THE USE OF HORMONE REPLACEMENT THERAPY AND MENOPAUSAL HEALTH NEEDS OF WOMEN IN TAIWAN

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Abstract

The use of hormone replacement therapy (HRT) has been surrounded by controversy regarding drug safety and to what extent it meets the health needs of menopausal women. HRT became the prevailing treatment in Western medicine for women with menopause-associated complaints, but a huge worldwide reduction in use began in July, 2002, following the release of the Women’s Health Initiative (WHI) reports warning of its risks. The implications of this large reduction on the health needs of menopausal women have not been fully appraised, particularly from the perspective of the women affected. This brings into question whether HRT use actually meets the health needs of menopausal women, and, indeed, what their health needs are.

This study investigates the use of HRT by middle-aged women in Taiwan and their menopausal health needs in order to identify these and recommend comprehensive strategies to promote women’s health and well-being. A broad and in-depth exploration of Taiwanese menopausal women’s health needs has been carried out using both quantitative and qualitative methods. As well as examining the allocation and efficiency of health resources associated with menopausal health, it presents and analyses the perspectives of the principal stakeholders of HRT use: women, doctors, health policy decision-makers, women’s health activists and researchers.

The study found that menopausal women in Taiwan have significant health needs. In each month of the study period (2000–2004 inclusive), over 60% of the middle-aged women insured with the National Health Insurance (NHI) Scheme utilised NHI-subsidised medical services. Moreover, these women frequently consulted doctors and medical specialists in different fields, indicating that they also had unmet health needs.

By 2004, a mere 5% of women adhered to three or more courses of HRT. The consistent proportion of ambivalent users—those only prescribed between three and five courses a year—over the study period also indicates unmet needs among women who, after being prescribed and taking HRT, discontinued its use, because of the WHI reports or for other unspecified reasons. The rising percentage of traditional Chinese medicine consultations and the concurrent fall in the percentage of gynaecology consultations implies a reluctance or even a resistance to HRT.
National HRT medication costs experienced a significant decrease after the WHI trials, a decrease which continued until 2008. The NHI expenditure on HRT medication in 2004 for the resistant users—those only prescribed one or two courses—was three times the Bureau of Health Promotion budget for all other menopausal health programmes in the same year and over six to eight times the budgeted figures in the years after 2004. This reflects an inefficient allocation of valuable and limited health resources.

The study presents its findings of the perspectives of the interviewed women, doctors and experts on women’s health, women’s health activists, and government policy makers regarding menopausal women’s health needs. The key findings regarding the menopausal health needs of middle-age women in Taiwan can be summed up in six points: (1) they seek clarifying information to ease worries and uncertainties about menopausal symptoms, and their health; (2) they want effective solutions to deal with menopausal distress; (3) the majority prefer natural regimes to HRT; (4) many are concerned with issues relating to their quality of life resulting from ageing; (5) most want to access to impartial information about their health and related issues, such as medication risks and effectiveness; and (6) social support to help them go through the transition associated with menopausal distress and midlife turmoil.

There is a significant gap between the ‘supply’ and ‘demand’ sides of menopausal healthcare: women and doctors have different priorities regarding menopausal health concerns. Doctors see the prevention of chronic disease as a priority of health services for menopausal women, in contrast to the priorities reflected in women’s seeking medical help primarily for irregular menstruation, vasomotor symptoms, vaginal dryness, and insomnia. The gaps between healthcare provision and women’s menopausal health needs are significantly due to providers and decision-makers delivering NHI healthcare services without an adequate understanding of women’s healthcare needs and preferences.

The study found that women became more concerned about the risks of taking medication but their wanting information about alternative health care and preventive health regimes was rarely catered to during clinic encounters. This study recommends that the health sector must work in collaboration with other relevant sectors: to promote healthy ageing in general; to develop policy and programs that provide menopausal women greater access to information, networking, resources and decision making; and finally, to improve
communications between service providers and women in order to provide appropriate and efficient healthcare services.

This study has comprehensively analysed Taiwanese women’s menopausal health needs and added another dimension to the current debate regarding HRT use by middle-aged women. It argues against routine and indiscriminate prescription of HRT and goes beyond examining the dichotomy between bio-medical and ‘natural’ approaches to include an assessment of HRT related public health resource allocations and their efficiency. More importantly, its analysis of the gap between women’s health needs and health care provision encompasses examining these from the perspectives of the users, the providers and relevant stakeholders. This study will thereby contribute to the still ongoing debate in the international literature on the use of HRT. Moreover, it provides evidence demonstrating the importance of adopting a needs-based, women-centred, holistic health promotion approach to promoting the health and well-being of menopausal women. In the context of a rapidly greying world with an increasing trend toward medicalising ageing, this study points to a viable more gender sensitive and sustainable model for the future.

**Key words:** Hormone replacement therapy, Menopause, Needs assessment, Health promotion, Taiwan
Statement of Originality

This work has not previously been submitted for a degree or diploma in any university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

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Chapter 1

Introduction

The use of hormone replacement therapy (HRT) has been surrounded by controversy about the safety of the drugs used and related menopausal health issues. Viewpoints about menopause are polarised: medical doctors and pharmaceutical companies regard menopause as an endocrine deficiency disease for which HRT is the dominant treatment. The other viewpoint, held by women’s health activists with feminist perspectives,\(^1\) is to consider menopause a natural part of the ageing process women undergo.

There was a significant reduction in the use of HRT following the release of the Women’s Health Initiative (WHI) reports in the USA. The WHI study terminated a trial of combined oestrogen-progestin for healthy menopausal women and indicated that its risks outweighed benefits. It came as a shock to doctors and millions of women when the first report WHI report was released in the July 2002 issue of the Journal of the American Medical Association. Consequently, the use of HRT and the market share of the relevant pharmaceutical products declined globally. Few studies, however, have discussed the implications of this large reduction on health needs of menopausal women, particularly from the perspective of the women affected.

The controversy and the drop in HRT use outlined above were mirrored in Taiwan. It is timely to examine more closely the reasons behind and experience of Taiwanese women’s use of HRT. Furthermore, it is possible to examine public health resource allocations spent on HRT in Taiwan and the efficiency of this expenditure as the Taiwanese government maintains a database containing the National Health Insurance registration files and original claim data for reimbursements, which are accessible to scientists for research purposes.\(^2\) This study will use material from this database to examine the national pattern of HRT use among mid-life women in Taiwan. It will also investigate and canvass the opinions of stakeholders, in particular those of middle-aged women, to identify their met and unmet menopausal health

\(^1\) See details in Chapter 2
needs. Based on this, it will then recommend appropriate strategies to promote menopausal women’s health.

1.1 Background

This chapter provides an overview of the thesis. This section first presents brief background information about the controversy and arguments surrounding both the use of HRT and menopausal health, the impact of the WHI reports, and the experience in Taiwan. It also explains the concept of ‘needs assessment’, an essential element of the approach to promoting women’s menopausal health and well-being which this study adopts. Based on the rationale this establishes, this section then introduces the objectives and methodology, and the scope and structure of the thesis.

1.1.1 Controversy surrounding HRT Use and Menopausal Health

Menopausal health has become a significant political issue as the population of female post-World War II baby boomers have reached midlife, and their life expectancy has continued to increase. Menopause is the cessation of menstruation and of the functioning of the ovaries. A predominantly biomedical approach within healthcare services has viewed menopause as an oestrogen deficiency syndrome and a risk factor for heart disease and osteoporosis (National Cancer Institute, 2003).

HRT has developed into a prevailing treatment to relieve women’s menopausal symptoms and menstrual disorders. This healthcare technology earned enthusiastic approval from the doctors who prescribed it³ and was favourably reviewed from the 1960s.⁴ Those who support HRT advocated it not only to be administered to alleviate symptoms but also promoted it for menopausal women for long-term preventive use to combat heart disease and osteoporosis, and to improve women’s quality of life in these transition years (Seaman, 2003). There has been a dramatic global expansion in the medical marketing of HRT since the 1990s (Watkins, 2007).

Those opposed to HRT emphasise that the menopausal transition is a natural phenomenon for women and that their ‘menopausal predicament’ is complex,

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³ In February 1943 the Journal of Clinical Endocrinology published four separate studies of the clinical use of Premarin.
resulting from multiple factors challenging midlife women. They refute the view of regarding menopause as a disease, or as a risk factor for chronic diseases. They point out the variety of self-reported menopausal symptoms among different ethnicities and cultures, and the iatrogenic\(^5\) diseases caused by HRT use, as well as the conflicts of interest embodied in the medicalisation of menopause. They strongly query uniformly prescribing HRT for menopausal women and point out that the priority should be to improve women’s health in general, including during menopause (Naughton, Jones, & Shumaker, 2005).

1.1.2 The Impact of the WHI Reports

The Women’s Health Initiative (WHI) was the first placebo-controlled, randomised clinical trial to assess the risks and benefits of the preventive administration of HRT to healthy women for primary care. The combination oestrogen-progesterone arm of the trial was halted in early July 2002 after an average 5.2 years of follow-up; the other arm, the administration of oestrogen-only, was halted at the end of February 2004 after an average 7 years of follow-up. Both regimes were halted prior to the originally scheduled timeline because the risks exceeded the benefits: cardiovascular disease (CHD), breast cancer, strokes, and the incidence of blood clots in legs and lungs increased in women who used the combination oestrogen-progesterone. No effects were found on the incidence of cardiovascular disease (the primary endpoint) in women who had undergone a hysterectomy who participated in the oestrogen-only arm of the study (Writing Group for the Women's Health Initiative Investigators, 2002; The Women's Health Initiative Steering Committee, 2004).

The WHI study, which revealed the risks associated with HRT, heightened the controversy surrounding its use and sparked a substantial drop in the use of HRT all around the world. Women and their doctors were confused by what had happened: such a promising medication had turned into a health threat. The reduction of HRT use involved a shaking of beliefs shared by both doctors and women.

This reduction had implications related to the unmet needs of those who had been prescribed HRT but stopped using it because of the WHI reports, particularly

\(^5\) Unfavourable responses induced by the treatment itself (Stedman’s Medical Dictionary, 6th ed. 2008)
women who suffered from menopausal distress but who had no alternative plan to follow after they discontinued HRT. There were also implications for the practices of some doctors who had routinely prescribed HRT, sometimes for women whose menopausal health needs did not necessarily call for it.

1.1.3 The experience in Taiwan

Epidemiological research into menopause in Taiwan has had the same focus as international research, with an emphasis upon the symptoms and the consequences for endometrial and breast cancer, cardiovascular disease, and osteoporosis. On the other hand, local qualitative studies have revealed that many women in Taiwan perceive menopause as a natural phenomenon and part of the life process. They seek help from doctors in a wide range of areas of medical specialisation, Western and traditional Chinese medicine, to relieve their menopausal discomforts (Tsao, 2002).

Low economic barriers and easy access to medical facilities has resulted in a high rate of healthcare use in Taiwan since the compulsory social health insurance scheme, the National Health Insurance, was introduced in 1995. Utilisation surveys indicate that women experiencing menopausal symptom primarily sought medical help and they were usually prescribed HRT (Lin Yu-Xuan 林宇旋, Chang Xing-Zhen 張幸真 & Chen Zi-Ling 陳姿伶, 2004). Most women, however, discontinued HRT autonomously and the adherence rate was low (Chen Ching-Min 陳靜敏, Ho Mei-Hua 何美華 & Chien Yi-Yi 簡逸毅, 2000). Women prescribed HRT in Taiwan have not been well informed about its risks and benefits by doctors, and women’s health activists have strongly argued that the system neglected women’s health care quality and that menopausal women’s health is a major issue in need of change in policy (Chang Chueh 張珏, 2003).

After the release of the WHI report, there was a sharp drop in the prescription of HRT for menopausal women in Taiwan, but their rate of seeking medical treatment still remained high (Wu, Wu, Lin & Chu, 2011). In Taiwan the discourse on menopause was contested—conflicting positions and views regarding menopause and the medicalising of menopause were held mainly by gynaecologists and by women’s health activists. The high utilisation of medical services by middle-aged women and

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6 Discussed further in Chapter 3
the intensity of the debate surrounding menopausal health between doctors and activists separately reflect the significance and still unresolved nature of this health issue.

1.1.4 Need for Comprehensive Assessment of Menopausal Health Needs

Middle-aged women’s needs for healthcare, met and unmet, and the unmet needs which arose as a result of the WHI reports have still not been comprehensively examined, particularly in a way that takes into account women’s own experience. Medical studies have tended to focus on medical professionals’ views, and overlooked women’s views of their menopause-related needs. Many have focused on the low rate of patient adherence to HRT regimens but few have focused on women’s experience of HRT. Moreover, little examination has been made of the efficiency of allocation of public health resources to HRT-related expenditure in the promotion of women’s health. Women’s health activists strongly defend menopause as being a completely normal natural phenomenon and women’s autonomy (Seaman, 2003); but the activists do not necessarily completely reflect women’s actual voices, particularly regarding the help-seeking behaviours related to their menopausal health needs.

1.2 Aims and Conceptual Framework of the Study

The aim of this study is to identify the health needs of menopausal women in Taiwan in the light of an analysis of the significant reduction in HRT utilisation after the WHI reports, as discussed by women and other stakeholders. The fundamental concern of this thesis can be distilled into a single question: ‘Does the use of HRT meet the health needs of menopausal women in Taiwan?’ The associated aims of this study are to:

(1) examine the utilisation pattern of HRT and healthcare provision in Taiwan;

(2) investigate the health needs of menopausal women in Taiwan from different perspectives;

(3) identify unmet needs and gaps in healthcare provision and policy; and then

(4) recommend strategies for promoting menopausal health in Taiwan.
Figure 1.1 presents the conceptual framework, illustrating the central research question and associated aims.

**Figure 1.1 Conceptual framework of this research**

1.3 Methodology

A critical literature review will examine the international and local controversy and debate surrounding HRT use, and the literature on menopausal health from various perspectives: biomedical, social-cultural, and feminist. This constitutes the background and context of this research.

A comprehensive needs assessment approach has been adopted to tackle the complexity of menopause. This study assesses the health needs of middle-aged Taiwanese women based on the approach of the ‘four types of social needs’ described by Bradshaw (1972)—namely: comparative, expressed, felt and normative needs—
using both quantitative and qualitative methods. The quantitative method is employed to investigate Taiwan’s national utilisation of healthcare services related to HRT and menopause, and HRT-related costs. The qualitative method is employed to examine women’s associated health needs as defined by women, doctors, health decision-makers and experts in women’s health.

The gaps between the provision of health services and the health needs of menopausal women in Taiwan are investigated using a multidisciplinary approach based on the concept of health embodied in the philosophy and theory of health promotion. Such an approach facilitates stakeholders’ substantive participation and involvement in the decision-making processes and provides information vital to effective planning, which helps to prevent costly mistakes. This study then makes recommendations about action that can be taken in both the public and private sectors to promote the health of menopausal women in Taiwan. The recommendations presented circumvent the mutually adversarial approach historically taken by biomedical professionals and feminist activists.

1.4 Scope of the Study

The focus of this thesis is an examination of menopausal women’s health needs by using a needs assessment approach (as described by Robinson & Elkan, 1996), and health promotion principles (described by Davies & Macdowall, 2006). It reviews the contexts of the HRT debates, the factors associated with HRT use and its prevalence. It examines HRT utilisation patterns and related costs, and the proportion of HRT use-related compared to other menopause-related public health resource allocations, and its efficiency. This is complemented by a comprehensive examination of the multiple aspects of menopausal health needs. It does not address the nature of menopause and disease, does not assess HRT as a health technology or undertake a cost-benefit analysis of HRT, nor does it examine the effectiveness of traditional Chinese medicine on menopause.

1.5 Structure of the Thesis

This thesis consists of eleven chapters: this introductory chapter, nine chapters forming the main body which are divided into two sections, and a conclusion chapter.
Section 1, consisting of Chapters 2 to 5, elaborates the background, rationale and methodology of the study. Chapter 2 discusses the controversy surrounding menopause and HRT and presents a review of the international literature. It presents the views of the various stakeholders in the menopausal health arena and discusses the importance of developing comprehensive menopause-related health promotion.

Chapter 3 discusses how menopause related issues have played out in Taiwan, after first introducing Taiwan’s healthcare system. In particular, it looks at differing local views of menopause, and local arguments surrounding the use of HRT and menopausal health provision.

Chapter 4 examines the medicalisation of menopause from feminist perspectives, and the theories behind and evidence pertaining to health promotion related to menopause. It underscores the necessity for needs assessment to bridge the gaps between the existing knowledge and health services available catering to menopausal women and their health.

Chapter 5 discusses the theoretical and conceptual framework of this study then describes the methodology used to collect the quantitative and the qualitative data, used in Section 2, and how the resulting data was analysed. Confidentiality and sensitivity aspects, and the issues of rigours and limitations are all discussed.

Section 2, Chapters 6 to 10, presents the analytical and fieldwork research undertaken to address the aims of this study employing both quantitative and qualitative methods. It has two distinct parts. Part 1, consisting of Chapter 6 and Chapter 7, presents a quantitative analysis of HRT use in Taiwan and its costs to Taiwan’s National Health Insurance (NHI) program. Chapter 6 examines the changes in the patterns of the prescription of HRT and of NHI-reimbursed consultations made by middle-aged women with a recorded diagnosis of menopausal syndrome, before and after the halting of the WHI study. Chapter 7 investigates the financial costs of HRT use, and the budget allocations for menopausal health programmes put in place by Taiwan’s government. Allocation efficiency is evaluated by comparing expenditure on menopausal health, incorporating some of the findings of the secondary data analysis presented in Chapter 6.
Part 2, consisting of Chapter 8, 9 and Chapter 10, presents a qualitative exploration of multiple aspects of menopausal women’s health needs: Chapter 8 from the perspective of middle-aged women, Chapter 9 from the perspective of doctors working in a range of fields, and Chapter 10 from that of experts on women’s health and women’s health issues. The gaps between the health needs of menopausal women in Taiwan and what is currently available are identified by comparing and contrasting the needs delineated by menopausal health stakeholders—clients, providers, and neutral parties—in Part 2.

The concluding chapter discusses the different perceptions of menopausal health needs and of HRT held by various stakeholders. It gives an overall appraisal of the unmet health needs of women undergoing menopause, using a health promotion framework, and recommends appropriate strategies and solutions to improve women’s health and well-being at this time of their lives.

The next chapter will discuss the international controversy surrounding HRT use and a range of views regarding menopausal health.
Chapter 2
Controversy surrounding HRT Use and Menopausal Health

HRT use and menopausal health have been surrounded by controversies, but the arguments have been scattered through biomedical and social science journals and there has been a lack of any systematic review. This and the following two chapters will review both the international and the Taiwanese literature and then indicate the importance of developing comprehensive menopause-related health promotion appropriate to Taiwan. This chapter reviews three separate areas of the literature: relating to menopause, hormone replacement therapy (HRT), and issues that have arisen about HRT use for relief of menopause symptoms. The first part summarises the multidisciplinary research undertaken on menopausal health and examines various menopausal health issues. The second part outlines the development of HRT, including the debate over its application. The third part presents the arguments surrounding menopausal health and the use of HRT from a wider global view.

2.1 Menopause and Women's Health

Menopause is a part of life experienced at the individual level by women, one which raises global issues for women collectively. This section gives a definition of menopause and information about the demographics of menopausal women worldwide and their health issues.

The World Health Organisation defines *menopause, or natural menopause* as ‘the biological event signalled by the cessation of menstruation for 12 consecutive months due to loss of ovarian follicular activity, for which there is no other obvious pathological or physiological cause. Peri-menopause is the period immediately prior to menopause (when the endocrinological, biological and clinical features of approaching menopause commence) and the first year after menopause. Pre-menopause encompasses the entire reproductive period up to the final menstrual period which generally occurs at approximately 50 years of age. Post-menopause is
defined as dating from the final menstrual period, regardless of whether the menopause was induced or spontaneous’ (WHO, 1996). The International Menopause Society (IMS) identifies the *climacteric* as referring to ‘the phase in the aging of women marking the transition from the reproductive phase to the non-reproductive state’ (Utian, 1999). This phase is more individually variable, extending from before the peri-menopause, through both peri-menopause and menopause, and beyond post-menopause.

Age at menopause has some cross-regional variation: it is likely to be higher, around the early fifties, in the industrialised countries than in the developing world, where it is around the late forties (Hill, 1996). Taking age 50 as a proxy for menopause, approximately 25 million women worldwide reach menopause each year. In 1990, the number of women aged 50 and above was close to 10% of the world’s population and was projected to increase to 14% by the year 2030. In that same year, Canada, the United States, Japan, Australia, New Zealand and Western Europe together had 27% of the world’s post-menopausal women. In 2030, China is expected to have the largest single number of post-menopausal women, with 23% of the world total. In 1990, post-menopausal women typically made up 5-8% of the total population (male and female) of countries in the developing world but over 15% in the industrialised world. By 2030, the percentage rises in India, China, other Asian countries and Latin America will roughly double, to approximately 14%, while increasing more quickly within the industrialised countries to almost 24% of the total population (Hill, 1996).

The increasing number of post-menopausal women and also their extended life expectancy will make the climacteric a more significant healthcare issue. Women today in the industrialised countries are living more than one third of their life after menopause, and women in many developing countries are experiencing similar physiological implications of menopause because their lifespan is lengthening. In

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7 These countries represent the Established Market Economics (EME) region used in the 1993 World Development Report, cited by Hill in 1996. These are the countries referred to as ‘the industrialised countries’ in this thesis.
8 The ‘developing countries’ are those countries not in the EME region, ibid.
9 Other Asia and Islands (OAI): This refers to all of Asia, excluding India, China, Japan, the republics of the former Soviet Union, and the Middle East as far east as Pakistan, plus all of Oceania excluding Australia and New Zealand, ibid.
10 Latin America (LAC): The Americas and the Caribbean, excluding Canada and the United States, ibid.
addition, women, doctors and researchers have recognised menopause as having a much longer time span – of up to 10 years – during which there is a complex transition involving biological, psychological, social, and cultural factors (Dennerstein, 1999; Kaufert, 1996).

Biomedical research has outweighed other research efforts in the fields of psychology, anthropology, and cross-cultural comparisons in defining menopause and developing etiological theory (Berger, 1996; Bieman, 2003). From the biomedical perspective, one which mainly emphasises biological and chemical factors, the climacteric is the time when a woman’s ovaries gradually produce lower oestrogen and progestogen. During this period, a woman may experience vasomotor symptoms (hot flushes or night sweats), insomnia, and urogenital symptoms (vaginal dryness or difficulties with intercourse). Those symptoms will be induced immediately and experienced more severely by those who undergo hysterectomy. Furthermore, it is suggested that deficiency of oestrogen and progestogen affect both morbidity and mortality in post-menopausal women. Osteoporosis and coronary heart disease, for example, are more common for women in the decades after menopause in the USA (National Cancer Institute, 2003). This hypothesis is based on the mortality advantage which women have over men aged in their 40s and 50s. Once their level of oestrogen and progestogen drops after menopause, women’s mortality risks rise again to levels similar to those of males (Hill, 1996; Meyer, 2001; Banks, 2002). Hormone therapy was therefore promoted to provide obvious relief from transitional symptoms of menopause and advocated as a means of combating osteoporosis and reducing the risk of heart disease as long-term benefits (Stampfer & Colditz, 1991; Grady et al., 1992; Barrett-Connor, 1998).

Epidemiological studies have suggested that there are other important variables, apart from sex hormone fluctuation, contributing to a variety of symptoms in the menopausal stage, variables such as age, race, body-mass index (BMI), life events, and a history of depression (Nelson et al., 2005). Studies of the aetiology of endocrine deficiency have provided evidence of a variety of risk factors leading to osteoporosis, cardiovascular conditions, and mental illness among post-menopausal women. The osteoporosis-related factors include age, Caucasian ethnicity, low weight or weight loss, a history of previous fracture, family history of fracture, a history of falls, low
calcium intake, lack of physical exercise, and smoking (Agency for Healthcare Research and Quality, 2001). Other major risk factors for heart disease—risk factors shared by women and men—are obesity, smoking, hypertension, sedentary lifestyle, and dyslipidemia. Natural menopausal transition is not necessarily associated with an increase in depressive illness in post-menopausal women, but prior depression is a predictive variable for depression (Dennerstein, 1996; Perez, Pinar & Hernandez-Aguado, 1997; Kuh, Hardy, Rodgers & Wadsworth, 2002; Amore et al., 2004). Yet another complaint amongst menopausal women is sleep disturbance: associated with more psychological distress, higher blood pressure and a higher waist/hip ratio than those who did not report trouble sleeping (Owens & Matthews, 1998). In particular, factors identified as associated with psychological distress are: negative attitudes towards menopause and ageing, health status, life stress, absence of social support, and surgical interventions (Dennerstein, 1996; Perez et al., 1997; Deeks, 2003).

Overall, comparison studies of different ethnic groups indicate that differences in menopausal symptom reporting are real and they highlight the importance of both biological variation and cultural differences contributing to the menopausal transition. How biology and culture interact in female ageing is an important direction for future research (Melby, Lock & Kaufert, 2005).

### 2.2 Hormone Replacement Therapy

As mentioned above, hormone therapy was promoted as relieving women from the transitional symptoms of menopause, based on the rationale that the symptoms arose from an endocrine deficiency. This section reviews the development of HRT—mainly in the USA where it became established as one of the most popular regimens—its demonstrated efficacy, and widespread adoption.

The history of menopause treatment can be traced to the 1899 *Merck Manual* 12, which described a product made from the powdered ovaries of cows being used to ease women’s symptoms at the climacteric (Seaman, 2003). In 1929, Edward A Doisy first isolated a sample of pure crystalline oestrogen from the urine of pregnant women.

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11. The prevalence of heart disease is greater in men than in women at any age, but more women die from heart disease than men because of their extended life expectancy (Institute of Medicine, 2001; Meyer, 2001)

12. The *Merck Manual* is a contemporary standard medical textbook, which was originated by the pharmaceutical company Merck & Co., in 1889 (Lane & Berkow, 1999)
In 1934, he was awarded two patents on the processes and products of obtaining the crystallised hormone in a form sufficiently concentrated and free of odour to be used as a therapeutic agent. A laboratory synthesis of oestrogen in Pennsylvania was reported by *Time* and *Newsweek* in 1936. The synthetic diethylstilbestrol (DES) and natural conjugated oestrogens have been available for more than 70 years in the United States of America since the 1930s when drug companies in both Europe and North America significantly commercialised various oestrogen products and put them onto the market (Watkins, 2007).

In 1941, the Food and Drug Administration (hereafter abbreviated to ‘FDA’) approved the use of stilbestrol, a synthetic hormone, for the treatment of menopausal symptoms and menstrual disorders. *Premarin* (PREgnant MAre urINe) was first developed and marketed by Wyeth-Ayerst in 1942 and became the most common oral hormone preparation used by postmenopausal women in the USA (Vance, 2007). Symptom relief is the primary indication for which oestrogen therapy was approved. It remained the most frequent reason for use in peri-menopausal women and was routinely given to the majority of women who underwent a hysterectomy (National Institute on Ageing, 2009). Little, however, was known about appropriate dosages, or potential short- and long-term risks and benefits, although studies in the early 1940s suggested that oestrogen induced mammary cancer in mice.13

Nevertheless, despite the scant research evidence about the treatment, during the 1950s and 1960s oestrogen therapy began to be marketed as a way for women to retain their youthful appearance and stave off the effects of the ageing process. After Wilson’s *Feminine Forever* (1966) first portrayed menopause as a deficiency disease, he was widely quoted during the 1960s and early 1970s, leading to the increased popularity of oestrogen treatment to alleviate menopausal symptoms and to restore women’s vitality and femininity (Banks, 2002; Krueger, 2004; Naughton, Jones & Shumaker, 2005).

Doctors began to notice a rise in endometrial cancer as the use of oestrogen therapy increased in the 1970s. Two articles published by the *New England Journal of

Medicine in 1976\textsuperscript{14} clearly identified an increased risk and there was a subsequent transient decline in oestrogen use (Krueger, 2004). This decline continued until progestin was demonstrated to protect against endometrial cancer\textsuperscript{15}, and hormone therapy regained popularity (Naughton et al., 2005). By the mid-1980s, preparations combining lower doses of oestrogen with progestogen were introduced into the market for women who had not undergone a hysterectomy but chose to use oestrogen. Prescription of HRT began to rise again, in two different forms: oestrogen alone for women without a uterus, and oestrogen plus progesterone for women who had not undergone a hysterectomy (Naughton et al., 2005; Vance, 2007).

During the 1970s and 1980s, industry and other researchers began to investigate other benefits of hormone therapy, beyond the alleviation of menopausal symptoms. Cumulative data from different studies\textsuperscript{16} supported the benefits of HRT for the prevention of bone loss, and in the 1990s the FDA approved the use of HRT for the prevention and treatment of osteoporosis. Other findings also began to suggest the potential role that oestrogen might play in the heart disease and dementia risk profiles of post-menopausal women. As a consequence, observational studies (both cross sectional and longitudinal) which explored the relationships between prior hormone use and heart disease and dementia began to appear. These studies, coupled with animal testing, for the most part provided support for the hypothesis that HRT might prevent and slow the progression of heart disease and dementia (Banks, 2002; Naughton et al., 2005).

There was a marked rise in the promotion of HRT for use by all menopausal women during the late ‘80s and into the ‘90s. Many doctors began to believe that


\textsuperscript{16}Christiansen C, Christensen MS, Transbol I: Bone mass in postmenopausal women after withdrawal of oestrogen/gestagen replacement therapy, Lancet, 1 (8218), 459-61, 1981

- Quigley MET, Martin PL, Burnier AM, Brooks P: Estrogen therapy arrests bone loss in elderly women, American Journal of Obstetrics and Gynecology, 156 (6), 1516-23, 1987
post-menopausal women should initiate HRT at the climacteric and remain long-term users in order to provide protection from heart disease, dementia, and osteoporosis (Stampfer & Colditz, 1991; Grady et al., 1992). As a result, HRT was strongly advocated by doctors and pharmaceutical companies and was one of the most commonly prescribed drugs in the United States—although prescription of HRT for the primary and secondary prevention of heart disease had not been approved by the FDA—and there was a booming market in various hormone formulations and delivery systems, such as transdermal, vaginal ring, SERMs (selective oestrogen receptor modulators) from 2001 (Krueger, 2004; Worcester, 2004; Naughton et al., 2005).

This trend was interrupted in 2002 by the findings of the Women’s Health Initiative study (WHI) which was then the largest hormone therapy clinical trial on women undertaken. It found an increased risk of breast cancer, dementia, heart attack, and strokes in women taking combination hormone therapy (oestrogen plus progestogen), and an increased risk of strokes in women taking oestrogen alone. The FDA subsequently reinforced and maintained the initial indications for combination oestrogen plus progestogen HRT in 2003. HRT is currently recommended only for the treatment of peri- and post-menopausal symptoms. Further, women and their doctors are encouraged to use the lowest dose for the shortest period of time to address such symptoms (Rossouw, Anderson, Prentice, LaCroix et al., 2002; Manson, Hsia, Johnson & Rossouw, 2003; Anderson et al., 2004; Worcester, 2004; Naughton et al., 2005).

HRT become commonly used in different countries, and with the exception of the US experience in the 1970s, the trend has been towards increasing use (Hemminki & Topo, 1997). In general, the use of HRT was high in North America, Western and Northern Europe, and Australia, but low in Central, Eastern and Southern Europe and China (Lundberg, Tolonen, Stegmayr, Kuulasmaa & Asplund, 2004). In the USA, for example, the rate of HRT use increased very rapidly during the 1990s, and reached a peak of approximately 42% of women aged 50–74 years in 2001 (Hersh, Stefanick & Stafford, 2004). Most prescriptions were of oestrogen alone for surgical menopause. Prescription of a combination of oestrogen plus progestin for women with intact uterus increased more significantly after 1995 (Keating et al., 1999; Brett & Reuven,
Similar trends occurred in Sweden, Australia, the UK, France, Norway, Denmark and Switzerland, where the community rate of HRT use reached from 30% to 40% between the late 1990s and 2000 (Oddens & Boulet, 1997; Schaad, Bonjour & Rizzoli, 2000; Bakken, Eggen & Lund, 2001; Banks, 2002; Bromley, de Vries, & Farmer, 2004; Thunell, Stadberg, Milsom & Mattsson, 2005; Taylor, MacLennan & Avery, 2006). These rises were interrupted in the 2000s. The use rate and prescription rate dropped dramatically after the 2002 WHI report. By 2004 these rates had decreased to around half their preceding popularity, mostly those of combined oestrogen-progestin (Strothmann & Schneider, 2003; Bromley et al., 2004; Hing & Brett, 2004; Main & Robinson, 2008).

Predisposing factors related to HRT use are: having a higher education level, undergoing a hysterectomy, a lower body mass index, doing more exercise, having more access to healthcare or gynaecologists, residing in the south or west regions of the USA, being Caucasian, and former use of oral contraceptives (Johannes, Crawford, Posner & McKinlay, 1994; Rosenberg, Palmer, Rao & Adams-Campbell, 1998; Keating et al., 1999; Levy, Ritchie, Smith, Gray & Zhang, 2003; Taylor et al., 2006). Women doctors were identified as having a higher rate of HRT use than menopausal women in the general population. Women users tended to be gynaecologists, younger, leaner, in good physical health, sexually active, to have no personal or family history of breast cancer, to be previous users of hormonal contraception, to have severe menopausal symptoms, to have experienced surgical menopause, and to have a family history of osteoporosis (Isaacs, Britton & McPherson, 1997; McNagny, 1997; Biglia, Cozzarella, Ponzzone & Marencio, 2004; Isaacs, Drew & McPherson, 2005).

In the late 1990s, however, studies indicated that women subsequently using HRT were already at lower cardiovascular risk before the commencement of treatment than women who remained untreated, a risk profile linked to a healthier lifestyle and behaviour (Perrson, Bergkvist, Lindgren, & Yuen, 1997; Rodstrom, Bengtsson, Lissner, & Bjorkelund, 1999). Women’s continuing to use HRT after the WHI reports was found to be related more to having undergone hysterectomy, having severe menopausal symptoms, or being encouraged to do so by doctors (Buist, LaCroix, Newton & Keenen, 1999; Barber, Margolis, Luepker & Arnett, 2004; Nress,
Poor adherence to HRT has also often been reported. Ettinger, Li, and Klein, for instance, found that approximately 40% of women did not refill their HRT prescription after the initiating therapy (1996). Various studies report figures of between that only between 28% and 42% of women completed one year of treatment (Ryan, Harrrison, Blake & Fogelman, 1992; Gavin, Thorp & ohsfeldt, 2001; Franic, Verdenik, Meden-Vrtovec & Svab, 2006). Data from a 1997 national survey showed that 45% of U.S. women born between 1897 and 1950 had used a menopausal hormone for at least one month, and 20% continued to use it for 5 or more years (National Cancer Institute, 2003). Causes of non-compliance include unpleasant side effects, a lack of doctor education, and low prevalence of acute physical symptoms.

There is a large variation in HRT use in Japan, Malaysia and southern China, which all had usage rates of less than 10% in the 1990s. This may be related to the phases of innovation diffusion of HRT and also to different perceptions of menopausal health (Ismael, 1994; Nagata, Matsushita & Shimizu, 1996). According to a report by Hemminki and Topo, the reason women in Finland used HRT was usually to treat symptoms, but doctors considered HRT also useful for the prevention of diseases. Gynaecologists had more favourable attitudes toward HRT than other doctors. This was probably due, at least in part, to various social and commercial forces: promotion of large-scale preventive medical use of HRT occurred before any systematic evaluation. Hemminki and Topo commented that one motivation behind conducting surveys on why doctors prescribe HRT or why women use it has been to facilitate HRT use (1997).

**2.3 Controversy surrounding Menopausal Health and HRT Use**

Menopause research has been taking a multidimensional approach, across many disciplines: biochemistry, psychology, healthcare, anthropology, and cross-cultural research. In biomedical studies, menopause is usually associated with biological degeneration and the onset of chronic diseases. This concept is commonly challenged by other disciplines. This section reviews the arguments raised by those who perceive...
menopause as a normal developmental phase for women and those who regard menopause as an endocrine deficiency disease.

2.3.1 Medicalisation of Menopause

Neglect of the socio-cultural significance of menopause

From the 1990s, socio-cultural studies have pointed out that most of the information on menopause came from research done in the industrialised countries. Women at the climacteric, however, experience stress very differently due to socio-culturally constructed expectations, economic powerlessness, and health problems (Kaufert, 1996; Robinson, 1996). These studies found that ageing women are likely to have more family care-giving responsibilities during the menopausal period, earn less than men during their working lives, and are more likely to be widowed or to live alone.

Menopausal symptoms vary widely between countries. North American samples reported twice as many symptoms as among Japanese women (Lock, 1998). The climacteric was experienced in a mild form in Southeast Asia, namely Hong Kong, Indonesia, Korea, Malaysia, the Philippines, Singapore and Taiwan (Boulet, Oddens, Lehert, Vemer & Visser, 1994). The prevalence of hot flushes and of night sweating was lower than in Western countries; something which may have been influenced by a range of factors, such as climate, diet, lifestyle, women’s roles, and women’s attitudes regarding the end of reproductive life and ageing (Kaufert, 1996; Obermeyer, 2000; Freeman & Sherif, 2007).

The health concepts of menopause in papers with a medical focus published in Europe and North America were inclined to be negative. These were based on a highly select group of women attending clinics and therefore likely to portray a distorted picture of midlife women (Meyer, 2001; Kowalcek, Rotte, Banz & Diedrich, 2005). Likewise, bias also occurs even in population-based studies. Women recruited from initial cohorts are often less representative of the general population or more representative of volunteers than of an entire community (Dennerstein, 1996). Most studies have been limited to focusing on menopausal symptoms, psychological distress, or attitudes toward menopause, apparently stripped of all social and cultural factors (Melby et al., 2005).
Women in developing countries did not actually report fewer symptoms than in women in industrialised countries, but the menopausal symptoms reported by the women in developing countries have different features and different frequencies (Obermeyer, 2000). The end of menstruation may, for example, be perceived as a time of freedom: freedom from the risks of childbirth and from restrictions such as cultural restrictions on their religious life\textsuperscript{17} (Kaufert, 1996; Fu, Anderson & Courtney, 2003; Kowalcek et al., 2005; Melby et al., 2005). Nonetheless, the priority for health and social service planning in developing countries remains with the needs of young and fertile women for family planning and safe motherhood, rather than the needs of women in middle age. And by the time they reach menopause, the health of women in the countries of Africa, Asia and Latin America has also been affected by chronic malnourishment (Kaufert, 1996; Reproductive Health Outlook, 2003; Tabloski, 2004).

In general, women in these countries tend to view menopause and its symptoms as a natural process that does not require medical care. At the same time, generally speaking they know less about the health issues related to menopause, the ageing process, and how to cope with their own needs effectively (Ismael, 1994; Punyahotra & Dennerstein, 1997; Berg & Taylor, 1999; Senanayake, 2000; Mashiloane, 2001; Fu et al., 2003; Kowalcek et al., 2005; Shea, 2006).

Menopause is socio-culturally significant: cross-cultural comparisons show that women in different societies report different types and/or frequencies of physical symptoms. But the global forces of medical studies have contributed to greater similarities of symptoms reported around the world (Obermeyer, 2000). Research on menopause conducted in Asia, Africa and South America has generally been modelled on and used similar questions, research designs and measures as those being used and asked in North America and Europe. In summary, the research mainly answered the questions of whether women in the developing countries experience menopause at the same age, with the same symptoms, and with the same consequences for endometrial and breast cancer, cardiovascular disease and osteoporosis as women in Canada, the United States, Australia, New Zealand, and Western Europe (Kaufert, 1996).

\textsuperscript{17} For example, Bariba women believed that menopause eliminates the polluting qualities of the female gender and thereby allows women healers to approach the prestige of respected male healers (Kaufert, 1996).
Menopause as a disease and a risk factor

More and more areas of women’s midlife have come under the influence and control of the medical domain, although medicalisation of the menopause has proceeded at an uneven pace in different parts of the world (Bell, 1990; Kaufert & Lock, 1997; Obermeyer, 2000). Dr Robert A Wilson’s 1966 book, *Feminine Forever*, funded by Ayerst Laboratories, labelled menopause as a hormone-deficiency disease. Interwoven with a long list of symptoms and descriptions of the destruction of body and mind, oestrogen replacement therapy was presented as able to help women escape ‘the horror of this living decay.’ In particular, a wave of books on women and menopause began in the late 1980s. Newspapers and magazines also created a menopausal megatrend in the 1990s. This trend added the fuel to create a booming market: millions of baby-boomer women are unwilling to accept the potential health consequences of menopause and are therefore exercising greater consumer power than ever on the pharmaceutical industries (Kaufert & Lock, 1997; Palmlund, 1997).

In the 1990s, many medical professionals urged women to consider HRT, not only as treatment for menopause, which had been labelled a hormonal deficiency disease, but also for the prevention of osteoporosis and cardiovascular disease for which menopause is a risk factor (Grady et al., 1992). On the one hand, the medical model classed oestrogen deficiency as an unnatural state and according to this model, women were wrong in believing that the menopause is a natural event (Toozs-Hobson & Cardozo, 1996). On the other hand, a number of US best-selling books18 claimed that doctors were neglecting their duties regarding middle-aged women’s health risks related to oestrogen deficiency and were ignoring treating women suffering from menopausal symptoms (Palmlund, 1997). Overall, as Palmlund indicated: ‘the social construction of menopause as a risk to women’s health and well-being has strong roots in a domain where the interests of the medical community and the pharmaceutical industry converge’ (*ibid*, 1997).

In the social construction of the climacteric, an exclusively female condition, feminists suggested a conspiracy—denoted “women take the pills, while men cash the

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bills”—in the fields of medical science and practice, fields which were exercised and dominated by males (Oudshoorn, 1997, p.140). The discourses of ‘femininity’ and ‘symptoms’ shifted toward the discourses of ‘diseases’ and ‘risk’, placing a growing burden on health services worldwide. Menopausal women were urged to take responsibility for their health. It was estimated that the use of HRT would save a national health budget several tens of millions of dollars annually by preventing cardiovascular disease, osteoporosis and other diseases (Toozs-Hobson & Cardozo, 1996; Kaufert & Lock, 1997; Murtagh & Hepworth, 2003a). Countering the interests of doctors and the drug companies, Western feminists proposed that women establish their own relationship with the nature of ageing and manage menopause as a healthy life-cycle transition. Menopause should not be considered as decay and loss, but as freedom and liberation (Richters, 1997). Apart from women taking responsibility for their own health while ageing, feminists also advocate ‘women’s choice’, ‘informed decision-making’ and ‘empowerment’ as key themes of the ethics of autonomy for women at the climacteric, beyond the use or non-use of HRT (Murtagh & Hepworth, 2003). Feminist perspectives will be further elaborated in the next chapter.

2.3.2 Uncertainty and Ethics associated with HRT Use

Arguments arising from the WHI study

The Women’s Health Initiative (WHI) was the first placebo-controlled, randomised clinical trial to assess the risks and benefits of preventive administration of HRT to healthy women for primary care. The combination oestrogen-progesterone arm of the trial was halted in early July 2002 after an average 5.2 years of follow-up; the other arm, the administration of oestrogen-only, was halted at the end of February 2004 after an average 7 years of follow-up. Both regimes were halted prior to the originally scheduled timeline because the risks exceeded the benefits (Writing Group for the Women’s Health Initiative Investigators, 2002; The Women’s Health Initiative Steering Committee, 2004).

The findings of the WHI study are summarised in Table 1. This randomised trial examining the effect of oestrogen plus progestogen on the prevention of heart disease and hip fractures in over 16,600 women, was stopped 3 years early, on advice from the study’s Data and Safety Monitoring Board (DSMB). The estimated hazard ratio
showed a 29 percent increase in cardiovascular disease (CHD), a 26 percent increase in breast cancer, a 41 percent increase in strokes, and a two-fold increase in the incidence of blood clots in legs and lungs. There was a decreased risk of bone fractures and colorectal cancer. No effects were found on the incidence of cardiovascular disease (the primary endpoint) in women who had undergone a hysterectomy who participated in the oestrogen-only arm of the study. There was an increased risk of stroke, a decreased incidence of colon cancer, and fewer hip fractures.

### Table 2.1
**Risks and Benefits of HRT – WHI study findings**

<table>
<thead>
<tr>
<th>Outcomes (Change in incidence)</th>
<th>Oestrogen + progesterone</th>
<th>Oestrogen only</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cancer:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast (invasive)</td>
<td>8 extra*</td>
<td></td>
</tr>
<tr>
<td>Endometrial</td>
<td>8 extra</td>
<td></td>
</tr>
<tr>
<td>Colorectal</td>
<td>6 fewer*</td>
<td></td>
</tr>
<tr>
<td>Ovarian</td>
<td></td>
<td>2 extra</td>
</tr>
<tr>
<td>Pulmonary embolism (PE)</td>
<td>8 extra</td>
<td></td>
</tr>
<tr>
<td><strong>Cardiovascular disease:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coronary heart disease</td>
<td>7 extra</td>
<td>12 extra</td>
</tr>
<tr>
<td>Stroke</td>
<td>8 extra</td>
<td>7 extra</td>
</tr>
<tr>
<td>Venous thromboembolism (VTE)</td>
<td>18 extra</td>
<td>7 extra</td>
</tr>
<tr>
<td>Total</td>
<td>25 extra</td>
<td>24 extra</td>
</tr>
<tr>
<td><strong>Fractures:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip</td>
<td>5 fewer</td>
<td>6 fewer</td>
</tr>
<tr>
<td>Vertebra</td>
<td>6 fewer</td>
<td>6 fewer</td>
</tr>
<tr>
<td>Other (including wrist)</td>
<td>39 fewer</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>44 fewer</td>
<td>56 fewer</td>
</tr>
<tr>
<td><strong>Cognitive function:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dementia</td>
<td>23 extra</td>
<td></td>
</tr>
<tr>
<td>Global index (total)</td>
<td>19 extra</td>
<td></td>
</tr>
</tbody>
</table>

**Unit: events per 10,000 women-years**

Source: Writing Group for the Women’s Health Initiative Investigators, 2002; The Women’s Health Initiative Steering Committee, 2004

Note: 1. The HRT regimen of oestrogen plus progesterone trial was the daily combination of oral conjugated equine oestrogen (0.625 mg) and medroxyprogesterone (2.5 mg), brand name Prempro.

2. The daily oestrogen-only HRT regimen was oral conjugated equine oestrogen (0.625 mg), trade name Premarin.
Compared to the placebo group, there were more or fewer cases of specific diseases in the trial group.

The observational data from epidemiological studies had been remarkably consistent in showing that HRT users tended to be at a lower risk of CHD than non-users, for which reason the diametrically opposed results of the WHI trials on hormone therapy and CHD have been roundly argued. Three main arguments are outlined below.

1. The women enrolled were considerably older (mean age 63 years, range 50–79) than those in early menopause; most (over 90%) had no menopausal symptoms, and a large proportion were overweight (69%) and had other additional risk factors. Critics therefore warned that these findings were not applicable to women who go on short-term hormone therapy for symptom relief at the time of menopause (Stampfer, 2004; Birkhaeuser, 2005).

2. The WHI used only one brand of hormone therapy, and the study halted its trials early, factors which both reduced the precision of the estimates of the possible effects of primary and secondary preventions of CHD (Machens & Schmide-Gollwitzer, 2003).

3. The absolute numbers of participants who suffered adverse events was very small, although the results were statistically significant (Luukkainen, 2003; Gambrell, 2004).

Quality of evidence regarding study design

Others refuted the above arguments, making the following points: (1) The target population of the WHI study was women aged 50–79 in order to investigate the use of HRT as a preventive not its use for menopausal syndrome. (2) The study concluded that oestrogen plus progestin therapy should not be initiated or continued for the prevention of cardiovascular disease. It did not address the role of HRT for the short term treatment of menopausal symptoms; women with difficult symptoms were the only people who were taking HRT at the lowest dose and for the shortest time (Manson et al., 2003). (3) From the WHI study, it remains unknown whether there is an increased risk of heart attack or stroke in younger women who use HRT for a short period of time (Lumsden, 2005).
Although observational studies consistently showed cardio-protective effects in women using HRT, oestrogen use merely showed a beneficial decrease in lipid profiles rather than directly proving any preventive effects against heart disease (Rossouw, 1999). Observational epidemiological studies do not prove causality but determine risk among and within populations through carefully measuring the independent and dependent variables in an unbiased fashion (Kuller, 2004). Unfortunately, some observational studies dismissed the potential differences or biases associated with the use of oestrogen or combined oestrogen-progesterone therapy. For example, women on HRT historically tended to be of higher socioeconomic status, healthier, and more likely to adopt healthy behaviour over time: especially to decrease cigarette smoking, control hypertension and lipid therapy, and to increase physical activity, behaviours that would reduce their risk of CHD and that resulted in the favourable outcomes reported in several observational studies (Persson et al., 1997; Piantadosi, 2003; Barrett-Connor, 2004; Lawlor, Smith & Ebrahim, 2004b).

The strongest feature of the WHI design was its randomisation. It was a randomised controlled trial (RCT) which controlled unknown and/or unobserved confounding factors evenly in case–placebo groups: most investigators, practitioners and patients have strong expectations that an RCT will yield a more unbiased estimate of treatment effect than an observational study (Piantadosi, 2003; Whittemore & McGuire, 2003; Vandenbroucke, 2004). But both observational and randomised studies found a higher relative risk of adverse effects such as venous thrombosis and breast cancer amongst HRT users (Lawlor, Smith & Ebrahim, 2004a; Vandenbroucke, 2004). Observational studies are reliable for estimating the adverse effects or health risks among and within populations rather than using to determine the effects of treatment in order to avoid the trap of ‘intended effects’ bias (Vandenbroucke, 2004).

**Dilemma between science and ethics**

Research on the appropriate doses of oestrogen and progestin to provide long-term preventive effects against future CHD risk, and on dose regimes and delivery methods will continue. In fact, these questions may never be able to be addressed. Ethical considerations do not permit randomising post-menopausal women for any oestrogen-progesterone combination. The WISDOM study (Women's International
Study of Long Duration Oestrogen after Menopause) in the UK, a study of similar design to the WHI study, was also halted prematurely subsequent to the WHI termination. The WISDOM steering committee had wanted to continue the trial to answer questions about the risk-benefit ratio of HRT after the WHI episode, but an international committee decided to halt it because a large reduction in the risk of CHD was no longer considered likely (Michels, 2003). From a clinical perspective, even if HRT was proven to be protective against CHD for young women, that still would not outweigh the excessive risk of breast cancer. Moreover, many safe options are available for reducing risk of CHD or osteoporosis, but there are few safe options available for breast cancer prevention (Stampfer, 2004).

The publication of the WHI findings had less impact in the UK than in the USA because HRT was rarely used in the UK for heart disease prevention alone. The UK regulatory authorities advised that HRT should only be used for symptoms relief and that the smallest possible dose should be given for the shortest possible time. Neither form of HRT should be prescribed as a first line treatment for osteoporosis, although both reduce fracture risk. The reasoning was that the risk of an osteoporotic fracture at the age of 50 is small, and that to receive bone protection when it is needed—when women are in their 70s or 80s—it would be necessary to take HRT for 25–30 years because there is little or no ‘carry over’ effect. This would lead to a significant increase in mortality from other causes, such as breast cancer and stroke (Lumsden, 2005).

Diverse risk perceptions

The perceptions of risk of adverse effects of HRT vary greatly from individual to individual. Apart from the medical indications, an individual woman may take into consideration many factors before deciding whether or not to undertake HRT. These factors are influenced by the media, marketing and advertising, her doctor, her family and the community, her belief systems, and the financial cost. Some women’s resistance to hormone treatment is based on concern regarding possible side effects of cyclical HRT, such as the risk of breast tenderness, weight gain, and spotting and abnormal bleeding (Notman & Nadelson, 2002). Bleeding is a common problem in

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19 Medicines and Healthcare products Regulatory Agency (MHRA), an executive agency of the Department of Health, UK
post-menopausal women taking HRT and this is often the single most important factor
deterring women from starting or continuing its use, since irregular bleeding is the
presenting symptom of endometrial adenocarcinoma which increases during women’s
mid-reproductive years. Women tend to not undertake HRT unless they have
significant symptoms (Thomas, Hickey & Fraser, 2000). One reason is the perceived
much stronger associated threat of breast cancer: breast cancer is a sensitive issue for
women even though the lifetime risk of cardiovascular disease is much greater
(Lumsden, 2005). Breast cancer in Australian women, for example, is one of the
leading causes of cancer-related death (Cancer Australia, 2011).20 Women making
oestrogen decisions in the peri-menopause period typically have friends in their age
group with breast cancer, not heart disease, which may help explain why even a small
increased risk of breast cancer is unacceptable for many women.

In addition, there is much still unknown about the long-term use of HRT. Further analyses of the WHI data indicate that the HRT group had a greater risk of fatal and nonfatal malignancies occurring after the intervention, and the global risk index was 12% higher in women randomly assigned to receive HRT compared with those receiving the placebo (Heiss et al., 2008). The incidence of breast cancer declined in both the clinical area and the general population, and in particular, there was a decrease in oestrogen-receptor-positive tumours in the USA, temporally consistent with the substantial drop of HRT use in 2003 (Clarke et al., 2006; Ravdin et al., 2007). The possible cause-and-effect relationship between HRT and primary breast cancer was given further evidence in that the incidence rate of breast cancer associated with the combined use of oestrogen plus progestin in the WHI trial declined markedly soon after the discontinuation (Chlebowski, Kuller et al., 2009). HRT has also been found associated with an increasing number of deaths from non-small-cell lung cancer (Chlebowski, Schwartz et al., 2009) and may exacerbate urinary incontinence (Cody, Richardson, Moehrer, Hextall & Glazener, 2009). A
WHO working group concluded that combined oestrogen-progestogen menopausal
therapy and oral contraceptives are carcinogenic to humans (WHO, 2005). Review
studies (Persson, 2000; Vecchia, Brinton & McTiernan, 2001) indicate that oestrogen,

20 Cancer Australia is an Australian Government body. In July 2011, National Breast and Ovarian
Cancer Centre (NBOCC) amalgamated with Cancer Australia to form a single national agency, Cancer
Australia, to provide leadership in cancer control and improve outcomes for Australians affected by
cancer.
progesterone/progestins and other sex hormones are important determinants of female cancers in the breast, endometrium and ovary. As a result, these medical interventions involve a trade-off between benefits and risk. It is impossible to determine to what degree an individual patient will tolerate risk to achieve a possible benefit, so it is important that medical practitioners provide the patient with the necessary information to make an informed decision (ABC Radio National, 2005).21

The WHI episode was a shock and challenge for many women, doctors and experts. Lumsden (2005) conjectured that women might find it difficult to accept that what they had been told years ago by someone they trusted had now changed. Doctors resisted the new findings of the WHI study: some may have built their reputation on their ability to treat suffering menopausal women for whom HRT really worked; they possibly made a substantial income by prescribing it; they may have been very reluctant to change their habits. Many menopause experts also felt that their professional integrity had been brought into question and some found it difficult to alter their earlier advice (Lumsden, 2005).

In clinical settings, the patient’s values and experience must be taken into account in order to provide optimum care: HRT treatment of patients must be individualised. The latest trend is for women and their doctors to determine what is significant for them. There is no problem with women taking HRT for as long as they consider it is necessary, so long as they are doing so fully informed about the risks. It pays to be an informed consumer when a doctor prescribes medication (ABC Radio National, 2005).22

Ethical issues in healthcare technology assessment

The final aspect to consider is that the dynamics behind HRT involve pharmaceutical interests, unseen publication bias, and risk communication. The pharmaceutical industry is interested in producing drugs to prevent disease—such as osteoporosis, coronary heart disease or sexual dysfunction—which large numbers of people will take for a long time. The ‘feminine forever’ idea has led women to the unnecessarily heavy proposition that they must commit themselves to using HRT for

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21 The Health Report – Hormone replacement therapy- Parts 1 & 2, presented by Norman Swan, Monday, October 24 & 31, 2005
22 Ibid
the rest of their lifetime. The advertising of the pharmaceutical industry is designed to increase their profits rather than having the best interests of the patients in mind (Dukes, 1997; Notman & Nadelson, 2002). ‘Patient education’ is the main marketing activity of pharmaceutical companies, but their representatives are also keen to meet with doctors who often report that they are under pressure from patients to prescribe and who say that they do not have the time to keep up-to-date with new information about the efficacy, risks and side effects of the constantly increasing number of medicines (Busfield, 2010).

In addition, pharmaceutical companies offer a broad range of relationship inducements to medical researchers and/or experts, in the form of gifts, various forms of hospitality, consultancies, reward or research grants, and stockholdings. This can easily create a conflict of interest when a medical expert is advising on government regulations or when a doctor is prescribing drugs for patients. These medical experts who task is to protect public health interests may inadvertently have developed predispositions or obligations to promote the commercial interests of particular pharmaceutical companies. The prohibition of conflicts of interest has made it more difficult for many governments’ regulatory agencies to recruit staff in Europe. This reflects how extensively scientific expertise about pharmaceuticals is intertwined with the drug industry (Abraham, 2010).

Publication bias can also be detected in the HRT studies. For example, unpublished data on links between HRT and cardiovascular disease was more often related to adverse effects which were not made public by the pharmaceutical industry before its licensing (Hemminki & McPherson, 1997, 2000; ABC Radio National, 2005). In general, journals are more likely to publish studies with statistically significant results rather than studies which find no difference between the groups studied, and this is also more likely to lead to a high citation impact factor. The tendency towards publication bias is greater for observational and laboratory-based experimental studies than for randomised clinical trials (Easterbrook, Berlin, Gopalan & Matthews, 1991). Selective reporting in the mass media is also more likely to result in publicity being given to studies with positive results which appeared in scientific journals with a high-ranking citation impact factor (Whiteman, Cui, Flaws, Langenberg & Bush, 2001).
Press releases inherently involve self-interest (Pickar, 2007). In reviewing a profound dissonance in medical journal papers on HRT and coronary events, Spector and Vessell (2002) highlighted the following modes in current publication policies:

(1) editors and journals focus on generating a high volume of reports to maintain sales, interest, and advertising revenue;

(2) it is more easy for academics to have certain types of studies (for example case-control studies) published. It is much more difficult to have controlled trials (which require a great deal of effort and resources) published;

(3) pharmaceutical industries have benefited by increasing their drugs sales (for example sales of HRT); and

(4) selected news media have enjoyed increased sales of papers and magazines from the controversy, a controversy based on poor medical science (Spector and Vessell, 2002).

Given this, improved strategies are needed to uncover and disseminate the results of unpublished as well as published studies.

The WHI study created confusion and anxiety amongst both clinicians and the general community, attributed to pre-emptively communicating the findings of the research to the news media (Dentzer, 2003). The committee for the study placed the news media in the role of primary communicator instead of first holding a major briefing in the clinical community. The media was criticised for tending to focus exclusively on either the small absolute risks or the larger relative risks, and neglecting to present a more balanced picture. It failed to convey that the WHI trial was designed to investigate disease prevention rather than symptom relief. As a result, many women suddenly quit taking HRT without discussing it with their doctors, and many doctors were uncertain about how to respond to their patients, regarding whether to continue or discontinue the hormone (BBC News, 2008). This history suggests that more concerted efforts are needed to communicate health risks to the public, including an action plan for empowering patients. Menopausal health has never been the same since the WHI publications were placed before the media.

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23 HRT hype ‘means women miss out’, Monday, 19 May 2008
Regardless of whether doctors and patients are more interested in absolute extra risk than relative risk, patient’s values and experience must be critically accounted for because these ‘affect[s] the impact of a small numerical increase in risk’ (Lumsden, 2005).

### 2.4 Conclusion

There are enormous differences in the individual experience of menopause both among women in the same culture and among those in different cultures. Menopausal symptoms are the result of a combination of physical changes, cultural influences, and individual perceptions and expectations. They occur in contexts of change including loss of fertility, loss of femininity, redefining of roles, the empty nest syndrome, and change of status (Robinson, 1996). The age distribution, demographics, and various menopausal needs differ from country to country, and it is important to consider interactions of culture and biology in the studies of menopausal health (Kaufert, 1996; Melby et al., 2005).

A 1996 WHO report\(^{24}\) concluded that only vasomotor symptoms and vaginal dryness have been convincingly related to menopausal hormone changes. Menopausal symptoms such as hot flushes usually dissipate over time. The trouble is that no-one can tell who will be fortunate and have any symptoms over and done with naturally within a year. Women experiencing severe menopausal symptoms may consider HRT; but on top of experiencing symptoms they are receiving constant diverse messages about HRT. Such women struggle with this decision in the face of conflicting opinions from doctors, the media, friends and family (ABC Radio National, 2005)\(^{25}\). A side-effect of the considerable debate in the medical, social scientific, and feminist literature over the medicalisation of women's experiences is that it can obscure attention from the promotion of menopausal health (this is discussed in Chapter 4).

The debate about the efficacy and safety of HRT continued throughout its development. Enthusiasm for the use of HRT for the treatment or prevention of a wide range of ailments grew in the 1990s (Lawrence D, 2002), but there was still much disagreement among health professionals with regard to its use as a first-line


\(^{25}\)ibid.
therapy for the prevention of osteoporosis or cardiovascular disease in women (Climacteric, 2004). Apart from the WHI study, there have been other critical research studies designed to investigate the effects of use of HRT, such as Heart and Estrogen/progestagen Replacement Study (HERS), and the Million Women Study (MWS), and the work of the Collaborative Group on Hormonal Factors in Breast Cancer (Steinberg et al., 1991; Beral, Bull, Doll, Key et al., 1997; Rossouw, 1999; Fleurence, Torgerson & Reid, 2002; Banks, Beral, Bull, Reeves et al., 2003). Nevertheless, the adverse side effects of HRT did not become significant warnings for stakeholders until the WHI study stopped its trials.

The results of the WHI studies had a major impact both in the USA and worldwide. Many women and doctors were reluctant to accept the ‘lost promise’ of HRT. The conflicting interests of women, doctors, and drug companies have played a significant role in the popularity of HRT and continue to fuel this controversy (Worcester, 2004, Naughtom et al., 2005). Most women in developed countries, now living longer, expect to have a high quality of life throughout their later years. Clinical practitioners often need to respond to their patients’ questions on the basis of information provided by drug companies (Kravitz, 2000). For hormone manufacturers, the stakes are billions of dollars of revenue in the worldwide markets, and drug companies have kept providing evidence and promises pertaining to this commodity. Furthermore, for some health professionals, “there may be a connection between receiving industry funding for speaking, consulting, or research and the publication of promotional opinion pieces on HRT” (Fugh-Berman, McDonald, Bell, Bethards & Scialli, 2011, p.1). But women’s own experiences of the needs for and the use of HRT must become an essential factor taken into consideration when providing healthcare services in the situations of conflicts of interest outlined above.

Since the WHI study which caused so much confusion, women have been increasingly encouraged to participate in making decisions about HRT use, and to

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26 Climacteric is the Journal of the International Menopause Society (IMS). It was founded in 1998 and according to their website, http://www.imsociety.org/, (accessed July 21, 2011) has become a leader in publishing peer-reviewed research on the menopause.

manage their health beyond the vasomotor aspects. Medical studies focused more on patient compliance with HRT regimens than on finding out about women’s own experiences (Pitkin, 2002). For example, the length of time that women used HRT was found to be shorter than doctors had recommended; the women’s reasons for using HRT were usually to treat symptoms rather than being based on doctors’ considerations of its possible benefits in the prevention of various diseases (Hemminki & Topo, 1997). Other studies question whether women have reliable sources of health information and whether they have really been given an equal opportunity to voice their health needs and improve their wellbeing both during and after the climacteric (Conboy, Domar & O’Connell, 2001; Huh & Cude, 2004; Pérez-López, 2004; Rigby, Ma & Stafford, 2007).

HRT is not a panacea for an unhealthy lifestyle and there is more to the middle years of life than just hormones. The aim of health services is not only to reduce or prevent menopausal symptoms or to improve the quality of life with minimum adverse effects but also to help women to adjust positively to the ageing process. This generally includes the onset of irreversible chronic conditions (Backett-Milburn, Parry & Mauthner, 2000; Rudholm, 2006; Rao, Singh, Parkar & Sugumaran, 2008). Menopausal and post-menopausal women have health needs that are different from those of younger women or males within the same age range, and women’s health problems around the menopause imply costs for society, both in terms of the quality of life losses, and costs arising within and outside the healthcare system (Zethraeus, Borgstrom, Jonsson & Kanis, 2004). As a result, the needs of menopausal women should be factored into health service planning and delivery mechanisms. Only multidisciplinary strategies can construct comprehensive evidence-based health policies able to meet the biomedical, psychological and socio-culturally significant multidimensional aspects of the requirements of women in the climacteric.
Chapter 3

Menopausal Health Issues and HRT Use in Taiwan

The previous chapter discussed the controversies around HRT and health promotion from the Western perspective, particularly that of Europe and the USA. After outlining Taiwan’s health system to provide essential background knowledge, this chapter focuses on how menopause related issues have played out in the Taiwanese setting, including the opposing medical and feminist views associated with menopause and HRT use. These are significant elements of the challenges that medicalisation of both menopause and ageing present to public health policy. This chapter is divided into four sections discussing: (1) Taiwan’s healthcare system, which underpins the dynamics of medical utilisation; (2) menopause and related health issues; (3) the use of HRT in Taiwan; and (4) the debate surrounding menopausal health and HRT use.

3.1 Taiwan’s Health System

This section outlines four aspects of public health in Taiwan: demographic health status data; the healthcare delivery system and workforce; the National Health Insurance program and its impact; and national health expenditure and allocations. This information is essential to understand the dynamics behind the utilisation pattern of healthcare in relation to menopause and HRT in Taiwan.

3.1.1 Demographic and Health Status Data

The population gender balance in Taiwan is similar to that in most developed countries. In 2008, Taiwan had a registered population of 23.04 million: 11.63 million males and 11.41 million females (MOI, 2009). In the same year the overall average life expectancy was 78.5 years: 75.5 years for males and 82.0 for females, with 10.4% of the population aged above 65 (DOH, 2008a).

The leading causes of death in Taiwan have not changed markedly in the 25 years up to 2010. The major leading cause of death for both men and women is malignant neoplasm; other leading causes of death, and underlying or contributing
conditions are heart disease, cerebrovascular disease, and diabetes mellitus (DOH, 2009). Women have the same prevalence of cancers of the lungs, liver, and colon-rectum as men. Breast cancer was the most common and the most frequent newly diagnosed cancer in women between 2002 and 2006. There was a reported age-related increase in the incidence of most cancers for both genders: more than 60% of malignant neoplasms occurred in women aged 50 and over, broadly corresponding to the time from menopause on. The average age of death from breast cancer in women, for example, was approximately 55 (Chie Wei-Chu 季瑋珠, Huang Chiun-Sheng 黃俊升, & Chang King-Jen 張金堅, 1997). The Department of Health has therefore been promoting adult and elderly health to encourage citizens to build healthy lifestyles to help lower the incidence of malignant tumours, and prevent and control hypertension, heart disease, cerebrovascular diseases, and diabetes, the main causes of death and loss of potential years of life (BHP, 2006).

3.1.2 Healthcare System and Expenditure

Healthcare in Taiwan encompasses preventive medicine, diagnosis and treatment of diseases, and long-term care. The task of the Bureau of Health Promotion (hereafter BHP) is to encourage people to build healthy lifestyles and thus prevent diseases and improve the quality of their life. Health bureaus (衛生局) in cities and counties, and public health centres (衛生所) in urban and rural townships are responsible for health administration and can also provide medical clinic services and vaccinations. Facilities providing medical care services are classified into four levels of accreditation, with corresponding differences in levels of size and range of available services and equipment facilities. These are:

1. academic medical centres, often associated with academic medical training providers: academic medical centres provide tertiary care services;

2. regional hospitals;

3. district hospitals; and

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28 The Bureau of Health Promotion (BHP) 行政院衛生署 國民健康局 is part of Taiwan’s Department of Health. It was established July 12, 2001 by merging the Bureau of Health Promotion and Protection of the Department, the Institute of Public Health, the Institute of Family Planning, and the Institute of Maternal and Child Health.

29 Taiwan is divided into 17 health-delivery regions and 63 sub-regions.
4. General practice clinics: generally speaking, these clinics provide primary care services. District and regional hospitals also both provide primary care services but focus more on providing secondary care.

The proportion of doctors trained in Western medicine in the population has reached the goal set in Taiwan’s holistic healthcare plan: there are 1.5 doctors per 1,000 persons, and with the exception of clinical psychologists and speech therapists, the numbers of medical specialists have met the target figures (DOH, 2009).

Equity in access to healthcare in Taiwan is provided by the National Health Insurance program (hereafter ‘the NHI’) which was launched in 1995. This is a government-directed single-payment compulsory health insurance system. The NHI is financed from a combination of premiums, taxes, and donations, and thereby funds the healthcare services delivered by both public and private medical facilities. It reimburses healthcare providers principally on a fee-for-service basis. It provides reimbursements for a broad range of benefits, including inpatient care, outpatient care at hospitals and in clinics elsewhere, dental care, traditional Chinese medicine, laboratory tests, prescription medication, some preventive medication, HIV/AIDS treatment, and organ transplants. In 2008 more than 93% of institutions and agencies providing such medical and healthcare services were contracted to the NHI Bureau (BNHI) and over 99% of the population was insured (BNHI, 2008b; DOH, 2009).

A high rate of healthcare use has been a feature of Taiwan’s medical culture since the NHI was introduced. This saw the number of doctor visits increase significantly because the NHI removed the economic barriers to healthcare for the insured (Cheng & Chiang, 1997; Cheng Tsung-Mei, 2003). The average annual number of clinic visits per capita was between 14.4 and 15.4 between 1997 and 2007, comparatively higher than in other countries with a similar health insurance program (BNHI, 2008a). Cheng (2003) identified the main causes for the high utilisation rate: on one hand, the beneficiaries, i.e. the insured population, have been allowed complete freedom of choice of providers and therapies. Insured people are not confined by a referral system—such as operates in Australia—and can seek care at tertiary care institutions, regardless of the nature or severity of their illness. In addition, Chang pointed out that a local culture of multiple help-seeking behaviours among most patients—who approach Western medicine, TCM, and the folk sector—
also fosters high rates of medical use (Chang Ly-Yun 張芷雲, 2003). On the other hand, the NHI reimburses medical providers on a classic fee-for-service basis which has an inherent danger of inducing providers to conduct a fee-driven practice style. Both these factors have contributed to shaping a culture of the ‘three-minute patient visit’ and ‘fast-food healthcare’ in Taiwan. A corollary is that this can result in misdiagnosis or inappropriate treatment.

The increasing rate of medical care utilisation has led to containment of the related health expenditure becoming a health policy priority. Per capita health expenditure has been on a steady increase especially since the implementation of the NHI program; the percentage of government social security expenditure spent on health has been increasing annually, and so too has household out-of-pocket spending. In 2008, Taiwan’s total health expenditure (both public and private) was 6.4% of GDP, approximately NT$ 788.6 billion30, approximately AUD $1,371 per capita (DOH, 2009). Although generally speaking, national health expenditure in Taiwan has been regulated to achieve a conservative growth rate compared to other developed countries,31 since 1998, NHI expenditure has exceeded its revenue, a situation which was exacerbated by a recession in Taiwan’s economic growth in 2008.

Moreover, examining the allocation of current health resources reveals another crisis further eroding the basis of Taiwan’s healthcare system. According to official statistics (DOH, 2008b), an increasingly large proportion of national health financial resources have been being spent in the private sector rather than the public sector: national health allocations for public health expenditure—such as for preventive healthcare, control of diseases, and teaching expenses for training hospitals—has been gradually decreasing. In addition, 54% of the government health budget subsidised the NHI program annually but NHI expenditure still lagged behind the growth in medical costs from 1999 (DOH, 2008b). A substantial proportion—more than 23%—of national health expenditure in 2008 was spent purchasing pharmaceuticals and other medical non-durables. This is nearly double the rate in Australia and the U.S.A., 13.7% and 12.2% respectively in 2006 (DOH, 2008c).

