

Contraception and high BMI: A guide for General Practitioners

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GPs play a critical role in providing contraceptive advice and managing reproductive health. Patients with high body mass index (BMI) present unique considerations due to potential impacts on contraceptive efficacy, safety and suitability.

This guide outlines key information for GPs to ensure safe and effective contraceptive care for patients with high BMI, aligning with current UK guidelines.

Understanding high BMI and contraception

High BMI is an independent risk factor for multiple health conditions that affect contraceptive safety and efficacy. Obesity (defined by NICE as BMI \geq 30kg/m², or \geq 27.5kg/m² in people of South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean background) increases the risk of venous thromboembolism (VTE), arterial thrombosis, type 2 diabetes and hypertension, all of which complicate contraceptive choices.

The Faculty of Sexual and Reproductive Health (FSRH) UK Medical Eligibility Criteria for Contraceptive Use (UKMEC) classifies obesity as a condition that restricts the use of oestrogen-containing contraceptives, such as combined oral contraceptives (COCs), patches and vaginal rings, due to heightened VTE risk.¹

The prevalence of high BMI among women of reproductive age (15–44 years) in England has risen significantly, reflecting national obesity trends.² The Health Survey for England 2021 reported that 5% of women aged 16-24, 23% of those aged 25-34 and 26% of those aged 35–44 were obese.³

This increase, driven by factors such as sedentary lifestyles, poor dietary habits and socioeconomic disparities, highlights the need for tailored contraceptive counselling.

GPs must balance efficacy, safety and patient preferences while addressing misconceptions and ensuring informed decision-making.

Key considerations

• Efficacy: Some contraceptives, particularly hormonal methods, may have reduced effectiveness in patients with high BMI.

 Safety: Certain methods carry increased risks, such as VTE with combined hormonal contraceptives (CHCs).⁴
 Access: Practical issues, like weight limits for certain procedures or devices, may arise.²

• **Patient-centred care**: Weight stigma and communication sensitivity are critical to ensure trust and adherence.

Contraceptive options and BMI-specific guidance

1. Combined hormonal contraceptives (CHCs)

CHCs, including COCs, patches and vaginal rings, contain oestrogen and progestogen.⁴ They are highly effective in the general population but require caution in patients with high BMI.

• Efficacy: Most evidence suggests that COC efficacy is not affected by body weight or BMI. Similarly effectiveness of the CHC vaginal ring does not appear to be affected, although this is based on limited evidence. Use of a CHC patch should be avoided if weight is ≥90kg, however, as the efficacy may be reduced.^{1,2}

• Safety: Oestrogen-containing contraceptives increase VTE risk, which is already elevated in obesity (2-3 times higher than in non-obese individuals).² For women with BMI ≥35 kg/m², CHCs are UKMEC Category 3 (risks outweigh benefits) unless no other suitable method is acceptable. For BMI 30–34 kg/m², they are UKMEC Category 2 (benefits generally outweigh risks).

• Recommendations:

- Consider alternative methods (eg, progestogen-only or non-hormonal options) for BMI \geq 35 kg/m².
- Screen for additional VTE risk factors (eg, smoking, immobility, family history).

2. Progestogen-only contraceptives

Progestogen-only methods include pills (POPs), implants, injectables and intrauterine systems (IUS). These are generally safer for patients with high BMI due to the absence of oestrogen. Support for the development of this educational Quick Guide was provided by Exeltis UK. Exeltis had no input into the content and only checked for accuracy.





• Progestogen-only pill (POP):

Efficacy: Available evidence indicates POPs do not have reduced effectiveness in women with higher BMIs.²
 Safety: UKMEC Category 1 (no restrictions) for high BMI. Suitable for patients with VTE risk. Becomes UKMEC Category 2 where obesity is one of multiple CVD risk factors (eg, also including smoking, diabetes and hypertension).^{1,2}
 Practical note: Requires daily adherence, which may challenge some patients. Counsel on timing and missed pill protocols.

• Progestogen-only implant:

– **Efficacy**: Highly effective (failure rate <0.1%) and unaffected by BMI.²⁵ The 3-year duration is convenient.²

- Safety: UKMEC Category 1. No increased VTE risk.^{1,5}

– **Practical note**: Insertion and removal may be technically challenging in patients with higher subcutaneous fat. Ensure trained staff perform procedures.

