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Reproductive health management in oversea enterprises in Thailand: Between focused and comprehensive approaches

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In Thailand, where new HIV infection cases have been decreasing and other sexual and reproductive health problems have become visible, HIV/AIDS management has come to be integrated into comprehensive sexual and reproductive health management. Based on the study on the sexual and reproductive health among factory workers in multinational companies in northern Thailand, I will explore the potential directions of sexual and reproductive health management in the workplace. The fieldwork was carried out intermittently from 2001 to 2003 in an industrial park in Lamphun province in northern Thailand. This study found that whilst factory workers had various sexual and reproductive health problems, they received inadequate care and treatment in the workplace. The workers looked for regular visits by reproductive health professionals such as family counselors, obstetricians and gynecologists to the nursing station of their companies. Based on the findings, I proposed that companies should provide a comprehensive sexual and reproductive health care by these health professionals, who in turn should provide good and qualified services whilst employing humanistic attitudes towards the workers. I also argued that a comprehensive approach in factories must be a part of a wider collaborative effort involving schools, families, community organizations and health institutions.

Key words : Reproductive health, Health management, Corporations, Thailand

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タイにおける海外企業のリプロダクティブ・ヘルス・マネジメント —焦点化されたアプローチと包括的なアプローチの間で

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タイでは、新規HIV感染者数は減少傾向であるが、性と生殖に関わる他の健康課題が明らかになり、エイズ対策は包括的な性と生殖の健康対策に統合されている。本研究では、タイ北部の多国籍企業で働く労働者の性と生殖の健康に関する調査に基づき、職場における性と生殖の健康管理の方向性について考察する。調査はタイ北部のランブーン県に位置する工業団地において、2001年から2003年まで断続的に行われた。調査の結果、労働者は性と生殖に関わるさまざまな健康課題を抱えているが、職場において十分なケアや治療を受けていないことが明らかになった。労働者は、家族カウンセラーや産婦人科医など性と生殖に関わる健康の専門家が定期的に工場の医務室に訪れて対応することを望んでいる。この結果に基づき、企業は性と生殖に関わる健康の専門家による包括的なケアを提供する体制を整え、専門家は質の高いサービスを提供し、人間的な態度で労働者に接することを提案する。さらにまた、工場における包括的なケアは、学校と家族、地域組織、医療機関とが協働して行う健康対策の一つに位置づけられなければならないと考える。

<キーワード> リプロダクティブ・ヘルス、ヘルス・マネジメント、企業、タイ

Introduction

In Thailand, where new HIV infection cases have been decreasing and other sexual and reproductive problems have become visible, HIV/AIDS management has come to be integrated into comprehensive sexual and reproductive health management. Based on my study on the sexual and reproductive health among factory workers in Japanese multinational companies in northern Thailand, I will explore the potential directions for sexual and reproductive health management in the workplace.

At the northern part of the province is an industrial estate with over 60 multinational companies employing about 37,000 workers in total. The electronics factories dominate the industry, employing approximately 70% of the total workforce. Japanese companies account for more than half the total capital investment in this industrial park. The cumulative capital investment in this park was 56 billion *baht* (1.4 billion US dollar) as of 2002, of which more than half was invested by Japanese factories. In these factories, young women aged from the late teens to early thirties are working as operators at assembly lines.

According to the Thai Working Group on HIV/AIDS Projection, estimated cumulative numbers of HIV-infected people in the year 2002 in Thailand is 1,033,424 (adults and children), of which 398,367 subsequently died of AIDS (MOPH, 2003). The projection showed that approximately 2% of men and 1% of women of the population live with HIV in 2000, with 50,000 dying annually from AIDS-related causes until the end of 2006. In 2000, youth and young adults (15-24 years) accounted for almost 60 % of all new HIV infections in the country with a gradual increase among teenagers.

Reported case rates of STD including gonorrhea and syphilis in Thailand remained stable during 1984-1989, about 7% per 1000 population, but after 1989 when the implementation of condom promotion began, the incidence dropped rapidly (towards 1% in 1994). STD rates in northern Thailand remained slightly higher than the national figure, yet dropped to 0.16% in 1996¹⁾.

As for factory workers in the research site, there were few reliable reports on HIV/AIDS and STD incidence. According to a personal interview conducted with health officer at the Lamphun Provincial Office of Public Health (LPH) in 1999, a baseline HIV seroprevalence survey targeted 499 factory workers in 1994 by a group of public health officers and researchers from the LPH, Center for Communicable Disease Control Region 10 (CDC10), Johns

Hopkins University and Chiang Mai University 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 factory workers in 1999 by the LPH and CDC10 found the prevalence of HIV was 3.9%²⁾. Data obtained from the personal department of selected factories at the study site in 2002 showed more moderate figure-from 1995 to 2000 annually between two and ten workers were found to be HIV/AIDS. Besides, an administrative data obtained from a hospital nearby the industrial park in 2002 showed that trichomonas infection ranked the top of health problems among outpatients who visited the department of gynecology.

