

**The Perception of Periods**  
***A Qualitative Study into the Experiences of, and Attitudes towards, Menstruation  
and Menstrual Suppression***

by

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## **ABSTRACT**

This study examines women's experiences of, and attitudes towards, menstruation and menstrual suppression. Using a grounded theory, approach one-on-one interviews with women highlight common motives behind the decision making process to manipulate and/or suppress menstrual cycles through use of hormonal contraception. While current advertisements by pharmaceutical companies for contraceptives work to be an influencer for menstrual suppression, they often fail to portray accurate representations of women and women's lives. Instead of being influenced by these advertisements, women are more and more commonly utilizing health care professionals, the Internet and friends as sources of information about contraception and menstrual suppression. This study highlights the contradictions experienced by women who wish to use hormonal contraceptives to continuously alleviate pain associated with menstruation, or for contraceptive purposes, but are hesitant about the presence of synthetic hormones in their bodies. While convenience is attractive, many women prefer to remain natural.

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## 1.0 INTRODUCTION

“Just as the penis derives its privileged evaluation from the social context, so it is the social context that makes menstruation a curse. The one symbolizes manhood, the other femininity; and it is because femininity signifies alterity and inferiority that its manifestation is met with shame” (Kissling, 2006, pp. 5).

### 1.1 Preface

Since Coutinho and Segal’s 1999 publication of the provocative book *Is Menstruation Obsolete?: How Suppressing Menstruation Can Help Women Who Suffer From Anemia, Endometriosis or PMS*, the notion of menstrual suppression has been actively discussed and debated amongst women, medical professionals and scholars alike. The book proposed that as a result of earlier menarches, later first births, and less frequent pregnancies, menstruation is becoming more and more obsolete and unnecessary, and is becoming increasingly harmful for women<sup>1</sup> (Repta and Clarke, 2011, pp. 92). The United States Food and Drug Administration’s 2003 approval, and Health Canada’s subsequent 2007 approval, of a new drug *Seasonale*, which was marketed primarily as a menstrual suppressor, and secondly as a contraceptive,

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<sup>1</sup> For the purpose of this paper, the following is understood: Not all women menstruate. Women may not menstruate for a variety of reasons, including, but not limited to: the result of not yet receiving her first menses, the result of impregnation, or the result of going through, or having gone through, menopause. Additionally, individuals identifying as transgendered may or may not experience menstruation, depending on their own unique experience. For the purpose of this paper, it is also understood that menstruation **does not** equate womanhood, and womanhood **does not** equate menstruation.

The term *woman*, as used in this paper and for this specific research purpose, refers specifically to the group of women who do menstruate. Although this excludes an obvious group of women who do not, it was the intention of this paper to speak to, and conduct research on, women who do.

only added fuel to the debate that menstrual suppression through use of hormonal contraceptives was a safe and growing trend.

While advocates for menstrual suppression (commonly understood as the altering or adjustment of a menstrual cycle through use of hormonal contraception), such as Coutinho, often highlight perceived health benefits associated with the practice, including relief from migraines, acne and dysmenorrhea, opponents of menstrual suppression are often more skeptical of the precedence it sets. Instead, scholars and researchers against the practice have argued that there is “nothing ‘natural’ about consuming hormones daily to reduce women’s menstrual cycles” (Repta and Clarke, 2011, pp. 92), and instead question the motivations of pharmaceutical companies for not only endorsing the practice itself, but for also manufacturing the means to suppress one’s cycle. Additionally, they have questioned the social stigmatization associated with women’s menstruation, and the ways in which asymmetrical gender relations (particularly the privileging of masculinity) are reinforced within society.

Menstrual suppression is often marketed as giving women a choice and control over their own bodies and reproductive rights. Pharmaceutical advertisements often play into the notion of empowerment, and while women with certain health conditions would most likely benefit from the practice, current literature is conflicted on whether or not women *actually* wish to eliminate their periods as much as is portrayed. In fact, contrary to much belief, some studies demonstrate that women view their menstrual cycle as “normal, healthy, and an important marker of womanhood” (Repta and Clarke, 2011, pp. 103), and as a

result, are hesitant to manipulate or suppress it using hormonal contraceptives. As such, it is important for literature to consider narratives and lived experiences of women who menstruate in order to accurately depict their needs and wants, and to situate women in terms of current ecological and environmental perspectives in order to generate an accurate portrayal of all intersectionalities of a woman's life, including race, sexuality and class standing.

Using a grounded theory approach, this research project aimed to examine mitigating factors behind a woman's decision to suppress and or/manipulate her menstrual cycle through use of contraceptives. One method used in this study involved conducting one-on-one interviews with women from Ottawa regarding their experience with, and attitudes towards, menstruation and menstrual suppression. While the main objective of the research was to identify why women may opt to use contraceptives as a means to suppress their menstrual cycle, and whether or not advertisements by pharmaceutical companies encouraged such practice, the research became much more complex. Instead, it was revealed that women and women's health are much more multifaceted in nature, and that aiming to categorize women based on menstrual experience was not sufficient in providing an accurate portrayal of women. As a result, informed by a feminist political economy approach, the findings of this project instead reveal the often-complicated dynamics between health care providers, women and women's lives, and society when deciding whether or not to use contraceptives and for what purposes.

## **1.2 Goals and Objectives:**

It was the intention of this research to:

- 1) Identify and analyze the ways in which women and women's lives are understood and interpreted by pharmaceutical companies through images and language used in print advertising;
- 2) Identify key reasons behind a woman's decision to suppress and/or manipulate her menstrual cycle; and
- 3) Determine whether, if at all, print advertisements by pharmaceutical companies are an influencing factor in a woman's decision to manage her menstrual cycle through menstrual suppression<sup>2</sup>.

## **1.3 Significance of Topic**

I was in the ninth grade when I received my period for the first time. At that time, menstruation was seen as dirty, awkward and embarrassing. Who was "on the rag" was whispered about at lockers during recess, and gym class was dreaded during "that time of the month." As I progressed into university and began to form

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<sup>2</sup> Menstrual suppression: For the purpose of this paper, menstrual suppression refers to the altering or ceasing of the menstruation process (the menstrual cycle) through use of hormonal contraceptives. This term is often used interchangeably with that of menstrual manipulation.

intimate and sincere friendships with the women in my life, I learned that not much had changed. Periods were commonly still seen as dreaded and an inconvenience to everyday life. Only now, through the use of hormonal contraceptives, we had the means to control it, and to ease the discomfort associated with menstruation that had once plagued our lives. We were no longer shy teens too embarrassed to purchase our own tampons, but rather independent and busy women, who wanted to remain in control of our lives all thirty-one days of the month. We had become the generation accustomed to what medical professionals were labeling lifestyle drugs. We were menstrual suppressors.

And we were not alone. A 2003 survey of women in the United States revealed that forty-percent of women and forty-four percent of health care providers believed that suppressing menstruation is a good idea (Gorman-Rose et al, 2008, pp. 689). Such finding is also consistent with a 2012 study of over four thousand women from eight countries, including Canada, which found that fifty-percent agreed or strongly agreed with the phrase “I wish to have the freedom to decide when my monthly bleeding occurs” (Sex Information and Education Council of Canada, 2012, n.p.) With a study reporting that seventy-seven percent of women reported to being on “the Pill<sup>3</sup>”, or having used it at some point in their lifetime (Greenberg and Berktold, 2006, pp. 5), there remains ease of accessibility for menstrual suppression. This ease of accessibility for menstrual suppression is often

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<sup>3</sup> “The Pill” refers to the birth-control pill, or the combined oral contraceptive pill. When taken correctly, it is designed to prevent female fertility.

increased for users of combined oral contraceptive pills<sup>4</sup>, as users of both the twenty-one day packets and twenty-eight day packets are able to forgo the week of no pills or the week of placebo pills, and continue with the next packet of pills; thus not receiving their monthly period. This accessibility only continues to increase as pharmaceutical companies continue to promote menstrual suppression in “press releases, continuing medical education, drug representations to physicians, and direct-to-consumer advertising in print, television, and the Internet” (Hitchcock, 2008, pp. 712).

Indeed, Hitchcock (2008) reports, “most advocates of menstrual suppression have financial ties to industry as consultants and speakers, and rarely do researchers take a stand to sever these ties” (pp. 712). Therefore, while the element of choice and empowerment continues to be a selling tool of pharmaceutical companies, it is important to consider whether or not menstrual suppression provides women with the same feeling of liberation that it claims, or whether women’s choices are instead being controlled and dictated by a larger power. Determining such may allow researchers and academics to have a better understanding of the ways in which women perceive and use contraceptives, and engage in the practice of menstrual suppression.

This topic is also especially relevant to social work as the field itself had a significant hand in providing not only family planning clinics for low-income

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<sup>4</sup> Oral contraceptive pills refer to a specific form of hormonal contraceptives. This specific variety is ingested orally, and contains both progesterone and estrogen. They are most commonly taken on a twenty-eight day cycle.

women, but also the opportunity to gain control over their fertility through the development and availability of birth control. While it was Margaret Sanger's original motive to provide access to contraceptives as a means for women to gain control over their lives and decisions, these products have since evolved in ways Sanger and her colleagues could not have imagined. This topic allows social workers to question whether the developments and advancements associated with contraceptive use are consistent with the goals of feminist social work, or whether they are contradictory in nature.

Although there is significant quantitative literature on the use of hormonal contraceptives for menstrual suppression, there appears to be very little qualitative literature that focuses on women's experiences with menstrual suppression. There is even less literature that considers the ways in which, if at all, print advertisements influence a woman's decision to suppress. Research that is available, such as Barnack et al.'s 2006 article *Kiss Your Period Goodbye: Menstrual Suppression in the Popular Press* work to determine what information about menstrual suppression advertisements give to women, but do so through a review of available articles rather than through a collection of narratives from women. Given the limited literature currently available on the topic, it may be beneficial for further literature to take a feminist approach and use the voices of women to dictate their research. Not only would doing so provide academics with a better understanding of women and women's lives, but it would also provide a starting point for health care providers to consider the ways in which their practices can be revamped in order to meet the needs and demands of women and women's lives accurately. It is

anticipated that the findings of this study will assist in the provision of this information, and add to current literature on menstruation and menstrual suppression.

#### **1.4 Analytical Framework**

My efforts to uncover the role pharmaceutical companies play in regard to a woman's decision to manipulate and suppress her menstrual cycle have led me to approach the subject from a feminist political economy perspective. Such a perspective allows us to not only focus on the social dimensions of gender, but also take into account the political and economic costs and benefits that shape the contradiction of contraception.

As Margaret Andersen (2005) notes in *Thinking About Women: a Quarter Century's View*, early themes of feminist theory and/or gendered studies conceptualized gender not biologically, but rather in social terms, which included "documenting and analyzing the status of women in different social institutions; situating women's lives in the context of other forms of inequality; and asking how women resist, such as through social movements or everyday acts of rebellion" (pp. 441). The early work of feminist scholarship in the 1970's and 1980's declared a need to study women exclusively, and warned against the consequences of excluding them from both sociological and political thought. It also warned against the dangers of class categorizing, citing that considering class from an immobile perspective "does not capture the experience of gender, race/ethnicity or class"

(Armstrong and Connelly, 1989, pp. 5). Focusing on the notion that the experiences of women were valid, and to be taken seriously, feminists advocated for welfare rights for women and reproductive rights – including access to abortions and contraception – in their movements. Feminists also began to consider where women fit in regards to concepts, such as class systems, and required them to work towards “trying to understand the relationship between systems of production and reproduction” (Andersen, pp. 441). This shift in thinking was perhaps one of the key factors that allowed sociological perspectives of women to develop and allowed for new questions and debates to arise. The realization that “early feminist scholarship tended to emphasize the victimization of women while also criticizing the dominant frameworks of the disciplines” (Andersen, 2005, pp. 439) encouraged thinking to shift towards understanding the ways in which gender was conceptualized, resulting in the consideration of gender in social-cultural terms, rather than strictly biological.

Dorothy Smith, Martha MacDonald and Pat Connelly were all among leading thinkers who encouraged the shift from class analysis of women to a gendered class analysis. These women were also catalysts in highlighting the ways in which a newly developed feminist political economy took into consideration the intersectionality of political, economic and historical contexts of women’s lives. By definition, a political economy approach “treats economics as an extension of politics and relations of power as they influence the production, distribution and consumption of goods and services, as well as the (political) management of these economic variables, relationships and functions” (Murphy, 2004, pp. 4). However, this

approach fails to take into consideration what we refer to as “social reproduction”, which includes child bearing and parenting, support networks and community structures, and social affinities. Murphy notes “there is an entire universe of complex actions and dynamics upon which society, including the ‘economics’ of society, fundamentally rely, but which are largely left out of the equations and investigations of reductionist economics” (pp. 5). Contrarily, feminist political economy allows us to consider the economics of groups, including families, communities and regions. These groups are not seen as units of production or consumption, but rather as agents in the ‘economic machine’ (Murphy, 2005, pp. 6). Feminist political economy also takes into consideration the lives of people as a whole, and the ways in which they are integrated into groups on a political, social and cultural level. Additionally, much of its work is undertaken using a *livelihood analysis*. That is, understanding that a “good” livelihood is not exclusive to productivity and income-generating activity, but rather the quality of life one can achieve. This holistic approach works to understand the ways in which wealth is distributed, and why it is so many women remain poor. One of its main arguments is that the Marxist approach of political economy, which holds the notion that “labour time is an objective measurement of work” (Lee, 2011, pp. 85) fails to take into consideration the unpaid labour undertaken by women.

Taking such an approach while researching the ways in which print advertising promoted by pharmaceutical companies encourages menstrual suppression allows us to understand the ways in which a woman’s “good” livelihood is affected through the process of menstruation, and takes into consideration the

quality of life one can arguably achieve while undergoing its biological process. Feminist political economy allows us to consider the ways in which political economists commodify women through the selling of menstrual products, and the subjection of women as a product. While feminist political economists understand the correlation between contraceptives, liberation and the politics of women's control, they also acknowledge the role menstruation plays on a woman's ability and likelihood to succeed or fail in the labour force, similar to that of unpaid labour.

This particular framework is used to gain a better understanding of the ways in which women and contraceptive-based pharmaceutical companies interpret women's lives. This study examined the reasons behind a woman's decision to use hormonal contraceptives, in addition to her experiences with menstrual suppression. While it was not the original intention of the research questions to work towards understanding why women use hormonal contraceptives (other than for menstrual suppression), the one-on-one interviews with women encouraged a shift in research. Through the interviews, it became evident that women use contraceptives for a variety of reasons, and although two women may both use contraceptives for family planning or pain management, each of their experiences remain unique to them and to their lives. As such, the researcher opted to further explore the reasons behind a woman's decision to use contraceptives to better capture the experiences of menstruation.

The following chapter utilizes current literature to garner a better understanding of the historical evolution of menstruation and contraception, in addition to current understandings of women's attitudes towards menstrual suppression.

## 2.0 LITERATURE REVIEW

An initial review of the academic literature revealed that there was very little to no information on the ways in which contraceptive-based pharmaceutical companies understand women and women's lives, nor the effect of advertisements directed explicitly at women. Although current literature, such as Gunson's *More Natural but Less Normal: Reconsidering Medicalization and Agency through Women's Accounts of Menstrual Suppression*, explores the ways in which women experience menstruation and use contraception, there is a disconnect, or gap in literature, regarding print advertisements and their actual effects on women. Additionally, much of the available research is quantitative and does not include women's narratives. This literature review identifies current available literature on menstruation and the use of contraception by focusing on a historical understanding of menstruation, the experience of menstruation and the medicalization of menstruation. It then works to review literature that focuses on the history of oral contraceptives, other uses and varieties, and the introduction of Seasonale as both a form of contraception and a tool for menstrual suppression. Finally, the notion of menstrual suppression is explored to garner a better understanding of the process, and to highlight possible benefits of the practice.

It is important to note that the literature reviewed in this chapter, and used throughout the paper, is primarily North American, and written in the English language. Additionally, the majority of the literature used was gathered from the fields of sociology, psychology, social work, medicine and business.

## **2.1 Menstruation**

### **2.1.1 Menstruation: a Historical Understanding**

Although the process of menstruation has been recorded since the early second century, it was not until the late eighteenth century that it began to be understood as a process separate and unique to female bodies. Historically, it was understood that the anatomical make-up of men and women was almost identical. As Nemesius, bishop of Emesa, stated in the fourth century, “women have the same genitals as men, except theirs are inside the body and not outside it” (Martin, 1992, pp. 15). Distinction was not made between the two sexes biologically, but rather, it was generally accepted that what could be seen of a man’s genitalia was mimicked in the interior of a woman. However, this assumed similarity did not imply social equality between the sexes. While women were not wholly different in kind, they continued to be seen as a lesser man. Martin (1992) notes that while “the discovery of the nature of the ovaries in the last half of the seventeenth century changed the details, medical scholars from Galen in second-century Greece to Harvey in seventeenth-century Britain all assumed that women’s internal organs were structurally analogous to men’s external ones” (pp. 16). In order to work towards an understanding of the difference between exterior and interior organs, scholars turned towards other animal species in order to identify differences between males and females within them. It was noticed that humans, as a species, generated more “heat” than other animals; a characteristic that made them the perfect species.

However, men possessed more “heat” than women, and were therefore considered to be the most perfect species of all. Since women were lacking the same, or comparative, “heat” as men, it was understood that “the relative coolness of the female prevented her reproductive organs from extruding outside the body but, happily for the species, kept them inside where they provided a protected place for conception and gestation” (Martin, pp. 16). It was this very comparison of levels of “heat” between men and women that was used to explain the reasons why women menstruate, but men do not. Hippocrates’ understood this difference to be compensation:

Women were of colder and less active disposition than men, so that while men could sweat in order to remove the impurities from their blood, the colder dispositions of women did not allow them to be purified in that way. Females menstruated to rid their bodies of impurities (Martin, pp. 17).

The process of menstruation was seen as a way of removing what was otherwise foul and unclean, and those unable to menstruate were understood as demonstrating a sign of disease.

In the eighteenth century, as Thomas Laqueur (1990) notes, “sex as we know it was invented” (pp. 149). The reproductive organs that once situated women as *lesser thans* in comparison to men went “from being paradigmatic sites for displaying hierarchy, resonant throughout the cosmos, to being the foundation of incommensurable difference” (Laqueur, 1990, pp. 149). As sexual organs that had once shared a name (such as ovaries and testicles) were distinguished, the idea that “nuanced differences between organs, fluids, and physiological processes mirrored a transcendental order of perfection” (pp. 149) was rejected.

While the revelation of two sexes as a new foundation for gender replaced the previous one-sex model and worked at redefining the social hierarchy that once existed between man and woman, scholars were still working towards understanding female menstruation. The nineteenth century brought forth an economic theory that set to dictate the reasoning behind a female's menstruation. Reverend John Todd, who viewed women as the main spenders within the economy, while man saved everything he could, utilized a spender/saver argument to explain menstruation. For Todd, "losing too much sperm meant losing that which sperm was believed to manufacture: a man's lifeblood" (Martin, pp. 20), whereby it was not unrealistic to assume that a woman would willingly lose blood, mimicking her ease to lose, or spend, money. Martin (1992) notes that such an understanding disappeared almost as quickly as it was formed, and instead, a pathological understanding of menstruation was used to understand the process in the early nineteenth century- "whereas in earlier accounts the blood itself may have been considered impure, now the process itself is seen as a disorder" (pp. 20).

Freidenfelds (2009) notes that during the late nineteenth to early twentieth centuries old practices and beliefs that had been followed for centuries were forgone, and that Americans "abandoned the conviction that regular menstruation was critical to women's general and reproductive health, and stopped worrying that mental or physical shock during menstruation could cause fatal injury" (pp. 1). The abandonments of previous practices and beliefs came largely in part as a result of drastic changes in the habits of education, work and childbearing by Americans. Many more Americans were able to achieve a lifestyle that included access to high

school education, having one or more partners engaged in white or pink-collar jobs, producing a family, and having access to mass-produced goods. This change in lifestyle also resulted in a “new level of attention to self-preservation and personal efficiency” (Freidenfelds, 2009, pp. 2), and required women to adapt new forms of technology in order to manage their monthly menstrual cycle. By adapting new forms of technology and practices to manage menstruation, women were also able to keep up with the Progressive thinking of the twentieth century, which included working towards a more equitable society and the practice of industrialization. Friedenfelds (2009) notes “Americans applied Progressive values not only to their work and schooling, but also to more intimate aspects of their lives” (pp. 2). Americans began to consider scientific explanations of menstruation, and advocated for education amongst young girls, or those who had not yet received their first menarche. Menstrual product advertisements were commonly found more often in stores, and women were encouraged to not only “participate in all their normal activities all month...” but also taught “...these activities would not endanger their health or cause serious discomfort during menstruation” (pp. 3). In addition to a new emphasis on efficiency and convenience, women also focused on modernity. An increase in willingness to openly discuss menstruation, in addition to a rise of the use of the Pill and the sexual revolution and feminist movements of the 1960s, led to generations in the late twentieth centuries having access to sophisticated information and menstrual management products. Freidenfeld (2009) asserts that with this newfound modernity of the late twentieth century came critiques and modifications of past generations, resulting in “young women expand[ing]

acceptable spaces for acknowledging menstruation, at times demanding that the efforts they made to manage menstruation, and the annoyance menstruation sometimes caused, be recognized and supported” (pp. 2).

