

The sexual health benefits of oral contraceptives

DO NOT

outweigh the adverse effects for sexually active women who seek contraception

Disclosures

**Consultant/Advisory Board: Apricus,
Emotional Brain, Exploramed,
Sprout, Strategic Science &
Technologies**

Speaker: Ascend, Shionogi

Research: Apricus, Neogyn

Learning objectives:

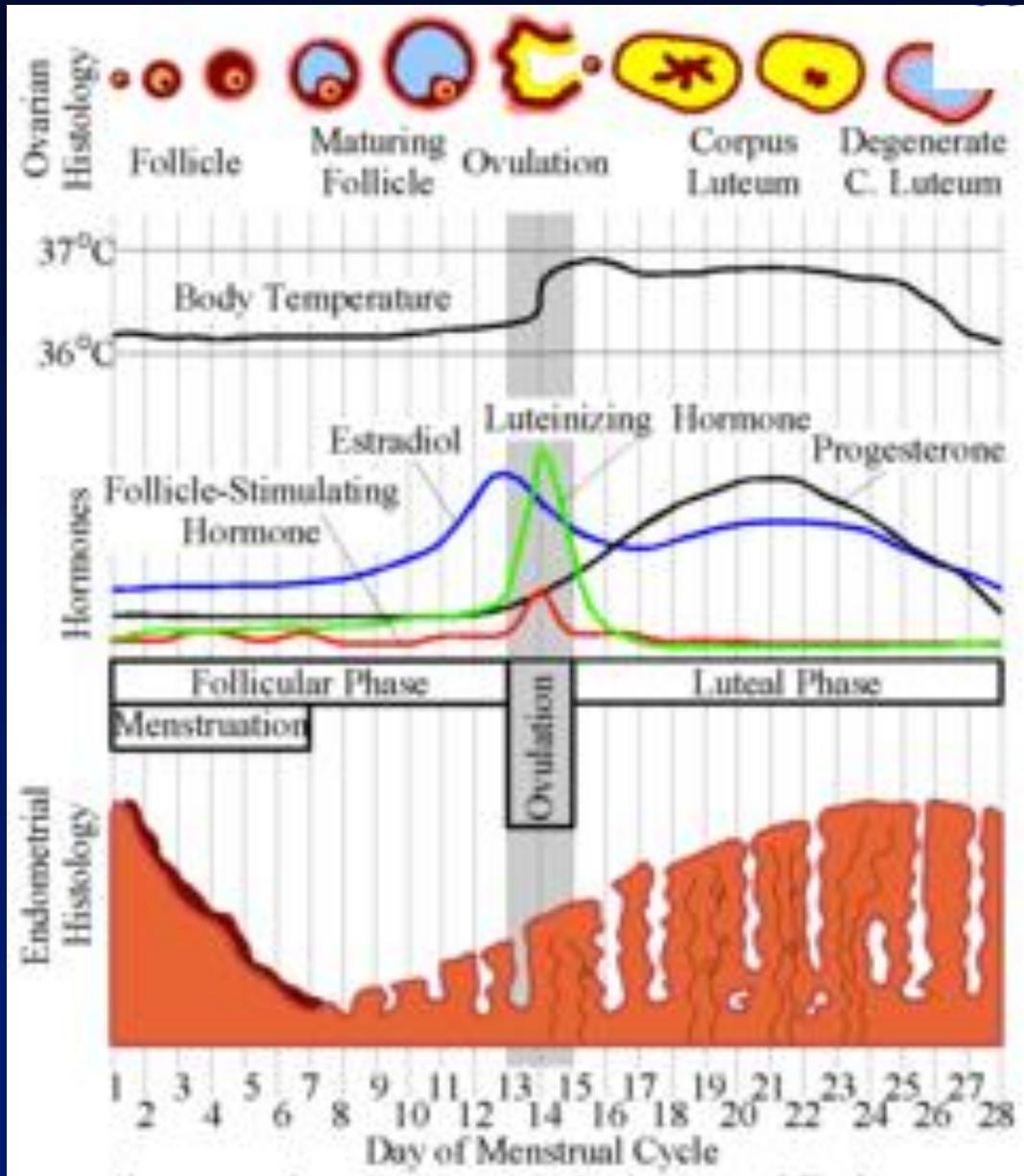
Describe the potential positive and negative impact of various contraceptive methods on sexual function.

**Oral contraceptive pills
were first approved for
contraceptive use in
1960's (>50 years ago)**

**They are currently used
by more than 12 million
women in the United
States**



Normal Menstrual Cycle



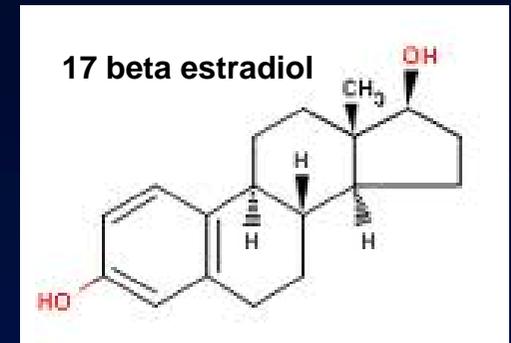
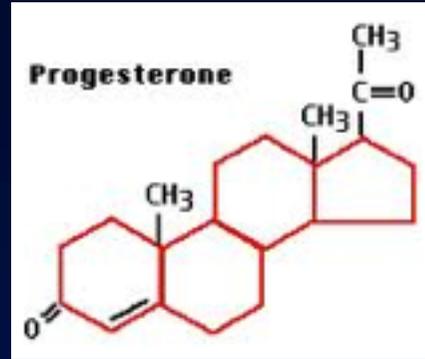
Oral (transdermal or vaginal) hormonal contraceptives consist of:

- 1. ethinyl estradiol**
- 2. a synthetic progesterone**

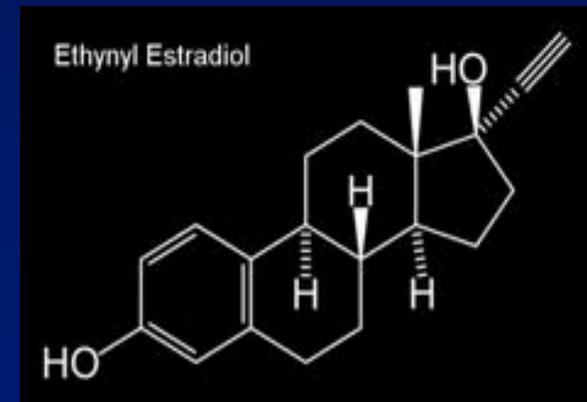
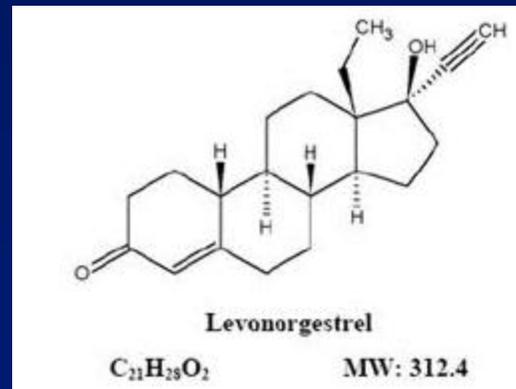


Ethinyl estradiol is not biologically identical 17 beta estradiol

Synthetic progesterone is not biologically identical



Rx
DESOGESTREL AND ETHINYL ESTRADIOL TABLETS USP



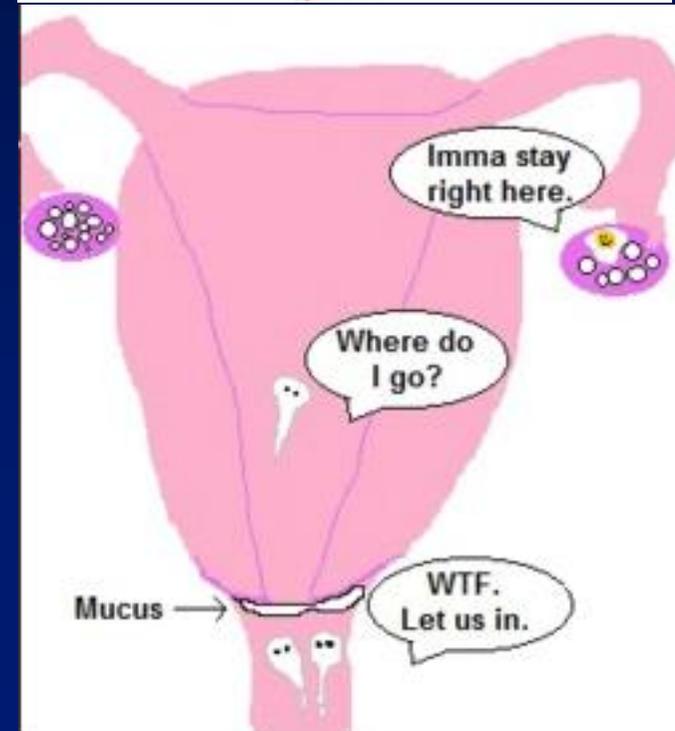
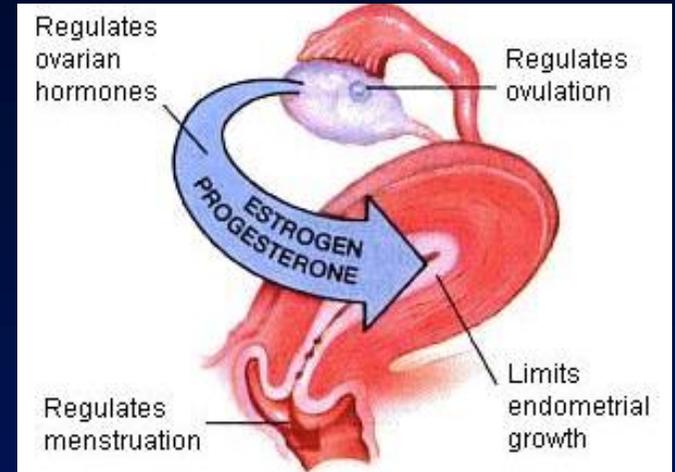
How do birth control pills work

Ethinyl estradiol and synthetic progesterone act to:

- 1. prevent ovulation**
- 2. thicken cervical mucous**
- 3. thin endometrial lining**

With typical use, about 8 in 100 women (8%) will become pregnant during the first year

When used perfectly, 1 in 100 women will become pregnant during the first year



Side effects of oral contraceptives IN SOME USERS include:

1. **biochemical changes in 100% of users**
2. clinically significant sexual health changes
3. clinically significant overall health changes
4. persistent and long-lasting changes



