Prevalence of depression, substance abuse, and stigma among men who have sex with men in coastal Kenya

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Background: Mental health conditions can have a severe impact on quality of life and interfere with health-related behaviours such as medication adherence. Our aim was to determine the prevalence of depression, substance abuse, and stigma among self-identified men who have sex with men (MSM) in coastal Kenya.

Methods: A cross-sectional study was conducted at the Kenya Medical Research Institute’s HIV/STD clinic in Mtwapa, Kenya. Participants were 112 self-identified MSM involved in ongoing cohort studies, who had consented to collection of health-related data. We used audio computer-assisted self-interview (ACASI) to collect data on the following psychosocial measures: depression (PHQ-9), alcohol use (AUDIT), other substance use (DAST), sexual stigma (modified China MSM Stigma Scale), HIV stigma (modified...
The health cost of misdiagnosis among obstetric providers in the Philippines

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Background: There is interest in examining the pervasiveness of misdiagnosis in clinical care around the world, which is stimulating a shift in how quality deficiencies are conceptualized. While diagnostic process can potentially be studied prospectively, real clinical settings makes this a substantial practical challenge, starting with resource constraints, case mix variation, clinical uncertainty, and challenges in measuring clinician cognitive thought processes. We used a case simulation measure, the Clinical Performance and Value (CPV) vignettes, to quantify the quality of care among obstetric providers (midwives and physicians) in an urban setting of the Philippines (Quezon City). Obstetric complications remain a major source of mortality and morbidity in the Philippines. We asked three questions: 1. What is the prevalence of misdiagnosis? 2. What are the predictors of mortality and morbidity in the Philippines. We examined the medical charts of providers who took the vignettes. Of the 70 patients that were linked to providers, 37 were classified as complications (defined by the presence of at least one obstetric complication as reported in the medical chart). Complications include cases with any of the following: fever, abnormal vaginal discharge, excessive bleeding, urinary incontinence, blood transfusion, perineal tears, high BP, jaundice, pallor, and prolonged labor. We examined whether providers who misdiagnosed on the vignette were more likely to have had a patient complication under their care.

Findings: The prevalence of misdiagnosis in this study group was notably high: 25.2% CPD, 33% PPH, 31% Pre-ec. Older providers had a slightly lower rate of misdiagnosis. Providers who misdiagnosed on the vignettes were more likely (p=0.0165) to have patients with a complication (any any of the following: fever, abnormal vaginal discharge, excessive bleeding, urinary incontinence, blood transfusion, perineal tears, high BP, jaundice, pallor, and prolonged labor) than providers who did not misdiagnose.

Interpretation: Diagnosis is arguably the most important early task a clinician performs as he or she determines the subsequent course of evaluation and treatment. The implications for the patient are significant as they may translate into significant morbidity and possibly mortality. Investments in improving provider decision-making skills may be necessary.

Funding: NIMH 1R34MH099946-01 (PI Graham).

Abstract #: 01NCD034

Strategies for prevention and control of rheumatic fever and rheumatic heart disease in Sub-Saharan Africa: a preliminary cost-effectiveness analysis

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Background: While mortality from acute rheumatic fever (ARF) and its sequel rheumatic heart disease (RHD) appear to be declining at the global level, these conditions remain the most common cause of heart disease in children and adolescents in low- and middle-income countries. Several interventions across the natural history of ARF/RHD are effective, including primary and secondary prevention as well as heart valve surgery. We developed a cost-effectiveness analysis model to assess the most important tradeoffs among various public health interventions that should be considered in scaling up programs in highly endemic, resource-constrained settings such as sub-Saharan Africa.

Methods: We developed a decision tree to analyze five different combinations of primary and secondary prevention with or without scale-up of surgical services, and we compared these to doing nothing. We modeled the natural history of ARF and RHD as a time-dependent Markov process with health states reflecting first and recurrent episodes of ARF, ARF remission, RHD (including severe heart failure and stroke as sequelae), and mortality from ARF/RHD. We used transition probabilities and intervention effectiveness data from previously published studies. To calibrate our model, we used South African life tables and published medical and surgical costs from a population-based intervention in Cuba. We took the healthcare system perspective in our costs, and we measured outcomes as disability-adjusted life-years (DALYs), incorporating disability weights from the Global Burden of