Contraception

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Objectives

- Motivate learners to identify historical inequities regarding contraception.
- Identify reasons why contraception may be important.
- Understand the decision-making process for contraception options.
- Feel comfortable counseling patients on different contraception options.
- Recognize absolute and relative contraindications for contraception.
- Identify common side effects with contraception options.

Historical Inequities in Contraception

- History of forced or coerced permanent sterilization based on race or socioeconomic status
- Implicit bias
- Experimentation
- Coercion
  - Country
  - State
  - Community
  - Family
  - Relationship
  - Doctor

ACOG 2022.
Belluck 1999.

Motivation for Contraception

- ¾ of adolescent pregnancies are unintended
- 45% of US pregnancies are unplanned
- 85% of premenopausal, sexually active patients with a uterus will be pregnant in 1 year with regular, unprotected sex

ACOG Practice Bulletin, 2019.

21yo G0P0 desires contraception

- Non-directive informed choice
  - Efficacy
  - Mechanism of action
  - Cost
  - Side effects
- Shared Decision-making model
  - Patient priorities and values
  - Healthcare provider knowledge

- Directive counseling- Priority of provider, ranked tiers

Freepik

Non-hormonal methods, non-barrier methods

- Natural Family Planning/ Fertility Awareness: 95-99.6% (perfect), 77-98% (typical)
- Withdrawal method: 96% (perfect), 80% (typical)
- Spermicide: 84% (perfect), 79% (typical)
- Vaginal gel- pH modulator with lactic acid, citric acid, potassium bicarbonate: 93% (perfect), 86% (typical)

Barrier Methods

- Female condom
- Male Condom
- Diaphragm
- Efficacy
  - Perfect Use: 98% effective
  - Typical Use: 87% effective
- Effort- Must use it every time!

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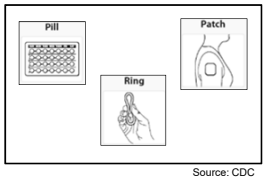
Short-acting reversible hormonal contraception

- Birth control pills
- Transdermal patch
- Vaginal ring
- Efficacy
  - Perfect use: 99.7% effective
  - Typical Use: 93% effective
- Side effects: Irregular bleeding, nausea, sore breasts
- Mechanism: Ovulation prevention, thick cervical mucus, inhospitable endometrium

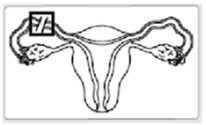


Source: CDC

Long-acting reversible contraception

- Intramuscular injection
- Implantable rod
- Intrauterine Device
- Efficacy
  - Perfect use: 99+% effective
  - Typical use: 96-99+% effective
- Side effects: abnormal bleeding, cramping, increased appetite
- Mechanism: inhibits ovulation, inhibit sperm transport, inhospitable endometrium, prevent implantation

Permanent sterilization



Source: CDC

- **Vasectomy**
- **Tubal sterilization**
- **Effectiveness**
  - **Perfect use: >99% effective**
  - **Typical use: >99% effective**
- **Procedural risks**
- **Regret?**

Emergency Contraception- <120 hours after sex

- **Yuzpe method and Levonorgestrel-based pills**
  - **Inhibits ovulation**
- **IUD (non-hormonal or hormonal)**
  - **Inhospitable lining**
- **Ulipristal acetate-**
  - **Prevents ovulation**
  - **Unfavorable intrauterine environment**
- **Efficacy:**
  - **Perfect and Typical Use: 85 to less than 100%**
- **Side effects: Nausea, irregular bleeding, cramping**

Contraindications to contraception- Estrogen

- Migraine with aura
- Poorly controlled hypertension
- Allergy to medication
- Smokers- 35 years old and up
- h/o DVT/ PE, superficial venous thrombosis
- Major surgery with prolonged immobilization
- Hereditary thrombophilia (antiphospholipid antibodies)
- Poorly controlled IBS
- Systemic Lupus Erythematosus (antiphospholipid antibodies)

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Special cases

- Breastfeeding patients: 4-6 weeks or more after delivery
- Obesity: No change in efficacy across BMI, limited evidence
- Depression: All options are reasonable
- Hypertension: Progestin-only options
- Migraines with aura: Progestin-only options
- Diabetes: 20 years of disease or more, microvascular disease need progestin-only
- Breast cancer: IUDs

ACOG Practice Bulletin 206, 2019.