30 Equivalent to around AUD $31.5 billion at the exchange rate of about 25 NTS for AUD $1.
31 By comparison, the proportion of GDP was 9.2% in Australia in 2003 and 15.3% in the U.S.A. in 2004, two other developed countries. Accordingly, this cost containment was appraised as a considerable accomplishment in health policy, one providing ‘healthcare for all’ (Cheng Tsung-Mei, 2003; Lu J-F R. & Hsiao, W. C., 2003)
3.1.3 Over-medication & HRT Utilisation in Taiwan

The high consumption of pharmaceuticals which characteristicises Taiwan may in fact have the unwanted effects of diminishing the quality of people’s health and seriously jeopardising the sustainability of the healthcare system. To illustrate this point, the largest single area of national health expenditure in the ‘personal healthcare expenditure’ category (個人醫療費用支出項目) was on diseases related to the respiratory system, amounting to 19% of the total in 2008 (DOH, 2008). Cheng Tsung-Mei pointed out that approximately 50% of doctors in Taiwan prescribed 4 or 5 drugs per consultation for upper respiratory tract infections; the ‘antibiotic resistance in streptococci [sic] pneumonia’ in Taiwan was reported as being the highest in the world (Cheng Tsung-Mei, 2003). In conjunction with this situation, the basis for achieving the objectives of public health provision was, and still is, essentially being eroded in two ways: (1) Taiwan’s health system allows hospitals and clinics to sell patients medications at prices higher than the purchase cost and allows doctors to make a profit on medications sold to insured patients (Cheng Tsung-Mei, 2003; Hsieh 謝幸燕, 2005); (2) some patients expect and want some form of prescription from medical visits (Chang Ly-Yun 張芀雲, 2003). Both these factors act to increase health expenditure on pharmaceuticals and inadvertently seriously endanger public health.

Given this situation of over-medication, a review of HRT utilisation in Taiwan became a critical aspect of ensuring the health quality of menopausal women. In 2005 a total of NT$13.6 billion of NHI expenditure was spent on treatment related to the genito-urinary system of women aged 40-59 years. This accounted for 2.1% of total government health expenditure and two-thirds of the public health budget (DOH, 2008a). How much of this large figure spent on these middle-aged women was for HRT is still unknown. Moreover, little has been established about the effectiveness of the public health expenditure related to HRT nor about the implications for squeezing the optimal benefit from every allocation of health resources for the promotion of women’s health.

To sum up, a high and increasing rate of medical care utilisation, and substantially high allocations spent purchasing pharmaceuticals have been significant
components of the dynamics underpinning the general pattern of over-medication in Taiwan including the prescription of HRT.

3.2 Menopause and Health Issues

Research on the menopause began flourishing in Taiwan from the late 1990s. The topic areas explored were the age of menopause onset, perceptions of HRT, the prevalence of different menopausal symptoms, quality of life, and menopause as a risk factor for various cancers, for osteoporosis, and for cardiovascular disease. This section summarises their findings.

3.2.1 Perceptions of and Attitudes toward Menopause

A 1995 study found the average age of Taiwanese women at menopause was 49.8 ±3.92 years (Chang, Chow & Hu, 1995). This indicates that in 2010 more than 3.50 million Taiwanese women, 15.2% of the population, would be living more than one third of their life post-menopause. Post-menopausal Taiwanese women may well face similar health issues to women in developed countries.

Studies in the 1990’s found that many women in Taiwan consider menopause to be a natural phenomenon and a normal life process and that maintaining their health is their main concern (Chang Chueh 張玨, Chen Fen-Ling 陳芬苓, & Hu Yow-Hwey 胡幼慧, 1993; Chen Yeou-Lan Duh, Voda & Mansfield, 1998; Tsao Lee-Ing 曹麗英, 1998). The women described menopause as for them meaning: “no longer young, getting old”; “wisdom and maturation”; “a symbol of achievement”; and/or “a time to start enjoying life” (Chen Yeou-Lan Duh et al., 1998). Tsao Lee-Ing (1998) reported women’s experience of menopause as being a journey of “living with changing health” (p.448) which commenced from their becoming aware of menopause. Throughout this journey, women experienced ‘a complex combination of feelings’: shock, embarrassment, irritability, frustration, worry, relief, happiness, and/or carefree moods. They ‘sought solutions’ through clarifying the nature of their physical and psychological changes, comparing and referring to other's experience, and then exploring and evaluating solutions presented. If their symptoms failed to improve, women might ‘come to terms with the situation’ by putting aside the focus from their distressing symptoms and tolerating the discomfort. Women ‘pursuing a better life’ reviewed the menstrual experience still to come and their future ageing life: they
anticipated becoming more free to extend their scope of activities and committing themselves to seeking and finding harmony through religion or friendship. They expected to still ‘keep on’ living as usual regarding their commitments working and/or caring for their families.

Women with a higher education who experienced vasomotor symptoms expressed a more negative attitude toward menopause. Post-menopausal women were inclined to be more positive than peri-menopausal women. This corresponds to various study findings that pre-menopausal women anticipated higher incidence rates of symptoms, projected more negative psychological reactions such as irritable temper and depression, and felt more fear of approaching menopause. These studies include those of Chang Chueh et al., 1993, Cheng Ming-Huei et al. 2005, and Pan H.A. et al. 2002.32

Some studies—Lu & Yen, (2000); Lee & Kuo (2002)—found women’s attitudes about the climacteric as being more positive than those of nurses or gynaecologists.33 Both these studies have the limitation that most of the female professionals surveyed were relatively young and of pre-menopause status, and therefore, as the studies cited above point out, they would be more likely to view menopause negatively. The clinical visits reported revealed several other findings: (1) professionals in the healthcare system are predominantly male doctors and young nurses; (2) significantly more health professionals were in favour of using HRT to alleviate menopausal symptoms than women, and (3) healthcare providers and menopausal women had different perceptions of menopause health needs.

Different studies have found that many women in Taiwan lack adequate knowledge about menopause. Evidence of the lack of knowledge of the body changes accompanying peri-menopause is a 1996 study in which 24% to 43% of women at various stages of menopause sought treatment because of ‘irregular menstruation’ or ‘missed periods’ (Chang Chueh & Chang Chu-Hui, 1996). This was further

corroborated by Tsao Lee-ing et al.(2004): the level of knowledge of the body changes accompanying peri-menopause and of HRT achieved the lowest scores in an appraisal of peri-menopausal women’s knowledge of menopause. The relationship between women lacking information and seeking medical help was examined and the following aspects, which are particularly relevant to this study, are summarised below:

(1) Chen et al. found that less than 40% of the study women gave serious thought to obtaining information about menopause beforehand. ‘A totally positive attitude can leave women without any preparation’ for menopause (Chen Yeou-Lan Duh et al., 1998). This may result in medical help-seeking once they begin experiencing symptoms.

(2) Media reports use too much medical terminology and have a disease oriented focus (Tsao Lee-Ing et al., 2004). This can result in some women viewing normal symptoms as some disease-related abnormality. Friends and publications such as newspapers and magazines were identified as being the principal major sources of information about menopause; information was less commonly sourced from medical personnel or family members (Chen Yeou-Lan Duh et al., 1998; Pan et al., 2002).

(3) Doctors often failed to provide women with enough information about treatment or to make informed choices about HRT, or they provided explanations in medical terms without considering women’s comprehension level (Chang Chueh & Chang Chu-Hui, 1996). A subsequent study by Pan et al. (2002) found that 71% of women who attended a health information seminar presented by a doctor thought that they should undertake HRT.

In conclusion, the findings of the above studies indicate that the information provided by doctors tended to be promoting HRT and it was neither comprehensive nor impartial. Moreover, the mass media a conduit of information which women very commonly use also presents menopause as disease–related. Despite various studies which point out that women see menopause as a completely normal stage of life, the significant role that the mass media and medical consultations have both played in framing menopause in terms of negative health issues cannot be overlooked.

34 Tsao Lee-Ing, Chang Wen-Yin, Hung Li-Ling, Chang Shu-Hung, & Chou Pi-Chun (2004).
3.2.2 Health Issues at Menopause

Symptoms and discomfort associated with menopause

A national interview survey\(^35\) undertaken by the BHP found that 46% of women aged between 40 and 59 experienced at least one menopausal symptom during 2002. The most commonly reported symptoms were: hot flushes, insomnia, heart palpitations, lack of energy or fatigue, headache and/or dizziness, night sweating, depression, vaginitis, urinary tract infection, dyspareunia, and urinary incontinence (Lin Yu-Xuan 林宇旋, Chang Xing-Zhen 張幸真 & Chen Zi-Ling 陳姿伶, 2004). Other common recurrent symptoms reported in smaller scale surveys included backache and lumbago, memory impairment, and decreased libido (Chang Chueh & Chang Chu-Hui, 1996; Chow, Huang & Lee, 1997; Lee & Wang, 2000).

The findings of studies on the relationship between the menopause and other health issues are summarised below.

1. Vaginal symptoms: A 2009 qualitative study by Chiang et al. found that menopausal women experienced vaginal itching, burning, and pain. These symptoms resulted in hesitation in asking for help, unwillingness to visit doctors, and reduced libido. Some women coped with dyspareunia by refusing to engage in sexual activity or engaged in compromised hasty sexual activity (Chiang 江雪美, Jou 周輝政, Kao 高千惠 & Tsao 曹麗英, 2009).

2. Muscle strength and balance: Menopause is an independent predictor of decreased muscle strength and balance. Peri-menopausal and postmenopausal women had a weaker grip strength and shorter standing balance times than pre-menopausal women. No variation was found in women’s physical flexibility at different stages of the menopausal transition (Cheng, Wang, Yang, Wang, & Fuh, 2009)

3. Urinary incontinence: Urinary incontinence was found to be associated with pre- and post-menopausal transition, ageing, and obesity (Chen, Chen, Hu, Lin & Lin, 2003; Tseng Ling-Hong et al., 2006; Tsai Yueh-Chi & Liu Chieh-Hsing, 2009; Pai Hsiang-Chu, Lee & Lee Sheuan, 2009). The major psychosocial impacts identified

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\(^35\) 2002 台灣地區國民健康促進知識態度與行為調查 (2002 National Survey on Knowledge, Attitude and Practice of Health Promotion)
were: worrying about symptom deterioration, feelings of inferiority, nervousness about loss of urinary control, and embarrassment caused by urinary leakage in public and its offensive smell - of even a small amount.

4. **Insomnia**: No conclusive relationship between menopause and insomnia has been established. Approximately half of the middle-aged women investigated in separate studies carried out by Hsu H-C et al. (2005) and Cheng M-H et al. (2008) felt dissatisfied with their sleep: they slept an average of around six hours. Hsu et al. (2005) argue that poor sleep quality in midlife women is associated with depression and ageing rather than with their menopausal status. Age and menopause are highly correlated variables and may confound each other, so it is difficult to adequately adjust for age in these two cross-sectional studies. Although no clear causal relationship—whether anxiety and/or depression made sleep quality worse or whether insomnia induced anxious moods or depression—has been established, Cheng et al. (2008) found that undergoing menopause and a higher anxiety score were both associated with sleep disturbance.

5. **Mental health related problems**: A study by Chang and Chang found that a peri-menopausal woman was likely to experience more psychological discomforts when experiencing more physical discomforts (Chang Chueh 張玨 & Chang Chu-Hui 張菊惠, 2000). Similarly, hot flushes and somatic symptoms were associated with anxiety and depression in women at pre-, peri-, and post-menopausal stages in a number of studies which appraised mental health in the climacteric, namely those of Juang et al. (2005), Lu et al. (2009), and Yen et al. (2009). Memory decline is a very commonly reported complaint during menopause Chang Chueh 張玨 & Chang Chu-Hui 張菊惠 (1996), but a study with an 18-month follow-up by Fuh et al. showed that menopausal transition was not accompanied by any significant cognitive decline (Fuh, Wang, Lee, Lu & Juang, 2006).

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Health threats in middle-age

A National Health Interview Survey\textsuperscript{37} in 2005 indicated that women who reported menopausal discomfort also reported feeling in poor health, and they used more medical services, and more suffered from hypertension, hyperlipidaemia, and diabetes in comparison with women who reported no symptoms.

\textbf{Osteoporosis and urinary incontinence:} According to Wu Shiow-Ing an increased prevalence of both osteoporosis and urinary incontinence is found with age. Around 30\% of women aged 55–64 had one of the health problems osteoporosis or urinary incontinence. Women with osteoporosis or urinary incontinence also had a higher incidence of hypertension, hyperlipidaemia, and diabetes than the women without these conditions (2007).\textsuperscript{38}

\textbf{Osteoporosis:} Chie W-C et al. found the incidence rate of hip fractures in women aged 50-100 to be 1.6 times higher and occurred about five years earlier than in men (Chie, Yang, Liu & Tsai, 2004). Hip and vertebral fractures are both associated with lower bone mineral density (BMD) values; the risk factors for low BMD identified in Taiwanese women are: ageing, years since menopause, high body mass index, low daily calcium intake, bone turnover rate, and low physical activity (Tsai 蔡克嵩, 1997; ShaChien, Wu, Yang, Lai, & Hsu, 2000; Shaw, Tzen, & Chang, 1998; Yao, Wu, Wang, Chang, Chiu & Yu, 2001). Yang Tzay-Shing et al. found the proportion of women with osteoporosis increased with age: 10.08\% of women over 40 years old had osteoporosis in the lumbar vertebrae and 7.45\% in the femoral neck (Yang Tzay-Shing, Chen Yue-Rong, Chen Yi-Jen, Chang Cheng-Yen, & Ng Heung-Tat, 2004).

Hypertension and coronary heart disease (CHD): The prevalence of hypertension and coronary heart disease (CHD) in women 50 years or older increased more rapidly than in men in the four years between 2001 and 2005. A comparison of data from national surveys undertaken in 2001 and 2005 shows the percentage of middle-aged women reporting having had hypertension diagnosed by a doctor or

\textsuperscript{37} 2005國民健康訪問調查 see Appendix 4

\textsuperscript{38} Wu Shiow-Ing: Health Behaviours of Menopausal Women in Taiwan, presentation at Department of Health, July 2007
nurse increased with year and age (see Table 4.1). The percentages for women aged 55 and over exceeded those for men 55 and over, in both 2001 and 2005 (BHP, 2001, 2005). A more recent study by Hsu et al. reported that females had a marked increase in the levels of coronary artery calcification—associated with an increased risk of cardiovascular disease—from 5% of women in the age range 40–49 to 21% of women in the age range 50–59. The increase was also significantly greater than that for in males in the same age range (Hsu et al., 2008).

Table 3.1
Percentage of people reporting having hypertension diagnosed by a doctor or nurse - in National Health Interview Surveys, 2001 & 2005

<table>
<thead>
<tr>
<th>Year</th>
<th>2001</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>45–49</td>
<td>10.4%</td>
<td>11.9%</td>
</tr>
<tr>
<td>50–54</td>
<td>17.8%</td>
<td>18.8%</td>
</tr>
<tr>
<td>55–59</td>
<td>27.0%</td>
<td>24.2%</td>
</tr>
<tr>
<td>60–64</td>
<td>33.9%</td>
<td>28.5%</td>
</tr>
<tr>
<td>Total</td>
<td>20.0%</td>
<td>19.0%</td>
</tr>
</tbody>
</table>


Note: a darker background indicates a higher proportion

Metabolic syndrome: This term refers to a cluster of risk factors for CHD, including abdominal obesity, hypertension, hyperglycaemia, and hypercholesterolemia. Both diagnosis and treatment of metabolic syndrome are intended to prevent CHD (ATP III, 2001). A longitudinal prospective cohort study by Chien Kuo-Liong et al. (2007) found that a higher prevalence rate of age-standardised metabolic syndrome in women (28.9%) than in men (16.6%), and that the rates increased progressively. Chang C-J et al. found that women’s total body fat content increased, through ageing and menopausal effects, favouring central body fat distribution (Chang et al., 2000). Various studies—such as those by Chang C-J et al.

39 Chien Kuo-Liong, Hsu Hsiu-Ching, Sung Fung-Chang, Su Ta-Chen, Chen Ming-Fong, & Lee Yuan-The (2007)
2000; Chien K.L. 2007; and Hou & Huang, 2009—have found that age, menopause, central obesity, high BMI, metabolic syndrome, low HDL cholesterol, and high blood pressure are all identified as independent and significant risk factors for cardiovascular disease in Taiwanese women.\(^{40}\) Cheng Yawen et al. (2005) indicated that CHD incidence and prevalence were anticipated to continue to rise in Taiwan since the ‘levels of per-capita cigarette consumption, dietary fat intake, body mass index, and prevalence of hypertension and diabetes had all increased over the past three decades’.

**Breast cancer:** Chie Wei-Chu et al. report that epidemiological studies identified the risk factors for breast cancer in Taiwanese women as including: living in urban areas, living in the northern part of Taiwan, being from mainland China within one or two generations, being unmarried, high socioeconomic status, early menarche, of low parity, late first full-term delivery, and a higher body weight after the age of 50 (Chie, Huang, & Chang, 1997).\(^{41}\) In Taiwan the age-standardised incidence of female breast cancer increased from 12.75 to 44.45 per 100,000 women-years between 1980 and 2006, especially after the introduction of the NHI in 1994 (Chiang et al. 2010)\(^{42}\). An age-period-cohort analysis by Shen Ying-Chun et al. shows a rapidly increasing incidence of invasive breast cancer in the generation born after 1960. ‘This strong birth cohort effect corresponds to the Westernisation of Taiwanese lifestyle since 1960 and the incidence may become increasingly similar to that in Caucasian Americans as Taiwanese women grow older’ (2005, p 198).\(^{43}\) Two studies indicated that mortality from breast cancer increased throughout the period 1964–2007 and the death rate was higher before age 50 than after 60 (Chen Chien-Jen et al., 2002;\(^{44}\) Shin Hai-Rim et al., 2010).\(^{45}\)

In summary, the many health issues and changes associated with and occurring during mid-life and menopause warrant women being adequately informed. The

\(^{41}\) Chie Wei-Chu 季瑋珠, Huang Chiu-Sheng 黃俊升, & Chang King-Jen 張金堅 (1997)
\(^{42}\) Chiang Chun-Ju, Chen Yong-Chen, Chen Chien-Jen, You San-Lin, & Lai Mei-Shu (2010)
\(^{43}\) Shen Ying-Chun, Chang Chee-Jen, Hsu Chiun, Cheng Chia-Chi, Chiu Chang-Fang, & Cheng Ann-Li (2005)
\(^{44}\) Chen Chien-Jen, You San-Lin, Lin Lih-Hwa, Hsu Wan-Lun, & Yang Ya-Wen (2002)
\(^{45}\) Shin Hai-Rim, Mathieu Boniol, Clementine Joubert, Clarisse Hery, Jari Haukka, Philippe Autier et al. (2010)
increased prevalence rate of both hypertension and breast cancer raises the need for caution about using HRT.

### 3.2.3 Health Needs during Menopause

**Help-seeking behaviours**

A national survey\(^{46}\) found that 70% of women who experienced amenorrhea or related symptoms visited a doctor at least once. They most commonly consulted a doctor in departments of: gynaecology, internal medicine, TCM, family medicine/general practice, cardiology, psychology, urology, and endocrinology (Lin Yu-Xuan 林宇旋 et al., 2004).\(^{47}\) An earlier study by Tsao found that women sought different treatment options to address different problems. For example, women consulting TCM doctors had more sleep disorders while women consulting Western medicine doctors reported more forgetfulness (Tsao 2002). A study by Chiou Yah-Wen et al. compared menopausal women not receiving any treatment with those using HRT, and those using TCM for menopause-related symptoms: “employed women were more likely to have received HRT or TCM treatment; those in the TCM group were more likely to have co-morbid non-climacteric physical symptoms; … less likely to have family support for the use of HRT … more likely to have an attitude regarding menopause as a natural phenomenon and as having little impact on their attractiveness and sexual life.” These studies indicate that women consulted different doctors about various discomforts and for other specific purposes during menopause.

Both TCM and other forms of complementary and alternative medicine (CAM) have become more popular since the risk of HRT was brought to light by the WHI study. Yang Y-H et al. found that in the 1997–2004 period of the NHI program, 64.9% of women aged 45–55 used TCM at least once, that “21.7% of these visits were because of diseases of the muscoskeletal system and connective tissue”, and that just 21.0% of those women made 79.2% of the total number of TCM visits. The most commonly prescribed TCM herbal medication for menopausal symptom such as hot

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\(^{47}\) Lin Yu-Xuan 林宇旋, Chang Xing-Zhen 張幸真, & Chen Zi-Ling 陳姿伶 (2004)
flushes, insomnia, and emotional disturbance was a prepackaged product: *jiawei xiaoyaosan*\(^\text{48}\) (Yang, Chen, Wang, Lee & Lai, 2009).

A 2006 cross-sectional study by Wang Yu-Chun found that 60.6% of menopausal women took between 1 and 9 dietary supplements: the mean number used was 1.8, a higher number than taken by non-menopausal women. Interviews Wang undertook revealed women were easily misled by the term ‘健康食品, *jiankang shipin*’, literally ‘health/y foods’, and regarded these as health or nutrient supplements. They lacked any perception of a possible risk in using such products (Wang Yu-Chun 王育群, 2006). A subsequent cross-sectional survey undertaken by Hsiao Mei-Chun et al. (2009) showed that 90.5% of women who sought treatment at a menopause-related clinic in an academic medical center had used CAM. The three most common forms of CAM used by these women, aged 40-65 years, were supplements: calcium (43.2%), isoflavone (38.9%), and megavitamins (32.6%). The average number of different CAM items used was 3.8 ± 3.0: these included ‘menopause-formula’ milk, vitamin E, glucosamine sulphate, fish oil, cranberry, vitamin C, ginkgo, vitamin B complex, grape seed products, evening primrose oil, and royal jelly. Nearly half of the women, 48.4%, reported that they had also used TCM in the past 6 months.

The above multi-faceted help-seeking behaviours of women—using various combinations of CAM, TCM and Western medicine—reflects the complexity of women’s health needs. Su Mei-Chen et al. found that both the severity and the frequency of occurrence of menopausal symptoms experienced by women who sought medical help were negatively correlated with the fulfilment of their health needs. Health needs were ranked in order of importance as: information, psychosocial support, and physical-health-related needs. The degree to which these health needs were being met were ranked in order as: psychosocial support, information, and physical health-related needs. Women’s most significant health needs were identified as to: (1) clarify their concerns and have a clear understanding of HRT use; (2) know how to prevent heart disease and osteoporosis; (3) guarantee stable employment and/or family income; (4) manage insomnia, incontinence, and general body and bone aches; (4) obtain the non-hormonal methods for releasing discomforts, and (5) assess...

\(^{48}\) 加味逍遥散
whether their diet and calcium intake were appropriate for their needs during menopause (Su et al. 2003).

Needs for health information

Help-seeking menopausal women repeatedly expressed their needs to know more about their climacteric transition process and appropriate measures they could use to manage discomforts. A study by Hsiao Shu-Tai (2003) undertaken in a gynaecological outpatient department identified menopausal women’s perceptions regarding and needs for health information as being to: establish positive feelings and attitudes related to the climacteric; understand the potential physical discomfort they might experience and to what extent it might impact their lives; make the necessary mental and physical preparation before menopause arrives; and know about the possible hormone therapy options available, and have a greater knowledge and understanding of HRT.

The role of the mass media in meeting needs for information related to menopausal health was also investigated. Two different context analyses of newspapers, by Li C. in 2001 and by Chuan Chia-Li in 2005, revealed that the writers of articles or sources of news about menopause and HRT were medical doctors and that the majority of these doctors were gynaecologists. The number of reports on menopause in two daily broadsheet newspapers increased sharply from 1996 to 2000, especially in 1999 and 2000 (Li Chieh, 2001). These reports mainly emphasised the negative effects of menopause and advocated using HRT to manage them.

The messages about HRT highlighted its benefits—such as preventing ageing, heart disease and osteoporosis, and delaying discomforts—more than its side-effects. Chuan Chia-Li (2005) also pointed out that medical professionals serve as opinion leaders and gatekeepers of the diffusion of medical reports about healthcare technology through the mass media. Chen Yea-Chyi investigated women searching for menopausal health information on the internet and their needs using an online

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49 Su Mei-Chen 蘇美禎, Huang Lian-Hua 黃璉華, Tsao Lee-Ing 曹麗英, & Chou Shon-Nan 周松男 (2003)
50 Li Chieh (2001); Chuan Chia-Li 全嘉莉 (2005)
51 Chinese Daily Times (中國時報) and the United newspaper (聯合報)
Women aged 40-49 were found to be the main group seeking information. Their greatest demands were for information about psychological symptoms, musculoskeletal symptoms, reproductive system-related symptoms, and urinary symptoms. There was a greater demand for information about natural diet therapies and nutritional supplements than for information about orthodox HRT (Chen Yea-Chyi 陳雅琪, 2008).

**Coping strategies**

Several studies, such as those by Chen Yeou-Lan Duh et al.; Su Mei-Chen et al.; and Tsao Lee-Ing et al., found most menopausal women emphasised promoting health to reduce physical deterioration and emotional changes. An early study by Lee and Wang shows that most self-care behaviours were focused on psychological self-adjustment strategies rather than being health promoting or focused on seeking resources and information. The top five self-care strategies that menopausal women were adopting were to: (1) ‘accept what I am experiencing as legitimate and real’; (2) ‘accept changes in my body’; (3) ‘find ways to feel good about myself’; (4) ‘put menopause out of my mind or ignore it’; and (5) ‘believe in myself, place more value on myself’. These imply the women were re-identifying their values and regaining confidence during the menopausal transition. In particular, middle-aged women of lower socio-economic status were not frequently involved in self-care behaviour, especially for menopause (Lin Yu-Xuan 林宇旋 et al., 2004).

Wu reported that the 2005 National Health Interview Survey identified the measures women undertook to promote menopausal health as: regular exercise, calcium supplements, vitamin supplements, nutritional supplements (for example oenothera, evening primrose, and isoflavones), Chinese herbal medicine, Chinese food therapy, over-the-counter style manufactured TCM medications, and Taiji and/or Qigong (Wu Shiow-Ing, 2008). The measures reported above clearly indicate

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52 The questionnaire was completed by 285 women, with a mean age of 36, who were internet-user consumers who visited a menopause-related website. The questionnaire was designed on the basis of a content analysis of 9 non-Taiwanese “quality menopause health information websites” [優質停經婦女健康資訊網站].


women’s inclination to focus on taking nutritional and similar supplements as a coping strategy.

3.2.4 Health Issues Concerning Quality of Life (QOL)

Research examining QOL aspects for the most part started emerging in Taiwan after 2000, particularly after the WHI report, possibly as one manifestation of the various new ideas about what constituted menopausal health being vigorously aired then by the doctors and the women’s groups. Their different positions and views are discussed further in section 3.4 below. This section outlines the findings of QOL related studies and what evidence they provide toward a better understanding of the implications for menopausal health issues of the new discourse being aired.

On the whole, age, emotional disturbance, insomnia and vasomotor symptoms had a negative impact on women’s quality of life (QOL). Fuh J-L et al. (2003) studied 1,360 women aged between 40 and 54, none of whom had used HRT or experienced surgically induced menopause. Their cross-sectional study found that “in general, QOL scores were poorer for peri-menopausal and post-menopausal status ... due to physical and emotional problems.” That is, “women with menopausal symptoms had significantly lower scores on all SF-36 dimensions.” Cheng M-H et al. (2007) undertook a longitudinal study which began with 734 premenopausal women in a baseline study, of whom 579 (78.9%) completed the follow-up 2 years later. Their study “found no significant effect of menopausal transition on quality of life among Taiwanese women. The decline in the role limitations due to emotional problems was related to vasomotor symptoms.” This longitudinal study and Fuh et al.’s cross-sectional study above both indicate that menopausal symptoms have an impact on women’s quality of life.

Lai J-N et al. (2006) pointed out that insomnia and emotional disturbance were the major problems related to the quality of life of climacteric women in Taiwan seeking medical advice. They compared the QOL of women who sought medical advice and those who had not visited a clinic and found the “mean scores for the physical, psychological and social domains were significantly lower among the women seeking medical advice than those” who had not. They also found that “after
controlling for demographic factors, insomnia and emotional disturbance were […] major determinants of the scores in the different domains.”

Regarding whether HRT had a favourable impact on QOL, Chiu Y-W et al. (2008) found “a direct positive effect of HRT and a direct negative effect of climacteric symptoms on both physical and mental components of quality of life” (p.209), concluding that relief of menopausal symptoms will improve women’s quality of life. Nevertheless, HRT is not the ‘magic answer’ to improve the quality of life for women experiencing severe symptoms. A recent study undertaken by Huang K-E et al. found that 24% of menopausal women in Asia—in China, Malaysia, Taiwan, Thailand and Hong Kong—described HRT as being a risk factor for breast cancer. Most women had used natural or herbal treatments (37%) for the alleviation of menopausal symptoms. Only 19% had received HRT” (Huang Ko-En, Xu Ling, Nik Nasri I, & Jaisamrarn, U. (2010). The following section will elaborate more about the use of HRT in Taiwan.

### 3.3 The Use of HRT in Taiwan

Few studies have systematically appraised the use of HRT in Taiwan. This section presents a review of the clinical trials of HRT implemented by local researchers, the development and application of HRT, and outlines the related experience of various stakeholders.

#### 3.3.1 Local Assessment of HRT

Ouyang Pei-Chuan et al. began assessing the tolerance of HRT taken orally by Taiwanese women in the treatment of menopausal symptoms in 1982. Their clinical study initially had 48 women but only 32 continued till the end. Various contraindications were listed very clearly as the criteria for excluding women from being given oestrogen replacement therapy. The study elaborated the women’s prominent menopausal symptoms and the side-effects of the therapy using empirical evidence. The major menopausal symptoms diagnosed were: hot flushes, sweating, dyspareunia (painful intercourse) or astrophic vaginitis, palpitations, and dysuria

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55 Ouyang Pei-Chuan 歐陽培銓, Chow Song-Nan 周松男, & Huang Su-Cheng 黃思誠 (1984)
56 The contraindications were: cerebrovascular disease, deep venous thrombosis and embolism, oestrogen-dependent tumours of breast, endometrial cancer, liver disease, chronic renal disease, hypertension, severe heart disease, and allergy to hormone treatment.
(difficult urination). These were improved or cured within 6 months by treatment using unopposed oestrogen (0.625mg or 1.25mg, given by mouth for 3 weeks and then 1 week off). Side-effects were mastodynia (breast tenderness), nausea, vomiting, and withdrawal uterine bleeding. Withdrawal symptoms experienced by 32 patients during the one-week-off period were hot flushes, sweating, and uterine bleeding. Twenty-five per cent of the patients experienced withdrawal bleeding; 16 of the women who participated in the initial part of the study (33.3%) did not participate in the follow-up. Subsequent clinical studies following this protocol appear to confirm the effectiveness of HRT for the treatment of menopausal symptoms (see Appendices 1, 2 and 3).

Clinical studies of the use of HRT by Taiwanese women began to flourish in the 21st century. Most evaluated the effects of different preparations of HRT; some investigated the effects of the well-established HRT medications, oestrogen and/or progesterone hormones, compared with those of new hormonal preparations or analogues, and some investigated the effects of HRT in women having a specific health problem.

In summary, the studies listed in Appendices 1, 2, and 3 focused on assessing the effects of HRT for alleviating vasomotor discomforts, and also investigated the effects of HRT on prevention of osteoporosis and heart disease in menopausal women. Most studies concurrently examined bone markers or serum lipid profiles as a measure of the metabolic effects of HRT on bones or lipoprotein. Different preparations of oestrogen and progesterone were demonstrated to alleviate menopausal symptoms; to be associated with favourable bone mineral density (BMD) and/or bone turnover results; and to decrease total cholesterol and LDL and/or increase HDL, decreasing coronary heart disease risk. Tibolone therapy was found to prevent withdrawal bleeding and be associated with improved libido; SERMs...
(selective oestrogen receptor modulators), such as raloxifene, were shown to have less potency than conventional HRT.

The Taiwanese clinical trials cited above and these studies experienced the common limitations of studies assessing the effects of HRT use:

1. Small sample sizes led to a lack of statistical power and preclude generalisation. More than half of the placebo-controlled studies had less than 30 in each group completing the study.

2. Measurement of short-term effects has limited capacity to provide valid evidence for weighing the benefits and risks of HRT use. Studies of the effectiveness of HRT in preventing CVD, for example, indicate inconsistent results: some show a risk of increasing platelet aggregation or atherosclerotic vascular disease after 6 months of treatment, but other trials conducted for 6–12 months show favourable lipoprotein metabolism measures. Most studies assessed the effectiveness of HRT for alleviating menopausal syndrome after 3–6 months of treatment, and determined the effects of HRT on BMD after 12–36 months.

3. A high rate of lack of follow-up by women participating at initial stages reflected the novelty of HRT use for Taiwanese women. The drop-out rate ranged from 14% (Chen, Lee, Soong & Huang, 2001) to 36% Chen et al., (2003)61. This high drop-out rate exacerbated the inherent limitation of originally having a relatively small number of participants. Two studies, those of Chow and Huang and of Tan, Haines, Limpaphayom, Holinka & Ausmanas, found that the adverse effects of HRT, especially vaginal bleeding, challenged the adherence of Taiwanese women (Chow, Huang & Lee, 1997; Tan, Haines, Limpaphayom, Holinka & Ausmanas, 2002). Multi-centre and multi-country studies which pool study samples, such as the Pan-Asia Menopause (PAM) study, were undertaken to address this problem.

Most reports of Taiwanese clinical trials in international journals were published between 2000 and 2004. After the dramatic WHI reports, the number of published clinical trials decreased significantly. These studies reveal the nature of the development of HRT regimens in Taiwan: the benefits of using HRT were

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demonstrated through evidence of improved BMD and favourable lipid profiles in postmenopausal women; and lower doses of exogenous hormone were used to decrease side effects.

Nevertheless, with the exception of studies examining adherence rates or lack of follow-up, the process—from the assessment of this new HRT health technology to the development of guidelines—did not include canvassing or investigating the views of menopausal women. The contraindications for HRT use were exhaustively listed in published articles detailing the criteria used to exclude people from the trials. Two related matters deserve attention, both of which involve ethical considerations in clinical practice: (1) the necessity for doctors to carefully check and communicate with women about their medical history to exclude prescribing HRT to those with contraindications; and critically (2) the question of whether surveys of women’s knowledge about HRT have included questions to determine whether these exclusion criteria have actually been employed by doctors. These two aspects are reviewed in section 3.3.3, ‘Experience of HRT use’, further below.

3.3.2 Prevalence of HRT Use

This section discusses HRT use rate and factors associated with HRT use. The prevalence of HRT use in Taiwan was examined on both a national and a local scale.

There are two sources of data for examining national usage of HRT in Taiwan: National Health Interview Surveys (hereafter NHIS) data and NHI medical reimbursement claim data. Four NHIS surveys have been undertaken since the first in 2001: in 2001, 2002, 2005, and 2009. In all these surveys, interviews of women included questions about menopausal health issues and HRT use, but the actual questions in each survey were not exactly the same and the data was not analysed or presented using the same age ranges. Table 4.2 presents some of the data from the 2001 and 2005 NHIS surveys and the 2002 KAP survey most relevant to menopausal women. An analysis of the 2002 KAP survey focused on women aged 40-59.

62 The National Health Interview Surveys 國民健康訪問調查
63 The 2005 survey covered 23 counties and cities, targeting the resident population. 3 separate questionnaires were used: for those under 12; those aged 12-64; and those aged over 65.
showed that less than 50% of the women reported having had menopausal symptoms. More than 50% of the women having had menopausal symptoms reported they had used or were using HRT: the ‘current use’ rate was 25.0%; ‘past use’ rate was 27.4%; and ‘never used’ rate was 45.9%. This study has estimated the prevalence of HRT use (both past and ‘current’) by Taiwanese women as 24% in 2002.

Table 3.2

Menopausal symptoms reported in 2001 & 2005 NHIS surveys & the 2002 KAP survey

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2002</th>
<th>2005</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample size</td>
<td>3,260</td>
<td>4,063</td>
<td>2,813</td>
<td>-</td>
</tr>
<tr>
<td>Age</td>
<td>40-64</td>
<td>40-59</td>
<td>45-64</td>
<td>-</td>
</tr>
<tr>
<td>Percentage that</td>
<td>25.0%</td>
<td>46.0%</td>
<td>30.2%</td>
<td>High % in 2002 mainly because of not including women aged 60 and over</td>
</tr>
<tr>
<td>reported menopausal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>symptoms</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Percentage that</td>
<td>-</td>
<td>70%</td>
<td>-</td>
<td>Only the 2002 KAP survey asked this question</td>
</tr>
<tr>
<td>consulted a doctor</td>
<td></td>
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</tbody>
</table>

The NHI claims database was used to trace and analyse the NHI medical claims of a cohort of women older than 40 between 2000 and 2004. The data gleaned indicates that the rates of diagnosis of menopausal syndrome and of prescription of HRT both peaked in 2001 and then decreased significantly from 2002 to 2004. A later cross-sectional study by Huang Weng-Foung et al. (2007) also provides evidence that the rate of prescription of HRT for women older than 45 dropped after the WHI report in 2002: before the report 83% of women diagnosed with menopausal syndrome were prescribed HRT; the rate dropped to 73% after the WHI report.

Findings of the rate of use of HRT by menopausal women varied from 12% to 35% depending on whether the study drew participants from the general community or healthcare facilities. Chang Chueh and Chang Chu-Hui investigated the prevalence of HRT use by women in Taipei city: 12% of peri-menopausal women, 14% of the post-menopausal women who had experienced natural menopause, and 34% of women who had experienced surgical menopause (Chang Chueh & Chang Chu-Hui

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65 16% of the women had been diagnosed with menopausal syndrome at some time in 2001 and 13% had been prescribed HRT (Kuo De-Jhen, Lee Yue-Chune, & Huang Weng-Foung (2007).
(1996). Nearly a decade later, a Kinmen Island community survey undertaken by Cheng Ming-Huei et al. showed that 25% of women aged 40–54 had formerly used HRT and 14% were current users (Cheng Ming-Huei et al., 2005).\(^6^6\) Chen R-J et al. found 31% of the women who underwent hysterectomy with bilateral oophorectomy before menopause were either former or current users of oestrogen replacement therapy (Chen, Chang & Chow, 2008). Two earlier studies undertaken at clinics in remote villages in northern Taiwan before the WHI report was released indicate similar figures of HRT use rate: Chang Jun-Yih et al. reported 32% in 2000; Chung Ding-Tien et al. reported 35% in 2001.\(^6^7\)

Generally speaking, the use rate of HRT in Taiwan has fluctuated at different times and been unevenly distributed. Summarising the 2002 KAP NHIS, and studies by Huang Weng-Foung et al, Chang Chueh, and other researchers, HRT use was reportedly: higher before the WHI report: higher in the questionnaire surveys than the analysis of the NHI claim database indicates; higher in patients in the medical clinics than in the community; and higher among women who have undergone surgical menopause. Apart from the impact of the 2002 WHI report, factors such as doctors’ area of specialisation, the accreditation level of the administering healthcare facility, and women’s educational level were identified as variously associated with the changing levels of the prescription of HRT (Huang Weng-Foung et al., 2007). More details of the forces pushing and pulling HRT use will be examined in the next section.

### 3.3.3 Experience of HRT Use

This section will examine the Taiwanese experience of the knowledge and behaviour aspects of the use of HRT from the perspective of women and of doctors.

**Knowledge about HRT use**

Tsao Lee-Ing et al. (2004) appraised the level of knowledge that middle-aged women have about menopause and found their understanding of HRT use was low. They found that ‘less than 1.4% (n = 353) of the women appraised knew that HRT required a doctor’s prescription and also subsequent regular health check-ups. …


About 25% thought that HRT should be taken for the rest of their lives after menopause’ (2004, P627). Women’s sources of information about HRT were family or friends, health professionals, and the mass media (Chang Jun-Yih 張俊毅 et al., 2000; Chung Ding-Tien 鐘頂天 et al., 2001; Pan et al., 2002).68

Surveys of gynaecologists’ and family doctors’ knowledge of and attitude to HRT, and their related practices show that quite a high percentage were well-informed about HRT and the need to physically assess patients before prescribing it, and that regular use can improve menopausal symptoms and prevent osteoporosis and cardiovascular disease (Yao, Hsu & Huang, 1996; Yeh Nan-Hung 葉南宏, 2002; Cheng Shao-Yi 程紹儀, 2005). Nevertheless, Yeh Nan-Hung (2002) found that before 2002 only one third of gynaecologists had actually collected patients’ medical history and completed a physical examination before prescribing HRT in their clinical practice. The studies showed that most gynaecologists and family doctors were simply concerned about women using HRT regularly to prevent osteoporosis and cardiovascular disease before 2002; they hardly questioned its use until the WHI report. These professionals’ knowledge of HRT was itself inadequate.

Patterns of, adherence to & discontinuation of HRT use

A healthcare issue related to efficient use of public health resources was patients' discontinuing HRT. The HRT withdrawal rate was high: four studies, three of which were undertaken before the first 2002 WHI report, reported it as variously 22.9% 69, 36.7% 70, 38.2%71, and 68.8% 72. Most of the women had discontinued HRT within three months of starting treatment without consulting doctors. The reasons for discontinuing HRT reported in these four studies were: not knowing about the necessity to continue taking the medication; forgetting to take it; symptoms being alleviated, or not significantly improving; reluctance to undergo long-term use; concern about cancers; recurring periods (bleeding); weight gain; unbearable side

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69 Chung Ding-Tien 鐘頂天 et al. (2001)
70 Lin Yu-Xuan 林宇璇 et al. (2004)
71 Chen Ching-Min 陳靜敏, Ho Mei-Hua 何美華, & Yi-Yi (2000)
72 Chang Jun-Yih 張俊毅 et al.(2000)
effects; or being advised by their doctor to avoid HRT because of having the contraindications of hypertension or diabetes. Adherence behaviour was predicted by receiving spouse’s support and by a woman’s health belief model: perceiving lower severity of menopausal symptoms; feeling fewer barriers to taking HRT; and reporting experiencing a better quality of life (Chen Ching-Min 陳靜敏, et al., 2000).

Explanations various researchers identified for using HRT included: to relieve menopausal symptoms; after hysterectomy or oophorectomy; on doctor’s advice; acting on information obtained from magazines or newspapers; it being recommended by friends or family, and worrying about osteoporosis, or suffering from back pain (Chang Chueh & Chang Chu-Hui, 1996; Chang Jun-Yih 張俊毅 et al., 2000; Chen Ching-Min 陳靜敏, et al., 2000; Chung Ding-Tien 鐘頂天 et al., 2001; Lee Shu-Keui 李淑桂 & Kuo Bih-Jaw 郭碧照, 2002; Wang M-C 王妙娟, Liu T-E 劉彩娥, Chiu S-C 邱淑瑾 & Chen J-T 陳進堂, 2005). ‘Starting HRT was also associated with having severe menopausal symptoms; the impact of vasomotor symptoms; the implementation of health maintenance or improvement related behaviours; work status; family support or friends’ experience of HRT use; negative attitudes toward menopause; and its impact on women’s attractiveness or on an active sexual life (Cheng Ming-Huei et al., 2005; Chiou Yah-Wen et al., 2006).

These studies had a range of conclusions. Cheng Ming-Huei et al.(2005) indicated HRT users were more likely to report depression, irritability and regret about menopause compared with non-users, whereas Chiou Yah-Wen et al.(2006) concluded that the group using HRT experienced significantly less severe climacteric symptoms. There were also inconsistent findings about whether HRT users had adopted more healthy life styles: Chang Jun-Yih et al.(2000) and Chung Ding-Tien et al. (2001) found that HRT users undertook more Pap smears and more breast self-examinations; Chiou Yah-Wen et al. (2006), however, found that HRT users adopted less dietary and lifestyle changes to address their climacteric symptoms. The reported effects of improved menopausal symptoms after HRT intake were also inconsistent. According to Chen R-J et al., women reported the main effects of HRT as being relief of the vasomotor symptoms insomnia, palpitations, and cold sweats (Chen, Chang & Chow, 2008).
National NHIS surveys and the 2002 KAP survey indicate that more than 40% of menopausal Taiwanese women never undertook HRT (see Table 4.2). Their reasons included: not experiencing any menopausal discomfort; fear of cancer; concern about the side-effects of HRT; never considering seeking medical help; exploiting other complementary and alternative therapies; and regarding hormone therapy as an unnatural measure to take in response to the menopausal phenomenon (Tsao Lee-Ing 曹麗英, 1998; Lee 李昭男, Tsai 蔡英美 & Chang 張永源, 2004). The rate of HRT use among those who have experienced surgical menopause in Taiwan was lower than that in the USA. Chen R-J et al. found that although 49.5% of such women ‘regarded HRT as necessary to improve vasomotor symptoms, 50.4% of them had never used it. They said that they would only use HRT if their doctors could persuade them that the benefits outweighed the risks’ (Chen et al., 2008).

The factors affecting doctors’ prescription of HRT were identified as:

(1) the doctor’s specialty, gender, the location of their practice, and the accreditation level of the hospital where they had completed their internship;

(2) their knowledge of and attitude regarding the use of HRT to prevent some chronic diseases and their knowledge of its potential harmful effects with regard to breast cancer and thrombo-embolism; and

(3) the aggressive promotion of HRT by the pharmaceutical industry, and the WHI reports (Cheng Shao-Yi 程紹儀, 2005; Huang Weng-et al., 2007). Cheng Shao-Yi found that family doctors tend to both consider the benefits of preventing chronic disease and evaluate the potential harm before prescribing HRT, whereas gynaecologists disproportionately place more emphasis on its beneficial effects. Female doctors were reluctant to prescribe HRT to treat vasomotor symptoms or osteoporosis in women with a family history of breast cancer (2005). Interestingly, a recent study indicated that only 7% of female doctors used HRT, a percentage significantly lower than that of the female relatives of doctors and of women in general (Chien, 2010).

73 Cheng Shao-Yi 程紹儀 (2005)
3.4 Arguments around HRT Use and Menopausal Health

3.4.1 Responses to the WHI Report

In response to the WHI report in July 2002, some medical professionals in Taiwan, primarily gynaecologists, argued that the regimen used in the American trial was different from that in Taiwan and that Western women have different physical constitutions to Taiwanese women. The Taiwanese Menopause Society, Taiwanese Osteoporosis Association, and Taiwan Association of Gynaecologic Oncologists issued a joint press statement in August 2002 stating that:

(1) HRT encompasses both benefits and risks which should be evaluated based on individual women’s characteristics, particularly women with a family history of breast cancer.

(2) Local variations in humans and different lifestyles might result in different outcomes of HRT use, i.e., it might not be appropriate to generalise the WHI findings to Taiwanese women.

(3) The WHI report revealed the relative risks of HRT rather than the absolute risks. The absolute risks for the whole female population were in fact fairly low.

(4) The report ascertained the effectiveness of HRT to prevent bone fracture and osteoporosis which have a higher incidence than stroke in Taiwanese women.

(5) HRT is still an effective regimen to relieve menopausal symptoms and women should consult their doctors before discontinuing its use.

(6) Women who have used HRT for more than four years were advised to have annual health checks for breast cancer and heart disease to assess whether they had developed these health problems reported as risks by the WHI.

(7) Women who had undergone a hysterectomy were advised to continue using HRT, since the WHI study had not identified any risks for such women.

(8) HRT was not recommended for the prevention of CVD.

74 台灣更年期醫學會 (Taiwanese Menopause Society, TMS), 中華民國骨質疏鬆症學會 (Taiwanese Osteoporosis Association); 台灣婦癌醫學會 (Taiwan Association of Gynaecologic Oncologists)
Women’s health activists expressed their opposition to this joint statement and highlighted it as an attempt by the medical “camp” to limit the impact of the WHI report on HRT use in Taiwan (Chang Chueh 張玨, 2003; Lu 盧孳豔, Chen 陳海焦 & Juan 阮月清, 2006). Their views were that:

(1) Taiwanese specialist medical associations were exercising a double standard when evaluating HRT: specialists were happy to prescribe HRT on the basis of evidence from studies undertaken in Western countries but then dismissed risks identified in studies with the same Western origins on the basis that the bodies of Taiwanese women are different.

(2) The government should declare its stand, review the reimbursements for the prescription of HRT, and commence local assessment of HRT.

(3) Health professionals should avoid conflicts of interest in any relationships with pharmaceutical companies; and

(4) the healthcare system should reconstruct its concept of ‘menopause’ rather than use the medicalised model (Taiwan Women’s Link, 2002).

Shu J-B reported in the United Daily News (16 June 2004) that the Breast Cancer Society of Taiwan had indicated that HRT use did increase the risk of breast cancer and therefore recommended that it be used for less than one year. The Breast Cancer Society advised women to use HRT for 6 months to one year and then discontinue treatment if they had no aggressive menopause symptoms and were able to do so, in order to avoid dramatically increasing their risk of falling victim to breast cancer.

In 2004 the Taiwanese Menopause Society put out updated guidelines about the use of HRT, based on the evidence from the WHI study and incorporating a statement by the North American Menopause Society and the International Menopause Society. Its 2004 hormone therapy guidelines made three position statements: (1) there was a slight increase in the risk of breast cancer after a five-year use of HRT; this, however, did not constitute a significant absolute risk for individual consideration; (2) a health check and risk appraisal are necessary for all women commencing or continuing HRT; and (3) lower dosages of HRT were recommended for commencement within 3 years.
of early menopause, and more than 5 years of HRT was recommended for preventing osteoporosis and/or minimising its severity.

Tan et al. report that since 2006 several updated guidelines for Asian women, including one for Taiwanese women, have been published in international journals to ‘aid gynaecologists, family doctors, and other health-care professionals providing optimal care to menopausal Asian women who desire HRT’ (Tan, Darmasetiawan, Haines, Huang & et al., 2006). Their study highlighted the diversity of Asian countries and the consequent importance of: individualising hormone therapy, women’s right to participate in the decision-making process, considering using low doses, and there being no reasons to place mandatory limits on the length of HRT treatment.

According to Tsai Wan-Fen (2005), there were divergent discourses on menopause in Taiwan after the WHI report. Doctors from different areas of specialisation had different attitudes toward HRT, as their attitudes toward the WHI report were. After the WHI report, the different views in the public arena became polarised between a female ‘body autonomy’ model of the women’s health activists and a male-oriented medical model of the medical fraternity. The conflict hinged on the question of “who possesses the legitimate power to speak?”: whether “medical professionals” or “non-professionals - the activists” had the power to speak about HRT became a focus of menopausal discourse and put this fundamental question under the spotlight.

Women’s groups adopted different strategies in response to the new situation, including calling public attention to the WHI report. An accompanying development was a change in the doctor-patient relationship. The medical world began to incorporate the concepts of “individualised treatment” and “letting women make their own treatment decisions”. Nevertheless, despite the transformation, the position of the medical world still essentially reflected the biomedical discourse of the clinical trials of the WHI (Tsai Wan-Fen, 2005).

### 3.4.2 Ongoing Debate

The menopause-related debate which mainly stems from different conceptualisations of menopause is still ongoing. Before the WHI report, the
menopause discourse in Taiwan was principally viewed quite separately, from a biomedical and from a socio-cultural and/or feminist perspective by those in the respective two ‘camps’ outlined above. A vast number of the early epidemiological studies concerning various aspects of menopausal health issues and HRT clinical trials cited above and the majority of the major QOL studies present a biomedical perspective and regard menopause as a risk factor to women’s ageing health.

In comparison with the number of biomedical studies, in the early 1990s there were very few studies undertaken in Taiwan that investigated socio-cultural aspects of menopause; it was not until the late 1990s that there was a noticeable increase in the number of such studies. This research can be broadly divided into two types: the first are studies that focus on discussing and making recommendations regarding the medical advice and treatment-seeking of menopausal women, and regarding these women’s unmet needs, presenting the perspective of nursing personnel. These studies, including those by Tsao et al. and Su et al. in the 2000s, found that doctors were promoting the effectiveness of HRT but neglected its side effects. A matter of serious concern is a number of surveys that indicate that although women with menopausal symptoms looking for medical treatment services were more likely to be prescribed HRT by their doctors, approximately 50% of the women using HRT were not well-informed, especially about its side effects and risks. (BHP, 2002; Chang & Chang, 2004; Lin Yu-Xuan 林宇旋 et al., 2004; Wang 王妙娟, Liu 劉彩娥, Chiu 邱淑瑾 & Chen 陳進堂, 2005).

The other main type are those studies examining the medicalisation of menopause undertaken from a public health and/or feminist position, and calling on the government to formulate health policies which respond and cater to the needs of the great majority of menopausal women in the population. Chang Chueh and Chang Chu-Hui (1998) argued before the turn of the century that menopause has actually been medicalised in Taiwan. An ethnographic analysis of women’s self-reported menopausal experiences in Taiwan undertaken by Lu Z-Y Jane and Yang S-C (2000) indicates that the medical world defined the health issues associated with the climacteric and categorised women by their different hormone levels; the mass media
presented data essentially constructing a package of “menopausal knowledge” but was silent about women’s subjective experience.\(^7^6\)

In a subsequent study, Lu Z-Y Jane and Lin H-K argued that the Western medicine approach in Taiwan’s healthcare system mostly reduced menopause to equating it with particular levels of oestrogen, a measurable and quantifiable product related to symptoms during the climacteric. Women were studied using traditional scientific methods and having decreased hormone levels was regarded as a disease. Research questions were formulated around symptoms and treatment, generally leaving a void regarding the aspect of individual women’s menopausal experience (Lu 區孳豔 & Lin 林雪貴, 2001).

Early in 2000, Chang Chueh and Chen Fen-Ling advocated promoting menopausal health by raising women’s awareness, and integrating a gender mainstreaming perspective into health policy.\(^7^7\) Lu Z-Y Jane and Yang S-C (2000) argued that midlife women should therefore become involved in their own healthcare through women’s collective power and cooperative actions. After the WHI report, Chang Chueh (2003) commented that women’s menopausal health should be an essential element addressed by Taiwan’s public health policy. Unlike the National Institute of Health in the USA, Taiwan’s Department of Health had never investigated the use of HRT nor responded appropriately to the WHI study. The medical community and government both failed to provide essential healthcare information to menopausal women, failed to put in place prevention and treatment strategies, failed to acknowledge recommendations made by women’s groups, and failed to scrutinise the ethics of medical conduct.

A more recent paper by Lu and Chen, one essentially challenging the medical model, argues that osteoporosis screening campaigns have become commonly and enthusiastically accessed in recent years by middle-aged women in the community who have come to consider such screening a routine part of their own health maintenance routines. This preventive health service was made available by a PPP cooperation of the public health sector and private companies—one strongly promoted by pharmaceutical companies—presented within a framework of individual

\(^7^6\) Lu Z.-Y. Jane 區孳豔 & Yang S.-C. 楊舒琴, (2000)
\(^7^7\) Chang Chueh 張玨 & Chen Fen-Ling 陳芬苓 (2000)
choice and freedom. The public sector is involved to lessen the medical cost burden of osteoporosis. Lu and Chen analyse how the policy of promoting this mass screening has also, however, created a knowledge of osteoporosis, i.e. a pathological condition, as being associated with the menopausal body. This raises the central question of how menopausal women's screening results are discussed and interpreted. They also called for an alternative preventative approach to ageing-related bone health issues: in the form of focusing on making environmental modifications to avoid falls and bone fractures rather than on individuals’ personal management (Lu, & Chen, 2007).

3.5 Conclusion

In Taiwan, easy access to the healthcare system and high rate of healthcare utilisation has facilitated the medicalisation of both menopause and of women’s ageing. As in the case of osteoporosis, widely available access to healthcare technology has helped give rise to a situation where it has become the norm for menopausal women to incorporate the use of such technology as part of their regular health checks. The population has been encouraged to use medications such as HRT and health screening services, expressions of the medical model, to maintain their health, and promote public health. But given the increasingly growing ageing population and demands for higher QOL, there is absolutely no way that the health and welfare of the people of Taiwan can continue to operate with these health resource consumption trend patterns. This issue has significant ramifications for Taiwanese women’s menopausal and ageing health policy.

This chapter has given a review of major studies regarding various aspects of menopausal health and the associated discourse in Taiwan. Whether embracing the biomedical or feminist model, these principally follow the models of Western countries, particularly the USA. But despite the numerous studies done over so many years and all the findings, there has still been no resolution of the central question about which the biomedical and feminist ‘camps’ hold contending views and approaches: how should menopausal women’s health needs be met? The next chapter will further examine this issue and women’s health situation in Taiwan. It discusses health policy and the health promotion approach as a possible effective means of
translating knowledge into better promotion of better health for Taiwanese women during menopause.
Chapter 4
Menopausal Health: Feminist Perspectives
and Health Promotion

The previous two chapters discussed the controversy surrounding menopausal health and the use of HRT based on the North American and European countries, and the Taiwan experience. The associated debate has gone on unabated, with supporters of the contending biomedical, social-cultural, and feminist models putting forward their strongly reasoned positions, but no one viewpoint is comprehensive enough to explain all the complexities of menopause. The biomedical perspective fails to take into account the holistic experience of women during the menopausal transition, and the socio-cultural and feminist perspectives can both be criticised for not offering effective viable ways to ease menopausal distress and for not offering strategic planning to improve women’s health and well-being.

This chapter presents the feminist perspectives on women’s health, particularly menopausal health; discusses public health policy approaches and implications; and outlines the relationship of women’s health and public health with the multidisciplinary approach of health promotion.

4.1 Feminist Perspectives on Menopausal Health

4.1.1 Feminists and the Women’s Health Movement

Reproductive issues became significant in the first wave of feminism in the USA at the beginning of the 20th century. In the 1910s and 1920s there was a focus on the birth control movement, creating public consciousness around the need for women to have control of their bodies (Rosser, 2008). Through the efforts of the first wave of the feminist women’s health movement, the language of reproductive health, gender and sexuality has undergone a process of legitimisation in academic settings and within social movements (Corrêa, 1997).

The 1994 International Conference on Population and Development (ICPD) in Cairo saw 179 governments agree to adopt a comprehensive Program of Action to ‘ensure universal access to reproductive health, uphold fundamental human rights, alleviate poverty, secure
gender equality and protect the environment’. This was a landmark achievement for feminist activists (Corrêa, 1997). At that conference, the World Health Organisation defined reproductive health as “a state of complete physical, mental, and social well-being, and not merely the absence of diseases or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and they have the capability to reproduce and the freedom to decide if, when, and how often to do so” (Corrêa, 1997, p.111).

There is ongoing debate between those calling for ‘reproductive health’ and those calling for ‘reproductive rights’. Many different interest groups and activists advocate ‘reproductive health’ but ‘reproductive rights’ remain a central concern on feminist health agendas worldwide (Corrêa, Germain & Petchesky, 2005). In the 1980s, policy makers, scientists, and women’s health and rights activists began to acknowledge the intrinsic relationship between health and human rights. But fundamentally, despite the Cairo consensus, the differences and debate between these two parties continued. In many developing countries, for example, the reproductive health objectives are to increase contraceptive prevalence rate and reduce population growth through government-sponsored family planning programs. Women there have become targets of programs to improve contraceptive use and to reduce fertility: the rights of individual women to make informed decisions regarding reproduction and sexuality are at times ignored in order to achieve a national political goal.

The human rights aspect of women’s reproductive health inevitably involves empowering women to have control over their own fertility and sexuality under conditions of voluntary choice and minimum health problems. Government policies should create and maintain the infrastructure necessary for delivering contraceptive services, health services, and public information delivery services on a basis of respect for individual decision-making to ensure people’s reproductive and sexual health, bodily integrity, and personal security. Policies should include a list of the top health threats to women worldwide, such as illness and death from complications of pregnancy and childbirth, unsafe abortion, the improper use of contraceptive methods, and sexually transmitted diseases (Pillai & Wang, 1999).

The second wave of the feminist women’s health movement in the USA which started in the late 1960s and the 1970s turned women’s health concerns into political issues. These included women being able to have “access to safe birth control, abortion and information
about their physiology and anatomy, to define their own experience as a valid aspect of their health needs; and to question the androcentric bias found in the hierarchy of the male-dominated healthcare system and its approach to research and practice” (Rosser, 2008, p. 407). Rosser pointed out that the “definition of women’s health in the industrialised countries should be expanded beyond reproductive health” (p. 409). Women’s health cannot simply be understood as ‘synonymous with obstetrics/gynaecology’, a field dominated by male medical professionals; nor could women continue to be excluded from being experimental participants, the conventional practice which had resulted in a ‘male-as-norm approach’ to treating disease in women, for example, cardiovascular diseases. The expanded definition of women’s health encompasses the interdisciplinary character of most issues in women’s health and disease, and provides a rationale for the interaction of healthcare professionals and researchers from diverse specialties, professions, and disciplines. Acquired immune deficiency syndrome (AIDS) in women presents an example of a disease which requires ‘social factors and power/gender interactions’ to be understood to be able to effectively combat it. Many diseases that occur in both sexes had been studied in males only and/or treated using a male-as-norm approach. Research and diagnosis based on this approach led to failure to identify and assess gender differences and under-diagnosis and under-treatment of women. The Women’s Health Initiative was established in the USA in 1991. It sought to fill the gaps in research and practice, collect baseline data, and look at interventions to prevent cardiovascular diseases, breast cancer, colorectal cancer, and osteoporosis (Rosser, 2008).

4.1.2 The Defining of Menopause

Illness is socially constructed. As Lorber and Moore (2002) indicate “the symptoms, pains, and weaknesses regarded as being sick are always experienced in a social context and shaped by cultural values” (p.2). Similarly, menopause is socially constructed: it too is “always experienced in a social context and shaped by cultural values”. At different stages of the life cycle, from childhood through to adulthood, a woman’s biological state changes: the phenomena of menstruation, pregnancy, childbirth and menopause are mediated and experienced socially (Lorber & Moore, 2002). Cross-cultural studies have demonstrated a wide variation in the presentation of menopause, although, in a strict biological sense, menopause is defined as the cessation of menstruation (Hunt, 1994).

Hunt reported the debate surrounding the definitions of menopause in the 1990s as reflecting a tension between seeing menopause as ‘natural’ and as ‘pathological’ (ibid, 1994
p.152). In the biomedical model, medical science is considered to be an application of socially neutral scientific research in individual cases. A biomedical approach encourages doctors to treat illnesses, not the patient. “Sociologists use the term *medicalisation* to explain how life events, including all aspects of the ageing process, and social problems such as alcoholism and obesity, come to be defined and managed by healthcare professionals” (p. 6).

Feminists aim to understand the experience of midlife women, and how their experiences are interpreted and influenced by the dominant medical model (Coupland & Williams, 2002). Regarding medicalisation, feminists aim to ‘understand how the “scientific truth” has set the standard of the “truth” for menopausal women, then how the game rules of “truth” can be adopted to control women’ (Hunt, 1994 p. 156). The provision of hormones to replace those lost after menopause is an example of the embodiment of the medicalisation of menopause. This medical control is particularly related to images of femininity and seeing menopause as an oestrogen deficiency syndrome (Lorber & Moore, 2002).

A dominant theme of second wave feminism has been the validation of women’s own experiences in the face of competing medical definitions (Hunt, 1994). Hunt highlighted the female body, life cycle, and experiences as ‘legitimate sources of knowledge’. This knowledge is ‘relational, contextual and fallible’, developed within both historical and cultural contexts. Quintanilla et al. point out “The menopause may be complete in itself while the climacteric continues; this is similar to young women reaching puberty, a transition which spans five or more years during which they adjust to a uniquely personal altered chemistry, and incorporate a new self-image” (2004, p. 102). They argue that the “biomedical model is brought about through an imperative to control and direct nature” (ibid, p. 103). Women, however, ‘own’ their menopause, something which encompasses a collection of experiences, attitudes, and interpretations (Quintanilla, Cano & Ivy, 2004). The feminist model views menopause as a natural transition women undergo rather than a disease or illness (Murtagh & Hepworth, 2003b). Menopause as a physical change is experienced bodily in various ways by individual women, and women are subject to being different social and cultural expectations which are far from universal (Wary, 2007).

A major focus of concern within feminism, in relation to both health and other issues, has been empowerment, particularly through the acquisition and dissemination of health information which enables women to participate in decisions regarding their own bodies, particularly during clinical encounters. Thus, the menopause and HRT both raise and
reverberate important issues for a feminist agenda (Hunt, 1994). The feminist model presented an alternative way to view and treat menopause, one which challenged the medical model of menopause as being a disease and a risk factor for osteoporosis and CVD. In the 1990’s Western feminists worked towards defining menopause from the perspectives of menopausal women and understanding their everyday experience in order to bring about changes. The feminist model means a discussion of menopause no longer leads to being about how women’s reproductive systems have failed; instead, it leads to a sensible discussion of how such women’s reproductive systems have fulfilled their purpose (Guillemin, 1999). This change presents a more positive image of menopause and challenges the implication that all women need medical treatment (Quintanilla, Cano & Ivy, 2004).

Women making their own choices, exercising informed decision-making and empowerment are three key themes for the twenty-first century; Murtagh and Hepworth (2003) highlighted these as the focus of feminist ethics in the area of primary medical care for Australian women during menopause. A shift toward including women’s experience in medical consultations about menopause and involving them in decision making about HRT can be identified in the medical literature on menopause. Some examples are: menopausal women’s anticipation for more information about the pros and cons of HRT when seeking doctor’s help (Havas, Reventlow & Malterud, 2004); women being in favour of communication to reach an informed and personalised choice (Walter, Emery, Rogers. & Britten, 2004); and women regarding HRT as a source of temporary relief rather than a long-term panacea (Hyde, Nee, Drennan, Butler & Howlett, 2010).

4.1.3 Challenges Faced by Feminists

The achievements of the women’s health movement have made women’s health an important social concern, as well as educating women about taking responsibility for their own health and health decisions. Sawer and Grey’s 2008 review, however, reported that a still ‘ongoing struggle for equality and autonomy’ after the second-wave women’s movement in Europe and North America (p.1). They reported on one hand, women’s groups gained access to the policy-making process and additional public funding for information services, domestic violence refuges and women’s health collectives through institutionalised activities in the 1970s and 1980s. On the other hand, ‘public funding itself led to demands for more conventional forms of organisational accountability which also placed increasing constraints on women’s advocacy’. Another factor, reducing the momentum of women’s groups’
advocacy of issues, was a ‘decline in street protests and strong grassroots activism’. This resulted in less media attention and a loss of interest on the part of political parties and government which ‘eroded the political base for interventions within the state’. This also ‘rendered women’s policy agencies vulnerable to downgrading and disappearance, a pattern seen particularly clearly in Australian women’s movements’ (Sawer & Grey, 2008, pp. 4-5).

Another new question arose in the late 1990s: ‘Who will speak for women in the electronic age?’ (Ruzek & Becker, 2002). Feminism is diverse and divergent: the various feminist theories reflect many of the distinct social changes intended to eliminate different sorts of gender oppression (Sherwin, 1992a). Ruzek and Becker (2002) pointed out that in the US, the surviving grass-roots advocacy groups from the 1970s and 1980s had ties to radical social movements emphasising social justice and social change. The more recent disease agenda groups which flourished in the 1990s were mostly comprised of women doctors and highly trained professionals. Their advocacy was typically focused on a single disease or health issue: “much of organised feminism, as it evolved both in media imagery and academe, came to be seen as distant or disconnected from ordinary women’s lives.” (p.296) Certainly neither the grass-roots nor the later professionalised groups adequately tackled how to communicate with their population effectively, partly because of the uncertain nature of virtual organisations on websites and because of communication gaps with middle-class feminists (Ruzek & Becker, 2002).

An additional complication is presented by the fact that what ‘healthcare’ itself encompasses is replete with imprecise elements. From a feminist perspective, using medical terminology to discuss menopausal symptoms may lead women to be more responsive to ‘the marketing of hormone products which play on the fears of specific disabling or life-threatening conditions and also, very purposefully, on women’s fear of ageing’ (Hunt, 1994 p. 153). Murtagh and Hepworth (2003) pointed out that the ‘ethic of autonomy’ (p. 1644) strongly advocated by feminists regarding women’s own experience of and their voices about menopausal healthcare is very different to what occurred in the 1990s when the focus was limited to women’s adherence to HRT. From the medical viewpoint, however, menopausal women who choose not to consult a doctor when they experience irregular menses may risk failing to detect some underlying pathology, and thereby miss out on the potential benefits of early detection and treatment.
Rosser (2008) pointed out that there was very little research on women’s experience of menopause and very little comparing the health of menopausal women taking HRT with those who did not take it until the Women’s Health Initiative. Quintanilla et al. adopted Gail Sheehy’s estimation (1998): that 20% of women go through menopause with no problems; about 10% are temporarily hampered; and the remaining 70% ‘wrestle to some degree with difficulties that come and go over a period of years of dealing with the lengthy transition from their previous reproductive state’ (pp. 103-104). Some women experience this passage into menopause as a result of surgery or cancer treatment. Individual women’s different experiences mean they have differing needs when going through menopause (Quintanilla et al., 2004).

The feminist approach offered women a positive view of menopause but many feminist intellectuals did not provide an ‘agenda exactly in line with what ordinary women want’ to address women’s menopausal health (Corrêa et al., 2005). “[H]ow they present themselves and are perceived” in the information age is not the only challenge for women’s health activists (Ruzek & Becker, 2002); another is that medical care has become dominated by market forces in which “healthcare has been driven by the profit motive” (Zimmerman & Hill, 2000, p.787). Biomedical approaches, however, were also still criticised for dominating the research on women’s health and for top-down population policies. What has kept the movement relevant and strong is its dedication to identifying and articulating women's needs until these are heard and formulated into specific demands, and working as activists to turn ‘needs’ and ‘demands’ into realities locally, nationally, and globally (Zimmerman & Hill, 2000; Quintanilla et al., 2004; Corrêa et al., 2005).

4.2 Women’s Health and Public Health Policy

4.2.1 Health Planning using Traditional Epidemiological Approaches

In the 1990s the research methods in the public health field were dominated by epidemiology (Baum, 2002, p.121). Epidemiology was even called the “basic science of public health” (Wing, 1994, p.74). Preventive medicine and health promotion policies were generally formulated based on identifying and quantifying exposure-disease relationships. Using this epidemiological approach effectively simplified the health needs and health outcomes of target groups (Baum, 2002; Brownson, 2006). Epidemiological techniques—such as surveys, case-control studies, cohort studies, and large trials and epidemiological
interpretations—are used to assign individuals to specific risk categories and trace biological pathways to health outcomes.

Public health has always been a contested and disputed area of practice and knowledge, in that there is a tension between medical understandings of health and those based on a more social interpretation (Baum, 2002). In medical models of preventive health, professionals largely maintain a disease-oriented approach and focus on risk factors and indicators of poor health, such as tobacco use, obesity, and a sedentary lifestyle. They examine those risk factors and how best to modify them, and publish material on decreasing risk factors or increasing clinical interventions, in spite of evidence that they do not have reliable paradigms for dealing with these issues (Scutchfield, 2004).

In the 1990’s many critics claimed that the fundamental public health dimension of epidemiology has been lost and replaced by the dominant disease model. Inhorn and Whittle (2001) commented that in mainstream epidemiology the ‘exposure-disease’ model frames health problems in terms of de-contextualised exposures to risk factors, or to the particular behaviour of individuals. This exposure-disease approach routinely evaluates the percentage of people in a population who responded to a survey or an investigation regarding a specific public health concern. But the exposure-disease approach mostly ignores why people do respond, and how people interpret the health concern being investigated. Furthermore, the model does not help to explain the sources of people’s health-related concerns nor the reasons for their health-related behaviours. The nature of epidemiology’s ‘closed’ system of knowledge precludes asking such questions or rigorously interpreting information presented about them: it ignores meanings as a determinant of human behaviour. The epidemiological modelling of disease causality within an exposure-disease paradigm informs both the personal, patient-oriented framework of biomedicine and that of population-based, community-oriented public health.

