

Effect of Sexual Function on Women Wellbeing during Continuation and Discontinuation of Used Oral Contraceptives Pills

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Abstract

The continuous and discontinued use of oral contraceptives may have detrimental effects on a women's wellbeing regarding to physical, mental, and emotional health as well as their interest, enjoyment, and frequency of sexual activity. So, **the aim** was to evaluate the effect of sexual function on women's wellbeing and its relation to continuation and dis-continuation of used oral contraceptives pills. **Design:** The study was carried out using a quasi-experimental design. It was conducted in the family planning and gynaecology outpatient clinics at the Menoufia University Hospital, A purposive sample of 380 women who use OCPs. **Three tools** used to collect data, Interviewing and assessment questionnaire schedule, Sexual Function questionnaire, and follow up questionnaire. **The results:** revealed that the mean age was (29.75 ± 5.59) years and the majority of women had sexual problems (57%) that affected on continuation and discontinuation of OCPs used. **Conclusion:** This study concluded that counseling program about sexual state succeeded in lowering sexual problems among women, and improving compliance as well motivating women for continuation of using OCPs. Documenting Sexual Function Scale as an assessment tool in family planning assessment clinics was **recommended**.

Keywords: counseling, OCPs continuation & dis-continuation, sexual function, women wellbeing.

Introduction:

According to the United Nations (2015), the third sustainable development goal (SDG) is achieving good health and wellbeing. Well-being is clearly of significance for women all over their stages in the life from child hood to post menopause age. Using all types of contraceptive methods has an effect on the women health and wellbeing. Hormonal contraceptive methods for birth control is very effective in controlling pregnancy, but they have negative side effects on woman's physical and emotional wellbeing without proper following up.

Oral contraceptives (OCs), usually denoted to as "the pill," are the greatest widely used type of birth control for women. Combined OCs ensure synthetic formulas of the ovarian hormone's estrogen and progesterone, destroying natural release of these hormones and eliminating variability over the menstrual cycle (Wakeman, 2019).

Oral contraceptive pills (OCPs) are twofold agents, decreasing endogenous concentrations of oestradiol and progesterone while simultaneously giving daily supplementation of exogenous oestrogen and

progesterin, according to Elliott-Sale, et al. (2020). All types of OCPs are taken into account, including combined estrogen-progesterone, progesterone-only, and continuous or prolonged use pills. It is thought to be the type of birth control that is administered the most frequently in the US. One-quarter of women between the ages of 15 and 44 who use contraception said they prefer the pill. (Cooper, et al., 2017).

About 9% of married women or people in relationships between the ages of 15 and 49 use combined oral contraceptives (COCs), which is among the most popular contraceptive methods globally (Wakeman, 2019). The most recent UK Office for National Statistics (ONS) study found that 25% of all female users were OC users (Rashed A. 2013).

Ovulation inhibition is the principal mechanism of action. Furthermore, oral contraceptives cause thick, unfavorable cervical mucus and an endometrium that is unsuitable for ovulation implantation. Tubal and endometrial tissues are both impacted by slow motility (Vincenzo, et al., 2016). While some women who use the birth control pill report mild side effects including spotting or

breakthrough bleeding (BTB), nausea, headache, breast discomfort, weight gain, mood changes, poor libido, and dermatological difficulties, the vast majority of women who use it report no adverse effects at all. It is common for minor, transitory interruptions to occur during the initial cycles of hormonal contraception. Usually, these disruptions subside after this period without posing any problems. (Moreau, et al 2007).& **Christin-Maitre, S. (2013).**

Furthermore, according to **Wakeman's** analysis from 2019, using oral contraceptives can have a detrimental impact on a woman's physical and emotional health, premenstrual syndrome (PMS), sexual desire and enjoyment, frequency of sexual activity, and unwanted pregnancy. 38% of the female users of OCs did so, 47% ceased using them, and 14% switched to another OC. 87% of patients were correctly identified as having emotional side effects, exacerbated PMS, less sexual thoughts, and reduced psychosexual arousability using logistic regression. Many clients, including some doctors, are unaware of the sexual negative effects that hormonal contraceptives might have. Mood or sexual side effects are not listed among the negative effects of oral contraceptive in a widely known online resource (Up To Date). One of the main reasons women stop using oral contraceptives is due to the adverse impacts on their sexual and emotional well-being (**Marchese, 2015**).

