

## **Reproductive health management in Japanese multinational companies in northern Thailand**

Ryoko Michinobu, PhD, MPH MA

School of Health Sciences, Sapporo Medical University

### **Abstract**

Globally, health management in the workplace has undergone a transition from that centered on traditional occupational health and safety (OHS) needs to that based on a combination of OHS and health promotion. Such an integrated approach to workplace health management aims to cover both traditional hazards and new hazards. At another level, the integrated approach to community health has faced various political, financial and managerial constraints. This article examines the ways to strengthen reproductive health measures in Japanese multinational companies as part of health promotion for employees, upon taking into account structural constraints in promoting an integrated OHS model in the companies. It is based on ethnographic case studies carried out intermittently from 2001 to 2003 in Japanese-affiliated companies operating in northern Thailand. The study has found that the employees of the case companies reported a wide array of reproductive health problems from HIV/STD to abdominal and menstrual pains, while not having treating them properly. It has been concluded that employees' health problems require a comprehensive reproductive health promotion so that reproductive health prevention and education should be included in the existing OHS measures. The study has also proposed that companies should utilize the group-based proposal system, with a theoretical insight from problem-based learning, in order to promote reproductive health awareness among their employees.

**Key words:** reproductive health, workplace health promotion, multinational corporations, Japan, Thailand

### **Introduction**

Globally, health management in the workplace has undergone a transition from that centered on traditional occupational health and safety (OHS) needs to that based on a combination of OHS and health promotion. Such an integrative approach to workplace health management aims to cover both traditional hazards and new hazards. The traditional hazards are characterized as occupational injuries; whereas the new hazards are exemplified by work stress, violence in the workplace, HIV/AIDS and various reproductive health problems

associated with use of young female workers. Ellis defined health promotion as “the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health.”<sup>1)</sup> It differs from the conventional OHS model that concerns health protection rather than promotion and considers social and environmental determinants of health than on individual behavior, thereby regarding the provision of a safe and healthy work environment the first health priority for employers.<sup>1)</sup>

An integrative approach to promoting workplace health has gained momentum around the world since the 1990s. Major events that promoted this approach included the Jakarta Declaration in 1997, the World Health Organization’s (WHO’s) conceptualization of an healthy work approach in 1997, and many independent workplace health promotion initiatives in countries and regions such as the European regional network for workplace health promotion as well as a program, “New Horizons in Health,” in the Western-Pacific regional network. In these initiatives, the workplace was identified as one of the “settings” for health promotion in the 21st century.<sup>2)</sup> There is a general consensus among international organizations and supranational organizations that health management in the workplace must reorient to better respond to the enormous challenges health institutions and private organizations have faced.<sup>2)</sup>

At another level, health promotion in the community, an official agenda in many countries since the adoption of the Ottawa Charter in 1986, has faced various political, financial and managerial constraints as a result of integrating a wide array of services into primary health care.<sup>3)</sup> For instance, integrating HIV/STD services with primary health care, as part of mainstream maternal and child care and family planning, has been advocated since 1994 to control the spread of HIV and to improve women’s reproductive health; but the integration remains incomplete. Moreover, there is little evidence that proves integration is effective.<sup>3)</sup>

Constraints to the service integration included well-established vertical systems, staff specialization, lack of political and ideological commitment, and absence of continual dialogue among powerful parties.<sup>3,4)</sup>

Hardee and Yount state that neither the implementation of specific interventions nor the international rhetoric of integration could solve the root causes of inadequate service integration.<sup>4)</sup> Blankenship and colleagues further states that what we need are, first, to fully understand the structural constraints for the service integration and, then, to strategically implement interventions that target the health-systems constraints, thereby improving service

delivery.<sup>5,6)</sup> In this regard, organizational structure, health attitudes and behavior, as well as power relationships among actors of particular settings, are some of the specific areas of intervention.

This article examines the ways to strengthen reproductive health measures in Japanese multinational companies as part of health promotion for employees, upon taking into account structural constraints in promoting an integrated OHS model in the companies. It is based on ethnographic case studies carried out intermittently from 2001 to 2003 in Japanese-affiliated companies operating in northern Thailand. This article argues that in accordance with the employees' needs, the reproductive health components must be added not only to the basic health care but also to the annual health education of Japanese companies. It also argues that the companies need to develop a corporate-wide integrative model of OHS management in the long run that goes beyond such a partial amendment. The greatest challenges are the managers' and health care providers' perceptions of their own roles and relationships with employees, and the solutions require an effort to empower the employees so that they can participate in the process for developing a new OHS management system.