The exposure-disease model frames the individual as the agent of prevention. Not only is society’s obligation to remove the adverse social circumstances damaging to health left unexplored, but illness is transformed into a private event (Lippman, 1992). Thus, mainstream epidemiological research encourages public health policies that:

(1) blame individuals for their poor health by portraying risk as a lifestyle choice;

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(2) limit our understanding and prevention of disease causation by ignoring meaning as a determinant of human behaviour: and

(3) leave unquestioned social rankings of gender, race, or income by ignoring how these relationships mediate an individual’s power, personal activity, and available choices relating to their health (Inhorn & Whittle, 2001). As a result, epidemiological information on gender-based differences manifestly simplifies the differences in the health needs of women and men. It cannot establish the facts of how everyday life practices of women and men are structured into their capacity to access vital social resources in terms of employment, income and education, and how gender inequality can thereby occur (Schofield, 2002; Shim, 2002).

More recent public health approaches have brought a social-structural perspective to understandings of the construction of social risk, the power exercised by participating in society, and the effects of income and wealth distribution on health patterns (Baum, 2002). Turning attention to ‘upstream’ health determinants, such as social capital development, and land-use planning, and dealing with the equitable distribution of wealth and society’s resources, calls for a broader understanding of the aetiology and interventions in health status than the traditional medical paradigm embodies. Such an ecological approach to health status requires an expanded knowledge base of public health and preventive medicine (Chu, 1994b; Scutchfield, 2004; Davies & Macdowall, 2006).

4.2.2 Gender Sensitivity and Equality

Gender sensitivity in the public health arena is awareness of the need to examine sex and gender as variables in health policy (Vlassoff & Moreno, 2002). Gender differences exist in the area of mortality, morbidity, and use of health services: for example since the 1970s, women in industrialised countries have been found to live longer than men and to have lower mortality rates from most causes of death, report more acute illnesses, and use health services at substantially higher rates than men (Nathanson, 1977). As Correa et al. (2005) pointed out, although women generally have a longer average life expectancy than men, they do not necessarily lead healthier lives, and there are significant differences in the health needs of both men and women.

Gender equity is increasingly being identified as one of the goals of health policy at both national and international levels. Health outcomes for both individuals and populations are profoundly influenced not only by the biological differences between men and women,
but also by the different social and cultural roles, expectations and constraints placed upon them in society by virtue of their gender. Many health problems which women face are not directly related to their biological characteristics. Gender inequalities in income and wealth, for example, make women especially vulnerable to poverty, which is one of the crucial socioeconomic determinants of women being unable to access healthcare and/or unable to have their basic health needs met. Thus, policies must be developed that ensure that both gender groups have equal access to social and economic resources, and that also take into account the socially constructed gender-role differences between men and women in all aspects of care, including curative healthcare, reproductive healthcare, preventive healthcare, information and education, health research, and infrastructure (Gijsbers Van Wijk, Van Vliet & Kolk, 1996; Zimmerman & Hill, 2000).

Major gender inequalities have been identified in access to services and in the way men and women are treated by the healthcare system. Gijsbers Van Wijk et al. (1996) found that women, in general, were under-represented in decision-making in healthcare, even though women are both major healthcare providers and major healthcare users. Secondly, they found that the quality of healthcare is not defined or assessed by existing differences in cultural roles and the needs of women and men. Apart from women’s bodies, physiology, and life cycle differing from those of men, large differences also exist between individual women: their age, socio-economic status, race, culture, sexual orientation, childbearing and motherhood experience, employment status, and so on. As Zimmerman and Hill (2000) pointed out, the healthcare systems mostly dominated by male providers fail to view women as a heterogeneous group, with consequently differing needs and expectations.

4.2.3 Gaps in Translation of Knowledge into Policy

Although knowledge of gender differences in health is increasingly available, such knowledge does not translate easily into health policy specifics. Ostlin et al. pointed out that a lack of translation of knowledge about gender inequalities into health promotion programs leads to misallocated resources and weakened potential for success (Ostlin, Eckermann, Mishra, Nkowane & Wallstam, 2007). Many public health strategies ignore making policy changes at the societal level and focus on behavioural change at the individual level where the material, social and psychological conditions are embedded. For example, working women’s strategies for coping with personal stress may not succeed without complementary measures to ease their burdens; measures including universal provision of accessible and
affordable day-care centres for children and/or the introduction of more flexible working hours. The traditional public health approach is top-down, with experts identifying problems and formulating interventions which do not necessarily correspond with target groups’ health needs. Menopausal health promotion programs simply cannot be effective unless women’s voices have been incorporated into all aspects of policy development (Baum, 2002).

The health concerns of midlife and ageing women are one of the pressing health needs of women throughout the world, and as women’s life expectancy increases, their health needs are becoming increasingly important. An immense number of baby boomers are now at midlife, and they are consulting doctors more often and being prescribed more medication than any previous generation (Scott, 2007). The specific health needs of midlife and ageing women include understanding and normalising the menopause experience, prevention and early treatment of the most prevalent women’s cancers (particularly breast and cervical cancer), and more attention being given to the physical, psychological, social, and economic aspects of ageing (McElmurry, Norr & Parker, 1993).

Menopausal symptoms cannot, however, be studied in isolation because other significant health issues can occur at this stage in a woman’s life. An analysis conducted by Wyn and Solis in America revealed a distinct pattern of an increasing incidence of chronic conditions such as hypertension, diabetes, arthritis, cancer, heart disease, and osteoporosis that began among middle-aged women (aged 45–64) and persisted into the elderly age cohort (Wyn & Solis, 2001).

According to Quintanilla et al., the reported experiences of menopausal women in the findings of different studies are such that some support the socio-cultural model and some support the biomedical model (Quintanilla, Cano & Ivy, 2004). Menopause has physical, mental and social components, and no single one of these three elements can be treated in isolation from the other two. For this reason, medical professionals should not be authorised to make unilateral decisions about matters with a significant social context, such as menopause or ageing. Sherwin pointed out that feminists recognise the complexity of various social restrictions that contribute to illness: most support a more holistic approach to health rather than taking purely physical measures (Sherwin, 1992b).

All these findings, centred on women’s health needs, and addressing cultural social determinants, empowering women, and raising awareness of gender sensitivities, suggest that
a comprehensive health promotion approach will be a more effective tool for managing women’s menopausal health issues.

4.3 Health Promotion

In medical systems the hormonal deficiency model underpins the use of HRT to treat menopausal women; international and Taiwanese feminists argued against the medical construct of menopause and women’s ageing health that it presents and embodies. During the feminist movements, the menopausal health policies based on epidemiological approaches were criticised either as being short on gender sensitivity, or as lacking strategic approaches to sustain women’s health policy. Health promotion incorporating a transdisciplinary approach introduces an opportunity to bridge existing gaps when formulating health policy affecting menopausal women.

4.3.1 Development of Health Promotion

Following the widespread growth of health education during and after World War II, and the exponential growth of investment in healthcare in Europe and North America throughout the post-WWII period, public health developed radically new paradigms from the 1980s. During this process, public health planners experimented with strategies that centred on individuals and their behaviour but these met with little success. Thereafter, more emphasis was placed on reforming the operation and practices of organisations, institutions, and communities instead of public health-related behaviour oriented experiments. Social interventions, such as supporting societies and communities, are assuming more prominence as public health issues.

Public health has been recognised as a result of complex inter-relationships between biology, the environment, lifestyles, and particular healthcare systems. In 1986 the World Health Organisation (WHO) defined health promotion as “the process of enabling people to increase control over the determinants of health and thereby improve their health”. The Ottawa Charter presented at the first WHO International Conference on Health Promotion that same year identified the determinants peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity as prerequisites for health. It identified five ‘key action areas’ to achieve ‘Health for All by the year 2000 and beyond’: 1. building healthy public policy; 2. creating supportive environments; 3. strengthening community actions; 4. developing personal skills; and 5. re-orienting health services to focus
on ‘the total needs of the individual as a whole person’. These were updated in the Jakarta Declaration and the Bangkok Charter, in 1997 and 2005 respectively. The Jakarta Declaration focused on creating partnerships between sectors, including private-public partnerships. The Bangkok Charter reviewed the new challenges in the context of a globalised world, challenges such as increasing health inequalities, environmental degradation, new patterns of consumption and communication, and increasing urbanisation (Davies & Macdowall, 2006).

4.3.2 Characteristics of Health Promotion

The Ottawa Charter was quite revolutionary (Lippman, 1992). Health promotion moved beyond factors at the level of the individual—such as healthy lifestyle or risk factors—and instead took into consideration the responsibility of social policy to enable citizens to improve and maintain their health. The knowledge-attitude-practice (KAP) approach, for example, was increasingly perceived as rather simplistic for identifying the relationship between education and lifestyle (Macdonald, 1992). Moreover, the health promotion ‘revolution’ took place in the areas of action of privileged groups and communities, not those of individuals on their own. Health promotion focuses on structural (societal) change; the strategies set out in the Ottawa Charter take policy and environment comprehensively into account, and acknowledge the importance of bottom-up approaches.

Health promotion establishes and consolidates its position by building on and drawing from ideas, theories and principles in other fields and subject areas, as well as by integrating approaches and themes into its practice (Macdonald, 1992). In the five key action areas of the Ottawa Charter, for example, action is required at both individual and environmental levels, inter-agency partnerships are highlighted, and a public health policy approach is advocated. It expands the gamut addressed by health education from health behaviours to much wider issues concerning social policy and social structures. This new version of the public health paradigm gives legitimacy to the new skill-sets of health promoters in the fields of policy

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78 The original Healthy People 2000 goals were adopted as an approach to health policy development by several countries, including the USA, Australia, New Zealand, and the UK. There have subsequently been Healthy People 2010 and Healthy People 2020 goals set.

79 KAP approach primarily focuses on evaluating the changes of in human Knowledge, Attitude and Practices in response to a specific intervention, usually outreach, demonstration, or education. This approach has been widely used and valued around the world for at least forty years in public health, education and other programs. National governments, nongovernmental groups, United Nations agencies and the World Bank use KAP evaluation methods. [http://files.dnr.state.mn.us/assistance/grants/community/6kap_summary.pdf](http://files.dnr.state.mn.us/assistance/grants/community/6kap_summary.pdf), 3 Nov. 2011
analysis and advocacy. It is argued by health promoters that all public policy may have a health dimension: this is evident in the concept of the WHO Healthy Cities program “which in essence takes cities as the units for public health program planning” (Baum, 2002).

Empowerment is a key concept in health promotion. As the WHO Ottawa Charter for Health Promotion declares: “‘new public health’ is based on a belief that the participation of communities in activities to promote health is essential to the success of those activities, as is the participation of experts.” The aim of empowerment is to reduce the number of people who are unable to get what they want or need. In this regard, ‘empowerment’ refers to the ability of people to gain understanding and control over personal, social, economic, and political forces in order to take action to improve their life situation. Empowerment can operate at the individual, organisational or community level. It ‘is a process of enabling groups and individuals to gain greater access to information, networking, resources and decision making’ (Chu C.M.Y., 2005, p.50).

Collective action increases people’s power. Participation empowers people when it results in a material change in their situation by enhancing their access to resources (Lippman, 1992; Baum, 2002). Participation is a keystone of the new public health paradigm, one which assures a wider involvement of people in decision-making (Baum, 2002). The demand for increased participation in decision-making processes can be misunderstood as a protest against the concentration of power. In the arena of public health in the 21st century, participation is still challenging for health policy makers, particularly as people and their needs are becoming more sophisticated to deal with. The involvement of a community in the needs assessment process can be a fundamental means of increasing participation in public decision-making and in public health endeavours.

4.3.3 Needs Assessment

Needs assessment is a means of facilitating stakeholders’ substantive participation and involvement in the decision-making processes of the planning, implementation, and evaluation of health initiatives, by identifying and addressing their needs. As such, it establishes a partnership between practitioners and clients to work together on assessing the needs. Furthermore, it enables people to ‘increase control over and improve their health’ (Chu, 1994a), a fundamental purpose of health promotion. In addition, needs assessment
provides information vital to effective planning and decision-making and helps to prevent costly mistakes.

From a public health perspective, ‘health needs’ can be defined as ‘the capacity to benefit from health services’ (Robinson & Elkan, 1996, p.16). The possible benefits of health services include physical, psychological, and social stability which extend life and/or enhance the quality of life. Health economists (Henderson, 2005) indicate that government cannot meet all health needs, given the scarce resources available to implement health services. For this reason each society has to establish priorities: to decide ‘who will get what and who will go without’ (Dunn, 1994).

Health needs assessments are underpinned by a variety of theoretical and ethical perspectives. This study has adopted Bradshaw’s typology of needs, because of its strength at both a theoretical and a practical level (Chu, 1994a; Robinson, & Elkan, 1996). In this study, the four categories of needs described by Bradshaw: normative need, felt need, expressed need, and comparative need, are understood as outlined below.

(1) **Normative need** is what the expert or professional administrator or social scientist defines as need in the domains of HRT use or chronic diseases prevention. There is a ‘desirable’ standard laid down. If middle-aged women fail to reach the desirable standard then they are identified as ‘being in need’. The particular identification of what is classed as normative need may vary according to different experts and may change when definitive criteria change as a result of new knowledge and shifting values.

(2) **Felt need** is what an individual woman ‘wants’ as defined by the person herself, when asked. To gather information on felt need is particularly important for providing opportunities for middle-aged women to actively participate in the decision-making process for the services related to their interests.

(3) **Expressed need** refers to a ‘felt need’ of women which the women have taken action to meet, demonstrated by their utilisation records of health services, for example, the HRT utilisation pattern. It is important to recognise that ‘expressed need’ is a function of service availability rather than a direct reflection of real need.

(4) **Comparative need** is determined by examining the differences between services and facilities in comparable geographic areas, for example examining the rate of
discontinuation of HRT use. Comparative need can be of value in identifying a service deficiency, but it can also be misleading because assessment of this category of need is based on the services available in the places under comparison, rather than also taking into account alternatives with socio-cultural significance.

As mentioned, the different categories of need outlined above are associated with different groups in society, and they reflect the involvement of particular policy stakeholders: they affect and/or are affected by government decisions. ‘Normative needs’, for example, reflect the value-judgements of professionals and experts, while ‘felt needs’ express the values of individuals or interest groups. An analysis of the different needs by different interest groups will be reflected in obviously different responses to the same information, and depend on the context in which policy-making is undertaken (Dunn, 1994).

4.4 Conclusion

Feminists draw attention to the social cultural factors of health, and the importance of incorporating women’s voices and needs, and gender sensitivity into policy making. The health promotion approach fits well with the feminist perspective on health, especially with respect to the shared emphasis on empowerment (Lippman, 1992; Davies & Macdowall, 2006). In many situations, the barriers to good health exceed an individual’s ability to overcome the obstacles on his or her own. Activists emphasise the political dimensions of women’s lives as being the major determinants of women’s health: they see the major determinants of women’s health as being more significantly the risk conditions that derive from power relationships in society rather than being the risk factors identified as individuals’ failures to eat, sleep, or exercise properly. For example, Zimmerman and Hill (2000) and Schofield (2002) have pointed out that one of the common problems has been the hierarchical relationship between predominately male medical practitioners and women patients. This hierarchical relationship embodies a failure of medical service to hear what women are saying about their bodies and the social conditions that they feel made them sick. From start to finish, the conduct of medical practitioners that women consult when seeking medical treatment and/or advice, and what such medical practitioners think is of benefit or advantage is simply not necessarily what women—or other patients—think is best, although ethically this should be so. Doctors, nevertheless, enjoy and maintain authority over the organisation and management of the healthcare system.
The feminist health movement position, like that which current health promotion theorists and activists advocate, is that there must be an end to poverty, an increase in social justice, and eradication of cultural myths. There were indicated by Lippman as essential conditions for women to be healthy (1992). Before the 1980’s, the feminist health movement focused on the de-medicalisation of women’s lives and provided an arena for women to work collectively, determine their own needs, develop their own responses to their bodies, and validate their own experiences and understandings of health: all with a view to promoting health rather than preventing disease. Many of the most important determinants of health are beyond individual control. Inequities in income, education, employment, working conditions, physical environment, social status, and social support are all determinants of poor health which must be addressed through health promotion activities. These risk factors are not merely aspects of individuals’ lifestyle choices and behaviours; they are factors in the development of illness which have a collective dynamic.

This study embraces a health promotion philosophy and approach, which have been discussed above. Health promotion takes people's needs as its starting point. These are identified and articulated by needs assessment to then formulate policies and implement programs. Health promotion provides a framework which can translate the knowledge provided by the feminist and biomedical models to formulate gender-mainstreaming policy in the menopausal health arena. The following chapters present the research undertaken to assess and articulate the health needs of menopausal women in Taiwan and the public health policy dynamics at play.
Chapter 5

Methodology

The previous chapters have presented a review of the controversy surrounding HRT use and menopausal health, in Taiwan and internationally, and of the health promotion approach—transdisciplinary and needs-orientated. This chapter presents this study’s conceptual framework, the mixed methods approach—the combination of quantitative and qualitative methods, and the processes undertaken, and discusses the issues of rigour, and this study’s limitations.

5.1 Conceptual Framework

As mentioned in Chapter 1, this is a study based on the concept of health promotion and needs assessment which investigates the gap between current health services and the health needs of menopausal women in Taiwan. As Baum (2002) pointed out “assessing needs is like doing a jigsaw” (p.479). It involves using a mix of methods and information from different resources—including epidemiological data, demographic and socio-economic information, the felt need of the target audience, and the needs of professionals who work with the target audience—to produce a more complete picture of an issue.

It is essential to use a combination of both quantitative and qualitative data; one type of evidence alone cannot tell the complete story of women’s menopausal health needs. As discussed in Chapters 2, 3 and 4, the debate between the supporters of the biomedical and feminist models over the use of HRT and menopausal health continues and they continue to maintain opposing, but no one viewpoint is comprehensive enough to explain all the complexities of menopause. The biomedical perspective fails to take into account the holistic experience of women during the menopausal transition. The biomedical studies are mostly based on quantitative approaches and are often criticised as being “weak in understanding the context or setting in which people talk. Also, the voices of participants are not directly heard. Quantitative researchers are in the background, and their own personal biases and
interpretations are seldom discussed.” (Creswell & Clark, 2007, p.9) Conversely, a major weakness of feminist studies associated with qualitative approaches is identified as they are “seen as deficient because of the personal interpretations made by the researcher, and the difficulty in generalising their findings to a large group because of the limited number of participants studied.” (ibid, 2007) Using the mixed methods approach, encompassing quantitative or qualitative data collection and analysis, provides a stronger underpinning to the study by allowing it to address a question that cannot be answered by either a quantitative or qualitative approach alone.

Both quantitative and qualitative methods are used to investigate the national use of HRT and women’s health needs to achieve triangulation (see Figure 5.1 further below). Part 1 of this study is an assessment of women’s healthcare utilisation and related treatment cost using an analysis of secondary data. Menopausal women seek reasonably accessible and affordable NHI health services to meet their needs, thus the beneficiary claims for the associated healthcare utilisation, and related expenditure data provide one objective measure of their needs. The associated objective data provides a knowledge base in the light of which the stances taken by other stakeholders in the menopausal health field—such as doctors, experts in women’s health, and policy makers—can be examined.

Part 2 of this study presents an exploration of the views of ‘the target audience’—middle aged women—and of a range of ‘professionals who work with the target audience’. A consideration of the nature and the determinants of Taiwanese women’s menopausal health needs requires an examination of some historical, cultural and political influences which have affected middle-aged women. This aspect is addressed by the literature review and the collection of data capturing women’s viewpoints. The contextual issues of the historical, cultural, political and philosophical forces which have shaped and continue to shape present-day healthcare services and projects, and the present-day influences of these forces on these programmes, have been examined in the literature review, and by undertaking fieldwork to canvass the opinions of medical practitioners of both Western and traditional Chinese medicine (TCM), activists, and experts in the women’s health field, and government policy makers.
This study then identifies the gaps between women’s menopausal health needs and healthcare provision, using the preceding comprehensive needs assessment approaches drawn from health promotion, and recommend strategies to close them.

Figure 5.1 Conceptual framework

5.2 Research Question and Focus Questions

As established in Chapter 1, the central concern of this thesis is to address the question: ‘Does using HRT meet the health needs of menopausal women in Taiwan?’
The aims of this study are to answer the following specific questions and then assess Taiwanese women’s menopause-related health needs.

(1) What are the patterns of the use of HRT and medical consultations undertaken by menopausal women in Taiwan?

(2) What are women’s menopausal health needs, as understood from the perspectives of various stakeholders, namely women, experts and government decision makers?

(3) What are the gaps between women’s menopausal health needs and health services and healthcare provision?

(4) What implications do these needs have for drawing up appropriate strategies for promoting menopausal health in Taiwan?

Table 5.1
Quantitative and qualitative methods used to examine health needs

<table>
<thead>
<tr>
<th>Type of need</th>
<th>Issue</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comparative needs</td>
<td>Examination of some historical, cultural &amp; political influences which have affected middle-aged women</td>
<td>Literature review</td>
</tr>
<tr>
<td>Expressed needs</td>
<td>The patterns of use of HRT &amp; menopausal women’s medical consultation in Taiwan</td>
<td>Secondary data analysis of NHI 2000–2004 database</td>
</tr>
<tr>
<td>Felt needs</td>
<td>Women’s own voices on their menopausal health needs</td>
<td>Focus group discussion &amp; in-depth interviews</td>
</tr>
<tr>
<td>Normative needs</td>
<td>Women’s menopausal health needs as seen by experts on women’s health &amp; government decision makers</td>
<td>In-depth interviews</td>
</tr>
</tbody>
</table>
A fundamental aspect of using a health promotion approach to address the central concern of this thesis is the need to identify and assess women’s health needs during menopause. The methods used to collect the health needs data are set out in Table 5.1. The health needs listed there are described in terms of Bradshaw’s four types of social needs.  

5.3 Data Collection Methods

The data was collected over three phases of fieldwork over a period of three years. The raw data for Part 1 of this study comprises the NHI research database, containing approximately 200,000 nationally representative beneficiaries and their medical claim data. This was purchased in 2006.  

The raw data for Part 2 of this study was collected from two focus group discussions with menopausal women, and subsequent in-depth interviews with both menopausal women and key informants.

5.3.1 Part 1: Quantitative Research

Estimates of HRT use in Taiwan have many limitations and no study has discussed the associated costs or the efficiency of the associated allocation of public resources. This study undertook a secondary analysis of the longitudinal NHI reimbursement data, using a cross-sectional approach, to describe changes in patterns of care and medical expenditure, and thereby evaluate the expressed health needs of Taiwanese women during menopause.

Data description

The target population of this study was women aged 45-64 years in Taiwan, most of whom were at one of the three stages of menopause—pre-, peri- and post-menopause—and were experiencing, or had experienced, climacteric and menopausal symptoms.

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80 See Chapter 4
81 The research database for the secondary analysis was purchased from the National Health Research Institutes in Taiwan.
82 According to the literature review in Chapter 4, and Wu, Wu, Lin & Chu, 2011.
All registered Taiwanese citizens in Taiwan must be enrolled in the NHI program. By the beginning of 2000 the NHI Bureau had accumulated administrative and claims records for 23.75 million people. The Bureau has a population-based, publicly available research database which includes the NHI claim data and data from the enrolment and provider files. The NHI claim data records the birthdate and sex of each patient, and uses anonymous identifiers for the patient, the hospital or clinic, and the doctor providing the service. It also records each diagnosis, the date of service, any medication prescribed which was NHI-reimbursed, the length of the course of medication, and other details, such as its administration route.

Each of the individuals included in the entire claim database (which in 2000 represented more than 96% of the general population) was allocated a different random number using a random number generator function. Simple random sampling of about 50,000 people at a time was then performed four times in 2000. This sampling dataset (combining these four simple randomly sampled subsets) finally consisted of 200,432 enrollees, representing approximately 1% of all NHI beneficiaries. Their insurance record from 2000 to 2004 was then traced.

**Definitions and background information**

The definitions of some key terms, as used in this study, are listed below, along with essential background information.

*Hormone replacement therapy (HRT), also known as hormone therapy (HT):* in Part 1 of this study, which comprises the database analysis section of the larger study, hormone replacement therapy (HRT), refers to a hormonal regimen—all types, modes and forms—prescribed by doctors under the NHI program for middle-aged women whom they had diagnosed at a clinic visit as having menopausal syndrome. The various HRT medications prescribed were all in the G03 category of medications reimbursed under the NHI program. This comprised more than 450 items related to sex hormones and modulators of the genital system.

The raw data recorded prescriptions for a course of HRT sufficient for any length of time from just one day to as long as 90 days. From these I selected the

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83 The database was established with the cooperation of the NHI Bureau and National Health Research Institutes which safeguard the privacy and confidentiality of the participants.
records of prescriptions for a course of HRT of between 7 and 30 days, inclusive, in length. These comprised about 95% of all HRT prescriptions recorded in 2000–2004. Selecting records of a course of HRT in the range from 7-30 days was advised by several doctors when I conducted interviews for Part 2 of this study in 2008.

*Menopausal syndrome (MS): a diagnosis by a doctor, recorded using any of the following ICD-9-CM codes when submitting an NHI claim: 627.0, 627.1, 627.2, 627.3, 627.4, 627.8, or 627.9.

*Study period: the five years from January 2000 to December 2004.

*Insured women: women enrolled in the NHI database in the five years from January 2000 to December 2004.

*Middle age: the age range of the insured women in the study. The range selected was between 45 and 64. Their data was examined divided into four five-year age groups: 45 to 49 years, 50 to 54 years, 55 to 59 years, and 60 to 64 years.

*Women in this study: women who were insured and middle-aged in the study period.

*HRT-related expenses (also referred to as ‘HRT-related costs’ and ‘HRT-related expenditure’): in this study this refers to two different direct expenses, one public expenditure and the other borne by the woman patient, incurred when a woman is prescribed HRT. The direct expenses are: the cost of the HRT medication and the copayment required for the consultation. There are also indirect expenses, such as those incurred for transportation and income foregone because of visit waiting time. These indirect expenses are specified as such when they are under discussion.

Data analysis

The data was subjected to extensive statistical analysis the findings of which are set out and discussed in Chapter 7. This included examination of the frequencies and percentages of various aspects— such as clinic visit rates, and the prescription rate—and Chi-square test. This was done using SAS (9.1.2) and Microsoft Office Excel
(2007). The data structure—i.e. the 34 variables and definitions which comprise it—is detailed in Appendix 5.

5.3.2 Part 2: Qualitative

Four types of interview were undertaken for Part 2 of this study. Of these, the first two were used at a preliminary stage, and the last two constituted the main interview data source. All interviews took place in a face-to-face setting:

First stage:

(1) Six pilot in-depth interviews were conducted between November 2007 and January 2008, with three menopausal women, two officials, and one doctor, to determine the most effective method of canvassing Taiwanese women’s views and experts’ opinions.

(2) Two focus group discussions were held, on 13 December 2007 and 21 December 2007, during the same period as the six pilot in-depth interviews.

Second stage:

(3) In-depth interviews of menopausal women were conducted between October 2008 and December 2008; and

(4) Interviews of key informants from the women’s health field were conducted in 2008.

The interviewees were not randomly selected: all were either individuals who had experienced menopause or who possessed associated knowledge or status, and all were willing to share in a joint construction of a more informed understanding of actual HRT use and menopausal health. The detailed information which these interviews yielded will be presented in Chapters 8, 9, and 10 respectively.

In-depth interviews were adopted as the principal method of data collection. Two formats were used: individual face-to-face interviews with myself, or interviews in a small group. All the experts, 26 altogether, and ten of the women were interviewed individually face-to-face. Most women were interviewed in small and intimate settings to enable them to feel comfortable to talk about highly personal
matters. Five of these ten women were from northern Taiwan, and five were from central Taiwan. The other women, fourteen, were interviewed in five small groups in different parts of Taiwan. One group of two women and another of four women in central Taiwan; two groups, each of three women, in eastern Taiwan; and one of two women in southern Taiwan. Each woman was invited to be part of the group she was in through snowball sampling.

**Focus group discussions**

Two focus group discussions were held in northern Taiwan in December 2007. This was a preliminary step, the purpose of which was to explore women’s willingness to reveal their private experiences during menopause, and to test the feasibility of this approach to exploring women’s views about their menopause, and the intended range of aspects to be encompassed. As Babbie points out, a group discussion in which a group of people interact using their own words can provide a rich and detailed set of data about their perceptions, thoughts, feelings, and impressions of issues (Babbie, 1995).

- **Participants**

  The focus group participants were women aged from 45 to 64. One group consisted of six women who were recruited by the female leader of a farmers’ association [農會] in an agricultural suburban area in Taipei County. The other consisted of eight women who were recruited by a director of a public health centre in a high socio-economic area of Taipei municipality. All but one woman (a peri-menopausal woman in the second group) had experienced menopause. Each focus group discussed their experiences of menopause\(^8\), their utilisation of healthcare services, and their peri- and post-menopausal health needs.

- **Procedure**

  The following procedure was used to recruit the menopausal women, both HRT users and non-users, and then conduct the focus group interviews:

\(^8\) The women in each group were familiar each other, as well as known by the recruiter.
1. **Contact resource people**: The leader of the peasant association and the director of the public health centre were contacted and requested to help to identify and recruit potential participants from among women who usually attended the routine activities of currently active women’s groups in their respective areas.

2. **Obtain each participant’s informed consent**: To ensure that potential participants were able to make a truly voluntary and informed decision, each woman was fully informed about the nature of the research being undertaken, of her right to withdraw at any time and that there would be an audio tape recording of the discussion. Signed consent forms were collected prior to the commencement of each meeting.\(^85\)

3. **Focus groups were conducted in two different locations**: Both focus groups were held in a local setting, convenient for the women to access. Six women attended one at a Farmers’ Association premises; eight women attended the other in the District Community Health Centre. These places are both in northern Taiwan.

**Table 5.2**

*Question sequence used for focus group discussions, & subsequent in-depth interviews*

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>What were your experiences during menopause?</td>
</tr>
<tr>
<td>Have you ever used hormone replacement therapy (HRT)? Why or why not?</td>
</tr>
<tr>
<td>What were your personal experiences with HRT use? Why or why not?</td>
</tr>
<tr>
<td>Have you ever tried any alternatives to HRT to cope with menopausal symptoms? Why or why not?</td>
</tr>
<tr>
<td>What general comment do you have about your experiences during menopause this transitional stage of your life? Was it a positive or negative experience for you?</td>
</tr>
<tr>
<td>In your opinion, what health services or self-care strategies are necessary to promote menopausal women’s wellbeing?</td>
</tr>
</tbody>
</table>

4. **Each discussion was facilitated using open-ended questions**: I used six open-ended questions (set out in Table 5.2) to initiate and guide the discussion.\(^86\)

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\(^85\) The Chinese-language forms used and a corresponding English version are given at Appendix 6 and Appendix 7 respectively.

\(^86\) The questions were developed on the basis of the literature review and discussions with one of my supervisors, Professor Cordia Chu, and three menopausal women who attended my pilot interviews.
When the participants discussed the questions, each was encouraged to tell her story uninterrupted and other people could comment later. The women in the agricultural suburban group spoke Taiwanese while those in the group of Taipei municipality mainly spoke Mandarin. All the participants could understand both languages but women spoke the language they usually naturally depended on for communication when they met.

The range and variety of responses in the focus group discussions and the wealth of information obtained from the secondary data analysis determined the major variables which had to have a range of corresponding situations included in the experiences of the women to be interviewed in-depth. These were: whether women had experienced natural or surgical menopause; whether they had been prescribed HRT, and if so their experience; their area of domicile; and their marital and socioeconomic status.

The focus group discussions helped me to explore women’s knowledge and experience of menopausal health from the point of view of very different types of individuals. In a relaxed group atmosphere, it was possible for such a sensitive issue as sex life to also be shared. Based on these experience and my findings, I established the confidence to undertake the in-depth interviews as described below.

**In-depth interviews**

Following the focus groups, face-to-face in-depth interviews were used to explore women’s views in more depth. My goal was to explore and articulate women’s perspectives and/or experiences of health issues related to menopause and/or HRT use, including historical and socio-cultural influences. In-depth interviews were used because as Liamputtong (2009) points out, they allow a researcher to access insider subjective understandings and experiences. Face-to-face one-on-one interactions offer an opportunity for the researcher to seek deep information, to examine and interpret the participants’ experience.

The number of interviewees was decided by the range of factors which needed to be included to encompass the variety of responses which occurred in the focus group discussions and the secondary data analysis. The major factors to be reflected
required including women with: experience both of natural menopause and surgical menopause; different experiences of being prescribed HRT; and different areas of domicile, marriage status, and socioeconomic status. Participants in the in-depth interviewswere identified individually by a ‘snowballing’ process. They were selected from, or introduced by, the women who had participated in the focus groups, or recruited from among my neighbours, relatives, and friends in Taiwan.

The general inclusion criteria and procedures were very similar to those of the focus groups. A total of twenty-four women from four different regions of Taiwan—the north, south, east and central Taiwan—were interviewed, all of whom were experiencing or had experienced menopause. I did in fact interview more than the twenty-four women whose data was used in the data analysis for Part 2 of this study. More than ten women did not show up to be interviewed face-to-face but did agree to a telephone interview with me. I subsequently decided not to include the data from those interviews in the data analysis because their interview setting was different and I wanted to maintain consistency. Nevertheless that non-included data can be usefully compared with the findings based on the face-to-face interview data - within the 5-year period that collected interview data will be stored for before being destroyed in line with regulations.

The in-depth interview participants ranged in age from 47 to 64, with an average age of 57.5. All the women were currently experiencing menopause or had experienced menopause within the last 10 years, which ensured that they were describing plausibly recent experiences. Most had undergone natural menopause; two of the 24 participants had experienced surgically-induced menopause, and four were experiencing transition symptoms at the general time of the data collection. Most of the respondents were married and 25% were widowed.

Informed consent, including permission to record the interviews, was obtained prior to data collection, as had been done for the focus groups. The locations were decided by the interviewees. Ten of the women were interviewed individually, and the

87 The main reason they gave was that they ‘preferred to be interviewed by telephone’.
88 See Table 8.1 in Chapter 8 for more details of the interviewees.
others were interviewed in small groups. Whether they were interviewed individually or in groups was not determined by me but by the key person who had contacted local women in the snowballing process. Some women asked to be interviewed with their friends in a group. In both settings the interviews were once again guided by the questions listed in Table 5.2. The small-group interviews were conducted differently from the focus group ones, in that an interview with a particular participant would start only after the previous person had finished responding to all the questions set out in the table. Most of the women did not interact after each had been through the questions.

I began each interview briefly introducing myself and the purpose of this study, and thanking the attendees and the key person who had recruited them. When an interview was held in an interviewee’s home, our hostess would prepare the setting and provide tea for everyone, and she would introduce the women she had recruited to attend to each other. When an interview was held at a cafe, after the recruiter had introduced the attendees and left, I would buy the drinks or meals for everyone. There were two exceptions to this when my interviewees bought me lunch at restaurant.

Each interview took an average of around 45 minutes for an individual and up to 2 hours for the small group interviews of between 2 and 4 women. All the interviews were tape-recorded to be subsequently transcribed. I also made notes of relevant observations immediately after each session, once my interviewees had left and listened to the entire interview recording.

Key informant interviews

Key informants played a significant role in ensuring both the richness of information collected for this study, and efficiency collecting it. The suitability of potential interviewees to be considered a stakeholder was determined on the basis of: their involvement in the women’s health movement, their academic journal publications, or their responsibility for climacteric health programmes in Taiwan. Potential key informants were selected from: women’s groups in non-government

89 Details of the number of people in each small group and a brief general description of each participant are given in Appendix 8.
organisations⁹⁰; different areas in the field of women’s health (for example, researchers, clinical practitioners, and social activists); and the government sector (for example, directors and/or high-ranking officials from the NHI, Bureau of Health Promotion).

I then contacted these people by email or telephone, and 26 people agreed to be interviewed: four people with particular expertise in the women’s health and/or women’s rights field⁹¹, five former high-ranking government officials, and seventeen medical practitioners. Of the medical practitioners, 15 were Western doctors—including seven gynaecologists, five GPs, and one doctor working in both fields—and two were TCM doctors. Some of the medical practitioners also held teaching positions.⁹² The appropriate permissions were obtained and I interviewed these key informants using the semi-structured questions set out in Table 5.3.

Table 5.3  
Question sequence used interviewing key informants

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your opinion of HRT use by menopausal women?</td>
</tr>
<tr>
<td>According to my research, the pattern of HRT use fluctuated from 1997 to 2004. What have you observed regarding changes in HRT use by menopausal women?</td>
</tr>
<tr>
<td>What is your opinion of alternative treatment and/or strategies used by menopausal women to eliminate menopausal symptoms and/or promote health during menopause?</td>
</tr>
<tr>
<td>In general, what do you think the health status of menopausal women in Taiwan is? Why?</td>
</tr>
<tr>
<td>In your opinion, what are the important health issues and health needs of menopausal women in Taiwan? Why?</td>
</tr>
<tr>
<td>What health services and/or self-care strategies are necessary to meet the health needs of women aged 46 to 64 years?</td>
</tr>
</tbody>
</table>

The interviews generally lasted from 30 to 45 minutes. They were all tape-recorded and subsequently transcribed. A copy of the transcript was sent to an informant who had requested one.

⁹⁰ Confidentiality precludes naming these NGOs as it would be easy to identify the individuals.

⁹¹ Two were associated with women's rights groups, one was a professor with many related international publications, and one was a midwife practising in a rural area.

⁹² See Appendix 9 for non-identifying details of the key informants.
Data analysis

Thematic analysis and a grounded theory approach were used for the methodological framework for data analysis of Part 2 of this study. Thematic analysis is a method for identifying, analysing, and reporting patterns or themes within data (Boyatzis, 1998). It has been used to illuminate women’s health needs through their experience of menopause and HRT use. Grounded theory is ‘a qualitative research inquiry in which the researcher generates a general explanation of a process, action or interaction shaped by the views of a large number of participants’. The critical process is to ‘consistently compare pieces of data to emerging categories’ (Liamputtong, 2009, p.207).

This study’s research questions are focused on exploring health needs in an area where a fully integrated theory has not yet been developed. The data was analysed using a grounded theory method, a method which is concerned with the generation of categories, properties, and hypotheses rather than with testing them (Liamputtong, 2009, p.207). This approach allows one to examine an individual’s experience from interviewee’s own words, to extract the meaning a person applies to a situation and to describe the sense-making process (Dey, 1999).

The data analysis included all the transcripts, and my notes, which helped me to identify the implications of the interviewee’s words, for example about visual cues such as a frown which cannot be not caught on a sound recording. The analysis was undertaken and managed in the sequence described below:

1. Transcription of the audiotape records of the interviews from tapes, and organisation of my notes The audio-recordings of the interviews were transcribed into Chinese. I transcribed two of the interviews: a one-hour interview took me 12-16 hours to transcribe. The rest were done by a professional typist. I posted or emailed the tapes to the typist straight after the interviews or within a week. It took the professional typist only about three times the length of each interview to transcribe it from the recording. To ensure the transcriptions were accurate, I listened to the original recordings and checked the transcripts against them.

93 The voice files were sent by emails in MP3 format.
2. Identification of meaningful ideas and concepts This was done through a combination of having been present at the interviews, listening to the tapes, and reading the transcripts and the notes I had made.

3. Repeated re-examination of the data, identifying different threads and patterns of information The transcripts were read repeatedly, and an iterative process followed. The stages were: familiarising myself with the data, identifying a thematic framework, and refining the coding scheme. For example, the raw qualitative information data collected from the two focus groups was the basis for articulating the patterns of themes and categories. The in-depth interview data was continuously collected and examined until data saturation was achieved.

4. Coding of each idea identified in the data Thematic analysis was used to develop a series of coding units. This study is data-driven: each transcript underwent a line-by-line examination to discover emerging themes within the text. The analysis involved separating the data into coding units. A coding unit was defined as a basic unit of text that presents a complete idea. A coding unit could vary in length and form: it could be a phrase, a sentence, a paragraph, or a number of paragraphs.

Development of a categorisation scheme and the substantive coding of data through the preliminary process is referred to as open coding (A Strauss & Corbin). The text of each interview was examined to discover patterns of words, phrases, themes and concepts that recurred. In this study, ‘recur’ means that at least two participants discussed a given theme. A qualitative data analysis software program, Nvivo 8.0, was used to organise the coded data across all participants.

5. Grouping of codes into categories and subcategories Similarities among categories and context were then examined through a process of continuous comparison and analysis, to identify meaningful relationships. In this way, a reconstructive process that puts the data back together in new ways after open coding is completed by connecting a category and its subcategories, known as axial coding. In addition, the memos—including ideas, insights, and feelings about the data, themes and the emerging conceptual scheme—were documented to help me to identify underlying assumptions, patterns in the data, and relationships between categories. I
subsequently reviewed and sorted the memos to explore theoretical explanations and searched for core categories.

6. Definition of themes - from the data categories and subcategories  After condensing and abstracting the meaning within each of the coded groups, I summarised the content of each code group to generalise descriptions and concepts reflecting the most important experiences from the women’s voices. The statements underpinning the relevant theme heading varied in size, from a sentence to a paragraph, and were systematically organised. Relationships within and across themes and categories were examined. Certain categories became more centrally focused and these were presented in the results section as emerging themes. The resulting themes and categories were interpreted in light of the research task: to identify and assess the divide between menopausal health needs and the use of HRT. The women’s interview data is presented and discussed in Chapter 8, and for the key informants, the medical practitioners’ interview data is presented and discussed in Chapter 9, and that of the activists and people from the government sector in Chapter 10.

5.4 Issues of Rigour

In both Part 1 and Part 2 of this study the need for rigour was addressed by giving attention to the measures to improve validity and reliability described below. The term ‘validity’ refers to the extent to which any assessment measure actually measures what is intended and so adequately reflects the actual situation being studied. The term ‘reliability’ refers to whether the same basic result is replicated under the same or very similar conditions. The measures used for quantitative and qualitative methods were based on different criteria (Babbie, 1995; Neuman, 2003; Liamputtong, 2009).

5.4.1 Part 1: Secondary Data Analysis

The database used for Part 1 of this study, the National Health Insurance Research Database, was purchased from the National Health Research Institute, a Taiwanese government agency. This material included coding books in which each variable is delineated with its official definition. To ensure validity, the definitions used in this study correspond to those given in the coding books. The codings for
diseases and injuries used in NHI outpatient service claims were changed by the NHI in 1999. For this reason, although data was available from 1997, this study undertakes comparisons from 2000 to 2004 inclusive, to ensure consistency of what is referred to by a diagnosis of ‘menopausal syndrome’ in the database, as this is a key variable. Any systematic error in the database made when collecting the initial information can be ignored when comparing the data on a monthly basis.

The reliability of the secondary analysis has been considered with regard to the three aspects discussed by Neuman (2003): stability, equivalence and representative reliability. The database was a randomised sample representing national beneficiaries’ medical claim data for reimbursement through the NHI programme. The standardised procedure for collecting information used in the repayment system is described as constant and comparable for medical institutes to abide by.

Representativeness is a key element in establishing the usefulness of this study. The goodness-of-fit for the distribution of the age groups was tested to see whether the sample appropriately represented the female beneficiary population aged 45–65 in each year between 2000 and 2004 inclusive, and that its findings are therefore generalizable.

5.4.2 Part 2: Interviews

Four criteria are widely used for establishing the rigour of qualitative research Liamputtong, 2009): 1. credibility (internal validity) 2. transferability (external validity) 3. dependability (reliability) and 4. confirmability (objectivity). This study has adopted the guiding principles of the following strategies to improve validity and reliability.

Credibility: Triangulation, involving the combination of multiple sources, is the most powerful means for strengthening credibility in qualitative research Liamputtong, 2009). This study employs multiple methods—focus group discussions and in-depth interviews—to listen to women’s voices. Both the snowball sampling method and small group individual interviews requested by the women increased their trust in the researcher and allowed them to better express their inner feelings.
Source triangulation involved using professionals from multiple disciplines to examine experts’ views of menopausal health needs for women: for example, medical practitioners, women’s health activists, policy makers, and researchers in the fields of public health and nursing. The data was collected by conducting comprehensive interviews in which participants could communicate authentic and in-depth subjective experiences. In addition, the report incorporates multiple quotes from the participants to confirm and illustrate emerging themes of interest.

**Transferability** The participants recruited in this study were middle-aged women from different backgrounds and locations who had undergone or were facing menopause and were willing to share their experiences. Their experiential knowledge resulted in the accumulation of large amounts of valuable information. The essence and meanings of the original data was transcribed into text and thoroughly annotated.

**Dependability** Dependability was sought through frequent discussions with a supervisor while coding and extracting the meanings and concepts from the data, in a reiterative process. If there was anything doubtful or unclear in my explanations, I returned to the original transcribed text and my original notes for further clarification. The data was analysed twice. The first analysis of the women’s data, identifying major themes and categories, was completed in August 2010. A second analysis was carried out in April 2011 to ensure that no data had been mislabelled during the first analysis and that no emerging categories had been overlooked. The two results were compared to check for any differences and inconsistencies in the codes and categories.

**Confirmability** Quotes from the interviewees related to the various themes are presented to reflect a range of views, both consensual and dissenting. Unavoidably, because of the nature of a doctoral study, the process of data coding, theme identification, and interpretation had to be undertaken by one person. This contributed to consistency in the method but meant that other people could not be incorporated to check from a variety of perspectives.

### 5.5 Ethical Considerations

All procedures were approved by Griffith University Human Research Ethics Committee in 2007. Anonymity of all participants has been preserved by identifying
them only by a number for the analysis and reporting of my findings. All transcribed interview data will be locked in a cabinet of my office in Griffith University and stored for a period of 5 years before being destroyed.

The database obtained from the National Health Research Institute used for the secondary analysis is de-identified data. Such databases are subject to regulation in accordance with Taiwanese laws and decrees to protect personal privacy, and no respondent can be recognised directly nor by inference.

No local health authority approval was required because all the participants were to be asked to express their own personal opinions, knowledge, and/or experience in response to the research questions. I obtained the necessary informed consent before commencing interviews. See Appendix 6 and 7 for examples of the Chinese/English language versions of the consent forms.

Summaries of the focus group discussions and the interviews (in Chinese), a summary of this study report and/or access to the thesis will be available to participants on request (see Consent Form, Appendix 6). A lay summary of the findings of this research project will be written in Chinese and sent to all participants.

5.6 Limitation

There are a number of limitations involved in the secondary data analysis. The diagnosis codes of medical claim database records NHI reimbursements may be payment driven. This factor will be examined and discussed in Chapter 6 by analysing the annual trends in medical utilisation, and in Chapter 9 by interviewing key informants. Moreover, a woman’s being prescribed HRT and taking the medication home does not mean she then takes it according to the standard instructions. This unavoidable limitation of the data is partly addressed in Chapter 8 where qualitative data collected in interview settings from menopausal women is presented and discussed.

The NHI database represented the enrolled participants rather than the overall population in Taiwan, although the NHI coverage rate in the study period was more than 96% of the general population. A few extreme cases, the very poorest or richest for example, may not be included in this database. Finally, this data comprises the
information from 2000 to 2004; it cannot simply be generalised to represent trends in more recent and current medical use patterns.
Chapter 6
Healthcare Utilisation during Menopause

This chapter examines women’s health needs during menopause as expressed in the form of NHI funded medical utilisation. Two dimensions of the healthcare needs of middle-aged women are investigated: (1) their use of clinics, and (2) the number of women prescribed HRT as a result of those clinic visits, and how many courses of HRT were prescribed annually for each of the various subgroups of the women in the sample. The patterns of doctors’ prescription of HRT are also examined.

6.1 Participants, Definitions of Terms and Background Information

The participants of this study are middle-aged women who were registered in Taiwan’s NHI programme during the period from 2000 to 2004 inclusive. The units of analysis comprise individual people and clinic visits, also referred to as ‘consultations’.

This chapter examines the statistical data on consultation rate, diagnosis rate, and various aspects of the HRT prescription rate associated with middle-aged women’s healthcare utilisation in Taiwan. The definitions of these and other key terms, as used in this study, are listed below, along with essential background information about related aspects of Taiwan’s health system.

6.1.1 Definitions

* consultation rate: the percentage of women who sought NHI-reimbursed healthcare at a clinic in a particular period of time. The consultation rate was examined for two categories of care: Western medical care and TCM medical care. This study does not include data about healthcare received as a hospital in-patient.

* diagnosis rate: the percentage of middle-aged women diagnosed with menopausal syndrome in a specific period of time. As mentioned in Chapter 5, ‘menopausal syndrome’ is a diagnosis recorded using any of the following ICD-9-CM

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94 Based on Bradshaw’s (1972) typology of social needs, outlined in Chapter 4
codes when submitting an NHI claim: 627.0, 627.1, 627.2, 627.3, 627.4, 627.8, or 627.9.

* (in) a year: unless otherwise indicated ‘year’ refers to the period from January 1 to December 31.

* study year: the period from January 1 to December 31 in any of the years 2000 to 2004 inclusive.

* a course of HRT: a course of HRT prescribed for menopausal symptoms in Taiwan between 2000 and 2004 could vary in length between 7 days and 30 days. For most women a course would be 28 days or 30 days, but doctors might prescribe a 7-day course for one of two reasons:

1. a short ‘try-out’ course of HRT might be prescribed initially because some women experience severe reactions or side effects;

2. some doctors told me that a few doctors prescribe a 7-day course to increase the number of women’s clinic visits and induce more medical use.

For this study any claim data recording a prescription of a course of HRT between 7 and 30 days in length (made at a clinic for a woman in the sample prescribed with menopausal syndrome) was collected and counted toward the annual number of courses each woman used.

* prescription: when a medication is prescribed in the Taiwanese context the medication is usually given to the patient at the clinic; patients do not usually need to go through a separate step of going to a pharmacy to have the prescription filled. The great majority of prescriptions are filled at the clinic: the patient pays any copayment and out of pocket costs when leaving and receives their medication from a pharmacist on site. There are a small number of signed prescription forms are given to patients to take to a pharmacy shop to buy their medication.\(^95\)

The amount of HRT being prescribed in Taiwan for menopausal syndrome was measured in three ways: (1) prescription rate (2) HRT usage rate (3) number of courses

\(^{95}\) An example are the ‘continuing prescriptions’ details of which are given in footnote 3, Chapter 9.
* prescription rate: the percentage of clinic visits in a specific period of time which resulted in a diagnosis of menopausal syndrome and HRT being prescribed. This was used to assess doctors’ practices.

* HRT usage rate: the percentage of insured middle-aged women who were prescribed HRT for diagnosed menopausal syndrome at a clinic in a specific period of time. This was used to assess women’s expressed needs.

* number of courses: the number of courses of HRT prescribed for a woman diagnosed with menopausal syndrome in a study year. The courses did not have to be continuously taken – only the total number was taken into account. This was calculated for three sub-groups of women: resistant, ambivalent, and faithful users.

1. Resistant users: women who were prescribed a course of HRT for their menopausal symptoms at a clinic only once or twice during a study year.

2. Ambivalent users: women who were prescribed three, four, or five courses of HRT in a study year but who for some reason discontinued therapy.

3. Faithful users: women who were prescribed six or more courses of HRT during a study year.

The reason for subdividing the data into these three subcategories of users was based on: (1) Tan et al. pointing out that using HRT for a mean duration of less than 3 months is unlikely to be sufficient time for a plausible biological effect. Women need to adhere to the therapy for at least three to six courses to noticeably alleviate menopausal symptoms, and then continue the therapy based on their individual situation (Tan, D., Haines, C.J., Limpaphayom, K.K., Holinka, C.F. & Ausmanas, M.K., 2002); (2) clinical trials of HRT in Taiwan (listed in appendices 1, 2 and 3) set a minimum of at least three courses as a criterion for follow-ups; and (3) a senior gynaecologist, D4, advised me to do so, during an in-depth interview conducted during my fieldwork for Part 2 of this study.\(^6\)

* accreditation level - of a medical facility. As outlined in Chapter 3, there are four levels with differing levels of size and differing ranges of facilities:

\(^6\) see Chapter 9, page 194.
1. academic medical centres - the most specialised

2. regional hospitals

3. district hospitals

4. community clinics - both public and private doctor’s practices

* Locality type: the locality of the medical facility location was classed into one of four categories:

1. metropolitan - Taipei, Kaoshung

2. city and county

3. village and township

4. remote areas i.e. mountains and islands

These generally reflect their level of urbanisation and to some extent the level of local access to a wide range of information and facilities. This was more so in the earlier study years when there was somewhat less pervasive use of the internet.

6.2 Findings

6.2.1 Study Sample and Target Population

Middle-aged women represented around 20% of the NHI female beneficiary population from which the sample was selected. The total number of women whose data was examined increased each year from 2000 to 2004 (Table 6.1).

97 See Chapter 5 for details of how the sample was selected.
Women aged 45–49 comprised the largest percentage of the study sample, followed by women aged 50–54. A test of the goodness-of-fit for the age group distribution indicated that the sample appropriately represented the female beneficiary population aged 45-64 years in each year from 2000 to 2004 ($\chi^2 = 0.48, 1.97, 0.12, 0.20, \text{and } 0.09$ respectively, d.f.= 3, $p > 0.05$). See Table 6.2.

### Table 6.2

**Number (n) and percentage (%) of women in the study sample, by age**

<table>
<thead>
<tr>
<th>Age</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>45-49</td>
<td>6,893</td>
<td>37.3</td>
<td>6,997</td>
<td>36.3</td>
<td>7,131</td>
</tr>
<tr>
<td>50-54</td>
<td>4,648</td>
<td>25.2</td>
<td>5,355</td>
<td>27.8</td>
<td>5,742</td>
</tr>
<tr>
<td>55-59</td>
<td>3,502</td>
<td>18.9</td>
<td>3,398</td>
<td>17.6</td>
<td>3,527</td>
</tr>
<tr>
<td>60-64</td>
<td>3,438</td>
<td>18.6</td>
<td>3,524</td>
<td>18.3</td>
<td>3,495</td>
</tr>
<tr>
<td>Total</td>
<td>18,481</td>
<td>100.0</td>
<td>19,274</td>
<td>100.0</td>
<td>19,895</td>
</tr>
</tbody>
</table>

6.2.2 Women’s Utilisation of Healthcare Services during Menopause

*Use of clinic services*

More than 90% of insured middle-aged women in the sample sought NHI-reimbursed services at a clinic in the period 2000–2004. The consultation rate—for
both Western and TCM clinic care—increased with age. The use of clinic services in 2003 was comparatively lower than in the other four years (see Table 6.3).

Table 6.3

**Annual consultation rate: number (n) of visits made (to a Western or TCM clinic), and percentage (%)**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>45-49</td>
<td>6,293</td>
<td>91.3</td>
<td>6,421</td>
<td>91.8</td>
<td>6,552</td>
<td>91.9</td>
<td>6,637</td>
<td>90.7</td>
<td>6,896</td>
<td>92.2</td>
</tr>
<tr>
<td>50-54</td>
<td>4,329</td>
<td>93.1</td>
<td>4,964</td>
<td>92.7</td>
<td>5,327</td>
<td>92.8</td>
<td>5,617</td>
<td>91.8</td>
<td>5,992</td>
<td>93.1</td>
</tr>
<tr>
<td>55-59</td>
<td>3,299</td>
<td>94.2</td>
<td>3,198</td>
<td>94.1</td>
<td>3,027</td>
<td>93.6</td>
<td>3,453</td>
<td>93.0</td>
<td>3,767</td>
<td>94.0</td>
</tr>
<tr>
<td>60-64</td>
<td>3,246</td>
<td>94.4</td>
<td>3,353</td>
<td>95.1</td>
<td>3,327</td>
<td>95.2</td>
<td>3,336</td>
<td>94.3</td>
<td>3,300</td>
<td>94.2</td>
</tr>
<tr>
<td>Total</td>
<td>17,167</td>
<td>92.9</td>
<td>17,936</td>
<td>93.1</td>
<td>18,508</td>
<td>93.0</td>
<td>19,043</td>
<td>92.1</td>
<td>19,955</td>
<td>93.1</td>
</tr>
</tbody>
</table>

Table 6.4 shows that more than one fifth of these visits were to general practitioners. The main specialists consulted by insured women were physicians (internal medicine specialisation), gynaecologists, and traditional Chinese medicine (TCM) practitioners. In total, these three types of specialists accounted for around 25% of total consultations. The numbers of consultations with other specialists—in the fields of orthopaedics and rehabilitation, cardiovasology, neurology, gastroenterology, endocrinology, psychiatry, urology, rheumatology and immunology—related to managing menopausal symptoms were comparatively minor and remained constant in each study year.

More than 90% of the clinic visits were to consult Western medicine doctors but TCM (traditional Chinese medicine) visits increased throughout the period (Table 6.4). In contrast, the use of physicians and gynaecologists showed an opposite trend.
Table 6.4
Number (n) and percentage (%) of NHI consultations in different areas of medical specialisation, made by women 2000–2004

<table>
<thead>
<tr>
<th>Specialization</th>
<th>2000</th>
<th></th>
<th>2001</th>
<th></th>
<th>2002</th>
<th></th>
<th>2003</th>
<th></th>
<th>2004</th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>General practice</td>
<td>95,859</td>
<td>22.1</td>
<td>95,336</td>
<td>21.3</td>
<td>94,343</td>
<td>20.7</td>
<td>100,707</td>
<td>21.2</td>
<td>110,333</td>
<td>21.1</td>
<td>496,578</td>
<td>21.2</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>43,071</td>
<td>9.9</td>
<td>39,887</td>
<td>8.9</td>
<td>35,916</td>
<td>7.9</td>
<td>35,706</td>
<td>7.5</td>
<td>38,100</td>
<td>7.3</td>
<td>192,680</td>
<td>8.2</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>33,564</td>
<td>7.7</td>
<td>36,182</td>
<td>8.1</td>
<td>35,217</td>
<td>7.7</td>
<td>28,919</td>
<td>6.1</td>
<td>31,766</td>
<td>6.1</td>
<td>165,648</td>
<td>7.1</td>
</tr>
<tr>
<td>TCM</td>
<td>33,388</td>
<td>7.7</td>
<td>34,555</td>
<td>7.7</td>
<td>36,843</td>
<td>8.1</td>
<td>41,985</td>
<td>8.8</td>
<td>48,967</td>
<td>9.3</td>
<td>195,738</td>
<td>8.4</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>12,013</td>
<td>2.8</td>
<td>12,649</td>
<td>2.8</td>
<td>12,795</td>
<td>2.8</td>
<td>12,923</td>
<td>2.7</td>
<td>16,008</td>
<td>3.1</td>
<td>66,388</td>
<td>2.8</td>
</tr>
<tr>
<td>Cardiovasology</td>
<td>6,574</td>
<td>1.5</td>
<td>7,907</td>
<td>1.8</td>
<td>9,029</td>
<td>2.0</td>
<td>8,877</td>
<td>1.9</td>
<td>10,652</td>
<td>2.0</td>
<td>43,039</td>
<td>1.8</td>
</tr>
<tr>
<td>Neurology</td>
<td>6,120</td>
<td>1.4</td>
<td>6,357</td>
<td>1.4</td>
<td>6,792</td>
<td>1.5</td>
<td>6,572</td>
<td>1.4</td>
<td>7,697</td>
<td>1.5</td>
<td>33,538</td>
<td>1.4</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>5,703</td>
<td>1.3</td>
<td>6,303</td>
<td>1.4</td>
<td>7,096</td>
<td>1.6</td>
<td>6,509</td>
<td>1.4</td>
<td>8,293</td>
<td>1.6</td>
<td>33,904</td>
<td>1.5</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>5,499</td>
<td>1.3</td>
<td>6,132</td>
<td>1.4</td>
<td>7,382</td>
<td>1.6</td>
<td>73,93</td>
<td>1.6</td>
<td>9,965</td>
<td>1.9</td>
<td>36,371</td>
<td>1.6</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>5,033</td>
<td>1.2</td>
<td>5,877</td>
<td>1.3</td>
<td>6,446</td>
<td>1.4</td>
<td>6,210</td>
<td>1.3</td>
<td>7,431</td>
<td>1.4</td>
<td>30,997</td>
<td>1.3</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>3,436</td>
<td>0.8</td>
<td>3,915</td>
<td>0.9</td>
<td>4,523</td>
<td>1.0</td>
<td>5,186</td>
<td>1.1</td>
<td>6,144</td>
<td>1.2</td>
<td>23,204</td>
<td>1.0</td>
</tr>
<tr>
<td>Urology</td>
<td>2,166</td>
<td>0.5</td>
<td>2,390</td>
<td>0.5</td>
<td>2,211</td>
<td>0.5</td>
<td>2,271</td>
<td>0.5</td>
<td>2,586</td>
<td>0.5</td>
<td>11,624</td>
<td>0.5</td>
</tr>
<tr>
<td>Rheumatics &amp; Immunology</td>
<td>1,286</td>
<td>0.3</td>
<td>1,586</td>
<td>0.4</td>
<td>1,775</td>
<td>0.4</td>
<td>1,884</td>
<td>0.4</td>
<td>2,119</td>
<td>0.4</td>
<td>8,650</td>
<td>0.4</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>253,712</td>
<td>58.5</td>
<td>259,076</td>
<td>57.9</td>
<td>260,368</td>
<td>57.0</td>
<td>265,142</td>
<td>55.8</td>
<td>300,061</td>
<td>57.3</td>
<td>1,338,359</td>
<td>57.3</td>
</tr>
<tr>
<td>Others</td>
<td>179,928</td>
<td>41.5</td>
<td>188,488</td>
<td>42.1</td>
<td>196,451</td>
<td>43.0</td>
<td>209,677</td>
<td>44.2</td>
<td>223,980</td>
<td>42.7</td>
<td>998,524</td>
<td>42.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>433,640</td>
<td>100.0</td>
<td>447,564</td>
<td>100.0</td>
<td>456,819</td>
<td>100.0</td>
<td>474,819</td>
<td>100.0</td>
<td>524,041</td>
<td>100.0</td>
<td>2,336,883</td>
<td>100.0</td>
</tr>
</tbody>
</table>

As Figure 6.1 shows, the shifts in the composition of consultations, from 2002 visits for gynaecology services began decreasing and those for TMC consultations began increasing.

Figure 6.2 shows that the percentage of women diagnosed with menopausal syndrome decreased from the middle of 2002 among women who consulted Western medicine practitioners, and in contrast, the diagnosis rate among those seeking TCM treatment rose. (Note: a different vertical scale is used to indicate the percentage range for each, that for Western medicine is shown on the left, that for TCM is on the right)
Figure 6.1 Percentages of consultations by different specialisation, 2000–2004

Figure 6.2 Monthly percentages of sample diagnosed with menopausal syndrome (MS) in Western medicine and TCM clinics, 2000–2004

**HRT usage patterns**

Between 2000 and 2004, the percentage of insured middle-aged women prescribed HRT initially rose, peaking at 21.6% in 2001, but it then declined from 2002 and dropped sharply to 9.7% in 2004 (Figure 6.3). The HRT prescription rate fell from its highest rate in 2001 by 13.1% in 2002, by 44.6% in 2003, and by more than 55% in 2004. These reductions occurred mainly in women in the 45–49 and 60–64 age groups.

![Image](image_url)


**Figure 6.3 Percentage of insured middle-aged women in different age-groups who were prescribed HRT in Taiwan at least once within each year, 2000–2004**

As Figure 6.3 indicates, the pattern of changes in the HRT prescription rate was similar across each age group. Between 2000 and 2001, prescription levels rose for all age groups except women aged 50-54. They started to drop from 2002 and continued to decline through to 2004. Women aged 50–54 were most frequently prescribed HRT, followed by those aged 55–59. The lowest prescription level was for women aged 45–49. The HRT prescription rate continually declined with age from 50 years old.

The monthly HRT prescription rate pattern presented in Figure 6.4 shows that HRT was prescribed to a higher proportion of women in the first half of 2002 than in
the second half. The prescription rate declined steadily from July 2002 to the end of 2004 with a further drop in April 2004. The sharper falls in both July 2002 and April 2004 coincided with the release of the first and second reports of the WHI trials.

![Graph showing the decline in prescription rate from July 2002 to April 2004 with notable drops in July 2002 and April 2004.]


**Figure 6.4** Percentage of insured middle-aged women who were prescribed HRT in Taiwan each month, 2000–2004

The total number of women in the sample using HRT for diagnosed menopausal syndrome was highest in 2001 and then declined steadily (see Table 6.5). The percentages of women in the sample in the faithful, ambivalent and resistant user groups show that the proportion of women prescribed 3–5 courses was close to a quarter in each study year, but the proportion who were only prescribed 1 or 2 courses, the resistant users, reached 50% in 2004. The women aged 50–54 constituted the highest proportion of users in all groups: i.e. in the faithful, resistant, and ambivalent user groups. Those in the 45–49 age group were more likely than those in other age groups to be prescribed less than three courses a year (see Table 6.5).
Table 6.5

Total number (n) and percentage (%) of women in the sample taking different numbers of courses of HRT, 2000–2004 - by age

<table>
<thead>
<tr>
<th>Age</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>1–2 courses a year (resistant users)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45-49</td>
<td>429</td>
<td>11.6</td>
<td>450</td>
<td>11.2</td>
<td>390</td>
</tr>
<tr>
<td>50-54</td>
<td>474</td>
<td>12.8</td>
<td>525</td>
<td>13.1</td>
<td>546</td>
</tr>
<tr>
<td>55-59</td>
<td>291</td>
<td>7.9</td>
<td>295</td>
<td>7.4</td>
<td>271</td>
</tr>
<tr>
<td>60-64</td>
<td>214</td>
<td>5.8</td>
<td>244</td>
<td>6.1</td>
<td>186</td>
</tr>
<tr>
<td>Subtotal</td>
<td>1,408</td>
<td>38.2</td>
<td>1,514</td>
<td>37.8</td>
<td>1,393</td>
</tr>
</tbody>
</table>

| 3–5 courses a year (ambivalent users) |
| 45-49 | 258  | 7.0  | 245  | 6.1  | 210  | 5.8  | 156  | 6.4  | 102  | 5.1  |
| 50-54 | 298  | 8.1  | 315  | 7.9  | 336  | 9.3  | 237  | 9.7  | 182  | 9.1  |
| 55-59 | 207  | 5.6  | 193  | 4.8  | 187  | 5.2  | 126  | 5.2  | 114  | 5.7  |
| 60-64 | 112  | 3.0  | 142  | 3.5  | 144  | 4.0  | 104  | 4.3  | 83   | 4.1  |
| Subtotal | 875  | 23.7 | 895  | 22.3 | 877  | 24.3 | 623  | 25.5 | 481  | 24.0 |

| 6 or more courses a year (faithful users) |
| 45-49 | 324  | 8.8  | 349  | 8.7  | 265  | 7.3  | 137  | 5.6  | 104  | 5.2  |
| 50-54 | 524  | 14.2 | 631  | 15.7 | 530  | 14.7 | 262  | 10.7 | 193  | 9.6  |
| 55-59 | 343  | 9.3  | 379  | 9.5  | 330  | 9.1  | 179  | 7.3  | 146  | 7.3  |
| 60-64 | 216  | 5.9  | 240  | 6.0  | 221  | 6.1  | 117  | 4.8  | 88   | 4.4  |
| Subtotal | 1,407 | 38.1 | 1,599 | 39.9 | 1,346 | 37.2 | 695  | 28.5 | 531  | 26.5 |

Total 3,690 100.0 4,008 100.0 3,616 100.0 2,442 100.0 2,003 100.0

Figure 6.5 indicates that the use rates among the faithful and ambivalent users were between 9% and 13% in 2001. This was the most popular year for HRT. As shown in Figure 6.3 above, HRT was used by 21.6% of middle-aged women. Thereafter, the rate among the faithful users in different age-groups decreased drastically to between 3% and 5% in 2004 in which year the HRT prescription rate had dropped to 9.7%. During the years 2000 to 2003, the proportion of resistant users was initially almost identical to that of the faithful users, indicating a polarised usage style. This pattern changed in 2004 when almost 50% (49.5%) of women taking HRT were resistant users who had taken only 1 or 2 courses, and the other 50.5% had taken 3 or more courses.
6.2.3 Doctors’ Prescribing Behaviours

This section examines doctors’ diagnoses and prescription of HRT in clinic care settings, an important aspect of examining menopausal healthcare services. Although a clinic visit is an interactive process between a doctor and the woman patient, the diagnosis and whether HRT is prescribed are both principally decided by doctors. In this section, the unit of analysis is a consultation, also called ‘a clinic visit’.

Less than 10% of the clinic visits made by middle-aged women in the sample resulted in a diagnosis of menopausal syndrome. This diagnosis was mainly made by gynaecologists (Table 6.6). In 2000, approximately 50% of visits to gynaecology clinics resulted in a diagnosis of menopausal syndrome, but this figure declined from 2002, reaching its lowest level, 30%, in 2004 (Tables 6.4 and 6.6). The diagnosis rate of menopausal syndrome in visits to general practitioner and other specialist clinics was comparatively rather minor. The diagnosis rate of menopausal syndrome in other specialist clinics followed the same change pattern as occurred in the gynaecology clinics. TCM was the exception. The diagnosis rate in TCM clinics increased over the study years. Fluctuations in the menopausal syndrome diagnosis rate paralleled those in the HRT prescription rate: the menopausal syndrome diagnosis rate was highest in 2001, dropped from 2002, and remained at its lowest level in 2004.
Table 6.6  
**Number (n) and percentage (%) of NHI consultations resulting in diagnosis of menopausal syndrome, 2000–2004 - by medical specialisation**

<table>
<thead>
<tr>
<th>Specialization</th>
<th>2000</th>
<th></th>
<th>2001</th>
<th></th>
<th>2002</th>
<th></th>
<th>2003</th>
<th></th>
<th>2004</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>General Practice</td>
<td>3,034</td>
<td>7.30</td>
<td>3,660</td>
<td>8.56</td>
<td>3,235</td>
<td>7.56</td>
<td>2,238</td>
<td>4.84</td>
<td>1,881</td>
<td>3.67</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>1,033</td>
<td>2.40</td>
<td>1,172</td>
<td>2.94</td>
<td>896</td>
<td>2.49</td>
<td>560</td>
<td>1.57</td>
<td>463</td>
<td>1.22</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>364</td>
<td>7.23</td>
<td>457</td>
<td>7.78</td>
<td>446</td>
<td>6.92</td>
<td>351</td>
<td>5.65</td>
<td>245</td>
<td>3.30</td>
</tr>
<tr>
<td>Rheumatics &amp; Immunology</td>
<td>47</td>
<td>3.65</td>
<td>27</td>
<td>1.70</td>
<td>27</td>
<td>1.52</td>
<td>28</td>
<td>1.49</td>
<td>42</td>
<td>1.98</td>
</tr>
<tr>
<td>Cardiovasology</td>
<td>152</td>
<td>2.31</td>
<td>170</td>
<td>2.15</td>
<td>199</td>
<td>2.20</td>
<td>164</td>
<td>1.85</td>
<td>148</td>
<td>1.39</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>51</td>
<td>0.89</td>
<td>51</td>
<td>0.81</td>
<td>68</td>
<td>0.96</td>
<td>32</td>
<td>0.49</td>
<td>31</td>
<td>0.37</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>16,220</td>
<td>48.33</td>
<td>17,918</td>
<td>49.52</td>
<td>15,886</td>
<td>45.11</td>
<td>9,739</td>
<td>33.68</td>
<td>9,559</td>
<td>30.09</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>80</td>
<td>0.67</td>
<td>79</td>
<td>0.62</td>
<td>49</td>
<td>0.38</td>
<td>19</td>
<td>0.15</td>
<td>17</td>
<td>0.11</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>38</td>
<td>0.69</td>
<td>20</td>
<td>0.33</td>
<td>14</td>
<td>0.19</td>
<td>14</td>
<td>0.19</td>
<td>6</td>
<td>0.06</td>
</tr>
<tr>
<td>Urology</td>
<td>11</td>
<td>0.51</td>
<td>12</td>
<td>0.50</td>
<td>20</td>
<td>0.90</td>
<td>14</td>
<td>0.62</td>
<td>24</td>
<td>0.93</td>
</tr>
<tr>
<td>Neurology</td>
<td>46</td>
<td>0.75</td>
<td>65</td>
<td>1.02</td>
<td>102</td>
<td>1.50</td>
<td>58</td>
<td>0.88</td>
<td>47</td>
<td>0.61</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>23</td>
<td>0.67</td>
<td>54</td>
<td>1.38</td>
<td>89</td>
<td>1.97</td>
<td>122</td>
<td>2.35</td>
<td>108</td>
<td>1.76</td>
</tr>
<tr>
<td>TCM</td>
<td>290</td>
<td>0.87</td>
<td>421</td>
<td>1.22</td>
<td>922</td>
<td>2.50</td>
<td>1,208</td>
<td>2.88</td>
<td>1,665</td>
<td>3.40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>21,389</td>
<td>8.43</td>
<td>24,106</td>
<td>9.30</td>
<td>21,953</td>
<td>8.43</td>
<td>14,547</td>
<td>5.49</td>
<td>14,236</td>
<td>4.74</td>
</tr>
</tbody>
</table>

During the study period, more than 80% of the clinic visits resulting in a diagnosis of menopausal syndrome, a vast majority, also resulted in the woman being prescribed HRT. This dramatic prescription rate decreased from July 2002 and dropped further from April 2004 (Figure 6.6).
Figure 6.6 Monthly percentage of women diagnosed with menopausal syndrome who were prescribed HRT in Taiwan, 2000–2004

A similar pattern of changes was also observed in the relationship in the figures below that trace MS diagnosis against women’s ages (Figure 6.7), the doctor’s specialty (Figure 6.8), the level of the medical facility’s accreditation, (Figure 6.9) and the location of the medical facility (reflecting its urbanisation level) (Figure 6.10).

