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Society of Family Planning Committee Statement: Contraception and body weight☆,☆☆

Noor Zwayne [a,*], Elizabeth Lyman [b], Ashley Ebersole [c], Jessica Morse [d], with the assistance of Elise Boos and Antoinette Nguyen on behalf of the Clinical Affairs Committee, and Monica Skoko Rodríguez

[a] University of Texas at Austin, Dell Medical School, Department of Women's Health, Division of Pediatric and Adolescent Gynecology, Austin, TX, United States
[b] Nationwide Children's Hospital, Medical Library, Columbus, OH, United States
[c] The Ohio State University College of Medicine, Department of Pediatrics, Columbus, OH, United States
[d] University of North Carolina, Department of Obstetrics & Gynecology, Chapel Hill, NC, United States

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ABSTRACT

Understanding the relationship between contraception and body weight is an important clinical consideration. Body weight and size has the potential to affect fertility and the effectiveness of some contraceptive methods, although historically this association has not been applied within a person-centered context that would allow individuals to select their preferred contraceptive method. Further, individuals with higher body weights and larger sizes have unmet contraceptive care and counseling needs. This document aims to provide evidence-based, person-centered, and equity-driven recommendations that destigmatize contraceptive care across all body weights. Clinicians should: provide person-centered, unbiased contraceptive care, including counseling pregnant-capable individuals on their risk of pregnancy based on sexual practices and contraceptive use regardless of body weight or size; utilize evidence-based and person-centered contraceptive counseling to offer the full range of contraceptive methods regardless of body weight or size; counsel patients about any risks and benefits associated with body weight and size to assist in their selection of contraceptive methods, including emergency contraception; counsel individuals about the potential for weight change, particularly weight gain, associated with contraceptive methods as a possible factor in decision-making; and counsel individuals regarding the potential impact of weight management approaches, such as bariatric surgery and glucagon-like peptide 1 (GLP-1) agonists, on contraceptive efficacy.

1. Background

Understanding the relationship between contraception and body weight is an important clinical consideration. Body weight and size has the potential to affect fertility and the effectiveness of some contraceptive methods, although historically this association has not been applied within a person-centered context that would allow individuals to select their preferred contraceptive method. Further, individuals with higher body weights and larger sizes have unmet contraceptive care and counseling needs [1]. This document, a revision of the 2009 *Contraceptive considerations in obese women* [2], aims to provide evidence-informed, person-centered, and equity-driven recommendations that destigmatize contraceptive care across all body weights.

Evaluating health and deciding care based on body weight alone is problematic, can contribute to stigma for people with higher weight, and can incorrectly imply that high weight directly leads to poor health. When body weight is relevant to clinical care, there are

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Disclaimer: This publication is designed as a resource to assist clinicians in providing family planning care. It should not be considered inclusive of all proper treatments or serve as the standard of care. It is not intended to substitute for the independent professional judgment of the treating clinician. Variations, taking into account individual circumstances, may be appropriate. This publication reflects the best available evidence at the time of publication, recognizing that continued research or major changes in the practice environment may impact future recommendations and should be evaluated for incorporation into care. Any updates to this document can be found at https://societyfp.org/clinical/clinical-guidance-library/. The Society and its contributors provide the information contained in this publication "as is" and without any representations or warranties, express or implied, of any kind, whether of accuracy, reliability, or otherwise.

* Corresponding author.
E-mail address: noor.zwayne@austin.utexas.edu (N. Zwayne).

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various ways to measure and evaluate body weight and size, including body surface area, total body weight, body composition, relative fat mass, waist circumference, measurements of visceral fat, body roundness index, body adiposity index, and the body mass index (BMI) classification system. Studies use a variety of body weight and size-related metrics when reporting outcomes, making it difficult to compare outcomes across studies. This document uses the measurements or terms reported in the literature.

