can choose from, including how they work, who can use them and possible side effects. These methods are:

caps

combined pill

condoms (female)

condoms (male)

contraceptive implant

contraceptive injection

contraceptive patch

diaphragms

intrauterine device (IUD)

intrauterine system (IUS)

natural family planning

progestogen-only pill

vaginal ring

There are two permanent methods of contraception:

female sterilisation

male sterilisation (vasectomy)

You can also find out about:

how effective contraception is, and

how effective emergency contraception is

Deciding which method suits you

Which method works best for you depends on a number of factors, including your age, whether you smoke, your medical and family history, and any medication you're taking.

Starting the combined pill

Most women can start the pill at any time in their menstrual cycle. There is special guidance if you have just had a baby, abortion or miscarriage. You may need to use additional contraception during your first days on the pill – this depends on when in your menstrual cycle you start taking it.

If you start the combined pill on the first day of your period (day one of your menstrual cycle) you will be protected from pregnancy straight away. You will not need additional contraception.

If you start the pill on the fifth day of your period or before you will still be protected from pregnancy straight away, unless you have a short menstrual cycle (your period is every 23 days or less). If you have a short menstrual cycle you will need additional contraception, such as condoms, until you have taken the pill for seven days.

If you start the pill on any other day of your cycle you will not be protected from pregnancy straight away and will need additional contraception until you have taken the pill for seven days.

Taking pill packs back to back

For monophasic combined pills (pills all the same colour and with the same level of hormones), it is normally fine to start a new pack of pills straight after your last one, for example if you want to delay your period for a holiday.

However, avoid taking more than two packs together unless advised to by a doctor or nurse. This is because you may have breakthrough bleeding as the womb lining sheds slightly. Also, some women find they feel bloated if they run several packs of the pill together.

What to do if you miss a pill

If you miss a pill or pills, or you start a pack late, this can make the pill less effective at preventing pregnancy. The chance of getting pregnant after missing a pill or pills depends on:

when the pills are missed

how many pills are missed

A pill is late when you have forgotten to take it at your usual time. You have missed a pill when it is more than 24 hours since the time you should have taken it. Missing one pill anywhere in your pack or starting the new pack one day late isn't a problem as you will still be protected against pregnancy (known as having contraceptive cover).

However, missing two or more pills or starting the pack two or more days late (more than 48 hours late) may affect your contraceptive cover. In particular, if you make the seven-day pill-free break longer by forgetting two or more pills, your ovaries might release an egg and there is a risk of getting pregnant. This is because your ovaries are not getting any effect from the pill during the seven-day break.

If you miss a pill, follow the advice below. If you are not sure what to do, continue to take your pill and use another method of contraception, such as condoms, and seek advice as soon as possible.

If you have missed one pill, anywhere in the pack:

take the last pill you missed now, even if it means taking two pills in one day

continue taking the rest of the pack as usual

you don't need to use additional contraception, such as condoms

take your seven-day pill-free break as normal

If you have missed two or more pills (you are taking your pill more than 48 hours late) anywhere in the pack:

take the last pill you missed now, even if it means taking two pills in one day

leave any earlier missed pills

continue taking the rest of the pack as usual and use an extra method of contraception for the next seven days

you may need emergency contraception

you may need to start the next pack of pills without a break (see Starting the next pack after missing two or more pills)

You may need emergency contraception if you have had unprotected sex in the previous seven days and have missed two or more pills (you are taking your pill more than 48 hours late) in the first week of a pack.

Starting the next pack after missing two or more pills

If there are seven or more pills left in the pack after the last missed pill:

finish the pack

have the usual seven-day break

If there are fewer than seven pills left in the pack after the last missed pill:

finish the pack and start the new one the next day, without having a break

Vomiting and diarrhoea

If you vomit within two hours of taking the combined pill, it may not have been fully absorbed into your bloodstream. Take another pill straight away and the next pill at your usual time.

If you continue to be sick, keep using another form of contraception while you're ill and for two days after recovering.

Very severe diarrhoea (six to eight watery stools in 24 hours) may also mean the pill doesn't work properly. Keep taking your pill as normal, but use additional

contraception, such as condoms, while you have diarrhoea and for two days after recovering.

Who can use the combined pill

If there are no medical reasons why you cannot take the pill and you do not smoke, you can take the pill until your menopause. However, the pill is not suitable for all women. To find out whether the pill is right for you, talk to your DOCTOR, practice nurse or pharmacist.

You should not take the pill if you:

are pregnant

smoke and are 35 or older

stopped smoking less than a year ago and are 35 or older

are very overweight

take certain medicines (ask your DOCTOR about this)

You should also not take the pill if you have (or have had):

thrombosis (a blood clot)

a heart abnormality or heart disease, including high blood pressure

severe migraines, especially with aura (warning symptoms)

breast cancer

disease of the gallbladder or liver

diabetes with complications or diabetes for the past 20 years

After having a baby

If you have just had a baby and are not breastfeeding, you can start the pill on day 21 after the birth. You will be protected against pregnancy straight away. If you start the pill later than 21 days after giving birth you will need additional contraception (such as condoms) for the next seven days.

If you are breastfeeding a baby less than six months old, taking the pill can reduce your flow of milk. It is recommended you use a different method of contraception until you stop breastfeeding.

After a miscarriage or abortion

If you have had a miscarriage or abortion, you can start the pill up to five days after this and you will be protected from pregnancy straight away. If you start the pill more than five days after the miscarriage or abortion, you'll need to use additional contraception until you have taken the pill for seven days.

Advantages and disadvantages

Some advantages of the pill include:

it does not interrupt sex

it usually makes your bleeds regular, lighter and less painful

it reduces your risk of cancer of the ovaries, womb and colon

it can reduce symptoms of premenstrual syndrome

it can sometimes reduce acne

it may protect against pelvic inflammatory disease

it may reduce the risk of fibroids, ovarian cysts and non-cancerous breast disease

Some disadvantages of the pill include:

it can cause temporary side effects at first, such as headaches, nausea, breast tenderness and mood swings – if these do not go after a few months, it may help to change to a different pill

it can increase your blood pressure

it does not protect you against sexually transmitted infections

breakthrough bleeding and spotting is common in the first few months of using the pill

it has been linked to an increased risk of some serious health conditions such as thrombosis (blood clots) and breast cancer

The combined pill with other medicines

Some medicines interact with the combined pill and it doesn't work properly. Some interactions are listed on this page but it is not a complete list. If you want to check your medicines are safe to take with the combined pill, you can:

ask your DOCTOR, practice nurse or pharmacist

read the patient information leaflet that comes with your medicine

Antibiotics

The antibiotics rifampicin and rifabutin (which can be used to treat illnesses including tuberculosis and meningitis) can reduce the effectiveness of the combined pill. Other antibiotics do not have this effect.