Additionally, (**Tabal, A. et al.,2021**) who conducted a study in the family planning and gynaecological clinics at Menoufia University Hospital and Menouf General Hospital on the impact of contraceptive methods on female sexual function. It was confirmed that female sexual function (FSF) was impaired by oral contraceptives containing just only progestin.

As a consequence, oral contraceptives have a high rate of cessation due to negative effects on mood, wellbeing, and sexuality. Users of lower dose contraceptive tablets appear to stop using them for depression and low libido less frequently, and side impact severity ratings are also lower. According to **Sartorius (2020)**, it is likely that premenstrual and depressive symptoms in women lead them to prefer not to take pills, leaving the remaining users with

greater stated well-being. The incidence of COC discontinuation, which may reach 44% in the first year, was found to be extremely high according to a meta-analysis of studied from 19 different nations. (**Ali MM. et al., 2012**) Concerns about side effects or one's health account for nearly half (47%) of all discontinuations.

There are ambiguities surrounding the qualitative changes in sexual enjoyment during contraceptive use, aside from the modifications in sexual function brought on by the hormonal contraceptive effects. According to some authors, a woman's choice of contraceptive contributes to the contraceptive's impact on sexual experience and enjoyment (**Higgins J.A., 2105**).

As a result, the core of family planning programme is the contact between women and service providers or counsellors. A woman can select an acceptable family planning strategy with the help of good counselling. It also equips the ladies with the knowledge and support they need to use a method effectively going forward as well as the ability to deal with any potential negative effects. (**Young, et al., 2001**), also, current researches clearly articulate the importance for healthcare professionals to involve in sexual counseling. It considers an interaction with women that includes information on sexual fears and safe return to sexual activity. Moreover, it takes place during a one-to-one exchange with a trained person or a nurse, with the aim of solving a problem and offering advice. **Steinke, et al., (2013)**.

Significance of the study:

Recent Egyptian Demographic and Health Survey (**EDHS 2014**), which is nearly equivalent to the 30% rate noted in 2000. Changes in the technique mix and a minor drop in the prevalence of contraception from 60% to 58% accompanied this. A segment of use is the continuous usage or non-use of a contraceptive **method** (measured in months), which has risen as a result of hormonal treatments. (**Mona, et al., 2019**) Single/multiple decrement life tables were created to determine discontinuation rates and to analyze different net rates of contraceptive discontinuation by causes.

Therefore, due to the high rate of discontinuing birth control tablets in our locality, Upper Egypt. Maternity nurses are responsible and play a crucial role in educating women about family planning methods especially OCPS due to their negative side effect on wellbeing of the women. However, there is a need to reassess the influence of oral contraceptives pills(OCPS) on women wellbeing generally, and on sexual health specifically. So, the present study was an attempt to evaluate the effect of sexual function on women's wellbeing and its relation to continuation and discontinuation of used oral contraceptives pills.

Aim of the study:

The aim of the study was to evaluate the effect of sexual function on women's wellbeing and its relation to continuation and discontinuation of used oral contraceptives pills.

Operation definition:

Sexual function of the women: defined as the ability for sexual arousal, lubrication, orgasm, and satisfaction. It leads to a healthy state of mind and a high-quality existence (Hassan et al. (2015).

Women wellbeing: defined as a phrase used to refer to a variety of characteristics, such as self-esteem, self-efficacy, self-determination, resilience, quality of life, mood enhancement, good mental health, life satisfaction, and worthwhileness (Huppert, 2017).

Research Hypotheses:

- H. 1:** Women who will receive counseling program about sexual status are expected to have less sexual problems than before.
- H. 2:** Women who will receive counseling program about sexual status are expected to not stop OCPs than before.
- H. 3:** Women who will receive counseling program about sexual status are expected to improve of their wellbeing than before.