Patient Care Pearls

- Bedsider.org
- US MEC: CDC Contraception

References

- American College of Obstetricians and Gynecologists' Committee on Health Care for Underserved Women, Contraceptive Equity Expert Work Group, and Committee on Ethics. Patient-Centered Contraceptive Counseling: ACOG Committee Statement Number 1. Obstet Gynecol. 2022 Feb;139(2):350-353. doi: 10.1097/AOG.0000000000004659.
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Adolescent Contraception

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Teen Birth Statistics

- Factors that contribute to the likelihood of teen pregnancy include individual goals, societal pressures, family pressures, pubertal timing, age of first intercourse, risk-taking behaviors, and knowledge of contraceptive options.
- Most recent data from 2017 shows an overall decline in teen birth rates and a decline for each race and ethnicity group
  - Likely attributed to an increase in sexual education and/or an increase in the use of contraception in the past 20 years
- Among teen births, mothers under the age of 17 are at an increased risk of preterm labor, low birth weight infants, and neonatal mortality

Adolescent Confidentiality

- Majority of states have specific laws regarding minor's reproductive health rights confidentiality and minor's consent to contraception.
- For states without these laws in place, best practice guidelines, federal statues, and federal case law may support minor confidentiality and consent.
- Confidentiality and consent limitations are linked to lower use of contraceptives and higher pregnancy rates.

Starting the Conversation

- Bright Futures/The AAP recommend taking a detailed and developmentally appropriate sexual history, evaluate STI/pregnancy risk, and provide appropriate screening, counseling, and contraception if needed.
- A honest, caring, nonjudgmental attitude, and matter of fact question asking are key in gathering an accurate history.
- 5 P's of sexual history intake: **p**artners, **p**revention of pregnancy, **p**rotection from STIs, **s**exual practices, **p**ast history of STIs and pregnancy
- Other important elements to assess: menstrual history, PMH, current medications, contraception history, BMI, weight, BP, FHX

Abstinence and Contraceptive Counseling

- Discussing abstinence is an important part in providing adolescent sexual health care.
- Abstinence is the only 100% effective approach to preventing pregnancy and STIs, so remains a valuable part of contraceptive counseling. However adherence to abstinence over time is low.
- Contraceptive counseling should include anticipatory guidance about possible menstrual changes, side effects, and non-contraceptive benefits of contraception including management or irregular periods, abnormal uterine bleeding, and treatment of dysmenorrhea.
- Pediatricians should continue to provide comprehensive sexual health information, including contraception initiation, supporting contraception adherence, managing adverse effects, and providing intermittent STI testing.

Contraceptive Methods

- Important to discuss typical use versus perfect use
  - Typical use: The likelihood of pregnancy during the first year of use and takes into consideration that varying degrees of adherence
  - Perfect use: The likelihood of pregnancy if used consistently and correctly every time.
- Most effective methods are those that rely less on individual adherence

Contraceptive Methods

It is recommended to discuss most effective methods first.

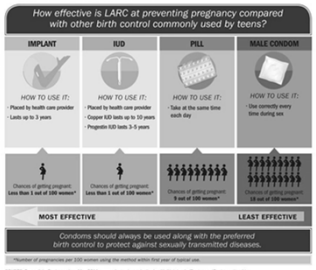


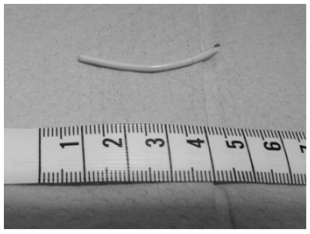
Photo source: CDC

Long-Acting Reversible Contraceptives (LARCs):

- When discussed contraception, it is important to have shared decision making.
- Adolescents have the right to chose their form of contraception (including LARCs) and have the same right to discontinue LARCs without any barriers. Provide anticipatory guidance that discontinuing a LARC will require an appointment for removal.