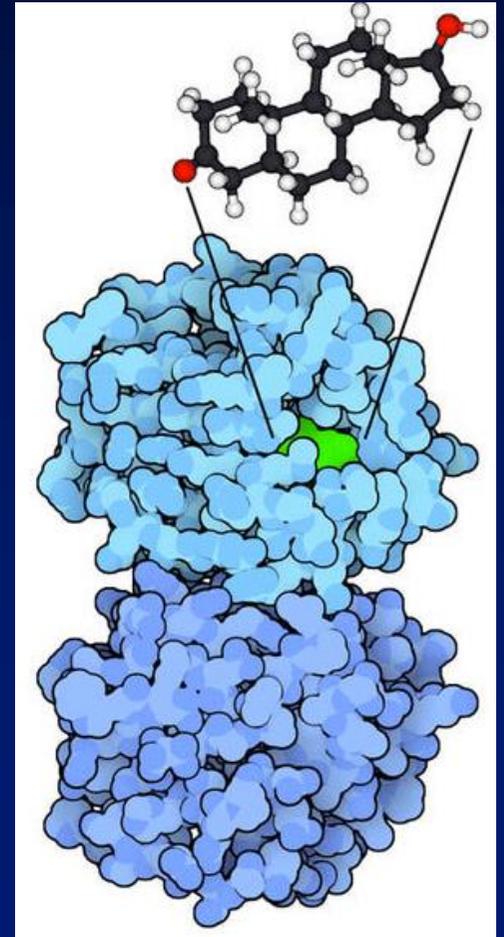
It's pill o'clock



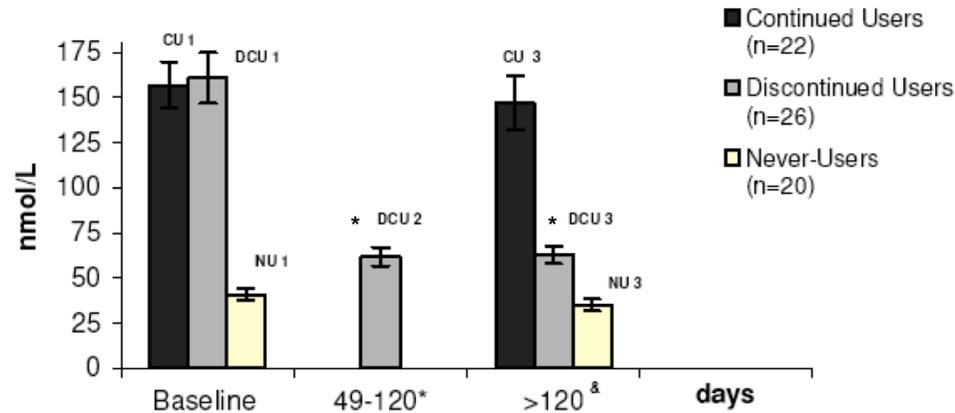
Biochemical changes in 100% of oral contraceptive pill users

Oral contraceptive pills cause testosterone deficiency:

- 1. Significant increase in sex hormone binding globulin**
- 2. Significant decrease in calculated free testosterone**



Impact of Oral Contraceptives on Sex Hormone-Binding Globulin and Androgen Levels: A Retrospective Study in Women with Sexual Dysfunction



Panzer C, Wise S, Fantini G, Kang D, Munarriz R, Guay A, Goldstein I. J Sex Med. 2006 Jan;3(1):104-13.

Never-users

Continued users

Free & Bioavailable Testosterone calculator

These calculated parameters more accurately reflect the level of bioactive testosterone than does the sole measurement of total serum testosterone. Testosterone and dihydrotestosterone (DHT) circulate in plasma unbound (free approximately 2 - 3%), bound to specific plasma proteins (sex hormone-binding globulin SHBG) and weakly bound to nonspecific proteins such as albumin. The SHBG-bound fraction is biologically inactive because of the high binding affinity of SHBG for testosterone. Free testosterone measures the free fraction, bioavailable testosterone includes free plus weakly bound to albumin.

Albumin [Explanation and examples](#)

SHBG

Testosterone

Free Testosterone

Bioavailable Testosterone

Disclaimer: Results from this calculator should NOT be solely relied upon in making (or refraining from making) any decision in any case/ circumstances without the prior consultation of experts or professional persons. No responsibility whatsoever is assumed for its correctness or suitability for any given purpose.

WARNING! The calculated free and bioavailable testosterone are reliable in most clinical situations, but should not be relied upon in situations with potential massive interference by steroids binding to SHBG; e.g. in women during pregnancy, in men during treatment inducing high levels of DHT (e.g. transdermal DHT, oral testosterone) or mesterolone

This calculator was developed at the Hormonology department, University Hospital of Ghent, Belgium. If you have suggestions to improve this calculator, or for further questions or help contact us [Dr. Tom Fiers](#) or [Prof. Dr. J.M. Kaufman](#)

Free & Bioavailable Testosterone calculator

These calculated parameters more accurately reflect the level of bioactive testosterone than does the sole measurement of total serum testosterone. Testosterone and dihydrotestosterone (DHT) circulate in plasma unbound (free approximately 2 - 3%), bound to specific plasma proteins (sex hormone-binding globulin SHBG) and weakly bound to nonspecific proteins such as albumin. The SHBG-bound fraction is biologically inactive because of the high binding affinity of SHBG for testosterone. Free testosterone measures the free fraction, bioavailable testosterone includes free plus weakly bound to albumin.

