international freedom of information and representation of nomindustrial non-government organisation on hazard assessment task forcesf The uright to knowii provisions which operate in the USA but not in Europe would help to produce more open debate and effective public education about environmental and occupational health risk assessments. This should be allied to registers of the interests and the funding of ’ group members and their organisations.

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HIV In South Africa

Since 1984, I have been involved in several aspects of the HIV pandemic, in Africa and elsewhere. Much of this work has been to encourage governments to implement preventive programmes, and in 1991/92 I was medical adviser to the South Afrim governmentis AIDS unit. A depressing feature of this pandemic is the certainty that whenever HIV arrives in a country the same cycle of responses has to be played out once again. Countries find it difficult to learn from othersi mistakes, and South Africa is no exception.

The first indicator came in gay white men, whose travel contacts hadi eased HIV into South Africais Cape. Education and support, generated almost entirely from within the gay community, ensured that the incidence of HIV infection dropped, and by 1992 the number of AIDS cases in gay men was the lowest since 1987. However, South Africa tends to forget that it is part of Africa, and seemed taken by surprise when the first evidence of HIV infection among’heterosexuals in the majority black population was noted, as recently as late 1987. Since then the screening of potential blood donors; sentinel surveillance in Johannesburg, three population-based surveys of HIV seroprevalence in part of Natal, and three national anonymous unlinked surveys in antenatal clinics have revealed the main features of the heterosexual epidemic. Young adults bear the brunt, and young women are affected earlier than and at least as often as young men. Children of primary school age seem free from infection. There is marked variation between geographical regions and to some extent between rural and urban areas. At the end of 1992 more than 1 in 40 young adults in South Africa were estimated to be infected . with HIV. The rate of spread is slowing, with a current doubling time of about 16 months. These data suggest that there are over 400 new infections every day and the total number of people infected could be about 300 000 today and 750. 000 by the end of next year, 1994. These calculations are not iidoomsdayii scenarios but figures from a consensus of the country’s leading mathematical modellers.

The pattern is that already seen in much of central and eastern Africa, and in South Africa HIV infection has been . documented more accurately and from an earlier stage of the pandemic. In that country, though not uniquely, two important co-factors are present. Sexually transmitted

diseases (STD) facilitate the spread of HIV infection while tuberculosis fosters the development of AIDS once individuals are infected with HIV. With an estimated 3 million STD cases annually and with about half the adult population infected with quiescent tuberculosis, the soil was ripe for AIDS to spread. Disaster should never be inevitable when it signals itself so obviously and so well in advance. An HIV epidemic out of control is to some extent a failure of public health. South Africa has the infrastructure and health ftmding required yet AIDS seems to have slipped past and became established. How?

The central health ministryis initial response was low key; AID S was tacked onto a health directorate of infectious diseases. A clumsy, but for its time not atypical, scary uAIDS educationii campaign was launched; blood donor screening was introduced; and data collection was set up. True education was barely considered. However, in mid-1990 a dedicated AIDS unit was established, headed by a psychologist, and the key role of education of children and young people was at last identified. A neutral AIDS information campaign was launched nationally. Research into AIDS prevention programmes in secondary schools was commissioned and used to draw up a schools package that was launched jointly by the ministers of health and of education. The package was available in eight languages. Funding sources were identified for teacher training and 3000 of the 12 000 secondary schools asked for the package. The AIDS unit held workshops to bring the epidemic to the attention of religious leaders, businessmen, social workers, womenis groups, and the like; and organisations, including some very critical of South Africais government, were given money to tackle hard-to-reach groups. It really seemed as if the lessons of AIDS had been learned. It was not to be.

Unannounced, and with no consultation, AIDS prevention was stopped. Funds were quietly removed from the AIDS unit; the schools package was withdrawn and research for a pre-school package was abandoned; the media campaign petered out and pamphlets were no longer available in any language other than English and Afrikaans. The AIDS unit was merged into a lacklustre health promotion section and the unitis head was sacked. An official complaint against the health department official who had in effect closed the AIDS campaign was made. A magistrateis report, believed to support the complainants, remains unpublished. AIDS prevention no longer exists, except as window dressing, and health department officials now claim that AIDS is iithe responsibility of individualsn --ie, the government no longer sees itself as having any responsibilities in this area.

There is a sinister interpretation being put on the halting of the AIDS campaign in some quarters. South Africa is in transition politically and officials speak of interim arrangements extending over ten years. By that time the majority black population could find itself as severely affected by HIV as Zimbabwe is now, and so, the argument runs, be less able to assert themselves politically. In the continued absence of any attempt to defend the new AIDS policy suspicion will not be stifled.

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