Methods:

Design of the study: The research design was A Quasi-experimental one group (pretest/posttest) design.

Study Setting: This study was carried out at the Obstetrics and Gynaecology department's outpatient (Family planning & gynaecology clinics) at Menoufia University Hospital. It was affiliated with Menoufia University.

Sample: A purposive sample of (380) women who were using oral contraceptive pills. It was selected based on the following criteria.

Inclusion criteria: women who are healthy married women and were sexually acting, used oral contraceptive pills, Between the ages of 18 and 45 years old, no history of chronic medical diseases (D.M, hypertension, renal failure, or liver cirrhosis.), and approve to share in the study.

Exclusion criteria: women who used other hormonal contraceptives methods, their age above 45 years. No abstinence of sexual relationship, no gynecological problems can affect the relationship, no mental or psychotic disorders, in addition to women who take antidepressant drugs. Finally, women decline to take part in the study.

Sample size: The sample size was determined according to the following formula, based on the research design (quiz experimental study):

$N = Z^2 \times P(1-P) / d^2$ (Danial, 1999). The estimated minimum sample size was 350 women with a prevalence of 10.4 percent, a confidence level of 95 percent and 5 percent accuracy A larger sample size of 380 with a prevalence of 10.5 percent women how used OCPs.

Tools of Data Collection:

The study used three different tools to collect data. The researchers created it based on a literature review.

Tool I: Interviewing and assessment questionnaire schedule: It was created by the researchers and included four parts:

Part one: is used to collect the study subjects' socio-demographic data, (women age, education level, occupation, place of residence).

Part two: Menstruation history (amount of menstrual bleeding, duration, regularity, and menstrual pain)

Part three: Obstetric history (No of gravidity, No of parity, and No of children)

Part four: Family planning history, duration of using oral contraceptive pills, and reasons for discontinuation of method.

Tool II: Sexual function scale questionnaire, after reviewing the pertinent literature *McGahuey et al., (2000)*. It has six items (sex drive, sexual arousal, sexual orgasm, vaginal lubrication, orgasms that are satisfying, and discomfort or pain during or after vaginal penetration). For each woman, there were two ways to respond to the questionnaire: 1 for "Yes" if the woman had good sexual function based on each topic, and 2 for "No" if they didn't.

Tool III: - Following up sheet, after three months of counseling program, this tool is used to identify reasons for stopping the use of the pills, related to sexual function, as well as how the wellness of women has improved.

Content validity and reliability

The tools were reviewed by five experts in the field of obstetric and maternal health nursing. This review was conducted to test the validity of the content, relevance and clarity of the tools, and then modifications were made accordingly. The reliability of the tools was tested using Cronbach's alpha test, and the score was highly reliable, respectively (0.85, 0.87, and 0.86) for tools (1, 2, and 3), which check the tools for relevance, comprehensiveness, and clarity. The reliability of the tools was tested using test-retest method.

Pilot Study: Conducted to evaluate the viability and clarity of the study tools prior to the start of data collecting. The analysis of the pilot study was conducted on 10% of the sample in order to identify any tool modifications that were necessary, and the pilot study participants (women) were not included in the main investigation.

Ethical consideration:

After obtaining formal approval from the Menoufia University Hospital Director, the Dean of the Nursing Faculty, and the Faculty of Nursing's Research Ethics Committee (Code of Ethics, 916). Researchers start to collect

women who meet the inclusion criteria and inform them of the purpose of the study in order to obtain their acceptance to participate in the study. Then obtain written consent from them. Anonymity and confidentiality are also ensured by researchers. The women were also given assurances that their participation in the study was voluntary and that they had the freedom to leave at any moment without affecting the health care facilities they would receive.

Study procedure:

The Directors of the previously stated sittings provided formal approval to the investigators. Then, the researchers collected data three days per week (Sunday, Monday, & Tuesday) to collect data from the studied women. Data collection began at January, to the end of August 2022. This study was conducted through two main phases: assessment & implementation phase, and evaluation phase.