Albumin [Explanation and examples](#)

SHBG

Testosterone

Free Testosterone

Bioavailable Testosterone

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5.

Impact of Oral Contraceptives on Sex Hormone-Binding Globulin and Androgen Levels: A Retrospective Study in Women with Sexual Dysfunction

J Sex Med 2006;3:104–113

Claudia Panzer, MD,* Sarah Wise, MS,[†] Gemma Fantini, MD,[†] Dongwoo Kang, MD,[†] Ricardo Munarriz, MD,[†] Andre Guay, MD, FACP, FACE,[‡] and Irwin Goldstein, MD[§]

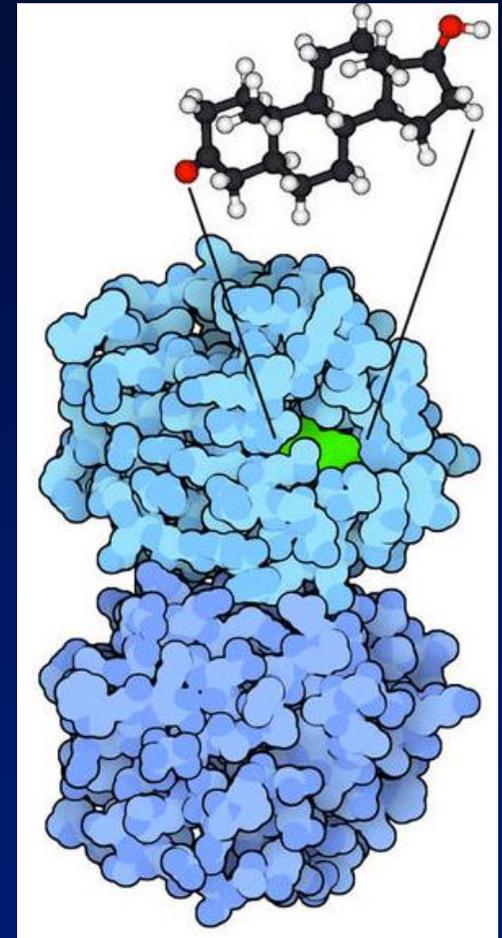
	Continued users	Discontinued users	Never users	
Total testosterone (ng/dl)	31.7	34.6	37.5	P = 0.086
SHBG nmol/L	149	89.7	35	P = 0.0001
Calculated free testosterone (ng/dl)	0.19	0.31	0.65	P = 0.0001

The effects of oral contraceptives on androgen levels and their relevance to premenstrual mood and sexual interest: a comparison of two triphasic formulations containing norgestimate and either 35 or 25 microg of ethinyl estradiol. Greco T, Graham CA, Bancroft J, Tanner A, Doll HA. Contraception. 2007 Jul;76(1):8-17

Both OCs produced reductions in mean testosterone [N/EE35: from 1.33 to 0.60 nmol/L, $p < .001$; N/EE25: from 1.12 to 1.02 nmol/L

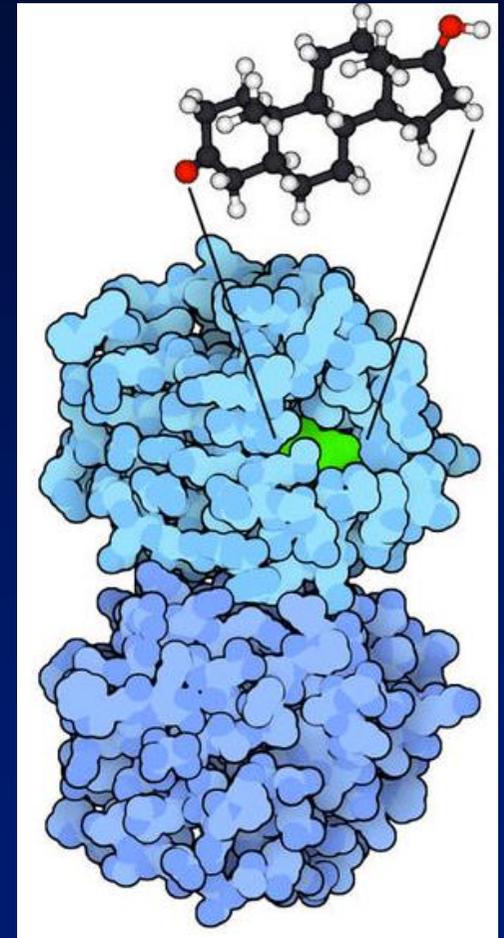
Free Testosterone (N/EE35: from 41.3 to 4.4 pmol/L, $p < .001$; N/EE25: from 25.4 to 7.9 pmol/L, $p < .01$)

Reduction in both Testosterone and Free Testosterone was significantly greater with the higher EE dose (N/EE35) ($p = .05$ and $p = .03$, respectively)



Does oral contraceptive-induced reduction in free testosterone adversely affect the sexuality or mood of women? Graham CA, Bancroft J, Doll HA, Greco T, Tanner A. *Psychoneuroendocrinology*. 2007 Apr;32(3):246-55.