If you are prescribed rifampicin or rifabutin, you may need additional contraception (such as condoms) while taking the antibiotic. Speak to your doctor or nurse for advice.

Epilepsy and HIV medicines, and St John's wort

The combined pill can interact with medicines called enzyme inducers. These speed up the breakdown of progestogen by your liver, reducing the effectiveness of the pill.

Examples of enzyme inducers are:

the epilepsy drugs carbamazepine, oxcarbazepine, phenytoin, phenobarbital, primidone and topiramate

St John's wort (a herbal remedy)

antiretroviral medicines used to treat HIV (research suggests interactions between these medicines and the progestogen-only pill can affect the safety and effectiveness of both)

Your DOCTOR or nurse may advise you to use an alternative or additional form of contraception while taking any of these medicines.

Risks of taking the combined pill

There are some risks associated with using the combined contraceptive pill. However, these risks are small, and for most women the benefits of the pill outweigh the risks.

Blood clots

The oestrogen in the pill may cause your blood to clot more readily. If a blood clot develops, it could cause a deep vein thrombosis (clot in your leg), pulmonary embolus (clot in your lung), stroke or heart attack. The risk of getting a blood clot is very small, but your doctor will check if you have certain risk factors that make you more vulnerable before prescribing the pill.

The pill can be taken with caution if you have one of the risk factors below, but you should not take it if you have two or more risk factors. Risk factors include:

being 35 years old or over

being a smoker or having quit smoking in the past year

being very overweight (in women with a BMI of 35 or over, the risks of using the pill usually outweigh the benefits)

having migraines (you should not take the pill if you have severe or regular migraine attacks, especially if you get aura or a warning sign before an attack)

having high blood pressure

having had a blood clot or stroke in the past

having a close relative who had a blood clot when they were younger than 45

being immobile for a long time, for example in a wheelchair or with a leg in plaster

Cancer

Research is ongoing into the link between breast cancer and the pill. Research suggests that users of all types of hormonal contraception have a slightly higher chance of being diagnosed with breast cancer compared with women who do not use them. However, 10 years after you stop taking the pill, your risk of breast cancer goes back to normal.

Research has also suggested a link between the pill and the risk of developing cervical cancer and a rare form of liver cancer. However, the pill does offer some protection against developing endometrium (lining of the womb) cancer, ovarian cancer and colon cancer.

Condoms

A woman can get pregnant if a man’s sperm reaches one of her eggs (ova). Contraception tries to stop this happening by keeping the egg and sperm apart or by stopping egg production. One method of contraception is the condom.

There are two types of condoms – male condoms, which are worn on the penis, and female condoms, which are worn inside the vagina. This page is about male condoms, where you can get them and how they work.

Male condoms are made from very thin latex (rubber), polyisoprene or polyurethane, and are designed to stop a man's semen from coming into contact with his sexual partner.

When condoms are used correctly during vaginal sex they help to protect against pregnancy and sexually transmitted infections (STIs).

When used correctly during anal and oral sex, they help to protect against STIs. Condoms are the only contraception that protect against pregnancy and STIs.

At a glance: condoms

If used correctly every time you have sex, male condoms are 98% effective. This means that two out of 100 women using male condoms as contraception will become pregnant in one year.

You can get free condoms from contraception clinics, sexual health clinics and some DOCTOR surgeries.

Oil-based products, such as moisturiser, lotion and Vaseline, can make latex condoms less effective, but they are safe to use with condoms made from polyurethane or polyisoprene.

Water-based lubricant, available in pharmacies and sexual health clinics, is safe to use with all condoms, including latex ones.

It's possible for a condom to slip off during sex. If this happens, you may need emergency contraception, and to get checked for STIs.

Condoms need to be stored in places that aren't too hot or cold, and away from sharp or rough surfaces that could tear them or wear them away.

Putting on a condom can be an enjoyable part of sex, and doesn't have to feel like an interruption.

If you're sensitive to latex, you can use polyurethane or polyisoprene condoms instead.

A condom must not be used more than once. Use a new one each time you have sex.

Condoms have a use-by date on the packaging. Don't use out-of-date condoms.

Always buy condoms that have the CE mark on the packet. This means that they've been tested to European safety standards. Condoms that don't have the CE mark won't meet these standards, so don't use them.

How a condom works

Condoms are a barrier method of contraception. They stop sperm from reaching an egg by creating a physical barrier between them. Condoms can also protect against STIs if used correctly during vaginal, anal and oral sex.

It's important that the man's penis does not make contact with the woman's vagina before a condom has been put on. This is because semen can come out of the penis before a man has fully ejaculated (come). If this happens, or if semen leaks into the vagina while using a condom, seek advice about emergency contraception from your DOCTOR or contraception clinic. Also, consider having an STI test.

How to use a condom

take the condom out of the packet, taking care not to tear it with jewellery or fingernails – do not open the packet with your teeth

place the condom over the tip of the erect penis

if there's a teat on the end of the condom, use your thumb and forefinger to squeeze the air out of it

gently roll the condom down to the base of the penis

if the condom won't roll down, you're probably holding it the wrong way round – if this happens, throw the condom away because it may have sperm on it, and try again with a new one

after sex, withdraw the penis while it's still erect – hold the condom onto the base of the penis while you do this

remove the condom from the penis, being careful not to spill any semen

throw the condom away in a bin, not down the toilet

make sure the man's penis does not touch his partner's genital area again

if you have sex again, use a new condom

Condoms with spermicide

Some male condoms come with spermicide on them. Spermicide's a chemical that kills sperm. These condoms are slowly being phased out as research has found that a spermicide called nonoxynol 9 does not protect against STIs such as chlamydia and HIV, and may even increase the risk of infection. It is best to avoid using spermicide-lubricated condoms, or spermicide as an additional lubricant.

Who can use condoms

Most people can safely use condoms. There are many different varieties and brands of male condom, and it's up to you and your partner which type of condom you use. However, condoms may not be the most suitable method of contraception for everyone.

Some men and women are sensitive to the chemicals in latex condoms. If this is a problem, polyurethane or polyisoprene condoms have a lower risk of causing an allergic reaction.

Men who have difficulty keeping an erection may not be able to use male condoms, as the penis must be erect to prevent semen leaking from the condom or the condom slipping off.

Advantages and disadvantages of condoms

It is important to consider which form of contraception is right for you and your partner. Take care to use condoms correctly, and consider using other forms of contraception for extra protection.