Long-Acting Reversible Contraceptives (LARCs):

Implants



Long-Acting Reversible Contraceptives (LARCs):
Implants

LARC type	Implant
Name	Nexplanon
Location	Upper arm
Active Ingredient	68 mg Etonogestrel
Efficacy	>99 %
Duration	3 years
Most Common Side Effects	Breakthrough bleeding Bleeding pattern the first 3 months is usually predictive
Least Common Side Effects	Weight gain, headaches, acne
Back-up Contraception After Placement	Not needed if inserted <5 days after onset of menstruation. If inserted >5 days after menstrual onset, use back up or abstinence for 7 days.

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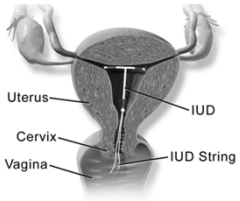
Long-Acting Reversible Contraceptives (LARCs):
Intrauterine Devices (IUDs)



Intraunterine Device (IUD)

Long-Acting Reversible Contraceptives (LARCs):
Intrauterine Devices (IUDs)

LARC type	IUD				
Name	Copper (Paragard)	Skyla	Kyleena	Liletta	Mirena
Location	Intrauterine				
Active Ingredient	Copper, non-hormonal	13.5 mg levonogestrel	19.5 mg levonogestrel	52 mg levonogestrel	
Efficacy	>99 %				
Duration	10 years	3 years	5 years	6 years	5 years
Most Common Side Effects	Heavy menstrual bleeding or dysmenorrhea	Infrequent or absent menstrual periods (can be helpful for those with history of menorrhagia) Can cause irregular bleeding/spotting			
Less Common Side Effects		Headache, acne, breast tenderness, mood changes			
Back-up Contraception After Placement	Not needed. May be used as an emergency contraceptive for up to 5 days after unprotected sex	Not needed if insertion <7 days after onset of menstruation If inserted >7 days after onset of menstruation, use back up or abstinence for 7 days			

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Contraceptive Implants
Approach to break through bleeding

- Changes in bleeding patterns are expected with contraceptive implants and are the main cause for discontinuing. However, adolescent discontinuation rates are fairly low at around 10% in the first year.
- The bleeding pattern that occurs within the first 3 months is generally predictive of future bleeding patterns.
- Provide anticipatory guidance on irregular bleeding prior to inserting.

Contraceptive Implants
Approach to break through bleeding

- If bleeding occurs, determine how bothersome it is for the patient
  - **If tolerable** → Provide reassurance and signs that warrant re-evaluation including pelvic pain, needing to change pad/tampon hourly, abdominal pain, nausea, vomiting, vaginal discharge/complaints
  - **If bothersome**→ Pending patient's symptoms, rule out pregnancy, infection, cervicitis, PID. Manage appropriately if any positive work up.
  - **If bothersome and negative for pregnancy/infection, other treatments include:**
    - Naproxen 500 mg BID x 5 days
    - COCs (unless estrogen contraindicated)-one pill pack (Levora/Nordette or Sprintec, Ortho-Cyclen)
    - Norethindrone Aetate 5 mg (Aygestin) once a day x 30 days
    - Implant removal
  - **If other treatments successful** → reassurance
  - **If other treatments unsuccessful or breakthrough bleeding** →offer removal

Progestin Injection

Short Acting Contraceptives	
Type	Progestin injection
Name	Depo-Provera
Location	intramuscular or subcutaneous
Active Ingredient	150 mg medroxyprogesterone acetate (IM) or 104 mg medroxyprogesterone acetate (SQ)
Efficacy	94%
Duration	11-13 weeks
Most Common Side Effects	irregular bleeding, weight gain (usually seen in the first 3 months), acne, headaches, hirsutism, mood concerns, bone density loss (likely reversible), and possible delay in return of ovulation
Back-up Contraception	7 days if repeat dose is >15 weeks from last injection
Other Indications	Treatment of dysmenorrhea and menorrhagia

