PREM 19/1863

New file cover

MT

Confidential Filing

Aquired Immune Deficiency Syndrome (AIDS)

National Health.

PART 1:

August 1985

Attached Folder: DHSS Briefing on Aids.

Referred to	Date	Referred to	Date	Referred to	Date	Referred to	Date
~~28.8.85~~		~~13.11.86~~					
)		~~19.11.86~~					
~~3.3.86.~~		~~20.11.86~~					
~~6.3.86~~		~~21.11.86~~					
~~11.3.86~~		~~26.11.86~~					
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~~22.8.86~~		31.12.86					
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~~11.11.86~~							

PREM 19/1863

PART 1 ends:-

MEA To DHSS 31.12.86

PART 2 begins:-

FCO To CDP 16.1.87

TO BE RETAINED AS TOP ENCLOSURE

Cabinet / Cabinet Committee Documents

Reference	Date
CC(86) 36th meeting, item 2	06/11/1986
CC(86) 37th meeting, item 1	13/11/1986
CC(86) 38th meeting, item 2	20/11/1986
CC(86) 40th meeting, item 2	05/12/1986

The documents listed above, which were enclosed on this file, have been removed and destroyed. Such documents are the responsibility of the Cabinet Office. When released they are available in the appropriate **CAB** (CABINET OFFICE) CLASSES

Signed _____ Date 16/10/2014

PREM Records Team

SUBJECT
cc master

6

cc Mr Ingham

10 DOWNING STREET

LONDON SW1A 2AA

31 December 1986

From the Private Secretary

Your Secretary of State discussed AIDS publicity with the Prime Minister this afternoon. It was agreed that your Secretary of State should seek the maximum media coverage for an explanation of the background to the nationwide household distribution of the AIDS leaflet, to coincide with the beginning of that distribution. It was also agreed that this would not involve a Ministerial broadcast.

I am copying this only to Nick Gibbons in the Lord President's Office.

Mark Addison

Tony Laurance Esq
(Department of ~~Education and Scien~~ce.)

DHSS

cc BI (all pps below).

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

31 December 1986

AIDS - MINISTERIAL BROADCAST

You will see from the attached exchange that the Prime Minister was unhappy at the idea of a Category 1 Ministerial Broadcast. I understand that Bernard Ingham will be discussing with the Department of Health and Social Security Press Office alternative ways of getting the message across through the media.

P A BEARPARK

N.F.J. Gibbons, Esq.
Lord President's Office

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

30 December 1986

AIDS - MINISTERIAL BROADCAST

The Prime Minister has seen your Secretary of State's minute of 30 December. She has asked me to say that she is against the idea of such a broadcast. Her view is that a leaflet drop to every house explains the seriousness of the problem, and that it would not be appropriate to have the first Ministerial broadcast for eight years on this subject.

(P.A. BEARPARK)

Tony Laurance, Esq.,
Department of Health and Social Security

I am against it. A leaflet drop to every house is to explain the reason why. To take the Prime Minister broadcast for 5 years would in my view be wrong not

Prime Minister

This is a very unusual request although it has the support of H(A), and the opposition. Content to approve subject to sight of the text? Or reserve position until you have seen that?

PRIME MINISTER

As you know, the nationwide household distribution of our AIDS leaflet starts on 12 January. I have been considering the possibility of arranging a short (5 minute) Ministerial broadcast to coincide with this.

PBS 30/1/2

This would be a Category 1 Ministerial broadcast as set out in the relevant Aide Memoire. There would be no right of reply by the Opposition. Ministerial Broadcasts of this type are rare - I understand the last one was in 1978 - but I think we would be fully justified in requesting one on this occasion.

not get Sbtained

A nationwide leaflet drop is an unprecedented step in this country and of course the leaflet addresses a sensitive subject. At the same time that the leaflet goes out will also be television advertisements on AIDS for the first time.

We need to explain to the public why we are undertaking a public education campaign on this scale and why, as part of this, it was felt necessary to send a leaflet to every household in the country. The broadcast would explain the threat of AIDS and the role which everyone has to play in combatting the spread of the disease. It would also explain why the message is not being limited to a few select groups - that everyone may have a role to play, even grandparents, for example, in counselling their grandchildren. It would aim to explain also the moral dimensions of the campaign, which is likely to be a matter of concern to some people.

I have consulted the Lord President and Members of H(A) about the idea of a Ministerial broadcast and they fully support it. I have also spoken to Michael Meacher who is content with it. We have gone to considerable lengths to ensure that our policies for combatting AIDS have the support of the whole House. I believe that a Ministerial broadcast will help to sustain that and that I should make reference to it in the broadcast.

E.R.

We have also approached the broadcasting organisations informally who, in keeping with their extremely helpful response on this issue generally, have indicated that they are quite content in principle and have provisionally earmarked time for it.

The aim would be for the broadcast to go out on all channels on Thursday 8 January to ensure that it preceded the first television advertisements and the commencement of the leaflet drop.

I hope you will agree to my going ahead on this basis.

N F

30th December 1986

CC/B1

2

PRIME MINISTER 16 December 1986

AIDS

H(A) reached two important decisions on the Aids campaign today.

Medical Research

The Committee felt that we now needed to balance the public education campaign with more research into the disease. Until recently, the Medical Research Council has pronounced itself satisfied that no good research projects were being turned down for lack of funds. But they have now come back with a request for a further £1 million in 1987/88 which H(A), including the Treasury, accepted. Although drug companies should do most of the work on Aids, the Committee agreed that the public sector should contribute to basic research and also epidemiological work.

The Medical Research Council also suggested scientists should be brought together in a centrally directed task force to deal with Aids. It is not clear whether this is what free-thinking scientists really want or whether it is merely self aggrandisement by the MRC. The Committee therefore agreed to consider it further.

Sterile Needles for Drug Addicts

The Commitee was nervous about this for obvious reasons. On the other hand, the sad fact is that the high rate of Aids amongst drug addicts in Edinburgh does seem to be linked with particular difficulties in getting sterile needles there. The Committee agreed to a limited pilot scheme whereby clean needles will be available in exchange for dirty ones. But, the needles will not be handed out to allcomers. They will only be issued as part of existing work on drug misuse with proper counselling and guidance.

Announcements

These two measures were thought by the Committee to be the minimum acceptable. They will be announced in written Parliamentary answers tomorrow or the day after. They will also be brought together in a press notice which may well receive considerable publicity.

David willetts

DAVID WILLETTS

PRIME MINISTER

To know of this
conversation

NLW
10/12

From the Principal Private Secretary

10 DOWNING STREET

10 December 1986

Dear Joan,

Mr Gavin Strang, M.P., telephoned me this afternoon about his Private Member's Bill to restrict the spread of aids.

Mr Strang said that contrary to some press publicity, he was anxious to sponsor a Bill which was modest in scope and non-controversial in nature. He did not tell me why he believed legislation was required, except to say that he thought that it could be helpful in implementing some aspects of the McClelland Report. Throughout our conversation he emphasised his wish that his Bill should be a constructive, modest, helpful measure. He asked me to "feed his views into the machine". I told him that I would pass his views to the offices of the Ministers concerned.

I am sending a copy of this letter to Tony Laurance (Department of Health and Social Security) and Robert Gordon (Scottish Office).

Yours ever,
Nigel Wicks

N.L. Wicks

Miss Joan MacNaughton
Lord President's Office.

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

5 December 1986

AIDS: THE INTERNATIONAL DIMENSION

I confirm that the Prime Minister has seen H(A)(86)12 and that no further briefing is required for the timebeing.

I am copying this letter to A Langdon (Cabinet Office).

P. A. BEARPARK

Miss Jane McKessack,
Department of Health and Social Security

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

5 December 1986

AIDS

Thank you for your letter of 3 December. The Prime Minister has noted these corrections.

P. A. BEARPARK

Mrs Gwyneth Lewis,
Department of Health and Social Security

CeBG

Prime Minister 2

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY
Telephone 01-407 5522 ext. 7442
From the Chief Medical Officer
Sir Donald Acheson KBE DM DSc FRCP FFCM FFOM

Mr A Bearpark
Private Secretary
10 Downing Street
LONDON
SW1

3 December 1986

AIDS: BRIEFING TO THE PRIME MINISTER

Following Sir Donald Acheson's visit with Mr Fowler to WHO Geneva he wishes to correct the briefing he left with the Prime Minister with the following particulars:

(i) in the USA the first stored blood sample so far discovered to have antibodies to HIV was taken from the person concerned in 1977 not 1979.

(ii) antibodies have been found in a few samples of stored blood in Zaire in the late 1960's.

Although this suggests that the virus came from Africa rather than the USA this is not conclusive as the numbers of samples available for study from high risk groups from the 1960's are small.

Gwyneth Lewis

GWYNETH LEWIS
Private Secretary


04 XII
4M86

SUBJECT
cc Master

Cite SH

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

28 November 1986

Dear Jane

AIDS

The Prime Minister had a meeting yesterday with the Lord President, your Secretary of State, the Minister for Health and Sir Donald Acheson to discuss the problem of AIDs. Anthony Langdon of the Cabinet Office was also present.

The purpose of the meeting was to brief the Prime Minister on the nature of the problem, and the measures which were being taken to combat it. Sir Donald Acheson left behind a briefing pack on which he based his presentation. The Prime Minister was very grateful for the thoroughness of the presentation, and noted particularly:

(i) that the figure of 30,000 carriers in the UK was subject to up to 100 per cent error;

(ii) there was no evidence of the existence of the virus in man before 1979, and it seemed likely that it was a mutation of the virus found in green monkeys;

(iii) there was no cure for the disease, nor was there any vaccination; the difficulties of testing meant that it would be some time before there was any prospect of vaccination;

(iv) the long period between infection and of becoming ill meant that the number of people developing the disease was steadily rising;

(v) the disease affected different groups in different countries. In the Netherlands it was not a major problem among drug users, presumably because they have more social support. Compulsory screening is impossible. And other forms of screening were of dubious value since it took 12 weeks for the majority of those infected to show a positive result.

In conclusion the Prime Minister agreed with Mr. Fowler that it was very important to maintain a balance between preventing the spread of the disease, and causing panic. She

SH

asked that the briefing be circulated as widely as possible, and that special briefing packs be prepared for the European Council meeting. She also asked if she could have details of what other countries were doing about the problem.

I am copying this letter to Joan MacNaughton (Lord President's Office) and Anthony Langdon.

Yours ever

Andy

P A BEARPARK

Miss Jane McKessack,
Department of Health and Social Security

PRIME MINISTER

AIDS

Tomorrow morning we have set aside half an hour at 0930 for you to be briefed on AIDS. The Lord President, the Secretary of State for Social Services, Minister for Health and Sir Donald Acheson, the DHSS Chief Medical Officer, will be present.

We have not asked DHSS for a brief for the meeting: the intention is to give them a chance to explain how the problem is developing, and what the various options are. A note by David Willetts is attached giving some questions you may wish to ask.

PAB.

ANDY BEARPARK
26 November 1986

PRIME MINISTER

26 November 1986

AIDS

I suggest you begin tomorrow's meeting by inviting the Chief Medical Officer, Sir Donald Acheson, to describe briefly the medical and scientific aspects of Aids. Norman Fowler and Tony Newton might then wish to talk about the measures they are taking.

Here are some questions you might wish to raise:

i. Aids is at present largely confined to homosexuals and drug addicts. But in America Aids has spread into the heterosexual population, via drug-taking prostitutes. What is the right public education message - that we are all at risk or that only specific groups are?

ii. 50% of drug addicts in Edinburgh are infected with the Aids virus because restrictions on supplies of needles have led them to share dirty ones. So the DHSS is now under great pressure to distribute free sterilised needles to drug addicts. The dilemma here is obvious. What is the best way forward?

iii. Most Aids cases are in London, so the costs are falling disproportionately on the London hospitals. Is this going to add more fuel to the RAWP issue? Are we heading it off?

iv. What is the weakest point in our argument? Where is the Government most exposed to criticism?

Finally, Aids has been absorbing most of the energies of both Tony Newton and Norman Fowler for the past few weeks. Is more of the 'normal' NHS management work therefore being handled by Roy Griffiths, Tony Newton's deputy on the Management Board?

David Willetts

DAVID WILLETTS

nbpm CC/BG

Foreign and Commonwealth Office

London SW1A 2AH

26 November 1986

Dear Tony

WILL REQUEST IF REQUIRED

Thank you for your letter to Colin Budd of 25 November about your Secretary of State's proposed visit to Geneva with the Chief Medical Officer to talk to the Director General and staff of the WHO about AIDS. The Foreign Secretary is content with these plans. The Foreign Secretary's minute of 7 October to Mr Fowler noted the possibility of stimulating further action by the WHO. We look forward to hearing the outcome of Mr Fowler's discussion with Dr Mann.

FILE WITH PAB

I am copying this letter to Andy Bearpark (No 10), Murdo Maclean (Chief Whip's Office) and Chris Cloke (Cabinet Office).

Yours Sincerely

Russell Dixon

(R K Dixon)
Assistant Private Secretary

A Laurence Esq
PS/Secretary of State for Social Services
DHSS
Alexander Fleming House
Elephant & Castle
SE1 6BY

NAT HEALTH Alos Aug 85

10 DOWNING STREET

4

Prime Minister

AIDS

You may like to glance at these H(A) minutes.

Screening is likely to become the most sensitive issue to be dealt with.

PBB
21/1,

SP

RESTRICTED

cc HO

nbpm 1

DEPARTMENT OF EDUCATION AND SCIENCE

ELIZABETH HOUSE YORK ROAD LONDON SE1 7PH
TELEPHONE 01-934 9000

FROM THE SECRETARY OF STATE

The Rt Hon Norman Fowler MP
Secretary of State for Social Services
Alexander Fleming House
Elephant and Castle
London SE1 6BY

19 November 1986

Dear Norman

AIDS: SCREENING OF OVERSEAS STUDENTS AND OTHERS ENTERING THE UK

Thank you for copying to me your minute of 7 November in response to Geoffrey Howe's of 7 October on this issue.

I agree with the approach you propose in your penultimate paragraph; it is important that we take account of the views and experience of other countries in reaching our own conclusions on screening in general and more specifically on students who enter the country. As soon as these views are known, we will need to give further consideration to the question, presumably through H(A).

I am copying this letter to the Prime Minister, Members of H(A), and to Sir Robert Armstrong.

Yours

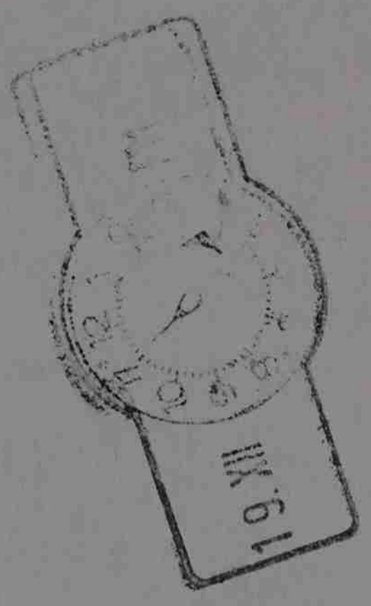
Kenneth

RESTRICTED

NAT. HERTH

ADS

8/15



SK/A51

Department of Employment
Caxton House Tothill Street London SW1H 9NF
Telephone Direct Line 01-213 5949
Switchboard 01-213 3000

16pm

The Rt Hon The Viscount Whitelaw CH MC
Lord President of the Council
Privy Council Office
68 Whitehall
LONDON
SW1A 2AT

18 November 1986

Dear Willie,

AIDS AND EMPLOYMENT

I am very sorry to discover that I will have to miss the second meeting of H(A) because the time clashes with my contribution to the Debate on the Address, particularly since EC Presidency duties prevented me from attending the first meeting last week. I believe there is now an urgent need for us to establish a clear overall policy direction and to make provision for a major continuing campaign of public information and education.

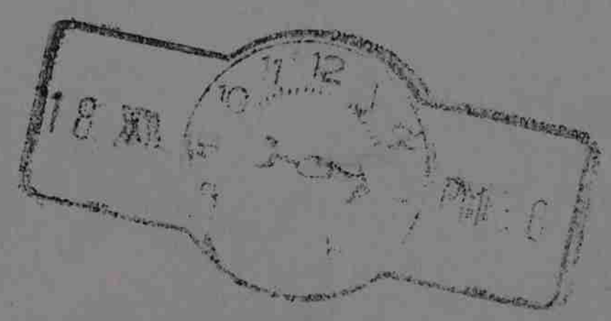
The paper (H(A)(86)2) which you considered on the current situation in the UK referred in Annex D to guidance for employers being prepared by the Department of Employment. I am happy to be able to tell you that this booklet is now printed and I enclose a copy for your information. I intend to publish it at a press conference on 24 November and to send copies directly to some 400,000 employers. This will offer some response to growing public interest in the employment implications of HIV infection, and may provide useful additional evidence of Government activity in advance of fresh initiatives in the public health field. My officials have worked closely with DHSS officials and the CMO throughout the preparation of the booklet and I shall naturally keep in touch with Norman Fowler to ensure that public presentation is co-ordinated.

I am copying this letter to the Prime Minister, to members of H(A), and to Sir Robert Armstrong.

Yours ever,

KENNETH CLARKE

3



Affix
stamp
here

A.I.D.S. and Employment
The Mailing House
Leeland Road
London
W13 9HL

PL 811

A.I.D.S.

Acquired Immune Deficiency Syndrome

AND EMPLOYMENT

Department of Employment DE
and the Health and Safety Executive

Please send ..... copies of the A.I.D.S. and Employment booklet to

Name _____ Telephone _____

Position _____

Company _____

Address _____

_____ Postal Code _____

Allow 14-21 days for delivery

TEAR HERE

Employment and Industrial Relations

Advisory, Conciliation and Arbitration Service (ACAS). This is an independent statutory organisation with a national network of offices and staff. ACAS provides information and advice on employment practice and industrial relations. It also provides conciliation, mediation and arbitration as a means of avoiding and resolving industrial disputes. Addresses and telephone numbers are in local telephone directories.

The following booklets and further copies of this booklet may be obtained free of charge from any jobcentre or unemployment benefit office:

Unfairly dismissed — a guide for employees (PL 712)
Fair and unfair dismissal — a guide for employers (PL 714)
Industrial action and the Law (PL 753)

Trade Unions and Professional Associations

Some unions and professional associations have issued their own guidelines. These include the following:

Confederation of Health Service Employees (COHSE)
Electrical Electronic Telecommunications and Plumbing Union (EETPU)
General Municipal Boilermakers and Allied Trades Union (GMBATU)
Institution of Professional Civil Servants (IPCS)
National Communications Union (NCU)
National Union of Public Employees (NUPE)
Society of Civil and Public Servants (SCPS)
Transport and General Workers Union (TGWU)
Royal College of Nursing (RCN)
British Medical Association (BMA)
The Hospital Infection Society
The British Society for Haematology

Prepared for the Department of Employment and the Health and Safety Executive by the Central Office of Information. 1986.
Dd 8934563 DEMP J0174NJ

A.I.D.S.

Acquired Immune Deficiency Syndrome

AND EMPLOYMENT

Department of Employment DE
and the Health and Safety Executive

FOREWORD

AIDS is a new and important public health hazard; it has attracted widespread publicity, and ill-informed speculation has caused considerable alarm. Much is now known about the condition and the virus responsible for it, although an effective cure has not yet been found. The major need at present is to prevent further spread of infection by ensuring that people know how it is transmitted and information on this is already available from various sources. Some of these sources are listed in the Annex to this booklet.

It is natural that specific questions should be asked about the implications for employment. There is in particular a need to put to rest groundless fears by providing the facts about AIDS and to prevent discrimination against individuals. In most jobs there is little or no risk of becoming infected.

This booklet attempts to answer the major questions which have been asked about employment aspects but it is also a contribution to a wider public information campaign. It has been issued jointly by the Department of Employment and the Health and Safety Executive and was compiled with the help and advice of doctors and specialists. It is based on the latest available scientific and medical information but does not attempt to cover all aspects. It also provides general guidance on legal obligations but should not be regarded as a complete or authoritative statement of the law.

After reading this booklet you may wish to seek more specific guidance on a particular point. The Annex lists a number of organisations which make information available.

Occupational health

The Health and Safety Executive (HSE) covers the health, safety and welfare of persons at work (and the public who may be affected by work activity).

The Employment Medical Advisory Services (EMAS). This is part of the HSE and has a national network of doctors and nurses available to give free advice to employers, employees and trade unions about all occupational health matters including AIDS.

Addresses and telephone numbers of both HSE and EMAS are listed in local telephone directories under Health and Safety Executive.

Employer's own company doctor/occupational health scheme.

LAV/HTLV-III — The Causative Agent of AIDS and Related Conditions — Revised Guidelines — issued jointly by the Health and Safety Executive (HSE) and the Department of Health and Social Security. These guidelines which have been prepared by the Advisory Committee on Dangerous Pathogens, include an assessment of the risk of infection, describe precautionary measures which are applicable generally, and give detailed guidance for those in the health care occupations.

General information for doctors (CMO(85)7 DHSS May 1985).

Infection control guidelines for community care of AIDS patients and other HTLV-III positive clients (DHSS 1985).

Advice to fire officers and police (Home Office 1985).

Guidance for surgeons, anaesthetists, dentists and their teams in dealing with patients infected with HTLV-III (CMO(86)7 DHSS April 1986).

ANNEX
FURTHER INFORMATION

General

Health Education Council, 78 New Oxford Street, London WC1A 1AH. Single copies of a free booklet *AIDS — what everybody needs to know* may be obtained by writing to Dept A, PO Box 100, Milton Keynes MK1 1TX. Extra copies may be obtained from the local health education unit (listed in the telephone book under the name of the local Health Authority).

Healthline Telephone Service 01-981 2717, 01-980 7222, (0345) 581151 for up-to-date information on AIDS. This is a confidential 24-hour service provided by the College of Health. (If you are phoning from outside London, use the 0345 number and you will be charged at local rates.)

Department of Health and Social Security AIDS Unit, Alexander Fleming House, Elephant and Castle, London SE1 6BY. Telephone 01-403 1893.

Welsh AIDS Campaign, c/o Health Education Advisory Committee for Wales (HEACW), Secretariat, Room 2003, Welsh Office, Cathays Park, Cardiff CF1 3NQ. Telephone 0222 823395

Scottish AIDS Monitor, PO Box 169, Edinburgh. Telephone 031-558 1167.

Standing Conference on Drug Abuse (SCODA), 1–4 Hatton Place, London EC1N 8ND. Telephone: 01-430 2341.

Sexually transmitted disease (STD) clinic, Special Clinic or GU (genito-urinary) clinic. Addresses and telephone numbers are in local telephone directories under VD (Venereal Disease).

Terrence Higgins Trust (BM/AIDS), London WC1N 3XX. This is a registered charity which offers help and counselling to infected persons and their relatives and friends. Helpline 01-883 2971 Monday to Friday 7pm–10pm, Saturday and Sunday 3pm–10pm.

London Lesbian and Gay Switchboard. Telephone 01-837 7324.

Haemophilia Society. Telephone 01-407 1010.

CONTENTS

THE FACTS

1. WHAT IS AIDS?

The initial letters "AIDS" stand for "Acquired Immune Deficiency Syndrome". Following infection by a virus now known as HIV (previously known as LAV/HTLV-III) the body's normal defences against illness may break down. Where this happens an individual is open to infections which otherwise would not have occurred. If a particular form of cancer or serious infection, commonly a type of pneumonia, develops as a result of this breakdown the individual is said to have AIDS, although this does not of course mean that everyone who has cancer or pneumonia has AIDS. Those who develop AIDS will eventually die from their illnesses, but not all individuals who become infected with the virus will necessarily develop AIDS. Some may develop less severe illnesses which are not fatal; some may have no symptoms at all and may even themselves be unaware that they are infected. Up to the end of September 1986, of the 30,000 people in the UK who were thought to be infected 512 had by that date developed AIDS.

2. HOW DOES INFECTION SPREAD?

Normal social and work contact with an infected person is safe for both colleagues and the public.

The virus is passed on by sexual intercourse with an infected person or by taking infected blood into your own bloodstream (for example, by using contaminated syringes and needles for drug injections). Although it has been found in many body fluids cases of transmission have been recorded only from blood, semen and possibly breast milk. Infection is *not* spread through the air (for example, by sneezing or coughing) or by touch. Nor is there any danger from handling objects which have been used by an infected person, or from sharing an office or washroom facilities with them. Studies have shown that there is little or no risk of infection even for members of an infected individual's family who have close non-sexual contact with them, for example, their children.

Further factual information about AIDS is contained in a booklet published by the Health Education Council – see Annex.

11. WHAT IF EMPLOYEES REFUSE TO WORK WITH AN INFECTED PERSON?

Employees are more likely to shun infected colleagues when they have only limited information about AIDS and consequently fear that they will themselves become infected. Providing general information, particularly about the methods of transmission, should help to allay fears and lead to a resumption of normal working relationships. It is best though to ensure that the general issues are aired and the facts understood *before* someone at the workplace is thought to be infected, by which time the climate is likely to have become emotionally charged. Employers, for example, may find it useful to take the initiative in this by circulating information about AIDS (for example, this booklet or the Health Education Council's booklet), by articles in house journals or by briefing safety representatives and trade union officials.

If employees refuse to work normally with an infected individual an employer would need to respond as he would to other forms of industrial action and seek a resolution through normal procedures. Dismissing individuals who are infected, or thought to be infected, simply because of pressure from other employees would in many cases expose the employer to a claim for unfair dismissal. And suspending them might serve only to reinforce the groundless fears of their colleagues. The Advisory, Conciliation and Arbitration Service (ACAS) or EMAS (see "further information") may be able to help by providing independent and expert advice. In addition, many trade unions have adopted constructive policies in this area and issued advice of their own. They may also be able to assist in resolving local difficulties.

5. IS THERE A RISK FOR THE PUBLIC?

Potential risk to the public arises only where the blood, semen or other body fluids of an infected employee can enter another person's body, for example, through an open wound. Occupations where this may happen also lie mainly in the health services. Measures to reduce the risk will vary with the exact circumstances but working methods adopted to protect doctors, dentists and other health care workers should also protect members of the public from any risk of infection.

6. DO EMPLOYERS NEED TO DO ANYTHING?

Each employer will need to review working methods to see whether there may be a risk of employees or the public coming into contact with infected body fluids.

In general this risk is likely to arise only from accidents and their treatment. The usual good hygiene practices adopted to prevent the spread of infection generally (see section 7) will be sufficient to prevent infection by the AIDS virus.

There is generally no obligation on individuals to disclose their infection or to submit to medical tests for the virus. Anything which can be interpreted as an inquisition into an employee's personal life-style should be avoided. If an employee is known to be infected there may be rare circumstances in which it would be appropriate either for their own safety or the safety of others to consider a move to alternative duties. Knowledge of their infection should however be treated in confidence and disclosed to others only with the employee's permission except where, on the basis of medical advice, it is necessary to protect the safety of others.

Any employer who feels unable to make an informed assessment of the risk should consult the Employment Medical Advisory Service (EMAS) at an area office of the Health and Safety Executive (HSE) — see "further information".

7. ARE THERE ANY SPECIAL PRECAUTIONS WHICH FIRST-AIDERS SHOULD FOLLOW?

In any situation requiring first-aid certain precautions already need to be taken to reduce the risk of transmitting other infections, including hepatitis. These standard precautions will be equally effective against the AIDS virus. For example, first-aiders should always cover any exposed cuts or abrasions they may have with a waterproof dressing before treating a casualty *whether or not* any infection is suspected. They should also wash their hands both before and after applying dressings.

Whenever blood, semen or other body fluids have to be mopped up disposable plastic gloves and an apron should always be worn and paper towels used; these items should then be placed in plastic bags and safely disposed of, preferably by burning. Clothing may be cleaned in an ordinary washing machine using its hot cycle. The AIDS virus is killed by household bleach and the area in which any spills have occurred should be disinfected using one part of bleach diluted with ten parts of water; caution should be exercised as bleach is corrosive and can be harmful to the skin.

If direct contact with another person's blood or other body fluids occurs the area should be washed as soon as possible with ordinary soap and water. Clean cold tap water should be used if the lips, mouth, tongue, eyes or broken skin are affected and medical advice sought.

First-aiders who may be called upon to give mouth-to-mouth resuscitation should be aware that mouthpieces are available for use when carrying out this procedure, but they should only be used by properly trained persons. Mouth-to-mouth resuscitation should never be withheld in an emergency because a mouthpiece is not available. No case of infection has been reported from any part of the world as a result of giving mouth-to-mouth resuscitation.

EMPLOYMENT RIGHTS

8. SHOULD AN INFECTED PERSON BE RECRUITED?

Employers are free in law to decide whom they wish to employ but they must not discriminate either directly or indirectly on grounds of sex or race. In almost all occupations there is no risk of an infected person passing the virus on to others, and this would not therefore generally be a reason for treating them any differently from other job applicants.

9. SHOULD AN INFECTED EMPLOYEE BE DISMISSED?

Employees have statutory rights against unfair dismissal (outlined in paragraph 10) which are not reduced in any way just because an individual is infected. In any case, there are generally no grounds for dismissal purely on the basis that an employee has become infected. Employers will need to take a reasoned view based on all the circumstances, weighing up factors such as the individual's ability to continue working satisfactorily, the possibility of a move to different duties, any medical advice received, and whether continued employment is against the employee's, the employer's or the public's interest.

10. WHAT ARE AN EMPLOYEE'S STATUTORY RIGHTS IF DISMISSED?

Employment legislation gives an employee who has been employed for two years or more (one year for those who started work before 1 June 1985 in firms which employ more than 20 people) the right to make an application to an industrial tribunal on the ground that the dismissal was unfair. There is no minimum qualifying period of employment where the reason for the dismissal is alleged to be sex or race discrimination. The tribunal will then decide whether dismissal was a reasonable response to the situation taking into account all the circumstances. If a tribunal decides that the dismissal was unfair or discriminatory, it can order the employer to re-employ or compensate the individual.

See "further information" for sources of advice about unfair dismissal.

EMPLOYMENT IMPLICATIONS

3. IS THERE A RISK OF INFECTION AT WORK?

There is no risk where there is no direct contact with the blood, semen or other body fluids of infected individuals. Few jobs involve contact with these and the majority of employees are therefore safe from infection whilst at work.

