

Contraceptive-Induced Menstrual Changes (CIMC) Meeting Q&A

This is a compilation of question and answer responses from those who presented at and coordinated the virtual technical consultation on contraceptive-induced menstrual changes held on November 17-18, 2020. This meeting was coordinated by FHI 360 through the [Research for Scalable Solutions \(R4S\)](#) and [Envision FP](#) projects with support from the U.S. Agency for International Development (USAID). The PowerPoint slides from [Day 1](#) and [Day 2](#) of the event are available for download and the full meeting recordings can be accessed [here](#).

CONTRACEPTIVE-INDUCED MENSTRUAL CHANGES (CIMCs)

QUESTION: Spotting and /or unexpected bleeding can be a manifestation of intermenstrual bleeding or breakthrough bleeding. Any insights on categorizing this type of bleeding?

- **RESPONSE:** Overall, the terminology used to describe menstrual changes is complicated and varies depending on context and audience. For example, the way providers discuss menstrual changes with family planning (FP) users and the way users understand menstrual changes can be very different from the terminology used by researchers and contraceptive developers. We recognize for some, it may be important to refer to bleeding while using hormonal contraception not as “menstruation,” and instead to refer to bleeding during the hormone-free interval of combined oral contraceptives as “withdrawal bleeding” or “scheduled bleeding.” Likewise, some may be more comfortable using terms like “menorrhagia” for increased bleeding volume or duration or the term “amenorrhea” for paused or no bleeding while using contraception, whereas others may prefer to restrict the use of those words to the clinical context or for truly pathological indications. That said, there are fairly well-established classification systems developed in the 1970s and 1980s by the World Health Organization (see [here](#) and [here](#)) that were used in clinical trials for combined hormonal contraceptives, and researchers have since adapted these definitions. Within these updated definitions, *spotting* refers to “evidence of minimal blood loss that does not require new use of any type of sanitary protection, including pantyliners”; and *unscheduled bleeding or spotting* refers to “any bleeding or spotting that occurs while taking active hormones, regardless of the duration of regimen” with two exceptions: “bleeding/spotting that begins during a hormone-free interval and continues through Days 1-4 of the subsequent active cycle” and “bleeding/spotting reported during Days 1–7 of the first cycle of any study medication” ([Mishell et al., 2007](#)). However, as mentioned above, these precise definitions may not translate well to user’s understanding and contraceptive decision-making in practice.

QUESTION: There were different ranges given for the “normal” or “standard” menstrual cycle throughout the conference (e.g., 21-35 days vs. 24-38 days, etc.). Where do these numbers come from and which range is most accurate?

- **RESPONSE:** The 24-38-day range comes from the International Federation of Gynecology and Obstetrics systems for normal and abnormal bleeding (see [here](#)), while the American College of Obstetrics and Gynecology uses 21-35 days as the “normal range.” Much of the data upon which these numbers are based, however, are dated and taken from a homogenous group of menstruators. Additional harmonization in this area is warranted.

FP-MH INTEGRATION AND PROGRAMMATIC INTERVENTIONS

QUESTION: If the FP field is providing women with contraceptive methods that change their bleeding patterns in some way, should we not also be providing menstrual products at the same time?

- **RESPONSE:** Providing menstrual products during FP counseling and service provision could be an important way to integrate the delivery of menstrual health (MH) and RH services, including FP moving forward (along with the list of interventions pictured here that were discussed during the meeting). A few organizations are beginning to explore this type of integrated service delivery, but there are a number of aspects of implementation that need to be carefully considered, including product costs, quality, choice, and distribution channels. More evidence on the benefits of FP-MH integration will be key to moving this agenda forward.