### **2.1.2 The Experience of Menstruation**

The act or process of menstruation is more commonly seen nowadays as a process that is often, though not always, depicted as an “inconvenience” or “annoying” by many of those that experience it. Most often occurring every twenty-one to thirty-five days, menstruation usually lasts three to five days, although a broader timespan of two to eight days is also considered “normal” in nature (U.S. Department on Health and Human Services, Office of Women’s Health, 2009, pp. 2). During this time frame, women experiencing menstruation will lose on average thirty-five millilitres of blood, or the equivalent of four to six teaspoons. Included in the blood loss is the shedding of the uterus’s endometrium lining, or what appears to be a thicker membrane within the blood. The experience of menstruation is also often unique to each individual female, with symptoms varying not only from female to female, but also from one menstruation period to another. Huang et al (2009) note that “lower abdominal cramping is the most common symptom”, but “symptoms can include nausea, vomiting, headaches, backaches and dizziness during menses” (pp. 900). Additionally, many women will experience symptoms associated with premenstrual syndrome occurring five days prior to menstruation, and concluding within four days after menstruation, which may include “depression,

angry outbursts, irritability, anxiety, confusion, and social withdrawal; somatic complaints include breast tenderness, abdominal bloating, headache, and swelling of extremities” (Huang et al, pp. 900). It should also be noted, that some women may experience little to no symptoms associated with each menstrual cycle.

While women who did not menstruate were historically seen as diseased, impure or damaged, we now understand that many women do not experience menstruation for a variety of reasons. Three most common reasons a woman may not menstruate include menopause, pregnancy and menstrual suppression. Menopause, which occurs in the latter part of a woman’s life, is the process by which the ovaries reduce the production of eggs, while simultaneously producing less estrogen and progesterone. A woman would most likely continue to experience menstruation during the early stages of menopause, and it is not until she has gone an entire year without menstruation that she would be considered post-menopausal. As a seemingly second natural alternative, a woman would not experience menstruation during pregnancy. When an embryo has become implanted and a placenta developed, a hormone called chorionic gonadotropin is produced. This hormone stimulates the ovaries to continue producing estrogen and progesterone, but no new eggs are produced. Additionally, because the uterine lining remains in place for the entire duration of the pregnancy (rather than deteriorate), it does not shed as it would normally do during menstruation. Women who continue to experience ‘menstruation’ during the duration of their pregnancy are most likely experiencing an ectopic pregnancy, and therefore not menstruating but rather experiencing similar blood loss.

Finally, many women choose to reduce the number of menstrual cycles experienced in a year through the practice of menstrual suppression, with the aid of hormonal contraceptives. While any form of hormonal contraceptive can be used to successfully suppress a menstrual cycle, the combined oral contraceptive pill is often the most common form used. Women who have been prescribed oral contraceptives in the form of a pill are often prescribed either twenty-one or twenty-eight day doses. Those who are prescribed twenty-eight pills are given three weeks' worth of 'active' pills, and one week of placebo or 'sugar' pills. The final week, during which no pills, or the sugar pills, are taken, women still do not experience menstruation, but rather withdrawal bleeding – the body's reaction to not receiving the prescribed hormones it receives the other three weeks of the month. Because the signs and symptoms of withdrawal bleeding are similar to that of menstruation, there is the common misconception that women are experiencing their period when in fact they are not. Women are able to halt the experience of withdrawal bleeding altogether through the use of menstrual suppression, whereby instead of taking a week's worth of sugar pills, the user continues onto the next week of hormonal pills. The user can continue to bypass her 'period' or withdrawal bleeding, for as long as she chooses, so long as she continually takes the pills containing active hormones.

While the previous three reasons for not experiencing menstruation described specific populations of women, they fail to take into account other women who may not experience menstruation – individuals who identify as inter-sexed,

transsexual or those in the pre-operative transiting stages from female to male, or male to female. Ashbee and Goldberg (2006) note that individuals transiting from female to male experience a halting of menstruation often between the first and sixth month of hormonal therapy, as a result of an increase of testosterone throughout the body (pp. 7). Additionally, those who have transitioned from male to female may opt to mimic the menstrual cycle, by safely increasing and decreasing hormonal levels so as to experience many of the symptoms associated with menstruation; bloating, fatigue and nausea. However, they are often unable to experience the process of menstrual blood loss and the shedding of the uterus' endometrium lining. This group of women is often ignored, however, when it comes to the discussion and advertisement of menstruation. Instead, it is often assumed that *all* women experience menstruation, and as such, advertisements and products are geared towards such ideology.

While the experience of menstruation is often considered from a physical perspective, taking into consideration the changes in body a woman experiences both as a marker at her first menses and from each subsequent cycle experienced, the experience of menstruation also often brings with it symbolic and cultural meaning. Montgomery's 2009 study *A Cross-Cultural Study of Menstruation, Menstrual Taboos and Related Social Variables* studied forty-four societies in efforts to understand the social taboos related to menstruation, in addition to the symbolism or cultural understanding of the biological process. While two societies associated menstruation with an inflicted wound: "the Maria Gond of India, who

believe that the vagina once contained teeth, and that when these teeth were removed, the wound never healed completely; and ... the Arunta of Australia, who attribute the flow to demons who scratch the walls of the vaginas with their fingernails and make them bleed” (Montgomery, 2009, pp. 143), it was revealed that the majority of societies make a connection between menstruation and the act of childbearing. She notes that, “menstruation is regarded as a signal of readiness for childbearing by many peoples, who hold initiation ceremonies at that time” (Montgomery, 2009, pp. 143). Such findings are also reflective of a 2003 Canadian study conducted by Rempel and Baumgartner, who found that “menstruation is a distinctive sign of both reproductive potential and sexual maturity ... it was concluded that menstruation is a pivotal event for reorganization of the adolescent girl’s body image and sexual identity” (pp. 155). While there is the consideration of menstruation as a signal of maturity, with it often comes varying attitudes towards menstruation. Gorman Rose et al (2008) note that attitudes towards menstruation can often be multidimensional and that factors such as “timing of menarche, sources of knowledge about menstruation, personal experiences with menstruation, gender stereotypes, and cultural beliefs about menstruation” (pp. 689) can all impact the ways in which menstruation is viewed. As a result, negative views – such as viewing menstruation as bothersome, debilitating or dirty – or positive – such as bringing forth power, self-confidence and sexual desire – often ultimately depend on the experiences held by a woman.

Such views and experiences of menstruation are often capitalized on by pharmaceutical companies who work to produce advertisements that appeal to

women who menstruate. Kissling (2006) notes that, “corporations believed that teenaged girls needed to be reached at an early age in order to become lifelong consumers of menstrual hygiene technologies ... becoming a modern teenager meant consuming products of all sorts, systematically maintaining a good-smelling hygienic body, and emerging as a consumer-citizen” (pp. 51). Tampons or hygienic pads that are small enough to be concealed by the palm of a hand are often perceived as appealing and marketed towards women who view menstruation as dirty or shameful, and as such, do not want their peers or coworkers to know that they are menstruating. Additionally, ‘wrinkle-free’ wrappers provide women with the opportunity to conceal menstruation within the confines of bathroom stall walls, while continuing to manage her period and maintain the ideal of femininity that is “contradicted by menstruation [with] menstrual products [positioned] as the only means of restoring clean, pure femininity” (Kissling, 2006, pp. 10).

### **2.1.3 The Medicalization of Menstruation**

As a result of often accompanying symptoms associated with menstruation, there has become a stronger push by the medical field, medical professionals and advocates for menstruation to be considered a medical issue. However, while it is argued that medicalizing menstruation can bring forth a variety of benefits to women, the repercussions that come as a result are also worth considering.

While the term medicalization first came into use in the 1970s, its original meaning and definition of “to make medical” has since widened and developed more

in-depth. Conrad defines medicalization as “defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to ‘treat it’” (Conrad, 1992, pp. 210). For Conrad (1992), medicalization often occurs during doctor-patient interaction, during which a physician defines an otherwise ‘social’ problem medically – i.e. administering a prescription for drugs for an unhappy family life (pp. 211). Similarly, Reiheld (2010) offers another definition for medicalization and says that “medicalization is, minimally, the process by which a mental or physical condition comes to be seen as a medical condition deserving of medical attention; some medicalized conditions are granted a disease label. Once this process has begun to occur, a patient’s complaints are taken more seriously by medical professionals” (pp. 73). Branson provides a succinct definition of medicalization in regards to menstruation by saying that medicalization theory “suggests the domination of medical knowledge over a concept of more authentic knowledge about the body held by women themselves” (Gunson, 2010, pp. 1326) Together, these definitions indicate a growing trend – that only through the process of medicalization are issues of concern to patients being taken more seriously by physicians and doctors. However, the process of medicalizing menstruation can become a ‘slippery slope’ by which medicalizing it ‘too much’ may reduce the amount of control a woman has over her body, but failing to acknowledge it medically may limit the number of resources available to women. As Morgan (1998) notes, “such medicalization has the dangerous potential to lead to real evil because the process is doubly camouflaged: first, as a technical, scientific one that is purely

objective in nature and, second, as a process done for the loftiest of altruistic and benevolent reasons ... as more and more domains of ordinary life become medicalized, they become increasingly camouflaged as apolitical, and resistance comes to look increasingly irrational since health ... cannot reasonably be called into question” (pp. 86).

With menstruation becoming increasingly medicalized in the 20<sup>th</sup> century, the first mention of “menstrual cycle-related changes in medical literature is attributed to Dr. Robert Frank in 1931 who used the term ‘premenstrual tension’ to describe a constellation of menstrual cycle-related changes experienced by women during the second half of the menstrual cycle” (Offman, 2004, pp. 18). However, it was not until 1953 when Katherine Dalton coined the term ‘premenstrual syndrome’ did we see a major step towards medicalizing menstruation. Her use of premenstrual syndrome was to “separate problems associated with the menstruation from those associated with other points in the cycle and to emphasize the variety of physiological changes associated with the ovarian cycle, most of which are not problematic” (Kissing, 2006, pp. 38). In 1987, Late Luteal Phase Dysphoric Disorder<sup>5</sup> (also referred to as LLPDD) was included in the Diagnostic and Statistical Manual of Mental Disorders as an “Unspecified Mental Disorder”. Because symptoms of Late Luteal Phase Dysphoric Disorder were similar to those of premenstrual syndrome, albeit affecting a smaller group of women, it became evident that

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<sup>5</sup> The DSM-III-R defines Late Luteal Phase Dysphoric Disorder as a combination of five of the listed ten symptoms, with at least one affective symptom, “occurring in the premenstrual week and lasting until a few days after the onset of menses during most menstrual cycles” (El-Defrawi et al, 1990, pp. 205).

discussion surrounding menstruation as a medical issue was here to stay. Pressure from women's groups to reject such a category was felt by the American Psychological Association, and in turn, LLPDD was never fully instated in the DSM-III-R, but was rather included in the appendix for "categories requiring further study" (Offman, pp. 19). LLPDD was eventually replaced in the DSM-IV in 1994 with the inclusion of Premenstrual Dysphoric Disorder, PMDD, also as a category for further study. The only key difference between LLPDD and PMDD was the reordering of symptoms and the addition of a new symptom – "a subjective sense of being overwhelmed or out of control" (Offman, pp. 19). Because previous research revealed that the most common symptom of LLPDD had been depression, many felt it should also be the top symptom for PMDD, as such, moving the condition to the "Depressive Disorders not otherwise specified" section of the DSM. The main concern with such a move, argued feminists, is that doing so would medically link menstruation to depression; something they argued could be related but not otherwise dependent. With the 2013 publication of the DSM-V, Premenstrual Dysphoric Disorder was moved from its previous location, Appendix B "Criteria Sets and Axes Provided for Further Study", to a permanent home in the main body of the manual under Depressive Disorders (American Psychiatric Publishing, 2013, pp. 4).

Similar to the concerns voiced by feminists during the move from Late Luteal Phase Dysphoric Disorder to Premenstrual Dysphoric Disorder, concerns still arise when deciding whether or not there is value in medicalizing menstrual-related symptoms. For many, such medicalizing is a good thing, argues Markens, because "prior to medicalization, a woman who complained of premenstrual distress was

seen as pathological with symptoms 'all in her head'. Medicalization legitimated her complaints by providing a physiological explanation of her now-acknowledged 'real' symptoms" (Markens, 1996, pp. 44). However, shifting the experiences of a woman from being stigmatized as 'insane' based on societal perceptions to being medically diagnosed as 'ill' through the use of the DSM has more than likely not "altered the conception of pathology as located in the individual woman" argues Markens (pp. 44). Instead, it demonstrates the ways in which medicalization may not be a medical process at all, but rather a social process by which medical professionals seek to solve or cure through medical means. Lorentzen accepts this view of medicalization as a social process, but contends that medicalizing menstruation should be of great concern to feminists alike. For her, medicalization, "a social process in which bodies and social circumstances are defined from a biomedical perspective as requiring biomedical intervention, not only contributes to the maintenance of gender inequality but directly impacts women's health and well-being" (Lorentzen, 2008, pp. 52). In fact, medicalizing menstruation may do more harm than good and may inadvertently create further bias between the male and female body. This bias may be similar to the historical explanations for menstruation, whereby the male body was seen as perfect as a result of being warmer and not needing to menstruate, in comparison to the female body. As such, medicalizing menstruation may reinforce the idea of male-body dominancy and encourage it as an ideal to be strived after. Conceptualizing premenstrual experiences as an illness or syndrome creates a difference between healthy and unhealthy. It labels menstruation, an otherwise normative biological function of most women as a disease or dysfunction of the

female body, while the male body is seen as healthy and normal. It creates not only a division between the two sexes, but also creates an unrealistic ideal for women to strive for – ‘healthy’ body sans period. It also inadvertently labels women as Other. Not only does it create a division between male and female bodies, but it also has the potential to create a divide between women themselves. Women who don’t experience menstruation would again be seen as ‘healthier’ than their menstruating counterparts, creating a tier-like effect within the society. The only way to reduce or limit this tier would be to reduce or limit menstruation – through hormonal suppression or in another manner.

## **2.2 The Introduction of Contraception**

The year 2010 marked the fiftieth anniversary of the introduction of the combined oral contraceptive pill, and with it a chance to reflect on the inception and evolution of all forms of contraception available today. Although the combined oral contraceptive pill was the first form of contraception of its kind (one that acted as an ovulation-suppressor), other forms and varieties were also available at that point in time, in addition to the development of newer options in the later twentieth century. These options varied from barrier methods to hormonal methods to encouraging those engaging in sexual acts to change or alter current habits, but all worked to promote the same outcome – to reduce or eliminate altogether fertilization and pregnancy. Over time, and as discussed within this subsection, contraceptives have become multipurpose in nature, and work not only as a form of family planning for

both men and women, but also provide the opportunity for women to alleviate pain or discomfort associated with their menstrual cycles, or to abolish their cycles altogether.

### **2.2.1 Contraceptive Forms and Varieties**

Planned Parenthood notes in its 2006 report *A History of Birth Control Methods*, “contemporary studies show that, out of a list of eight reasons for having sex, having a baby is the least frequent motivator for most people” (pp. 1). Various forms of contraceptives have historically been used as a means by which to decide when and whether to have a child. While historical methods were often lethal and extreme in nature – i.e. the drinking of mercury and lead to control fertility by Chinese women, or the use of amulets in European Middle Ages (Planned Parenthood Federation of America, Inc., 2006, pp. 1), contraceptive methods today include behavioural methods (i.e. abstinence or withdrawal), barrier methods (i.e. condoms or diaphragms), and hormonal methods (i.e. the Pill or the intrauterine device), as well as permanent methods, such as a vasectomy or tubal sterilization.

Although much literature focuses on the development and use of combined oral contraceptives, it is important to note that many other behavioural, barrier and hormonal methods are available to women. One of the most well-known forms of behavioural contraception is that of abstinence. Russo and Nelson (2006) note that “worldwide, it has been estimated that 200 million reproductive-aged women use abstinence as their method of birth control, where abstinence is defined as the

avoidance of penile-insertive vaginal intercourse” (pp. 180). While some women may opt to use abstinence for only a temporary period of time, others opt to make it a permanent choice. When practiced without fail, it carries with it a one hundred percent effectiveness rate. ‘Natural family planning’ and ‘fertility awareness’ methods are other forms of behavioural contraception, where sexual intercourse is often avoided during the days in which a woman is most fertile. The ‘calendar’ or ‘rhythm’ method, both forms of ‘natural’ family planning, use calculations to determine the length of days an egg is vulnerable to fertilization, the number of days sperm can live, the fertile period of a woman, the period of ovulation, and the days necessary to remain abstinent (Russo and Nelson, 2006, pp. 185). Other methods include the basal body temperature method (charting basal body temperatures to determine when ovulation has occurred), the billings technique (charting sensations associated with the vulva and identifying vaginal discharge), and other forms of ovulation detection methods. It is important to note that behavioural methods, with the exception of abstinence, do not protect against sexually transmitted infections, nor do they prevent pregnancy. Instead, they provide the opportunity for a woman to become in-tune with her body and her monthly ovulation patterns, thus determining the periods of time at which she is most fertile.

According to Narrigan (2006), seven available devices were marketed in the United States as cervical barrier methods for women (pp. 478). These devices include three standard diaphragms, two cervical cap devices, the female condom and the sponge (Narrigan, 2006, pp. 478). While the diaphragm had been available in Europe since the early twentieth century, it wasn’t until Margaret Sanger’s

spouse, Noah Slee, imported the devices from Germany and the Netherlands that they were available for purchase in the United States. Slee later provided Sanger's friend Herbert Simonds with funding to create the devices in the United States via a manufacturing company. Since its introduction, the diaphragm, which is meant to be inserted prior to sexual intercourse, has changed very little. Available in both latex and silicone, it carries with it a failure rate of twenty percent in the first year of use. This is comparable to both the FemCap and Lea's Shield (two forms of cervical caps), which have a twenty-three percent and a fourteen percent failure rate respectively (Narrigan, 2006, pp. 480). Women often reject barrier methods due to their level of difficulty to use, and the necessity of insertion just prior to intercourse. Narrigan (2006) notes that diaphragms and caps are, "relatively complicated to use, requiring a more complex series of actions than, for example, remembering and taking a daily pill" (pp. 482). Finally, alternative hormonal methods than oral contraceptives are available for use by women. These methods can include an intra-uterine device (which may be left in the uterus for up to five years), depot medroxyprogesterone acetate injections (given at ninety day intervals), transdermal contraceptive (a transdermal patch worn for week intervals), contraceptive vaginal rings, and etonogestrel implantable contraceptives (which can provide contraception for up to three years) (Hicks and Rome, 2010, pp. 447-8).

Similar to behavioural methods of contraception, only the male and female condoms provide users with protection against sexually transmitted infections. While all the forms of barrier contraceptives act as a method of pregnancy-protection, they often require planning or thinking ahead. In order to be effective,

women must have access to their chosen method, in addition to time to insert the device (i.e. a diaphragm), or must have planned well in advance (i.e. visiting the doctor to have an inter-uterine device inserted) prior to sexual intercourse. Additionally, only hormonal forms of barrier methods (i.e. the transdermal contraceptive patch) as opposed to none-hormonal barrier methods (i.e. the male or female condom) allow for menstrual suppression<sup>6</sup>. While many believe the inter-uterine device rids women of their monthly cycle, it often only reduces the amount of blood lost per cycle, and is thus not considered to be a tool for menstrual suppression.

### **2.2.2 The History of Oral Contraceptives**

Although *Seasonale*, described by Mamo and Fosket as “the first extended-cycle oral contraceptive marketed to suppress women and girls’ monthly menstruation” (2009, pp. 925) became available in the United States in 2003, oral contraceptives have been made available to women since the early 1960’s. Originally designed and encouraged as a means to “allow women to control the number and spacing of births” (Mamo and Fosket, 2009, pp. 928); the Pill was the product of hard and determined work undertaken by New York social worker Margaret Sanger, and Massachusetts Institute of Technology graduate Katharine McCormick. In an effort to assist poor immigrant families who had no or limited

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<sup>6</sup> Although not studied as often as menstrual suppression through the use of continued combined oral contraceptives, the transdermal contraceptive patch allows women to suppress their menstrual cycle so long as a patch is continuously placed on the women’s body. Studies are lacking determining the exact efficiency of such practice, nor is the safety of such method known.

access to family planning, Sanger opened and operated family planning clinics, working towards gaining new methods to allow women more control over their own fertility and family planning desires.