### **Research Setting**

The study was carried out in an industrial park located at the northern part of Lamphun province. It was a rapidly industrializing area in northern Thailand, with over 60 multinational companies employing about 37,000 workers in total in the park alone. The cumulative capital investment in the park was 56 billion baht (1.4 billion US dollars) as of 2002, of which more than half was invested by Japanese companies. The electronics companies dominated the industry, employing approximately 70% of the total workforce. Young women aged from the late teens to early 30s accounted for nearly 80% of the workforce and worked as operators on assembly lines.

The spread of HIV/AIDS incidence seriously affected the health situation in Lamphun, where in 1998 AIDS ranked as the second main cause of death following heart disease. Besides, reproductive health problems such as STD, unwanted pregnancy and induced abortion have been increasing.<sup>7)</sup> There were few reliable reports on HIV/AIDS and STD incidence specifically for company employees. A baseline HIV seroprevalence survey conducted for 499 company employees in 1994 by the Lamphun Provincial Office of Public Health (LPH)

and the Center for Communicable Disease Control Region 10 (CDC10) found that an overall prevalence of HIV was about 2.4%. This study also found that syphilis prevalence among the survey participants was 3.8%. Another survey done for 127 company employees in 1999 by the LPH and the CDC10 found the prevalence of HIV was 3.9%.<sup>8)</sup> Data obtained from the personnel department of the participating companies in 2002 showed more moderate figures from 1995 to 2000; between two and 10 employees were found to be HIV positive annually. Besides, administrative data obtained from a hospital near the industrial park in 2002 showed that trichomonas infection ranked at the top of health problems among outpatients visiting the department of gynecology.

## Methods

Ethnographic case studies were carried out in seven Japanese-affiliated companies in the above-mentioned industrial park. I conducted participant-observation in the companies, dormitories and communities surrounding the industrial park; a semi-structured personal interview of 60 to 90 minutes' duration targeted 30 female company employees; an open-ended personnel interview of two hours' duration targeted seven nurses working at the nursing station of each of the companies; and a self-administered health survey was administered to 500 male and 500 female employees. Interview participants were selected during the course of the participant-observation basically via snow-ball sampling. The selection of the nurses was based on their availability or seniority; in other words, if there were two nurses at the nursing station, one who was available for the interview on the date or who was senior to the other was selected.

The 1,000 survey respondents were selected from each of the seven companies in proportion to the number of the workforce. Questionnaires were developed in Thai and sent out with a help of the personnel staff of each of the companies in October 2003, and collected two weeks later. This gave the respondents sufficient time to complete the questionnaire without disturbing their work schedules. Nine hundred and eighteen of the survey participants, consisting of 421 men and 497 women, were finally used in the study, with a 91.8 % response rate. Youth literacy rate or the percent of people between the ages of 15 and 25 who are literate in Thailand during the study period was 98%; accordingly, respondents did not report difficulties in reading and understanding the content of the questionnaire. The questionnaire

asked the respondents to describe what actually had happened regarding the following seven items—gastrointestinal disorders, occupational health, chronic health, pregnancy and contraception, STD, reproductive health, and other miscellaneous health problems.

## Results

### 1. Characteristics of research participants and companies

The profiles of interview and survey participants appear in Tables 1 and 2 respectively.

**Table 1 : Profile of interview participants**

| Characteristics        | Participants<br>(n=30) |
|------------------------|------------------------|
| <b>Age (years)</b>     |                        |
| 19 and less            | 1                      |
| 20 to 24               | 24                     |
| 25 and more            | 5                      |
| Mean                   | 22.2 (STDV 2.1)        |
| <b>Region of birth</b> |                        |
| North                  | 16                     |
| Northeast              | 3                      |
| Central                | 1                      |
| <b>Marital status</b>  |                        |
| Single                 | 12                     |
| Married                | 18                     |
| <b>Education</b>       |                        |
| Secondary              | 22                     |
| Technical college      | 6                      |
| University             | 1                      |
| n.a.                   | 1                      |
| <b>Work status</b>     |                        |
| Clerical worker        | 2                      |
| Operator               | 28                     |