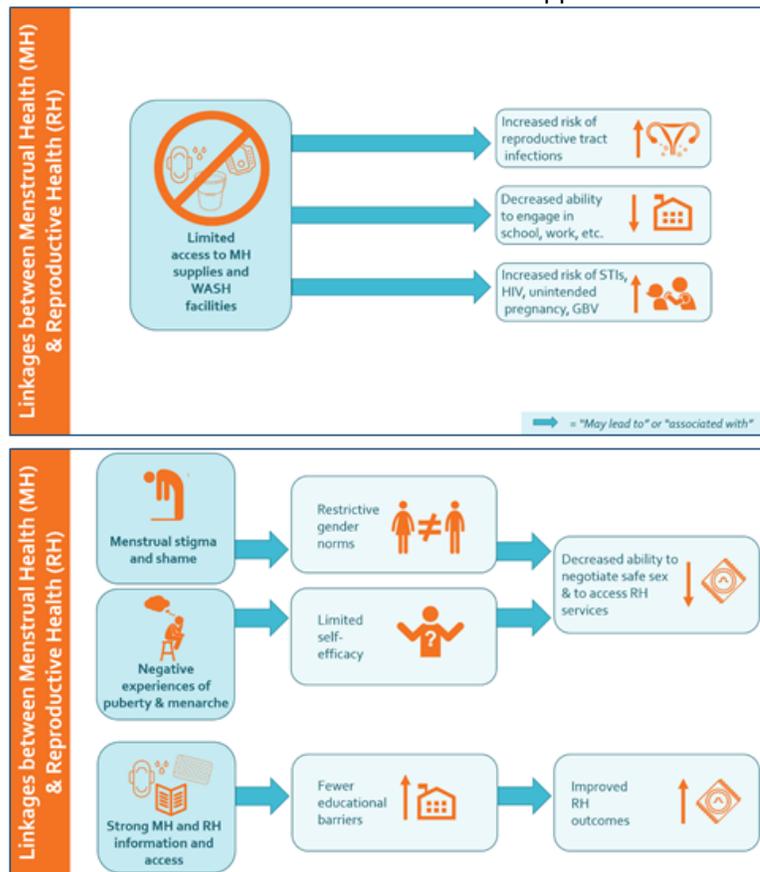
QUESTION: Do we have any research/programmatic information on demand for services among young women? For instance, would providing MH products and information bring more young women to a "one stop shop" or youth-friendly health services location, and give an opportunity to expose them to FP counseling? Or does FP attract young women and thus give an opportunity to provide MH education and products? Have we still not integrated services enough to know this?

- **RESPONSE:** There is anecdotal evidence that integrating FP and MH may improve uptake of both. For example, formative research conducted by [ZanaAfrica](#) suggests that there is significant demand for integrated services. While limited in scope, anecdotal and qualitative evidence gathered from youth and families in the communities ZanaAfrica serves in Kenya points to strong interest in a one stop shop approach that could apply to both physical locations and virtual ones. The organization has [tested](#) a low tech virtual one stop shop using menstrual pads and printed materials to promote uptake of health and education services, and uptake has grown steadily from about 3% to 10%. While this data is suggestive there is a need for more rigorous scientific research exploring the assumption that FP-MH integration would improve uptake. There is currently a pilot cluster-randomized clinical trial being conducted in Zimbabwe called [CHIEDZA](#), which provides free RH services to the treatment arm, including menstrual health education and products along with FP counseling and services. An [article](#) was recently published on the findings from this pilot trial.

QUESTION: Is there evidence that links poor menstrual hygiene with menstrual changes, reproductive tract infections (RTIs), STIs, and/or fertility? Is there evidence that links poor menstrual hygiene with school absenteeism?

- **RESPONSE:** As you'll see in the diagram below, which was presented by Lucy Wilson during the meeting, there is [evidence](#) that [poor menstrual health and hygiene can lead to reproductive tract infections \(RTIs\)](#), which implies that ensuring menstruators have access to private facilities with water, as well as safe, effective menstrual products could reduce RTIs.

There is also some [evidence](#) that the provision of menstrual products may reduce menstruators' risk for STIs. A reduction in STIs with improved menstrual health could be explained by a reduction in bacterial vaginosis (which is associated with STIs, [including HIV](#)). It could also be explained by a social situation in which menstruators are no longer [relying on their partners](#) to purchase menstrual products (see the second diagram below). The connections between poor menstrual hygiene and STIs is still not fully understood and further research is needed to explore this link, especially as it relates to infertility. While there is evidence that RTIs and STIs can lead to issues with fertility (for example, untreated [STIs lead to pelvic inflammatory disease, which can lead to issues with fertility](#)), there is no evidence that makes the causal linkages to poor menstrual health and hygiene. Finally, there is no evidence that poor menstrual health and hygiene leads to more or different contraceptive-induced menstrual changes (CIMC). However, it is true that some FP users may choose a contraceptive method based on the fact that it reduces menstrual bleeding, and so reduced the need for menstrual health supplies and facilities.