Figure 6.7 Percentage of women in sample diagnosed with menopausal syndrome who were prescribed HRT, 2000–2004 – by age
Figure 6.8 Percentage of women in sample diagnosed with menopausal syndrome who were prescribed HRT, 2000–2004 – by medical specialisation

Figure 6.9 Percentage of women in sample diagnosed with menopausal syndrome who were prescribed HRT, 2000–2004 – by accreditation level
Figure 6.10 Percentage of women in sample diagnosed with menopausal syndrome who were prescribed HRT, 2000–2004 – by locality type

Although the prescription rate decreased after 2002, HRT was prescribed more frequently for (1) women aged 55 and above, (2) by general practitioners and gynaecologists, and (3) at district hospitals and community clinics, and (4) in less urbanised areas in general.

6.3 Discussion and Conclusion

6.3.1 Healthcare Utilisation and Expressed Needs

Utilisation of clinics, a measure of women’s health needs, remained constant among the insured middle-aged women in Taiwan. The utilisation level indicates that middle-aged women have significant health needs: the average number of clinic visits per middle-aged woman per study year was approximately 25 (Tables 6.3 and 6.4). This is very much higher than the national average in Taiwan, which ranged between 14–15 visits between 1997 and 2007 (BNHI, 2008a). More than 60% of the women sought NHI-subsidised medical advice or services in a Western medicine clinic and/or a TCM clinic in each month from January 2000 to December 2004 (Wu C.Y., Wu S.L., Lin S.J. & Chu C.M.Y., 2011). Both sets of figures demonstrating the frequent demand for and utilisation of clinic services, i.e. figures of the average annual number of consultations, and of the proportion of women involved, suggest that insured middle-aged women are ‘doctor shopping’ in Taiwan. This is a phenomenon which
has been indicated by a number of studies (Chen T.J., Chou L.F. & Hwang S.J., 2006). In an earlier study, Tsao found that women’s health needs were high but the quality of healthcare available at clinics was not adequate to meet those needs. The researcher also suggested that this was the probable reason that they continued to seek other NHI-subsidised medical help which is highly accessible in Taiwan (Tsao L.-I., 2002).

This study found a substantial change regarding which medical specialists were consulted. This suggests either changes in women’s health needs or their perceptions and understanding of them. A 2002 study observed that hormone-related and age-related symptoms both strongly contributed to women in mid-life becoming the most frequent visitors to gynaecological clinics in Taiwan (Pan H.A., Wu M.H., Hsu C.C., Yao B. L. & Huang K.E., 2002). This study found that the number and percentage of clinic visits for gynaecology began to decrease from 2002, but the number and percentage of TCM clinic visits both increased (Table 6.4). There was an increased number of diagnoses of menopausal syndrome in these TCM clinic visits between 2002 and 2004, the same time as a decrease was occurring in Western medicine clinics (Figure 6.2). These changes commenced from July 2002, the time of the first WHI report publication. This suggests that some middle-aged women in Taiwan chose NHI-reimbursed TCM as an alternative source of care for their menopausal health needs.

6.3.2 HRT and Women’s Health Needs

HRT was the prevailing treatment prescribed for menopausal syndrome in Taiwan before the WHI reports. Thereafter, a reduction in the HRT prescription rate can be observed, occurring in two stages between 2002 and 2004 (Wu et al., 2011). The first reduction from July 2002 is most likely to have resulted from women reacting to news of the WHI report. This was widely broadcast through the mass media. The second period of decline, in late 2004, was most likely due to changes in the prescription practices of Western medical doctors in response to the WHI reports. This was verified by doctors during the in-depth interviews which are outlined and discussed in Chapter 9.98 The approach taken by this study, however, does not allow it to rule out that other effects may have been at work here and a possibility of a coincidental nature.

98 See for example Chapter 9, p.197, D05.
HRT is not essential for middle-aged women in Taiwan. The 55% decline in the HRT prescription rate between 2002 and 2004, due to the impact of the WHI reports, demonstrates the elasticity of the demand for HRT. As Wu et al. (2011) point out, after the decline in HRT prescription under the influence of the WHI reports, the rate did not rebound to its previous level after the local SARS epidemic in 2003 which caused a great reduction in the number of people attending clinics.

Significantly, approximately 40%–50% of women prescribed HRT did not adhere to the therapy to relieve the symptoms which had caused them to go to the prescribing clinic. This indicates a great deal of unmet menopausal health needs. These women discontinued HRT during or after finishing one or two courses during the period 2000–2004. They resisted using HRT although their doctors had prescribed it after diagnosing them with menopausal syndrome. The percentage of resistant users was initially almost identical to that of faithful users; but from 2002 the proportion of faithful users decreased, whereas that of resistant users increased. By contrast, the percentage of the ambivalent users remained comparatively constant throughout the 2000–2004 period (Figure 6.5).

Ambivalent users took at least three courses of the therapy, but using five courses at most means they did not continue using it as long the protocol demanded they need to in order to noticeably relieve menopausal syndrome symptoms. The proportion of women in this user type stayed relatively constant, at more or less a quarter of all women prescribed HRT, before and after the WHI reports. These women most likely decided to stop using HRT on their own without consulting their doctor about it because they were not acquainted with the necessity to take HRT continuously to relieve symptoms, as mentioned in the Chen et al. study (2000), or because they were worried about the risk of cancer.

Most consultations during which menopausal syndrome was diagnosed or identified as the reason for the visit, and HRT was therefore prescribed, were made by gynaecologists, a pattern similar to that in Western countries (Levy, B.T., Ritchie, J.M., Smith, E., Gray, T. & Zhang W., (2003). The doctors practising in academic medical centres and metropolitan locations prescribed HRT more conservatively than those in other medical facilities and in other categories of location over the period of the study, a finding confirmed by Huang et al. (2007). This was most likely due to a
combination of factors: interaction between better quality in healthcare being provided in the medical facilities with the highest accreditation level, and more up-to-date information being available to and adopted by the women living in the most urbanised locations.

The comparatively coherent patterns of monthly rates between HRT prescription and the diagnosis of menopausal syndrome highlight unavoidable limitations of using the NHI database. Women’s clinic visits for menopausal symptoms do not necessarily equate to a need for HRT, but the fluctuations in the monthly rate of diagnosis of menopausal syndrome made by doctors in Western medicine clinic settings (Figure 6.2) between 2000 and 2004 do correspond closely to the fluctuations in the monthly HRT prescription rate (Figure 6.4). The distribution figures in Table 6.1 shows that with only one exception (the numbers of women aged 60–64 which stayed constant between 2000 and 2004) the numbers of women in this study increased year on year over the period, especially those aged from 45 to 54 years. Women in this age range constitute the largest section of the population experiencing menopause. This reflects one of the limitations that the medical claim database records NHI reimbursements rather than patient clinical records, and the diagnosis codes were inclined to being payment driven. This complicating factor is further examined in Part 2 of this study by interviewing key informants.

**Conclusion**

Middle-aged insured women in Taiwan have significant health needs but an analysis of the overall utilisation of NHI-reimbursed clinic visits reveals that by 2004 fewer than 10% of these women would adhere to or refill HRT prescribed by doctors; a mere 5% of women adhered to three or more courses of HRT. Nevertheless, insured middle-aged women’s having unmet health needs is indicated by the facts that they visited doctors frequently, and that they also frequently consulted specialists in different fields. The rising percentage of TCM consultations and the concurrent fall in the percentage of gynaecology consultations implies a resistance to the use of HRT. If the initial prescription of HRT was considered by the prescribing doctor to have been necessary (using a Western medical approach), the consistent proportion of ambivalent users also indicates unmet needs among these women who, after being
prescribed and taking HRT, but dropped out due to the WHI reports or unidentified reasons over the study period.

The NHI expenditure associated with HRT prescription, especially the essentially inefficient expenditure on resistant and ambivalent users, and women’s unmet health needs all require more comprehensive investigation. The next chapter, Chapter 7, examines the allocation of public health resources to reimburse HRT medication costs, and to menopausal health programs. To provide effective and appropriate healthcare services, it is necessary to better understand the nature of women’s needs. Chapter 8 examines menopausal health needs by articulating the voices of women affected and their experiences.
Chapter 7
HRT-treatment related Expenditure

HRT assessment has typically focused on clinical outcomes; few evaluate the efficiency of the allocation of health resources between the HRT and other health measures. The medical expenditure for HRT used by menopausal women in Taiwan has not yet been analysed and assessed. This chapter investigates the annual direct expenditure, public and personal, associated with HRT prescribed to women NHI beneficiaries in the period 2000 to 2004. It examines the public sector budget allocations for promoting menopausal health, and it compares this with the NHI expenditure on HRT, raising questions about the efficient use of scarce health resources.

7.1 Data and Definitions

7.1.1 Data

The information relating to HRT-related expenses was obtained from four sources:

(1) The data relating to HRT-related treatment costs was obtained from the dataset discussed in the previous chapter: the medical claims records from Taiwan’s NHI database.

(2) Information about the national expenditure on various categories of hormonal products used to treat menopause-related health problems was obtained from the 2002-2008 NHI pharmaceutical database.99

(3) Data reflecting the changing demand for various categories of hormonal products used to treat menopause-related health problems between 2004 and 2008 inclusive was obtained from the pharmaceutical company Wyeth-Ayerst Taiwan Inc.100

99 Provided by private sources
100 Provided by the pharmaceutical company: Wyeth-Ayerst Taiwan Inc.
(4) The figures for the public sector expenditure on menopausal health campaigns made by the Bureau of Health Promotion are from budget statements from Taiwan’s Department of Health.101

7.1.2 Definitions and Background Information

The definitions given in Chapter 6 also apply to this chapter. Additional definitions are set out below:

*medication cost*: the reimbursement which the medical facility can claim from the NHI for the HRT medication prescribed to treat an insured woman diagnosed with menopausal syndrome. This corresponds to variable 29, ‘hrt_drug’, in Appendix 5. It was only counted if there was also a corresponding record of this diagnosis at that consultation, i.e. if there was also a ‘1’, at variable 26, ‘mrs_mk’. The NHI pays out a fixed standard price for each medication included in its categories. As with the Australian Pharmaceutical Benefits Scheme, not all brands of all medications are covered by the NHI. If a patient asks for, or agrees with the doctor’s recommendation to use, a particular medication which the NHI does not reimburse the cost of, then the patient has to pay its full price themselves.

There are four categories of NHI covered HRT medications relevant to this investigation:

1. G03F (oestrogen and progestogen);
2. G03C (oestrogens - excluding G03A, G03E, G03F);
3. G03X (other sex hormones and similar products); and
4. G02F (topical sex hormones).

*copayment*: the out-of-pocket payment for a clinic visit above and beyond the associated NHI reimbursements made for the consultation and medication costs. The administration fee allowed to be charged by the medical facility varies with the accreditation level of the medical facility: the insured women typically paid a higher administration fee to visit an academic medical centre and a lower fee at a community

101 Provided by the BHP
Many HRT users, particularly those consulting doctors at level 4 clinics, did not need to pay any co-payment because such clinics often did not charge any copayment as a form of incentive to encourage people seeking medical services to use their facility. The copayment could also include a cost for the medication above the NHI reimbursement medication cost: medical facilities, including hospitals are permitted to make such charges.

A new Taiwan National Health Insurance (NHI) copayment policy was enacted July 15, 2005. The secondary data analysis was all done using data from within the earlier copayment policy environment.

7.2 HRT-related NHI Expenditure

There are two different direct expenditures related to HRT use in Taiwan:

(1) the medication cost, paid by the NHI, and

(2) the copayment for the clinic visit resulting in HRT being prescribed, paid by the patient.

7.2.1 Expenditure on Women in the Sample

The NHI expenditure on the medication cost for all visits by women in the sample during which they were prescribed HRT is set out in Table 7.1. The mean statistics cannot appropriately represent the unit cost of an NHI HRT reimbursement for each year because there are major differences between visits (see SD abbreviation ‘standard deviation’). The following values are given in current prices, but inflation rates over the relevant study period in Taiwan were very low (GDP deflator levels suggest less than 1% over the entire period).

---

Table 7.1
*NHI expenditure statistics regarding HRT medications per visit made by women in the sample, 2000-2004*

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of visits</td>
<td>18,068</td>
<td>20,557</td>
<td>17,634</td>
<td>10,104</td>
<td>8,029</td>
</tr>
<tr>
<td>Mean</td>
<td>153</td>
<td>151</td>
<td>160</td>
<td>157</td>
<td>160</td>
</tr>
<tr>
<td>SD</td>
<td>107</td>
<td>100</td>
<td>140</td>
<td>135</td>
<td>108</td>
</tr>
<tr>
<td>Median</td>
<td>104</td>
<td>119</td>
<td>139</td>
<td>130</td>
<td>130</td>
</tr>
<tr>
<td>Mode</td>
<td>94</td>
<td>239</td>
<td>239</td>
<td>238</td>
<td>238</td>
</tr>
<tr>
<td>Minimum</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Maximum</td>
<td>864</td>
<td>3,040</td>
<td>6,680</td>
<td>6,680</td>
<td>1,210</td>
</tr>
<tr>
<td>Percentiles 25</td>
<td>88</td>
<td>85</td>
<td>80</td>
<td>79</td>
<td>77</td>
</tr>
<tr>
<td>50</td>
<td>104</td>
<td>119</td>
<td>139</td>
<td>130</td>
<td>130</td>
</tr>
<tr>
<td>75</td>
<td>158</td>
<td>239</td>
<td>239</td>
<td>238</td>
<td>232</td>
</tr>
<tr>
<td>Total</td>
<td>2,763,118</td>
<td>3,111,139</td>
<td>2,814,215</td>
<td>1,588,095</td>
<td>1,286,467</td>
</tr>
</tbody>
</table>

The distribution of the NHI expenditure on medication cost over the resistant, ambivalent, and faithful users in the sample are detailed in Tables 7.2, 7.3, and 7.4 respectively. The associated copayment costs are detailed further below.

Table 7.2
*NHI expenditure on HRT medications for resistant users, 2000-2004*

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of women</td>
<td>1,408</td>
<td>1,514</td>
<td>1,393</td>
<td>1,124</td>
<td>991</td>
</tr>
<tr>
<td>Mean</td>
<td>214</td>
<td>218</td>
<td>237</td>
<td>226</td>
<td>218</td>
</tr>
<tr>
<td>SD</td>
<td>162</td>
<td>152</td>
<td>338</td>
<td>242</td>
<td>152</td>
</tr>
<tr>
<td>Median</td>
<td>165</td>
<td>179</td>
<td>231</td>
<td>218</td>
<td>201</td>
</tr>
<tr>
<td>Mode</td>
<td>94</td>
<td>239</td>
<td>239</td>
<td>238</td>
<td>238</td>
</tr>
<tr>
<td>Minimum</td>
<td>11</td>
<td>14</td>
<td>12</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Maximum</td>
<td>928</td>
<td>1,527</td>
<td>6,919</td>
<td>6,680</td>
<td>1,200</td>
</tr>
<tr>
<td>Percentiles 25</td>
<td>94</td>
<td>96</td>
<td>118</td>
<td>115</td>
<td>95</td>
</tr>
<tr>
<td>50</td>
<td>165</td>
<td>179</td>
<td>231</td>
<td>218</td>
<td>201</td>
</tr>
<tr>
<td>75</td>
<td>287</td>
<td>278</td>
<td>239</td>
<td>239</td>
<td>238</td>
</tr>
<tr>
<td>Subtotal</td>
<td>301,720</td>
<td>329,610</td>
<td>330,451</td>
<td>253,551</td>
<td>215,785</td>
</tr>
</tbody>
</table>
Table 7.3
*NHI expenditure on HRT medications for ambivalent users, 2000-2004*

(Unit: NT$)

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of women</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>604</td>
<td>590</td>
<td>621</td>
<td>582</td>
<td>598</td>
</tr>
<tr>
<td>SD</td>
<td>416</td>
<td>365</td>
<td>363</td>
<td>349</td>
<td>376</td>
</tr>
<tr>
<td>Median</td>
<td>470</td>
<td>479</td>
<td>555</td>
<td>495</td>
<td>533</td>
</tr>
<tr>
<td>Mode</td>
<td>376</td>
<td>717</td>
<td>717</td>
<td>714</td>
<td>714</td>
</tr>
<tr>
<td>Minimum</td>
<td>15</td>
<td>60</td>
<td>60</td>
<td>80</td>
<td>90</td>
</tr>
<tr>
<td>Maximum</td>
<td>3,815</td>
<td>3,628</td>
<td>4,072</td>
<td>2,375</td>
<td>3,088</td>
</tr>
<tr>
<td>Percentiles 25</td>
<td>352</td>
<td>328</td>
<td>340</td>
<td>312</td>
<td>308</td>
</tr>
<tr>
<td>50</td>
<td>470</td>
<td>479</td>
<td>555</td>
<td>495</td>
<td>533</td>
</tr>
<tr>
<td>75</td>
<td>710</td>
<td>730</td>
<td>797</td>
<td>717</td>
<td>771</td>
</tr>
<tr>
<td>Subtotal</td>
<td>528,422</td>
<td>528,318</td>
<td>544,193</td>
<td>362,587</td>
<td>287,652</td>
</tr>
</tbody>
</table>

Table 7.4
*NHI expenditure on HRT medications for faithful users, 2000-2004*

(Unit: NT$)

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of women</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>1,374</td>
<td>1,409</td>
<td>1,441</td>
<td>1,398</td>
<td>1,475</td>
</tr>
<tr>
<td>SD</td>
<td>973</td>
<td>905</td>
<td>941</td>
<td>979</td>
<td>1,122</td>
</tr>
<tr>
<td>Median</td>
<td>1,074</td>
<td>1,100</td>
<td>1,190</td>
<td>1,188</td>
<td>1,200</td>
</tr>
<tr>
<td>Mode</td>
<td>752</td>
<td>1,047</td>
<td>1,434</td>
<td>2,144</td>
<td>1,428</td>
</tr>
<tr>
<td>Minimum</td>
<td>78</td>
<td>184</td>
<td>117</td>
<td>118</td>
<td>133</td>
</tr>
<tr>
<td>Maximum</td>
<td>9,195</td>
<td>9,715</td>
<td>9,022</td>
<td>12,185</td>
<td>15,730</td>
</tr>
<tr>
<td>Percentiles 25</td>
<td>792</td>
<td>783</td>
<td>781</td>
<td>721</td>
<td>744</td>
</tr>
<tr>
<td>50</td>
<td>1,074</td>
<td>1,100</td>
<td>1,190</td>
<td>1,188</td>
<td>1,200</td>
</tr>
<tr>
<td>75</td>
<td>1,540</td>
<td>1,807</td>
<td>1,912</td>
<td>1,848</td>
<td>2,063</td>
</tr>
<tr>
<td>Subtotal</td>
<td>1,932,976</td>
<td>2,253,211</td>
<td>1,939,571</td>
<td>971,957</td>
<td>783,030</td>
</tr>
</tbody>
</table>

Comparing Table 7.1 with Tables 7.2 and 7.3, the median statistics provide a better representation of the unit annual costs of NHI HRT reimbursement than the
mean values. Looking at the HRT medication costs set out in these three tables, the median values in Tables 7.2 and 7.3 increase with the increases in the amount of HRT prescribed and increases of the same proportion in the medication costs. The resultant unit cost of NHI HRT reimbursement ranged between a low of NT$104 (in 2000) and a maximum value of NT$139 (in 2002).

The copayment costs associated with the figures above are detailed in Tables 7.5. The figures for resistant, ambivalent, and faithful users are given in Table 7.6, 7.7, and 7.8 respectively. Table 7.5 shows that the average copayment decreased each year and the median, mode, and percentile statistics follow the same trend. As the administration fee component remained constant between 2000 and 2004, the values between percentiles 25 and 75 indicate that NHI HRT was mostly issued by district hospitals and community clinics. The median statistics more appropriately represent the copayment than the mean statistics, which ranged from the highest figure of NT$110 in 2000, to NT$70 in 2004.

Table 7.5
Annual copayments made by women in the sample for each clinic visit at which HRT was prescribed for menopausal syndrome, 2000–2004

(Unit: NT$)

<table>
<thead>
<tr>
<th>No. of visits</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>112</td>
<td>108</td>
<td>108</td>
<td>103</td>
<td>92</td>
</tr>
<tr>
<td>SD</td>
<td>67</td>
<td>68</td>
<td>81</td>
<td>94</td>
<td>81</td>
</tr>
<tr>
<td>Median</td>
<td>110</td>
<td>100</td>
<td>90</td>
<td>70</td>
<td>70</td>
</tr>
<tr>
<td>Mode</td>
<td>70</td>
<td>70</td>
<td>0</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Minimum</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Maximum</td>
<td>300</td>
<td>400</td>
<td>720</td>
<td>710</td>
<td>420</td>
</tr>
<tr>
<td>Percentiles 25</td>
<td>70</td>
<td>70</td>
<td>50</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>50</td>
<td>110</td>
<td>100</td>
<td>90</td>
<td>70</td>
<td>70</td>
</tr>
<tr>
<td>75</td>
<td>160</td>
<td>150</td>
<td>150</td>
<td>150</td>
<td>140</td>
</tr>
<tr>
<td>Total</td>
<td>2,017,522</td>
<td>2,222,780</td>
<td>1,911,510</td>
<td>1,045,210</td>
<td>734,990</td>
</tr>
</tbody>
</table>
Table 7.6
Annual copayments made by resistant users for clinic visits at which HRT was prescribed for menopausal syndrome, 2000–2004

(Unit: NT$)

<table>
<thead>
<tr>
<th>No. of women</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>151</td>
<td>149</td>
<td>151</td>
<td>157</td>
<td>143</td>
</tr>
<tr>
<td>SD</td>
<td>97</td>
<td>94</td>
<td>108</td>
<td>137</td>
<td>114</td>
</tr>
<tr>
<td>Median</td>
<td>130</td>
<td>130</td>
<td>120</td>
<td>110</td>
<td>100</td>
</tr>
<tr>
<td>Mode</td>
<td>70</td>
<td>90</td>
<td>90</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Minimum</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Maximum</td>
<td>600</td>
<td>640</td>
<td>740</td>
<td>1,060</td>
<td>680</td>
</tr>
<tr>
<td>Percentiles 25</td>
<td>70</td>
<td>90</td>
<td>90</td>
<td>70</td>
<td>70</td>
</tr>
<tr>
<td>50</td>
<td>130</td>
<td>130</td>
<td>120</td>
<td>110</td>
<td>100</td>
</tr>
<tr>
<td>75</td>
<td>200</td>
<td>190</td>
<td>190</td>
<td>200</td>
<td>180</td>
</tr>
<tr>
<td>Subtotal</td>
<td>212,420</td>
<td>225,690</td>
<td>210,280</td>
<td>176,480</td>
<td>141,660</td>
</tr>
</tbody>
</table>

Table 7.7
Annual copayments made by ambivalent users for clinic visits at which HRT was prescribed for menopausal syndrome, 2000–2004

(Unit: NT$)

<table>
<thead>
<tr>
<th>No. of women</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>423</td>
<td>419</td>
<td>413</td>
<td>423</td>
<td>376</td>
</tr>
<tr>
<td>SD</td>
<td>233</td>
<td>235</td>
<td>258</td>
<td>329</td>
<td>279</td>
</tr>
<tr>
<td>Median</td>
<td>380</td>
<td>380</td>
<td>360</td>
<td>310</td>
<td>290</td>
</tr>
<tr>
<td>Mode</td>
<td>210</td>
<td>150</td>
<td>150</td>
<td>150</td>
<td>150</td>
</tr>
<tr>
<td>Minimum</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Maximum</td>
<td>1,250</td>
<td>1,750</td>
<td>1,750</td>
<td>1,740</td>
<td>1,660</td>
</tr>
<tr>
<td>Percentiles 25</td>
<td>250</td>
<td>250</td>
<td>240</td>
<td>200</td>
<td>200</td>
</tr>
<tr>
<td>50</td>
<td>380</td>
<td>380</td>
<td>360</td>
<td>310</td>
<td>290</td>
</tr>
<tr>
<td>75</td>
<td>570</td>
<td>530</td>
<td>540</td>
<td>540</td>
<td>500</td>
</tr>
<tr>
<td>Subtotal</td>
<td>370,160</td>
<td>375,300</td>
<td>362,450</td>
<td>263,660</td>
<td>180,940</td>
</tr>
</tbody>
</table>
The median copayment made by faithful users was over NT$900 in 2000, then fell each year. As the minimum copayment figures in Table 7.8 show, visits by some faithful users incurred a ‘zero’ copayment. In fact, this was the mode for the faithful users of HRT in all years except 2004. Comparing the median statistics for HRT medication cost and copayment figures set out in Tables 7.4 and 7.8, proportionally based on the increases there, it is estimated that the majority of faithful users had 9 or 10 courses of HRT a year. This estimated figure was subsequently confirmed in discussions with the women who had had experience of long-term HRT usage (discussed in the next chapter).

### 7.2.2 Estimated Corresponding National Expenditures 2000-2004

The expenditure figures for the sample group were analysed, producing the results presented in the tables above, and then used to estimate the corresponding national expenditure for the entire population of insured middle-aged women in Taiwan. As mentioned in Chapter 6, a test of the goodness-of-fit for the age group distribution indicated that the sample appropriately represented the female beneficiary population aged 45-64 years in each year from 2000 to 2004. The figures for the sample group were therefore extrapolated using the ratio of the total in Table 6.2
against the total in Table 6.1 for each respective study year. For example, the ratio to use to extrapolate to the entire relevant population for Taiwan for 2000 is 117:1 (18,481: 2,112,915). The ratio for 2001 is 19,247: 2,214,269, and so on. The results are set out in the tables below.

According to the estimates obtained, between 2000 and 2004 the annual national expenditure on both medication costs (Table 7.9), and copayments (Table 7.10), peaked in 2001 and then began to decrease.

Table 7.9
**Estimated national expenditure on HRT medication, 2000–2004**

<table>
<thead>
<tr>
<th>Annual national expenditure on HRT medications</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resistant users (1–2 HRT courses)</td>
<td>34.50</td>
<td>37.87</td>
<td>38.15</td>
<td>29.39</td>
<td>25.08</td>
</tr>
<tr>
<td>Ambivalent users (3–5 HRT courses)</td>
<td>60.41</td>
<td>60.70</td>
<td>62.82</td>
<td>42.03</td>
<td>33.44</td>
</tr>
<tr>
<td>Faithful users (6 or more HRT courses)</td>
<td>221.00</td>
<td>258.86</td>
<td>223.89</td>
<td>112.67</td>
<td>91.02</td>
</tr>
<tr>
<td>Total</td>
<td>315.90</td>
<td>357.42</td>
<td>324.86</td>
<td>184.10</td>
<td>149.54</td>
</tr>
</tbody>
</table>

The total annual cost of HRT medications peaked in 2001 at close to NT$357 million and then fell. It had fallen by approximately 60% to NT$150 million in 2004. As Table 7.9 clearly shows, the highest amount of medication expenditure was consistently incurred by women in the faithful users category. The proportion of the medication cost expenditure incurred by the other women, the resistant and ambivalent users comprising those women prescribed at least one but fewer than six courses, increased from 2002, and the two figures combined comprised 40% of the total medication cost in 2004.

As Table 7.10 shows, the estimated total copayments for consultations at which HRT was prescribed was at its highest, just over NT$255 million, in 2001 and had fallen to just over NT$85 million by 2004. This paralleled the medication cost expenditure pattern.

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104 See Chapter 6 p.109 for details of the total figures in Table 6.1 and 6.2
Table 7.10

*Estimated corresponding copayments for clinic visits resulting in HRT being prescribed for insured middle-aged women, 2000–2004*  
(Unit: NT$ in millions)

<table>
<thead>
<tr>
<th>Annual expenditure on copayments for clinic visits resulting in HRT prescription</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resistant users (1–2 HRT courses)</td>
<td>24.29</td>
<td>25.93</td>
<td>24.27</td>
<td>20.46</td>
<td>16.47</td>
</tr>
<tr>
<td>Ambivalent users (3–5 HRT courses)</td>
<td>42.32</td>
<td>43.12</td>
<td>41.84</td>
<td>30.56</td>
<td>21.03</td>
</tr>
<tr>
<td>Faithful users (6 or more HRT courses)</td>
<td>164.06</td>
<td>186.32</td>
<td>154.54</td>
<td>70.14</td>
<td>47.94</td>
</tr>
<tr>
<td>Total</td>
<td>230.66</td>
<td>255.36</td>
<td>220.65</td>
<td>121.17</td>
<td>85.44</td>
</tr>
</tbody>
</table>

7.2.3 Expenditure on and by Women with Different User Profiles

Chapter 6 evaluated the proportion of HRT users with different use profiles. Although women using HRT need to adhere to at least three to six courses of therapy to begin to alleviate menopausal symptoms (Tan et al., 2002), many discontinue their treatment before this threshold is reached. The large proportion of women in the resistant and the ambivalent user groups raises the questions of how many women were prescribed HRT imprudently and how many of the courses prescribed actually met women’s needs and their preferences. HRT is promoted in medical settings on one hand due to doctors’ belief that ageing-related hormone deficiency is a pathological condition. On the other hand, there is also a direct profit incentive for doctors to prescribe it.105

As the data in Chapter 6 indicates (Figures 6.7 to 6.10), women aged 55 and above, women in less urbanised areas, and those attending community clinics and district hospitals were more likely to be prescribed HRT, particularly after 2002. The expenditure data presented above provides further evidence that faithful users of HRT were prescribed more by district hospitals and community clinics, that is, the relatively less sophisticated medical facilities with accreditation level 3 or 4.

There were definitely women who wanted and/or needed to use HRT. The greatest proportion of the medication cost was spent on such faithful users: the average cost per woman in this group was approximately NT$1,413. This is

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105 The associated issues of medicalisation and commercialisation are discussed in Chapter 9.
dramatically higher than the average cost of approximately NT$603 per woman in the ambivalent user group, and that of approximately NT$223 per woman in the resistant user group. It is almost double the average cost of approximately NT$733 per woman in the entire group of women who had been prescribed at least one course of HRT.

The mode values recorded in Tables 7.6, 7.7, and 7.8 show that more faithful users paid a ‘zero’ copayment for a consultation at which HRT was prescribed. The median copayment for faithful users decreased consistently, and the median copayments made by women in the other two groups fell overall between 2000 and 2004. The medication cost stayed constant during this five-year period so this suggests that more prescriptions were being issued by community clinics and district hospitals. These typically have lower administration fees and are therefore more likely to not exceed the level which the NHI covered. A zero copayment was used by some medical facilities as an incentive to encourage patients to use their services.

The drastic drop in the HRT prescription rate in academic medical centres from 2002 (Table 6.8) implies that there was a time lag before information about the WHI results disseminated to primary care medical facilities with lower accreditation levels. It also implies that there was a lack of alternative measures for menopausal care and/or information about such alternatives available at the primary care medical facilities with lower accreditation levels.

7.3 The HRT Pharmaceutical Market in Taiwan

Information from two sources relating to the sales of HRT pharmaceutical products was examined to give a better understanding of the HRT prescription patterns in Taiwan. This data was also sourced from the NHI database, but these two sets of figures were obtained from two different sources to the database which forms the central part of the secondary data analysis constituting Part 1 of this thesis and also a substantial part of this chapter. The two databases cover different although partly overlapping periods of time, and no information is available about the age-group breakdown of the users of the pharmaceutical products. Moreover, as mentioned above, a new Taiwan National Health Insurance (NHI) copayment policy was enacted July 15, 2005. For these reasons, neither can be used for direct comparisons. The figures nevertheless provide a valuable picture of the trends in NHI
pharmaceutical expenditures on HRT medications, and pharmaceutical sales reflecting consumer (women’s) demand for various such products which corroborates other evidence.

The first set of data was from the NHI pharmaceutical database covering the years 2002 to 2008: this provided details of the annual national expenditure on different categories of sex hormones and modulators of the reproductive system. The figures are set out in Table 7.11.

**Table 7.11**  
*NHI expenditure on sex hormones & modulators of the reproductive system (G03)*

<table>
<thead>
<tr>
<th>ACT code</th>
<th>Description</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>G03F</td>
<td>OESTROGEN + PROGESTOGEN</td>
<td>288.76</td>
<td>182.16</td>
<td>167.15</td>
<td>145.09</td>
<td>119.86</td>
<td>109.72</td>
<td>98.56</td>
</tr>
<tr>
<td>G03C</td>
<td>OESTROGENS, EXCLUDING G3A, G3E, G3F</td>
<td>146.87</td>
<td>88.78</td>
<td>75.45</td>
<td>64.71</td>
<td>54.11</td>
<td>45.47</td>
<td>40.56</td>
</tr>
<tr>
<td>G03X</td>
<td>OTHER SEX HORMONES AND SIMILAR PRODUCTS</td>
<td>51.23</td>
<td>43.79</td>
<td>52.89</td>
<td>45.69</td>
<td>38.95</td>
<td>37.38</td>
<td>41.24</td>
</tr>
<tr>
<td>G02F</td>
<td>TOPICAL SEX HORMONES</td>
<td>39.50</td>
<td>28.28</td>
<td>33.03</td>
<td>35.02</td>
<td>31.43</td>
<td>30.53</td>
<td>31.28</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>526.36</td>
<td>343.01</td>
<td>328.52</td>
<td>290.51</td>
<td>244.55</td>
<td>223.10</td>
<td>211.64</td>
</tr>
</tbody>
</table>

Source: National Health Insurance pharmaceutical database

As Table 7.11 shows, expenditure on prescribed hormonal medications in the sub-categories G03F and G03C decreased consistently from 2002 to 2008, dramatically at first, then steadily. During this same period, the expenditure on other products—namely other sex hormones in the G03X sub-category, for example Tibolone and the selective oestrogen receptor modulators (SERMs), and topical hormones in the G02F category—was comparatively constant between 2006 and 2008.

The second set of data was from Wyeth-Ayerst (Asia) Ltd Taiwan, a pharmaceutical company. The company was not willing to give the actual monetary sales figures for commercial confidentiality reasons, but they did provide the relative share of annual sales of different menopausal hormonal products between 2004 and 2008. The cost of some but not all of the products indicated by these overall sales-related figures would have been reimbursed for by the NHI. The company’s figures, set out in Table 7.12, indicate a similar decrease in the proportion of sales of hormonal medication products, oral oestrogens in the sub-categories G03F and G03C, after 2004. But at the same time, the proportion of sales of G02 topical products and
of Livial, an alternative hormonal product, both increased during this period (Table 7.12).

**Table 7.12**

*The percentage of total sales of various Wyeth-Ayerst hormonal products*

<table>
<thead>
<tr>
<th>ACT code</th>
<th>Name</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>G03F</td>
<td>Premelle 2.5 S.C. Tabs 14x2</td>
<td>43.41</td>
<td>44.37</td>
<td>41.48</td>
<td>41.78</td>
<td>40.85</td>
</tr>
<tr>
<td>G03C</td>
<td>Premarin S.C. Tabs 0.625mg 28x3</td>
<td>38.31</td>
<td>36.18</td>
<td>35.73</td>
<td>29.10</td>
<td>27.86</td>
</tr>
<tr>
<td>G03X</td>
<td>Livial Oral Tabs 2.5mg 28x3 (Tibolone)</td>
<td>14.61</td>
<td>15.33</td>
<td>16.51</td>
<td>21.31</td>
<td>22.98</td>
</tr>
<tr>
<td>G02F</td>
<td>Premarin Vag. Cream 0.625mg/g 42.5g</td>
<td>3.68</td>
<td>4.12</td>
<td>6.28</td>
<td>7.81</td>
<td>8.32</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Source: Wyeth-Ayerst (Asia) Ltd. Taiwan

G02 topical products and Tibolone (such as Livial oral tablets) in particular enhance sexual responsiveness and pleasure and their increased proportion of sales of hormonal products is a significant indicator of the nature of some women’s needs. It is evidence of a demand for quality sexual activity among menopausal women which is corroborated by the qualitative data presented in the following chapters.

The relatively steady sales of other sex hormone therapies, such as the relatively new Livial, are an urgent reminder of the ongoing need for their critical assessment. HRT has a history of being promoted on the basis of insufficient research evidence and given that the baby boomers provide an often affluent significant potential market for the pharmaceutical industry, there is a danger that the commercial incentive will lead to aggressive marketing of products not adequately researched re-occurring with new drugs.

### 7.4 Public Sector Menopausal Health Promotion Expenditure

The figures in all the tables above reflect different aspects of expenditure directly related to a medicalised model of menopause. The Bureau of Health Promotion (BHP) also had annual budget allocations for various activities promoting menopausal health. The annual allocations to each of the categories are shown in Table 7.13. Between 2002 and 2009, the BHP implemented menopausal health programs in the general categories of:
1. Community campaigns;

2. Health information services – in the form of a health information phone line;

3. Developing educational materials for women;

4. Increasing national awareness;

5. Continuing education for health professionals, and

6. Research funding

**Table 7.13**

**Annual national Department of Health budget allocations for BHP programs to promote menopausal health, 2002–2009**

<table>
<thead>
<tr>
<th>Program</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community campaigns</td>
<td>0.60</td>
<td>2.19</td>
<td>3.68</td>
<td>2.48</td>
<td>0.85</td>
<td>2.56</td>
<td>0.35</td>
<td>–</td>
</tr>
<tr>
<td>Health information services</td>
<td>–</td>
<td>1.34</td>
<td>1.41</td>
<td>1.39</td>
<td>1.10</td>
<td>1.32</td>
<td>1.55</td>
<td>1.70</td>
</tr>
<tr>
<td>Developing educational materials</td>
<td>–</td>
<td>1.33</td>
<td>–</td>
<td>–</td>
<td>0.26</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Raising national awareness</td>
<td>–</td>
<td>–</td>
<td>0.05</td>
<td>0.07</td>
<td>–</td>
<td>0.30</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Continuing education for health professionals</td>
<td>–</td>
<td>0.29</td>
<td>1.23</td>
<td>0.3</td>
<td>–</td>
<td>0.46</td>
<td>1.84</td>
<td>–</td>
</tr>
<tr>
<td>Research funding</td>
<td>–</td>
<td>7.22</td>
<td>1.75</td>
<td>–</td>
<td>–</td>
<td>0.09</td>
<td>–</td>
<td>1.50</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>0.60</td>
<td>12.36</td>
<td>8.13</td>
<td>4.24</td>
<td>2.21</td>
<td>4.73</td>
<td>3.54</td>
<td>3.20</td>
</tr>
</tbody>
</table>

The highest amounts allocated by the BHP for menopausal health promotion between 2002 and 2009 occurred in 2003 and 2004, NT$12 million and NT$8 million respectively (Table 7.13). These were the two years immediately following the release of the WHI report in 2002. Thereafter, the budget allocation on menopausal health promotion was substantially reduced. Specific activities funded under each of the general category headings and the years they were undertaken are itemised in Table 7.14 below.

Generally speaking, the greatest proportion of the budget for menopausal health was allocated to community campaigns: spent on activities such as promoting women’s groups and training volunteers, and organising symposiums and workshops to raise awareness of menopausal health. The second-largest proportion of funding was allocated to information gathering, including surveys on women’s knowledge,
attitude, and practices (KAP) regarding menopause; on the use of HRT and osteoporosis; on the epidemiology of osteoporosis, and menopausal symptoms; reviews of HRT risks; and reviews of osteoporosis-related policy. Most of these surveys and studies were carried out in 2003. The third-largest proportion of the budget was spent on a free telephone information line to provide women with information services. This maintained stable budgeting between 2003 and 2009. Educational programs for women mainly took the form of developing pamphlets and brochures on menopause and osteoporosis. This was allocated a relatively low amount in the budget.

The sizes of the overall budget and the budget allocations to different categories of programs shown above indicate the priority given to menopausal health programs by the Bureau of Health Promotion. The comparatively minor amounts allocated in the budgeting for the promotion of menopausal health is clear evidence that health policy in Taiwan has relied more on a medical-pharmaceutical approach.

Most resources were allocated to campaigns, research and information gathering, and the free phone information line. The community campaigns were generally designed around one-shot events, such as symposiums, workshops or special days of action. These are far more likely to raise public concern rather than substantially contribute to creating and maintaining a strong awareness of menopausal health among the general public. The funded research centred on KAP surveys and epidemiological investigations. None assessed women’s needs or preferences. The research and surveys all had an expert-oriented perspective: this is one with a strong tendency to give rise to and perpetrate policy which is driven by normative needs rather than by what clients want: as just pointed out, none of the funded research specifically investigated what menopausal women want or consider their needs to be. The free women’s information service was established in an academic medical centre. This venue would inevitably be prone to espousing a biomedical model of menopausal health.
Table 7.14  
*Department of Health Bureau of Health Promotion national programs to promote menopausal health, 2002–2009*

<table>
<thead>
<tr>
<th>Program</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community campaigns</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promoting women’s groups and training their volunteers</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Women’s health symposiums on menopause</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Menopausal women’s health symposiums in remote areas</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Menopausal health workshops</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pelvic health promotion and prevention of urinary incontinence in post-menopausal women</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Health information services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Menopausal health phone line</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Developing educational materials for women</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Menopausal health promotion</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osteoporosis prevention</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bone density information and screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Raising national awareness</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>World Osteoporosis Day Campaign</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2007 World Menopause Day Campaign</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td><strong>Continuing education for health professionals</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuing education for doctors as menopausal health consultants</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training for community public health nurses</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developing nursing guidelines on preventing osteoporosis</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Menopausal health care consultants training programme</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developing educational modules, and women’s pelvic health and urinary incontinence prevention materials</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Research funding</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review of HRT risk and benefit</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KAP survey of menopausal symptoms and HRT</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intervention to improve the KAP of women with emotional problems through group consultancy</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National health survey on menopause</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epidemiology of osteoporosis in Taiwanese women</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KAP survey of the screening for osteoporosis and the results</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>
7.5 Implications for Resource Allocation

As pointed out in Chapter 6, women need to adhere to HRT for at least three to six courses to alleviate menopausal symptoms; having only one or two courses of HRT would not have a significant effect relieving hot flushes and other major symptoms, and at least six courses were advised to establish and maintain the effects. This means that the expenses of the resistant users of HRT represent a menopausal health opportunity cost, trading off other choices of public health services and of individual alternative care. This cost consists of both direct and indirect expenses: the direct costs are those spent on the HRT medication reimbursed by the NHI and women’s out-of-pocket copayment expense; the indirect costs include the value of the time and money spent on transportation to a clinic and of the waiting time there.

The combined total of the publicly funded NHI medication cost expenditure and the personal copayment expenditure for resistant user groups ranged from a high of almost NT$63.8 million in 2001 to almost NT$41.6 million, in 2004 (Tables 7.9 and 7.10). This represents a lowest estimated opportunity cost of over NT$42 million between 2000 and 2004; it was in a much higher range before the WHI report. This is an extremely conservative estimate as it does not take into account the opportunity cost associated with ambivalent users.

From a societal perspective, the allocation of health resources on the expenditure for the resistant and ambivalent users of HRT was inefficient. Women in Taiwan aged 45–64 have a comparatively lower employment rate in the female population (Council of Labor Affairs, 2005) so the out-of-pocket copayment expense for clinic visits has an economic impact, to a greater or lesser extent, on women in this menopausal age group. Individually, apart from the essentially wasted expenses personally incurred by women prescribed fewer than six courses of HRT, this use pattern was both ineffective for alleviating menopausal symptoms and would often still have resulted in side-effects of HRT such as uterine bleeding or breast tenderness. It would also have often heightened women’s concerns regarding endometrial cancer and/or breast cancer. Collectively, these HRT use-related discomforts and uncertainties may have led to higher NHI medical expenditure if women then

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106 Indicated by a doctor interviewee (D04). See Chapter 9, p. 194.
consulted other specialists in various fields for medical advice (Tsao, 2002). In this cycle of events, multiple medical visits and medications increase the possibility of iatrogenic disease, which further erodes the basis of healthcare finance in Taiwan.

7.6 Conclusion

The NHI expenditure on HRT medication for resistant users totalled an estimated NT$37.9 million in 2001 and NT$25.1 million in 2004 (Table 7.9). Compared to the annual NHI expenditure on clinic medication, NT$69.2 billion and NT$88.2 billion in 2001 and 2004 respectively\textsuperscript{107}, these HRT medication costs were miniscule. The impacts on women’s health indicated above, however, simply cannot be allowed to go ignored. The lowest expenditure on HRT medication, in 2004, was equal to three times the budget for BHP menopausal health programmes in the same year and more than eight times the figure in more recent years. If this opportunity cost had been spent on implementing BHP programmes, it could have financed a four-fold increase in the number of women’s supporting groups in communities, or more than 15 free telephone health consultation and information lines every year, or distribution of a brochure or pamphlet (at a unit cost of approximately NT$12 dollars) to every middle-aged woman each year. This opportunity cost is the lowest estimation: it does not include all the more indirect costs such as those incurred by the time taken for a clinic visit.

In conclusion, national HRT medication costs experienced a significant decrease after the WHI trials and this decrease continued until 2008 (see Table 7.11). Most expenses were paid for, and by, the faithful users who used at least six courses of HRT to alleviate menopausal symptoms. Changes in the type of HRT regimen indicate that more research on the health needs of users of topical hormones and other sex hormonal products is required, along with rigorous safety testing.

A maximum amount of only NT$12 million was allocated for menopausal health promotion by the BHP in the study years 2000-2004. In this same period at least NT$42 million dollars was inefficiently spent on and by those who were prescribed HRT without achieving desirable outcomes. This inefficiency in health

\textsuperscript{107} Sources: Department of Health websites: Retrieved 26 Jun. 2011
resource allocation indicates a wasteful expenditure resulting in part at least from the nature of Taiwanese women’s menopausal healthcare needs and doctors’ prescribing them HRT in response.

It is essential to listen to women’s own voices for more efficient allocation of scarce health resources to enhance menopausal health, and offer sustainable publicly-funded assistance to promote the well-being of middle-aged women in Taiwan. It is only possible to deliver efficient and effective NHI healthcare services if services genuinely and appropriately meet women’s needs. The following chapter presents some such women’s voices.
Chapter 8

Women’s Experience and Voices

This chapter presents the findings of the interviews of a number of middle-aged Taiwanese women. It is the first of three chapters presenting the results of Part 2 of this study. This provides a qualitative dimension to ‘flesh out’ the quantitative data of Part 1, discussed in the earlier chapters. The focus is on presenting women’s own voices regarding their experience of menopause, HRT use and strategies for coping with the changes accompanying the menopausal transition, and their suggestions regarding ways to better promote menopausal health.

This chapter consists of four sections: (1) background information; (2) women’s voices presenting their experience; (3) suggestions for menopausal health; and (4) discussion and conclusion.

8.1 Data Collection & Characteristics of Participants

Data was gathered through semi-structured interviews conducted in focus group discussion and in-depth interview settings. The data relates to women’s menopausal discomforts, healthcare help-seeking experience, and their suggestions for promoting health. The selection and interview processes are detailed in Chapter 5. The participants came from both rural and urban locations, with a range of socioeconomic status and diverse life experiences. Fourteen women from two organisations in northern Taiwan were recruited for two focus group discussions, and 24 women were selected by snowball sampling from four regions of Taiwan to participate in the in-depth interviews.

108 Details of the various interviews and questions posed are given in Chapter 5, Methodology.
Table 8.1

*Characteristics of the sample: 24 in-depth interviewees*

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>No. of women</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age range</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45–49</td>
<td>2</td>
<td>8.3</td>
</tr>
<tr>
<td>50–54</td>
<td>3</td>
<td>12.5</td>
</tr>
<tr>
<td>55–59</td>
<td>12</td>
<td>50.0</td>
</tr>
<tr>
<td>60–64</td>
<td>7</td>
<td>29.2</td>
</tr>
<tr>
<td><strong>Education - in years</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10</td>
<td>10</td>
<td>41.7</td>
</tr>
<tr>
<td>Between 10 and 12</td>
<td>9</td>
<td>37.5</td>
</tr>
<tr>
<td>More than 12</td>
<td>5</td>
<td>20.8</td>
</tr>
<tr>
<td><strong>Menopausal status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peri-menopausal</td>
<td>4</td>
<td>16.7</td>
</tr>
<tr>
<td>Post-menopausal</td>
<td>18</td>
<td>75.0</td>
</tr>
<tr>
<td>Surgical menopause</td>
<td>2</td>
<td>8.3</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With spouse or partner</td>
<td>17</td>
<td>70.8</td>
</tr>
<tr>
<td>Widowed</td>
<td>6</td>
<td>25.0</td>
</tr>
<tr>
<td>Separated</td>
<td>1</td>
<td>4.2</td>
</tr>
<tr>
<td><strong>Employment status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In paid employment</td>
<td>10</td>
<td>41.7</td>
</tr>
<tr>
<td>Not in paid employment</td>
<td>6</td>
<td>29.2</td>
</tr>
<tr>
<td>Retired</td>
<td>8</td>
<td>29.2</td>
</tr>
<tr>
<td><strong>Occupational status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manual (blue-collar)</td>
<td>7</td>
<td>29.2</td>
</tr>
<tr>
<td>Non-manual (white-collar)</td>
<td>12</td>
<td>50.0</td>
</tr>
<tr>
<td>Self employed (business)</td>
<td>5</td>
<td>20.8</td>
</tr>
<tr>
<td><strong>Residential region</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North</td>
<td>5</td>
<td>20.8</td>
</tr>
<tr>
<td>South</td>
<td>2</td>
<td>8.3</td>
</tr>
<tr>
<td>East</td>
<td>6</td>
<td>25.0</td>
</tr>
<tr>
<td>Central</td>
<td>11</td>
<td>45.8</td>
</tr>
<tr>
<td><strong>HRT use</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous long-term user (6 months to ten years)</td>
<td>7</td>
<td>29.2</td>
</tr>
<tr>
<td>Previous short-term user (less than 6 months)</td>
<td>6</td>
<td>25.0</td>
</tr>
<tr>
<td>Current user - including sporadic use</td>
<td>2</td>
<td>8.3</td>
</tr>
<tr>
<td>Never used</td>
<td>9</td>
<td>37.5</td>
</tr>
<tr>
<td><strong>Interview setting</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual, face-to-face</td>
<td>10</td>
<td>41.7</td>
</tr>
<tr>
<td>In small group, face-to-face</td>
<td>14</td>
<td>58.3</td>
</tr>
</tbody>
</table>

The in-depth interview participants ranged in age from 47 to 64, with an average age of 57.5. All had undergone menopause within the previous 10 years, which ensured that they were describing plausibly recent experiences. Most went through natural menopause, two had experienced surgically-induced menopause, and four were still experiencing transition symptoms at the time of the data collection.
Most were married and 25% were widowed. More than 70% of the women were employed and 6 were full-time housewives. Eleven were residents of central Taiwan and two were from the south. Almost two-thirds had used HRT; the longest period of use being ten years. Some reported using isoflavones after they stopped using HRT.

Table 8.1 above summarises the characteristics of the 24 women interviewed in the in-depth interview settings at the end of 2008. One woman was recruited from the first focus group. Appendix 8 provides brief details of each woman and the composition of the small groups.

8.2 Women's Experience

The results of women’s experience, derived from their interview data, is divided into three sections: on (1) the experience of menopause; (2) the use of HRT; and (3) women’s strategies for coping with menopausal stress. Each section is preceded by a summary of what the data analysis yielded and then presents detailed information-rich quotes from the women themselves.

8.2.1 Experience of Menopause

These Taiwanese women acknowledged menopause as a stage of female life that ‘must be’. It is an unalterable stage of life which every woman has to face, just like birth and death. The women viewed this natural transition stage positively and concluded that the proper attitude toward menopause is to accept it and not to worry. Nevertheless, although they consider menopause is a natural phenomenon, the age of the onset of amenorrhea was still a significant factor. A number of women believe that menstruation is involved in regularly removing noxious substances from the body and keeping them healthy and young. Menopause therefore signalled the commencement of ageing and susceptibility to illnesses if such substances remained in the body.

Most women identified the commencement of menopause by noting the changes in their menstruation, and also mood and/or body reactions which differed from those which accompanied their former menstrual cycles. Some go through the transition with very mild symptoms, whereas others frequently experienced a number of symptoms. Their menstrual changes caused some menopausal women to worry and
they had consulted doctors, particularly gynaecologists, to identify whether their changes were normal. Consulting doctors across several specialisations was quite a common practice as the women needed to relieve discomforts occurring in different parts of their body, and the Taiwanese healthcare system allows people to do so without requiring any referral. Women also reported detecting physical degeneration during menopause and they regarded this as the commencement of ageing. Thus, some commented that menopause was a time when they accepted the reality of getting old, and a time to make health their priority and attain quality of life.

For several women, reviewing the process of menopause brought up profound and vivid memories. For these women menopause varied in duration from one year to eight years. It was not a silent passage in these women’s lives, but after reporting their plight juggling multiple stresses they were reassured. Their observations and reporting of their specific experience of menopause, allowed these women to acknowledge individual differences and conclude that these are a function of a woman’s ‘personal physical constitution’ and ‘individual circumstances’. As such, there is no one standardised therapy or single coping strategy that suits or can ‘fix’ all women in relation to their menopausal health needs.

This section discusses three health needs abstracted from women’s reports of their menopausal experiences: (1) a need for reassurance that the changes being experienced are ‘normal’ and to rule out any pathology, to relieve worries; (2) a need to take particular care of herself and attain quality of life during menopause; and (3) the need to realise that experience varies, and no single strategy fits all.

Women’s experiential knowledge of menopause is elaborated in their own voices below. This includes their attitudes toward menopause and ageing and the impact on their life of the associated menopausal discomforts and physical changes. It provides evidence highlighting women’s health needs, based on their experiential perceptions.

**Recognising menopause as a natural transition**

Menopause is one of the natural transition stages of a woman’s life just as puberty is. Taiwanese women do not consider it something to worry or think too much about, or that they have to take medicine to counteract this natural process.
These women were encouraged to accept menopause and take it easy when the time comes. Otherwise, things might turn out to be exactly the opposite, and they might become ill.

- Every woman has to face this process at one point in her life, no matter whether she likes it or not. Menopause comes naturally. (W02) It’s much like a baby after its birth, growing to be able to crawl and walk. (W26) Menstruation comes and then goes; it’s all a natural process. These bodily changes are very normal and they’re not alterable. It’s impossible to stop them happening, so just accept them. ... So, it’s better to take it easy, accept it peacefully, and don’t be afraid. (W01)

- Let nature take its course. Don’t take menopause too seriously; otherwise it will only make things worse. Some women try many medicines because of unnecessary worries. But instead, that strained their body. Taking medicine carelessly, especially during this stage of your life, will cause more troubles to your kidneys. (W11)

The benefits for women experiencing amenorrhea included being liberated from the practical logistic aspects of menstruation and being able to enjoy water activities and their sexual life carefree.

- There are many benefits after menopause. No more preparation for menses; it really was bothersome, every month. No more worries about your period and stained pants when travelling ... All of this stopping is like a job has all been done. (W01, W22)

- I’ve met a lot of women at the spa centre. They might be older than I am but they still looked very beautiful. I guessed their periods had certainly stopped; otherwise they wouldn’t be able to enjoy a sauna every day. (W04)

- Menopause means no more reproductive function, no more contraceptives needed, and it makes no difference to your sexual pleasure. Many women bear pain caused by the side effects of contraceptives. So, I think the body changes will be all right or even make things better for us, because we’ve been liberated from the task of pregnancy. (W10)

Furthermore, menopause signified a harvesting stage of their lives: such as an expanding role as a grandparent in the family, a further career promotion, or being able to retire.

- Getting old is completely normal. Everyone will be a grandpa or grandma at some point. Men will also go through their own around their sixties, and for women it’s during their fifties. So, it’s necessary for couples to be patient with each other during these periods. (W08)
- Menopause can be a harvest time for those who’ve worked very hard for so many years. A woman’s past efforts may result in a promotion to be a director of a section, or she can finally consider retirement and get her pension. (W10)

Some women expressed the view that menstruation is a part of the metabolic cycle that removes noxious substances. Thus, when they were no longer experiencing regular menstruation, women felt vulnerable and prone to ageing more quickly since those substances were accumulating inside their bodies. Menstrual reoccurrence, one of the side-effects of HRT use, may surprisingly have the benefit of addressing these concerns.

- But I felt as if I’d lost something when my menses stopped. The menses would remove harmful elements from our body every month. When this function stopped, it seemed as if my body was failing (W04) ... If we no longer have our menses, the toxins will pile up inside and make us older. ... I’ve heard this said by doctors of both Western and Chinese medicine. (W01, W09)

- When I was 40 years old, I got gout because of menopause that came on after surgery. The doctor said it’s rare for women to have gout as we’re benefited by menses which purifies our body every month. Poor me, to get gout after menopause. (W02)

- One time, I took hormone tablets for two months and my period didn’t come. I asked my doctor what the reason was when I refilled the prescription. The doctor said those particular tablets wouldn’t cause menstrual periods. Then he thought for a bit and said that I was still young, and it would be better for me to have periods. So he changed the prescription. (W05)

The age at which many participants had expected to experience the onset of menopause was approximately 50 years old. If amenorrhea occurred earlier than this, women tended to regard it as an ailment rather than something normal, and they were inclined to attempt to resurrect menstruation.

- Doctors told me not to worry about my early amenorrhea (in middle 30s) if I didn’t plan to have any kids. But I told myself: no way! And I kept consulting doctors and looking for treatments. (W08)

- My period always lasted 3–4 days every month, but this changed to 1–2 days when I was 42. It still came regularly. The seniors always say it’s not good to have an early menopause. So I tried taking medicine ... and I also went to hospitals to see gynaecologists and get injections. Then my menses came again. (W26)
Some women had been persuaded to take measures to delay the age of menopause until their late 50s by their doctors or peers. The career status or reference group to which the woman belonged was a key determining factor in this choice. 109

- The gynaecologist told me: it’s best for women to have menopause at around 58 years old. I was around 53 or 54 at that time. He suggested supplying me with some hormones to ease my symptoms, so I started taking hormones again. (W05)

- After I hadn’t had any bleeding for 4 or 5 years, my friends asked me why I didn’t take some hormones. So, I consulted doctors and tried them for a couple of months. But when I heard about the cancer I didn’t dare to take any more. I stopped right away and let things be. (W01)

**Impact of menopause**

Menstrual changes result in different health concerns to different extents among menopausal women. Some did not notice any distinction between their menopausal transition and their previous menstrual cycles, particularly women who were very busy with work and inclined to ignore any symptoms.

- I felt nothing special, and I didn’t care about it at all. I had no time for menopause; my work preoccupied me. (W01)

Most interviewees detected the onset of menopause via identifying changes in their periods: either variations in the amount of menstrual blood loss (heavier or lighter than before), the regularity (more or less frequent), or different mood and body reactions. These changes and new unpredictability about their periods caused doubt, annoyance, trouble, or uncertainty.

- It’s very different from before. The signs at the onset of menstrual periods were clear but they weren’t obvious at menopause. You couldn’t work out when menses would come or if they’d stopped ... sometimes the bleeding was heavy and sometimes it was light. (W07)

- My periods became very chaotic when I came back from overseas, and this lasted for almost a year ... I only realised later that this was a sign of menopause rather than of menstrual problems. (W04)

- I was affected when my periods changed and came late or earlier. I felt odd when I had heavy menses ... I worried about menses coming suddenly and staining my pants ... felt bad and burdened ... I was very unsure if it was

109 This is discussed more in the section headed Experience of HRT use below
Menopausal symptoms experienced frequently by women were hot flushes; sweats; feeling chilly; palpitations; headaches; dryness or itchiness of the skin, eyes or vagina; pain during intercourse; general irritation; and insomnia.

- I’d suddenly feel a burning sensation and I had to take off some of my clothes ... sometimes, I then felt so cold and I had to put more clothes on again ... (W02, W13) In the middle of the night, I would sweat a lot and become very wet ... and I’d get out of bed and take a shower, and hope to fall asleep again. (W04, W15)

The impact of these symptoms varied between different women. Some women suffered vasomotor symptoms day and night; some became susceptible to illness; some regretted losing control of their temper during menopause.

- I got a cold very often in those days, most possibly because of sweating, and catching a chill ... In the morning, my nose was itching and I sneezed repeatedly. (W02, W03, W14)
- Soon after the (hysterectomy) surgery, I had headaches, followed by palpitations, and shaking, and I couldn’t breathe ... I felt I was almost fainting when it became worse. (W14)
- Lately, my mood’s dropped and I’ve felt very bad; I sometimes got hot, edgy and angry very easily. It may last for a while ... I’m really unhappy to see myself losing my temper at menopause. (W02, W08)

Menopausal symptoms had multiple influences on women’s bodies, minds and social relationships. For example, women not only felt uncomfortable but also embarrassed, when experiencing hot flushes or sweats in public situations. For some, insomnia introduced tiredness and gloominess into their days. And the reported symptoms of vaginal dryness and dyspareunia may have led to some discord with their sexual partner.

- I felt unwell when I experienced hot flushes and sweating. It sometimes happened in class when I was teaching. I worried whether everyone was looking at my face. ... I wonder how those female managers handle hot flushes and sweats, especially when they’re hosting meetings. (W04)
- I just couldn’t sleep. My waist and back ached and I was very tired and sad. I also got angry and upset. I took things very hard and I was depressed. ... When I went home after work and saw nobody there, I’d cry badly. It was as if I had depression! (W16)
- At menopause, my vagina was dry and making love became very painful. ... I didn’t like the activity ... (W11, W17, W23) I tried to fall asleep earlier at night so as to avoid sexual intercourse. (W22)

Several women reported that they felt a sense of having lost their identity when they were faced by unexpected changes in their appearance.

- My symptoms were headaches, my hair becoming stiff, and my skin darkening, and I disliked myself ... everything just changed. I care very much about my looks. I became ugly because of those changes. I was very miserable that year, I didn’t dare to go outside and I refused all social contacts. (W06)

**Seeking medical help**

Menstrual changes resulted in concerns. Some menopausal women were bothered by their menstruation having become irregular and they worried whether it was a sign of unexpected pregnancy or some uterine disease. They would therefore consult doctors to rule out any abnormality or pathology and reassure themselves.

- My menses sometimes came, sometimes didn’t. I’m 46 years old ... and I went to a doctor. She kindly told me ... this is natural when your menses begin to stop coming. (W10)

- My menses became random when I was 40. Friends told me to consult a gynaecologist, because I was also afraid that I might be pregnant. (W02)

- I had my period every day for a whole year; it never stopped ... I went to doctors and hospitals for many checks ... after that, I felt dizzy and unbalanced when I walked. (W23)

Gynaecologists were the specialists that women mostly thought of consulting first in their help-seeking process when they experienced menstrual changes and menopausal distresses. They also consulted other specialists in other departments depending on which part of their body was experiencing symptoms: for example, orthopaedics or rehabilitation for bone aches, ophthalmology for eye dryness, cardiovasology for palpitations, gastroenterology for indigestion, and endocrinology, psychiatry, or TCM for feelings of general malaise. No referral is required in the Taiwanese healthcare system, so exploring multiple avenues of medical help and both consulting many specialists and also getting a second opinion, was therefore quite common behaviour among women during these transition years.
- My periods still came very regularly when I was around 48 years old. But I often felt sleepless. I found it very hard to fall asleep, and then I got nervous and chilly. I thought I was weak and I went to see a gynaecologist ... I also usually had backache, and I found out later on that that was from disk herniation, so then I regularly went to physiotherapists ... When it hurt badly, I thought it might be a problem with my bones and so then I saw an orthopaedic specialist. ... I once went to the hospital for advice about whether I should go to the urology department because of incontinence, but they told me to see gynaecology for women’s incontinence. Anyway, I’d feel uncomfortable about seeing a male urologist. (W05)

- I go and see the TCM doctors. They can check your whole body from headaches, and palpitations to stomach aches. I usually deal with my stomach first, otherwise it would cause me to be sick for the whole day. I tried Western medicine in the gastroenterology and cardiology departments, but they could do nothing to help me. (W14)

- My main problem is backache. ... I’ve been to doctors of both Western and Chinese medicine. If the Western medicine couldn’t fix it, then I went to the TCM clinics; and vice versa: if they couldn’t help, I switched back to the Western medicine doctors. But now, I’ve given up on any treatment and I just let my back feel sore. (W23)

### Physical changes and ageing

Apart from the symptoms reported above, women were also concerned about the physical changes and degeneration which followed menopause. The most frequent symptoms reported by the interviewees were eye dryness and/or deteriorating eyesight, weight gain, hypertension, loss of physical strength, and their muscle or joints weakening.

- Recently, my eyesight has deteriorated. I have eye dryness and my eyes feel easily tired. Generally speaking, it’s long-sightedness (W01, W08, W11, W21)

- Surprisingly, I had hypertension after my menopause, around 55 years old. (W18) I felt unwell and went to see a doctor. And he was really surprised that I didn’t know about it. (W01, W23)

- It’s degeneration. For example, my bones ache without any clear reasons, I get low back pains ... (W01, W16, W23) my knees hurt and feel weak, and I can’t even walk upstairs. (W06)

When women identified menopausal changes as a transition to old age and part of the ageing process, they still tried to look ahead into the future and identify their priorities. These included improving their health and quality of life.

- I remember how I used to be so scared when I was approaching 40 years old.
But when I was 50 I didn’t complain at all, probably because I finally accepted the fact that I was old. You know for women, menopause means no more youth. It feels like no matter how much I try, I just can’t get my youth back. But personally I still think that becoming old is quite acceptable. It may depend on your personal circumstances. For me, most importantly, I enjoy my simple life and appreciate the improving quality of my life. For example, I have no worries about my husband’s loyalty, no more limits on my activities because of menses, and my children behave well and are independent. It’s probably due to having this attitude that my mind feels refreshed and things have become easy for me. (W05)

- My sleep quality deteriorated after menopause. Generally speaking, your existing health problems will get worse when menopause comes. That’s called ‘ageing’. But by the way, isn’t menopause a part of ageing? I found health is what is most important. I only wish to not have any more headaches or dizziness and to stay happy every day. I wonder what else to expect after menopause? (W11)

- From now on, there’s no more duty to raise children. ... Life should be more colourful, not just black and white ... you can be happier ... We need change; and there’s no way to avoid it. (W01)

**Accepting personal changes and individual differences**

Overall, these Taiwanese women resigned themselves to the uncertainties they experienced while they went through the changes and accepted the challenges of menopause. They became patient with years of transition and kept alert about the tendency to relapse into menopausal distress, particularly those women who had experienced severe distressing menopausal symptoms, such as insomnia.

- Right now I have a sort of feeling of ‘having gone through’. Even though this year, my periods have been chaotic, unlike before. (W03)

- I believe menopause is responsible for many of my symptoms. ... I feel miserable. It’s been 3 years now, and I still can’t get rid of this suffering. The doctor said my case isn’t the worst; for some people it can take up to seven years. I encourage myself to wait patiently and see if I might be the worst one. (W06)

- One night I had some tea with friends ... it caused me to be sleepless for a couple of days. Then I started to panic and worried if the menopausal symptoms might come back, especially insomnia. That’s why I started to take phyto-oestrogen again, after almost 10 years of menopause. (W19)

Some women were afraid of being labelled as a ‘menopausal woman’ and typified as someone hard to get along with or prone to ‘flying off the handle’. The
fear of becoming the stereotype of a menopausal woman is clearly a concern for pre- and peri-menopausal women to cope with.

- It’s like those days when my mum was going through it; you couldn’t talk to her because she always suddenly got angry ... Her body was painful everywhere. Even my dad had to be very careful. It was such an intense time for the whole family. Now when anyone gets angry randomly, I always joke that she’s going through menopause. Is menopause really that scary though? It does scare me. I’m afraid that I’ll affect my family, just like my mum did, and if my husband isn’t able to accept it, what will it mean for my marriage? (W02)

Reflecting on their firsthand experiences and observations of menopause, the women concluded that one’s physical constitution varies with each individual and that an individual woman’s bodily or mental responses to menopause are all a product of her personal character, family background, and social circumstances. For this reason any advice about coping with menopause has to be modified to best cater for each individual, taking these differences into account.

- I know this is a necessary journey for all women, just like giving birth: it’s very laborious. But it’s different from woman to woman, depending on her individual body constitution and her surroundings. My circumstances aren’t well-off but my situation is pretty relaxed; besides, I have no male partner to worry about, so I walked through this process quite peacefully. (W18)

- I guess a career woman will feel more stressed than a housewife during menopause?! She may have to face stresses from both work and the physical changes. I still have no idea how to handle those challenges. (W02)

- Every woman has her own physical constitution, so, I don’t think I’d have a good suggestion that would be effective for all women. (W02, W17) ... I’ll take or eat something or try some method and weigh up the effects. But a particular one which works for me is not guaranteed to help others. (W02)

8.2.2 Experience of HRT Use

The women using HRT, or who had done so, usually commenced it as a result of consulting doctors or after a hysterectomy. The perceived benefits of HRT reported by these women were: retaining quality of life in terms of improving the relationship of couples; easing menopausal symptoms; and delaying age-related degeneration. A few women tried HRT due to peer experience and practices. The main reasons that women discontinued HRT or used it sporadically were the side effect of bleeding and
their fears of breast cancer. Some women suffered repetitive relapses of hot flushes and sweating well into their 60s because of intermittent usage.

The practices associated with the prescribing of HRT in Taiwan raise a number of concerns. Many women reported having had the medication prescribed without knowing the potential side-effects and/or without having been given a comprehensive physical examination, let alone being advised to evaluate their use after they have taken HRT for 10 years or more. Many other women looked for alternative care instead of using HRT. Their personal health beliefs and medical help experience were key factors in determining which alternative measures they sought. Some chose exercise as they regarded this as a natural way to boost their metabolic cycle which in turn would assist purifying their body. Others chose natural foods or natural food extracts, and natural therapies as they considered them to be better than prescription medications. These women were of the view that doctors are prone to advocating pharmaceutical benefits, and believe that natural therapies and self-reliance are the best remedies.

Career-women and housewives had different reasons for their HRT use. The most commonly reported reason was its effect on skin beauty, but career women were also inclined to use it to maintain their energy and vitality in the workplace. Most women considered that HRT was effective in relieving menstrual symptoms but did not mention it as offering long-term preventive benefits.

Two health-related considerations became apparent from analysing women’s reports of their HRT practices. Women needed (1) a quick and effective way to relieve their daily discomforts, physical and/or mental, to be able to juggle the competing priorities in their lives; and (2) acceptable viable measures instead of making a trade-off between HRT and their health.

Women’s own accounts of their experience of HRT use are detailed below. This includes their reasons for commencing and discontinuing the use of HRT, the events leading up to obtaining the prescription, and their general appraisal of this therapy.
Commencement of HRT

Consulting doctors and experiencing hysterectomy were two key factors for women to start using HRT. Consistent with the findings of Part 1 of this study, discussed in Chapter 6, gynaecologists were particularly inclined to prescribe HRT when women sought help for irregular menstruation, vasomotor symptoms, tiredness, and/or incontinence.