BMI, calculated by dividing weight in kilograms by height in square meters, is ubiquitous in research and clinical practice despite having critical limitations. It was originally developed as an indirect population-level measure of body fat not intended to be used to predict an individual's health. The BMI system is based on measurements of White European men and has been used as a tool for racist exclusion, causing historical harm [3–5]. Further, it does not differentiate weight from muscle, bone, fat, or organs [4,5] and can perpetuate the incorrect assumption that body weight is a proxy for health. The terms used within the BMI classification system are often not preferred by patients and can contribute to weight stigma, bias, and discrimination. For example, "healthy weight" incorrectly implies there is one specific weight at which an individual is healthy; "overweight" implies any weight above "normal weight" is aberrant; and "obese" and "morbidly obese" pathologize body weight and size [5–7].

Despite these challenges, the BMI system remains pervasive, inexpensive, and easy to assess in a clinical setting. The Society recommends avoiding the terms used within the BMI classification given the imprecise and problematic nature of the system and its unclear clinical impact on health management. As such, when reporting data from the literature that uses BMI, this document references BMI classification measurements rather than classification terms.

Clinicians should address body weight in relevant clinical situations and utilize person-centered approaches when discussing body weight. These approaches should include using person-first language, such as "people with higher body weight" instead of "obese people" [8], and, when discussing body weight and size with a patient, use the language preferred by the patient.

The increased stigma and discrimination faced by people with higher body weights and larger sizes, including from within the healthcare system, can negatively impact their relationship with clinicians and their mental and physical health [6,9]. Patients with multiple stigmatized identities (e.g., individuals who are people of color, gender-diverse, differently-abled) may experience mutually reinforcing sources of oppression that can negatively impact their health [6]. Factors such as gender, race, sexual orientation, ability status, and type of care being provided may intersect with weight stigma and impact the internalization of this stigma [7,10]. Clinicians should be familiar with the barriers to care faced by people with higher body weights and larger sizes and employ approaches to create welcoming clinical spaces for people of all body weights and size; this can help ensure patients receive the individualized care they need without stigma, minimize care avoidance, and improve contraceptive and overall reproductive health in the long term. Weight-inclusive practices include focusing on treating the person or condition rather than the weight; providing waiting room chairs, exam tables, and blood pressure cuffs that accommodate all body sizes; making appropriately sized medical equipment – such as longer speculums for intrauterine device (IUD) placement or longer needles for intramuscular medication injection – readily accessible; using electric beds that can be adjusted easily; and asking permission before discussing weight with the patient [6,9,11]. The potential for a positive impact may be most notable in individuals with overlapping oppressions and seeking other stigmatized care (e.g., abortion care, substance use disorder treatment).

Table 1
US Medical eligibility criteria for contraceptive use in individuals with larger bodies

BMI category	Cu IUD	LNG IUD	Implant	DMPA	POP	CHC
BMI ≥ 30 kg/m^2	1	1	1	1	1	2
Menarche to < 18 y and BMI ≥ 30 kg/m^2	1	1	1	2	1	2

BMI, body mass index; CHC, combined hormonal contraceptives; Cu, copper; DMPA, depot medroxyprogesterone acetate; IUD, intrauterine device; LNG, levonorgestrel; POP, progestin-only pill.
Key: 1 = No restriction (method can be used); 2 = Advantages generally outweigh theoretical or proven risks.

2. Committee statements

2.1. Clinicians should provide person-centered, unbiased contraceptive care. This includes counseling pregnant-capable individuals on their risk of pregnancy based on sexual practices and contraceptive use regardless of body weight or size.

Clinicians should identify and work to minimize their own potential implicit biases about sexual activity in patients with higher body weight and larger body sizes.

Abnormalities in metabolism and extremes in body weight can affect the reproductive system. BMI of 30 kg/m^2 or higher is a known risk factor for reduced fertility because of menstrual cycle abnormalities, ovulatory dysfunction, polycystic ovarian disease, and insulin resistance [12,13]. Menstrual cycle abnormalities and ovulatory dysfunction may be further explained by leptin and adiponectin, which are secreted by adipose tissue. Leptin receptors have been found on ovarian cells and may inhibit ovarian function [14]. Similarly, adiponectin is expressed in the female reproductive tract, which may alter the ovarian cycle [15]. The correlation between higher BMI and fertility may be stronger when a BMI of 30 kg/m^2 or higher occurs in the adolescent years [13]. However, most pregnant-capable individuals, regardless of height and weight, ovulate regularly and are at risk for pregnancy [12].