There are jobs in the health care services which can involve some risk. Doctors, nurses, dentists, laboratory and hospital support staff may come into close contact with infected blood, semen or other body fluids and there is therefore the possibility of infection through a cut or accidental injection. The only other groups of workers who may face a risk are those which have *incidental* exposure to blood, semen or other body fluids in the course of their work. These might include community, welfare, custodial and emergency service workers and those responsible for the retrieval and disposal of bodies, but there have been no reported cases of infection arising from these activities.

Workers who look after patients and deal with their blood, semen or other body fluids already face a risk from other infections. Many of the standard precautions in use are equally effective against the AIDS virus. Specific additional advice on precautions to reduce the risk of infection by the AIDS virus has nonetheless been prepared for these workers. Training and hygiene practices generally are being reviewed to ensure that they are satisfactory. Occupational codes of practice may also refer to the risk of infection and ways to minimise it.

See "further information" for sources of advice and help.

4. CAN SOMEONE WHO IS INFECTED CONTINUE TO WORK?

As with many other illnesses, someone who is infected should be able to work as normal whilst medically fit to do so.

Most individuals who have been infected with the virus will continue working, although those who actually suffer from one or more of the related illnesses may not be well enough to work all the time. If in doubt medical advice should always be sought.

Life SS

PRIME MINISTER

AIDS

H(A) met for the first time this afternoon. The main points agreed were as follows:

1. There will be a major round of advertising in the Sunday newspapers starting on 23 November.

2. This will be followed immediately by a poster campaign.

3. In December the poster campaign will continue and will be aimed at young people.

4. The issuing of a leaflet to every household was agreed. This will start as soon as possible, although it may be a month or so before the GPO can be geared up to handling it.

5. Discussions are to take place with the BBC/IBA on a possible television campaign.

The main points to be decided next are:

1. Whether there should be a separate AIDS Education Advisory Body.

2. Whether there should be any form of compulsory screening.

P A BEARPARK

11 November 1986

SL3ASY

010

CCBG

PRIVY COUNCIL OFFICE

WHITEHALL, LONDON SW1A 2AT

11 November 1986

Dear Bernard,

The Lord President was very grateful for your note on how to deal with press enquiries about the work of H(A) Committee.

As I explained when we spoke last night, the Lord President is generally content with the approach you propose. He has however asked me to stress that he fully supports the proposition that DHSS and the Scottish Office should be in the lead in dealing with enquiries as they are, of course, on the substantive policy. The Lord President himself has made it clear that he is not prepared to give interviews. Generally he would prefer as little as possible to be said publicly about his own role and the work of the Committee. The Lord President would not personally object to your giving unattributable guidance on the membership of the Committee, since much of it seems to be known to the Press already, although in normal circumstances he would much prefer to adhere to the tradition of not briefing on the constitution of Cabinet Committees.

I also mentioned that the Lord President would not like the media to form any expectation that briefing or announcements will follow individual meetings of the Committee, the timing of which should remain confidential. For the present, the line should be that announcements can be expected shortly; but no indication should be given either of likely substance or timing.

I am sending a copy of this letter to Nigel Wicks, to the Private Secretaries to the Secretaries of State for Social Services and Scotland (together with your note), and Sir Robert Armstrong, and to Miss Christopherson in the DHSS.

Yours sincerely

Joan.

JOAN MACNAUGHTON
Private Secretary

Bernard Ingham Esq

Mr Beamish PDB?

Mr Wicks

70 WHITEHALL, LONDON SW1A 2AS

01-233 8319

From the Secretary of the Cabinet and Head of the Home Civil Service

Sir Robert Armstrong GCB CVO

Ref. A086/3218

MISS MACNAUGHTON

H(A) Committee

I have seen Mr Wicks's minute of 7 November and Mr Ingham's minute of the same date to the Lord President, on the response which should be made to press enquiries about the work of the H(A) Committee.

2. I agree generally with Mr Ingham's minute of 7 November, save on one point: I am sure that it would be better not to make the membership of the Committee known, even unattributably. To do so would lead other Ministers to want to be present or to be represented; and might make it more difficult to operate with substitutes, where it was necessary to do so.

3. I think that we should discourage the press from thinking that the first meeting of the Lord President's Committee is expected to be a major decision-taking meeting. It is likely to be more in the nature of a meeting to take stock of the situation, put work in hand, and lay down timetables and so on.

4. Clearly the Lord President's meeting tomorrow will need to consider, before it breaks, what line is to be taken with the press and who is to be the spokesman for it.

AIDAAA

5. I am sending copies of this minute to Mr Wicks, Mr Ingham and Miss Christopherson.

RCH

10 November 1986

AIDAAA

FILE CAJ(61)

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

10 November 1986

AIDS

I mentioned on the telephone this morning that the Prime Minister would welcome a briefing on the above subject: if possible she would like this to be next week following her return from Washington.

BF 11 Could you please let me know urgently who you think should attend such a meeting. The Minister of Health and Chief Medical Officer would seem most appropriate, but I should be grateful for advice on anyone else from DHSS who you think should attend, and in particular if your Secretary of State would like to be present. The aim is to keep the meeting as small as possible and I do not think we would wish to invite representatives from other Departments, although the Lord President would of course be welcome if he wished to attend in view of his Chairmanship of H(A).

I am copying this letter to Joan MacNaughton (Lord President's Office) for advice on this last point.

P. A. BEARPARK

Miss Jane McKessack,
Department of Health and Social Security

PRIME MINISTER

AIDS

The new sub-committee of 'H' - 'H(A)' meets for the first time next Tuesday.

The attached paper includes the draft of the leaflet which it is proposed should be delivered to every household. It is not offensive, and as the attached Policy Unit minute points out public opinion is moving very quickly - the issue has been constantly in the news over the last month.

It is now clear that the spread of the disease is going to affect the community generally, and not just sub-groups such as drug addicts and gays.

The formation of 'H(A)' - although not announced officially - has been welcomed but I agree with David Willetts and Bernard Ingham that there would be every advantage in involving you rather more closely, and arranging for you to be briefed by the CMO and Minister of Health.

Content to:

Indicate agreement with the leaflet campaign? Yes
and
Be briefed by CMO and Minister of Health on return from Washington? Yes

Lord Privy Seal's Office as DHSS informed. PAB 10/11

PAB

(P.A. BEARPARK)

7 November 1986

PRIME MINISTER

7 November 1986

AIDS

30,000 people in this country are probably infected with the Aids virus, though only 4,000 know they are. Not everybody infected with the virus develops the disease - at the moment we expect about 25% to contract clinical Aids. 550 people currently have clinical Aids.

10-20 people are being infected with the virus every day. There are three ways of getting infected:

i. drug addicts sharing dirty needles;
ii. sex (not just amongst homosexuals);
iii. pregnant mothers passing it to their foetuses.

The costs of Aids will be enormous - about £20,000 per person with the disease. Cases of the disease are doubling every year and so are the costs. Next year they may be £30m.

Popular concern has increased dramatically over the past months. Public education measures which only a year ago might have been attacked for bad taste will be more acceptable now. There was not a single complaint about obscenity in the newspaper advertisements earlier this summer. The proposed new leaflet is hardly more explicit, though it will be go to every household. It may be backed by TV advertisements.

I recommend that you agree to the leaflet as a sensible public education measure. I also think it might be worthwhile having a short meeting with the Chief Medical Officer and the Minister for Health. This would enable them to brief you on what is probably the most important public health issue this century. You could also discuss how best to carry forward the campaign.

David Willetts

DAVID WILLETTS

CONFIDENTIAL

SECRETARY OF STATE FOR FOREIGN AND COMMONWEALTH AFFAIRS

AIDS

Thank you for your minute of 7 October about screening for AIDS.

As you recognise, the proposal from the Director General of the British Council that screening for AIDS infection should be introduced for students entering this country under Council auspices cannot sensibly be considered separately from the wider question of the screening for overseas visitors to the UK generally. Press speculation in recent weeks has in any case concerned itself with the wider question and it is on that question which we must make up our minds before we can decide whether British Council students represents a special case.

We have considered the matter here with the benefit of the Chief Medical Officer's advice.

If the aim is to prevent anyone with the AIDS virus from entering the United Kingdom, then the only logical position is to require the screening of all visitors and the screening of returning residents. But the practical implications of this are daunting.

First, the number of visitors is very large. In 1985 there were some 7.6 million visitors to the UK - and that excludes EC nationals and persons returning to the UK after a period abroad. To screen these numbers at the port of entry would I believe be totally impracticable. Each test would be likely to impose a delay of several hours and much longer if found positive.

Second, screening in the country of origin would not only require the cooperation of other Governments. It would require reliable facilities and reliable records of the outcome - requirements which a number of countries could not meet.

E.R.

This means that if we were to make any move on screening it would have to be on a more limited basis. It could be linked to:

- the reason for entering the country, eg to study or take up employment;

- the country of origin;

- the proposed length of stay, eg only those intending to stay for more than six months.

If we were to screen on a more selective basis, the practical difficulties would be lessened. But there would be other factors to consider:

first, we know that any proposal to pick out certain countries and screen only visitors from them would provoke a sharp reaction and risk retaliatory measures. This was made clear, for example, at the Commonwealth Health Ministers' Conference. As you will have seen from Simon Glenarthur's letter to me, very hostile comments were made about the UK press reports about the possibility that we might introduce screening, especially on a discriminatory basis in relation to country of origin. Such a reaction would be reinforced by the hostile line taken by the WHO on screening as reported in today's Times;

second, and probably even more important, once we accept the case for screening some visitors, however defined, it will be extremely difficult to produce convincing reasons for drawing the line between some visitors and others.

These considerations do not rule out the possibility of screening on a selective basis, particularly where, as is the case with British Council students, medical screening is already routinely undertaken. But they do underline the international dimensions of AIDS. We cannot sensibly aim to settle these matters unilaterally

E.R.

without taking account of the views or experience of other countries, particularly our EC partners, Commonwealth countries and the United States.

I propose, therefore, that our next step should be to consult these other countries on AIDS issues generally, but with particular reference to matters of common concern such as the dealing with visitors who carry the AIDS virus. Until these consultations have been completed, it would be unwise to agree to the extension of existing medical tests on British Council students to cover tests for the AIDS virus. Given the publicity there has been, this would be taken as a decision by the UK Government to go down the screening path.

If colleagues agree to this approach, I would propose to take the line publicly that the Government recognises that screening of visitors is a proposal that has been put on the table publicly and has to be addressed. But it would not be sensible for the Government to address it without taking careful account of the views and experience of other countries, particularly our EC partners, Commonwealth countries and the United States. Accordingly, we propose first to consult them on AIDS issues generally and on the question of visitors specifically. We could also take the opportunity of briefing informally on the implications of screening.

I am copying this minute to members of H(A), the Prime Minister and Sir Robert Armstrong.

7 November 1986

N F

NAT HEALTH : AIDS : Aug 85

file GA 59

10 DOWNING STREET

From the Principal Private Secretary

SIR ROBERT ARMSTRONG

H(A) COMMITTEE

The Lord President has asked Bernard Ingham for his advice on the response which should be made to press inquiries about the work of H(A) Committee. You should be aware of Bernard's advice, set out in his minute attached, especially what he says should be said publicly about the existence of the Committee.

You will no doubt let the Lord President's Office and Bernard Ingham have any comments before Tuesday's meeting of the Committee.

I am sending a copy of this minute to Joan MacNaughton (Lord President's Office), Bernard Ingham, and to Romola Christopherson (Department of Health and Social Security).

N.L.W.

N. L. WICKS

7 November 1986

cc: Mr Wicks
Miss Christopherson, DHSS

10 DOWNING STREET

From the Press Secretary

LORD PRESIDENT

AIDS COMMITTEE

I promised you a note on H(A) over which you are to preside. This is because, unusually, a Cabinet sub-committee presents a public relations problem because of its known existence.

Both DHSS and No 10 - and presumably other Departments - have a stream of inquiries about the Committee and this will intensify early next week both in advance and after your first meeting. The media are mildly hysterical about the matter and it is important that the Government gets this under control at the outset. Consequently, you may care to raise at your first meeting the points made below in the form of a speaking note.

Points to Make

Understandably, since the establishment of this Committee has become public knowledge, there is very great media interest in this first meeting, as there will be in subsequent meetings if the media find out when they are being held.

In one sense this media interest is helpful, since public awareness and education are crucial. But I think the level of this interest requires us to consider today how we are to handle the media.

Could I make one thing clear at the outset? I regard myself as chairman-coordinator and in no sense in the lead on the subject. The issue is primarily one for DHSS and the Scottish Office and I would expect Ministers who are in the lead not merely to make announcements which flow from our work, but also to handle the media.

Unusually, I would see some advantage in letting it be known the strength and weight of this Committee and therefore if you agree I would not object to its membership being made known unattributably.

However, having done that, I think we need to make several other things clear through guidance offered by No 10 Press Office and those of our Departments after this meeting.

1. The first meeting of this group does not signal the start of the Government's attack on the AIDS problem; that started many months ago. This first meeting represents a more formal

coordinated approach to the most serious health problem to arise for many years.

2. Action following from its work will be announced by the appropriate Minister, generally through Parliament.

3. Meetings of the group will be held regularly but guidance will not generally be given on its work after them; decisions, as indicated, will be announced by the responsible Ministers as and when appropriate.

4. The machinery for dealing with the AIDS issue is similar to that adopted in the past to cope with very serious and urgent problems confronting the nation. The Government is proceeding to tackle it in a necessary manner which is well tried and which has long served the nation well.

If this line is acceptable, it would be helpful to be able to deploy it immediately after Tuesday's meeting.

BERNARD INGHAM
7 November 1986

CF file pl.

cc Mr Ingham

Ref. A086/3180

MR ADDISON

Cabinet Committee on AIDS

Please find attached an attributable public line to take on the Cabinet Committee on AIDS which has been agreed with the Department of Health and Social Security following our discussion yesterday. I am copying this minute to the Private Secretaries to members of H(A)(O).

Trevor Woolley

T A WOOLLEY

Private Secretary to
Sir Robert Armstrong

5 November 1986

new

Cabinet Committee (defensive)

The threat of AIDS requires a determined and co-ordinated response by Government. We have, of course, ensured that the appropriate machinery is available within Government to enable this effort to be fully co-ordinated among the Departments concerned.

10 DOWNING STREET

PRIME MINISTER

AIDS

The first meeting of the new Sub-Committee of H is due to meet on 10 November. We should be able to show you papers next week covering a number of proposals including the leaflet campaign.

(P. A. BEARPARK)
31 October 1986

late

ECh

MR. WILLETTS

AIDS

Your minute of 27 October refers. You will wish to see the attached personal and confidential minute from Sir Robert Armstrong to the Prime Minister. I should be grateful if you could ensure that this goes no further than the Policy Unit.

You may wish to study this before we discuss: I understand that the first meeting of the Ministerial Sub-Committee is planned for 10 November.

P.A. BEARPARK

30 October 1986

c: Mr Bearpark

PAB

MR WILLETTS

AIDS

Reference your minute of October 27.

There is certainly a feeling abroad that the Government is doing too little, and is not treating the issue with sufficient urgency. There is also a feeling that the Prime Minister is acting as a brake on educational publicity.

The 24 provincial editors who dined with the Prime Minister last week will have gone away with the view that the Prime Minister was cautious on the idea of a house-to-house leaflet drop.

It is interesting that in a short free-for-all discussion of this issue the editors:

- showed they are very much alive to the AIDS threat and are dealing with it seriously

- consider that, whatever they do, only a Government publicity campaign will lend ultimate authority to their campaigns

- claimed that only a Government campaign could counteract the damaging effects of the sensational treatment of the issue by such papers as the Sun

- argued that the Government should not be reticent on grounds of public taste - after all, the Government ran VD information campaigns during the war in a much more morally repressive climate

- suggested that the Government should also take decisive action to screen visitors and immigrants.

(I have told Romola Christopherson, DHSS, of this discussion.)

Against this background, I believe there is much to be said for the Prime Minister's having a briefing/review meeting with DHSS Ministers and officials - and for her letting it be known she is doing so. Ideally, however, that meeting ought to be followed not merely by a Lobby briefing by me, but by a DHSS statement demonstrating that action is flowing.

In short, I see merit in the Prime Minister's being seen to be taking a close personal interest in the issue, but there is much greater merit in being able to report action immediately after the meeting, if only trailing an early announcement of new action.

BERNARD INGHAM
29 October 1986

PPS PSC

MR BEARPARK

27 October 1986

cc MR INGHAM

AIDS

Aids is probably the most important public health issue this century. During a personal discussion with Mr Newton last week he emphasised that it was the most important single issue on his desk.

The media are getting increasingly interested - we have had two major television programmes in the past week, with more to come. There is a perception that the Government in general, and the Prime Minister in particular, is reluctant to treat the issue with the seriousness it deserves.

The DHSS are currently evaluating how best to carry forward their campaign of public education. We do not wish to stampede them into early decisions which would give an appearance of panic and complicate the PESC negotiations. However, I think it would be worthwhile when they have formulated their proposals, for the Prime Minister to hold a review meeting with interested Ministers. This could both bring her up to date on the latest facts regarding the epidemic and give her an opportunity to consider the DHSS proposals for public education. It should be made known to the media that such a meeting was taking place.

If you think this is a good idea, perhaps we could discuss the best way to carry it forward.

David Willetts

DAVID WILLETTS

NAT HEATH

AIDS

8/85

PERSONAL AND CONFIDENTIAL

ECL

late.

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

SIR ROBERT ARMSTRONG

AIDS

The Prime Minister has seen your minute of 21 October and is content with your proposals.

P.A. BEARPARK
23 October 1986

PERSONAL AND CONFIDENTIAL

ECL

PERSONAL AND CONFIDENTIAL

fle AC
LOLAHC

10 DOWNING STREET

From the Principal Private Secretary

SIR ROBERT AMRSTRONG

AIDS

The Prime Minister has now studied your minute of 21 October in which you recommend the appointment of a Committee of Senior Ministers, in the form of a Sub-Committee of the Home Affairs Committee, to be chaired by the Lord President to discuss the issues described in your minute and to take decisions. You suggested, too, that a supporting Official Committee under Cabinet Office chairmanship should be established.

The Prime Minister agrees that you should proceed as you suggest and in particular that the Ministerial Committee should be established composed as you propose in paragraph 8 of your minute.

The Prime Minister will want to be kept in the closest touch with the deliberations of the Committee.

N. L. WICKS

23 October 1986

RESTRICTED

CCBC

P

Abpm

1

DEPARTMENT OF EDUCATION AND SCIENCE

ELIZABETH HOUSE YORK ROAD LONDON SE1 7PH

TELEPHONE 01-934 9000

FROM THE SECRETARY OF STATE

Rt Hon Sir Geoffrey Howe QC MP
Secretary of State for Foreign and Commonwealth Affairs
Whitehall
LONDON SW1

22 October 1986

Dear Geoffrey,

AIDS

Your minute of 7 October to Norman Fowler raised the issue of screening generally, arising from the specific question of whether to introduce it for overseas students coming to this country under the auspices of the British Council.

This raises difficult and complex problems, as you rightly say: clearly there was no prospect that the line to be taken could be settled in advance of the meeting of Commonwealth Health Ministers which took place last week, but I agree that we should meet to discuss the issues as you propose. Accordingly I support your suggestion that senior officials should meet soon to consider the position.

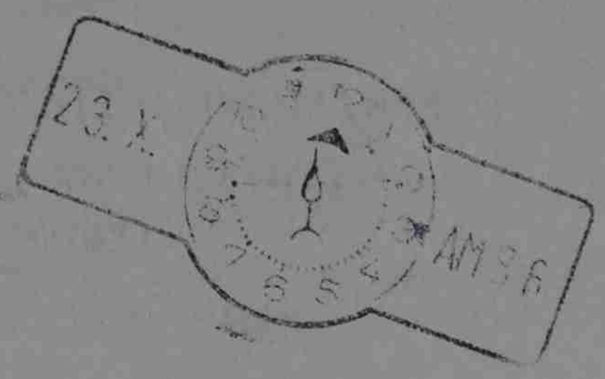
I am copying this letter to the Prime Minister, Douglas Hurd and Norman Fowler.

Yours ever,

Norman

RESTRICTED

Nat Health; AIDS Aug '85



ANNEX B IS IN QUESTIONS FILING

PERSONAL AND CONFIDENTIAL

Ref. A086/2990

PRIME MINISTER

Prime Minister
Agree to proceed as R.T.A. suggests?

N.L.W.
22.10

Yes

AIDS

The latest reports about the spread of AIDS are extremely worrying.

2. In this country there have so far been 512 cases of AIDS. For every case of the disease there are perhaps 50 people infected with the virus, most of whom are unaware of the fact, feel and look well, and are capable of spreading the virus sexually. On this basis there may be around 25,000 people in this country already carrying the infection. Of these, at least 25 per cent can be expected to develop AIDS and most of them will die. The proportion who develop AIDS may prove to be much higher. Most of those who die will be young people. If there is no change in habits and practices, particularly but not exclusively among those currently most at risk (homosexual and bisexual men and drug misusers), there could at the end of five years be half a million infected carriers, of whom a substantial number would subsequently develop the disease; and that is a sober estimate.

3. The spread of the infection will not be confined to homosexuals and drug misusers. The infection is already beginning to spread to the general heterosexual population - women as well as men. A pregnant woman who is infected can pass the infection to her child: 20 infected babies have been born in Edinburgh to women who are drug misusers or who are the sexual partners of drug misusers.

4. In the view of the Government's Chief Medical Adviser there is an urgent need for a much more substantial and forceful programme of public education than anything that has so far been undertaken. Annex A outlines some public health and moral issues. Annex B outlines what the Government have so far done or encouraged. Our advisers point out that there is no cure or vaccine in sight and only palliative treatment. The only way we know of slowing down the spread of the infection is by ensuring that the public understand how AIDS is spread and how they can avoid putting themselves or others at risk, and persuading them to act accordingly. In a matter of this gravity and urgency there is a clear and pressing need for a sustained and effective public education campaign, to persuade people, especially those particularly at risk through their behaviour, that they must modify their lifestyle. Any campaign will need to strike a balance so as to avoid appearing on the one hand to be persecuting the afflicted or to be creating the impression of a crusade against homosexualtiy and promiscuity, and on the other hand to encourage or condone sexual licence or drug misuse.

5. It would be possible for such a public education campaign to be mounted directly and expressly by the Government. But it is arguable that such a campaign could be mounted just as effectively, and with less risk of political embarrassment, either by the existing Health Education Council (which would need to be enhanced for the purpose) or by a new AIDS Public Education Council, consisting of people with suitable qualifications and able to command the respect and confidence both of the general public and of those to whom the campaign would be particularly addressed. Such a Council would need to be publicly financed; but the cost should not be very great, and could probably be met within the DHSS programme.

6. There are other issues of policy which the Government itself has also to consider in connection with AIDS: for example, the question of screening visitors and those returning from certain parts of the world (eg parts of sub-Saharan Africa and the United States) where the infection is especially prevalent, the problem of drug addicts and measures to stop the spread of infection from needles, the question of screening recruits to the public services (including the armed forces), the problems raised by the prospect of an increasing level of infection in the prison population. But these are in a sense secondary to the issue of public education, since other measures will be in themselves less effective unless those most at risk can be persuaded to behave differently.

7. These matters need to be addressed by Ministers urgently; and the existing machinery is not proving to be adequate for the purpose. The issues are now so difficult, urgent and politically sensitive that they need to be driven from the centre. I therefore recommend the appointment of a Committee of senior Ministers - I suggest a sub-Committee of the Home Affairs Committee - to be chaired by the Lord President, to address these issues and to take decisions.

8. The composition of such a Committee might be:

Lord President of the Council (Chairman)
Foreign and Commonwealth Secretary
Home Secretary
Secretary of State for Defence
Secretary of State for Wales
Lord Privy Seal
Secretary of State for Social Services
Secretary of State for Northern Ireland
Secretary of State for Education and Science
Paymaster General

RTAADG

Chief Secretary, Treasury
Secretary of State for Scotland
Minister of State, Privy Council Office

9. Its terms of reference might be:

> "To consider and co-ordinate proposals for measures to limit the spread of the AIDS virus in the United Kingdom and to deal with its effects."

10. It would probably be sensible to set up a Committee of officials under Cabinet Office chairmanship to co-ordinate and expedite the preparation of proposals for consideration by the Ministerial Committee.

11. I should be grateful to know whether you are content to authorise me to proceed accordingly. In that event I will take steps to set up the Committees and to prepare to circulate as soon as possible a note of issues requiring urgent consideration, so that Ministers can give instructions for a programme of work to be undertaken without delay.

ROBERT ARMSTRONG

21 October 1986

RTAADG

ANNEX A

The Mode of Spread of the AIDS Virus (HIV): Some Public Health and Moral Issue Relating to its Control

In the vast majority of instances HIV+ infection is transmitted from person to person in the UK in the following ways:

1. as a result of penetrative sexual intercourse (homosexual or heterosexual);

2. by blood or blood products from an infected person entering the body of another person. Since the introduction of screening of blood donations and heat treatment of Factor VIII* the principal circumstances in the UK where this happens is as a result of sharing infected syringes, needles and other equipment between drug abusers;

3. from mother to baby before or during birth.

Heterosexual Intercourse

2. HIV infection is known to pass from infected men to women as a result of sexual intercourse. For example some of the female partners of haemophiliac men who are infected as a result of therapy with Factor VIII have also become infected, as have a number of the female partners of infected drug abusers and of bisexual men. Although in Europe and the USA documented examples of transmission in the opposite direction (from female to male) have been less common they have also occurred and are likely to increase as more women become infected. In some areas of Africa, 10 to 20 per cent of both men and women in sexually

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* Factor VIII is the blood clotting factor deficient in haemophiliacs

+ HIV (human immunedeficiency virus) is the AIDS virus

active age groups are infected with a virus similar to that in the UK. Spread is thought to have occurred there largely through heterosexual intercourse.

3. As in other sexually transmitted diseases, there is a clear moral aspect which can and does arouse much anxiety. Thus if a person is faithful to one sexual partner and his or her partner is also faithful to him throughout life and neither has become infected by drug abuse both will remain free of infection. To that extent, the general public can be reassured. But as from time immemorial a substantial fraction of the population has been unable to sustain mutual monogamous partnerships for life, the advice "stick to one partner", although sound from the public health point of view, is insufficient to cover all needs. It is therefore essential that there should be a second line of defence. This advice is that a condom should be used where there is any doubt whether the partner may be infected or where the partner (eg in the case of a married haemophiliac) is known to be infected.

4. It has been known for many years that a condom properly used reduces the risk of transmission of sexually transmitted diseases. It has been standard practice in the Armed Forces during and since the Second World War to make condoms freely available to personnel at least outside the UK.

Homosexual Intercourse

5. Penetrative intercourse between men is an effective means of transmission of HIV. Although such behaviour is regarded as reprehensible by many and immoral by a number of religious groups, in the UK homosexual intercourse between consenting adults (over 21) in private is lawful. As in relation to heterosexual intercourse, if a mutual monogamous relationship can be sustained throughout life there is no risk of infection. However as such relationships are currently unusual and in view

of the high prevalence of infection in this group and uncertainty about the effectiveness of condoms in these circumstances, the next line of defence is for advice that anal intercourse should be avoided. Such advice is more likely to be followed if information is also given about alternative safer sexual practices which do not involve penetrative intercourse. Such advice is being given for restricted use directed exclusively at homosexual men by the Terence Higgins Trust. When men are not prepared to abstain from anal intercourse, the use of condoms is recommended as a further line of defence. According to a recent survey, a substantial fraction of homosexual men also have sexual relations with women. Such women may become infected with HIV as may subsequent children born to them.

Drug Abusers who Inject

6. Although their use of narcotics other than on prescription is illegal, narcotics and other psycholeptic drugs are widely used and injected. The use of infected syringes and needles is probably the most dangerous of the current risky practices that lead to transmission of the virus. A single experiment with someone else's needle may be sufficient to transmit infection.

7. The deplorable situation that has to be faced from the public health point of view is that there is now a substantial reservoir of infection among drug abusers of both sexes, notably but not exclusively in Scotland, and that this infection is spreading to sexual partners and babies. HIV infection is more often fatal than most types of drug abuse and a greater risk to the health of the public at large.

8. The first line of advice to the public must be "do not abuse drugs", followed by - "do not abuse drugs by injection", but there is an essential further line of advice - "if you inject, do not share equipment". Further - "if you inject drugs

and know you are infected with HIV, avoid penetrative intercourse, and if that is not possible, use a condom".

9. But there are other dilemmas with legal and moral implications. It has been suggested that one factor in the rapid spread of HIV in Edinburgh's drug misusers as compared with Glasgow's may have been a more strict enforcement of the law by the police in respect of the "small user" in the former city. In order to avoid being found carrying a syringe, misusers are said to have resorted to sharing syringes in groups in houses known as "shooting galleries".

10. A redirection of police activity exclusively to "pushers" and away from the "small user" may therefore be indicated together with (as the Scottish Advisory Committee has recommended to the Secretary of State for Scotland) medical support including the provision of clean equipment on an exchange basis for misusers who cannot abstain.

Stigma and Driving the Infection Underground

11. A double stigma attaches to AIDS and HIV infection. First there is the stigma attached to any sexually transmitted disease and secondly that attached to homosexuality and to drug abuse. When persons who suffer from or are carriers of a communicable disease are stigmatised, control of the spread of infection becomes more difficult. If the groups particularly at risk feel they will be the subject of hostility or discrimination or prosecution they will be less likely to come forward for advice and to co-operate on adopting safer behaviour from the public health point of view and at worst will go underground. This is why strict confidentiality in respect of diagnostic information about HIV is essential and why it is so important that those able to give authoritative advice should maintain good working relationships with the gay community.

12. In the field of drug abuse the majority of injectors are currently rarely if ever in contact with support services and it is difficult to bring advice or hygienic direction home to them. There may be a need to consider providing support for drug misusers who refuse to abstain, and altering police policy on the confiscation of syringes. This "underground" reservoir of infection constitutes a very substantial public health risk which is growing.

