THE ADULTING VAULT

Reproductive Health and Family Planning

The Information You Were Supposed to Get and Probably Did Not

EVERYTHING THEY FORGOT TO TEACH YOU

Most people leave school knowing less about their own reproductive system than about the water cycle. This guide fills that in plainly — how the cycle actually works, what each contraceptive method does and how well it works in real life rather than in theory, what fertility looks like when you are trying and when you are not, and how to get care when the system is confusing or expensive. It is written to be useful whatever you are planning, including if you are planning nothing at all.

Please Read This First

This guide is general educational information, not medical advice. It is not a substitute for diagnosis, treatment, or care from a qualified clinician who knows your history. Nothing here creates a provider-patient relationship. Do not delay seeking care, or disregard advice you have been given, because of something you read here. If you think you may have a medical emergency, call 911 or go to your nearest emergency department.

CURRENCY OF THIS GUIDE

Contraceptive effectiveness figures are drawn from published United States research and reflect the most recent estimates available as of mid-2026. Screening intervals, treatment options, and the legal framework around reproductive care differ by state, by professional body, and over time. Verify anything you intend to act on with a clinician and with a current authoritative source.

Part One: How the Cycle Actually Works

Useful whether or not you have one.

The menstrual cycle is usually taught as a calendar. It is more usefully understood as a hormonal sequence with one event at its centre: ovulation, the release of an egg. Everything else is preparation for that or consequence of it.

Phase	What is happening
Menstruation	The uterine lining sheds. Typically three to seven days. Counted as day one of the cycle.
Follicular phase	Follicles in the ovary mature; oestrogen rises and the lining rebuilds. This phase varies most in length, which is why cycles differ.
Ovulation	An egg is released. The egg survives roughly 12 to 24 hours. This is the fertile window's centre.
Luteal phase	Progesterone rises to support a possible pregnancy. Relatively consistent, typically around 14 days. If no pregnancy, hormones fall and the cycle restarts.

THE FERTILE WINDOW IS WIDER THAN THE EGG'S LIFESPAN

Sperm can survive several days in the reproductive tract. That means intercourse in the days before ovulation can result in pregnancy, not only on the day itself.

This is why "I tracked my cycle" is a weaker contraceptive strategy than people expect — the window is longer than the ovulation date, and ovulation timing shifts with stress, illness, travel, and sleep.

What is worth mentioning to a clinician

- Cycles consistently shorter than 21 days or longer than 35
- Bleeding heavy enough to soak through protection hourly, or lasting beyond seven days
- Pain that stops you functioning, or that painkillers do not touch
- Bleeding between periods, after sex, or after menopause
- Periods that stop for three months or more without pregnancy

Severe period pain is frequently dismissed, including by clinicians. Conditions such as endometriosis and fibroids are common and take years to diagnose on average. If you are told pain is normal and it is disabling you, that is a reasonable thing to seek a second opinion about.

Part Two: Contraception

What each method is, and how well it works when actual humans use it.

Typical use versus perfect use

Every method has two numbers. Perfect use is how it performs when used consistently and correctly every single time. Typical use is how it performs across everyone who uses it, including the missed pill, the late refill, the condom put on halfway through. Typical use is the number that describes your actual life.

The figures below are the percentage of users who experience a pregnancy within the first twelve months of use. Lower is more effective.

Method	Typical use	Perfect use	Notes
Implant	Under 1%	Under 1%	Small rod in the upper arm. Lasts several years.
IUD (hormonal or copper)	Under 1%	Under 1%	Placed in the uterus. Lasts years. Copper is non-hormonal.
Sterilisation	Under 1%	Under 1%	Considered permanent. Reversal is possible but difficult.
Injection	About 4%	Under 1%	Every few months. Requires keeping appointments.
Pill, patch, ring	About 7–9%	Under 1%	Daily, weekly, or monthly. The gap is entirely about consistency.
External condom	About 13%	About 2%	Also protects against STIs.
Internal condom	About 21%	About 5%	Also protects against STIs.
Withdrawal	About 20%	Around 4%	Better than nothing. Considerably worse than most alternatives.
Fertility awareness	Highly variable	Variable	Ranges widely by specific method and consistency. Requires real training.

THE SINGLE MOST USEFUL PATTERN IN THAT TABLE

The methods with no gap between typical and perfect use are the ones that do not depend on you remembering anything — implants, IUDs, sterilisation. They are called long-acting reversible contraception, and their real-world effectiveness is

Method	Typical use	Perfect use	Notes

dramatically higher than user-dependent methods for exactly that reason.

Condoms are the only methods on this list that also reduce STI transmission. Nothing hormonal does. Using a condom alongside another method covers both.

Choosing

Effectiveness is one axis. It is not the only one, and the best method is the one you will actually use.

