and 2–10 years, the parents or the head of household were interviewed to obtain the responses. Impairments, activity limitations and restriction of participation were considered in defining disability which is consistent with the International Classification of Functioning, Disability and Health framework.

Results The overall age standardised prevalence of disability per 1000 was 46.5 (95% confidence interval, 44.4–48.6). The prevalence was significantly high among the respondents living in rural areas at 50.2 (47.7–52.7), compared to urban areas at 31.0 (27.0–35.0). Overall, females had more disability 50.0 (46.9–53.1) than males 43.4 (40.5–46.3). Educational deprivation was closely linked to higher prevalence of disability. Commonly reported prevalence (per 1000) of cause specific disability was illness (20.2) followed by congenital (9.4) and injury (6.8) and these were consistent in males and females.

Conclusions Disability is a common problem in this typical district of Bangladesh, which is largely generalizable. Interventions at community level with special attention to the socio-economically deprived group are warranted.

115 UNDERSTANDING TRAJECTORIES OF MENTAL DISTRESS AFTER MODERATE OR SEVERE INJURY AMONG ADULTS IN KENYA

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Background Injuries present a major burden to populations in developing countries. Despite major psychological distress have been found among injury survivors in developed settings, there has been a lack of literature on the mental health consequences among all types of injury in developing countries, especially in sub-Saharan Africa.

Methods The Health, Economic and Long-term Social Impact of Injuries (HEALS) Study is a multi-country prospective longitudinal study currently underway. In Kenya, the study includes adult patients age 18 years or above who are hospitalised due to injury for at least one day in Kenyatta National Hospital. Eligible patients are being enrolled in the study until the sample size of 1000 patients is reached. Patients are interviewed in-person while in hospital, and followed up at 1, 2, and 4 months after hospital discharge through phone interviews. Distress symptoms severity is assessed using Hopkins Symptoms Checklist (HSCL-25) at baseline and follow-ups, and post-traumatic stress disorder symptoms are assessed at follow-up interviews using PTSD Checklist for DSM-5 (PCL-5).

Results 320 patients have enrolled in the study and completed baseline interview, 246 patients completed first follow-up interview, and 119 respondents completed second follow-up interview. Preliminary total score of HSCL-25 is 1.18 (SD: 0.17) at baseline, 1.15 (SD: 0.18) at first follow-up, and 1.10 (SD: 0.14) at second follow-up interview. Exploratory factor analysis will be conducted to determine the underlying factor of distress. Latent growth mixture modelling will be to determine the latent construct of mental distress. Risk factors such as sex, age, type of injury, severity of injury, and previous exposure to traumatic experience will be assessed.

Conclusions Mental distress continues months after hospitalisation among some injury patients. This highlights the importance of screening and attending to the mental health of patients in recovery from their injury.

116 FUNCTION, HEALTH RELATED QUALITY OF LIFE AND COST AFTER INJURY IN A CITY OF NORTH INDIA: A MULTI SITE COHORT STUDY

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Background The burden of traumatic injury in India is high, but remains ill-defined and poorly quantified. The aim of this project was to measure the impact of traumatic injuries on functioning and health-related quality-of-life (HRQoL), economic impactand to identify predictors of poor outcomes post-injury.

Methods A prospective observational study was conducted at three hospital sites in Chandigarh, North India in 2014–2015 for all ages admitted with an injury. Consent was sought and participants were followed at 1, 2, 4 and 12 months after injury; face to face or telephonic interviews collected data on socio-demographics, circumstances of injury, cost associated with injury, disability, function and health related quality of life. Interim analysis for 4 months is reported below, with 12 months interviews underway.

Results 2950 (90% of eligible) participants were recruited, with a follow-up rate of 74% (2180) at 4 months. Road traffic injuries (1622/55%) followed by falls (914/31%) and burns (383/13%) were the leading cause of injury; 86% were males, 79.5% were in paid employment at the time of injury. The average out of pocket expenditure per hospitalisation and up to 4 months post discharge was USD 388 (95% CI: 332–441) and USD 946 (95% CI: 771–1021) respectively. The prevalence of catastrophic expenditure was 30% (95% CI: 26.95–31.05), which was significantly associated with lower income quartile (OR 23.3 [95% CI: 5.7–73.9]; $p < 0{\cdot}01$), inpatient stay greater than 7 days (OR 8.8 [95% CI: 3.8–20.6]; $p < 0.01$), major surgery (OR 4.9 [95% CI: 2.7–8.4]; $p < 0.01$), and occupation as wage labourers (OR 8.1 [95% CI: 1.6–24.6]; $p = 0.01$).

Conclusions Injury has a substantial impact with a high proportion of patients sustaining catastrophic health expenditure, particularly the poor. Measures aimed at increasing public health spending for sustained prevention programs and providing financial risk protection to those injured deserve urgent priority in India.

117 LONG-TERM HEALTH, ECONOMIC, AND SOCIAL IMPACT OF INJURY IN FOUR LOW- AND MIDDLE-INCOME COUNTRIES

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Background With 90% of the burden of injuries concentrated in low- and middle-income countries (LMICs), the impact on individuals, families, and society, especially in the case of non-fatal injuries, is exacerbated by the absence of insurance or social support mechanisms. There is a dearth of information in the literature on the occurrence of non-fatal injuries, and their long-term consequences. This study aims to understand the health (disability), social and economic impact of injuries in LMICs.