- When I was around 47 years old, my period came a bit later than usual. The doctor did a blood test, and said there was a sign of menopause. He told me, “If you don’t want any more menses then you have to take some medication, but if you want it to come again, you also have to take some. It’s up to you”. I’ve always thought that my periods are annoying, so I decided to stop menses. I started taking the combined hormones - it was called progesterone and something else. Then after that, no more periods. (W02)

- I started my menopause earlier than the others because of a hysterectomy. The doctor said I needed to supply my body with hormones; otherwise, I’d age more rapidly, and also develop osteoporosis very quickly. So he told me to take hormones for at least five years to delay degeneration. (W12)

HRT was prescribed by doctors rather rashly for its advocated benefits of retaining women’s quality of life by maintaining bone density, improving couple’s relationships, and delaying degeneration. Its prescription involved a regular oral intake; an injected form was also promoted, for those who were prone to forgetting to take tablets.

- I had my menopause at 46 years old, and I started taking hormones at 50. ... the doctor said my menopause had come too early, and asked me whether I felt dryness on my skins and eyes. I said: yes, that’s exactly right, just as you said. (W02)

- During menopause, my vagina became dryer and this caused some problems when we were having sex. At the beginning, the doctor persuaded me to take hormones. I tried them, but I didn't take the tablet every day. And sometimes I just forgot. Then my doctor said if we were too lazy to take the tablets, he’d give us injections instead, once a month. (W23)

- Frequent urination during menopause confused me and made me worried whether there were any problems with my urinary tract. The doctor told me “Would you want to wear a urine bag when you’re old?” which really scared me. It sounded like my life would get very bad if I hadn’t been taking hormones. So I tried some... (W04)
On the other hand, a few women tried out HRT as a result of peer experience or practices. They consulted their ‘role models’ about how to relieve menopausal discomforts and/or were encouraged to have a try.

- I met a lady when I went to a sauna in an entertainment club. We talked about the problems of menopause. She suggested that I take some hormones as they don’t really harm our bodies at all, and can improve our quality of life. She said her mother-in-law was still taking hormones even at 80 years old, and that she looked very pretty, because hormones can delay the ageing process and keep your skin beautiful. (W05)

- I didn’t really worry about my symptoms during those years, since I’d heard that hormones weren’t good for the body. After four or five years of the menopause, when I was working in a hospital, I saw a very careful and hard-working colleague who’d taken hormones for a couple of years. This was why I also started taking them. (W20)

**Effects of HRT**

The most common reasons career women continued using HRT were to avoid flushes and sweats, and to maintain their energy levels at work. Although HRT had a convincing effect on maintaining their beauty and/or nice skin, these women were ambivalent about using HRT. They saw its use as juggling a solution to work-related stress against the risk of cancer. They set conditions: for example they planned to discontinue HRT after retirement or they amended the dosage, without consulting a doctor, as an attempt to exercise some control over the safety of the medication.

- I was quite busy at work, so taking hormones was OK for me ... I’d taken it for around 6 years, and never stopped. I had a very regular schedule of when to buy the medicine and when to eat, and I didn’t feel any discomfort: no hot flushes, nothing bad. Then one day I had an ultrasound check and found a fatty lump (脂肪瘤) in my breast, maybe a cyst. Actually, it was OK, not a big deal. But I just felt it was time to stop for I’d already taken hormones for so many years. (W02)

- I went to the hospital and saw the Obstetrics & Gynaecology director when I started having hot flushes and sweats. He said that since I had the symptoms, I should start taking hormones. [From then on] I used to take hormones because I worried about hot flushes affecting me when I was working, and I’d also heard that this stuff was good for your skin; it would help women to look more beautiful. So, I thought I should use it and I planned to stop using it after I retired from my job, [because] I could manage the symptoms at home after retirement. ... I took HRT for five or six years ... (W11)
After menopause, I would feel very hot all of a sudden, my heart would be beating very fast, and my face would turn red. Sometimes, it seemed to be freeing if I took off some clothes, but I became hot if I had many clothes on, so I didn’t know what to do. I went to a gynaecologist, and he told me to take hormones until I was 65 years old. After trying them about three or four months, the symptoms had gone. ... Later, in my 50s, the symptoms were becoming mild and I started to decrease the daily dose by myself. For example, I refilled the prescription and got enough tablets for three months but I’d take them just once in two days, or I broke the tablet in half, and I’d make them last four or five months. This decrease in dose didn’t cause me any trouble or make any difference. It all lasted for about 10 years, and I stopped using them when I was 60. (W24)

Some women encountered confusion and difficulty while using HRT. They had contradictory feelings about the effects of HRT to ease life stress and their fears of using something which might potentially cause them breast cancer. If they simply discontinued using HRT without consulting their doctor they might then suffer from menopause-related discomforts. The decision to continue or discontinue using HRT became like gambling in some wonderland with no reliable or responsible information available.

I couldn’t sleep well and constantly felt backache. I was tired, and very uncomfortable. I went to a hospital and saw a gynaecologist. He said taking tablets may help, but he didn’t say the tablets were hormones. ... I took them but when I was busy I’d sometimes forget to take them ... for three or four years. I took hormones without knowing it and it was helpful for my temper, my spirit, and my sleep. ... Those hormones also gave me the strength to work. In those days, I had to work very hard to make money, even when I was so tired. ... I stopped taking the tablets right away when I realised they were hormones because people said I might get cancer if I took hormones too long. In the beginning, I didn’t feel as good as before, so I’d occasionally restart HRT. But at the same time I was still scared of its harm. I finally dropped it and my periods then stopped, when I was around 51 years old. Now I don’t need them anymore. There’s no point for me to use HRT. I took it before just because I could hardly ever sleep ... (W16)

I took HRT for five or six years until I heard that the hormones were bad for your health. I was quite scared and stopped taking it right away. I’ve stopped for two or three years now. During this period, I’ve gotten serious hot flushes and dizziness. Especially dizziness, it wasn’t as bad as it is now. (W11)

I started taking HRT after a hysterectomy but I still struggled throughout this period, like when my children told me about the risk of breast cancer. I once stopped for around two months, but I was still considering if I should take hormones or not. Then I decided to take them, mainly because I felt I would age more quickly if I didn’t. I might lack calcium and develop osteoporosis, and if so, a fall would cause me to be immobile and then I’d become a big burden to my family. But if I took it, I could at least use the Medicare to have
free adult health check-ups every year to follow-up and check whether I had any breast tumour. Anyway frankly, I’m still a bit scared of the idea that I have to take hormones for five years. (W12)

Discontinuing the use of HRT

The side-effects and fears of cancer were the main reasons that women discontinued HRT or used it sporadically. The reoccurrence of menstruation after taking HRT was a nuisance, but any consequence related to the breast was a crucial health concern for women and their peer group would play a significant role in women’s decision to discontinue HRT usage.

- The doctor prescribed me hormones, and my periods recurred after the medication. Someone said my menses will stop soon or later and I can’t rely on hormones forever. ... the menses just reappeared whenever I took the tablets ... , that’s why I stopped using it without discussing it with the doctor. (W01)

- After taking hormones my sweating eased. I only sometimes got hot but not as badly as before. ... One day I had a mammogram and I was asked to go back for a second check. I wondered if it was caused by the hormones. The result of the second check was fine, but I still stopped taking them. (W20)

- The doctor suggested that I take Premarine. I read the instructions and understood it’s not good for long-term use. I thought about the usage: its benefit was it would help me feel more comfortable than before. It’s not bad actually. ... I asked some women and none of them took hormones because they were all concerned about cancer. ... I also thought about the risk, but I felt OK because my family doesn’t have any history of breast cancer. But then I started thinking about what would happen if I stopped taking it? And why should I take it? ... I also asked my elderly friend and she had felt nothing at all during menopause. She said it would be nothing if I ignored it. Then I realised that not everyone had symptoms during menopause. ... I stopped using it after taking it for three months and I only had hot flushes occasionally, nothing worse than that. From then on, I didn’t take any more. (W04)

Some women discontinued HRT and simply waited until their discomforts finally dissipated, or they used alternative products such as phyto-hormones instead.

- If I take HRT then I won’t feel my body ‘burning’. If I don’t, the heat would come back again. I’m over 60 and it’s been years. Why has it been like this for so long? (W13, W20)

- I used to take hormones randomly before, but I’ve stopped using it for a
I recently went back to a gynaecologist to get some hormones prescribed again because of new symptoms striking me, symptoms like sweats and hot flushes. (W02)

As mentioned above, two women experienced a relapse of symptoms until their 60s after they had discontinued using HRT.

- I got hormone injections after surgery, and then I had Premarin treatment and I felt OK. Later I found a breast cyst when I had a health check when I retired. So I stopped the Premarin, but I use phyto-hormones. When I’m not taking them regularly, I sometimes get flushes, sweats and sleeplessness, and I feel dry in my genital area. (W02)

- I took both hormones and phyto-hormones for 5 years, and then I guessed it was long enough and I could stop using them. But again, I was sleepless for 3 days, and I worried about the relapse of menopausal symptoms. Then I started taking phyto-hormones every day. I felt that was also helpful for my sex life. (W19)

**HRT prescribing practices in Taiwan**

The practices of many doctors prescribing HRT in Taiwan are very controversial. Women reported that the prescribing doctor did not fully inform them about HRT beforehand and did not mention the potential side effects until they felt uncomfortable.

- The doctor prescribed me hormones immediately after an internal check, and I tried to make sure that it was OK for me to take because I suffer from varicose veins. I started the medication when the doctor thought it was fine. ... I wasn’t assigned to any check-ups during the period I was on the medication. ... My periods returned a year after amenorrhea and I worried whether it was abnormal bleeding. [This time] the gynaecologist gave me a series of checks: a Pap smear, an ultrasound, and mammograms. He prescribed hormones after assuring me the results were fine. ... I hesitated and asked him whether the hormones aren’t good for your health. He told me there was a better one but it wasn’t reimbursed by the NHI and he asked if I’d like to pay for that one. I agreed. (W05)

Also, the doctor did not follow the protocol of first conducting a physical examination to identify any contraindications before prescribing HRT, nor afterwards.

- A gynaecologist assured me that the medication would help me but didn’t tell me it was hormones. So I didn’t really know what it was. ... I had no idea about the side effects of hormones. The situation was that my periods came
every month when I took the tablets, although before that my menses weren’t regular. (W16)

- My breasts became swollen and sensitive after taking hormones. The doctor never told me they had this side effect when he prescribed the tablets. The doctor just left patients alone to experience the side effects without knowing about them. I don’t dare to take hormones. (W14)

- I hardly took the hormones on time even though I’d been prescribed some. So the doctor advised me to get injections. I had an injection once and then never did it again. A lady told me that it was terrible that the injection aroused high sexual desires, for she’d been widowed for years. (W23)

Predictably, doctors had also seldom advised women about discontinuing HRT: one interviewee reported that her mother-in-law who had reached her 70s and been using it for more than 10 years had not been advised to discontinue.

- My mother-in-law had also taken hormones for more than 10 years, until she was nearly 70. She complained of genital dryness causing her a lot of pain, so she used to consult the gynaecologist for hormones. When I told her about the risks of hormones, on my advice she reduced her intake bit by bit and stopped. (W09)

Rationales for choosing alternative care instead of HRT

Many women looked for alternatives to HRT to deal with their menopausal discomforts. This was in response to both the contradiction of its promised beneficial effects being entangled with fatal risks and because of women’s experiences when seeking medical help.

- I tried to find a trustworthy doctor but he still prescribed me hormones. Every time I could only take the tablets for just a couple of days because I really wanted to rely on my own willpower or some other way to overcome it. I’ve heard so much talk about the increased risk of cancers if you’re taking hormones. My husband and children were against my using them and encouraged me to try other ways. (W03)

- The doctor said that there were few side effects and I should take the hormones, and that if I didn’t, some symptoms would come about. ... The doctor also told me that the clinical trials didn’t prove any higher probability of causing cancer and that a lot of women had taken them and they’re safe. But the two of us had different ideas about them; the doctor has his own reasons to say positive things about hormones. (W12)

- I didn’t actually take the medicine prescribed by the doctors. ... I just wanted to know what the doctors had to say about my state of health and whether the second doctor would make the same diagnosis. ... I’d rather take care of
myself than go to the doctors. We should be very careful of medications. ... Doctor’s opinions can be used as a reference and you should just use the advice that works best with the nature of your own body. (W14)

The rationale underlying women’s preferring alternative measures was mostly rooted in their health beliefs. Overall, women emphasised that menopause and these alternative regimens were natural.

- Many of my relatives are gynaecologists and they also advised me to take hormones but for no more than five years. At that time, some friends proposed to start exercising, so I did too. Exercise is good; it made my body sweat and it’s a natural way to help your metabolic cycle. (W04)

- I did indeed worry about the risk when I was using hormones. My friend introduced me to royal jelly. It was generally thought to contain natural hormones and cause fewer side effects. Anyway, the hormonal tablets are [not natural but] made with chemicals. ... I only took one of them at a time: if I took royal jelly then I wouldn’t take hormones at the same time. ... In general, I think taking royal jelly produces the same effect as the hormones did. (W12)

- I didn’t continue the Chinese medicine because I worried about the safety aspect. (W09) It’s very unnatural ... My periods would come or not come depending on whether or not I took the medication ...(W26) I decided to let my menses stop naturally. (W09, W26)

**Attitudes towards HRT**

In general, women’s attitudes towards HRT reflected their different reasons for adopting or not adopting its use. Breast cancer was the most feared risk most women associated with HRT; career women, however, were more likely to decide to use HRT if they considered that it could help them to go through the physical, cognitive and emotional aspects of this transition stage more easily, at the same time as they were juggling many and varied daily stresses. HRT was mostly understood as having short-term effects relieving symptoms; it was not used anticipating long-term effects preventing disease.

- Let’s say that taking hormones doesn’t cause any harm at all. If it could actually benefit women without any side effects then I’d like to take it. ... Menopause makes you age quicker, so its use is all about keeping you young and preventing degeneration. But the truth is, it does harm and will lead to cancer. (W01)

- Some people say hormones aren’t good because they cause cancer. But compared to the suffering insomnia causes, it’s better to use hormones to
get over this difficulty first. I’ve always said to friends: let hormones help you to relieve the suffering and wait until things are settled; and you can stop taking it then. Even if there’s a risk of cancer, it won’t happen in a short time. I agree that hormones aren’t a panacea, but they can be effective when you need them. (W02)

- Doctors generally hope for their patients to have a better quality of life and so they provided us with suggestions. But, it all comes down to a patient’s own choice. There was no absolute right or wrong. Their suggestions were based on statistical data. When women were suffering from symptoms, doctors suggested hormones to relieve their discomforts, to settle anxieties, and help you feel better. That’s good. (W04)

The effects of HRT were not as good as had been promised for every woman who complied with the prescription regime: HRT was not, for example, a panacea for insomnia. Instead, from the women’s point of view, having their problems listened to properly was one of the effective remedies.

- I’m not sure why it’s necessary to take hormones. Every time I saw a gynaecologist, he always said it’s better to take them. Every gynaecologist said hormones can help you to pass through menopause smoothly, with fewer symptoms and an improved quality of life. They also said that hormones won’t really harm me and that I should take them. But my heart doctor disagreed with them. I asked his opinion when I went back to get more of the medicine for my high blood pressure. He’s been very kind and likes to talk to me about any health problems. He told me directly “Don’t take hormones, you shouldn’t take them ... ” I asked him many times, and he always gave me the same answer. (W05)

- I heard that if it’s only menopause causing insomnia, taking hormones would be very helpful. ... But for me, they didn’t really do anything. At that time, I needed sleeping tablets every night. Afterwards I realised the problem might be being caused by the stress from work. (W19)

- I felt a lot better after talking to the psychiatrist and making a clean breast of things. So, all those hormones I took before had no effect at all. Now, I don’t take any hormones, and no injections, and it’s not necessary to try any other treatments. (W06)

### 8.2.3 Other Coping Strategies

Using Lazarus and Folkman’s model, the coping strategies women used for managing stressful situations during menopause can be classified into two types: *problem-focused* coping, and *emotion-focused* coping (Lester & Keefe, 1997). *Problem-focused* coping strategies involve adopting some behaviour to change the stressful situation, for example, seeking medical help or changing one’s diet.
*Emotion-focused* coping strategies involve regulating the individual ‘internal reactions to a stressor’. Strategies of this type typically include distraction and seeking social support. ‘Each coping strategy can be potentially adaptive or maladaptive depending on the situation’ (Petrie & Moss-Morris, 1997).

Apart from seeking medical help and HRT use, the main problem-focused coping strategies used were seeking information about menopause, and trying dietary changes and exercise regimes. Women were inclined to trust their individual firsthand experience and judgment as they weighed up the reliability of information available from a variety of sources, and then accepted or rejected that information. The extent of dietary adjustment that a woman made for menopause was related to her social status and her belief in natural health regimes. Most participants understood the value of doing exercise but were unable to persevere with it.

Women tried many measures to distract themselves from menopausal distresses by managing their thoughts and emotions: for example by setting themselves a full daily schedule, developing hobbies, seeking social support, and re-orienting their thoughts – “reinventing themselves”. Overall, the conflict between their family and workplace roles, and the stigma of menopause in society are uncontrollable stressors that women had to cope with during this transition period. The details of these women’s coping strategies are elaborated in the following section.

Two of women’s coping strategies strongly reflect their own understanding of their health needs. The first is an example of problem-focused coping, the second is of emotion-focused coping: (1) **use and advocate natural health regimes to manage physical changes**; and (2) **rely more on various forms of emotion regulation throughout their menopausal transition, rather than changing the situation creating the stress**.

*Management of menopausal changes*

Seeking medical care and taking medication to manage menopausal symptoms are an adaptive problem-focused coping strategy. Some women, however, resisted consulting doctors during menopause. Some had been too busy to pay any attention to the changes, some anticipated being offered few choices when seeing a doctor except being prescribed medication, and some were unwilling to take any medication.
- I didn’t go to the doctors when my periods not on time, because I was very busy in those days and I never really paid attention to them. (W01)

- I really didn’t like to see doctors, because they always prescribed hormones for my situation (sweating); it’s always been like that. If you said you were having troubles with sleep, they would just give you sedatives. (W20)

- I wouldn’t go to a doctor, about my periods being irregular or ending. I know my own body ... I’m very healthy and perfectly normal, so I never went to a doctor or took any tablets during menopause. I hate taking medicine. (W25)

Seeking information about menopause

Women also tried other problem-focused strategies to cope with menopausal distresses. As mentioned above, these included seeking information about menopause, and trying dietary changes, and exercise regimes.

- I need practical knowledge of menopause. I’ve seen many women suddenly became ... just like my mum before. I’m really scared of following in the same track some day. After attending the supportive group, I realised that some women had the same symptoms as I did, and some were very different from us. I’m not a freak, and we’re all normal. (W02)

- I’m not sure how to judge which information related to menopause or hormonal products on the Internet is trustworthy ... but I rely on my personal experience of using the products to weigh up their effects ... If a product’s advertised indications are consistent with many of my existing symptoms, I’ll try it; if it only mentions one or two of my symptoms, I might not. (W02)

The main sources of information about menopause for women in the community were newspapers, radio, television, websites, peer groups, lectures, notice boards, and doctors. Some women made a critical appraisal of the information by reading, observing, comparing, and studying. Some obtained information by word of mouth, and some then applied the information to their own body and evaluated the effect.

- I didn’t go to doctors ... I read some magazines and looked for information relevant to menopause and sexual life. I understood that my last two periods were very heavy and were flagging that menstruation would end. I’d prepared for menopause and I had no worries about it. (W18, W22)

- The information is scant. Whenever I asked the TCM doctor, he always said I was ‘yin xu’ (feeble) and needed to restore my ‘qi’ using Chinese medicine. But, what would be his explanation about why my discomforts eased when I took the B group vitamins? ... Just like many others, I didn’t take medications prescribed by doctors either, because I usually got very serious side effects when I took Western medicines. Frankly, those medicines were a total waste.
For drug security, I did do some study to be sure about the drug safety aspect: I documented the prescribed medicines in a notebook, and checked their indications and side-effects, so I could follow-up my body responses. Otherwise, I wouldn’t really know what those tablets were doing to me. (W11)

- I asked my mum and sisters if they’d had the same symptoms as I had, but they didn’t. So, I read reports. Indeed, I’m very interested in reading health reports. But it’s a pity to hear many women still follow the oldest way – gossip – and use such ‘heard about it’ information. The government should do more to give women correct information. (W08)

**Adjusting diet**

Most women take charge of the cooking duties and dietary arrangements in a family. The way and the extent to which a woman makes changes in her diet or takes nutrient supplements in response to menopausal distress is related to her status in Taiwanese society, and status display.

- Nutrient supplements

Women tried many kinds of nutrient supplements, mostly to provide natural hormones, stave off the effects of the ageing process, and repair degenerating tissues. The supplements broadly speaking fell into four groups:

1. Those containing natural hormones: royal jelly, placenta extract, isoflavones, phyto-oestrogens, evening primrose oil, *nupau*\(^{110}\), and *dong-quai* (*Angelica sinensis*);

2. vitamins: multi-vitamins (such as Centrum, a popular product), B group vitamins, vitamin E, and fish oil;

3. those said to be reparative or assist tissue-renewal: glucosamine, calcium, and collagen; and

4. those with antioxidant effects: soy bean extract, lecithin, gingko, pollen, bee propolis, and grapeseed extract. These nutrient products were bought from local stores, and grey goods retailers\(^{111}\), bought overseas for private use, or were received as gifts.

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\(^{110}\) This is the Taiwanese name of 女寶 (MSC: nūbao), literally ‘women’s treasure’, a supplement for women who are still menstruating.

\(^{111}\) A grey goods retailer (委託行) is a shop selling a wide range of quality goods from abroad which have been imported by self-employed commercial travellers - items such as leather handbags, womenswear, and accessories, native products, and drugs. These goods were favoured by celebrities.
Some women were satisfied with the products they used, although they might not take them regularly. The use of nutrient supplements has associations with a woman’s pride as these are also a form of status display: they indicate her comfortable (possibly improved) economic status, her being able to afford these items, her children’s filial respect or good income, and/or her being well-connected overseas.

- Now, I don’t take hormones but I do take royal jelly. It’s made in Australia and it was bought in a weituohang112. (W24) I used to take vitamin E, but I take lecithin now. It was bought from the USA. That’s for restoring my memory. (W01) I bought a pack of glucosamine once, but I haven’t taken much so far. I also took multivitamins as well, but only when I remembered … it’s easy to forget to. (W26)

- I take more or less supplements, but not for long-term use. Like isoflavones, and nupau. This includes selenium for women who are still having their menses, and it also includes the B group vitamins, soy extract, and dong quai, but I haven’t taken it regularly. I’ve tried evening primrose oil but not seriously. I’m still continuing to take grapeseed extract. That’s not for menopause but to prevent ageing. I’m not sure if it’s helpful or not. Anyway, my friends said I haven’t changed a lot in these years. I hardly go to doctors in a year and I have lots of vitality … I guess that’s what people called ‘rejuvenation’. (W04)

- I took a collagen capsule and placenta extract every night. The collagen is for bone degeneration, because of the pain… and placenta extract is a natural hormone. These last three months I’ve been taking B group vitamins regularly, and my head dizziness and sleeplessness are getting better. You know, my daughter bought these for me from Australia. I won’t waste them. (W11)

- Traditional Chinese food therapies

“Chinese culinary culture has included health supplements and nutrition enhancers as well as medicinal concoctions” (Cliff Yang, 2011). Particular TCM medicines, such as siwutang, shenghuatang, and bazhentang, are considered both nutritional supplements and therapeutic ingredients to be used for women’s reproductive health. Women can buy a package of these herb nutrients in Chinese medicine stores or grocery stores. They have usually been cooked with meat and are sold as a remedial concoction. Women take such therapeutic products to regulate their menstruation, irregular menses or excessive bleeding, after a period, and during and in Taiwan they sold for high prices and high profits, particularly up till the 1980s. The purchase of grey goods has declined since the economy developed and travel restrictions were eased. (Huang Tzu-Chun 黃姿淳, 2009)

112 See footnote 4.
menopause. Chinese food therapies like these are a popular way of preserving health by ‘increasing body heat’ in the cold season, and they are also used to ‘restore qi’ after menstrual blood loss.

- Many Min (Fujian) people know more traditional remedies than non-Min people. They follow the Japanese custom of taking a tonic to restore your vitality. For example, drinking shenghuatang after your menstrual periods or during menopause. (W02)

- I made bazhentang myself and I adjusted the formula to suit my body. You know, bazhen doesn’t necessarily contain eight different medicinal plants; it depends on your personal body constitution. I knew what I was short of and needed and I just added in those parts. It can regulate menstruation and supply your body with hormones. (W08)

- My friend’s son-in-law is a TCM doctor and she often drank siwutang, which her son-in-law provided her with. So, her menopause was very smooth. She still takes the tonics. (W09)

- Dietary habits

Most of the women preferred natural food and believed that it is much safer than chemical products or extracts.

- To tell the truth, I’m quite against medicine and I hardly ever take supplements. My children or nephews would buy Centrum or glucosamine for me, but I think they’re still a kind of medicine and I don’t like them … Every supplement claims that its product is healthy, and safe, and has no side-effects, but who knows. Maybe it’s OK at the beginning, but the side effects will come out after continuing use. So, I’d rather eat natural foods, and have more soy milk, Chinese chives, and yam to supply hormones. (W12)

They would change their diet to alleviate menopausal discomfort, body degeneration, and metabolic syndrome. Common strategies were: obtaining natural hormones from food, consuming natural foods with a variety of colours, eating less oily and less salty food, eating more fruits and vegetables, and drinking sufficient water as a method of purifying the body. Some foods were indicated as having a remedial impact on the “body’s internal heat and cold, which they termed Yin and Yang syndromes” (Cliff Yang, 2011). Yang foods, which generally have dark colours, tend to be energy dense, particularly for women after menstruation.

- We value natural food very much now. (W06, W14, W15) Combinations with green, red … the more colourful the better. Collagen is important and so are nuts, like walnuts, pine nuts. And dark chocolate, black fungus, black rice, and red dates are all necessary. You know, the black and red foods are
warming ones; they’re helpful for women to replenish their qi and blood. Most of us are somehow lacking in qi and blood after our periods. (W14)

- When we’re ageing, our metabolism slows down. So, don’t eat food that’s too oily, salty, or sweet … I’ve changed my taste towards lighter food and I eat more fruits and vegetables now. (W01, W04, W09)

- It’s important to detoxify yourself. Drink more water and make your body sweat; that’s all a natural way of your body purifying itself, and then the menopausal symptoms will ease. (W08)

**Doing exercise**

Many women realised they needed to exercise. Their physical practices were mostly directed towards walking, yoga, dancing, or cycling. Some women had received advice from their doctor to exercise to improve their post-menopausal health.

- I learnt to swim after my menopause, because my doctor said if hormones were unhelpful for my foot pain, then I should do some exercise. Swimming is an excellent way for me to relax and decrease stress. (W01)

- Exercise is very good. Aerobic dance makes me happy; it increases your heart-rate, and improves your cardiopulmonary function, and metabolism. The sweating is especially extremely helpful at menopause. I guess menstruation used to help us to remove interior wastes out of our body but now we have to rely on sweating them out. (W04)

- If I can’t sleep well at night, it must be because I didn’t do enough exercise during the day. If I work out as much as I can, then I have no sleep problem at all. But, it was never a problem before menopause. (W02)

Some had learnt the benefits of following a health regime. Many, however, found it challenging to do exercise on a regular basis.

- In those days, when I was still in the club, I did aerobic gymnastics and joined dancing classes. It lasted about four or five years … But I don’t do it any more, because I’m taking care of two grandchildren now. (W26)

- People said walking would be good for my back pain. I tried walking for an hour in the morning, but not every day. Sometimes I’m a bit lazy … (W16)

**Managing thoughts and emotions**

Women employed multiple approaches to draw their attention away from the menopausal distresses they were experiencing: focusing on work or activities instead of transition-related changes, enjoying hobbies, seeking religious consolation,
thinking positive thoughts, accepting and reframing life events in a positive light, and obtaining social support. These strategies helped women to regulate their emotional response to stressors during menopause.

**Keeping a full daily schedule**

Many women planned a busy schedule to remain occupied and avoid negative thoughts and a poor mood that would more easily occur when they stayed alone at home.

- She had symptoms, but I didn’t. Because I do exercise, I’ve got many friends, and I keep myself busy for the whole day. Anyway, I don’t have any time for being sick. (W01)

- The first priority is to make arrangements. I have a very busy schedule: I’m a volunteer doing a part-time job in a hospital, (W19, W21) and I attend lectures, art activities, and educational programmes. (W21) Just go out and mix with people, don’t be alone at home. (W05, W19, W21)

- I’ve found a job; it’s my re-employment. My children have grown up, and I need new plans to fill my life. (W12)

**Improving knowledge or skills**

Some women would go and learn new skills, either to draw their attention away from their daily problems and cares, or to fulfil wishes they had not been able to in the past. They attended lectures about keeping healthy and/or classes to learn to play a musical instrument, cooking skills, painting, a language, and/or about investment and financial transactions.

- I went to many classes and kept very busy. (W01, W05) For example, learning how to play musical instruments. (W01) Anyhow, I can now fulfil the dreams which I missed out on in my childhood. ... You know, studying is sometimes a distraction: I felt quite happy whenever I went to classes. (W01, W05)

- I want to learn some new skills - like English, financial management, or cooking art. My dreams will be able to come true because I’ve finally retired from my job. (W11)
**Enjoying or developing hobbies**

Some women developed hobbies and enjoyed their achievements dancing, singing karaoke, or cooking meals for friends. An amusing hobby worked particularly well for distracting the introverted women from distress.

- If we’re lucky, we can have good friends to lighten our mood, but I’m not used to mixing with people. I enjoy music a lot: listening to music, reading the lyrics, and singing out my feelings. I sometimes sing karaoke and overcome my troubles that way. (W09)

- I hardly ever talk about any personal matters with others, but I enjoy reading - that’s my way of easing whatever’s on my mind! By the way, I like cooking very much. My friends always appraise my cooking skills very highly, and I like providing a feast for them. (W26)

**Seeking religious support**

Religion sometimes helped women to think rationally about the stressors in their life and take concrete cognitive and/or behavioural steps to control them, using their religious teachings. Praying, hoping, or positive thinking assisted them get through uncontrollable situations.

- In fact, Buddhist philosophy helps me a lot, I’m learning how to let go and not get myself into a dead end. As I was a member of the group, the master would sometimes visit me and tell me teachings during a chat, or provide me with some books to read. I feel lucky now and I realise forgiveness is essential. (W03)

- I’m a Christian; my belief gives me strength and it calms me down. Everything is just a process and I believe that I can get through it. (W04)

**Reviewing psychological effects**

The women agreed that the anxiety and distress reduced as time passed and they went through cycles of menopausal symptoms. This reflected an increased familiarity with the nature of what they were experiencing and an accompanying habituation of their emotional responses. They also found that individual personality traits, such as anxiety or optimism, were associated with individual emotional disturbances and acted to influence their coping with menopausal distresses.

- After menopause, four or five years later, I became more optimistic. I don’t think too much and I’ve become more open-minded. I found that my
thinking processes and mental state affected the quality of my life during menopause. (W01)

- I agree that your mental state is also important during menopause. Working women have to juggle many duties, and housewives have their own worries too. The key point is, if you can see it through and let things go. Sometimes the problem is due to your personal attitudes: not being open-minded and having no enjoyment. I think it would be healthier if people look at things in a positive way. Don’t get upset about things, it won’t help. You still have to go through this, no one else can do it for you. (W02)

- Some women suffered from symptoms and sleep disturbance, and became oversensitive, picky and grumbling. (W04, W25) I do believe that everyone can enjoy a happy life, no matter whether they’re rich or not. The most important thing is to be healthy, be positive, and change your mental state. It’s only a stage; it will all pass. Don’t make things difficult for yourself. I guess it’s related to personality traits; a lady will suffer more at menopause if she wasn’t usually happy before. (W04)

Reframing life events in a positive light

Reviewing life events played a key role in helping women to readjust their cognitive and behavioural patterns after experiencing changes, and apply coping strategies. The process of reinterpreting situational cues helped them adjust the emotional responses they had formerly had that were generated by particular situations.

- I’d sometimes cry when reviewing the past ... I had to accept someone new into my family (a daughter-in-law), my husband’s cancer and chemotherapy, and myself: a lot of changes. I was used to being pleased by my staff; I was the boss in the company. But ... in those days I just felt everything had gone wrong and I had nothing left. Anyway, it’s getting better now. I enjoy dancing and teaching, or leading others to dance. Many women look forward to seeing me in the class. I feel good! (W06)

- At my age, I feel very lucky that I only need to take care of my grandchildren. In the past, I had to take care of two kids, I had a main job and another side-line job. I would rush in, feed the family, bath the kids, do the laundry ... It’s been much better now. (W26)

- I grew up in a well-off family. My parents loved me dearly ... After my husband passed away, I put all my heart into taking care of my two kids ... to educate them. I cherish my life being so colourful. It might be boring if I had no challenges at all. (W25)


**Praising friendship**

Apart from the support of their spouse and children, women emphasised the importance of friendship. They enjoyed the opportunity for emotional expression, discussion of improved coping strategies, and extracting meaning from their distressing experiences in a supportive atmosphere.

- Frankly, we all need some friends. If there’s something on your mind it’s better to talk about it out and stay with friends. I’d have foolish reflections when I was alone. (W01)

- I felt easier when doing things with a group of people. I’d be nervous if I managed things alone instead. (W13) ... I felt odd doing things alone, for example, eating alone in a restaurant. I need companionship to have a chat and enjoy the food. (W20)

Chatting and companionship in a women’s group were crucial and enjoyable. Interpersonal relationships signified personal well-being: they offered women multidimensional criteria for evaluating their own individual health status – physically, mentally, spiritually, and socially.

- Friendship is most important... With companions, we enjoy chatting. Someone can lighten your mood, or share the wisdom of being positive about things ... You let the hardship and sadness go when you talk about it. (W02, W09, W10, W12)

- Generally speaking, I think interpersonal relationships disclose the level of a person’s mental and physical well-being. For example, if a senior has a nice social network that means he or she has done well financially, and in their friendships and health. So, isolation means someone has big problems, especially in their old age. (W05)

**Limits to making changes**

Family and workplace stressors limited the actions middle-aged women could take or the changes they could make during menopause. The restraints they mentioned included changes in their family composition, such as those arising from becoming widowed or divorced, a child leaving home, or someone joining the family.

- Yes, I agree that companionship is necessary, especially for attending functions, travelling, or doing exercise. I know I need more exercise, but I felt very uncomfortable when I went walking alone. It’s impossible for me to go out ... I hope you’ll be able to if you’re ever like me [a widow]. (W21)
- I’d sometimes cry when reviewing the past ... I had to accept someone new into my family (a daughter-in-law)... (W06)

Other challenges include the conflict between child-rearing and paid work roles, economic powerlessness, relationships within the family, and women’s role expectations and obligations. The stigma associated with menopause put a greater burden on women at the time when they had to cope with physical and psychological menopause-related distresses.

- I was a housewife and I tried to enter the job market when kids had grown up. My menopause happened at the same time. If I hadn’t had a job and if I were still financially dependent, I’d be having many foolish thoughts. My body was changing, the kids had left home and I no longer felt needed. My husband wasn’t often at home, and our relationship wasn’t as intimate as it used to be. I wouldn’t be able to stop having foolish thoughts if I was still financially powerless. (W12)

- At the age of 46 or 47, I suffered from working hard and having rebellious teenage kids. I lost my temper very often, perhaps because I’m a perfectionist. I put high expectations on myself about my job performance, I had a loan for the house, my husband hadn’t yet got a promotion, and the kids were going to private schools ... the stresses came in various ways and from various sources. Maybe that’s why I felt it so hard to bear things in those days. (W05)

- My husband and I are both at work, but he doesn’t care about doing any house duties at all. I have to clean up the mess, cook three meals, and do the laundry. I have to take care of everything at home even after work. Of course, I’ve lost my temper so often ... my poor daughter [unfairly on the receiving end of my anger]! (W17)

8.3 Suggestions for Menopausal Health

After recounting and reviewing their experiences of coping with menopausal distress and seeking health services, some women put forward suggestions about sourcing help from outside individuals. They want support from family members, mutual assistance within their community, and a positive perception of menopause and reliable information sources from society. These points can be summarised as two health-related needs: (1) a supportive social atmosphere for menopausal women. This still needs to be established; and (2) unbiased information about preserving health during both menopause and ageing. Details of these women’s points of view are presented below.
8.3.1 Support from Family

Understanding and concern on the part of family members were critical factors contributing towards women’s quality of life during menopause. Feeling lonely in a family can make things become more intolerable and can have an impact on women’s mental health.

- During menopause I told my husband to be patient with me, and he was very considerate. For example, he’d talk to me when I was sleepless and he cared about my situation ... He’d give me suggestions or bought products which his friends recommended. (W03) My kids were very good too. They worried about me when they knew about my situation. I feel that being accompanied and cared for by family members is very important. (W03, W19)

- My sons and daughters-in-law live with me, but they all go out to work. I also have grandchildren. Maybe because we lack topics of conversation, but no words pass between us. We’re not like other families that have intimate communications. But I don’t know why we’ve just had nothing to say to each other. If I went out and didn’t return, no-one would look for me, I know ... (W13)

8.3.2 Assistance from the Community

Many women wanted more interaction or connections within their community, particularly during the empty nest period. They appreciated the value of support groups being established in a community and anticipated participating in more activities in order to interact with people in their neighbourhood. The participants counted on ‘someone’ to do ‘something’ in a community; in particular, they hoped for a mutual supportive environment in their living area.

- I think support groups are necessary for helping us to go out ... Many women stayed at home, had few contacts, were very reserved, and just couldn’t go out. But I also saw that some women stepped out of their home, and they were totally changed: they became very confident and happy. It was so great to see. (W02) ... In a group, we can exchange our experiences. For example, I was once quiet ... , but I’m so happy to have stepped out of my home. (W01)

- The government should encourage communities to hold some activities every month for people of the same age - such as fun gatherings, and outings, or cooking and sharing dishes. Just let us get together every month to have a chat or learn skills from each other. (W20)

- The village head should do some promotion and inform every family ... I didn’t have any information ahead of the activities being held in the community. Things such as the classes on flower arrangement, and on
making dumplings to celebrate the Dragon Boat Festival ... If I were village head, I’d hold some classes ... You know, the community spent most of its budget on things like dancing classes and pleasure-seeking activities, but there was a lack of classes for improving people’s knowledge. I think they’re necessary ... on things like skills for preserving health, and information about the changing processes in our body. People say ‘I've gotten old, I’m old now’... but in fact, we do need to prepare ourselves mentally for it. Some people are ageing very smoothly, but some people aren’t. (W06)

8.3.3 Hopes for Health Policy Measures

The interviewees strongly advocated having public opportunities to learn or be given information about preserving health. They wanted the government to play an active role in providing health information and to be proactive and deliver such information effectively as a preventive health measure, rather than just provide treatment for health problems once they occur. The need for cultivating a positive social image of menopause was also highlighted.

- The Bureau of Health Promotion should advocate menopausal health more aggressively. After all it’s a life process for every woman. And the government should find effective ways to promote it. Health maintenance doesn’t necessarily depend on doctors, but women can use the free health check-ups regularly during menopause. We can’t just simply let people just go and see doctors and take medications, because some people mightn’t take what’s been prescribed or might not take it the way they should, and some might suffer from side effects after taking it. (W08)

- I think the government should encourage community colleges or ‘colleges for the middle-aged’ to provide more information about menopausal health and ageing health. (W01, W02) This would improve mental health which is more important than curing the body ... (W07) I think the topics such as diabetes, menopause etc. ... should have courses designed and provided to people at a young age. Otherwise, it’s too late to prevent chronic diseases or menopausal symptoms after they’ve happened. (W21)

- I wondered why menstrual pads are advertised so vigorously, but older women are invisible. Menopause seems to be considered a bad thing for a woman. Society should be positive and encourage women to face the changes happily when they’re turning the role from a mother to a grandma, pointing out that this is a good time to enjoy life without any troubles, including no more of the duties of rearing kids. (W04)

8.4 Discussion

Analysis of the preceding material yields two primary themes: menopausal experience, and health needs at climacteric. The data provides insight into participants’
views and their understandings of their health needs. These can be divided into four categories: physical, psychological, social, and strategic, a summary of which is given below in Table 8.1. First, women look for confirmation of ‘having no problem’, and assurance of their physical well-being, and want alleviation of the daily impact on their lives resulting from menopausal symptoms. Secondly, women recognise that the menopausal transition is a time to begin to make maintaining their health a priority. They tend to regulate their emotions to cope with stress. Thirdly, they called for a socially supportive atmosphere to help women to adapt to menopausal changes. Finally, women wanted to be able to obtain reliable information about and safe measures for improving their quality of life, based on and catering to the individual differences between them.

Table 8.2
Categories of women's health needs and strategies adopted during menopause

<table>
<thead>
<tr>
<th>Experience</th>
<th>Health and health-related needs</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Menopause</td>
<td>(1) Reassurance that the changes being experienced are ‘normal’, and rule out any pathology to relieve worries.</td>
<td>Physical &amp; psychological</td>
</tr>
<tr>
<td></td>
<td>(2) Realisation that menopause flags the time for a woman to take care of herself and attain quality of life.</td>
<td>Psychological</td>
</tr>
<tr>
<td></td>
<td>(3) Realisation that experience varies, and no single strategy fits all.</td>
<td>Strategic</td>
</tr>
<tr>
<td>HRT use</td>
<td>(4) Quick and effective relief from day-to-day discomforts, physical and/or mental, to be able to juggle the competing priorities in their lives.</td>
<td>Physical, psychological &amp; strategic</td>
</tr>
<tr>
<td></td>
<td>(5) Find acceptable viable measures instead of making a trade-off between HRT and health.</td>
<td>Strategic</td>
</tr>
<tr>
<td>Coping measures</td>
<td>(6) Use and advocate natural health regimes to manage physical changes.</td>
<td>Strategic</td>
</tr>
<tr>
<td></td>
<td>(7) Rely more on various forms of emotion regulation throughout their menopausal transition, rather than changing the situation creating the stress.</td>
<td>Psychological</td>
</tr>
<tr>
<td>Suggestions</td>
<td>(8) a supportive social atmosphere for menopausal women - <em>this still needs to be established</em></td>
<td>Social</td>
</tr>
<tr>
<td></td>
<td>(9) unbiased information about preserving health during both menopause and ageing.</td>
<td>Strategic</td>
</tr>
</tbody>
</table>
The following section reviews women’s menopausal health issues and the identified needs which emerged. It discusses whether using HRT answered women’s menopausal health-related requirements.

### 8.4.1 Menopausal health needs

Women tended to emphasise that menopause is something natural, a finding corresponding with the observation of Chen et al. (1998, p.30) that “women experience menopause according to Taoist teaching … in conformity ‘with’ rather than ‘against’ nature.” This current study also confirms two other research studies, those of Chang and Chang (1996) and Tsao (1998) that found that women regard menopause as a natural, normal life process of transition from the reproductive stage of their life to greying and ageing. They also highlighted the health maintenance concerns associated with this transition. This disposition to see menopause as something natural has an impact on women’s practices and interpretation of what is happening when they are experiencing menopausal changes.

The duration, severity and symptoms of menopause and the associated stress vary from woman to woman. Some felt relieved or neutral about menopause, while some others experienced severe biological or psychological changes at climacteric, but women did not regard menopause as a disease. Most were inclined to view the transition as a temporary part of their life and anticipate that their discomforts would be allayed as time passed. As a result, when the time came, some chose to simply ignore and/or tolerate the symptoms. Some interviewees had consulted a doctor to check whether the menstruation changes were normal and to confirm that they were not pregnancy or cancer related. This qualitative evidence suggests that the high rate of clinic visits and low compliance rate associated with HRT use in the data from the large sample of menopausal women in Part 1 of this study, discussed in Chapters 6 and 7, reflects medical help-seeking of a similar sort. This also corresponds with what Tsao described as ‘reassurance of health’ (Tsao, 2002).

Menopausal women engaged in medical help-seeking mostly want to find a way to manage daily hassles rather than to prevent disease but their help-seeking and use of alternative natural remedies highlights the need for safety in all remedies used. Women sought medical help to reduce the impact of hot flushes, confusion, vaginal
dryness, tiredness, insomnia, backaches, and of susceptibility to colds and other ailments on their day-to-day duties and activities, and on their general well-being. But some would take it on themselves to decrease the dosage of the HRT they were taking, without consulting the prescribing doctor, because of their fear of its side effects. They were worried about the risk of breast cancer resulting from HRT use. Few women mentioned or reported being concerned about cardiovascular disease, osteoporosis, or other chronic illnesses, but they had noticed degeneration. Women looked for natural hormones to supplement their oestrogen deficiency and/or used phytoestrogens as an alternative to HRT. In brief, women want natural regimes and safe remedies and they are reluctant to use medications during menopause. This is in keeping with these women thinking that the end of their menstrual periods and the decline in the functioning of their metabolic cycle were both unfavourable for body purification: medications have inevitable side-effects which their body could no longer easily purify itself of and so medications were associated with violating the naturalness of menopause and quite at odds with women’s expectations and perceptions about preserving their health.

8.4.2 Health needs resulting from Midlife Turmoil

In identifying menopause as a natural and inevitable process, women also acknowledged their own physical degeneration and adjusted themselves to changes such as deteriorating vision, weight gain, hypertension, loss of physical strength, and muscles and/or joints weakening. They also recognised that their existing health problems got worse when menopause came. These health problems have a direct impact on women’s wellbeing status. In contrast to women in North American culture (Lock, 1998), Taiwanese women did not view menopause as a negative stage—in terms of oestrogen deficiency or the risk of CVD and osteoporosis—but they did have the same concerns about developing breast cancer. Similarly, some women struggled with the changes in their appearance, losing their youth and beauty, and/or a self-identity crisis resulting from body image issues. As Gibbs observed, ‘Women get to wrestle their hormones through a Change of Life; but however disruptive menopause may be for some women, the changes that matter most are often more psychic and spiritual than physical’ (Gibbs, 2005).
Midlife turmoil is primarily a cultural construct (Stewart & Ostrove, 1998). This study found that these women’s predicaments usually reflected their personal life events and the accumulated stress of years of juggling multiple roles. Women were reserved about discussing sexual dysfunction and its impact on their intimate romantic relationships. Loss of their former sexual identity and their children leaving home may exacerbate housewives’ fear of financial powerlessness. Career women confronting work-life balance, excessive stress at work, potential job loss or career disappointment are as likely as men to report having had a midlife crisis (Shek, 1996; Wethington, 2000). Women may also experience other challenging major life events, such as becoming widowed or divorced, and the death of relatives during menopause.

Women go through various physical and psychological disturbances and display a disparate range of behaviours. Their coping strategies reveal that they have made personal adjustments, not only to deal with menopausal changes but also with midlife turmoil. Many coping strategies adopted—such as seeking reliable information, using nutrient supplements, dietary adjustment, or doing exercise—were not focused on specific menopausal discomforts but on general physical degeneration and health maintenance. In addition, their coping strategies were more focused on emotional measures, such as diverting attention from daily hassles, seeking religious support, reframing life events, and praising friendship, which also confirms the study by Lee and Wang (2000). While agreeing with Lee and Wang about the need to empower women to adopt more problem-focused coping strategies, this current study also argues that these emotion-focused strategies indicate that these women were also actively coping with midlife stress.

Midlife is generally a time for reflection and reassessment. Women recognise individual differences throughout experiencing and coping with multiple changes and become less concerned about what others think (Wethington, 2000; Gibbs, 2005). Attitudes toward menopause become more positive as menopause proceeds. Postmenopausal women generally take a more positive view than premenopausal women and agree that menopause created no major discontinuity in life, except for the underlying biological changes. Their conclusively recognising menopause as a natural process indicates that the women have accepted the fact they are “getting old” and have been liberated from the reproductive role used to identity women in society.
The coping strategies adopted, however, mostly focused on satisfying temporary needs—either relieving menopausal distress or coping with midlife turmoil—rather than on long-term needs such as achieving ‘the time to take care of herself and attain quality of life’. For example, the social networks within their peer groups or in women’s groups were used for sharing menopausal experiences and making ‘midcourse corrections’ (Stewart & Ostrove, 1998). Similarly, needs for information to make decisions or undertake self-care were mostly met by using the approaches: “I heard someone say that … ”; consulting one or more doctors; or relying on their personal firsthand experience. These approaches reverberate the point made by Backett-Milburn et al. (2000) that most women are disinterested in a preventive issue unless they have had experiential knowledge which rendered that health problem particularly salient, for example osteoporosis. This is a real challenge for those in health promotion wanting to develop and emphasise early preventive strategies for an illness (Backett-Milburn, Parry & Mauthner, 2000). Women hoped the government would provide women with a systematic range of information before the onset of menopause. This may indicate that women were aware of the fact that there was a lack of reliable information, but it does not indicate that they had been well-prepared. Women need information material before menopause begins, and to prevent chronic diseases.

8.4.3 Needs related to HRT Use

Satisfactory communication during clinic encounters may improve the efficacy of HRT in menopausal healthcare for middle-aged women. This confirms a finding of Su et al. (2003) that sufficient and reliable information is necessary for women to be able to use HRT to achieve the best outcome. Many women experienced unexpected side-effects when using HRT—such as the relapse of menstruation, breast tenderness, and unwelcome libido—side-effects which were in stark contrast to their perceptions of menopause as a natural phenomenon. These side-effects mostly resulted in worries and decreased women’s willingness to use HRT. According to these women’s accounts, many doctors had used a patriarchal tone or threatening language to deliver a message that the use of HRT was necessary for them; many had neglected to provide them with essential information about the remedy, and doctors had even neglected to follow the protocol of conducting a physical examination before
prescribing HRT. As mentioned in the previous section, obtaining reliable information is a primary expectation and what women want when they seek medical help. The gap between these women’s expectations and many doctors’ conduct undermined and decreased the trust in their doctor-patient relationship, and served to preclude the full appropriate employment of HRT to meet women’s health needs. In the midst of multiple sources of information and manoeuvres, many women instead relied on their own diverse experiences to identify a ‘helpful remedy’ and they expressed their belief in the need to cater to each woman’s ‘individual physical constitution’. This approach is in stark contrast to the approach of using a universal identical remedy, the HRT prescribed by their doctors.

Despite the confusion caused by the communication gap outlined above, HRT was frequently mentioned as the medication recommended for some women who found themselves in a predicament during menopause. Career women, particularly, were advised to use HRT to combat insomnia and tiredness, to maintain their energy and vitality while juggling multiple stresses in the workplace and their family, and to retain their femininity and confidence in social interactions. Some interviewees reported that they would monitor their usage and that they planned to discontinue it after retirement. Their using it echo the findings of the Su et al. survey (2003) which indicate that one of the prime health needs of peri-menopausal women was to be able to ‘guarantee stable employment and/or family income’. HRT was wanted by and usually helpful for some women.

HRT was not an elixir suitable for most of these women. Many menopausal women had looked for natural hormones, such as royal jelly, placenta extract, isoflavones, evening primrose oil, yam and *dong-quai*, to replace HRT as a source of oestrogen supplementation. This demand for alternative care was also revealed in other studies. On one hand, these alternatives were regarded as more natural and safer for long-term use. On the other hand, doctor’s imprudent attitudes towards HRT prescription and improper behaviour had probably increased women’s doubts about the drug safety aspect, quite apart from the messages about long-term use of HRT to prevent a number of serious diseases which had to be weighed against contradictory messages about potential links with breast cancer.

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113 Su Mei-Chen 蘇美禎, Huang Lian-Hua 黃連華, Tsao Lee-Ing 曹麗英 & Chou Shon-Nan 周松男, 2003; Hsiao et al., 2009
8.5 Conclusion

The health issues in midlife and the health needs during menopause revealed in the preceding discussion, are summarised in Figure 8.1:

The women I interviewed detected the signs of menopausal changes and physical degeneration, and coped with challenges emerging in midlife. They adopted multiple strategies, such as consulting doctors and referencing peers’ experience, to search for suitable measures, trustworthy information, and social support. Thereafter, confirming their ‘normalness’, they relied on their own experiential knowledge and skills to go through this transformation.

Figure 8.1 Women’s voices about their menopausal health needs

Some of these middle-aged women used HRT as a temporary means of relieving menopausal distress but not as a preventive measure against chronic diseases as part of looking after their future ageing health. HRT can only be a potential answer to women’s short-term health needs if they are well-informed when they commence it and again when they subsequently discontinue its use. It is recommended that strategies to meet the needs for maintaining the health of the ageing female population should integrate women’s awareness of their gradual degeneration and the onset of the ageing process which occurs during menopause.
Chapter 9

Menopausal Health - the Doctors’ Perspective

This chapter elaborates doctors’ views of menopause, HRT and the WHI report; women’s health needs; the doctor-patient relationship, and the ethos of medical practices; and their observations regarding some of the challenges to healthcare system. Their views, from their perspectives as the healthcare providers, contribute to the assessment of the normative needs of menopausal women. The views and opinions of policy decision makers, activists, and women’s health researchers, all other significant stakeholders in the areas of HRT utilisation and menopausal health, will be investigated in the next chapter, to give a comprehensive view of the normative needs of menopausal health in this study.

9.1 Data collection & Characteristics of Participants

The interviewees were selected based on the findings of Chapter 6, primarily determined by their medical specialisation, gender, the accreditation level and location of the medical facility where they were employed, and their involvement in Taiwan’s initial clinical use of HRT and/or in menopausal health promotion (see Appendix 9). They include people who advocated HRT during the early stage, and who were vigorously involved in promoting and advancing medical education, and in health promotion projects.¹¹⁴

Seventeen doctors participated in the key informant interviews. Most worked in gynaecology-obstetrics or family medicine departments, or general practice clinics, and of the rest, one worked in psychiatry, one in urology, and two were TCM practitioners. More than 75% were male. The four female doctors worked in general practice, gynaecology-obstetrics, and psychiatry. Most of the participants were mid-career medical professionals. The interviews were mainly conducted in the eastern and Western regions of Taiwan, to ensure inclusion of different regions with different

¹¹⁴ Details of the selection process are given in Chapter 5, Methodology.
levels of urbanisation because the data analysis in Part 1 showed that these have different HRT prescription rates.

**Table 9.1**

**Characteristics of medical practitioner interviewees**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>13</td>
<td>76.5</td>
</tr>
<tr>
<td>Female</td>
<td>4</td>
<td>23.5</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 35</td>
<td>4</td>
<td>23.5</td>
</tr>
<tr>
<td>35-50</td>
<td>6</td>
<td>35.3</td>
</tr>
<tr>
<td>51-65</td>
<td>5</td>
<td>29.4</td>
</tr>
<tr>
<td>Over 65</td>
<td>2</td>
<td>11.8</td>
</tr>
<tr>
<td>Specialisation area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General practice (Family medicine)</td>
<td>5</td>
<td>29.4</td>
</tr>
<tr>
<td>Gynaecology-obstetrics</td>
<td>7</td>
<td>41.2</td>
</tr>
<tr>
<td>Two specialisations (GP and gynaecology-obstetrics)</td>
<td>1</td>
<td>5.9</td>
</tr>
<tr>
<td>Traditional Chinese Medicine</td>
<td>2</td>
<td>11.7</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>1</td>
<td>5.9</td>
</tr>
<tr>
<td>Urology</td>
<td>1</td>
<td>5.9</td>
</tr>
<tr>
<td>Residential region</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North</td>
<td>6</td>
<td>35.3</td>
</tr>
<tr>
<td>East</td>
<td>10</td>
<td>58.8</td>
</tr>
<tr>
<td>Central</td>
<td>1</td>
<td>5.9</td>
</tr>
</tbody>
</table>

**9.2 Summary of Results**

Doctors’ attitudes toward menopause mostly depended on their specialisation. Gynaecologists spoke more about menopausal symptoms and the significant onset of ageing during menopause. General practitioners and the two TCM doctors focused on the prevention of chronic diseases. Common health issues affecting middle-aged women commented on by all the doctors were: women’s lack of accurate knowledge about menopausal changes, the threat of osteoporosis, worries about body-image, the predicaments of discomfort during sex and ‘empty-nest’ stress, and over-consumption of nutrient supplements.

The WHI reports had a significant impact on doctors’ attitudes towards HRT and the patterns of the way they prescribed it. After the reports, most doctors prescribed HRT more conservatively and followed the guidelines more strictly, prescribing it mainly for severe symptoms, topical treatment, and short-term usage. Two of the female doctors expressed concerns about drug dependence resulting from
commencing or discontinuing HRT. Gynaecologists remained comparatively positive and enthusiastic about the effects of HRT on delaying the ageing process for women experiencing menopause and preventing chronic disease.

Doctors were well aware that the WHI reports had influenced women’s medical help-seeking behaviours and had had impacts on the healthcare market. The attitudes of women towards HRT had generally become more polarised: more women would rather bear the symptoms of menopause which would dissipate over time than use HRT, while a few women were satisfied with it and continued long-term usage. The demand for gynaecological services had reduced, partly because of a fallen birth-rate and also because the mainstream use of HRT has been shrinking, and that had led to a ‘turf war’ between doctors. The range and variety of highly popular phytoestrogen products and nutrient supplements available has increased, and is continuing to do so. This is occurring in a context of surrounding arguments about product safety, inconclusive evidence of their effectiveness, and commercialisation of medical services and healthcare.

Doctors identified the health needs of middle-aged women including knowledge about how to cope with menstrual changes and sex life, reliable easily-accessible information about the use of hormones and health foods, and a supportive medical atmosphere at clinics. But medication was the principal treatment offered during consultations; these doctors made little reference to other health regimes that could also alleviate menopausal distress, and they had no aspirations, or were unwilling, to be responsible for delivering health education.

Alarming aspects of the doctor-patient relationship which became obvious after the WHI reports deserve attention. Women looked at the medical profession in a completely different way when they became aware of the risky way HRT was being prescribed in a context of being shuttled around, from one hasty clinic visit to another. Most women found information by themselves and had to weigh up the choices of various health products promoted by doctors and those available in the market. Some doctors commented on medical ethical codes and on the uncertainty of healthcare technologies. The crisis of a “shrinking market” for gynaecological care may on one hand underpin an opportunity for better integrated services for women’s healthcare to
emerge; at the same time, on the other hand it may also exacerbate the medicalisation of the ageing process given the rampant associated commercialisation of medicine.

This section presents what doctors said about the short-term and long-term aspects of women’s menopausal health needs: this was in the short term to (1) use HRT to relieve severe menopausal symptoms and prepare beforehand for discontinuing its use once it became unnecessary. Regarding the long-term aspects, doctors highlighted the need to (2) apply evidence-based and economically affordable health regimes to maintain health, starting from menopause. The section following that will elaborate doctors’ views on menopausal health, the use of HRT, their experience of interacting with women patients, and emerging challenges to the healthcare system.

9.3 Doctors’ Perceptions Regarding Menopause

9.3.1 The Nature of Menopause

Attitudes towards menopause varied among doctors mostly depending on their specialisation. In general, general practitioners focused on ageing health issues—particularly various chronic diseases—rather than menopausal symptoms, and they emphasised the similarity of the ageing process in men and women.

- Is menopause ... caused by a reduction or changes in hormones, or is it normal ageing? ... The body can actually cope with the symptoms of menopause. ... During this period women—actually, it’s very much the same for men— are all entering middle-age and old age, and various chronic diseases appear ... I consider that normal ageing is what we should emphasise, not menopause. Men and women both have to pay attention to looking after their health from the beginning of middle-age on. ... Looking after their health requires balanced attention to body, mind and social aspects ... including avoiding excessive medications. (D08)

Gynaecologists highlighted the years women are experiencing the menopausal transition as ‘a golden time’ and an ideal opportunity for health interventions, such as delaying the ageing process, and preventing bone density loss and/or heart disease.

- Before this stage (menopause), we have to give thought to how to enable her to delay ageing ... especially women. When a woman’s periods stop it’s quite sudden, so clearly obvious, so then ... increase your (a woman’s) vigilance ... do screening tests ... be proactive. (D02)
Doctors working within the framework of the philosophy of TCM indicated menopause was a normal life change process. In itself it had no impact on a woman’s health, but chronic diseases following menopause were real threats. Increasing women’s inner resistance to disease and reducing their vulnerability to illnesses were their priority.

Menopause ... is essentially a normal transformation. It won’t affect her life ... There are some other more important diseases that can affect her life at this stage ... high blood pressure, diabetes, heart disease, some chronic problems ... So the menopause aspect is just not given particularly serious attention ... because what it actually affects is just quality of life ... Traditional Chinese medicine doesn’t simply look at menopause in isolation. It’s one aspect of the body’s disease resistance, so the approach is how to have the body maintain the strongest disease resistance. (D14)

Other specialists, the urologist for example, underscored that menopause is the time of entry into old age, and a time at which many physical changes are starting. This is the same for both females and males, and not simply related to hormones.

The time of menopause is precisely the time when people are entering old age. That ageing will naturally trigger and drive many changes in our body’s physiological functions. These changes aren’t necessarily related to hormones. Males will also become old in the same way. (D17)

9.3.2 Menopausal Health Issues

Based on their experience in medical practice, doctors reported the primary health issues affecting women experiencing menopause, including the physical, psychological and social aspects. They commented that middle-aged women were always concerned about the changes resulting from menopause, particularly irregular menstruation and its implications. Low back pain and insomnia were also common complaints but the doctors did not consider these to be severe.

I feel the first is menopause (itself). They (women) still don’t really understand it: they seem to but in fact they don’t. For example, from what age to what age does menopause occur? Whether something (a symptom) is menopause related. Perhaps it isn’t. In the end, do they have to take
hormones? Or ... should they take isoflavones? ... And are these actually effective? ... And just how should their calcium be supplemented? (D13)

- The thing which will give rise to a complaint is probably menstrual irregularities. ... They really care\textsuperscript{115} about this. Especially people in rural areas... She’ll say ‘I’ve never experienced anything like this before, my periods have become irregular’. This will be very much on her mind. She’ll feel she has some major illness, so she comes to see you. ... (D07)

- Menstruation is very important for females. But when they reach this time they really care about this. Especially people in rural areas... She’ll say ‘I’ve never experienced anything like this before, my periods have become irregular’. This will be very much on her mind. She’ll feel she has some major illness, so she comes to see you. ... (D07)

The prevention of osteoporosis during menopause was a goal thoroughly shared by the gynaecologists, although this was not necessarily related to the advocacy of HRT. They still recommended the use of medication and at present know of no alternative preventive medication measures. The medicalisation of postmenopausal osteoporosis has been criticised as in recent years (Erol, 2011).

- Actually, the main thing, I think, is the osteoporosis ... This period from the age of 45 to 65 is when (bone) loss is most rapid. If we can get her to not lose bone density too rapidly during this period then she can avoid becoming bedridden between 65 and 70. This could happen to her because of a fall ... Many patients will pass away after that ... because she’s entirely prone, and that finally ends in pneumonia or something similar. (D05)

Sex issues were a topic that women were usually too shy to speak out about. Painful intercourse, worries about losing intimate relationship, and stresses associated with seeking trustworthy information are a shared predicament of menopausal women.\textsuperscript{116}

- I think we need to give serious attention to menopausal females’ sex issues. Many don’t dare to talk about this. Menopause-related ... loss of (vaginal) lubrication and dryness cause painful intercourse, but women worry that their husband will have an affair ... so they force themselves to take part, but they’re very unhappy. ... Many married couples decide whether to sleep apart at this time ... (D16)

\textsuperscript{115} All words shown in bold in these transcript extracts were English words interspersed in the Chinese during the interviews
\textsuperscript{116} This is discussed further below, see page 203.
Body image and weight control was another topic of prime concern for many women experiencing their metabolism slowing down during menopause. The beauty industry manipulates and exploits this concern and escalates its commercial benefits, using the free-market model.

- The gap regarding Taiwanese menopausal women’s own body image is still very important, because many people mention this. And you can see that from Taiwan’s many weight loss clinics ... the waiting queues are very long ... Sometimes a woman won’t take hormones, worrying they’ll make her fat ... What you most commonly hear is “I eat very little. Why am I always fat when I eat so very little?” (D16)

‘Empty nest’ stress was seen as arising in response to two factors: loss of the familiar focus on child care-giving, and readjusting to more frequent contact than before with a spouse. Psychosomatic symptoms diagnosed in clinic visits were recognised as a possible sign revealing the stresses that women were coping with.

- At around 50, the children have all left home. This is the empty-nest time in the family cycle, and many psycho-social problems can occur. ... In fact, you can very quickly recruit many volunteers from the age group between 45 and 50. This is an empty nest symptom. They need a support network. In fact at this time ... they don’t have many severe symptoms. (D11)

- The so-called ‘empty nest’ time. The vast majority of husbands have retired ... now suddenly there’s a rather unfamiliar ‘other half’ in the family. Every day they look at each other at a loss what to do, and they have to confront the tensions and pressures of various emotions. Many anxieties, things that don’t get talked about with outsiders ... Emotions are often expressed in the form of physical symptoms ... “psychosomatic disorders” ... are actually a signal. (D15)

Doctors observed that many women use ‘health foods’ such as vitamins, food extracts, and phytoestrogenic hormones as daily nutritional supplements. Some were concerned about safety issues associated with taking excessive amounts of these products. Some questioned the aggressive market competition between the hormonal HRT products and phytoestrogen, after the WHI reports. For example, isoflavones have usurped the market for HRT but there is a lack of reliable evidence about the potential risks and benefits.

- During this period they also take many ... health foods ... like vitamin A, vitamin C, vitamin E ... Heavy smokers use carotene, but that’s harmful. ... From the treatment concept, if it’s just food extracts, then that’s fine. ... But
what if they contain some unknown ingredients will that create an excessive amount of some particular thing, or if they're combined with things that other people have given them? (D08)

- (After the WHI report) nutritional products took advantage of the opportunity to make inroads. Their position was to definitely say: taking hormones can lead to cancer, our phytoprogenic ones won’t. ... Western medication is evidence based, I don’t understand these isoflavones ... Their potency is much lower than traditional female hormones. Because you need to look at the potency of medications, and their efficacy; their therapeutical effectiveness. Western medication is very strong (D01)

9.3.3 HRT Prescription Regulations

The NHI regulations on submitting claims for reimbursements for various aspects of healthcare services have acted as an incentive, prompting particular behaviours on the part of many doctors when prescribing medication and when recording diagnosis codes. An example is the regulation requiring doctors prescribing HRT to include the code indicating a diagnosis of ‘menopausal syndrome’ on the reimbursement application in order to be reimbursed.

- The current NHI reimbursements link the medication to the diagnosis code. If these two don’t both appear together, any hormones you prescribe will very easily be ruled ineligible for reimbursement. Actually, if you haven’t prescribed hormones, then you don’t necessarily have to put down a diagnosis code ... Doctors usually include the diagnosis code as well because they want to prescribe hormones ... There may well be major differences between the prescription behaviour in academic medical centres and in private clinics. What I think is that more HRT prescriptions are written in primary care settings than in hospitals. (D11)

- Generally speaking, a course of medication can only be prescribed for as long as a month if there’s been a diagnosis of chronic illness. ... You consider the patient’s symptoms: for something such as an aching waist or backache [symptoms not in the list of ‘chronic conditions’], they would probably have to take the medication for two weeks [but the regulations do not permit more than a one-week course]. ... But if the patient just happens to have menopausal syndrome, then I’ll include that diagnosis, and then I can prescribe a two-week course of that (medication). So actually, this diagnosis (menopausal syndrome) ... as far as doctors are concerned, it makes prescribing medication convenient. I can’t write this if the patient doesn’t have these symptoms, but as long as they have a tiny hint of them then I’ll put that in as well ... And it’s possible to put in this diagnosis and not use hormones. I now also do this! (D10)
Doctors were encouraged to prescribe women one-month or three-month courses of HRT as a ‘continuing prescription’\(^\text{117}\), unless the women had some special circumstances. Most standard types of HRT were reimbursed by the NHI; only a few were fully paid for by patients.

- Generally speaking, it (HRT) is prescribed for a week when there is a patient who complains that she easily has a sensitivity reaction when she takes medications. Some women will experience severe vomiting... sometimes it’s to test and see. These days 90% of people who use medications for the most part don’t have any problems. ... What’s generally prescribed is a month-long course because you need treatment for at least two weeks or longer before you can see any effect. A month, three months ... once the whole situation is stable, then you can give her a ‘continuing prescription’. (D04)

- The proportion of patients that pay for it (HRT) themselves isn’t high, because you can get it reimbursed by the NHI. Of course Europe has put some products on the market like Livial, products patients pay for fully themselves. It’s emphasised that they stimulate the breast [tissue] comparatively less and have a lower probability of bleeding occurring. Their market share isn’t really very high. ... Doing business in the HT market is becoming increasingly difficult. ... A lot of pharmaceutical plants are no longer producing NHI medications, and a lot of new ones have come out ... the so-called low dosage products which all have to be fully paid for by the patient. But is the utilisation rate high? I think that after something’s had a label (breast cancer) put on it, it’s not so easy at all to take label off. (D03)

**9.3.4 Impact of the WHI Report**

*Attitudes towards HRT*

Even after the WHI report, HRT was still recommended for women experiencing severe symptoms. In particular, many gynaecologists maintained their endorsement of the benefits and the irreplaceable role of HRT in delaying ageing-related degeneration and managing menopausal distress. The innovative forms of HRT recently coming onto the market strengthened their faith.

- It’s very simple. To this day I’ve always said its (HRT) positives outweigh its negatives ... I’ve held this view for many decades. I say: go and turn the idea over: if you’ve taken it, or if you haven’t, will your physical strength be better and better as you age from 40 to 60? Will your organs have become more atrophied? *Your energy serve you confidence, energetic!* Every part of you is naturally ageing.

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\(^{117}\) A continuing prescription (連續處方籤) is a category of prescription which is regularly refilled to treat a chronic condition or illness. The NHI regulations described here, guiding doctors’ prescribing practices, were the fundamental information deciding the definitions used in the secondary data analysis presented in Chapters 6 and 7.
We ... don’t **add something new**, we **supply your original thing to you**. ... I previously maintained the position that perhaps 98% or 92% was entirely beneficial. Afterwards (after WHI) ... I **keep** it at 70% to 80% **benefit**. **Against**: maybe twenty to thirty per cent. Do you want to take it? You decide for yourself. I give my patients **free choice**. I explain things. You’re responsible for deciding whether or not you want to take it. (D01)

- Ideas about **HT** have been changing again in the last two years, regardless of whether it’s about the delivery method or the dosage ... Is the risk as great as it’s said to be? ... Were the reports in the past over exaggerated? ... Any medication always carries some risks, so I feel that to a certain extent HT has been somewhat politicised. And that it’s had a label put on it ... Because putting it most simply, all the family members surrounding me have problems, but I still use **HT**. My own close family members are all still using HT. I think that its shortcomings have been excessively highlighted and its excellent features have been excessively overlooked and lost sight of ... When hormones are mentioned, the first thing people think of is that they’ll cause cancer. (D03)

A number of the gynaecologists advocated the use of HRT as a preventive healthcare measure: on one hand, women’s health will be better served by having the series of regular physical examinations required in accordance with the protocol for users of HRT. On the other hand, HRT has been defended as providing cardio-protective benefits as long as healthy women begin using it in their early years of menopause.