Regarding contraceptive use, an analysis of the Family Planning Module of the Behavioral Risk Factor Surveillance System (BRFSS; 7943 pregnant-capable individuals) found that pregnant-capable people with a BMI of 30 kg/m^2 or higher were significantly less likely to use contraception as compared to pregnant-capable people with BMI of 18–25 kg/m^2 [16]. A European study of postpartum individuals also demonstrated a higher rate of unplanned pregnancy among pregnant-capable individuals with a BMI of 30 kg/m^2 or higher, which was associated with a lower rate of contraception usage [17]. Whether these disparities are due to patient, clinician, or systems challenges is unclear.

2.2. Clinicians should utilize evidence-based and person-centered contraceptive counseling to offer the full range of contraceptive methods regardless of body weight or size.

No type of contraceptive method is absolutely contraindicated based on an individual's body weight or size, including for individuals with a BMI of 30 kg/m^2 or higher (Table 1) [18]. Clinicians should use shared decision-making to counsel patients about the individualized risks and benefits of each contraceptive method.

2.3. Clinicians should counsel patients about any risks and benefits associated with body weight and size to assist in their selection of contraceptive methods, including emergency contraception.

When pregnancy prevention is the patient's primary goal, counseling should include information on the association between body weight and size and contraceptive method effectiveness,

recognizing that the risk of decreased effectiveness varies by method and an individual's body weight and size. Contraceptive effectiveness relies on the correct and consistent use of the method(s), sexual practices (see 2.1), fecundity (see 2.1), individual patient characteristics, and the inherent efficacy of the method.

Oral contraceptives

For oral contraceptives (OC), data on the effectiveness of OCs for people with a BMI of 30 kg/m^2 or higher is limited because it was not until 2007 that the Food and Drug Administration (FDA) recommended that clinical trial entry criteria be more reflective of real-world prescribing, including enrollment of participants with BMIs that reflect the population of reproductive-age individuals [19]. In addition, limited studies were available regarding the incidence and prevalence of individuals with BMIs of 30 kg/m^2 or higher [20]. While a BMI of 30 kg/m^2 or higher affects how steroid hormones are processed, contraceptive efficacy is likely the same in pregnant-capable people regardless of BMI [21–27].

Combined oral contraceptives (COCs) and combined hormonal contraceptives (CHCs). Most OC failures are associated with incorrect or inconsistent use of OC. However, some evidence suggests that the effectiveness of some COC formulations might decrease with increasing BMI [18,28]. While the observed reductions in effectiveness are minimal and evidence is conflicting, clinicians should counsel patients regarding the potential for decreased effectiveness of COCs in pregnant-capable people with a BMI of 30 kg/m^2 or higher. Additionally, individuals with a BMI of 30 kg/m^2 or higher who use CHCs are more likely to experience venous thromboembolism (VTE) than individuals with a BMI of 30 kg/m^2 or higher who do not use CHCs [18], making a BMI of 30 kg/m^2 or higher an independent risk factor for VTE in individuals who use CHCs [29,30]. This risk is still lower than the four- to fivefold increased risk of VTE during pregnancy compared to nonpregnant individuals [31].

Progestin-only pills (POPs). Limited data suggests that there is no difference in contraceptive efficacy by BMI [32], and individuals with higher BMIs can safely use POPs [18,33]. The over-the-counter availability of some POP formulations may be considered an additional benefit. It has the potential to reduce barriers and increase contraceptive access, particularly for people who may already face bias and sigma in their interactions within the healthcare system [33].