In the 1940s and 1950s, Margaret Sanger closely followed scientific research on birth control and personally funded some of it, while Planned Parenthood Federation of America made support for new birth control technology a major focus of its advocacy efforts. The turning point came, though, when a remarkable woman named Katharine Dexter McCormick (1875–1967) threw her financial support behind research to produce an oral contraceptive (Planned Parenthood Federation of America, Inc., 2006, pp. 9).

Research at the time had found that “progesterone was known to block ovulation in animals, but ... was very expensive and had to be given in very high doses by mouth or by injection thus making it unsuitable for routine use as a contraceptive” (McCracken, 2010, pp. 684). However, both Sanger and McCormick remained adamant that with enough money and time, these findings could be transferred to humans, making ovulation blocking in women a reality. Dr. John Rock, who was running his own fertility clinic in Boston, agreed to join the team, which also included reproductive biologist Gregory Pincus, and undertake the testing in women. As a result, Rock administered “large amounts of progesterone by mouth supplemented with Diethyl Stillbestrol, the first non-steroidal synthetic estrogen which was originally promoted for clinical use by Sir Charles Dodds in the UK” (McCracken, 2010, pp. 684). Although the original tests underwent changes in regards to dose level and active materials within the contraceptive, all twenty-five of the women engaged in the trials showed inhibition of ovulation. Findings were then presented to a less-than-enthusiastic crowd at the International Planned Parenthood Federation meeting in Tokyo, Japan in 1955, who were skeptical of the

effectiveness and usability of this invention. While the initial crowd was slow to be impressed by the introduction of the 'Birth Control Pill', its innovation garnered attention in global press, including that of the pharmaceutical company G.D. Searle, whose compound Norethynodrel was the most promising in the drug's 'potion' of ingredients.

In 1960, the Food and Drug Administration (FDA) officially approved the Pill. McCracken reports that side effects were especially present during its initial introduction, including "an increased incidence of thrombophlebitic and cardiovascular disease as well as a suspected slight increase in the incidence of breast cancer" (2010, pp. 685). However, according to his 2010 report, the Pill also demonstrates "a reduction of nodular disease of the breast and a reduction in menstrual blood loss. Importantly, it has emerged that the incidence of ovarian cancer in women using the Pill is reduced by as much as 80%, even after they discontinued using it" (pp. 685-686). The history of the Pill remains a unique feature in the history of social work, as it captures the driving forces behind it, and the ways in which the dominant three – Sanger, McCormick and Pincus – worked to improve family planning options and ovulation control for women, regardless of backlash from the religious community, and the Comstock Law, which had made the advertising, the sale or the procurement of contraceptive devices a federal crime in the United States<sup>7</sup> (McCracken, 2010, pp. 684).

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<sup>7</sup> Canada too had similar legislature banning the advertising or use of contraceptives – the Criminal Code of Canada. Prior to the Criminal Law Amendment Act of 1968-1969, which was introduced as Bill -150, women were unable to legally undergo an abortion, or use contraception. Once overturned, women were able to seek an abortion if their mental, physical or emotional well-being was compromised, and the use of contraception became decriminalized.

Prior to the introduction of contraceptives, women could have as few as fifty menstrual cycles in a lifetime – a number that has more than quadrupled to four hundred and fifty for women today (Miller and Notter, 2011, pp. 771). With a reported twenty-five percent of American woman using birth control pills as their main form of contraception, the Pill itself has advanced and changed dramatically since its inception. Oral contraceptives (also known as OC) include a combination of progestin and estrogen, and are most commonly taken on a twenty-eight day cycle. Women therefore take active pills for twenty-one days, and inactive (commonly referred to as “spacer” or “sugar” pills) for seven days. During the inactive week, women will commonly experience “withdrawal bleeding”, which allows for the shedding of thin and atrophic endometrium lining (Miller and Hughes, 2003, pp. 653). Researchers note that the twenty-eight day cycle was originally designed to “follow the lunar cycle in the hope it would be, in the words of Dr. John Rock, a ‘morally permissible variant of the rhythm method,’ thereby making it acceptable to women, clinicians and the Catholic Church” (Hicks and Rome, 2010, pp. 446). However, this 21/7 regimen has often been rejected by researchers and medical professionals, and women are encouraged or permitted to bypass the inactive week altogether, and continue onto the next week of active pills.

### **2.2.3 Seasonale**

“‘What’s In? Winter White, and Labradoodles,’” one news release declared in reference to a newly presented controversial birth control aimed to delay a

woman's monthly cycle. "What's out? A monthly period" (Rabin, 2004, n.p.). With this news release came the introduction of a new pharmaceutical drug, *Seasonale*, which was described by Hicks and Rome (2010) as "the first oral contraceptive marketed in the United States with an extended active regimen" (pp. 447). The Women's Health Specialists (2012) note that the introduction of *Seasonale* was different than that of other combined oral contraceptives largely in part *because* of its marketing – not only was it approved by the United State's Food and Drug Administration in 2003 as a method of contraceptive, but it was "the first birth control pill marketed as a period suppressor" (n.p.). Contrary to women prescribed traditional oral contraceptives, whereby twenty-one active pills would be taken, followed by one week, or seven days, placebo pills, *Seasonale* users take eighty-four active pills, followed by seven placebo pills. This extended use of active pills result in withdrawal bleeding or "periods" only four times a year, as opposed to monthly withdrawal bleeding from the use of traditional oral contraceptives (Barnack, 2006, pp. 353). *Seasonique*, approved by the FDA in 2006, mimics the active pills and even packaging of *Seasonale*, but offers users a low-dosage week of estrogen, versus a week of placebo pills. Duramed Pharmaceutical Incorporated's (producer of *Seasonale*, and a subsidiary of Barr Pharmaceuticals) product monograph echoes these dosages, noting:

The dosage of *Seasonale* is one pink (active) tablet taken daily for 84 consecutive days followed by 7 days of white (inert) tablets. To achieve maximum contraceptive effectiveness, *Seasonale* must be taken exactly as directed and at intervals not exceeding 24 hours. Ideally, the tablets should be taken at the same time of the day on each day of active treatment (2007, pp. 33).

In 2007 Health Canada followed the FDA's approval of *Seasonale*, and approved its distribution through Paladin Labs, which began production and distribution of the drug in 2008. *Seasonique* was later approved by Health Canada for distribution in Canada in 2011. Similar to both *Seasonale* and *Seasonique*, *Lybrel* was approved by the FDA in 2007 as both a contraceptive and a menstrual suppressor. "*Lybrel* contains fewer hormone-like drugs than *Seasonale*" and continues to suppress a menstrual cycle so long as it is taken (Women's Health Specialists, 2012). *Lybrel* has yet to be approved for use or distribution in Canada.

### **2.3 Menstrual Suppression**

Although all forms of hormonal contraception alter a woman's menstrual cycle to some degree or another, the 2003 introduction of *Seasonale* and the 2006 introduction of *Lybrel* into American markets thrust the notion of menstrual suppression into the spotlight of Western academia, popular press and the medical world. The marketing of these particular drugs, which Repta and Clarke note were promoted as "a new reproductive option whereby women severely limit their menses by taking birth control pills daily with either no breaks for menstruation (*Lybrel/Any*) or with only four breaks per year (*Seasonale, Seasonique*)" (2011, n.p.), allowed women and medical professionals alike to reconsider the ways in which menstruation was accepted and experienced. Hormonal contraceptives were no longer viewed as solely having the purpose of preventing fertilization, but also

gave women using them the opportunity to have full control over when, and if, they menstruated. Women who desired to experience menstruation less-frequently were able to alter their current cyclical pattern through manipulation and/or suppression.

### **2.3.1 The History of Menstrual Suppression and Manipulation**

Asserting that “women in earlier societies had far fewer menstrual periods as a result of later menarche, earlier first births, more frequent pregnancies, and longer periods of breastfeeding between pregnancies (when menstruation is typically absent)” (Repta and Clarke, 2011, n.p.), advocates of menstrual manipulation and suppression have long argued that menstruation is becoming progressively obsolete in today’s societies. Brazilian endocrinologist and author of *Is Menstruation Obsolete?* Elsimar Coutinho is commonly acknowledged to be the key pioneer of menstrual suppression. Viewing menstruation as risky and unnatural, he asserts that

Menstruation is an unnecessary, avoidable byproduct of the human reproductive process... Understanding why cyclic bleeding is unnecessary would be the first step. This would be followed by more women becoming comfortable with the idea of not menstruating. With the cooperation and supervision of their physicians, women would use currently available means to stop menstruation for several months and, growing more confident, would lengthen the menstruation-free interval. As the benefits become evident, other women would be encouraged to try this procedure and medical researchers would be motivated to find more advanced methods to control menstruation (Coutinho, 1999, pp. 163-4).

Rationalizing that menstrual suppression “mimics the number of cycles that women in ‘hunter-gatherer’ populations are *imagined* to have experienced” he suggests that

fewer years of pregnancy and lactation have resulted in more frequent menstrual cycles for women, and that these changes are “detrimental and ‘unnatural’” (Gunson, 2006, pp. 17). However, such an assertion brings with it the debate of what is considered natural, and why remaining natural is seen as good. Repta and Clarke note that the argument of whether or not remaining natural is ideal has become more complex as technological advancements continue to occur:

It is important to note that the concept of “natural” becomes more complex as technological improvements in health and medicine take us further away from our understandings of appropriate medical treatment. This can be seen in the medical discourses of menstrual suppression in the way that advocates of the practice argue that “natural” menstruation today requires pharmaceutical intervention (2011, n.p.).

Critics opposed to menstrual suppression often argue that menstruation is a natural process by which the body is able to clean itself out on a regular basis. Using combined hormonal contraceptives for extended periods of time to suppress a menstrual cycle denies the body the opportunity to undergo this process. Gunson (2006) also finds difficulty with the way in which Coutinho approaches menstruation from a medical and paternalistic approach, and notes that pharmaceutical companies, thinking similar to Coutinho, promote extended-cycle combined contraceptives “in ways that [construct] menstruation as unhealthy, deviant to social norms, and in need of suppression” (pp. 1135). The findings of Beverly Strassmann also contradict Coutinho’s stance, as she studied the Dognon of Mali, who use no contraception, and found that these women “have an average of 128 menstruations” which contrasts with “an estimated 400 menstrual cycles for modern Western contracepting women” (Hitchcock, 2008, pp. 706). As such,

because the assumption that women using contraceptives experience fewer menstrual cycles may not be accurate, it may not be a valid argument for those opposed to menstrual suppression, such as Coutinho.

### **2.3.2 Defining Menstrual Suppression and Manipulation**

Burbidge et al define menstrual suppression as “the temporary or permanent cessation of menstruation by the use of pharmacologically active substances or surgical intervention” (2003, pp. 11). This definition is consistent with the work of other academics, including Corrina, who in *I, Being Born Woman and Suppressed*, defines menstrual suppression as “the use of oral contraceptives, Depo-Provera, or other hormonal methods either to prevent menstruation from occurring with its normal frequency or to stop it altogether” (2011, pp. 208).

Although menstrual suppression and menstrual manipulation are often used interchangeably (and much of current literature fails to differentiate between the two), there remain three acknowledged methods of menstruation suppression/manipulation: skipping a single period, extended use (skipping some periods), and continuous use. When manipulating or suppressing a single period, any oral contraceptive pill can be used by “skipping the period pills and going directly to another pill package, so a total of 6 weeks of the hormonal pills are taken followed by the usual pill free or period week” (Menstrual Suppression Guidelines, n.d., n.p.). Extended use, skipping some periods, or skipping every other period, is often achieved through use of a monophasic-combined oral contraceptive. The

Association of Reproductive Health Professionals note in *What You Need to Know: Menstrual Suppression*, that with this method, “the placebo week from the standard 21/7-day cycle, (i.e., 21 days of active pills followed by 7 days of placebo) is eliminated and a new pack of pills is started immediately thereafter” (2008). The 2003 introduction of *Seasonale* marked the first combined oral contraceptive designed exclusively for extended-use. Finally, continuous use is often achieved through “the administration of COCs for an unlimited time without interruption to eliminate menstrual periods” (Association of Reproductive Health Professionals, 2008). *Lybrel* is an example of COCs packaged and marketed entirely as a full year of active pills. Although research frequently refers to oral contraceptives as a mode of menstrual suppression or manipulation, it is also important to note that *any* form of hormonal contraceptive (including, but not limited to, Depo-Provera, Ortho-Evra, or the Nuva-Ring) can be used in order to adjust the regime of the menstrual cycle, so long as they are used continually.

### **2.3.3 The Benefits to Menstrual Suppression**

Greenberg and Berktold (2006) note in the Association of Reproductive Health Professional’s *Menstruation and Menstrual Suppression Survey* that there exists a distinct group, or target population, of women who would exclusively benefit from the act of menstrual suppression or manipulation. The pair discovered that those considered benefiting greatly from the process of suppression are often those who do not have to make “substantial lifestyle changes, or greatly alter their

way of thinking” (pp. 14). Additionally, the pair believe that data collected from the survey depicts a specific ‘suppression profile’, or a subgroup of women who would benefit in particular from fewer menstrual cycles:

Interestingly, educated women and higher income women make less good targets than their less privileged counterparts, who carry fewer assumptions of a way a woman’s body is supposed to be. It is appealing to women already following a daily regimen to have the added bonus of no period by doing nothing different (Greenberg and Berkold, 2006, pp. 14).

In particular, Greenberg and Berkold find that women of a lower economic standing are more likely than women with a higher economic standing to voice interest in delaying or suppressing their menstrual cycle. The pair found that “nearly thirty-one percent of women with incomes less than \$20,000 are very interested” (2006, pp. 15) in delaying or suppressing their menstrual cycle, versus eighteen percent of women with incomes greater than sixty-thousand. This is also consistent with the findings of Schooler et al (2005) who found that “low-income women appear to be less likely to celebrate menstruation” (pp. 327). However, low-income women are also less likely to have access to health insurance that will support continuous contraceptive regimes, which indicates there is a disconnect between women who are interested in suppressing their menstrual cycle, and those who are actually able to.

In regards to health, many advocates believe that menstrual suppression can alleviate, if not cure, women of specific and often debilitating symptoms associated with menstruation. These may include: “endometriosis, dysmenorrhea (severe menstrual pain), menorrhagia (excessive blood loss), epilepsy, chronic pelvic pain, acne, migraine headaches, mood symptoms, polycystic ovarian syndrome”, (Repta

and Clarke, 2011, pp. 92). The use of menstrual suppression may also lessen associated cramping or back aches. Additionally, women with disabilities who rely on assistance from others for body care during menstruation may find menstrual suppression beneficial (Mamo and Fosket. 2009, pp. 940).

In addition to health benefits, there is also the belief that menstrual suppression has the ability to provide women with benefits in their everyday life. For many, convenience remains one of the most ideal lifestyle benefits associated with menstrual suppression. Having the ability to determine when and where a woman will receive her menstrual cycle allows her to engage in activities that her period may otherwise limit her from – such as camping, swimming or attending formal events. Women interested in engaging in sexual activity may also opt to forgo their period out of convenience. Reducing the amount of pain associated with menstruation also enables women to be more active in their everyday life, and can help some women limit the amount of days they miss work or school as a result of menstrual pain.

Although current literature reveals that there are existing benefits associated with menstrual suppression, Repta and Clarke (2011) note that for some women, the trade-off is simply not enough to use hormonal contraceptives to alter or reduce the experience of menstruation. The pair featured narrative from a thirty-year old common-law married woman, who was quoted in saying:

I have so much pain myself that I can appreciate why other women would not want to go through that...but it's [a] trade-off. I'm just not willing to make the trade-off that would be necessary [to suppress]...if some fairy godmother came up to me and said, 'You could not have your period for the rest of your life if I say bingo three times', I might consider it. But if it requires continued

chemical intervention, I'm not willing to make that trade-off for pain that I know how to manage and a nuisance that I know how to manage (n.p).

The pair concluded that eighty-six percent of women who opted to not suppress their menstrual cycle regardless of pain or discomfort was a result of distrust of pharmaceutical products required for such suppression or manipulation (Repta and Clarke, 2011).

## **2.4 Contraception and Young Canadian Women**

While the literature used in this review often takes either a North American perspective, or an American perspective, it is important to note that perceptions and experiences of both menstruation and contraceptive use often vary between American women and their Canadian counterparts. However, as a result of insufficient literature, these perspectives and experiences often go undocumented or unnoticed. In fact, it wasn't until 2003 when Health Canada linked *Yaz* and *Yasmin* to the deaths of twenty-three Canadian women did the discussion surrounding contraceptives come back into Canadian limelight.

Brigitte Noel's 2011 blog post *Why Canadian Women Lack Non-Hormonal Birth Control Options* highlights the difficulty Canadian women often experience when attempting to be prescribed birth control options other than the standard combined hormonal contraceptive options, and notes that birth control advancement is low on the priority list for Canadian research. In particular, while

fourteen percent of women worldwide use an inter-uterine device as their primary form of reversible birth control, only one percent of Canadian women report using an IUD (this additionally contrasts with thirteen and a half percent European women, who are reported to use an IUD) (Noel, 2011, n.p.). Perhaps one of the reasons behind this statistic is the normalization of hormones North American women experience in contrast to women worldwide. With many advertisements geared towards hormonal contraceptives (i.e. the Pill), there remains a lack of information and education towards alternative methods. She also notes that there is a cyclical effect in regards to the acceptance and advertisements of hormonal contraceptives – as these products become more and more accepted, more money goes into marketing them, and as such, more advertisements are available for young women to see, thus making them even more accepted. Canada is also lacking in regards to research made into the advancements of contraceptives. While research into pregnancy and conception has received more than twenty million dollars in funding since 2008, the Canadian Institute of Health Research has spent just over nine-hundred thousand dollars on birth control-related research (Noel, 2011, n.p.). This demonstrates a reliance on other nations to fund and research contraceptive options, but with Health Canada blocking the distribution of particular brands or varieties (such as *Lybrel*), Canadian women are again left in the cold when it comes to contraceptives.

What *is* known in regards to young Canadian women and contraceptives is that most women engaging in sexual activity use some form of contraception, and

that this number is rising. A 2008 survey into young women in British Columbia by Saewyc et al found that the percentage of women who had used contraception the last time they were sexually active was on the rise from 1998 to 2003. Additionally, seventy-four percent of women aged fifteen to nineteen reported always using some form of contraception, as did sixty-eight percent of women in their twenties (Sex Information and Education Council of Canada, 2010, n.p.). Because this study focused on women using contraceptives as a prevention of pregnancy (as opposed to as a method for pain alleviation from menstruation), it indicates that Canadian women are using methods to not only protect themselves against sexually transmitted infections (as condoms were the most commonly used method reported), but also to reduce their likelihood of becoming pregnant. Such a trend may correlate to findings that Canadian women are interested in postponing childbearing until later in life, post-completion of school or once financially settled<sup>8</sup>.

As is evident from this literature review, there has been little qualitative literature exploring women's narratives in regards to menstrual suppression through the use of hormonal contraceptives, nor narratives detailing women's experiences with menstruation. Additionally, the authors used in the literature review have not considered the political, economic and social implications for women in making decisions about menstruation, and as a result, fail to take into

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<sup>8</sup> Such assumption is made based on the findings from Saewyc et al's 2008 study which also revealed that only forty-five percent of women in their thirties used some form of contraception the last time they were sexually active

consideration the intersectionalities of women. This research is an attempt to fill that gap in current literature, and provide a better understanding of the ways in which women use contraceptives, and view menstrual suppression.

## 3.0 METHODOLOGY

### 3.1 Research Method: Utilizing a Grounded Theory Approach

It was the original intention of the researcher to use a research method that would allow for the research objectives, which include: 1) identifying key reasons behind a woman's decision to suppress and/or manipulate her menstrual cycle; 2) determine whether or not, and how, pharmaceutical companies encourage women to suppress their menstruation through print advertising and; 3) explore the ways in which women and women's lives are understood and interpreted by pharmaceutical companies, to be met.

As Maxwell (1996) noted in *Qualitative Research Design: an Interactive Approach*, qualitative research often does not adhere to a set of methodological rules or frameworks, but rather, is dependent on each study's specific phenomena or setting (pp. 63). While structured research allows the researcher to collect data that is easily comparable (and therefore, has the ability to answer questions that have been designed to compare differences), unstructured approaches allow the researcher to focus on "the particular phenomena studied" and make sense when "researchers have plenty of time and are exploring exotic cultures, understudied phenomena, or very complex social phenomena" (pp. 64). As a result, a grounded theory approach was used.