- Theoretically speaking, the healthcare these people (HRT users) get is relatively good ... We’ll **routinely** give them these **exams** ... Is their cholesterol too high? Are their blood lipids too high? Do they have kidney dysfunction or liver dysfunction? ... We frequently ask to see whether her blood pressure is normal. So these patients that have been given these prescriptions are essentially under the doctors’ protective umbrella ... (D04)

- We now know that the effect of **HT** on vascular disease is related to age and to the state of her blood vessels. If her blood vessels are healthy then using **HT** has a protective effect on the blood vessels, but if one day **plaque** forms in them, it can induce the **plaque** to rupture, and that creates opportunities for a stroke or myocardial infarction. So it’s age-related. (D03)

Apart from the gynaecologists, many of the other doctors pointed out that HRT was only prescribed for women with specific needs. Some doctors mentioned that they followed the guidelines for easing severe symptoms and prescribed it only for short-term use. Some mentioned using other alternatives rather than HRT as the first line treatment.
- General practitioners are probably in a relatively neutral position. We look at the symptoms and decide … We … give it (HRT) to her if it’s really very necessary. But we’ll talk with her about all the advantages and disadvantages. This is in line with the guideline … If she decides she wants it then she must … have regular breast and uterine screening tests. (D08)

- I think that the HRT hormones are prescribed with a different approach taken in each specialisation … Some say they target urinary incontinence or overactive bladder. I (a urologist) don’t really endorse prescribing this medication (HRT) for urinary tract inflammations … as the first line treatment … If it’s something recurrent (urinary tract infections) … You must find an urologist to take charge of treating urinary voiding obstruction and urinary incontinence. This is the only correct choice. (D17)

The female doctors had inconsistent opinions regarding HRT. A gynaecologist highlighted the significant effects of HRT on alleviating menopausal discomfort and that it improved women’s quality of life. Two other female doctors expressed concern about drug dependence after women commenced HRT, or severe consequences, such as an onset of major depression as a result of discontinuing the medication.

- Speaking for myself, (a female doctor in a gynaecology-obstetrics department), if I reach menopause, personally I’ll be very careful taking hormone supplements. I do endorse them taking it. … I think about the bone aspect … Things like hot flushes can cause a woman a lot of discomfort, so then she should take it. She doesn’t need to endure these things. … There are now very good medications that can do away with them, so why not take them. … At least our Menopause Medical Association … says if you take the recommended dose, it won’t cause any increase in cancers within two years; and half a year after you discontinue hormones, the inherent danger (of breast cancer) returns to the original level. (D07)

- I would almost never be inclined to prescribe it (HRT), unless her symptoms are really very marked … Because from my experience … it seems that once you prescribe it, if you want to reduce the dosage it’s very difficult. … The majority feel that once you take it (HRT), it’s not too easy if you want to discontinue. (D09)

- As soon as the media published details, many women … were very alarmed. … Many patients came running from the gynaecology-obstetrics departments … and said … this medication (HRT) was very clearly addictive … It was that all the symptoms occurred after discontinuing the medication, and moreover caused very serious major depression. The phenomenon she described is in fact one that can occur. (D16)
Changes in medical practices

Doctors’ prescribing of HRT became more conservative, globally across all specialisations after the WHI report. General practitioners were inclined to avoid HRT as the first line treatment and attributed women’s discomforts to psycho-social factors.

- Before the report came out in 2002, when we encountered neurosis or psychosomatic conditions, many doctors, including myself, would first try hormone therapy for a certain period of time, and observe what effect it had. We’re more conservative now. First we have a discussion with her. ... If she doesn’t have any relatively obvious vasomotor symptoms, for example perspiration or hot flushes, I much more prefer to first, for example, say ‘you’re now at the empty nest time’. Or for psychosomatic diseases ... explain it to her ... Tell her to go and find the reason or reasons behind it; and do some appropriate exercise, and/or some relaxation method that suits her, or get involved in community activities. I only advise her to consider first taking soy isoflavones and seeing if they help, if she has a cluster of symptoms. ... I first advise her to try this food approach for a period of time and see what happens. Most of the time I give them to her for two months. If she’s not doing better in two months, then we try using hormones. (D12)

A few of the gynaecologists mentioned that they actively advised or helped women to stop their long-term usage of HRT. Most of the discontinuation of HRT was mainly initiated by women when they obtained information about the first WHI report from the mass media in 2002. The second wave of reduction of HRT use was most probably initiated by doctors in response to the prescription guideline released in 2004.

- After 2002, I began changing, but ... at that time I didn’t have a very strong motivation ... to firmly say to a patient you can QUIT. ... When the WHI report had just come out, the main momentum behind the reduced number of prescriptions at that time came because the patients themselves quit. What happened was a woman would find out - especially from TV or a newspaper ... that there was a link with breast cancer. So many patients ... no longer came to get hormone therapy. ... In contrast, when the guideline came out in 2004, at that time there wasn’t actually that much information available to the general public. ... I’m a doctor, and I was the person who helped my patients discontinue... (D05)

After the first WHI report, some doctors prescribed alternative drugs as the first line treatment to manage women’s menopausal distress, rather than using HRT. The
hormone medication was reserved more for improving vaginal discomforts, and prescribed for topical usage.

- There are other medications that can be used to regulate some of the (menopausal) symptoms that patients have ... anti-anxiety or sympathomimetic regulator medications. ... It’s just about symptoms ... If there’s discomfort then take it. If you’re not experiencing any discomfort, then discontinue it. ... But... (these) medications can’t improve her skin or her external appearance and can’t improve the essential way she comes across as a female. (D10)

- Before (WHI) everybody took it orally. For example, some women had sexual dysfunction, or she had more of a problem with dryness, atrophic vaginitis ... Anyway they took it ... and it affected the whole body. So, formerly, there was less use of vaginally delivered hormones, but there were many patients in this category. Then after 2002 the situation changed to ‘use it if there are symptoms’. ... So after 2002 the use of vaginally delivered hormone medication increased, because nobody dared to take it orally. The situation then changed to the only remaining symptoms (treated) being vaginal ones, so vaginal medicinal creams or pessaries were used. ... At least from the feedback that the chemist shops gave me ... there was an obvious increase in the use of vaginally delivered medications. (D06)

The gynaecologists commented on two factors taken into account when individualising HRT for women. The first was that there were a variety of HRT products serving women’s different specific health targets with short-term or long-term use. Secondly, a primary criteria for safe HRT use was to check women’s health history and family health history relevant to breast cancer.

- With hormones there are different dosages for different aims. For example, there’s a particular dose if I want to prevent osteoporosis ... to prevent cardiovascular disease ..., if I want to rejuvenate myself ... The possible (dose) amounts aren’t the same. But we can’t use the same dose for all patients, so we need to turn things around and talk about what it is that you want to achieve, after that I’ll give you the corresponding therapy ... But if you’re not sure, you may consider that menopause is just a time for taking hormones (D06)

- Individualisation is taking, for example, an individual’s family history, background, and also her individual physical circumstances into account. For example if an individual has a family breast cancer history, or if she personally has a high risk for breast cancer, then her case needs to be especially individualised! ... Everybody will be more thorough (with follow-up test/s) concerning her breasts (after WHI). Especially the breasts; anything else, that’s OK. (D01)
Women’s responses to the WHI findings

One doctor described women’s common responses to menopausal distress after the WHI reports. Some experienced severe symptoms and sought medical help regardless of any worries about risk. Most women preferred to wait and see if the symptoms would dissipate by themselves over time. Some chose to use alternative remedies rather than HRT. A few experienced severe symptoms which HRT could have relieved because they did not want to use HRT because of their fear of breast cancer, while others remained confronted by the dilemma of not being able to find a satisfactory choice.

- I think it’s probably the same all over the world. First of all, the majority of menopause symptoms will resolve themselves within 2 to 4 years. The second thing is that all the experiments tell us that there’s a very strong placebo effect with things like HRT, so ... some people will slowly come to think and say that using alternative treatments might be effective. Or she’ll just put up with the situation and endure it, and it will pass. But there are other people who will keep using it... We see too many cases in the clinics ... she doesn’t dare to use hormones, but other methods aren’t effective. She doesn’t know what she should do, and the situation deteriorates into a real mess. She only comes back as a last resort when she has no other alternative. I believe that there are some women in similar situations who haven’t come back. She chooses to continue feeling undecided, not knowing what to do (laughed). Some people choose to continue wandering about, trying one therapy after another. (D03)

As well as seeking help from within the Western medical paradigm, discussed above, some Taiwanese women looked to TCM as an alternative source of care. These women might have subsequently experienced more physical and psychological problems than those who sought gynaecology specialist help, as reported by Chiou et al. (2006).

- Generally, regarding menopause, there are very many women who were originally using hormones who’ve changed over to using traditional Chinese medicine and medications. During that period of time it was in response to the media reporting on hormones, and so many were worried. Probably 60% or 70% of people have symptoms, and for as many as one in three, the symptoms can be so severe that they affect their everyday quality of life. They didn’t dare to use hormones, but they did want to find a way to resolve the symptoms. At this time, traditional Chinese medicine presented them with an alternative. (D14)
The use patterns of HRT in Taiwan were generally polarised. One group of women strongly resisted using HRT, whereas there was another group of women who have used HRT for more than ten years and are happy to continue doing so. Doctors pointed out that maintaining femininity was one of the primary motivations and expectations of the long-term users of HRT.

- We’ve found two extreme scenarios here in Taiwan. There are cases of women who began to take it (HRT) at around possibly 39 or 40, and they’re now approaching their early 50s. She’s been using it for over ten years, and as soon as she stops using it she experiences great discomfort. She says the set of measures prescribed for her were very good ... She continues using it. The WHI matter hasn’t affected her. The present tendency with the majority of cases is: if it’s possible not to use it (HRT), then don’t. If you have to use it, if you’re genuinely experiencing great discomfort, then do so short-term, with complementary measures. And they all understand this pretty well ... The complementary measures are mammograms and breast ultrasounds, and these are free for women aged 50 and over. (D16)

- I think the majority of those using it (HRT) now were using it before. They feel completely comfortable with it, and hope and want to continue on using it. Separately, there are possibly some women whose hopes are more about using hormone therapy for the vaginal or sexual aspects, or ... external expression’s of a woman’s female nature. If some women emphasise their relationship with their husband more, or emphasise their relationship with their external appearance more, then they’ll be more likely to want to continue its use. ... Looking at some of the women who definitely keep using it: her appearance is that of someone who knows how to use cosmetics and cares more about external appearances. In contrast, more working class women insist on continuing it far less. This is what I’ve observed. Certain women want to continue using hormones. It could be that they’re in certain occupations that require them to maintain external appearances and be radiant or beautiful ... (D10)

Interaction between specialists from different areas

The WHI report had a predominant impact on the gynaecological healthcare model. Frustration arising from this was shared by some of the male gynaecologists. They pointed out that there is a shrinking market for menopausal healthcare, and that changes reorientating and expanding women’s health services are necessary and that these changes offer gynaecologists new career opportunities.

- We most recently did some on-the-job education for medical practitioners about holistic women’s care ... (covering) osteoporosis, cardiovascular, breast, metabolism these aspects of ageing. ... It can’t be limited to just prescribing hormones ... How to take care of heart disease, from the age of
50 ... to 90. And this is a market orientation. ... with traditional use of **HRT shrinking** ... the only option was to reposition ourselves outside the old paradigm, and go into **re-opening** with a more holistic care approach. ... The majority of patients come to our gynaecology-obstetrics department first because they’re **female**. Our gynaecology-obstetrics department is at the front-line ... She wants to get something from our gynaecology-obstetrics department first of all (our opinion), so we’re duty-bound to do further education. (D01)

- **These days women’s medical examinations are misunderstood by people as just meaning having a cervical smear test. It shouldn’t only be a cervical smear test. ... An ultrasound test should be done at the same time. Check whether there are any womb or ovary problems. Especially now when the most difficult thing for us to diagnose is ovarian cancer ... Most recently, endometrial cancer has been constantly increasing in the last few years. So if we can use ultrasound tests, it should be possible to find these cancers with a screening test. (D06)**

The potential for gynaecologists expanding the scope of the care they could offer, mentioned above, was not endorsed by other doctors, particularly general practitioners. They argued that gynaecologists have not been adequately trained to comprehensively monitor women’s health. Gynaecologists’ inclination to attribute women’s ageing process to hormone deficiency and to prescribe hormone treatment was also critically questioned.

- **Women seeking medical advice or treatment doesn’t mean women having a gynaecology-obstetrics department consultation. ... I think that for women’s health-care we still have to go back to her relationship with her family doctor. ... Gynaecology-obstetrics department doctors aren’t able to do (women’s) comprehensive health monitoring. What they do the very most of is testing for cancer. Only general practitioners are able to do comprehensive monitoring. (D08)**

- **The majority of gynaecologists-obstetricians ... definitely don’t have an EBM approach ... Many of the problems which occur post-menopause are because of hormone insufficiency, so hormones are a ‘cure-all’... So putting all these things down to a lack of hormones, and then using hormones for all kinds of things, as if they can change everything. I think this approach to therapy is really one that involves a slightly excessive reliance on assumptions and guesswork. (D17)**

Some specialists were delighted to be involved with gynaecology-obstetric departments in providing integrated care, providing women comprehensive menopausal healthcare services. This new model was mainly targeting establishing collaborative links between various departments of Western medicine, but the
combining of TCM and Western medicine and medications in order to manage temporary menopausal distress and prevent the onset of chronic disease in the future was also mentioned.

- Our own women’s mental health and gynaecology-obstetrics departments do have links. The thing is that menopause medicine can involve many aspects ... including neurology, psychiatry, nursing. In the area I look after, everybody’s moving toward a collaborative model, and I view this beginning very optimistically. (D16)

- We can use hormones for a short period, when we’re suppressing short-term symptoms, but for taking care of your subsequent long-term physical health, as I just said, you get the body’s own disease resistance to be as strong as possible for the longest time. This is something that traditional Chinese medication can be used for. So we usually often talk about combining traditional Chinese and Western medicine and medications. (D14)

9.4 Doctors’ Views of Women’s Menopausal Health Needs

In summary of the sections above, doctors identified two categories of health needs of middle-aged women: (1) management of menopausal distress and (2) prevention of chronic disease. The following section elaborates women’s demands by examining doctors’ observations of their health beliefs, their recurrent health issues, and doctors’ recommendations, given their role as agents of women’s healthcare.

9.4.1 Women’s Health Beliefs Associated with Health Needs

As pointed out in the previous chapter, many middle-aged women sought medical help to exclude the possibility of their symptoms indicating some unknown illness rather than to restore their reproductive function. Doctors’ observations about women’s worries about irregular menstruation echoed what the women themselves said. Menstrual irregularities are a phenomenon which represent a disturbance to women’s reproductive health and sexual identity (Graziottin & Basson, 2004). At the same time, rather than bemoaning the loss of their femininity, many women celebrate their liberation from the threat of pregnancy and the social duty of reproduction.

- Menstrual irregularities ... will be very much on her mind ... It could be a traditional idea: that menstruation should follow a certain schedule and occur at certain times, and if it isn’t happening in line with her idea of how it
Women generally preferred using food-based products rather than Western medicine to maintain their health, and they paid attention to protecting themselves from the possible side-effects of medications. Doctors were also concerned about the possible side-effects, but at the same time they pointed out that women needed to exercise proper adherence behaviours in cases where they were being treated for chronic diseases.

- Our general public ... will halve the medication prescribed by a doctor, or take one tablet for just two days. But ... they just can’t have enough of ... what friends, or sons or daughters give them (nutritional products). And then there’s soy isoflavones ... They say: this is a food extract, this won’t cause cancer, it’s natural. ... Our general public ... worry about two organs: one is the liver, one is the kidneys. ... when they take Western medication, they’re fearful about every possible thing ... they have misgivings and apprehensions about Western medication (D08)

Some women had unrealistic expectations about medications, reflected in commonly heard questions reported by doctors: for example, women who wanted to find medications with quick effects to lose weight rather than adjusting their life style to control and maintain a healthy weight. A timeworn medical culture—that seeing a doctor means being prescribed medication—still existed.

- What you most commonly hear is ‘I eat very little. Why am I always fat when I eat so very little?’ ... You explain to her ... Your lifestyle and habits are very important ... But many patients feel doctors prescribe medication relatively quickly. (D16)

- There are some patients who feel ‘what kind of consultation is that?’ if they consult a doctor and aren’t given some medication. (D16)

9.4.2 Needs for Coping with Sex Issues

Menopausal women generally experience menopause-related changes affecting their sexual life. Vaginal dryness and lack of sex drive were common issues affecting women seeking medical help, issues which very likely affected couples’ relationships. This area of distress was interpreted differently depending on the doctor’s gender and/or specialisation. Changes in a woman’s sexual life during menopause are not strictly a medical condition that needs treatment, but they do fall within a broader
definition of what good health encompasses and women need reliable information sources to get help; HRT should not be the only choice offered.

- They just can’t bring themselves to talk about these things (sex issues) ...
  Some women get jelly directly from me. They would feel embarrassed about talking about it if they went to get it from some outside pharmacy. Some tell their husband to go to a sex accessories shop, not knowing whether what he’ll buy and bring home is what they need. Some look very strange: you wouldn’t dare apply them. There’s a very high demand of this nature. ... Some gynaecologist-obstetricians over-discuss the sex aspect, some don’t give it much attention ... (D16)

- You just need to do an internal gynaecological examination ... You’ll probably get a very precise knowledge of approximately 90% of what problem, or problems, she has. Problems like atrophic vaginitis. When oestrogen levels fall, that can very easily cause problems such as vaginal and vulvar inflammation, cystitis ... cause difficulty with sexual intercourse, and frequent urination ... Some patients complain about libido problems, and want to know how to resolve them. Her relationship with her husband can very easily be set right if you give her a tiny prescription. ... When the differences between two people’s sex drive or opinions are too large, it can cause many problems. (D04)

9.4.3 Need for Monitoring the Safety of Health Foods/Nutrient Supplements

Doctors were non-conclusive about the use and safety of health foods. They agreed that at the very least they had a placebo effect for women coping with distresses during this transition stage of their life. They also shared concerns about the associated expenses, given the huge market for nutrient supplements and isoflavones, all of which fall outside of NHI-reimbursed care.

- I say to my patients: “If it’s really useful, then it’s medicine; if not then it’s a health food” ... They’re not medicines, so it doesn’t matter! Absolutely doesn’t matter the slightest - except that they’re a waste of money. (D13)

- Phytogenic hormones, soy isoflavones, things in this category ... if she feels she took it and it was effective, I won’t usually oppose it, but I have to let her know its effect was probably much like a placebo. And if she understand this, then that’s fine. But if what’s awaiting her is an osteoporosis problem, then I have to make her clearly aware that the possible consequences are not very ideal. Let patients make the choice ... Menopause includes many symptoms, for example insomnia ... Some people feel that their sleep improved after they took phytogenic alternative hormones. Of course that’s OK, why not? As long as it doesn’t become too expensive. (D11)

- I heard that the consumption of isoflavones reached several billion ... it grabbed this corner of the action; it followed this event (WHI) and came in
(into the market). … There are masses of them, here in Taiwan and overseas. Now ... Western medicine is being sidelined. (D01)

9.4.4 Need for a Regulated Healthcare Market

Apart from regular healthcare services provided by doctors, there is a whole range of private healthcare services in the market which the general public must pay for from their own pocket. Being evidence-based and economically affordable were identified as essential criteria in the regulation of all healthcare. One doctor also pointed out that the government must scrutinise health food and prophylactic services to safeguard public health.

- During this period they also take many ... health foods ... Tour guides now take tour groups to buy health foods. Old people buy them themselves, and young people buy them and give them to the old people in their family... I think that the government should, must, take a clear direction about these. (D08)

- There’s no evidence for too many of the medical tests ... and people hand over many tens of thousands of NT dollars at a time. I oppose these kinds of tests. There isn't enough evidence, and some of the figures cause the general public a lot of anxiety. ... The government has a responsibility to promote things for which there’s supporting evidence and which are low-priced ... right now (there are things on) the Healthcare register, and the Bureau of Health Promotion pays out money. (D08)

9.4.5 Need for Menopausal Health Information

In summary, the discussion in the sections above indicates that information needs encompass knowledge of menstrual changes, HRT, health foods, drug use safety and side effects, and means of coping with sexual changes. Doctors also recommended that preventive knowledge about conditions such as cardiovascular syndromes, metabolic syndrome, and bone density should be provided earlier, to pre-menopausal women. Workplaces were suggested as places this could be done, and the information must be delivered in a comprehensible style.

- ... middle-age presents openings for education ... The government should invite having things like on-the-job gender education in workplaces. ... Females go through such major changes ... We should make them fully informed with knowledge during the pre-menopause period - from 30 to 45 years of age ... (D04)

- One thing that cases need is pamphlets and ... (information) resources ... 40-year-old women have many issues ... A lot of preventive knowledge can be
provided at this time - about menopause and cardiovascular syndromes, and bone density. And include unmarried women ... Target these women before they reach menopause, and do a “vaccination shot” beforehand ... and avoid tension, anxiety and panic when that time arrives. (D16)

- People in this age-group will put on weight, and also have some of the metabolic syndrome factors. ... The response of the general public is that the things nutritionists talk about are all too hard ... They then simplify things themselves: they cut everything by half; at least this way they reduce the calorie load by half. (D08)

Many women relied on their own efforts to obtain health information, primarily from the mass media and peers, although they also frequently sought medical help in the healthcare system. A female doctor advocated delivering balanced information through a multiple range of channels rather than simply depending on obtaining medical advice at clinic visits. Clinic consultations are typically hasty encounters which are treatment oriented and easily result in a prescription being given.

- Taiwanese patients are probably all inclined to be self-dependent: they go and deal with their problems themselves ... The knowledge that the majority of women have is derived from the media and/or their social sphere, so at times the media has a very great influence, especially in the earlier period, when all the talk about hormones and breast cancer occurred. ... the doctors had no way to resolve some of the misgivings the patients had. (D11)

- I feel the opportunities for these matters to be medicalised may perhaps be somewhat reduced if they (women) can obtain relatively balanced information, through a wider range of different channels. ... I think it’s already too late ... when patients run to the hospital to ask a doctor; the quickest most simple thing for the doctor to do is to give people some medicine. (D09)

The contribution of the women’s health movement to increasing women’s awareness of their health rights and patient autonomy was affirmed. At the same time constructive communication was also recommended, to achieve mutual understanding between medical professionals and social activists, so as to better meet women’s health interests.

- Women’s rights groups helped a lot. They got women to tackle situations head-on, but sometimes ... some were too extreme, too radical in meetings, making ... gynaecologists and obstetricians or male doctors feel that they didn’t know how to hold talks. I feel it’s now time to transform the previous more radical approach. That’s already achieved its effects. The task now is to work out how to hold talks and communicate amicably, and how to combine
forces to do various things together. (D16)

9.4.6 Needs for Supportive Atmosphere during Medical Consultations

Creating a supportive environment, such as by listening to women’s problems patiently in clinical settings, was a critical need but one that has been overlooked in the healthcare system. Listening to women and the kind of support that listening provides may in fact make any medication work more effectively, by eliciting such women’s better adherence and/or a placebo effect.

- A woman’s demands need to be understood and listened to attentively. I think that other symptoms are of relatively secondary importance when she feels this need is being met. Medications ... are supplementary. ... Regardless of whether people use Chinese or Western medication, the critical question is ... Can this branch of medicine or area of specialisation satisfy the patient? (D15)

- Especially their emotional, and mental needs ... (some women) constantly question you about issues in this category, turning things over in their minds. They seem a bit absent-minded and have an extreme sense of insecurity. She wants the doctor to personally reassure her and only then does she stop worrying. You’ll wonder whether she has something a bit like obsessive-compulsive disorder ... If an environment can create an atmosphere that is more accepting of patients like this ... it could be in the form of things like mutual support groups of people in similar circumstance. This would make them feel they’re not being socially looked down on. That would be sufficient. (D15)

- So there are definitely a lot of good reasons why a patient will believe a doctor. There’s no secret recipe: you just consider what’s best for them, and give them a little more time. (D02)

9.5 Appraising the Doctor-Patient Relationship

One doctor summed up the nature of ongoing doctor-patient relationships using a simile, essentially pointing out that the relationship is mutually comfortable, and both doctors and patients choose people they get along with.

- Actually, patients and doctors are just like the saying “A particular teapot has a particular lid, a lid has a teapot it’s just right for”. In this vein, all the patients who consult me are people who can keep a record of their blood pressure, and pay attention to what they eat ... So, each doctor tends to cater to patients they get along with. (D08)
Menopausal women have become well aware of the time limits and hurried nature of a medical consultation, and they tailor consultations about their health complaints accordingly. For example they select a specialist corresponding to their focal discomfort, or some directly ask for a HRT prescription, particularly from a junior doctor.

- There are many specialists a woman might consult when she’s passed middle-age. And what a woman speaks to her doctor about also depends on what type of specialist they are. If she doesn’t expect that the doctor can resolve her problem then she won’t bring the matter up. For example if her knee hurts ... then she’ll only talk about her knee at the orthopaedic department. General practitioners hear about the greatest variety of things. ... What she’s using is this doctor’s expertise. If I go to a cardiologist then it’s to talk to them about my heart, and I don’t expect this doctor to ask me about other things. (D08)

- Also patients will come and say to me I have to prescribe the medication the senior doctors did (HRT) because those doctors all did things that way ... Actually, some patients come and say ‘I’ve reached menopause’. The person tells you that’s what her symptoms are caused by and then tells you to prescribe this medication (HRT) for her. ... Very few consult me for information and say “I’m currently using that medication. Should I not have it prescribed any more?” (D09)

Many women individualised their regimes, accompanied by a series of medical help-seeking experiences. They themselves integrated use of Chinese and Western medical services in order to meet what they saw as their needs. Many women reduced the dosage or discontinued using medication on their account without consulting a doctor, due to their fear of side effects.

- Many of my patients have taken HRT several times. Afterwards all of them changed over to traditional Chinese medication. A year later they came to the gynaecology-obstetrics department to be examined. Many use Western medicine for a check-up and traditional Chinese medicine when they want some medication. (D16)

- This is a characteristic of Taiwanese patients ... if they want to take medication then they might discuss the matter with their doctor. If they don’t take the medication they absolutely won’t discuss it with their doctor: if she doesn’t take the medication, then she’ll discuss it with her neighbours. They all talk with their neighbours about what they read in articles and magazines; after reading some article, they won’t take it. And she won’t come and ask a doctor whether or not something is really the case, and what should be done. It just won’t happen. (D06)
Doctors display different moods during clinical encounters. The quality of the service doctors provide is no doubt affected by being overloaded with having too many patients to see in a certain period, and some experience a sense of resentment or frustration resulting from taking women’s inquiries as a challenge to their professional authority. Many women would be aware of this expression of ‘temperament’ and so modify their responses during clinic interactions, possibly further inhibiting communication of critical information in the already limited time available.

- Many doctors will communicate with patients about menopause, but people differ, and it depends on the situation in the clinic on the particular day. ... Some doctors can be temperamental. ... When a patient talks about being uncomfortable after taking menopause hormones, then the doctor will say ‘well then, you don’t have to take it, just have a medical examination and that’ll be fine’. ... Sometimes that will upset a doctor somewhat, making them somewhat unhappy. (D16)

- Patients use other alternative treatments. For example they take ‘queen bee milk’ (royal jelly) and pollen. Whether they discuss it with their doctor differs, depending on the patient’s expectations about whether their doctor will berate them. When the doctor is relatively accepting and willing to listen, then she’ll say, ‘I take things like fish oil, evening primrose’ ... Patients are often not very willing to speak out in a Western medicine setting ... Patients are really good at concealing things from doctors ... (D15)

Many factors contribute to whether women can make an autonomous decision during a medical consultation, for example a woman’s cognitive ability and information resources. Women residing in rural areas generally rely more on doctors’ instructions than those residing in more urbanised areas.

- Gynaecologist-obstetricians discuss this with patients and say ‘Do you want me to prescribe it (HRT)? The decision rests with you.’ But some patients reply ‘I don’t know, you have to tell me’. ... Some, if you give her this (HRT), then she’ll take it; but if you say too much, her comprehension won’t be very great. (D16)

- There’s actually generally quite a lot of information available to the general public in the northern region and the western region ... a woman will very easily have peers or family and friends ... give her advice ... But the general public in the eastern region is basically not in the same position: a woman there is still more mentally inclined to rely on and trust her doctor, and accept the doctor’s advice. (D05)
9.6 Doctors’ Views on Medical Practice

9.6.1 Rationale for Practices

Every doctor has their own individual rationale for how they conduct their medical practices. In summary, as one doctor pointed out, the factors influencing the making of a medical treatment decision vary according to the priority given to each of three elements: the medical evidence and guidelines, the patient’s characteristics, and the doctor’s own professional experience.

- When dealing with a patient, the evidence and the several guidelines constitute only one of three things influencing my choice. Another is that patient’s choice, and the third is my past experience ... Basically, an expert has things they should do, and they can only decide to do treatment after taking into account their personal experience as a practitioner and the patient’s choice. ... The guideline is a general principle, and you mustn’t violate it. If the guideline says something cannot be used, but you’re determined to use it, then that’s going against it. It’s not okay to do that. (D10)

Many doctors avoided prescription of HRT because they consider it potentially risky: women have been becoming more aware of law suits brought against doctors by patients who came down with breast cancer considered to have resulted from HRT use. Gynaecologists highlighted that they have a very professional approach to prescribing HRT and that they were prepared to accept responsibility for their decision.

- I’m not a gynaecologist-obstetrician, so I may possibly differ with them regarding it (HRT). I know about it, the knowledge aspect, and about the method, but there are many aspects of actually using it therapeutically that I’m not expert in ... It would be better to consult a specialist for their opinion. This is the medical field they specialise in and they might naturally do things differently. (D12)

- WHI being published like this ... When a doctor still prescribes this medication, that doctor then has to take the responsibility. So if a patient sues you for breast cancer caused by your HT, that doctor will definitely end up having lost the suit, and have to pay compensation. So for a doctor (who prescribed) HT it’s really, really serious (D04)
9.6.2 Preferred Work Practices and Responsibilities

Doctors, particularly those who worked in hospitals, did not accept health education or health promotion as being their responsibility.

- Health promotion is something that can be done anywhere; it doesn’t necessarily have to be placed in the hospitals. ... This responsibility has all been added to the load the doctors carry. I feel this is fundamentally unfair. The government must take a great deal of responsibility ... Public health has been looked down on for a long time, and nothing has been invested in the public health sector budget ... As I remember, the post of Minister of the Department of Health has always been held by a doctor ... (D09)

Doctors’ own individual attitude determines whether they treat women’s hormone changes at midlife as a clinical indicator of disease. A ‘naturalist’—someone who sees menopause as a natural part course of a woman’s life—regards medication as a tool merely to relieve anxiety and temporary short-lived symptoms. Those not in the ‘naturalist’ category, in contrast, recommend HRT as a medication for revitalising women’s bodies as they approach menopause (Leist, 2003), to retain their youthful appearance and stave off the effects of the ageing process. An advocate of evidence-based medicine would follow the current guidelines to help women discontinue using HRT.

- It (menopause) isn’t an illness, it’s just a course ... this process is undergone in a short time, and a woman is able to adjust to it. She doesn’t necessarily have to take any medication. ... Medication is a tool ... it has an intrinsic placebo effect, and moreover there are very large variations. (D15)

- Some people support and advocate nature, everything is natural. I must say that I think our medicine is anti-nature. Don’t you think so? Formerly, by the time our grandparents were 40 or 50, 50 or 60, their body and physical health had already began to deteriorate ... so why do we now have to extend a woman’s life? That is, in the past you were in a natural situation. These days in situations that you shouldn’t survive, they always keep on extending life, including that of a patient inside the ICU in poor condition. (D06)

- Some patients took it (HRT) continuously, because at that time the doctor who prescribed this for her thought ... hormones were a ‘magic elixir of life’ ... But after (WHI), when the guideline that there’s no need to take it unless it’s absolutely necessary came out, so ... some women I saw had already taken it for over ten years, or for seven or eight years. I spoke with them and said ‘don’t keep taking it’ ... The majority of the many menopause syndromes will have disappeared in 3 to 5 years at the most. In fact many people don’t have the so-called ‘post-menopausal syndrome’ ... but many patients still continue taking it. (D05)
9.6.3 Uncertainty Associated with Healthcare Technology

The nature of medical care includes uncertainty resulting from the constant changes in the evidence available about the risk and benefit of a particular healthcare technology: HRT is one example. Some doctors chose to be more conservative about prescribing HRT, reviewing scientific reports but not using the new products until the technology had become well-established in the medical market for years.

- In fact the field of medicine is constantly renewing itself, so when we talk about hormones being effective, before we speak, we have to first wait a while and see. When we talk about hormones not being effective, that’s also a case of ‘wait and see’. Because looking at every paper written about it (HRT): some say OK, some say NO... In general I compare how great the effects of its cost benefit and burden are... (D10) (D10)

- Hormone therapy has always been with us from the early times in the 60s and 70s ... And it’s constantly been changing. So the hormone therapy we use now will possibly change again in future ... We’ve become more conservative ... Only take it when there really is a need to do so. (D05)

- Some doctors want to experiment with new medications. I’m more conservative. I think that medications have to be used for many many years, and then all its associated problems will have surfaced. And I’ll only be prepared to take that medication then. (D08)

9.6.4 Medical Ethics

Medical ethics involve two simple core moral principles: ‘do good’ and ‘do no harm’, but many things which doctors do in the course of their practice, prescribing HRT for example, can have both beneficial and harmful effects. Sometimes, there is no satisfactory solution to an ethical dilemma this presents. A doctor should, however, know clearly whether it is likely that a treatment will harm a particular patient. They must make it their business to be well-informed about and follow all the relevant protocols.

- When we do therapy, what’s the best for the patient, one that’s least harmful, is what’s actually chosen, and afterwards the effects are better. ... So during this, we can get the patient to plan. (D14)

- We doctors want to use the very latest information and the very latest technology to help our patients, but we have to be careful about ... whether there’s any danger ... Some doctors want to experiment with new medications. I’m more conservative. I think that medications have to be used for many many years, and then all its associated problems will have surfaced.
There are many competing interests in a clinical setting, including the doctor’s own interests, the patient’s interests, and the interests of the doctor’s medical community (Rodwin, 2007). A doctor must be aware of the potential conflict of interests caused by commercial inducements when making a medical decision.

- We doctors want to use the very latest information and the very latest technology to help our patients, but we have to be careful about the commercial dynamic behind them ... In fact, this doesn’t only apply to medications: testing instruments and reagents, and therapeutic tools all have the same associated problem. They all have a great deal of vested interest in the background. In the end, are doctors fundamentally oriented towards the goals of human health, or have they been polluted by the desire to obtain personal benefits? And the pharmaceutical companies too ... (D08)

Medical professional ethics have been challenged since the values of market competition began dominating the discourses, construing medical care as an economic commodity and doctors as the providers. Relman (2007) warned that a personal financial ambition seems to be increasingly trumping medical ethics.

- Doctors now ... I don’t know ... just don’t have any sense of social responsibility ... And the medical specialist associations are quite awful ... There’s nothing professional or specialisation-related about them to speak of. That’s what I feel. (D10)

- (there are) many weight loss clinics ... and the media are constantly manipulating body image ... many doctors are making ill-gotten gains ... (D16)

9.7 Challenges to the Healthcare System

9.7.1 Commercialisation

Doctors acknowledged that the environment in which they practised was surrounded by enticing commercial incentives proffered by healthcare enterprises. They reported that continuing education offered by the medical professional associations was sponsored by healthcare manufacturers, and became occasions where new healthcare technologies were vigorously promoted. Some doctors were reported as making commercial gain from women’s health concerns, in line with the mass
media’s manipulating women’s body-image and manufacturers promoting health foods and supplements.

- Doctors now ... I don’t know ... just don’t have any sense of social responsibility ... Go and observe a medical specialist association meeting. They’re all very commercialised ... Those meetings are simply occasions for all the major pharmaceutical companies to set up their stands ... And the doctors who give presentations have probably all been sponsored. (D09)

- (there are) many weight loss clinics ... the waiting queues are very long ... Taiwan’s cosmetic liposuction is increasing, and the media are constantly manipulating body image ... many doctors are making ill-gotten gains ... (D16)

- health foods ... they’re a waste of money. ... I know that the profits they make on them are actually all very high. ... Clinics ... promote (and sell) them very fiercely! (D13)

Out in community settings, free physical examinations sponsored by medical and pharmaceutical companies are potentially creating a demand for series of subsequent treatments and health products. This occurs through women’s anxieties being heightened when they receive the results of such free health-checks. Some medical professionals advocated new healthcare technologies featuring easy and convenient approaches but these currently lack sufficient peer-reviewed evidence.

- Demands are orchestrated. Do a free health check ... and lead people into this corner. Create a situation. Make you afraid. Then you obediently dig out your money. I think it’s just too meaningless if this is all that treatment is. ... (D15)

- Too many of the medical tests that people can get now aren’t covered by the NHI. Like one drop of blood being used to test for something or rather, and whole-body scans. And people hand over many tens of thousands of NT dollars at a time. ... There isn’t enough evidence, and some of the figures cause the general public a lot of anxiety. (D08)

The high market demand for healthcare products was observed as an expression of women’s uncertainty about the menopausal transition and mid-life changes. Healthcare products’ placebo effect alone, accompanied by a well-designed promotion strategy, can easily attract women to try them. Some at least were reported to have had a healing effect.

- Women of this age are very easily led. ... If someone talks about ‘Eastern’
then they do whatever that is; if someone talks about ‘Western’ then they do that. It’s because they feel insecure, and so they “follow the crowd”. (D15)

- There are some so-called teachers selling medications on radio or television. They’re not doctors. ... they’re thinking of ways to latch onto women’s demands. A placebo is 30% effective, so simply having a prescription is probably 30% or 40% effective. For example TCM medications such as Jiawei gusao pills and Jiawei xiaoyaosan, actually, basically pass the test: women will feel they’re “effective”. (D15)

Commercialism deeply affects the interaction between doctors and patients (Rodwin, 2007). Doctors can induce a demand for particular medical ‘commodities’, and women patients can insist on being given a specific medication particularly when seeing a young and inexperienced doctor. This reciprocal action on the part of doctors and patients contributes to overuse of healthcare, which in turn exacerbates the difficulty of providing quality medical consultations.

- I feel the whole day is spent terrorising patients, and creating a demand, and then afterwards wanting the patients to take this, take that ... (D15)

- Also patients will come and say to me I have to prescribe the medication the senior doctors did (HRT) because those doctors all did things that way ... Actually, ...very few consult me for information and say “I’m currently using that medication. Should I not have it prescribed any more?” (D09)

- Taiwanese consultation times are very short, so doctors and patients both hope to resolve the most important problem the patient has come to see about as quickly as possible in the very few minutes available. (D08)

9.7.2 Medicalisation of Ageing

Osteoporosis has been portrayed as an inherent risk when women step into the climacteric. While this is quite true, in response, nutrient supplements such as calcium and glucosamine, bone density examinations, and medications for treatment and prevention have become indispensable elements of many middle-aged women’s health maintenance regimes. This new medicalisation of the ageing process will almost inevitably become even more intense given that it is closely associated with the general commercialisation of the provision of medical goods and services.

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- This period from the age of 45 to 65 is when (bone) loss is most rapid. If we can get her to not lose bone density too rapidly during this period then she can avoid becoming bedridden between 65 and 70. This could happen to her because of a fall ... Many patients will pass away after that ... because she’s entirely prone, and that finally ends in pneumonia or something similar. (D05)

- Actually, the main thing, I think, is the osteoporosis ... Most of the general public don’t have this idea ... She should go and do a ... test, and afterwards, if it’s osteoporosis ... she doesn’t necessarily have to have hormone therapy ... There are many medications now ... that can help people in this situation... (D05)

- At present the entire treatment atmosphere seems to be one of constantly emphasising giving patients a bone density examination. Afterwards, this leads to a shadow overwhelming patients: ‘my bone density isn’t good ... I have to take something’... (D15)

9.7.3 Legal Liability

Some doctors felt frustrated about the impact of the WHI report on their professional reputation and on the doctor-patient relationship. Its impact clearly revealed a glaring breakdown in the mutual trust between doctor and patient in their relationship. In 2003, the following year, a popular Taiwanese actress, Hu Zjin, reported her experience of using HRT and breast cancer in the mass media. This case heightened the attention of both doctors and women.

- WHI being published like this ... when a patient sues you for breast cancer caused by your HT, that doctor will definitely end up having lost the suit, and have to compensate you. So for a doctor (who prescribed) HT it’s really, really serious. (D04)

- There’s actually generally quite a lot of information available to the general public... For example if some situation arises today ... a woman will very easily have peers or family and friends ... give her advice or stir her up about it. She may even ... want to bring a suit against the doctor, and so on. (D05)

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9.8 Discussion

9.8.1 Discrepancy between the Supply and Demand Sides of Healthcare

The doctors’ viewpoints regarding menopausal health issues and needs presented above reveal priorities which differ from women’s. Doctors considered most symptoms of menopausal syndrome are not severe and will settle down and dissipate in time. Their concern was the various chronic diseases following menopause, this natural trigger. The healthcare services they commonly spoke about were the prevention of osteoporosis, cardiovascular diseases, and metabolic syndrome, and screening tests for gynaecological cancers. On the other hand, as the women’s voices presented in Chapter 8 show, many women consult doctors in gynaecology-obstetrics departments because they are concerned about irregular menstruation, vasomotor symptoms, vaginal dryness, and insomnia. A national survey (Lin, Changert al., 2004) confirmed that these are frequent discomforts of women experiencing menopause. The discrepancy between women’s help-seeking needs and gynaecologists’ concerns, and between the ‘demand’ and ‘supply’ sides with regard to the provision of healthcare services is depicted in Figure 9. The implications of this discrepancy will be explored in the next section.

![Figure 9.1](image.png)

*Figure 9.1 The women-demand and doctor-supply factors regarding menopausal health issues at play in gynaecology-obstetrics department clinics*
Gynaecologists were very interested in putting in place an integrated healthcare model for mid-life women, but such a model cannot be established if there is no balance between supply and demand. HRT was the approach more often advocated by gynaecologists to prevent osteoporosis, whereas general practitioners did not support its use as a first-line medication. Gynaecologists saw themselves as being “at the front-line” for healthcare for women experiencing menopausal transition and they spoke of planning to provide a more holistic care approach to women’s health “from the age of 50 ... to 90”. This idea, however, was challenged by general practitioners who argued that gynaecologists are not adequately trained to comprehensively monitor ageing health, except for screening for gynaecological cancers.

It was anticipated that integrated healthcare would spare women the effort of doctor-shopping and enhance the universal use of government-funded prophylactic services to detect disease conditions at an early stage. Women’s health must take precedence over medical commercial benefit. This includes developing supportive surroundings, the design of which must include to “consider what’s best for them, and give them a little more time”. If not, neither expanding gynaecological services nor providing more integrated healthcare in which different medical departments cooperate and work collaboratively can improve menopausal women’s well-being. Instead, it may in fact induce more demand for healthcare services and result in escalating treatment expenses.

9.8.2 Limitations of Medical Services

Many doctors are accustomed to women consulting them about various health needs during middle-age, health needs to which doctors respond selectively. The impact that menopausal distress has on women has been underplayed, possibly because of a lack of a pharmaceutical replacement for HRT after the WHI reports. As many doctors commented, after the WHI reports, and the associated publicity, many women chose to bear their symptoms, preferring to take a wait-and-see approach. Some women still sought help for irregular menstruation (to exclude any pathology) and sex-related discomforts, but women rarely sought medical advice about how to prevent osteoporosis and/or heart disease. Women preferred food-based products and often discontinued medication or halved the dosage without consulting a doctor.
Despite this, doctors saw the public health sector and government as being responsible for meeting women’s shortage of menopausal health information and education. Clinic visits were still hurried and doctors have endorsed anti-depressants and/or phytoestrogen (which a number of doctors described as at the very least having placebo effects; they also pointed out that HRT also does). Free health examinations sponsored by medical manufacturers, such as free bone density checks, have been aggressively promoted in the community.

Doctors employed few means to address women’s menopausal health needs except for medication, although some doctors reported the challenge of struggling to persuade patients to eat smarter or do exercise for weight control. Women’s intimate needs, such as those associated with concerns about their body image, vaginal dryness and associated difficulty with intercourse, and fading external expressions of their female nature, can be examined during clinic consultations. Doctors also diagnosed those women who voiced tension and anxiety when they had children leaving home and who found themselves confronted by their suddenly ‘unfamiliar other half’ who had recently retired from a job, as having ‘psychosomatic disorders’. These emotions taking form in physical symptoms are often expressed in the utilisation of medical services. Only a few doctors commented on women’s need to be properly listened to; many simply prescribed medication to relieve the perceived ‘maladjustment’.

“Medicine is of necessity a pragmatic profession” (Jenkins, 2009). Jenkins criticised the biomedical model pointing out that it “treats patients as body-machines with damaged parts, rather than serves the whole person with feelings, concerns, and contexts.” In the medical field lacking effective workable strategies, women’s sex issues, midlife turmoil, and preferences about how to go about maintaining health can be generalised to tablets: hormones, anti-depressants, or nutrient supplements. Tablets have almost mythical status at times and the media was implicated in leading women to have a blind faith in medicine to magically prevent a loss of their femininity and have a beautiful youthful body even in midlife, and therefore happiness. This interrupts and undermines a presentation of the positive alternative: of perceiving midlife as a time for new opportunity. Some doctors were reported as being quite prepared to ‘make ill-gotten gains’. This is easily done when there are women who
look forward to a doctor being able to provide the quick effect of some medication, as D16 pointed out.

9.8.3 Responsibility for Health Information

The question of whether a doctor should take on the task of health education at their clinic presents them with a dilemma. Doctors are used to paying more attention to providing treatment rather than providing advice or information during a consultation. The time available during a clinical encounter is very short, particularly for those ‘famous doctors’ who are generally fully booked with dozens, sometimes even more than a hundred appointments every day. Both the doctors and the patients hope to resolve the patient’s problem in the very few minutes available. With this tacit understanding of the logistic restraints, most patients usually dovetail their health problems to match the doctor’s specialisation in order to reach a quick resolution. In this healthcare environment a patient cannot really expect the doctor to provide “well-balanced impartial information” but she does expect answers or a decision about treatment, especially if she herself has to make a choice.

If a patient is not satisfied with a doctor’s answers, she will seek a second opinion, often from a highly well-known specialist. There is a common phenomenon in Taiwan of women impressed by reputation seeking out highly-renowned doctors for a consultation. If the well-known specialist confirms the former doctor’s opinion that makes it ‘acceptable’. These “famous” doctors are constantly booked out and difficult to get to see. For this reason women do not anticipate establishing a relationship with such a doctor. In fact many prefer to have as little to do with doctors and hospitals as possible - unless they are experiencing an unusual undesirable illness. Doctors cannot be blamed for having too many ‘admiring patients’; it is in part simply a result of the NHI system not requiring a patient wanting to consult a specialist to have any referral.

Women’s information needs are usually given a low profile by the medical profession. Despite women strongly preferring natural regimes for managing their health problems and maintaining their health, doctors would not discuss these with women patients. Their attitudes to remedies such as those in the category of
complementary or alternative medicine (CAM), were generally non-committal; they were very reluctant to discuss them because they considered there was not sufficient evidence available. A number emphasised that such products, like HRT and all medications, have a placebo effect. Some simply refused to make any comment. To exacerbate matters, for their part, few women are interested in obtaining information about early strategies to prevent chronic disease until things come to a head (Backett-Milburn, Parry, et al. (2000). As mentioned just above, the NHI system is one in which women can access tertiary and specialist care without requiring a referral: this providing the general public with highly accessible medical services has the side-effect of decreasing the awareness of the overall medicalisation of health issues – because one doctor is unaware of the other doctors their patient is consulting. The commercialisation in the current medical context has eroded mutual trust between doctor and patient. One result of this and doctors’ disinterest in patient health education is an opportunity to reorientate health information provision services.

9.8.4 Monitoring the Safety of Healthcare Technology

Few studies discuss the unexpected symptoms which occur after discontinuing HRT or its drug dependence, both of which were mentioned by two of the female doctors interviewed. Sudden termination of HRT may result in major depression. This which was a common complaint during the period after the first WHI report was released when many women had panicked and suddenly stopped using it. One female doctor pointed out that it is difficult to reduce the dosage once HRT has been prescribed. This immediately raises two ethical questions: the first is whether women are being properly well-informed about these potential problems, as well as about the other better known benefits and risks of HRT, at the time when they commence using it. The second question raised is whether both the doctor and the woman have prepared any plan for the future cessation of the HRT at the time treatment is begun. Doctors interviewed for this study presented two different scenarios which could be described as ‘healthy use of HRT’. One doctor was determined to help patients to stop their use: “I’m a doctor, and I was the person who helped my patients discontinue HRT. … I spoke with them and said ‘don’t keep taking it (D05)”’. The other scenario is the case of some extremely enthusiastic users: they began using HRT at around 40, and had continued to do so for over ten years. They felt very satisfied with it, were
keen to continue using it, and paid attention to having the specified regular health examinations to ensure the safety (D16).

The WHI report was another of many historical examples, once more confirming the uncertainty of healthcare technology. Evidence based medicine (EBM) requires comprehensive and ongoing scrutiny of all health products and services, including the following: alternative medications, such as anti-anxiety or sympathomimetic regulators for regulating menopausal symptoms; the accuracy and efficacy of ultrasonography to screen for breast cancer, ovarian cancer or endometrial cancer; and the privately marketed physical examinations paid for at people’s own expense. Doctors were divided and had inconclusive opinions about whether nutrient supplements should be subject to regulation. But there is a huge highly profitable market for ‘health foods’ and ‘nutritional products’ and some clinics have reaped fabulous profits selling them. The safety of using nutrient supplements, particularly in combination with other medications which older members of the population are taking, must also be monitored.

Regarding women’s anxiety about their body-image, ‘beauty does give joy; however, one should not endeavour to create beauty at the price of health’ (Leist, 2003). The beauty business has exacerbated the stigma of menopause for middle-aged women by manipulating stereotypical ideals of physical beauty, in particular youth and slimness, which have been transplanted from the West. In recent years, there have been increasing numbers of clinics, both Western and TCM style, featuring provision of weight-control services. Several high-profile cases of associated malpractice and lawsuits were reported by the mass media and predictably, there were many others that were resolved by a confidential settlement. The socially constructed notions of ‘beauty and health’ intimately related to women’s life cannot be left to profit-driven free-market manipulation: the government must intervene and regulate.

9.9 Conclusion

There is a significant gap between the ‘supply’ and ‘demand’ sides of menopausal healthcare. Doctors see the prevention of chronic disease as a priority of health services for menopausal women: this is the exact opposite to the priorities reflected in women’s demands when seeking medical help. The treatment-oriented medication-driven approaches at clinics are diametrically opposed to and so unable to meet women’s preferences and needs for natural, sustainable, and individualised regimes to relieve the daily hassles their menopausal symptoms caused them and maintain their health, free from the side effects of medication. After the WHI reports, women become more aware of the risks of taking medication but their needs for information about alternative health care and preventive health regimes were rarely fulfilled during clinic encounters. Provision of impartial information of this nature is critically required.

A set of comprehensive regulations are needed in response to the increasing medicalisation of health and the commercialisation of medicine. All healthcare services provided at clinics must be required to follow the norm of evidence-based medicine. To be well-informed about medications is a primary health right for women, one which should be safeguarded and which doctors and healthcare facilities should be compelled to implement. Finally, more energy and resources need to be invested in providing health information and chronic disease prevention strategies, ahead of menopause in particular, and also during menopause. These strategies cannot simply rely on the provision of medical treatment services and access to doctors. A wider lifestyle-encompassing health promotion approach is essential.
Chapter 10

Other Stakeholders’ Views of Menopausal Health

The previous two chapters examined the viewpoints of women and doctors regarding HRT use and menopausal health. The women and doctors had different priorities regarding menopausal health concerns when women sought medical advice. Nevertheless, maintaining health is their common goal although individuals have their own preferred approach. This chapter explores the views of three other key groups of shareholders: social activists, scholars of women’s health, and government policy decision makers. Their comments can be regarded as those of a third party, separate from the supply-demand sides of healthcare, which allow triangulation in this investigation of women’s health needs during menopause.

This chapter comprises four sections presenting: (1) background information; (2) the results of interviews of social activists and women’s health researchers regarding various aspects of menopause, HRT use and women’s health needs; (3) the results of interviews of government officials on the same topics; and (4) discussion and conclusion.

10.1 Data collection & Characteristics of Participants

A total of nine key informants attended interviews: two were interviewed at the pilot stage in 2007 and the other seven were interviewed in 2008. The question sequence used was the same as that used for the interviews of the doctors.121

These key informants, whom I approached and who agreed to be interviewed, were originally recommended by two different groups of people: attendants of a meeting122 held by the BHP in 2002 to discuss the HRT issues resulting from the first WHI report, and a number of other people devoted to the women’s health campaign or working on academic journal publications. All but one of the interviewees were female. I recruited most through my own network, one was introduced by a mutual

121 Details of the selection procedure, methodology, and data analysis are set out in Chapter 5.
122 This meeting was held by the BHP in meeting room 1301 at the Department of Health, 19 July 2002. Source: Geng nian qi he’ermeng bucong liaofayantaohui huiyi jiluju 更年期荷爾蒙補充療法研討會 會議紀錄
acquaintance, and I contacted two through the email address given on their official websites. In particular, one of the scholars was also a pioneer advocating women’s health in Taiwan. (For details see Table 10.1 and Appendix 10)

Table 10.1
**Characteristics of the participants**

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*Note: One of the senior scholars was also a social activist*

10.2 Results of Interviews of Social Activists and Women’s Health Researchers

The three principal goals and/or concerns propelling women’s groups menopausal health campaign were to: (1) promote the perception of menopause as being a natural part of women’s lives rather than a disease; (2) address the concern that doctors have medicalised women’s menopause and bone health, and (3) empower women to make their own informed decision about whether to use HRT.

Key people formerly involved in the social campaign to promote menopausal health in Taiwan reported that women’s groups considered that the WHI report had a vital impact on changing doctors’ prescribing behaviour. The women’s groups successfully brought specific attention to the WHI report through mass media campaigns. They exerted pressure on the government to provide women with comprehensive information, advocated gender sensitivity among medical professionals, and worked to empower women to make properly informed decisions when consulting a doctor at a clinic. In the course of this experience, the social
activists also became familiar with how to position themselves publically, and how to engage in dialogue with doctors regarding women’s health issues.

Nevertheless, menopausal women did not have a better knowledge of HRT after the news of the WHI reports, particularly the first report, faded from the headlines. Their fears of breast cancer were still very real; the activists worried that women’s vigilance about HRT risks had decreased while at the same time some doctors were still constantly advocating many new forms of hormone therapy. These included the hormonal products using lower dosages being used as a decoy in pharmaceutical market promotions.

The women’s health experts indicated that the two central health needs of middle-aged women were: (1) to be empowered to make autonomous medical decisions by being provided with health information via a range of diverse channels; and (2) integrated healthcare including regular physical examinations and screening checks, to promote menopausal health.

10.2.1 Perceptions regarding the Nature of Menopause

The central idea—that menopause is not a disease or a health problem but a life process every woman will experience—was generally shared by women’s health activists and those scholars who supported the WHI reports findings and the subsequent health campaign in Taiwan. A critical aspect of presenting a new perception of this stage of life was identifying menopause as a key time to equip women with information to prevent or tackle chronic disease as they start to face ageing.

- Menopausal women are approaching stepping into old age, and various diseases of old age will slowly appear ... This is actually life taking its course ... I think ... menopause should not be regarded ... as a disease, nor as some unusual health situation. (E04)

- At this stage (menopause) she may begin paying more attention to issues associated with ageing. How do we slowly give her more accurate information before she actually enters old age, and have her more willing to take on good health management behaviours? (E04)
10.2.2 Women’s Groups’ Advocacy

The women’s groups strongly highlighted women’s rights to make well-informed medical decisions. They advocated enabling women to make their own choice about whether to use HRT, particularly through providing reliable comprehensive information, instead of women being regarded as vulnerable or helpless patients. They opposed the patriarchal style of medical consultations in clinics.

- What we’ve said is that women have the right to decide, and the capacity to decide ... What’s most important during that process is whether or not women have been fully provided with all the information to enable them to make their decision ... The majority seem to consider patients ... are helpless people who require a doctor to tell them what to do about every single thing. I feel we’ve made some great changes regarding this. (E04)

The groups approached implementing this general campaign by addressing three dimensions: urging government action, challenging the medical paradigm, and empowering women with regard to menopausal health. An elected official, Legislator Huang Sue-yiing, took a lead exercising pressure on the government to take a positive stance on menopausal health, to provide impartial information to women to enable them to have a comprehensive knowledge of HRT, and provide general health education.

- Before the WHI reports came out, women’s groups ... primarily legislator Huang Sue-yiing ... who was also a member of the government’s Women’s Rights Promotion Committee, were vocal, targeting this issue, and constantly put to the government that the government must take a stance ... At the very least it had to provide comprehensive information, and not simply rely on doctors, or the pharmaceutical companies (that were) constantly undertaking promotion and public education activities. (E04)

- This included demanding of the government: you have to come out with good health education information, and allow us women to be able to make our choices. (E04)

Secondly, the groups vigorously promoted the inclusion of the topic of gender sensitivity to basic medical education and to continuing professional education in order to increase doctors’ awareness of women’s specific health needs.

- We’re trying to go along with the reform of the ideas and culture of Taiwan’s medical world ... constantly raising gender awareness ... Most recently we
(women’s groups) have been holding talks with professors involved in medical humanities reforms\textsuperscript{123}, hoping to have gender concepts included in the medical education process. Doctors have continuing education points they have to accrue, so we’ve put in gender education worth 2-credit points ... (E04)

Thirdly, a key goal of the campaign was to empower women. This was done by starting women’s support groups in the community and hospitals, and delivering lectures at workshops held by different public health sector divisions.

- We’ve been doing empowerment work targeting menopausal women for several years. For example going to hospitals and each Bureau of Health helping them set up menopause groups, and with how to find resources, but even more people have to get behind this and give it impetus. (E01)

The main topics dealt with at such workshops were women’s menopausal health and HRT use. The last was to help women decide whether to agree if their doctor recommended HRT. As the interviewee E01 quoted above pointed out, despite years of work, more resources and support and further impetus were still needed.

10.2.3 Menopausal Health Issues

The WHI reports resulted in a series of concerns about women’s health rights during consultations and this led to medical services and medication information being carefully reviewed. A scholar pointed out that women’s health-seeking behaviour in mid-life exhibited two extremes: doctor-shopping, and reluctance to consult doctors. The doctor-shopping women depended heavily on the healthcare system, consulting doctors to allay their health uncertainties or to obtain a second opinion about how to relieve their menopausal distress.

- Doctor shopping ... occurs in every area of specialisation. ... There’s a group of women who spend the whole day, morning till night, seeking medical advice or treatment. They consider menopause is a health problem, and they very much depend on physicians\textsuperscript{124}. They don’t understand how to deal with the usual menopause symptoms. (E02)

Other women, those reluctant to consult doctors, were in danger of neglecting to have symptoms which might indicate a potential threat to their health checked.

\textsuperscript{123} The term ‘medical humanities reforms’ refers to a reform movement in medical schools in Taiwan, attempting to better equip the new-generation medical personnel by “bring[ing] the humanities back into medicine”.

\textsuperscript{124} ‘physicians’ is the American usage, simply indicating ‘doctors’ rather than specialist physicians.
- There’s also a group of women who won’t consult a doctor, no matter what ... They themselves put too many symptoms down to hormones. For example, hysteromyoma causes increased blood in the body and many clots, but they would consider symptoms like this to be menopause ... If they really have some disease and don’t go and have it dealt with, this is actually quite dangerous. (E02)

The health activists challenged doctors’ customary practice of automatically prescribing medication. Apart from the simple lack of time available for discussion in a normal consultation, many doctors were unaware of alternatives for women unwilling to take medications and argued that using medication was necessary.

- Doctors essentially consider some medication that should be used, must be used. The problem is, if you can’t make your patients believe what you say, then you’re not a good doctor. (E01)

Their attitudes towards the prescribing of HRT was a key area of argument between some activists and doctors. A scholar questioned whether doctors prescribed HRT based on women’s individual differences, and whether doctors were able to inform women properly when prescribing HRT because many women are so anxious. This makes it more difficult for the women to really absorb information provided – regardless of any doctor’s efforts in what is an already extremely limited time period.

- The current (HRT prescription) guidelines emphasise that treatment must be individualised. But the question is whether Taiwan really does treat women “differently on the basis of individual differences”? ... (E01)

- It’s now being emphasised that women must be ensured “quality of life”, but the question is: how can a doctor convey that information when women are afraid and don’t dare to or refuse to use it (HRT)? (E01)

Using a medication with known risks to prevent disease—such as using HRT hormones to prevent osteoporosis—was pointed out as unacceptable by at least one activist.

- Personally I’m not opposed to taking hormones, but I think that when it comes to using medications wanting to prevent diseases, that’s wrong, it’s stupid. They’re now saying that HRT can prevent osteoporosis ... How can there be doctors hoping to use medications with risks to prevent diseases? I think this is simply unfathomable. (E04)
10.2.4 Activists’ Assessment of the Health Campaign

An activist, E04, commented on three aspects of the women’s health campaign: the tactics, the achievements, and its negative impact. A mass media campaign was the primary tactic adopted by the women’s groups to present a view of HRT challenging the dominant bio-medical model after the WHI reports. The activists presented topics in a way designed to draw the media’s attention.

- We (women’s groups) definitely haven’t said people mustn’t use it (HRT). ... The media possibly deliberately construed the opinions of the two sides as being in conflict. I think the media does at times operate in this way. ... with all the doctors saying that it was something good, I sometimes definitely had to respond in a relatively extreme way. ... I had to clearly highlight the bad things about it (HRT) ... In the social movement groups, of course we played around with the topic in this way, hoping the media would be willing to cover it ... (E04)

- A women’s group doesn’t have the resources ... The action we women’s groups can take is to hold a press conference. At a press conference you can, for example, talk about “what the doctors haven’t told you” ... This might make the doctors feel uncomfortable. ... HRT was possibly the first challenge to their profession... (E04)

The women’s groups saw a main achievement of their menopausal health campaign as women having come much closer to achieving “health information equity”. The media reports which had given a great deal of coverage to the WHI findings, and to the women’s groups’ associated questions, had presented a significant challenge to doctors’ traditional authority. Consequently, as Chapter 6 discussed in detail, there was a significant reduction in the amount of HRT prescribed, due both to women’s unwillingness to commence or continue its use, and to doctors becoming more conservative in their prescription behaviour.

- Regarding HRT, the Taiwan women’s health movement very successfully made the information being talked about in the past available to the public. Perhaps it was health information equity ... Calling on the doctors and reminding them: you should fully inform women and allow them to make their own judgment. (E04)

This health campaign also had a number of negative impacts. Many gynaecologists felt uncomfortable about the media portrayal of a conflict with the health activists. They were also upset about losing women’s trust in their profession because of their prescribing HRT. The contradictory messages about HRT from the
activists and doctors, particularly doctors who continued to prescribe something said to have strong possible links to cancer, contributed to making women feel confused and uncertain: what had been widely presented as and considered a panacea had turned out to have a toxic side, and they simply no longer knew whom they should or could trust.

- A women’s group doesn’t have the resources ... The action we women’s groups can take is to hold a press conference. At a press conference you can, for example, talk about “what the doctors haven’t told you” ... This might make the doctors feel uncomfortable. ... HRT was possibly the first challenge to their profession... (E04)

- The WHI reports coming out certainly affected ordinary women. I think that women are now more confused about using HRT; they don’t understand whether they should take HRT or not. ... Before WHI, there was little or no negative information, and people just took it. ... After WHI ... they heard it could cause cancer. But then they found gynaecologist-obstetricians telling them to take it. They were more confused, and didn’t know whether they should take it or not. (E04)

10.2.5 Views of Women’s Health Needs during Menopause

The viewpoints of the health activists and scholars regarding menopausal health needs were primarily identified from their research findings, findings which were confirmed by the secondary data analysis undertaken for Part 1 of this study. These included that middle-aged women primarily sought medical help to ascertain their health status; they preferred doctors to give them reliable advice about alternative treatment options rather than to simply be prescribed medication; and they were disappointed about insufficient discussion, health-related information or advice being given during a typical short consultation.

- Actually, women seeking medical advice or treatment ... At this stage of her life it’s to verify whether or not she’s healthy, and she’ll often go to see a doctor. That’s actually to make sure whether she’s normal. ... She likes to have health checks but doesn’t like to be given medication. Some definitely don’t directly take medication [they’re given] (E02)

- When a patient isn’t taking any medication (HRT) but is experiencing a lot of discomfort, the doctor should be responsible for explaining to her what else she can do if she doesn’t use medication. I think this is something that should be a part of a doctor’s basic training ... (E01)
Publicly funded health checks are available to help people monitor their health status, follow-up any problems detected with treatment as quickly as possible, and prevent chronic disease.

- Middle-age women ... have the needs associated with chronic conditions. ... to prevent them occurring and maintain their health. So, we should go about this by addressing things like whether menopausal women have undertaken preventive health-care tests; whether they understand how to use hormone therapy; whether they regularly undertake the cancer screening tests they should; whether or not they lead healthy lifestyles such as exercising ... prevent obesity, chronic conditions, diabetes, and related risk factors (G03)

But the scholars pointed out that despite the high utilisation rate of healthcare services, the basic, regular government-provided health checks—such as those to screen for cervical cancer that should be routinely done—were not being popularly accessed by middle-aged women. This was a matter for concern.

- If you talk about the high rate of women seeking medical advice or treatment, you have to look at which services they're accessing. For example the overall take-up rate of routine cervical smear tests is just inadequate. And the free medical tests available at community health centres aren't widely accessed either. (E01)

The preferred scenario outlined was one in which middle-aged women are well-informed and understand what constitute healthy measures of various aspects of health that can be tested for. This is in much the way that weight has always been a relatively well understood measure but now body mass index, waist measurement, and cholesterol levels are relatively familiar to a very much greater proportion of the general population. E02 below identifies this as an essential aspect of the health literacy described as lacking by various interviewees and also as an essential element of making optimal use of the currently under-utilised free health checks available mentioned by E01 above.

- The most important thing is that women must have a base line for their own health checks. They have to know what the healthy levels are. For example, we have to prevent heart and blood vessel problems ... During menopause blood lipids can be on the high side, blood pressure can be high ... And osteoporosis, what checks should be used for that. (E02)

Alleviation of discomfort associated with sexual intercourse was a common need identified by one scholar in their fieldwork. Women generally sought a solution
by trial and error and usually bypassed medical professionals when trying to obtain products such as lubricants. This study has found that these highly personal details were all pointed out by female professionals, both doctors and nurses. This suggests that women patients felt more comfortable to raise these concerns with a woman rather than a male professional.

- **Sex** is also an issue. I feel nobody's education is very adequate. Some go to shops like Cosmed or Watsons, and buy lubricants. Some basically don’t know about these things and just endure the situation ... There are women who say, as soon as she sees her husband take Viagra, she thinks it’s going to be a very painful uncomfortable night for her tonight. I’ve visited women in rural settings who use saliva. Some people use things like vitamin E Kanyu Liver Oil Drops. ... Many women ... bypass the professional staff and go and get themselves lubricants from chemist shops or similar. And there are women who go and buy such things but who are very shy: they'll only go when there’s nobody else around. ... (E02)

Women need the support of having people prepared to listen to them properly with an affirmative attitude, whether in professional settings or in a women’s group. A midwife in rural area was able to play this role successfully for her former clients when they were at the end of the reproductive stage of their lives.

- You have to listen to what she says when she’s describing her circumstances, and then she’ll be very happy. I think generally she can get through that time okay; as long as it’s not something very serious, or she’s very depressed or thinking of committing suicide. It’s a process for her to go through. ... I think that some support groups are extremely important. (E03)

A government worker, G04, saw menopausal women’s support needs in the wider social context of ageing and as including the psychological aspects of overall health.

- For their part, the general public can broaden their idea of menopause: for example to include how to age in a healthy way; psychologically, how to smoothly navigate the feelings that confront them about entering middle-age and old age. Actually, these feelings can be given more attention and care. (G04)

**Information needs**

The health activists and scholars emphasised women’s right to access impartial information and suggested various approaches to deliver such information. The
women’s health campaign pushed the government to provide women with complete facts in order to counterbalance the dominant situation at clinics, a primary interface where women’s menopausal experience was being medicalised and commercialised by the pharmaceutical companies. The general public needs to be aware of the commercial dynamics underpinning the information which is delivered by the mass media and become ‘smart readers’.

- We’ve definitely found that the entire range of information provided concerning women’s health is often biased or incomplete. ... because all the information is provided by doctors, and the vast majority of the information which doctors have was given to them by the pharmaceutical companies. We consider this information is not balanced. (E04)

- Let women be able to know the range of scenarios menopause can present ... through newspapers and magazines; listening to the radio; activities run by community health centres ... TV and so on. These should all be able to help. (E03)

Inter-personal communication is usually an enjoyable means for women to exchange information. This was confirmed by women’s own reports of their experience in Chapter 8. As well as support groups, developing information channels outside of medical clinics and empowering women within their existing social networks were recommended.

- My job is to provide them an information channel. ... If not, she goes straight to a treatment centre. She generally wants to listen to my opinion. She may have already sought help somewhere, and feels it didn’t seem to be effective. Or listened to what friends say, and only comes here afterwards. In reality, women will make their own choice. (E03)

- Many Taiwanese housewives get involved in primary schools as volunteer “loving mothers”, but then when their children go to secondary school and senior high school, they have comparatively less such opportunities. How we maintain these mothers’ ability to obtain information, and frequent social contacts, are, I think, things that could be a faster way to reach them than through public health education. (E04)

It was recommended that channels for delivering health information become more diversified, for example distributing pamphlets at chemists and cosmetic outlets and other places where women frequently interact socially. The content should

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125 Community health centre, 衛生所: These centres are run by the government and provide vaccinations, and actively promote government health campaigns. Some also provide clinic services.
emphasise health promotion for menopause rather than continuing to focus on links between HRT and cancers.

- I recommend displaying health education sheets at outlets selling medicinal and cosmetic products, and no longer limiting them to clinics and health centres. (E02)

- The language used in promotion and education should no longer be about cancer-causing hormones. That time has already passed. What comes next should be health promotion. (E02)

10.2.6 Recommendations for Health Policy and Services

To improve the quality of doctor and patient interactions, the activists recommended strategies focused on reorientating healthcare services. Firstly, the medical facilities must share the responsibility for enhancing women’s health literacy when women go there to seek help. One speaker intimated that a possible way to encourage doctors to do this would be to modify the NHI payment rules to provide financial incentives for them to provide their professional advice. Another proposal was to establish systems of ancillary staff or volunteer organisation to provide information for patients, rather than necessarily impose another task on time-poor doctors.

- Basically I consider, if a doctor is not simply equivalent to the use of medication, then healthcare payouts shouldn’t only be made for medication. (E01)

- Doctors often insist that they don’t have the time to do health education ... have a nurse outside the consulting room providing the appropriate explanation ... And hospital volunteers could also be involved. Hospital treatment services should essentially be patient-centred. (E01)

Secondly, health policy, healthcare projects and medical services must all be gender sensitive. Good quality healthcare for women not only requires a reduction of the current level of medicalisation of women’s reproductive life and an increase in the individualisation of women’s clinical care. It also requires women being empowered to make decisions in healthcare settings and to avoid having a male model of health and illness imposed on them - in the management of cardiovascular disease, lung cancer, and kidney failure, for example (Gijsbers Van Wijk, Van Vliet & Kolk, 1996).

- I think that the government must distinguish between females and males,
when addressing their middle-aged and old age health. ... (E02)

- Many doctors in Taiwan don’t even know the difference between sex and gender. ... And when there’s talk about women’s health, many only think about reproductive health. The second thing thought about was the right to privacy, or how to communicate with female patients. But not just these. (E04)

Thirdly, having integrated programs was recommended to address both the overuse and underuse of different medical services, and to make this an accreditation criterion to ensure it was done. Integrated care could, for example, focus on health assessments and provision of information and advice—rather than typically prescribing medication as clinics currently did—and to refer patients on for tertiary care only when that is called for, rather than the rampant doctor-shopping which is a drain on the public health purse. Convenience would act as incentive for menopausal women to do regular health checks, and women wanted health assessments more than medications.

- The best thing is to have an integrated program for women, and avoid them going everywhere doctor-shopping. ... If a gynaecology-obstetrics department changes into a women’s health clinic, it doesn’t necessarily prescribe medication. It just does a health assessment ... equivalent to a referral centre. That could be a better approach. And I recommend that this be added into a hospital’s accreditation. (E02)

- Breast cancer and cervical cancer screening tests can all be done by gynaecology departments, and there are now hospitals that integrate these in a “3-in-1” visit. It has to be convenient for women. (E01)

10.2.7 Concerns about a HRT ‘Comeback’

The activists interviewed were still alert to the possible revival of HRT use in the medical world, although the impact of the WHI report and women’s initial resulting vigilance had since dissipated. One activist strongly pointed out that the concept of ‘menopause health’ in empowering women could act as a counter to those gynaecologists who constantly promoted the use of HRT as a preventive medication to maintain women’s bone health during ageing.

