Providing culturally sensitive evidence-based care for Orthodox Jewish women

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Orthodox Jewish tradition requires married women to abstain from physical intimacy with their husbands whenever they begin a menstrual flow, in Hebrew known as her "niddah" state (Leviticus 15:19-24). The laws regarding this tradition date back to bible texts, known as the Torah, as early as the Talmudic era in the 6th century of the Common Era. The doctrines are known as the laws of family purity and often extend beyond the monthly menstrual cycle. Every time uterine blood is shed, be it via normal menses, breakthrough bleeding from medications, postpartum bleeding, or even some procedural bleeding, a woman must count 7 clean days after the cessation of blood flow with internal self-examinations. If she encounters any blood during her checks, she must restart the process of counting until she reaches 7 clean days. Only then can she purify herself in a ritual bath called a "mikvah" and resume physical intimacy with her husband. These laws impact the women's healthcare provider, who is often approached to manage and manipulate scheduled or unscheduled menstrual bleeding to ease the emotional burden of niddah separation. A bride-to-be may approach her provider wishing to avoid having her period on her wedding night so she can consummate her marriage. A couple may experience infertility due to shortened menstrual cycles and the inability to have intercourse during a woman's fertile window. Women may experience unscheduled bleeding while using hormonal contraception and therefore frequent niddah issues arise. This article explores the reproductive years of an Orthodox Jewish female patient as she navigates different scenarios in hopes to guide clinicians through the care of this unique population of patients.

The Orthodox bride pre-wedding consult

Sarah, a 22-year-old female, presents to the office for her first well-woman exam. She tells the clinician "I would like to discuss how to regulate my periods so that I don't bleed for the week leading up to my wedding." The clinician asks for more information about Sarah's periods and learns they are regular every month and she has no problems with spotting or bleeding between periods. Further, Sarah tells the clinician the wedding is about 5 weeks away so she expects she will have a period

before then and wants to make sure it ends at least 7 days before the wedding comes.

Sarah shares information with the clinician about niddah and mikvah and is asking for assistance in controlling the timing of her scheduled menstrual flow, as well as preventing any spotting or bleeding for a period of at least 7 days leading up to her wedding. Brides too are considered niddah until immersing in the mikvah for the first time prior to their wedding day.[1] This process purifies them so that they are ritually pure for intimacy with their husbands on the first night they are allowed to physically be together. The clinician thanks Sarah for sharing this information and suggests two options that can be used to manipulate the menstrual cycle to meet Orthodox Jewish niddah tradition, each with advantages and disadvantages.

Combination oral contraceptives (COCs) are commonly used to regulate the menstrual cycle for patients who have irregular periods and for those who want to skip periods during a specific time period. To skip or delay a period, the individual takes COCs continuously without the placebo pills when bleeding typically occurs. For the individual desiring ongoing contraception and who will have a few months before the wedding to become regulated, this could be a reasonable option. The clinician and Sarah decide that is not a good fit. Unscheduled bleeding and spotting with COCs are most likely to occur within the first 3 months of use. Sarah also shares with the clinician that she and her husband-to-be want to start a family right away.

Administration of norethindrone acetate for up to 21 days prior to the wedding is an option less likely to cause any unscheduled bleeding or spotting. Norethindrone acetate is a synthetic progesterone that is indicated for the treatment of secondary amenorrhea, endometriosis, and abnormal uterine bleeding due to hormonal imbalance in the absence of pathology.[2] In a retrospective study of over 500 Orthodox Jewish brides treated with 5 mg of norethindrone acetate dosed three times daily for up to 21 days leading up to their wedding, 100% experienced no bleeding or spotting from within 36 hours of initiation until 2 to 3 days following cessation of the medication.[3] The only significant side effect that was reported by 18% of patients was some bloating or water retention, which was treated successfully with a diuretic when it was so troublesome that intervention was necessary. The author of the study, an endocrinologist, noted that in ideal circumstances, norethindrone acetate should be started on day 12 of the menstrual cycle or 14 days before the wedding. In the event that the time before the wedding is shorter than this, she should begin the medication as soon as she receives the prescription and continue taking as long as she would like to avoid bleeding.[3] Time to conception after discontinuing norethindrone acetate is generally shorter (on average, 2 months) when compared to that with COCs (on average, 3–6 months).[2] Sarah chooses this option.

Religious infertility

Sarah and her husband Jonah come to the office again after 15 months of marriage, using no contraception, desiring pregnancy. The clinician obtains a menstrual and sexual history and learns that Sarah continues to have regular monthly periods, occurring every 24 days, and her bleeding lasts 6 to 7 days. She denies any significant dysmenorrhea as well as any intermenstrual bleeding or spotting. When discussing the couple's timing of intercourse, Sarah reminds the clinician that she is an observant Orthodox Jew and keeps the laws of family purity, where they abstain from intercourse until after she has counted 7 clean days following the cessation of her monthly menses. During niddah, the couple must sleep in separate beds and not touch each other. Once she immerses in the mikvah each month, the couple has had penetrative vaginal intercourse every other day in hopes of becoming pregnant. Yet, month after month they are disappointed to see her menses begin right on time.