QUESTION: In what format is the NORMAL tool available? Are there posters or messages or fliers?

- **RESPONSE:** The current version of the NORMAL counseling tool can be accessed [here](#). It is a tool meant to be printed and used by healthcare providers or other others who are providing FP counseling and/or education. It is open-access and we encourage others to use/adapt it (and include in research or program evaluations). You can also read more about the tool in [this article](#). In addition, we are in the process of developing and evaluating a community-based version of the NORMAL tool which is intended for lower literacy clients

and use by community health workers (e.g. in group education sessions). That tool will be pre-tested in Kenya in early 2021 and then disseminated widely.

QUESTION: Increasingly we are seeing task-shifting of the group education part of FP counseling for contraceptive methods to community-health workers (CHWs), either at the community-level or while clients are waiting at the facilities for services. How can we further strengthen the effectiveness of this engagement to prepare knowledgeable and empowered clients?

- **RESPONSE:** Integrating trained, equipped, and supported community health workers (CHWs) into the health system is a proven [high-impact practice for family planning](#). Tapping into this group is essential to the success of any program that attempts to counsel clients on CIMCs. As noted above, we have developed a community-based version of NORMAL that will pre-tested in Kenya in early 2021. This evaluation in Kenya will obtain feedback from both community health volunteers (CHVs) and community members about this lower-literacy version of the NORMAL tool. The tool will then be revised and disseminated. Stay tuned!

QUESTION: Merci à la presentation de Madagascar. quelle est la tranche d'âge et niveau d'instruction des femmes qui acceptent d'avoir une aménorrhée avec leur méthode contraceptive. (**Translation:** Thank you for the presentation from Madagascar. What is the age range and level of education of women who agree to have amenorrhea with their contraceptive method?)

- **RESPONSE:** There is no data on acceptance of amenorrhea disaggregated by age in Madagascar. However, age data is available for those who chose to use the hormonal IUS in Madagascar, many of whom were interested in the effects of the method on menstrual periods. In this pilot, 30% of clients were under age 25, 21% were age 25-29, 19% were 30-34, and 30% were over 35. 82% of clients also had at least a secondary school education. In different settings, research on amenorrhea acceptability in Uganda and Burkina Faso has found higher acceptability among younger women in Burkina Faso (Mackenzie et al., 2020).
- **RÉPONSE:** : Il n'y a pas de données sur l'acceptation de l'aménorrhée ventilées par âge à Madagascar. Cependant, des données d'âge sont disponibles pour ceux qui ont choisi d'utiliser le SIU hormonal à Madagascar, dont beaucoup étaient intéressés par les effets de la méthode sur les règles menstruelles. Dans ce projet pilote, 30% des clients avaient moins de 25 ans, 21% avaient entre 25 et 29 ans, 19% avaient entre 30 et 34 ans et 30% avaient plus de 35 ans. 82% des clients avaient également au moins un diplôme d'études secondaires.
Dans des contextes différents, la recherche sur l'acceptabilité de l'aménorrhée en Ouganda et au Burkina Faso a révélé une plus grande acceptabilité chez les jeunes femmes au Burkina Faso (Mackenzie et al., 2020).

QUESTION: Why are some stakeholders reluctant to include education on FP in schools?

- **RESPONSE:** Some stakeholder groups, including governments and parents, do not fully support comprehensive sexuality education (CSE) and prefer an abstinence-based approach to be taught in schools. This is due to the belief that CSE will lead to sexual activity and higher rates of teen pregnancy (something that is not supported by the data). Importantly, in more conservative settings, menstrual health education can be very helpful because it

acts as an entry point into communities and conversations about other, potentially more controversial, topics.

QUESTION: The Nia project results presented by ZanaAfrica will be exciting to see. When is a publication expected?

