

**UNDERSTANDING MENOPAUSAL WOMEN'S EXPERIENCE
OF HORMONE USE FOR SKIN ANTI-AGING IN VIETNAM**

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ABSTRACT

The use of hormone replacement therapy (HRT) for skin anti-aging is becoming increasingly common among Vietnamese menopausal women. As HRT involves health risks, it is necessary to understand the cultural and social factors that drive menopausal women to choose the treatment.

The objective of this study was to understand menopausal women's experiences of hormone use for skin anti-aging in Vietnam.

Qualitative medical anthropology methodology was used. Four dermatologists and 8 menopausal patients of dermatologists using HRT for skin anti-aging were interviewed, and 4 dermatologist-patient interactions were observed in a public hospital in Ho Chi Minh City, Vietnam.

The women's beauty ideals included having white, smooth, moist, natural-looking skin with no wrinkles or other imperfections. They believed beauty was necessary for them to ensure a happy family life and success with their career. This belief had a superstitious element as they explained seemingly unrelated misfortunes with their own reduced attractiveness. They thought this reduction in their attractiveness resulted from menopause. The interviewed patients had previously tried many beauty treatments but were not satisfied. When dermatologists (as well as media, friends, husbands, etc.) explained to them that their complaints resulted from menopause and could be alleviated by HRT, they accepted the explanation and the treatment. Dermatologists usually prescribed a brand name product with plant estrogens and collagen, combined with antioxidants, sun screens and health advice. None of the patients questioned the medical menopause discourse that conceptualized their complaints as symptoms of hormone and collagen deficiency. Their affluence made HRT available for them. They faced great pressure from husbands, colleagues, and others to look beautiful, which also explained their belief that beauty was necessary for them.

Evidence on the safety of HRT is inconclusive, but the women patients were not told this and believed HRT is safe. Menopausal women need to be given comprehensive, unbiased information about menopause and HRT. The cultural beliefs behind HRT use need to be deconstructed among Vietnamese women.

KEY WORDS: MENOPAUSE / DERMATOLOGY / HORMONE
REPLACEMENT THERAPY / SKIN ANTI-AGING /
CULTURAL BELIEFS

100 pages

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LIST OF ABBREVIATIONS

%	Percent
HCM	Ho Chi Minh
HRT	Hormone replacement therapy
IDI	In-depth interview
IRB	Institutional review board
IPL	Intense pulsed light
RF	Radio frequency
SPF	Sun protection factor

CHAPTER I

INTRODUCTION

1.1 Background and justification

1.1.1 Menopausal women and their health

Currently, older women striving to enhance their quality of life are facing important challenges because of the global phenomenon known as of “feminization of aging”. This term means that while women live longer than men, they are affected by aging more than men, because of ill health or negative social outcomes. Unless specific attention is paid to the specific challenges that old age poses for a growing number of women, many of them face the burden of ill health rather than a happy, long life (Davidson, DiGiacomo & McGrath, 2011).

Many societies believe that men get old slowly but women get old rapidly; for males, aging is viewed as normal and as a sign of maturity (McPherson, 2003). In many societies, reaching menopause may lead women to experience certain health problems in the context of the predominant medical influence that explains menopause as a disease (Lupton, 2003).

In Vietnam, according to the 2009 census, there are over six million women aged 50 to 70 years (Central Population and Housing Census Steering Committee, 2010, p. 38). On a more global scale there are millions of mid-life women who, although they are healthy, must negotiate menopause as an illness that risks their future health.

The topic of menopause has been given an international attention increasingly since the First International Menopause Congress in Southern France, held in 1976, as the result of the growing interest in women's health and the worldwide increase in the number of aging women (World Health Organization/WHO, 1981; WHO, 1994; WHO, 1996).

1.1.2 Women's beauty and hormone use

Beauty is different things to different people, different cultures and different time periods. Every woman wants to look beautiful and works hard to reach her full potential. The great majorities of menopausal women at least in some countries believe that menopause is a sign of aging and associated with hormone deficiency (Lindh-Åstrand, Brynhildsen, Hoffmann, Liffner & Hammar, 2007).

Skin aging problems among menopausal women are particularly important because of their social impact to women's self-esteem (Puizina-Ivić, 2008). Aging skin's appearance consists of wrinkles, dryness, or sagging. Many women consider these symptoms as a sign of the onset of a pathological, aging state (Raine-Fenning, Brincat & Muscat-Baron, 2003).

I have been working for ten years as a dermatologist in Ho Chi Minh City. Each day that I was practicing in my clinic, more than eight menopausal women came to see me with problems related to skin aging. They complained about wrinkling, black spots, white spots, dark skin around their eyes and so on. In my experience, skin aging is a main concern for menopausal Vietnamese women in Ho Chi Minh City and they use several methods such as diet, exercise, certain vitamins and nutritional supplements, as well as skin care with herbal medicine, collagen leaf masks and other types of anti-aging masks and other professional methods in order to prevent skin aging. They worry when their bodies change, because they want to be beautiful – not only in their husband's eyes but also in social life. Concerns with their beauty and their quality of life lead them to look for ways to enhance their body's beauty by intervening with skin aging.

In Ho Chi Minh City (as in any other big city in the world), there are numerous products available on the general market that are aimed to slow down skin aging. However, among these practices aimed at slowing down skin aging, the use of hormone replacement therapy (HRT) is particularly common among menopausal Vietnamese women in Ho Chi Minh City (Hormone Replacement, 2011).

The use of HRT in the short term can solve many symptoms during the first menopausal period: hot flushes and sweats, vaginal and urinary symptoms, altered libido, and skin complaints, especially wrinkled, sagging skin (Raine-Fenning, Brincat & Muscat-Baron, 2003). However, HRT can have long term side effects on women,

including the risk of breast (National Institutes of Health, 2002) and ovarian (Beral, 2007) cancers.

Use of hormones for skin beauty is common among both women and transgender people in Southeast Asia (Chang & Chang, 1996). It is a popular belief among many women in Southeast Asian countries that HRT and other types of hormones use improve internal health and eventually result in a better appearance (Chang & Chang, 1996). However, women who use HRT in the long term to maintain their beauty without knowing its side effects on their reproductive healthcare in great risk of cancer of the reproductive organs. Menopausal women's hormone use practices are thus a significant issue for women's health advocates and health social science researchers to work on to produce a body of knowledge on this issue and use such information for evidence-based advocacy and raise awareness among menopausal women on how their reproductive health can be protected.

In Vietnam, the recent past has seen fast economic growth and development of the educational system. These factors influence more women to have concerns about their physical appearance, not only for their own happiness, but also that of their family. However, not all menopausal women understand enough about HRT, and there are cultural and social barriers between doctors and female patients in Vietnam (Nie, 2012). Hence, there is an urgent need to study menopausal women's experiences of hormone use practices aimed at slowing down skin aging in Vietnam.

1.2 Research questions

1.2.1 General question

What are menopausal women's experiences of hormones use for skin anti-aging in Vietnam?

1.2.2 Specific questions

1) What cultural beliefs are there on skin-related beauty among menopausal women in contemporary Vietnamese society?

2) What cultural beliefs are there on the effects of menopause and menstruation on skin-related beauty among Vietnamese menopausal women?

3) What kinds of patterns of health practices are there for skin anti-aging among Vietnamese menopausal women?

4) What kinds of patterns of hormone use for skin anti-aging are there among Vietnamese menopausal women?

5) What kinds of social and cultural factors lead Vietnamese women to use HRT for skin anti-aging?

1.3 Objectives

1.3.1 General objective

To understand menopausal women's experiences of hormone use for skin anti-aging in Vietnam.

1.3.2 Specific objectives

1) To understand the cultural beliefs on skin-related beauty among menopausal women in the contemporary Vietnamese society.

2) To describe cultural beliefs on the effects of menopause and menstruation on skin-related beauty among Vietnamese menopausal women.

3) To explain patterns of Vietnamese menopausal women's health practices on skin anti-aging.

4) To explore HRT use practices on skin anti-aging among menopausal women in Vietnam.

5) To explore the social and cultural factors, which influence the use of HRT for skin anti-aging among Vietnamese menopausal women.

CHAPTER II

LITERATURE REVIEW

2.1 Theoretical concepts

2.1.1 Michel Foucault's conception of power, knowledge and discourse

Michel Foucault (1929-1984) was both a sociologist of the body and a post-structuralist theorist who introduced a new conception of power (Jones, 2003: 123-125). Power, which was traditionally viewed as a resource or in terms of social relations, was perceived by Foucault in terms of truth and knowledge. Foucault demonstrated the relation between knowledge and power by demonstrating that knowledge has power in the construction of truth that plays a role in regulating power relations (Manokha, 2009). Foucault's new conception of power enables the study of power to separate from the conception of power in Marxist theory because power is no longer exclusively bound to issues concerning social class and dominant idealism (Kumar, 2009). For further study on Foucault's conception of power, it is important to understand the following terms.

2.1.1.1 Discourse

Foucault used the term discourse to refer to a knowledge-based way of thinking and acting. Just as a child has no choice about the language(s) it has to learn as it grows, so we have no choice about the particular knowledge about the world we have to acquire. For Foucault, it was through the discourses that dominate a time in history and place in the world that people acquired their mind-set, or world-view (Jones 2003:125). According to Foucault, power and knowledge are fused in an arena called "discourse". Power is exercised by dictating what is true, good or moral. Foucault believed that there is no 'real', objective truth. What we believe to be truth is a discourse concerning truth that is formed and fused to be believed that way, making people accept it as truth. Foucault pointed out that truth is not an object that humans

search and, after finding it, accept it as it is. Instead, truth is an outcome of construction, like other forms of social construction.

Medical discourses view menopause as pathology, an abnormal state. Menopause is a phenomenon which is represented as malfunctioning, breaking down a system of authority because of the lack of response on the part of the reproductive organs. This is a strong influence on women's attitudes toward menopause. Some women desire to lose menstruation because they think menstruation is physically damaging and weakening; losing menstruation means they will be free from pregnancy. Other women don't want to lose menstruation because they regard menstruation as vital to their well-being, as rejuvenating. For these women, menopause is conceived as a "threat" to their femininity. These notions illustrate the conflicting discourses among women concerning the value and importance of menstruation, and subsequently menopause, to their self-identity (Lupton, 2003).

So, for Foucauldians, if one wants to understand human behavior in a particular place and time, it is necessary to find out what discourses dominate in that place and time. And if one wants to know why particular discourses came to power, one has to trace the origins of the way on which its rise to power rested. In the case of menopausal women, if one wants to understand the sexual behavior of these women, one should look at the history of these women's lives and the context in they live (Winterich, 2003).

2.1.1.2 Power

Foucault's theory of power contributes to the conceptualization of power in postmodernism. It can be seen as a critical reaction against Marxist conceptualizations of power based on economic factors, defining power as sovereign power generated from a source, centralization and legitimacy. In the Marxist view, the government uses power to force people to follow its regulations. In a modern society, however, power is exercised through various disciplinary techniques including surveillance, categorization and intervention from the social specialists (Jones, 2003).

According to Foucault, the notions of health and illness hold analogous power in our lives as the notions of good and evil held in the lives of pre-modern humans. Foucault characterized the exercise of a discourse's power as a form

of surveillance to ensure the conformity of a population to particular notions of truth and falsehood, good and bad. Thus he described the shift from the dominance of religion in pre-modernity to the dominance of medicine in modernity as the emergence of the Medical gaze or the Clinical gaze. (Jones, 2003).

Gaze is another concept constantly mentioned in Foucault's work, including *Madness and Civilization* (Foucault, 1965), *The Birth of the Clinic* (Foucault, 1973) and *Discipline and Punish* (Foucault, 1977). Foucault stated that the medical gaze views a human body as a docile body. The body is perceived as a machine; thus, any problem occurring to the body has a solution. Doctors constantly develop and search various techniques to control people's lives from birth to death. People who are under surveillance and aware of the surveillance learn to control themselves, to follow the regulations imposed on them and, finally, become "subjects" of self-surveillance. Likewise, patients in a hospital who are under the gaze of doctors and nurses have to control themselves to follow the regulations and norms of the place. According to Foucault and his followers, the policing power of the medical gaze can also be seen in the widespread medicalization of modern life. This term refers to the way in which universally experienced features and functions of human existence are, in modernity, appropriated and commandeered by medicine, defined in terms of the essential categories "health" and "illness" and managed accordingly (Jones, 2003).

2.1.1.3 Power and the body

Michel Foucault's theory of control and discipline best illustrates the relationship between the body and power. He suggested that power is at the root of the oppression of women. He believes that the powerful institutions of patriarchal society govern and control the body, hence the body is produced by and exists in discourse – "for Foucault, the body is not only given meaning by discourse, but is wholly constituted by discourse. In effect, the body vanishes as a biological entity and becomes instead a socially constituted product which is infinitely malleable and highly unstable" (Shilling, 2005: 65).

Foucault believed the body to be a socially constituted phenomenon, which allows it to be controlled by those in power. This form of power is most effectively exercised through the beauty system, as it ensures most women will

be manipulated. Every period of history has had its own standards on what was and was not considered beautiful (Sullivan, 2000).

2.1.2 Social construction of the body

The female body has been the target area of the medical profession for centuries. Aspects of production such as sexuality, menstruation, contraception and fertility have principally occupied the minds of physicians. According to Foucault, the body and its role in society is a product of power, knowledge, the political economy and discourse. Foucault's conception of microphysics of power can be applied to notions of women's bodies as sites of male domination. The human body has become the territory of invasive manipulation for the sake of youth and against natural processes of aging. The body is regarded to be a domain of expert-led intervention, not only with regard to physiological functioning but also on aesthetic composition. Both of these functions link together which is particularly relevant where menopause is concerned. The promise of hormone-engineers is offers of "forever young" packages to aging women. Through the historical studies of Foucault (1973, 1994), the socio-cultural meaning of the human body has been deconstructed to an extent never envisaged before (Berger & Wenzel, 2001).

Foucault's micro-studies of the impact of the political system, that is, systems of power, on human beings and their lifestyles and living conditions have opened an entire new perspective of looking at "human behavior". Foucault demonstrated that there are underlying currents predetermining the ways and means of human interaction in the social and cultural environment. Foucault stressed the embeddedness of all human action in the social, political, economic, and cultural context, which makes up society. The social construction of the body differs from the medical construction in so far as it positions the body in the center of human interaction. That is, the body is seen as the existential basis of human interaction within given social, political, economic, cultural, and environmental conditions (Berger & Wenzel, 2001). Crawford (2003: 275) has described the significance of the body as follows:

“The body is a cultural object. As our most immediate natural symbol it provides us with a powerful medium through which we interpret and give expression to our individual and social experience. “Human nature”, the category of the inevitable (and often the desirable), finds its truth in the body. We live within a nature/culture opposition and the “natural body” confirms our place within a more “authentic” order. It is a vital foundation upon which behavior and values are predicated. Conversely, as a symbol of nature the body must be contained and transformed by culture. We invest the body with culture, thereby distinguishing ourselves from the rest of nature. Moreover, our biological being, always mediated by culture, delimits many of our most important social roles. It defines us in relation to others in kinship, sex, age groups, and larger social units such as race or caste. Bodily states are key markers in which are invested the social definitions of the self – not only regarding role, but normality and abnormality. The body also supplies a universally experienced model of a living and dynamic unit, an organic whole, a prototype from which we can draw in our attempts to explain and give meaning to larger social units and experiences. It is our richest source for metonymy and metaphor.”

However, these different aspects of the body are rarely consciously perceived. For instance, we may be engaged in selecting clothes to underline our body shape; we may take care of our body in terms of hygiene and cosmetics; we may become particularly aware of our body when we feel ill. This is one of the reasons why we are often surprised when we see ourselves in videos or listen to our recorded voice, both of which seem rather strange because we are not used to see ourselves the same way as we are seen by others. Our “manners of locomotion” are surprising (Hall, 1977, cited in Berger & Wenzel, 2001).