Nonoral contraceptives

Norelgestromin/ethinyl estradiol (EE) and levonorgestrel (LNG) contraceptive transdermal patch. One pooled analysis suggests a higher rate of contraceptive failures among pregnant-capable people who weighed 90 kg (198 lbs) or more, and another secondary analysis suggests a BMI greater than 30 kg/m^2 is associated with increased failure [28,32,34,35]. Additionally, the FDA label for the LNG transdermal patch states that it is contraindicated in individuals with a BMI of 30 kg/m^2 or higher due to decreased effectiveness and a higher risk of VTE [36]. While the evidence is limited, clinicians should counsel patients regarding the potential for decreased effectiveness of and increased risk of VTE from the contraceptive patch in pregnant-capable people with a BMI of 30 kg/m^2 or higher.

Etonogestrel (ENG)/ethinyl estradiol (EE) and segesterone acetate/ethinyl estradiol (EE) contraceptive vaginal rings. Similarly, a prospective study including 20 pregnant-capable people with a BMI of 30 kg/m^2 or higher using the ENG/EE contraceptive vaginal ring found that these individuals had lower serum EE levels but still had suppression of ovarian follicular development similar to that of pregnant-capable people with a BMI of 18.5–24.9 kg/m^2 [37]. Clinical trials for the segesterone acetate/EE contraceptive vaginal ring had a limited number of participants with a BMI greater than 29 kg/m^2. Therefore, safety and efficacy have not been adequately evaluated in this population [38].

Etonogestrel (ENG) contraceptive implant. The contraceptive implant is highly acceptable among pregnant-capable people with a BMI of 30 kg/m^2 or higher [39], although acceptability and preference is ultimately determined by each individual patient. While the serum concentration of ENG may be lower in people with higher BMIs, most people will maintain serum concentrations that consistently suppress ovulation [39,40]. An analysis of 1,168 pregnant-capable people using the contraceptive implant, including 324 participants who had a BMI of 25–29.9 kg/m^2 and 405 with a BMI of 30 kg/m^2 or higher, found that the effectiveness of the contraceptive implant does not vary by BMI [41]. Extended use of the contraceptive implant may be offered to patients of any BMI. However, given data is limited in individuals with a BMI of 40 kg/m^2 or higher, shared decision-making is encouraged, particularly around extended use [42].

Levonorgestrel (LNG) IUD. There are no known differences in efficacy in people with higher BMIs, although increasing BMI has been associated with an increased expulsion rate [43–45]. A BMI of 30 kg/m^2 or higher is associated with an increased risk of abnormal uterine bleeding, endometrial hyperplasia, and endometrial cancer, especially in the setting of polycystic ovary syndrome (PCOS) [46–48]. The use of a progestin-containing method, particularly an LNG IUD, can provide endometrial protection [49]. Clinicians should counsel individuals with a BMI of 30 kg/m^2 or higher about the potential benefit of endometrial protection with the use of progestin-containing contraceptive methods, particularly an LNG IUD.

Depot medroxyprogesterone acetate (DMPA). There is limited evidence that DMPA increases the risk of VTE by more than twofold, regardless of BMI [18,50,51], although there is no direct evidence that individuals using DMPA with a BMI of 30 kg/m^2 have an increased absolute risk of VTE. However, VTE risk is multifactorial, with increasing BMI and DMPA use being independently correlated with increased VTE risk [18]. For individuals with a BMI of 30 kg/m^2 or higher, clinicians should counsel about the increased risk of VTE with the use of DMPA, and that when combined with other risk factors for VTE, such as genetic predisposition for thrombosis, diabetes, older age, dyslipidemia, and smoking, overall risk for VTE may increase.

Emergency contraception

There is a relationship between body weight and the effectiveness of emergency contraception, with decreasing effectiveness of oral emergency contraception with increasing body weight [52–54]. Recommendations regarding emergency contraception, including considerations regarding body weight, are outlined in separate guidance, Society of Family Planning Clinical Recommendation: Emergency contraception [54].

2.4. Clinicians should counsel individuals about the potential for weight change, particularly weight gain, associated with contraceptive methods as a possible factor in decision-making.