Advantages

when used correctly and consistently, condoms are a reliable method of preventing pregnancy

they help protect both partners from sexually transmitted infections (STIs), including chlamydia, gonorrhoea and HIV

you only need to use them when you have sex – they do not need advance preparation and are suitable for unplanned sex

in most cases, there are no medical side effects from using condoms

male condoms are easy to get hold of and come in a wide variety of shapes, sizes and flavours

Disadvantages

some couples find that using condoms interrupts sex – to get around this, try to make using a condom part of foreplay

condoms are very strong but may split or tear if not used properly

some people may be allergic to latex, plastic or spermicides – you can get condoms that are less likely to cause an allergic reaction

when using a male condom, the man has to pull out after he has ejaculated and before the penis goes soft, holding the condom firmly in place

If male condoms aren't used properly, they can slip off or split. If this happens, practise putting them on so that you get used to using them properly.

Can anything make condoms less effective?

Sperm can sometimes get into the vagina during sex even when using a condom. This may happen if:

the penis touches the area around the vagina before a condom is put on

the condom splits or comes off

the condom gets damaged by sharp fingernails or jewellery

you use oil-based lubricants, such as lotion, baby oil or petroleum jelly, with latex condoms – this damages the condom

you are using medication for conditions like thrush, such as creams, pessaries or suppositories – this can damage latex condoms and stop them working properly

If you think that sperm has entered the vagina, talk to your DOCTOR or staff at a contraception clinic about emergency contraception and the risk of STIs.

As well as condoms, you can use other forms of contraception, such as the contraceptive pill, for extra protection against pregnancy. However, other forms of contraception will not protect you against STIs. You will still be at risk of STIs if the condom breaks.

Using lubricant

Condoms come ready lubricated to make them easier to use, but you may also like to use additional lubricant, or lube. This is particularly advised for anal sex to reduce the chance of the condom splitting.

Any kind of lubricant can be used with condoms that are not made of latex. However, if you are using latex condoms, do not use oil-based lubricants, such as:

body oil or lotion

petroleum jelly or creams (such as Vaseline)

This is because they can damage the latex and make the condom more likely to split.

If a condom splits or comes off

If the condom splits or comes off, you can use emergency contraception to help prevent pregnancy. This is for emergencies only and shouldn't be used as a regular form of contraception.

Risks

For most people, there are no serious risks associated with using condoms although some people are allergic to latex condoms. You can get condoms that are less likely to cause an allergic reaction.

The contraceptive injection

A woman can get pregnant if a man’s sperm reaches one of her eggs (ova). Contraception tries to stop this happening by keeping the egg and sperm apart or by stopping egg production. One method of contraception is the injection.

There are two contraceptive injections – Depo-Provera, which lasts for 12 weeks, and Noristerat, which lasts for eight weeks. The most popular is Depo-Provera.

The injection contains progestogen. This thickens the mucus in the cervix, stopping sperm reaching an egg. It also thins the womb lining and, in some, prevents the release of an egg.

At a glance: the contraceptive injection

If used correctly the contraceptive injection is more than 99% effective. This means that less than one woman in 100 who use the injection will become pregnant in a year.

The injection lasts for eight weeks or 12 weeks (depending on the type), so you don't have to think about contraception every day or every time you have sex.

It can be useful for women who might forget to take the contraceptive pill every day.

It can be useful for women who can't use contraception that contains oestrogen.

It's not affected by medication.

The contraceptive injection may provide some protection against cancer of the womb and pelvic inflammatory disease.

Side effects can include weight gain, headaches, mood swings, breast tenderness and irregular bleeding. The injection can't be removed from your body, so if you have side effects they'll last as long as the injection and for some time afterwards.

Your periods may become more irregular or longer, or stop altogether (amenorrhoea). Treatment is available if your bleeding is heavy or longer than normal – talk to your doctor or nurse about this.

It can take up to one year for your fertility to return to normal after the injection wears off, so it may not be suitable if you want to have a baby in the near future.

Using Depo-Provera affects your natural oestrogen levels, which can cause thinning of the bones.

The injection does not protect against sexually transmitted infections (STIs). By using condoms as well as the injection, you'll help to protect yourself against STIs.

The contraceptive injection is usually given into a muscle in your bottom, although sometimes it may be given in a muscle in your upper arm. The contraceptive injection works in the same way as the implant. It steadily releases the hormone progestogen into your bloodstream. Progestogen is similar to the natural hormone progesterone, which is released by a woman's ovaries during her period.

The continuous release of progestogen:

stops a woman releasing an egg every month (ovulation)

thickens the mucus from the cervix (neck of the womb), making it difficult for sperm to pass through to the womb and reach an unfertilised egg

makes the lining of the womb thinner so that it is unable to support a fertilised egg

The injection can be given at any time during your menstrual cycle, as long as you and your doctor are reasonably sure you are not pregnant.

When it starts to work

If you have the injection during the first five days of your cycle, you will be immediately protected against becoming pregnant.

If you have the injection on any other day of your cycle, you will not be protected against pregnancy for up to seven days. Use condoms or another method of contraception during this time.

After giving birth

You can have the contraceptive injection at any time after you have given birth, if you are not breastfeeding. If you are breastfeeding, the injection will usually be given after six weeks, although it may be given earlier if necessary.

If you start injections on or before day 21 after giving birth, you will be immediately protected against becoming pregnant.

If you start injections after day 21, you will need to use additional contraception for the following seven days.

Heavy and irregular bleeding is more likely to occur if you have the contraceptive injection during the first few weeks after giving birth.

It is safe to use contraceptive injections while you are breastfeeding.

After a miscarriage or abortion

You can have the injection immediately after a miscarriage or abortion, and you will be protected against pregnancy straight away. If you have the injection more than five days after a miscarriage or abortion, you'll need to use additional contraception for seven days.

Who can use the injection?

Most women can be given the contraceptive injection. It may not be suitable if you:

think you might be pregnant

want to keep having regular periods

have bleeding in between periods or after sex

have arterial disease or a history of heart disease or stroke

have a blood clot in a blood vessel (thrombosis)

have liver disease

have migraines

have breast cancer or have had it in the past

have diabetes with complications

have cirrhosis or liver tumours

are at risk of osteoporosis

Advantages and disadvantages of the injection

The main advantages of the contraceptive injection are:

each injection lasts for either eight or 12 weeks

the injection does not interrupt sex

the injection is an option if you cannot use oestrogen-based contraception, such as the combined pill, contraceptive patch or vaginal ring

you do not have to remember to take a pill every day

the injection is safe to use while you are breastfeeding

the injection is not affected by other medicines

the injection may reduce heavy, painful periods and help with premenstrual symptoms for some women

the injection offers some protection from pelvic inflammatory disease (the mucus from the cervix may stop bacteria entering the womb) and may also give some protection against cancer of the womb

Using the contraceptive injection may have some disadvantages, which you should consider carefully before deciding on the right method of contraception for you. These are as follows.

Disrupted periods

Your periods may change significantly during the first year of using the injection. They will usually become irregular and may be very heavy, or shorter and lighter, or stop altogether. This may settle down after the first year, but may continue as long as the injected progestogen remains in your body.