In medical anthropology, the primary concerns are the linkages between the body as a physiological entity and a social entity, the relationship of one body to another body, and the relationship of a body to society. These relationships have been examined using the concept of three bodies (Scheper-Hughes & Lock, 1995: 207): The individual body, the social body, and the body politic. The first, the individual body, which includes not only the physical body but also the mind, the self and the ways the

body, is experienced in sickness and health. The second is the social body, which considers the body as natural symbols that represent social, natural and cultural attributes of the body. The third, the body politic, refers to the power relationships between individuals and/or particular social groups of individuals, the way regulation of a person's body occurs within society, in order to maintain conformity within the group (Scheper-Hughes & Lock).

In addition, from the perspective that sees the body as a medium of control, Lupton (2003) has explained several types of female body including the gendered body, the medicalized body, the sexualized body and the commodified body. The concept of the gendered body refers to masculine and feminine bodies. The medicalized body refers to how strong, weak, diseased, normal or abnormal a body is. The sexualized body is the "sexy" body. The body can also be viewed in terms of bodily integrity. This means the right to personal security and control over one's body, which refers not only to protection from harm but the enjoyment of the full potential of the body (Lupton).

2.1.3 Gender and the body

Gender means how people define themselves or are defined by others as being male or female (Simon, 2004). Sex and gender are the terms used in defining maleness and femaleness, or manhood and womanhood from different perspectives. Sex refers to biological criteria for classifying persons as females or males. Females have different physiological characteristics from males as they have a uterus, a vagina, breasts, mammary glands and menstruation, all of which men don't have. Gender refers to the social aspects of manhood or womanhood. The gender distinction between women and men lies in their social roles, power, duties and responsibilities, which are determined by the family and society. Culture, education, religion, economic factors, politics and law all influence how this social distinction is made.

Older women face prejudice not only about advanced age; the prejudice they face also concerns the intersection of their age and gender. The belief that men get old slowly but women get old rapidly reflects such prejudice. Vietnamese society also values aging in males and females differently. For males, aging is viewed as normal and as a sign of maturity. Men with grey hair are considered charismatic and

esteemed. On the contrary, aging women are viewed in terms of impairment and illness. Older women are also considered asexual (and may be frowned upon if they are not) by Vietnamese society whereas older men are not (Hien, 2006).

2.1.4 The social and medical construction of menopause

Humans and their behavior (or their actions) have to be seen in their specific environmental context. The process of aging is more acutely felt by women than men because their aging process has a clear social and cultural indicator –the menopause. Menopause marks the end of menstruation, once generally accepted as the closure of women’s reproductive lives. The current medical view of menopause sees it as a pathological event with its own distinct set of symptoms and diseases (Lock & Kaufert, 2001). However, historical and cross-cultural research on menopause suggests that menopause is best understood not as a fact, but as a social and medical construct. Even the definition of menopause as a woman’s last menses does not match an experience which most women describe as a prolonged process rather than a singular event. The conflation of menopause with the end of menstruation is relatively recent in origin and was not always the case even within the medical literature. Writing in 1813, Halford (1813, cited in Stolberg, 2007, p. 112) commented: “I should observe, that though this climacteric disease is sometimes equally remarkable in women as in men, yet most certainly I have not noticed it so frequently, nor so well characterized in females.”

The social construction of menopause as the entry point to old age represents menopause as a challenging and often difficult time, because while women may feel rather young and full of energy, society tends to perceive menopausal women becoming increasingly less attractive and less fully functioning. For women, the time of menopause is characterized by a series of losses such as loss of youth, beauty, fertility, libido, health, hormones, femininity and calcium, a biological marker of aging that leads to deterioration of health and youthfulness. Added to this, with the accumulation of knowledge on a woman's endocrine system, views about menopause as a natural transition began to change.

However, the view of menopause as a time of loss in need of medical intervention is not universally accepted. In a seminar on menopause, Pimpawun

Boonmongkon, a Thai women's health advocate used her personal experience to illustrate that the women can go through menopause smoothly without hormone pills. In other words, if women understand that the physiological and psychological changes during menopause are natural and, for the most part, can be managed through positive attitudes, a proper diet, regular exercise and group support, women can have a much smoother menopause experience and avoid the use of hormone replacement medication (Ekachai, 2000). In conclusion, these contrasting views suggest that menopause should not be seen as a pathologic endocrine deficiency disease because female hormones normally abate with advancing age as reproductive function comes.

2.1.5 Medical definition of menopause

The WHO defines menopause as the permanent cessation of menstruation resulting from the loss of ovarian follicular activity with subsequent hormonal changes (WHO, 1996).

2.1.6 Physiological concepts on menopause

According to physiological concepts, menopause is a transitional stage of adjustment to the changing level of sex hormones in the body (Gannon, Hansel & Goodwin, 1985). This point of view emphasizes the role of the reproductive hormones, known as estrogen and progesterone. At the age of the middle or late thirties, the concentration of estrogen in the blood of women starts decreasing (Kass-Annese, 1999). When it decreases to a certain level, it will influence the estrogen-dependent tissues such as ovaries, other kinds of hormones, menstruation, uterus, fallopian tubes, vulva, vagina, vaginal cytology, breasts, pelvic floor, urinary tract, skin and musculoskeletal system (Chang & Chang, 1996).

This point has been supported by laboratory evidence based on measuring the level of estrogen in menopausal women's blood and strongly supported by the effect of exogenous estrogen in relieving some menopause symptoms such as vasomotor symptoms or atrophic symptoms, cardiovascular symptoms, and osteoporosis (Hulka & Meirik, 1996). However, psychological symptoms such as mood swings do seem not to be successfully reduced with estrogen treatment

(Gannon, Hansel, Goodwin, 1985). This theory is limited in explaining why menopausal symptoms occur in some women and not others (Hulka & Meirik).

2.1.7 Psychological concepts on menopause

The basic idea of this the concept is that life events in the women's life come first and menopausal symptoms come later. Psychologists primarily view menopause as biological pathology characterized by emotional disturbances, loss of femininity, sense of incompleteness, and old age. However, Morse, Smith, Dennerstein, Green, Hopper & Burger (1996, p. 161) have critiqued this view, stating that "biased views of menopause as a time of considerable distress and ill-health are being perpetuated and over-generalized. This perspective appears to have little relevance for the majority of middle-aged women." The available evidence supports the idea that the menopausal experience appears to be more associated with pre-existing problems or other long-standing difficulties due to marital dissatisfaction, financial difficulties, parents' death, and children rebelling, children leaving home, and problems in early development. These events in the woman's life facilitate or exacerbate the menopausal symptoms (Hulka & Meirik, 1996).

2.1.8. Hormones and hormone replacement therapy

HRT is based on supplementation of synthetically produced estrogen. In our bodies, natural estrogen consists of a group of steroid compounds which function as the primary female sex hormones. The three types of estrogens are estrone (E1), estradiol (E2, 17 β -estradiol) and estriol (E3) (Mandal, 2012). They are synthesized primarily in the ovaries, testes, adrenal glands and also our fat tissues. Estrone is a precursor to estradiol; it is a breakdown or storage form of it. (Estrogens, n.d.) There are many types and forms of hormone in the consumer market such as contraceptive pills, tablets and cream. Examples of brand names used by dermatologists for skin anti-aging purposes include Diane 35 and Cilest. When used for skin care, these products are used continuously for at least three months.

The use of HRT for the treatment of menopausal symptoms is based on the medical concept of supplementation of hormone to replace the natural hormone, which is present in reduced quantity. HRT provides relief to hot flashes and other vasomotor

symptoms, reduction of vaginal impairments, maintenance of skin tightness and moisture (which helps prevent wrinkles), prevention of osteoporosis and reduced risk of bone fractures and prevention of cardiovascular disease and heart attack. The therapy is also beneficial for the central nervous system and helps improving memory and sleep, resulting in good health and better sexual relationships (Westerlind, 2003).

However, there has been a lot of media attention to the risks of taking HRT, particularly after the results of some big studies about HRT were published between 2002 and 2004. These studies raised concerns over the safety of HRT, particularly over a possibly increased risk of breast cancer and also a possible increased risk of heart disease (Wright, 2000). One study found that HRT increased the risk of breast cancer by 10% for each five years of treatment (Ross, Paganini-Hill, Wan & Pike, 2000).

2.1.9. Anthropological perspectives on beauty

Throughout history, people in every culture have sought to change the natural appearance of their bodies. They reshape and sculpt their bodies and adorn them with paint, cosmetics, clothing, and jewelry. These customs, however, are diverse and particular to a culture at a specific period of time. The diversity of body costumes has led anthropologists to conclude that a body is both a physical and a symbolic artifact, forged by nature and by culture at a particular moment in history (Sullivan, 2000). Therefore, social institutions, ideology, values, beliefs, and technology transform a physical body into a social body. Bodies provide important clues to the mechanics of society (Sullivan). Body customs have social significance. The body can be a site for the expression of power in a culture and for communicating group membership, social status, social identity and associated beliefs and values. All body customs, whether temporary, like tweezing eyebrows, or more permanent, like tattoos and cosmetic surgery, are forms of self-creation that establish a connection with a reference group. The cultural and social context influences individual body choices and gives them social meaning (Sullivan). When powerful cultural ideologies and institutions change, body standards and customs change. This is clearly evident in the changing standards for feminine and masculine beauty over the last two centuries.

However, there is no record of a culture in which women would actively seek to be unattractive to men (Sones, 2002). According to Wendy Chapkis (1986), “The beautiful body is women's responsibility and their authority. She will be valued and rewarded on the basis of how close she comes to embodying the ideal.”

2.2 Literature review

2.2.1 Cultural beliefs on menopause

In any society, women's status, self-image and roles are conditioned by when, where and how they live, as well as with whom. These factors connive together to create an expectation of what women and their bodies are for. Therefore, menopause is a bodily experience but it has big social and cultural implications that are tied up with fertility, sexuality, independence and aging (Berger & Wenzel, 2001). What menopause really means in any given society is a reflection of how middle aged women are valued. Many women now enjoy long lives into their 80s and spend almost a third of their lifetime in their menopausal years because menopause is a cultural process, so each culture has its own views and meanings related to it (Berger & Wenzel, 2001).

In Chirawatkul's study in Thailand (2002), a decline in sexual desire and less enjoyment in sexual activities were reported by almost all postmenopausal women. It was not regarded as a problem but is expected and regarded as appropriate. The cultural ideologies of ‘calm’ and ‘cool’ at this age lead women to view menopause as a gain more than a loss.

Hien (2006) analyzed that in Vietnam, economically independent women gave more positive meanings to menopause than did economically dependent women.

2.2.2 Doctor's attitudes and practices influence the use of HRT among menopausal women

Dermatologists work in both public and private hospitals and clinics and need to build and maintain their status so as to attract clients. Many women patients

themselves are busy and want to manage their time for their own convenience and want to please their husbands. For both of these reasons, dermatologists prefer to choose HRT for anti-aging. However, they sometime encounter complications. There is evidence that some doctors not only unnecessarily suggest and encourage initiation of HRT but also readily accept requests from patients who want to use HRT to maintain their beauty, without discussing possible side effects (Fugh-Berman & Bythrow, 2007).

2.3 Conceptual framework

The main focus of this study is to understand menopausal women's experiences of hormone use for skin anti-aging which include cultural beliefs on skin-related beauty, on menstruation and menopause related effects on skin beauty, social and cultural factors that influence HRT use patterns for skin anti-aging treatment. A modified Foucauldian framework was used to develop the conceptual framework. The framework (Figure 2.1) consists of dermatologist's HRT prescription patterns as clinical practices, and the medical discourse gazing at menopausal women and their menopause health related problems, including skin-aging. In this framework, it is assumed that women's bodies are viewed by dermatologists as docile bodies; women who continuously use hormones are considered to be engaged in the self-surveillance of their skin-aging problems.

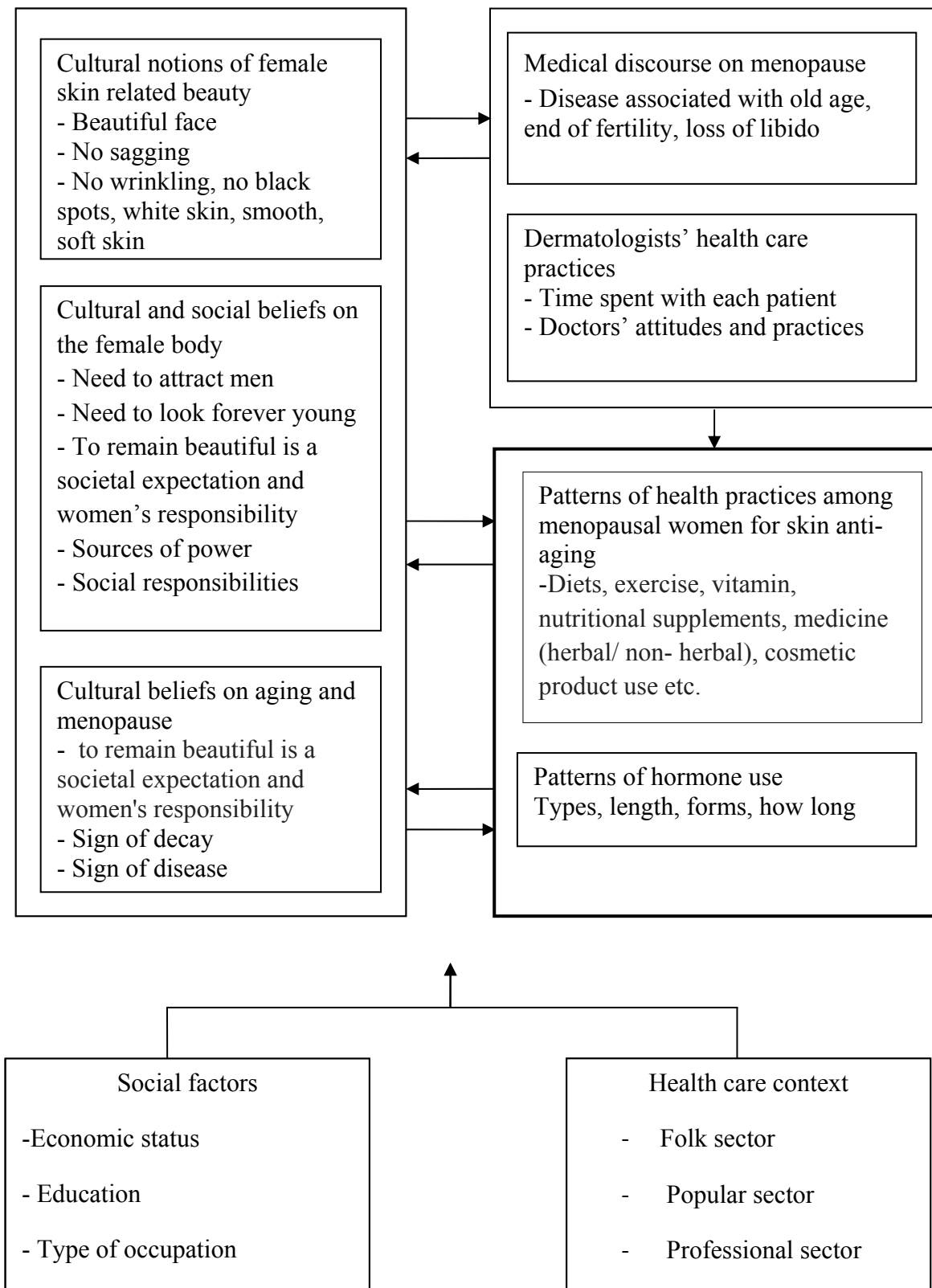


Figure 2.1 Conceptual framework

CHAPTER III

RESEARCH METHODOLOGY

The purpose of this research was to explore Vietnamese menopausal women's experience of using HRT to solve their skin and other menopause related problems. This study focuses on how cultural beliefs, cultural and social factors related to menopause and aging, cultural and social construction of beauty, and dermatologists' attitudes and practices influence women's decisions on HRT use for preventing skin aging. So far, there has not been any research conducted in Vietnam to understand this group of women's experience of using HRT to solve skin problems. As a consequence, very limited amount of, if any, relevant knowledge has been obtained.