**Table 2 : Profile of survey participants by gender**

|                        | Total<br>(n=918) |      | Male<br>(n=421) |      | Female<br>(n=497) |      |
|------------------------|------------------|------|-----------------|------|-------------------|------|
|                        | n                | %    | n               | %    | n                 | %    |
| <b>Age</b>             |                  |      |                 |      |                   |      |
| 19 and less            | 7                | 0.8  | 2               | 0.5  | 5                 | 1.0  |
| 20-24                  | 234              | 25.5 | 108             | 25.7 | 126               | 25.4 |
| 25-29                  | 389              | 42.4 | 185             | 43.9 | 204               | 41.0 |
| 30-34                  | 218              | 23.7 | 94              | 22.3 | 124               | 25.0 |
| 35-39                  | 50               | 5.4  | 22              | 5.2  | 28                | 5.6  |
| 40 and more            | 11               | 1.2  | 8               | 1.9  | 3                 | 0.6  |
| n.a.                   | 9                | 1.0  | 2               | 0.5  | 7                 | 1.4  |
| <b>Region of birth</b> |                  |      |                 |      |                   |      |
| North                  | 799              | 87.0 | 365             | 86.7 | 434               | 87.3 |
| Central                | 52               | 5.7  | 23              | 5.5  | 29                | 5.9  |
| Northeast              | 32               | 3.5  | 13              | 3.1  | 19                | 3.8  |
| South                  | 13               | 1.4  | 9               | 2.1  | 4                 | 0.8  |
| n.a.                   | 22               | 2.4  | 11              | 2.6  | 11                | 2.2  |
| <b>Marital status</b>  |                  |      |                 |      |                   |      |
| Single                 | 365              | 39.8 | 160             | 38   | 205               | 41.3 |
| Married                | 502              | 54.7 | 243             | 57.7 | 259               | 52.1 |
| Divorced               | 22               | 2.4  | 7               | 1.7  | 15                | 3.0  |
| Widowed                | 4                | 0.4  | 0               | 0    | 4                 | 0.8  |
| n.a.                   | 25               | 2.7  | 11              | 2.6  | 14                | 2.8  |
| <b>Education</b>       |                  |      |                 |      |                   |      |
| Primary                | 30               | 3.3  | 12              | 2.9  | 18                | 3.6  |
| Secondary              | 513              | 55.9 | 223             | 52.9 | 290               | 58.4 |
| Technical college      | 233              | 25.4 | 124             | 29.5 | 109               | 21.9 |
| Bachelor and higher    | 132              | 14.4 | 60              | 14.2 | 72                | 14.5 |
| n.a.                   | 10               | 1.1  | 2               | 0.5  | 8                 | 1.6  |
| <b>Work status</b>     |                  |      |                 |      |                   |      |
| Manager                | 7                | 0.8  | 6               | 1.4  | 1                 | 0.2  |
| Supervisor             | 166              | 18.1 | 94              | 22.3 | 72                | 14.5 |
| Clerical worker        | 64               | 7.0  | 6               | 1.4  | 58                | 11.7 |
| Operator               | 615              | 67.0 | 266             | 63.2 | 349               | 70.2 |
| Quality administrator  | 9                | 1.0  | 4               | 1    | 5                 | 1.0  |
| Technician             | 48               | 5.2  | 43              | 10.2 | 5                 | 1.0  |
| n.a.                   | 9                | 1.0  | 2               | 0.5  | 7                 | 1.4  |

Table 3 presents the characteristic of the seven companies participating in this study. All of the seven were Japanese-affiliated companies, consisting of both large scale (more than 1,000 total employees) and small scale (fewer than 1,000 total employees) companies.

**Table 3 : Characteristic of the companies participating in this study**

| Company | Primary products  | Total employees | Japanese <sup>a</sup> | Thai |       |
|---------|-------------------|-----------------|-----------------------|------|-------|
|         |                   |                 |                       | Men  | Women |
| A       | Machineries       | 1390            | 10                    | 630  | 750   |
| B       | Electronics       | 3111            | 20                    | 216  | 2875  |
| C       | Electronics       | 3522            | 30                    | 439  | 3053  |
| D       | Glass             | 715             | 10                    | 78   | 627   |
| E       | Clothing products | 136             | 1                     | 67   | 68    |
| F       | Wooden products   | 429             | 2                     | 202  | 225   |
| G       | Electronics       | 293             | 3                     | 17   | 273   |

Source: Administrative documents of seven case companies in 2002

<sup>a</sup> All Japanese workforce were men, except Companies C and G, each of which has one Japanese female employee.