- **RESPONSE:** The protocol for the RCT evaluation of the Nia project is available [here](#) and baseline results are available [here](#). We are hoping for publication of end-line results in 2021.

QUESTION: It was good to see data about the use of period trackers during the PSI LAC (Latin America and the Caribbean) presentation. Many apps intended as period trackers may be used to predict ovulation (which may or may not be accurate) and users may be relying on these to time sex (for pregnancy prevention). Did their study look into this at all?

- **RESPONSE:** There are fertility apps that can be used as an effective method of contraception (i.e., the FDA recently approved Natural Cycles), but they must be used consistently and correctly. In the case of the PSI LAC's period tracker data, most girls and young women were using it to remember when they should expect their period. The PSI team has not done research on its use otherwise, but misinformation regarding ovulation and tracker apps is evident and should be addressed through education and information.

QUESTION: Has the SBC project for Youth SRH presented by PSI LAC engaged men and boys in conversations about CIMCs?

- **RESPONSE:** Men and boys have not been explicitly involved in conversations about CIMCs through this particular project, but it is something to consider for the future. In general programs that integrate MH and FP will need to consider strategies to meaningfully engaging men and boys. Notably, an organization called Grow & Know led by Marni Sommer, one of the presenters in the meeting, has done some of this work in the MH field, developing [puberty books for boys](#) in three countries. These include content on menstruation and do not include the depth of what young men might need about CIMCs, but they can be used start to having boys be part of the conversation and supportive of menstruation.

QUESTION: Evidence shows that young people often prefer private sector points of care for privacy and stigma-free services. How can pharmacists and community shops be engaged in MH programming?

- **RESPONSE:** The private sector offers an important point of entry for MH programming that has not yet been tapped into on a large scale. A majority of menstruators in low-and-middle-income countries who purchase menstrual products do so through pharmacies and small drug shops. In poor and rural areas, menstrual supplies are often limited, expensive, or out-of-stock. (e.g., see webinars from [Menstrual Health Supplies Workstream](#) at RHSC for more detailed information). [Working to improve supply chains](#) and providing lower-cost, high-quality options would be a good first step for engaging with these private sector points of care. Additionally, pharmacists and shop owners could be trained to provide education about the meaning and importance of good menstrual health and hygiene and/or could be provided with written information, education, and communication (IEC) materials to provide to every client who purchases a menstrual product, such as the NORMAL tool once pilot is complete. More research is needed to explore this type of work but there is evidence from other fields that it may be an important intervention. For example, training and supporting

drug-shop and pharmacy staff to provide a wider variety of FP methods and information is considered a promising High Impact Practice (HIP) for FP (see the HIP brief on this topic [here](#)).

QUESTION: Are there any studies that show the impact of early integrated RH intervention on their future RH outcomes, including contraceptive uptake and continuation?

- **RESPONSE:** There is a growing body of [evidence](#) that suggests providing young people with age-appropriate, puberty education improves their ability to communicate about reproductive health and more easily access services such as FP later in life. Research has also shown that youth-friendly, curriculum-based [comprehensive sexuality education](#) (CSE) can contribute to delayed initiation of sexual intercourse, decreased frequency of sexual intercourse, decreased number of sexual partners, reduced risk-taking, increased use of condoms, and increased use of contraception. Additionally, puberty and CSE education for young men creates gender supportive environments that enable women to more easily access and use family planning.

USER EXPERIENCES PANEL

QUESTION: There has been discussion in the medical field recently about viewing menstruation as a vital sign (the 5th vital sign). Could you elaborate on what this means and how it might relate to contraceptive-induced menstrual changes (CIMCs)?

- **RESPONSE:** Menstruation occurs when women are healthy; any decline in health has the potential to disturb menstrual frequency, duration, regularity and/or volume. The thought that it could be used as another indicator of health comes from recent [convenings](#) and [research](#). What use of this “fifth vital sign” means for contraceptive users is certainly an important question to consider, especially as use of long-acting, reversible contraceptives (LARCs) is increasing world-wide, which leads to fewer menstruators with “standard” menstrual cycles.