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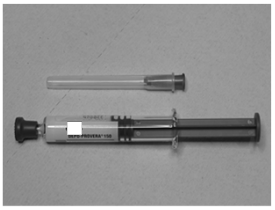

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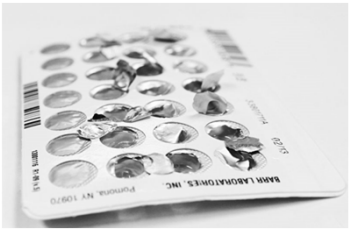
Combined Oral Contraceptive (COCs) Pills



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Combined Oral Contraceptive (COCs) Pills

- Most popular method, 91% effective
- Prevent ovulation by inhibiting the gonadotropin-releasing hormone axis. They also thicken cervical mucus→endometrial atrophy→changes the tubal transport mechanism
- Benefit: can be started same day with negative pregnancy test
- Contraindications: thromboembolic disorder, migraines with aura, severe hypertension
- Most common side effects: irregular bleeding, headaches, nausea
- May need to adjust strength and type of hormones depending on patient's needs
- Back up contraceptive for the first 7 days.

Combined Oral Contraceptive (COCs) Pills

- Recommended to prescribe 1 year of COCs at a time to prevent lapse. Can be helpful to follow up 1-3 months after initiation to evaluate side effects and adherence
- Consider extended cycle or continuous cycle regimens for patients with menstrual-related problems including anemia, menorrhagia, bloating, dysmenorrhea, endometriosis, menstrual headaches, or those with premenstrual dysphoric disorder or hyperandrogenism.
  - Most common side effect of extended or continuous cycle is breakthrough bleeding.
- Non-contraceptive benefits: treatment for dysmenorrhea, menorrhagia, PCOS, premenstrual tension syndrome, and acne.

Combined Oral Contraceptive (COCs) Pills

- Discuss ideas to promote daily adherence including cell phone alarms or familial support/reminders.

I missed a pill, what do I do?

Number of pills missed	When to take	Do I need back up protection?	Do I need emergency contraception?
1	As soon as remembered	No	Consider if missed other pills within month
2 in a row	Only take the (1) most recently missed pill as soon as remembered	Yes x 7 days	Consider if during first week
2 in a row, during last week	As above **PLUS** skip placebo or use back up	Yes, until 7 hormonal pills taken.	Consider

Remind patients that 7 consecutive hormonal pills need to be taken to prevent ovulation!

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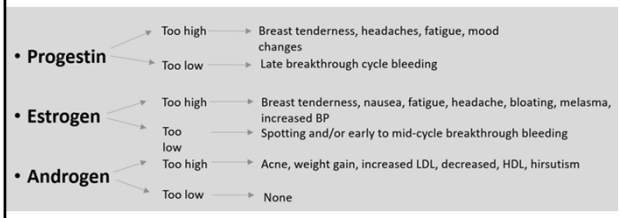
Hormone Effects



So I want COCs, now what?

- Do not need a pelvic exam prior to start but *do* need a negative pregnancy test and current BP. Consider STI screening. Pap smears 3 years after first time having sex or 21 years of age, whichever comes first.
- 3 types of COCs:
  - Monophasic
  - Biphasic
  - Triphasic
    - Multiphasic agents have no clinical advantage and there are differing tablet strengths and colors, which can be confusing to patients.
- Recommended to start with a low-dose monophasic option (ethinyl estradiol <35 mcg +levonorgestrel 0.15 mg or norgestimate 0.25 mg) to help balance safety and efficacy.