A. Assessment and implementation phase.

In this phase, all women (380 women) were interviewed and assessed for 40 minutes to collect socio-demographic data, menstrual history, and obstetric history. Women with no sexual problems were excluded. Then,

- Researchers collect data **pre** counseling program from the selected subjects who have sexual problems (217) women due to OCPs using. Also collection of data about effects on a woman's wellbeing regarding to physical, mental, and emotional health as well as her interest, enjoyment, and frequency of sexual activity with its relation to continuation and discontinuation of oral contraceptives pills.
- Implementing the Counseling program: that a method that helps women's welfare by using a management guide for typical side effects.

Application:

Women who had sexual problems due to OCPs interviewed at two sessions (one-to-one counseling sessions) on the counseling room of the designated centers.

The first session lasted 5 to 10 minutes; each woman received the same amount of consulting

time. A questionnaire about demographic and sexual function was used to obtain the data in the first session by a sexual function scale which based on six domains (sexual desire, sexual arousal, vaginal lubrication, orgasm, sexual satisfaction, and discomfort during intercourse).

The **second session** was 25 to 30 minutes long. In which researchers began to give health instructions based on counseling program, it should match across six levels. (Bringing up the issue, Explaining, Telling, Timing, Training, and finally recording.

B: Evaluation phase: Post/ test evaluation

- In this phase, after three months, researchers met the women at the family planning clinic who had come to use the monthly method OCs (those women who had attended counseling sessions with both general and problem-specific issues).
- Only (206) Women who complete participation in the study, and shared in the posttest evaluation. Post-test assessment was carried out to reassess the sexual problems and its relation to continuation and discontinuation of oral contraceptives pills. If participants were discontinuing the pills, they were required to provide documentation for this choice.

Limitation of the study:

- Because of the sensitivity of the subject and the inability to talk about sexual problems, some women refused to participate in the study due to their ashamed to discuss sexual problems with the researchers.
- Some women (11) withdraw from the research and did not complete the study.

Statistical analysis:

SPSS 20.0 software was used to analyze the data that had been gathered. Mean and standard deviation (Mean \pm SD) were used to describe continuous variables, whereas number and percentage were used to represent categorical variables. The chi-square test and correlation were used to compare continuous and categorical variables in place of the t-test.

Results:

Table (1) explains distribution of socio-demographic data among studied women (having

sexual problems). It showed that the mean age for studied women is (29.75 \pm 5.59) years, the most women are at age 25-30 yrs.(40.6%) and that (65.5%) of participants are housewives and attained university education degrees(36.4%)in preparatory(8.8%) and secondary schools(22.6%), while (15.2%) attained a Illiterate.

Fig (2) illustrates the distribution of sexual problems among oral contraceptive users. It reflects that (57%) of participants have sexual problems.

Table (2): shows distribution of sexual function on woman wellbeing (pretest) (n= 217). About three-quarters (78.2%) of participants had not strong sexual drive .More than two- thirds (72.9%) had not sexually aroused easily. Three-quarters (75.5%) had dry vagina while more than two- thirds (70.5%) had not reach orgasm. Also the majority of them (89.2%) had not sexually satisfied and more than half (41.1%) of them suffering of pain during or following vaginal penetration.

Table (3) shows pretest and post-test of sexual function scale among participants using Oral Contraceptive Pills (OCP). There were highly statistically significant differences between pretest and post-test in sexual function scale for all six items at (P<0.001)

Table (4) illustrated distribution items of sexual status and it's relation to continuation/ discontinuation of OCPs (post-test) (n= 206). There were highly statistically significant differences related to all items of sexual status in continued and discontinued using of OCPs at (P<0.001).

Table (5) demonstrates correlation among items of sexual status according to continuation and discontinuation of OCPs. There were highly statistically significant differences at (P<0.001) with positive correlation for the majority of every items. Where the values of both variables tend to increase together, that except items for how strong is your sex and vaginal penetration? With a negative correlation related to continuation and discontinuation of OCPs.