- My opinion is that it’s not possible for the word “menopause” to just disappear. In those years women’s awareness and understanding of menopause had to be raised, and that’s now been done, but HRT is being pushed by doctors. ... (E01)
Generally speaking, doctors are still inclined to say to use hormones, because more medications with a range of dosages are now available ... there’s a slight tendency to be saying they should be taken younger to prevent cardiovascular disease ... (E01)

Now the president of the Osteoporosis Association is a doctor in a gynaecology-obstetrics department, not an orthopaedic specialist ... He often says the proportion of our women using hormones is much lower than in America. We only have somewhere around 15% using this medication ... The 2002 report confirmed that HRT is good for osteoporosis, so osteoporosis is used promoting it. ... (E01)

The commercialisation of medical services was a matter about which the women’s health groups were extremely concerned. They were very aware of current features of HRT which could readily further medicalise women’s health, for example the rebranding of HRT promoting it as useful for enhancing women’s quality of life. They were also very aware of the enormous financial and other resources used by the pharmaceutical companies to promote HRT as a preventive medicine, for example in doctors’ medical columns in the mass media.

- Doctors ... write special columns on the (mass media) medical pages every day ... They collaborate with the pharmaceutical companies ... There are many ways to increase sales. (E04)

- The medical world has even transformed the whole model of menopause they expound in some ways. For example they began using some of the language of the women’s groups. Saying ‘Well menopause is actually is one of the stages of a woman’s life, it’s something that every woman will experience, and they should use HRT to go through this stage more comfortably or enjoy a better quality of life’. (E04)

### 10.2.8 Experiences Interacting with Doctors

Interviewees who had been involved in the women’s groups spoke about Taiwan’s first women’s health campaign and the first WHI report. They summarised what they had learnt from their experience interacting with medical professionals and carefully applied it advocating other health agenda matters. The dynamics between these two parties are discussed in detail under a separate heading further below, but E04 outlines the approach and action taken very clearly in brief.

- Here in Taiwan, the medical world has always considered women’s groups as non-professional groups, and considered HRT therapy to be a professional issue. ... Reflecting back on things, the breakthrough regarding HRT... I think the actual factor behind this was WHI, the reports. ... The
medical world may have been more willing to listen to what we were saying after the reports came out, because the reports proved what the women’s groups had been saying for a long time. (E04)

- And since WHI we’ve become fully aware that when holding talks with doctors in particular, the question of scientific proof is very important to them. ... found a great number of papers overseas ... in constant dialogue with doctors ... found several doctors whose views are relatively similar to ours, and began tentatively discussing matters with them ... held talks with different medical associations, and held talks with the government. ... These things really must be done early on, while you’re still formulating just what your position is. And then you need to start taking certain action, to have your position unfold in the direction you want, rather than wait until it’s already changed into some predetermined package. (E04)

Nevertheless, these social activists, like health service consumers, are still frequently confronted with difficulties when collecting medical knowledge. This is partly unavoidable, given the complexity and scope of medical knowledge, but improving health literacy for the ageing population, including women, is simply absolutely essential.

10.3 Results of Interviews of Government Officials

A distinguishing feature of the menopausal health policy implementation in Taiwan was ‘learning by doing’. The approach taken by the newly born Bureau of Health Promotion\(^{126}\) (BHP) to deal with the social health issues resulting from the first WHI report in 2002, included the following features:

1. reference was made to overseas experience, particularly from the USA;

2. there was a lack of local epidemiological evidence available;

3. policy decisions were made relying on the opinions of experts, doctors, and women’s groups;

4. vigilantly fair treatment of the different stakeholders in the menopausal health issues arena with corresponding unavoidable conflicts of interest. The quote from G02 on page 242 below exemplifies this.

\(^{126}\) the Bureau of Health Promotion (BHP)
The discussion of menopausal health was mainly led by the representatives of the women’s groups because their consistently voiced opinions had been supported by the WHI report. Accordingly, the government took a stance focused on ensuring women’s right to comprehensive information and incorporating the concept that menopause is not a disease. The publication of a menopause-hormone therapy handbook was a major achievement. It represented a common understanding having been reached among the stakeholders and provided women with educational information soon after the release of the WHI report.

A series of menopausal health programs are being implemented, all using the model used promoting adult and elderly health. But healthcare delivery reflects a ‘free-market’ ideology in which medications are a key element of an interaction between patients and doctors; healthcare has been commodified. Hence the quality of healthcare relies significantly on smart consumption. Menopausal health issues such as HRT use, the medicalisation of osteoporosis and integrated healthcare could still play out just as occurred with the WHI reports: after initially being a major news topic and raising a great deal of social attention and concern, matters were dealt with on a case by case basis, rather than ongoing systemic changes incorporating sustainable management being introduced.

Policy directions to meet women’s health needs during middle age were identified by the government official interviewees as:

(1) to improve women’s health literacy to enable them to utilise healthcare services intelligently; and

(2) to shift the policy focus from menopausal health to women’s ageing health. Other issues challenging the implementation of women’s health policy include the over-utilisation of healthcare, the shortage of budget allocations for health promotion, and a lack of cooperation between different public sector agencies. The following section provides details based on the interviewees personal opinions.
10.3.1 Government Implementation

**Bureau of Health Promotion**

The Bureau of Health Promotion (BHP) established in July 2001, is the main body in Taiwan’s Department of Health responsible for promoting adult and elderly health. Following the international news attention given to the WHI report in mid 2002, the BHP quickly drew up a number of national menopausal health projects ‘on the run’, by means of strategic decisions made by an elite group, and ‘learning by doing’.

- The Bureau of Health Promotion was set up in July 2001 ... menopausal women’s health fell into our Adult and the Elderly Health Division ... This coincided with WHI (in 2002), and this was the main thing when we began working. When we started we didn’t have much understanding of menopause, and we had to go and learn about it. We read the WHI reports when they came out, and we had to consult relevant specialists for information and advice. ... Of course we still needed to rely on a panel of experts for determining policy and strategies. We’re administrative personnel. We sought out various experts from all different walks of life, including representatives of women’s groups, to discuss matters together. (G02)

**Menopausal health stakeholders**

When managing the social impact brought about by the first WHI report, the BHP identified the key stakeholders in the menopausal health that must be involved as: women’s groups, both from political parties and associated with other government agencies; doctors belonging to medical associations; and scholars of women’s health. Among these, the delegations of women’s groups had the ‘moral high ground’ because their long-held position corresponded to the results of the WHI reports. This gave them added impetus and they pushed the government to take action, particularly regarding women’s rights to obtain proper information. It also effectively gave them more standing and they were seriously listened to when their views countered those of doctors with their professional authority in discussions.

- After the WHI report came out, many Legislators, Committee for Promotion of Women’s Rights members, and women’s groups constantly said that women’s problems have been excessively medicalised in Taiwan. They pushed the government to give the general public opportunities to distinguish between the (HRT-related) options available, or information. ... Women’s groups were relatively prominent at that time (in 2002). They
didn’t particularly endorse it (HRT) before the (WHI) findings were published ... After the findings came out, their voices became even louder. (G01)

- The sticking point was that the medical world didn’t want the women’s group version (education handbook), saying it wasn’t professional enough; and the women’s groups couldn’t accept the Menopause Society’s which focused too much on treatment. Finally, the Medical Women’s Association said they were female doctors, and they wanted to look after women, and furthermore they had the professional standpoint of doctors, so everybody accepted it ... We reached a common understanding. (G02)

**Government stance**

The government reacted positively to the women’s groups’ advocacy, and took a stance supporting women’s rights to have unbiased information for making choices about HRT use. Official health information was then oriented to presenting menopause as a normal phenomenon, one which will vary from individual to individual. Rather than becoming bogged down in HRT issues, the government focused on promoting women’s health.

- At that time, the government position was that the general public had a right to know. We had to provide them channels to access information. So we organised some menopause seminars, and a dedicated phone line, and did a lot of promotion and dissemination of ideas. (G01)

- Official public education campaigns ... began to give the general public the idea that menopause is a normal phenomenon, not a disease. It’s different for each person, and they have to discuss things properly with their doctor and assess whether or not to use any medication ... (G03)

- Subsequently, we took a women’s health position. A review of other countries showed they also all thought they shouldn’t get bogged down in the HRT issue. (G02)

**Rationale behind policy making**

The evidence informing policy-making mainly came from overseas experience, particularly the American focus on middle-aged women’s health provision and promotion rather than on menopause per se. The findings of local epidemiological surveys were not yet systematically being used for policy planning.

- Formerly, menopause health-care was only a very small area of interest ... as time went on ... we discovered that the women’s health area overseas pays serious attention to middle-aged women ... They basically don’t have health promotion for menopause overseas: they have health promotion for
middle-age ... America ... they don’t have separate menopause health-care. They just...provide some correct information, information about treatment. This included urinary incontinence, and osteoporosis. (G03)

- Heart disease is actually the No.1 cause of death in America. Here in Taiwan, heart disease is not yet that serious ... But whatever America is doing, we also do, so last year (2007) we also ran a female heart disease campaign ... (G02)

- We’ve actually found an increased prevalence of diabetes in post-menopausal females, and it’s somewhat greater than heart disease. So we’re planning to have a campaign next year (2009) about preventing and managing post-menopause diabetes. And of course, as well as that there’s osteoporosis. There’s a “Look after your bone density: defend against falls” project.127 (G02)

10.3.2 Strategies for Managing the Impact of the WHI Reports

A driving principle underpinning management of the immediate social impact of the WHI report and menopausal health issues was to balance the interests of the stakeholders. The government extended the involvement, inviting various representatives from medical professionals and different women’s groups to participate in discussions. The officials preferred rational conversation rather than enter into using language reflecting political and ideological positions which could alienate people.

- We all adopted a very genuinely cordial attitude, and avoided confrontation and conflict. We wanted to reach a common understanding. ... The government’s position has to be fair and impartial, we had to compromise. We had to allow everybody to reach a common understanding, everyone wanted their point of view looked after, and we couldn’t have any big fights ... (G02)

- There were doctors, representatives of women’s groups, and also individual women involved in promotion and education activities ... those who conducted the various types of community support groups128 came and had some input (developing a handbook). I felt that this way would be relatively balanced, and that what the general public absorbed would be relatively knowledge-based, rather than simply things reflecting various ideological mindsets. (G02)

127 The Chinese name contains a pun “保密防跌”. The play on words gives it extra interest and engages the public.

128 Groups where menopausal women could share and discuss their individual experience were established in communities.
Among the series of public education campaigns to increase women’s knowledge and access to health information, the publication of a menopause-hormone therapy education handbook was the greatest achievement. Apart from its practical value, it was a palpable symbol of the common understanding reached by the stakeholders at that time. This handbook included comprehensive information on HRT use, chronic disease prevention, and promoting healthy lifestyles. It was expected that this would help provide women with better health literacy for communicating with doctors and making decisions at clinic visits.

- This menopause-hormone therapy health education handbook was printed in response to the release of the WHI reports findings, very rapidly after they came out. It wasn’t only about hormones; it was informed by the women’s health concept, a holistic approach. From bone loss, nutrition, exercise ...

(G02)

- How we now do things here in Taiwan, regarding doctor-patient communications when women seek medical advice or treatment during menopause, is to let women know how to go about asking questions. ... We produced a hormone therapy handbook ... They can read through it before speaking with a doctor. What she should ask and what she can ask. (G03)

10.3.3 Current Schemes for Implementing Menopausal Health Policy

Subsequent to the management of the urgent impact of the WHI report on Taiwanese society, various programs have been implemented to promote middle-aged women’s health. For example, the government designed and published official sets of materials related to menopausal health. These were distributed to public health sector facilities, made openly accessible on official websites, and could be freely duplicated.

- The general public will also hope to see some official publications. ... If funds are available, official sets of material should be published for all the different topics ... Invite experts from all quarters to meet together, put the materials through some review mechanism, then the contents will be a bit more impartial. ... The only thing is that wanting us to comprehensively supply all the material is simply beyond our capacity because the government’s budget is limited. (G02)

- Distribute them (official publications) to each Bureau of Health ... And then put them on websites where people can get them all as a free download. If other treatment centres or NGOs, or even some companies, want to print copies for their staff and ask us to authorise that, we’ll do so. (G02)
The issues surrounding HRT use were primarily identified as being about the nature an interaction between consumers (patients) and providers (doctors) concerning the purchase of a pharmaceutical product (HRT). Given this underlying ‘free-market’ ideology, the quality of healthcare relies on consumers shopping smartly. A predictable result has been the NHI financial deficit, year after year, since this compulsory national health insurance program was implemented in 1994.

- The relationship between these two people (doctor/patient) is very much like the saying: “It’s difficult for even an upright official to settle a family quarrel”. The patient comes with a problem, and they seek a way to resolve it together (with the doctor) ... It’s a matter of how a doctor and patient come to some compromise ... Each person has their choice. Can a doctor force a patient to do something? Or again, can a patient demand that a doctor do some particular thing? Both these things are possible! (G05)

- HRT and glucosamine are both a treatment behaviour. It’s an interaction between a buyer and a seller concerning a medication. (G01)

In recent years the central government has restructured its tactics and initiated an overarching women’s health policy to house women’s health needs at different stages. The menopausal health programs were returned to being the regular responsibility of the Adult and Elderly Health Division within the BHP, and the main focus is on preventing chronic disease in females. The monitoring of health foods, however, falls within the regular food safety investigations.

- We used to have a panel of experts: a menopause health-care work group. It met until this year (2008) then had to be wound up, because everything has come back under the umbrella of the Department of Health women’s health policy ... It takes a comprehensive approach, encompassing everything to do with women's health ... Our division is responsible for female chronic diseases, and also menopause. (G02)

- Promoting menopausal women’s health are the same as the strategies for preventing and treating diseases of middle-age and old age. ... Healthy ageing, for cardiovascular disease, diabetes, osteoporosis ... do exercise, and pay attention to your diet. So, I think you can say that menopause is a golden time. It’s a very important bridging stage in slowing down ageing, healthy ageing. Perhaps it’s more appropriate for us to honour it in this very positive way, and women will be more inclined to take in our message. (G04)

- Health-related policy ... about health foods ... can exercise some controls, just as for foods in general. There can’t be any false advertising. Has anything been added which shouldn’t be? Are all the contents of a food exactly the same as what the packaging says? But these controls aren’t particularly well enforced. (G04)
10.3.4 Health Issues regarding Menopause

HRT related

Interviewees commenting on changes that occurred after the release of the WHI findings reported over-reactions on the part of both doctors and women. The inclination of some doctors to then under-prescribe HRT was as irrational as the over-prescribing before the reports. Whether the HRT should or should not be prescribed is beyond the scope of this study, but women’s fear of breast cancer certainly led many to simply abandon HRT use. Apart from some women thereby no longer being able to manage their menopausal distress, more significantly, they discontinued HRT without consulting a doctor, overgeneralising their fear of HRT possibly causing cancer to a distrust of the medical profession. As mentioned in Chapter 9, this carries with it the danger that women entering a stage of their lives when many chronic diseases emerge, do not seek medical advice about symptoms which might be associated with serious conditions. And for any condition, early treatment is most effective, sometimes critical, and cost effective.

- Its (HRT) excessive use in the past was possibly because doctors considered that that was what had to be used for menopause, and then prescribed it without really giving it a second thought. There possibly really was over-prescription during the period before (before 2002). But I worry about whether there’s been under-prescription in this period (since 2004). Perhaps this was an overcorrection ... perhaps neither of these two extremes is best. (G01)

- The positive effect of the social movement which was spurred on by the women’s groups was that the status quo had a very rapid turnaround ... But the focus has now become blurred. As soon as hormone therapy is mentioned, everybody thinks that it has harmful effects (breast cancer), and now some women with symptoms no longer go and use the standard hormones. Instead they go and put their faith in the many health foods out there in their neighbourhood. ... (G03)

Prevention of osteoporosis

Taiwanese women, probably a large majority, prefer natural health regimes: as G04 comments further below: “All the women I’ve come in contact with in the last year or two give priority to wanting to use natural methods.” Nevertheless the nature of the Taiwanese system and associated treatment patterns had the effect of women
generally adopting the attitude that it was better to take tablets to relieve their physical discomforts and mental worries, and improve their health status quickly, in response to their menopausal symptoms. This is in fact a typical response to what is a worldwide medicalisation phenomenon. Osteoporosis is a major health threat to individual women entering the post menopause stage of their lives and therefore also constitutes a major disease burden for the public healthcare system and area of responsibility for the BHP. Effective preventive measures, and popularising routine screening and lifestyle factors such as adequate calcium intake and exercise are all recognised as important: but osteoporosis was reported as also very much a target of commercially driven medicalisation. This is creating another financial burden for the public health sector.

- Osteoporosis is worth paying attention to, but many bone density checks are done now ... especially of middle-aged and old women. As soon as they have any kind of ache or pain, especially backache, then you’ll hear “the doctor said she has a bone spur”129 or that it’s “osteoporosis”, and then they have to take calcium tablets, or weiguli (glucosamine, ‘protect-bone-strength’). So this has also been medicalised ... It’s a particular phenomenon of our treatment patterns and system. ... In other countries glucosamine can be bought in supermarkets, and comes out of pocket money. It doesn’t have to be paid for by the health-care system. (G01)

**Integrating health services**

Integrated healthcare for middle-aged women, independently undertaken by some private hospitals and doctors on their own initiative, was reported as already emerging in some urban areas. The dramatic reduction in the number of women using HRT had the side-effect of a shrinking market for gynaecological services and it was considered that this driving factor would see this development continue.

- The constant hope now is to be able to promote this (integrated approach to looking after women). The work that gynaecology-obstetrics departments do is shrinking because fewer children are being born, and they have to develop this aspect of gynaecology. So slowly, slowly, some hospitals will develop women’s body and mind health clinics, and they might combine their gynaecology-obstetrics department, psychiatric department ... and have many specialists available for treatment: the very well-resourced treatment centres will be able to do this. Nevertheless, the doctors in stand-alone gynaecology-obstetrics departments are also slowly taking on this approach.

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129 A colloquial Chinese term was used, *guci*, 骨刺, medically known as *guyou*, 骨疣. This refers to softening of the bone and other joint problems, said to be caused by a number of things.
They can also help women have breast ultrasound (breast cancer prevention) screening tests, help patients check their bone density, and also have things like weight-reduction, and beauty care. (G01)

Nevertheless, despite the positive aspects of integrated healthcare delivery, putting it in place is a complex goal. As a government official pointed out:

- Actually, women’s health is something, which should cross departmental and other boundaries much more. This could be related to the fragmentation of our entire treatment and healthcare ... An integrated approach is something relatively difficult. (G01)

Whether the emerging new service model will adequately respond to women’s health needs and preferences or continue to induce unnecessary utilisation of NHI-subsidised medical services remains to be assessed.

10.3.5 Views of Women’s Health Needs

Although described as having inadequate health literacy, women were very aware at a ‘gut level’ of the need to avoid potential carcinogens and the sensitive nature of their body’s endocrine system. Women were concerned about menopause and wanted to use natural methods to maintain their health.

- There are definitely many women who are concerned about it (menopause) ... It seems that what society is concerned about is hormones, but all the women I’ve come in contact with in the last year or two give priority to wanting to use natural methods. On one hand they fear getting cancer; on the other hand they worry about whether what they’ve already taken will affect their body’s endocrine system. I feel that the general public already has a common understanding like this. (G04)

Women’s health needs were clearly understood as being wider than simply the comfortable transition of menopause. As well as routine preventive health-care tests and healthy lifestyles, women’s psychological needs during ageing were pointed out. Amongst other things, this includes women needing to be properly listened to, as pointed out above.

- Middle-age women ... have the needs associated with chronic conditions. ... to prevent them occurring and maintain their health. So, we should go about this by addressing things like whether menopausal women have undertaken preventive health-care tests; whether they understand how to use hormone
therapy; whether they regularly undertake the cancer screening tests they should; whether or not they lead healthy lifestyles such as exercising ... prevent obesity, chronic conditions, diabetes, and related risk factors (G03)

- For their part, the general public can broaden their idea of menopause: for example to include how to age in a healthy way; psychologically, how to smoothly navigate the feelings that confront them about entering middle-age and old age. Actually, these feelings can be given more attention and care. (G04)

10.3.6 Challenges to Implementing Menopausal Health Policy

A number of challenges emerged following the declining media interest after the news coverage of the WHI reports. These stemmed from the medical system and the government environment.

Taiwan’s medical system

Both women and doctors personally suffered because of the over-utilisation of medical care in Taiwan’s universal healthcare system. Menopausal women, for example, spent a great deal of time and energy doctor-shopping seeking what they considered reliable information and satisfactory remedies. Doctors generally had to endure enormous workloads, and some doctors could easily become irritated when women challenged their decision to prescribe HRT during a consultation, as D16 pointed out in Chapter 9.

- There’s no way to modify what women do when they need help but they don’t have to go and see a doctor ... You often see a whole lot of people running around in the hospitals. Is it that they want to do this? They don’t want to if they’re tired, and there’s no second opinion available. ... (Healthcare) over-utilisation constitutes a form of suffering for the medical world, and for the doctors as well. ... (G05)

- I think the situation of women going to a hospital and then using medications is relatively largely related to the treatment ‘ecology’. In a hospital [clinic], if you don’t fully understand the medication you’re using, the doctor really ought to tell you, but ... there are so many patients seeing a doctor, and s/he simply doesn’t have the time to exchange two or three sentences with you. ... (G03)

The NHI’s features of both treatment-driven services and a lack of any referral system actually acted as barriers against women obtaining systematic comprehensive health information on which they could make medical decisions. Compartmentalisation between the different areas of medical care provision in the
public health sector was pointed out as another barrier: it is extremely difficult for women to exercise their acknowledged right to be properly and fully informed if they are going to a number of independent service providers, each possibly focusing on just one reported symptom.

- [the general approach is:] Give her some hormones ... it might be a menstruation problem or menopause symptoms. But gynaecologist-obstetricians simply don’t consider women’s heart [health] or prevention of senile dementia, strokes, or colon cancer, to be their professional responsibility. So ... other doctors from other specialisations look after those things. The situation is certainly fragmental (sic), relatively compartmentalised. (G01)

The public health sector was being required to establish support groups in its community health centres as an alternative to HRT in medical settings. This strategy was described by one official as effectively implying that hospital clinics were tacitly permitted to merely prescribe medications such as HRT but neglect patient health education.

- Bureau of Health Promotion policy is to require community health centres to set up support groups ... (it) has terms such as “community menopause” which I feel are quite strange ... It’s as if the general public has been divided into two: those who want to use natural methods go to community health centres, and if you want to use hormones, then you go to the hospital. There’s a very clear division. Hospitals are more likely to think that members of the general public that come to them want hormones ... and that there’s no need to provide menopausal women complete comprehensive care. (G04)

The emphasis on improving women’s health literacy for when they see doctors and seek medical advice is, however, only a partial solution. The typical Taiwanese three-minute consultation effectively acts as an incentive to prescribe medications. The government clearly has to create mechanisms, backed up by regulations, to build patient-oriented supportive environments. It also needs to encourage healthcare institutes to reorient auxiliary and voluntary staff towards including patient education in their work repertoire.

- I think that everything revolves around literacy ... there are actually many good doctors ... It’s (patients’) health literacy that’s failing ... A patient’s literacy is inadequate before she enters the treatment system. (G05)

- Those administering the health system and hospitals have to assist the
doctors to set about improving things... First of all there has to be an external environment that helps doctors resolve the situation. This is the only way they’ll be able to spend a bit more time with the patients that need to consult them... I think that there should be some voluntary assistance available for them (patients) at the hospital entrance when they’re admitted or discharged. (G05)

**Government system**

An anticipated shortage of allocated funds for health prevention and lack of cooperation between official departments impeded policy planning and strategy implementation. The priorities identified in the face of the reduced funding, clearly demonstrated by the figures provided in Chapter 7, were to continue providing a telephone inquiry line and the BHP official website to provide information and help empower women by improving their health literacy.

- In the past few years, we developed two core mechanisms: the first was a special phone advice line, and the other was community groups. When there are no funds, I’ll axe the community support groups first, and keep the special inquiry line. That’s because I feel such a phone advice service is relatively free of geographic limitations... for those middle-aged women with no way to come and attend a class (group activities)... We only have 1.5 million [NTD] left for next year (2009), so the best thing to do is to keep the special phone line going. (G03)

Another principal challenge was to establish working cooperatively across different divisions of responsibility. This was essential given that a shortage of personnel was the commonly reported practical resource problem. Within the BHP, inter-divisional teamwork for middle-aged women’s health directly involves at least three divisions: the Adults and the Elderly Division, the Community Health Division, and the Cancer Prevention and Control Division. A lack of cooperation has been recognised in many civil service bureaucracies, and this predictably had an impact on the restructuring of women’s health policy.

- Actually... middle-age women who already have chronic conditions have the needs associated with chronic conditions. Those who don’t have a chronic condition need to prevent them occurring and maintain their health. So, we should go about this by addressing things like whether menopausal women have undertaken preventive health-care tests; whether they understand how to use hormone therapy; whether they regularly undertake the cancer

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130 The groups, where menopausal women could share and discuss their individual experience, were established in communities to support them.
screening tests they should; whether or not they lead healthy lifestyles such as exercising ... prevent obesity, chronic conditions, diabetes, and related risk factors ... But doing this is like taking on the tasks of other (Bureau of Health Promotion) sections. With the number of staff I currently have ... this presents some difficulties. (G03)

Menopausal healthcare encompasses monitoring and ensuring the safety of long-term HRT use, and quality assurance for medical care in general. These responsibilities variously fall under the jurisdiction of the Food and Drug Administration, the Bureau of Medical Affairs, and the Bureau of National Health Insurance. Apart from related problems within the BHP itself, lack of co-ordination and collaboration with other Department of Health agencies was observed. The provision of health information services was not adequately consumer-oriented and far from ‘user-friendly’. Information, for example, was dispersed over various official websites of these public health bodies, a clear demonstration of the lack of communication and cooperation between them.

- Women’s health is extremely important. Looking at the overall situation, I consider policy, services, and strategies are really all inadequate. The entire Department of Health’s women’s health has simply been delegated to the Bureau of Health Promotion, and other places seem to have nothing ... There’s no thorough, comprehensive approach to women’s health. ... Actually, women’s health is something which should cross departmental and other boundaries much more. This could be related to the fragmentation of our entire treatment and healthcare ... An integrated approach is something relatively difficult. (G01)

- As far as I know, Australia has an official website which provides correct treatment information about diseases. All you have to do is type in a keyword and it’s provided. ... The Department of Health’s current “health99” website is a policy information platform, disseminating policy. It doesn’t provide treatment information ... Now [treatment information provision] is [something for which] each agency has its own separate website, based on what they do. So there are a whole lot of those, such as the Food and Drug Administration’s webpage about how to use medications. (G03)

10.3.7 Inconsistency in Problem Definition

Inconsistency in identifying problems and therefore policy implementation priorities was reported as common among officials. For example, opinions differed at the central and local government levels about whether regulation of the enormous market of nutrient supplements was necessary, and if so, whether at the supply side or the demand side.
- Personally, I’m really worried about the safety of health foods and the amounts of money spent on them. (G03)

- I personally think that health foods aren’t medicines. They’re dietary items and they can be considered a culture. Scientifically speaking health foods are helpful, and I think they’re really effective ... Some menopausal women go to a hospital and the doctors themselves will tell them about nutritional foods. ... (G04)

Their assumptions about the nature of the interaction between doctor and women at clinics were idealistic: in fact, the communication between doctors and women could hardly be equal because the information available at clinics was not balanced, in the sense of supporting a particular treatment orientation, and/or difficult to understand and absorb. Officials’ communication with doctors, as pointed out by the health activists in the previous section, was based on the bio-medical scientific evidence-based model, which both parties consider to be precisely where doctors’ valuable expertise lies. Doctors are understandably seen and trusted as the people most able to make medically and technically correct decisions.

- We consider that the use of any medication falls within the professional responsibility of the doctor. We respect doctors as the professionals who write the prescriptions ... we don’t want to intervene too much. We just want doctors and patients to communicate really well and understand ... and know what the benefit (of HRT) is, that’s all. (G03)

But beyond the simple medical information expertise factor was a quite separate political equity issue, essentially about the public’s right to choose. In fact their medical expertise makes it more difficult to educate doctors to understand or support women’s preference for natural regimes.

- And instead, we need to really effectively re-educate doctors: firstly they need to be more able to allow the general public have the right to choose; secondly, get the doctors to believe that the general public wants natural methods; and thirdly, if the general public chooses natural methods and approaches, the doctors have to understand how to support the general public’s choice. ... (G04)

Re-education about patient-interest-centred communication is needed.

There is an argument about whether the highly accessible medical services in the NHI are beneficial for women’s health literacy. If a doctor has no role taking on
the responsibility of patient education, as many doctors and officials too think, women would hardly obtain appropriate information regardless of how many doctors they consult. And if women are actually using frequent consultations to obtain menopausal health information or because they simply lack it, the associated costs are definitely not an efficient allocation of health funds, as the data presented in Chapter 7 demonstrates. The comments below reflect this.

- I think that it should absolutely not be the doctor’s role to take this responsibility (health education) on, but they can’t avoid doing it. They more or less simply have to address these details. The patients know this is important, and then afterwards they’ll listen to the nursing staff ladies, and then they can catch well. (G05)

- The treatment system has become very wasteful, but what are its excellent features? At a time when our women’s knowledge of treatments isn’t that good, more often many women go and see a doctor several times. Will that doctor make you more frightened, or will you be able to obtain some education or information from them? ...(G05)

A director of a district community health centre indicated the kind of innovative effective health strategies mobilising communities that were envisaged as an alternative way for many of people’s needs to be met in a more effective way than going to clinics.

- I’ve always thought ... if a community can look after those in their own immediate neighbourhood, people looking after one after, that’s far more effective than having community health centres with so many (members of the general public) coming wanting to be seen. So, our task is to find out how to get communities to be able to do this themselves. (G04)

There were mixed perceptions of the strategies for implementing the menopausal health programs reported: these were described as being the same as those already used for preventing chronic diseases of adults and the elderly. This same director was, however, aware that there were in fact some ‘major differences’ with ‘how things were done in the past’.

- Actually, the methods of promoting menopausal women’s health are the same as the strategies for preventing and treating diseases of middle-age and old age. There’s no need to come up with special strategies for menopause. ... It’s a normal ageing process, and there’s nothing different in the health promotion strategies, so what need is there to definitely mention menopause? (G04)
- I personally feel that health promotion is an excellent idea ... But in the end there are major differences between how this idea is operationalised and the way we went about working with the ideas we had in the past, and so people in the public health field aren’t particularly adept at working with it. Do they believe it? Is this approach useful? It amounts to a challenge to how things were done in the past ... (G04)

G04 identified the government’s task: “Our task is to find out how to get communities to be able to [look after one another] themselves.” This approach to public health promotion has practical implications: empowerment of the workforce at health stations is also vital. They require the skills to identify specific local health needs so as to construct the most supportive environment possible to help women to manage their life in a healthy way as they age.

10.4 Discussion

Health policy for middle-aged women is still ‘not fully cultivated land’ for the Taiwanese government, although the baby boomers, born between 1946 and 1964 and aged between 46 and 64 years old, made up more than 10% of the whole population in 2010. Spurred by the issues arising in the wake of the WHI reports, policy and strategies were gradually shaped by looking at the overseas experience particularly what occurred in the USA, and convening a panel of experts primarily doctors and researchers. This issue, however, saw the traditional approach to drawing up health policy—an approach in which decisions were generally made deferring to the opinions of medical professionals—essentially abandoned: instead, a compromise was reached in conjunction with the activists from women’s right groups and other experts. The policy decision-making process was surrounded by new challenges, and being prepared to compromise and working to reach a consensus has been the hallmark of the approach adopted for the promotion of women’s health since the WHI reports.

10.4.1 Dynamics of Promoting Menopausal Health

I consider that the role that the women's groups played after the release of the WHI findings in 2002 was crucial in promoting menopausal women's health. Changing medical healthcare in Taiwan was an extremely difficult task to take on, particularly as the majority of the posts of director of the various government health agencies were held by doctors. The dynamics involved are outlined below.
The menopausal health campaign put great weight on advocating women’s rights to make autonomous medical decisions, and to achieve “health information equity”. The activists took a strong public stand about the way doctors’ were prescribing HRT and pushed the government to take an impartial stance regarding the menopause aspect of women’s health. In the immediate wake of the WHI report, the women’s groups launched and orchestrated a media campaign to increase women’s awareness of the risks associated with HRT. In doing so, they helped set in train a process that ultimately successfully challenged the patriarchal authority of medical professionals and the biomedical model of menopause. At the same time, they pressed the government to provide balanced and comprehensive information to educate women. The activists considered that in order to achieve “health information equity” the government had a duty to provide women with a knowledge of menopausal health, and doctors had a responsibility for patient health education; they themselves got involved in women’s empowerment by setting up support groups in the community.

This campaign changed the ecology of menopausal healthcare: before the WHI reports, menopausal health was mainly looked after in the context of consultations between women and doctors. At that time essentially all the information available in these clinic settings was provided by the pharmaceutical companies; a small amount by medical people. After the first WHI report, the women’s groups introduced an intervening dynamic into this doctor-patient interaction (see Figure 10). The women’s groups took the WHI report ‘bull by the horns’ and pressed doctors and the government to make changes in the provision of health services. As a result: official health information material became available as one of the sources of information in the menopausal healthcare ‘marketplace’; dialogue among the stakeholders was given a transparent agenda; the BHP women’s health policy was reviewed and then renewed in 2008; and women’s political power and place at the healthcare policy-setting table was recognised. Nevertheless, factors at play in the interactions between the women’s groups and the other main groups of stakeholders during the course of this intervention raise a number of questions.
Figure 10.1 Interactions between menopausal health stakeholders before & after the 1st WHI report

10.4.2 Status of Women’s Groups

A key question is ‘who was speaking for women?’, as indicated by the broken line in Figure 10. The representatives of women’s groups who were invited to attend the meeting held by the BHP on 19 July 2002\textsuperscript{131} to discuss the HRT issues resulting from the WHI report were selected by the BHP. These ‘spokeswomen’ were recruited from a political party, a government agency working in the area of women’s rights, and the Medical Women’s Association, and two were university professors. Their being women balanced the other invited male attendants, from medical associations and hospitals, and they spoke out in this forum for all Taiwanese women’s rights to make autonomous health decisions.

Nevertheless, the leadership of the women’s health campaign in Taiwan were all from the middle-class. Although one of the attendees was a spokeswoman from a political party, it was not a party largely representing grass-roots women. These representatives of all Taiwanese women were professional elites in their fields. It is

\textsuperscript{131}更年期荷爾蒙補充療法研討會會議紀錄, in the Department of Health, 19 July 2002, held by the BHP
questionable whether non-middle class women would be aware of the call for “women’s rights to be properly informed” and “exercise autonomy making autonomous medical decisions”. The language itself is that of the educated middle-class and the talk of “women’s rights” was a phenomenon of the political climate at that time. My own experience speaking with a number of my interviewees who were working-class women, clearly indicated that many such women were simply not adequately prepared to make a medical choice. They were used to relying on the authority of the doctor giving treatment instructions, and some still wanted to be given medication at clinics.

It would not have been possible to canvass all women’s opinions for this urgent response to the WHI reports. The three parties—the women’s group activists, doctors, and government officials—all endorsed taking action to actualise "women's right to know", as E04, G01, and G02 commented. The women’s groups were the driving force: the government was responding to the demands to ‘do something’ being made by a number of politically vigorous women active in various quarters at that particular time. These women took very strategic advantage of the favourable opportunity the WHI findings presented and activists put “pressure” on the government to institute changes. The doctors’ position was more ambivalent. They were also defensive about doctors’ established authority to prescribe medications as they saw fit, that their treatment decisions were well-founded, and about their reputation as highly educated highly skilled professionals. Formulating regulations and measures affecting medical practitioners could turn out to be the slowest and very last matters tackled.

The menopausal health campaign had unforeseen consequences. The publicity campaign, in particular, increased awareness of the safety concerns associated with HRT and the need to comply with the protocols. An overcorrection in some quarters also affected women’s decision-making. The health activists confirmed that women became more uncertain and ambivalent about taking HRT after the WHI reports. Although some doctors were still inclined to endorse the use of new hormone products, a negative effect of the media campaign was that women became distrustful of the information they were given by doctors. Having already had their former trust ‘betrayed’ and having a strong fear of breast cancer distorted their ability to evaluate
information and make properly informed decisions about alleviating menopausal distress.

A large-scale long-term social movement promoting women’s health is crucial. A social movement would affect women’s consciousness about many health issues, including their health rights, removing the stigma of menopause, availability of alternative health regimes, and healthy ageing choices, and bring about and be accompanied by social change in many arenas (Ruzek & Becker, 2002). This process of promoting menopausal health was essentially a health campaign rather than a social movement. Women must be fully informed about their health rights and have reliable sources of up-to-date information far beyond any relatively short-lived media frenzy in response to a social issue, such as the women’s groups were able to attract immediately after the release of the first report of the WHI findings.

10.4.3 Interaction between the Women’s Groups and Doctors

The dialogue between the women’s groups and the doctors was initially more like a quarrel between a spokeswoman and an agent: doctors were essentially taking on the role of an agent when they made medical decisions for their individual women patients. Both were fighting for women’s medical affairs; each insisted on their mandate to protect women’s health rights. The discourse of the activists countered the biomedical model dominating the perception and treatment of women’s bodies which was the status quo. It challenged medical patriarchal authority and their target was to establish women’s equity in health rights. The doctors were claiming to speak on behalf of their female patients on the basis of their understanding of women’s health needs: needs identified by internal gynaecological examinations, and clinical interactions. The women’s groups and the doctors both partially conveyed women’s menopause-related needs, but initially did not reach a common understanding from which to work in the best interests of women’s wellbeing.

The activists recognised there was a high threshold when communicating with doctors: the doctors essentially defined the issue as one falling within the exclusive jurisdiction of medical professionals. The health advocacy of women’s groups was therefore automatically classified as being unprofessional in nature. As a result, these groups had to learn to articulate their position regarding matters such as increasing
gender sensitivity in a way that the doctors would be able to set aside their prejudices and actually direct their attention to the ideas being conveyed. As E04 outlined above, this involved gathering scientific evidence and allying themselves with the doctors having similar ideals when they started taking specific action.

The women’s group all being middle-class also acted in their favour: despite their different professional spheres, the women were still highly educated articulate professionals, like the doctors themselves. Moreover this task they took on, of learning to speak ‘doctor-speak’, was exactly what they were asking the medical profession to do for their women patients: to learn a completely new way of speaking about a range of matters. In this case to speak to ordinary women about possibly complex medical situations as comprehensively as possible. There was an inbuilt equity expressed by these women’s efforts to communicate with the doctors by being sensitive to their listeners’ ‘needs’ for ‘user-friendly familiar language’ and their efforts were rewarded.

Nevertheless, although HRT was possibly the first challenge to the medical profession in Taiwan, the achievement of increasing women’s awareness of the need to be informed about what they were being prescribed and to be enabled to make treatment decisions was attributed to the WHI report.

10.4.4 Implications of Government Strategies

Some central government officials were inclined to attribute the failing quality of healthcare to women’s lack of health literacy. They anticipated that an increased health literacy among women would be helpful resolving the suffering associated with but not helped by over-utilising medical services. Nevertheless as Chapter 7 clearly demonstrated, the public funds spent funding the utilisation and any over-utilisation far outweighed the relatively paltry amounts allocated to other menopausal women’s health promotion activity, including enhancing health literacy. Furthermore, it was somewhat naively expected that after simply reading the hormone therapy handbook women would then know how to speak with and ask questions of a doctor. No doubt the handbook was very informative and did improve women’s health literacy about this particular aspect of menopausal health. But the idea that what occurs in a three-
minute consultation can be changed merely by improving women’s health literacy is very unconvincing.

Their expectations were based on imposing a free-market ideology on medical services. The needs and expectations of women seeing a doctor to ascertain their health status or obtain advice about treatment alternatives simply cannot be met in a three-minute consultation, particularly if a doctor is not willing to deliver health information. Quickly dealing with a patient by prescribing medication rather than providing information resolving the problem will almost always occur if the payment system continues to provide a financial incentive by reimbursing the medication will almost always occur incurred. And doctors will still consider that they have treated the patient.

Moreover, the sheer complexity of medical knowledge is a major unavoidable factor contributing to the information imbalance: it is extremely difficult for patients to be well-informed about matters doctors have taken years and years to study, and are constantly needing to stay up-to-date about (Henderson, 2005). The attitudes toward doctors’ responsibility for health education were inconsistent among the officials. There was also lack of agreement among officials about whether it was necessary to monitor doctors’ HRT prescription behaviour. They indicated their respect for doctors as the professionals who write the prescriptions and their confidence that no doctor would intentionally use HRT to harm patients. Nevertheless, there were differing opinions regarding the ethical question of who was benefitting from the rash prescription of medications occurring at clinics, given the now ubiquitous commercialisation of medical services and associated medicalisation of menopause and osteoporosis.

The current approaches for menopausal health may undermine how future incidents are dealt with. First, merging the menopausal health programs with the regular tasks of promoting adult and the elderly health may cause a loss of focus on serving the high demands of the ageing female baby boomers in Taiwan. Secondly, while a good start, the preference for pursuing knowledge-based discourse rather than promoting various ideological mindsets underestimates the cultural complexity in women’s health issues. Thirdly, medicalisation presents a continuous challenge: the
public health budget is limited and health information is costly: a shortage of funding within the government is an ongoing real difficulty.

10.5 Conclusion

The points of intersection between the activists and the officials were the goals to empower women by providing balanced and impartial information and to increase women’s awareness of maintaining health, starting from menopause. Immediately following the WHI reports, the government made concessions to the differences between medical professionals and women’s health activists, and took a stance endorsing health information equity for women, and the provision of reliable knowledge-based information to the general public. The limited public health budget means that reallocated healthcare resources will need to provide women with easily accessible health information through a more diverse range of channels.

Taiwanese women need more reliable sources of health information. Medical institutes could be providers of health information services to alleviate doctors’ workloads, and to help improve the comprehensiveness of healthcare. But the quality of the information they offer would have to be monitored vigilantly to safeguard women’s benefits. As the researcher E01 said, more people have to get involved and work for women’s empowerment. Having a neutral party providing impartial health information and monitoring healthcare is necessary. Non-profit organisations should be given serious consideration as a suitable neutral party for monitoring health policy implementation and facilitating the changes in healthcare system essential for answering women’s needs in the context of health help-seeking.
Chapter 11

Discussion, Recommendations and Conclusion

This study has examined and presented the perspectives of the principal stakeholders—women, doctors, officials, health activists and researchers—as part of a comprehensive assessment of the health needs of menopausal women. It has brought together, presented and discussed the still unreconciled positions of the opposing ‘camps’ in the long-time debate over various aspects of HRT use and menopausal health issues. It has also presented and discussed the multi-dimensional factors that it is essential to examine and evaluate to resolve these health issues. Chapters 6 to 10 present the broad and in-depth exploration of Taiwanese menopausal women’s health needs, undertaken using both quantitative and qualitative methods, constituting this assessment, and doing so identified the various gaps between demand and provision and the many various factors involved.

This chapter has three sections. The first section summarises the findings concerning women’s health needs and current healthcare provision, including HRT and other health regimes available, the gaps in current healthcare provision for menopausal women, and their unaddressed needs. This includes a summary of the examination of the allocation of health resources associated with menopausal health and its efficiency. The second section makes recommendations incorporating a health promotion approach—including recommended policy strategies—to promote menopausal women’s health and wellbeing based on the findings of the assessment process undertaken. Directions for further research are indicated. The third section answers the central research question: ‘Does the use of hormone replacement therapy meet women’s health needs during menopause?’ and the focus questions this gave rise to, and then concludes this study.

11.1 Menopausal Health Needs and Current Healthcare Provision

This section summarises menopausal health issues and menopausal women’s needs, based on the quantitative clinic utilisation data presented in Chapters 6 and 7,
and the results of the qualitative interviews presented in chapters 8, 9, and 10. It then summarises the discussions of these result chapters regarding the gaps between the current healthcare provision and each of the women’s health needs which need to be addressed. The findings of the women’s health needs assessment are presented in Table 11.1, broadly grouped into five general areas: (1) the first category, Effective solutions, addresses health treatment and advice seeking during menopause; (2) Natural regimes addresses the supply and demand; (3) Ageing QOL issues addresses the prevention of chronic disease; (4) the Information related findings address the availability of and access to appropriate health information; and (5) the Social support area addresses this essential aspect of health promotion. There is naturally a great deal of overlap, for example all the areas affect QOL, and a particular finding could be listed in more than the one area where it is. The issue of safety aspects of health regimes is one that arises across all areas.

These findings show that each identified health need was either for the most part similarly perceived by the different stakeholders with their different perspectives, for example the findings 1 and 2 in Table 11.1; or that their views reflect a current divide between a particular need and ways being available to address it, for example findings 4 and 5. This confirms Dunn’s finding, cited in Chapter 4, that an analysis of the different needs by different interest groups will be reflected in obviously different responses to the same information (1994).

11.1.1 Seeking Effective Solutions

Menopausal women consulted doctors, particularly gynaecologists, to identify whether their menstrual changes were normal. There was frequent utilisation of clinics offering a wide range of areas of specialisation (the demand)—a result of women experiencing menopause and health-related uncertainty, sex-related difficulties and degeneration-related symptoms in many parts of their body—was reflected in women’s reported felt needs. This finding corroborates the National Health Survey (Lin 林宇旋 et al., 2004) and Tsao (2002). It is also consistent with doctors’ associating this utilisation pattern with women’s ageing: “There are many specialists a woman might consult when she’s passed middle-age … (D08).” Career women, in particular, want a quick and effective way to relieve the distresses of
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<td>Women want effective ways to quickly relieve menopausal distress and to juggle the competing priorities in their lives</td>
<td>NHI healthcare: diagnosis and symptom treatment services are most frequently provided by gynaecologists, GPs, and TCM doctors</td>
<td>Lack of alternatives offered: doctors rely mainly on prescribing HRT or medication; few employ or give advice about other health regimes</td>
<td>Ensure well-informed HRT use; systematically appraise and provide evidence-based health regimes and information, including alternatives to HRT</td>
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<td>Frequent utilisation of clinic services of GPs, gynaecologists, doctors in many other areas of specialisation, and TCM doctors implies women’s demands for relief of discomforts, exclusion of pathology, and health information</td>
<td>Highly accessible NHI healthcare services: diagnosis of menstrual changes, treatment of menopausal symptoms, insomnia, incontinence, and discomfort in different parts of the body</td>
<td>Hasty medical consultations: medication-driven care; doctors generally lack the time and a commitment to personally undertake women’s menopausal health education</td>
<td>Train nurses and/or volunteers at medical facilities to provide patients with educational information</td>
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<td>Women want help coping with sex issues: particularly vaginal dryness, lack of sex drive, and effects on a couple’s relationship</td>
<td>NHI healthcare: most medical help is sought from and provided by gynaecologists or GPs</td>
<td>Focus on treating physical symptoms by prescribing HRT, lack of advice or counselling about managing couple relationships</td>
<td>Establish and support women’s support groups; provide information for couples in sensitive, culturally appropriate ways</td>
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<td>Gynaecologists remained comparatively positive and enthusiastic about both HRT and its effectiveness for managing menopausal distress</td>
<td>NHI healthcare: reimburses use of HRT for treating menopausal syndrome</td>
<td>Overlooked: Women’s voices about 1. preferring natural health regimes, and 2. drug safety, particularly for faithful HRT users</td>
<td>Monitor the safety of HRT use, particularly long-term Provide impartial balanced information to both women and doctors, nurses, and other healthcare personnel</td>
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Table 11.1 Findings of Assessment of Health Needs of Menopausal Women (continued)

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<td><strong>Natural Regimes</strong></td>
<td>Women want natural health regimes to manage physical changes during menopause instead of making a perceived trade-off between HRT and their health</td>
<td>NHI, personal social networks, the mass media, firsthand trial-and-error experience</td>
<td>Doctors were inconclusive about the effectiveness of alternative care, e.g. CAM; there are few evidence-based alternative means of addressing women’s needs</td>
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<td>Changes in the patterns of visits made to gynaecologists and TCM doctors from mid-2002 to 2004, after the WHI report, imply women preferred an alternative to consulting a gynaecologist about relieving menopausal symptoms</td>
<td>NHI healthcare: no barriers within the system to seeking help from many quarters, nor to seeking a second opinion</td>
<td>Fragmented and compartmentalised healthcare provided by different specialists can easily result in repeat prescriptions, and/or dangerous medication interactions. Lack of individualised HRT prescription; unresolved drug safety issues</td>
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<td><strong>Aging QOL Issues</strong></td>
<td>Women realise they need to transfer their focus to taking care of themselves, rather than focus on taking care of others, and enjoy quality of life during menopause and the ageing process</td>
<td>NHI healthcare for diagnosis and treatment of degeneration-related problems: general aches and pains, susceptibility to illness. Out-of-pocket expenses on body image related issues, and on health foods and supplements</td>
<td>Biomedical model treats patients as a body-machine with damaged parts; women lack holistic preventive health options: health screenings, health screening records for follow-up self-care, healthy life-styles</td>
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<td>Prevention of chronic disease is a key health issue for mid-life women: metabolic syndrome, diabetes, heart disease, osteoporosis</td>
<td>Doctors address this concern by advocating health screening, medication-driven treatment, and/or nutrient supplements: essentially a medicalised approach</td>
<td>The medicalising of ageing health overlooks women’s demand for natural, sustainable, and individualised health regimes</td>
<td>Reorient the healthcare system: implement needs assessment and translate epidemiological findings into planning and delivery of holistic ageing healthcare services</td>
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<td>Information</td>
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<td>Women need easily accessible unbiased information about how to maintain their health during both menopause and ageing</td>
<td>Materials developed by BHP and official websites provide health information sporadically</td>
<td>Lack of budget funding to deliver health education information broadly, systematically, and continuously</td>
<td>Involve the private sector in contributing toward non-profit provision of health information</td>
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<td>HRT is prescribed more conservatively in the most advanced medical facilities and mostly highly urbanised locations where the most up-to-date information is available to both doctors and women</td>
<td>The NHI healthcare system has a free-market management orientation: based on people having free choice (between healthcare providers), and a freely competitive market</td>
<td>Inherent inequity between urban and rural settings: this affects distribution of health resources, and services available including range of expertise, and access to up-to-date information</td>
<td>Market regulation and monitoring; provide sufficient information for women to know their legal rights as consumers and as patients and to make decisions and choices</td>
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<td>Social support</td>
<td>Women and healthcare providers all need to realise that experience varies, and no single strategy will adequately address the menopause-related needs of all women</td>
<td>Experiential knowledge shaped by NHI and private healthcare services, peer experience, and women’s own firsthand trial-and-error experience</td>
<td>Collect women’s experiential knowledge and translate it into public health services to support the needs of various groups of women</td>
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<td>Women rely more on various forms of emotion regulation through the menopausal transition rather than on changing the situation creating the stress</td>
<td>Relatively little from the public sector or community; women primarily depend on themselves and their personal social networks</td>
<td>An inclination to blame the victim, and to silence women about their predicament during menopause and the midlife transition</td>
<td>Establish and support women’s support groups; create a supportive social atmosphere; undertake and promote supportive public discussion and dialogue in the media, including online social media</td>
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<td>Menopausal women need a supportive social atmosphere</td>
<td>Easily accessible NHI healthcare; Women’s groups; community activities</td>
<td>Patriarchal medical interaction; inadequate number of women’s groups and range of community activities; stigmatisation of menopausal women</td>
<td>Support and empower women’s groups to increase gender awareness; strengthen community action to support women living alone: single, divorced, or widowed, and women experiencing the empty-nest period</td>
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menopause to better juggle their multiple daily competing priorities. Their needs may be fulfilled through adherence to the use of HRT advocated by many gynaecologists because of the lack of more effective alternative means of relief. Nevertheless, my analysis of the database details of NHI-reimbursed clinic visits reveals that merely 5% of women adhered to HRT for three and more courses in 2004, and the related expenses on and by the resistant users represent an inefficient allocation of health resources.

The greatest part of the expression of women’s needs in the form of seeking medical help to alleviate physical distress or obtain health information was undertaken in the NHI healthcare system. In the five study years, an average of approximately 25 NHI-subsidised clinical visits a year were made by more than 90% of the women. It is difficult, however, to adequately and fully answer women’s needs in the inevitably short hasty medical consultations in Taiwan. The ‘biomedical model treats patients as a body-machine with damaged parts’ and overlooks individualised prescription, and hasty consultations provide medication-driven care. Women’s frequent utilisation of medical services implies ‘doctor-shopping’ because of unmet needs, i.e. there is a gap between women’s demand and what doctors are providing.

11.1.2 Natural Regimes Preferred

Many women are against taking HRT because of the associated risk and prefer to find a suitable effective natural health regime. Women sought treatment and/or advice from doctors to relieve discomforts and exclude pathology, but they also wanted to obtain information about alternatives to medication. Women tended to emphasise that menopause is something natural, but they did highlight the need for safety in all remedies they used to sustain their health. Some women thought that menopause meant a decline in the functioning of their metabolic cycle that was involved in body purification and removal of toxins and that toxins are an inevitable side-effect of medications; they are reluctant to use medications during menopause. Women want natural regimes, for example natural hormones, and safe remedies. This has been confirmed by the investigation at a clinical setting (Hsiao et al., 2009). Some chose TCM as an alternative to consulting a gynaecologist to relieve their menopausal symptoms, particularly after the WHI report.

Issues of drug safety were raised by women health activists and some doctors. These included: the lack of explanations being provided about the risks and benefits of HRT; lack of
individualised prescription of HRT; and the potential for drug dependency among faithful users of HRT. Unresolved drug safety issues include the fragmented and compartmentalised healthcare provided by different specialists easily resulting in repeat prescriptions, and/or dangerous medication interactions. Doctors were inconclusive about the effectiveness of alternative care; there are few evidence-based complimentary or alternative medicine regimes (CAM) addressing women’s needs. Few doctors saw patient education as their responsibility: this may simply be a realistic practical consideration given the short consultation-time regimes under which doctors work.

11.1.3 Ageing QOL Issues

An unexpected divide was identified between women’s prioritising the need to take particular care of themselves and attain quality of life during menopause, and doctors’ prioritising the need to prevent chronic disease during the menopausal transition. Gynaecologists in particular saw this as a ‘golden time’, and an ideal opportunity for health interventions such as delaying the ageing process, and preventing bone density loss and/or heart disease. This is similar to the positive attitude of using HRT in North America during the late ‘80s and ‘90s (Draper & Roland, 1990; Torgerson & Bell-SyerHormone, 2001). Taiwanese women do not regard menopause as a disease but they do recognise it as the time of a woman’s life to change the focus from caring for others to ‘caring for herself’ when the body is entering a stage of ongoing degeneration. Their coping strategies—such as using nutrient supplements, dietary adjustment, doing exercise, and seeking reliable information—did not address relieving specific menopausal discomforts but focused on delaying and minimising general physical degeneration and general health maintenance. Few women reported being concerned about cardiovascular disease, osteoporosis, or other chronic illnesses, but they were worried about the risk of breast cancer resulting from HRT use.

Women’s perceptions and practices differed from doctors’ views regarding menopausal health. Doctors are rightly concerned about the various chronic diseases triggered by menopause. Women’s health activists and researchers also advocate chronic disease preventive measures for mid-life women. They pointed out that menopause is a key time to equip women with information to help prevent or tackle chronic disease, and they supported promotion of the basic, regular government-provided health checks as part of women’s self-care regimen. Doctors, however, generally were not concerned about menopausal syndromes which will ease with the passing of time and employed few means to address women’s
immediate menopausal health needs; they mainly prescribed medication. Some did report being challenged by the difficulty and effort involved when they struggled to persuade patients to eat smarter and do exercise for weight control, means of helping patients which reflect a health promotion approach.

11.1.4 Accessing Impartial Information

The need for unbiased information on how to maintain menopausal and ageing health reverberated in the trends seen in changes in the varying HRT prescription rates in different settings. HRT was prescribed more conservatively in academic medical centres and metropolitan locations than in other medical facilities and other categories of location. As discussed, this is most likely due to a combination of factors: an interaction between better quality healthcare being provided in the medical facilities with the highest accreditation level and access to state-of-the-art information, and more up-to-date information being available to and adopted by the women living in the most urbanised locations.

Women’s experience of shuttling around seeing different doctors and sharing experiences and ideas with their peers reveals their desire and need for information about natural treatments, and for sustainable individualised health regimes. The doctor-shopping women are discouraged by doctors’ lacking adequate information about the popular health foods and natural alternative treatments used, and about their possible interactions with other more conventional medications.

Separately, the NHI healthcare system imposes a free-market ideology on medical services, and an inevitable effect of this is the ongoing commodification of healthcare. Obtaining good quality healthcare therefore essentially becomes reliant on consumers’ making smart (or lucky) choices – from the range available that they are aware of. These choices depend heavily on their health literacy. Both health activists and government officials stressed the need to increase women’s health literacy. Doctors saw the public health sector and government as being responsible for meeting women’s currently inadequately met needs for menopausal health information and education. Patients cannot expect and, more seriously, cannot rely on doctors to provide “well-balanced impartial information” when most of the information in medical settings is provided by the pharmaceutical industry. At the same time, medical professionals serve as opinion leaders and gatekeepers for the diffusion of medical
reports about healthcare technology, which itself is mostly underpinned by commercial intention (Li Chieh, 2001; Chuan Chia-Li, 2005).

Given the current ‘free market’ approach, healthcare provision policy must also encompass proper protection of consumer rights. It is compulsory for Taiwanese citizens to pay a healthcare premium and also copayments for the NHI healthcare services they receive: they have the right to be properly informed about the ‘products’ they are considering using or trying to wisely select between, and for such information to be readily available. All the more so as healthcare products affect people’s own body and health and the correct choice can be a matter of life and death. The needs and expectations of women who see a doctor to ascertain their health status or obtain advice about treatment alternatives should be addressed, and all patients’ safety must be protected. The NHI must do whatever it can to ensure that doctors and users alike are provided with impartial and balanced information for making treatment choices. As broadcasted “it pays to be an informed consumer” (ABC Radio National 2005), this is also the core of feminist ethics (Murtagh & Hepworth, 2003a). Very challengingly, the public sector provides health information on a not-for-profit basis but it has to effectively compete for access to media and other communication channels.

11.1.5 Social Support

Women in Taiwan primarily depend on themselves and their personal social networks for support: they receive relatively little support from the public sector or their community. This confirms the findings of Lee and Wang (2000). Most women rely on various forms of emotion regulation throughout the menopausal transition rather than changing the situation creating the stress to thereby alleviate it: for example, by setting themselves a full daily schedule, developing hobbies, seeking social support, and re-orienting their thoughts. Women’s inherent reserve, shyness, and reticence about airing some matters was amply noticeable in the responses of the women I interviewed for this study. I observed that they did not find it easy to speak directly, precisely, and unambiguously clearly about their own health needs, but they were willing to articulate and share their menopausal experience including their worries, their misgivings and doubts, what they did in response, and their hopes.

This study conducted in-depth interviews in which women elaborated their experiences; the transcripts of recordings of what they had said were then analysed to comb out their needs. I heard surprisingly courageous voices, yet very few women had any suggestions about how
to source help. Women were aware of the stressors resulting from the extremely individual and differing experiences of menopausal changes to their body, emotions, state of mind and psyche; they were also aware of the family and/or workplace stressors which limited their actions. Middle-aged women want support from family members, mutual assistance within their community, and a positive perception of menopause—in other words a supportive social atmosphere for menopausal women.

The cultural stereotypes of menopausal women—as someone hard to get along with or prone to ‘flying off the handle’—tend to ‘blame the victim’, and which emphasise that women should take charge of their own emotional regulation, act to silence women about their predicament experiencing negative aspects of menopause and turmoil associated with the midlife transition. Only two of the doctors I interviewed commented on there being a need to create a supportive environment in clinical settings: having ideal doctor-patient relationships which include open-mindedly listening to women about their problems is a critical need, but one that has so far been overlooked in the healthcare system.

11.2 Recommendations for Improving Menopausal Health Policy

The key findings of this study regarding menopausal women’s health needs, presented above in Table 11.1, indicate that the health sector must work in collaboration with other sectors to raise awareness of healthy ageing and women-centred policies that promote health.

There are major obstacles to effective management of women’s ageing healthcare in general and menopausal health in particular, in particular the long history of opposition between approaches underpinned by the feminist model and doctors’ biomedical model. This study recommends a range of comprehensive strategies to close the gaps between the provision of healthcare and women’s menopausal health needs in Taiwan, set out below. These are based on the Ottawa Charter action concepts outlined in Chapter 4.

11.2.1 Recommendations Empowering Women

Empowering women to make choices and decisions is an essential element of women’s health promotion. As the WHO 7th Global Conference on Health Promotion, empowerment points out, empowerment ‘is a process of re-negotiating power in order to gain more control’ (WHO 2009). It is essential that any recommendations, and measures and policies put in place are designed to incorporate ways to reach all women in Taiwan, not just those living in
highly urbanised areas, and must include women in aboriginal community settings in culturally appropriate ways. According to Chu’s definition (2005), recommendations to help this are set out below, grouped under Information, Networking, Resources, and Decision-making subheadings.

**Information**

- Provide impartial balanced information promoting menopausal health to both women and doctors, on matters such as: HRT use; evidence-based health regimes, including complementary and alternative therapies; couple relationship issues in sensitive, culturally appropriate ways; and how to make health-related decisions and choices.
- Provide clear easily understood information to women about their legal rights as consumers and as patients. Such information should be clearly displayed in medical facilities.
- Link menopausal and ageing health by enhancing women’s awareness of the degeneration accompanying and following menopause.
- Improve access to information by means of channels women prefer, such as the mass media, chemists and cosmetic outlets; and other places where women frequently interact socially: school volunteer associations such as the “Loving mothers”, and social functions involving inter-personal communication.
- Equip those working in the public health sector with the information and appropriate state-of-the-art skill-sets to facilitate women obtaining impartial information. This must include appropriate ways to reach women not living in highly urbanised areas and women in aboriginal community settings.
- Integrate official health websites to provide a user-friendly ‘one-stop’ entry-point for the general public to search for official health information and services.

**Networking**

- Organise volunteer workers and build the capacity of women’s support groups in the community and workplaces to support women experiencing psycho-social distress. This is commonly associated with menopausal transition, empty-nest stress, and stresses arising from being single, divorced, or widowed.
• Establish an internet-based information exchange mechanism to collect and translate women’s experiential knowledge into material for public services to use to support various groups of women prepare for their mid-life transition.

**Resources**

• Develop fund-raising activities involving the private sector in contributing resources toward not-for-profit provision of health information and services.
• Promote women’s having regular health-checks by widely publicising such services, especially free ones, for example when they consult clinics or other healthcare providers for menopause-related help.
• Enhance women’s awareness of the useful helpful effects of regular exercise and widely publicise facilities available, especially free ones.
• Create user-friendly environments for exercise: for example, provide fitness time or facilities in workplaces to improve career women’s health and well-being.

**Decision-making**

• Establish more women's support groups in the community and build their capacity to use their social influence and networks to increase gender awareness and sensitivity. Possible avenues are public discussion, and airing the voices of women and such groups through the media.
• Approach women’s groups to canvass women’s opinions and input into policy-making and administrative decisions.
• Increase women’s health literacy to ensure well-informed HRT use and increase medication safety, and to enable women to be discerning about the reliability of information, and have a better understanding of the real price and of the hidden interests behind the provision of information.

**11.2.2 Menopausal Health Policy Recommendations**

The recommendations set out below primarily focus on building healthy public policy and re-orienting health services to improve healthcare services for middle aged women.
**Improve Communications between Services Providers and Women**

- Undertake an assessment to comprehensively articulate women’s demands for natural regimes and safe remedies.
- Design and deliver holistic ageing healthcare services on the basis of epidemiological findings and help guarantee their cost-effectiveness by undertaking regular needs assessment to ensure women’s needs are being met.
- Enhance satisfactory communication during clinic encounters to improve the efficacy of both medication use, for example HRT, and healthcare delivery for middle-aged women. This must be included in medical training programs: optimising communication effectiveness has implications for patients’ health and therefore for the national public health budget.
- Train nurses and/or volunteers at medical facilities to provide patients with educational information. This will help prevent problems which can arise because essential details were not fully conveyed or not fully taken in during hasty medical consultations.
- Involve representatives of women’s groups in the policy decision-making processes affecting health.
- Involve women and representatives of women’s groups in formulating action taken the ‘medical market’ to mitigate negative consequences of commercialisation, monitoring the quality of medical services.
- Involve representatives of women’s groups in working with government healthcare policy groups to remove the stigma associated with menopause. This topic, and the wider topic of stigmatisation of people experiencing various health-related situations, should be included in medical training programs because it has implications for mental health and therefore the public health budget.
- Provide information services through bodies similar to Women’s Health Queensland.

**Improve Healthcare Services Efficiency**

- Reform the NHI payment system, building in incentives to encourage integrated healthcare and health consultancy-driven services.
- Examine methods of decreasing public expenditure on medication. Cost benefit analysis of the economic efficiency of alternatives—over a range of various time-spans—should be undertaken as part of the government’s duty: it is its responsibility to make the best
use of public resources and to therefore avoid identify and then avoid inefficient spending.

- Put in place electronic alerts in the NHI computer system, triggered, for example: 1. if a patient is getting the same medication prescribed by different doctors; 2. if a patient is prescribed two medications within a short period of time which are counter-indicated; 3. if a patient is prescribed a medication counter-indicated by a diagnosis recorded in their NHI database record.

- Train and equip auxiliary medical personnel, such as nurses and nutritionists, to provide patients with educational information. This could be made a requirement for accreditation or reaccreditation of medical facilities, or for access to certain privileges.

- Establish and maintain easily accessible mechanisms to inform doctors about the latest scientific evidence on health regimes, medical treatments, and medications, and also the quality of such evidence. At the same time, strengthen the cultivation of evidence-based practice in all medical training and education courses, and give students the ability to judge the quality of evidence regarding health regimes, medical treatments, and medications and a strong awareness of potential conflicts of evidence, and the need to exercise such judgment.

**Directions for Future Research on the Provision of Better Healthcare**

The link between women’s health needs and healthcare provision policy is a fundamental concern which requires much further research. In particular, a national survey of women’s healthcare preferences should be undertaken using a variety of methods.

- Women’s health needs should be regularly included in National Health Interview Surveys and the findings should be made available to inform and help shape the health policy decision-making process.

- Clinical investigation should be undertaken of reliance on HRT

- Given the WHI evidence of the effectiveness of the short-term use of HRT to alleviate vasomotor symptoms, clinical investigation should be undertaken of dosage modulation for subsequently discontinuing its use.

- Systematically appraise and provide evidence-based health regimes and information, including alternatives to HRT
- Research and set in place mechanisms to scrutinise the safety of health regimes and their interactions with other medications, for example potential interactions between Western and traditional Chinese medicines provided by the NHI to relieve menopause-related complaints. Their findings should be readily available to doctors and the general public.
- Examine the impact on menopausal women of the social stigma associated with menopause and develop viable strategies to support women and help them to overcome their multiple life stressors during their menopausal transition.

11.3 Conclusion

This study has examined menopausal women’s health needs and HRT use patterns in Taiwan. It has examined the gaps between current healthcare provision and the identified health needs of middle-aged women. In the light of this, it has presented a set of recommended strategies which address the empowering of women and health policy planning to promote women’s menopausal health and well-being in Taiwan.

The initial fundamental concern of this study was expressed as a single question: ‘Does the use of HRT meet the health needs of menopausal women in Taiwan?’ Clearly the answer is “no”: at best HRT meets some of the needs of some Taiwanese menopausal women. The associated aims of this study were to:

1. examine the utilisation pattern of HRT and healthcare provision in Taiwan;
2. investigate the health needs of menopausal women in Taiwan from different perspectives;
3. identify unmet needs and gaps in healthcare provision and policy; and then
4. recommend strategies for promoting menopausal health in Taiwan.

Section 1 presented the background and the nature of this study. It reviewed the controversy surrounding the use of HRT and menopausal health in Western industrialised countries and in Taiwan. It outlined the knowledge gaps and then the health promotion framework adopted to address menopausal women’s health issues in Taiwan.

The literature review established that menopause is socially constructed. It is determined by multiple factors: age, race, sex hormone fluctuations, ageing, health status, lifestyle, personal and family health history, life events, economic stress, social expectations, and social support, and there are enormous differences in the individual experience of menopause,
both among women in the same culture and between those in different cultures. The health issues considered fundamental to women’s menopause by medical doctors, health researchers, and women’s health activists vary, depending on which conceptual model—biomedical, socio-cultural, or feminist—underpin their discourses.

When examining the debate surrounding menopausal health issues, a core factor that becomes evident is that women’s ageing process has been, and continues to be, medicalised and commercialised by promoting the use of HRT for example: the increasing number of post-menopausal women and their extended life expectancy represent a ready market fuelling commercialisation. In Taiwan easy access to the healthcare system and a high rate of healthcare utilisation has facilitated the medicalisation of both menopause and of women’s ageing. But given the increasingly growing ageing population and their demands for higher QOL, the patterns of the continually increasing expenditures and consumption of Taiwan’s health resources are simply not sustainable, and people’s health and welfare will be affected.

The results of the WHI studies had a worldwide impact, including in Taiwan. Many women and doctors were reluctant to accept the ‘lost promise’ of HRT. The conflicting interests of women, doctors, and drug companies have played a significant role in continuing to fuel this controversy, although since the WHI reports, women have been increasingly encouraged to participate in making decisions about HRT use, and to manage their own health.

Menopausal women have specific health needs but the ‘camps’ holding contending views have reached no resolution over the central question: how should menopausal women’s health needs be met? The result has been a lack of strategic and sustainable approaches to women’s health policy, and the associated need for mainstreaming of gender sensitivity also still remains unresolved. Moreover, the health problems associated with the menopausal transition imply costs for society, in terms of both associated quality of life losses, and costs arising within and outside the healthcare system.

For these reasons, the needs of menopausal women must be factored into health service planning and delivery mechanisms. A fundamental concept is that a comprehensive needs assessment is essential to address the complexity of menopause, to then factor these needs into such mechanisms. Only a multidisciplinary approach can construct comprehensive
evidence-based health policy able to meet the multidimensional biomedical, psychological and socio-culturally significant requirements of menopausal women.

Section 2 of this study reported the primary findings of the assessment of the first three of the four categories of social need articulated by Bradshaw (1972): expressed, felt, normative and comparative. The comparative points of view of women’s health-related needs are discussed in the literature review in the preceding chapters; this section reported the quantitative and qualitative investigation undertaken of the other three categories of health needs. (See Table 11.2)

First: a secondary data analysis was conducted to identify the utilisation of HRT and healthcare services reflecting women’s expressed needs. Each month a consistent proportion of the middle-aged insured women, more than 60%, sought NHI-subsidised medical services and/or advice, indicating that these women had significant health needs. At the same time, the findings that they visited doctors frequently and that they frequently consulted specialists in different fields indicate that these women also had unmet health needs.

The overall utilisation of NHI-reimbursed clinic visits showed that by 2004 a mere 5% of women adhered to three or more courses of HRT. The consistent proportion of ambivalent users over the study period also indicates unmet needs among women who after being prescribed and taking HRT discontinued its use, whether due to the WHI reports or for other unidentified reasons. The rising percentage of TCM consultations and the concurrent fall in the percentage of gynaecology consultations implies a resistance to the use of HRT.