Recommended Starting COCs

Name	Dose	Pills
Levonorgestrel/EE	Ethinyl Estradiol 30 mg/ Levonorgestrel 0.15 mg	21 hormonal pills 7 placebo
Lillow		
Levora		
Marlissa		
Portia-28		
Sprintec	Ethinyl Estradiol 35 mg/ Levonorgestrel 0.25 mg	
MonoNessa		
OrthoCyclen		
Previfem		
Norgestimate/EE		

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Patient Considerations

Patient condition	Options	Medication	Other FYI
Acne, Unwanted hair	Increase estrogen/progesterone and decrease androgen *Higher estrogen is recommended	Desogestrel 0.15 mg/EE 30 mcg (Desogen)	
		Drospirenone 3mg/EE 20 mcg (Yaz)	FDA approved for acne
		Drospirenone 3mg/EE 30 mcg (Yasmin)	
		Norgestimate 0.25 mg/EE 35 mcg (Ortho-Cyclen)	
Bloating	Change progestin to drospirenone	Drospirenone 3mg/EE 20 mcg (Yaz)	Higher risk of DVT with drospirenone
		Drospirenone 3mg/EE 30 mcg (Yasmin)	
Breast Tenderness	Lower estrogen, lower progestin, or progestin only	Drospirenone 3mg/EE 20 mcg (Yaz)	
		Drospirenone 3mg/EE 30 mcg (Yasmin)	
		Levonorgestrel 0.1 mg/EE 20 mcg (Aviane)	
		Norethindrone 0.35 mg (Ortho Micronor)	
		Norethindrone acetate 1mg/20mcg EE/75mg Ferrous fumarate (Loestrin Fe 1/20)	
Breakthrough bleeding	Change to higher estrogen, higher progestin, lower androgen	Desogestrel 0.15 mg/EE 30 mcg (Desogen)	
		Drospirenone 3mg/EE 30 mcg (Yasmin)	
		Ethynodiol diacetate 1 mg/EE 35 mcg (Zovia 1/35E)	
		Ethynodiol diacetate 1 mg/EE 50 mcg (Zovia 1/50E)	
		Norethindrone acetate 1.5mg/30 mcg EE/75 mg Ferrous fumarate (Loestrin Fe 1.5/30)	
		Norethindrone 0.4 mg/EE 35 mcg (Ovcon 35)	
		Norethindrone 0.5 mg/EE 35 mcg (Nortrel 0.5/35)	
		Norethindrone 1mg/EE 35 mcg (Norinyl 1+35)	
		Norethindrone 1mg/EE 50 mcg (Norinyl 1+50)	
		Norgestrel 0.3 mg/EE 30 mcg (Low Ogestrel)	
		Norgestrel 0.5 mg/EE 50 mcg (Ogestrel 0.5/50)	

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Patient Considerations

Patient Condition	Options	Medication	Other FYI
Depression/Moodiness	Lower progestin	Norgestimate 0.25 mg/EE 35 mcg (Ortho-Cyclen)	
		Norethindrone 0.4 mg/EE 35 mcg (Ovcon 35)	
		Norethindrone acetate 1mg/20 mcg EE (Loestrin 1/20)	
		Drospirenone 3mg/EE 30 mcg (Yasmin)	
Dysmenorrhea and Irregular Periods	Low progestin, low androgen or no-period pills	Drospirenone 3mg/EE 20 mcg (Yaz)	FDA approved for premenstrual dysphoric disorder (PMDD)
		Norethindrone acetate 1mg/20 mcg EE/75 mg Ferrous fumarate (Loestrin Fe 1/20)	
		Levonorgestrel 0.15mg/EE 0.03mg (84 pills) 0.01 mg EE (7 pills). (Seasonique)	
Endometriosis	Lower estrogen, higher progestin, or no-period pills	Norethindrone acetate 1mg/20 mcg EE (Loestrin 1/20)	Take continuously without placebo pills to skip periods.For a light period, take 4 days of placebo pills
		Norethindrone acetate 1.5mg/30 mcg EE (Loestrin 1.5/30)	
		Ethynodiol diacetate 1 mg/EE 35 mcg (Zovia 1/35E)	
		Levonorgestrel 0.15mg/EE 0.03mg (84 pills) 0.01 mg EE (7 pills). (Seasonique)	
Headache	Low estrogen, low progestin. Hormonal fluctuations can trigger headaches.	Ferrous fumarate (Loestrin Fe 1/20)	
		Levonorgestrel 0.1 mg/EE 20 mcg (Aviane)	
		Drospirenone 3mg/EE 20 mcg (Yaz)	
		Levonorgestrel 0.1 mg/EE 20 mcg (Aviane)	
		Norethindrone acetate 1mg/20 mcg EE/75 mg Ferrous fumarate (Loestrin Fe 1/20)	