## 2. Reproductive health status and perception among employees

Table 4 summarizes the result of the self-reported reproductive health status of survey participants. The reported rates of problems were higher among female than male, so that I examined in detail how female workers perceived their health status by interviews.

**Table 4 : Reproductive health conditions of survey participants**

|                               | Male<br>(n=421) |     | Female<br>(n=497) |      |
|-------------------------------|-----------------|-----|-------------------|------|
|                               | n               | %   | n                 | %    |
| HIV/AIDS                      | 0               | 0.0 | 3                 | 0.6  |
| Gonorrhoea                    | 3               | 0.7 | 4                 | 0.8  |
| Syphilis                      | 0               | 0.0 | 3                 | 0.6  |
| Unwanted pregnancy            | —               | —   | 26                | 5.2  |
| Miscarriage                   | —               | —   | 31                | 6.2  |
| Induced abortion              | —               | —   | 23                | 4.6  |
| Side effects of contraception | —               | —   | 150               | 30.3 |
| Infertility                   | —               | —   | 16                | 3.2  |
| Impotence                     | 1               | 0.2 | —                 | —    |
| Uterus pain                   | —               | —   | 35                | 7.0  |
| Uterus infection              | —               | —   | 34                | 6.8  |
| Vaginal discharge             | —               | —   | 87                | 17.5 |
| Menstrual pain                | —               | —   | 208               | 41.9 |
| Irregular menstruation        | —               | —   | 108               | 21.7 |
| Lower abdominal pain          | —               | —   | 101               | 20.8 |
| Pain during having sex        | —               | —   | 84                | 17.0 |
| Genital ulcers                | —               | —   | 28                | 5.6  |

In regard to HIV/STD, all of the interview participants, except a participant who were infected with a STD by having sex with her boyfriend, were not well aware that there is a potential risk of HIV/STD infections in their sexual relationships. Neither did they understand that vaginal discharge and discomfort with urination might be signs of STD, and thus necessitate an examination. Actually, only three interviewees had received a STD examination. Such cultural beliefs that STD is a problem only of sexually promiscuous persons and that condom use disclosed a feeling of mistrust towards one's sexual partner influenced their reluctance to take preventative actions to manage STD.

A holistic term, *puat toong* or abdominal pain, was used by the interview participants to describe various reproductive health problems. *Toong* or the abdominal part consisted of the uterus, ovary, vagina, bladder, pelvis, colon and small intestine; but they neither had specific anatomical images of each part nor referred to the specific part when they were sick. Three informants did not even know the structure of the vagina and cervical canal, stating that they feared using condoms for they might be left in the *toong*. The interview participants believed that unpleasant symptoms occurring in the abdominal area are mostly endogenous.



For instance, it was believed that vaginal discharge and itching occurred as a result of not washing the area properly and thereby allowing bacteria to overgrow in the vagina. Certain kinds of food, such as sunflower seeds, were also believed to increase the discharge. They even believed that development of cancer in the *toong* could be attributed to untreated vaginal discharge or an overgrowth of “bad” organisms that have the power to destroy the abdomen internally.

The majority of the interview participants stated that the most serious symptom of abdominal pain occurred during menstruation. They thought that the pain during menstruation resulted from black and coagulated blood, potentially disturbing the normal blood flow. In the normal situation, the blood was believed to be red and flow smooth like water. They also believed that contraceptive pills and injections affected the blood flow directly, causing and increasing the coagulation and that an extended use of these methods would result in dryness of the abdominal part, which they feared strongly as a cause of infertility. Since atrophic bleeding occurs when one takes contraceptive pills whereas injections stop bleeding completely, they believed that injections would produce a stronger effect of dryness and thereby preferred taking pills to injections. This belief about dryness of the body influenced the way they took pills; they missed taking pills deliberately when they felt their body had become excessively dry.

### 3. Reproductive health care and treatment

Table 5 shows the first treatment methods of choice taken for the top four reproductive health problems among female survey participants. The majority resorted to treatment at hospitals, clinics or the nurse station of the company; very few opted for self-treatment; and a number of them left the problem(s) untreated. Interview findings attested to the similar situation that reproductive health problems, especially abdominal pain (*puat toong*), were not treated appropriately. If the symptoms were light, they consulted with their older friends or lovers, who listened to their problems sincerely but did not have appropriate knowledge and decision-making abilities. They rarely consulted with their family members because they were afraid of worrying them. They also administered pain-killers or antibiotics obtained from a drug store or nursing station in the company. When the symptoms became severe, they went to see a doctor at a hospital or clinic. The survey results addressed to these severe cases.

