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South Africa Revisited

After returning from a trip to evaluate the Alexandra Health Centre (AHC) in Alexandra Township, South Africa, I read with great interest and respect the articles by Geiger,[1] Yach and Tollman,[2] Phillips,[3] and Susser[4] in the July 1993 issue of the Journal. In commemorating the contributions of pioneers in South Africa in the field of community health, particularly the contributions of Sidney and Emily Kark at Pholela Health Center, the authors provided a historical context in which to look at community health issues today. I can report with enthusiasm that new models for community-based primary health care continue to be developed in South Africa today.

AHC, which was started by a missionary nurse in 1929, was where Mervyn Susser and Zena Stein, in the tradition of Sidney Kark's work, contributed to the emerging model of primary health centers in the 1950s. The governmental policies of apartheid, which created separate and inadequate health facilities for Black South Africans, restricted the center's growth and influence. However, in 1986, when the anti-apartheid struggle erupted in Alexandra, a group of new physicians joined the AHC staff and promoted a vision of primary urban health care based on the needs of the community it serves, committed to strong nursing leadership, and resolved to participate as a full partner in the struggle against apartheid. AHC today is living reality that this model works.

Serving more than 200 000 patients yearly, AHC provides a full range of health care services. The AHC Outpatient Department provides medical, pediatric, and well-woman care. The 24-Hour Unit provides emergency services, used by more than 35 000 patients a year, and labor/delivery care in the Mary Thema Maternity Unit. This unit is staffed by nurse-midwives and delivers more than 2600 babies yearly. The Outreach Unit performs community assessment to determine the health care needs of Alexandra's residents and to develop appropriate services. When AHC discovered that more than 20% of Alexandra's adults suffered from hypertension, it opened the Chronic Disease Clinic in 1991. The Alexandra Disability Movement was started after AHC staff consulted with Alexandra residents about the lack of resources for the disabled. When a community-needs assessment revealed that 40% of children were not immunized, AHC created the Well-Baby Clinic and Child Health Outreach Program, which uses a mobile unit to reach members of the community. And when political violence erupted in spring 1992, AHC became a refuge for the people of Alexandra.

Today, AHC offers a new model for community health care. Breaking through the old rigid lines of authority between doctors and nurses, the AHC model is based on nursing leadership. Each unit is run by an advanced-level nurse. In-service workshops and continuing education provide senior nurses with the knowledge and skills they need to expand their areas of expertise. The AHC model gives high-quality, yet cost-effective, care.

Along with professional barriers, social barriers also are being chiseled away at AHC. Management is struggling to develop a democratic and participatory means of operating, breaking through decades of societal behaviors that gave only certain people the power to make certain decisions. It was no minor event the first time AHC's director sat down to eat with the maintenance workers and buried the policies of segregation. Each step puts the staff at AHC closer to the vision of what the new society should be like.

Though it is a small haven, AHC has taken the best of the traditions of Pholela and developed them in new ways, including using advanced-level nurses in leadership capacities and openly linking health care to the struggle for a just society. AHC may well signal the future direction for health care in South Africa as well as serve as a model for humane and caring life-styles. And time may well show that the new South Africa will offer examples for resolving current problems in the US health care system. □

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The Role of City and State Agencies in Injury Prevention

Though we applaud the theme of the editorial by Dr Pless, "Unintentional Childhood Injury—Where the Buck Should Stop,"[1] we hasten to correct a misperception concerning our article.[2] The author is critical of the limited role of health departments in injury prevention and states that in our work "it appears that the involvement of the city and state departments of health was restricted to providing access to data."