Figure (1): Algorithm of the study

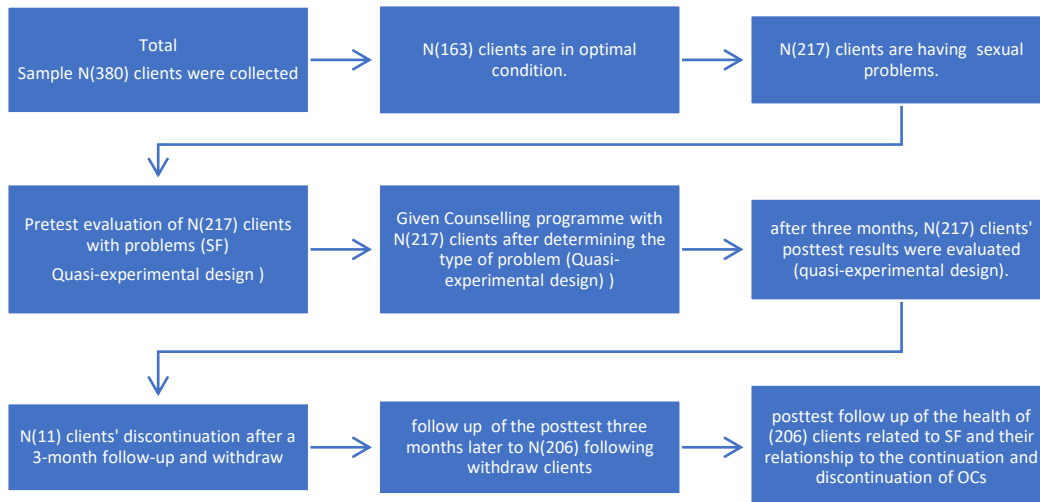


Table (1): Distribution of Socio-demographic Data among Studied Women (having sexual problems) (n= 217)

| Items | Studied Women (having sexual problems) (n= 217) | |
|----------------------------|-------------------------------------------------|-------------|
| | No. | % |
| Age: (years) | | |
| < 25 years | 45 | 20.7 |
| 25 - 30 years | 88 | 40.6 |
| > 30 years | 84 | 38.7 |
| Mean ± SD (Range) years | 29.60 ± 5.62 (18.0 – 44.0) years | |
| Residence: | | |
| Rural | 89 | 41.0 |
| Urban | 128 | 59.0 |
| Level of education: | | |
| Illiterate | 33 | 15.2 |
| Read & write | 21 | 9.7 |
| Primary | 16 | 7.4 |
| Preparatory | 19 | 8.8 |
| Secondary | 49 | 22.6 |
| University | 79 | 36.4 |
| Occupation: | | |
| Housewife | 141 | 65.0 |
| Employee | 76 | 35.0 |

Figure (2) Distribution of sexual problems among oral contraceptive users.

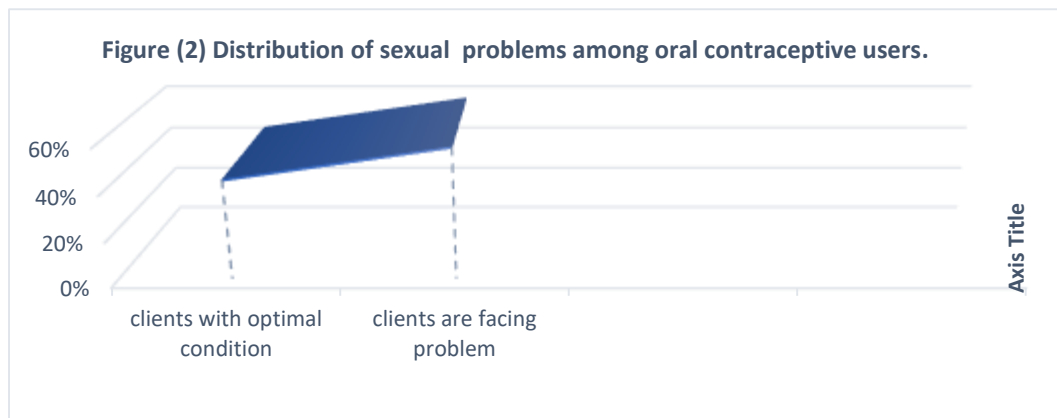


Table (2): Distribution of sexual function on woman wellbeing (pretest) (n= 217)