It can take a while for your periods and natural fertility to return after you stop using the injection. It takes around eight to 12 weeks for injected progestogen to leave the body, but you may have to wait longer for your periods to return to normal if you are trying to get pregnant.

Until you are ovulating regularly each month, it can be difficult to work out when you are at your most fertile. In some cases, it can take three months to a year for your periods to return to normal.

Weight gain

You may put on weight when you use contraceptive injections, although some women lose weight. Use of the injections may be associated with an increase in weight of up to 2–3kg over one year.

Depo-Provera, oestrogen and bone risk

Using Depo-Provera affects your natural oestrogen levels, which can cause thinning of the bones but it does not increase your risk of bone fracture (breaking a bone). This isn't a problem for most women because the bone replaces itself when you stop the injection, and it doesn't appear to cause any long-term problems.

Thinning of the bones may be a problem for women who already have an increased risk of developing osteoporosis (for example because they have low oestrogen, or a family history of osteoporosis). It may also be a concern for women under 19 because the body is still making bone at this age. Women under 19 may use Depo-Provera, but only after careful evaluation by a doctor.

Other side effects that some women report are:

headaches

acne

tender breasts

changes in mood

loss of sex drive

Will other medicines affect the injection?

No – the contraceptive injection is not affected by other medication.

Risks

There is a small risk of infection at the site of the injection. In very rare cases, some people may have an allergic reaction to the injection.

Contraceptive diaphragm

A woman can get pregnant if a man's sperm reaches one of her eggs (ova). Contraception tries to stop this happening by keeping the egg and sperm apart, or by stopping egg production. One method of contraception is the diaphragm.

A contraceptive diaphragm is inserted into the vagina before sex, and it covers the cervix so that sperm can't get into the womb (uterus). You need to use spermicide with it (spermicides kill sperm).

The diaphragm must be left in place for at least six hours after sex. After that time you take out the diaphragm and wash it. They're reusable. Diaphragms come in different sizes – you must be fitted for the correct size by a trained doctor or nurse.

At a glance: contraceptive diaphragm

When used correctly with spermicide, a diaphragm is 92-96% effective at preventing pregnancy – this means that between four and eight women out of every 100 who use a diaphragm as contraception will become pregnant within a year.

There are no serious health risks.

You only have to think about it when you have sex.

You can put a diaphragm in several hours before you have sex.

It can take time to learn how to use it.

Some women develop cystitis (a bladder infection) when they use a diaphragm. Your doctor or nurse can check the size – switching to a smaller size may help.

If you lose or gain more than 3kg (7lbs) in weight, or have a baby, miscarriage or abortion, you may need to be fitted with a new diaphragm.

By using condoms as well as a diaphragm you'll help to protect yourself against sexually transmitted infections (STIs).

A diaphragm (like a cap) is a barrier method of contraception. It fits inside your vagina and prevents sperm from passing through the cervix (the entrance of

your womb). Diaphragms are soft, thin domes made of latex (rubber) or silicone, and come in different shapes and sizes.

To be effective in preventing pregnancy, diaphragms need to be used in combination with spermicide, which is a chemical that kills sperm.

You only have to use a diaphragm when you have sex, but you must leave it in for at least six hours after the last time you had sex. You can leave it in for longer than this, but do not take it out before.

When you first start using a diaphragm, a doctor or nurse will examine you and advise on the correct size or shape to suit you. They will show you how to put in and take out a diaphragm, and also how to use the spermicide, which must be applied every time you use the diaphragm.

A diaphragm provides only limited protection against sexually transmitted infections (STIs). If you're at a high risk of getting an STI – for example, you or your partner has more than one sexual partner – you may be advised to use another form of contraception.

Inserting a diaphragm

Your doctor or nurse will show you how to put in a diaphragm. Diaphragms come with instructions and are all inserted in a similar way.

with clean hands, put a small amount of spermicide on each side of the diaphragm (also putting a little spermicide on the rim may make the diaphragm easier to put in)

put your index finger on top of the diaphragm and squeeze it between your thumb and other fingers

slide the diaphragm into your vagina upwards

this should ensure that the diaphragm covers your cervix

always check that your cervix is covered – it feels like a lump, a bit like the end of your nose

if your cervix is not covered, take the diaphragm out by hooking your finger under the rim or loop (if there is one) and pulling downwards, then try again

some women squat while they put their diaphragm in, others lie down or stand with one foot up on a chair – use the position that's easiest for you

you can insert a diaphragm up to three hours before you have sex – after this time you will need to take it out and put some more spermicide on it

You may be fitted with a temporary diaphragm by your doctor or nurse. This is for you to practise with at home. It gives you the chance to learn how to use it properly, see how it feels and find out if the method is suitable for you. During this time you are not protected against pregnancy and need to use additional contraception, such as condoms, when you have sex.

When you go back for a follow-up appointment with your doctor or nurse, wear the diaphragm so they can check that it is the right size and you have put it in properly. When they are happy that you can use a diaphragm properly, they will give you one to use as contraception.

Removing a diaphragm

A diaphragm can be easily removed by gently hooking your finger under its rim, loop or strap and pulling it downwards and out. You must leave all types of diaphragm in place for at least six hours after the last time you had sex.

You can leave them in for longer than this, but do not leave them in for longer than the recommended time of 30 hours (including the minimum six).

Looking after your diaphragm

After use, you can wash your diaphragm with warm water and mild unperfumed soap. Rinse it thoroughly, then leave it to dry. You will be given a small container for it, which you should keep in a cool, dry place.

Never boil a diaphragm.

Do not use disinfectant, detergent, oil-based products or talcum powder to keep it clean, as these products can damage it.

Your diaphragm may become discoloured over time but this does not make it less effective.

Always check your diaphragm or cap for any signs of damage before using it.

You can visit your DOCTOR or nurse when you want to replace your diaphragm. Most women can use the same diaphragm for a year before they need to replace it. You may need to get a different size diaphragm if you gain or

lose more than 3kg (7lb) in weight, or if you have a baby, miscarriage or abortion.

Who can use a diaphragm?

Most women are able to use a diaphragm. However, they may not be suitable for you:

if you have an unusually shaped or positioned cervix (entrance to the womb), or if you cannot reach your cervix

if you have weakened vaginal muscles (possibly as a result of giving birth) that cannot hold a diaphragm in place

if you have a sensitivity or an allergy to latex or the chemicals in spermicide

if you have ever had toxic shock syndrome (a rare but life-threatening bacterial infection)

if you have repeated urinary tract infections (infection of the urinary system, such as the urethra, bladder or kidneys)

if you currently have a vaginal infection (wait until your infection clears before using a diaphragm or cap)

if you are not comfortable touching your vagina

if you have a high risk of getting a sexually transmitted infection (STI), for example, if you have multiple sexual partners

Research shows that some spermicides, which contain the chemical nonoxynol-9, do not protect against STIs and may even increase your risk of getting an infection.