Methods

This study is based on ethnographic fieldwork carried out intermittently from 2001 to 2003 in an industrial park in Lamphun province in northern Thailand. The ethnographic research was undertaken after obtaining permissions of the National Research Council of Thailand and Mahidol University in Thailand. These institutions had ethics committees that require an ethics application and review. The ethical codes required the confidentiality of participants be maintained; they also required informed consent with a clear statement of the nature of the research. Specifically in this research, participant observation was done under the permissions of the corporate managers, and interviews and questionnaires were done after obtaining informed consent from the participants. All of the information collected were held in anonymized form, and identities of individuals were concealed in this result.

The ethnographic study consisted of participant-observation; 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 female employees. Interview participants were selected via snow-ball sampling. The selection of the nurses was based on their availability or seniority.

The 500 survey respondents were selected from each of the seven companies in proportion to the number of the workforce. Questionnaires with a letter of informed consent were sent out with a help of the personnel staff of each of the companies in October 2003, and both were collected two weeks later. This gave the respondents sufficient time to think about participation as well as to complete the

questionnaire without disturbing their work schedules. Four hundred and ninety-seven of the survey participants were finally used in the study, with a 99.4% response rate. 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. It also asked the first treatment methods of choice taken for the top four reproductive health problems.

Results

The profiles of interview and survey participants appear in

Table 1 Profile of interview participants

Characteristics	Participants (n=30)
Age (years)	
19 and less	1
20 to 24	24
25 and more	5
Mean	22.2 (STDV2.1)
Region of birth	
North	16
Northeast	3
Central	1
Marital status	
Single	12
Married	18
Education	
Secondary	22
Technical college	6
University	1
n.a.	1
Work status	
Clerical worker	2
Operator	28

Tables 1 and 2 respectively. The interview and survey participants shared general characteristics: they were young (aged between 20 and the mid-30s), born in the North, either

Table 2 Profile of survey participants

	Participants (n=497)	%
Age		
19 and less	5	1.0
20—24	126	25.4
25—29	204	41.0
30—34	124	25.0
35—39	28	5.6
40 and more	3	0.6
n.a.	7	1.4
Region of birth		
North	434	87.3
Central	29	5.9
Northeast	19	3.8
South	4	0.8
n.a.	11	2.2
Marital status		
Single	205	41.3
Married	259	52.1
Divorced	15	3.0
Widowed	4	0.8
n.a.	14	2.8
Education		
Primary	18	3.6
Secondary	290	58.4
Technical college	109	21.9
Bachelor and higher	72	14.5
n.a.	8	1.6
Work status		
Manager	1	0.2
Supervisor	72	14.5
Clerical worker	58	11.7
Operator	349	70.2
Quality administrator	5	1.0
Technician	5	1.0
n.a.	7	1.4

Table 3 Characteristic of the companies participating in this study

Company	Primary products	Total employees	Japanese ^a	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

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

single or married, having secondary education or higher, and working as operators. The larger proportion of the survey participants was older than the interview participants and had higher educational statuses; accordingly, some of them were at the managerial or supervisory ranks. 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.

1. Sexual and Reproductive Health

Table 4 summarizes the result of sexual and reproductive health conditions of survey participants. It shows the participants had a variety of sexual and reproductive health problems.

Table 4 Sexual and reproductive health conditions of survey participants

	Participants (n = 497)	%
HIV/AIDS	3	0.6
Gonorrhea	4	0.8
Syphilis	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
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

2. Lay explanation for the sexual and reproductive health problems

In my interviews, many participants were little aware of the fact that many of the sexual and reproductive disorders such as vaginal discharge and discomfort with urination would be symptoms and signs of the presence of STI (sexually transmitted infection), such as trichomonas infection. Believing that their sexual and reproductive disorders have nothing to do with STI, only a small percentage of the interviewees had received a STD examination. A belief that STDs are diseases only of sexually promiscuous men and women also prevents the

young women from taking positive actions to manage their STD. Another idea that condom use exemplifies their mistrust towards their partner further makes them hesitate to take such actions. These suggest there remains a potential risk of HIV/AIDS and other STDs among factory workers.

My interview participants described various sexual and reproductive disorders using the holistic term *puat toong* or abdominal pain. *Toong* or the abdominal part contains the uterus, ovary, vagina, bladder, pelvis, colon and small intestine, and these women did not have specific anatomical images of specific parts nor refer to particular anatomic parts when they were sick. Some women did not know the vagina or cervical canal and stated that they feared using a condom since it might be left in the uterus.

