56 ETHICAL RESPONSIBILITIES ALONG THE SUPPLY CHAIN – CALL TO ACCOUNT THE PRINCIPALS

[1]E Kuhn, [2]S Müller, [2]L Heidbrink, [1]A Buyx. *[1]Christian-Albrechts-University Kiel, Institute of Experimental Medicine (Division of Biomedical Ethics), Kiel, Germany; [2]Christian-Albrechts-University Kiel, Chair of Practical Philosophy, Kiel, Germany*

10.1136/oemed-2018-ICOHabstracts.901

Introduction During the last years a remarkable number of companies, especially in the Northern hemisphere, established an in-house Occupational Health Management or at least came up with a broad range of workplace health promotion (WHP) programmes. At the same time, most companies increased their efforts in Corporate Social Responsibility (CSR), becoming aware of their responsibility towards the environment and society. However, these ethical responsibilities do not end at a country's borders. Regarding global players as corporate citizens, they also have a special ethical and social responsibility for their workers in the supply chain. Moreover, they already have the WHP-tools and resources to care for and enhance the health of these workers.
Methods A qualitative interview study was conducted and evaluated with the Qualitative Content Analysis. Interviews were carried out with German and Swiss companies of all different sizes and sectors, their stakeholders, final consumers and industry representatives. They all were asked questions about ethical responsibilities along the supply chain, especially regarding topics of occupational health and CSR.
Result The analysis reveals that most companies do not regard themselves responsible for their stakeholders beyond the contractual commitment and legal framework. Not surprisingly, the stakeholders along the supply chain as well as the industry representatives emphasise the companies' voluntary assumption of responsibility.
Discussion The interviews show that the CSR strategies of many companies already include the awareness to be responsible for future generations, a proper education of youth and general educational work regarding health in the global south (e.g. vaccination campaigns). The social and ethical arguments considered in CSR can build a bridge to reasons for the promotion of occupational health programmes beyond occupational safety especially in the supply chain. Such actions, again, will have an impact on the perception of a company's CSR and, ideally, lead to positive reinforcement.

65 BASIC OCCUPATIONAL HEALTH: A KEY ISSUE FOR ACHIEVING HEALTH EQUITY IN INDIA

Shyam Pingle*. *Indian Institute of Public Health Gandhinagar, Gandhinagar, India*

10.1136/oemed-2018-ICOHabstracts.902

India is the second highest most populous country in the world after China. It is also becoming an economic powerhouse having already achieved fourth position globally (purchase power parity). In spite of technological advances, the health scenario in India presents a paradoxical situation with lack of basic occupational health services for the majority of working population.

India's population crossed 1.21 billion according to the census carried out in 2011, 833 million reside in rural area and 377 million reside in urban area. Current population estimates exceed 1.3 billion. Those in working age group are estimated to be 63.6%. More than 90% work in the informal economy, mainly agriculture and services (60% self-employed and 30% without regular jobs). Less than 10% have jobs in the organised sector; mainly industry, mining and some services. The proportion of workers engaged in agriculture is steadily declining and that in services is increasing.

Leading occupational risks are accidents, pneumoconiosis (especially silicosis) and lung diseases, musculoskeletal injuries, pesticide poisoning, asbestosis, noise induced hearing loss and workplace stress. Women are subjected to the dual burden of home work and occupation. Statistics on accidents and occupational illnesses is not easily available. Typical employer employee relationship cannot be established in self-employed, home based work and much of the unorganised sector. There are no fixed wages, leave or social security for this population for occupational injuries and diseases. Further, the focus on health and safety is lacking in the expanding service sector.

Important OSH needs include legislation to extend OSH coverage to all sectors of working life, spreading stakeholder awareness about occupational health, development of OSH infrastructure and professionals, integration of occupational health with primary health care.

Equity in health system cannot be achieved in India unless the lack of basic occupational health services for all working population is addressed.

748 HEALTH CHECK-UP RESULTS AMONG MIGRANT WORKERS AT BANGKOK METROPOLITAN ADMINISTRATION HOSPITALS

P Nagavajra, M Sripramote. *Medical Service Department, Bangkok Metropolitan Administration, Bangkok, Thailand*

10.1136/oemed-2018-ICOHabstracts.903

Introduction Thailand is a country with many unskilled labourers from three neighbouring countries namely Myanmar, Laos, and Cambodia. The difference in quality of the health service systems in

Thailand and these three countries could expose Thailand to contagious diseases. The objectives of this study were to evaluate the results of health check-ups of migrant workers and to evaluate the prevalence of infectious diseases and positive urine screenings for methamphetamine.
Methods This was a cross-sectional study conducted on migrant workers who needed health check-ups from 1 st January 2014 to 31 st December 2016. Data was collected from hospital computer databases and standard physical check-ups were controlled by the physicians from the three tertiary hospitals of BMA. They included chest radiography, blood tests for Syphilis, Microfilariasis, Malaria and other diseases, urine tests for methamphetamine, pregnancy tests and other tests as requested.
Results A total of 2 69 286 migrant workers were enrolled in this study, 3162 were pregnant (1.17%) and 5470 were classified as abnormal (2.03%), 3083 of whom were male (1.14%) and 2387 of whom were female (0.89%). In terms of nationality, 0.69% were Cambodian, 0.78% were Burmese and 0.56% were Lao.

The highest prevalence of cases were suspected pulmonary TB (1.23%), Cardiac screening abnormalities (0.75%) and