QUESTION: Regarding the data that was shared from Burkina Faso or Uganda, where 65% and 40% would choose a method that causes amenorrhea, is female genital mutilation (FGM) an issue? For some menstruators, FGM can make periods intolerable so would amenorrhea maybe be preferred? What kind of research has been conducted connecting FGM, MHH, and/or FP?

- **RESPONSE:** According to the [World Health Organization](#) (WHO), the percent of women age 15-49 who have undergone FGM is 1% in Uganda and 76% in Burkina Faso. FGM can initially cause severe bleeding and problems urinating, and later cysts, infections, complications in childbirth, and increased risk of newborn deaths. There are case studies and a growing body of [evidence](#) that suggests FGM can also lead to painful and prolonged periods caused by a narrowing of the vaginal opening, which slows down menstrual flow and causes it to pool in the vagina. Despite this, there is very little research that attempts to connect FGM, MH, and FP. Some researchers posit that contraceptive use is lower among women who have undergone FGM because the contexts, power dynamics, and gender norms that lead to both of these issues are similar, though there is very little evidence in this area. One [study](#) conducted in Egypt (where the prevalence of FGM is 91%) analyzed data from the 2014 DHS and found that FGM status was associated with the type of contraceptive used.

They found that women with FGM were more likely to use hormonal methods like pills, injectables, and implants and less likely to use IUDs, barrier methods, and natural methods. This difference in the types of methods used is most likely due to the physical changes caused by FGM but could also be explained by psychological and social factors. Future studies should examine the reasons for contraceptive use/nonuse and the types of contraceptives chosen by women with FGM.

QUESTION: Do we have any data about sexual practices, including sex, during menstruation?

- **RESPONSE:** See Higgins & Smith (2016), [The Sexual Acceptability of Contraception in the Journal of Sex Research](#). Additionally, there is a paper by Chelsea Polis and colleagues that is under review and that presents the results of a study in Ghana that has some data on sex during menstruation. Stay tuned!

QUESTION: In the user experiences presentation from Uganda, one of the qualitative findings related to amenorrhea was “acceptability related to alleviation of problematic standard bleeding.” Can you explain further the problems with "standard bleeding"?

- **RESPONSE:** In focus group discussions from this study in both Uganda and Burkina Faso, the most common reason for viewing contraceptive-induced amenorrhea as desirable was seeing as a way to alleviate issues experienced with standard menstrual bleeding (and here, standard bleeding refers to the bleeding and associated symptoms experienced with menstruation while not using hormonal contraception or a copper IUD). For some women, the issue was simply disliking menstruation in general, but others reported seeing amenorrhea as a way to address standard bleeding they found problematic (e.g., bleeding high in volume or duration, or associated menstrual cramping) ([Mackenzie et al., 2020](#)).

QUESTION: In the user experiences presentation from Uganda, one of the qualitative findings was that women believed amenorrhea caused other side-effects. Could you give a couple of examples of the "other" side effects women are attributing to amenorrhea?

- **RESPONSE:** In this study, some women in focus group discussions in both Uganda and Burkina Faso reported viewing some or all other perceived contraceptive side effects as being *caused* by contraceptive-induced amenorrhea, rather than viewing all side effects, including amenorrhea, as caused by the contraception. Often, these other perceived side effects were related to a broad sense of health, weight changes, or changes in feelings of strength or energy ([Mackenzie et al., 2020](#)).

QUESTION: When cycle stopping oral contraceptives (e.g., Lybrell, Seasonique) were first introduced, there was a dearth of data (re: resumption of fertility, especially in younger users). What is the status of that literature now? That is, can we assert confidently that there is no risk to long term fertility for users, including for those who suppress the menstrual cycle for many continuous years?

- **RESPONSE:** This is a very common concern among women globally but there is no evidence that hormonal contraceptives have a long-term impact on fertility. For example, Yaland et al. (2020) explored this in a recent paper titled [Pregnant contraceptive use and fecundability: prospective cohort study](#). It concluded that the use of some hormonal contraceptive methods was associated with delays in return of fertility, with injectable contraceptives showing the longest delay, but there is little or no lasting effect of long term

use of these methods on fecundability (the probability of achieving a pregnancy within one menstrual cycle).