Weight regulation is a major health and personal concern for many pregnant-capable people. Some people are specifically interested in the role of contraceptive methods in weight loss, but no high-quality evidence suggests weight loss is associated with contraceptive use, and concerns about weight gain with contraceptive use are more prevalent. Adults tend to gain weight over time, regardless of contraceptive use. This gain, which is estimated to be approximately 1 kg a year, is most likely due to a combination of genetic, environmental, and lifestyle factors [55,56]. Pregnant-capable people's perceptions of weight gain are variable and not always consistent with their actual weight gain [57]. Because many pregnant-capable people use contraception throughout their lifetime, weight gain is often attributed to contraception use. For individuals who desire pregnancy, it is important to consider that pregnancy is

known to be associated with weight gain, and many individuals struggle to return to their pre-pregnancy weight [58].

Discontinuation of contraceptive methods due to perceived side effects plays a major role in the rates of unplanned pregnancy in the US [57]. Concerns about weight gain are frequently cited as reasons for discontinuation or non initiation of a method [59–62] and are often more marked in adolescents [63]. In discrete choice experiments where participants are asked to rank contraceptive side effects in order of preference, weight gain is among the least favored side effects [60]. For people who use OCs in the US, perceived weight gain is one of the leading reasons for discontinuation [61,62]. This is similarly true for people who use contraceptive implants, where both adults and adolescents report weight gain as the reason for implant removal up to a third of the time [64–66].

The extent to which contraception affects body weight depends on the contraceptive method. Available data do not support clinically significant weight gain with the use of most contraceptive methods, except DMPA. Most of the studies evaluating weight change have included participants with a BMI of less than 30 kg/m^2. This has left many unanswered questions for a modern population, including differential effects based on age (adolescents vs. adults) and baseline weight or BMI.

Nonhormonal contraceptive methods (e.g., copper IUD and barrier methods). Clinicians should counsel individuals that these methods have not been associated with a change in body weight and can be used without concern for weight gain [64].

Combined hormonal contraceptives (CHCs). There is no evidence that CHCs contribute to significant weight gain. A 2014 Cochrane review did not find evidence supporting a causal association between CHC and weight change, but there was insufficient evidence for a definitive recommendation [67]. Multiple trials since then (many comparing across CHC methods as opposed to placebo) have also found no significant differences in weight or BMI changes [68–73].

Progestin-only contraceptives. Overall, data on weight gain associated with progestin-only contraceptives is inconsistent and variable by method. There does not appear to be weight gain above what is anticipated over time in people who use progestin-only methods aside from DMPA. However, variations by method and population and potential changes in body composition (increased body fat and decreased lean mass) may account for weight changes in some people who use progestin-only methods [74].

Levonorgestrel (LNG) IUD. LNG IUDs can be used without concern for significant weight gain. In people who use LNG IUDs for longer than one year, use has been associated with a weight gain equivalent to the weight gain associated with increasing age and is not usually a reason for discontinuation [58,75–77].

Etonogestrel (ENG) contraceptive implant. The ENG contraceptive implant is associated with a weight gain equivalent to the weight gain associated with increasing age [75,78–82]. This can be a reason for discontinuation among some individuals [83]. For adolescents and young adults using the ENG contraceptive implant, non-randomized trials suggest that use does not increase BMI or weight gain trajectory [64,84]. However, a recent retrospective cohort study in adolescents and young adults using the ENG contraceptive implant suggested an increase in BMI by approximately one unit during a 36 month period compared to those prescribed a weight neutral or no hormonal contraception [85]. Data on whether baseline BMI may predict weight gain are mixed [64,86,87]. Among postpartum individuals initiating the ENG contraceptive implant, the use of the device and timing of placement (immediately versus at six weeks postpartum) do not appear to predict a return to prepregnancy weight [88,89].

Depot medroxyprogesterone acetate (DMPA). Studies examining DMPA and weight change have reported conflicting results. Some studies show an association of DMPA with weight gain, particularly among individuals with a BMI of 30 kg/m^2 or higher and adolescents, while others show no change in weight [18,74–76,80,90–94]. Although most adolescents (> 85%) do not gain weight while using DMPA, there seems to be a subset who gain excessively (> 10% of baseline body weight), with baseline weight and early weight gain seemingly predictive of excessive or ongoing weight gain [91,95]. The physiology of these changes is unclear, as changes in appetite, intake, and eating behavior are variable [96].