To understand this group of women's experience, I adopted a qualitative research approach to allow me to understand the meaning of these women's actions and thoughts, especially regarding their decision-making on HRT and skin care related HRT use practices.

3.1 Study site

All interviews and observations were conducted in Ho Chi Minh City (HCM City, see Figure 3.1). I chose this city as my research site for three main reasons. First, I have been working as a dermatologist in HCM City for 10 years and have known a lot of patients and doctors there. Second, HCM City is the most populous city in Vietnam. It is a major center of economy, education, politics, social development, culture, and modern tourism in Vietnam. Therefore, many women in HCM City can afford HRT which is an expensive treatment, especially if used for a long period of time. Third, HCM City is the center of health services for all Vietnamese who want to take care of their health or enhance their beauty. There are many high quality hospitals with modern technology and knowledgeable doctors

including lot of dermatologists with lots of experience who provide HRT treatment and care for menopausal women. These three reasons together meant that I could recruit both menopausal women participants who had concerns on skin-related beauty, and dermatologists providing services to them (including HRT) more easily in HCM City than in other cities.

I chose one large public hospital, “HCM Hospital” (pseudonym), where I have worked as a dermatologist, as my research site. In this hospital, there are 70 doctors and half of them are experienced in treatment of skin diseases and skin problems. Roughly two thousand patients come from HCM City and from elsewhere to check their skin and consult on their health problems in this hospital every day.

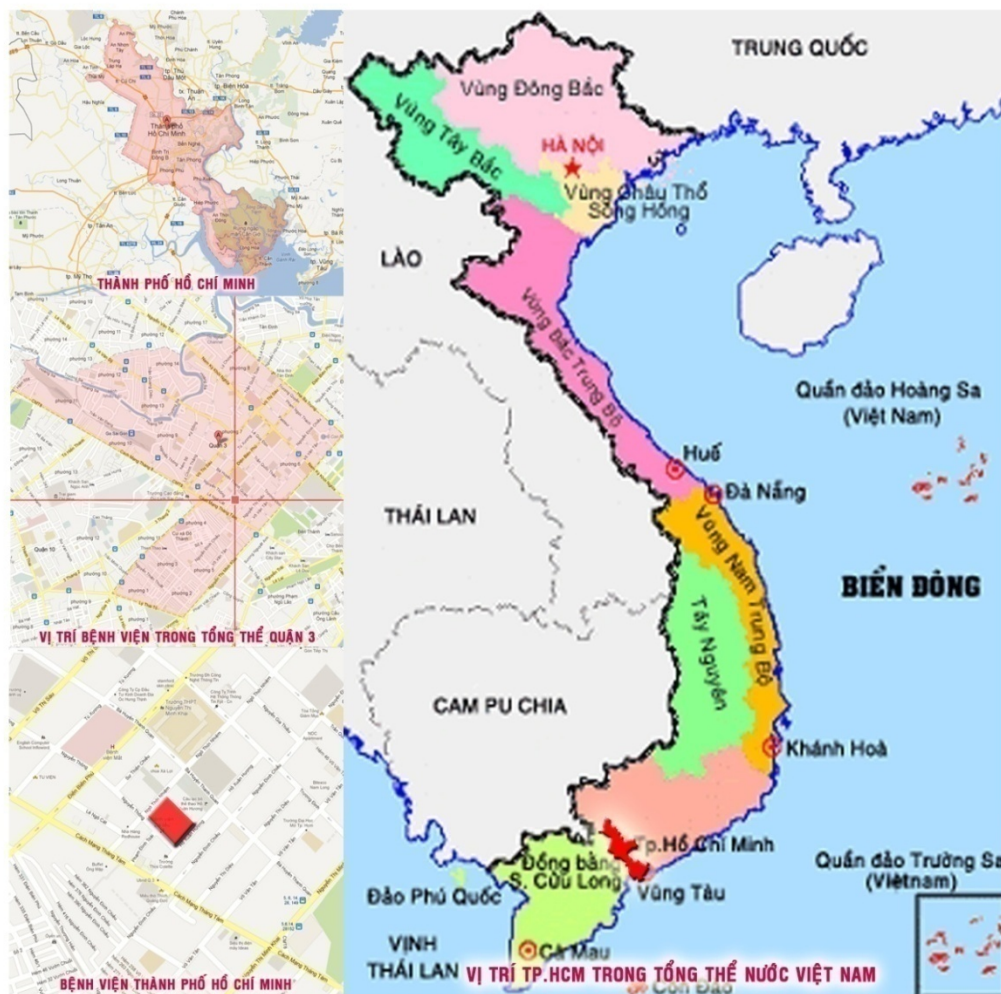


Figure 3.1 Maps of Vietnam and Ho Chi Minh City

3.2 Research participants

3.2.1 Selection of research participants

3.2.1.1 Dermatologists

I recruited four dermatologists, two male and two female, from “HCM Hospital” to participate in my research, each with at least ten years work experience in the field and willing to participate in my study.

3.2.1.2 Menopausal women

Additionally, I intended to recruit 16 women patients of these dermatologists. The inclusion criteria for these women were that they had to be women who had had natural menopause, were 40 to 60 years old, had used HRT for skin anti-aging purposes for at least one year, were Vietnamese, lived in HCM City and were fully willing and comfortable to participate in the study. I decided to recruit only two patients per each dermatologist. Through the recruitment process, I finally chose eight women who fulfilled all the inclusion criteria.

3.2.2 Procedure of recruiting research participants

My first step to recruit informants was to obtain permission from the hospital I had chosen as my study site. So, I contacted the director of this hospital and scheduled a meeting with him. During our meeting, I handed him a letter from Mahidol University requesting the hospital’s participation and stating the study had received ethical approval from Mahidol’s institutional review board (IRB), together with the research plan and my full research proposal. I explained to him the study’s objectives and asked his permission to conduct my study in the hospital. The director agreed with my topic and gave me permission to do research in the hospital as planned.

The following day after giving me permission to conduct my qualitative research (the day after our first meeting), the director introduced me to all doctors and the dean of the outpatient faculty at a meeting in the hospital. He explained to everyone in the meeting that I would do my research project “on menopausal women’s

experience of hormone use for skin anti-aging” and needed their help during the time I did this research. I was welcomed by all.

I personally knew all the four dermatologists I asked to join the study as participants, two through my studies and two through my work in this hospital. All four have agreed to join the study as participants and let me interview them after work.

I also requested each of these four dermatologists to let me observe their clinical interactions with a number of their patients. After each patient had finished consulting the dermatologist, if the patient seemed to fit the inclusion criteria for patient participants, I made a non-verbal sign to the dermatologist to help introduced me to the patient. After I had been introduced by the dermatologist, if the patient was willing to talk to me, I went with the patient to a room next door and conducted a short screening interview with them.

Through the observations, I initially selected 16 patients who seemed to fit the inclusion criteria for patient participants. However, only eight women were willing to participate in my study. Some of the 16 women I screened for their suitability to participate were not fully comfortable to share about their lives. In the selection process I emphasized their readiness and willingness to share about their experience; if they appeared hesitant or unwilling to share about their experience, I did not choose them as participants. If they expressed full willingness to participate and fit all the inclusion criteria, I asked for their address and telephone number as well as the time for their next follow-up visit with the doctor, because I would conduct the first in-depth interviews during their follow-up appointment.

3.3 Methods of data collection

The methods used for data collection were in-depth interviews with eight patients, semi-structured interviews with four dermatologists and observation of dermatologist-patient interactions. I used a digital sound recorder and took some field notes during all interviews and observations.

3.3.1 In-depth interviews

I used in-depth interviews (IDIs) to explore cultural notions belief on skin aging, beauty, patterns of health practices for skin anti-aging, including HRT and other medical and non-medical methods used for skin anti-aging, as well as the factors that affected women's choice of these practices. Specifically, the interviews aimed at trying to understand the lives of the patients in the context of their norms, beliefs, and their perceptions about choosing HRT and its positive and negative health consequences.

As explained above, I conducted the first screening interviews with potential patient participants immediately after their consultation with their dermatologist, in the room next to the doctor's consultation room. The actual in-depth interviews with these women I also conducted in the same room in the same hospital, in the context of their follow-up visits to their dermatologist. Most interviews were 45 minutes long; however, sometimes I just talked with them for around 30 minutes and stopped the interview since I realized how tired and busy they were. I then scheduled the next interview to take place after their next follow-up visit to their dermatologist. I interviewed each woman patient three times.

I began the interviews with general topics like their age, how long since they had entered menopause, and then moved to more complicated issues like their beliefs on what menopause symptoms women get and try to overcome, or why they had decided to contact a dermatologist to obtain HRT treatment. See Appendix 1.1 for the full in-depth interview guidelines.

I introduced myself as a student collecting data for research, not as a dermatologist. I had not requested my dermatologist colleagues (whom I had recruited as participants) to present me as a dermatologist to their patients, but they did so anyway. Although this kind of introduction was unintended on my part, it seemed to make my participants very willing to share details of their menopause experience such as low libido, hot flashes, vaginal dryness, wrinkles and sagging skin.

To compensate for these patient participants' time, I gave each participant a small sun block cream gift.

3.3.2 Observation of patient-dermatologist interactions

As already stated above, I observed doctor-patient interactions between the four dermatologist participants and their patients. The first round of observation was only conducted to screen potential patient participants. After I had selected the four dermatologists and eight patients as participants, I conducted a second round of observation. During this second round, I specifically observed patients while they were visiting the dermatologist when already recruited as participants, this time focusing on the doctor-patient communication and the clinical decisions the dermatologists made during these consultations about prescribing HRT. See Appendix 1.2 for the full observation guidelines.

Each observation of doctor-patient interactions lasted about 30 minutes. Sometimes if the doctor spent a long time explaining details to the patient he or she would be interrupted by a nurse because other patients were waiting for their consultation.

3.3.3 Semi-structured interviews (with dermatologists)

In addition to the interviews with the patients, I also conducted semi-structured interviews with the four dermatologists recruited as participants. These were all highly experienced on giving HRT treatment to patients who desired the treatment to maintain their skin's beauty, and understood attitudes and practices related to HRT use for skin anti-aging.

I began these semi-structured interviews, with general questions like how many patients they saw per day, how often they saw menopausal women patients who had complaints related to skin aging issues, and what kinds of complaints they had in general. I then explored the reasons why they chose to prescribe HRT treatment for skin anti-aging instead, or in addition to other methods like Botox, IPL and so on; and how they managed their patients and prevented overuse of medication.

Interestingly, in these interviews, the two women doctors were more open about their treatment choices and motivations, whereas the two male doctors were more guarded and defensive. For example, when I asked these male doctors why they chose to use HRT, they might evade the question by saying bluntly that they always

chose the best method to treat their patient. See Appendix 1.3 for the full semi-structured interview guidelines.

3.4 Research instruments

The research tools for data collection in my study were:

- 1) In-depth interview guidelines for menopausal women (Appendix 1.1).
- 2) Semi-structured interview guidelines for dermatologists (Appendix 1.2)
- 3) Participant observation guidelines (Appendix 1.3)
- 4) A digital sound recorder.

3.5 Data processing and analysis

3.5.1 Data processing

All interviews were conducted in Vietnamese. After all the interviews, I transcribed and translated all interviews into English. I also translated my field observation notes into English.

3.5.2 Data analysis

I read and reread every line of my field notes to make sense of the data. I then entered all the raw data documents into MAXQDA 11.0, a qualitative analysis program, to perform content analysis with open coding. I did this by assigning codes, line by line, on emerging themes and subthemes, loosely informed by the conceptual framework, research questions and theoretical concepts guiding the study. In addition, I identified and followed up any missing or incomplete information in subsequent interviews. Then, in the Code System window of the program, I grouped relevant codes into categories reflecting the specific research objectives of the study. Finally, based on the emerging themes, I formed tentative working hypotheses that seemed to best represent the constructions presented by my data sources.

3.6 Interpretation and presentation of findings

I interpreted the findings from an anthropological perspective informed by my conceptual framework and research objectives. My emphasis was on identifying menopause related health practices as well as the cultural beliefs and social and cultural factors influencing such practices.

I present the overall findings in Chapter 4. Detailed individual information about the participants, both patients and dermatologists, as well as about my case observations, is given in the summary tables in the Appendix (p. 97-118).

3.7 Validity of the data

Different research methods provide different aspects of the same symbolic reality and shed different kinds of light on the same topic. Triangulation combines several viewpoints to obtain a better, more substantive picture of reality (Berg, 2004:5).

3.7.1. Triangulation

In research, triangulation is a way to increase validity of data by using more than one method. In qualitative approaches, multiple methods help to get more complete data from the informants. Methodological triangulation of data can be achieved by using different methods of data collection such as formal/informal conversations, interviews, field note taking, and observation. Data in this study came from in-depth interviews with menopausal women, who were on HRT, dermatologists frequently prescribing HRT, and the observations of these patients and dermatologists' interactions. So, I got to triangulate my data by comparing these three different kinds of data.

3.7.2. Trust building

Skin anti-aging is a topic that many people are concerned with, menopausal women especially so. However, in Vietnamese society, women are expected to behave in a modest way and hide their desires.

This posed a challenge for me as some women were not comfortable to talk about their private matters with me. I worked my way around this problem in two ways: firstly, I only chose as my patient participants women who seemed the most comfortable to talk about their lives. Secondly, I met each woman three times, and during our first meeting, I simply conducted a screening interview. This gave them time to begin to trust me. Although I first did not intend to use my background as a dermatologist to make my patient participants feel more comfortable, I realized that they respected and trusted me as a dermatologist because the doctors who had introduced these patients to me had told them I was a dermatologist. I also built trust with these women by speaking with them in a nonjudgmental manner about their decision to use HRT for skin anti-aging.

3.8 Ethical considerations

Social science research in general should contribute to human well-being and do not harm the participants of a study. Therefore, attention to ethical issues was essential while conducting this study. There were some standard ethical considerations that had to be paid attention to in a qualitative study like this, particularly privacy, confidentiality, informed consent, and benefit to the participants. I requested an ethical approval for the study from Mahidol University's IRB and only started data collection after getting the approval.

While collecting data for this study, I experienced ethical dilemmas specific to my situation as both a dermatologist and a social science researcher. I approached my participants as a researcher, not as a medical practitioner. However, because I am also a medical practitioner by profession, I had a particular responsibility to safeguard my patient participants' health. This became an important dilemma when I felt that the clinical decisions made by my colleagues (the practitioner participants)

might have a negative impact on my patient participants' health, for example when I felt my colleagues were prescribing too many medications at the same time, or had gathered insufficient information on their patients' health to make their decisions.

On one hand, it would have been unprofessional of me as a researcher to openly question my colleagues' clinical judgment, which could also have jeopardized the research. On the other, I felt that as a medical practitioner, I had to do what I could to minimize the health risks faced by my patient participants' over use of medication, especially HRT. The compromise I reached was that although I refrained from questioning the clinical decisions made by my colleagues, I nevertheless provided additional health information to the patient participants on issues like better nutrition, exercise, correct timing of medicine-taking and so on, which could help to reduce the risks and side effects these women faced. My colleagues were often too busy to give these kinds of information, so I could offer an additional benefit to my patient participants by giving this information in the context of interviews.

In the course of my research, I also gained an insight on another ethical issue in medical research: the influence of pharmaceutical companies on research. I was approached by a pharmaceutical company who offered to pay me for doing this study in a way that would have been covert advertisement for the products of the company. I declined the offer but simply having received the suggestion showed to me how easily pharmaceutical corporations could bias medical research to suit their commercial interests. If I would have accepted their money, they would surely have wanted to use my research findings. It would have been unethical for me to provide my research findings for others to publish in their name or for me to allow pharmaceutical companies to use these findings to improve their HRT marketing strategy, which was beyond the original research objectives.