A menstrual calendar and ovulation tests indicate that Sarah is ovulating on day 12 of her 24-day cycle. Because her periods last 6 to 7 days and she follows Orthodox Jewish laws, Sarah cannot resume coitus until day 13 of her cycle at the earliest. This reality is preventing her from immersing in the mikvah until after she has already ovulated. With her shortened cycle and number of days of bleeding, by the time she is able to return to physical intimacy with her husband, she has already missed her fertile window, which begins as early as 5 days prior to ovulation.[4] This conundrum is known as "religious infertility" and unfortunately affects 20% of Orthodox Jewish couples.[5]

For Sarah and Jonah, the goal is to lengthen the preovulatory phase, as shortening the count of days of ritual impurity is not an option for them.[5] Lengthening the preovulatory phase will provide enough time for her to follow the niddah laws and immerse in the mikvah prior to ovulation. The clinician provides the couple with information about strategies to achieve their goal that are evidence-based, safe, and in keeping with their religious laws.

A number of studies conducted in the early 2000s focused specifically on this population have looked at the use of estrogen to delay ovulation so as to enhance chances for conception.[5–7] Different formulations of estrogen were used including 6 mg β-estradiol or estradiol valerate beginning on day 1 of the cycle and taken for 5 consecutive days, 4 mg of estradiol starting on day 1 of the cycle and stopping 2 days after cessation of menses, and a COC containing 35 µg of ethinyl estradiol and 180 µg norgestimate for 5 days to begin on the first day of menses. The studies all demonstrated a delay in ovulation that allowed couples to have sexual intercourse after mikvah immersion during their fertile windows. Because the studies had only a small number of participants and prior fertility was not confirmed, it is difficult to base the success of these strategies on achieving pregnancy, but all of the studies had promising positive pregnancy results. In another small study, women experiencing religious infertility who were given gonadotropin-releasing hormone (GnRH) antagonist 250 µg subcutaneous injection daily for 5 days, starting on the second day of their cycle for up to 3 months or until they conceived, showed similar delays in ovulation and success in conceiving as with the use of estrogen.[8] The effective use of a GnRH agonist provides an option for women with contraindications to estrogen.

Contraceptive methods

Sarah arrives at the office again 1 year later for a postpartum visit following the birth of her first child. The clinician asks Sarah the question she routinely asks reproductive-age patients, "Do you wish to become pregnant in the next year?" Sarah responds "Not really, but contraception is a bit complicated according to Orthodox Jewish law. I need to avoid methods that could cause irregular bleeding, as well as any barrier methods that do not allow for my husband's sperm to go into my body." The clinician is eager to learn more about Sarah and Jonah's religious and cultural expectations regarding contraception, and Sarah is happy to share information.

The Rabbi will allow contraception for married couples who already have children and would like to space pregnancies for optimal maternal health and to benefit the family's emotional and financial wellbeing.

Orthodox Jewish couples who are interested in contraception will usually approach their rabbinic authority as well as their healthcare clinician to discuss the best options for them. The clinician can start by asking the woman what the Rabbinic authority has advised for her. The Rabbi will determine if and which type of contraception is appropriate and permissible in Jewish law. According to Orthodox Jewish laws surrounding family planning, there are two overarching principles: the prohibition to "waste seed" or masturbation and the prohibition of any form of castration.[9] Additionally, any form of contraception that interrupts the natural form of intercourse, such as the withdrawal method, is not acceptable because these reduce the couple's pleasure and interfere with normal procreation.

The Rabbi will allow contraception for married couples who already have children and would like to space pregnancies for optimal maternal health and to benefit the family's emotional and financial wellbeing. The Rabbinic leadership generally will not grant permission for contraception for a newlywed couple who simply want to delay having children for convenience, as according to the Torah, Jews have an obligation to "be fruitful and multiply." It is common for Orthodox Jewish families to have many children, and larger families are culturally the norm. Married couples are expected to keep trying to have children throughout their marriage unless there is a reason pregnancy would be medically dangerous to the mother's life, in which case the mother is permitted to use a more permanent form of contraception to preserve her own health.[10] If contraception is deemed appropriate for a particular couple, there are methods that are preferable and those that are not permissible within the parameters of Jewish law.

A main foundation to the practices of niddah is to preserve sexuality as something holy and special between husband and wife, an act regarded with utmost importance.[11] There are boundaries regarding when intimacy is permitted to keep the excitement in the relationship and prevent physical intimacy from becoming something that feels stale and taken for granted. Due to the holiness of the act of pene-

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trative intercourse, abstinence as well as coitus interruptus as forms of contraception are both strictly prohibited.[9] Barrier methods that prevent the natural flow of intercourse, such as condoms and some diaphragms, also are not allowed due to the prohibition against "wasting seed" because sperm would not make its way all the way into the vaginal canal with a barrier method in place. All forms of sterilization, both vasectomy and tubal ligation, are forbidden due to the prohibition of castration and the nonreversible nature of these interventions.