Grounded theory, as explained and explored by Denscombe, often lacks specific rules or procedures in comparison to other research approaches, but rather, provides researchers with room for creativity or ingenuity (McCallin, 2003, pp.

204). It relies heavily on constant comparative analysis (particularly in smaller research projects), where “data is systematically collected, organized and examined after each interview. Data collection and analysis are concurrent. The researcher looks for similarities and differences in the data and considers where to go next to ask questions to clarify emerging theoretical concepts” (McCallin, pp. 204). Because the primary source of data for this research project came from the one-on-one interviews with women in the Ottawa community, this specific research approach enabled the researcher to continually review transcriptions and interactions with each woman to look for emerging themes or ties. In many cases, data collected through the one-on-one interviews was supported by existing and used literature. However, the narratives collected also provided new and meaningful insight into menstrual suppression; something that was noticeably absent in much of the current literature. This required further analysis and reflexivity on the part of the researcher, consistent throughout the duration of the research project. Denscombe notes that a flexible attitude on the part of the researcher is required when using a grounded theory approach, and that the researcher “must be willing to put aside or to critically examine preconceived ideas, to try to understand actions and interactions in a particular context from the point of view of the people involved” (McCallin, pp. 204).

This flexibility must also be present in the original design of the research project, whereby a hypothesis is not the beginning step, but rather research and data collection is. Data is collected and coded, with each code grouped into similar concepts to allow for comparisons and contrasts to be made (if that is the nature of

the project). Categories are then formed from these concepts, and a reverse engineered hypothesis emerges from these categories. As a result, it is advised that researchers “keep the questions general, flexible, and open, asking ‘what is happening here?’” (McCallin, pp. 206). In this particular project, the researcher aimed to explore the fairly broad topics of menstruation and menstrual suppression, by using the three previously mentioned research questions as loose boundaries within the participant interviews. However, as the interviews progressed, and data was collected and analyzed, the research shifted into a deeper focus on fear or distrust of hormonal contraceptives as described by the research participants, experiences with medical professionals, and attitudes towards menstruation. This coding and collection was the basis for newly developed hypotheses or research questions, which shifted the research project almost entirely.

## **3.2 Participants and Method of Selection**

### **3.2.1 Participant Method of Selection**

Prior to participant recruitment and selection, a set of criteria was created in order to determine the population to be used for one-on-one interviews. In order to be considered for interview, each participant had to meet four requirements: 1) each participant must self-identify as a menstruating woman; 2) each participant must be between the ages of eighteen and thirty; 3) each participant must have attended, or is attending, a post-secondary institution; and 4) each participant must currently reside in Ottawa. These requirements were made in order to coincide with

participants used in other Canadian studies that looked into the experiences of menstruation and contraceptive use amongst Canadian women, such as that of Saewyc et al (Sex Information and Education Council of Canada, 2010, n.p.). Additionally, although it was not a formal point of criteria, participants were unable to have been recruited directly by the researcher herself.

Interested participants were informed of the study through print advertisements posted throughout Ottawa (see Appendix 3). Ten community health centres and organizations within the Ottawa region were also contacted requesting assistance with participant recruitment. Of the ten centres and organizations contacted, all but one, the Graduate Students' Association at Carleton University, either declined, or did not respond to the request<sup>9</sup>. Finally, the School of Social Work at Carleton University forwarded an email drafted by the researcher to all current Bachelor of Social Work and Masters of Social Work students at Carleton University (see Appendix 4).

Interested participants were required to contact the researcher for more information about the research project, at which time the voluntary nature of their participation was highlighted, and an acceptable time and location for each one-hour interview was determined<sup>10</sup>. Interested participants were also provided with the list of interview questions (see Appendix 5) prior to the interview, so as to allow for careful thought and reflection into each question prior to the actual, and

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<sup>9</sup> Of the nine that declined or did not respond, one included a sexual health centre, whose online description of services offered include free counseling on healthy sexuality, free testing for STI's, emergency contraception, and affordable contraception. However, an email declination was received, with the message "I am afraid that we will not be able to help you with your thesis. We are not a contraceptive service".

<sup>10</sup> Because of ease and accessibility, all interviews were conducted at Carleton University.

recorded, interview. Although it was not emphasized prior to interview participation, each interviewee was awarded with a \$10 gift card for their time.

### **3.2.2 Participants**

Although the research project was open to women in the Ottawa area between the ages of eighteen to thirty, who met the additional criteria of the study, there were a disproportionate number of participants who were in their mid-to-late twenties. In fact, zero of the participants identified as being eighteen or nineteen. One participant identified as being twenty years old, two participants identified as being twenty-three years old, one participant identified as being twenty-five years old, one participant identified as being twenty-six years old, one participant identified as being twenty-seven years old, one participant identified as being twenty-eight years old, and the final participant identified as being thirty-years old. Two participants were unaccounted for, as they did not reveal their ages during the one-one-one interview.

In addition to the age of each participant, other facets of the participants' lives were gathered in order to create entire snapshots of the women's lives. This included information on the age of first menses, current educational or employment standing, and use of contraceptives (see table below)<sup>11</sup>.

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<sup>11</sup> All names below have been changed to protect anonymity of the research participants.

| Name      | Age         | Educational Background                           | Current Employment Status     | Age at First Menses | First Form of Contraception Used | Varieties of Contraceptives Used in Lifetime                               |
|-----------|-------------|--|-------------------------------|---------------------|----------------------------------|--|
| Ashley    | 25          | Currently in post-secondary                      | Employed full-time            | 13                  | Condoms                          | - Condoms<br>- Oral contraceptives   |
| Brittany  | 26          | Two undergraduate degrees                        | Employed full-time            | 13                  | Condoms                          | - Condoms<br>- Oral contraceptives   |
| Christine | Unspecified | Currently in post-secondary                      | Employed full-time for summer | 12 or 13            | Oral contraceptives              | - Oral contraceptives<br>- Condoms<br>- NuvaRing<br>- Inter-uterine device |
| Diana     | 23          | Currently in post-secondary                      | Unemployed                    | 13                  | Oral contraceptives              | - Oral contraceptives  |
| Elizabeth | Unspecified | Currently in post-secondary                      | Unemployed /interning         | 11                  | Oral contraceptives              | - Oral contraceptives  |
| Fiona     | 23          | Currently in post-secondary                      | Employed                      | 14                  | Oral contraceptives              | - Oral contraceptives<br>- Withdrawal method                               |
| Gillian   | 20          | Currently in post-secondary                      | Unspecified                   | 13 or 14            | Oral contraceptives              | - Oral contraceptives  |
| Hayley    | 27          | Currently in post-secondary                      | Employed                      | 13                  | Oral contraceptives              | - Oral contraceptives<br>- Condoms   |
| Irene     | 30          | Graduate with undergraduate and graduate degrees | Employed full-time            | 12                  | Oral contraceptives              | - Inter-uterine device<br>- Oral contraceptives<br>- Inter-uterine device  |
| Jennifer  | 28          | Graduate with undergraduate and graduate degrees | Employed full-time            | 12 or 13            | Oral contraceptives              | - Oral contraceptives<br>- Condoms   |

### 3.3 Data Collection and Analysis

A semi-structured twenty-question interview process was developed as part of data collection from participants. Upon completion, all interviews were coded following a framework used by Weston et al, which allowed sections of the interview to be evaluated using four distinct markers: 1) POS (positive); 2) NEG (negative); 3) N (neutral); and 4) MX (mixed) (2001, pp. 396).

Data was collected for the print advertisement analysis by sampling high circulation magazines that are read by, and often aimed at a readership that includes the target population. Magazines that were examined were: US Weekly, People Magazine, Cosmopolitan Magazine, Fitness Magazine, Redbook, Good Housekeeping, Glamour, Flare, Chatelaine, and Ms. Magazine. These magazine titles were selected based on the assumption that they are all directed at women, usually in their late-teens to early forties. Random sampling was used to choose particular issues. Four issues each were selected from each of the magazines for the year August 2012 to August 2013. This means that for one title, August 2012, October 2012, January 2013 and May 2013 may have been chosen, while for another, August 2012, November 2012, February 2013 and June 2013 may have been chosen. As a result, the researcher was able to work towards answering the following questions:

- 1) How do print advertisements from contraceptive-based pharmaceutical companies attempt to influence a woman's decision to suppress and/or manipulate her menstrual cycle?

This was accomplished almost entirely through the analysis of the ten interviews, and supplemented using an analysis of literature. Although each interviewee was explicitly asked to describe their experience with print advertisements for contraceptives (see Appendix 5), the interviews were also analyzed for underlying themes or responses to determine whether the interviewees had identified advertising as a reason for their own menstrual suppression. Information from each interview was then compared to one another to determine if links were present.

2) What images and understanding of women and women's lives do print advertisements reveal?

An in-depth analysis of current print advertisements was used in order to answer this question. The languages and colours used in the ten identified advertisements (see Appendix 7-16) were coded following a manner similar to that of the interviews to determine key themes and messages amongst the advertisements. Once key themes were identified, they were compared to coded data from the participant interviews, primarily questions sixteen to nineteen, which dealt exclusively with interviewee's experiences with advertisements promoting contraception and/or menstrual suppression.

3) Why do women suppress and/or manipulate their menstrual cycle using pharmaceuticals?

The third question, is answered using an analysis of all three forms of data collection used in the research project. Data collected from one-on-one interviews was used in conjunction with the literature to determine a variety of reasons behind a woman's decision.

### **3.4 Ethical Considerations**

Prior to the commencement of the study and data collection, the research project itself was submitted to Carleton University's Research Ethics Board for review and approval. As each participant recruited was not tied to organizations or service providers, no additional ethics application was needed. An ethics application was originally submitted as it was determined that the topic of the research project could be considered sensitive in nature for some women. Women who had negative experiences associated with menstruation or contraceptive use, or who had suffered sexual trauma could be particularly vulnerable in relation to some of the interview questions asked. While the questions used were created to take this into consideration, it was possible for women to feel a sense of distress or discomfort, particularly when revisiting first menstrual experiences, reasons for using contraception, or when retelling times that contraception had failed them (and as such, emergency contraception was needed). In an effort to alleviate this, questions were designed to be open-ended, allowing each interviewee the ability to decide what information they felt comfortable in sharing.

Each participating interviewee was provided with a copy of a letter of information (see Appendix 1) prior to the interview. In this letter, information about myself as the researcher, in addition to the research project itself, was provided. Contact information for myself, supervisor Susan Braedley, and Carleton University's Research Ethics Board representative Professor Andy Adler was provided, in addition to detailed information surrounding the interview process, and potential associated risks involved. Participants were also provided with a letter of consent (see Appendix 2). The letter of consent explicitly detailed that each interviewee meets the required criteria for participation, that two recording devices would be used for the duration of the interview, and that it was the intention of the researcher to use the data from each interview in her final paper. The letter of consent also emphasized the voluntary nature of participation, and reiterated that participants had the right to pause the interview at any point (thus turning off the recording devices for said break), were given the option of "prefer not to answer" to any question they felt uncomfortable with<sup>12</sup>, to stop the interview completely, and to withdrawal from the research project (and as such, have any collected data from them removed from the study). Participants were also made aware that they had until August 1, 2013 to completely withdrawal from the study, and as such, any data resulting from their interview would be removed from the thesis, prior to defense and submission.

In order to ensure data was collected from each interview properly and in its entirety, two recording devices (the Quicktime Player application on a MacBook,

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<sup>12</sup> No participants opted to use the "prefer not to answer" option.

and a hand-held recording device) were used in each interview. Participants were made aware of this before the interview began, in both the letter of information and the letter of consent, and each recording device was clearly displayed on a table for the duration of the interview. Participants were assured of the security of raw data by being made aware that interview recordings, jotted notes, and full interview transcriptions would be stored on a password-protected and encrypted USB device in a locked filing cabinet for the duration of the research project, and would be deleted on December 31, 2013. Only the researcher and research supervisor would have access to the raw data, but, participants were made aware prior to the interview that data from their interview may be used in the final report, and that the final report may be published. In order to ensure confidentiality in the final report itself, each interview participant was given an alias. Participants were told that they may recognize identifying features from their interview, or direct quotations, but were not told which name they had been assigned (names were not assigned based on interview order, but rather randomly).

### **3.5 Limitations of the Project**

One of the main limitations found within the research was the way in which questions were both formulated and posed. This particularly came into play with question eleven, where participants were asked “if you could describe the perfect menstrual cycle for you, what would it look like?” It was the original intention of this question to allow participants to use a solutions-focused miracle question to

describe what they consider their ideal to be, rather than to simply describe what their actual experience is. The data collected from this question was then used in comparison to Greenberg and Berktold's 2006 study, which asked women to describe their preferred frequency of menstrual cycles. Forty-percent of Greenberg and Berktold's participants said that they preferred not to menstruate at all, in comparison to the twenty-percent of women who said the same thing during this study. However, because Greenberg and Berktold provided their participants with predetermined intervals, more participants may have selected that answer, than the participants in this study who were provided no intervals at all. As a result, the women in this study may not have known that answering "prefer not to have a period at all" was an option, and data may then be skewed as a result. For future research, it is felt that solutions-focused miracle questions are still an important part of interviews, as they allow women to imagine outside of everyday life, but that providing interviewees with some form of limitations may generate data that is more easily comparable.

Additionally, because the sample size used in the study was small, the participants used for the interview portion of the study is not an accurate representation of the greater population of women, making the findings of the research difficult to transfer to different social or economic groups. Each of the women presented themselves as white, middle-class women who have attended a post-secondary institution, meaning the voices of women from a different racial, cultural or economic background were unheard. While the women used in the interviews reflect the main target population of the pharmaceutical companies'

advertisements (middle-class Caucasian women), women who looked or identified differently from these advertisements may have produced different results.

The research project itself received funding only from the Masters of Social Work Student's Association at Carleton University, for the purchase of one hand-held recording device. This meant that the majority of the project was unfunded, and compensation was paid for entirely by the researcher. Although each participant received compensation in the form of a \$10 gift certificate for their time during the interview, no additional compensation – i.e. cost of transportation, food provisions – was provided<sup>13</sup>.

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<sup>13</sup> Although each interview was held at Carleton University, participants also had the ability to request an interview location that was closer/more accessible to them, in order to reduce travel burden on participants. None of the participants requested an interview at a location other than Carleton University.

## **4.0 WOMEN'S EXPERIENCES WITH MENSTRUATION AND MENSTRUAL SUPPRESSION**

The following two chapters describe and discuss the findings of this research project. Chapter 4.0 presents the findings of the ten one-on-one interviews conducted with women in Ottawa. Originally, it was the intention of both the research and this chapter to recount the individual experiences of the women's first menses, to examine feelings towards menstrual cycles, to report attitudes towards the use of contraceptives, and to highlight experiences with menstrual suppression. It was believed that such a route would allow the original research questions to be answered in a complete and comprehensive manner. However, through the process of data collection it was realized that aiming to answer the original research questions meant that many of the stories and experiences of the women would go untold. Menstruation, it was found, is not a cut-and-dry topic, but instead is multifaceted in nature, and often dictated by the social, economic and political experiences of women. As a result, three distinct key themes emerged from the one-on-one interviews that differed from the original research topics. As a result, this chapter works to explore these topics, which include *No Longer a Curse*, *The Expertise of the Medical Field*, and *Maintaining Body Integrity*.

### **4.1 No Longer a Curse**

What comes to mind when we think about the experience of menstruation? Our imaginations may take us to mentions of menstruation in popular culture, such

as the movie *Carrie*, whereby the leading lady receives her first menses while at school, only to have her classmates throw menstrual products at her and have her mother lock her in a closet for hours; or perhaps to the early-nineties movie *My Girl*, where Veda, who has been raised by her single father after the passing of her mother, is convinced she is hemorrhaging to death upon receiving her menstrual cycle for the first time. More recent depictions from Hollywood include feelings of shame or embarrassment when a period shows up at the wrong place and wrong time, like during *Degrassi: the Next Generation*, when character Emma receives her period for the first time in junior high school, while wearing a white skirt. Or perhaps our imagination might take us in another direction – recounting advertisements and commercials for menstrual management products that seemingly always involve a field of flowers, dancing women, and that mysterious blue liquid mimicking the effects of menstrual blood on a feminine hygiene pad.

Outside of these fictional and Hollywood portrayals of menstruation remains the lingering question – how do *real* women experience menstruation? Do women experience the same feelings of shame, embarrassment, disgust or disappointment with her first menses, as represented on the big screen, or are women today more prepared and empowered to celebrate a societal marker into womanhood than depicted? Do women share these experiences with the people in their lives, including friends, sisters, parents or partners? And do factors, including sexual education, pain association and intimate relationships, influence a woman's attitude towards her menstrual cycle?

#### **4.1.1 Age of Menarche**

As indicated in Chapter 3.0, participants of this study were required to self-identify as menstruating women. While participants did not necessarily need to currently be menstruating (i.e. they could be currently using methods of menstrual suppression, or could no longer experience menstruation as a result of contraceptive use), they all must have undergone their first menses. Such requirement in addition to the age requirement of the study corresponds with the 2010 publishing of a cross-Canadian study by Al-Sahab et al, which found that the median age and mean of Canadian girls at menarche was 12.78 (Al-Sahab et al, 2010, pp. 2). It was also reported that this age was higher than the median age and mean of girls in the United States, who on average, experienced their menarche at 12.34 years of age (Al-Sahab et al, 2010, pp. 6). The women in this study fell just below the median age of Canadian girls, but just above that of American girls, at 12.5 years of age. Only a handful of participants fell outside of this mean, with Elizabeth experiencing menstruation for the first time at eleven, and Fiona experiencing menstruation at fourteen. While Al-Sahab et al's 2010 study focused on the reasons behind early, or later, menarche (which indicated that a higher family income correlated to lower early menarche rates (pp.6)), this research study did not take into account social or economic factors that may influence the age at which participants received their first menses, but instead, focused on the emotional and psychological aspects of the experience.

In the interviews, the majority of the women candidly recounted the age at which they received their menarche, with some women remembering the exact age down to the day. For Irene, the experience is something that has stuck with her for the past eighteen years – “I remember it to the day. I was twelve years, and four and a half months. Which, was really funny, because that was the exact age my mom was when she got her period. And I got my first bleed on her birthday.” Hayley also reflected on her experience with much detail, remarking, “I think I was almost fourteen, I was like thirteen and like nine months. And I remember, I had to go to camp the next day.” The narratives gathered from this question indicate that for many women, the experience of menstruation for the first time is memorable, whether the experience itself was negative or positive. It is a marker in a woman’s life, and demonstrates that even young girls, such as Elizabeth, understand the biological and societal implications of the process. Additionally, as each woman described the age of her menarche, all responded either while laughing or looking into the distance wistfully, indicating feelings of attachment or sentiment to the experience.

#### **4.1.2 Menstrual Discussion: ‘It Was Never Talked About’ ... Until Now**

When they spoke of their experiences surrounding their menarche, most women also touched on whether or not they had received sexual education, specifically education surrounding menstruation, at some point or another in their youth. The majority of the women shared that they had received some form of

education about menstruation prior to their first menses. For many, this came in the form of conversations shared between their mothers and them, and for others, public school touched on the topic enough to educate them on the biological process that would soon be coming. Some mothers, such as Fiona's, celebrated the arrival of her daughter's menstrual cycle by offering up gifts and congratulatory words. However, some women indicated that menstruation had been an off-the-table topic, and as such, they felt unprepared when their menstruation actually began. Both Ashley and Gillian indicated that they had received little to no education from their mothers on the topic, and as such, were specifically ill-prepared to use menstrual management products (such as feminine hygiene pads or tampons). For Ashley, this lack of education carried with her for several years, as she revealed she avoided using tampons for almost ten years because she was uncertain as to *how* to use them – “my mom just kind of told me what to do, and she gave me pads, but she didn't teach me about tampons or anything like that ... I was just using pads because it was just foreign to me and I was afraid of them, and I couldn't imagine like inserting it ... so I stuck with pads until like three years ago when I became more comfortable sexually.” In the past, books such as Judy Blume's 1990 *Are You There God? It's Me, Margaret* and Joann Loulan Gardner's 1991 *Period: With Parent's Guide* aimed to act as resources for young women as well as parents and guardians, and worked to initiate conversations on puberty and the process of menstruation prior to the age of the Internet. Today's parents often have more access to information, as a quick search on Google of “teaching girls about menstruation” indicates that there are many resources readily available to assist in talking to young women about

menstruation. Both SexualityandU and KidsHealth’s websites provide information on leading discussions about menstruation, and aim to breakdown discomfort or embarrassment experienced by mothers or fathers approaching the subject, and instead emphasize a positive outcome as a result of education. However, for many households, such a point of topic still remains untouchable as a result of culture or religion, regardless of how available information is to parents and caregivers. In her interview, Jennifer noted that at the time of her menarche, discussing the experience with her mother was not an option – “I was highly embarrassed and trying to hide it – because we grew up in a family household, Polish, Eastern-European, we don’t have feelings. And you never spoke about anything hygienic or whatever else. So I was trying to hide it.”