The cost analysis presented in Chapter 7 shows national HRT medication costs experienced a significant decrease after the WHI trials, a decrease which continued until 2008. The NHI expenditure on HRT medication in 2004 for the women prescribed HRT without achieving desirable outcomes was three times the BHP budget for menopausal health programmes in the same year and more than eight times the budgeted figure in more recent years. This is inefficient allocation of valuable limited health resources. This essentially wasted expenditure was, in part at least, a result of Taiwanese doctors’ prescribing menopausal women HRT without an adequate understanding of their healthcare needs or preferences. It is only possible to deliver more efficient and effective NHI healthcare services if services genuinely and appropriately listen to women’s own voices.
## Table 11.2
### Women’s Health Needs Identified & Investigated Quantitatively and Qualitatively

<table>
<thead>
<tr>
<th>Finding</th>
<th>Expessed</th>
<th>Felt</th>
<th>Normative</th>
<th>Comparative</th>
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</thead>
<tbody>
<tr>
<td><strong>Effective solutions</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Women want effective ways to quickly relieve menopausal distress and to juggle the competing priorities in their lives</td>
<td>(Doctor shopping)</td>
<td>√ Career women</td>
<td>√ Gynaecologists advocated HRT</td>
<td>√ Advocating HRT</td>
</tr>
<tr>
<td>Frequent utilisation of clinic services of GPs, gynaecologists, doctors in many other areas of specialisation, and TCM doctors implies women’s demands for relief of discomforts, exclusion of pathology, and health information</td>
<td>√</td>
<td>√ Because of Discomforts</td>
<td>√ Because of Degeneration</td>
<td></td>
</tr>
<tr>
<td>Women want help coping with sex issues: particularly vaginal dryness, lack of sex drive, and effects on a couple’s relationship</td>
<td>√</td>
<td>√ couple’s relationship</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Gynaecologists remained comparatively positive and enthusiastic about both HRT and its effectiveness for managing menopausal distress</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td><strong>Natural regimes</strong></td>
<td></td>
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<tr>
<td>Women want natural health regimes to manage physical changes during menopause instead of making a perceived trade-off between HRT and their health</td>
<td>(Doctor shopping)</td>
<td>√ Using nutrient supplements</td>
<td>√ Safety of using nutrient supplements</td>
<td>√ CAM</td>
</tr>
<tr>
<td>Changes in the patterns of visits made to gynaecologists and TCM doctors from mid-2002 to 2004, after the WHI report, imply women preferred an alternative to consulting a gynaecologist about relieving menopausal symptoms</td>
<td>√</td>
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</tbody>
</table>
Table 11.2 Women’s Health Needs Identified & Investigated using Quantitatively and Qualitatively (continued)

<table>
<thead>
<tr>
<th>Finding</th>
<th>Expressed</th>
<th>Felt</th>
<th>Normative</th>
<th>Comparative</th>
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</thead>
<tbody>
<tr>
<td><strong>Ageing QOL issues</strong></td>
<td></td>
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<tr>
<td>Women realise they need to transfer their focus to taking care of themselves, rather than focus on taking care of others, and enjoy quality of life during menopause and the ageing process</td>
<td>√</td>
<td>Because of Degeneration</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Prevention of chronic disease is a key health issue for mid-life women: metabolic syndrome, diabetes, heart disease, osteoporosis</td>
<td>(Bone density screening)</td>
<td>(Bone density screening)</td>
<td></td>
<td></td>
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<tr>
<td><strong>Information</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Women need easily accessible unbiased information about how to maintain their health during both menopause and ageing</td>
<td>√</td>
<td>Health literacy</td>
<td>√</td>
<td>Controversial</td>
</tr>
<tr>
<td>HRT is prescribed more conservatively in the most advanced medical facilities and mostly highly urbanised locations where the most up-to-date information is available to both doctors and women</td>
<td>√</td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td><strong>Social support</strong></td>
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<td></td>
</tr>
<tr>
<td>Women and healthcare providers all need to realise that experience varies, and no single strategy will adequately address the menopause-related needs of all women</td>
<td>(Doctor shopping)</td>
<td>(Doctor shopping)</td>
<td>√</td>
<td>Individualising HRT</td>
</tr>
<tr>
<td>Women rely more on various forms of emotion regulation through the menopausal transition rather than on changing the situation creating the stress</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Menopausal women need a supportive social atmosphere</td>
<td>√</td>
<td>Social stigma</td>
<td>√</td>
<td>Medical consultations</td>
</tr>
</tbody>
</table>
Secondly: menopausal women’s *felt needs* are presented in Chapter 8 which articulates women’s voices and their experiences. These Taiwanese women viewed menopause positively, as a natural transition stage. Their menstrual changes caused some menopausal women to worry and they had consulted doctors, particularly gynaecologists, to identify whether the changes they were experiencing were normal. Consulting doctors across several specialisations was a common practice. Women commented that menopause was a time when they accepted the reality of ‘getting old’, and a time to make health their priority and attain quality of life. Their observations and reporting of their personal experiences of menopause allowed them to acknowledge individual differences and they concluded that these are a function of a woman’s ‘personal physical constitution’ and ‘individual circumstances’.

The women interviewees indicated that the use of HRT was usually commenced as a result of consulting doctors, gynaecologists in particular, or after a hysterectomy. The perceived benefits of HRT reported were: easing menopausal symptoms; delaying age-related degeneration; retaining quality of life by improving the quality of couples’ relationships and the effects on skin beauty; and for working women, maintaining energy and vitality in the workplace. Most users considered that HRT was effective in relieving menstrual symptoms but did not mention it as offering long-term preventive benefits. The main reasons that women discontinued HRT or used it sporadically were its side-effect of bleeding and their fears of breast cancer.

Many women looked for alternatives to using HRT to cope with menopausal distress. Some chose exercise, regarding this as a natural way to boost their metabolic cycle which in turn would assist purifying their body. Some chose natural foods and therapies, considering them to be better than prescription medications. Women also tried many measures to manage their thoughts and emotions and distract themselves from menopausal and midlife distresses. The enjoyable experience of chatting and companionship in a women’s group was significantly meaningful. Women met their needs for information to make decisions or undertake self-care mostly by: simple hearsay “I heard someone say that … ”; consulting one or more doctors; and relying on their personal firsthand experience. The conflict between women’s family and workplace roles, and the stigma of menopause in society are uncontrollable stressors that women had to cope with during this transition period.

Thirdly: the opinions of doctors, officials, health activists and researchers, presented in Chapters 9 and 10, deliver their *normative* appraisal of women’s health and health needs. In
During the interviews, doctors working in different specialisations expressed different attitudes toward menopause, but their comments about midlife women’s health issues were very similar: women lack accurate knowledge about menopausal changes, feel confronted by the threat of osteoporosis, worry about body-image, manage the predicaments of discomfort during sex and ‘empty-nest’ stress, and many considered that women over-consume nutrient supplements. Accordingly, they indicated that women need to know how to cope with menstrual changes and sex life, and reliable easily-accessible information about the use of hormones and health foods. These doctors did not, however, see delivering health education as doctors’ responsibility. Medication was the principal treatment offered during consultations and the doctors made little reference to other health regimes that could also alleviate menopausal distress.

The findings show that after the WHI reports, most doctors prescribed HRT more conservatively and followed the guidelines more strictly, prescribing it mainly for severe symptoms, topical treatment, and short-term usage. Two of the female doctors were concerned about drug dependence resulting from HRT use and associated problems discontinuing it. Furthermore, doctors reported having observed the impact of the WHI reports on the healthcare market: women’s use of HRT had generally become more polarised; aspects of the doctor-patient relationship had become alarming; and the demand for gynaecological services had reduced, which had led to a ‘turf-war’ between doctors, effectively ‘competition for market share’.

The final chapter of Part 2 presents the perspectives of health activists and scholars. Their principal concerns were to promote the perception of menopause as being a natural part of women’s lives rather than a disease; to address the concern that doctors have medicalised women’s ageing experience; and then to empower women to make their own informed decision about whether to use HRT. The women’s groups recognised that the WHI report had had a vital impact on changing doctors’ prescribing behaviour, and that they had successfully brought public attention to the WHI report through their mass media campaigns. The activists were worried, however, that menopausal women did not have a better knowledge of HRT and that the vigilance about HRT risks had decreased after the news of the WHI reports faded from the headlines.

For their part, the government officials interviewed confirmed that the 2002 discussion of menopausal health had been led mainly by the representatives of the women’s groups
because their consistently voiced opinions had been supported by the WHI report. Policy directions to meet women’s health needs during middle age were focused on improving women’s health literacy to enable them to utilise healthcare services intelligently; and emphasised a wider women’s ageing health policy, rather than having a more limited menopausal health focus. Nevertheless, issues challenging the implementation of women’s health policy remain. These include: a series of menopausal health programs being implemented are all using the model used to promote adult and elderly health, instead of developing and using a model incorporating gender-sensitivity concepts; insufficient cooperation between different public sector agencies delivering such programs; increasing healthcare commodification caused by the ‘free-market’ ideology and the over-utilisation of healthcare; and inadequate budget allocations for health promotion.

Finally: this study discussed and pointed out that women and doctors have different priorities regarding menopausal health concerns. After the WHI reports, women become more aware of the risks of taking medication but their requests for information about alternative health care and preventive health regimes were rarely fulfilled during clinic encounters. Based on all the research findings, this study has made recommendations to empower women; to improve communication between women and health service providers; and to increase the efficiency of health services for middle-aged women. Some of the recommendations would of course actually benefit a great many more people in the general population: for example evidence-based prescription of medications, health foods and alternative regimes are used by people of all ages, female and male alike.

The aim of this study was to analyse Taiwanese women’s menopausal health needs and identify the gaps between those needs and healthcare provision in Taiwan. In doing so it importantly includes an examination of the views of the users, the providers and relevant stakeholders in this area through the lens of HRT use. This study will thereby contribute to the still ongoing debate in the international literature on the use of HRT. Moreover, it provides evidence demonstrating the importance of adopting a needs-based, women-centred, holistic health promotion approach to promoting the health and well-being of menopausal women. In the context of a rapidly greying world with an increasing trend toward medicalising ageing, this study points to a viable more gender sensitive and sustainable model for the future.
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Backett-Milburn, K., Parry, O. et al. (2000). "'I'll worry about that when it comes along': osteoporosis, a meaningful issue for women at mid-life?" Health Education Research 15(2): 153-162.


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Appendix 1
Clinical trials conducted in Taiwan on the effects of HRT in healthy postmenopausal women, 2001-2009 (All studies were prospective)

Abbreviations:
1. HRT Medications: E2: estradiol, CEE: conjugated equine oestrogen, SERMs: Selective estrogen receptor modulators, MPA: medroxyprogesterone acetate, * indicates a drug brand name

<table>
<thead>
<tr>
<th>Study</th>
<th>Objective</th>
<th>HRT Medication(s) Investigated</th>
<th>Study Design &amp; Length</th>
<th>Sample size</th>
<th>Aspects Investigated: Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chen, Lee et al., 2001</td>
<td>Study whether short- and long-term use of HRT have different effects on cardiovascular factors</td>
<td>• oral E2 valerate (2 mg/d) combined with MPA (10 mg)</td>
<td>24 month randomised</td>
<td>21 postmenopausal women enrolled</td>
<td><strong>Short-term effects:</strong> The maximum aggregation and slope of platelet aggregation were significantly reduced only during the first 12 months of HRT <strong>Long-term effects:</strong> favourable effect on lipoprotein metabolism and fibrinolytic activity <strong>During the 24 months:</strong> total cholesterol, low-density lipoprotein cholesterol (LDL-C), and atherogenic indices (total cholesterol-to-high-density lipoprotein cholesterol (HDL-C) and LDL-C-to-HDL-C) were significantly reduced.</td>
</tr>
<tr>
<td>Chen, Lee et al., 2001b</td>
<td>Compare effects of oral and transdermal estrogen-progestin HRT on lipid profile and hemostatic factors</td>
<td>• Oral E2 valerate + cyproterone acetate • transdermal E2</td>
<td>12 month randomised</td>
<td>41: 20 - oral 21 - transdermal</td>
<td><strong>Both groups showed reduced concentrations of:</strong> total cholesterol, low-density lipoprotein cholesterol, tissue plasminogen activator, plasminogen activator inhibitor-1, antithrombin III, and protein S. <strong>Both groups showed increased concentration of:</strong></td>
</tr>
<tr>
<td>Study</td>
<td>Objective</td>
<td>HRT Medication(s) Investigated</td>
<td>Study Design &amp; Length</td>
<td>Sample size</td>
<td>Aspects Investigated: Findings</td>
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<tr>
<td>(CVD risk factors)</td>
<td>+ oral MPA</td>
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<td></td>
<td>protein C after 12 months of treatment. LPD: favourable effects on both groups. Oral HRT had more prominent effect on lipoprotein metabolism; transdermal HRT had stronger effect on triglyceride and coagulation factors. The study noted that it needs to be considered that there was an increased risk of venous thrombotic events in the first year of treatment.</td>
</tr>
<tr>
<td>Yang, Liang et al., 2002</td>
<td>To compare the effects of continuous combined hormone replacement therapy (Kliogest®) and a placebo on climacteric symptoms, bone turnover markers, and serum lipid profiles, and examine the safety of Kliogest®.</td>
<td>• Kliogest*</td>
<td>4 month</td>
<td>56 women with intact uterus, between 6 months and 3 years after a natural menopause</td>
<td>Lipid profile: including total cholesterol, high-density lipoprotein, low-density lipoprotein and triglyceride: LPD: an improvement in lipid profiles. MS: Continuous Kliogest® treatment resulted in significant reduction in menopausal symptoms. BMD: significant reduction in bone resorption marker, deoxypyridinoline observed in the Kliogest® group. Safety: No report of serious adverse events, endometrial hyperplasia or cancer in Kliogest® treated patients</td>
</tr>
<tr>
<td>Pan, Li et al.,</td>
<td>Investigate the effect</td>
<td>• CEE (0.625 mg)</td>
<td>3 month</td>
<td>Initially 40 then 35:</td>
<td>Ovarian stromal flow indices: a significant increase in</td>
</tr>
<tr>
<td>Study</td>
<td>Objective</td>
<td>HRT Medication(s) Investigated</td>
<td>Study Design &amp; Length</td>
<td>Sample size</td>
<td>Aspects Investigated: Findings</td>
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<tr>
<td>2003</td>
<td>of continuous combined HRT on ovarian circulation</td>
<td>+ MPA (5 mg) • no HRT</td>
<td>prospective case-control</td>
<td>15 – HRT group</td>
<td>ovarian stromal flow indices after 3 months of treatment in the HRT group, but not in the controls. Monitoring the ovarian flow changes by 3D power Doppler may be of clinical importance when HRT is given.</td>
</tr>
<tr>
<td>Chang, Chen et al., 2003</td>
<td>To investigate the difference in histopathology and cell cycle kinetics in the menopausal endometrium treated with sequential-combined hormone replacement therapy (HRT) using different types and doses of progestins.</td>
<td>A • CEE (0.625 mg) + MPA (5 mg) B • CEE (0.625 mg) + MPA (10 mg) C • CEE (0.625 mg) + dydrogesterone (20 mg)</td>
<td>12-month randomised double blind case-control</td>
<td>241 postmenopausal women using HRT: A. - 102 B. - 66 C. - 73 52 premenopausal women were also enrolled for the comparative studies group.</td>
<td>Cycle kinetics of the menopausal endometrium: no difference found between the effect of MPA and dydrogesterone used in sequential-combined HRT</td>
</tr>
</tbody>
</table>
| Yang, Wang et al., 2004 | To compare the metabolic effects on lipids and acceptability and safety of, and compliance with, a conjugated oestrogen (0.625 mg) (Premelle*, Premarin*) | • conjugated oestrogen (0.625 mg) (Premelle*, Premarin*) | 6-month randomised                     | 66 generally healthy, female, early post-menopausal | Sexual dysfunction: improved  
LDL-C and total cholesterol levels: Premelle was effective decreasing these  
Menopausal symptoms: some decrease with Premelle, |
<table>
<thead>
<tr>
<th>Study</th>
<th>Objective</th>
<th>HRT Medication(s) Investigated</th>
<th>Study Design &amp; Length</th>
<th>Sample size</th>
<th>Aspects Investigated: Findings</th>
</tr>
</thead>
</table>
|       | continuous administration of conjugated estrogen plus medroxyprogesterone acetate (Premelle) versus a placebo in non-hysterectomised postmenopausal women. | +MPA (2.25 mg) • placebo | double blind placebo | women, aged 45-60 | eg. vasomotor and sexual dysfunction symptoms  
**Bleeding**: no significant bleeding with Premelle  
**Adverse events**: no statistically significant difference |
| Chang, Lien et al., 2004 | To compare the effect of HRT using  
1. estrogen plus dydrogesterone or  
2. estrogen plus medroxyprogesterone acetate (MPA) on risk factors for coronary heart disease in postmenopausal women. |  
• CEE (0.625 mg) + dydrogesterone (10mg)  
• CEE (0.625 mg) + MPA (5mg) | 12-month randomised | 279 post-menopausal woman:  
1. 140  
2. 139 |  
**Liver function, renal function, PT, PPT**: no significant changes  
**LPD**: favourable effects in both groups.  
**CHD risk factors**: dydrogesterone appears superior for modifying CHD risk factors |
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<tr>
<th>Study</th>
<th>Objective</th>
<th>HRT Medication(s) Investigated</th>
<th>Study Design &amp; Length</th>
<th>Sample size</th>
<th>Aspects Investigated: Findings</th>
</tr>
</thead>
</table>
| Ho, Chen et al., 2006         | To investigate the effects of HRT via different administration routes on markers for ASVD and endothelial function in healthy postmenopausal women. | • Oral CEE (0.625mg) • gel 17β-E2 (0.6mg) • no treatment                                      | 6-month randomised + control group | 66 healthy postmenopausal women: 18 - oral 18 –transdermal 30 – control group | C-reactive protein: rose in oral group only  
Flow-mediated vasodilation (FMD) in brachial artery: significant increases in both oral and transdermal groups  
Endothelial function: positive effects with both oral and transdermal routes  
ASVD risk: data suggests that oral estrogen induces ASVD risk by increasing acute inflammation |
| Tan, Haines et al., 2005      | 1. Compare efficacy of three HRT dosage combinations on vasomotor symptoms  
2. Examine differences in prevalence of VMS among ethnic groups          | 3 different dosage combinations: CEE + MPA  
   • 0.625 mg +2.5 mg  
   • 0.45 mg +1.5 mg  
   • 0.3 mg + 1.5 mg | 6-month randomised, double blind, multi-nation, multi-centre no placebo | 1,028 healthy postmenopausal women of nine ethnic groups from 11 Asian countries/regions | Uterine bleeding: lowest dose associated with the most favourable bleeding pattern  
Prevalence of vasomotor symptoms: differs substantially among ethnic groups and decreased in all three dosage groups |
| Limpaphayom et al., 2006      | 1. Assess the prevalence of (29) menstrual symptoms in 4 domains            | 3 different dosage combinations:  
   6-month (after 2 weeks of baseline)                                        | 1,028 healthy postmenopausal women of nine ethnic groups from 11 Asian countries/regions | Menstrual Symptoms as QOL:  
   Taiwanese (and Malay, and Thai) women were least afflicted according to baseline scores. In the overall population, intervention resulted in statistically |
<table>
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<tr>
<th>Study</th>
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<th>HRT Medication(s) Investigated</th>
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<th>Sample size</th>
<th>Aspects Investigated: Findings</th>
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</thead>
</table>
| (PAM study) | (vasomotor, psychosocial, physical, sexual) as markers of QOL in nine ethnic groups of Asian women. 2. To evaluate changes in quality of life (MENQOL scores) in Asian women following hormone therapy with three conjugated estrogens | **CEE + MPA**  • 0.625 mg +2.5 mg  • 0.45 mg +1.5 mg  • 0.3 mg + 1.5 mg | observation)  randomised, double blind, multi-nation, multi-centre no placebo | 11 Asian countries/regions | Significant decreases in the scores of all four domains within 4 weeks.  
**MENQOL scores**: significantly lowered in the overall population in the course of the study, indicating an improvement in quality of life. In the absence of a placebo group, the relative contribution of hormones and placebo in the intervention is unknown. The prevalence of four domains of menopausal symptoms, representative of QOL was found to vary considerably among ethnic groups of Asian women. |
| Taechakraichana, Holinka et al., 2007 (PAM study) | 1. Compare lipid profiles in different ethnic groups of postmenopausal Asian women. 2. Investigate the effects of estrogen/progestin therapy on lipid/ | 3 different dosage combinations:  **CEE + MPA**  • 0.625 mg +2.5 mg  • 0.45 mg +1.5 mg  • 0.3 mg + 1.5 mg | 6-month randomised, double blind, multi-nation, multi-centre | 1,028 healthy postmenopausal women of nine ethnic groups from 11 Asian countries/regions | **Mean concentrations of total cholesterol, LDL-C, VLDL-C and triglycerides**: differed significantly among the nine ethnic groups of postmenopausal women, independent of BMI and age, two factors that also influence lipid/lipoprotein profiles. The different lipid/lipoprotein profiles evaluated by this study suggest a relationship to differences in the prevalence of cardiovascular disease reported for different regions in Asia.  
LPD: favourable changes for each dosage group. |
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<th>Study</th>
<th>Objective</th>
<th>HRT Medication(s) Investigated</th>
<th>Study Design &amp; Length</th>
<th>Sample size</th>
<th>Aspects Investigated: Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holinka et al. 2008 (PAM study)</td>
<td>lipoprotein profiles.</td>
<td>no placebo</td>
<td>6-month - six 28-day cycles of continuous therapy after baseline evaluations, randomised, double blind, multi-nation, multi-centre no placebo</td>
<td>1,028 healthy postmenopausal women of nine ethnic groups from 11 Asian countries/regions</td>
<td>Lipid/lipoprotein changes in response to estrogen/progestin therapy observed were consistent with those reported for Western women.</td>
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<td></td>
<td>Compare biomarkers of bone turnover and cartilage degradation and their responsiveness to HT among 9 ethnic groups.</td>
<td>3 different dosage combinations:</td>
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<td>Biomarker levels: significantly lowered in all 9 ethnic groups, with a few exceptions for CTX-II in the lowest dose group. The biomarker levels varied widely among the ethnic groups, showing ranges of ααCTX = 0.78-1.14 μg/mmol for Taiwanese vs. Malay women;</td>
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<td></td>
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<td>CEE + MPA</td>
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<td></td>
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<td>• 0.625 mg +2.5 mg</td>
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<td>• 0.45 mg +1.5 mg</td>
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<td>• 0.3 mg + 1.5 mg</td>
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<td>6-month</td>
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<td>1,028 healthy postmenopausal</td>
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<td>women of nine ethnic groups</td>
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<td>from 11 Asian countries/regions</td>
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<tr>
<td>Huang, Fu et</td>
<td>Evaluate whether continuous combined oral estradiol and norethisterone had any</td>
<td>• 17β-E2 (2 mg) + norethisterone</td>
<td>4-month</td>
<td>40 healthy postmenopausal women with no history of hormone</td>
<td>Pulsatility index of the internal carotid and uterine arteries: no significant change in the PI of the internal carotid and the uterine arteries after 4 months of HT.</td>
</tr>
</tbody>
</table>

Note: The PAM studies above were all part of the Pan-Asia Menopause study, a prospective, randomised, double-blind clinical trial evaluating 1028 postmenopausal women at 22 investigational centers in 11 Asian countries/territories to survey the prevalence of menopausal symptoms in nine ethnic groups of Asian women, and to evaluate responsiveness of various symptoms to three estrogen/progestin doses. This study included 62 Taiwanese women.
<table>
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<th>Study</th>
<th>Objective</th>
<th>HRT Medication(s) Investigated</th>
<th>Study Design &amp; Length</th>
<th>Sample size</th>
<th>Aspects Investigated: Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>al., 2009</td>
<td>effect on the pulsatility index (PI) of the internal carotid and uterine arteries in Taiwanese early postmenopausal women.</td>
<td>(1 mg)</td>
<td>randomised + placebo</td>
<td>20</td>
<td><strong>Vascular resistance:</strong> This HT regimen showed no significant negative impact on vascular resistance in Taiwanese early postmenopausal women.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• placebo</td>
<td>group</td>
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</table>
Appendix 2  Clinical trials conducted in Taiwan comparing alternative treatments and HRT in healthy postmenopausal women, 2001-2004

All studies were prospective

<table>
<thead>
<tr>
<th>Study</th>
<th>Objective</th>
<th>HRT Medication/s Investigated</th>
<th>Study Design &amp; Length</th>
<th>Sample size</th>
<th>Aspects Investigated: Findings</th>
</tr>
</thead>
</table>
| Wu, Pan et al., 2001 | To investigate the effects of hormone replacement therapy (HRT) and tibolone on the sexuality and quality of life of postmenopausal Taiwanese women. | • Tibolone (Livial*)  
• CEE + MPA | 3-month randomised  
QOL measures assessed using the Greene Climacteric Scale; attitudes of sexuality were evaluated using the McCoy Sex Scale | 48 postmenopausal women received either HRT or tibolone | QOL: both tibolone and continuous combined HRT have positive effects on QOL  
Withdrawal bleeding: tibolone effectively prevented withdrawal bleeding, which may occur during HRT  
Perceived improvement of sexual performance - including general sexual satisfaction, sexual interest, sexual fantasies, sexual arousal and orgasm, with decreased frequencies of vaginal dryness and painful intercourse: associated with tibolone |
| Tsai, Yen et al., 2001 | Evaluate densitometric and biochemical effects of SERMs (Raloxifene) and HRT (continuous combined estrogen/progestin therapy) in healthy postmenopausal | • Raloxifene 60 mg  
• CEE (0.625 mg)  
+ MPA (5 mg) | 12-month randomised double-masked, active-control | 116 healthy postmenopausal women (age 47-66, mean age 57 years)  
92 - raloxifene  
24 - HRT | BMD at hip sites: both increased with no significant difference between regimens.  
Spinal BMD: increased significantly in both groups  
Osteocalcin levels and urinary type I collagen C-telopeptide/creatinine ratios: decreased significantly in both regimens, but significantly larger decreases with HRT.  
Vaginal bleeding: less vaginal bleeding with raloxifene, only 3 participants (3.3%) reported, compared with 31% (7/22) in |
Taiwanese women.

<p>| Chen and Chow, 2001 | Evaluate the effect of 1alpha-hydroxy vitamin D3 on bone mineral density of the lumbar spine in postmenopausal women receiving HRT and calcium supplement. No patients had received HRT for menopausal syndrome or osteoporosis before being enrolled in the study. | • Alfacalcidol + sequential combined HRT + calcium | 24-month randomised | Initially 240. 197 completed the first 1-year study: 105 – combination 92 – HRT + calcium 176 completed the 2-year trial: 96 - combination 80 – HRT + calcium | BMD in lumbar spine: The combination of alfacalcidole with HRT is superior to HRT alone to preserve BMD in postmenopausal women receiving calcium supplementation |
| Pan, Wang et al., 2002 | Compare the vascular resistance and serum lipids of postmenopausal women assigned to tibolone therapy or continuous combined HRT. | Daily: • CEE (0.625mg) + MPA (5 mg) • Tibolone (Livial*) | 6-month randomised single-blind, single centre study | Initially 50 40: 23 - CEE 17 - tibolone | Pulsatility index and the resistance index of the common carotid artery, internal carotid artery, and middle cerebral artery: no significant differences between the groups in terms of changes within the study period. Total cholesterol level: effectively reduced in both groups, with no significant differences. High-density lipoprotein (HDL) cholesterol levels: significantly lower in the tibolone group at either 3 months or 6 months after treatment. Triglycerides: significantly higher levels observed in the CEE + MPA group after 3 months of treatment. Low-density lipoprotein (LDL) cholesterol levels: no significant differences between the two groups after treatment. |</p>
<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Study Details</th>
<th>Design and Participants</th>
<th>Findings</th>
</tr>
</thead>
</table>
| Chen, Tsao et al., 2003 | Pilot study to evaluate and compare Jia-Wey Shiau-Yau San, a traditional Chinese herbal prescription, and continuous combined HRT on QOL | • JWSYS  
• CEE + MPA (*Premelle)  
4-month randomised controlled  
62 post menopausal women with climacteric symptoms who had not had hysterectomy enrolled, 38 finished: 24/14 | Discontinuation: lower rate with JWSYS  
Adverse effects (bleeding, breast tenderness): better in JWSYS group  
MS: both regimens effectively alleviated symptoms  
Estrogenic effects and metabolic alterations: none with JWSYS  
Study had some statistical concerns |
| Cheng, Shaw et al., 2004 | To determine the effects of soy isoflavones on glucose, insulin, and lipid profiles in postmenopausal Taiwanese women. | • 100mg isoflavone soft capsules + 300 mg calcium + blank vitamin capsule daily  
• 0.625 mg conjugated estrogen + 300 mg calcium + blank isoflavone soft capsules daily (estrogen active control group).  
6-month randomised double-blind active placebo-controlled  
30 postmenopausal Taiwanese women randomly assigned to two groups | Fasting glucose and insulin levels: significantly affected by estrogen and isoflavone treatments after 6 months.  
Average blood genistein concentration: 6-10 times higher in the isoflavone group than in the estrogen group.  
RESULT: Soy isoflavones (100 mg) and 0.625 mg conjugated estrogen equally lower fasting blood glucose and insulin levels in postmenopausal women. |
Appendix 3  Clinical trials conducted in Taiwan on the effects of HRT on specific health problems of postmenopausal women 2000-2006

All studies were prospective

<p>| Study                        | Objective                                                                 | HRT Medication/s Investigated | Study Design &amp; Length | Sample size | Aspects Investigated:                                                                                           | Findings                                                                                                                                                                                                 |
|------------------------------|---------------------------------------------------------------------------|-------------------------------|-----------------------|-------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Wang, Liao et al., 2000      | To examine the effects of estrogen therapy on cognition, mood, and cerebral blood flow in patients with Alzheimer’s disease | • Premarin* (1.25 mg/day)    | 3-month randomised doubleblind placebo controlled         | 50 female patients with AD: 24 - Premarin* 23 – control group   | Cognitive performance, dementia severity, behaviour, mood and cerebral perfusion (CASI, CDR, CIBIC-plus, BEHAVE-AD, HARS, HDRS, and cerebral blood flow): No meaningful differences were found between the outcome measures taken from the estrogen-treated group and those from the control group. |
| Raymund o, Yu-cheng et al., 2004 Asia | Investigate the effects of 2 months of treatment with topical estrogens on atrophic vaginitis and gynecological health in Asian women. | • CEE (0.625 mg) vaginal cream | 2-month multi-centre open-label no placebo                  | 150 post menopausal Asian women less than 70 years old with atrophic vaginitis | Vaginal tissues: beneficial changes                                                                                                            |
| Long, Liu et al.,            | To compare the effects of oral and                                         | • CEE: Oral                  | 3-month               | 57 postmenopausal women with prior                           | Serum level of E2: higher in oral group                                                                                                          |</p>
<table>
<thead>
<tr>
<th>Year</th>
<th>Study Title</th>
<th>Material</th>
<th>Method</th>
<th>Participants</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006a</td>
<td>Vaginal estrogen therapy on the lower urinary tract in postmenopausal women with prior hysterectomy</td>
<td>CEE: vaginal cream</td>
<td>randomised study</td>
<td>hysterectomy: 27 - oral group 30 - topical group</td>
<td>Urinary frequency and nocturia: significantly decreased in both groups. Incontinence: no statistically significant change in stress incontinence or urge incontinence, but subjective improvement of stress incontinence in 72.7% of oral group, 60% of topical group.</td>
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<td>Dosage 0.625 mg for both delivery modes</td>
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<tr>
<td>Long, Liu et al., 2006 b</td>
<td>To compare the effects of oral and vaginal estrogen therapy on vaginal blood flow and sexual function in postmenopausal women with prior hysterectomy</td>
<td>CEE: Oral  CEE: vaginal cream</td>
<td>3-month randomised study</td>
<td>57 postmenopausal women with prior hysterectomy: 27 - oral group 30 - topical group</td>
<td>Number of vaginal vessels and the minimum diastole: significant increases in both groups. Pulsatility index values: marked decreases in both groups. Anorgasmia: decreased significantly in both groups. Low libido, coital frequency: no significant changes. Symptom relief: topical preparations better despite lower serum level of estradiol. Vaginal dryness, dyspareunia: statistically significant improvement of sexual function only in topical preparation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dosage 0.625 mg for both delivery modes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tseng, Sheu et al., 2006</td>
<td>Evaluate the effect on osteoporosis of combining alendronate (Fosamax*) with HRT</td>
<td>Daily doses: alendronate +CEE (0.625 mg) +MPA (5 gm)</td>
<td>36-month randomised study</td>
<td>151 postmenopausal osteoporotic Chinese women living in Taiwan (age range, 47-70; mean age 61 years):</td>
<td>BMD at lumbar spine: significantly higher percentage increases in alendronate group + HRT group. BMD at femoral neck and trochanter: no difference in between the 2 groups. Urine NTx/Cr and serum OC: significantly greater.</td>
</tr>
<tr>
<td>Treatment</td>
<td>Outcome</td>
<td>Notes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>---------</td>
<td>-------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+calcium (500 mg) + CEE (0.625 mg) + MPA (5 gm) +calcium (500 mg)</td>
<td>79 - alendronate 72 - placebo</td>
<td>percentage decrease in alendronate plus HRT group. Serum OC: decreased by 52.2% in the alendronate + HRT group compared with a 1.5% increase in the HRT-only group. Upper gastrointestinal or drug-related side effects: no difference between groups. This study does not indicate whether HRT plus alendronate has any greater effect on BMD than alendronate alone.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4  The National Health Interview Surveys

The National Health Interview Surveys are one of the principal sources of information that enable Taiwan’s public health sector to monitor the health status of the population. Their specific aims are to:

1. understand the current status of various aspects of such factors as physical and mental health, medical care utilisation, primary health care, KAP of health promotion, health risk behaviours.;
2. identify health and health promotion related issues and the demographic cross section of the population with such issues;
3. provide information to planners of health promotion programs; and
4. monitor and assess the effects of action programs on health promotion.*

The first National Health Interview Survey (NHIS) in Taiwan was conducted in 2001 with the joint efforts of the National Health Research Institutes (NHRI) and the Bureau of Health Promotion (BHP). Since then, the survey has been conducted every four years to collect policy related information for priority setting and objective establishment. The surveys were redesigned in 2005, incorporating the design element and strength of the regional representation of the 2001 NHIS and the city/county representation of the 2001 2002 National Survey on Knowledge, Attitude and Practice (KAP) of Health Promotion. In addition to the core questionnaire interviews that focus on health status, behaviors, and medical care utilisation of the population, an additional self-administered questionnaire was included to collect information about illicit drug use for, and with the involvement of, the National Bureau of Controlled Drugs (NBCD).

### Appendix 5 Data Structure

<table>
<thead>
<tr>
<th>No.</th>
<th>Variable</th>
<th>Byte Width</th>
<th>Data Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>fee_ym</td>
<td>6</td>
<td>String</td>
<td>Clinic visit in a specific month</td>
</tr>
<tr>
<td>2</td>
<td>id</td>
<td>10</td>
<td>String</td>
<td>Woman's id (randomly assigned number)</td>
</tr>
<tr>
<td>3</td>
<td>id_birthday</td>
<td>8</td>
<td>String</td>
<td>Woman's date of birth</td>
</tr>
<tr>
<td>4</td>
<td>id_sex</td>
<td>1</td>
<td>String</td>
<td>Gender - Female only</td>
</tr>
<tr>
<td>5</td>
<td>unit_ins_type</td>
<td>3</td>
<td>String</td>
<td>Classification type of the insured woman</td>
</tr>
<tr>
<td>6</td>
<td>area_no_1</td>
<td>4</td>
<td>String</td>
<td>Area where the woman is enrolled in the NHI</td>
</tr>
<tr>
<td>7</td>
<td>self_amt_c</td>
<td>4</td>
<td>Number</td>
<td>Monthly insurance premium</td>
</tr>
<tr>
<td>8</td>
<td>appl_type</td>
<td>1</td>
<td>String</td>
<td>Claim type (1: core submission 2: supplementary report)</td>
</tr>
<tr>
<td>9</td>
<td>hosp_id</td>
<td>10</td>
<td>String</td>
<td>Medical institution code number</td>
</tr>
<tr>
<td>10</td>
<td>appl_date</td>
<td>8</td>
<td>String</td>
<td>Application date (YYYYMMDD)</td>
</tr>
<tr>
<td>11</td>
<td>case_type</td>
<td>2</td>
<td>String</td>
<td>Case category (mainly: Western medicine Chinese medicine; dentistry; special arrangement pharmaceutical; hospital admission)</td>
</tr>
<tr>
<td>12</td>
<td>seq_no</td>
<td>6</td>
<td>String</td>
<td>Serial number (based on case category type separate consecutive number coding)</td>
</tr>
</tbody>
</table>

The above five variables, #8, #9, #10, #11, and #12, (including id), were bundled together to identify a specific beneficiary in the NHI research database.

<table>
<thead>
<tr>
<th>No.</th>
<th>Variable</th>
<th>Byte Width</th>
<th>Data Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>func_type</td>
<td>2</td>
<td>String</td>
<td>Doctor's specialisation</td>
</tr>
<tr>
<td>14</td>
<td>part_no</td>
<td>3</td>
<td>String</td>
<td>Copayment classification</td>
</tr>
<tr>
<td>15</td>
<td>icd1</td>
<td>5</td>
<td>String</td>
<td>Main diagnosis</td>
</tr>
<tr>
<td>16</td>
<td>icd2</td>
<td>5</td>
<td>String</td>
<td>Secondary diagnosis</td>
</tr>
<tr>
<td>17</td>
<td>icd3</td>
<td>5</td>
<td>String</td>
<td>Tertiary diagnosis</td>
</tr>
<tr>
<td>18</td>
<td>op1</td>
<td>4</td>
<td>String</td>
<td>Surgery code</td>
</tr>
<tr>
<td>19</td>
<td>drug_amt</td>
<td>5</td>
<td>Number</td>
<td>Cost of all medication resulting from this visit</td>
</tr>
<tr>
<td>20</td>
<td>dsvc_amt</td>
<td>3</td>
<td>Number</td>
<td>Pharmaceutical service fee for this visit</td>
</tr>
<tr>
<td>21</td>
<td>part_amt</td>
<td>3</td>
<td>Number</td>
<td>Copayment (out-of-pocket fee) for this visit</td>
</tr>
<tr>
<td>22</td>
<td>t_appl_amt</td>
<td>5</td>
<td>Number</td>
<td>Reimbursement claimed by medical facility for this visit</td>
</tr>
<tr>
<td>No.</td>
<td>Variable</td>
<td>Byte Width</td>
<td>Data Type</td>
<td>Description</td>
</tr>
<tr>
<td>-----</td>
<td>-------------</td>
<td>------------</td>
<td>-----------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>23</td>
<td>in_date</td>
<td>8</td>
<td>String</td>
<td>Date of this visit</td>
</tr>
<tr>
<td>24</td>
<td>age</td>
<td>2</td>
<td>Number</td>
<td>Woman’s age in the study year (the woman’s year of birth subtracted from the study year)</td>
</tr>
<tr>
<td>25</td>
<td>drug_day1</td>
<td>2</td>
<td>Number</td>
<td>Longest course of medication prescribed at this visit – in days</td>
</tr>
<tr>
<td>26</td>
<td>mrs_mk</td>
<td>1</td>
<td>Number</td>
<td>Was menopausal syndrome diagnosed? ‘1’ means Yes ‘0’ means No</td>
</tr>
<tr>
<td>27</td>
<td>case_mk</td>
<td>2</td>
<td>String</td>
<td>Type of clinic visited: 01 - Western medicine 02 - traditional Chinese medicine 03 - dentistry</td>
</tr>
<tr>
<td>28</td>
<td>hrt_qty</td>
<td>6</td>
<td>Number</td>
<td>Length of course of HRT prescribed (in days)</td>
</tr>
<tr>
<td>29</td>
<td>hrt_drug</td>
<td>7</td>
<td>Number</td>
<td>Medication cost of HRT prescribed at this visit</td>
</tr>
<tr>
<td>30</td>
<td>ins_mk</td>
<td>2</td>
<td>String</td>
<td>Woman’s insurance status in the study year: 01 - enrolled 00 - not enrolled</td>
</tr>
<tr>
<td>31</td>
<td>op_ym</td>
<td>8</td>
<td>String</td>
<td>Date of gynaecological surgery</td>
</tr>
<tr>
<td>32</td>
<td>cen_area2</td>
<td>2</td>
<td>String</td>
<td>Location of the medical facility: 01 - municipal, 02 - city 03 - township 05 - mountainous region 06 - islet 99 - other</td>
</tr>
<tr>
<td>33</td>
<td>area_no_h</td>
<td>4</td>
<td>String</td>
<td>Area code of medical facility location — extracted from # 9</td>
</tr>
<tr>
<td>34</td>
<td>dept</td>
<td>1</td>
<td>String</td>
<td>Accreditation level of medical facility: 1 - medical centre at teaching hospital 2 - regional hospital 3 - local hospital 4 - medical practitioner's clinic</td>
</tr>
</tbody>
</table>

Although enrolment in the NHI program is compulsory for Taiwanese citizen and residents, a very small number of people do not enrol in it for reasons such as being unable to afford the premiums or living in isolation.
Appendix 6 Information Sheets and Consent Forms for Women and Key Informants (in Chinese)

澳洲昆士蘭州格里菲斯大學
環境與人口健康中心

親愛的女士，您好

非常感謝您慷慨應邀接受訪談。本次訪談的內容，主要是為瞭解您本人的更年期經驗以及相關的健康需要。您的經驗和看法將十分有助於增加對台灣本地更年期婦女健康需要的瞭解，也將作為本研究「台灣荷爾蒙補充療法的使用情形：相關爭議、醫療利用分析與更年期婦女的健康需求」中政策建議的依據。

訪談將分兩種方式進行：一是團體討論，約四到六位婦女一起分享個人處理更年期健康的經驗；二是個別訪談，由吳昭原女士和您面對面交談，瞭解您的親身經驗。懇請您在參考下頁的附件資料後，於 月 日以前利用回郵信封寄回「訪談同意書」以及您的聯絡方式，或以電話(02-26181178; 0989892081) 或電子郵件(cathypali@yahoo.com.tw)通知吳女士，以便能進一步聯絡、安排您的訪談時間和地點。非常感謝您的協助！

敬祝您

身體健康 精神愉快

格里菲斯大學博士候選人

敬上

中華民國 九十六年 月 日

343
附件：研究相關資料

中文題目：台灣荷爾蒙補充療法的使用情形：相關爭議、醫療利用分析
與更年期婦女的健康需求

英文題目：The use of hormone therapy in Taiwan: Controversies, cost analysis and health
needs of menopausal women

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研究背景與目的

婦女使用荷爾蒙補充療法的安全性經常引起爭議與關注，連帶影響著成千上萬更年期婦女在促進健康上的選擇。本研究將同時分析贊成與反對
使用荷爾蒙補充療法兩方的論點與證據，並以台灣的經驗為個案研究，
瞭解更年期婦女的健康需求，再以此為基礎，發展促進更年期婦女健康的政策建議。

-- 附件 第一頁--
訪談的進行規則

參與程度：您可能受邀參加團體討論或個別訪談，請您分享處理更年期健康的經驗。團體討論將由四到六位婦女所組成的小組共同分享討論，而個別訪談將由研究者當面向您請教。討論或訪談的時間大約 45--60 分鐘，全程都將錄音，以便事後的資料整理與分析。訪談紀錄經整理後，將請您過目確定是否忠於原意，錄音檔案將在資料整理分析後刪除。

徵詢同意：是否參與訪談純屬個人自願的決定，沒有義務性，更沒有罰則。如果您選擇參加訪談，進行過程中仍可以隨時終止訪談，毋須解釋理由。本研究或許未能直接有益於您個人，但預期將有助於增進全體更年期婦女的健康服務品質。

可能風險：本研究沒有身體危害，訪談內容只和您的更年期健康經驗有關。或許訪談過程可能因觸及您過去的經驗而引起不快，本人願意隨時暫停，經得您的同意後再討論相關議題。按照過去的研究經驗，相信此次的訪談內容將不至於引起壓力或焦慮，反而可能對您有所助益。

隱私保護：本研究將搜集、取得或應用到您的個人資料，但整個過程都是保密的，未經您的同意均不會對第三者公佈，除非是政府法令規定的例外情形。為了研究目的，所有資料都以匿名方式處理及保護。所有訪談文字資料將依規定，存放在格里菲斯大學的研究人員辦公室櫥櫃內，五年後銷毀。您可以取得本研究的結果報告。若需瞭解更多的隱私保護規定，請查看大學的相關網頁： www.griffith.edu.au/ua/aa/vc/pp 或電詢：+61 7 3735 5585。

服務或抱怨處理：關於研究問題的相關討論，請聯絡吳昭原女士、朱明若教授或林秀娟教授。此外，您還可以聯絡大學相關申訴機構：格里菲斯大學伯來中心研究倫理辦公室主任，電話：+61 7 3735 5585，電子郵件：research-ethics@griffith.edu.au，通訊地址：the Manager, Research Ethics: Office for research, Bray Centre, Griffith University, Kessels Road, Nathan, QLD 4111。

---格里菲斯大學感謝您同意參與本研究訪談---

--附件第二頁--
訪 談 同 意 書

研究題目：台灣荷爾蒙補充療法的使用情形：相關爭議、醫療利用分析與更年期婦女的健康需求

在簽署同意書前，本人已閱讀並瞭解該研究的相關資料，包括：

- 研究目的將分析使用荷爾蒙補充療法正反雙方的論點與證據，並以台灣更年期婦女的健康需求資料為基礎，發展促進更年期婦女健康的政策建議。
- 我受邀參加團體討論或個別訪談，分享與更年期健康相關的個人經驗，該訪談為期約45到60分鐘。
- 這次訪談不涉及身體的危害，也相信不致引起壓力或焦慮。
- 我的參與是自願性的，而且訪談中間可以隨時終止，毋須解釋理由或受罰。
- 該研究的報告或出版將採用概述性用語，不會使用可識別個人的資訊。
- 訪談紀錄會隱密保管在研究單位櫥櫃內，五年後銷毀。
- 若有疑問，我可以聯絡研究團隊的任一成員。
- 若有研究倫理的質疑，我也可以聯絡格里菲斯大學研究部的負責主管。
- 我可以取得個人受訪的整理報告，總體訪談結果摘要，研究結果摘要等資訊。

我同意參加本研究的訪談活動且自願簽署同意書。我瞭解訪談過程將按照附件資料所述進行，而且我已持有該附件資料。關於參與訪談的疑問，我已獲得滿意的答覆。

受訪人簽名：............................................ 日期..................

研究者簽名：............................................ 日期..................

** 務請填寫下列選項：

1. 本人同意参加 □ 羣體討論 □ 個別訪談 □ 兩者皆可

2. 本人希望取得 □ 個人訪談報告 □ 總體訪談摘要報告 □ 研究結果摘要 □ 研究論文報告網路檢索資源 □ 都不需要

郵寄地址：

聯絡電話：

346
澳洲昆士蘭州格里菲斯大學
環境與人口健康中心

親愛的鈞安

非常感謝您慷慨應允接受訪談。久仰鈞座對促進台灣婦女健康的卓越貢獻，此次的訪談內容，主要向您請益有關台灣本地更年期婦女的健康照護經驗與健康需求。您的經驗和看法將十分有助於建構台灣婦女更年期健康需求的知識系統，也將作為本研究「台灣荷爾蒙補充療法的使用情形：相關爭議、醫療利用分析與更年期婦女的健康需求」中政策建議的依據。

敬請參考下頁附件資料，並惠請於月日前利用回郵信封寄回「訪談同意書」，或以電話（02-26181178；0989892081）或電子郵件（cathypali@yahoo.com.tw）提供您方便受訪的時間和地點，便於進一步聯繫、安排。非常感謝您的協助!! 敬祝

身體健康 万事如意

格里菲斯大學博士候選人

敬上

中華民國 九十七年 月 日
附件：研究相關資料

中文題目：台灣荷爾蒙補充療法的使用情形：相關爭議、醫療利用分析與更年期婦女的健康需求

英文題目：The use of hormone therapy in Taiwan: Controversies, cost analysis and health needs of menopausal women

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電子郵件：sjlin@mail.ncku.edu.tw

研究背景與目的

婦女使用荷爾蒙補充療法的安全性經常引起爭議與關注，連帶影響著成千上萬更年期婦女在促進健康上的選擇。本研究將同時分析贊成與反對使用荷爾蒙補充療法兩方的論點與證據，並以台灣的經驗為個案研究，瞭解更年期婦女的健康需求，再以此為基礎，發展促進更年期婦女健康的政策建議。
訪談的進行規則

參與程度：鉅座將受邀由研究者當面請教您在增進婦女更年期健康的醫療服務、教學研究，或政策規劃和執行等方面的經驗。訪談將配合鉅座最合適的時間與地點來安排，該訪談時間大約 30–60 分鐘，訪談全程將錄音建檔，以便事後的資料整理與分析。訪談紀錄經整理後，將請您過目確定是否忠於原意，錄音檔案將在資料整理分析後刪除。

徵詢同意：是否參與訪談純屬個人自願的決定，沒有義務性，更沒有罰則。如果您選擇參與訪談，進行過程中仍可以隨時終止受訪，毋須解釋理由。本研究或許未能直接有益於您個人，但預期將有助於增進全體更年期婦女的健康服務品質。

可能風險：本研究沒有身體危害，訪談內容只和您的服務經驗有關。或許訪談過程可能因觸及您過去的不快經驗，雙方得以隨時暫停，再經得同意後繼續討論相關議題。按照過往的研究經驗，相信此次的訪談內容將不至於引起壓力或焦慮。

隱私保護：本研究將搜集、取得或應用到您的個人資料，但整個過程都是保密的，未經您的同意均不會對第三者公佈，除非是政府法令規定的例外情形。為了研究目的，所有資料都以匿名方式處理及保護。所有訪談文字資料將依規定，存放在格里菲斯大學的研究人員辦公室櫥櫃內，五年後銷毀。您可以取得本研究的結果報告。若需瞭解更多的隱私保護規定，請查看大學的相關網頁：www.griffith.edu.au/ua/aa/vc/pp 或電詢：+61 7 3735 5585。

服務或抱怨處理：關於研究問題的相關討論，請聯絡吳昭原女士、朱明若教授或林秀娟教授。此外，您還可以聯絡大學相關申訴機構：格里菲斯大學伯來中心研究倫理辦公室主任，電話：+61 7 3735 5585，電子郵件：research-ethics@griffith.edu.au，通訊地址：the Manager, Research Ethics: Office for research, Bray Centre, Griffith University, Kessels Road, Nathan, QLD 4111。

---格里菲斯大學感謝您同意參與本研究的訪談---
同 意 書

研究題目：台灣荷爾蒙補充療法的使用情形：相關爭議、醫療利用分析與更年期婦女的健康需求

在簽署同意書前，本人已閱讀並瞭解該研究的相關資料，包括：

• 研究目的將分析使用荷爾蒙補充療法正反雙方的論點與證據，並以台灣更年期婦女的健康需求資料為基礎，發展促進更年期婦女健康的政策建議。
• 我受邀參加個別訪談，分享與促進更年期健康相關的個人服務經驗，該訪談為期約30到60分鐘。
• 這次訪談不涉及身體的危害，也相信不會引起壓力或焦慮。
• 我的參與是自願性的，而且訪談中間可以隨時終止，無須解釋理由或受罰。
• 該研究的報告或出版將採用概述性用語，不會使用可識別個人的資訊。
• 訪談紀錄會隱密保管在研究單位櫥櫃內，五年後銷毀。
• 若有疑問，我可以聯絡研究團隊的任何成員。
• 若有研究倫理的質疑，我也可以聯絡格里菲斯大學研究部的負責主管。
• 我可以取得個人受訪的整理報告，總體訪談結果摘要，研究結果摘要等資訊。

我同意參加本研究的訪談活動且自願簽署同意書。我瞭解訪談過程將按照附件資料所述進行，而且我已持有該附件資料。關於參與訪談的疑問，我已獲得滿意的答覆。

受訪人簽名：........................................ 日期：...........................

研究者簽名：........................................ 日期：...........................

本人希望取得 □ 個人訪談報告 □ 總體訪談摘要報告 □ 研究結果摘要 □ 研究論文報告網路檢索資源 □ 都不需要

通訊地址：

聯絡電話： 電子郵件：

350
Information Sheet (for women)

Research topic: The use of hormone therapy: controversy, treatment costs and women’s health needs at menopause – A study in Taiwan

Student Investigator                      Ms Chao-Yuan Wu
Health                                    Centre for Environment and Population
Studies                                   Australian School of Environmental Health
Telephone: +61 7 37311 9908, +886 2
26181178                                   E-mail: c.wu@griffith.edu.au

Supervisors

Professor Cordia Chu
Centre for Environment and Population Health

Dr. Peter Daniels
Australian School of Environmental Studies

Professor Shio-Jean Lin
School of Medicine, National Cheng-Kung University (Taiwan)

Australian School of Environmental Studies

Griffith University
Telephone:
+61 7 3735 7189
E-mail:
p.daniels@griffith.edu.au

+886 6 235 3535#5286
E-mail:
sjlin@mail.ncku.edu.tw

Background

This study is being conducted by Ms Wu as a partial requirement of a PhD study on promoting menopausal women’s health. You are invited to participate in a focus group discussion or an interview because your experiences of menopause, health care for the climacteric, and your opinions on peri- and post-menopausal healthcare and health needs would be helpful to construct a more comprehensive understanding of women’s health needs during menopause. Please read this information sheet and indicate your willingness to be involved by telephoning Ms Wu on +61 7 37311 9908 within the next week, or by leaving your telephone number so that she can contact you at a later date. Alternatively, you could email her at c.wu@griffith.edu.au.
The use of hormone therapy is a subject of continuing controversy with regard to whether it is safe for women to use or not. This ongoing debate impacts on the choices made by millions of women worldwide experiencing menopause each year. This research will examine current evidence for both sides of the debate on hormone therapy use and focus on studying the situation in Taiwan to assess the health needs of menopausal women as the basis for developing recommendations for promoting climacteric health policy.

What participation in this study involves
Participation in this study asks that you attend a focus group discussion/an interview, and share your experiences of health care regarding menopause. A focus group involves discussion with the researcher and up to 6 other women in a group interview. An interview will be conducted with the participant by the researcher to allow a private communication. It will take approximately 45-60 minutes to complete. The focus group discussion/interview will be audio-taped to help with the data analysis. The interview data will be transcribed and following transcription, the audio tapes will be destroyed.

Consent to participate
Your participation is voluntary and you are not under any obligation to consent to participate in this research. Non-participation will not involve any penalty. If you chose to participate you may discontinue participation at any time without penalty and without providing an explanation. While the research may not benefit you directly, it may have the potential to improve the quality of health care services for menopausal women.

Risk
There are no physical risks involved in this project. The interview questions relate to your experience of health care regarding menopause. You may feel upset during the interview when discussing your experience. If this happens, I would like to stop the interview, and discuss these issues with you. However, I am experienced in interviewing adults and I do not believe any of the questions will cause undue distress or anxiety and may actually be soothing.

Confidentiality
Your identity as a participant in this research will remain confidential. I will not use your name in any published or unpublished accounts of this research. All transcribed interview data will be locked in a cabinet in the School of Griffith University for a period of 5 years before being destroyed. A report of the general findings from the study will be made available to participants.

Questions, concerns or complaints
You may contact Ms Chao-Yuan Wu, or Professor Cordia Chu, or the other two supervisors if you have any matter of concern regarding the research that you wish to discuss, or if you prefer to speak with an independent person you may contact the Manager, Research Ethics: Office for research, Bray Centre, Griffith University, Kessels Road, Nathan, QLD 4111, telephone: +61 7 3735 5585, or e-mail: research-ethics@griffith.edu.au

Griffith University thanks you for your consent and participation in this study.
CONSENT FORM

Research topic: The use of hormone therapy: controversy, treatment costs and women’s health needs at menopause – A study in Taiwan

I have read the information form and understand that:

- This research will examine the evidence associated with the debate over hormone therapy use and assess the health needs of menopausal women, as the basis for recommendations to promote climacteric health policy.
- I am being asked to attend a focus group/interview and to discuss my experience of health care regarding menopause.
- The focus group/interview will take about 45-60 minutes to complete.
- My participation is voluntary and I may discontinue my participation at any time without penalty or explanation.
- Any reports or publications from this study will be reported in general terms and will not involve any identifying features.
- The data will be kept confidential at all times and in a locked filing cabinet in the PhD student office for a period of 5 years before being destroyed.
- A report of the study findings will be made available to me (see below).

I agree to participate in this study and give my signed consent freely. I understand that the study will be carried out as described in the information statement, a copy of which I have retained. I have had all my questions about participating in this research answered to my satisfaction.

.......................................................................................... ........................................
Name and Signature                                           Date

.......................................................................................... ........................................
Investigator’s Name and Signature                           Date

** Please tick the following choices as appropriate:

1. I agree to take part in □ a group discussion □ an interview alone □ I am happy to take part in both

2. I would like to receive: □ a report of my personal interview  □ a summary of all the interviews
   □ a summary of the study’s findings □ details of how to find the research thesis online □ none of these

Postal address:                                               Contact phone number:
Information Sheet (for key informants)

Research topic: The use of hormone therapy: controversy, treatment costs and women’s health needs at menopause – A study in Taiwan

Student Investigator

Ms Chao-Yuan Wu
Centre for Environment and Population Health
Australian School of Environmental Studies
Telephone: +61 7 37311 9908
E-mail: c.wu@griffith.edu.au

Supervisors

Professor Cordia Chu
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Griffith University
Telephone: +61 7 3735 7189
E-mail: c.chu@griffith.edu.au

Dr. Peter Daniels
Australian School of Environmental Studies
Telephone: +61 7 3735 7458
E-mail: p.daniels@griffith.edu.au

Professor Shio-Jean Lin
School of Medicine, National Cheng-Kung University (Taiwan)
Telephone: +886 6 235 3535#5286
E-mail: sjlin@mail.ncku.edu.tw

Background

This study is being undertaken by Ms Wu as a partial requirement of a PhD study on promoting menopausal women’s health. I have learnt of your many experiences and reputation for having made an important contribution in the field of women’s health. Please accept my request to participate in a key informant interview. Please read this flyer and indicate your willingness to be involved by telephoning the researcher within the next week or by leaving your telephone number for the researcher to contact you on a later date.

The use of hormone therapy is still subject to continuing controversy and debate regarding whether it is safe to use. This debate will impact on the choices regarding midlife health of approximately 25 million women worldwide experiencing menopause each year. This research will include undertaking an investigation in Taiwan to examine the evidence pertaining to the debate on hormone therapy use and
to assess the health needs of menopausal women as the basis for developing recommendations for promoting climacteric health policy.

What participation in this study involves
I hope that you will agree to attend an interview and share your experiences of enhancing women’s health regarding menopause, and introduce women participants who can discuss their climacteric needs. The interview will be held at a time and venue in accordance with your availability. It will take approximately 30-60 minutes to complete. The interviews will be audio taped to help with the data analysis. The interview data will be transcribed, and following the transcription, the audio tapes will be destroyed.

Consent to participate
Your participation is voluntary and you are not under any obligation to consent to participate in this research. Non-participation will not involve any penalty. If you chose to participate you may discontinue participation at any time without penalty and without providing an explanation. While the research may not benefit you directly it may have the potential to improve the quality of health care services for menopausal women.

Risk
There are no physical risks involved in this project. The interview questions relate to your experience of enhancing women’s health regarding menopause. You may feel upset during the interview when discussing your experience. If this happens, I would like to stop the interview, and discuss these issues with you. However, I believe there are no questions that will cause undue distress or anxiety.

Confidentiality
Your identity as a participant in this research will remain confidential. I will not use your name in any published or unpublished accounts of this research. All transcribed interview data will be locked in a cabinet in an office at Griffith University for a period of 5 years before being destroyed. A report of the general findings from the study will be made available to participants.

Questions, concerns or complaints
You may contact Ms Chao-Yuan Wu, or Professor Cordia Chu, or the other two supervisors if you have any matter of concern regarding the research that you wish to discuss, or if you prefer to speak with an independent person you may contact the Manager, Research Ethics: Office for research, Bray Centre, Griffith University, Kessels Road, Nathan, QLD 4111, telephone: +61 7 3735 5585, or e-mail: research-ethics@griffith.edu.au

Griffith University thanks you for your consent and participation in this study.
CONSENT FORM

Research topic: The use of hormone therapy: controversy, treatment costs and women’s health needs at menopause – A study in Taiwan

I have read the information form and understand that:

- This research will examine the evidence associated with the debate over hormone therapy use and assess the health needs of menopausal women, as the basis for recommendations to promote climacteric health.
- I am being asked to attend an interview to discuss my experience of enhancing women’s menopause-related health.
- The focus group/interview will take about 30-60 minutes to complete.
- My participation is voluntary and I may discontinue my participation at any time without penalty or explanation.
- Any reports or publications from this study will be reported in general terms and will not involve any identifying features.
- The data will be kept confidential at all times and in a locked filing cabinet in the PhD student office for a period of 5 years before being destroyed.
- A report of the study findings will be made available to me (see below).

I agree to participate in this study and give my signed consent freely. I understand that the study will be carried out as described in the information statement, a copy of which I have retained. I have had all my questions about participating in this research answered to my satisfaction.

…………………………………………………………….. ………………….
Name and Signature Date

…………………………………………………………….. ………………….
Investigator’s Name and Signature Date

I would like to receive: □ a report of my personal interview □ a summary of all the interviews
□ a summary of the study’s findings □ details of how to find the research thesis online □ none of these

Postal address:
Contact phone number: E-mail address:
Appendix 8  Details of women participants in a. focus groups and b. in-depth interviews

a. Focus groups - 14 participants

<table>
<thead>
<tr>
<th>ID code</th>
<th>Background</th>
<th>Interview setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>W01_1</td>
<td>A housewife</td>
<td></td>
</tr>
<tr>
<td>W01_2</td>
<td>A retired blue collar worker</td>
<td></td>
</tr>
<tr>
<td>W01_3</td>
<td>A housewife</td>
<td></td>
</tr>
<tr>
<td>W01_4</td>
<td>A housewife</td>
<td></td>
</tr>
<tr>
<td>W01_5</td>
<td>A housewife</td>
<td></td>
</tr>
<tr>
<td>W01_6</td>
<td>A free-lance art teacher, teaching in several primary schools *also interviewed individually</td>
<td></td>
</tr>
</tbody>
</table>

1st focus group - held in an agricultural suburb – 6 participants

1st focus group held 11.30am – 12.45pm (including 15-20 minute lunch), 13 Dec 2007 face-to-face

<table>
<thead>
<tr>
<th>ID code</th>
<th>Background</th>
<th>Interview setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>W02_1</td>
<td>A retired government employee</td>
<td></td>
</tr>
<tr>
<td>W02_2</td>
<td>A housewife</td>
<td></td>
</tr>
<tr>
<td>W02_3</td>
<td>A private trading company manager</td>
<td></td>
</tr>
<tr>
<td>W02_4</td>
<td>A private insurance saleswoman</td>
<td></td>
</tr>
<tr>
<td>W02_5</td>
<td>A retired nurse</td>
<td></td>
</tr>
<tr>
<td>W02_6</td>
<td>A housewife - pre-menopausal</td>
<td></td>
</tr>
<tr>
<td>W02_7</td>
<td>A retired junior high school teacher</td>
<td></td>
</tr>
<tr>
<td>W02_8</td>
<td>A house wife</td>
<td></td>
</tr>
</tbody>
</table>

2nd focus group - held in a high socioeconomic suburb of Taipei city - 8 participants

2nd focus group held 11.30am – 1.45pm, 1 Dec 2007 face-to-face

<table>
<thead>
<tr>
<th>ID code</th>
<th>Background</th>
<th>Interview setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>W03</td>
<td>A farmers' cooperative section chief</td>
<td></td>
</tr>
<tr>
<td>W04</td>
<td>A private girls high school English teacher</td>
<td></td>
</tr>
<tr>
<td>W05</td>
<td>A retired government employee</td>
<td></td>
</tr>
<tr>
<td>W06</td>
<td>A retired formal wear company manager</td>
<td></td>
</tr>
<tr>
<td>W07</td>
<td>A free-lance art teacher, teaching in several primary schools *also in 2nd focus group</td>
<td></td>
</tr>
</tbody>
</table>

b. In-depth interviews – 24 participants

<table>
<thead>
<tr>
<th>ID code</th>
<th>Background</th>
<th>Interview setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>W03</td>
<td>A farmers' cooperative section chief</td>
<td></td>
</tr>
<tr>
<td>W04</td>
<td>A private girls high school English teacher</td>
<td></td>
</tr>
<tr>
<td>W05</td>
<td>A retired government employee</td>
<td></td>
</tr>
<tr>
<td>W06</td>
<td>A retired formal wear company manager</td>
<td></td>
</tr>
<tr>
<td>W07</td>
<td>A free-lance art teacher, teaching in several primary schools *also in 2nd focus group</td>
<td></td>
</tr>
</tbody>
</table>

Northern Taiwan – 5 women

face-to-face, individually

face-to-face, individually

face-to-face, individually

face-to-face, individually

face-to-face, individually
**Central Taiwan – 11 women**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>W08</td>
<td>A government employee</td>
<td>face-to-face, individually</td>
</tr>
<tr>
<td>W09</td>
<td>A blue collar worker</td>
<td>face-to-face, individually</td>
</tr>
<tr>
<td>W10</td>
<td>A private insurance saleswoman</td>
<td>face-to-face, individually</td>
</tr>
<tr>
<td>W11</td>
<td>A retired political party employee</td>
<td>face-to-face, individually</td>
</tr>
<tr>
<td>W12</td>
<td>A government employee</td>
<td>face-to-face, individually</td>
</tr>
<tr>
<td>W13</td>
<td>A retired township elected representative</td>
<td>face-to-face, in a group</td>
</tr>
<tr>
<td>W14</td>
<td>A housewife</td>
<td>face-to-face, in a group</td>
</tr>
<tr>
<td>W15</td>
<td>A retired private hospital cook</td>
<td>face-to-face, in a group</td>
</tr>
<tr>
<td>W16</td>
<td>A retired blue collar worker</td>
<td>face-to-face, in a group</td>
</tr>
<tr>
<td>W17</td>
<td>A blue collar worker</td>
<td>face-to-face, in a group</td>
</tr>
<tr>
<td>W18</td>
<td>A housewife</td>
<td>face-to-face, in a group</td>
</tr>
</tbody>
</table>

**Eastern Taiwan – 6 women**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>W19</td>
<td>A retired public hospital chief nurse</td>
<td>face-to-face, in a group</td>
</tr>
<tr>
<td>W20</td>
<td>A retired public hospital accountant</td>
<td>face-to-face, in a group</td>
</tr>
<tr>
<td>W21</td>
<td>A retired public hospital nurse</td>
<td>face-to-face, in a group</td>
</tr>
<tr>
<td>W22</td>
<td>A housewife</td>
<td>face-to-face, in a group</td>
</tr>
<tr>
<td>W23</td>
<td>A hairdresser</td>
<td>face-to-face, in a group</td>
</tr>
<tr>
<td>W24</td>
<td>A dental clinic assistant</td>
<td>face-to-face, in a group</td>
</tr>
</tbody>
</table>

**Southern Taiwan – 2 women**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>W25</td>
<td>A retired manager, self-owned business</td>
<td>face-to-face, in a group</td>
</tr>
<tr>
<td>W26</td>
<td>A retired accountant, self-owned business</td>
<td>face-to-face, in a group</td>
</tr>
</tbody>
</table>
Appendix 9  Details of key informants who participated in in-depth interviews

**Medical Practitioners – Western medicine & TCM**

<table>
<thead>
<tr>
<th>ID code</th>
<th>Gender</th>
<th>Background</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>D01</td>
<td>Male</td>
<td>Senior obstetrician/gynaecologist at a public academic medical centre, and medical school professor</td>
<td>Taipei City</td>
</tr>
<tr>
<td>D02</td>
<td>Male</td>
<td>Senior obstetrician/gynaecologist at a public academic medical centre, and medical school professor</td>
<td>Taipei City</td>
</tr>
<tr>
<td>D03</td>
<td>Male</td>
<td>Senior obstetrician/gynaecologist at a private regional hospital</td>
<td>Taipei City</td>
</tr>
<tr>
<td>D04</td>
<td>Male</td>
<td>Senior obstetrician/gynaecologist at a private academic medical centre, and medical school professor</td>
<td>Northern Taiwan</td>
</tr>
<tr>
<td>D05</td>
<td>Male</td>
<td>Senior obstetrician/gynaecologist at a private academic medical centre, and medical school professor</td>
<td>Eastern Taiwan</td>
</tr>
<tr>
<td>D06</td>
<td>Male</td>
<td>Obstetrician/gynaecologist at a private academic medical centre</td>
<td>Eastern Taiwan</td>
</tr>
<tr>
<td>D07</td>
<td>Female</td>
<td>Junior obstetrician/gynaecologist at a public health clinic</td>
<td>Eastern Taiwan</td>
</tr>
<tr>
<td>D08</td>
<td>Female</td>
<td>Senior GP at a public academic medical centre, and professor teaching preventive medicine in a school of public health</td>
<td>Taipei city</td>
</tr>
<tr>
<td>D09</td>
<td>Female</td>
<td>Junior GP at a private academic medical centre</td>
<td>Eastern Taiwan</td>
</tr>
<tr>
<td>D10</td>
<td>Male</td>
<td>Senior GP at a private academic medical centre, and medical school professor</td>
<td>Eastern Taiwan</td>
</tr>
<tr>
<td>D11</td>
<td>Male</td>
<td>Junior GP at privately-owned clinic</td>
<td>Eastern Taiwan</td>
</tr>
<tr>
<td>D12</td>
<td>Male</td>
<td>Junior GP at privately-owned clinic</td>
<td>Eastern Taiwan</td>
</tr>
<tr>
<td>D13</td>
<td>Male</td>
<td>Senior GP and senior gynaecologist at a regional hospital</td>
<td>Middle Taiwan</td>
</tr>
<tr>
<td>D14</td>
<td>Male</td>
<td>TCM doctor at a private academic medical centre</td>
<td>Eastern Taiwan</td>
</tr>
<tr>
<td>D15</td>
<td>Male</td>
<td>TCM doctor at a private academic medical centre</td>
<td>Eastern Taiwan</td>
</tr>
<tr>
<td>D16</td>
<td>Female</td>
<td>Psychiatrist at a private academic medical centre, and medical school lecturer</td>
<td>Northern Taiwan</td>
</tr>
<tr>
<td>D17</td>
<td>Male</td>
<td>Senior urologist at a private academic medical centre, and medical school professor</td>
<td>Eastern Taiwan</td>
</tr>
</tbody>
</table>
Appendix 10  Details of government officials, women’s health researchers and social activists who participated in in-depth interviews. Male interviewees are indicated by shading, all others were male.

A. Government officials – 5 participants

<table>
<thead>
<tr>
<th>ID code</th>
<th>Background</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>G01</td>
<td>Former high-ranking Bureau of Health Promotion official</td>
<td>Taipei City</td>
</tr>
<tr>
<td>G02</td>
<td>Former high-ranking Bureau of Health Promotion official</td>
<td>Central Taiwan</td>
</tr>
<tr>
<td>G03</td>
<td>Former high-ranking Bureau of Health Promotion official</td>
<td>Central Taiwan</td>
</tr>
<tr>
<td>G04</td>
<td>A District Health Centre official, responsible for policy implementation</td>
<td>Taipei City</td>
</tr>
<tr>
<td>G05</td>
<td>Former high-ranking Bureau of National Health Insurance official</td>
<td>Taipei City</td>
</tr>
</tbody>
</table>

B. Social activists – 4 participants

<table>
<thead>
<tr>
<th>ID code</th>
<th>Background</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>E01</td>
<td>Associate-professor of Public Health, and prominent women's health activist</td>
<td>Taipei City</td>
</tr>
<tr>
<td>E02</td>
<td>Professor of Nursing, with many publications related to menopausal health</td>
<td>Taipei City</td>
</tr>
<tr>
<td>E03</td>
<td>Senior midwife, private practitioner in a rural area</td>
<td>Eastern Taiwan</td>
</tr>
<tr>
<td>E04</td>
<td>Chief secretary of a leading women's group</td>
<td>Taipei City</td>
</tr>
</tbody>
</table>