Infected Babies and Children

13. About half of the children born to infected mothers are themselves infected. It is not known what proportion will survive puberty, but current experience is that they fail to thrive and mortality is high. So far as is known they are likely to be infectious sexually should they survive until sexual maturity. There are also over a hundred haemophiliac boys infected as a result of contaminated Factor VIII. Many will die of AIDS but some have survived puberty. They are sexually infectious and must be advised not to have children. The predicament of these children illustrates the complexity of the moral and public health issues involved, and the gravity of the implications of the spread of the HIV infection. At present the only means we have to protect children is to use the measures mentioned above to stop the spread of infection among adults of both sexes.

Statutory Notification* and Quarantine

14. In the UK AIDS cases are reported to CDSC on a voluntary basis by doctors on the understanding that the personal

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*There is a statutory requirement on all doctors to notify certain specified diseases (about 30 in all) to the "proper officer" of the local authority. Notifications are then passed to the Office of Population Censuses and Surveys for its health statistics and to the Commonwealth Diseases Surveillance Centre.

particulars are strictly confidential. Positive antibody tests are reported on a similar basis. Both systems work well. Statutory notification eg as for cholera and typhoid would confer no advantage: unlike those conditions, in HIV infection and AIDS no means short of compulsory isolation for ever for all infected carriers (see paragraph 15) would control the spread of infection. Indeed, in view of the implications of statutory notification regarding confidentiality, its introduction could result in a decline in the number of cases reported.

15. Quarantine (isolation of those suffering from infectious communicable disease) is used in such conditions as smallpox and African haemorrhagic fevers where relatively brief periods of intense infectivity occur. In HIV infection, where persons remain infectious in sexual terms for many years, perhaps for life, such isolation would clearly be impracticable, even if the majority of "healthy" carriers could be identified by testing. Pressure on people thought to be at risk to come forward for testing in such circumstances would tend to cause the condition "to go underground".

Original in Questions Briefing

ANNEX B

Government Action on AIDS

1. This note sets out (a) the public education measures taken in the UK, (b) criticism made of the UK campaign, and the measures taken in other countries and (c) briefly outlines the Government's programme of action as a whole.

(a) The Public Education Campaign

2. £2½ million has been allocated to the public education campaign (£½ million in 1985/86 and £2 million in 1986/87).

3. The campaign has three main elements:

i. A comprehensive booklet produced by the Health Education Council AIDS: What Everybody Needs to Know. This is available on application from individuals or organisations. About 600,000 copies have so far been printed.

ii. A telephone advisory service, the Health Line, run by the College of Health. In the busiest weeks over 2,500 phone calls have been dealt with.

iii. Press advertising. Four rounds of advertising have been held, the latest in September. The advertisements have been kept factual and low key, the aim being to provide general information rather than to emphasise any specific message. The September advertisements have, however, been more direct in their approach and have focused on the questions of how to avoid AIDS and what constitutes risky behaviour.

RTAADD

Other Measures of Public Education

4. Several other measures to increase public awareness of the problem have been taken, including:

i. Several voluntary bodies funded by the Government, notably the Terence Higgins Trust and the Standing Conference on Drug Abuse, have produced literature aimed at at risk groups: homosexuals and existing and potential drug misusers.

ii. The issue of guidance material for health professionals, local authority staff, civil servants, diplomatic service staff and schools; guidance for employers is being prepared by the Department of Employment.

iii. Leaflets are issued to all blood donors.

iv. The advisory leaflet, SA35, issued to Britons, travelling abroad, is being expanded to include a section on AIDS.

v. The assistance of press and television journalists has been sought on the most effective way of putting the message across.

vi. As part of the anti-drugs campaign, a radio advertisement is being prepared warning of the risks of sharing needles and other equipment.

vii. The Department of Education and Science has issued guidance for LEAs, teachers and schools concerning the care of infected pupils and the teaching to be offered to all pupils. It recommends that the basis of any teaching offered should be the presentation of straightforward

RTAADD

factual information about the virus and about modes of transmisison of infection in order to balance the incomplete and inaccurate impression which pupils may have gained from other sources.

5. There have also been separate initiatives in Scotland, Wales and Northern Ireland and at local level in a number of areas.

(b) Adequacy of Present Campaign

6. In July the College of Health published a report criticising the Government campaign for being "too little, too late". It was claimed that £62 million not £2 million was needed for health education. The Government's expert advisers have also criticised the limited nature of the campaign. There has been some public concern on the question of screening overseas students and others travelling to this country from countries where AIDS is especially prevalent.

7. Other activitiy undertaken in other countries but not yet in the UK:

Universal leaflet drop (to every household)
TV/Cinema Advertising
Posters
Leaflets on Public Display
Condom Advertising

(c) Government Action in the UK

8. In addition to the public education campaign action has been taken on a number of fronts to combat the spread of AIDS:

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i. Screening of blood donations, heat treatment of blood products and the provision of testing facilities for individuals.

ii. Allocation of extra funds to the three NHS Regions meeting the bulk of AIDS cases; establishment of counselling courses for NHS staff.

iii. Funding of research projects by the Medical Research Council and direct support for epidemiological research by the Health Departments.

iv. Funding of a number of voluntary bodies.

aid ?

v. Support from the civil budget for the WHO programme for the prevention and control of AIDs.

RTAADD

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FROM THE MINISTER OF STATE

SCOTTISH OFFICE

WHITEHALL, LONDON SW1A 2AU

CONFIDENTIAL

The Rt Hon Norman Fowler MP
The Secretary of State for Social Services
Department of Health & Social Security
Alexander Fleming House
Elephant and Castle
LONDON
SE1 6BY

17th October 1986

Dear Norman,

SCREENING FOR AIDS

As you know, I have just returned from representing the United Kingdom at the 8th Commonwealth Health Ministers' Meeting in Nassau.

A full report of the discussions will follow in due course but one matter of concern, which I feel bound to bring to your immediate attention is the reaction of certain African countries to recent reports (notably the Daily Telegraph article) that the UK might introduce screening for AIDS at the port of entry. I had discussions with, particularly, Health Ministers of Uganda and Tanzania who stressed their grave concern. The matter was also raised in general terms by other countries.

There is considerable depth of feeling but I explained that there was no substance to the press speculation. Whilst stressing that no decision to implement screening had been taken I explained that the serious problems which AIDS poses for the UK was bound to lead to consideration of a number of options.

Both Tanzania and Uganda are prepared to take strong and immediate retaliatory action should we implement screening. The Ugandan Chief Medical Officer stated that they had diagnostic equipment which they would use to screen all UK citizens within Uganda (including all High Commission staff) as well all UK citizens seeking entry to that country.

The strength of feeling amongst the Commonwealth on this issue is as I have said considerable. It is my view that, whilst not in any way minimising the seriousness of the UK's problem, any introduction of screening for Commonwealth visitors would have very damaging consequences for our relations with many Commonwealth countries and give rise to results out of all proportion to the threat their particular countries pose to our AIDS problem.

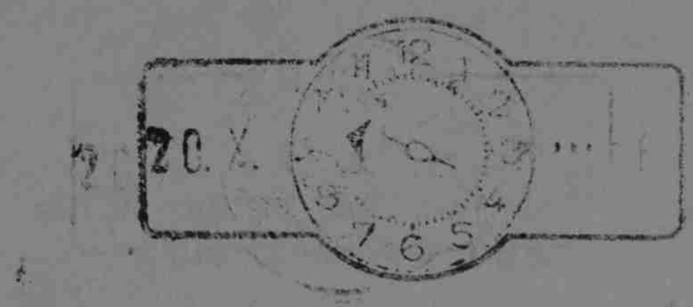
DHA29005

I am copying this letter to the Prime Minister, the Foreign Secretary, Members of H and Sir Robert Armstrong.

Yours ever,
Linar

GLENARTHUR

DHA29005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PRIME MINISTER

AIDS

Some papers carried a story today claiming that you had endorsed the proposal for a leaflet campaign: I understand this was also mentioned on the BBC this morning.

As you know nothing has been decided yet. The proposal is to be considered by 'H', probably in the next week or two. I will keep you informed on this.

(P. A. BEARPARK)

16 October 1986

[BARONESS YOUNG.]
organisations behind the Iron Curtain as Charter 77; so it is not a very representative group.

Lord Kennet: My Lords, does not the noble Baroness agree that while many people—indeed, most people—in this country fully share the Government's view on the record of this hoary old Soviet warhorse, yet many would also feel that NATO is strong enough to stand up to the organisation holding a conference in a NATO country?

Baroness Young: My Lords, I am quite sure that we all agree that NATO is strong enough to stand up and make perfectly plain its view on negotiations at world level. I make quite plain our view about this particular organisation because I think it is the kind of organisation which can mislead some people into thinking that it is doing one thing when in fact it is not.

Lord Orr-Ewing: My Lords, is my noble friend aware that the agenda includes items such as the elimination of weapons in space—presumably that means the SDI but not Russian anti-missiles—the removal of all foreign military bases and the dissolution of military *blocs* such as NATO? Have not those for a long time been the foreign policy aims of the Soviet Union? Indeed, there is some resemblance also to official Labour Party policy.

Baroness Young: My Lords, I have not looked in detail at the agenda for the conference, but I think that my noble friend and I both agree that the conference is not the forum which is likely to make any progress on the real questions concerning the reduction of nuclear weapons in the world.

Lord Gladwyn: My Lords, is this conference, if held, likely to have any noticeable influence on public opinion anywhere except possibly in Denmark?

Baroness Young: My Lords, I could not say what effect it will have on public opinion here. Judging from reports we have seen of the numbers attending it, there will be nothing like so many delegates as originally expected. We must hope that it will not have very much effect.

Lord Paget of Northampton: My Lords, does not the noble Baroness agree that it is probably less mischievous to leave this sort of organisation to sound off where it likes rather than to give it added publicity by trying to object?

Baroness Young: My Lords, this is all very much a matter of judgment, but I believe that it is important we should be warned about these matters, even if, as we hope, they are not successful in achieving their end.

Lord Paget of Northampton: My Lords, have we not learnt by now that any organisation with the word "peace" in its title is fraudulent?

Baroness Young: My Lords, the noble Lord may look at organisations such as that and be able to interpret what the word "peace" in that context means. We have to remember that there are generations coming along who are perhaps not so familiar with all the lengthy propaganda which often precedes such events, and it is important that they should be told of the dangers of these organisations.

Viscount Craigavon: My Lords, can the noble Baroness confirm that in the letter from the Danish Foreign Minister in *The Times* last Friday he was saying that it appears so many problems and difficulties have occurred to the organisers in the promotion of this meeting that it is becoming counter-productive, and that the true face and origin of the World Peace Council is becoming much more apparent to the Danish people than if the Danish Government had tried to suppress the conference from the beginning?

Baroness Young: Yes, my Lords, and the point that the Danish Foreign Minister is making is that Danish society is strong enough to withstand the congress, as is NATO. As it happens, the organisation does not seem to have been very successful and has not attracted as many delegates as expected. Nevertheless, it is right that we should be warned about these organisations and the dangers to those who are unaware of their activities.

Lord Jenkins of Putney: My Lords, is the Minister aware that the only comment I have read in any section of the British press concerning this proposed conference has been extremely hostile to it? Is it not extremely hard for anyone in this country to discover anything, anywhere, mentioning it in favourable terms? Your Lordships may therefore rest easy in your beds.

AIDS: Prevention

3 p.m.

Baroness Sharples: My Lords, I beg leave to ask the Question standing in my name on the Order Paper.

The Question was as follows:

To ask Her Majesty's Government what is being done to prevent the spread of AIDS.

The Parliamentary Under-Secretary of State, Department of Health and Social Security (Baroness Trumpington): My Lords, the Government regard the control of the spread of this terrible disease as of the very highest priority. Urgent action has been and is being taken on a number of fronts. These include a public information campaign, additional resources for treatment, training of National Health Service staff, research, testing of all blood donations, funding for voluntary organisations and the issue of advice to professionals. However, I must emphasise that ultimately it is the responsibility of each and every one of us to ensure that our behaviour does not put ourselves or others at risk.

Baroness Sharples: My Lords, I should like to thank my noble friend for that reply, as far as it goes. Will my noble friend consider setting up a committee to co-ordinate the efforts of the DHSS, the educationists especially and the Home Office, with a possible view to

[illegible]th checks for visitors coming from those countries where AIDS is rife? Is my noble friend aware that the French have invented a machine which takes only 10 minutes to screen people; and is she further aware that Saudi Arabia, the Arab Emirates and India already screen visitors?

Baroness Trumpington: With regard to the first of my noble friend's supplementary questions, the Government attach great importance to the public education campaign. We are concerned that it should be run as efficiently and effectively as possible. No decision has been taken to set up a separate body to run the campaign. As regards the screening of visitors to the United Kingdom, I do not have at my fingertips information about France or Saudi Arabia. There has been much press speculation about this matter. I can confirm that the present position is that visitors, or for that matter those returning to the United Kingdom, are not screened for AIDS and that the Government have taken no decision to introduce such screening in the future.

Lord Cledwyn of Penrhos: My Lords, the noble Baroness has described the disease as a terrible one, and all of us would agree with that. Can she say to what extent the incidence of the disease is increasing in this country? We support entirely the steps which the Government are taking to seek to control and if possible eliminate the disease, but to what extent is there any danger that it could reach epidemic proportions? Secondly, may I ask to what extent it is true that the incidence of the disease is greater in the prisons of this country? Is there any truth in that suggestion and has she any statistics to support it? If it is true, what further steps are our right honourable friends taking to deal with the situation?

Baroness Trumpington: In answer to the noble Lord, Lord Cledwyn, at the end of September there were 512 cases, of whom 250 have died. The estimated number of those infected with the virus is about 30,000. The number of cases may be doubling roughly every 10 months but it is difficult to make longer term predictions with confidence. Everything depends on the behaviour of individuals. Our aim is to inform people about AIDS and how to avoid becoming infected, because on present evidence it appears that once infected a person remains infectious for life even though he may have no symptoms. As regards the second part of the question from the noble Lord, Lord Cledwyn, I do not think that it is right to suggest that there is a higher incidence of the disease in prisons. The greatest incidence of the disease is in the Greater London area.

Lord Campbell of Croy: My Lords, is my noble friend aware that there is a high proportion of AIDS cases in the Edinburgh area, where the disease is being spread by drug addicts who are sharing needles or syringes? Have the Government any plans to deal with this serious risk, bearing in mind that it is the Scottish Office that is responsible for health in Scotland and not the DHSS, which is my noble friend's department?

Baroness Trumpington: My Lords, the Government have taken note of the report issued last month by the Scottish Committee on AIDS and Drug Misuse and will be responding as soon as possible to its far-reaching recommendations.

Lord Kilmarnock: My Lords, are the Government aware of the calculation that has been made that in four years' time 465 people per month will die from AIDS—the equivalent of those killed in a crash of a full Jumbo jet? In view of that terrifying forecast, are they satisfied that their advertising campaign is adequate? Are the Government aware that it has been widely criticised as being much too feeble, possibly because of fear of public disapproval, and has failed to provide enough information to help to prevent the spread of the virus? Finally, are the Government satisfied that sufficient funds are being devoted to research into this disease?

Baroness Trumpington: My Lords, the main components of the campaign are a series of newspaper advertisements, a comprehensive booklet produced by the Health Education Council and a telephone advisory service—the Health Line—run by the College of Health. Most helpful literature has also been produced for the at-risk groups by several voluntary bodies such as the Terrence Higgins Trust and the Standing Conference on Drug Abuse. The effectiveness of the current measures is being kept under review. No options for the future have been ruled out. I know that the Chief Medical Officer and Health Ministers are only too ready to go anywhere, speak on television, radio, or at public meetings if they are invited to do so.

We have already made considerable resources available—for example, £2·5 million for the AIDS information campaign, £2·5 million for the three Thames regions, support for the voluntary sector, training and research. This is in addition to the resources that have already been committed by health authorities. Funding requirements are being kept under review in the light of the developing situation.

Baroness Masham of Ilton: My Lords, may I ask the Minister how much research has been carried out on why drug addicts in Edinburgh and New York City use "shooting galleries"—that is, the sharing of contaminated needles? Can the noble Baroness say whey they are doing this? Concerning this matter, is she aware that in Scotland there is now a baby being fostered who is up for adoption?

Baroness Trumpington: My Lords, I do not know why drug addicts share contaminated needles. It may be because drug addiction is illegal and underground and therefore needles are shared in a clandestine manner. I did know about the baby.

Lord Avebury: My Lords, further to the question asked by the noble Lord, Lord Cledwyn, with regard to prisons, is the noble Baroness aware that even if the incidence of AIDS in prisons is not higher than it is among the general public, there are widespread, if possibly unfounded, fears among both prison inmates and staff about the risks that they incur through close proximity with sufferers from AIDS in overcrowded prisons? Can the noble Baroness say what sums of money are being made available, through the prison

[LORD AVEBURY.]

service or otherwise, to ensure that proper information about the kinds of risk that are peculiar to the prisons is given to both inmates and staff?

Baroness Trumpington: My Lords, the situation in prisons is no different from that in the outside world. AIDS is not highly infectious, and dedicated isolation units are not considered appropriate for AIDS patients. The wide spectrum of illness associated with the infection requires the use of normal district general hospital in-patient and out-patient facilities.

Lord Elwyn-Jones: My Lords, can the Minister indicate what contribution this country is making to medical research into this problem? Our scientists and doctors possess great expertise. Are they being adequately called upon in this very serious challenge to the world's health?

Baroness Trumpington: My Lords, the Government-funded Medical Research Council is responsible for co-ordinating research on AIDS in the United Kingdom. At present 12 special project grants have been awarded at a total cost of about £1 million. That includes a contribution from health departments of up to £300,000 per annum for epidemiological research and for the new United Kingdom Centre for Co-ordinating Epidemiological Research on AIDS.

Baroness Lane-Fox: My Lords, perhaps I may refer to the earlier reply given by my noble friend the Minister, and ask her whether she is aware that there is general concern at the lack of a screening method for visitors and immigrants, especially as it is believed that that would emphasise the heterosexual aspect in transmitting this vile disease?

Baroness Trumpington: My Lords, the screening of visitors, whether on a comprehensive or selective basis, would involve a number of formidable practical problems; and its effectiveness as a method of combating the spread of AIDS in this country has been questioned by medical experts. All the relevant factors will be examined before any decision on this matter is made.

Lord Chalfont: My Lords, following the exchange concerning the incidence of AIDS in prison, is it true that medical statistics show a close correlation between AIDS and promiscuous homosexual activity? If that is so, are we in any way inhibited from making that clear in the information which we give to our people to enable them to avoid this dreadful disease?

Baroness Trumpington: No, my Lords, we are not inhibited. One of the valuable contributions that the voluntary organisations, including the gay community, can make, is by spreading information. As I said at the beginning, education is the most important matter, so that each person knows that he is responsible for his own behaviour and for not spreading this disease.

Viscount St. Davids: My Lords, is the noble Baroness aware that although a higher figure for AIDS has not yet turned up in our prisons, it should be watched for as being extremely likely, because the statistical bag which contains those in our prisons also contains the criminal and the incompetent?

Baroness Trumpington: My Lords, the greatest care is of course being taken in prisons, as it is everywhere else. I repeat that education is the most important thing to impart to everybody.

Financial Services Bill

3.12 p.m.

Lord Lucas of Chilworth: My Lords, I beg to move that the Report be now received.

Moved, That the Report be now received.—(*Lord Lucas of Chilworth.*)

Lord Williams of Elvel: My Lords, before the Question is put perhaps I may make one or two brief comments on the progress of the Bill so far, both elsewhere and in your Lordships' House, and the proposed conduct of the Opposition on Report.

The Bill went through all its stages in another place without a guillotine being imposed. In your Lordships' House we had four days in Committee. In order to get through the business in Committee it was arranged, through the usual channels, that we on our side would co-operate by not challenging or scrutinising the new clauses moved by the Government in Committee. We reserved for ourselves the right to scrutinise the new clauses when the Bill came back to your Lordships on Report.

Furthermore, we asked for and obtained assurances from the Government that no Government amendment, other than those honouring commitments made to your Lordships in Committee, would be submitted on Report.

In return, the Government assured us that we would have three days in your Lordships' House on Report. On that basis, we on our side considered that we should get through the Bill in three days. Since then, the Government have tabled 68 pages of amendments, many of which do not honour previous commitments made either to your Lordships in Committee or to Members in another place.

I fully understand that procedure. I recall that the noble and learned Lord the Lord Advocate said on Second Reading that the Government had to remain flexible on the Bill. They have remained flexible, but I must point out that that imposes an extra strain on the timetable that we had originally thought was possible.

The noble Lord, Lord Lucas, and the department have been extremely helpful in giving the Opposition all possible information on the amendments that the Government have tabled. We are most grateful to the noble Lord and to the department for the Notes on Amendments that they have tabled.

As an opposition we shall also try to be helpful on Report. We shall try to be constructive. As far as possible we shall observe Report stage procedures, but I am sure that your Lordships will recognise that a number of technical points have been raised by the amendments introduced in Committee and by the new

CCB/G

1) CGS
2) cf nbpm

CONFIDENTIAL

FCS/86/236

SECRETARY OF STATE FOR HEALTH & SOCIAL SECURITY

AIDS

1. The Director General of the British Council has proposed that screening for AIDS be introduced for all overseas students entering this country under the Council's auspices. Since it is for your Department to determine what measures are necessary and practical in the interest of protecting public health, I would welcome your views on this proposal.

2. The British Council were right to identify the danger of public criticism if they were judged to have taken inadequate precautions over students coming under their auspicies. But the issues involved are complex and sensitive. We must avoid any action which may expose us to unjustified allegations of discrimination or to a backlash that could be detrimental to our interests.

/3.

CONFIDENTIAL

3. Our attitude is likely to come under scrutiny at the meeting of Commonwealth Health Ministers in Nassau from 13-17 October. It would be best to reach a collective decision on screening before the Conference: failing that, we should take the initiative in describing what we are doing domestically in terms of health measures and public education, and we should encourage others to recognise that this is a problem which all members of the Commonwealth share. We should adopt a positive stance, drawing attention to the contribution we are making to the AIDS programme of the WHO, and encouraging other governments to cooperate with it.

4. The attitude of our Community partners will also be crucial. No meeting of Health Ministers of the Twelve is scheduled under our Presidency. But I believe that any decision on screening would be better defended if it were consistent with decisions taken by our partners.

5. We might also look at action in other fora. I know that the WHO Secretariat are opposed to screening. But there could be advantage in promoting an international and public exchange of views on the travel aspects of AIDS and on screening, under the auspices of the WHO. Any document which emerged from such a forum could provide useful support for whichever arguments we deploy domestically.

/6.

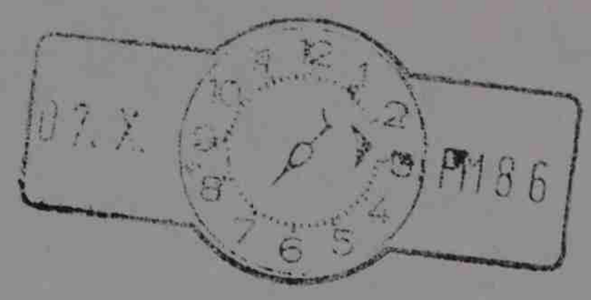
6. I propose a meeting together with Douglas Hurd and Kenneth Baker. Meanwhile I think our senior officials might meet soon to prepare the ground.

7. I am copying this letter to the Prime Minister, Douglas Hurd and Kenneth Baker.

(GEOFFREY HOWE)

Foreign and Commonwealth Office

7 October 1986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10 DOWNING STREET

From the Private Secretary

10 September 1986

Dear Joan

AIDS - PUBLIC EDUCATION

The Prime Minister has seen the letter of 21 August from the Secretary of State for Social Services to the Lord President. She has also noted the views of various of his colleagues. The Prime Minister is concerned that there are various risks attached to the proposal, and would like to propose that if he agrees the Lord President should arrange for 'H' Committee to discuss the proposal when a full draft text and professional advice on the likely impact are available.

I am copying this letter to the Private Secretaries to members of H Committee, the Ministerial Committee on AIDS and to Michael Stark (Cabinet Office).

Yours ever

Andy

(P. A. BEARPARK)

Miss Joan MacNaughton,
Lord President's Office.

Ministerial Committee on Aids

Tony Newton Esq., OBE, MP.	DHSS
Mrs Edwina Currie MP,	DHSS
Tim Eggar, Esq., MP.	FCO
The Lord Glenarthur	Home Office
Roger Freeman, Esq., MP.	MOD
Peter Brooke, Esq., MP	HMT
Bob Dunn, Esq., MP	DES
David Trippier, Esq, MP	D/Emp
Mark Robinson, Esq., MP	Welsh Office
Richard Needham, Esq. MP.	Northern Ireland Office
John Patten, Esq., MP.	D/Env
John MacKay, Esq. MP	Scottish Office
Michael Howard, Esq., M.P.	DTI.

As confirmed with DHSS by telephone - 10.9.86

CCBC
nbpm.

QUEEN ANNE'S GATE LONDON SWIH 9AT

9 September 1986

Dear Willie,

AIDS - PUBLIC EDUCATION

will request if required.

In his letter of 21 August Norman Fowler outlined his proposal to make more effective the Government's public education campaign on the nature of the threat from the AIDS virus.

I am sure that the only way to control the spread, already alarming, of the virus is to provide sufficient education in an effective manner to influence and change for the better the life-style of those at risk.

We must not put ourselves in the position of having neglected our duty when that duty was clear. Indeed, it may be that whatever we do may not seem enough with hindsight. This means that what we do decide upon should be well directed and effective. I think the campaign proposed probably gets it right at this stage of public awareness. I believe we may have to go further in the future, and the not too distant future at that. Our main aim now should be to keep those free of infection, uninfected. In other words, our target is not now the high risk groups, but the majority of the population, as yet uninfected, with emphasis on the young and the needs and duties of parents.

My only specific comment on the draft material is that the antepenultimate paragraph of annex B seems to take illicit drug taking too much for granted. I would prefer something like: "Second, drugs. Those who illegally inject themselves should be aware of the terrible risk they are taking, particularly if they share needles or other equipment. Just one fix with an infected needle can pass on the AIDS virus."

Yours,
Douglas.

The Rt Hon Viscount Whitelaw, CH, MC

We apologise
for not copying
this earlier 19/9/88

HOME SECRETARY

L Goodall

WITH
THE COMPLIMENTS OF THE
PRIVATE SECRETARY

HOME OFFICE
50 QUEEN ANNE'S GATE
LONDON SW1H 9AT

Nat. Health: Aids Aug. '85.

PRIME MINISTER

AIDS

You were unhappy with Mr. Fowler's suggestion of a campaign to deliver an AIDS leaflet to every household and wish to see your colleagues' comments. These are attached. Kenneth Baker and Tom King support the idea, but Nicholas Edwards is concerned at the risk of causing offence, Peter Brooke considers it essential to estimate the impact of the proposal and John MacKay shares both their doubts. Lord Hailsham has stronger reservations and you might like to glance at his letter at "A".

Invite H to discuss this when a full draft text and professional advice on the likely impact are available?

Yes

PSB

ANDY BEARPARK

8 September 1986

FROM:

THE RT. HON. LORD HAILSHAM OF ST. MARYLEBONE, C.H., F.R.S., D.C.L.

HOUSE OF LORDS,
LONDON SW1A 0PW

RESTRICTED

3 September 1986

The Right Honourable
The Lord President of the Council
Privy Council Office
Whitehall
LONDON
SW1

My dear Willie:

AIDS - EDUCATION

The more I reflect about Norman Fowler's letter on AIDS - Education of 21 August, the more doubtful I become of the wisdom of the policy proposed.

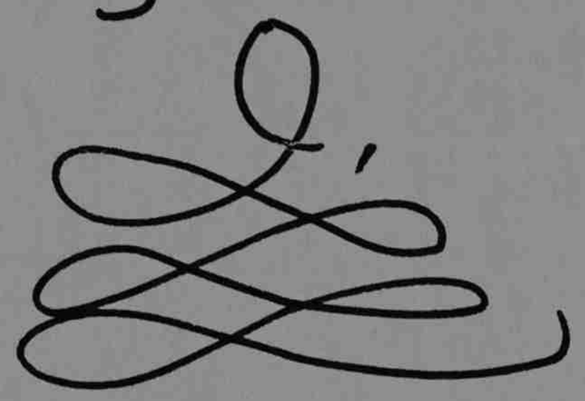
What is proposed as I understand it is that through the letterbox of every household in the UK should be dropped an unsolicited document.

AIDS is, of course, a matter we must take extremely seriously and education, properly understood, is no doubt one of our key weapons in combating its spread. But the classes at risk do not correspond with the entire population. Unsolicited correspondence is not universally popular, and not always effective as a means of communicating information or advice. The appearance on every doormat of the document in question is liable to cause controversy or even offence, and might well spread panic instead of creating a cautious approach to sexual practices and drug injections. Moreover, the proposed advertisement contains obvious omissions (eg no prohibition of persons at risk becoming blood donors), is expressed in language dangerously vague and sometimes almost ludicrous, and it does not reassure those who may need blood transfusion that the blood and plasma banks are now free from risk. It is essential that those shortcomings be not carried forward into any leaflet.

/I wonder

I wonder whether sufficient professional advice has been taken about all this. There are public relations experts and health advisers who might be prepared to give assistance. In any case I would suggest that more thought and wider consultation is required before embarking on what is undoubtedly an ambitious scheme, but one which needs careful and professional handling. I am copying this letter to those on the attached list.

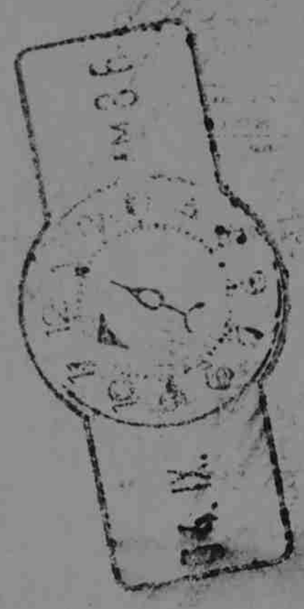
yrs:



Copies to:

Members of H Committee
The Ministerial Committee on AIDS
The Prime Minister
Sir Robert Armstrong

NAT. HEALTH: Aids: Aug. 1985



The Prime Minister cc BG

FROM THE MINISTER FOR HOME AFFAIRS, HEALTH AND SOCIAL WORK

SCOTTISH OFFICE
NEW ST. ANDREW'S HOUSE
ST. JAMES CENTRE
EDINBURGH EH1 3SX

PM

Norm at this stage

The Rt Hon The Viscount Whitelaw CH MC
Lord President of the Council
Privy Council Office
68 Whitehall
LONDON
SW1A 2AT

1 September 1986

Dear Willie

AIDS - PUBLIC EDUCATION

In Malcolm Rifkind's absence on holiday I am responding to Normam Fowler's letter to you of 21 August proposing that we should step up considerably our public education campaign on the threat of AIDS. The aim would be to bring home to people the real magnitude of the risk from AIDS and after considering the options, Norman proposes that an AIDS leaflet should be delivered to every household in the UK spelling out in simple and explicit language what they need to know.