On the contrary, while some of the women had reported a lack of dialogue with their mothers, all the women reported that they currently have no problem discussing their own menstrual cycles with others. For some women, such as Diana or Fiona, discussing menstruation with their mothers or a sister wouldn’t be a big issue. Instead, bonding with other females in their life would allow them to compare shared symptoms between them, and to bond over similar experiences. In fact, all of the women had shared feelings of being comfortable with sharing their own experiences with menstruation with *someone* in their lives, be it mothers, friends, roommates, researchers or even asking a coworkers for a tampon. For other women, such as Brittany or Elizabeth, discussion between both the men and women in their lives wasn’t seen as a big deal. Brittany reflected on conversations she had shared with an intimate partner, which would include whether or not to engage in sexual

activity during ‘that time of the month.’ For Elizabeth, menstruation was seen as a normative, biological process, and as such, any awkwardness felt by males in her life, including friends or partners, was seen as weird:

I’m pretty comfortable with it. It doesn’t really bother me. I think it’s interesting that a lot of men my age get really uncomfortable about it. I find that really weird. Because, they know it’s happening, like, that’s how they got here. So I find it really weird that it’s still kind a taboo ... I definitely don’t make an effort to hide it around me because they get uncomfortable, because that’s got a lot more to do with them than it does me.

With all ten women reporting a willingness or openness to talking about menstruation to someone in their lives (even those who hadn’t received ‘the talk’ from their own mother), there is an indication that perhaps menstruation is becoming a less off-the-table topic than previous generations may have experienced. Although Jennifer, in particular, had shared not receiving sexual education from her mother as a result of her cultural background, she indicated that she currently has no feelings of embarrassment in talking about it with her sisters, or men she was in intimate relationships with. This indicates that a lack of sexual education or discussion in the household does not necessarily lead to a lack of comfort later on in life, and that these women are seeing menstruation as something that has potential to be open and honest about.

### **4.1.3 Accepting Menstruation**

We typically make the assumption that, if given the choice, women would eliminate their periods altogether. This is largely due in part to the depictions Hollywood has given to us, even to those individuals who don’t menstruate. Seeing

scenes of embarrassment, disgust, shame or inconvenience on the big screen can often lead us to assume that many women share these same feelings, and getting rid of menstruation altogether would eliminate these feelings from returning every month. Some literature, such as that of Greenberg and Berktold (2006) support this hypothesis. In fact, the pair found that women have little affection towards their menstrual cycles. Of the women they studied, seventy-seven percent responded that menstruation was just something they had to put up with every month, and seventy-four percent felt that men were at an advantage by not menstruating (Greenberg and Berktold, 2006, pp. 3). They also found that, similar to societal assumptions, if given the choice, forty percent of women would prefer to never receive their monthly periods (Greenberg and Berktold, 2006, pp. 4).

But what does it say about the women who simply do not mind receiving that monthly marker regularly? Are these women actually as far and few between as we are led to believe? Because of the small sample size used in this study, we are unable to generate realistic answers to these questions, or accurately compare our sample to the sample used in Greenberg and Berktold's study. However, what was found was that of the ten women used in this project, almost all of the women responded as not necessarily viewing menstruation as a negative monthly occurrence that they wish to eliminate. Although Jennifer preferred to have a period that simply lasted a few hours each month, and Hayley preferred to never receive a period, the other eight women showed some form of attachment to their current menstrual cycle when asked what an *ideal* period would look like for them. Although the length, flow level, and associated symptoms (such as back aches or pre-menstrual syndrome)

varied between each woman, the other eight shared the same sentiment as Irene, who felt that “there’s something to be said for getting your period because you know you’re not pregnant.” Responses such as this indicate that for these women, while the symptoms associated with their current menstrual cycle can be bothersome or painful, the actual process itself is accepted and understood as something that is normal and healthy. For these women, menstruation isn’t seen as the curse it once was, but rather an indication that their body is working as it should be, and that they have no reason to be concerned that it is not.

The combination of women’s willingness to share their experiences with menstruation to others, in addition to their acceptance of menstruation, signals something of a revolutionary change when it comes to women’s attitudes towards menstruation. And slowly, depictions of menstruation on the big screen are following this shift in thought. The commercial *Camp Gyno* by Hello Flo advertises “care packages” sent to young girls who have begun their menstrual cycle. Such a commercial follows the trend that menstruation is becoming an increasingly popular topic, and that for many young women menarche can be an exciting and vital point in their lives.

## **4.2 The Expertise of the Medical Field**

Who is the expert when it comes to menstruation? Debates between academics have often taken two different routes – one arguing that women

themselves are the experts when it comes to menstruation. These debates are often highlighted in qualitative work, such as that of Repta and Clarke's (2011), which allows women to discuss and share their own attitudes and experiences towards menstruation, in a manner that is valued and respected. However, others (as noted in Corinna's 2011 article, *I, Being Born Woman and Suppressed* (pp. 210-212)) argue that it is in fact the medical field that remains the most knowledgeable when it comes to understanding menstruation – not only have they worked with countless women in their own practices, but they are also the ones who have the ability to prescribe women with the contraceptives that they use. While there might not be a 'right' answer in terms of who is the expert, understanding the role of medical professionals in relation to menstruation can work to create an understanding of the hierarchal structure associated with the gendered phenomenon of menstruation. Working towards this understanding, emerges key questions – what do women's experiences with medical professionals say in regards to their attitudes towards contraceptives? Are medical professionals held in high regard when it pertains to information seeking, or are women turning to other professionals for help? And what happens when women don't get the care they need or deserve when it comes to contraception?

#### **4.2.1 Seeking Information on Contraception**

All of the women in the sample of menstruating women have used contraceptives at one point or another throughout their lives. Although the purpose

for this use may vary (i.e. pain management versus pregnancy prevention), in addition to the variances of contraceptives used, each of the women required information on contraception prior to their use. Because of technological advancements that make the sharing and consuming of information easier than ever, it can be assumed that young women nowadays are privy to a wider variety of information sources than ever before. When speaking on the topic of where they originally sought information on contraceptives, prior to their first prescription or use, a large number of the women admitted to turning to the Internet. For some women, such as Fiona, turning to Google was the natural thing to do, as it allowed her to get feedback from other women on which contraceptives worked for them, and what to avoid – “like, you Google stuff. I Googled to see what people’s reactions were, and that’s where I got scared of Yasmin.” Gillian also shared the same experience, turning to the Internet prior to her visit with her doctor – “I looked a few things up on the Internet just ... before I went to the doctor because I kind of wanted to know a bit about it.” This common thread indicates that the women in the study are wishing to be educated about their options prior to visiting the doctor, and that the Internet is becoming a more useful tool for doing so. Women-focused forums, or forums discussing contraceptive options, allow women to discuss different contraceptive options, to hear what did and didn’t work for other women, and to share their own experiences in an environment that is often understanding and productive. It also decreases distance between groups of women, allowing women from one side of the world to the other to be connected in part to a similar experience – menstruation and contraceptive use.

For women who sought information elsewhere, talking to friends or to other family members seemed to provide the same benefits as using the Internet, except that women were speaking to individuals they knew personally. This again allowed women to share experiences of what worked and what didn't. But instead, it also relied on establishing an element of trust. One woman reported that she valued the opinion of her friend because her friend seemed knowledgeable and experienced, and as such, trusted her opinion on specific varieties of contraception.

Finally, a small portion of women reported that they used their doctors as their primary source of information provision when it came to birth control. Ashley reported having never even had a discussion with her doctor about different types or brands before her doctor prescribed her Alesse. Ashley's experience with her doctor is consistent with literature that found many women feel a lack of autonomy when engaging with medical professionals. Oinas (Gunson, 2010) studied the way in which medical experts interacted with young women in advice columns on menstruation. Her research found that advice columns, whereby the doctor provides a direct and succinct answer to a question, "operated as a channel through which medical experts could emphasize medical authority" (Gunson, 2010, pp. 1326). This medical authority often results in a lack of agency for young women, such as Ashley, whom had no control over the hormones suggested for her specific body. The women in this study indicated that for them, although visits are a one-on-one experience shared between a doctor and a patient, they consider the Internet and individuals in their lives to be more personable and more knowledgeable on the topic, than a doctor who has little to no time to develop rapport or a patient history.

#### 4.2.2 Experiences with Medical Professionals

Of the women who reported seeking advice or information on contraception from a medical professional, there emerged two themes of feelings about the experience: negative and positive. It seemed that none of the women felt apathetic towards the experience, and instead, most either remember it as being something helpful and wonderful, or something that made them feel embarrassed or ashamed. For some women, such as Diana, remembering the awkwardness associated with the visit has stuck with her for years:

My doctor was really weird about it ... he kept talking about how things get out of control at parties, and was referring to me wanting to take birth control for the wrong reasons... when really it was just because I had a boyfriend. It was really awkward to be honest with you.

However, while the memory of it being a negative event has remained with Diana, she hasn't let it impact the rest of her decisions pertaining to contraceptives. This is different from Ashley, who is still recovering from a negative interaction with a medical professional:

She didn't make it a comfortable space for me to ask a lot of questions about it. You know like, you know "I feel uncomfortable putting chemicals in my body, what's the long term effect?" There's no, you know, "You'll be fine, this is something that women have been doing for forever" ... and there's kind of no opening for like a discussion about it. So I feel like that's just kind of what it was. And when I stopped taking birth control pills a couple of times, I didn't talk to her about it. I just stopped. I didn't ask her, because she would have just told me to stay on it. I wonder what of that is really believing that all women should be on birth control, or her pushing it or something. What her reasoning is. I didn't feel like it was 100% about me, and what was best for me, and that kind of thing.

Experiences such as Ashley's are particularly concerning as they reveal the impact a negative experience with a medical professional can have on a woman, and the

lasting effect of poor treatment. This again supports the findings that more than half of the women in this study prefer seeking information about contraceptives from the Internet or from friends – places that they feel safe, comfortable, and that they won't be judged. Instead, we are left to wonder what would happen if every woman were to have a positive experience with medical professionals when seeking contraceptives. Would taking the time to learn patient history and determine patient needs allow for more open and honest conversations between doctors and patients down the road? Would women be more likely to visit their doctor with questions or concerns if they felt the environment was non-judgmental and that their opinions were valued?

#### **4.2.3 Approaching Medical Professionals with Concerns**

Contraceptives work differently for every woman. Even if two women were of the same stature, weight, ethnicity or economic background, each form of contraceptive has the ability to react differently with each woman. As a result, many women often switch between different forms and varieties in efforts to find the contraceptive that works for them. As Grady et al (2002) note, the two-year contraception-switching rate for unmarried woman aged fifteen to forty-four is sixty-one percent (pp. 139). This indicates that women who are prescribed one form or brand of contraceptive may switch once or more than once in the years to come in order to find one that best suits their body. Switching contraceptives may occur for a variety of reasons, including as a result of unwanted side-effects, or a dislike

for the way in which the contraception is to be taken (i.e. remembering to take a hormonal pill at the same time every day). Grady et al's findings are also reflected in this study, as seven of the women (with the exception of Diana, Elizabeth and Gillian) reported to using one or more forms of contraception in their lifetime. For some, this was as straightforward as opting to use condoms or the withdrawal method in addition to using oral contraceptives, while others, such as Christine, have used four different varieties. A willingness to switch from what was originally prescribed to something different indicates that even those women who had originally reported having a negative experience with a doctor, were unafraid to voice concerns when something didn't feel right (i.e. continual spotting when using the IUD). Ashley, in particular, who had spoke of having a particularly negative incident with her doctor, and also later reported to having difficulty finding a contraceptive that worked for her, remained confident that she would find one that worked, and that she would speak up when needed. When asked whether forms other than oral contraceptives had been considered (which she is currently using, but having severe side effects with), she noted that "I know about them, and if I was interested I would ask."

These women appear to prefer to use the Internet or friends as their main form of information provision when it comes to contraceptives. As they became more knowledgeable on the specific brand that they were using, and on the effects it has on their body, comfort level increases in regards to having personal conversations with their doctors. Although medical professionals may be seen as

having the ultimate power when it comes to the hierarchal structure or doctor/patient relationships, these women demonstrate a continuation of the trend of questioning medical authority, as originally demonstrated by second-wave feminists.

### **4.3 Maintaining Body Integrity**

The third, and final, key theme that emerged from the interviews with the women was that of body integrity. Those skeptical of the use of contraceptives, in particular for extended periods of time (such as for the purpose of menstrual suppression), argue that tampering with the body's natural hormones violates the integrity of the body, and that doing so would make a woman "less natural." While women, who continuously use contraceptives for the purpose of menstrual suppression, in theory, have more agency and control over their own bodies than those who do not, some experts warn against the consequences of continuously feeding the body something so unnatural. This then poses the question; do women actually consider the debate of natural versus unnatural when using contraceptives? Why do women use contraceptives in the first place? And would women opt to continuously suppress their menstruation using contraceptives if they knew they would be less "natural"?

### 4.3.1 Reasons for Using Contraceptives

The reasons for contraceptive use provided by the women in this study seemed inconsistent with the findings in Frost and Duberstein's (2012) work, *Reasons for Using Contraception: Perspectives of US Women Seeking Care at Specialized Family Planning Clinics*. In their study, the pair found that women were more likely to use contraception for economic reasons. Sixty-five<sup>14</sup> percent of their population reported that they opted to use contraception because they were unable to financially care for a child at that time (Frost and Duberstein, 2012, pp. 17), while twenty-three percent reported that their or their partner's unemployment status entirely dictated their decision to use contraception (pp. 17). Fifty-seven percent of Frost and Duberstein's respondents also reported that using contraception allowed them to focus on stabilizing their careers, or to remain in school. While two participants in this research project cited their disinterest in conceiving a child at this time as their reasons for contraceptive use, neither elaborated on how having a child may affect their life (as participants in Frost and Duberstein's study did). In fact, none of the participants made any indication that contraception was used to allow them to finish school, focus on their career, or remain financially stable. Additionally, while forty-one percent of Frost and Duberstein's one-thousand, one-hundred and ninety-two respondents noted that they used contraception as a means to regulate their periods or to clear their skin (pp. 17), five of the ten participants

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<sup>14</sup> Respondents to Frost and Duberstein's 2012 study were able to select more than one option for using contraception.

(or fifty-percent) in this survey responded that contraception enables them to control pain associated with menstruation, or to clear frequent acne.

Such findings indicate that while contraceptives are frequently marketed as a means to prevent pregnancy, they actually provide women with other associated benefits. As such, while women may consider the ways in which hormones may assist in preventing pregnancy, the benefits of using contraceptive for pain management or acne reduction purposes may outweigh the risks of such hormones. For many women, such as those in the study, being able to complete daily activities, to know that their flow is under control, and to not have to manage difficult side effects, is worth the addition of extra hormones in their body.

#### **4.3.2 Mistrust of Hormones with Menstrual Suppression**

In order to ensure that all participants had a similar understanding of the concept of menstrual suppression, each participant was provided with a definition in their letter of information. The definition provided read, “Menstrual suppression is defined as any altering or adjustment of the menstrual cycle, through use of hormonal contraception. This adjustment allows women to experience periods on a less frequent basis, and dictate when their period will arrive. Some women opt to suppress their menstruation using contraception (i.e. forgoing the week of “sugar” pills) for a number of different reasons.” For the study, this definition was

complimented by Hicks and Rome's (2010) understanding of menstrual suppression, whereby they write:

"Reasons for suppression menstrual flow range from avoiding bleeding during a particular event (eg, a wedding, graduation, or sports competition) to finding relief from dysmenorrhea or reducing or elimination menstruation in the treatment of endometriosis, migraine and other medical conditions exacerbated by hormonal changes around the time of menses. Alternatively, some women may practice menstrual manipulation for no other reason than to simply avoid menstruation" (pp. 445).

Greenberg and Berkold's 2006 finding that the majority of women would eliminate their menstrual cycle if they could, agrees with the assumption that most women would either like to forgo their period altogether, or at least have the power to determine when and where it arrived. However, because it was determined that the majority of the women in this study did not share the same attitude, it was important to determine why. Why did these women *not* want to suppress their menstrual cycle if it meant more convenience and less pain? Had they even ever tried it?

For more than half of the women, continuously using hormones in their body created a feeling of distrust and nervousness, and was the main reason why menstrual suppression didn't seem as appealing as one would think it would be. When Christine was asked if she had ever use hormonal contraceptives to suppress her menstrual cycle, she responded "mostly no because the whole hormonal birth control kind of freaks me out. I feel like it can't be super great for your body to have all those additional hormones being falsely put into your body." Irene shared similar feelings when it came to her own experiences with menstrual suppression - "I

probably doubled up and maybe even tripled up once without getting my period but I'd be way more cautious about doing that now. Like, I did that when I was younger, and I don't, I don't know like at this point now thinking in the later years, thinking how I'd like to have kids, I don't know how much I'd like to mess with my body." Perhaps just as surprising was the finding that *none* of the women currently use hormonal contraceptives to suppress their menstrual cycles. While reasons such as convenience during travel, interest in continuing to engage in sexual activities, and attending formal events were cause for some of the women to skip a period once, many of the women had reported that they had never even tried it. Brittany noted that for her, simply planning her events around her monthly cycle was more important and more appealing than eliminating her period altogether:

Yeah, no, I've never done that. I have a lot of friends that do it. I just don't, like, if I know that I'm going to get my period I just plan for it. So if I have a, a running event, or I have to wear a bathing suit, I'll just use tampons, and like, just be mindful to make sure there's a washroom around. But, no, because I know that it doesn't really fully go away. You're still going to get spotting, so it's like, may as well just have the period. And I don't want to mess up anything. So I'd rather just follow the instructions.

Just as surprising, perhaps, may be the finding that when asked what potential benefits are associated with menstrual suppression, five of the women, or fifty percent, could see none. Women, such as Hayley, made mention that altering your body's natural flow through continuous contraceptive use is unnatural, and something that should be avoided – "It's freaky. If you're doing something unnatural to your body, I don't know. I don't trust it. There's got to be some serious consequences to that because we have a period for a reason. So I think we should probably just let nature take its course on that one." Other women's responses

shared similar sentiments to Hayley, which indicates that women have growing concern about the effects of menstrual suppression, a topic that academically, has not yet been studied greatly.

The findings associated with menstrual suppression indicate that for many women, the cost/benefit associated with the practice is simply just not worth it. Although most of the women had reported experiencing symptoms associated with menstruation, and mentioned the hassle menstruation often caused every month, for them, eliminating their periods through the use of contraception just wasn't an option. This finding also resonates with an earlier finding in the study that determined that the women in the study's sample didn't dislike their menstrual cycle as much as is often assumed. Again, the women in this study would simply rather have their period on a monthly basis, to either know that they are not pregnant, or for the sake of routine, than alter this using hormonal contraceptives.

#### **4.3.3 Menstrual Suppression and the "Other"**

There is a term for the effect that happens when one sees an advertisement and makes the assumption that it has no ability to influence them or their life, but would most likely influence someone else. Connors (2005) calls this the 'third-person effect.' It is the likelihood that "individuals who are members of an audience that is exposed to a persuasive communication (whether or not this communication is intended to be persuasive) will expect the communication to have a greater effect

on others than on themselves” (pp. 3). This is often determined by asking individuals how an advertisement influences them, and how an advertisement would influence someone else, and often creates a ‘me’ versus ‘them’ perception of reality. The women in this study were asked two separate questions that aided in determining whether or not this ‘me’ versus ‘them’ perception existed when it came to menstrual suppression advertisements. Surprisingly, it does.

While the women in the study found that advertisements for contraceptives, or advertisements aimed to encourage menstrual suppression, were too ‘fluffy’, ‘glamorous’, ‘misleading’ and not ‘informative’ enough for them, many women felt that *someone else* may be impacted by the message of advertisements, even if they had not been. For Brittany, menstrual suppression had never been seen as attractive, because for her continually taking contraceptives without a week off to receive her period wasn’t natural in her eyes. As such, she didn’t feel as though advertisements encouraging the practice would ever influence her and her values, but would most likely influence someone less educated than herself:

You kind of have to read up, and you need to be educated, but I think it could affect women who don’t really care. Or don’t really realize that they should be looking into what they’re taking, and... because there’s a lot of medications that interact with your birth control and you need to know that, and women don’t normally know that. So I would say that younger women might be more influenced than women who are in their mid to late 20s. I think women in their mid to late 20s are more aware of their body, and how their body works, versus, than I would say if I was 18 I might be more influenced.

Again, this finding supports findings whereby the women in this study didn’t engage in the practice of menstrual suppression themselves, but could see benefits of the

practice *for others*. But could this practice of 'me' versus 'them' tell us about women?