QUESTION: Bleeding changes, especially heavier or longer bleeding may cause problems for discreet FP users. How should clinicians, community health workers (CHWs) and FP providers manage discreet users during FP counseling?

- **RESPONSE:** This is a very important point, and any changes to the menstrual cycle could result in suspicion or detection by a partner, parents, or other person from whom a user is concealing contraceptive use. Recent work provides great insights into the challenges, considerations, and consequences of discreet use ([Kibira et al, 2020](#)). Focus group discussions conducted with youth [in Nigeria](#) found that after a description of the hormonal IUS was shared, several participants (mostly unmarried) worried that girls' parents would notice any bleeding changes and would either think their daughter was pregnant or would discover her use of FP. More research and programmatic work are needed in this area. Similarly, ensuring FP users' privacy and confidentiality during service delivery is an important factor, especially for CHWs who may be providing services in the home or a community location.

MEASURES AND INDICATORS

QUESTION: Have any gender based violence indicators been looked at as potential impact indicators for Menstrual Health and Hygiene (MHH) interventions from the M&E perspective? Also, is there any interventional evidence on this from LMICs?

- **RESPONSE:** There was a [Violence, Gender, and WASH Toolkit](#) published a few years ago that highlighted attention to GBV and WASH, noting the vulnerability experienced for those who menstruate and others. There is also a gender section in [the Monitoring Menstrual Health and Hygiene](#) report published in 2019. Additionally, the [new UNICEF MHH Monitoring Guidance](#) includes some relevant indicators. Very little research has been conducted exploring how menstrual health interventions impact gender-based violence. These hypothesized linkages need to be evaluated. [One study](#) did look at the association between menstrual restrictions (such as [chaupadi](#), a practice in which girls and women are separated from other people and the activities of daily life while menstruating) and intimate partner violence (IPV) and did not find a relationship between the two amongst a large sample in Nepal. More thinking and research is needed in this area.

QUESTION: On a practical level, what and how we measure is often shaped by the Ministry or government department involved (i.e., the way menstrual health is measured will be very different for a Ministry of Health (MoH) vs. a Ministry of Education (MoE)). How can we better share evidence and metrics across governments in an accessible, user-friendly way?

- **RESPONSE:** When it comes to developing measures and studies, researchers and development partners need to keep the purpose and end-use of their work in mind from the very start. Our measures need to be fit for purpose and their audience. For example, an independent study testing the relationships between unmet menstrual health needs and health/education (as in the question above) or a clinical trial of the CIMCs associated with a

new contraceptive have time and space for more detailed measures to address some critical gaps in our evidence. In contrast, monitoring efforts or tests of interventions undertaken in partnership with Ministries are going to be shaped by those involved and likely have a different purpose. It is important to stress that we may need measures for both types of contexts. Here it is critical that we understand the relationship between the measures and can link our research and M&E evidence.

In terms of measuring menstrual health at a national level or under the programs of different Ministries, bringing sectors and stakeholders together to identify and share priorities and identify priority outcomes would be a good place to start (a good example is the [Monitoring MHH](#) meeting that convened a multi-sectoral group of researchers, practitioners, and monitoring and evaluation specialists around menstrual health).

QUESTION: There seems to be some evidence that poor menstrual health is linked to a number of poor health and education outcomes. How can measurement be improved to definitively prove these connections (one way or another)? How can this then be translated into advocacy work?

- **RESPONSE:** At the moment, most of the evidence that unmet menstrual health needs result in broader consequences for health and education is qualitative. We need quantitative estimates to test these relationships to inform policies and programming, as well as for advocacy. Being able to adequately measure unmet menstrual health needs is an essential step to being able to test the associations between menstrual health and our outcomes of interest.

Specifically, we need thoughtful, rigorously developed, and tested measures that capture menstrual health needs. There is no ‘short cut’ for this. It requires investment in building theory and understanding around menstrual health so that we can select ‘what’ to measure. We then need to develop and test measures across a variety of settings (and build evidence about their relationships with health and education outcomes). We are likely to need multiple measures. This will include measures for different concepts (e.g., menstrual knowledge, menstrual management needs), as well as different approaches (e.g., observational vs. self-reported) to be able to triangulate our assessment of relationships between menstrual health and other outcomes (for example, we may want hard observational data about sanitation facility quality alongside a measure of perceived adequacy for menstrual management to test associations with health/education).