The 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, are also believed to increase the discharge. It was thought that uterus and cervical cancer result from untreated vaginal discharge or an overgrowth of "bad" organisms that destroy the abdomen internally. In many ways, cancer was recognized as endogenous.

The most serious symptom of abdominal pain occurs during menstruation, which corresponds with the results of this survey. The pain during menstruation was thought to result from black and coagulated blood, which disturbs the normal blood flow. In the normal situation, it was believed to be red and flow smooth like water.

Contraceptive pills and injections were thought to affect the abdominal part directly, causing or increasing the pain. It was believed that the black and coagulated blood (the perceived cause of the pain) resulted from taking contraception. It was also assumed that use of contraceptive pills over a long period will result in the "dryness" of the abdominal part. Dryness of the abdominal part was strongly feared as it was believed to be a cause of infertility. Since atrophic bleeding occurs when one take contraceptive pills whereas injections stop bleeding completely, women believe that injections produce a stronger effect of dryness.

They therefore prefer taking pills to injections. Contraceptive pills are often used before married or having the first child. One may change to injections after having the first child and finally do sterilization after having the second child or desired number of children. Worries about the dryness of the body are some of the reasons why women

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

	Menstrual pain (n=208)	Irregular menstruation (n=108)	Lower abdominal pain (n=101)	Side effects of contraception (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)

miss taking pills deliberately: they stop when they feel their body has become excessively dry.

3. 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 problems were mostly treated in hospitals, clinics or the company nurse station. Very few women opted for self-treatment, but a number of women left the problem untreated.

Interview findings showed that abdominal pain (*puat toong*) was not treated appropriately. When they had light symptoms, they talked with their older friends or lovers. These people listened to their problems sincerely but did not have appropriate knowledge and decision making abilities. Women rarely talked about their abdominal problems with their families since they were afraid of worrying them. If the symptoms were light, they also administer pain-killers or antibiotics obtained from a drug store or nursing station. When the symptoms became severe, they went to see a doctor at a hospital or clinic, whom they regard as being more professional than nurses and pharmacists. The survey results must have addressed to this severe case.

Factory workers had health insurance and were entitled to receive a basic health care for free at a hospital designated by their company. However, they felt that doctors at the designated hospital were not friendly, rarely listened to them and prescribed drugs, mostly pain-killers and antibiotics, promptly. They felt that the "free" health care was the worst care and doctors at the designated hospital were the

least sincere. Those who did not like the designated hospital went to clinics or other hospitals spending their own money. Overall, factory women were not satisfied with the treatment either at the nursing station or hospitals, where doctors and nurses prescribed pain-killers and antibiotics readily without thoroughly examining the real cause of the symptoms.

4. Health Care Services at Factories

Factory workers' sexual and reproductive health problems require professional advice, care and treatment. In reality, hospitals, clinics, nursing rooms, and public health centers are available to meet workers' needs, but this research found that these health institutions do not function in a way to alleviate workers' health problems and concerns. This study found that there are structural limitations for factories to provide a comprehensive care for their sexual and reproductive health. The main challenge in this regard is how factory workers' health problems and concerns can be addressed efficiently within the structural limits.

Health care structure at factories

Participant observation and everyday conversation with corporate personnel have revealed that three major health services at factories were first aid, annual health examination and health education. First aid was provided in a nursing room for everyone 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 8 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 workers. Those who have chronic pain could consult with the doctor on his/her visit. The physician was also responsible for doing annual health examination at factories.

Health education was planned and implemented by factory personnel annually. It consisted of a variety of topics such as HIV/AIDS, drugs, maternal health care, and traffic accident. In many cases, instructors came to the factories from outside institutions, such as the public health office, the maternal and child health center and a police station. From 1995 to 2001, for instance, LPH and a local NGO supported by CARE international conducted project-based AIDS education at major companies.

In factory health care, work injuries were prioritized and sexual and reproductive issues were of secondary concern. Accidents and injuries of workers would disturb production processes and raise criticism by the workers, family, and community if the accidents result from the mismanagement of the factory. Besides, accidents and injuries would cause huge financial burden on the company.

On the other hand, sexual and reproductive health disorders would not affect the company management directly, nor raise criticism against the company since they are seen as individual problems. Thus, managers were reluctant to promote workers' sexual and reproductive health care services in factories. They thought it is enough for them to provide opportunities for other health institutions to conduct HIV/AIDS education and maternal health care training at factories.