A diaphragm may be less effective if:

it is damaged – for example, it is torn or has holes

it is not the right size for you

you use it without spermicide

you do not use extra spermicide with your diaphragm every time you have more sex

you remove it too soon (less than six hours after the last time you had sex)

you use oil-based products, such as baby lotion, bath oils, moisturiser or some vaginal medicines (for example, pessaries) with latex diaphragms – these can damage the latex

If any of these things happen, or you have had sex without contraception, you may need to use emergency contraception.

You can use a diaphragm after having a baby but you may need a different size. It is recommended that you wait at least six weeks after giving birth before using a diaphragm. You can use a diaphragm after a miscarriage or abortion, but you may need a different size.

Advantages and disadvantages

A diaphragm has the following advantages:

you only need to use a diaphragm when you want to have sex

you can put it in at a convenient time before having sex (but do not forget to use extra spermicide if you have it in for more than three hours)

there are no serious associated health risks or side effects

you are in control of your contraception

A diaphragm has the following disadvantages:

it is not as effective as other types of contraception

it only provides limited protection against sexually transmitted infections (STIs)

it can take time to learn how to use it

putting it in can interrupt sex

cystitis (bladder infection) can be a problem for some women who use a diaphragm

latex and spermicide can cause irritation in some women and their sexual partners

Risks

There are no health risks associated with using a contraceptive diaphragm.

The IUD as emergency contraception

The intrauterine device (IUD) is a small, T-shaped contraceptive device made from plastic and copper. It's inserted into the uterus by a trained health professional. It may prevent an egg from implanting in your womb or being fertilised.

If you've had unprotected sex, the IUD can be inserted up to five days afterwards to prevent pregnancy. It's more effective at preventing pregnancy than the emergency pill, and it does not interact with any other medication.

You can also choose to have the IUD left in as an ongoing method of contraception.

How effective the IUD is at preventing pregnancy

There are several types of IUD. Newer ones have more copper and are more than 99% effective. Fewer than two women in 100 who use a newer IUD over five years will get pregnant. IUDs with less copper in them are less effective than this, but are still effective. The IUD is more effective than the emergency pill at preventing pregnancy after unprotected sex.

Who can use the IUD

Most women can use an IUD, including women who have never been pregnant and those who are HIV positive. Your DOCTOR or clinician will ask about your medical history to check if an IUD is suitable for you.

You should not use an IUD if you have:

an untreated sexually transmitted infection (STI) or a pelvic infection

certain abnormalities of the womb or cervix

any unexplained bleeding from your vagina – for example, between periods or after sex

Women who have had an ectopic pregnancy or recent abortion, or who have an artificial heart valve, must consult their DOCTOR or clinician before having an IUD fitted.

Pregnancy and breastfeeding

The IUD should not be inserted if there is a risk you may already be pregnant, for example if you have had previous unprotected sex in the same menstrual cycle. The IUD can be used safely if you're breastfeeding.

What are the side effects of the IUD

Complications after having an IUD fitted are rare, but can include pain, infection, damage to the womb or expulsion (the IUD coming out of your womb). If you use the IUD as an ongoing method of regular contraception, it may make your periods longer, heavier or more painful.

The IUD and other medicines

The emergency IUD will not react with any other medication.

Contraception for the future

If you're not using a regular method of contraception, you might consider doing so in order to lower the risk of unintended pregnancy. Long-acting reversible contraception (LARC) offers the most reliable protection against pregnancy, and you don't have to think about it every day or each time you have sex.

LARC methods are the:

injection

implant

IUS

IUD

Female sterilisation

A woman can get pregnant if a man's sperm reaches one of her eggs (ova). Contraception tries to stop this happening by keeping the egg and sperm apart or by stopping egg production. One method of contraception is female sterilisation.

Female sterilisation is usually carried out under general anaesthetic but can be carried out under local anaesthetic, depending on the method used. The surgery involves blocking or sealing the fallopian tubes, which link the ovaries to the womb (uterus).

This prevents the woman’s eggs from reaching sperm and becoming fertilised. Eggs will still be released from the ovaries as normal, but they will be absorbed naturally into the woman's body.

At a glance: facts about female sterilisation

In most cases, female sterilisation is more than 99% effective, and only one woman in 200 will become pregnant in her lifetime after having it done.

You don't have to think about it every day, or every time you have sex, so it doesn't interrupt or affect your sex life.

Sterilisation can be performed at any time during the menstrual cycle. It won't affect hormone levels.

You'll still have periods after being sterilised.

You will need to use contraception until the operation is done and until your next period or for three months afterwards (depending on the type of sterilisation).

As with any surgery, there's a small risk of complications. These include internal bleeding, infection or damage to other organs.

There's a small risk that the operation won't work. Blocked tubes can rejoin immediately or years later.

If the operation fails, this may increase the risk of ectopic pregnancy (when a fertilised egg implants outside the womb, usually in a fallopian tube).

The sterilisation operation is difficult to reverse.

Female sterilisation doesn't protect against sexually transmitted infections (STIs), so always use a condom to protect yourself and your partner against STIs.

How female sterilisation works

Female sterilisation works by preventing eggs from travelling down the fallopian tubes. This means a woman's eggs cannot meet sperm, and fertilisation cannot happen.

How female sterilisation is carried out

Before the operation

Recovering after the operation

How female sterilisation is carried out

There are two main types of female sterilisation:

when your fallopian tubes are blocked, for example with clips or rings (tubal occlusion)

when implants are used to block your fallopian tubes (hysteroscopic sterilisation, or HS)

It can be a fairly minor operation, with many women returning home the same day. Sterilisation is usually carried out using tubal occlusion (blocking the fallopian tubes).

Tubal occlusion

First, your surgeon will need to access and examine your fallopian tubes, using either laparoscopy or mini-laparotomy.

A laparoscopy is the most common method of accessing the fallopian tubes. The surgeon makes a small cut in your abdominal wall near your belly button and inserts a laparoscope. A laparoscope is a small flexible tube that contains a tiny light and camera. The camera relays images of the inside of your body to a television monitor. This allows the surgeon to see your fallopian tubes clearly.

A mini-laparotomy involves a small incision, usually less than 5cm (2 inches), just above the pubic hairline. Your surgeon can then access your fallopian tubes through this incision.