• Depot medroxyprogesterone acetate (DMPA):

 - Efficacy: The available evidence suggests that effectiveness of DMPA is not affected by body weight or BMI.²

– **Safety**: UKMEC Category 1. However, DMPA use becomes UKMEC3 if obesity is one of multiple CVD risk factors. It appears to be associated with some weight gain, particularly in younger women under 18 years with obesity. Discuss potential weight changes and monitor.^{1,2}

– **Practical note**: If using intramuscular DMPA consider use of a longer needle or deltoid administration to ensure the muscle layer is reached, or consider use of subcutaneous DMPA.²

Levonorgestrel-releasing intrauterine system (LNG-IUS):

 Efficacy: Highly effective with no BMI-related reduction in efficacy.² Suitable for 5–8 years depending on the device.
 Safety: UKMEC Category 1.¹ Minimal systemic progestogen absorption reduces metabolic risks.

– **Practical note**: Insertion may be more complex in patients with high BMI due to anatomical challenges or comorbidities.

Ultrasound guidance may be needed in some cases.²

3. Non-hormonal methods

Non-hormonal options may be suitable for patients with contraindications to hormonal methods or those preferring hormone-free contraception.

• Copper intrauterine device (Cu-IUD):

- Efficacy: Highly effective (>99%) and unaffected by BMI.²
 Provides up to 5–10 years of contraception.
- Safety: UKMEC Category 1. No hormonal or metabolic risks.^{1,2}
- **Practical note**: As with LNG-IUS, insertion requires skilled practitioner (see point 2 above). Counsel on the potential for heavier or irregular menses as a potential side effect.

Barrier methods:

– **Efficacy**: Condoms (male/female) and diaphragms have higher failure rates (12–18% with typical use) but are unaffected by BMI.²

– **Safety**: No medical contraindications. Useful for STI prevention.

– **Practical note**: Ensure correct sizing for diaphragms and proper use education to mitigate the risk of method or user failure.

• Fertility awareness methods (FAMs):

– **Efficacy**: Less reliable (up to 24% failure rate with typical use) and not BMI-dependent but requires regular cycles and patient commitment.¹

- **Safety**: No medical risks but unsuitable for patients with irregular cycles, common in obesity.²

– **Practical note**: Rarely recommended as a primary method due to high failure rates.

4. Emergency contraception

Emergency contraception (EC) options include levonorgestrel (LNG-EC), ulipristal acetate (UPA-EC) and Cu-IUD.

• LNG-EC:

– Efficacy: Likely reduced with 1.5mg LNG-EC in women with BMI ≥26kg/m² or weight >70kg. FSRH recommends considering UPA-EC and, if this is not suitable, doubling the dose of LNG-EC (to 3mg) if BMI ≥26kg/m² or weight >70kg, though the effectiveness is unknown and this is off-license.² Sofety: No PML related contraindications ²

- Safety: No BMI-related contraindications.²

– **Practical note**: Available over-the-counter. Counsel on timing (within 72 hours).

• UPA-EC:

– Efficacy: More effective than LNG-EC but may have reduced efficacy in BMI >30kg/m² or weight >85kg. No dose adjustment is recommended.

– **Safety:** UKMEC Category 1.^{1,2}

– **Practical note**: Prescription-only. Avoid in patients using enzyme-inducing drugs.

- Cu-IUD:
 - **Efficacy**: Most effective EC option (>99%) and unaffected by BMI. Can be inserted within 5 days of unprotected intercourse or ovulation.
 - Safety: UKMEC Category 1.^{1,2}
 - **Practical note**: As above, requires trained insertion (see point 3). Offers ongoing contraception if retained.



Additional considerations

Comorbidities

High BMI is often associated with conditions like type 2 diabetes, hypertension, or polycystic ovary syndrome (PCOS), which may influence contraceptive choice. For example:

• **Diabetes**: Avoid CHCs in patients with vascular complications (UKMEC Category 3–4).¹

• PCOS: LNG-IUS or COC may help manage symptoms like irregular bleeding, but BMI-related risks must be assessed.²

Weight stigma

GPs should use sensitive, non-judgmental language when discussing BMI and contraception. Avoid assumptions about lifestyle and focus on medical suitability. Offer weight management support only if requested, referring to local services per NICE guidelines.

Use of weight-loss medication

NICE recommends use of tirzepatide, alongside diet and exercise, for weight-loss in patients with obesity (BMI ≥35kg/m²) and other comorbidities.

Some evidence suggests that tirzepatide – a dual glucose-dependent insulinotropic polypeptide (GIP) and glucagon-like peptide-1 (GLP-1) receptor agonist – may reduce the bioavailability of oral contraception.

