A cross-sectional community study of post-traumatic stress disorder and social support in Lao People's Democratic Republic

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Objective

To estimate post-traumatic stress disorder (PTSD) symptoms in those injured and not injured by landmines or unexploded ordnance (UXO) in rural Lao People's Democratic Republic and to determine whether the perception of social support was associated with PTSD symptom severity.

Methods

A community survey was conducted among 190 people injured by landmines or UXO and 380 age-, sex- and neighbourhood-matched non-injured individuals in the Sepone district of Savannakhet Province, the part of the Lao People's Democratic Republic most heavily bombed during the Viet Nam War. Using the Harvard Trauma Questionnaire and the Medical Outcomes Study Social Support Survey, trained health-care workers conducted face-to-face interviews to assess PTSD symptoms and level of perceived social support. Multiple linear regression was performed to explore the association between social support and other factors and PTSD.

Findings

The prevalence of PTSD was higher among the injured (10%) than among the non-injured (4%), but the level of perceived social support was not significantly different between the two groups. A higher level of perceived social support was associated with milder symptoms of PTSD. Women, older people and those with a formal education were more often and more severely affected by PTSD.

Conclusion

The perception of strong social support might help to alleviate the symptoms of PTSD among people injured by landmines or UXO in rural parts of the Lao People's Democratic Republic. Psychosocial interventions should be incorporated in assistance for the injured because they have more severe and longer-lasting symptoms of PTSD than the non-injured.
Economic evaluation of neonatal care packages in a cluster-randomized controlled trial in Sylhet, Bangladesh


Objective

To evaluate and compare the cost-effectiveness of two strategies for neonatal care in Sylhet division, Bangladesh.

Methods

In a cluster-randomized controlled trial, two strategies for neonatal care – known as home care and community care – were compared with existing services. For each study arm, economic costs were estimated from a societal perspective, inclusive of programme costs, provider costs and household out-of-pocket payments on care-seeking. Neonatal mortality in each study arm was determined through household surveys. The incremental cost-effectiveness of each strategy – compared with that of the pre-existing levels of maternal and neonatal care – was then estimated. The levels of uncertainty in our estimates were quantified through probabilistic sensitivity analysis.

Findings

The incremental programme costs of implementing the home-care package were 2939 (95% confidence interval, CI: 1833–7616) United States dollars (US$) per neonatal death averted and US$ 103.49 (95% CI: 64.72–265.93) per disability-adjusted life year (DALY) averted. The corresponding total societal costs were US$ 2971 (95% CI: 1844–7628) and US$ 104.62 (95% CI: 65.15–266.60), respectively. The home-care package was cost-effective – with 95% certainty – if healthy life years were valued above US$ 214 per DALY averted. In contrast, implementation of the community-care strategy led to no reduction in neonatal mortality and did not appear to be cost-effective.

Conclusion

The home-care package represents a highly cost-effective intervention strategy that should be considered for replication and scale-up in Bangladesh and similar settings elsewhere.
Hospital payment systems based on diagnosis-related groups: experiences in low- and middle-income countries

Inke Mathauer & Friedrich Wittenbecher

Objective

This paper provides a comprehensive overview of hospital payment systems based on diagnosis-related groups (DRGs) in low- and middle-income countries. It also explores design and implementation issues and the related challenges countries face.

Methods

A literature research for papers on DRG-based payment systems in low- and middle-income countries was conducted in English, French and Spanish through Pubmed, the Pan American Health Organization’s Regional Library of Medicine and Google.

Findings

Twelve low- and middle-income countries have DRG-based payment systems and another 17 are in the piloting or exploratory stage. Countries have chosen from a wide range of imported and self-developed DRG models and most have adapted such models to their specific contexts. All countries have set expenditure ceilings. In general, systems were piloted before being implemented. The need to meet certain requirements in terms of coding standardization, data availability and information technology made implementation difficult. Private sector providers have not been fully integrated, but most countries have managed to delink hospital financing from public finance budgeting.

Conclusion

Although more evidence on the impact of DRG-based payment systems is needed, our findings suggest that (i) the greater portion of health-care financing should be public rather than private; (ii) it is advisable to pilot systems first and to establish expenditure ceilings; (iii) countries that import an existing variant of a DRG-based system should be mindful of the need for adaptation; and (iv) countries should promote the cooperation of providers for appropriate data generation and claims management.
Smoking-attributable mortality in Bangladesh: proportional mortality study

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Objective

To directly estimate how much smoking contributes to cause-specific mortality in Bangladesh.

Methods

A case–control study was conducted with surveillance data from Matlab, a rural subdistrict. Cases (n = 2213) and controls (n = 261) were men aged 25 to 69 years who had died between 2003 and 2010 from smoking-related and non-smoking-related causes, respectively. Cause-specific odds ratios (ORs) were calculated for “ever-smokers” versus “never-smokers”, with adjustment for education, tobacco chewing status and age. Smoking-attributable deaths among cases, national attributable fractions and cumulative probability of surviving from 25 to 69 years of age among ever-smokers and never-smokers were also calculated.

Findings

The fraction of ever-smokers was about 84% among cases and 73% among controls (OR: 1.7; 99% confidence interval, CI: 1.1–2.5). ORs were highest for cancers and lower for respiratory, vascular and other diseases. A dose–response relationship was noted between age at smoking initiation and daily number of cigarettes or bidis smoked and the risk of death. Among 25-year-old Bangladeshi men, 32% of ever-smokers will die before reaching 70 years of age, compared with 19% of never-smokers. In 2010, about 25% of all deaths observed in Bangladeshi men aged 25 to 69 years (i.e. 42 000 deaths) were attributable to smoking.

Conclusion

Smoking causes about 25% of all deaths in Bangladeshi men aged 25 to 69 years and an average loss of seven years of life per smoker. Without a substantial increase in smoking cessation rates, which are low among Bangladeshi men, smoking-attributable deaths in Bangladesh are likely to increase.
Variations in catastrophic health expenditure estimates from household surveys in India

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Objective

To assess the comparability of out-of-pocket (OOP) payment and catastrophic health expenditure (CHE) estimates from different household surveys in India.

Methods

Data on CHE, outpatient and inpatient OOP payments and other expenditure from all major national or multi-state surveys since 2000 were compared. These included two consumer expenditure surveys (the National Sample Survey for 2004–05 [NSS 2004–05] and 2009–10 [NSS 2009–10]) and three health-focused surveys (the World Health Survey 2003 [WHS 2003]; the National Sample Survey on Morbidity, Health Care and the Condition of the Aged 2004 [NSS 2004]; and the Study on Global Ageing and Adult Health 2007–08 [SAGE 2007–08]). All but the NSS 2004–05 and the NSS 2009–10 used different questionnaires.

Findings

CHE estimates from WHS 2003 and SAGE 2007–08 were twice as high as those from NSS 2004–05, NSS 2009–10 and NSS 2004. Inpatient OOP payment estimates were twice as high in WHS 2003 and SAGE 2007–08 because in these surveys a much higher proportion of households reported such payments. However, estimates of expenditures on other items were half as high in WHS 2003 as in the other surveys because a very small number of items was used to capture these expenditures.

Conclusion

The wide variations observed in CHE and OOP payment estimates resulted from methodological differences. Survey methods used to assess CHE in India need to be standardized and validated to accurately track CHE and assess the impact of recent policies to reduce it.