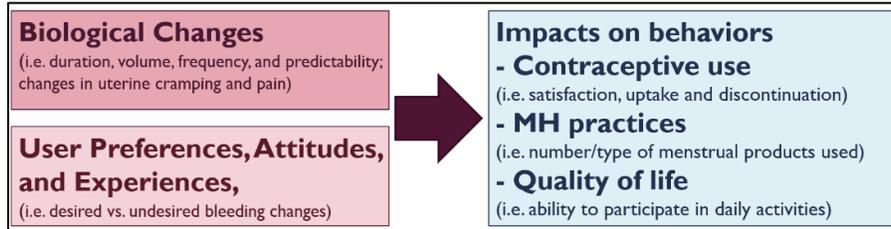
These measures take time. Julie Hennegan and her team developed the [Menstrual Practice Needs Scale](#) (MPNS-36) to start to fill some of this gap. This tool assesses the extent to which respondent’s menstrual bleeding management (or menstrual practice) needs are being met. As we test this measure across contexts, we can then assess the relationship between unmet menstrual management needs and health/education outcomes.

In short, we need funding for thoughtful measure development and testing, and funding for studies to then use these measures to test these relationships with health and education outcomes.

QUESTION: Are you going to propose any new CIMC indicators or a universal definition of indicators during this meeting?

- **RESPONSE:** During the CIMC meeting, a measurement framework and set of indicator categories were presented during plenary and discussed during the interactive break-out sessions (see image below). These discussions will be used to inform a larger “call to action,”

which will include a research and learning agenda with a list of draft indicators that can be used by those working on CIMCs. Stay tuned!



BIOMEDICAL INTERVENTIONS

QUESTION: A statistic mention was that about 1 in 3 women suffer from heavy menstrual bleeding. Where does this come from?

- **RESPONSE:** According to the American College of Obstetricians and Gynecologists (ACOG), any of the following is considered “heavy menstrual bleeding”:
 - Bleeding that lasts more than 7 days,
 - Bleeding that soaks through one or more tampons or pads every hour for several hours in a row,
 - Needing to wear more than one pad at a time to control menstrual flow,
 - Needing to change pads or tampons during the night, and/or
 - Menstrual flow with blood clots that are as big as a quarter or larger.

However, this is just one definition, it can be difficult to measure, and may not be consistently reported. The 1 in 3 figures is an estimate that is very difficult to make because it requires comparing across varied research studies. There may be different figures cited for heavy menstrual bleeding, which may come from incidence vs. prevalence, as well as a host of other factors - cultural, genetic, lack of standardization of definitions. There is much work to be done here!

QUESTION: Is there any evidence that more menses leads to higher rates of reproductive health-related cancers? Perhaps due to exposure to hormones? On the other hand, is there any evidence that suggests high cancers rates among hormonal contraceptive users?

- **RESPONSE:** There is evidence that oral contraceptives (and possibly other methods) reduce the risk of endometrial and ovarian cancer. Several large-scale epidemiologic studies have confirmed these findings. The Cancer and Steroid Hormone ([CASH](#)) study conducted in the United States is possibly the most well-known and found a 40 percent reduction in the risk of both endometrial and ovarian cancers. The reasons for this protection are not completely understood but many posit that it is due to reduced exposure to hormones. The reverse relationship (i.e., whether hormonal contraceptives cause cancer) is controversial but the large majority of epidemiological studies do not show an increased risk for cancers (particularly breast cancer or cervical cancer). Overall, there are inconsistencies among studies and further research is needed.

QUESTION: What level of healthcare provider can diagnose and treat menstruation-related conditions?

- **RESPONSE:** In LMICs, lower-level providers, including nurses, are often the ones who assist clients with menstrual disorders because they are the ones who are available at clinics and

other medical facilities. If available, medical doctors also provide care for these problems, and are usually able to provide more help to the patient. In all cases, medical providers are limited because they do not have access to laboratories and/or the diagnostic tools they need.