A laparoscopy is usually the preferred option because it is faster. However, a mini-laparotomy may be recommended for women who:

have had recent abdominal or pelvic surgery

are obese (have a body mass index of 30 or over)

have a history of pelvic inflammatory disease (a bacterial infection that can affect the womb and fallopian tubes)

Blocking the tubes

The fallopian tubes can be blocked using one of the following methods:

applying clips – plastic or titanium clamps are closed over the fallopian tubes

applying rings – a small loop of the fallopian tube is pulled through a silicone ring, then clamped shut

tying and cutting the tube – this destroys 3-4cm (1–1.5 inches) of the tube

Hysteroscopic sterilisation (fallopian implants)

Removing the tubes (salpingectomy)

If blocking the fallopian tubes has been unsuccessful, the tubes may be completely removed. Removal of the tubes is called salpingectomy.

Before the operation

Your DOCTOR will strongly recommend counselling before referring you for sterilisation. Counselling will give you a chance to talk about the operation in detail, and talk about any doubts, worries or questions that you might have.

If you decide to be sterilised, your DOCTOR will refer you to a specialist for treatment. This will usually be a gynaecologist at your nearest hospital. A gynaecologist is a specialist in the female reproductive system.

If you choose to have a sterilisation, you will be asked to use contraception until the day of the operation, and to continue using it:

until your next period if you are having your fallopian tubes blocked (tubal occlusion)

for around three months if you are having fallopian implants (hysteroscopic sterilisation)

Sterilisation can be performed at any stage in your menstrual cycle.

Before you have the operation you will be given a pregnancy test to make sure that you are not pregnant. It is vital to know this because once the surgeon blocks your fallopian tubes there is a high risk that any pregnancy will become

ectopic (when the fertilised egg grows outside the womb, usually in the fallopian tubes). An ectopic pregnancy can be life-threatening because it can cause severe internal bleeding.

Recovering after the operation

Once you have recovered from the anaesthetic, passed urine and had something to eat, you will be allowed home. If you leave hospital within hours of the operation, ask a relative or friend to pick you up, or take a taxi.

The healthcare professionals treating you in hospital will tell you what to expect and how to care for yourself after surgery. They may give you a contact number to call if you have any problems or any questions.

If you have had a general anaesthetic, do not drive a car for 48 hours afterwards. This is because even if you feel fine, your reaction times and judgement may not be back to normal.

How you will feel

It is normal to feel unwell and a little uncomfortable for a few days if you have had a general anaesthetic, and you may have to rest for a couple of days. Depending on your general health and your job, you can normally return to work five days after tubal occlusion. However, you should avoid heavy lifting for about a week.

You may have some slight vaginal bleeding. Use a sanitary towel rather than a tampon until this has gone. You may also feel some pain, similar to period pain. You may be prescribed painkillers for this. If the pain or bleeding gets worse, seek medical attention.

Caring for your wound

If you had tubal occlusion to block your fallopian tubes, you will have a wound with stitches where the surgeon made an incision (cut) into your abdomen. Some stitches are dissolvable and disappear on their own, and some will need to be removed. If your stitches need removing you will be given a follow-up appointment for this.

If there is a dressing over your wound, you can normally remove this the day after your operation. After this, you will be able to have a bath or shower as normal.

Having sex

Your sex drive and enjoyment of sex will not be affected. You can have sex as soon as it is comfortable to do so after the operation.

If you had tubal occlusion, you will need to use contraception until your first period to protect yourself from pregnancy.

If you had hysteroscopic sterilisation, you will need to use another form of contraception for around three months after surgery. After scans have confirmed that the implants are in the correct position, you will no longer need contraception.

Sterilisation will not protect you from sexually transmitted infections, so continue to use barrier contraception such as condoms if you are unsure of your partner's sexual health.

Who can have it done?

Almost any woman can be sterilised. However, sterilisation should only be considered by women who do not want any more children, or do not want children at all. Once you are sterilised it is very difficult to reverse the process, so it's important to consider the other options available before making your decision. Sterilisation reversal is usually hard.

Surgeons are more willing to perform sterilisation when women are over 30 years old and have had children, although some younger women who have never had a baby choose it.

Advantages and disadvantages of female sterilisation

Advantages

female sterilisation can be more than 99% effective at preventing pregnancy

tubal occlusion (blocking the fallopian tubes) and removal of the tubes (salpingectomy) should be effective immediately – however, doctors strongly recommend that you continue to use contraception until your next period

hysteroscopic sterilisation is usually effective after around three months – research collected by the National Institute for Health and Clinical Excellence

(NICE) found that the fallopian tubes were blocked after three months in 96% of sterilised women

Other advantages of female sterilisation are that:

there are rarely any long-term effects on your sexual health

it will not affect your sex drive

it will not affect the spontaneity of sexual intercourse or interfere with sex (as other forms of contraception can)

it will not affect your hormone levels

Disadvantages

female sterilisation does not protect you against sexually transmitted infections so you should still use a condom if you are unsure about your partner's sexual health

it is very difficult to reverse a tubal occlusion – this involves removing the blocked part of the fallopian tube and rejoining the end

Risks

with tubal occlusion there is a very small risk of complications, including internal bleeding and infection or damage to other organs

it is possible for sterilisation to fail – the fallopian tubes can rejoin and make you fertile again, although this is rare (about 1 in 200 women become pregnant in their lifetime after being sterilised)

if you do get pregnant after the operation, there is an increased risk that it will be an ectopic pregnancy (when the fertilised egg grows outside the womb, usually in the fallopian tubes)

If you miss a period, take a pregnancy test immediately. If the pregnancy test is positive, you must see your DOCTOR so that you can be referred for a scan to check if the pregnancy is inside or outside your womb.

With hysteroscopic sterilisation, there is a small risk of pregnancy even after your tubes have been blocked. Research collected by NICE has shown that possible complications after fallopian implants can include:

pain after the operation – in one study, nearly eight out of 10 women reported pain afterwards

the implants being inserted incorrectly – this affected two out of 100 women

bleeding after the operation – many women had light bleeding after the operation, and nearly a third had bleeding for three days

What is the male pill?

In the past 50 years, there have been few changes in male contraception compared with the range of options available to women.

Today, the only contraceptive methods available to men are:

condoms – a barrier form of contraception that stops sperm reaching and fertilising an egg

vasectomy – a minor surgical procedure that stops sperm being ejaculated from the penis during sex (it is usually permanent)

Some men use withdrawal to try to prevent pregnancy, when they pull their penis out of their partner's vagina before ejaculating. However, this is not a recommended method of contraception. Sperm can be released from the penis before ejaculation.

Ongoing research

There are many ongoing research projects into different methods of male contraception.

Researchers are optimistic that a safe, effective and reversible method of male contraception will eventually become a reality, although this is still several years away.

Types of research

There are two main areas of research into male contraception:

hormonal contraception – where synthetic (man-made) hormones are used to temporarily stop the development of healthy sperm

non-hormonal methods – where other techniques are used to prevent healthy sperm from entering a woman's vagina

Hormonal contraception

In fertile men, new sperm cells are constantly created in the testicles. This process is triggered by the hormone testosterone.