Norman asked for agreement to this proposal by the end of August. The draft text of the proposed leaflet only reached my officials on 27 August, however, and I have delayed my response until I had had a chance to see it.

Despite Norman's view that it should be possible to say more in the leaflet than in the newspaper advertising which we have undertaken already and which Norman proposes to supplement in England by a further round of advertising to commence in September, the draft leaflet circulated to officials on 27 August (on which there had been no prior inter-Departmental consultations) deals very superficially with the issues, and says nothing new about the threat of AIDS. We therefore run the risk of being heavily criticised both for delivering sexually explicit leaflets to every household in the country whether the occupiers wish to receive this or not, and for the inadequacy of the guidance in the leaflet, while at the same time we would not achieve any advance on what has been and can be achieved by public advertising.

If we are to contemplate delivering a leaflet to every household, I believe that we need to take time now to get it right. The questions arise whether it can be more informative than the advertisements on the medical issues; and also whether we should involve in its preparation our professional experts on health education, the Health Education Council,

the Scottish Health Education Group and the Welsh Health Education Advisory Committee. If these bodies are seen to be involved, the Government can to some extent distance itself from possible criticism of the exercise.

The substantial expenditure that would need to be incurred on the leaflet would leave me without any scope for further health education initiatives that may be required in the current financial year. The Scottish contribution would be of the order of £250,000, and we would need to be very sure that this expenditure could be fully justified. I would like to reserve judgement on that until officials have considered the content of the leaflet further.

While I acknowledge that we must do more to increase public awareness of the issues relating to AIDS, we should take time to get our publicity right if it is to have the desired effect.

I am sending copies of this letter to the recipients of Norman's.

Yours ever

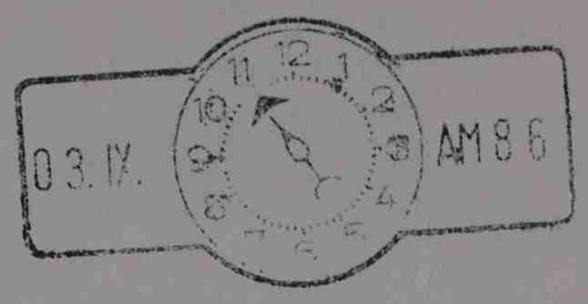
John

JOHN J MACKAY

NAT HEALTH

AIDS

8/85



CCBG

PM

NORTHERN IRELAND OFFICE
WHITEHALL
LONDON SW1A 2AZ

10 bpm at this stage

SECRETARY OF STATE
FOR
NORTHERN IRELAND

Rt Hon Norman Fowler MP
Secretary of State for Social Services
Department of Health and
Social Security
Alexander Fleming House
Elephant & Castle
LONDON SE1 6BY

1 September 1986

Dear Secretary of State,

AIDS - PUBLIC EDUCATION

Thank you for copying to me your letter of 21 August 1986 to Willie Whitelaw.

The incidence of AIDS in Northern Ireland is considerably less than in the rest of the United Kingdom. However I am most concerned to halt the spread of infection and recognise that the problem of AIDS must be tackled on a national basis.

I agree that we need to step up the public education campaign and would support your proposals for the distribution of literature on AIDS to every household in the UK. We would of course be prepared to contribute towards the cost of distributing the leaflets to households in Northern Ireland.

I am copying this reply to the Prime Minister, other members of H Committee, and Sir Robert Armstrong.

Yours sincerely
N Sheard
Private Secretary

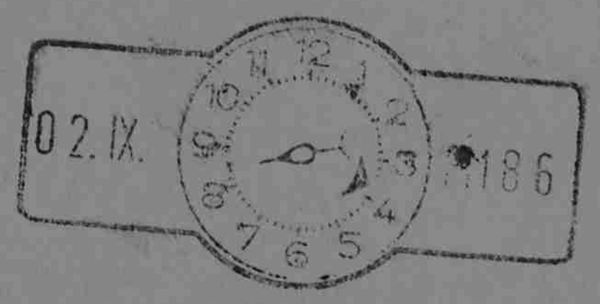
fa TK

(Approved by the Secretary of State and signed in his absence in Northern Ireland)

NAT HEALTH

AIDS

8/85



CCBG

PM

Treasury Chambers, Parliament Street, SW1P 3AG

The Rt Hon Norman Fowler MP
Secretary of State
Department of Health & Social Security
Alexander Fleming House
Elephant and Castle
LONDON SE1 6BY

NBPM Matthew Hyde

29 August 1986

Dear Secretary of State,

AIDS - PUBLIC EDUCATION

I agree very much with the points made in your letter of 21 August to Willie Whitelaw. There is still a great deal we need to do by way of increasing public awareness of the magnitude of the AIDS threat.

It is important, nevertheless, to make sure that we are applying resources to the maximum effect. To this end, I consider it essential that a proper evaluation of the leaflet drop you propose is carried out to ensure that it has the impact necessary to make it worth the investment.

I note that you expect the cost of the leaflet drop itself to be around £2 million, most of which at least you intend to find from within your central health programme. I hope that Tom King, Nicholas Edwards and Malcolm Rifkind will feel able to participate. There could of course be no question of additional funding.

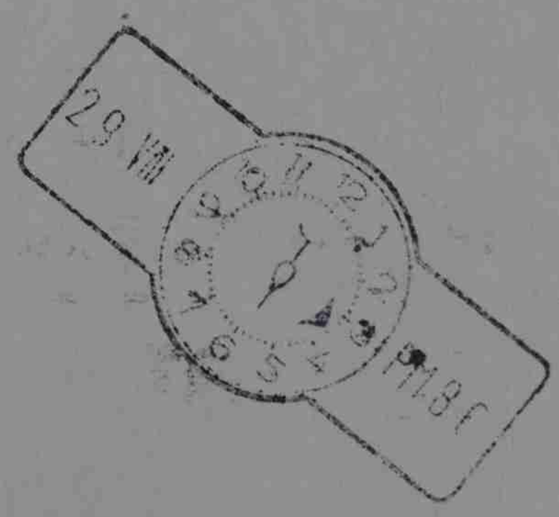
I am sending copies of this letter to the recipients of yours.

Yours sincerely,

MJ Morgan (Private Secretary)

for **PETER BROOKE**

(Approved by the Minister of State and signed in his absence)



CC86

Y SWYDDFA GYMREIG
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-233 3000 (Switsfwrdd)
01-233 8545 (Llinell Union)

ODDI WRTH YSGRIFENNYDD
PREIFAT YSGRIFENNYDD
GWLADOL CYMRU

NBPM at this stage

WELSH OFFICE
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-233 3000 (Switchboard)
01-233 8545 (Direct Line)

FROM THE PRIVATE SECRETARY
TO THE SECRETARY OF STATE
FOR WALES

29 August 1986

Dear Mr Laurance.

AIDS - PUBLIC EDUCATION

You will have seen my Secretary of State's letter of 28 August and will be aware that it had not been circulated. I apologise for the oversight to you and to recipients of this letter who are now receiving the letter of 28 August.

/ Copies go to the Prime Minister, members of H, members of the Ministerial Committee on Aids and Sir Robert Armstrong.

Yours sincerely,

K L DALLIMORE

A Laurance Esq
Principal Private Secretary
Secretary of State for Social Services

Y SWYDDFA GYMREIG
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-233 3000 (Switsfwrdd)
01-233 6106 (Llinell Union)

Oddi wrth Ysgrifennydd Gwladol Cymru

WELSH OFFICE
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-233 3000 (Switchboard)
01-233 6106 (Direct Line)

From The Secretary of State for Wales

PM

The Rt Hon Nicholas Edwards MP

28 August 1986

Dear Secretary of State,

AIDS - PUBLIC EDUCATION

Thank you for copying to me your letter of 21 August to Willie Whitelaw concerning the above. I agree with your view about the need to step up considerably our public education campaign.

I have no comment to make about the material from which you propose to select further newspaper advertisements other than to ask that we be given an opportunity to agree the precise form of words you plan to use and that perhaps the advertisements should be attributed to all four Health Departments.

I am afraid that I have a number of reservations about your proposals for a national leaflet drop. I entirely agree that we need to get the message home and I accept that our campaign so far has attracted criticism of its lack of explicitness but (as I understand the COI have advised) the danger of offence is significantly increased if material is put through people's doors, thus giving them no choice but to receive it. I understand the COI also warn about the sensitivities of religious and ethnic minorities, as well, obviously, as the sensitivities of every parent about the exposure of their children to material which many will find offensive.

It is because of considerations of this kind that I have taken the first steps in Wales to mount an extensive and specific campaign while at the same time distancing my Department from its contents. I have authorised the appointment of an AIDS Co-ordinator for Wales who will work under the auspices of the Health Education Advisory Committee (Wales). His function, under the supervision of HEAC(W), will be to co-ordinate and direct the dissemination of information and to set up a network of volunteers, working with the health authorities, to ensure that the message gets home to all sectors of the community in a form which best meets the circumstances and sensitivities of each sector. That seems to me to be a better approach than the somewhat hit or miss effect of a national leaflet drop.

/If we

The Rt Hon Norman Fowler
Department of Health and Social Security
Alexander Fleming House
Elephant & Castle
LONDON
SE1 6BY

If we decide collectively that the idea of a leaflet drop should be pursued, I would prefer to await the outcome of a pilot exercise before we take a final decision. I have to say, very regrettably, that I would find it extremely difficult to make a financial contribution since my PES provision under this heading is already fully committed. The best that I could offer would be to pay for the Welsh version of the leaflet which would have to issue in Wales.

My doubts are not about the need for an increasingly intensive campaign but whether your proposals are the most effective way of carrying it forward.

Yours sincerely

R. C. Williams

(approved by the Secretary of State and signed in his absence)

JSF DIA01

CCBG

DEPARTMENT OF EDUCATION AND SCIENCE

ELIZABETH HOUSE YORK ROAD LONDON SE1 7PH

TELEPHONE 01-934 9000

FROM THE SECRETARY OF STATE

The Rt Hon Norman Fowler MP
Secretary of State for Social Services
Alexander Fleming House
Elephant and Castle
SE1

MBPM acknowledge

28th August 1986

Dear Norman,

AIDS - PUBLIC EDUCATION

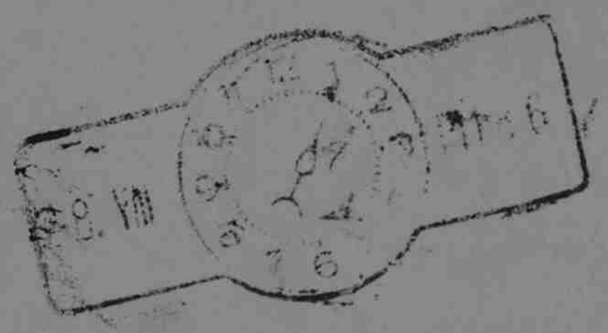
I share your concern about the increase in the number of AIDS cases and of those becoming infected with HIV - Human Immuno-deficiency Virus. I also agree that we should step up our public education campaign, and should aim particularly at getting the message across to young people.

Clearly we must maintain the newspaper advertising campaign, and try to make it more effective. I agree that we need to do more, and I entirely support your proposal for an AIDS Leaflet to be delivered to every household in the UK. I look forward to seeing the draft text.

I am copying this letter to other members of H Committee, the Ministerial Committee on AIDS, to the Prime Minister and Sir Robert Armstrong.

Yours

Kenneth



CP

I have conveyed the gist of this to DHSS. PL [illegible] 28/8

MGA 28/8

PRIME MINISTER

AIDS

Mr. Fowler's letter, attached, has two purposes:

(i) informing colleagues that he intends to mount a further advertising campaign in September using the texts attached to his letter. The copy is very much along the lines used earlier.

(ii) seeks colleagues' support for a proposal to deliver an AIDS leaflet to every household in the country. This is the important part of the letter.

The Secretary of State notes that the AIDS leaflet would be able to say more than has been possible in the advertising - he may or may not have in mind more explicit language than the advertising copy has so far contained. The Secretary of State also notes that the exercise would need careful preparation and piloting, and that it will generate some criticism. It would cost up to £2 million. He will circulate the text of the leaflet as soon as he can.

I do not think you would wish to give unconditional agreement to leafleting on this scale without knowing what the leaflet might contain.

Agree to indicate that you are content in principle with the proposal to leaflet, but you would not wish to give final approval without having an opportunity to agree the text itself?

Mark Addison

Mark Addison

22 August 1986

Why universal delivery of AIDS leaflet – but nothing about drugs? My first reaction is against the idea – but await other comments

JA2ADE

CeBG

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

The Rt Hon the Viscount Whitelaw CH MC
Lord President of the Council
Privy Council Office
68 Whitehall
LONDON
SW1A 2AT

21 August 1986

Dear Lord President

AIDS - PUBLIC EDUCATION

Recent press publicity has highlighted the growing public health menace of AIDS. It has also emphasised that the only way we have of limiting the spread is by effective public education to get people to change their behaviour. The number of reported cases of AIDS is rising all the time. I attach a graph illustrating the trend in notified AIDS cases - which reflect only a small proportion of the numbers infected with the virus.

The first AIDS case in the UK was in 1981. By mid-1986 we had 465 cases and in addition probably over 30,000 people are infected with the AIDS virus. Even if we halted the spread of infection now we could expect about 2,000 cases of AIDS by 1988. But at the estimated current rate of infection we could have between 100,000 and 200,000 infected persons by then each capable of spreading the infection. At least 25 per cent of those infected and possibly considerably more - we simply don't know as yet - will develop AIDS and die. These deaths will not be confined to homosexuals, bisexuals and drug addicts but will increasingly include others such as their sexual partners. The children of infected mothers have been infected during pregnancy or during birth. Already more than one baby has died from AIDS, and many more are known to be infected.

Faced with this prospect I am convinced that we must step up considerably our public education campaign this year and beyond. The present newspaper advertising needs to be sustained and developed and the messages put over more simply and clearly. I have approved a further round of advertising for September and we shall be developing a campaign aimed particularly at young people,

E.R.

alongside our main campaign aimed at the general public, and the work which voluntary bodies are doing with our help to influence the high risk groups of injecting drug abusers and committed homosexuals. I am enclosing for information copies of the advertising material from which we shall be selecting the September advertisements. There may of course be some minor changes in the final versions used.

But we need as soon as possible to make a special effort to bring home to people the real magnitude of the risks from AIDS, what must be done if we are to control it and the priority the Government gives to this. Having considered the options, I propose that we should have an AIDS leaflet delivered to every household in the UK spelling out in simple and explicit language what they need to know. A number of other countries, including West Germany, Austria, Switzerland and Denmark have already done this. The leaflet 'drop' will need substantial related advertising and other publicity to ensure it gets maximum attention. The aim will be to achieve this in November. I would hope in this single step to achieve a breakthrough in public recognition of the seriousness of the problem. We shall be able also to say more in the leaflet than has been possible in the newspaper advertising or would be possible in television commercials.

The exercise will need careful preparation and special steps to minimise the risk of offence whilst not watering down the messages. These will include some sample testing of the leaflet, and warning on the envelope and in the pre-drop publicity about the use of explicit language. There will still be criticism but I think we must accept that as a necessary price to be paid.

I should be glad to know that I have colleagues' support for this action which I would hope we could agree should be on a UK basis. If so I will circulate the text of the leaflet as soon as a suitable version is available and provide more details about the arrangements. The cost, with associated publicity, is likely to be up to £2 million. I will find most of that but I hope that Malcolm Rifkind, Tom King and Nicholas Edwards will make pro rata contributions.

I am copying this minute to other members of H Committee, the Ministerial Committee on AIDS, to the Prime Minister and Sir Robert Armstrong. I would be glad to have responses before the end of this month as firm decisions will be needed by then if the leaflet drop is to go ahead by end November. If we miss that deadline it has to be postponed until the New Year and time is not on our side.

Yours sincerely

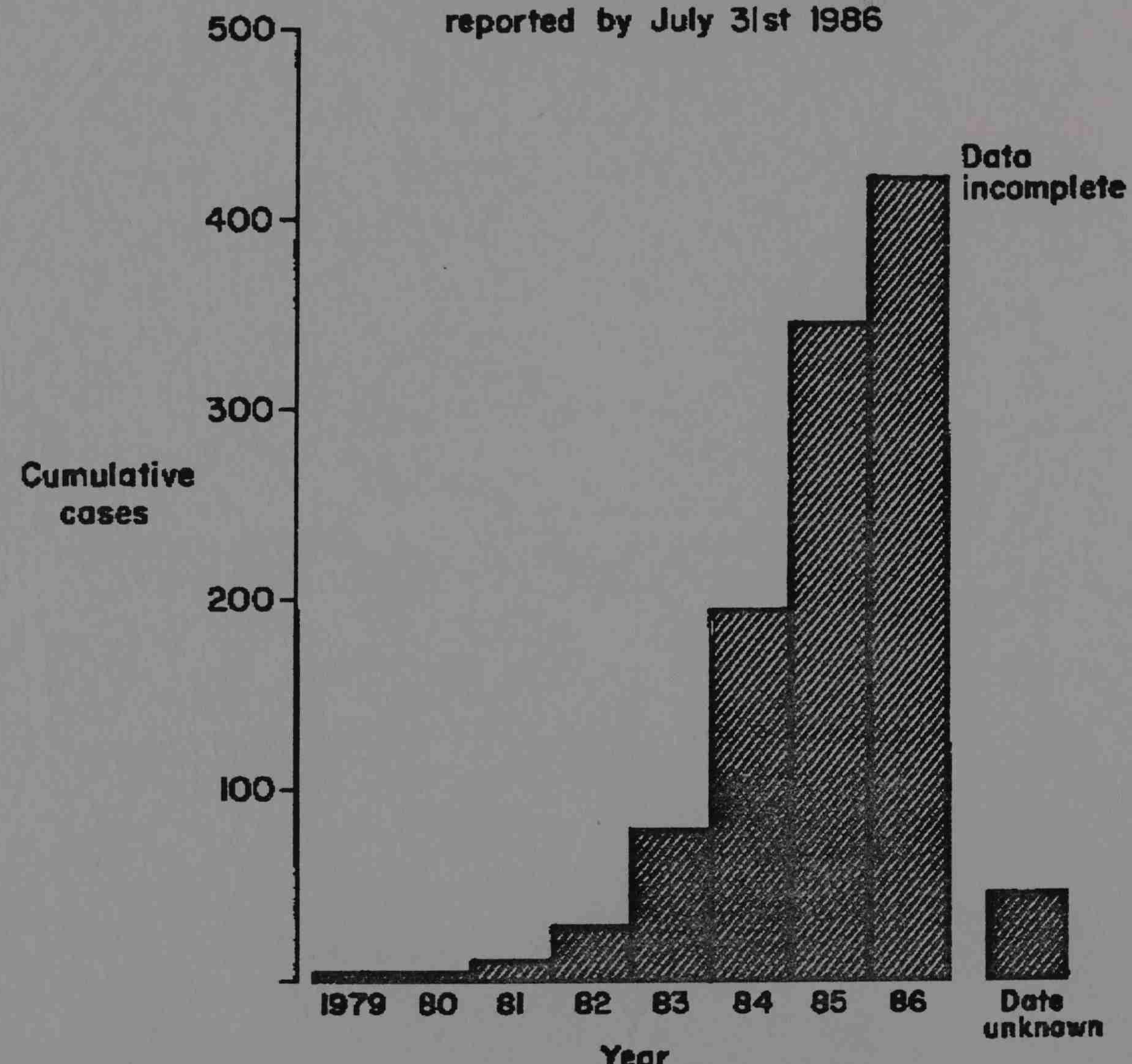
Jane McKessack

pp NORMAN FOWLER

(Approved by the Secretary of State
and signed in his absence)

AIDS IN THE U.K.

Cumulative total of cases reported by July 31st 1986



Prepared by CDSC

WHAT KIND OF PEOPLE GET AIDS?

THE KIND THAT DON'T KNOW THE FACTS.

Kisuaheli ne Rewitz gofe

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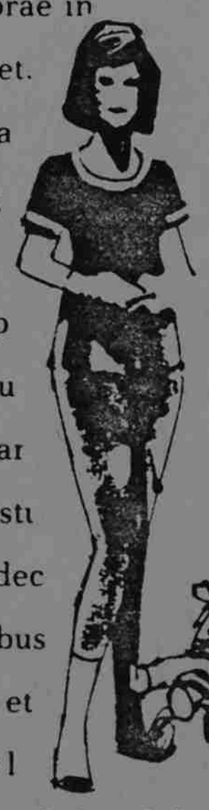

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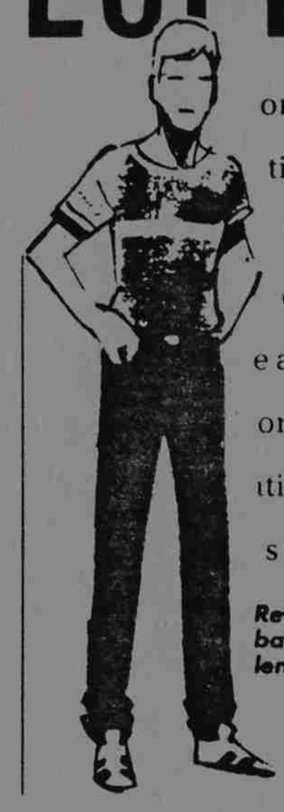

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THE HEALTHLINE TELEPHONE SERVICE:
01-981 2717, 01-980 7222 or 0345 581151.

consisterent hostium fugam.

DON'T AID AIDS

ERANT EIUSMODI FERE SITUS NAVIS MAPPULSO NAMQUE NOSTRIS TE TELEPHONE 01-834 3434. TEMPESTATI MERECIPIEBANT QUANVIS CONFECTI POTERANT NEQUE.

TBWA

B

COPY

Client: COI/DHSS

Product: AIDS

Subject: What Kind of People

Script No.

Date

Job No.

WHAT KIND OF PEOPLE GET AIDS?

THE KIND WHO DON'T KNOW THE FACTS

These are the facts.

Doctors don't have a cure for AIDS yet.

But we do know how it's spread and how to control it.

The AIDS virus is not just caught by drug addicts and gay men. Many more men than women are infected so far. But all men and women can catch it and pass it on. It depends on how you behave.

The only ways you are likely to catch the AIDS virus is through sex with an infected person - and by sharing needles if you inject drugs.

You can't tell if someone is infected. They can look and feel completely well - and not know they have the AIDS virus. Probably 30,000 people are already infected in the UK. Don't join them.

First, about sex. There is no risk if both partners know they're not infected. But if you're not sure about your partner, then the safest option is not to have sex. If you do have sex, men should wear a condom (also called a sheath or a rubber) which can cut down the risk of infection.

The more partners you have, the more likely it is that one of them will be infected. So beware of casual sex.

Sex which might damage the anus, vagina, penis or mouth is particularly dangerous if one of the partners is infected. Anal sex involves the greatest risk and should be avcided.

Second, if you inject drugs, do not share needles or other equipment. Better still don't inject at all. Just one fix with an infected needle can give you the AIDS virus.

So remember these are the only two ways you are likely to get AIDS. No one has been infected through normal day to day contact.

As children grow up they may experiment with sex or drugs. So if you are a parent, make sure that they too know the risks.

COPY	COPY	COPY	CLIENT APPROVAL DATE
C.D	AC.D	AC.D	
D	C.D	C.D	

B

For more detailed information write for the booklet on AIDS to Dept. A, P.O. Box 100, Milton Keynes MK1 1TX.
You can also get information on the confidential Healthline telephone service on 01 - 981 2717, 01 - 980 7222, or 0345 581151. If you are dialling from outside London, use the 0345 number and you will be charged at local rates.

DON'T AID AIDS

Issued by the Department of Health and Social Security

CAPTIONS FOR PICTURES

Young man in suit: Many more men than women have been infected so far.

Juvenile boy : Young people who experiment with sex or drugs are vulnerable

Young woman with child : Women can catch the AIDS virus too. And they can pass it on to their unborn child.

THIS IS THE ONLY KNOWN CURE TO HALT THE SPREAD OF AIDS.

Erant eiusmodi fere situs posita oppidorum ut lingulis promotorisque neque pedibus aditum havere cum ex alto se aestus incitavisset, quod accid semper horarum spatio.

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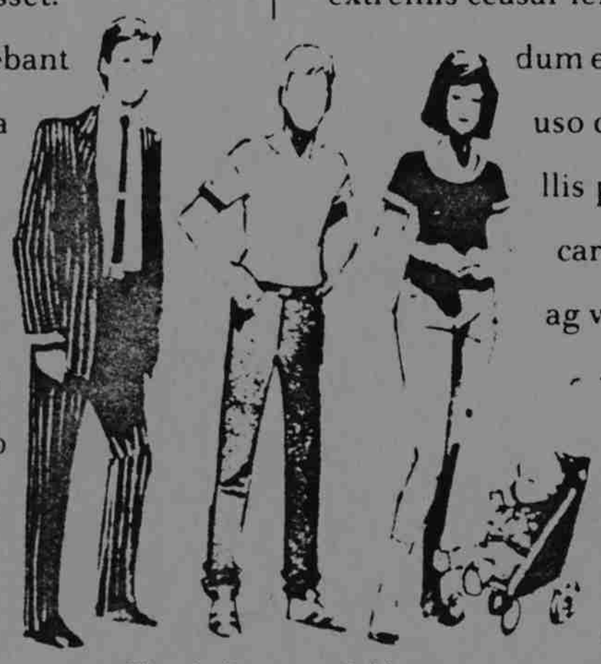

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THE HEALTHLINE TELEPHONE SERVICE:
01-981 2717, 01-980 7222 or 0345 581151.

consisterent hostium fugam.

DON'T AID AIDS

ERANT EIUSMODI FERE SITUS NAVIBUS QUE AQUE NOSTRIS ET TELEPHONE 01-834 3434. TEMPESTATUM RECIPIEBANT QUE ANTUS CONFECTI POTERANT NEQUE

COPY

C

Client COI/DHSS

Product AIDS

Subject Only Known Cure

Script No.

Date

Job No.

THIS IS THE ONLY KNOWN CURE TO HALT THE SPREAD OF AIDS

Doctors don't have a cure for AIDS yet.

But we do know how the AIDS virus is spread and how to control it.

The virus is not just caught by drug addicts and gay men. Many more men than women are infected so far. But all men and women can catch it and pass it on. It depends on how you behave.

The only ways you are likely to catch the AIDS virus is through sex with an infected person - and by sharing needles if you inject drugs.

You can't tell if someone is infected. They can look and feel completely well - and not know they have the AIDS virus. Probably 30,000 people are already infected in the UK. Don't join them.

First, about sex. There is no risk if both partners know they're not infected. But if you're not sure about your partner, then the safest option is not to have sex. If you do have sex, men should wear a condom (also called a sheath or a rubber) which can cut down the risk of infection.

The more partners you have, the more likely it is that one of them will be infected. So beware of casual sex.

Sex which might damage the anus, vagina, penis or mouth is particularly dangerous if one of the partners is infected. Anal sex involves the greatest risk and should be avoided.

Second, if you inject drugs, do not share needles or other equipment. Better still don't inject at all. Just one fix with an infected needle can give you the AIDS virus.

So remember these are the only two ways you are likely to get AIDS. No one has been infected through normal day to day contact.

As children grow up they may experiment with sex or drugs. So if you are a parent, make sure that they too know the risks.

COPY	COPY	COPY	CLIENT APPROVAL DATE
AC.D	AC.D	AC.D	
C.D	C.D	C.D	

For more detailed information write for the booklet on AIDS to Dept. A, P.O. Box 100, Milton Keynes MK1 1TX.
You can also get information on the confidential Healthline telephone service on 01 - 981 2717, 01 - 980 7222, or 0345 581151. If you are dialling from outside London, use the 0345 number and you will be charged at local rates.

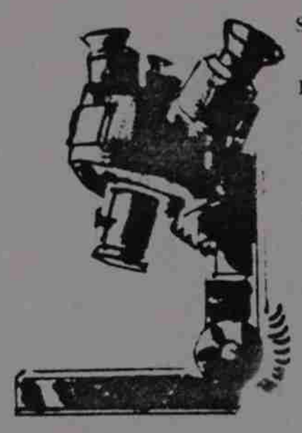
DON'T AID AIDS

Issued by the Department of Health and Social Security

Captions: The AIDS virus can be caught by men, women, and unborn children.

FINDING A CURE FOR AIDS WILL TAKE YEARS OF RESEARCH.

BUT IT CAN BE CONTROLLED BY COMMON SENSE PRECAUTIONS



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Oppidi contumeliam puppes eret oppirodis laborum namque erant oper timerent deportabant seque inima.

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DON'T AID AIDS

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THE HEALTHLINE TELEPHONE SERVICE:
01-981 2717, 01-980 7222 or 0345 581151.

consisterent hostium fugam.

DON'T AID AIDS

ERANT EIUSMODI FERRE SITUS NAVIUM APPULSO NAMQUE NOSTRIS FE **TELEPHONE 01-834 3434.** TEMPESTATUM RECIPIEBANT QUAMVIS CONFECTI POTERANT NEQUE

IBWA

COPY

Client COI/DHSS

Product AIDS

Subject Common Sense Precautions

Script No. D

Date

Job No.

FINDING A CURE FOR AIDS WILL TAKE YEARS OF RESEARCH
BUT IT CAN BE CONTROLLED BY COMMON SENSE PRECAUTIONS

Doctors don't have a cure for AIDS yet.

But we do know how it's spread and how to control it.

The AIDS virus is not just caught by drug addicts and gay men. Many more men than women are infected so far. But all men and women can catch it and pass it on. It depends on how you behave.

The only ways you are likely to catch the AIDS virus is through sex with an infected person - and by sharing needles if you inject drugs.