**Table 5 : The first treatment methods of choice taken for the top four reproductive health problems**

|  | Menstrual pain<br>(n=208) | Irregular<br>menstruation<br>(n=108) | Lower<br>abdominal pain<br>(n=101) | Side effects of<br>contraception<br>(n=150) |
|--|---------------------------|--------------------------------------|------------------------------------|---|
|  | n (%)                     | n (%)                                | n (%)                              | n (%)                                       |
| See a doctor at a hospital designated by the company     | 13(6.3)                   | 14(12.9)                             | 28(27.7)                           | 13(8.7)                                     |
| See a doctor at a hospital not designated by the company | 0                         | 0                                    | 0                                  | 2(1.3)                                      |
| See a doctor at a clinic                                 | 5(2.4)                    | 14(12.9)                             | 11(10.9)                           | 19(12.7)                                    |
| See a nurse at the nurse station of the company          | 132(63.5)                 | 25(23.1)                             | 32(31.7)                           | 18(12.0)                                    |
| See a public health officer                              | 1(0.5)                    | 2(1.9)                               | 2(1.9)                             | 10(6.7)                                     |
| Consult with friends                                     | 18(8.7)                   | 13(12.0)                             | 7(6.9)                             | 33(22.0)                                    |
| Consult with lovers                                      | 2(1.0)                    | 4(3.7)                               | 6(5.9)                             | 10(6.7)                                     |
| Consult with parents                                     | 4(1.9)                    | 0                                    | 0                                  | 2(1.3)                                      |
| Buy drugs at a drug store                                | 17(8.2)                   | 7(6.5)                               | 3(2.9)                             | 8(5.3)                                      |
| Consult with a shaman                                    | 0                         | 0                                    | 0                                  | 0   |
| Do nothing   | 12(5.8)                   | 24(22.2)                             | 7(6.9)                             | 31(20.7)                                    |
| Others   | 2(1.0)                    | 5(4.6)                               | 5(4.9)                             | 4(2.7)                                      |

The cost of treatment at a hospital or clinic was covered by the Social Security Fund, and they were entitled to receive a basic health care for free at a hospital which entered into a contract with their company to provide the service. All of the case companies in this study made a contract with a private hospital operating in front of the industrial park. This hospital was not popular, however, because company employees felt that the doctors were not friendly and that they prescribed pain-killers and antibiotics readily without carefully listening to the interviewees' problems or thoroughly examining the real cause of the symptoms. The interview participants unanimously stated that the "free" health care was the worst care, and that doctors at the designated hospital were the least sincere. Some of them instead chose to go to see a doctor at clinics or hospitals in Chiang Mai, spending their own money. Overall, the participants were not satisfied with the treatment either at the nursing station or at the designated hospital. Table 6 summarizes the results of the reproductive health interviews.

**Table 6 : Reproductive health conditions and perceptions of interview participants**

| Content                                | Conditions and perceptions  |
|--|---|
| HIV/STD                                | Low perception of a potential risk of HIV/STD infection in their sexual relationships<br>Only three interviewees reported ever having STD examinations  |
| Abdominal pain<br>"puat toong"         | Referred to various reproductive health problems<br>The most serious symptoms occurred during menstruation  |
| Reproductive health care and treatment | Not treated appropriately<br>Light symptoms: consult with friends or lovers, administer pain-killers or antibiotics<br>Severe symptoms: go to see a doctor<br>Cost of treatment covered by the Social Security Fund |

#### 4. Health care provision at company

The major health services at the researched companies consisted of first aid, annual health examination and health education. The provision of first aid and annual health examination is required under the Thai law and also follows a conventional OHS management in domestic Japanese companies. First aid was provided in the nursing station for every employee who needed care and treatment for acute illness and injuries. In large-scale companies, a nurse was stationed for 24 hours in a rotation; in small-scale companies, a nurse was stationed for eight hours of the daytime, and personnel staffs sent patients to hospitals in case of emergency.

Some of the large-scale companies had a regular visit by a physician at the nursing station once or twice a month, providing additional medical services for employees. Those who have prolonged health problems could consult with the physician on his/her visit, and the physician was also responsible for doing annual comprehensive health examination at companies.