First, it may indicate that although the women in this study identified themselves as having some comfort level in discussing menstruation with others (hence, their reason for engagement in the study in the first place), they understand that not all women have the same experience. For some women, menstruation may still be considered taboo, and something to hide, and as such, suppressing it seems appealing. Additionally, with the exception of Ashley, who had noted that she was frequently in absolute pain when it came to her menstrual cycle, the rest of the women all felt that their menstruation was manageable, and only somewhat painful. They then suggested that for women who do experience debilitating pain associated with menstruation, menstrual suppression might be the only option. Therefore, the finding that women often consider a 'me' versus 'them' approach when it comes to advertisements for contraceptives or menstrual suppression may be less of a naïve assumption that advertisements do not affect them, and more of an understanding that all women experience menstruation differently. For some, it is painful, an inconvenience, and greatly impacts their lives on a monthly basis, and as a result it may be helpful. Additionally, for these women, it may matter less that they are altering their body with continuous hormones, and matter more that they have the ability to manage pain and their menstruation altogether. The women in this study indicated that they can appreciate that aspect.

#### **4.4 Conclusion**

This chapter has unpacked the questions how do women perceive menstruation? Who is the expert when it comes to menstruation? And, how important is it for women to maintain the notion of body integrity, when it comes to the use of hormonal contraceptives? For the ten women in this study, menstruation is not a taboo and shameful topic, and as such they have no problem with talking about their menstruation with others, nor do they hesitate to find information about menstruation and contraceptives in places other than their doctor's office. It also revealed that for these women, menstruation is no longer seen as "the curse", but rather a welcome marker each month to either indicate lack of pregnancy, or to simply let them know that 'everything is working as it should.'

The interview data also suggests that women are not as passive as they may be thought of when it comes to menstruation. These women indicated that they understand their own bodies, and as such, are not afraid to speak up when something just isn't right for them. While medical experts continue to be near the top of the hierarchal structure of expertise when it comes to menstruation, it would be no surprise for women to soon hold this title. After all, their willingness to share their own experiences with the topic, in addition to their own lived experiences with menstruation, means they deserve it.

## 5.0 ANALYSIS OF PRINT ADVERTISEMENTS

The following chapter aims to describe and discuss key emerging themes that were found during the analysis of the ten advertisements (see appendices 7-16) used in this research project<sup>15</sup>. It was the intention of this chapter and the research project to determine what messages advertisements by contraceptive-based pharmaceutical companies were sending to women, what understanding of women and women's lives these companies held, and whether or not advertisements directed at women had any influence over a woman's decision to suppress her menstrual cycle. As Medley-Rath et al notes in their 2010 project *Consuming Contraceptive Control: Gendered Distinctions in Web-Based Contraceptive Advertising*, conducting an analysis into the ways in which advertisements promoting contraceptives is important, because "oral contraceptives are taken by women with little question and manufacturers and healthcare workers promote oral contraceptives as the best form of birth control when other contraceptives can be nearly as effective and are without risky side-effects" (Medley-Rath et al, 2010, pp. 783). Additionally, because many of the women interviewed for the research project

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<sup>15</sup> As evident in appendices 7-16, the advertisements used for this project do not focus solely on menstrual suppression, but rather pregnancy prevention. Additionally, while Seasonale was discussed largely in this paper, an advertisement for the product was not used. This was in part because it was the goal of the researcher to use advertisements that women have frequent access to, and to find advertisements at random, rather than to actively seek out specific advertisements (thus mimicking the action of a woman flipping through a magazine, but not purchasing a specific magazine in order to find a specific advertisement). As a result, the advertisements used speak more to ways in which women can reduce the likelihood of pregnancy, but not reduce the frequency of their periods. The researcher felt these advertisements were still relevant to the project as they often poised pregnancy as inconvenient or not desired. This can then lead to the question of, "if it is that simple to prevent pregnancy, is it not as simple to prevent menstruation?" This transgression is supported by participants such as Hayley and Elizabeth, who felt advertisements such as these made the shift to menstrual suppression natural as a result of the images or taglines used (see page 96).

revealed that they do read magazines but did not remember seeing specific advertisements for contraceptives or for menstrual suppression, the analysis is even more important in determining why more women weren't noticing them, and why messages from the advertisements were not effective. Determining this could indicate what understanding, if any, pharmaceutical companies believed they have in regards to women and women's lives. As indicated in Chapter 4.0, because none of the women in the research study engaged in the practice of menstrual suppression on a regular basis, were advertisements encouraging the practice even necessary? In order to explore and answer these questions, this chapter breaks down *Colours and Keywords Used*, *Information Provided to Women*, and *Messages Sent to Women through Advertisements*.

## **5.1 Colours and Keywords Used**

Of all the ways in which print advertisements can draw in a potential consumer, colours used are one of the most important. Pamela Schnidler (1986) reported in her article *Color and Contrast in Magazine Advertising* that "color ads capture higher readership in comparison with black and white ads" (pp. 70), which is also consistent with the work of Meyers-Levy et al (1995), who found that "because color is likely to enhance the perceived attractiveness of [these] objects, consumers are likely to produce more favorable product attitudes when ads contain color rather than only black and white" (pp. 121). This is especially true for advertisements that don't have the multimedia advantage – such as advertisements

in magazines or newspapers – as they do not have the ability to rely on catchy jingles or taglines to draw in the audience. As such, determining an appropriate colour-scheme for an advertisement can be a make it or break it factor, and requires careful thought on the advertiser’s part. In fact, most of us can probably remember one or two advertising campaigns based on their colour schemes alone. Whether the blackness of the page stood out to us in comparison to the other vast amount of colours used throughout the magazine, or whether the starkness of a white background emphasized a product, we often remember the page itself based on what stood out to us. But is this true for menstrual advertisements? Do advertisements working to sell contraceptives or to encourage menstrual suppression really stand out that much? And if so, what do we recall about the colours and keywords used?

### **5.1.1 An Analysis of the Images Provided**

Reviewing the ten advertisements for this chapter, which included two advertisements for ParaGard, two advertisements for Essure, one advertisement for Nexplanon, and five advertisements for NuvaRing, indicates there is a different marketing scheme for each company, depending on which product they are interested in selling. Typically, the NuvaRing used a stark white background as their main colour, which allowed reader’s eyes to be drawn to the model in the middle of the advertisement. While using a white background allowed the readers to focus on the product itself, it also blended in with the other pages of the magazine, and could

easily be missed, unless you were going out of your way to look for it. On the contrary, Nexplanon opted to use a black background, which created a large contrast between the advertisement itself and the rest of the magazine. Doing so ensured that women took notice of it, and as a result, took the time to figure out what the advertisement was promoting. Seemingly in the middle ground, ParaGard and Essure both opted to use a variety of colours in their advertisements, which allowed the brands to create a more scenic advertisement, rather than one that simply advertised the product to the readers.

While Lanis et al (1995) found that women are typically sexually exploited in advertisements, and that there has been a sixty-percent increase of “women in purely decorative roles” since 1970 (Lanis et al, 1995, pp. 640) the advertisements say otherwise. While nine of the ten advertisements featured women, or a cartoon depiction of a woman, in them, none of the advertisements did so in a manner that was sexually suggestive or risqué. In fact, all of the women featured were wearing full clothing; clothing that could generally be considered non-risqué (such as t-shirts that were not low-cut in the front) in comparison to other advertisements. The women featured in the NuvaRing advertisements donned either blue or green t-shirts, and the woman featured in Nexplanon’s advertisement was even wearing a coat. For the most part, this makes sense. Often times, if an advertising company is taking the “sex sells” approach specifically in regards to contraceptives, it is typically, though not always, used to sell a product to men (such as an advertisement for LifeStyle condoms which features the tag line “Well Rounded”,

and uses the image of a woman's behind in skimpy underwear). Because the advertisements used in this study primarily used women to sell products to other women, the advertisements take a different approach, and opt to not use graphic images or overtly sexual and suggestive taglines. They allow women to feel as though they themselves could be in those advertisements, and opt to use the product as the main point of attraction, not sex. Doing so may encourage a woman to feel as though that is a product she could have in her life, rather than depict it as something unattainable. But, the question then arises – does taking a safe and relatable approach really work? Do women notice the dull colours of the advertisements, and when they see an image of a woman, do they picture themselves?

### **5.1.2 Women's Reactions towards Advertisements**

While the advertisements aim to create an atmosphere of trust and understanding for women, it appears as though these messages are falling on deaf ears. In fact, many of the women in this study can hardly recall a time in their lives when they noticed an advertisement for contraception, let alone what brand it was for, or what message it was sending. For some women, recounting advertisements they had seen was easy, simply because the advertisement itself was for a product they were currently using, and as such, they remember making that connection. This was true for Irene, who noted "I've seen the Mirena. I've definitely seen the Mirena in magazines. I don't remember anything about it, I just remember that it says

Mirena, and I recognized it because I was like ‘Oh, that’s what I have.’” Other women recalled advertisements for Alesse being popular in their younger years, and taking notice of the advertisements because they weren’t entirely sure what the product was for. Finally, Fiona recalled seeing advertisements for contraceptives, and actually being turned off by the message and images used. “I remember there’s a lot of those Trojan ads, which I find are kind of, like, kind of gross,” she said. “I guess maybe they’re targeted towards men or something, because it’s super like ‘sex, sex, sex.’” Such a reaction may explain why current advertisers opt to avoid the “sex sells” route when it comes to advertising contraceptives for women, but does that mean that women wouldn’t appreciate something more bold and out-there?

Based on this study, the answer to that question, is no. While some women in the study were turned-off by the aggressive advertising used by companies such as Trojan (which typically gear their advertisements towards men), others were simply turned off by the advertisements directed at women. The colours that were used in an effort to emphasize the product were seen as fluffy and out of touch with women’s lives by the women interviewed in this project. Additionally, the plain colours and simple images left many women confused as to what product was actually being advertised. As Elizabeth mentioned “I remember not being able to tell what the fuck they were for. It’s just these stylish ladies walking around, wearing like peasant shirts to make them look like it was all bohemian, and fleeting about on their bicycles. I have no idea whether they’re trying to sell me an antacid, an antidepressant or a contraceptive,” which was similar to Hayley’s feelings “I think a lot of prescription advertisements kind of look the same to me. I just see everyone in

a field, everyone's happy, they're smiling, they're always Caucasian, twenty to thirty, soft, nice colours ... this is how I see these advertisements all the time. Because I think that's how they are all the time, it doesn't matter if they're for incontinence, of for like whatever, everyone's always running through the field." As such, the women felt advertisements would be better received if they ignored the pastel colours that made the women feel like children (as hinted at by Jennifer), and instead focused on providing information that is accurate and interesting. Women were also interested in diversity used in advertising, which correlated to the analysis findings that only three of the ten advertisements featured a woman who was not Caucasian.

## **5.2 Information Provided to Women**

As it is the ultimate purpose of advertising to sell goods and market products, it can be assumed that advertisements need to be direct in providing information to their consumers if they wish for a purchase to be made. Doing so helps to answer any lingering questions a consumer may have, and as a result, help consumers feel informed and empowered when making decisions. However, because of the nature of some products, providing full information to consumers is not always possible. One of the biggest difficulties in terms of advertising contraceptives in Canada is the varying laws set in place in both Canada and the United States. Because a large portion of print media (such as magazines) are imported to Canada from the United States (think Seventeen magazine, or Cosmopolitan magazine), they generally following American guidelines. This differs from the potential of advertisements

found in Canadian magazines. For Canadians, only products that have been approved by the Health Products and Food Branch of Health Canada may be advertised, and under strict guidelines. Section C 01.044 of the Food and Drug Regulation requires that “advertising of prescription medicines (e.g. drugs listed in *Schedule F of the Regulations*) be limited to the drug's name, price and quantity” (Health Canada, 2005, n.p.). The purpose of such a regulation is to provide readers with the facts presented in an objective manner, and for emphasis to be placed on the merits of the drug.

Because all of the advertisements were taken from American magazines<sup>16</sup>, this regulation did not come into play, and as a result, advertisements were able to use taglines and messages that were not entirely informative in nature. These included “prefers her birth control hormone free and her commute stress free” and “prefers her birth control hormone free and her coffee caffeine free”, both by ParaGard. While these taglines emphasized that the product displayed was a hormone free form of birth control, any other information is irrelevant to the product. Information is also lost when it comes to Essure’s advertisement, which features a photo of five children playing in a bathtub and the tagline “you’ll know when your family’s complete. You’ll know when it’s time for Essure.” Unless you were aware that Essure was a permanent form of birth-control, or continued to read the advertisement further, the tagline may appear to be convoluted in nature.

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<sup>16</sup> Although an effort was made to use advertisements as promoted in Canadian literature, no advertisements could be found.

### 5.2.1 Women's Reactions Towards Information Provision

For the women of the study, continuing to flip the pages is exactly what they did. Many of the women felt as though advertisements were dishonest in nature, and did not provide them with enough information to either trust the product, or be interested in it. Both Irene and Brittany felt that while the advertisements talked about the contraceptive itself, they made no mention of protection against sexually transmitted infections, and that many women may believe using hormonal contraception is protection enough. For Ashley, she felt information provided in the advertisements implies that using the product would be a “cure” for women. For her, “happy periods” don’t exist, and she would prefer advertisements to acknowledge this, and instead focus on how contraceptives could alleviate pain associated with menstruation, rather than promising women they will feel free and happy to do whatever it is they want. Therefore, it may be realized that current print advertisements that are circulating in popular magazines may not be entirely directed towards women such as Ashley, who have painful periods and have yet to find a way to manage and alleviate the pain. Instead, these advertisements may be directing themselves towards women who feel as though their period is inconvenient, annoying or disliked. For *these* women, the products advertised may provide some form of relief or allow for more convenience in their lives, and as such, these women are more likely to become active consumers of the product, making the advertisement a success for the pharmaceutical company.

The words “transparent” and “factual” arose in many of the discussions with the women. Similar to Irene and Brittany, many women felt the advertisements were misleading, and preferred ones that acknowledged real-life symptoms or experiences associated with contraception, instead of putting on a façade. Jennifer, who was very adamant that advertisements stopped using baby colours for advertisements designed for adults wanted ads that “were showing like, a real woman, you know, I don’t care what she’s doing. Having a cup of coffee in her hand. It’s morning. She looks like shit. A little bit of humour and you know “Life sucks. But Yasmin or whatever else, you know, drives out some of that suckiness.” Just you know, a little bit more of a realistic picture, and certainly not in cartoon.” However, the desire for more honest ads creates difficulty. First, what may be considered honest by the women who participated in this study (such as the provision of more facts or straight-forward taglines) may not be considered to be honest by all women, such as an individual who presents herself as HIV-positive, and therefore has additional anxiety about her menstrual cycle when she is actively bleeding. Additionally, because many of the advertisements that women have access to are American, with little to no regulation on how they must be presented, women will continue to be exposed to taglines and advertisements that require further reading or research to be understood. Out of all the women, only Irene acknowledged that she knew the difference between Canada and American advertising. She noted that “in the US, if you’re looking for a certain commercial or advertisement for a drug, they list all the side effects, but in Canada, I believe there are rules about what you can and cant say about what a drug is doing ... if you’re going to show the drug, you

can't actually show what the drug does." However, many women (and men) do not know about this difference in regulation, and would be unaware about the Canadian guidelines that restrict the provision of information.

The expression of preference for honest and mature advertisements for women resonates with the participants' expression that menstruation is no longer a taboo topic. Because many of the women speak freely of menstruation to others in their lives, they are unsure as to why advertisements continue to dodge the topic. For them, having an honest advertisement would assist in eliminating the shame associated with menstruation, and with birth control. This was supported by both Christine and Gillian, who felt that using contraception and engaging in sexual activity was slowly becoming normalized for women, and that advertisements have the ability to further de-stigmatize this. As Gillian noted,

I feel like, I think maybe like having advertisement for like, birth control kind of shows that, like there are a lot of people in society who like, don't approve of pre-marital sex, but, I think it kind of says, if you are going to do it, kind of have back-up and be safe. So, I feel like it's maybe just kind of, showing, I don't know if acceptance would be the right word, but kind of like assurance I guess. So, just kind of knowing that there's something out there I guess.

Because Canadian guidelines restrict what advertisers are able and unable to use in an advertisement, it is even more important that the advertisements are as direct as possible, that the images used link the product to the message the advertisement is sending, and that women have access to more information (such as through the provision of an Internet URL) where they can do additional research on their own.

### **5.3 Messages Sent to Women through Advertisements**

For many women, advertisements are an everyday part of life. Checking emails may result in seeing pop-up advertisements, or reading the newspaper over breakfast may do the same. Advertisements on buses, billboards, on the radio and on the Internet continue to flash before a woman's eyes. Continuing until bedtime, when she winds down watching her favorite show, with twenty minutes of the hour consisting of commercials, women have the opportunity to see hundreds of advertisements in a day. How many messages of these advertisements are actually noticed? And what are these messages trying to tell women? For contraceptive-based advertisements, are they encouraging women to use a specific product? Do they promote a lifestyle that could be improved if only a specific product was used? And if so, are women buying these messages, or do they believe the products would only be beneficial for other women, but not themselves?

#### **5.3.1 Presumptuous Messages through Contraceptive-Based Advertising**

Of the ten advertisements studied for the purpose of this research project, one emerging theme was evident: using contraception enabled women to be more in control of their lives. In the advertisements analyzed, the majority of the advertisements promoted their products as adding convenience or freedom to a woman's life. This was especially true for the advertisement of Nexplanon, who used

the tagline “When getting pregnant isn’t part of your three year plan - start with Nexplanon. YOU take care of the rest.” The rest, being six distinct bubbles featured in the advertisement that common life markers in a woman’s life: buying a house; falling in love; taking a trip; finishing school; getting a job and; saving money. The advertisement indicates that a) all women share the same life goals or plans, b) achieving these plans are completely impossible without the use of contraception and c) achieving these plans *are* possible in three years when using contraception. It implies that in order for women to be successful, contraception must be used to not only manage menstruation, but to also prevent pregnancy. It implies that a woman who is pregnant or who has given birth could not purchase a house on her own, or complete secondary or post-secondary education. It also gives women an unrealistic timeline of three years to achieve major life accomplishments that often take more than that. It suggests that through the use of Nexplanon, women are able to be Superwoman, a stereotype that is enforced far too often.

Additional taglines used, such as those by NuvaRing – “do I put it in myself like a tampon?” and “isn’t it tricky to get in there?” provide women with the additional feeling of being in control. The flexible nature of many contraceptives allow women to determine when and how they will use the contraceptives, and for what purpose. However, some forms of contraception, such as the NuvaRing, require planning prior to use and prior to sexual activity. A woman must have the resources and time available to insert it, which isn’t always possible. As a result, contraception may not be as empowering as advertisements sometimes portray.

### 5.3.2 Women's Attitudes towards Advertisement Messages

As previously discussed in Chapter 4.0, many of the women in this research study are examples of the third-person effect when it comes to advertising. They see and understand the messages advertisements are selling but believe that they don't buy into these messages, while other women do. As a result, they may believe that they do not need contraception to achieve their life plans, but suggest others may use contraceptives to manage or alleviate pain, resulting in more opportunity for them to be successful. This perception of the third-person effect was evident when women were discussing the effects advertisements have on women, and whether or not they would be more or less likely to suppress their own menstrual cycles based on the messaging from advertisements. While many women felt that they would most likely make this decision on their own, they suggested other women might be persuaded by advertisements. Hayley felt that the smiling women in the advertisements might encourage other women to be happy while menstruating or while using contraceptives, and noted "in the advertisements everyone is happy and smiling and thin, and ... I think it's very easy to make that next step and suppress your menstruation." Elizabeth, too, agreed that women viewing advertisements may be more likely to suppress their menstrual cycle as a result, but felt it was due to allusions of convenience that these contraceptives promised. While Elizabeth doesn't suppress her own cycle, she felt as though advertisements encouraging women to do so might be effective:

Yes. Absolutely. Because they make periods seem like they're an inconvenience if they don't happen at the exact perfect moment for you, or

like when is your most convenient moment ... there's one side of it that makes it seem very convenient and can be kind of empowering, but then there's this other side that's like why cant that just be a normal part of who you are. Maybe periods don't need to be such a hassle; it's just that they're being framed that way.

For Elizabeth, the problem isn't necessarily period themselves, but rather the fact that advertisements assume they are an inconvenience, and annoying, and disliked by women. Taking this assumption and then gearing advertisements towards it only continues to spread the myth that menstruation is still stigmatized.