- Do you want to avoid hormones? Copper IUD and barrier methods are the non-hormonal options.
- Do you want something you cannot forget? LARC.
- Do you need it hidden? Implant and IUD leave nothing to find.
- Do you want a return to fertility quickly? Most methods return quickly; the injection can take longer.
- Do you have migraines with aura, clotting history, high blood pressure, or take other medications? These genuinely affect which methods are safe. Say so.
- Is cost the constraint? Coverage varies, and many clinics provide methods at reduced or no cost.

What matters most to me in a method, ranked? Take this to the appointment.

Emergency contraception

Emergency contraception can reduce the chance of pregnancy after unprotected sex or a method failure. There is more than one type, they work differently, and effectiveness depends heavily on how quickly you act and on other factors including body weight.

- Sooner is substantially better in every case
- Some options are available without a prescription; others require one

- A copper IUD placed within a defined window is among the most effective options and provides ongoing contraception afterwards
- A pharmacist can advise, and this is a normal question to ask one
- Emergency contraception is not the same thing as medication abortion — they are different drugs with different mechanisms

Part Three: Fertility

For people trying, and for people who want to know what is normal.

How conception timing actually works

Conception is possible during the fertile window — roughly the five days before ovulation and the day of it. Intercourse every day or two across that window is as effective as elaborate timing, and considerably less stressful.

Even with perfect timing and no fertility problems, the chance of conception in any single cycle is modest — commonly cited around one in four for people in their twenties, declining with age. Several months without conceiving is ordinary, not a signal.

Tracking, if you want to

- Cycle length over several months, to establish your own pattern
- Cervical mucus changes, which shift predictably around ovulation
- Basal body temperature, which rises slightly after ovulation — confirming it happened rather than predicting it
- Ovulation predictor kits, which detect the hormone surge preceding release

> **WHEN TO SEEK AN EVALUATION**
>
> General guidance is to seek evaluation after twelve months of trying without conception if you are under 35, and after six months if you are 35 or over.
>
> Seek advice sooner regardless of age if you have irregular or absent cycles, known endometriosis or fibroids, previous pelvic infection or surgery, a history of pregnancy loss, or a known male-factor concern.
>
> Fertility evaluation involves both partners. Male factors contribute to a substantial share of infertility, and semen analysis is simple, quick, and inexpensive — it is often the sensible first test rather than the last.

If evaluation is needed

A first workup typically looks at ovulation, the fallopian tubes and uterus, and semen quality. From there, options range from medication that supports ovulation, through procedures such as intrauterine insemination, to in vitro fertilisation. Which is appropriate depends entirely on what the workup finds.

Costs and insurance coverage for fertility treatment vary enormously, including by state mandate and by employer. Ask about total cost and coverage before starting, not partway through.

Part Four: Pregnancy and Early Care

The first steps, briefly.

- Home pregnancy tests are accurate when used from around the time of a missed period. Testing very early produces false negatives.
- Prenatal care ideally begins early. First appointments typically confirm the pregnancy, establish dating, review medications and history, and screen for conditions that matter.
- Folic acid before and during early pregnancy reduces the risk of certain birth defects, which is why it is often recommended to anyone who could become pregnant.
- Some medications, supplements, and substances are not safe in pregnancy. Do not stop a prescribed medication without advice — for many conditions, stopping is the greater risk.
- You have a choice of provider type in many areas, including obstetricians and midwives, and of birth setting. Ask what is available where you are.

> **SYMPTOMS THAT NEED SAME-DAY ATTENTION IN PREGNANCY**
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> Heavy bleeding, severe abdominal pain, severe headache with visual changes, sudden swelling of face or hands, fever, or reduced fetal movement later in pregnancy.
>
> If you are worried and unsure, call. Being told it was nothing is a good outcome, not a wasted call.

Part Five: Pregnancy Loss

Far more common than the silence around it suggests.

A substantial proportion of recognised pregnancies end in miscarriage, most in the first trimester. The overwhelming majority are caused by chromosomal abnormalities that were present from the start — not by lifting something, working, stress, exercise, or anything else the person did.

People blame themselves anyway, almost universally. It is worth stating plainly: in the great majority of cases there was nothing to do differently.

What to know

- Bleeding in early pregnancy is common and does not always mean loss. It should still be reported.
- There are several management approaches — waiting, medication, or a procedure. Each is legitimate; the choice is often yours to make with your clinician.
- Recurrent loss — generally defined as two or three consecutive — warrants investigation. Ask for it.
- Grief after miscarriage or stillbirth is real grief, whatever anyone else thinks about how far along you were.

> **SUPPORT**
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> Loss support groups exist specifically for miscarriage, stillbirth, and infant loss, and hospital or hospice bereavement services can often refer you whether or not they were involved in your care.
>
> If you are struggling badly, or having thoughts of not wanting to be here, call or text 988, or chat at 988lifeline.org. Perinatal mental health conditions are common, treatable, and not a reflection of anything about you.