Hormonal contraceptive methods do not waste sperm and do not interrupt the flow of normal intercourse, so these are permissible according to the simplest explanation of Orthodox Jewish law.[12] However, some hormonal contraceptive options are preferable based on their bleeding profiles and prompt return to fertility following cessation of the method. In general, methods that lend themselves to increased unscheduled bleeding or spotting create issues in the realm of niddah practices, which can cause emotional strain on the relationship between husband and wife.[9]

Combined oral contraceptives, especially those formulations with greater than 20 µg of the estrogen component, have a low unscheduled bleeding profile after the first 3 months of use.[13] Those which allow for continuous dosing and fewer or no bleeding days may be popular among Orthodox Jewish women who would like to decrease scheduled bleeding, decreasing overall time spent in her niddah state. Contraceptive vaginal rings and transdermal patches are permissible under Orthodox Jewish law. The progestin-only implant as well as levonorgestrel-intrauterine devices are permissible. There may be some spotting and light bleeding during the first several months of use but then often these methods cause amenorrhea. It is important with any of the hormonal methods to review the potential for unscheduled bleeding or spotting especially in the first few months of use so couples have the information they need to make informed choices that will work for them. On cessation of any of these methods, the couple is likely to have a return to prior fertility within a couple of months. The copper intrauterine device is also an acceptable option with a quick return to prior fertility when discontinued. Unscheduled bleeding and spotting are less likely with this nonhormonal method, but some individuals do experience heavier and longer bleeding with menses, especially in the first few months of use.[13] Nonsteroidal anti-inflammatory drugs when taken around the clock at the time of monthly menses have been shown to lighten the overall menstrual flow.

Abnormal uterine bleeding

Sarah is now 42 years old. She is a happily married mom of five, juggling a full-time job, kid's school schedules, dinner prep, and laundry that seems to never end. She comes to the office for her well-woman exam. She tells the clinician she is not currently using any contraception and a pregnancy would be okay. Then she says "But my periods are getting all weird. I have bleeding that seems to never be predictable anymore. I'll bleed for a couple days, think I am done, start my 7 days of checking myself so I can go to the mikvah, and then on day 6, I'll see bleeding again and have to start all over. I haven't been able to be intimate in a few months now, since I just can't get 7 clean days in a row. Is this what I should expect with menopause?"

Abnormal uterine bleeding (AUB) is the term used to describe a range of symptoms such as heavy menstrual bleeding, intermenstrual bleeding, and a combination of both heavy and prolonged menstrual bleeding.[14] AUB affects up to 14% of women in their reproductive years. The clinician will conduct a thorough diagnostic workup with history, physical examination, and laboratory and diagnostic tests to identify the cause and determine appropriate treatment. The treatment for every cause of AUB is beyond the scope of this article. The clinician taking care of the Orthodox Jewish patient should understand the emotional strain that unpredictable bleeding causing prolonged and frequent states of niddah can have on a couple. A few practical considerations are suggested in the literature.

Only blood that is shed from the uterine lining causes prohibitions associated with niddah to go into

effect.[15] If the patient is having postcoital spotting or bleeding, an examination may reveal the cause to be a friable cervix. The cause should be investigated, but because this is not from the uterine lining, it does not render her niddah. If the cervix bleeds a little with the speculum exam, the clinician can explain the nature of the bleeding and that any spotting experienced later that day is cervical and not from the uterine lining. If possible, invasive uterine diagnostic procedures can be scheduled close to the time of expected menses so that post-procedure bleeding or spotting does not shorten her state of mikvah.[16]

In the absence of pathology, a high-dose progesterone-only derivative (eg, norethindrone acetate) may be effective to regulate bleeding and minimize unpredictability.[14] If the patient desires contraception, COCs can be an option for cycle control.

Implications for practice

Such a scenario as depicted here has occurred in clinical settings around the world for decades. Couples who observe the Orthodox tradition of Judaism know there are a set of laws involving the menstrual cycle and permitted sexual intimacy. Clinicians may not understand all of the nuances of niddah and mikvah. They can provide an environment that allows the patient to feel comfortable sharing important details about menstruation that go beyond physiology to encompass the emotional, cultural, sexual, and social constructs of their lives. They can provide respectful care that is responsive to each patient's values, needs, and preferences. There are limited studies to provide evidence for the best strategies to address these issues relevant to the Orthodox Jewish population. Clinicians do have evidence for the management of menstrual bleeding, regulating the timing of ovulation, providing contraception, and managing abnormal uterine bleeding. Engaging with patients to understand what matters to them and providing information on treatment options respectful of their values, needs, and preferences facilitates shared decision making that is meaningful and valuable to the patient. ■

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