Diana, on the other hand, didn't agree with the notion that in order to be successful or active, one must use contraceptives. She was exceptionally put off by an advertisement from ParaGard, which used the tagline "prefers her birth control hormone free and her commute stress free." The advertisement featured a cartoon depiction of a woman riding a scooter, her hair blowing in the wind. She brought up the associated problem that "she's on a scooter... why is this relevant? She can scoot even with [menstrual] blood." The arising question is then, couldn't women who were on another form of birth control, or even no birth control at all, experience a stress-free commute? Similar to the Nexplanon advertisement, can't women who don't use contraceptives, or who do not use contraceptives to suppress their cycle, be just as active and engaged as women who do? If so, why do advertisements continue to frame messages in a manner that indicates otherwise? These questions come back to the critique that companies are indirect and dishonest, and having companies acknowledge the benefits of contraception in an open and honest manner. As Ashley puts it,

I think I would like an advertisement that was more, informative. You know, instead of, pretty ladies ... I think it would be more realistic, you know. This is, this is what can happen. Like, if your periods are hurting you, or, you know, if you, rely on condoms, then you know this is something you look into ... You know, I look at an advertisement that says have a 'happy period' and I'm like, that, that doesn't exist. So like, let's be real and talk about why, why this could actually, how this could actually help you.

Because many of the women felt as though they were not the target audience of the advertisements, or did not respond to the advertisements positively, it is important to question who is. The third-person effect implies that a demographic of women *is* responding to the advertisements. While the advertisements typically depicted middle-class, Caucasian women, similar to the demographic of women interviewed for this study, the messages associated with the advertisements imply that the advertisements are seeking reactions from another population, specifically, groups of women who do not feel in control of their period, and for whom periods are seen as a negative or debilitating process. They may be directed at women who are not highly educated, as opposed to the women in this study, but rather women for whom the advertisements will have direct implications. Similar to the third-person effect that was revealed by the participants, it is almost impossible to know whom the advertisements are seeking to provoke without speaking to the company directly (as Amanda Ehrlich did in her study *Portrayal of Women in Print Advertisements for Hormonal Contraceptives: Using Qualitative Interviews and Focus Groups to Study Agency Professionals and their Target Consumers*), but rather we must work towards understanding the mode of address employed by the pharmaceutical companies. If Caucasian, middle-class women were being depicted in the advertisements, but were not responding positively to them, who would?

Would these advertisements be more beneficial for a woman of lower socioeconomic standing, who couldn't afford to miss a shift at work because of period pains? Or a woman in an abusive relationship whose partner beats her every month when she is on her period and does not feel comfortable engaging in sexual intercourse while bleeding? Perhaps the use of white, middle-class women in advertisements is not meant to appeal to that population, but rather appeal to women who *aren't* that population in an effort to create desire to change who they are and how they feel. This may explain why the ten participants did not present feelings of attraction or relation to the advertisements, but instead mocked the messages they were sending.

#### **5.4 Conclusion**

This chapter has unpacked the question, how do advertisers view women and women's lives, and do they hold any influencing power over a woman's decision to use contraceptives or to suppress her menstrual cycle? It was found that many women view advertisements as not completely honest, and using marketing tactics that are not appealing and relevant, resulting in little attention from women. While there is the element of the third-person effect, it remains uncertain as to what effect advertisements have on a larger population of women. Because each of the women in the study were already using contraceptives, it may be interesting to study young women who are not, and find out whether or not their decision to first use contraceptives could be influenced by advertisements. It may also be useful to study young women of various social and economic positions to assess the ways in which

advertisements inform and influence women outside of the white, middle-class populations. Using narratives from a variety of populations may prove to be more successful in understanding the target audiences of print advertisements by working to understand who *is* affected by the advertisements, rather than deducing who is not, as this project did.

Additionally, I have argued that because the women in this study are seeing menstruation as less of a taboo topic and something that they would prefer to speak to friends about for information, advertisements may not always be relevant. Promoting contraceptives as something that will create convenience and power in a woman's life may appeal to women who feel as though menstruation is inconvenient or annoying, but does not appeal to every woman, as indicated in this study. Instead, advertisements that take on a variety of approaches, such as focusing on sexual health, pain alleviation, menstrual management, or simply presenting the facts of the product, may be more likely to appeal to a wider population of women, who seek to use contraceptives for a variety of reasons. This would not only allow the advertisements to be more inclusive in nature, in addition to taking in a wider understanding of the needs of women, but would also provide women with another forum to learn about different forms of contraceptives and to consider her options before approaching a medical professional. Instead, women have no time for advertisements when trying to achieve all the life markers that are expected of them.

## 6.0 RECOMMENDATIONS FOR FUTURE RESEARCH

The purpose of this research project was to develop a better understanding of the ways in which women use contraceptives, their attitudes towards menstrual suppression, and how women and women's lives are understood and interpreted by pharmaceutical companies. Through an analysis of current scholarly literature, ten one-on-one interviews with menstruating women, and an analysis of ten print advertisements for contraceptives, the researcher sought to attain information on primary motivations for menstrual suppression and to highlight benefits and repercussions of the practice, as identified by women. A secondary aim of this study was to determine how contraceptive-based pharmaceutical companies interpreted women's lives and needs through print advertising, and whether or not marketed campaigns were reaching their targeted audience. It was determined through the duration of the process that the experience of menstruation and the use of contraceptives is a complex experience, often subjected to umbrella-like categorization. For many women, menstruation was not a simple process, but rather involved careful thought and planning both in terms of the experience itself, in addition to methods of managing it. The findings that women use contraceptives for a variety of reasons were not included in the original purpose of the research project, but turned out to be a large part of both the research and its findings. Because of both this turn in research, as well as the emphasis placed on it by each of the ten women during their one-on-one interviews, the following chapter suggests recommendations for future research that focus primarily on contraceptives. These

recommendations are solely from the findings, and as a result are not analytical and therefore speak only to the specific sample group used in this study.

## **6.1 Recommendations for Future Research**

The evidence available for the ways in which socio-economic standing influences a woman's menarche, in addition to her later attitudes towards menstruation, is clearly lacking. Although Section 4.1.1 *Age of Menarche* touches on research undertaken by Al-Sahab et al, much of the research fails to take into consideration the ways in which family income, household location, and family diet affect both the arrival of a woman's menarche, in addition to her experience with the life marker. Because the interviews were open-ended, and did not *explicitly* deal with the socio-economic standing of the women, this project did not further add to that area of study. It is suggested that future research further take into consideration social and economic factors in a woman's life that may affect menstruation. Additionally, how do social and economic factors affect a woman's ability to receive accurate and relevant information on contraception, in addition to accessing contraceptives themselves? Do contraceptive-based advertisements generally market themselves towards women of a higher income, or are all women their primary targets? Taking into consideration these potential areas of study would allow future research to fully capture the complex nature of menstruation, in addition to the intersectionality of women. It would also allow for a more diverse

population of women to be studied, as opposed to the sample group used in this study.

## **6.2 Recommendations for Future Areas of Improvement**

As mentioned in Chapter 4.0, many of the women in the study felt as though they were no longer using medical professionals as their primary source of information provision when it came to birth control, but were rather using the Internet and opinions of friends or family to guide them towards a decision. For these women, this came as a result of feeling ignored by medical professionals, and having their opinions and needs ignored during an appointment. These women described feeling hustled in and out of appointments, with doctors failing to build rapport, or develop a patient history. As a result, changes in health care organizations need to be made in order to ensure that women who share similar sentiments to the study's participants are receiving fair and equal treatment, and are receiving care that is tailored specifically to them. One method of achieving this is through the use of Family Health Teams. Currently available in Ontario, a Family Health Team consists of family doctors, registered nurses and other health care providers, often working out of hospitals or medical clinics. However, not only would it be more beneficial to have these more of these teams, and in easily-accessed areas, but it would also be increasingly beneficial for each team to be outfitted with one or more social worker. While many teams currently are, ensuring that each team is would allow women to meet with a social worker prior to their

medical appointment. The social worker, taking a feminist approach, can act as an advocate for women, providing women with their needs to be heard, and their questions to be addressed. It is felt that doing so would assist in building trust in the medical field, reduce the perception medical professionals as experts, and enable women to have power in the decision-making process.

### **6.3 Final Thoughts and Closing**

Although researching the ways in which women experience menstruation, use contraception and are understood by pharmaceutical-based advertisements, will never be enough to fully capture the lived experiences of women, doing so provides another forum for women's voices to be heard, and for women to take an active role in women-focused research. It is hoped that this project positively contributed to current research, and that the narratives used through the study provided qualitative substance to an otherwise quantitative area of study.

In the beginning, it was the original intent of the research project to work towards three main goals: identify the ways in which women and women's lives are understood by pharmaceutical companies through the use of print advertising, identify reasons behind a woman's decision to suppress her menstrual cycle through use of hormonal contraceptives, and determine whether or not print advertisements are an influencing factor in these decisions. It was thought that the nature of the interview questions would encourage dialogue from the interviewees

that would work in answering the research questions, and produce a study that was direct and to the point. However, upon reflection, it is evident that the project took an entirely different direction. Perhaps as a result of the open-ended nature of the interview questions, or the inexperience of the interviewees with the topic of menstrual suppression, the project instead focused primarily on the ways in which women experience and perceive menstruation, the methods women use to access information surrounding contraception, and a growing distrust for additive hormones found in contraception. While these findings did not meet the original goals of the project, they are still considered to be a success. Instead of creating a better understanding of why women opt to suppress their menstrual cycles through use of hormonal contraceptives, we have learned that women, or at least the sample of women studied in this project (which consisted of middle-class, Caucasian women) *really aren't* suppressing their cycles at all. In fact, the women used in this study demonstrated a fear or distrust of the practice, or do not believe the practice would benefit them personally, but rather believe the practice may be beneficial to *someone else*. This indicates that not only is there a lack of current research surrounding this topic, but that we may be over-assuming the number of women who even practice menstrual suppression. It also indicates that research that focuses exclusively on menstrual suppression, or exclusively on contraceptives, or exclusively on menstruation misses the point – that women and women's lives are complicated in nature. It is not enough to study menstruation without understanding the intersectionalities of both a woman, as well as the complexities of menstruation.

Doing so also allows researchers to employ the feminist political economy framework, as this project does. The feminist political economy framework allows researchers to focus on the well being of all humans, and to focus on the lived-experiences of women. It also allows for an appreciation and value of a woman's autonomy. This is consistent with the findings and direction of the paper, which worked to understand the autonomy sought by women both in regards to hormonal contraceptives, in addition to the feeling of power or expertise when dealing with medical professionals.

In the course of this research it became obvious that each women's experience with menstruation and contraceptive use is unique, and deserves consideration. However, medical professionals and advertisers often overlook these unique stories and experiences, and instead lump women together, forgoing individual accounts of race, class and ethnicity. This creates both a considerable obstacle in undertaking relevant research, in addition to providing care for women that is tailored to specific needs and wants.

Developing approaches that are inclusive of individual women, such as Family Health Teams, can not only strengthen the medical profession, but assist in promoting menstruation as a positive experience. Although those who experience substantial pain associated with menstruation may believe that menstruation could never be positive, having a team willing to work towards alleviating that pain and providing alternative solutions ensures that even their voices are heard. After all, not every period is a "happy period."

Women are strong agents in regards to their own bodies, and it is important that they are seen as such. Their openness to discuss menstruation, to speak up to medical professionals, and to continue to make decisions based on their own education, as opposed to being swayed by advertising, indicates a change has arrived. For many women, as indicated in the study, menstruation is no longer a curse, but rather a celebration in many women's lives, and an opportunity to bond with other women. It is hoped that this study contributes to the literature dedicated to emphasizing the power of menstruation and furthering open and honest discussion about contraceptives and the menstrual process.

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## APPENDIX 1: LETTER OF INFORMATION



School of Social Work c/o Lauren Gouchie  
1125 Colonel By Drive  
Ottawa, ON Canada K1S 5B6  
laurengouchie@cmail.carleton.ca

### **Women's Liberation or Body Control?: is Menstrual Suppression and Manipulation Encouraged Through Pharmaceutical Advertisements Letter of Information**

#### **What is this project about?**

This project, conducted by a Masters of Social Work student at Carleton University, asks why women aged 18-30 may suppress or manipulate their menstrual cycle. Additionally, it looks to understand whether or not advertising promoted by pharmaceutical companies has any influence on this decision.

#### **Wait, menstrual suppression? What's that?**

Menstrual suppression is defined as any altering or adjustment of the menstrual cycle, through use of hormonal contraception. This adjustment allows women to experience periods on a less frequent basis, and dictate when their period will arrive. Some women opt to suppress their menstruation using contraception (i.e. forgoing the week of "sugar" pills) for a number of different reasons.

#### **Who is running this project?**

A Masters of Social Work student at Carleton University.

#### **Who is the researcher?**

Lauren Gouchie, who is being supervised by Dr. Susan Braedley from the Faculty of Social Work at Carleton University.

#### **What does participating entail?**

As a participant, you will engage in an interview lasting 60-90 minutes. The length of the interview is dependent on the length of responses you give to each question. We will begin by acknowledging that you understand the research project, and have read and signed the consent form. At that time, I will turn on the two (2) recording devices used to record our interview. We will work our way through the pre-designed interview, and I encourage you to speak freely and openly about your experiences and responses. Should any question make you uncomfortable, you will always have the option of *prefer not to answer*, at which time we will move on to the

next question. At the end of the interview, I will switch off the recorders, and we will undergo a short debriefing period.

**What will happen to the info I give?**

The information will be used as narrative/dialogue in my thesis project for my graduate program.

**Will it be private?**

Yes! Your name, and any identifying information (such as your place of employment, university program etc.) will not be identified on any transcription, document or publication.

**Are there any risks?**

Sometimes talking about personal experiences or memories can be a bit overwhelming. If you feel this is the case for any particular question, please remember you always have the option of *prefer not to answer*. Additionally, the tape recorders may be turned off if you need a few moments to relax. I also have contact information for support should you be interested in further assistance.

**How long will you keep my survey information?**

The researcher will keep all the data on a secure and locked USB until December 31, 2013. On that date, all the data, interviews and interview transcriptions will be destroyed.

**Who do I contact if I have questions about this survey?**

If you have any questions about the interview, research project or your ethical rights, you can contact any one of the contacts listed below.

If you have any concerns or questions about your involvement in this study, please contact:

Carleton University Research Ethics Board  
Professor Andy Adler  
Carleton University  
1125 Colonel By Drive  
Ottawa, On, K1S 5B6  
613 520 2517  
ethics@carleton.ca

Researcher  
Lauren Gouchie  
School of Social Work  
1125 Colonel By Drive  
Ottawa, On, K1S 5B6  
laurengouchie@cmail.carleton.ca

Research Supervisor  
Susan Braedley  
School of Social Work  
1125 Colonel By Drive  
Ottawa, On, K1S 5B6  
susan\_braedley@carleton.ca

## APPENDIX 2 LETTER OF CONSENT



School of Social Work c/o Lauren Gouchie  
1125 Colonel By Drive  
Ottawa, ON Canada K1S 5B6  
laurengouchie@cmail.carleton.ca

### **Women's Liberation or Body Control?: is Menstrual Suppression and Manipulation Encouraged Through Pharmaceutical Advertisements Consent Form**

I'm almost ready to begin the interview! Before I do, I, \_\_\_\_\_  
agree that:

- I fit into the demographics of the survey – which means I am between the ages of 18 and 30, live in Ottawa, and identify as a menstruating female;
- I understand what the interview is for, and why this particular research project is being done;
- I can opt to end my interview at any time, which will result in my responses and data being destroyed;
- I understand that if I have any questions or concerns while completing the interview, I will be provided with names and contact information of services or organizations I can contact.

I understand that some questions in the interview may cause me psychological or emotional harm (i.e. answering a particular questions may cause me to remember unpleasant or uncomfortable memories or experiences).

I understand that as a participant in this interview I can opt out of the interview at any time, by letting the researcher know I do not wish to continue. I understand that by opting out of the interview, all my previous data or information will be deleted, and will not be used in the study. I also understand that I have until August 1, 2013 to opt out of the study altogether, and by doing so all my previous data or information will be deleted, and will not be used in the study.

I understand that I will be recorded using two (2) recording devices. I understand this is to ensure the researcher has a recording of my interview. I also understand

that this data will be encrypted and stored with password-protection on the researcher's computer, and will only be accessed by the researchers.

I understand that the data collected through my interview will be analyzed with that of other participants in the study and will be used publicly. I understand that this analysis will be used in both the researcher's thesis project, as well as in potential articles for publication.

I understand that the data collected through this interview will be stored until December 31, 2013. At this time, it will be destroyed.

**I understand this research project has been reviewed and approved by:**

Carleton University Research Ethics Board  
Professor Andy Adler  
Carleton University  
1125 Colonel By Drive  
Ottawa, On, K1S 5B6  
613 520 2517  
ethics@carleton.ca

Researcher  
Lauren Gouchie  
School of Social Work  
1125 Colonel By Drive  
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laurengouchie@cmail.carleton.ca

Research Supervisor  
Susan Braedley  
School of Social Work  
1125 Colonel By Drive  
Ottawa, On, K1S 5B6  
susan\_braedley@carleton.ca

I have read this entire form, and understand it completely. As such, I consent to participate in this research project.

\_\_\_\_\_  
Signature of participant

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Signature of witness

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Date



## APPENDIX 4: RECRUITMENT EMAIL



School of Social Work c/o Stephanie Mulville  
1125 Colonel By Drive  
Ottawa, ON Canada K1S 5B6  
stephanie.mulville@carleton.ca

### **Email sent to all SSW students**

Are you a woman between the ages of 18 and 30? Have you ever suppressed your menstrual cycle (through the use of hormonal contraceptives) - why or why not? Carleton University graduate student Lauren Gouchie, supervised by Professor Susan Braedley, is seeking research participants for one-on-one interviews to discuss your experience and opinion on menstrual suppression for her ethics-approved graduate thesis. Each interview will take approximately 60 minutes to complete, and all research participants will be compensated for their time. Interested participants must currently live in the Ottawa area.

For more information, and to register as a participant, please contact Lauren Gouchie at [laurengouchie@mail.carleton.ca](mailto:laurengouchie@mail.carleton.ca)

## APPENDIX 5: INTERVIEW QUESTIONS

### **Women's Liberation or Body Control?: is Menstrual Suppression and Manipulation Encouraged Through Pharmaceutical Advertisements**

This interview will take approximately 60-90 minutes. The following lists of topics will be discussed in the interviews. This is a semi-structured, open-ended interview schedule therefore the topics will vary slightly based on the answers to questions.

#### A. Interviewee Background

- Can you tell me a little bit about your life right now? (Age, employment, school, living arrangements, etc.)

#### B. Menstrual Background

- I'd like to ask you some questions about your menstrual history. Can you tell me a little bit about your menstrual history and first menses?
- Can you tell me what a "typical" menstrual cycle for you is like? (Do you experience pain?, Is it uncomfortable?, etc)
- Is the experience of your menstrual cycle something you would share with others? If so, who? (i.e. partner, mother, sister, friend)

#### B. Contraceptive Background

- Can you tell me about your sexual history/past, particularly as it relates to birth control? Pain control? Menstrual management?
- Can you tell me about your decision to use birth control?
- What was your source of birth control provision? Of information?

#### C. Current Information

- Can you tell me about your current sexual life in regards to birth control?
- How does your sexual history/ history with birth control affect your decisions right now?
- If you use contraceptives, why? Which product? If you no longer use contraceptives, why not?
- If you could describe the perfect menstrual cycle for you, what would it look like?

#### D. Menstrual Suppression

- Can you tell me about your experience with menstrual suppression? Have you used contraceptives to "skip" a menstrual cycle?
- If you haven't, why not?
- Can you tell me some benefits you believe are associated with menstrual suppression? Some drawbacks?

- Have you ever seen advertisements for contraceptions in magazines, newspapers, etc? What do you remember about them? Could you describe them using language and colours?
- What messages do you think these advertisements send? Do you think they have any effect on a woman's decision to use or not use contraceptives?
- Have these advertisements had a negative or positive effect on you? How so?
- If you could create your own advertisements for contraceptives, what would they look like? What words would they use?
- Do you believe there is a relationship between advertisements and menstrual suppression? Why or why not?

Finally, are there any questions I should have asked, and didn't?