These data, although inconclusive, can aid shared decision-making conversations with individuals who are balancing their concerns about weight gain and other contraceptive priorities.

2.5. Clinicians should counsel individuals regarding the potential impact of weight management approaches, such as bariatric surgery and glucagon-like peptide 1 (GLP-1) agonists, on contraceptive efficacy.

Bariatric surgery

Multiple professional organizations recommend avoiding pregnancy for 12–18 months after bariatric surgery [97]. This postoperative period is often associated with rapid weight loss (sometimes gastrointestinal distress) and may be associated with increased unintended pregnancy rates and complications [97–100]. Malabsorptive surgeries, such as jejunoileal bypass, biliopancreatic diversion with or without duodenal switch, and Roux-en-Y bypass (gastric bypass), can impair gastrointestinal absorption, leading to theoretical concerns for decreased effectiveness of OCs [97,98,101].

Based on US survey data, OCs and condoms appear to be the most used methods after bariatric surgery [102]. Data regarding contraceptive efficacy after bariatric surgery is limited to older, small, nonrandomized trials with minimal, albeit reassuring, data; findings suggest limited OC failures in individuals who have undergone biliopancreatic diversion and no clinically significant differences in serum estradiol or progestin levels in individuals who have undergone jejunoileal bypass surgery [103–105]. There continues to be concern about an increased risk of failure if an individual experiences ongoing digestive disorders after surgery (vomiting and diarrhea) that reflect impaired absorption [101]. Given the limited evidence on efficacy and guidelines from other professional organizations recommending avoidance of oral methods [18,106], we suggest integrating surgery type along with the individual's preferences into contraceptive decision-making if an individual is considering OC methods.

Clinicians should counsel individuals that:

- OC methods can be used without concerns for failure in people who have undergone adjustable gastric band and sleeve gastrectomy and do not have diarrhea or vomiting.
- There is limited evidence on OC effectiveness in people who have undergone Roux-en-Y gastric bypass surgery, and these individuals may want to consider nonoral contraceptive methods.
- There is a possibility of malabsorption in people who have undergone biliopancreatic diversion, and these individuals may want to consider nonoral methods.
- There is insufficient evidence to assess the impact of nonoral methods on contraceptive effectiveness in people who have undergone bariatric surgery. A small case series of three individuals undergoing Roux-en-Y gastric bypass who had an ENG contraceptive implant placed prior to surgery reported therapeutic ENG levels at 6 months postoperatively and no unintended pregnancies [107]. The biologic plausibility for a major impact on efficacy for other nonoral methods is low, but data remain limited.

Glucagon-like peptide 1 (GLP-1)-based therapies

GLP-1-based therapies, such as semaglutide and tirzepatide, have been used for the treatment of type 2 diabetes mellitus and BMI of 30 kg/m^2 or higher. The mechanism of action of these medications

includes delayed gastric emptying, promotion of satiety, inhibition of glucose production, and decreased glucagon secretion [108,109]. Their interactions with other common medications, including contraceptives, have not been thoroughly evaluated. Concerns have been raised regarding the impact of such medications on contraception, given their effect on delayed gastric emptying and potentially altered oral drug absorption. One systematic review demonstrated no change in the bioavailability of COCs while taking a GLP-1 analogue [110]. However, this review did not include tirzepatide, a GLP-1 receptor agonist and glucose-dependent insulinotropic polypeptide (GIP); tirzepatide is also widely used and has a dual mechanism of action which may affect oral COC metabolism differently than pure GLP-1 agonists. It is recommended that individuals who are taking oral contraceptives switch to a nonoral method or use backup contraception for four weeks when initiating tirzepatide and after every dose increase [111].

A meta-analysis showed that the use of GLP-1 agonists restored the regularity of menstrual cycles versus the use of metformin or placebo, increasing spontaneous pregnancy rates in individuals with polycystic ovary syndrome [112]. Although data are limited, counseling patients regarding the potential increase in menstrual regularity and subsequent fertility is important.