Perception of the nurses

With regard to sexual and reproductive disorders expressed by workers as "*puat toong*," companies can only administer first aid at the nursing station. According to the information given by the nurses in the interviews, they prescribed drugs after a medical interview and recommended the patient to consult a doctor outside if the condition became severe. Some nurses stated that they would not know the real cause of the problems, but prescribed drugs on the basis of their own experience. Many abdominal problems, such as menstrual pain, were chronic. Workers were accustomed to putting up with the disorder until the symptoms became unbearable, at which point they then seek out a doctor for treatment.

The nurse might well be aware of the severity of their sexual and reproductive disorders, but they stated that the

care and treatment go beyond what can be done at the nursing station. In addition, nurses perceived that sexual and reproductive disorders of workers relate to their personal and family matters, and, as such, are something which cannot be dealt with by medical treatment. The nurse strongly believed that family counselors who are familiar with the social aspects of sexual and reproductive health issues should be the main provider of these services for workers.

Besides, some nurses stated that they had difficulty in making good relations with workers. In factories, a clear class hierarchy was visible, separating workers who mostly came from lower-class peasant families from officers, managers, nurses, many of whom were from middle-class families of merchants, public officials and school teachers. Workers were skeptical about officers, managers and nurses, as being mistreated as lower-class people on everyday bases. Officers, managers and nurses, on the other hand, regarded workers as immature, ignorant, lazy and deceptive, and these dispositions were the cause of their health disorders. A nurse told me a story that there was a woman worker who came to receive contraceptive pills without telling a nurse that she was pregnant. According to a nurse, the woman tried to use the pill to abort the baby. When asked why she thought like that, the nurse replied that she knew it from her experience. As this example shows, the class hierarchy served as a barrier against establishing mutual trust and understanding between workers and nurses.

Discussion: Challenges and Future Directions of Factory Health Care

Professional Care

This study shows that whilst factory workers had various sexual and reproductive health problems, they received inadequate care and treatment at the nursing station. In the factories, mutual misunderstandings between the nurses and workers perpetuated, leaving workers looking for sincere and good quality care from somebody else. They looked for regular visits by reproductive health professionals such as family counselors, obstetricians and gynecologists to the nursing station.

In listening to the workers' problems, these professionals need to deal with their sexual and reproductive health in a holistic manner, as they are seen by the workers themselves, namely as "*puat toong*." Professionally, they should explain anatomical facts about their reproductive organs and medical facts regarding the causes of reproductive disorders. This would increase workers' awareness about sexually transmitted infections and thereby improve self-management

of reproductive health. In addition, health professionals, including those at the designated hospitals and nearby clinics should provide good and qualified services whilst employing humanistic attitudes towards the patients.

Health Education

A comprehensive sexual and reproductive health education should be developed in order to raise awareness of HIV risk and other sexual and reproductive health risks without stigmatizing factory workers as sexually casual. Such an education should incorporate topics concerning social norms of gender and sexuality as well as workers' empowerment. A comprehensive sexual and reproductive health education should also be promoted for a medical reason. As we have seen, some of the factory women's reproductive health problems, such as vaginal discharge caused by sexually transmitted infections, can be addressed by comprehensive program and raised awareness about the importance of condom use. The problems of the side effects of contraceptive pills and injections can also be effectively reduced if condoms are promoted as alternatives to contraceptive pills and injections. As Wilson and Miller argued, addressing the cultural context in which both health risk behaviors and protective factors develop is an essential factor in organizing effective HIV prevention³⁾.

There remains the obstacle of how to support such health education. Integrating HIV/STD services with other reproductive health care has been advocated globally to address community health problems, especially to improve women's health⁴⁾. However, the rhetoric of integration is more powerful than the evidence for its feasibility; and those who advocate the approach of integration "have taken little account of political, financial and managerial constraints to implementation"⁴⁾. The similar phenomenon would happen in companies unless the managers fully understand these constraints.

The major obstacle is that health education in factories must be organized within the limited amount of time that is available to workers. They work full-time for 8 hours a day with a 40 minute lunch break and two 10 minute breaks in the morning and afternoon. In reality, a health education program conducted outside of working hours would be impossible. If it is done within the working time, it has to be concise and short. In many companies, the maximum number of topics covered in health education is three to five per year. Sexual and reproductive health could be one of the topics but taking place only once a year. If organized within such a limited time space, the most efficient educational approach would be a well-focused problem-solving one.

Comprehensive sexual and reproductive health education requires time and long-term commitment by the company personnel involved.

In practice, the promotion of sexual and reproductive health among factory workers has to be addressed not only in the context of factories but also within the wider community and throughout people's lifecycles. Thus, a comprehensive approach in factories has to be a part of a wider collaborative effort involving schools, families, community organizations, and health institutions. This goal remains to be achieved.

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