Significant decreases in Testosterone, Free Testosterone were found after 3 months, although the extent of reduction was variable across women



1. ESTRADIOL – DEPENDENT ORGAN - Labia Minora

FOUR GENITAL TISSUE CHANGES NOTED IN OCP USERS

2-4. TESTOSTERONE – DEPENDENT ORGANS: 2) glans clitoris, 3) minor vestibular glands and 4) peri-urethral (G-spot) tissue



Clitoral atrophy



Provoked vestibulodynia



Labial resorption



Limited robust peri-urethral tissue



YASMIN 28 TABLETS
(drospirenone and ethinyl estradiol)

PHYSICIAN LABELING

Rx only

PATIENTS SHOULD BE COUNSELED THAT THIS PRODUCT DOES NOT PROTECT AGAINST HIV INFECTION (AIDS) AND OTHER SEXUALLY TRANSMITTED DISEASES.

DESCRIPTION

YASMIN[®] provides an oral contraceptive regimen consisting of 21 active film coated tablets each containing 3 mg of drospirenone and 0.03 mg of ethinyl estradiol and 7 inert film coated tablets. The inactive ingredients are lactose monohydrate NF, corn starch NF, modified starch NF, povidone 25000 USP, magnesium stearate NF, hydroxypropylmethyl cellulose USP, macrogol 6000 NF, talc USP, titanium dioxide USP, ferric oxide pigment, yellow NF. The inert film coated tablets contain lactose monohydrate NF, corn starch NF, povidone 25000 USP, magnesium stearate NF, hydroxypropylmethyl cellulose USP, talc USP, titanium dioxide USP.

- d. Sex-hormone-binding globulins are increased and result in elevated levels of total circulating sex steroids and corticoids; however, free or biologically active levels remain unchanged.

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The following are the most common adverse events reported with use of **YASMIN** during the clinical trials, occurring in > 1% of subjects and which may or may not be drug related: Headache, Menstrual Disorder, Breast Pain, Abdominal Pain, Nausea, Leukorrhea, Flu Syndrome, Acne, Vaginal Moniliasis, Depression, Diarrhea, Asthenia, Dysmenorrhea, Back Pain, Infection, Pharyngitis, Intermenstrual Bleeding, Migraine, Vomiting, Dizziness, Nervousness, Vaginitis, Sinusitis, Cystitis, Bronchitis, Gastroenteritis, Allergic Reaction, Urinary Tract Infection, Pruritus, Emotional Lability, Surgery, Rash, Upper Respiratory Infection.

Sexual Function in Well Women: Stratification by Sexual Satisfaction, Hormone Use, and Menopause Status

J Sex Med 2008;5:1214–1222

Sonia L. Davison, MBBS, FRACP, PhD,* Robin J. Bell, MBBS, FAFPHM, PhD,*
 Maria LaChina, Assoc Dip Med Sec Prac,* Samantha L. Holden, BSc,[†] and
 Susan R. Davis, MBBS, FRACP, PhD*

Table 4 Daily diary scores, premenopausal women, stratified by oral contraceptive pill (OCP) use

	On OCP Total <i>n</i> = 21		Not on OCP Total <i>n</i> = 163		Mean difference (95% CI)	<i>P</i> value for difference
	Mean + SD* (range)	Median [‡]	Mean + SD* (range)	Median		
Sexual thoughts per day	1.6 ± 0.7 (1–3.4)		2.0 ± 0.8 (1–5)		0.4 (0.1–0.8)	0.03
Sexual interest per day	1.7 ± 0.8 (1–3.7)		2.1 ± 0.9 (1–5)		0.5 (0.1–0.9)	0.02
Number of days with sexual activity per month	(2–18)	5.0	(2–27)	8.0		0.08*
Number of events per month	(2–32)	5.0	(2–57)	9.0		0.06*

**P* value for difference by Mann–Whitney *U*-test.

Medians have been reported for non-normally distributed data.

CI = confidence interval; SD = standard deviation.

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Table 5 Premenopausal women: sexual activity by oral contraceptive pill (OCP) use and sexual satisfaction status

	On OCP Total <i>n</i> = 21	Not on OCP Total <i>n</i> = 163	Mean difference (95% CI)(years)
Mean age ± SD [†] (years)	37.0 ± 5.9	39.8 ± 6.9	2.9 (−0.2 to 6.0)
Satisfied, <i>n</i> = 92	5 (24%)	87 (53%)	
Dissatisfied, <i>n</i> = 92	16 (76%)	76 (47%)	

Pearson chi-square value for OCP users = 5.4; *P* = 0.02.

[†]*P* value for difference between oral contraceptive users and nonusers = 0.06.

CI = confidence interval; SD = standard deviation.

Prevalence of Sexual Dysfunction and Impact of Contraception in Female German Medical Students

J Sex Med 2010;7:2139–2148

Christian W. Wallwiener, MD,* Lisa-Maria Wallwiener, MD,† Harald Seeger, PhD,* Alfred O. Mück, MD, PhD,* Johannes Bitzer, MD,‡ and Markus Wallwiener, MD§

A total of 1,219 completed questionnaires were received, and 1,086 were included in the analyses after screening

Based on domain scores, 8.7% for were at risk for FSD concerning orgasm, 5.8% for desire, 2.6% for satisfaction, 1.2% for lubrication, 1.1% for pain and 1.0% for arousal.