You can't tell if someone is infected. They can look and feel completely well - and not know they have the AIDS virus. Probably 30,000 people are already infected in the UK. Don't join them.

First, about sex. There is no risk if both partners know they're not infected. But if you're not sure about your partner, then the safest option is not to have sex. If you do have sex, men should wear a condom (also called a sheath or a rubber) which can cut down the risk of infection.

The more partners you have, the more likely it is that one of them will be infected. So beware of casual sex.

Sex which might damage the anus, vagina, penis or mouth is particularly dangerous if one of the partners is infected. Anal sex involves the greatest risk and should be avoided.

Second, if you inject drugs, do not share needles or other equipment. Better still don't inject at all. Just one fix with an infected needle can give you the AIDS virus.

So remember these are the only two ways you are likely to get AIDS. No one has been infected through normal day to day contact.

As children grow up they may experiment with sex or drugs. So if you are a parent, make sure that they too know the risks.

COPY AC.D C.D

COPY AC.D C.D

COPY AC.D C.D

CLIENT APPROVAL DAT

For more detailed information write for the booklet on AIDS to Dept. A, P.O. Box 100, Milton Keynes MK1 1TX.
You can also get information on the confidential Healthline telephone service on 01 - 981 2717, 01 - 980 7222, or 0345 581151. If you are dialling from outside London, use the 0345 number and you will be charged at local rates.

DON'T AID AIDS

Issued by the Department of Health and Social Security

C(86)

SCOTTISH OFFICE
WHITEHALL, LONDON SW1A 2AU

The Rt Hon Norman Fowler MP
Secretary of State for Social Services
Department of Health and Social Security
Alexander Fleming House
Elephant & Castle
LONDON
SE1 6BY

23 July 1986

Dear Norman,

AIDS CAMPAIGN

I refer to your letters of 24 June and 9 July to Willie Whitelaw about your intention to undertake a second round of advertising in selected newspapers in order to maintain the momentum of the earlier campaign in March to dispel unwarranted fears about AIDS and highlight how the disease can be caught.

Your decision to launch a further round of publicity on 20 and 21 July and 27 and 28 July creates problems for us in Scotland. These dates come in the middle of the traditional Scottish holiday period and we do not think that the advertisements would make the same impact then as they would later in the year. Furthermore, our Scottish Health Education Group are still testing the text of a Scottish leaflet on AIDS and it is not likely to be ready until the late autumn. I think it is important that this leaflet should be available before the next round of AIDS publicity in Scotland.

I do not therefore propose to undertake an AIDS publicity campaign in Scotland to coincide with the one you are launching this month, though I have no objections whatsoever to your own proposals. I hope to launch a second round of AIDS publicity in Scotland later this year and my officials will keep in touch with yours about our plans for this.

I am copying this letter to the Prime Minister, other members of H Committee, members of the Inter-Departmental Ministerial Group on AIDS and Sir Robert Armstrong.

Yours ever,

MALCOLM RIFKIND

HMP20301

NAT HEALTH: Aids, Aug 85

CONFIDENTIAL

CC BC

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

The Rt Hon The Viscount Whitelaw CH MC
Lord President of the Council
Privy Council Office
68 Whitehall
LONDON
SW1A 2AT

9 July 1986

1. Nyel Wicks - to see.
2. CR to p.c.

Dear Willie.

AIDS CAMPAIGN

Following my letter of 24 June, I am enclosing a copy of the final version of the text of the advertisement for the next round of national newspaper advertising in our AIDS campaign. The advertisement will appear in a selection of national newspapers on 20 and 21 July and 27 and 28 July.

I have seen Quintin's comments in his letter to you dated 27 June. I feel it would be better not to make further changes to this text, which intentionally uses simple and colloquial language. But I will certainly take account of his views in the next round of advertising.

I am copying this letter to the Prime Minister, other members of H Committee, members of the Inter-Departmental Ministerial Group on AIDS and to Sir Robert Armstrong.

Yours ever Norman -

NORMAN FOWLER

AIDS: NEED YOU WORRY ?

AIDS is a deadly disease. Not all the information about it has been entirely accurate, so many people are confused about who is at risk, how the disease is spread and how dangerous it is.

Please read this carefully. It is up-to-date and authoritative. Only if the facts about AIDS are understood can we hope to control its spread and prevent unnecessary suffering and death.

Sir ~~Dr~~ Donald Acheson

Dr Iain S MacDonald

Dr G Crompton

Dr R J Weir

Chief Medical Officers to the Health Departments of the United Kingdom

WHAT IS AIDS?

AIDS stands for Acquired Immune Deficiency Syndrome. It is caused by a virus that attacks the body's natural defence system.

However, Not everyone who carries the virus has developed AIDS itself. In fact most have not. But anyone who has the virus can pass it on, even if they feel and look completely well.

It is vital for everyone to avoid catching the virus, as there is still no known cure for AIDS.

HOW IS AIDS SPREAD?

If you and the people close to you are to keep yourselves free from AIDS, it is important that you know how the virus is spread.

The only likely way for someone to catch the AIDS virus is for the blood or semen from an infected person to get inside his/or her body.

Most people who have the AIDS virus caught it by having sex with an infected person. Almost all the rest have caught it by injecting themselves with drugs using equipment shared with an infected person.

YOU DON'T NEED TO WORRY ABOUT AN INFECTED PERSON GIVING YOU AIDS FROM:

Normal social contact such as shaking hands, touching and hugging.

Swimming pools, restaurants and other public places.

Coughs, sneezes and spitting.

Clothing.

Toilet seats, door knobs, food, glasses and cups.

NOR SHOULD YOU WORRY ABOUT CATCHING AIDS FROM:

Being a blood donor

Having a blood transfusion

Having injections or any other treatment from your doctor, dentist or other health care worker.

WHEN SHOULD PEOPLE BE WORRIED?

Sex with an infected person is always risky. People may not know they are infected so casual sex is risky. And the more partners, especially male partners, someone has, the more likely they are to have sex with an infected person. Sexual acts with infected people that may damage the anus, penis, mouth or vagina are extremely risky. Anal sex involves the highest risk and should be avoided.

Using a sheath can help reduce the risk of catching AIDS.

So can cutting out casual relationships.

For people who inject drugs and cannot give it up, it is very important never to share needles or other equipment. Just one injection with an infected needle could mean catching the virus. Of course the best advice is not to inject at all.

Remember AIDS is not a disease to take risks with. There is no cure, so its control must depend on how people behave.

MORE INFORMATION

For a free booklet on AIDS, write to Dept A, P.O.Box 100, Milton Keynes MK1 1TX. You can also get information on the confidential Healthline telephone service on: 01 981 2717, 01 981 7222 or 0345 581151. If you are calling from outside London, use the 0345 number and you will be charged at local rates.

DON'T AID AIDS

Issued by the Department of Health and Social Security.

NATIONAL
HEALTH

AIDS

8/85

SPD1BM13

cc BS

DEPARTMENT OF EDUCATION AND SCIENCE

ELIZABETH HOUSE YORK ROAD LONDON SE1 7PH
TELEPHONE 01-934 9000

FROM THE SECRETARY OF STATE

The Rt Hon Norman Fowler MP
Secretary of State for Social Services
Alexander Fleming House
Elephant and Castle
LONDON SE1 6BY

9 July 1986

NBPM

Dear Norman.

Thank you for copying to me your letter of ~~24~~ 27th June concerning the AIDS Campaign.

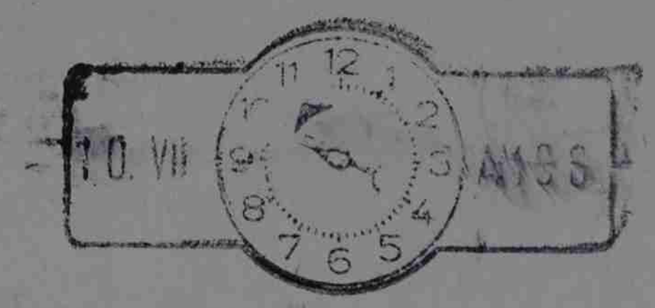
It was useful to be brought up to date on the campaign so far, and to hear what you have in mind regarding a further round of advertising.

I have no detailed comments to make on your draft: I support the use of shorter text and simpler language.

I am copying this letter to the Prime Minister, other members of H Committee, members of the Inter-Departmental Ministerial Group on AIDS, and to Sir Robert Armstrong.

Yours
Kenneth

NAT HEALTH : AIDS Aug 85



Y SWYDDFA GYMREIG
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-233 3000 (Switsfwrdd)
01-233 6106 (Llinell Union)

Oddi wrth Ysgrifennydd Gwladol Cymru

The Rt Hon Nicholas Edwards MP

WELSH OFFICE
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-233 3000 (Switchboard)
01-233 6106 (Direct Line)

From The Secretary of State for Wales

8 July 1986

AIDS CAMPAIGN

I have seen Norman Fowler's letter of 24 June 1986 and the draft wording he proposes to use in the next round of newspaper advertisements.

I am disappointed that the DHSS had not consulted other Health Departments more widely prior to putting proposals to Ministers. I understand, however, that discussions are now belatedly taking place at official level with a view to resolving outstanding difficulties. That caveat entered, I do believe that advertising should resume without delay. I also hope that the campaign will be discussed by the Ministerial Group on AIDS.

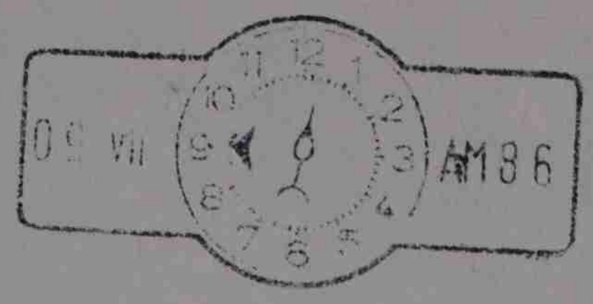
I am copying this letter to the Prime Minister and to Norman Fowler, the other members of H Committee, the members of the Inter-Departmental Ministerial Group on AIDS and to Sir Robert Armstrong.

The Rt Hon Viscount Whitelaw CH MC
Lord President of the Council
Privy Council Office
68 Whitehall
LONDON
SW1A 2AT

NAT HEALTH

AIDS

8/85



P.R.

1

PRIME MINISTER

AIDS

DHSS Private Office have told me that they want to add the following sentence to the material on AIDS which you saw the other day. The sentence reads, "Anal sex (rectal intercourse) carries the highest risk and should be avoided." and it would be included in the paragraph at flag "When Should People Be Worried?".

This addition, which has been endorsed by Mr. Fowler, follows representations from the Chief Medical Officer that the phrase "anal sex (rectal intercourse) carries the highest risk and should be avoided" is essential to convey the meaning. The words "rectal intercourse" are, according to the Department, not sufficiently understood.

Agree to this addition?

NLW

30 June 1986

FROM:
THE RT. HON. LORD HAILSHAM OF ST. MARYLEBONE, C.H., F.R.S., D.C.L.

HOUSE OF LORDS,
LONDON SW1A 0PW

CCRG

The Right Honourable
The Viscount Whitelaw, CH., MC.,
Lord President of the Council,
Privy Council Office,
Whitehall,
London, SW1A 2AT.

27 June 1986

My dear Willie.

AIDS CAMPAIGN

I have read Norman Fowler's letter of 24th June 1986 and the draft he envisages.

Whilst I share his view that the further round of national advertising should be much on the lines of the last round, but with shorter text and simpler language, I am convinced that there must be some limit to vulgarity* Could they not use the literate "sexual intercourse"? If that is thought to be too narrow then why not "sexual relations" or "physical sexual practices", but not "sex" or, still worse, "having sex".!!!

I am copying this letter to the Prime Minister and to Norman Fowler, the other members of H Committee, the members of the Inter-Departmental Ministerial Group on Aids and to Sir Robert Armstrong.

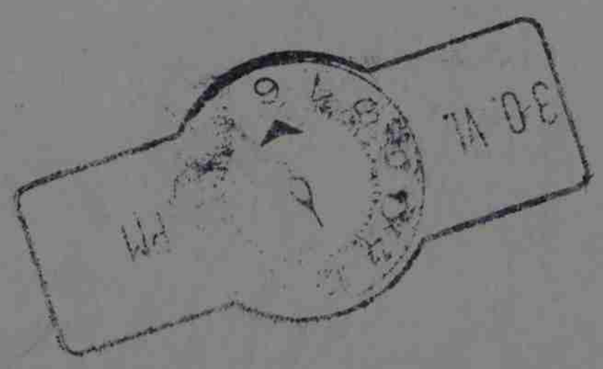
Yrs:

* and illiteracy. "Sex" means that you are either male or female. It does not mean the same thing as sexual practices. Nor does "having sex" mean anything at all.

NAT HEALTH

AIDS

8/85



Nick
I have submitted
in box.

N

AIDS

10 DOWNING STREET

Nigel.

DHSS plan a continuation of the campaign. The draft text attached seems to follow the earlier pattern quite closely and looks unobjectionable.

I suspect, however, this report on the evaluation of the first campaign conceals the fact that it was largely a flop. I hope the layout of the rerun can be clearer and snappier.

MEA 25/6

VM0046P

NEA.
to see
F.

DEPARTMENT OF HEALTH & SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

Prime Minister

The text looks unobjectionable!

24 June 1986

N. L. W.
25.6

The Rt Hon the Viscount Whitelaw CH MC
Lord President of the Council
Privy Council Office
68 Whitehall
LONDON
SW1A 2AT

Dear Willie.

AIDS CAMPAIGN

You will recall that in March we launched a national advertising campaign aimed at the general public. Advertisements were placed in all national Sunday and daily newspapers on 16 and 17 March and again on 6 and 7 April. This followed H Committee consultation on the draft wording. The intention was to dispel unwarranted fears about AIDS, and to highlight how AIDS could be caught.

Evaluation of the public reaction to the advertisements has shown that it was successful in getting over a greater number of messages than are usual in advertising; that public interest in AIDS is considerable and that people generally approve and are receptive to Government action of this kind. Few appeared to find the material offensive and there was strong support for the need for explicit language so that people understood the dangers. The evaluation also suggested that further advertising would be more effective if it were shorter and the language simpler.

We have now also received detailed research reports on attitude testing on AIDS and related matters. There is a wealth of findings here that we will want to take into account in taking forward our publicity campaign over the longer term. But meanwhile I am anxious not to lose momentum in the campaign for the general public and propose that we should have a further round of national advertising as soon as possible. This should be much on the lines of the last round, but taking on board the need to have shorter text and simpler language.

E.R.

I enclose a draft on the lines we envisage. It quite deliberately does not break ground at this stage in terms of sexually explicit wording. There may be some minor adjustments to the final text and its presentation in the light of informal consultations now in hand with the Chief Medical Officer's Expert Advisory Group and the campaign agents. I will see that copies of the final text are circulated to colleagues with details of when they will appear. Meanwhile I thought you would like to have this brief report on the campaign so far and of the intention to resume advertising. At present the earliest date for placing the advertisements would be Sunday 6 July.

I am sending copies of this letter to the Prime Minister, other members of H Committee, and members of the Inter-Departmental Ministerial Group on Aids, and to Sir Robert Armstrong.

Yours ever.

NORMAN FOWLER

AIDS - NEED YOU WORRY?

WHAT IS AIDS?

AIDS stands for Acquired Immune Deficiency Syndrome. It is caused by a virus that attacks the body's natural defence system. Not everyone who carries the virus develops AIDS. But anyone who has the virus can pass it on, even if they feel and look completely well. There is no cure for AIDS so it is very important not to catch the virus.

HOW IS AIDS SPREAD?

The only way someone is likely to catch the AIDS virus is for blood and semen from an infected person to get inside their body. Most people who have the AIDS virus have caught it by having sex with an infected person. Almost all the rest have caught the virus by injecting with equipment shared with an infected drug addict. It is important people know how the virus is spread, if they are to keep themselves safe from AIDS.

YOU DO NOT NEED TO WORRY ABOUT AN INFECTED PERSON GIVING YOU AIDS FROM:

Contacts such as shaking hands, touching, hugging

Swimming pools, restaurants and other public places

Coughs, sneezes or spitting

Clothing

Toilet seats, door knobs, food, glasses or cups

AND YOU DON'T NEED TO WORRY ABOUT

Having injections or other treatment from your doctor or dentist

Being a blood donor

Having a blood transfusion

WHEN SHOULD PEOPLE BE WORRIED?

Any sex with infected persons is risky and they may not always know they have the virus. The more partners - especially male partners - someone has, the more likely it is they will have sex with an infected person. Sexual acts which may damage the anus, penis, mouth or vagina are particularly risky. Using a sheath can help reduce the risk of AIDS. So can cutting down on casual relationships.

For those who inject drugs and cannot give up, it is very important not to share needles or other equipment. Just once with a needle that carries the virus could mean catching AIDS. Best of all, don't inject.

Remember there is no cure, so the only way to control this disease is <u>not to take risks.</u> So control depends on how people behave.

MORE INFORMATION

For a free booklet on AIDS, write to Dept A, P.O.Box 100, Milton Keynes MK1 1TX. You can also get information on the confidential Healthline telephone service on: 01 981 2717, 01 981 7222 or 0345 581151. If you are calling from outside London, use the 0345 number and you will be charged at local rates.

DON'T AID AIDS

Issued by the Department of Health and Social Security.

Mark

Lancet article as requested.

Jane.

DHSS

With the Compliments of
the Private Secretary to
the Secretary of State

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Alexander Fleming House
Elephant and Castle
London, SE1 6BY

Prime Minister (2)
This is the AIDS article in the Lancet you said you would like to see. MEA 21/3

disorders developed in 1 in 28. Nevertheless, the possibility of individual misclassification remains and could be resolved only by a review of all 1979 smears.

Further confirmatory evidence comes from the histology reports on the 19 women who had a biopsy within 6 months of the smear. Not all pathologists routinely reported evidence of HPV infection on biopsy specimens, but 13 of 19 (68%) were reported as showing evidence of wart virus infection, and no pathologist specifically commented that there was no evidence of wart virus infection. Only 4 of the 19 samples showed evidence of mild dysplasia. The mild dysplasia may have been missed at the time of the cytology report, but it is also possible that in some subjects it may have developed subsequently.

The number of cases of carcinoma-in-situ in this cohort might have been even greater had not 33 women undergone cervical biopsy and cautery when the histological diagnosis was dysplasia. This procedure may modify the natural history of exposure to wart virus infection. In addition 174 of 846 women (21%) had not had a smear for more than 4 years and carcinoma-in-situ might have developed in some of these women.

In the South Australian Central Cancer Registry the ratio between incidence rates for in-situ and invasive carcinoma of the cervix is 2·9. This ratio is comparable to published data from the United States,[10,11] but a little lower than that for the UK.[12] Nevertheless, the in-situ incidence rates for South Australia probably under-represent the true population rates, since even today 60–80 cases per year are notified to the Registry at an invasive stage.

This study determined a very highly significant relative risk of 15·6 for the development of cervical cancer after cytological evidence of HPV infection, derived from 30 observed cases and 1·9 expected cases. For reasons outlined above we believe both these figures may be underestimates, but 20 expected cases would be needed for the relative risk to remain significant at $p<0·05$.[8] It is unlikely that the incidence figures for the general population are inaccurate to the extent of a 10-fold under-representation.

Because the data used here were routinely collected by the VCGS, information on some potential confounding variables is not available. However, the degree of risk is much larger than that which confounding would normally induce.

Since 1979 was the first year when wart virus infection was commented on cytologically, we do not know how long this infection may have been present. Before 1979 cytological abnormalities subsequently attributed to HPV infection were likely to have been reported as mild dysplasia. All subjects with a previous report of dysplasia were excluded from the study, and in 1979 dysplasia was not considered to be evident on the smears of the members of the cohort. The follow-up period may be short, but the number of cases of carcinoma-in-situ is large.

The trend shown for an increased relative risk with younger age groups is important. Further research is needed to ascertain the interaction of this risk factor with other established risk factors, such as smoking[13–15] and use of the oral contraceptive.[16] Identifying such a high-risk population may have important implications for screening policies.

We thank Dr Graham Giles and the staff of the Victorian Cancer Registry for helpful assistance.

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References at foot of next column

ADMINISTRATION OF 3′-AZIDO-3′-DEOXYTHYMIDINE, AN INHIBITOR OF HTLV-III/LAV REPLICATION, TO PATIENTS WITH AIDS OR AIDS-RELATED COMPLEX

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Summary In a 6-week clinical trial 4 dose regimens of 3′-azido-3′-deoxythymidine (AZT), a thymidine analogue with potent anti-viral activity against HTLV-III in vitro, were examined in 19 patients with the acquired immunodeficiency syndrome (AIDS) or AIDS-related complex (ARC). AZT was given intravenously for 2 weeks, then orally for 4 weeks at twice the intravenous dose. AZT was well absorbed from the gut and crossed the blood-brain barrier. Therapeutic levels were maintained with 5 mg given intravenously or 10 mg given orally every 4 h. Treatment was not limited by side-effects, the commonest of which were headaches and depression of white-cell counts. 15 of the 19 patients had increases in their numbers of circulating helper-inducer T lymphocytes ($p<0·001$) during therapy, 6 who were anergic at entry showed positive delayed type hypersensitivity skin test reactions during treatment, 2

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had clearance of chronic fungal nailbed infections without specific anti-fungal therapy, 6 had other evidence of clinical improvement, and the group as a whole had a weight gain of 2·2 kg. Also, with the highest dose regimen cultures of peripheral blood mononuclear cells for HTLV III became negative.

Introduction

3′-azido-3′-deoxythymidine (AZT), a drug not previously given to man, is a potent inhibitor of the in-vitro replication and cytopathic effect of HTLV-III/LAV.[1] This drug is a thymidine analogue in which the 3′-hydroxy (-OH) group is replaced by an azido ($-N_3$) group (fig 1). AZT is converted to a triphosphate form by cellular enzymes and this triphosphate form is utilised by retroviral DNA polymerase (reverse transcriptase).[2,3] The 3′ substitution makes subsequent 5′→3′ phosphodiester linkages impossible (AZT can thus act as a chain terminator of DNA synthesis). Cellular DNA polymerase alpha is 100 times less susceptible to inhibition by AZT-triphosphate than is HTLV-III reverse transcriptase[2,3]

TABLE I—CLINICAL AND VIROLOGICAL FEATURES OF PATIENTS RECEIVING AZT

Patient no and diagnosis	Symptoms and findings at entry	Drug toxicity	Clinical course during therapy	Weight change (kg)	HTLV-III isolation*
1 mg/kg IV, then 2 mg/kg PO every 8 h					
1. AIDS—post-PCP	Weight loss, fevers, diarrhoea	None	Fevers ceased, then returned Diarrhoea improved Megaloblastic anaemia with B_{12} malabsorption diagnosed Platelets increased from 164 000 to 477 000/μl	+4·4	Virus detected while on IV therapy, but not at end of oral
2. AIDS—KS	Fevers, progressive visceral KS	Slight headache	Visceral KS progressed; taken off protocol	+0·8	Virus detected sporadically
3. ARC	Lymphadenopathy, oral candida	Slight headache	No clinical change	−0·6	Decreased virus during initial AZT administration
4. AIDS—post-PCP	Slight oral candida (on oral 'Nystatin')	Abdominal discomfort	Stopped nystatin; oral candidiasis did not recur	+3·6	Virus not detected on day 0 or on AZT
2·5 mg/kg IV, then 5 mg/kg PO every 8 h					
5. ARC	Fevers, weight loss, night sweats	None	Increased sense of well-being Localised herpes zoster; treated with acyclovir	+2·7	Low levels of virus detected early, then negative
6. AIDS—post-PCP	Weight loss, oral candidiasis, fevers	None	Episode of sinusitis Fevers decreased	+3·2	Virus detected throughout
7. ARC	Oral candidiasis, night sweats, fevers	None	Transient febrile episode	+7·2	Virus detected throughout
8. ARC	Peripheral neuropathy, oral candidiasis, malaise	Slight headache	Improved sense of well-being Increased exercise tolerance	+0·7	Virus detected throughout
9. ARC	Oral candidiasis, fevers	None	Fevers decreased Increased ability to concentrate	+0·4	Virus detected throughout
10. AIDS—post-PCP	Malaise	Slight headache	No clinical change	+5·2	Low level of virus at entry, then virus not detectable
2·5 mg/kg IV, then 5 mg/kg PO every 4 h					
11. AIDS—post-PCP	Weight loss, fatigue Appetite loss Severe aphthous ulcers Onychomycosis	Headache	Improved appetite and energy Aphthous ulcers cleared Onychomycosis clearing	+3·6	Virus detected sporadically
12. AIDS—post-PCP	Malaise	Tremors† Headache Confusion Neutropenia Anaemia	Upper lobe pneumonia developed during therapy, treated with trimethoprim/sulphamethoxazole erythromycin; taken off protocol.	−0·9	Not available
13. ARC	Fevers Lymphadenopathy	None	No clinical change	0·0	Virus detected sporadically
14. ARC	Oral candidiasis	None	No clinical change	+4·7	Virus detected sporadically
15. AIDS—KS & post-PCP	Oral candidiasis Onychomycosis	Slight headache	Onychomycosis clearing, KS lesions unchanged	+3·8	Virus detected during first 2 weeks, but not after
5 mg/kg IV, then 10 mg/kg PO every 4 h					
16. ARC	Weight loss Lymphadenopathy Night sweats	Decreased WBC (8700–2600)	Night sweats cleared Oral candidiasis developed	+12·0	Virus detected on day 0 and day 7, but not after
17. AIDS—KS	Cutaneous KS	Slight headache	KS lesions increased	+4·1	Virus not detected on day 0 or on AZT
18. AIDS—KS	Cutaneous KS Oral candidiasis Fevers Lymphadenopathy	Headache Decreased WBC (4000–2300)	Became afebrile 2 new KS lesions appeared	+4·8	Virus detectable on day 0, but not on AZT
19. AIDS—KS	KS	None	No clinical change	+2·8	Virus not detected on day 0 or on AZT

IV = intravenously; PO = orally.
*HTLV-isolation in lectin-stimulated primary cultures of peripheral blood lymphocytes.
†While receiving trimethoprim/sulphamethoxazole for upper lobe pneumonia he had tremors, slight mental confusion, a decrease in haemocrit (from 27·3 on admission to 21·6), and neutropenia (from 2200 on admission to 900), all of which resolved on discontinuation of the three drugs.

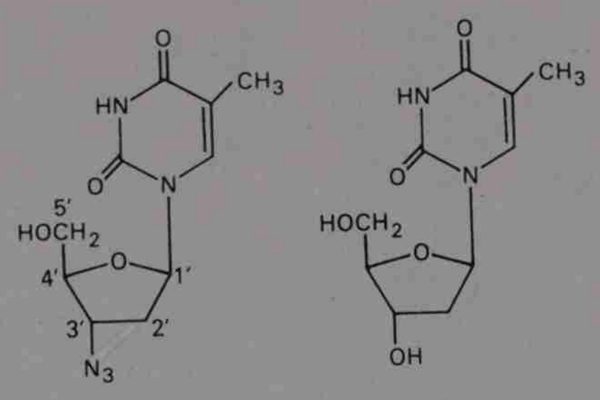

Fig 1—Structures of 3′-azido-3′-deoxythymidine (left) and thymidine (right).

(and Furman PA, personal communication), and this difference may account for the selective antiviral activity of AZT against HTLV-III. AZT exhibits little toxicity in animals even at doses beyond 80 mg/kg/day (Ayers K, personal communication). We have explored the feasibility of giving AZT to patients with HTLV-III/LAV infection.

Materials and Methods

Patients

19 patients with HTLV-III infection (18 males and 1 female) were entered into the study (table I). Of the 11 AIDS patients 6 had a history of *Pneumocystis carinii* pneumonia (PCP), 4 had Kaposi's sarcoma (KS), and 1 had both PCP and KS. Each of the 8 patients with ARC had either weight loss or oral candidiasis. All 8 had decreased numbers of helper T cells (Leu 3^+ or $OKT4^+$ cells). In addition, 3 of the ARC patients had fever, 3 had lymphadenopathy, and 1 had peripheral neuropathy attributed to HTLV-III infection. Patient 6 was a haemophiliac and patient 11 had received several units of blood; the other patients were either homosexual or had had sexual contact with prostitutes. Each of the subjects had circulating antibodies to HTLV-III detectable by enzyme-linked immunosorbent assay (ELISA) and/or western blot, and each had had HTLV-III isolated by primary culture of lectin-activated peripheral blood lymphocytes (see below). Patients 1, 2, 4, 5, 8, 10, 11, 12, 15, 17, and 19 were treated at the Warren G. Magnuson Clinical Center of the National Institutes of Health and the rest at Duke University Medical Center; the protocols were approved by the respective institutional review boards. Each subject gave informed consent for the study.