This cannot be further from the truth. The current tight restrictions on the length of Journal papers required that we remove several paragraphs that described the Safe Kids/Healthy Neighborhoods Coalition in more detail, and this led to Dr. Pless' misperception. The New York state and city departments of health were involved in our project from the start and supported us in many ways. They certainly gave us access to data, but they also worked with us in developing our strategy. They facilitated the initiation of collaboration with other agencies, such as the New York City Department of Transportation. The state and city health departments provided some financial support for such coalition activities as safe playgrounds and helmet distribution programs and supported our attempts to garner financial support for our projects from both private and governmental sources. The health departments helped us resolve difficulties that arose in collaborating with other organizations, and their representatives attended countless long planning meetings.

The New York state and city departments of health used our expertise to their advantage by involving us in the development of injury prevention strategies for both the state and the city. Members of our coalition and our evaluation team were invited to join the planning group for the New York City Injury Prevention Forum, and coalition members chaired several of its subcommittees. One coali-

tion member was a charter member of the New York State Injury Control Steering Committee and New York State Disability Prevention Council. The state and city health departments also invited us to help other groups in the city develop similar programs.

Neither the city nor the state health departments have opted out of taking responsibility for injury control programs in New York City. There is more to do, of course. For instance, we worked with the New York City Department of Health for several years to establish statutory reporting of gunshot injuries to the city's children, a program that still has not been implemented.

We agree that city and state agencies should implement effective injury prevention programs as a matter of urgency, and we have endeavored to work with such agencies in conducting our injury prevention activities. □

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A Community-Based Needle Clean-Up Project

In 1993, several former injection drug users in Baltimore City met to discuss how they might help their community. After having observed discarded contaminated needles and syringes on playgrounds, school yards, and other public areas, the group approached the Baltimore City Health Department with the idea for the Needle Clean-Up Project. Subsequently, members of the group were trained in biosafety procedures, and their services are supplied by the Environmental Control Unit of the health department.

Project members meet with community organizations to educate them about the dangers of discarded injection equipment. When citizens call the city health department when they observe discarded needles or syringes, the health department notifies the Needle Clean-Up Project, whose members collect these items in approved biosafety containers. In early 1994, the team, in the course of only two site visits, collected 102 contaminated needles and 129 contaminated syringes.

This ongoing demonstration project is an example of a partnership between a local health department and the community. The project demonstrates the active interest of former drug users who want to reduce and start to reverse the effects of drug abuse in one city. □

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More on Methadone Treatment

In their article,[1] Dr. Umbricht-Schneiter and her colleagues presented dramatic empirical evidence in support of concomitant treatment for narcotic addiction as well as for associated medical problems. In this study, comprehensive medical care was provided at an addiction treatment site. It should be noted, however, that there is an alternative way of achieving concomitant treatment: permitting the prescribing of methadone to narcotic addicts, for whom it is deemed appropriate, within a medical facility whose primary focus is not addiction.

Few would quarrel with the premise that fragmentation of medical care is destined to be less than optimal. A patient should not be required to go to different physicians working in different locations to receive care for diabetes and hypertension, tuberculosis and AIDS, asthma and angina, etc. And yet, there is a generally unchallenged assumption, codified in federal and state laws, that methadone for the treatment of narcotic addiction should be prescribed exclusively in formal methadone programs.

Providing comprehensive care to narcotic addicts by incorporating an array of general and specialized medical services in a methadone program is attractive on a theoretical basis. From a practical standpoint, however, such an approach is unlikely to be feasible on the massive scale that is required to reach those in need. Even the relatively modestly staffed methadone treatment facilities that exist today operate at capacity and leave more than 80% of narcotic addicts with absolutely no access to care. Accordingly, the more promising approach would be to allow methadone, just like any other medication, to be prescribed by facilities and practitioners that handle the full spectrum of medical problems. □

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NRA Claims Distortions of Second Amendment in Journal Article

From the abstract on, "Firearms and Health: The Right To Be Armed with Accurate Information about the Second Amendment"[1] distorts the meaning of the Second Amendment, court decisions interpreting the amendment, similar state protections of the right to keep and bear arms, and the position of the National Rifle Association (NRA) regarding fire-