#### The nurses' perceptions and health care behavior

The nurse station of the company was the first place for workers to seek treatment (see Table 5). For irregular menstruation and side effects of contraception, the nurses gave them advice to change birth control pills. They had a stock of pills at the station, from which they selected some pills that they thought might be appropriate for the patient. With regard to menstrual pain and lower abdominal pain, nurses were able to only administer pain killers at the nursing station or advise the patient to take a rest. The nurses prescribed the drugs after a brief

medical interview and recommended that the patient consult an outside doctor if the condition lasted long and became severe. According to a nurse who worked for company A, menstrual pain was chronic for many patients and they were accustomed to putting up with the pain until the symptoms became unbearable, at which point they sought out treatment from an outside doctor.

The behavior of the nurses was affected by the way they perceived their professional roles and responsibilities and also their relationships with the patients or employees in general. Some nurses had difficulty in forming good relations with employees, especially those on the production lines. In the case companies, a clear class hierarchy was visible in the occupational ranks separating production line workers from managers, clerical workers and nurses. The majority of the former came from lower-class peasant families in northern villages, whereas many of the latter were from middle-class families of merchants, public officials and school teachers in Chiang Mai, Lamphun and other provincial centers. Mutual mistrust and antagonism developed in such a way that the production line workers were skeptical about the managers, clerical workers and nurses, who looked down upon them as lower-class. Conversely, the managers, clerical workers and nurses perceived that production line workers were immature, ignorant, lazy and deceptive, and that these dispositions often related to their health problems. A nurse of Company C told me a story that a female production line worker came to get contraceptive pills without telling her the real intention—the worker tried to use the pills to abort the baby. She complained that young production line workers had sexual relationships casually without being aware of the consequences and taking into account their health. While not all of the line workers acted like this person, as this statement illustrates, the class hierarchy served as a barrier against establishing mutual trust and understanding between them.

## **Discussion**

This study has found that study participants reported a wide array of reproductive health problems from HIV/STD to abdominal pains and also to various menstruation-related problems. Interviews with female employees have revealed that the majority of them were not well aware of their personal risk for HIV/STD in their sexual relationships nor informed that vaginal discharge and discomfort with urination could be signs of the presence of STD. Not

clearly identifying which part of the internal organs really caused pain or discomfort, they also used a holistic term, *puat toong*, to describe various abdominal ailments. Furthermore, the belief about dryness of the body influenced the way they perceived their bodily function and disruption. These findings show a tendency among the study participants to understand their body holistically, which corresponds to an ethno-medical belief of a body among northern Thai villagers.<sup>9)</sup> This supports the global consensus that there is a need to promote an integrative model of OHS management that incorporates a comprehensive reproductive health measures.

In terms of care and treatment, the majority of survey respondents resorted to hospitals, clinics or the nurse station of the company; but a significant number of them left their problems untreated. There existed both individual and organizational reasons for this. First, employees were not satisfied with the treatment either at the nursing station or at the designated hospital; second, in a conventional OHS management in Japanese companies, work injuries and accidents are prioritized over reproductive health; and third, health care providers' perception of their professional role and responsibilities and their general relationships with employees affected the way they cared for and treated them.

These situations seem to be not peculiar to the case companies but rather emergent issues in the rapid globalization of the industrial sector and in women's increasing employment opportunities in multinational companies. In her study on the health of women who work within export processing zones work, one of the rare studies that investigate the relationship between globalization, women's work and occupational health, Loewenson has found that women's health problems were unrecognized, understudied and unregulated globally.<sup>10)</sup> She called for more research and intervention on the area that intersects women's health, women's work and the global economy. In a similar vein, Muto and his colleagues found that a major problem in occupational health in Japanese companies is lack of attention paid to women's and minority health.<sup>11)</sup> While the lack of attention seems a global situation, their study has revealed that Japanese companies in general fall far behind other global companies in managing women's health.

