

Menstrual suppression among female Nigerian pilgrims during Hajj

Some religious rites of Hajj (the obligatory pilgrimage that many Muslims make to Mecca) cannot be performed during menstruation, so women may wish to suppress their menses. Eliminating monthly periods could further improve the quality of women's lives, reducing both physical pain and mood swings that can be disruptive or debilitating, to say nothing of the inconvenience and cost of managing monthly bleeds.¹

Technology to make menstruation an event of choice for many women has existed

for decades and includes combined oral contraceptive pills (COCs), skipping the placebo tablets in 28-pill packs¹ and, more recently, as reported in the April 2012 issue of this Journal, a flexible, extended regimen of ethinylestradiol and drospirenone.² Other methods include taking norethisterone (Primolut N[®]), medroxyprogesterone acetate (Depo-Provera[®]), danazol, low-dose mifepristone or the use of gonadotrophin-releasing hormone analogues, endometrial ablation or hysterectomy. Breakthrough bleeding (BTB) and other side effects may limit the use of some of the aforementioned methods and some are obviously not suitable for short-term menstrual suppression.¹

On a related topic, we thought that Journal readers might be interested to hear about a cross-sectional study we conducted during the 2007 Hajj season to study the knowledge, attitude and practice of menstrual suppression among female pilgrims during Hajj. Pre-tested questionnaires were administered randomly to 150 female Nigerian pilgrims, of which 116 (77.3%) were returned. Of the respondents, 82.7% were aged between 22 and 44 years and the remaining 17.3% were 45+ years old. Age, parity and level of education had no significant influence ($p>0.05$) on the use of drugs to delay menses during Hajj. Occupation and previous use of contraception were, however, significant ($p<0.05$) in this regard. The majority (70.7%) of respondents were aware that drugs could be used to delay menses and 16.7% had previously used a drug for this purpose: 41.7% had used COCs, 33.3% injectable progestogen and 25.0% an oral progestogen. Only 11.2% of the women questioned would be willing to use a drug to delay their menses, and 9.5% of the respondents were undecided on this point.

Civil servants were more likely to use menstrual suppression than women in other occupations, probably because of the financial implications of going on Hajj. COCs were used more commonly because previous users (who used COC for regular contraception) were more aware and may have tolerated amenorrhoea as one of the side effects of COC use. The majority (69%) of respondents had attained tertiary level education and previously performed Hajj (41.4%), factors that are likely contribute to the high level of awareness (70.7%) about the use of drugs to suppress menses.

Awareness about the use of drugs to delay menses did not, however, affect the utilisation of these drugs, and the majority of respondents would also not advise other women to use these drugs. This may be because the women concerned may be unaware of the fact that a consensus has been reached among Islamic scholars that permits a woman to use these

drugs provided a gynaecologist has confirmed that it is safe for her to use them.³

COCs were found to be the drugs most frequently used by respondents to delay menses, and that they started taking these drugs shortly before the commencement of the Hajj rites. It is, however, better to make small adjustments to this medication over a number of menstrual cycles rather than making a sudden major change, as this will minimise the chances of BTB.⁴ In the first month of use, BTB and spotting rates for most low-dose COCs (i.e. those containing 30–35 µg estrogen) range from 10% to 30%. For formulations containing 20 µg estrogen the rates found in many studies are even greater.²

Despite high awareness, there is low utilisation of menstrual suppression among Nigerian female pilgrims. Menstrual suppression does, however, remain a safe and permissible option for female pilgrims.

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References

- 1 Szarewski A. Sisters doing it for themselves. *J Fam Plann Reprod Health Care* 2009;**35**:71–72.
- 2 Klipping C, Duijkers I, Fortier MP, et al. Contraceptive efficacy and tolerability of ethinylestradiol 20 µg/drospirenone 3 mg in a flexible extended regimen: an open-label, multicentre, randomised controlled study. *J Fam Plann Reprod Health Care* 2012;**38**:73–83.
- 3 Frankovich RJ, Lebrun CM. Menstrual cycle, contraception and performance. *Clin Sports Med* 2000;**19**:251–271.
- 4 Loudon NB, Foxwell M, Potts DM, et al. Acceptability of an oral contraceptive that reduces the frequency of menstruation: the tri-cycle pill regimen. *BMJ* 1977;**2**: 489–490.