The goal of hormonal contraception research is to find a way of temporarily blocking the effects of testosterone so testicles stop producing healthy sperm cells. However, this needs to be achieved without lowering testosterone levels to such an extent that it triggers side effects, such as a loss of sexual desire.

Synthetic testosterone and other steroid combinations

One way of doing this is by giving men a synthetic version of testosterone, together with a hormone called progestogen. Progestogens are synthetic versions of a female sex hormone often found in female hormonal contraceptives, such as the progestogen-only pill.

This approach stops the testes producing testosterone which, in most cases, prevents normal sperm production. However, at the same time it keeps the amount of testosterone in the blood normal, preventing side effects.

This is a very effective approach, but some men still carry on producing enough sperm to cause a pregnancy. The reason why this happens is unknown, but it may be that some men carry on producing enough testosterone to continue to stimulate some sperm production.

Research is now focusing on different combinations of synthetic testosterone and progestogens. Several trials in different countries are looking at the effectiveness and long-term safety of hormonal contraceptives for men, including some phase III trials. Phase III trials are the last clinical trials carried out before a medicine is given a marketing licence.

An important disadvantage of using synthetic testosterone is that sperm production is suppressed at different rates in men of different ethnic origins.

These differences may be due to genetic, dietary or environmental factors, but the exact reasons are unknown. Understanding the reasons may lead to new ways of providing effective contraception for all men of diverse ethnic backgrounds.

Non-hormonal contraception

Many of the non-hormonal methods of contraception currently being studied involve the vas deferens. The vas deferens is the tube that sperm pass through on their way to the penis. This tube is cut during a vasectomy.

RISUG and the IVD

One promising avenue of research is a technique called reversible inhibition of sperm under guidance (RISUG). During this technique, a non-toxic synthetic chemical is injected into the vas deferens. The chemical reacts and blocks the vas deferens. It also kills sperm when they come into contact with it. The chemical is effective almost immediately after it is injected.

The chemical stays in place until a man decides that he wants to have children. It can then be washed out using another injection which dissolves and flushes it out of the vas deferens.

A variation of this technique is the intra-vas device (IVD). It involves injecting a "plug" into the vas deferens which can be removed later. The IVD filters out the sperm as it passes through the vas deferens.

Initial results of RISUG and IVD are promising, but further research is needed to assess the long-term effectiveness and safety of both techniques.

Epididymis

Other research is focusing on the epididymis. This is a long, coiled tube behind the testicles that allows sperm to mature normally, which is essential for normal fertilty.

Attempts have been made to interfere with the way the epididymis works and the way sperm matures inside the epididymis. However, so far neither approach has been successful.

Vasectomy (male sterilisation)

A woman can get pregnant if a man’s sperm reaches one of her eggs (ova). Contraception tries to stop this happening by keeping the egg and sperm apart or by stopping egg production. One method of contraception is vasectomy (male sterilisation).

During a minor operation, the tubes that carry sperm from a man's testicles to the penis are cut, blocked or sealed.

This prevents sperm from reaching the seminal fluid (semen), which is ejaculated from the penis during sex. There will be no sperm in the semen, so a woman's egg can't be fertilised.

Vasectomy is usually carried out under local anaesthetic, and takes about 15 minutes.

At a glance: facts about vasectomy

In most cases, vasectomy is more than 99% effective. Out of 2,000 men who are sterilised, one will get a woman pregnant during the rest of his lifetime.

Male sterilisation is considered permanent – once it's done, you don't have to think about contraception again.

You need to use contraception for at least eight weeks after the operation because sperm stay in the tubes leading to the penis.

Up to two semen tests are done after the operation to ensure that all the sperm have gone.

Your scrotum (ball sack) may become bruised, swollen or painful – some men have ongoing pain in their testicles.

As with any surgery, there's a slight risk of infection.

Reversing the operation isn't easy.

Vasectomy doesn't protect against sexually transmitted infections (STIs). By using a condom you'll protect yourself and your partner against STIs.

How vasectomy works

Vasectomy works by stopping sperm from getting into a man's semen. This means that when a man ejaculates, the semen has no sperm and a woman's egg cannot be fertilised.

Vasectomy is a quick and relatively painless surgical procedure. The tubes that carry sperm from a man's testicles to the penis are cut, blocked or sealed with heat. In most cases, you will be able to return home the same day.

Most vasectomies are carried out under local anaesthetic. This means only your scrotum and testicles will be numbed, and you will be awake for the procedure. You will not feel any pain, although it may feel slightly uncomfortable.

In rare cases, a general anaesthetic may be required. This means you will be asleep during the procedure. A general anaesthetic may be used if you are allergic to local anaesthetic or have a history of fainting easily. However, most people will only need a local anaesthetic.

A vasectomy has no effect on sex drive or ability to enjoy sex. You will still have erections and ejaculate normally. The only difference is that your semen will not contain sperm.

There are two types of vasectomy. The traditional technique, called conventional vasectomy, involves making two small incisions in the scrotum (the pouch of skin that surrounds your testicles) using a scalpel (surgical knife).

The other type, called a no-scalpel vasectomy, is a newer technique now in common use. The doctor doing your vasectomy will discuss with you which is best for you.

Conventional vasectomy

During a conventional vasectomy, the skin of your scrotum is numbed with local anaesthetic. The doctor makes two small incisions (cuts), about 1cm long, on each side of your scrotum.

The incisions allow your surgeon to access the tubes that carry sperm out of your testicles. These tubes are known as vas deferens. Each tube is cut and a small section removed. The ends of the tubes are then closed, either by tying them or sealing them using diathermy (an instrument that heats to a very high temperature).

The incisions are stitched, usually using dissolvable stitches, which will disappear naturally within about a week.

No-scalpel vasectomy is usually carried out under local anaesthetic. During a no-scalpel vasectomy, the doctor will feel the vas deferens underneath the skin of your scrotum and then hold them in place using a small clamp.

A special instrument is then used to make a tiny puncture hole in the skin of the scrotum. A small pair of forceps is used to open up the hole, allowing the surgeon to access the vas deferens without the need to cut the skin with a scalpel. The tubes are then closed in the same way as in a conventional vasectomy, either by being tied or sealed.

During a no-scalpel vasectomy, there will be little bleeding and no stitches. The procedure is also thought to be less painful, and less likely to cause complications than a conventional vasectomy.

Before you decide to have a vasectomy

Your doctor will ask about your circumstances and provide information and counselling before agreeing to the procedure.

You should only have a vasectomy if you are certain that you do not want to have any, or any more, children. If you have any doubts, consider another method of contraception until you are completely sure.

You shouldn't make the decision about having a vasectomy after a crisis or a big change in your life – for example, if your partner has just had a baby, or has just terminated a pregnancy.