The method of contraception and smoking were factors with significant effect on the total FSFI score whereby **hormonal contraception was associated with lower total FSFI scores and lower desire and arousal scores than no contraception and non-hormonal contraception only**

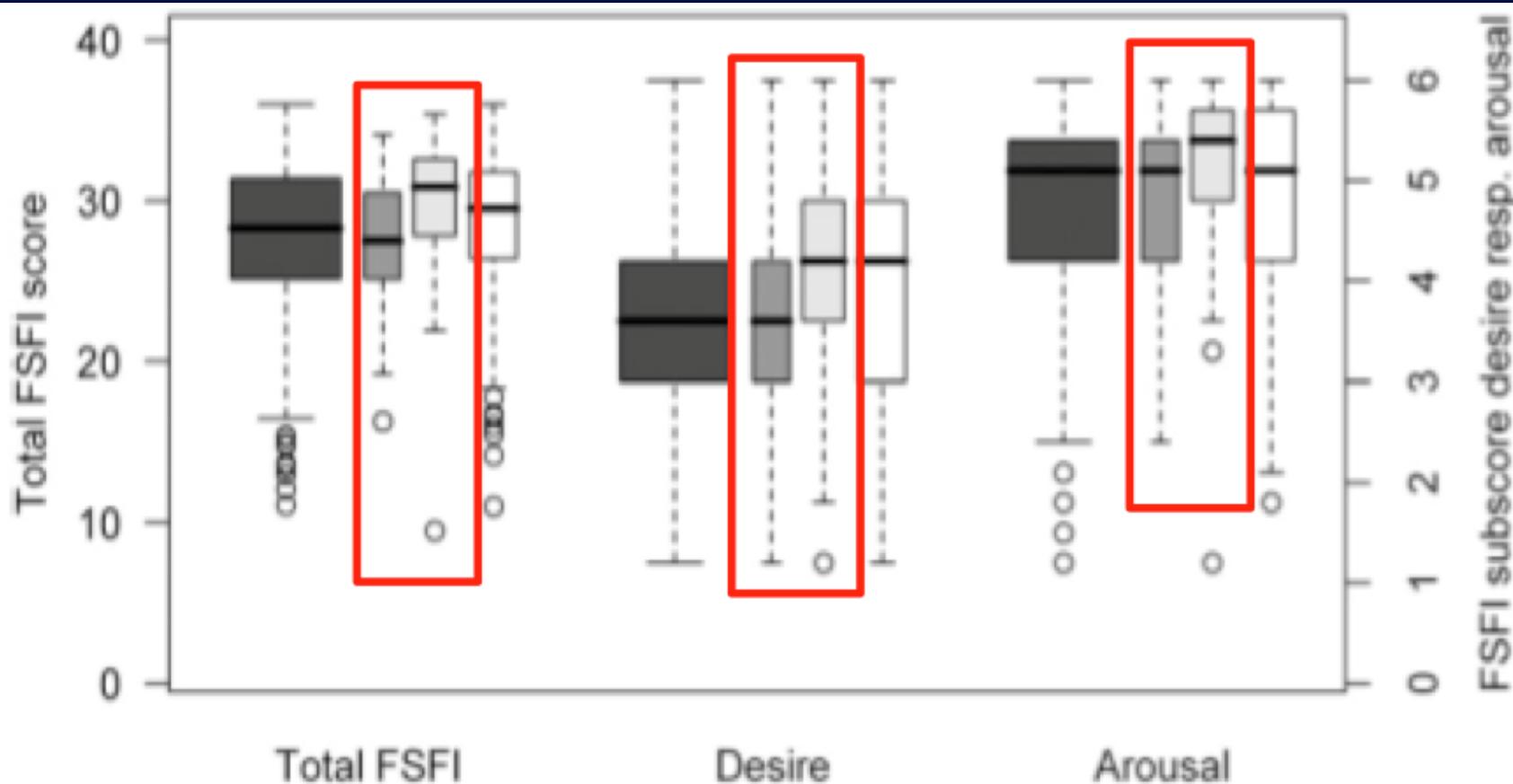
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Dark Gray =
Hormonal
contraception

Light gray =
Non-hormonal
contraception



Clitoral Vascularization and Sexual Behavior in Young Patients Treated with Drospirenone–Ethinyl Estradiol or Contraceptive Vaginal Ring: A Prospective, Randomized, Pilot Study

J Sex Med 2014;11:471–480

Cesare Battaglia, MD, PhD,* Elena Morotti, MD,† Nicola Persico, MD, PhD,* Bruno Battaglia, MS,* Paolo Busacchi, MD,* Paolo Casadio, MD,* Roberto Paradisi, MD,* and Stefano Venturoli, MD*

Table 1 Physical, clinical, and hormonal profile before and after the treatment with Yasmin (group I; n = 21) or NuvaRing (group II; n = 19)

Variable	Group	Baseline (a)	6 months (b)	P value	
				a vs. b	I vs. II at 6 months
Age (years)	I	26.1 ± 2.7			
	II	27.0 ± 1.9			
BMI (kg/m ²)	I	20.8 ± 2.2	21.1 ± 1.0		
	II	22.0 ± 1.5	22.2 ± 0.9		
Estradiol (pmol/L)	I	199 ± 57	110 ± 49	0.01	
	II	222 ± 104	197 ± 112		0.003
Androstenedione (nmol/L)	I	9.9 ± 2.7	8.1 ± 2.4		
	II	9.3 ± 1.5	8.8 ± 1.6		
Testosterone (nmol/L)	I	1.9 ± 0.6	1.3 ± 0.4	0.007	
	II	2.1 ± 0.9	1.6 ± 0.5	0.011	
SHBG (nmol/L)	I	53 ± 15	171 ± 11	<0.001	
	II	55 ± 13	162 ± 17	<0.001	
FAI (%)	I	3.6 ± 2.0	0.6 ± 0.3	<0.001	
	II	4.0 ± 1.9	1.1 ± 0.3	<0.001	0.026
FEI (%)	I	4.0 ± 2.1	0.6 ± 0.3	<0.001	
	II	4.0 ± 2.0	1.5 ± 0.3	<0.001	<0.0001