| Sexual Function Items | Pretest women wellbeing (n=217) | | | |
|----------------------------------------------------------------------------|------------------------------------|-------------|-----|-------------|
| | Yes | | No | |
| | No. | % | No. | % |
| 1- Is your sex drive strong (present)? | 83 | 21.8 | 134 | 78.2 |
| 2- Are you easily sexually aroused (turned on)? | 103 | 27.1 | 114 | 72.9 |
| 3- Does your vagina easily become moist or wet during sexual intercourse? | 93 | 24.5 | 124 | 75.5 |
| 4- Can you easily reach an orgasm? | 112 | 29.5 | 105 | 70.5 |
| 5- Are your orgasms satisfying? | 41 | 10.8 | 176 | 89.2 |
| 6- Do you feel discomfort or pain during or following vaginal penetration? | 156 | 41.1 | 61 | 58.9 |

Table (3): pretest and post-test of sexual function scale among women using Oral Contraceptive Pills (OCP) .

| Sexual function scale | Pre-test (n= 217) | | Post-test (n= 206) | | P-value |
|----------------------------------------------------------------------------------------------------------------|----------------------|------|-----------------------|-------------|---------|
| | No. | % | No. | % | |
| 1-How strong is your sex drive? | | | | | 0.000* |
| Very strong | 31 | 14.3 | 61 | 29.6 | |
| Somewhat strong | 103 | 47.5 | 114 | 55.3 | |
| Somewhat weak | 61 | 28.1 | 21 | 10.2 | |
| Very weak | 15 | 6.9 | 8 | 3.9 | |
| No sex drive | 7 | 3.2 | 2 | 1.0 | |
| 2-How easily are you sexually aroused (turned on)? | | | | | 0.000* |
| Very easily | 24 | 11.1 | 72 | 35.0 | |
| Somewhat easily | 90 | 41.5 | 94 | 45.6 | |
| Somewhat difficult | 71 | 32.7 | 27 | 13.1 | |
| Very difficult | 23 | 10.6 | 13 | 6.3 | |
| Never aroused | 9 | 4.1 | 0 | 0.0 | |
| 3-How easily does your vagina become moist or wet during sexual intercourse? | | | | | 0.000* |
| Very easily | 29 | 13.4 | 87 | 42.2 | |
| Somewhat easily | 95 | 43.8 | 77 | 37.4 | |
| Somewhat difficult | 58 | 26.7 | 31 | 15.0 | |
| Very difficult | 35 | 16.1 | 11 | 5.3 | |
| Never | 0 | 0.0 | 0 | 0.0 | |
| 4- How easily can you reach an orgasm? | | | | | 0.000* |
| Very easily | 24 | 11.1 | 99 | 48.1 | |
| Somewhat easily | 81 | 37.3 | 65 | 31.6 | |
| Somewhat difficult | 82 | 37.8 | 28 | 13.6 | |
| Very difficult | 27 | 12.4 | 8 | 3.9 | |
| Never reach orgasm | 3 | 1.4 | 6 | 2.9 | |
| 5- Are your orgasms satisfying? | | | | | 0.000* |
| Very satisfying | 39 | 18.0 | 76 | 36.9 | |
| Somewhat satisfying | 137 | 63.1 | 103 | 50.0 | |
| Somewhat unsatisfying | 32 | 14.7 | 24 | 11.7 | |
| Very unsatisfying | 7 | 3.2 | 2 | 1.0 | |
| Can't reach orgasm | 2 | 0.9 | 1 | 0.5 | |
| 6-How would you rate your level (degree) of discomfort or pain during or following vaginal penetration? | | | | | 0.000* |
| Very high | 9 | 4.1 | 38 | 18.4 | |
| High | 52 | 24.0 | 48 | 23.3 | |
| Moderate | 76 | 35.0 | 64 | 31.1 | |
| Low | 48 | 22.1 | 40 | 19.4 | |
| Very low or none at all | 32 | 14.7 | 16 | 7.8 | |