If you have a partner, discuss it with them before deciding to have a vasectomy. If possible, you should both agree to the procedure but it is not a legal requirement to get your partner's permission.

You can have a vasectomy at any age. However, if you are under 30, particularly if you do not have children, your doctor may be reluctant to perform the procedure.

How long will I have to wait for the operation?

Speak to your DOCTOR or ask at your local contraception clinic about vasectomies in your area. As waiting lists for vasectomies can be long, some men choose to pay to have the procedure carried out privately.

You can request a male doctor, but in some cases this may mean you have to wait longer. Your DOCTOR may be able to offer you options of where the vasectomy can be carried out.

Recovering after the operation

It's common to have some mild discomfort, swelling and bruising of your scrotum for a few days after the vasectomy. If you have pain or discomfort, you can take painkillers, such as paracetamol. Contact your DOCTOR for advice if you are still experiencing considerable pain after taking painkillers.

It's common to have blood in your semen in the first few ejaculations after a vasectomy. This isn't harmful.

Some other common questions about recovery are outlined below.

Underwear

Wearing close-fitting underwear, such as Y-fronts, during the day and at night will help to support your scrotum and will also help ease any discomfort or swelling. Make sure you change your underwear every day.

Hygiene

It is safe for you to have a bath or shower after your operation, but make sure you dry your genital area gently and thoroughly.

Returning to work

Most men will be fit to return to work one or two days after their vasectomy, but you should avoid sport and heavy lifting for at least one week after the operation. This is to minimise the risk of developing complications (see below). If any symptoms continue after a few days, consult your DOCTOR.

Having sex

You can have sex again as soon as it is comfortable to do so, although it is best to wait for a couple of days. However, you will still have sperm in your semen immediately after the operation, as it takes time to clear the remaining sperm in your tubes. It takes an average of 20-30 ejaculations to clear the tubes of sperm. You will need to use another method of contraception until you have had two clear semen tests.

Once the operation has been carried out successfully and semen tests have shown there is no sperm present, long-term partners may not need to use other forms of contraception.

However, a vasectomy does not protect against HIV infection or any other sexually transmitted infections, so you should still use condoms with any new partner.

How will I know if my vasectomy has worked?

After the vasectomy, there will be some sperm left in the upper part of the vas deferens tubes. It can take more than 20 ejaculations to clear these sperm from the tubes so, during this time, there is still a risk of pregnancy.

Until it has been confirmed that your semen is free of sperm, you should continue to use another form of contraception.

At least eight weeks after the procedure you will need to produce a sample of semen which will be tested for sperm. This will also help to identify the rare cases in which the tubes naturally rejoin themselves. Once tests have confirmed that your semen is free of sperm, the vasectomy is considered successful and you can stop using additional contraception.

A few men continue to have small numbers of sperm in their system, but these sperm do not move (they are known as non-motile sperm). If you are one of these men, your doctor will discuss your options with you. The chances of

making your partner pregnant may be low enough to consider the vasectomy successful, or you may be advised to have further tests or consider other options.

Is reversal possible?

It is possible to have a vasectomy reversed. However, the procedure is not always successful. You have a better chance if it is done soon after the vasectomy.

If a reversal is carried out within 10 years of your vasectomy, the success rate is about 55%. This falls to 25% if your reversal is carried out more than 10 years after your vasectomy.

Even if a surgeon manages to join up the vas deferens tubes again, pregnancy may still not be possible. This is why you should be certain before going ahead with the vasectomy. Your doctor can help you to make your decision.

Who can have a vasectomy

Having a vasectomy should always be viewed as permanent sterilisation. This is because, although reversal is sometimes possible, it may not be successful. A reversal operation requires delicate microsurgery to join the tubes together again. Even with a successful operation, it still may not be possible to father a child.

Advantages and disadvantages of vasectomy

Advantages

the failure rate is only one in 2,000 – out of 2,000 men who have a vasectomy, only one will get a woman pregnant in the rest of his lifetime

there are rarely long-term effects on your health

vasectomy does not affect your hormone levels or sex drive

it will not affect the spontaneity of sex or interfere with sex

vasectomy may be chosen as a simpler, safer and more reliable alternative to female sterilisation

Disadvantages

vasectomy doesn’t protect against sexually transmitted infections

it’s difficult to reverse.

you need to use contraception after the operation until tests show your semen is free of sperm – if your semen contains sperm, you could make your partner pregnant

complications can occur – the risks are listed below

Risks

Most men feel sore and tender for a few days after the operation, and will usually experience some bruising and swelling on or around their scrotum.

However, in some cases, a vasectomy can cause more serious problems, some of which are outlined below.

Haematoma

A haematoma is when blood collects and clots in the tissue surrounding a broken blood vessel. Following a vasectomy, you may develop a haematoma inside your scrotum.

Haematomas are mostly small (pea-sized), but can occasionally be large (filling the scrotum) and, rarely, they can be very large. This can cause your scrotum to become very swollen and painful. In severe cases, you may need further surgery to treat the blood clot.

Sperm granulomas

When the tubes that carry sperm from your testicles are cut, sperm can sometimes leak from them. In rare cases, sperm can collect in the surrounding tissue, forming hard lumps that are known as sperm granulomas.

Your groin or scrotum may become painful and swollen either immediately or a few months after the procedure. The lumps are not usually painful and can often be treated using anti-inflammatory medication, which your DOCTOR will

prescribe. If the granulomas are particularly large or painful, they may have to be removed surgically.

Infection

After a vasectomy you may be at risk of developing an infection as a result of bacteria entering through the cuts made in your scrotum. Therefore, after the operation, it is important to keep your genital area clean and dry to keep the risk of infection as low as you can.

Long-term testicle pain

Some men get pain in one or both of their testicles after a vasectomy. It can happen immediately, a few months or a few years after the operation. It may be occasional or quite frequent and vary from a constant dull ache to episodes of sharp, intense pain. For most men, however, any pain is quite mild and they do not need further help for it.

Long-term testicular pain affects around one in 10 men after vasectomy. The pain is usually the result of a pinched nerve or scarring that occurred during the operation. You may be advised to undergo further surgery to repair the damage and to help minimise further pain.

Testicles feeling full

After a vasectomy, some men may develop the sensation that their testicles are 'fuller' than normal. This is usually caused by the epididymis becoming filled with stored sperm. The epididymis is the long, coiled tube that rests on the back of each testicle. It helps to transport and store sperm.

Any such feelings should pass naturally within a few weeks. However, speak to your DOCTOR if you are still experiencing fullness after this time.

Fertility

In a very small number of vasectomy cases, the vas deferens reconnects over a period of time. This means that the vasectomy will no longer be an effective form of contraception. However, it is rare for this to happen.