3.8.1 Privacy

"Privacy" is the right of person or group to determine for themselves when, how, and to what extent information about them is not shared with or withheld from others (Kimmel, 1996). All my interviews were conducted in the hospital in a private room, with only me and my participant present in the room.

3.8.2 Confidentiality

The most important ethical issue in my study was confidentiality. In all documents, I used pseudonyms to replace the real names of both doctors and patients. I also use a pseudonym for the hospital. All informants' voice recordings, field notes, and transcribed interviews were kept securely in a locked cabinet. I will destroy the field notes, recordings and transcribed interviews when my study is completed and reported in a journal. I did not share information given to me by the women patients with anyone else, including their doctors.

3.8.3 Informed consent

Informed consent means asking potential participants' permission to conduct research with them, after giving them unbiased, comprehensive information about the research process. I asked everyone I recruited as a participant to express their consent to participate in writing after explaining to them about my study.

3.8.4 Benefit and reciprocity

Benefit refers to the potential benefits a research study's participants receive from participating in the study, and also to the benefits other people in society may gain. Reciprocity refers to the idea that the research has benefits not only to the researcher or other people but also to the participants themselves.

The benefit of this study to menopausal women in general is an improved understanding of their health practices aimed at skin anti-aging, especially HRT use, and of their cultural beliefs and social factors that affect such health practices. This knowledge can be used to advocate for safer skin anti-aging practices for both dermatologists and the menopausal women themselves, while understanding the context and conditions behind their current practices.

My patient participants themselves benefited by gaining extra opportunities to discuss their complaints and health practices with a dermatologist (myself), which they otherwise lacked because their dermatologists frequently were very busy and did not have the time to give their patients comprehensive information. As I stated above, I did not question the clinical judgments of their treating doctors, but I gave my patient participants extra health information on safer medicine use and

helped them to understand HRT more comprehensively. I also gave them a small sun block cream gift. The final report will be shared with the participants after project is completed.

CHAPTER IV

FINDINGS

The purpose of this study was to understand menopausal women's experiences of hormone use for skin anti-aging in contemporary urban Vietnamese society. In the following section I firstly describe cultural beliefs about skin-related beauty and about the effects of menopause and menstruation on skin-related beauty among the menopausal women I interviewed. I then describe their health practices aimed at skin anti-aging, including their use of HRT. In the last section, I analyze the social and cultural factors that influence the use of HRT for skin anti-aging among Vietnamese menopausal women.

The study setting

Ho Chi Minh is the Centre of the economic, cultural, educational, political and social development of the south of Vietnam. The city was founded in 1698, and then called Saigon. In 1976, after the reunification of the northern and southern parts of the country, it was renamed as Ho Chi Minh City.

With its high economic growth, in 2009, the city only counted for 0.6 per cent of the total land area and 8.3 per cent of the population of Vietnam, but contributed 20.2 per cent to the gross national product, 26.1 per cent to the value of total industrial output, and 44 per cent of all investment in the country. The city is also a shopping and entertainment center. It leads the nation in the number of banks and sales, finance and credit relationships. Strong growth is still forecast for the city in all aspects.



Since 1975, Ho Chi Minh city's population has increased rapidly. Illegal immigration has played a part in this process. The population growth has fuelled uncontrolled housing construction. According to official statistics, the population of Saigon in 1975 was 3,498,120 people. As of 2011, Ho Chi Minh city's population was 7,521,100; 6,250,700 people lived in urban areas and 1,270,400 people in rural areas administratively counted as a part of the city (General Statistics Office, n.d.). The male population was 3,585,000 and the female population was 3,936,100. The city's land area is 2095.6 km² and the population density was 3589 people/km² in 2011. The rate of natural increase of the local population (excluding migration) was 7.4 %.

Ho Chi Minh City has followers of 13 officially recognized religions; 1,983,048 are officially categorized as members of these religious groups. Most of them are Buddhist, followed by Catholic Christians, followers of Cao Dai (a Vietnamese syncretistic religion), Protestant Christians.

According to the General Statistics Office, as of April 1, 2009, Ho Chi Minh City inhabitants belonged to 54 different ethnic groups. The most numerous ethnic group were the Kinh (6,699,124 people), followed by ethnic Chinese (414,045 people), ethnic Khmer people (24,268), and other smaller groups.

HCM City is seen as a place to work hard and earn a lot of money. There is considerable migration both into the city and out of it. Consequently, much of the population now living in HCM City are originally from other parts of Vietnam.

About one-quarter to one-third of the population are considered internal migrants from other parts of the country; these people have mostly come to the city seeking a better livelihood provided by the dynamic economy boosted by market reforms started in the 1980s. However, many of these migrants are economically disadvantaged and face problems with issues like housing (Waibel, n.d.).

Due to being an economic hub, Ho Chi Minh City has a high demand for highly educated workforce. This, together with the high number of educational institutions means that the overall educational levels are higher in the city than in other parts of the country. Correspondingly, salaries are higher than in other parts of the country. A higher proportion of Ho Chi Minh City residents are business people than in other parts of the country. Recent migrants typically have lower education than long-term residents, many being self-employed and many migrant women employed as domestic workers.

When people in Ho Chi Minh City get ill, they have many options for taking care of their health. They can go to drugstores, government health centers, private clinics, public or private hospitals. Private clinics are usually used in situations demanding urgent care. Government health centers are usually used in case of common illnesses, especially when the patient is covered by insurance. When in need of more specialized care, people tend to go to hospitals rather than clinics. Many buy medicines from drugstores after having originally been prescribed such medicines by their doctor, or if introduced to specific medications by their friends or relatives.

Income level affects health patterns. Vietnamese people on low incomes are particularly affected by diabetes, kidney disease and hypertension due to diets high in carbohydrates and salt, but with low vegetable intake. Those on higher incomes tend to have more healthy diets, eating less salt and more vegetables. However, women on high incomes are particularly concerned about their beauty, regardless of their age, and have the means to access expensive treatments. They take care of themselves very carefully, they can go to spa every week or buy a lot of expensive cosmetic products for their skin. Some spas offer various medical treatments, including HRT, available to their customers. Some such spas employ medical doctors, but not all.

One popular choice for skin care in Ho Chi Minh City is the public hospital. It is located in the Centre of the city. This hospital is the biggest in the city; it has 500 beds and modern equipment for skin care. It has 70 dermatologists with abundant experience. Nowadays, more and more women go to this hospital to check up their health and to solve their skin problems and choose services they need. Having observed in this hospital, I know that all dermatologists seem busy because every day many women come there to check up their health and their skin. The numbers of patients who come to the hospital to check and solve their skin problems is steadily increasing.

Based on my observation and interviews, it seemed clear that the women who came to the hospital with menopause complaints were financially well off and had high education, had engaged in previous beauty treatment at establishments like spas and fitness centers and had been introduced to the hospital through their social contacts from such contexts. Their financial standing made it possible for them to commit to expensive HRT treatment. They also shared a set of beliefs on the importance of beauty. They believed that their own of beauty was crucial to their and their families' happiness and also necessary in order to have good luck in other aspects of their lives. These factors combined made them very willing and able to request HRT.

Table 4.1 gives the background details of my dermatologist participants and Table 4.2 gives the background details of the menopausal women patients I interviewed.

Table 4.1 Background details of dermatologist participants

No	Pseudonym	Sex	Age	Educational level	Professional experience (years)
1	B V Dung	M	58	Ms MD	32
2	Tr N Sang	M	47	Ms MD	15
3	P T Thanh	F	55	MsMD	30
4	N T B Lam	F	48	Phd,MD	20

Table 4.2 Background details of patient participants

No	Pseudonym	Age	Occupation	Educational level	Years since last menstruation
1	L T T Hue	46	Nurse	BA	2
2	N T A Dang	53	Nurse	BA	3
3	T T N Mai	53	Corporate employee	BA	3
4	L T Phung	52	Hospital employee	BA	3
5	B T K Thuy	55	Corporate employee	BA	3
6	N T L Thuan	50	Business	BA	3
7	N T Ba	50	University professor	BA	3
8	D T Nhu	44	Business	BA	3

4.1 Cultural beliefs on the beauty of skin and the body

4.1.1 Beauty ideals

The eight menopausal women interviewed all had similar beauty ideals. Beautiful skin in their view means skin that is white, wrinkle-free (smooth), moist,

healthy-looking and spotless. For example, Nhung, a 44-year old fashion vendor, said: “my skin must be smooth and white”.

Smooth skin is the dream of all women, as it makes people look younger than their age. However, some women I interviewed were particularly concerned about wrinkles in specific parts of their face. Wrinkles in specific spots were associated with types of bad luck that looked similar to the skin complaint. For example, some associated wrinkles extending down from the nose with money flowing out of the household, while others associated wrinkles under the eyes with crying and overall unhappiness in life.

Changes in skin color sometimes indicate an unhealthy condition. When Vietnamese women notice appearance of new pigmentation they may suspect they are aging more rapidly than usual, or are ill. White skin is generally considered desirable by Asian women regardless of the country; this is also the case among Vietnamese women. However, some consider a honey-colored tone most attractive. Women also found consistency of skin color important.

An oval face shape was generally considered most beautiful, while too round or square a shape was considered less attractive.

Breasts were also considered important for a woman’s attractiveness. For example, Ba thought that “for women, breasts are the main part to make the body more attractive.” Larger breasts were generally considered more attractive, but women also thought their breasts needed to look natural. Natural-looking breasts were associated with size proportionate to the rest of the body, and breasts enlarged with silicone were not thought of as attractive because it could be seen in some body positions they had been enlarged due to their lack of flexibility.

A slim body shape was likewise important – Nhung, for example, explained: “I need my body thin and healthy.” However, too thin a body was also considered undesirable. A balance between the size of the breasts, belly and buttocks was considered important, with a preference for an hourglass shape (full breasts and buttocks but little fat in the belly area).

Not only Nhung but also many other women said they wanted to look “healthy”. In their view this meant having facial skin without spots, not looking too

pale, red or tired (wrinkly, with dark under eyes). Looking tired could be associated with mental health trouble, which was naturally considered undesirable.

4.1.2 Cultural beliefs on the significance of women's beauty

For the female patients I interviewed, beauty was highly important for several reasons. They believed that looking beautiful was essential to both a happy family life and a successful professional life. All the women patients interviewed expressed the magical belief that looking ugly is not just socially harmful, but also inauspicious – an omen but also a cause of bad luck in their health, family and professional lives.

The most common type of bad luck in family life – one that affected all the eight women I interviewed – was the husband having extra-marital sexual relationships with younger women. The women thought that besides sexual problems, these relationship problems resulted from their reduced attractiveness which they in turn attributed to menopause. One of the participants was bluntly told by her husband she was no longer attractive and looked like a pillow because she was overweight. Dang, a 55-year old nurse, explained the connection between beauty and her relationship with her husband like this: “My husband wants me to be beautiful and I myself don't want to be ugly. I know that my husband had some girlfriends outside so I need to make my face and body look beautiful.”

The interviewed women also emphasized how their looks were essential to success in their professional lives. For example, Thuy, a 55-year old corporate employee stated that “because my work is business, I have to meet a lot of people. My face needs to be bright and fresh. It makes my business develop.” Likewise, Dang, a 53-year old nurse said: “I feel confident when my face is bright and my body shape is beautiful. I feel comfortable when I stand in front of my patients.” And Ba, the 55-year old university lecturer also cited her job as her reason to be concerned for her appearance.

The interviewed women's accounts also clearly reflected how they thought “ugliness” to be inauspicious and beauty to be auspicious. Thuy, a 55-year old corporate employee, said: “Every woman wants to be beautiful because beauty brings lucky life to a woman.” She said she had done a face lift after a series of misfortune.

Phung, a 52-year old hospital employee noted her work had suffered, her patients had complained about her, and her husband had got an accident – all because her face was “ugly.”

4.2 Cultural beliefs on effects of menopause and menstruation on skin-related beauty among menopausal women

4.2.1 Effects of menopause on the beauty of the body

The women I interviewed were concerned with wrinkles appearing on their skin, especially around the eyes. Many of the women thought that menopause had caused their skin to become dry and have sagging, especially around the eyes and around the nose. For example, Phung, a 52-year old hospital employee said: “for the first year I got menopause ... my skin was very dark with lots of black spots and my skin around the eyes was wrinkly.” And during a patient-doctor observation, one woman patient explained: “my skin is dry and too wrinkly, especially two lines in the middle of eye brows and nose.” Many had further concerns with black, brown or white spots, acne or hair loss.

Some, like Thuy (a 55-year old corporate employee) interpreted these as signs of illness: “My skin tells me my health is not good such as when my face is dark, my skin has some black spots and white spots on both sides of my face.” However, doctors commented that some of these problems were side effects of cosmetics or medicines rather than symptoms of menopause. For example, Dung, a 58-year old male dermatologist explained: “They asked why when they used cosmetic products, their skin became white and the black spot was removed at the beginning. But later their skin became dark again, and was worse than before. They also asked why they got too much acne and had dry lips even after taking pills for about two weeks, which did not happen before.”

Women patients also believed that menopause was to blame for their weight problems, their muscles feeling soft and weak, and their breasts too small and soft.

4.2.2 Effects of menopause on other physiological and sexual problems

Besides skin problems, sexual problems were another key complaint the interviewed women attributed to menopause. All of them had such problems, such as pain and discomfort when having sex, vaginal dryness, and low sexual desire. Dang, a 53-year old nurse, said: “I was scared when I had sex with my husband because it made me uncomfortable. My vagina was always dry and had pain.”

Other problems the interviewed women attributed to menopause were irritability, mood swings, hot spells and pain in the pelvic region. Some said these symptoms made their lives very difficult. Ba, a 50-year old university lecturer, reminisced: “I was very bad. I couldn’t do anything. I felt I was getting 10 years older.”

4.2.3 Effects of menopause on family problems

As already explained above, the interviewed women believed that menopause had caused several problems in their families, including divorce from their husband or the husband having mistresses. The other family problems that happened after menopause were illness of the children, quarreling between the woman and the husband, the woman and her children, or problems with the husband’s business. Hue, a 46-year old nurse, explained: “After I got menopause, I was unhappy. My family was broken. My husband remarried with a young woman because I had low sexual desire and got ugly.” The other participants’ husbands simply took mistresses or girlfriends while remaining married. Ba, a 50-year old university lecturer said: “My husband is an architect. He usually goes out due to his contract and has to meet some people. I know he had some young girls outside.”

The women I interviewed also attributed things like their children getting ill or the husband’s business suffering to their own beauty that had suffered as a result of their menopause. Many thought it was due to menopause that they got easily into arguments with their husbands or children.

4.2.4 Effects of menopause on career problems

The interviewed women believed that because of menopause, they were not as attractive as before, which made their professional lives suffer. For example,

Nhu, a 46- as year old fashion vendor believed that because her job was selling clothes, she had to look like a model and make the customers impressed with new designs by wearing them herself and looking good in them: “I think I should take care my body because I sell fashion and jewelry ... if my skin is too dark or not smooth it will make me uncomfortable and I can’t try on new clothes... when the customers come to my shop”. Now, she thought she couldn’t sell well because of her face was dry and she had some wrinkles.

Other professional problems the women attributed to their menopause included their inability to get business contracts, conflicts with co-workers, and not feeling confident when interacting with their clients or students. In some cases, the women explained their career problems resulted from their own menopause-caused irritability.

As seen above, the connection they thought their menopause had with their career problems was also in part explained by the idea of ugliness as inauspicious. Underlying this was a belief that the characteristics of the woman herself were somehow magically connected with the characteristics of their work or business; for example, if they thought they were getting old, less energetic, their business might also get less dynamic and less successful.

4.3 Health practices related to menopause

In addition to HRT, two other main types of health practices were referred to by both menopause patients and dermatologists: 1) lifestyle-related practices like exercise, taking care of one’s nutrition, spa treatments and positive social activities and 2) medical but non-HRT practices like antioxidant supplements, Botox injections, IPL treatments and so on. I outline these practices below.