3. Continued discussion

During the development of this document, we identified multiple areas where further discussion, research, and consensus are needed, and we invite further exploration:

- The Society encourages continued conversation regarding the utility of weight-based clinical decision-making and, when weight-related discussions are appropriate, optimal terminology for weight-related discussions, outcomes, and research.
- While it is clear there are extensive limitations to the BMI system, more discussion and research is needed to identify the ideal method(s) to measure weight and evaluate body size, particularly as it relates to contraceptive care and research.
- Most standardized BMI reference ranges use BMI of 30 kg/m^2 or higher as the highest BMI category. This leads to fewer data for patients at the highest ends of the weight range, such as those with a BMI of 40 kg/m^2 or higher, who already bear the brunt of clinician and societal weight stigma and *may* be those most likely to benefit from targeted research and counseling.
- While extended use of the ENG contraceptive implant may be offered to patients of any BMI, data is limited in individuals with a BMI of 40 kg/m^2 or higher and more research is needed in this population.
- With weight gain cited as a reason for both discontinuation and noninitiation of a method, more research is needed to better understand the association between different contraceptive methods and the potential for weight gain. This should include analysis of outcomes by population (e.g., age, baseline body weight and size).
- For people who use weight management approaches such as bariatric surgery or GLP-1-based therapies, more research is needed on the effectiveness of oral and nonoral methods in these populations, as well as the potential increase in menstrual regularity and subsequent fertility.

4. Summary of statements

Evidence-based, person-centered, destigmatized care is essential for patients across all body weights and sizes. As such, clinicians should:

- Provide person-centered, unbiased contraceptive care. This includes counseling pregnant-capable individuals on their risk of pregnancy based on sexual practices and contraceptive use regardless of body weight or size.
- Utilize evidence-based and person-centered contraceptive counseling to offer the full range of contraceptive methods regardless of body weight or size.
- Counsel patients about any risks and benefits associated with body weight and size to assist in their selection of contraceptive methods, including emergency contraception.
- Counsel individuals about the potential for weight change, particularly weight gain, associated with contraceptive methods as a possible factor in decision-making.
- Counsel individuals regarding the potential impact of weight management approaches, such as bariatric surgery and glucagon-like peptide 1 (GLP-1) agonists, on contraceptive efficacy.

5. Sources

A series of clinical questions was developed by the authors and reviewed by representatives from the Society of Family Planning's Clinical Affairs Committee. A medical librarian created the search strategies, and searches were run in Medline (PubMed) and Cochrane Library on July 12th, 2023 using a combination of keywords and subject headings including but not limited to adiposity, body weight, bariatric surgery, overweight, obesity, contraceptive agents, birth control, and intrauterine devices. English language was used as a filter due to team language restrictions, and publication dates from 2007–present were applied to capture literature published since the last guidance. After running for duplicates, 2747 results were exported to Covidence for screening. Additional articles were added through forward and backward citation searching and author-provided papers. The search was updated on May 3, 2024 to include GLP-1 agonists and contraception and pregnancy. This resulted in 308 results in PubMed. The authors also reviewed guidelines published by organizations or institutions, such as the Centers for Disease Control and Prevention, the American College of Obstetricians and Gynecologists, and the Society of Family Planning, as well as relevant product labels. When reliable research was unavailable, expert opinion from family planning clinicians was used.

6. Intended audience

This Clinical Recommendation is intended for the Society of Family Planning members, family planning and reproductive health service clinicians, family planning and reproductive health researchers, consumers of family planning care, and policymakers.

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The North American Society for Pediatric and Adolescent Gynecology and the Planned Parenthood Federation of America endorse this document.

Author contributions

This Clinical Recommendation was prepared by Noor Zwayne, MD, MPH; Elizabeth Lyman, MLIS, AHIP; Ashley Ebersole, MD, MS; Jessica Morse, MD, MPH, with the assistance of Elise Boos, MD, MSc and Antoinette Nguyen, MS, MPH on behalf of the Clinical Affairs Committee, and Monica Skoko Rodríguez, DNP, MPH, RN. It was reviewed and approved by the Clinical Affairs Committee on behalf of the Society of Family Planning Board of Directors.

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