to describe and explain the spectacular fall in mortality which has occurred in all currently industrialised countries, it can also be used to speculate on the likely consequences of future changes in mortality in countries which are lagging behind those which have already completed the epidemiologic transition: will a fall in infectious disease mortality in currently developing countries lead to a rise in chronic diseases and accidents?[28] In addition, this notion of a more or less fixed pattern of changes over time in cause specific mortality may lead us to interpret cross sectional differences between countries in cause specific mortality as being due to a different timing of the epidemiologic transition, which in turn would suggest differences in stage of economic and social development as likely causes.

In order to live up to these expectations, however, it is essential to investigate the historical changes in mortality much more thoroughly than has hitherto been done. Careful reconstruction of national time series of cause specific mortality are a necessary first step,[29] and possibly cause specific mortality data from the pre-registration era, which are available for certain subnational populations such as London[8] and Amsterdam,[30] would also be useful. Systematic and comparative descriptive analyses of these time series may disclose common patterns of change, and thereby lead to a clearer notion of the transition (or transitions) which have taken place. Finally, we may try to develop comprehensive hypotheses on the explanation of the epidemiologic transition(s), perhaps incorporating recently accumulated evidence on the link between childhood deprivation and adult heart disease.[31] Clearly, this enterprise is too exciting to be left to demographers and geographers.

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AIDS in Spain: lessons learned from a public health disaster

World Health Organisation data currently shows that Spain has reported the highest figures for AIDS in the whole European region. At the beginning of the epidemic, however, the situation was very different, as Spain was one of the countries with the fewest cases.[1] The most prominent epidemiological characteristic of HIV infection in Spain is the great importance of transmission between intravenous drug users (IVDUs), which accounts for 60% of all the AIDS cases reported up to 1993. The Spanish IVDU population could be estimated in 150 000 people; of these 50% were already infected by HIV.[2-4]

This dramatic spread could have several causes, and by trying to understand these we may be able to avoid repeating past mistakes we have made as public health professionals or ordinary citizens. In addition, our experience in Spain could be of some value to those countries in which the AIDS problem has not reached this proportion.

A rapid spread of HIV among IVDUs was described in some western cities at the beginning of the epidemic.[5] Spanish data support this pattern of transmission,[6] and the HIV prevalence in IVDUs between 1983 and 1985 increased from 11 to 47%. Recently, the incidence rate in Spanish IVDUs was accurately measured and was deemed to be the highest ever reported in western countries – 12 cases per 100 person/years (95%CI 9·6, 14·4) between 1987 and 1992.[7] The current high prevalence of the infection in Spain makes it even more difficult for risk reduction schemes to succeed. An IVDU who fails to use clean syringes has a higher risk of HIV infection in Valencia (prevalence = 50%) than in Liverpool (prevalence = 3%), to mention one of the European cities with a good record in risk reduction strategies.[3,8] High prevalence of HIV infection, however, cannot be considered the only predictor of a high incidence. In some Italian cities the

prevalence of infection is similar to that in Spain but nevertheless the reported incidence rates are lower.[9–11] Why again, is Spain different?

The Spanish response to AIDS in the past 10 years has been medically oriented and unpragmatic. Since the detection of the first cases in 1983, expert committees were created at national and regional levels and later some health authorities of the autonomous communities and the national government developed AIDS programmes. These committees and programmes have focused on case ascertainment for epidemiological surveillance, production of guidelines for health care professionals, and mass media campaigning. An enormous gap has grown between these medically and virologically dominated vertical structures, and the affected or potentially affected people, which has effectively divorced their needs from the response of professionals and the public sector.

As a result of this orientation, AIDS/HIV programmes have generally been sporadic and there has been no continuous effort on the ground. There are AIDS policies on AZT treatment or isolation of patients in almost every Spanish hospital but no risk reduction schemes or outreach worker services at the community level. The clinical management of HIV related diseases is adequate in Spain but there is an enormous need for a greater public health response. An example of the lack of a continuing commitment to AIDS prevention at the national level is the fact that while this editorial was being written there was no one responsible for the national AIDS programme. The last person in charge was unexpectedly dismissed from his post, and three months later no new appointment has been made.

In addition to the lack of continuous risk reduction oriented community programmes, the existing AIDS policies in Spain have been severely criticised by the more conservative groups in the country, especially the Catholic Church hierarchy. The popularisation of the condom, the availability of needle exchange schemes, or the widespread implementation of safer sex programmes among teenagers, prostitutes, or the gay community have been strongly opposed in the media, the parliament, and even in the courts. The public health professionals have been unable, with a few exceptions, to overcome these barriers and win the debate on the need for pragmatic public policies.

Jonathan Mann recently pointed out the urgent need to assess critically the reasons for the failure to apply the "right things" in the fight against AIDS – a new area of work which could be called AIDS policy analysis.[12] Spain is obviously a "good" country in which to apply these approaches. Meanwhile, some reasons for the weaknesses of the Spanish AIDS policies can be identified and two lessons could be learned from this public disaster.

Religious or moral arguments used by conservatives against public health measures should not be answered in the *ideological* arena. Arguments showing the health consequences of the different approaches should be used to obtain a shift in the public debate towards greater pragmatism. The current situation in Spain may be attributed not only to the active role of the Spanish Catholic Church and conservatives but to the relative weaknesses of our public health service compared with the "treatment" side of the national health service.

Persistence and ground work orientation, with the participation of the community, are crucial to public health responses. The political difficulties of implementing risk reduction programmes have been perceived by many Spanish public health professionals as an alibi which releases them responsibility compromising the health of the public. *Persistence* is the only way to create and disseminate models of good practice, and to have subsequent impact on policies, because as Nancy Milio said, "projects can demonstrate, but only policies can perpetuate the effects, projects can create oases of health, but only policies can distribute and equalize their benefits".[13]

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