Table (4): Distribution of sexual status items related to continuation/ discontinuation of OCPs (post-test) (n= 206)

| Sexual Status | Women Using OCPs post Counseling(n=206) | | |
|----------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------------|---------|
| | OCPS Continuation | OCPS Discontinuation | P-value |
| | Mean ± SD | Mean ± SD | |
| 1- How strong is your sex drive? | 2.37 ± 0.93 | 1.91 ± 0.80 | 0.000* |
| 2- How easily are you sexually aroused (turned on)? | 2.55 ± 0.97 | 1.91 ± 0.85 | 0.000* |
| 3- How easily does your vagina become moist or wet during sexual intercourse? | 2.46 ± 0.92 | 1.83 ± 0.87 | 0.000* |
| 4- How easily can you reach an orgasm? | 2.56 ± 0.90 | 1.82 ± 1.00 | 0.000* |
| 5- Are your orgasms satisfying? | 2.06 ± 0.73 | 1.78 ± 0.72 | 0.000* |
| 6- How would you rate your level (degree) of discomfort or pain during or following vaginal penetration? | 3.19 ± 1.09 | 2.75 ± 1.19 | 0.000* |

Table (5): Correlation among Items of sexual status according to continuation and discontinuation of OCPs

| Items of sexual status | | How strong is your sex drive? | How easily are you sexually aroused (turned on)? | How easily does your vagina become moist or wet during sexual intercourse? | How easily can you reach an orgasm? | Are your orgasms satisfying? | How would you rate your level of discomfort or pain during or following vaginal penetration? |
|------------------------------------------------------------------------------------------------|---------|-------------------------------|--------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------|------------------------------|----------------------------------------------------------------------------------------------|
| 1-How strong is your sex drive? | r-value | | | | | | |
| | P-value | | | | | | |
| 2-How easily are you sexually aroused (turned on)? | r-value | 0.473 | | | | | |
| | P-value | 0.000* | | | | | |
| 3-How easily does your vagina become moist or wet during sexual intercourse? | r-value | 0.388 | 0.800 | | | | |
| | P-value | 0.000* | 0.000* | | | | |
| 4-How easily can you reach an orgasm? | r-value | 0.479 | 0.760 | 0.781 | | | |
| | P-value | 0.000* | 0.000* | 0.000* | | | |
| 5-Are your orgasms satisfying? | r-value | 0.451 | 0.593 | 0.510 | 0.569 | | |
| | P-value | 0.000* | 0.000* | 0.000* | 0.000* | | |
| 6-How would you rate your level of discomfort or pain during or following vaginal penetration? | r-value | -0.104 | -0.371 | -0.404 | -0.382 | -0.310 | |
| | P-value | 0.126 | 0.000* | 0.000* | 0.000* | 0.000* | |

Discussion

Due to negative effects of compound oral contraceptive pills (COCPs), on mood, wellness, and sexuality, they have a high incidence of discontinuation. Low libido and sadness seem to be less common reasons for users of lower dosage contraceptive pills to discontinue taking them, and side impact severity ratings are similarly lower. According to **Sartorius (2020)**, a meta-analysis of study from 19 different countries revealed that the dropout rate for compound oral contraceptive pills (COCPs), which may reach 44% in the first year, is unusually high.

Regarding to socio-demographic characteristics about the women who participated in the study, most of the participants were between the ages of 25 and 30; the average age of the women was 29.60 ± 5.62 (18.0 – 44.0) years. These results concur with those of **Kelly et al. (2010)**, who investigated the "Effects of oral contraceptives containing ethinyl estradiol with either drospirenone or levonorgestrel on various parameters associated with well-being in healthy women," with participants aged 18 to 35 years old.

The study's analysis of educational attainment shown the following: Extra than one-third of respondents had a university degree, which was

roughly on par with the findings from **Graham et al.**(2007), Despite the fact that one third of women held a university degree, two thirds of women were housewives. This roughly matched the findings of a study regarding the "Importance of Appropriate Counselling in Reducing Early Discontinuation of pills in a Northern District of Bangladesh" published in (2014) by **Chowdhuri R.et al.**, which found that about three quadrants of study women were housewives.