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Patient Considerations

Patient Condition	Options	Medication	Other FYI
Migraines	Change to progestin only	Norethindrone 0.35 mg (Ortho Micronor)	For menstrual migraines, Seasonale or Seasonique can help to keep hormones stable, preventing a migraine-induced "drop."
Nausea	Lower estrogen	Levonorgestrel 0.1 mg/EE 20 mcg (Aviane)	
		Norethindrone acetate 1mg/20 mcg EE/75 mg Ferrous fumarate (Loestrin Fe 1/20)	
PCOS	Low androgen, low progestin	Norethindrone acetate 1mg/20 mcg EE (Loestrin 1/20)	
		Drospirenone 3mg/EE 30 mcg (Yasmin)	
		Drospirenone 3mg/EE 20 mcg (Yaz)	
Severe Cramping	Higher progestin or no-period pills Most pills will be effective	Drospirenone 3mg/EE 30 mcg (Yasmin)	
		Levonorgestrel 0.15mg/ EE 0.03mg (84 pills) 0.01 mg EE (7 pills). (Seasonique)	
Weight Gain	Lower estrogen or progestin.	Drospirenone 3mg/EE 20 mcg (Yaz)	
		Drospirenone 3mg/EE 30 mcg (Yasmin)	
		Levonorgestrel 0.1 mg/EE 20 mcg (Aviane)	
		Norethindrone acetate 1mg/20 mcg EE/75 mg Ferrous fumarate (Loestrin Fe 1/20)	

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Progestin Only Pills (POPs)

- Known as “mini pills.”
- Work by thickening cervical mucus and not by inhibiting ovulation
- Stringent adherence is necessary, leading to higher failure rates than other progestin-only methods or COCs.
- Consider for patients with history of migraines with aura <35 years of age that are non smokers with a normal blood pressure or for breastfeeding moms.
- Back up contraception:
  - None if started within first 5 days of menstrual period.
  - If >5 days from start of menstruation, abstain or additional protection x 2 days

Progestin Only Pills (POPs)

- Norethindrone 0.35 mg (Micronor) and Droperinone 4mg (Slynd)
  - Both act as contraceptive
  - Slynd has 24 active pills and 4 inactive per pack
  - Micronor has 28 active pills without a placebo week
- Norethindrone acetate 5-15mg (Aygestin), Medroxyprogesterone acetate 10-30 mg daily (Provera), or Megestrol acetate (Megace)
  - Non-contraceptive

Transdermal Patch

- Ethinyl estradiol- norelgestromin 35 µg/150 µg
  - Xulane or Zafemy.
  - Exposed to higher concentration of EE, which can heighten the risk for venous thromboembolic events.
- Ethinyl estradiol-levonorgestrel 30 µg/120 µg
  - Twirla

Transdermal Patch

- 91 % effective
- Benefit: less frequent dosing however more expensive
- Side effects: skin irritation/rash, higher incidence of breast discomfort and dysmenorrhea. Can have breakthrough bleeding that typically improves after the first month.
- Application: worn for 7 days at a time for 3 consecutive weeks, followed by 1 week without a patch.
- Application sites: buttocks, upper lateral arm, lower abdomen, and upper torso (excluding breasts). Rotate sites with each application.

Transdermal Patch

- Adolescents may continue to participate in exercise, bathing, swimming, and the use of the whirlpool/sauna
- A single patch can prevent ovulation up to 9 days.
- Consider for patients when concerned about daily adherence or those that are not candidates for LARC or depo.