The implications of this study for reproductive health management in Japanese multinational companies are as follows. First, factory employees' reproductive health problems require a comprehensive reproductive health promotion so that the component must be integrated into the existing OHS measures. This follows a direction set out at the Jakarta Declaration as well

as regional guidelines for the workplace health promotion developed by WHO's Regional Office for the Western-Pacific.<sup>12)</sup> The existing measures in the case companies consisted of providing first-aid at a medical office; specifying rules for safety, operations and training; carrying out annual health checkups stipulated by law; organizing a safety committee to promote bottom-up occupational safety activities; and conducting educational activities for health, ISO (International Organization for Standardization), safety and industrial hygiene. A lack of reproductive health policies and activities as well as the interests of managers on the issue of reproductive health was a specific feature among overall OSH in the case companies, so that an integrated management of reproductive health and OSH should be promoted.

The main challenge in this regard is how the companies seek out assistance from outside organizations, as articulated in the WHO's Global Healthy Work Approach that fundamental to the integrative health management in the workplace are multisectoral partnerships and cooperation among key actors both within and outside the workplace.<sup>12)</sup> In the research site, hospitals, clinics, and public health centers are available to meet employees' needs. The case companies should establish a community-based collaborative network of reproductive health promotion with these outside organizations and ask them to dispatch family counselors to their companies, to provide voluntary HIV counseling and testing, STD screening and cervical screening as well as to establish the referral services in case of emergencies.

Second, empowerment-oriented health promotion such as problem-based learning should be enacted in the companies. It requires active participation by the employees in the assessment of health-related problems, both individual and organizational; the formulation of the goals, plans and strategies; and their implementation and evaluation.<sup>13)</sup> In the case companies, a system for employees to make bottom-up proposals in a group in the workplace had facilitated group discussion and improved production management. Utilizing the group-based proposal system with a theoretical insight from problem-based learning is an option for the companies to promote reproductive health awareness among the employees as well as to reduce misunderstanding and mistrust that arise in the heterogeneous work environment.

Third, a top-down measure can be incorporated into the bottom-up measure, such as formulating a corporate-wide reproductive health promotion policy and clarifying the commitment and roles of the top management, the personnel staff and the health care providers in the company. A fundamental reorientation of OHS management requires changes in

managerial and employees' perceptions and thus necessitates capacity building on both sides.<sup>14)</sup>

## **Conclusion**

Globally, OHS management has evolved from that focused on a single illness of individual employees to those that are more integrative, addressing both individual risk factors and organizational issues.<sup>2)</sup> This study has demonstrated that OHS management in Japanese-affiliated companies still focused narrowly on work-related injuries and accidents, and that reproductive health components were largely overlooked. Based on the findings, this study has proposed utilizing a group-based proposal system for a bottom-up reproductive health promotion activity within the workplace and setting up a community-based collaborative network of reproductive health promotion beyond the workplace.

Reproductive health promotion in the occupational setting is a relatively new research topic and not many empirical studies have been done globally. Continued empirical investigation is necessary to advance our knowledge and actions so as to better promote employees' health in the organizational setting. In regard to the current study, further research into OHS management policies at headquarters and male employees' reproductive health perception is needed so as to make a more comprehensive proposal.

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## 北タイの日系多国籍企業における リプロダクティブ・ヘルス・マネジメント

道信 良子\*

### 要 旨

世界的に見ても、職場の健康管理は労働安全衛生(OHS)に関する従来のニーズに焦点を当てたものから、OHSとヘルス・プロモーションを統合したものへと変化している。職場の健康管理は、従来の健康リスクと新しいリスクの両方に対応するために統合的なアプローチを模索しているといえる。しかし、コミュニティ・ヘルスの領域で明らかにされたように、統合的なアプローチはさまざまな政治的、財政的、管理的制限を受けている。本稿では、企業で包括的なOHSモデルを推進することの構造的限界を考慮した上で、日系多国籍企業においてヘルス・プロモーションの一要素としてリプロダクティブ・ヘルス対策を強化する方法を考察する。本調査は2001年から2003年まで北タイの日系多国籍企業において断続的に行われた民族誌的事例研究に基づいている。調査の結果、対象企業の従業員はHIV/STD(性感染症)、腹痛、生理痛などさまざまなリプロダクティブ・ヘルスに関する問題を報告したが、適切な治療を受けていないことが明らかになった。これらの健康課題に取り組むには包括的なリプロダクティブ・ヘルスの推進が必要であり、リプロダクティブ・ヘルス予防対策や教育を職場のOHSに統合すべきである。また、リプロダクティブ・ヘルスに関する従業員の認識を高めるには、問題基盤型学習理論が示すようにグループを基盤とする提案制度が有効であり、社内の提案制度を活用することを提案する。

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\* 札幌医科大学保健医療学部