The study's findings regarding residence were consistent with those of (**El-zanaty, 2009**), who found that about two thirds of urban women were more likely to use contraceptives than more than one half of rural women, and only twelve percentage rely on the pill). In current study, more than half of women were from urban areas and less than half of participants were from rural areas. This is demonstrated by the fact that our findings are consistent with national statistical surveys published by the ministry of health in Egypt.

Related to sexual problems due to OCPs in the present study, More than seventy eight percent of women had no strong sexual initiative, seventy-two percent were not easily sexually aroused, seventy-five percent had dry vagina, seventy percent had not experienced orgasm, and eighty-two percent were not happy, according to our survey. This was consistent with findings from the study "Psychosexual well-being in women using oral contraceptives was containing drospirenone" conducted by **Nappi et al.** in (2008), which came to the conclusion that women's welfare is influenced by their sexual orientation. According to a different study, a woman's well-being may be impacted by her sexual attraction, enjoyment, enjoyment, enjoyment, and lack of vaginal lubrication (**Sanders, et al., 2001**). Comparable in meaning **Hassan et al. (2015)** found that the mean FSFI rating in the categories of desire, arousal, and lubrication were significantly lower in the contraceptive group than in the non-contraceptive group.

In relation to effect of counseling program on women wellbeing, and continuation /discontinuation of OCPs, The present study found that, counseling has a positive impact on wellbeing, which is in line with a study by **Dempsey (2014)**, that examined "Strategies to

improve compliance among oral contraceptive pill users" and came to a verdict that counselling or educational interventions increase OCP adherence or continuation. Furthermore, **Lu C, et al. (2019)** noted that the variety of contraceptive effects on women's sexual experiences shape their use and opinions of the product, leading to either increased motivation and consistent use or poor adherence and discontinuation. As a result, knowledge of these unique experiences can help providers better understand and direct their clients towards successful contraception.

Current study reveals that, counseling has a positive (pre-posttest) impact. Sexual status demonstrates that there are highly statistically significant differences in the sexual function scale for all over six items, indicating that these items may be changed by the counseling programme. This is also in agreement with **Sakinci et al. (2016)**, findings substantially scored lower on the arousal, lubrication, orgasm, pain, and overall FSFI scales than non-users ($p < 0.001$) and $p = 0.021$, respectively).

Also, According to **Battaglia et al. (2012)** the use of OC resulted in a substantial reduction in the number of sexual encounters weekly, a decrease in the occurrence of orgasms, and an increase in the amount of discomfort experienced during sexual encounters. A prospective study of the effects of oral contraceptives on sexuality and well-being and their relationship to discontinuation was conducted by **Sanders et al. in 2001**, the results indicated that extra than one third of women were still using the same OC at the conclusion of the study. Our study's continuation rate of using oral contraceptives revealed that more than three quadrants of women were still using pills. As **Sanders, et al.** only used half of our sample, this might be due to different sample sizes.

The correlations between each item of sexual dysfunction status according to the continuation and discontinuation of OCPs in the present study shows that there are highly statistically significant and positive correlations with the majority of every item that is consistent with The study's strongest features were the comparison of sexual function between individuals who use contraception and those who do not, as well as the evaluation of sexual function amongst the most

widely used contraceptive methods in Egypt. (Tabal, A. et al.,2021).

Conclusion:

The current study's findings led to the conclusion that, counseling program about sexual state succeeded in lowering sexual problems among women, and improving compliance as well motivating women for continuation of using OCPs. Moreover, counseling program is very important in improving women wellbeing.

Recommendations:

- ✓ Increased counseling programs for married women about safe and quality of sexual function and wellbeing.
- ✓ Sexual functions status should be included in family planning programs and clinics to improve women health and wellbeing.
- ✓ Documenting Sexual Function Scale as an assessment tool and essential part in family planning assessment clinics.

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