QUESTION: Are there good educational resources available to learn about the science of normal and abnormal menstruation for low-biology literacy people? Especially for youth populations?

- **RESPONSE:** There are many curricula and resources that provide simple but scientifically accurate information about puberty and menstruation. Most of these can be accessed through online resource libraries, including those housed on the [MH Hub](#) and [MH Day](#) site. Additionally, there is currently an effort to more fully include menstrual health information (including information about the menstrual cycle, cycle irregularities and menstrual disorders) in CSE and RH guidelines at the international, national, and local levels. While many of these curricula and resources are useful, organizations and educators face a myriad of challenges when implementing them in different contexts. In many contexts, the full set of topics included in CSE is not acceptable for various reasons, but menstrual health and puberty education can act as an entry point because it is a more acceptable and less controversial way to introduce youth to reproductive health topics to parents/caregivers and teachers in many contexts. This in turn can serve the role of an entry point discussion, building a foundation for later conversations or information sharing on more comprehensive content. Several of this meeting's presenters have resources that might be useful in this type of programming, including Marni Sommer's [puberty books](#), with over two million copies distributed across 8 countries. Jackie Maybin's [HOPE](#) (Healthy Optimal Period for Everyone) and the NHS.UK page on [periods](#) are also useful resources, especially related to the topic of abnormal periods and menstrual issues and disorders. Finally, while it is essential to reach young people, menstruators of all ages need to be provided with simple, science-based information about menstruation and the menstrual cycle.

R&D

QUESTION: Is there any research that would help users predict the bleeding pattern that they are likely to experience on a specific method?

- **RESPONSE:** This is a question that is an area of interest for future research, more specifically in the field of [precision medicine](#). Additionally, a study by Darney et al. (2018) titled [Amenorrhea rates and predictors during 1 year of levonorgestrel 52 mg intrauterine system use](#) may also be of interest. It found that the only significant predictor of amenorrhea at 12 months was self-reported baseline duration of menstrual flow of fewer than 7 days vs. 7 or more days (18.2% vs. 5.2%, adjusted odds ratio 3.70 [1.69, 8.07]). They found no relationships between 12-month amenorrhea rates and age, parity, race, body mass index, baseline flow intensity or hormonal contraception use immediately prior to IUS placement.

QUESTION: Laneta Dorflinger from FHI 360 mentioned work on including CIMC information in product packaging. Could you expand on this? Will this information also be included in product marketing or user-friendly labelling?

- **RESPONSE:** Current labels for providers and users of all hormonal contraceptives include information on menstrual changes that might occur during use, including changes in

menstrual bleeding patterns (such as amenorrhea, irregular spotting or bleeding, prolonged spotting or bleeding, and heavy bleeding) as well as other side effects. For combined hormonal contraceptives, the FDA has provided specific guidance, which includes both class labeling as well as information from studies of the specific product that were conducted for marketing approval. It is important for researchers to include data collection on this topic in the future (see measurement and indicator section above). For examples, FHI 360 collects data in all our clinical trials related to CIMCs. We anticipate that this information will be included in prescribing and user counseling information and inform broader planning for method introduction and roll-out.

Access additional resources and information about the virtual technical consultation on contraceptive-induced menstrual changes (including slides and full sessions recordings) [here](#). For additional questions please contact Emily Hoppes, ehoppes@fhi360.org.

Referenced Materials

- ACOG Committee on Adolescent Health Care. (2006). ACOG Committee Opinion No. 349, November 2006: Menstruation in girls and adolescents: using the menstrual cycle as a vital sign. *Obstetrics and gynecology*, 108(5), 1323. Access [here](#).
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- Darney, P. D., Stuart, G. S., Thomas, M. A., Cwiak, C., Olariu, A., & Creinin, M. D. (2018). Amenorrhea rates and predictors during 1 year of levonorgestrel 52 mg intrauterine system use. *Contraception*, 97(3), 210-214. Access [here](#).
- Grow and Know Puberty Books for both girls and boys, access [here](#).
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