Transdermal Patch

Delayed attachment or patch detachment

Less than 48 hours since application or reattachment:

- Apply ASAP, if <24 hours since original patch applied may try to reapply with same patch.
- Keep same patch change day
- No additional contraceptive protection is needed
- Usually do not need emergency contraception but consider if occur early in current cycle or last week of previous cycle

Transdermal Patch

Delayed attachment or patch detachment

More than 48 hours since application or reattachment

- Apply new patch ASAP
- If delayed application or detachment in 3rd patch week, skip patch free week, start a new patch, and keep same patch change day.
- Use back up contraception or avoid sexual intercourse until 7 days of consecutive wear of the new patch.
- Consider emergency contraception if delayed application/detachment occurred in the first week of patch use and if unprotected intercourse in the previous 5 days.
- Default to >48 hours patch detachment if patient is unsure of when the patch detached

Vaginal ring

- Ethinyl estradiol-Etonogestrel 15µg/0.12mg
  - Brand names: NuvaRing or EluRyng
  - Most comparable to the 30µg OCP
- Ethinyl estradiol-segesterone acetate 13µg/0.15 mg
  - Brand name: Annovera
  - Reusable over the entire year
- Lower exposure of daily ethinyl estradiol

Press the Sides Together

Vaginal ring

- 91% effective
- Inserted into the vagina and stays in place for 3 weeks, with removal for 1 week to induce withdrawal bleeding before a new ring is inserted.
- Instruct to insert a new ring even if bleeding has not stopped.
- Adverse effects include vaginal discomfort/irritation, nausea, vomiting, headache, bloating, and breast tenderness. Spotting may occur but usually improves over time.

Vaginal ring
Delayed insertion or reinsertion

Less than 48 hours since insertion or reinsertion

- Insert ring ASAP
- Keep ring in until scheduled ring change day
- No additional contraception needed
- Emergency contraception usually not needed, but consider if delayed insertion was early in the current cycle or in the last week of previous cycle

Vaginal ring
Delayed insertion or reinsertion

More than 48 hours since insertion or reinsertion

- Insert new ring ASAP
- If ring removal occurred in the 3rd week, skip the hormone free week and start a new ring immediately. Keep new ring in until scheduled removal day.
- Use back up contraception or avoid sexual intercourse until 7 consecutive days with new ring in place.
- Consider emergency contraception if delayed insertion/reinsertion happened within the first week of ring use and unprotected sex occurred within the previous 5 days.

When to Start Using Specific Contraceptive Methods

Contraceptive method	When to start (if the provider is reasonably certain that the woman is not pregnant)	Additional contraception (i.e., back up) needed	Examinations or tests needed before initiation[1]
Copper-containing IUD	Anytime	Not needed	Bimanual examination and cervical inspection[2]
Levonorgestrel-releasing IUD	Anytime	If >7 days after menses started, use back-up method or abstain for 7 days.	Bimanual examination and cervical inspection[2]
Implant	Anytime	If >5 days after menses started, use back-up method or abstain for 7 days.	None
Injectable	Anytime	If >7 days after menses started, use back-up method or abstain for 7 days.	None
Combined hormonal contraceptive	Anytime	If >5 days after menses started, use back-up method or abstain for 7 days.	Blood pressure measurement
Progestin-only pill	Anytime	If >5 days after menses started, use back-up method or abstain for 2 days.	None

Abbreviations: BMI = body mass index, IUD = intrauterine device, STD = sexually transmitted disease; U.S. MEC = U.S. Medical Eligibility Criteria for Contraceptive Use

[1] Weight (BMI) measurement is not needed to determine medical eligibility for any methods of contraception because all methods can be used (U.S. MEC 1) or generally can be used (U.S. MEC 2) among obese women. However, measuring weight and calculating BMI (weight (kg)/height (m²) at baseline might be helpful for monitoring any changes and counseling women who might be concerned about weight change perceived to be associated with their contraceptive method.

[2] Most women do not require additional STD screening at the time of IUD insertion. If a woman with risk factors for STDs has not been screened recently and declines testing, she can be treated according to CDC STD Treatment Guidelines (http://www.cdc.gov/std/treatment), screening can be performed at the time of IUD insertion, and insertion should not be delayed. Women with current purulent cervicitis or chlamydial infection or gonococcal infection should not undergo IUD insertion (U.S. MEC 4).

Source: CDC

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