BMI = body mass index; FAI = Free Androgen Index; FEI = Free Estrogen Index

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Table 2 Ultrasonographic, Doppler follow measures monitoring before and after the treatment with Yasmin (group I; n = 21) or NuvaRing (group II; n = 19)

Variable	Group	Baseline (a)	6 months (b)	P value	
				a vs. b	I vs. II at 6 months
Clitoral Volume (mL)	I	0.85 ± 0.09	0.65 ± 0.13	0.050	
	II	0.98 ± 0.32	0.75 ± 0.15	0.039	

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Table 3 Behavioral profile indices before and after the treatment with Yasmin (group I; n = 21) or NuvaRing (group II; n = 19)

Variable	Group	Baseline (a)	6 months (b)	P value	
				a vs. b	I vs. II at 6 months
MFSQ Sex (score)	I	51.2 ± 5.0	42.0 ± 8.9	0.001	
	II	54.1 ± 4.4	47.5 ± 10.3	0.001	0.037
Intercourse/week (n)	I	2.6 ± 0.6	1.8 ± 0.8	0.036	
	II	2.7 ± 1.2	2.5 ± 1.1		0.050
Orgasmic Frequency (score)	I	6.0 ± 1.4	4.2 ± 1.3	0.019	
	II	6.1 ± 0.9	5.4 ± 1.4		0.050
Orgasmic Intensity (score)	I	6.0 ± 1.1	5.5 ± 1.3		
	II	6.6 ± 0.5	5.7 ± 2.5		
Pain During Intercourse (score)	I	6.6 ± 0.3	3.0 ± 0.5	0.011	
	II	6.7 ± 0.5	5.6 ± 1.0		0.003
BDI (score)	I	6.8 ± 3.3	6.7 ± 5.0		
	II	6.2 ± 5.2	6.5 ± 4.4		

BDI = Beck's Depression Inventory; MFSQ = two-factor McCoy Female Sexuality Questionnaire

Sexual Behavior and Oral Contraception: A Pilot Study

J Sex Med 2012;9:550–557

Cesare Battaglia, MD, PhD,* Bruno Battaglia, MS,* Fulvia Mancini, MD, PhD,† Paolo Busacchi, MD,* Maria Chiara Paganotto, MD,* Elena Morotti, MS,* and Stefano Venturoli, MD*

Table 1 Hormonal and biochemical profile before and after 3-month treatment with an oral contraceptive containing 30 µg ethinylestradiol and 3 mg drospirenone in 21 young, healthy women without sexual problems

	Normal range	Baseline (N = 21)	After 3 months (N = 21)	Significance (<i>P</i> < 0.05)
Estradiol (pmol/L)	45–350	187 ± 86	81 ± 44	0.021
Testosterone (nmol/L)	0.70–2.70	1.2 ± 0.2	1.0 ± 0.7	0.477
Androstenedione (nmol/L)	1.0–11.5	8.4 ± 1.1	7.8 ± 0.8	0.124
SHBG (nmol/L)	30–120	56 ± 29	115 ± 44	0.029
FAI (%)		2.1 ± 0.7	0.8 ± 0.7	0.011
FEI (%)		0.32 ± 0.02	0.06 ± 0.05	<0.001

FAI = free androgen index; FEI = free estrogen index; SHBG = sex hormone binding globulin

