Children outcomes and intimate partner violence research

We commend Kelsey Hegarty and colleagues (July 20, p 249) for taking a rigorous approach to assess universal screening for intimate partner violence (IPV) in health-care settings. As paediatricians, we have a unique perspective on their findings and potential implications.

40% of women experiencing IPV live with children who are subsequently exposed to chronic and unpredictable violence in the home. It is well documented that IPV-exposed children are at an increased risk for adverse physical and mental health outcomes, child maltreatment, and academic failure. Unfortunately, many studies of IPV interventions fail to address these paediatric outcomes.

Although Hegarty and colleagues noted a clinically significant reduction in maternal depression symptoms in the intervention group, they did not discuss the implications of this finding for children. Current data suggest that the adverse outcomes of childhood IPV exposure are compounded by co-existing maternal depression. From a paediatric perspective, this primary care intervention has the potential, over time, to improve the health, wellbeing, and resilience of IPV-exposed children.

In view of the need to identify and intervene on behalf of IPV-exposed children, we are concerned that many will read this study and the linked Comment and conclude that universal IPV screening is ineffective. We suggest that without addressing the long-term effect of these interventions on paediatric outcomes, it would be premature to conclude that universal IPV screening in health-care settings should be discontinued.

We declare that we have no conflicts of interest.

*Mario Cruz, Kimberly A Randell, Megan H Bair-Merritt, M Denise Dowd mario.cruz@drexelmed.edu

Authors’ reply

As primary care researchers and practitioners in the field of intimate partner violence (IPV) and children’s health and wellbeing, we acknowledge the adverse physical and mental health outcomes for children experiencing violence in the home. We completely agree that child outcomes should be measured and reported in IPV research. We are undertaking participant evaluation of qualitative outcomes of the WEAVE project through participant interviews (40 women). A related study, the SARAH project, specifically explored children’s safety and resilience in the context of IPV and questioned mothers and children about the role of primary care in responding to children experiencing IPV, with the aim of developing a primary care intervention for both mothers and children. In 2009, Feder and colleagues in their systematic review noted that the most robust evidence for interventions in this field were those involving both mothers’ and children’s outcomes. Such an intervention has not been tested in the primary care setting. A recent Cochrane review concluded that screening only, without a brief intervention in health-care settings is not recommended.

We would like to highlight that we did not conclude from our data that universal screening followed by brief intervention is ineffective. We are also concerned that the linked Comment implies that our trial is connected to other ineffective screening only trials. Rather we stated that the method of postal screening surveys is not supported by data because there was a low response rate (29%).

Our study showed some effect of a brief counselling intervention by primary care doctors on women’s depressive symptoms. As Mario Cruz and colleagues suggest, we are currently analysing 2-year follow-up of WEAVE to assess if the depression outcomes are sustained over time. We agree that improving women’s mental health could potentially help children, and we recommend further research of interventions that address the mental health of both mother and child.

We declare that we have no conflicts of interest.

*Kelsey Hegarty, Anita Morris k.hegarty@unimelb.edu.au

Community health workers: an opportunity for reverse innovation

Prabhjot Singh and Jeffrey Sachs’ Viewpoint (July 27, p 363) describes well the rationale for scaling-up a subsystem of community health...
workers (CHWs) in sub-Saharan Africa and the progress to date.

It is well recognised that CHWs can bring multiple benefits to individuals and populations, and improve efficiency and equity within health systems. WHO now recommends an expanded CHW role. What is less well recognised is that such a system is applicable to all WHO member states.

CHWs signpost patients to services, proactively identify health-care and social-care problems at the household level, provide low-level health promotion advice, improve communication with primary care services, and gather important sociodemographic data from their micro-areas. This is valuable for any health system.

It seems increasingly important that lean innovations, developed in or for resource-poor settings, be considered seriously in rich countries. There is an emerging field of health-care reverse innovation—simple low cost solutions that draw on innovations from developing countries. It is much harder, however, to identify initiatives in developed countries that explicitly draw on such innovations, although some examples exist. Whether this is due to barriers to innovation diffusion, or post-colonial double standards, is worthy of examination.

Matthew Harris

department of primary care and public health, Imperial college london, London W6 8RF, UK


Authors’ Reply

We welcome Matthew Harris’ comments on our viewpoint. For decades, publicly subsidised investments in biomedical sectors in developed countries have resulted in real innovation with global relevance, ranging from penicillin to portable electrocardiograms. This has resulted in a persistent perception that innovation flows in one direction: from North to South. However, there are substantial contributions to the architecture of health system delivery in developed countries through the yet underdefined process of reverse innovation.

For example, Jack Geiger—inspired by Sidney Kark and John Cassel—built community health centres in the USA in 1965 on the basis of their experience in rural Natal, South Africa. The system of community health centres is projected to cover 44 million Americans by 2015. This system forms the basis of scale-up of community health workers (CHWs) in the USA. As the emphasis in developed countries shifts from traditional notions of biomedical innovation to innovations in efficiently delivering high-quality health care, examples of reverse innovation will be both more visible and more acceptable to implement. As Harris points out, programmes like City Health Works in Harlem, New York, explicitly credit global innovations in CHW development because they develop an operational approach tailored to the complex American health reform environment. We hope this becomes more common.

There should be more explicit focus on the concept of reverse innovation for three reasons: first, to rebalance the idea that innovation simply flows from North to South, enabling a more equitable global dialogue on how to achieve better health; second, to understand the factors that accelerate the translation and uptake of low-resource innovations in developed countries; and finally, to recognise the core expertise of practitioners and scholars from developing countries who have spent decades working on achieving universal health care in challenging environments.

We declare that we have no conflicts of interest.

Prabhjot Singh, Dave A Chokshi

psingh@ei.columbia.edu

Columbia university, New York, NY 10015, USA (PS); and department of veterans affairs, Washington, DC, USA (DAC)


Chemical poisoning-related injury in China

Chemical poisoning is an important cause of morbidity and mortality worldwide. In China, 2 million chemical poisonings are reported annually, leading to more than 150 000 deaths annually. Intentional chemical poisoning is not only a complex social issue, but also a serious public health problem. In China, suicides result in 195 000 deaths annually, and 60% of suicides are through consumption of pesticides.

Three factors are important to understand chemical injuries in China. First, more than 45 000 chemical products, including about 770 approved pesticides, are available in China. Although China has comprehensive laws for managing these chemicals, they are not strictly enforced by relevant authorities. In rural areas, many pesticides (70%) are stored at home unlocked; and...