4.3.1 Lifestyle-related health practices to prevent skin aging

The interviewed dermatologists explained that their first line treatment for menopause symptoms was often lifestyle-related health advice, for example on exercise, a healthier diet, avoiding stress, engaging in pleasant activities to reduce their

stress, exerting care in choosing their cosmetic products, avoiding alcohol, tobacco, excess salt and sun exposure, and so on. For example, Lam, a 48-year old dermatologist, said: “I will tell them that they should eat more vegetables, drink more fresh water, do exercise, use sun cream and skin care products. If the patients’ breasts or other parts of their bodies are sagging, they can do exercise, yoga...”

The interviewed women’s accounts reflected that these women did indeed engage in such healthier lifestyle practices to minimize the impact of menopause on their skin. Nhu, a 44-year old fashion vendor said she would “exercise every day in the early morning, diet, eat fruit, vegetables, and drink water.” Others’ accounts were similar.

Many got spa treatments – Thuy, a 55-year old corporate employee, said she got such treatments every week.

The women also used ordinary cosmetic products (sun screen, night cream) topically on their skin and took nutritional supplements such as “collagen water”. Many had used a variety of cosmetic products available on the general consumer market but found that such products worked in the short term to reach their skin beauty goals but had negative effects in the long run, such as acne, red spots, wrinkles or a darker skin tone than before.

The patients’ and dermatologists’ accounts also matched in that more medical treatments, including HRT, were usually only introduced when these methods didn’t bring the desired results, especially on their skin complaints. Dang, a 53-year old nurse, for example said: “I did yoga to maintain my muscles and health for 2 hours every day in the evening at the gym. It improved my backache and my sweat symptoms very much. I didn’t feel headache any more but my skin didn’t improve. I used many kinds of creams to treat my wrinkles and black spots in my face but it didn’t improve though I used them for a long time.”

4.3.2 Non-HRT medical practices to prevent skin aging

Both the patients' and dermatologists' accounts showed that HRT was not used alone, but in combination with other treatments.

All the interviewed women had taken antioxidants (selected vitamins, especially A, C, and E, and minerals, particularly selenium) at some point, and all the dermatologists interviewed prescribing them. However, in combination with HRT, the dermatologists only prescribed vitamin C and vitamin PP (niacin) for skin whitening and prevention of sun sensitivity. Selenium was also commonly prescribed in combination with HRT. One woman (Thuy) referred to antioxidants as "anti-aging tablets". Vitamin C injections for whiter skin were also mentioned.

Other popular medical treatments included collagen cream for smoother and moist skin and Botox or Macrolane (a type of hyaluronic acid) injections for smoothing out wrinkles and making the face look fuller. IPL, laser and hydroquinone were used for removing black spots. Individual doctors mentioned using Dermaroller and Juventure (a brand name of a stem cell treatment). Both patients and doctors noted the importance of protecting the skin against sun exposure with high SPF sun screens. Some patients took weight loss pills to counteract the weight gain they experienced during menopause.

Plastic surgery was also mentioned by both patients and doctors, such as eyelid surgery, facelift, and breast surgery. Some doctors noted the high cost of such surgeries, however. For example, Thanh, a 55-year old woman dermatologist said: "or they can have plastic surgery if they have the money."

Many women patients had tried numerous other methods before trying HRT. For example, during a patient-doctor interaction observation, a patient explained to her dermatologist that "about two years ago my skin and body became ugly and I tried to use many methods (Botox, vitamin C injection, creams, breast surgery, eyelid lift) to solve my skin and body problems."

4.3.3 Medical treatments requested by women from dermatologists

When I asked the women I interviewed what they asked from their dermatologists, they answered in very general terms that they wanted to check their skin, renew their prescriptions and get advice.

The dermatologists I interviewed noted both specific skin concerns and specific treatments the women requested. Thanh, a 55-year old woman dermatologist, stated that “they want to get bright skin, decrease their wrinkles. They want to treat the side effects of creams and use sun block. They want to do IPL, Botox, Macrolane, RF Matrix [a type of laser], or facelift to make their face younger than before.”

Lam, 48-year old woman dermatologist noted her women patients proactively requested all kinds of the services she had available, including HRT: “In general, they want their faces to be bright and feel smooth quickly. Because this is a skincare room, they want to use all the methods here. Menopausal women request me to give HRT because they read the brochure outside this room and their friends also introduced it to them.”

4.4 Patterns of HRT use

4.4.1 Purpose of HRT use

The women patients I interviewed all said they had used HRT not only for skin problems, but also mentioned many other physical and psychological menopause symptoms they wanted help with. In the same way, the dermatologists’ accounts also reflected the idea that HRT could solve several problems at the same time, both medical and not so medical. Sang, a 47-year old male dermatologist enthusiastically emphasized these benefits: “I like to choose HRT for menopausal women because HRT can solve both menopause symptoms and skin aging. They want to please their husbands, to get happy in their lives, and solve their skin aging problems. Why wouldn’t I choose it for them?” Two of the dermatologists also noted the role of HRT in preventing osteoporosis and cardiovascular disease, which none of the patients talked about.

The key problems the women patients talked about were skin related problems (dry skin, wrinkles, darker skin tone, white and black spots etc.) and sexual problems (vaginal dryness, pain during sex, and reduced sexual desire).

In several cases, the women were open about not only using HRT to make themselves feel or look better; they also said they wanted to please their husbands by looking better and having better sex. For example, when asked why she used HRT, Nhu, a 44-year old fashion vendor, said: “To maintain my skin and make my husband happy”; Thuan, a 50-year old corporate employee similarly said she used it “to maintain my skin and for vaginal dryness; to please my husband and for myself.” And one woman patient said to her dermatologist during one of my observations: “I want to keep my husband and my business. When I am beautiful I will get many new chances in my life.”

4.4.2 Types of HRT used

See Summary of Patient Interviews (p.97) for the types of HRT mentioned by the participants of this study.

The most often mentioned product was Evaskin, a product combining plant-derived estrogen (phytoestrogen) and collagen. It was most commonly used because of its perceived effectiveness for skin symptoms, the main concern in a dermatological context. At the same time, its main component, phytoestrogen, was also thought to be less risky than other hormone products.

Some of the products mentioned were used primarily as contraceptives but were also sometimes used for menopause symptoms, for example Diane-35 or Ovestine. Marverlon, Mercilon and Cilest were less often used for skin care. Sang, the 47-year old male dermatologist implicitly shared his idea that there might be a choice to be made between effectiveness and safety – for example, that Diane-35 might resolve skin symptoms more quickly than phytoestrogen products, but also carry more risks. He added that if the patient also had particularly difficult problems in their sexual life, he might opt for Diane-35 rather than phytoestrogens.

Both patients and dermatologists also mentioned the use of vaginal hormone creams for vaginal dryness and pain during sex, but no particular brand names were mentioned.

Table 4.3 HRT products mentioned by participants

Product name	Route of administration	Primary ingredients	Uses mentioned by participant
Evaskin	Oral	Phytoestrogen, collagen and others	Management of menopause symptoms, especially skin
Phytoestrogen (generic)	Oral	Phytoestrogens	Management of menopause symptoms, especially skin
Diane-35	Oral	Cyproterone and ethinyl estradiol	Contraceptive, management of menopause symptoms
Ovestin	Oral	Estriol	Management of menopause symptoms
Marverlon / Mercilon	Oral	Ethinylestradiol and desogestrel	Contraceptive
Cilest	Oral	Ethinylestradiol and norgestimate	Contraceptive
“hormone cream” (various brands)	Topical (vaginal)	Depends on the product	For vaginal dryness and pain during sex
Evra patch	Skin patch	Norelgestromin, ethinyl estradiol	Contraceptive

4.4.3 Process of HRT treatment

Based on my observations, in the first meeting between the patient and the dermatologist, the dermatologist usually began the interaction by asking what kind of complaint the patient had. After this, the patient explained about her skin problems. The doctor would then ask how long she had had the problem. At this point, the woman patient typically took up the issue of menopause, linking the skin problem with her menopause. After this, the dermatologist typically asked how long since she had entered menopause, how many children (if any) she had, if she had ever consulted an obstetrician about her menopause related symptoms or used any methods to treat her menopause or skin symptoms, if the patient had any illnesses, and if the patient had ever had her ovaries checked with ultrasound. If the patient didn't have any health conditions the doctor would have thought contraindicated HRT (see next section), the doctor would then recommend the treatment. However, in addition to writing the prescription, the doctor would request the patient to go for a number of tests, and if these tests indicated the patient did not have any contraindicating health condition, the patient could either buy the HRT medication from the hospital's pharmacy or an unaffiliated drug store nearby. If the tests showed the patient had a problematic health condition, the patient would come see the doctor within a few days and the doctor would prescribe other treatments than HRT.

Some women patients proactively requested HRT after reading or hearing about it, but mostly the dermatologists were the first to recommend it for solving both skin complaints and other menopause symptoms. Although some of the women interviewed noted they had started to use HRT following their doctor's suggestion, some said they had made the decision to use it by themselves.

After starting the HRT treatment, the patient would typically come see the dermatologist again in two weeks' time. During this meeting, the dermatologist would discuss with the patient how the treatment was working and if she had any side effects. If the patient was satisfied with the treatment and did not have troublesome side effects, the dermatologist would renew the prescriptions and thereafter have follow-up meetings with the patient, usually once a month. Interviews with both the patients and dermatologists, as well as the observations, indicated that most patients would use the

treatment for four to six months continuously, some repeating the treatment in one or two following years.

4.4.4 Dermatologists' considerations related to HRT use

Based on my interviews with dermatologists and patient-doctor observations, after finding out about the women patients' clinical histories, the dermatologist would choose anti-oxidants or other alternative methods to resolve their patient's skin problem, especially if they doctor knew or suspected the woman patient or some others in her family had a history of certain illnesses. As seen above, the dermatologists always asked their patient to do some tests such as blood tests or ultrasound tests before starting HRT. Illnesses and symptoms the dermatologists considered ruled out the use of HRT included breast cancer, heart disease, hypertension, hepatitis or other liver trouble, high cholesterol, ovary problems, recent infections of the reproductive system, and pelvic pain.

For deep wrinkles and heavy menopause symptoms, or if other treatments had not worked well enough, the doctors recommended HRT. Some dermatologist would prescribe HRT more easily, and also combine it with other methods (e.g., HRT with Botox injection to smooth out wrinkles; HRT with day and night cream to keep smooth skin; IPL or QS laser with HRT for black spots; HRT with Vitamin C or Niacin for antioxidant effects) to solve the patient's problem more quickly, while others were more cautious about prescribing HRT or combining it with other methods. Unsurprisingly, those doctors who were more enthusiastic emphasized its benefits, while those who were not so enthusiastic were more concerned about its risks.

4.4.5 Patients' experiences of treatment

Overall, all the menopausal women patients I interviewed were happy with HRT at the time I interviewed them. The expressions they used to describe how they felt while on HRT included "being comfortable" (Mai, Thuy & Dang) and "feel much better" (Mai, Phung, Dang, Thuy) while using it and agreed with their doctor that it was good for them. Hue said she felt "better" and was "willing" to continue using HRT. Nhu, a 44-year old fashion vendor, who had become menopausal in her early forties, had been prescribed HRT to restart her menstruation. She said the

menstruation did not restart but her health was better in general. The patients generally said their “skin and body” were better while on the treatment. For example, Ba, a 50-year old university lecturer, said: “I’ve used it for 3 months and now my skin and health are much better”.

However, when the women patients described what in particular had improved in their lives, their answers focused on how their relationship with their husband had improved. All seven women patients who were still together with their husbands felt their sex life and relationship with their husband was now better, both because their husbands now found them more attractive, and because they did not suffer from vaginal dryness and pain during sex. Dang, a 53-year old nurse, was the most enthusiastic about the change. From being afraid of having sex with her husband, she now felt she couldn’t wait to meet her husband while at work:

“Much better, I feel happy with this method and my health is good, my face is bright, my vagina is not dry, I feel comfortable when I have sex with my husband. Whenever I have time during my work, I just want to come back to meet my husband! My family is happy.”

Another key improvement these women patients talked about was that they felt more confident in other social situations. Thuy, a 55-year old corporate employee, said: “I am so confident when I go out with my husband or my friends” and many others also expressed the same idea.

None of the eight women patients I interviewed said they had got side effects from HRT they used for skin care. None of them felt worried about potential negative health consequences of HRT, either. The reasons they gave for this were that they had already been tested for illnesses that could rule out the use of HRT, would be tested frequently during the treatment, and would only use HRT for a short time anyway. Some said their colleagues had used it before and hadn’t experienced any problems.

Three participants who worked in hospitals (Hue, Dang, Phung) felt particularly confident that HRT would be safe. Mai, a 53-year old corporate employee, had initially been concerned if HRT could be dangerous to her because she was overweight. Her doctor had explained to her that if she paid attention to controlling her food intake and exercised regularly, she would be fine; she believed this explanation.

This shows how the doctors also played a role in making women feel confident in the safety of HRT.

4.5 Cultural and social factors affecting HRT use

4.5.1. Cultural factors affecting HRT use

The key cultural factor affecting HRT use was the belief that beauty brought good luck whereas ugliness brought bad luck. This belief was repeated again and again in the interviews and observations. For example, during a patient-doctor interaction observation, one of the patients explained to the dermatologist: “If my face is so dark, it is a bad omen. My business is going down, my husband had a girlfriend, some accidents happened in my husband’s workplace ... my children did not have good health and were kidnapped.” Another observed woman expressed her surprise that although she had already had extensive plastic surgery, her family life had not improved: “I did surgery for my breasts, eyelid lift but my family is still not good.”

The list of misfortune associated with deteriorating beauty was long and went well beyond situations where beauty could directly affect the treatment these women received, for example from husbands, clients or colleagues. Examples of such bad luck associated with ugliness included accidents or ill health in the family, children being kidnapped, or negative things happening at the husband’s workplace.

4.5.2 Social factors affecting HRT use

Two key social factors played key roles in determining which women would access HRT. The first of these was that only affluent women could afford HRT. During my observation, I noted that the doctors would tell their menopausal women patients that HRT is expensive and once started the patients cannot stop in the middle of the treatment. At this point, all patients indicated that money was not an issue for them. Many were businesswomen themselves, were in other highly paid positions, and/or had husbands who were well-earning businessmen. These women also had time to spend on skin care.

The second factor was that being in such social positions, the women who accessed HRT often did so because they faced considerable social pressure to look good. As seen above, many women felt it was necessary for them to look good to succeed with their job or business. The fact that their husbands were wealthy and in high social positions also made it affordable and easy for them to find mistresses or girlfriends if they wanted to – and all did.

Other than through economic support and pressure, women patients' husbands influenced their decision-making to use HRT in various other ways as well. Many husbands had very bluntly told these women they were no longer attractive in their eyes, like Phung's (52-year old hospital employee) husband: "My husband told me that I was so ugly." Many suffered from pain and vaginal dryness during sex. This indirectly drove such women to seek treatment.

Some husbands added to this pressure by indirectly communicating to their wives how they felt about having a menopausal wife: "Sometimes he jokes with me that when women get menopause it is the main cause leading husbands having young girls outside. I need to be healthy and beautiful because of my family and my husband" (Ba, 50-year old university lecturer).

Several husbands also directly encouraged their wives to see a doctor and seek treatment for their ailments. The most direct influence to start HRT treatment by a husband was told of by a woman observed during her interaction with her dermatologist: "I used vaginal cream because my husband gave it to me, he went to his doctor and his doctor gave it to him." Some husbands encouraged their wife on HRT to continue the treatment because the treatment had perceived benefits also for the husband himself:

"I and my husband feel comfortable with sex life, and he advised me I should continue using HRT. He told me that I should take care of my body not only for me but also for him and I know that I should take care of my health and keep my body healthy because it will make my family happy and lucky." (Ba, 50-year old university lecturer)

In some other cases, it was the woman's son who suggested a visit to the doctor. For example, in Ba's case, also her son "suggested that I had to take care of my

eyes and skin because I looked older than my age”. In Thuy’s and Phung’s cases, their colleagues urged them to see a doctor to improve the condition of their skin.