Drug Regimens and Monitoring of Patients

AZT was synthesised according to a modification of the method described by Lin and Prusoff.[4] All patients received test doses of AZT. They were then given AZT intravenously for 14 days according to the following regimens: 1 mg/kg every 8 h for patients 1–4 (regimen A), 2·5 mg/kg every 8 h for patients 5–10 (regimen B), 2·5 mg/kg every 4 h for patients 11–15 (regimen C), and 5 mg/kg every 4 h for patients 16–19 (regimen D). Each dose was administered over a period of 1 h. Patients 1, 2, 3, and 12 received additional intravenous doses for another 7–14 days. Except for patients 2 and 12 who were withdrawn from the study (see below), the patients next received 4 weeks of oral therapy at twice the intravenous dose. Patients were closely monitored for clinical and laboratory changes. They also underwent skin testing for delayed type hypersensitivity at entry, at the end of the intravenous course, and at the end of the oral course of AZT. The antigens used were 0·1 ml of candida extract (Hollister-Stier, Elkhart, New York; 1/100 dilution), intermediate strength (5 TU) purified protein derivative (PPD) (Connaught Labs, Willowdale, Ontario), tetanus toxoid (Lederle Labs, Pearl River, New York; 10 LF/ml), and trichophyton extract (Hollister-Stier; 1/30 dilution). Lymphocyte subsets reacting to Leu 3 or OKT4 (helper-inducer) or to Leu 2 or OKT8 (suppressor-cytotoxic) were analysed by flow cytometry. Patient 19 was monitored for his ability to manifest a secondary in-vitro

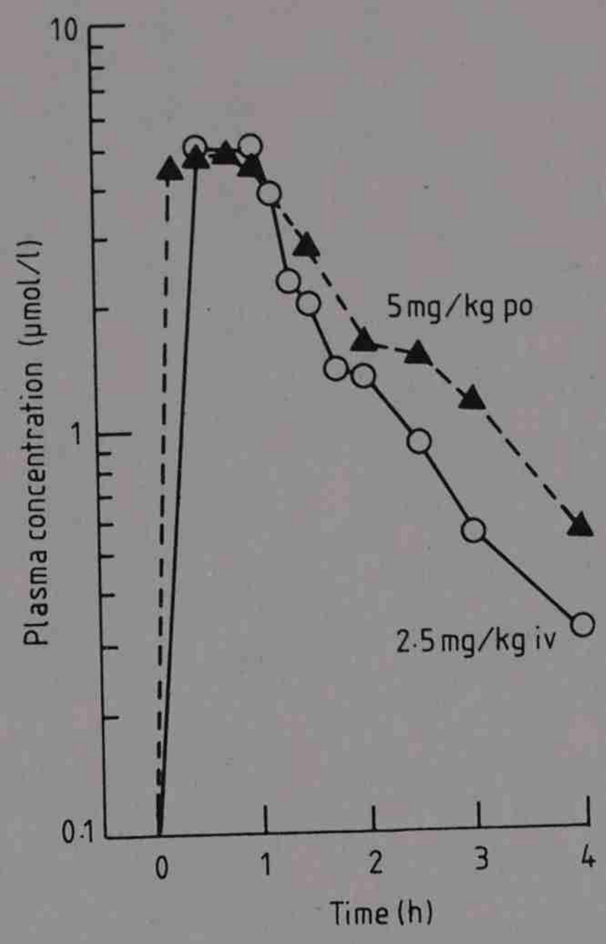

Fig 2—Plasma concentrations of AZT in patient 5 after 2·5 mg/kg of AZT had been infused intravenously over one hour (○) or after 5 mg/kg orally (▲).

histocompatibility locus-restricted cytotoxic response against influenza-virus-infected autologous lymphocytes as previously described.[5]

Heparinised plasma samples were obtained at various times after intravenous or oral doses of AZT for measurement of AZT levels according to a modification of a procedure recently described for measuring another nucleoside analogue, tiazofurin.[6] In brief, the beta isomer of azidothymidine was added as an internal standard to 0·5 ml plasma samples. The samples were then passed through C18 extraction and analytical columns and eluted isocratically; the mobile phase for analytical separation was pH 6·5 acetate in 23% methanol. The amount of AZT was measured by comparing ultraviolet absorption at several wavelengths (254, 267, and 280 nm) with that of a known standard; the lowest amount measurable was 0·1 μmol/l.

Peripheral blood mononuclear cells were cultured for HTLV-III as previously described[7,8] at entry to the study and periodically during treatment. Additional cells from the patients were co-cultivated with a clone of Jurkat known to be susceptible to infection by HTLV-III. Supernatant fluids were sampled twice a week for up to 42 days and assayed for the presence of precipitable reverse transcriptase activity by using $dT_{15} \cdot rA_n$ as the primer-template and Mg^{++} as the divalent cation.[7,8] In addition, the cells were periodically tested for expression of HTLV-III viral proteins by indirect immunofluorescence.

Statistical Analysis

Immunological variables before and after treatment were logarithmically transformed and compared by the use of the two-tailed Wilcoxon signed rank test for paired samples.

Results

Clinical Pharmacology

Figure 2 shows plasma concentrations of AZT in a representative patient (no 5) after an intravenous infusion of 2·5 mg/kg of AZT over 1 h and after an oral dose of 5 mg/kg mixed with 75 ml of orange juice. The plasma concentration reached a peak of approximately 5 μmol/l after the intravenous dose; plasma disappearance had a half-life of

approximately 1 h. A similar peak level of the drug was attained 1 h after an oral dose of 5 mg/kg; for this subject, the bioavailability of the oral dose (ratio of the area under the curve for the oral *vs* the intravenous dose, corrected for the dose) was approximately 60%. Because of the rapid clearance of this drug, we increased dose frequency to every 4 h for the last two dose regimens (C and D).

Analyses of plasma concentrations of AZT in other patients (nos 1, 2, 4, 8, 10, 11, 17, and 19) yielded peak values of 1·5 to 2 μmol/l after 1 mg/kg given intravenously or 2 mg/kg taken orally, of 4 to 6 μmol/l after 2·5 mg/kg given intravenously or 5 mg/kg given orally, and of 6 to 10 μmol/l after 5 mg/kg given intravenously or 10 mg/kg given orally. The average bio-availability of orally administered drug was 60% with little patient-to-patient variation. Finally, cerebrospinal fluid obtained from patient 19 by lumbar puncture 4 h after the start of an intravenous infusion of 5 mg/kg contained 0·86 μmol/l of AZT; a simultaneously obtained plasma sample contained 1·14 μmol/l of AZT.

Clinical Evaluation (Table I)

2 patients (nos 2 and 12) were withdrawn from the study, one because of advancing KS and the other of a possible drug reaction (see below); all the other patients completed at least 6 weeks of therapy. 9 of the 19 subjects complained of slight headaches and 1 of mild abdominal discomfort. Haematocrit levels dropped by 5–10% in several patients (this did not seem to be dose related), and by 10–20% in 3 (nos 1, 2, and 12). The pernicious anaemia in patient 1 was incidental and responded to intramuscular vitamin B_{12} injections. 1 of the patients on regimen C and 2 of the patients on regimen D had drops in their total white blood cell counts while on AZT. None had thrombocytopenia; 1 even had a progressive rise in platelet counts (table I). The side-effects that patient 12 seemed to have (table I) resolved after all drugs were withdrawn. We believe that they were due to the trimethoprim/sulphamethoxazole that he was taking for his pneumonia, but all the same he was taken off the protocol and is considered to be a case of possible drug toxicity. Otherwise, the patients tolerated AZT well, and none showed signs of renal, hepatic, or cardiac dysfunction that could be attributed to the drug.

5 of the patients had KS at entry into the study. 1 of them (patient 2), who was put on the lower dose regimen of AZT, had aggressive gastrointestinal and cutaneous KS before the study. During his 3 weeks on intravenous AZT, his KS lesions progressed and caused oesophageal pain. He was taken off the protocol and given cytotoxic anti-tumour drugs but he died 5 months later. In the other 4 patients with KS, the tumours enlarged in 2 and remained unchanged in the other 2.

Mild infections (localised herpes zoster, sinusitis, or oral candidiasis) developed in 3 of the patients who completed the protocol (nos 5, 6, and 16) and resolved with appropriate therapy, and a transient febrile episode developed in patient 7. In other patients chronic infections improved with AZT—chronic fungal nailbed infections in patients 11 and 15 cleared without specific therapy, as did debilitating ulcerative aphthous stomatitis in patient 11.

On average, patients gained 2·2 kg during the 6–8 weeks of therapy (table I). This weight gain was not associated with

TABLE II—IMMUNOLOGICAL CHANGES IN PATIENTS RECEIVING AZT

Patient no	Helper-inducer lymphocytes (/μl)*		Ratio of helper-inducer/ Suppressor-cytotoxic lymphocytes		Total lymphocytes (/μl)		Skin tests		
							Proportion positive		
	Pre	Post†	Pre	Post	Pre	Post	Pre	Post	Tests converting (mm)‡
1 mg/kg IV, then 2 mg/kg PO every 8 h									
1.	33	136	0·08	0·14	660	1944	0/4	1/4	PPD (23 mm)
2.	224	264	0·21	0·24	1728	2204	0/4	0/4	..
3.	296	264	0·42	0·37	1508	1764	1/4	1/4	..
4.	<10	<10	<0·02	0·02	378	580	1/4	1/4	..
GM(SEM)§	68(2·23)	99(2·18)	0·11(1·93)	0·13(1·90)	897(1·43)	1456(1·36)	..	..	..
2·5 mg/kg IV, then 5 mg/kg PO every 8 h									
5.	<10	109	0·03	0·26	403	1221	0/4	0/4	..
6.	<10	24	0·25	0·48	108	200	0/4	0/4	..
7.	38	102	0·05	0·16	1290	1088	0/4	1/4	Candida (12 mm)
8.	365	853	1·33	1·79	1015	1984	0/4	1/4	Tetanus (20 mm)
9.	75	118	0·30	0·17	984	1296	0/4	0/4	..
10.	19	91	0·05	0·09	972	1520	0/4	3/4	Candida (15 mm); PPD (20 mm); Tetanus (15 mm)
GM(SEM)	30(1·89)	116(1·59)	0·14(1·81)	0·29(1·54)	615(1·47)	1006(1·40)	..	..	
2·5 mg/kg IV, then 5 mg/kg PO every 4 h									
11.	12	70	0·05	0·17	594	696	0/4	0/4	..
12.	<10	34	0·03	0·54	396	168	0/4	0/4	..
13.	36	82	0·05	0·11	726	1020	0/4	0/4	..
14.	207	653	0·38	0·53	1161	2688	0/4	0/4	..
15.	31	69	0·04	0·08	1539	1386	0/4	1/4	Candida (20 mm)
GM(SEM)	31(1·71)	97(1·65)	0·06(1·57)	0·21(1·49)	789(1·27)	850(1·59)	..	..	..
5 mg/kg IV, then 10 mg/kg PO every 4 h									
16.	396	231	0·59	0·62	2175	1118	0/4	0/4	..
17.	475	295	0·97	0·43	1440	1476	2/4	2/4	..
18.	52	107	0·12	0·16	720	1334	0/4	0/4	..
19.	114	365	0·21	0·68	950	1218	0/4	1/4	Tetanus (14 mm)
GM(SEM)	183(1·69)	227(1·31)	0·35(1·61)	0·41(1·39)	1209(1·27)	1279(1·06)	..	..	..

*Normal range: helper-inducer lymphocytes, 540–1170/μl; ratio of helper-inducer/suppressor-cytotoxic lymphocytes, 0·75–2·5; total lymphocytes 1360–2310.
†Post treatment values are as at end of therapy, except in the case of skin tests. Skin test reactions were measured at the time of first conversion to positive.
‡Average induration at 48 h, measured in mm.
§ GM(SEM)—Geometric mean (standard error of the mean).

oedema or fluid retention but with increased appetite and waist size. Patient 8, who had peripheral neuropathy with weakness and dysaesthesia attributed to HTLV-III, noted considerable improvement in these symptoms while he was on AZT. Finally, 6 patients (nos 5, 6, 8, 9, 11, and 18) noted cessation of fevers or night sweats or marked improvement in their sense of well-being while they were on AZT. Patient 1 recently had PCP, which responded to pentamidine, patient 2 died from progressive visceral KS, patient 6 recently had cryptococcal meningitis, and patient 10 recently had herpes zoster (localised to a dermatome) and PCP, which responded to trimethoprim-sulphamethoxazole; otherwise the patients are alive and stable at the time of this report, 4–8 months after entry to the study.

Immunological and Virological Changes

There was no clear trend in the absolute lymphocyte counts or lymphocyte subsets in the patients receiving the lowest dose regimen (1 mg/kg intravenously; 2 mg/kg orally every 8 h) of AZT (table II). By contrast, 14 of the 15 patients receiving the higher three dose regimens had rises in their absolute numbers of helper-inducer T cells by the end of their course of intravenous AZT ($p<0\cdot001$ compared with numbers at entry) and 13 of the 15 had rises by the end of their course of oral therapy ($p<0\cdot001$ compared with numbers at entry) (table II; fig 3). With regimens B, C, or D the number of helper-inducer T cells rose by a mean 2·5 times. Of the entire group of 19 patients, 15 had increases in their helper-inducer T cells at the end of therapy ($p<0\cdot001$ mean 2·2-fold increase). There were also improvements in other immunological variables—15 patients had increases in their ratio of helper-inducer to suppressor-cytotoxic T cells ($p<0\cdot02$) and 15 patients had increases in their absolute lymphocyte count ($p<0\cdot02$).

Only 3 of the 19 patients had positive delayed type cutaneous hypersensitivity skin tests to at least one antigen upon entry; the other 16 patients were anergic (had no measurable reactivity to any of the four test antigens at 48 h). 6 of the 16 anergic patients gave positive skin tests (induration of 10 mm or greater present at 48 h) to at least one of the four test antigens during the course of treatment (table II and fig 3). Patient 1 showed a positive skin reaction of 5 TU PPD 2 weeks after starting on 1 mg/kg intravenously; 2 weeks later he reacted again to low strength (1 TU) PPD, but 6 weeks after completion of therapy, he was again anergic. Of the other anergic patients who gave positive skin reactions during treatment, 3 were on regimen B, 1 on regimen C, and 1 on regimen D. In addition, during therapy 1 anergic patient (patient 11) reacted with erythema but no induration to tetanus, and another (patient 13) with 8 mm induration to candida. All anergic patients who gave positive skin tests while on AZT also had increases in the number of circulating helper-inducer T lymphocytes.

The cytotoxic T-cell response to influenza-virus-infected autologous cells requires both helper-inducer T cells and cytotoxic effector T cells, and has been absent in each of 30 untreated AIDS patients tested so far[5] (and Shearer GM, unpublished). At entry, peripheral blood cells from patient 19 did not show a detectable cytotoxic response (0% cytotoxicity at 40:1 effector:target ratio). After 2 weeks of intravenous therapy, a response was detectable (11% cytotoxicity), and after the course of oral therapy it was in the normal range (38% cytotoxicity). Thus, the patient's increase in the number of helper-inducer T cells (from 114 to 365/μl) was accompanied by a restoration of cytotoxic effector function.

For most of the patients on regimens A–C, virus continued to be detected in cultures established during therapy but virus was not detected in cultures established from any of the 4 patients on regimen D after 2 weeks of therapy. In 2 of these patients (nos 16 and 18) virus cultures established at entry had been positive, which suggests that the failure to isolate virus was related to the administration of AZT. 1 patient (no 15) on regimen C also became virus negative while on AZT.

Discussion

The results of this study show that treatment of AIDS or ARC patients with 2 weeks of AZT intravenously (up to 30 mg/kg/day), followed by 4 weeks of AZT orally (up to 60 mg/kg/day), was not limited by toxicity, and that except for the depression of white blood counts, the side-effects did not appear to be dose related. On the highest dose regimen tested (regimen D), plasma drug levels were maintained above 1 μmol/l (a minimum level for an in-vitro antiviral effect) for 3

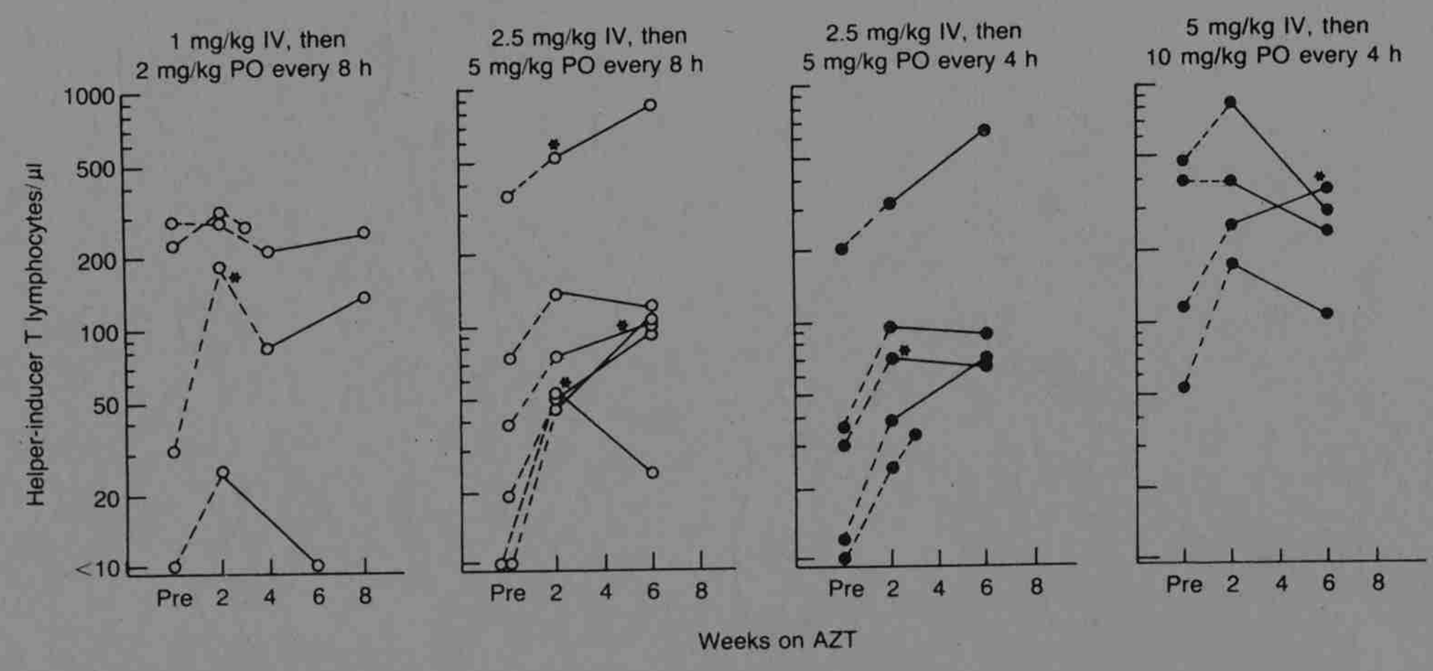

Fig 3—Absolute number of helper-inducer (Leu 3^+ 7 or 0KT4^+) lymphocytes in subjects receiving AZT.

Broken lines (- -) depict intravenous AZT and solid lines (—) oral AZT. Open circles (○) depict 8 hourly administration and closed circles (●) 4 hourly doses. Asterisks denote times when previously anergic patients first gave positive skin tests.

out of every 4 h. We also found that, administered orally, AZT is well absorbed. Moreover, AZT enters the cerebrospinal fluid, as has been shown in rhesus monkeys (Poplack D, personal communication). The ability of the drug to penetrate the cerebrospinal fluid is important because HTLV-III can infect the nervous system.[9–11]

The dual aim of our trial was to determine the safety and feasibility of administering a DNA-chain terminating thymidine analogue to patients with AIDS or ARC (ie, to do a phase I study). However, the results also suggest that at least some immunological reconstitution occurred in most of the patients (particularly those in the three highest dose regimens), and that a clinical response was obtained in some. In particular, 15 of the 19 patients had increases in numbers of their circulating helper-inducer T lymphocytes, 6 previously anergic patients gave positive skin test during treatment, and the 1 patient in whom it was tested showed restoration of a virus-specific cytotoxic T-cell response. Furthermore, 2 patients showed a clearing up of chronic fungal nailbed infections, 13 patients had weight gains of 2 kg or greater, and 6 patients had other clinical improvement.

We have to ask whether our findings were related to the administration of AZT or whether they were due to variable and spontaneous improvement. Moreover, entry into a clinical trial may have a strong placebo effect in influencing such factors as appetite and sense of well-being, and it is even possible that improved nutrition may then induce changes in immune function. Similar improvements, however, were not observed when suramin was given to patients with HTLV-III infection.[12] Another concern is that repeated skin testing may lead to an increase in the size of positive tests in normal persons.[13,14] This is unlikely to be responsible for all the observed skin test conversions since (1) positive reactions rarely develop in previously anergic individuals as a result of repeated skin testing, especially in the case of PPD;[13] (2) patient 1, who became a positive skin test reactor while on AZT, was anergic again 2 months after treatment; and (3) loss of anergy occurred only in patients who had increases in their numbers of helper-inducer T lymphocytes.

Although our findings suggest that AZT is virustatic at the highest dose examined, it should be recognised that only a small proportion of circulating cells in patients with ARC or AIDS express the HTLV-III virus[9] and that present technology does not permit precise measurement of the viral load, nor does it distinguish between cells bearing spontaneously replicating virus and cells producing virus only upon exogenous stimulation in vitro. Virus is more likely to be isolated from patients with ARC than from patients with fulminant AIDS and low numbers of helper-inducer T cells,[2] and constistent culture results are not always obtained on repeat testing of an individual patient. Moreover, recent studies suggest that HTLV-III can infect T cells,[15] EBV-infected B cells,[16] and macrophages (Popovic M, personal communication) without killing them. Viral isolation from patients who have improved in other ways with AZT may theoretically reflect the presence of such long-lived HTLV-III-infected cells. Thus, although our findings suggest that an antiviral effect was responsible for the improvement observed, one must be aware of the limitations in interpreting the viral cultures. Another possibility is that AZT reduces levels of a virus-related toxic lymphokine that is responsible for certain immunological and clinical abnormalities in AIDS at doses that do not completely suppress viral replication.

Although our findings suggest partial immunological reconstitution in certain patients given AZT, it must be stressed that the increases in numbers of helper-inducer T cells were often small and were most substantial during the first 2 weeks of intravenous therapy; we cannot be sure that starting with an oral course of therapy will yield similar results. Also, decreases in helper-inducer T cells or total white blood cells in 3 of the patients on the highest dose tested suggest that this dose may be lymphotoxic. Recent observations suggest that the accumulation of phosphorylated AZT within cells may cause a substantial depression of thymidine triphosphate (Balzarini J, Broder S, unpublished); long-term toxicity of AZT may theoretically be reduced by regimens designed to limit the depression of thymidine trisphosphate concentrations.

Thus, although the results of present study indicate that some of the patients treated with AZT improved over 6 weeks, we cannot say whether AZT can be tolerated over a long time, whether immunological improvements will be sustained, whether viral drug resistance will develop, or ultimately whether AZT will affect disease progression or survival in patients with HTLV-III-induced disease. These are issues which can be resolved only by appropriately controlled long-term studies.

We thank Mr L. Edward Kirk, Dr Joan Drucker, Ms Jean F. Jenkins, Ms Rose V. Thomas, Ms Susan Tapson, Dr Jerome F. Groopman, Dr Robert R. Redfield, Dr Michael S. Gottlieb, Dr Annette E. Maluish, Mr Roy Overton, Mr Keith Veren, Mr Atul Patel, Dr Robert W. Makush, and the clinical staffs of the National Cancer Institute and Duke University Medical Center for their help.

Correspondence should be addressed to R. Y., Clinical Oncology Program, Bldg 10, Rm 6B15, National Institute of Health, Bethesda, Maryland 20892, USA.

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CONFIDENTIAL

10 DOWNING STREET

From the Principal Private Secretary

11 March 1986

AIDS

The Prime Minister has seen your Secretary of State's minute of 10 March in which he offers two suggestions for amending the part of the advertisement on AIDS which refers to risky sex.

In the light of your Secretary of State's further advice, the Prime Minister agrees that the advertisement should be published this coming weekend, amended in the two ways which your Secretary of State suggests in his 5th paragraph.

I am sending a copy of this letter to the Private Secretaries to the Lord President, the Secretary of State for Wales, The Secretary of State for Northern Ireland and the Secretary of State for Scotland.

N. L. WICKS

Tony Laurance, Esq.,
Department of Health and Social Security.

PRIME MINISTER

AIDS

Mr. Fowler's office tells me that the minute below follows a long meeting this morning between Mr. Fowler, Mr. Hayhoe, Baroness Trumpington, Ken Stowe and the Chief Medical Officer, at which they concluded, after much agonising that the proposed advertisement would lose much of its effect if the passage of "risky sex" was omitted. Mr. Fowler has therefore proposed some (quite small) amendments, which I have marked up on the original draft in the H Committee paper below. Mr. Fowler wants the advertisement to appear in the newspapers next weekend for which space has already been booked.

Are you content with the draft advertisement, as amended?

N.L.W.

Yes - Thanks so much

(N. L. WICKS)
10 March 1986

PRIME MINISTER

AIDS

I have seen your Private Secretary's letter of 6 March setting out your continuing reservations about the proposed AIDS advertisements.

I recognise that some of the material in the proposed advertisements might shock some people. Indeed, the Chief Medical Officers' introduction admits as much. But the advertisements are intended to deal with a grave and unprecedented problem involving a potentially lethal infection which is already spreading outside the original high risk groups to women and children. Given that there is no vaccine and no cure the only option open is public eduation.

Because the problem is urgent I have been pressing ahead with the arrangements for putting the first advertisements into the Sunday Press on 16 March. I have done so with the unanimous support of H Committee, both as to the urgency and as to the use of explicit references to sexual practices which, the Committee agreed, are a regrettable necessity. This is a conclusion which other countries have had to face. I am enclosing a copy of an advertisement from the New Zealand Government which appeared in their press in August 1985. You will see that it is more explicit than the language H accepted.

But I have considered, in the light of your anxieties, how our advertisements might be modified. I have to say that our room for manoeuvre is small. For example, unless there is a reference to anal intercourse, which has been linked with 85 per cent of AIDS cases so far, the advertisement would lose all its medical authority and credibility. Not only should we be criticised for dodging the issue, but it is certain that the media would start to ferret out what the advertisements had lost along the way and why. No one is

E.R.

condoning these practices - quite the contrary; but they exist and are one of the ways by which AIDS spreads. Unless they are checked - through knowledge of their consequences - the spread into the population at large will accelerate.

Having said that, I have two suggestions to offer about that part of the advertisements which refers to risky sex. First, we could substitute for the sentence about anal intercourse the following - "Rectal sex involves the highest risk and should be avoided." Second, we could delete the word "Obviously" from the next sentence, to make the message more clinical.

These are changes in style only, I know, but 'H' Committee saw no scope for avoiding the concepts with which the sentence in question must deal. We cannot now decline to advertise, nor do so in terms which would fail to convey the essential message about this serious disease. To do so would be to jeopardise the public health unnecessarily, and there would be many who would bring that charge home. I shall, of course, insist that after the first two advertisements there should be a pause for proper evaluation of their effects.

But subject to the suggestions I have made, which I hope you find helpful, I see no alternative to proceeding with publication this coming weekend.

I am copying this minute to Willie Whitelaw, Nicholas Edwards, Tom King and Malcolm Rifkind.

10 March 1986

N F

AIDS

HOW TO KEEP YOURSELF SAFE

We realise that some people will find some of the details in this article offensive. However, it was considered necessary to include this information in the interests of public health.

By now you will have heard a lot about AIDS on radio or TV, in newspapers and magazines. You probably know the basic facts about AIDS:

- *It is a very serious disease.*
- *It is caused by a virus which can be passed on from one person to another.*
- *There is at present no cure.*
- *There is at present no vaccine to immunise people against it.*
- *Thousands of people throughout the world have already died from it.*

But there may still be some things that you are confused about. This article gives you the most reliable and up-to-date information about AIDS. There is still a great deal that we do not yet know. But we do know enough to give you sensible guidelines for protecting yourself and others from AIDS.

Please read this information. It could save your life.

YOU ARE RIGHT TO BE CONCERNED ABOUT AIDS

AIDS can be spread from one person to another. Anyone, not just homosexual men, can get it. People who seem perfectly healthy can spread it. So you are right to be concerned.

It is important to remember that AIDS is spread only in certain limited ways. It is now much clearer what these are.

AIDS IS NOT SPREAD THROUGH ORDINARY DAY-TO-DAY CONTACT WITH OTHER PEOPLE

You cannot get AIDS from just being near someone who has it.

When people have AIDS, the virus which causes it is found in their blood and semen. To become infected yourself, this blood or semen has to get into your body — not just on the skin, but into your bloodstream through an open cut, sore, graze, or other break in the skin. This will not happen through ordinary day-to-day contact with other people.

- *It is still as safe as it ever was to meet and talk with other people, hug them, shake hands with them, be with them at work or school.*
- *There is no evidence that AIDS can be spread by talking to people, social kissing, sharing cups and glasses, and so on.*

It is true that the AIDS virus has been found in small quantities in saliva. But it is only possible for it to be spread through very close contact with someone else's saliva — as in sexual (wet) kissing.

YOU CANNOT GET AIDS FROM THINGS TOUCHED BY A PERSON WHO HAS AIDS

The AIDS virus lives only a short time outside the human body.

No-one has ever caught AIDS from toilet seats, door knobs, second-hand clothes, or badly-washed cups, forks, spoons, or other such things. It is still as safe as it ever was to use public toilets, eat in restaurants, and so on.

BLOOD TRANSFUSIONS ARE SAFE

All blood given by blood donors in New Zealand is tested for AIDS. The risk of getting AIDS from a blood transfusion is now very remote.

*Remember, you will only be offered a blood transfusion if it is really necessary. The risk to your life from not having the transfusion would be much greater than any risk of getting AIDS from the blood. **DONATING BLOOD IS NOT AND NEVER HAS BEEN DANGEROUS.***

AIDS CAN BE SPREAD IN TWO MAIN WAYS

- *Through sexual contact.*
  The AIDS virus is carried in the blood and semen of a person who has the infectious disease. It can be spread when these fluids come into direct contact with the bloodstream of a healthy person, for example, through an open cut, sore, or graze. This can happen during sex.
- *If infected blood gets directly into a person's bloodstream.*
  This can happen when drug addicts who inject drugs share needles or syringes. Blood from one person is passed on to another in the needle or syringe.

There may be other times when a person could come into direct contact with another person's blood, and it could get into his or her bloodstream. These situations are rare and the risk is very small.

KNOW YOUR RISK

Most New Zealanders are not drug addicts who inject drugs. So for most of us, the only chance of coming in contact with the AIDS virus is through sexual contact.

You have almost no risk of coming in contact with the AIDS virus if you:

- *Have no sexual partners.*
- *Are in a stable relationship and both you and your partner are completely faithful.*

If you are not in either of these groups, you may have some risk of coming in contact with the AIDS virus and should read and follow the guidelines in the next section.

HOW YOU CAN AVOID AIDS

AIDS is not easy to catch. But it can be spread by people who seem perfectly healthy. It is up to you to make sure you do not put yourself at risk.

Safer Sex

- *You are safest if you are in a stable relationship and both you and your partner do not have sex with anyone else.*
- *If you have one partner, you share his or her risks. Talk it over.*
- *Sex with more than one partner puts you at risk — and endangers others. The fewer sexual partners you have the less risk there is. It's as simple as that.*
- *Casual sex is always a risk — get to know your partner.*
- *Having sex with a prostitute, bisexual or homosexual man, or a drug addict who injects drugs can be especially risky.*
  AIDS is more common among these groups.
- ***Use a condom — this will reduce the risk of getting AIDS and other diseases.***
- *Wet kissing may be risky.*
- *Semen in the mouth is risky.*
- *Anal intercourse is very risky for men and women and should be avoided.*

Pamphlets explaining in more detail the risk involved in different sexual practices are available. (See the "More information" section).