The FSRH has therefore advised that individuals using tirzepatide and oral contraception should change to a non-oral method or add a barrier method of contraception for four weeks after the initiation or a dose increase of tirzepatide.⁶

No clinically relevant effect has been observed with the GLP-1 receptor agonists semaglutide, liraglutide, dulaglutide, exenatide or lixisenatide. As such the FSRH does not recommend a change or addition of a barrier method to oral contraception in patients using these drugs.

Existing recommendations should be followed for those using oral contraception who have vomiting or severe diarrhoea as an adverse effect of a GLP-1 agonist, or severe diarrhoea with orlistat.

Access and equity

Patients with high BMI may face barriers, such as limited access to trained providers for IUD insertion or weightbased stigma in healthcare settings. GPs should advocate for equitable care and refer to specialist services if needed.

Contraceptive counselling

• Use shared decision-making, discussing efficacy, safety, side effects and practicalities.

• Provide written information or digital resources (eg, NHS or FSRH patient leaflets).

• Address myths, such as the belief that IUDs are unsuitable for obese patients.



YEEM MOBILE GMBH / VIA GETTY IMAG

Practical tips

• Use UKMEC guidelines: Always consult the FSRH UK Medical Eligibility Criteria for contraceptive use to assess suitability.

• **Document discussions**: Record BMI, comorbidities, risks and patient preferences in the medical record.

• Refer when needed: For complex cases (eg, BMI \geq 40kg/m² with multiple comorbidities), consider referral to sexual and reproductive health specialists.

• **Stay updated**: Regularly review FSRH and NICE guidelines, as evidence on BMI and contraception evolves.

• **Training**: Ensure practice staff are trained in IUD/implant insertion for patients with high BMI.

Key points

• Prescribing contraception in patients with high BMI requires

GPs to balance efficacy, safety and patient preferences. • Progestogen-only methods (eg, LNG-IUS, implants) and non-hormonal options (eg, Cu-IUD) are generally the safest and most effective for this group.

• CHCs require careful consideration due to VTE risks. It is important to address comorbidities and foster sensitive communication.

References

1 FSRH. UK Medical Eligibility Criteria for Contraceptive Use (UKMEC). Last updated September 2019

- 2 FSRH Guideline. Overweight, Obesity and Contraception. April 2019
- 3 Health Survey for England 2021. Health Survey for England, 2021. December 2022 4 FSRH Clinical Guideline: Combined Hormonal Contraception. Last updated October 2023
- FSRH Clinical Guideline: Combined Hormonal Contraception. Last updated Octo
 FSRH Clinical Guideline: Progestogen-only Implant. Last updated July 2023
- 6 FSRH Statement and Public Leaflet: Glucagon-like peptide-1 (GLP-1) agonists and oral contraception. February 2025

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App store. Adverse events should also be reported to Exeltis UK Limited by email to uk.pharmacovigilance@exeltis.com



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† Bleeding days per treatment cycle: Cycle 2-4: desogestrel 16.9 days (n=222) vs. drospirenone 9.6 days (n=527), p<0.0001; Cycles 2-6: desogestrel 23.7 days (n=172) vs. drospirenone 13.7 days (n=422), p<0.0001; Cycle 2-9: desogestrel 34.7 days (n=116) vs. drospirenone 21.5 days (n=305), p=0.0003, Study drop-out rate due to abnormal uterine bleeding: desogestrel: 6.6% (n=322); drospirenone: 3.3% (n=858); p<0.05.⁸⁶

FSRH and UKMEC

Slynd[®] is recommended as a contraceptive in the 2022 Faculty of Sexual and Reproductive Healthcare (FSRH) guidelines and is covered by POP guidance in the UK Medical Eligibility Criteria (UKMEC).^{2,7}

Abbreviations: AE, adverse event; DRSP, drospirenone; DSG, desogestrel; FSRH, Faculty of Sexual and Reproductive Healthcare; HFI, hormone free interval; POP, progestogen-only pill; UKMEC, UK Medical Eligibility Criteria.

References: 1. Slynd® Summary of Product Characteristics. 2. FSRH Clinical Guidelines progestogen-only pills. 11/2022. 3. Palacios, S., *et al. BMC Women's Health.* 2020. 20:218. 4. Archer, D.F., *et al. Contraception*. 2015. 92:439-444. 5. Palacios, S., *et al. Arch Gynae Obs.* 2019. 300:1805-1812. 6. Palacios, S., *et al. PLOS ONE*. 2020. 15(6): e0231856. 7. UK Medical Eligibility Criteria. For Contraceptive Use. 2016 (Amended 2019).