Some patient participants were reminded of the inauspiciousness of “ugliness” by friends. For example, Phung, a 52-year old hospital employee, said:

“When my face got ugly, my work got problems, my patients complained about me, and my husband got an accident. My friend told me that because my face was dark it was a bad omen. So I have to make my face bright although the symptoms of menopause make my skin become ugly.”

Mai, a 53-year corporate employee was influenced by a fortune teller: “My children got heavy disease, my husband lost money. The fortune teller suggested I need to take care of my face, make my face bright.”

4.5.3 Medical discourse on menopause and women’s beauty and its power

Based on my interviews and observations, it seems that many women patients first thought their symptoms were due to an illness, possibly a serious one, not menopause.

However, the doctors did not call menopause an illness. The first key concept they used was “symptom”. In many interviews, the women patients said their doctors had explained to them that they did not have a disease, but symptoms (of menopause). For example, during an observation, a male doctor said to his patient: “The menopause symptoms are vaginal dryness, libido, sweating, hot flashes, dry skin, and hair loss. You will get sad easily or angry with some people around you.” One problem with this word was that patients understood it differently from doctors – they thought that if some health trouble happened again and again, it could not be a “symptom” but was surely “disease”.

The second key concept doctors used was “aging”. For example, during an observation, a female dermatologist described aging to a patient like this:

“... because you are aging. You are not young, you are in the middle age. So your skin is not like that of young people who are 25 or 35 years old. Because you are having menopause, your hormones and collagen are aging.”

Using these two concepts, the doctors explained to women patients that the health problems they were experiencing were symptoms of menopause, which in turn was caused by aging and the resulting lack of hormones and collagen. The key consequence of this was that in the doctors' view, because the problem – menopause symptoms – were caused by a lack of hormones, then adding hormones by using HRT must be the solution. During an observation, a female doctor made the point to a patient like this:

“When you got menopause, it means you were aging because of hormone and collagen aging. That you are unhealthy and feeling tired is because of a lack of hormone. Your lack of hormone can make your muscles soft and your skin dry.”

Dung, a 58-year old male dermatologist with 32 years' work experience described this model to me in our interview:

“The main cause of menopause is lack of hormone and hormonal aging; hormones play an important role in sex life. I use HRT to help those women increase their hormone level. When the main problem is solved, their health will be better and their skin problems will be solved easily.”

Overall, the women patients I interviewed all accepted this explanation and therefore thought that using HRT was safe and good for them, provided they did it under their doctor's supervision, took the tests their doctor asked them to take, and didn't use HRT too long.

Thanh, a 55-year old female dermatologist with 30 years' work experience, made the comparison that when women age and have less female hormones, they become almost like men and their bodies cannot adapt to this new situation. However, none of the patients mentioned this idea.

CHAPTER V

CONCLUSION, DISCUSSION AND RECOMMENDATIONS

5.1 Conclusion

This qualitative study was aimed at increasing our understanding of menopausal women's experience of hormone use for skin anti-aging in Vietnam. Specifically, the study sought to describe menopausal Vietnamese women's cultural beliefs on skin-related beauty and on how menopause and menstruation affect it, describe their health practices, including HRT use, aimed at preventing skin aging, as well as to explore the social and cultural factors that influence their HRT use for skin anti-aging. I interviewed eight menopausal patients and four dermatologists, as well as conducted four observations at a large public dermatology hospital in Ho Chi Minh City in 2012, and performed content and discourse analysis of these types of raw data.

The findings indicated that beauty is very important for affluent, urban, middle-aged Vietnamese women. They believe that beauty is the key to happy family lives, professional success and generally necessary for them to have "good luck" in their lives. They felt that if they looked "ugly", their husbands ridiculed them and took mistresses or divorced them; and they might not earn respect from their colleagues, clients and students, either. Their experiences suggested these beliefs to be quite realistic. However, they also held superstitious beliefs about beauty – they believed it was due to their lack of beauty that their children had fallen ill or been kidnapped, or that accidents happened at their husband's workplace. On the other hand, if they could regain their beauty that had deteriorated at menopause, they believed that they could make their relationship (and especially the sex) with their husband satisfying again, their careers or businesses flourish, and that they and their families would be blessed with good luck in all aspects of life.

For these women, skin played a very important role in their conception of beauty. Beautiful skin for them meant skin that is "white" or "honey-colored" but definitely not "pale", has consistent color, is smooth, moist, and free of wrinkles or

spots, looks healthy and doesn't look tired. This not only included their facial skin but also the skin in other parts of their bodies, especially breasts. They considered large breasts more attractive, but also thought that breast size must be proportionate with body size. Some mentioned that breasts that looked unnaturally tight due to a silicone injection would not be as good as breasts that looked natural. Other aspects of beauty included slimness and an oval-shaped face.

These women patients believed that menopause was the reason their faces had wrinkles, dry skin, spots of various colors, and a darker tone than before. They also believed that menopause was the cause of their mood swings, hair loss, their muscles feeling soft and weak, their breasts looking too small and soft, and very importantly, the vaginal dryness and pain they felt during sex, which had a very negative effect on their sexual lives with their husbands. Taken together, they felt that menopause had affected them very negatively in both their family lives and professional lives.

Both the women patients and the dermatologists I interviewed described a range of general health practices used by menopausal women to prevent or reverse skin aging. The dermatologists gave general health advice, for example urged their menopausal patients to take regular exercise, avoid tobacco, alcohol and stress, eat less salt and more vegetables, drink plenty of fresh water, and protect their skin against sun exposure. The women patients' interviews suggested they did engage in all these kinds of health practices.

Both the dermatologists and women patients also described many generally available skin care methods like spa treatments or cosmetic products. The dermatologists also talked of a range of more specialized treatments like Botox or Macrolane injections for smoother or fuller-looking skin, IPL, laser or hydroquinone treatments to remove black spots or plastic surgery on the face or breasts. Antioxidants (especially vitamin A, C, and E, and minerals, especially selenium) and high SPF sun screens were two key treatments recommended to, and used by, basically all women patients of dermatologists.

HRT entered the picture when other treatments didn't give good enough results. Some dermatologists were keener to prescribe it while others were more cautious. In all cases, dermatologists took their menopausal women patients' case

histories of illness in the woman herself and her family, and requested them to do laboratory tests to exclude contraindicating conditions like cancer, hypertension, high cholesterol or various diseases of the reproductive organs. The most common type of HRT prescribed was a commercial product combining phytoestrogens and collagen, specifically produced for skin care with menopausal women. To a lesser extent, vaginal hormone creams and medicines primarily used as oral contraceptives were also prescribed. The dermatologists typically had first follow-up meeting at two weeks' time and then at one month intervals. HRT was usually used for four to six months per year, often during two or three consecutive years.

For the women patients, key physical problems that prompted them to use HRT related to their skin or sexual problems. However, when asked what they used HRT for, they often replied that their true aim was to keep their husband by "making him happy" (with their looks and with improved sex) and to keep their job or secure their business. All eight women patients were satisfied with the physical results of the treatment, saying they felt better while on the treatment. More importantly still, seven interviewed patients who were still together with their husbands felt their marital relationship had improved because their husbands found them more attractive and because the sex was better. None of the women patients said they had experienced side effects, and when interviewed, all seemed convinced that the treatment was fully safe for them.

The key cultural factor affecting HRT use for skin care was the beliefs in the all-importance of beauty for marital relationships, professional success and good luck in general. The most important social factors influencing HRT use were having the means to access it, and the pressure from husbands, colleagues, clients and even one's own children to look good. The husband's economic standing was also an important factor not only because an affluent husband could finance expensive HRT treatment, but also because richer men could afford to take mistresses, thus putting more pressure on the woman to impress her husband with her looks and in bed.

The medical discourse on menopause in this context, as communicated by the dermatologists to both patients and me, emphasized that menopause is not a disease. Nevertheless, the complaints of the patients were explained as symptoms of menopause, and explained in terms of deficiency of hormones and collagen, caused by

aging. In this way, menopause could be medicalized without viewing it as a disease. This explanation in turn legitimized the use of HRT: If menopause symptoms result from a deficiency of hormones, then the straightforward way to address them is to treat them with hormones.

5.2 Discussion

5.2.1 Cultural beliefs on beauty: Making beauty obligatory

The most important new finding of this study was that the menopausal women I studied had cultural beliefs about the importance of beauty which made it almost an obligation for them to maintain their looks. They believed that if they remained beautiful, they could keep their husband and their job, their (or their husband's) business would thrive, and their families were less likely to have bad luck. Conversely, they believed that if they became "ugly" a range of misfortune could follow, some with a plausible connection (e.g., the husband taking a mistress or their colleagues ridiculing them), some clearly superstitiously (e.g., their children falling ill or the husband getting in trouble at work). So, when they felt their beauty was threatened by menopause, they turned to dermatologists.

5.2.2. Role of the economic development: Making HRT affordable

However, when Nguyen (2001, p. 57) surveyed 734 postmenopausal women in Hanoi, she found that most of them had very little knowledge about menopause and very few menopause-related health practices, although almost all of them had some menopause-related symptoms. The situation of my eight menopausal women participants in HCM City was very different: They were receiving media messages about menopause; their colleagues, husbands and children talked to them about it, and they were seeing advertisements for HRT on television. More importantly, they had tried just about every method available to them to take care of their skin and beauty during menopause, including HRT. How did this change come about?

One major factor has been economic growth. In 2001, Vietnam's per capita GDP was 413 US dollars; in 2012, when I conducted my interviews, it was 1498 dollars – almost four times bigger (International Monetary Fund, 2012). In my practice as a dermatologist in HCM City, I saw this change. In the early 2000's, many were still struggling with not having enough to eat, so the thought of how to maintain their beauty wasn't foremost in their mind. Living standards have improved tremendously, and especially so in the center of economic growth in Vietnam – HCM City. This has given a number of Vietnamese women living there the time and money to spend on taking care of their beauty, with HRT and many other methods.

5.2.3 HRT for skin anti-aging: For well-off wives (and husbands)

However, even in 2012, HRT as a skin care method was still only affordable for relatively affluent Vietnamese women. For these women, their high social status and also the wealth of their husbands not only provided them with the money to use HRT, but actively put pressure on them to do so, too. With their high social standing, they faced great pressure to look good at work, whether in the eyes of clients, colleagues or students.

More importantly still, because their husbands were wealthy, it was easier it was for the husband to find mistresses, and so the pressure on the woman herself to impress her husband with her looks and in bed was greater, too. Similarly, in one study conducted in the United States, the most important predictor for a woman's HRT use in the multivariate analysis was her husband's occupational status: the higher the husband's status, the more likely the wife's use of HRT became (Marks & Shinberg, 1998).

5.2.4 Complementary variants of menopause and HRT discourse: “Treating symptoms” and “beauty from within”

As I explained above, HRT was just one among many beauty treatments my women participants tried, usually when they felt dissatisfied with the results from other treatments and health practices. But it was a treatment they felt greatly impressed with, to an extent because it made them feel generally better, but especially because it improved their sex lives and made their husbands feel they were looking great. Many

of them were aware that they were not just taking the treatment for their own, but also for their husband's happiness, and some husbands eagerly cheered HRT for their wives because it improved *their* sex lives. As Nguyen (2006) has analyzed before, even when Vietnamese women themselves don't feel much sexual desire, they feel that it is their duty to please their husbands sexually. HRT helped the women I interviewed to please their husbands *and* enjoy it – this was very important for them.

Why has HRT been able to satisfy these women's desire for skin anti-aging and general improvement of their looks, where other methods have been unsatisfying? According to the dermatologists I interviewed, the cause of these women's numerous skin complaints, whether wrinkles, dry skin, darker skin tone, or various kinds of spots, is their lack of female hormones and collagen. So, adding these "missing" hormones (as well as collagen) to their bodies seems (for some of them) the perfect answer. The women I interviewed generally accepted this explanation and were thus willing to use HRT.

Convincing the women that their symptoms are due to menopause, and that HRT is the answer, is what Foucault would have called the power of the medical discourse. However, medical discourse on menopause as expressed by doctors and their patients in this setting had one key difference from typical characterizations of the medical menopause discourse: Here, the doctors emphasized that menopause is *not* a disease, contrary to what social health research literature (e.g., Goldstein, 2000; Women's Health Council, 2008) would suggest. This is not to say that menopause wasn't medicalized in this setting – though the doctors did not view it as a disease, they medicalized it nevertheless by conceptualizing it in terms of "deficiency" (of hormones and collagen), "aging" and "symptoms". Following this conceptualization, HRT was no less legitimate than if menopause had been called a disease.

The women patients I interviewed expressed a somewhat different discourse on HRT. For them, HRT fit into the idea of "beauty from within", or looking more beautiful through making the body healthier. In their view, HRT enhanced their beauty much like exercise did. This was also related to their attempts to look beautiful in a natural way – looking beautiful without others being able to tell what treatments they had had. Hue, for example recounted how she had spent a lot of money on expensive beauty treatments like spa treatments, cosmetics, plastic surgery and Botox

injections, and how her husband had nevertheless left her. Her interpretation was that she had become like an “out-of season fruit” for her husband: Expensive and pretty on the outside, but not tasty inside. The explanation that HRT would correct these women’s skin problems “from within” thus fit in very well with their attempts to look beautiful in a natural way, not just in their faces but also in other parts of their bodies.

The women I interviewed believed that if HRT was prescribed by their doctor and if they took the tests requested by the doctor, it would be safe. Among the women I interviewed, nobody expressed the kinds of resistance or disbelief of the medical discourse on menopause and its management with HRT that seem common in Western countries (e.g., Women’s Health Council, 2008) and have also been reported among Thai menopausal women (e.g., Srivilai, 2003).

Based on the dermatologists’ accounts, their menopausal women patients’ agency was expressed mostly through their choice to continue buying HRT products from pharmacies (where they are freely available) after the dermatologist discontinued or paused the treatment. These dermatologists were rightly concerned about the health risks of such health behaviors, yet it was clear that when women continued HRT treatment on their own, many they did so because the dermatologists themselves had in the first place convinced them that the treatment would give good results and be safe.

5.2.5 Safety of HRT: Are plant estrogens safer?

Throughout the decades that HRT has been available, scientific knowledge of its safety has undergone radical changes. In the 1960s and 1970s, it was touted as a panacea that all menopausal women should take. Then the risk of endometrial cancer was publicized, and progesterone was added to the HRT cocktail to counter this risk. In early 2000’s, major studies (especially Womens’ Health Initiative and the Heart and Estrogen/Progestin Replacement Study) suggested that combined HRT actually did not have some of its purported health benefits, such as prevention of heart disease and actually increased the risk of stroke, heart attacks and breast cancer; the risks of estrogen-only therapy were also considered to outweigh the benefits to continue this arm of the Women’s Health Initiative trial. Media reports of the findings of these

studies radically reduced HRT use in Western countries for some time (Women's Health Council, 2008).

In the late 2000s, HRT has seemed to be making a comeback. What seems particularly "hot" right now is plant-derived estrogens (phytoestrogens), which are being advertised as "natural hormones" and believed to be safer than other hormone products (Bedell, Nachtigall, & Naftolin, 2013). In the context of the dermatology practice I studied, what most interviewed women reported taking, and what most dermatologists also reported prescribing for skin anti-aging, was a commercial product combining plant estrogens and collagen. Reviews of the available scientific evidence do suggest that plant estrogens are less risky than for example animal-derived estrogen, but they also point out that the available evidence on their safety is still limited (e.g., Bedell, Nachtigall & Naftolin; Eden, 2012). Patisaul and Jefferson (2010, p. 407) even stated that "no clear consensus has been reached on whether or not phytoestrogens are helpful or harmful". In this sense, the women using these products are taking risks with their health without realizing it.