WHAT YOU CAN DO

- *LEARN ABOUT AIDS. Reading this is a good first step. If you have any questions or want to learn more see the "More information" section.*
- *BE AWARE OF THE RISKS as outlined on this page. Use common sense. Be safe: when in doubt, don't.*
- *AVOID RISKY SITUATIONS. This may mean changing your way of life, which may not be easy. On the other hand getting AIDS will certainly change your life.*
- *TALK ABOUT AIDS. The more people that are aware of the problem, the more chance there is of controlling AIDS. Fear, secrecy and blame do not help. Remember, the problem of AIDS affects everyone. It is something everyone should know about.*
- *BE RESPONSIBLE. Preventing AIDS is very much up to you. Don't put yourself at risk. If you think there is a serious possibility that you have been exposed to AIDS, don't ignore it. Seek medical advice.*
- *ABOVE ALL, DON'T PANIC. Concern is helpful, senseless worry isn't.*

MORE INFORMATION

- *If you want to know more about AIDS*
- *If you are worried you may have AIDS*
  - *ring the AIDS hotline: Auckland (09) 395-560. All calls are free and confidential — you will not have to give your name.*
  - *write in confidence to the NZ AIDS Foundation, P.O. Box 6863, Wellesley Street, Auckland 1.*
  - *contact your nearest district office of the Department of Health.*
  - *contact the nearest VD (sexually transmitted disease) clinic.*
  - *talk to your doctor.*

Leaflets giving greater detail about AIDS and safer sex practices are freely available.

FOR PARENTS

Children in New Zealand are not likely to get AIDS.

The main way that children might become infected is by being born to a mother already infected.

Experience from overseas shows that children are not at risk of catching AIDS from other children by normal person to person contact as might occur at school.

If your children ask about AIDS, remember everyone needs to understand this disease; discuss it with them.

You will be the best judge of your child's maturity. For little ones a simple direct answer — AIDS is a disease that can kill people — plus plenty of reassurance is all that is needed.

As children approach adolescence, they may start to experiment with sex. They need to know the dangers they face and how to avoid getting AIDS. If you find it hard to talk to your children about these things ask your doctor or the school nurse for help, or see the "More information" section. You could save your children's lives.

Dr R.A. Batter
DIRECTOR-GENERAL OF HEALTH

DEPARTMENT OF HEALTH

NAT. HEALTH: AIDS: aug 1985

DG2 AXA

CONFIDENTIAL

10 DOWNING STREET

From the Principal Private Secretary

6 March 1986

AIDS

The Prime Minister has seen your letter of 5 March in which you provide answers to her questions about the proposed advertisements concerning the prevention of the spread of AIDS.

The Prime Minister has emphasised that she still remains against certain parts of the advertisement. She thinks that the anxiety on the part of parents and many teenagers, who would never be in danger from AIDS, would exceed the good which the advertisement might do. In her view it would be better to follow the "VD" precedent of putting notices in doctors' surgeries, public lavatories, etc. But to place advertisements in newspapers which every young person could read and learn of practices they never knew about would, in her view, do harm.

BF 11

Your Secretary of State will now wish to consider how to proceed in the light of the Prime Minister's firmly held views. He may wish to consider showing the Prime Minister an amended advertisement which omits the parts which, in the Prime Minister's view, would be likely to offend. Another possibility is for your Secretary of State, and others from your Department, to discuss the matter with the Prime Minister.

I should be grateful for your further advice as soon as possible.

N. L. Wicks

Tony Laurance, Esq.,
Department of Health and Social Security.

CONFIDENTIAL

BM

CCBG

DEPARTMENT OF HEALTH & SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

Mark Addison Esq
Private Secretary
10 Downing Street

5 March 1986

Prime Minister (1)

Content on this basis for the DHSS to go ahead with the advertisement?

MEA 5/3

I remain uneasy about certain parts of this advertisement. I think the anxiety on the part of parents and many teenagers who would never be in danger from Aids - exceeds the good it may do. It would be better in my view to follow the 'VD' practice of putting notices in surgeries, public lavatories etc. But adverts where every young person will need to learn of practices they never knew about will do harm.

MT

Dear Mark,

AIDS

You sent me a copy of your letter of 3 March to Joan MacNaughton. The answers to the Prime Minister's Questions are as follows.

We have consulted the Advertising Standards Authority. They consider that, given the purpose of the advertisement and the fact that the advice in it is given by the Chief Medical Officer, the text shows a reasonable respect for commonly held standards of decency and propriety. They are confident that this view would be shared by their Council should any complaint be received.

We had checked the possibility of the advertisement being caught by the Obscene Publications Act, and we have consulted the Home Office again. In order to secure a conviction under the Act, it would be necessary to prove that the material tended to "deprave and corrupt" those who were likely to see it. The courts have held judicially that these words impose a stiff test. In practice, prosecutions in respect of the written word are rarely undertaken and even more rarely successful. The expectation, therefore, is that the proposed advertisement would not be found obscene. In the unlikely event that it were, Section 4(1) of the Act provides a relevant defence of the "public good" on the ground that the material is in the interests of "learning, or of other objects of general concern". The Home Office have little doubt that, even if a court considered material in the advertisement obscene, it would share their view that the overwhelming public interest requirement to provide factual information to the public to prevent the spread of AIDS provided a full "public good" defence.

MT

E.R.

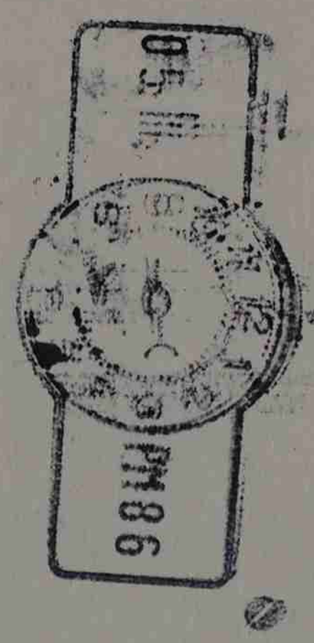
It must, therefore, be virtually certain that the proposed advertisement would not fall foul of the Act although, of course, with legal matters it is never possible to be entirely sure.

Officials here are in close touch with the Home Office on any implications for public education in AIDS of Mr Winston Churchill's bill.

Yours sincerely

A Laurance
Private Secretary

NAT HEALTH Aids: Aug. 1985



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10 DOWNING STREET

3 March 1986

From the Private Secretary

AIDS

The Prime Minister has seen the Lord President's minute of 26 February, reporting the conclusion that 'H' Committee reached on 25 February.

The Prime Minister has raised two points on the Lord President's report. She has asked, first, whether the advertisement would be acceptable to the Advertising Standards Authority. Secondly, she has asked whether a check has been conducted to see that the advertisement does not fall foul of the Obscene Publications Act.

I am copying this letter to Tony Laurance (Department of Health and Social Security) and Michael Stark (Cabinet Office).

MARK ADDISON

Miss Joan MacNaughton,
Lord President's Office

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cc HOUSING
Private Rented Secs
NAT HEALTH
Contraception advice

PRIME MINISTER

H COMMITTEE: TUESDAY, 25 FEBRUARY

Aids

I attach a minute from the Lord President, reporting on the conclusions reached by the Committee. H agreed that the publicity should go ahead as proposed.

Contraceptive advice and treatment for young people

H agreed that the guidance, as drafted, should be issued as soon as possible. This would follow the line determined by the Court of Appeal, covering in particular the circumstances identified by Lord Fraser when contraceptive advice and treatment could be provided to those under 16 without parental consent. H believed that, for now, the issue of confidentiality between doctor and patient should be left entirely to the General Medical Council.

Private rented sector

H agreed that the Assured Tenancy Scheme, under which newly built property can be let at market rents outside the terms of the Rent Acts, should be extended to buildings which had been substantially improved, repaired or converted. L Committee will be considering including this in the Housing and Planning Bill currently before Parliament.

Mark Addison

MEA

27 February, 1986.
JD3AJT

With regard to the Bill's added - have we checked (1) that it is acceptable to the Education authority (2) that it does not come within the Obscenity Bill

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Prime Minister.
To note H's conclusion on AIDS.
The Lord President voiced your concerns, but H appear unanimously to have felt the material simply had to be included. MEA 26/2

PRIME MINISTER

CONTROLLING THE SPREAD OF ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

Your Private Secretary wrote to mine yesterday to let me know of your comments on this and to ask me to report the conclusion that H Committee reached in their discussion that evening.

2. The Committee were clearly most concerned about the threat of AIDS, and anxious that the Government should be seen to be doing all that could reasonably be expected of it in response. I think, indeed, that every one of the questions put to the Social Services Secretary and the Chief Medical Officer was designed to explore whether it was possible to go beyond the sort of publicity programme that they have in mind. I made it clear that I viewed the proposed public advice "What is risky sex?" with very considerable distaste, and I asked the Committee to think most carefully before we authorised the release of this particular material - some passages of which I thought more offensive than others.

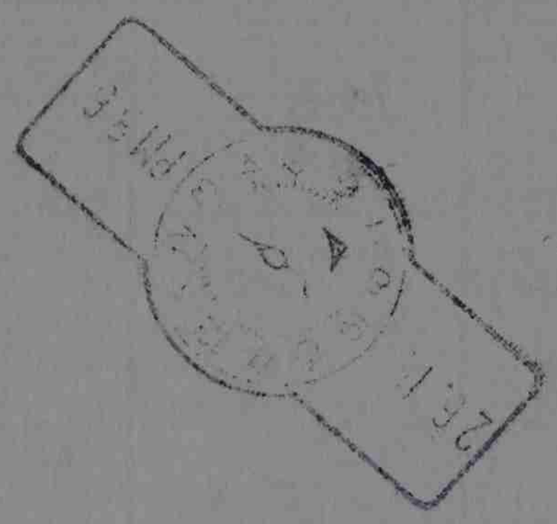
3. The Chief Medical Officer explained to me that, as there was no cure for AIDS, avoiding the riskiest practices was the only way to limit the spread of the disease; that the passages to which I had drawn attention contained the essence of the message that he needed to get across; and that in his professional judgement their inclusion in the publicity was vital. I was also told by colleagues that material on AIDS published by some other governments was far more explicit than what is being proposed here, and the Health Ministers reminded me that, partly because of the kind of doubts I had raised, the advice would be attributed personally to the Chief Medical Officer rather than to the Government.

4. As there was no support at all for the doubts I had aired, the Committee agreed that the publicity should go ahead next month, substantially as the Social Services Secretary had proposed.

5. I am sending a copy of this minute to the Social Services Secretary and to Sir Robert Armstrong.

Privy Council Office
26 February 1986

Wat Health: AIDS Aug 85.



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(80) ECL

bc Sir K.
Stowe.

10 DOWNING STREET

From the Principal Private Secretary

25 February 1986

AIDS

The Prime Minister read overnight the memorandum by the Secretary of State for Social Services on "Controlling the Spread of Acquired Immune Deficiency Syndrome (AIDS) (H(86)9) which is due to be considered by H Committee today.

The Lord President will wish to know that the Prime Minister has commented on this paper:

> "Do we have to have the section on risky sex?
> I should have thought it could do immense harm
> if young teenagers were to read it."

I should be grateful if the Lord President could draw the Prime Minister's view to the attention of the Committee. I should also be grateful if he could report the conclusions of the Committee to the Prime Minister.

I am sending a copy of this letter to Tony Laurance (Department of Health and Social Security) and Anthony Langdon (Cabinet Office).

(N.L. Wicks)

Miss Joan MacNaughton,
Lord President's Office.

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Prime Minister ②

For reference. Unpleasant, but I am sure DHSS are right to prepare a press campaign like this. I meet on Tuesday to discuss. MEA 24/2

PRIME MINISTER 24 February 1986

AIDS Do we have to do the techno-Dr. Risky act? I should have thought it could do more harm if long winded

Norman Fowler is proposing to place explicit and distasteful advertisements about AIDS in all the Sunday papers. The AIDS problem is now so serious that we must do as he proposes, though his advert could open with more facts about the spread of AIDS. needs to read it. no

We have so far had 275 cases of clinical AIDS in this country. But approximately 20,000 people are known to be carrying the virus. The Chief Medical Officer estimates that perhaps 25% of these people go on to develop clinical AIDS. But he may be optimistic - it is possible that they will all develop AIDS over the coming years.

The cost of treating someone with clinical AIDS is very cautiously estimated at £10,000-£20,000. That represents a bill between £50m and £100m just for the people currently with the virus who can be expected to catch the disease. The number of people with the virus is doubling every year.

The virus is mainly transmitted between homosexuals and between drug addicts who share contaminated needles. In Edinburgh 50% of drug addicts have the virus (as against 10% of addicts elsewhere) because pharmacists clamped down on providing needles for addicts. The challenge is to achieve proper public health supervision of addicts without encouraging drug-taking. AIDS isn't just transmitted between drug-takers and homosexuals. It can also be transmitted by normal intercourse. The following causal chain is perfectly possible: a drug-taker who finances her addiction by prostitution transmits the virus to a male client who passes it on to his wife who gives birth to a baby with the virus. These are the sorts of mechanism whereby AIDS can spread out to the population at large.

David Willetts

DAVID WILLETTS

CONFIDENTIAL

cc DWW

WYDDFA GYMREIG
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-233 3000 (Swits fwrdd)
01-233 6106 (Llinell Union)
Oddi wrth Ysgrifennydd Gwladol Cymru

WELSH OFFICE
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-233 3000 (Switchboard)
01-233 6106 (Direct Line)
From The Secretary of State for Wales

The Rt Hon Nicholas Edwards MP

24 December 1985

Dear Keith

NBPM

AIDS

I have been following with interest your correspondence with Norman Fowler regarding the proposed national centre for co-ordination of epidemiological research on AIDS.

I agree that we must respond urgently to research needs identified in relation to AIDS and I am content in principle to contribute to the funding of this project. I understand that it is proposed that my contribution would be about £15,000 per annum.

You will appreciate, however, that it would be helpful before I make a final commitment to have rather more detail of what is planned than has so far been provided for my officials or is available to me. I would want also to be sure that the Welsh Office is involved adequately in the project, perhaps through an observer on the relevant steering group. Perhaps I may have a more detailed account of what is being proposed.

I am copying this letter to all members of the Cabinet and to Sir Robert Armstrong and Sir Robin Nicholson.

Yours ever
Nick

The Rt Hon Keith Joseph Bt MP
Secretary of State for Education and Science
Department of Education and Science
Elizabeth House
York Road
LONDON
SW1 7PH

CONFIDENTIAL

Nat. Health Aug-85

AIDS

cc BG

SCOTTISH OFFICE
WHITEHALL, LONDON SW1A 2AU

CONFIDENTIAL

The Rt Hon Sir Keith Joseph Bt MP
Secretary of State for Education and Science
Department of Education and Science
Elizabeth House
York Road
LONDON
SE1 7PH

11 December 1985

NO - 20,000?

Dear Keith,

AIDS

I refer to your letter of 2 December to Norman Fowler about the proposal by the Medical Research Council to establish a national centre to co-ordinate epidemiological studies on AIDS at a cost of £0.5 million in a full year. You offered to contribute £0.2 million of this sum and invited the Health Ministers to find the balance of £0.3 million.

Norman Fowler's letter of 5 December offers to contribute £0.25 million annually towards the total cost. I am writing to confirm that I am prepared to offer £30,000 each year towards the cost of this centre.

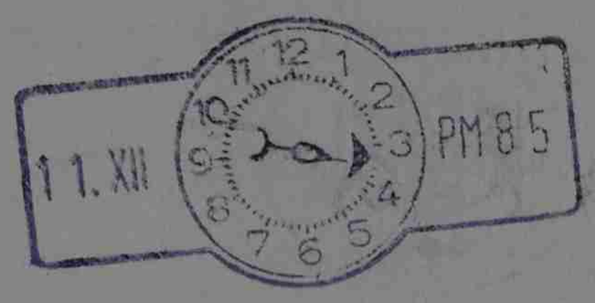
I am copying this letter to Cabinet colleagues and to Sir Robert Armstrong and Sir Robin Nicholson.

Yours ever,

Cuyler

MDH34407

Not Health; AIDS; Aug 85



CONFIDENTIAL

CC BY

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

The Rt Hon Sir Keith Joseph Bt MP
Secretary of State for Education and Science
Department of Education and Science
Elizabeth House
York Road
LONDON
SE1 7PH

5 December 1985

NBPM

Dear Secretary of State.

AIDS

We had a word today about funding of the MRC for the proposed national centre for co-ordination of epidemiological research on AIDS about which you wrote to me on 6 November and further on 2 December.

There is no difference between us that this research is crucial to our understanding of the spread of the AIDS virus in the UK. In view of the very high priority which we attach to effective action to control the spread of the disease, therefore, I am content to join you in providing funds to meet the cost of the MRC's AIDS epidemiological research centre. You have offered to contribute £200,000 a year; I am willing to make available from my Vote my share of the balance needed to mount the project. On present costings, which are, I understand, not yet finalised, this would mean my contribution would be up to about £0.25 million. I hope George Younger and Nick Edwards will be able to see their way to contributing likewise. However, I should say that this is in no sense intended to alter the arrangements for financing the MRC which we set up in 1980.

I am copying this letter to all members of the Cabinet, to Sir Robert Armstrong and Sir Robin Nicholson.

Yours sincerely

for NORMAN FOWLER
(Approved by the Secretary of State and signed in his absence)

CONFIDENTIAL

NAT HEALTH : Aids : Aug 1985

ES

CONFIDENTIAL

DEPARTMENT OF EDUCATION AND SCIENCE

ELIZABETH HOUSE YORK ROAD LONDON SE1 7PH

TELEPHONE 01-934 9000

FROM THE SECRETARY OF STATE

The Rt Hon Norman Fowler MP
Secretary of State for Social Services
Alexander Fleming House
Elephant and Castle
London SE1 6BY

2 December 1985

Dear Norman.

AIDS

I wrote to you on 6 November about the MRC's plans to establish, at the request of your Department, a national centre to coordinate epidemiological studies on AIDS. My letter pointed out that to meet the costs of this centre the MRC would need to cut back disruptively on this year's other commitments and on their future plans. I argued that the very modest financial contribution which you had so far been able to offer failed to reflect the primary responsibility of you and your fellow Health Ministers for action on what is essentially a national public health emergency.

The Advisory Board for the Research Councils had some discussion about this when they met on 27 November to consider the final Science Budget allocations for 1986-87. The Chairman of the Board, Professor Sir David Phillips, has since written to me conveying the Board's views. A copy of his letter is attached.

As you will see the Board advised me that it would be unreasonable for the costs of the AIDS epidemiological research centre to be met from the Science Budget. Their view is that the Health Departments should contribute to the costs "on a scale commensurate with their responsibility for public health and for the Health Service."

In my letter of 6 November I said that I would be willing to find £0.2m per annum from 1986-87 towards the cost of the centre. That remains my position. In the light of the Advisory Board's advice I do not feel able to offer any more than £0.2m nor am I willing to direct the MRC to meet the balance of the costs from within their share of the Science Budget.

CONFIDENTIAL

CONFIDENTIAL

As you may have heard I had some discussion about this matter with Barney Hayhoe on 13 November in the margins of a meeting about clinical academics' pay. When we met Barney explained that there were pressures on your research budget, but I question whether these can be greater than or even as great as those on the Science Budget. Barney also referred to the additional funds which the Wellcome Trust will have available for funding biomedical research from next year. My understanding, however, is that the Trust would not be prepared to see any of these funds used in substitution for Government funding: it is therefore not realistic to expect the Trust to make any money available for the MRC's epidemiological studies which will be clearly seen as related to public health needs.

I am very anxious that Ministers should not be seen to be squabbling amongst themselves about responsibilities for meeting the cost of work which is urgently needed in the face of the AIDS emergency. As I said in my earlier letter it is important that the Government makes a collective response. The MRC has already committed substantial funds to AIDS research from within its existing budget; while I am offering a further £0.2m per annum towards the cost of the new centre. I repeat my request that you, George Younger and Nicholas Edwards between you find the further £0.3m per annum which is needed from 1986-87.

There is some urgency about resolving this: Sir James Gowans is to speak to the Parliamentary and Scientific Committee on AIDS on 10 December and it could be acutely embarrassing for the Government if Sir James were able to claim on that occasion that inter-departmental wrangling was holding up vital work.

I am copying this letter to Cabinet colleagues and to Sir Robert Armstrong and Sir Robin Nicholson.

Yours ever,

Ken

CONFIDENTIAL

Advisory Board for the Research Councils
Elizabeth House 39 York Road London SE1 7PH
Telegrams Aristides London SE1 Telex 23171
Telephone NEW TELEPHONE NUMBERS
From 4 March 1985
Direct line 01-934 9851
Switchboard 01-934 9000

Rt Hon Sir Keith Joseph Bt, MP.

Your reference

Our reference

Date 29 November 1985

Dear Secretary of State,

ABRC ADVICE ON DISTRIBUTION OF SCIENCE BUDGET

AIDS

I have today written to you forwarding the Board's advice on the distribution of the additional £15m which you have secured for the Science Budget from 1986-87. Paragraph 18 of that advice reads as follows:

> "Following the emergence of the AIDS problem in the UK, the MRC took steps to promote research on AIDS in mid 1983 and has already awarded some £430,000 in research grants. We understand that, after an approach from the DHSS, the MRC is setting up a national centre for coordination of epidemiological research on AIDS which is likely to cost £150,000 in 1985-86 and about £0.5m per annum thereafter. We are clear that the establishment of the centre is an urgently needed response to a public health emergency and that as such the DHSS should meet all the costs."

I thought I should write to you separately to amplify the Board's discussion on this point, as recorded above.

The MRC were represented at the Board's discussion by Dr Malcolm Godfrey, their Second Secretary, in the absence overseas of Sir James Gowans. Dr Godfrey explained to the board that the MRC were already running an AIDS research programme at a cost of £430,000 when, in the middle of this year, they were asked by the DHSS to undertake in addition studies of the UK epidemiology - particularly to establish the pattern of the spread of the disease in this country. DHSS need a better understanding of the epidemiology of AIDS in order to take the public health measures needed to counter the spread of infection. In response to DHSS' request, the MRC identified the need to establish a centre to coordinate epidemiological studies on AIDS and to act as a "database" from which specific investigations into the ways in which the disease is spreading in the UK will be mounted. The Council estimates that it would need

to spend some £150,000 on these activities in 1985-86; and £0.5m per annum thereafter.

The MRC do not regard work of this kind as falling outside its remit. They do however consider that it is unreasonable for the costs to be met from the Science Budget given that the Council have already awarded £430,000 on AIDS research and given the severe pressures on their overall budget which mean that they are unable to fund many very high quality research projects.

The Board were given to understand that the DHSS, in response to a request from MRC, had indicated that they might be able to find £50,000 towards the total costs of the epidemiological research programme either this year or next. The Board were of the view that this was an inadequate response from the Department. It was pointed out that the total costs of the epidemiological research programme are dwarfed by the potential costs of caring for AIDS victims within the Health Service.

The Board were also of the view that it would not be appropriate for any of the new money for the Science Budget - the £15m - to be diverted to the epidemiological research programme. We understand that the additional £15m was secured to meet the twin objectives of sustaining strategic research of industrial relevance and helping to halt the brain drain of talented British scientists. The Board could not advise that the AIDS epidemiological research would have a high priority against these criteria.

I urge you therefore on behalf of the Board to seek to persuade your DHSS ministerial colleagues to contribute to the costs of MRC's epidemiological research programme on a scale commensurate with their responsibility for public health and for the Health Service.

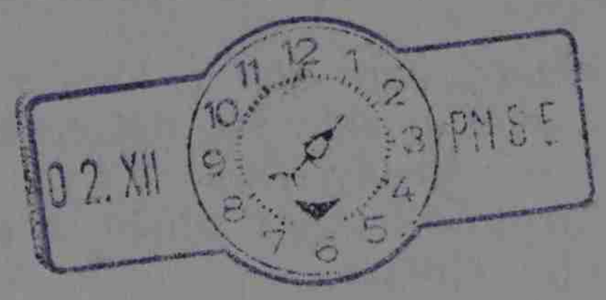
Yours sincerely,

Helen Williams

p.p DAVID PHILLIPS

Approved by Sir David Phillips
but signed in his absence.

NAT HEALTH
AIDS
AUG 85



CC/SG

DEPARTMENT OF EDUCATION AND SCIENCE

ELIZABETH HOUSE YORK ROAD LONDON SE1 7PH
TELEPHONE 01-934 9000

FROM THE SECRETARY OF STATE

NBPM

The Rt Hon Norman Fowler MP
Secretary of State for
Social Services
Alexander Fleming House
Elephant and Castle
London SE1 6BY

6 November 1985

Dear Secretary of State

AIDS

1. Sir James Gowans came to see me last Wednesday to tell me about AIDS; with Dr Acheson, he gave Sir David Hancock a similar briefing a week or two earlier. In particular Sir James described research on AIDS - what is being done and what needs to be done, distinctively by and for the UK - specifically the need for a national epidemiological surveillance centre.

2. In these matters the public health aspects are, of course, your responsibility and that of George Younger and Nicholas Edwards; and, on the related research, the MRC is one of our prime sources of advice (and performance). Against that background I drew these tentative conclusions from my briefing with Sir James:

(i) AIDS, in the UK, is a special, urgent national public health problem; there is a real possibility of its developing into a national emergency.

(ii) The situation in the UK is extremely unstable; present evidence suggests that the infected (and infectious) population is doubling every six months; and the cost of caring for new victims could double annually from a base of perhaps £40-80M next year.

(iii) The best working assumption for now must be that an effective vaccine is at least 5 years away.

(iv) Thus the best present prospects for curbing the spread of AIDS are through public health education coupled with an understanding of the UK epidemiology.

3. We need to match our response to the potential scale, urgency and uniqueness of the problem. I am not clear that collectively we have yet recognized the gravity of the situation and the potential costs of an inadequate response now. For its part, the MRC has decided - rightly in my view - to press ahead with establishing the UK epidemiological surveillance centre at a cost of £150,000 this year and £0.5m in 1986-87 and subsequent years. To do this, they will have to cut back disruptively on this year's other commitments and on their future plans. Other research of high priority will have to go and Sir James Gowans has reasonably asked me whether the MRC can look to the Government for additional resources for this work, which carries public health as well as research implications.

4. I know that your officials and particularly Dr Acheson, have been involved in drawing up plans for the centre. Clearly the Science Budget has a contribution to make and I am ready within my own resources to find £0.2m, a year from 1986-87 towards the cost of the centre. The nature of the disease gives this work a priority that goes beyond the intrinsic importance of the research. Given the importance of the public health aspects of the problem I very much hope that you together with George Younger and Nicholas Edwards would see your way between you to finding the balance. I recognise the £50,000 you have already agreed to contribute this year but in the face of what is a national public health emergency of gathering momentum there seems to me an overwhelming case for doing more.

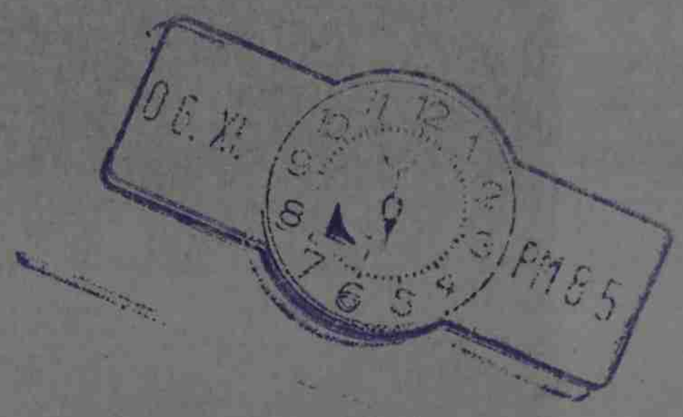
5. I am copying this letter to all Cabinet Ministers, Sir Robert Armstrong and Sir Robin Nicholson.

Yours sincerely,

Robert Smith

Private Secretary

Approved by the
Secretary of State
and signed in his
absence



Northern Ireland Office
Stormont Castle
Belfast BT4 3ST

The Rt Hon Barney Hayhoe MP
Minister for Health
Department of Health and Social Security
Alexander Fleming House
Elephant and Castle
LONDON
SE1 6BY

23 October 1985

Dear Barney

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS): WIDER ISSUES

Thank you for copying to me your letter of 5 October to Geoffrey Howe. I have also seen a copy of Norman Fowler's minute of 25 September to the Prime Minister.

I appreciate the urgency with which you are tackling this problem, and the steps that have already been taken. In particular I am glad to note that the CMO(NI) is represented on Dr Acheson's Expert Advisory Group. I also very much welcome the decision to establish a Ministerial Steering Group and an interdepartmental team of officials to consider the wider issues relating to this disease. It is important that we should learn from the experience of others who have had to contend with AIDS from much longer than we have and that we should be properly prepared to deal with the variety of AIDS-related problems which will undoubtedly present themselves in the months and years ahead.

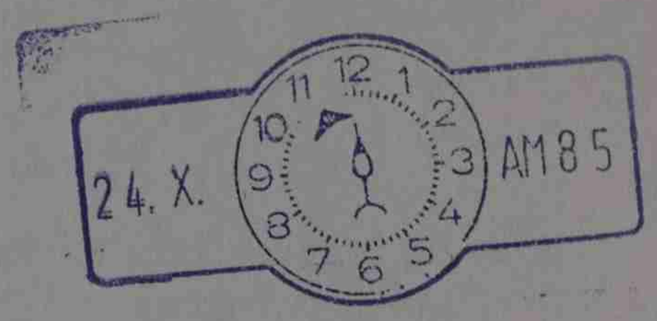
I would expect Northern Ireland to be represented on both Groups. I have asked Richard Needham to attend the Ministerial Group, and Dr Rob McQuiston (Assistant Secretary, Health Policy, DHSS) to join the official Group. It seems appropriate that they should also attend the proposed presentation on AIDS.