**If you have any concerns or questions about your involvement in this study, please contact:**

**Carleton University Research Ethics Board**

Professor Andy Adler  
Carleton University  
1125 Colonel By Drive  
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## APPENDIX 6: POST-INTERVIEW CONTACT INFORMATION



School of Social Work c/o Lauren Gouchie  
1125 Colonel By Drive  
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laurengouchie@cmail.carleton.ca

### **Women's Liberation or Body Control?: is Menstrual Suppression and Manipulation Encouraged Through Pharmaceutical Advertisements**

#### **Need someone to talk to?**

Planned Parenthood Ottawa: 613-226-3234; [www.ppottawa.ca](http://www.ppottawa.ca)

Sexual Assault Support Centre of Ottawa: 613-725-2160; [www.sascottawa.org](http://www.sascottawa.org)

The Sexual Health Centre: 613-563-2437 or 1-800-267-7432;  
[info@sexualhealthcentre.com](mailto:info@sexualhealthcentre.com)

Pink Triangle Services: 613-563-4818; [www.ptsottawa.org](http://www.ptsottawa.org)

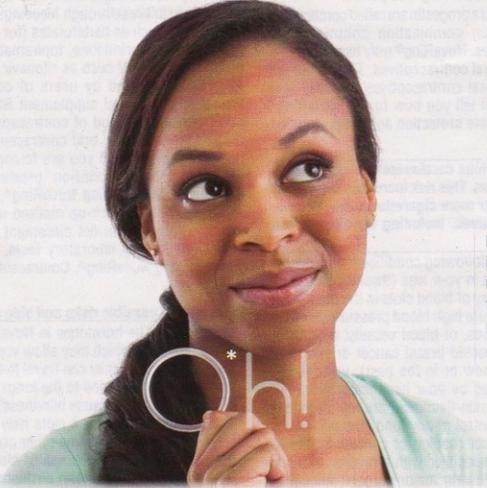
## APPENDIX 7: ADVERTISEMENT 1

**NUVARING™**  
(etonogestrel/ethinyl estradiol vaginal ring)  
delivers 0.120 mg/0.015 mg per day

**“How does this work to prevent pregnancy?”**

**Here’s how...**

When NuvaRing is placed in your vagina, it releases a continuous low dose of hormones that helps prevent pregnancy. You put it in for 3 weeks, take it out, then put a new one in a week later. When used as directed, it is 99% effective.



Prescription NuvaRing is a monthly vaginal ring that is approved for the prevention of pregnancy in women.

\*Actual NuvaRing shown.

**Important Safety Information**

Cigarette smoking increases the risk of serious cardiovascular side effects when you use combination oral contraceptives. This risk increases even more if you are over age 35 and if you smoke 15 or more cigarettes a day. Women who use combination hormonal contraceptives, including NuvaRing, are strongly advised not to smoke.

- The use of combination oral contraceptives is associated with increased risks of several serious side effects, including blood clots, stroke, or heart attack. NuvaRing is not for women with a history of these conditions. The risk of getting blood clots may be greater with the type of progestin in NuvaRing than with some other progestins in certain low-dose birth control pills. It is unknown if the risk of blood clots is different with NuvaRing use than with the use of certain birth control pills.
- NuvaRing is not for women with certain cancers or those who may be pregnant.
- NuvaRing does not protect against HIV infection and other sexually transmitted diseases.
- The most common side effects reported by NuvaRing users are: vaginal infections and irritation, vaginal secretion, headache, weight gain, and nausea.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit [www.fda.gov/medwatch](http://www.fda.gov/medwatch) or call 1-800-FDA-1088.

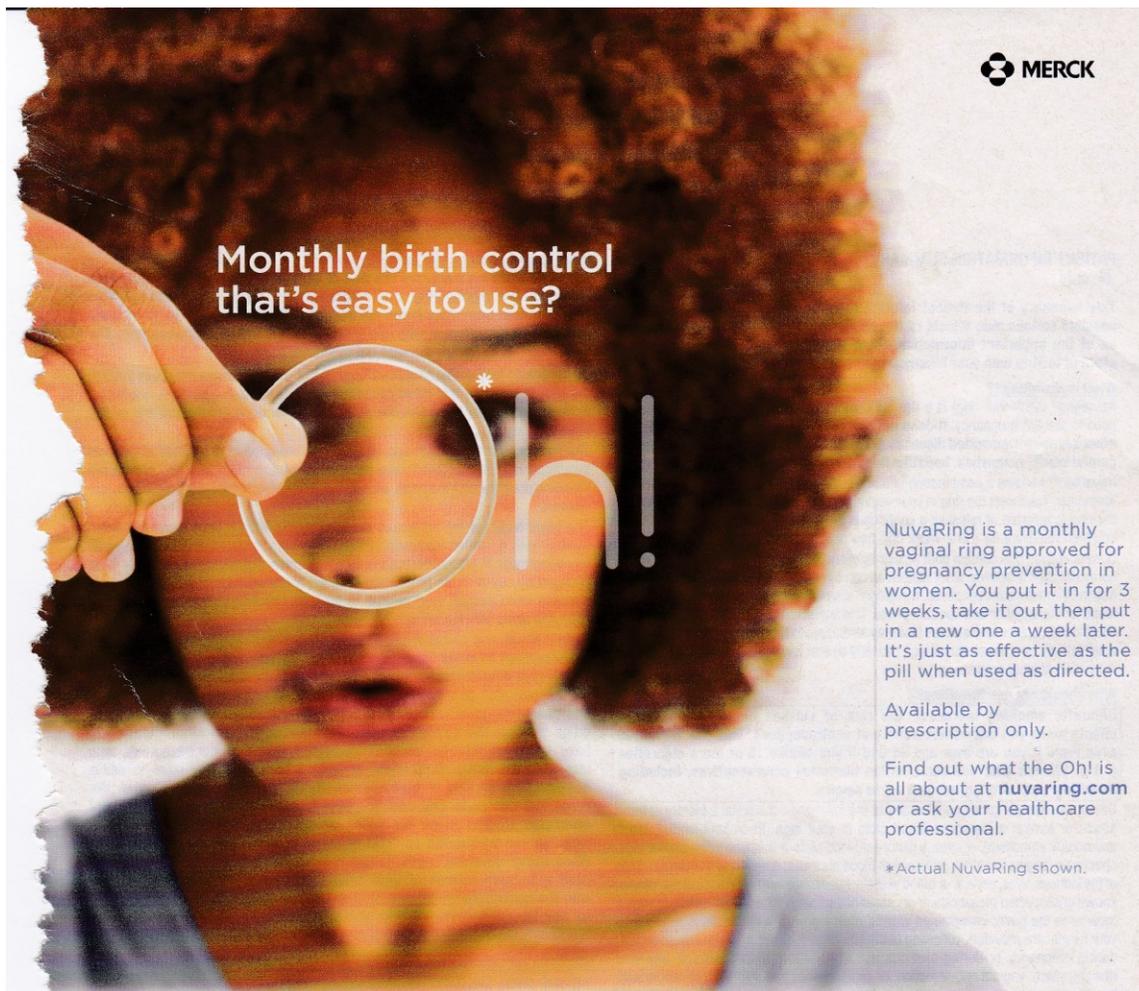
**Please read the Patient Information Summary on the adjacent pages for more detailed information.**

**Ask your health care provider about NuvaRing or visit [NuvaRing.com](http://NuvaRing.com).**



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## APPENDIX 8: ADVERTISEMENT 2



 MERCK

Monthly birth control  
that's easy to use?

\*  
Oh!

NuvaRing is a monthly vaginal ring approved for pregnancy prevention in women. You put it in for 3 weeks, take it out, then put in a new one a week later. It's just as effective as the pill when used as directed.

Available by prescription only.

Find out what the Oh! is all about at [nuvaring.com](http://nuvaring.com) or ask your healthcare professional.

\*Actual NuvaRing shown.

### Important Safety Information

**Cigarette smoking increases the risk of serious cardiovascular side effects when you use combination oral contraceptives. This risk increases even more if you are over age 35 and if you smoke 15 or more cigarettes a day. Women who use combination hormonal contraceptives, including NuvaRing, are strongly advised not to smoke.**

- The use of combination oral contraceptives is associated with increased risks of several serious side effects, including blood clots, stroke, or heart attack. NuvaRing is not for women with a history of these conditions. The risk of getting blood clots may be greater with the type of progestin in NuvaRing than with some other progestins in certain low-dose birth control pills. It is unknown if the risk of blood clots is different with NuvaRing use than with the use of certain birth control pills.
- NuvaRing is not for women with certain cancers or those who may be pregnant.
- NuvaRing does not protect against HIV infection and other sexually transmitted diseases.
- The most common side effects reported by NuvaRing users are: vaginal infections and irritation, vaginal secretion, headache, weight gain, and nausea.

Please see next page for additional important patient information.

**You are encouraged to report negative side effects of prescription drugs to the FDA. Visit [www.fda.gov/medwatch](http://www.fda.gov/medwatch) or call 1-800-FDA-1088.**

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**NUVARING®**  
(etonogestrel/ethinyl estradiol vaginal ring)  
delivers 0.120 mg/0.015 mg per day

## APPENDIX 9: ADVERTISEMENT 3

**NUVARING™**  
(etonogestrel/ethinyl estradiol vaginal ring)  
delivers 0.120 mg/0.015 mg per day

**“Do I put it in myself, like a tampon?”**

**Yup...**

You insert and remove NuvaRing yourself, similar to a tampon. Except you leave NuvaRing in for 3 weeks, take it out, then put in a new one a week later.



Prescription NuvaRing is a vaginal ring that releases a continuous low dose of hormones. It is approved for the prevention of pregnancy in women.  
\*Actual NuvaRing shown.

### Important Safety Information

Cigarette smoking increases the risk of serious cardiovascular side effects when you use combination oral contraceptives. This risk increases even more if you are over age 35 and if you smoke 15 or more cigarettes a day. Women who use combination hormonal contraceptives, including NuvaRing, are strongly advised not to smoke.

- The use of combination oral contraceptives is associated with increased risks of several serious side effects, including blood clots, stroke, or heart attack. NuvaRing is not for women with a history of these conditions. The risk of getting blood clots may be greater with the type of progestin in NuvaRing than with some other progestins in certain low-dose birth control pills. It is unknown if the risk of blood clots is different with NuvaRing use than with the use of certain birth control pills.
- NuvaRing is not for women with certain cancers or those who may be pregnant.
- NuvaRing does not protect against HIV infection and other sexually transmitted diseases.
- The most common side effects reported by NuvaRing users are: vaginal infections and irritation, vaginal secretion, headache, weight gain, and nausea.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit [www.fda.gov/medwatch](http://www.fda.gov/medwatch) or call 1-800-FDA-1088.

**Please read the Patient Information Summary on the adjacent pages for more detailed information.**

**Ask your health care provider about NuvaRing or visit [NuvaRing.com](http://NuvaRing.com).**



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## APPENDIX 10: ADVERTISEMENT 4



Monthly birth control that's easy to use?

Oh!

MERCK

NuvaRing is a monthly vaginal ring approved for pregnancy prevention in women. You put it in for 3 weeks, take it out, then put in a new one a week later. It's just as effective as the pill when used as directed.

Available by prescription only.

Find out what the Oh! is all about at [nuvaring.com](http://nuvaring.com) or ask your healthcare professional.

\*Actual NuvaRing shown.

### Important Safety Information

Cigarette smoking increases the risk of serious cardiovascular side effects when you use combination oral contraceptives. This risk increases even more if you are over age 35 and if you smoke 15 or more cigarettes a day. Women who use combination hormonal contraceptives, including NuvaRing, are strongly advised not to smoke.

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NuvaRing is not for women with certain cancers or those who may be pregnant.

NuvaRing does not protect against HIV infection and other sexually transmitted diseases.

The most common side effects reported by NuvaRing users are: vaginal infections and irritation, vaginal secretion, headache, weight gain, and nausea.

See next page for additional important patient information.

are encouraged to report negative side effects of prescription drugs to the FDA. Visit [www.fda.gov/medwatch](http://www.fda.gov/medwatch) or call 1-800-FDA-1088.

**NUVARING**  
(etonogestrel/ethinyl estradiol vaginal ring)  
delivers 0.120 mg/0.020 mg per day

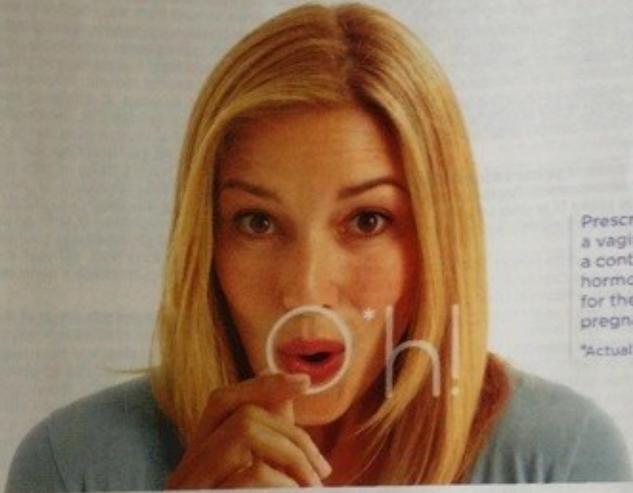
## APPENDIX 11: ADVERTISEMENT 5A & 5B

**NUVARING™**  
(etonogestrel/methinyl estradiol vaginal ring)  
delivers 0.020 mg/0.015 mg per day

**“Isn't it tricky to get that in there?”**

**Nope. It's easy to use.**

NuvaRing is a small, flexible vaginal ring. Like a tampon, you insert and remove it yourself. Except you put NuvaRing in for 3 weeks, take it out, then put a new one in a week later.



Prescription NuvaRing is a vaginal ring that releases a continuous low dose of hormones. It is approved for the prevention of pregnancy in women.  
\*Actual NuvaRing shown.

### Important Safety Information

Cigarette smoking increases the risk of serious cardiovascular side effects when you use combination oral contraceptives. This risk increases even more if you are over age 35 and if you smoke 15 or more cigarettes a day. Women who use combination hormonal contraceptives, including NuvaRing, are strongly advised not to smoke.

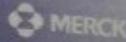
- The use of combination oral contraceptives is associated with increased risks of several serious side effects, including blood clots, stroke, or heart attack. NuvaRing is not for women with a history of these conditions. The risk of getting blood clots may be greater with the type of progestin in NuvaRing than with some other progestins in certain low-dose birth control pills. It is unknown if the risk of blood clots is different with NuvaRing use than with the use of certain birth control pills.
- NuvaRing is not for women with certain cancers or those who may be pregnant.
- NuvaRing does not protect against HIV infection and other sexually transmitted diseases.
- The most common side effects reported by NuvaRing users are: vaginal infections and irritation, vaginal secretion, headache, weight gain, and nausea.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit [www.fda.gov/medwatch](http://www.fda.gov/medwatch) or call 1-800-FDA-1088.

Please read the Patient Information Summary on the adjacent page for more detailed information.

**Ask your health care provider about NuvaRing or visit [NuvaRing.com](http://NuvaRing.com).**

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## APPENDIX 12: ADVERTISEMENT 6



Prefers her birth control hormone free  
and her commute stress free.

Presenting ParaGard<sup>®</sup> intrauterine contraceptive, the only reversible birth control that's more than 99% effective and 100% hormone free.

ParaGard<sup>®</sup> is hassle-free birth control that can fit your life. It's designed to be small and fit comfortably in a woman's body. ParaGard<sup>®</sup> is commonly placed by your doctor in minutes during a routine office visit to provide continuous pregnancy prevention for as long as you want—2, 5, even up to 10 years. There are no daily or weekly routines\* to follow—no pills to remember and no monthly trips to the pharmacy. You can be intimate with your partner without interruption because it doesn't interfere with sexual spontaneity. ParaGard<sup>®</sup> has been FDA approved and used by women for over 20 years. Ask your doctor if ParaGard<sup>®</sup> is right for you.

ParaGard<sup>®</sup> is indicated for the prevention of pregnancy. Learn more about ParaGard<sup>®</sup> at [paragard.com](http://paragard.com)

**IMPORTANT SAFETY INFORMATION:** Do not use ParaGard<sup>®</sup> if you have a pelvic infection, get infections easily or have certain cancers. Less than 1% of users get a serious infection called pelvic inflammatory disease. If you have persistent pelvic or stomach pain, or if ParaGard<sup>®</sup> comes out tell your healthcare provider. If it comes out, use back-up birth control. In rare cases, ParaGard<sup>®</sup> may attach to or go through the uterine wall and cause other problems. Although uncommon, pregnancy while using ParaGard<sup>®</sup> can be life threatening and may result in loss of pregnancy or fertility. Bleeding or spotting may increase at first but should decrease in 2 to 3 months. **ParaGard<sup>®</sup> does not protect against HIV or STDs.**

You are encouraged to report negative side effects of prescription drugs to the FDA at [www.fda.gov/medwatch](http://www.fda.gov/medwatch) or call 1-800-FDA-1088.

\*With ParaGard<sup>®</sup>, there's just a simple monthly self-check.

BIRTH CONTROL THAT FITS YOUR LIFE, NATURALLY.™

ParaGard<sup>T 380A</sup>  
intrauterine copper contraceptive



How do I know if it's right for me?  
Get fast answers to the six most common questions now. Just scan here.

Please see the following page for a brief summary of Prescribing Information.

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When getting *pregnant* isn't part of your

# 3 YEAR PLAN

↓

**START WITH NEXPLANON**  
(etonogestrel implant) 68mg  
up to 3 years of continuous pregnancy prevention

↓

**YOU** take care of the rest

→

- get my own place
- take a trip
- get a job
- fall in love
- save up
- finish school

## APPENDIX 14: ADVERTISEMENT 8

You'll know when your family is complete.  
You'll know when it's time for Essure.<sup>®</sup>



**Essure is the most effective\* permanent birth control there is**—even more effective than tying your tubes. Essure is hormone-free, surgery-free, and is a quick procedure that can be performed right in your doctor's office. Since there's no slowing down to recover, you can get back to your family right away. Essure inserts are soft and flexible, and when placed in your fallopian tubes, they work with your body to form a natural barrier that permanently prevents pregnancy. That's why nearly a million women trust Essure.

To learn more about Essure and find a doctor, visit [essure.com](http://essure.com) or call 1.877.ESSURE4 (1.877.377.8734)

**essure<sup>®</sup>**  
permanent birth control

**Essure is covered by your insurance at no cost under the Affordable Care Act. Some restrictions may apply. Visit [Essure.com](http://Essure.com) to learn more.**

\*Based on a comparison of five-year clinical data.

Essure has been FDA-approved and available in the US since 2002.

The Essure procedure may not be suitable for all women and there are risks. The procedure is not reversible, and you must continue to use another form of birth control for at least three months after the procedure. Risks may include cramping, pain, nausea, vomiting, dizziness, light-headedness, bleeding, or spotting. Visit [www.essure.com](http://www.essure.com) to learn more and see a complete list of risks and considerations.

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Scan to see how  
Essure works.



APPENDIX 15: ADVERTISEMENT 9

I love having kids.

I love my family just the way it is.

I love the memories we are making.

I love *being done* having kids.



That's why I love *Essure*.

When you're done having kids, Essure is the hormone-free, surgery-free permanent birth control you can trust.

Essure is the most effective\* permanent birth control there is—even more effective than tying your tubes. The Essure procedure can be performed right in your doctor's office in as little as 10 minutes, and since it's surgery-free, there's no slowing down to recover. Essure inserts are soft and flexible, and when placed in your fallopian tubes, they work with your body to form a natural barrier that permanently prevents pregnancy. That's why over half a million women who are done having kids don't just depend on Essure, they love Essure.

To learn more about Essure and find a doctor, visit [essure.com](http://essure.com).

**essure**<sup>®</sup>  
[www.essure.com](http://www.essure.com)

\*Based on five years of clinical data.  
Essure has been FDA-approved and available in the US since 2002.  
When performed in a doctor's office, depending on your specific insurance plan, the cost may be as low as a single co-pay.  
The Essure procedure may not be suitable for all women and their are risks. The procedure is not reversible, and you must use another form of birth control for at least three months after the procedure. Risks may include cramping/bleed, possible burning, discomfort/light-headedness and breathing/sleeping. Visit [www.essure.com](http://www.essure.com) for a complete list of risks and considerations.  
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Scan to see how  
Essure works.

APPENDIX 16: ADVERTISEMENT 10

Prefers her birth control hormone free  
and her coffee caffeine free.



Presenting ParaGard<sup>®</sup> intrauterine contraceptive, the only reversible birth control that's more than 99% effective and 100% hormone free.

ParaGard<sup>®</sup> is hormone-free birth control that's just as effective as the Pill. It's designed to be small and fit comfortably in a woman's body. ParaGard<sup>®</sup> is commonly placed by your doctor in minutes during a routine office visit to provide immediate pregnancy prevention for as long as you want — 2, 5, even up to 10 years. Since it is 100% hormone free, you don't have to worry about hormone-related side effects, such as associated weight gain, mood swings or headaches. Plus it doesn't affect your natural cycle. ParaGard<sup>®</sup> has been FDA approved and used by women for over 20 years. Ask your doctor if ParaGard<sup>®</sup> is right for you.

ParaGard<sup>®</sup> is indicated for the prevention of pregnancy. Learn more about ParaGard<sup>®</sup> at [paragard.com](http://paragard.com)

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BIRTH CONTROL THAT FITS YOUR LIFE, NATURALLY.™ **ParaGard<sup>®</sup>**  
intrauterine copper contraceptive



How do I know if it's right for me?  
Get fast answers to the six most common questions now. Just scan here.