5.2.6 Gender issues in HRT research and HRT for skin anti-aging

Interestingly, among the four dermatologists I interviewed, the two female doctors were more open than the male dermatologists to share their information and well cooperated to answer all my questions. The female doctors seemed more motivated to answer all of my questions in detail. The two male doctors seemed uncomfortable when I tried to get them to elaborate their answers, and evaded some questions by changing the topic. The male doctors saw themselves as being in a more powerful position than me when they interacted with me in my capacity as a female researcher. Of course, it was easier for the female dermatologists to be open with me because I am also a woman.

Gender issues were also clearly present during medical consultations. Based on my observations, many women patients felt shy and afraid to discuss their issues with male doctors, and the male doctors were not as responsive to their menopausal women patients' questions as the female doctors. This suggests a gender barrier in the male doctors' practices with their menopausal women patients.

In summary, as economic development makes HRT available to an increasing number of Vietnamese menopausal women, it becomes all the more important to focus on the cultural beliefs on beauty that make these women believe they must take care of their beauty by all possible means, including HRT. These beliefs should be discussed and questioned in Vietnamese society to empower Vietnamese menopausal women to make more informed choices about their skin anti-aging care.

5.3 Recommendations

5.3.1 Recommendations for further study

Based on my findings, the following kinds of future research are needed:

1. Further qualitative research should try to identify alternative, non-medical ways that menopausal women in Vietnam and elsewhere currently use to cope with their menopause related health issues and their social consequences, and then disseminate these alternative ways with other menopausal women. Recruiting the participants in community rather than clinical settings might make it easier to find women who have identified non-medical, alternative ways to cope with their menopause symptoms and their social consequences.

2. Further clinical research is needed to create reliable evidence on the effectiveness, safety and health risks of HRT used primarily for skin care in menopausal women. Specific studies are needed with Asian menopausal women from several countries. Specific research is also needed on the effectiveness and safety of phytoestrogens that are now widely used without reliable evidence about their benefits and risks.

5.3.2 Recommendations for health care providers

- 1.) Physicians should provide comprehensive about menopause from the beginning of pre-menopause, during menopause and post-menopause.

2.) Physicians should provide comprehensive and unbiased information about HRT, its benefits and risks, and let their women patients make their own informed choice about using or not using HRT.

3.) Physicians should actively give unbiased and comprehensive information about menopause and HRT also outside their hospital or clinic, for example communicate with the general public through the mass media and seminars in places like the Women's Cultural House.

4.) Hospitals should arrange seminars, workshops, counseling groups, individual counseling and information materials for menopausal women to help them manage the health problems and related social problems they experience during menopause.

5.3.3 Recommendations for policy makers and public sector bodies

1.) The state should seek ways to control the use of HRT products by ensuring they are available by prescription only.

2.) The Women's Cultural Houses, especially in HCM City and in other cities are places where many women already come to attend health and beauty related seminars and training. Thus, Women's Cultural Houses should also arrange seminars on menopause, skin aging, HRT and cultural beliefs on beauty to provide menopausal women comprehensive and unbiased information in an easily accessible context.

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APPENDIX

1.1 In-depth interviews with patients

Name:.....**Age:**.....
Address:.....
Education:.....
Job/Occupation:.....
Marriage status:.....**Single**.....**Married**.....
How many children:.....
Last menstruation:.....**Month**.....**Year**.....

Cultural beliefs on skin-related beauty, female body, aging and menopause

- What are your ideas about female skin related beauty?
- What is your ideal female body?
- Why? What for? Why women need to fulfill ideal female body
- As a menopausal woman, what do you do to achieve skin-related beauty and your ideal body? (ask about black spots, white spots, wrinkles, soft muscles, dark skin around eyes...)
- What is your ideal/belief about being an older/aging woman?

Health care context

- What are the sources, persons and places that you can go to seek care/treatment for skin aging? (friends, media,)

Patterns of health practices for promoting skin beauty and prevent skin aging

- What have you done for promoting your skin beauty and preventing skin aging?
- When did you start this?
- Who did you go to seek information, sources of care and treatment? Tell me one by one and how long you have used each treatment? Why do you change from one to another?
- What does each method do to your body in positive and negative ways?

Patterns of Hormone Use

- Among the methods you use to promote and prevent skin aging, do you use hormones?
- How do you use them, when, how long?
- What type of hormones did you use?
- Why do you use them? How do you feel, are you satisfied with the hormones? What does hormones do to your body in negative and positive way?

Dermatologist health care practices

- Tell me about your treatment with your dermatologist
- How often do you visit him/her? Where? (hospital or clinic)
- What for?
- In each visit, what do you ask/request from her/him?
- What does he/she ask/tell you?
- What does he/she prescribe?
- How did you feel/ react when he/she prescribed you HRT?
- What kinds of information did he/she tell you about HRT?

Medical discourse on menopause

- What did doctors tell you about menopause in terms its causes and effects on your body and skin, and about how to maintain a healthy life after menopause, how to protect your skin and prevent/correct your skin aging?
- What did your doctor tell you about hormone use for skin anti-aging (in terms of time period to use, amount and times to take, benefits to your body, side effects on your body, certain practices that you should have while taking hormones?)

1.2. Guidelines for semi-structured interviews with dermatologists

- Name:Male.....Female.....
- Work experience (how many years?)
- How many patients come to meet you per day?
- How often do menopausal women come to consult you on skin related beauty and aging?

- What are their complaints and requests?
- What kind of information did you ask from them before prescribing your treatment?
- In what kinds of cases do you prescribe HRT to your menopause patient to prevent or treat skin aging?
- What kind of medicine/hormone do you prescribe?
- Why do you do that?
- What is your idea about prescribing HRT for skin anti-aging and skin beauty enhancement?
- What do hormones do to menopausal women's body and their skin?
- What are the positive and negative effects of HRT on menopausal women?
- How long should menopausal women use hormones for skin anti-aging?
- What kind of information you give to women when prescribing the hormones?
- What is menopause? What does menopause do in terms of its effects on women's bodies and skin?
- How to maintain healthy life after menopause? How to protect one's skin and prevent/correct skin aging?
- What should doctors tell menopausal women about hormone use for skin anti-aging (in terms of how long to use, dosage, timing, benefits to women's bodies, side effects on women's bodies, certain practices that women's should have while taking hormones?)

1.3 Observation Guidelines

Time start.....Time

end.....

1). What symptoms does the patient present to doctor/screening nurse?

(tick)

- Black spots
- Wrinkles around the eyes
- Sagging cheeks
- Dry vagina
- Hot flashes
- Others, specify

2). How long has the patient experienced complaints (both skin aging and menopause)

- a) First time b) Now and then (recurrent) c) Often (recurrent)

3). How severe are the complaints?

- a) Mild b) Moderate c) Acute

4). Who has the patient seen before regarding this problem?

- | | |
|-----------------|-------------|
| Places | No of times |
| Private clinic | |
| Drug store | |
| Herbalist | |
| Other hospital | |
| Others, specify | |

.....

5). How many times has this woman been to this hospital before this time?

Of

times.....

6). Has the patient self-treated the skin aging problem with any health practices before seeing this doctor?

7). Was the patient referred here by another doctor/freind?

8). Has the patient ever been here before with other complaints/skin problems?

9). What medical procedures does the doctor use?

10). Does the patient ask for a hormone prescription?

11). How does the doctor reaction to a request for hormones?

12). What kind of case history does the doctor take before prescribing the treatment?

13). Does the doctor ask about how the problem has been treated before?

14). Doctor's biomedical diagnosis (recorded-charted)

15). What does the doctor/nurse tell the patient the patient's problem is?

16). Does the patient ask doctor any questions? What questions?

- Make observation about quality of care
- Doctor competency
- Examination
- Courtesy
- Information given
- Treatment-medications
- Time spent

18). What does the medicine doctor prescribe?

19). If there is HRT, record the type, amount and information explained to the patient?

20). Does the doctor tell the patient about side effects of HRT and length of HRT use during the treatment procedure? Details of information given?

21). Also observe:

Time spent with one patient, gestures, length of conversation

Women's concerns about their skin and their health

Cultural beliefs about the family and society

Social roles, including in the family

Patient's education, living conditions, types of professional careers and lifestyles (housewife, career woman), media consumption, consumer product consumption

Summary of patient interviews

	Cultural beliefs on beauty of skin and body	Problems attributed to menopause	Menopause related health practices	Patterns of HRT use	Social and cultural factors affecting HRT use
1. Hue	<p>Definition of beauty: no wrinkles, not dark, not dry, no black spots,</p> <p>Significance: lack of beauty, looking sad brings bad luck</p>	<p>Bodily: Dark, dry, wrinkly skin; soft muscles, hot flashes, low libido, tired, hair loss, couldn't sleep, couldn't concentrate, mood swings</p> <p>Family: Divorce, husband remarried with young woman.</p> <p>Professional: patients and colleagues complained a lot</p>	<p>Non-pharmaceutical: exercise two hours every day, swim three times a week</p> <p>Non-HRT treatment: antioxidant tablets, anti-wrinkle cream, collagen water, sun block, collagen injection, cosmetic products</p>	<p>Reason to use: for skin beauty.</p> <p>Process: Begun treatment 1 year after menopause, 1 tablet at night, planning to use 5 more months. First saw doctor twice a month, now once a month. Previously used oral contraceptive. Dermato-</p>	<p>Son urged to seek skin treatment.</p> <p>Cultural belief that lack of beauty brings bad luck.</p> <p>Husband's remarriage with a young woman.</p>

	Cultural beliefs on beauty of skin and body	Problems attributed to menopause	Menopause related health practices	Patterns of HRT use	Social and cultural factors affecting HRT use
				logist recommended HRT as “natural hormone”. Satisfaction: Feels better since starting treatment.	
2. Dang	Definition of beauty: “fresh and strong”, no wrinkles, not dry, not dark; healthy Significance: Dark face will negatively affect family, husband’s work or the family’s finances,	Bodily: dark skin around eyes, wrinkles, lost hair, sweating, vaginal dryness and pain, dizzy, felt weak, backache. Family: Afraid when having sex; husband had girlfriends and	Non-pharmaceutical: do yoga, gym 2 hours every day Non-HRT treatment: collagen cream, herbal cream, day cream and night cream, face mask, sun block, facial massage, antioxidant for 3 months per year.	Reason to use: for skin beauty, increasing sexual desire, reducing vaginal dryness, and to please husband. Tried other methods first but they did not help her skin to improve. Process:	Husband suggested she should seek treatment for skin beauty and increasing her sexual desire. Cultural belief in lack of beauty making family unhappy and causing husband’s business to suffer. Believed it is her duty to look

	Cultural beliefs on beauty of skin and body	Problems attributed to menopause	Menopause related health practices	Patterns of HRT use	Social and cultural factors affecting HRT use
	<p>while “fresh face” gives good luck.</p>	<p>complained about her looks; she had arguments with her children. Professional: Felt uncomfortable dealing with clients because of her looks.</p>		<p>Previously, used HRT for vaginal dryness (15 days/month). Her doctor suggested her to use HRT 4 months/year for 3 years. She meets her doctor once a month. Satisfaction: Feels very happy about the results of the treatment – she feels healthy, confident about her looks and comfortable when having sex. No side effects.</p>	<p>attractive enough for husband. Husband is a manager, so she has high social status and thus money but also pressure to look good. She is a nurse and feels pressure to look good when seeing clients; feels it is easier to go see a doctor because she works in a hospital.</p>

	Cultural beliefs on beauty of skin and body	Problems attributed to menopause	Menopause related health practices	Patterns of HRT use	Social and cultural factors affecting HRT use
3. Mai	<p>Definition of beauty: not dark, no wrinkles, body not overweight.</p> <p>Significance : Beauty brings luck to a woman.</p>	<p>Bodily: dark, dry, wrinkly skin; lost hair, overweight, low libido, felt dizzy, had headache, vaginal dryness and pain, sweating, felt tired and hot.</p> <p>Family: got easily angry with her children; uncomfortable and afraid when having sex with husband. Children were scared, husband sad and worried</p>		<p>Reason to use: to improve skin and beauty, increase libido. Tried many other methods but wasn't happy with results. Dermatologist and obstetrician suggested her to use HRT, "natural hormone".</p> <p>Process: Used for 3 years, each year for 4 months. Sees her doctor once a month for blood tests.</p>	

	Cultural beliefs on beauty of skin and body	Problems attributed to menopause	Menopause related health practices	Patterns of HRT use	Social and cultural factors affecting HRT use
		<p>Other: her friends ridiculed her looks.</p>	<p>Non-pharmaceutical: do exercise, yoga 2 hours a day, diet to lose weight Non-HRT treatment: Diet pill, Botox injection for wrinkle, IPL for black spots, collagen cream for smoother skin. Eat regularly, avoid stress, use sun block to protect skin.</p>	<p>Satisfaction: Feels happy with the method: feels her health is good, her face bright, and her family happy. She feels more confident.</p>	<p>Husband requested her to go to see a doctor. He is younger than her and has a high salary, both putting pressure on her to appear younger. Holds the cultural belief that her having dark skin will cause problems in the family. A fortune teller suggested she should take care of her face.</p>

	Cultural beliefs on beauty of skin and body	Problems attributed to menopause	Menopause related health practices	Patterns of HRT use	Social and cultural factors affecting HRT use
4. Phung	<p>Definition of beauty: not dark, not fat around eyes, white skin, healthy.</p> <p>Significance: Dark skin is a bad omen; ugly face results in numerous problems.</p>	<p>Bodily: Dark, dry, wrinkly skin, black spots, fat around eyes, sagging breasts, overweight, low sexual desire and vaginal dryness; headaches, sweating, mood swings.</p> <p>Family: Husband told her she was ugly. He also got in an accident.</p> <p>Professional:</p>	<p>Non-pharmaceutical: exercise, walk, do yoga, drink more water, eat fruit, vegetable, go to spa for skin care.</p> <p>Non-HRT treatment: spa treatment, antioxidant tablets, anti-wrinkle cream, breast surgery, surgery to remove fat around eyes, facelift surgery, Macrolane</p>	<p>Reason to use: for skin beauty (eyes and breasts), to please her husband, to get good luck in life and job.</p> <p>Tried other methods first, but was not satisfied.</p> <p>Process: Treatment 1 year after menopause, until now. In the past used to take HRT and antioxidant.</p> <p>Satisfaction: body felt much better</p>	<p>Colleagues suggested she should see a doctor, do plastic surgery, move fat around eyes to get good luck.</p> <p>She herself also believes beauty brings good luck. As a businesswoman, she feels pressure to look “bright and fresh” at work. Also pressure from husband.</p>

	Cultural beliefs on beauty of skin and body	Problems attributed to menopause	Menopause related health practices	Patterns of HRT use	Social and cultural factors affecting HRT use
			injections.	1 month after treatment and wanted to continue treatment.	
5. Thuy	<p>Definition of beauty: no sagging, no wrinkles, no spots, attractive body, white skin, looking healthy.</p> <p>Significance: face is old get bad luck in her family and life,</p>	<p>Bodily: Wrinkly skin, dark especially around eyes, breasts sagging, lost hair, muscles soft, low libido, overweight, afraid when having sex with husband due to vaginal dryness and pain. Had hot, sweaty spots.</p>	<p>Non-pharmaceutical: Yoga every day; high SPF sun block, drink 2 liters of water per day, dieting.</p> <p>Non HRT treatment: antioxidant, facelift, breast surgery, filler injection every year, collagen</p>	<p>Reason for use: To please husband, increase her sexual desire, make she look younger.</p> <p>Process: Dermatologist suggested HRT, both tablets and vaginal cream. Has used for 2 years, 3 months per year; she</p>	She felt the problems in her life were due to menopause and not looking good. Also influenced by information on TV and papers.