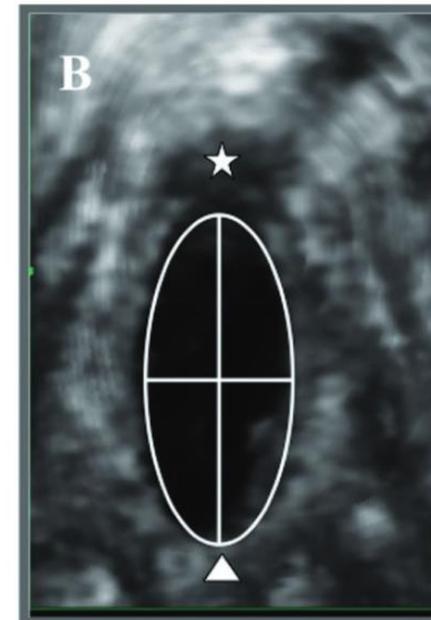
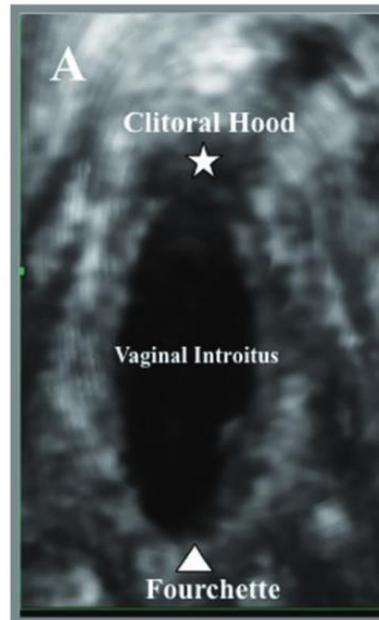
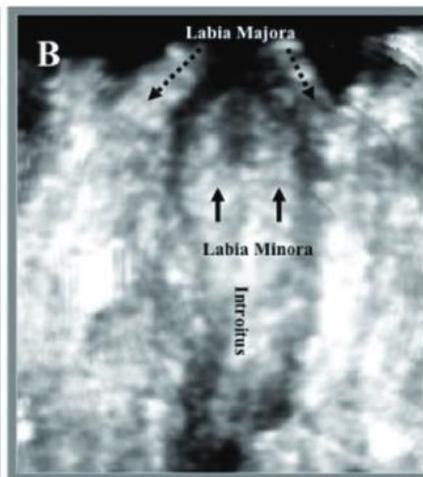
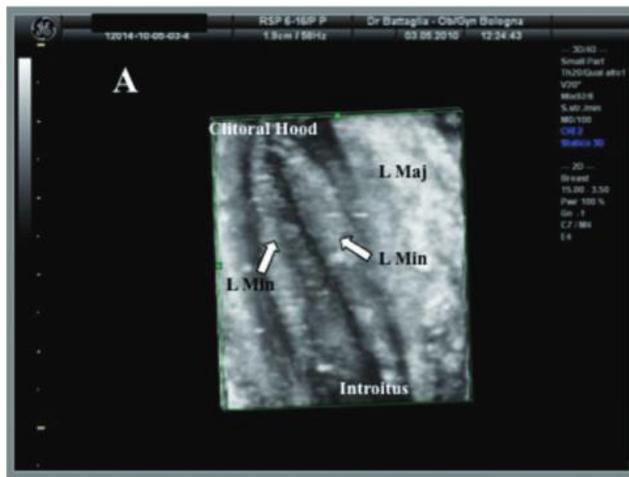
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Table 2 Ultrasonographic and Doppler indices before and after 3-month treatment with an oral contraceptive containing 30 µg ethinylestradiol and 3 mg drospirenone in 21 young, healthy women without sexual problems

	Baseline (N = 21)	After 3 months (N = 21)	Significance (<i>P</i> < 0.05)
Labium minus thickness (mm)	4.5 ± 0.4	3.9 ± 0.4	0.001
Vaginal introitus area (cm ²)	1.04 ± 0.23	0.81 ± 0.21	0.044



Sexual Behavior and Oral Contraception: A Pilot Study

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Table 3 Behavioral profile indices before and after 3-month treatment with an oral contraceptive containing 30 µg ethinylestradiol and 3 mg drospirenone in 21 young, healthy women without sexual problems

	Baseline (N = 21)	After 3 months (N = 21)	Significance (<i>P</i> < 0.05)
MFSQ sex (score)	49.6 ± 8.6	45.9 ± 8.4	0.033
Intercourse/week (N)	2.6 ± 1.3	1.5 ± 1.0	0.047
Orgasmic frequency (score)	6.1 ± 0.7	4.5 ± 0.6	0.005
Orgasmic intensity (score)	6.0 ± 1.1	5.3 ± 1.4	0.248
Pain during intercourse (score)	6.6 ± 0.6	3.0 ± 0.5	<0.001

MFSQ = McCoy Female Sexuality Questionnaire

Table 1 Demographic data

	All participants	
	Number	Percentage
Participants (after screening for unserious responders)	1,086	100.0
Contraception in past 6 month		
Yes	945	87.0
No	141	13.0
Method of contraception in past 6 month(multiple answers possible)		
Oral contraceptives (OC) total	752	69.2
Contraceptive implant	8	0.7
Intrauterine methods	19	1.7
Vaginal contraceptive ring	78	7.2
Condoms	243	22.4
Fertility awareness	17	1.6
Other contraception	8	0.7
Sexually active in the past 4 weeks		
Yes	1,057	97.3
No	29	2.7
Age (years)		
<25	856	78.8
≥25 and <35	223	20.5
>35	7	0.6
Stable relationship		
Yes	869	80.0
Mean duration	3.2 (std 2.6) years	
No	217	20.0
Pregnancy		
No pregnancy	1,046	96.3
One pregnancy	29	2.7
More than one pregnancy	11	1.0
Pregnant in the last 2 years		
Yes	26	2.4
No	1,060	97.6
Active wish for children		
Yes	37	3.4
No	1,049	96.6
Smoking		
Yes	131	12.1
Mean number of cigarettes/day	8.7 (std 6.8) cigarettes / day	
No	955	87.9

Prevalence of Sexual Dysfunction and Impact of Contraception in Female German Medical Students

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The method of contraception and smoking were factors with significant effect on the total FSFI score whereby hormonal contraception was associated with lower total FSFI scores and lower desire and arousal scores than no contraception and non-hormonal contraception only. Other variables such as stress, pregnancy, smoking, relationship and wish for children had an important impact on sexual function as expected according to earlier studies.

The contraception method has a significant effect on the sexual functioning score and women using contraception, especially hormonal contraception, had lower sexual functioning scores

THE GREAT SEX FACTS!!!

#1 and #2 are not separate!!!!

The priorities of many young women are:

#1: TO HAVE SEXUAL ACTIVITY

#2: NOT BECOMING PREGNANT HAVING #1



THE GREAT SEX FACTS!!!

IT IS OUR RESPONSIBILITY AS
HEALTH CARE PROVIDERS TO
PROVIDE INFORMATION THAT:

To achieve #1

Some strategies to prevent #2

....

Will adversely affect their
enjoyment, satisfaction,
function of #1