Part Six: Decisions About a Pregnancy

A neutral orientation to a genuinely contested area.

People facing an unplanned or complicated pregnancy generally weigh some combination of continuing the pregnancy and parenting, continuing it and pursuing adoption, or ending it. Which options are available to you, and under what conditions, depends heavily on where you live.

> **WHY THIS GUIDE DOES NOT TELL YOU WHAT THE LAW IS**
>
> The legal framework governing abortion in the United States varies substantially from state to state and has changed significantly and repeatedly since 2022. It continues to change, including through litigation.
>
> Any specific legal statement printed here would risk being wrong by the time you read it, and being wrong about this carries real consequences. So this guide does not attempt one.
>
> For current, jurisdiction-specific information, consult a licensed clinician, a legal aid organisation, or your state health department directly.

What is generally useful regardless of what you decide

- Confirm the pregnancy and how far along it is with a clinician. Timing affects what options exist everywhere.
- Verify what an organisation actually provides before an appointment. Not every facility that advertises pregnancy services offers the full range of medical care, and some do not employ clinicians.
- Ask directly about cost, confidentiality, and what happens at the appointment.
- If you want to talk it through, ask for non-directive counselling — support that helps you reach your own decision rather than steering you to a particular one.
- Whatever you decide, follow-up care matters. Do not skip it.

This guide takes no position on what anyone should choose. That is a question involving values, circumstances, and beliefs that belong to you, and reasonable people reach different conclusions about it.

Part Seven: Preventive Care

The appointments that catch things early.

Screening recommendations differ between professional bodies and are revised periodically, particularly cervical cancer screening intervals and the age at which breast screening begins. Rather than printing intervals that may be out of date, this section covers what the screenings are and what to ask.

Screening	What it looks for
Cervical screening	Cell changes and high-risk HPV that can precede cervical cancer. May involve cytology, HPV testing, or both.
Breast screening	Changes not detectable by feel. Timing depends on age and personal and family risk.
STI screening	Many infections are asymptomatic. What is recommended depends on age, partners, and practices.
Blood pressure and metabolic markers	Conditions that affect pregnancy and long-term reproductive health.
Testicular self-awareness	Changes in size, shape, or texture. Relevant particularly for younger men.

Questions to ask at your next appointment

- ❑ Which screenings am I due for, given my age and history?
- ❑ Does my family history change any of this?
- ❑ What am I not being screened for that I might expect to be, and why?
- ❑ Which of these does my coverage pay for in full?

Men's reproductive health, which routinely gets left out

- Semen analysis is simple and inexpensive, and male factors contribute to a large share of infertility
- Vasectomy is among the most effective and lowest-risk contraceptive procedures available, and is considerably simpler than female sterilisation
- Testicular changes should be checked promptly; testicular cancer is highly treatable when caught early and disproportionately affects younger men

- Erectile difficulty is frequently an early sign of cardiovascular or metabolic conditions and is worth raising rather than ignoring

Part Eight: Getting Care

Cost, confidentiality, and finding someone.

If cost is the obstacle

- Federally qualified health centres provide care on a sliding fee scale regardless of ability to pay, and many include reproductive services
- Title X funded clinics provide family planning services on a sliding scale
- Local health departments frequently offer contraception and STI testing at low or no cost
- University and student health services, if you are eligible
- Ask any clinic directly what they charge uninsured patients. Many have a rate they do not advertise

Confidentiality

Confidentiality rules vary by age, by state, and by how the care is billed. A common practical issue is that an insurance explanation of benefits is sent to the policyholder, which can disclose care to a parent or partner. If that matters to you, ask the clinic before the appointment how billing will appear and what alternatives exist.

Getting taken seriously

Reproductive symptoms are dismissed at high rates, and pain in particular. If you feel unheard, these help.

- Lead with impact rather than sensation: "this stops me working three days a month"
- Bring written notes, including dates and duration. Written records are treated as more credible than recalled ones
- Ask for your concern and the response to be documented in your record. This question alone frequently changes the conversation
- Bring someone with you if you can
- Second opinions are normal and you do not need permission

What do I want to raise at my next appointment? Write it now, take it with you.

Closing

Most of what makes reproductive health confusing is not that the biology is complicated. It is that the information is distributed unevenly, wrapped in embarrassment, and frequently delivered too late to be useful.

The practical version is short. Know roughly how your own body works. Pick a method that matches your actual life rather than an idealised one. Get the screenings. Ask direct questions and expect answers. And treat pain that disables you as a reason to be persistent rather than as something to accommodate.

> **VERIFY BEFORE YOU ACT**
>
> Screening intervals and clinical recommendations are revised periodically — confirm current guidance with a clinician.
>
> The legal framework around reproductive care varies by state and changes. Consult a licensed clinician, legal aid organisation, or your state health department for current, jurisdiction-specific information.
>
> If you are in distress: call or text 988, or chat at 988lifeline.org.