	Cultural beliefs on beauty of skin and body	Problems attributed to menopause	Menopause related health practices	Patterns of HRT use	Social and cultural factors affecting HRT use
		<p>Family: husband had a girl friend, her family was unhappy and she felt angry with her children.</p> <p>Professional : She felt irritable with her friends at work; they noticed it and told her she should go see a doctor.</p> <p>Other: She lent money to a friend but the friend disappeared with the money.</p>	<p>cream, yearly Macrolane injections</p>	<p>sees her doctor once a month during this time.</p> <p>Satisfaction: Feels much better since starting HRT; feels more confident about her looks, her family is happy, no side effects.</p>	

	Cultural beliefs on beauty of skin and body	Problems attributed to menopause	Menopause related health practices	Patterns of HRT use	Social and cultural factors affecting HRT use
6. Thuan	<p>Definition of beauty: not dark, no wrinkles, no sagging in breasts.</p> <p>Significance: Dark skin signifies bad health. “Bright and fresh” face will help business develop, but looking old will make business go down.</p>	<p>Bodily: neck and hand muscles weak and soft, breasts sagging, lost hair, wrinkles around eyes, felt very tired but couldn’t sleep, pain in legs at night, dark skin, black and white spots.</p> <p>Family: husband met a young girl at a bar.</p> <p>Professional: Business slowed down, could not get contracts, goods could not sell.</p>	<p>Non-pharmaceutical: do yoga, long walks, go to spa for skin care every week.</p> <p>Non HRT treatment: antioxidant tablet for 3 months.</p>	<p>Reason for use: to reduce wrinkles, improve libido, reduce hot flashes and vaginal dryness. Felt that other treatments worked too slowly. Dermatologist suggested using HRT combined with cosmetic cream and antioxidant.</p> <p>Process: Started HRT 3 months after</p>	<p>Her colleagues suggested her go to see doctor. Felt pressure to look good due to being a businesswoman.</p>

	Cultural beliefs on beauty of skin and body	Problems attributed to menopause	Menopa use related health practices	Patterns of HRT use	Social and cultural factors affecting HRT use
				beginning of menopause, first took one type for 3 months, then another for 2 months. First saw doctor once in 2 weeks, now once a month. Satisfaction: Willing to continue treatment.	
7. Ba	Definition of beauty: Skin not dry, dark, or wrinkly, breasts not sagging or small. Significance: Looking	Bodily: dark skin, had skin tags around eyes; breasts looked sagging and small, lost hair, muscles soft, Had dry skin, low	Non-pharmaceutical: Exercise every day, swimming, eating lots of vegetable, fruits; organized speaking club, used sun block	Reason for use: To please husband, make her look younger. Process: Started 1 year after	Husband suggested her go to see doctor. Feels pressure to look good because of her job as a teacher at a

	Cultural beliefs on beauty of skin and body	Problems attributed to menopause	Menopause related health practices	Patterns of HRT use	Social and cultural factors affecting HRT use
	<p>good is important both for work and to please her husband. If face looks sad, family will get unlucky, but if beautiful, family will be happy and lucky.</p>	<p>libido, hot flashes, backache, tired, lazy. Felt ugly, as if 10 years older.</p> <p>Family: husband had girlfriends and even joked with her men do this because of their wives' menopause.</p> <p>Professional: felt not confident in front of her students.</p>	<p>with SPF50.</p> <p>Non HRT treatment: Spa for skin care, used antioxidant, had eyelid surgery, sun cream, night cream.</p>	<p>menopause. Dermatologist suggested HRT, both tablets and vaginal cream, first year used 5-6 months, later 3 months per year. She first saw doctor every 2 weeks, then once a month.</p> <p>Satisfaction: Feels better; both she and her husband more comfortable with their sex life. Wants to continue treatment.</p>	<p>university, and to please her husband.</p>

	Cultural beliefs on beauty of skin and body	Problems attributed to menopause	Menopause related health practices	Patterns of HRT use	Social and cultural factors affecting HRT use
8. Nhu	<p>Definition of beauty: Thin, look healthy, skin smooth and white. Breasts are important.</p> <p>Significance : her job is fashion, if her face is dark it will make her job get unlucky, business go down.</p>	<p>Bodily: dark, dry skin; hot flashes, breasts looked soft and small, got overweight, felt tired and ugly, had low libido.</p> <p>Family: husband had problems with his business.</p> <p>Professional: her business was affected.</p>	<p>Non-pharmaceutical : Exercise early in the morning, eating fruit and drinking plenty of water, sun block with SPF90.</p> <p>Non HRT treatment: spa for skin care, used antioxidant, vitamin cream.</p>	<p>Reason for use: To get good luck, to maintain her health, make her skin look better and please her husband.</p> <p>Process: First tried HRT for 4 months to treat early menopause (6 months after menopause) and cause menstruation to resume. Dermatologist suggested HRT, both tablets and</p>	<p>Her job as a fashion seller put pressure on her to look good. Her husband urged her to take care of herself.</p>

	Cultural beliefs on beauty of skin and body	Problems attributed to menopause	Menopause related health practices	Patterns of HRT use	Social and cultural factors affecting HRT use
				vaginal cream, used for 5 months per year. First met dermatologist every 2 weeks, now once a month. Satisfaction: Menstruation did not resume but her health got better. Wants to continue treatment.	

Summary of dermatologist interviews

	Purpose, criteria of prescribing HRT	Considerations before prescribing HRT	Way of explaining about menopause to patients (menopause discourse)	Health practices other than HRT recommended to menopause patients	Number of patients per day
1. Dr Dung (male, 32 yrs experience)	HRT (Evaskin or Diane 35, Pre-MS, vaginal hormone cream) can solve both symptoms of menopause and skin problems. The main cause of menopause symptoms is lack of hormones, so HRT addresses the main	Must have no family and personal history of cancer. Will take case history, require blood test and ultrasound test to check for cancer in the ovaries and vagina. Will also check history of cosmetic and medicine use history, and stress level at work and with family. Will only try HRT if other treatments didn't solve the	When women get menopause, they lack hormones and their bodies can't adapt. The main cause of menopause is lack of hormones and hormonal aging; hormones play an important role in sex life. Don't have time to explain	Antioxidants, collagen tablets combined with cosmetic products (e.g. vitamin C cream, collagen cream). IPL, Laser, Botox, or Juventure injection. Health advice: don't eat too much salt, do exercise, eat fruit, vegetables, and don't get stressed. Don't use cosmetics of unknown origin. Don't	25- 30 at the clinic, 50 in the hospital, of these 45% menopausal women

	Purpose, criteria of prescribing HRT	Considerations before prescribing HRT	Way of explaining about menopause to patients (menopause discourse)	Health practices other than HRT recommended to menopause patients	Number of patients per day
	problem.	problem.	details but will give brochure; if patient does not understand will explain more.	buy HRT drugs without doctor's permission.	
2. Dr Thanh, (female, 30 yrs experience)	HRT (Evaskin, Phytosoya, Diane 35, vaginal hormone cream) when patients have menopause symptoms such as low libido and	Must first explain to them very carefully about menopause symptoms and the purpose of HRT. Must take blood tests to see if they have cancer or other chronic disease. Ask patient about 1) sun	Give brochure to patients about menopause symptoms so they can read and understand health issues like feeling tired, getting angry easily, vaginal	Antioxidants (vitamin E, vitamin C), Selenium. In some cases, Botox injection or dermabrasion. Or plastic surgery if they have the money. Health advice: 1) Accept and	40 patients in the hospital

	Purpose, criteria of prescribing HRT	Considerations before prescribing HRT	Way of explaining about menopause to patients (menopause discourse)	Health practices other than HRT recommended to menopause patients	Number of patients per day
	<p>vaginal dryness and patients cannot adapt to; or many wrinkles all over the face, which topical drugs cannot treat completely. Will also prescribe HRT to prevent osteoporosis, cardiovascular disease and treat low libido.</p>	<p>exposure, 2) if patient takes contraceptive pills, 3) patient's sources of stress, 4) internal diseases (especially heart disease, hypertension, cervical cancer, high cholesterol, osteoporosis) and 5) previous medicine use. Must make sure patient understands that she must not purchase HRT in the pharmacy after HRT from the hospital ends.</p>	<p>dryness, and low libido.</p>	<p>understand these stages (menopause) in oneself and other people. 2) Avoid sun, alcohol, tobacco; 3) Eat fresh foods; 4) have enough leisure time to read books, do sports, travel; 5) de-stress; 6) take care of skin as early as possible; 7) exercise (e.g. yoga).</p>	

	Purpose, criteria of prescribing HRT	Considerations before prescribing HRT	Way of explaining about menopause to patients (menopause discourse)	Health practices other than HRT recommended to menopause patients	Number of patients per day
3. Dr Lam, (female, 22 yrs experience)	HRT for menopause symptoms such as low libido, vaginal dryness when patients cannot adapt, or too many wrinkles all over the face that topical drugs cannot treat completely. HRT gives better results than	Must take case history carefully (hypertension, cervical cancer; habits: smoking, drinking, too little sleep etc.) and do blood test or other tests. Consider how long symptoms (headache, libido, vaginal dryness, osteoporosis) have bothered them. Also: Do they usually work outside? Have they ever used sun block? Did	Will explain very carefully about menopause symptoms and good and bad sides of HRT. Will also give brochure.	Botox or Macrolane, antioxidants. Health advice: eat more vegetables, drink more fresh water, exercise, use sun cream and skin care products, find time for pleasant activities to reduce stress. Should see doctor again when they get any other skin or health problems. If the	150 both in clinic and hospital.

	Purpose, criteria of prescribing HRT	Considerations before prescribing HRT	Way of explaining about menopause to patients (menopause discourse)	Health practices other than HRT recommended to menopause patients	Number of patients per day
	other treatments, solve many symptoms, and prevent illness. Will prescribe HRT to prevent osteoporosis , cardiovascular disease and treat low libido.	they use the contraceptive pill before or not? Did they get stress from their lives or job during menopause or before? How is their marriage (happy or not)?		patients' breasts or other parts of their bodies are sagging, do exercise, yoga, have plastic surgery if they want.	
4. Dr Sang (male, 16 yrs experience)	HRT (phytoestrogen, Evaskin, Diane 35) because it can solve	Should do blood test and PAP smear before starting HRT. Must not have family or personal history	Menopause is hormone and collagen aging. Will give a brochure and talk about	IPL + avoiding sun shine exposure, protect skin very carefully. Sun cream, night cream, or	

	Purpose, criteria of prescribing HRT	Considerations before prescribing HRT	Way of explaining about menopause to patients (menopause discourse)	Health practices other than HRT recommended to menopause patients	Number of patients per day
	both menopause symptoms and skin aging; to please their husbands, to feel happy with their lives. Why not?	of cancer or other diseases. Will check history of beauty product and medicine use.	menopause symptoms. Will explain about side effects of HRT and related dietary restrictions. HRT needs to be taken at correct time and can be combined with other methods.	Botox. Pynocare, Preastig (antioxidant), selenium. Health advice: should not eat too much salt, sugar; should eat more vegetables, fruit; should do pleasant activities and relax. Should have a health check (blood tests, PAP smear, ultrasound...) every year.	

4.6 Summary of patient-dermatologist observations

	Patients' complaints	Explanation given about menopause and related symptoms to patients	Explanation given about HRT to patients	Quality of doctor-patient interaction	Time spent per patient
Observation 1 (male doctor)	<p>Physical: Skin darker than before, sweating, dry, hot skin, hair loss, insomnia, black spots, white spots, vaginal dryness</p> <p>Family: Husbands had other girls when the women's sexual desire and the quality their sexual life suffered during</p>	<p>Menopausal symptoms make women feel tired (vaginal dryness, libido and depression). They can get stressed with their jobs and get angry with their family easily, which makes their skin problematic.</p>	<p>Doctor gives antioxidant combined with some cream or another method: laser to remove black spot, red spot, do exercise ... if these method cannot solve the skin and menopause problems, then finally he will give HRT.</p>	<p>One woman patient felt shy and scared when she talked with male doctor because the doctor suggested that she should answerer what he asked her. The doctor interrupted the patient while she kept talking because he had a lot of</p>	<p>20 minutes for one patient on Mondays; more than 20 minutes on other days of the week.</p>

	Patients' complaints	Explanation given about menopause and related symptoms to patients	Explanation given about HRT to patients	Quality of doctor-patient interaction	Time spent per patient
	menopause. Professional: fear of business going down if look bad.			patients waiting.	
Observation 2 (female doctor)	Physical: skin dry and very wrinkled, especially two lines in the middle of eye brows and nose, at nose and chin, mouth. Brown and black spots on face, acne around mouth after menopause or after used cream to	Doctor explains that what the patient believes about beauty is an incorrect belief, that the patient is nervous; it is a symptom of menopause. In menopause, “your	Doctor gives antioxidant combined with some cream first and suggests the patient do yoga, at least two times a week, 1 hour each time to adapt to menopause symptom. Doctor suggests the	Patient was satisfied with doctor, but the doctor had to interrupt her to ask questions because the doctor had many patients waiting.	20 minutes

	Patients' complaints	Explanation given about menopause and related symptoms to patients	Explanation given about HRT to patients	Quality of doctor-patient interaction	Time spent per patient
	<p>remove spots. Feel tired and pain when has sex with husband, vagina very dry, pain in the pelvic region.</p> <p>Family: Patient complains that if her face is dark, it is a bad omen. Husband had a girlfriend, accidents happened in husband's workplace, children did not have good health and were kidnapped.</p>	<p>hormones and collagen are aging". Menopausal symptom make women feel tired, stressed, so skin and body become ugly.</p>	<p>patient use sun cream to protect her skin when she goes out, because her skin is so thin (skin paper). if it cannot solve the skin problem, next time she will give HRT to the patient. The patient can also use hormone cream.</p>		

	Patients' complaints	Explanation given about menopause and related symptoms to patients	Explanation given about HRT to patients	Quality of doctor-patient interaction	Time spent per patient
	Professional: Business going down, lost money.				
Observation 3 (female doctor)	Physical: Poikiloderma; skin became ugly at menopause; headache, tired, sweating, hot flashes, soft muscles, legs have pain at night, vaginal dryness Family: sex life is tired, make husband scared due to vaginal dryness and pain when had	Doctor told patient her beauty related beliefs were not correct. Menopause negatively affects skin, sex life, and women may easily get angry or sad. Menopause is hormone and collagen aging. Patient's ill health results from	Doctor said she will give new kind of medicine to patient but patient will need to check that their health is good first (no cancer, hypertension, heart attacks, high cholesterol).	Patient felt comfortable with the doctor. The doctor tried to answer her questions and explained side effects of the patient's cosmetics and symptoms of menopause	10-20 minutes

	Patients' complaints	Explanation given about menopause and related symptoms to patients	Explanation given about HRT to patients	Quality of doctor-patient interaction	Time spent per patient
	sex Patient says she wants to keep her husband. Professional: Patient says she wants to keep her business.	lack of hormones.		.	
Observation 4 (male doctor)	Physical: Dark, wrinkly, ugly skin, sagging in neck skin. Hot flashes, vaginal dryness, low libido. Patient asks about medicine (Ovestine + cream for vagina) that	Doctor explains to patient her skin lost water during menopause so it looks dry and wrinkled. Doctor added that during menopause, hormones	Doctor said he will give new medicine to patient that will increase her hormone levels but patient should do tests and show results to doctor before using	Patient felt happy because doctor told her skin would be better. Patient was shy when talking about sexual desire and vaginal	20 minutes (nurse kept reminding doctor there were many patients)

	Patients' complaints	Explanation given about menopause and related symptoms to patients	Explanation given about HRT to patients	Quality of doctor-patient interaction	Time spent per patient
	<p>another doctor gave her.</p> <p>Family: Patient tried cosmetic surgeries (breast, eyes) to improve her family life but with no results. Husband told to go to doctor because of menopause.</p>	<p>and collagen go down and so patient feels tired.</p>	<p>it. Doctor points out HRT is expensive and cannot be discontinued once started.</p>	<p>dryness. After his explanation, doctor wrote prescription while patient was talking.</p>	

Research Timeline

	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Developing thesis proposal											
Thesis proposal											
Developing and revising tools											
Data collection											
Data analysis and thesis writing											
Thesis defense											

BIOGRAPHY

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