I am copying this letter to the Prime Minister, to Geoffrey Howe, Douglas Hurd, Nigel Lawson, Keith Joseph, Kenneth Baker, Leon Brittan, Michael Heseltine, David Young, George Younger, Nicholas Edwards and to Sir Robert Armstrong.

Yours

SP

NATIONAL HEALTH ! AIDS AUGUST 85.



DEPARTMENT OF EDUCATION AND SCIENCE
ELIZABETH HOUSE YORK ROAD LONDON SE1 7PH
TELEPHONE 01-934 9000

FROM THE SECRETARY OF STATE

21 October 1985

Dear Barney.

ACQUIRED IMMUNE DEFICIENCY SYNDROME: WIDER ISSUES

You wrote to Geoffrey Howe on 5 October inviting him and other Ministers to a presentation on AIDS to be given by the Chief Medical Officer.

This is a subject in which my Department has a number of interests. We need to consider how schools and colleges should behave towards young people who are infected, and how we can educate all our young people to behave responsibly and try to prevent the spread of the disease: in addition, I have a responsibility for ensuring that adequate resources are available for research into the subject.

If it can be arranged, Bob Dunn, who will be a member of the Ministerial Steering Committee, and I would both like to attend the presentation. We would be accompanied by the official who is coordinating our interests, Mr B C Peatey. Perhaps your office would consult mine about dates.

I am copying this to the Prime Minister, Geoffrey Howe, Douglas Hurd, Nigel Lawson, Kenneth Baker, Leon Brittan, Michael Heseltine, David Young, George Younger, Nicholas Edwards, Tom King and to Sir Robert Armstrong.

Yours ever,
Kenneth

Barney Hayhoe Esq MP
Minister for Health
DHSS
Alexander Fleming House
Elephant & Castle
LONDON SE1 6BY

HMG/T06
010

cc DW

Caxton House Tothill Street London SW1H 9NF

Telephone Direct Line 01-213 .....6460.....
Switchboard 01-213 3000

Sarah Bateman
Private Secretary to the
Minister for Health
Department of Health and Social Security
Alexander Fleming House
Elaphant and Castle
LONDON SE1

18th October 1985

Dear Sarah,

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

WILL REQUEST IF REQUIRED

My Secretary of State has seen the letter which your Minister wrote to the Foreign Secretary on 5 October inviting him and other Ministers concerned to a presentation on AIDS to be given by the Chief Medical Officer. He would like to be present at the presentation, and will if possible be accompanied by Peter Bottomley, Parliamentary Under Secretary of State here, Tim Carter, Director of Medical Services at our Health and Safety Executive and Mike Chapman, AIDS Specialist in the HSC.

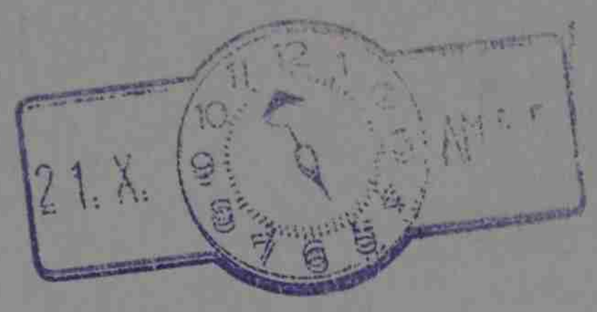
I am copying this letter to the Private Secretaries of the Prime Minister, the Chancellor of the Exchequer, the Home Secretary, the Secretaries of State for Education, the Environment, Defence, Health and Social Services, Scotland, Wales, Northern Ireland and also Sir Robert Armstrong.

Yours sincerely,

Iain Mackinnon

IAIN MACKINNON
Private Secretary

NAT HEALTH
AIDS
AUG 85



cc DW

HOME SECRETARY

QUEEN ANNE'S GATE LONDON SWIH 9AT

16th October 1985

W 17/10

Dear Barney,

Thank you for copying to me your letter of 5 October to Geoffrey Howe about Norman Fowler's proposed Ministerial Steering Group to direct the work of an interdepartmental team of senior officials, who will co-ordinate action towards the wider issues raised by AIDS.

I agree with you that this disease presents us with a major public health problem. I am particularly concerned about its implications for the prison system. As you know I am responsible for the medical treatment provided for prisoners. AIDS is worrying both as regards the health of inmates and also the health and understandable anxiety of prison staff.

Clearly there will be a need for Home Office representation on both of your groups. I have asked Simon Glenarthur to represent us on the Ministerial Steering Group and John Kilgour, Director of Prison Medical Services, to represent us on the team of officials. They will attend the presentation by the Chief Medical Officer which you mention in your letter.

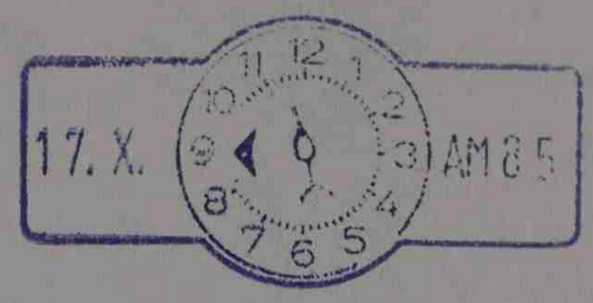
Copies go to recipients of your letter.

Yours,

Douglas.

The Rt Hon Barney Hayhoe, MP

Nat-Healllt : Aids . Aug 85



CC DW

SCOTTISH OFFICE
WHITEHALL, LONDON SW1A 2AU

RESTRICTED

The Rt Hon Norman Fowler MP
Secretary of State for Social Services
Alexander Fleming House
Elephant and Castle
LONDON
SW1 6BY

16 October 1985

Dear Norman,

I read with interest your note of 25 September to the Prime Minister and Barney Hayhoe's letter of 5 October to Geoffrey Howe.

I welcome the initiative to set up a Ministerial Steering Group to direct work on the wider implications of AIDS and I should like John MacKay to represent the Scottish Office on the Group. I would of course also wish the Scottish Office to be represented on the interdepartmental team of senior officials which is to consider the problems and make recommendations to the Steering Group.

We would also wish to accept Barney Hayhoe's invitation in his letter of 5 October to attend a presentation on AIDS to be given by your Chief Medical Officer, and on that occasion I hope that John MacKay will be accompanied by Dr G A Scott, Deputy Chief Medical Officer.

I am copying this letter to the Prime Minister, to Geoffrey Howe, Douglas Hurd, Nigel Lawson, Keith Joseph, Kenneth Baker, Leon Brittan, Michael Heseltine, David Young, Nicholas Edwards, Tom King and to Sir Robert Armstrong.

Yours ever,

Cuimhe

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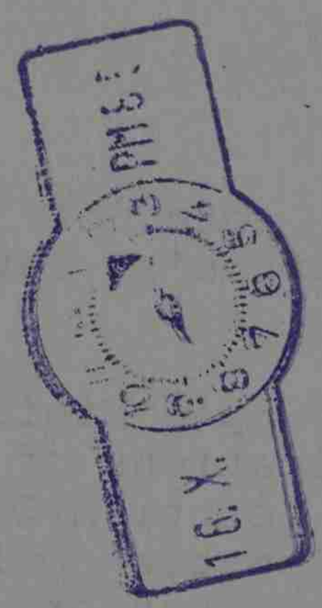
AIDS : NAT. HEALTH. Aug 85.



CONFIDENTIAL

cc DH

SWYDDFA GYMREIG
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-233 3000 (Swits fwrdd)
01-233 6106 (Llinell Union)

Oddi wrth Ysgrifennydd Gwladol Cymru

WELSH OFFICE
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-233 3000 (Switchboard)
01-233 6106 (Direct Line)

From The Secretary of State for Wales

The Rt Hon Nicholas Edwards MP

Our Ref: CT/5442/85

8th October 1985

NBPM
Fr.

Dear Norman

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

I read with interest your letter of 25 September to the Prime Minister.

The initiative to set up a Ministerial Steering Group to direct work in the wider implications of AIDS is timely. Since my Department has responsibilities for housing, education and employment as well as health services I am particularly conscious of the need to address these wider issues and look forward to hearing about Steering Group arrangements. Mark Robinson will represent the Welsh Office on the Group.

You mentioned in your letter the establishment of an interdepartmental team of senior officials to make recommendations to the Steering Group. The Welsh Office will need to be represented on that too at a senior level. This would go some way to promote the close liaison that is needed between our Departments, both on the wider implications of AIDS and on those aspects relating primarily to health services.

It seems to me that the Government's strategy for containing and combating AIDS rests heavily upon the sensitivity and reliability of the testing kits that the BTS and the PHLS will use and upon public confidence in these tests. I think it is important that monitoring of the kits' performance, and if necessary their manufacture, be instituted as soon as they are brought into use, and that arrangements be made to ensure quality control, and so maintain public confidence. I hope that this is being actively considered.

I am copying this letter to the Prime Minister, to Geoffrey Howe, Douglas Hurd, Nigel Lawson, Keith Joseph, Kenneth Baker, Leon Brittan, Michael Heseltine, David Young, George Younger, Tom King and to Sir Robert Armstrong.

Following talks I had during my recent visit to the USA. I regard the work of the Steering Group as being of the first importance, which will have to face important and difficult issues

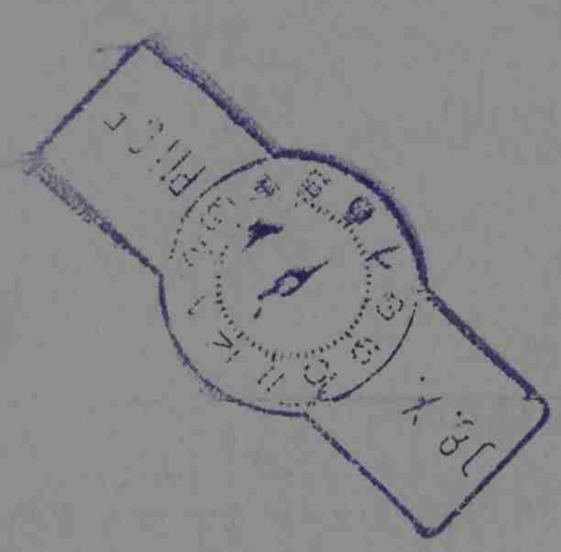
Yours ever

Nick

The Rt Hon Norman Fowler MP
The Secretary of State for Health and Social Security
Alexander Fleming House
Elephant and Castle
LONDON
SW1 6BY

NATIONAL HEALTH

AIDS AUG 05



10 DOWNING STREET

From the Private Secretary

MR STARK

CABINET OFFICE

AIDS

The Prime Minister has seen Sir Robert Armstrong's minute of 1 October about the establishment of a Ministerial steering group and an inter-departmental team of senior officials on this subject. The Prime Minister did not think it was necessary to bring these bodies within the Cabinet committee network. But she would be grateful if you could ensure that the Cabinet Office was kept fully in touch with their activities in whatever way is thought most appropriate.

(TIM FLESHER)

3 October 1985

PM

Ref. A085/2490

MR WICKS

Prime Minister:
Jan agreed to the announcement made by Mr Hayhoe. I should have thought Cabinet Office representation would be sufficient. Agree? Yes

Acquired Immune Deficiency Syndrome (AIDS)

The Secretary of State for Social Services sent me a copy of his minute of 25 September to the Prime Minister. That minute proposed the setting up of a Ministerial Steering Group and an interdepartmental team of senior officials.

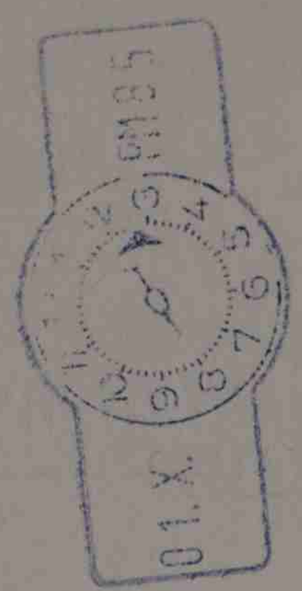
2. I am perfectly content to leave these bodies to be serviced by the Department of Health and Social Security if that is what the Prime Minister would like. But it occurs to me that on this highly sensitive political subject the Prime Minister might like to have the opportunity to keep an eye on what is going on by constituting these two bodies within the Cabinet Committee network and by servicing the secretariats at least partly with Cabinet Office people.

RA

ROBERT ARMSTRONG

1 October 1985

NAT HEALTH: Aids: Aug 85



MRS RYDER

DIARY MEETING

AIDS

David Willetts has suggested that the Prime Minister may like to open the £30 million blood products laboratory at Elstree next year. The lab will ensure that haemophiliacs can be supplied from our own pure sources with special blood plasma, to protect them from becoming innocent victims of AIDS. I suggested the Prime Minister discuss this at the next diary meeting, and she agreed.

My own feeling on this is that the Prime Minister should stay clear of AIDS (!), even when it is a question of opening laboratories to help innocent victims. I think this is all something for Norman Fowler. If she is going to do a medical visit, I should prefer to suggest opening a hospital, or a home for children with incurable diseases, etc. Furthermore, I do not think we could entertain the idea of a visit to Elstree (where the lab is) without combining it with something else.

I attach the papers which you may like to hold together for the time being.

Mark Addison

MARK ADDISON

26 September 1985

VC4ABT

Prime Minister

You will wish to be aware of the announcement by Mr Hayhoe tomorrow on AIDS, and these points of the Policy Unit's.

PRIME MINISTER

25 September 1985

AIDS

On the Elstree laboratory, I think there is no reason why David Willetts should not discreetly send it out further. But I think you would not want to do this as a 'one-off' and, as health visits go, a hospital might give better publicity.

Barney Hayhoe's proposed announcement tomorrow of an extra £1 million to deal with AIDS seems sensible. Although Norman Fowler's minute doesn't say so, the money will be found from within his budget: there is no claim on the Contingency Reserve.

For discussion at Monday's diary meeting? MEH 25/9

We have to walk a difficult tightrope between being accused of bureaucratic inertia, and being so active as to whip up public hysteria. Barney Hayhoe's announcement gets it about right. But Norman Fowler's note does not bring out two crucial political points you should be aware of.

First, about three-quarters of all AIDS cases are in the London area. So it is already being exploited by London teaching hospitals and London MPs, who argue that the RAWP formula is hitting London too hard. As you know, the Health Service is more of a losing issue for the Government in London than elsewhere. That is why Norman Fowler is, in effect, diverting extra funds to London.

Secondly, we now have the knowledge and technology to test for the AIDS virus in the blood. As from mid October, everybody giving a blood transfusion will undergo a test for AIDS. This will eliminate the already extremely low risk of

getting AIDS through a blood transfusion. The medical profession is now debating whether the results of the blood tests should be made known to the donors. They probably will be. But that may in turn fuel further popular concern about AIDS if, for example, there are hitherto unsuspected cases of AIDS amongst heterosexuals who have caught the disease via dirty drug needles, or possibly AIDS-infected prostitutes.

At the moment, only about 10% of people known to have the AIDS virus have actually contracted clinical AIDS. We simply don't know whether everybody with the virus will eventually go down with the symptoms of the disease. So we would be telling people that they may get the clinical disease, but we don't know; and if they have got it, we can't cure it. That's not a very satisfactory message, but seems to be the best course out of several unattractive alternatives.

We are spending over £30 million rebuilding the Blood Products Laboratory at Elstree so that haemophiliacs, who need special blood plasma, can be supplied from our own pure sources. The Laboratory is due to be opened next year. Could I see whether it would be worthwhile you opening it yourself? It combines attractive themes - high-quality British science, action to protect innocent victims of AIDS, and spending on health infrastructure.

David Willetts

DAVID WILLETTS

PRO

RESTRICTED

CC HB

PRIME MINISTER

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

The AIDS infection represents one of the most serious public health hazards faced by this country for many decades. With the help of our Expert Advisory Group on AIDS a range of measures has been taken to control the spread of the infection, for which there is at present no specific treatment or vaccine.

Further action is in the pipeline. Barney Hayhoe will be announcing a package of measures on 26 September. This will include new money for the Thames Regions treating the majority of UK cases, assistance to Haemophiliac Reference Centres for counselling and further support for voluntary sector organisations doing valuable information and counselling work.

Experience in the United States (they have 12,000 fully developed cases while we have just over 200) indicates that we will shortly have to deal with a number of long term problems resulting from the spread of the infection. Problems already identified lie in the areas of housing, education, insurance, employment generally and particularly in bodies like the prison service and the armed forces. Cooperation between Departments on an ad hoc basis has worked well so far, but I am sure we need to establish more formal arrangements for the resolution of problems which will arise in the areas I have mentioned.

I therefore propose to ask Barney Hayhoe to invite colleagues from those Departments which have these broader interests to join him in a Steering Group. It will direct the work of an interdepartmental team of senior officials, under DHSS chairmanship, who will explore the details of problems and make recommendations to the Steering Group.

RESTRICTED

E.R.

I think it is important that the Government should be seen to be taking action to cope not only with the public health problems involved, on which we are well advanced, but also with these wider implications. The announcement planned for 26 September will cover both aspects. I enclose a draft of what we intend to say.

I am copying this to Geoffrey Howe, Douglas Hurd, Nigel Lawson, Keith Joseph, Kenneth Baker, Leon Brittan, Michael Heseltine, David Young, George Younger, Nicholas Edwards, Tom King and to Sir Robert Armstrong.

25 September 1985

N F

THE FIGHT AGAINST AIDS - MORE GOVERNMENT MONEY

Barney Hayhoe, Minister for Health, today spoke about the Government's concern about AIDS (Acquired Immune Deficiency Syndrome). He gave details of the measures already taken to control the spread of the disease, and announced that nearly £1 million more money would immediately be devoted to the fight against AIDS.

Mr Hayhoe said; "AIDS is a very serious disease. Although the number of cases in this country is still small - by the end of August this year 206 patients had been confirmed as AIDS cases of whom 114 had died - we know that the number of new cases is bound to increase steadily over the next few years. Some 10,000 people may already have been exposed to the virus, but only a small proportion of these have developed clinical AIDS. It is vital to do all we can to control the further spread of the disease and to help those who have already been exposed to the virus.

"In this country we have had the benefit of learning from the experience of the United States where more than 12,000 fully developed AIDS cases have occurred. Knowledge of the disease is progressing rapidly and much has already been achieved but much

/remains...

remains to be done. In the absence of a cure for AIDS or a vaccine which protects against the virus we must take all the precautions indicated in the light of current knowledge and experience.

"The Government has already given nearly £1 million towards combatting the disease, in addition to the resources committed by Health Authorities themselves. We will be providing a further £1 million this year to help three Thames Regions who are carrying the heaviest AIDS burden to provide treatment and counselling to those exposed to the infection. Extra funding will also be given to the Haemophilia Reference Centres to support their counselling work. Additional help will be provided to the voluntary sector too, as support for the valuable information and advice work they are doing.

"A programme of public education is the linchpin of our strategy to control the spread of the disease. We are urgently considering proposals for a National Co-ordinated Campaign of Public Education to improve understanding of the disease by those most at risk of contracting AIDS and also by the general public, and the ways in which its spread can be controlled. We must also extend our understanding of what services need to be provided for those who are infected with the virus.

"Information provided by the Thames Regional Health Authorities, which have the greatest experience in treating AIDS cases, will help us to calculate what demands are likely to be placed on the NHS. We shall also be sharpening up

/arrangements...

arrangements for ensuring interdepartmental co-operation for dealing with the wider long term issues raised by the disease."

"The Government fully understands public concern about AIDS. We are tackling the disease on a broad front and, with the continuing co-operation of those in the at-risk groups, I am hopeful that we will be able to control the spread of the disease and reduce the appalling suffering which accompanies it.

NOTES FOR EDITORS

Listed below are details of the additional funding being provided this year as well as that previously announced, and the major measures already taken and planned to control the spread of the disease.

* Funding
* health education
* screening of blood donations
* other blood testing
* heat treatment of blood products
* counselling
* research
* information for health professionals
* co-operation with the voluntary sector
* setting up of an advisory group of experts
* confidentiality

/Funding...

Funding

The Government has so far contributed nearly £1 million directly towards the fight against AIDS in addition to resources already committed by Health Authorities. Besides funding various research projects the Government has contributed:

£50,000	for the training programme for counsellors
£58,000	for evaluating screening tests at PHLS
£80,000	for evaluating screening tests in the NBTS
£750,000	for testing blood samples at PHLS
£25,000	for the Terrence Higgins Trust
£15,000	for the Haemophilia Society
£978,000	

Additional funding announced today for this financial year will be:

NE Thames RHA	£275,000	for upgrading outpatient facilities, for counselling and for inpatient and out-patient treatment
NW Thames RHA	£275,000	
SE Thames RHA	£130,000	
Haemophiliac Reference Csntres	£90,000	for counselling
Terrence Higgins Trust	£10,000	for development of a counselling package
Haemophilia Society	£20,000	for advice work
	£12,000	for national conference on AIDS for health professionals
	£912,000	

/Health Education....

Health Education

The main at-risk groups are homosexual and bisexual men; intravenous drugs abusers; haemophiliacs who have received contaminated blood products; and the sexual contacts of people in these groups. Information leaflets have been produced by the Health Education Council, the Haemophilia Society and the Terrence Higgins Trust. A leaflet warning those in the at-risk groups not to give blood has also been produced for the National Blood Transfusion Service (NBTS).

Screening of Blood Donations

The risk of contracting AIDS from a blood transfusion is already extremely small, but the planned introduction of a screening test within the NBTS will reduce this risk still further. All the commercially available screening tests have neen evaluated by the Public Health Laboratory Service (PHLS) and two kits are now being tested in the NBTS. Routine screening of all blood donations should be introduced by mid-October.

Other Blood Testing

Health authorities are also making arrangements for blood samples to be taken in sexually transmitted disease clinics so that people who are worried that they may have been exposed to the virus can have their blood tested to discover whether they are antibody positive.

/Heat...

Heat Treatment of Blood Products

All Factor VIII - a blood-clotting agent needed by haemophiliams - is now being heat-treated. The major re-development, costing £38 million, of the Blood Products Laboratory in Elstree will come on stream at the beginning of 1986 with the capacity for achieving self-sufficiency in blood products by the end of that year.

Counselling

Anyone whose blood is found to contain antibodies to the AIDS virus will be offered counselling, which will also extend to families and friends. A counselling training course has been developed at St Mary's Hospital, Paddington, and over 180 people will be trained by the time the blood test becomes available in October.

Research

The Government-funded Medical Research Council is co-ordinating a number of important research projects costing nearly £400,000. The MRC also maintains valuable links with researchers working in the United States and elsewhere.

Information for Health Professionals

Special guidance has been produced for groups of health professionals who are involved in caring for AIDS patients. This has included:

- general information for doctors on the diagnosis of the disease and infection control measures
- information for nurses on the care of patients living in the community
- guidelines of safety measures for health workers and those working in the emergency services.

/Co-operation...

Co-operation with the Voluntary Sector

The voluntary sector has a major role to play in offering advice, support and counselling. The Government has already given £25,000 to the Terrence Higgins Trust to support its work on AIDS and £15,000 to the Haemophilia Society in addition to the sums announced today.

Expert Advisory Group on AIDS

The introduction of all these measures in such a short time has been made possible by the setting up of an advisory group of experts on AIDS (EAGA). Sub-groups of EAGA work on various topics such as counselling and blood testing and give advice on the policies to adopt.

Monitoring

The Communicable Disease Surveillance Centre (CDSC), which is part of the PHLS, began national surveillance of AIDS in 1982. They have close contacts with similar centres in other countries including the Center for Disease Control (CDC) in the United States and the WHO AIDS Collaborating Centre for Europe in Paris.

Confidentiality

A letter has been sent to all health authorities reminding them that anyone who goes for a blood test at a sexually transmitted disease clinic must be treated under terms of strict confidentiality. AIDS patients, those found to be antibody positive and any who are treated at STD clinics are protected by the NHS (Venereal Diseases) Regulations 1974.

DEPARTMENT OF HEALTH & SOCIAL SECURITY
Alexander Fleming House, Elephant & Castle, London SE1 6BY
Telephone 01-407 5522 ext 6981
From the Permanent Secretary
Sir Kenneth Stowe KCB CVO

MEA

Nigel Wicks, Esq.,
No. 10 Downing Street,
LondonSW1

19 September, 1985

Dear Nigel.

AIDS

... I enclose as promised a copy of Donald Acheson's latest report dated June 1985 on the Aids situation which I have sent to all Permanent Secretaries because of the very wide repercussions in Government of the complex issues arising.

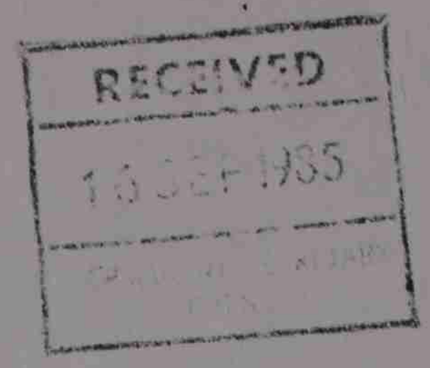
... I also attach a copy of Chris France's recent submission to Ministers here which is a useful digest of action on several fronts.

Yours ever.

Ken.

CONFIDENTIAL

for Sec
KR3



Ms Bateman

HTLV3 INFECTION AND AIDS

CMO's minute of 11 September to you recorded certain action which MS(H) wished to see taken. CMO asked me to pursue the proposed action. This submission, which follows discussion with medical and finance colleagues, provides an assessment of the present position and suggests ways ahead on the points.

Resources

2.1 Paragraph (b) of CMO's minute records a decision that resources should be made available for public education, counselling, diagnosis, treatment and research in relation to HTLV3 infection. We have exlored the possibility of finding additional finance for expenditure related to AIDS in this financial year. It should be possible to provide up to £1 million from funds hitherto allocated to health authorities. But expenditure thus financed would imply continuing commitments. PES bids have been made for 1986/87 and the two succeeding years for the extra cost of imported heat treated blood products, the continuation of the screening test for HTLV3 antibodies and treatment of AIDS and AIDS-related conditions. A briefing meeting with MS(H) is to be held on 17 September to discuss PES bids.

2.2 So far as the details of such a programme are concerned, we have been having urgent discussions with representatives of three Thames Regional Health Authorities - North East Thames, North West Thames and South East Thames - who are at present coping with most of the AIDS cases in the parts of London worst affected. They are putting together packages to meet the capital and revenue consequences of AIDS. These bids are expected to reach us by the end of next week, and it should then be possible to attach a price tag to the measures required to cope with the developing situation.

2.3 So we need to have the PES content clear and get properly costed programmes from the Regions before we can invite MS(H) to approve detailed expenditure proposals related to the £1 million we have been able to find. We should be able to do this around 23 September.

3. Public Health Education Campaign

The advertising agency TBWA has already been commissioned and briefed by officials. They are drawing up proposals as a matter of urgency for a campaign aimed at educating those in high risk groups on ways to reduce the spread of the virus and informing the general public about AIDS. £100,000 has been earmarked for the health education campaign in this financial year, but we

/cannot...

cannot say what the full cost might be until we have developed proposals and their associated costings from the agency. An outline strategy and costings are expected at the end of next week, and a presentation to the CMO by the agency has been arranged for 25 September. We shall report back to MS(H) after that.

Research

4.1 Research in the UK is co-ordinated by the Medical Research Council, the main Government-funded body undertaking the national biomedical research effort. The MRC are setting up a group which will steer AIDS epidemiological research. They also maintain valuable links with researchers working in the United States and elsewhere. The MRC is currently funding five major projects at a cost of £369,000 and the DHSS is contributing to two of these. Within the Department, a bid is being made for OCS funds for AIDS-related research in 1986/87.

4.2 Since the AIDS threat is worldwide so is the research effort. One of our objectives should be to secure access to the massive research being mounted in the USA and to avoid duplicating work which they already have in hand and on which we might draw.

Introduction of tests for HTLV3 antibody

5. The general introduction of a test for the HTLV3 antibody is planned for 14 October, including most importantly the screening of all blood donations in the National Blood Transfusion Service. A CMO letter will shortly be going out to doctors giving details of the arrangements for testing, but not the date of introduction. A letter to Regional General Managers is also planned. We had in mind a Ministerial announcement on this aspect in the second week of October.

Inter-Departmental Group on AIDS

6.1 It was at one stage proposed that CMO should first air the interdepartmental aspects with his Permanent Secretary colleagues, and I understand that this is still in hand for 25 September. If MS(H) then wishes to open up these issues at Ministerial level the way ahead might be as follows:

i. MS(H) might write to colleagues inviting them, together with their senior officials, to a presentation on AIDS to be given by the CMO in order to provide them with an authoritative account of the threat, against which they could begin to assess the implications for their Departments; and

ii. following this meeting, an Inter-Departmental Group of senior officials might be set up, under DHSS chairmanship, to explore the implications of AIDS in detail. Officials might then report back to Ministers, under MS(H) (if he agrees).

/6.2

6.2 We suggest that Ministers from the following Departments might be invited to the initial presentation: Environment (Housing), Employment, Trade and Industry, Education, Home Office, Foreign and Commonwealth Office, Defence, Treasury, and the Scottish, Welsh and Northern Ireland Offices. Not all of them may feel a sufficient interest, but all are potentially concerned with the consequences of AIDS, as we could explain to MS(H) if he wishes. A draft of a possible letter of invitation is attached.

Public Announcement of proposals

7.1 I understand that MS(H) wishes to make an early announcement, in particular to set out Government measures to combat the problem. There are I think three possible slots for an announcement;

i) something within the next two or three days, which would have to be largely retrospective in content, describing what had already been done and simply trailing what is in mind. A statement on these lines was prepared for the then PS(H) a few weeks ago, but he decided to withhold it for the time being.

ii) An announcement towards the end of September giving the retrospective material but also covering proposals for expenditure by the three Thames regions (para 2.2 above).

iii) An announcement in mid-October covering the introduction of screening (para 5 above).

MS(H) may feel that a promising combination would be to go for ii), around the end of this month, followed by iii).

7.2 I attach a shot at a Press release which might be used for the end-September announcement. It will need polishing, and could be expanded to take some of the 'Notes for Editors' into the text. But this draft will serve to give MS(H) an idea of the kind of material that could be deployed.

7.3 Would MS(H) wish to discuss both the substance and the presentation of all this?

C W FRANCE
D802 AFH

13 September 1985

cc: Miss Mothersill
Ms McKessack
Mr Langston
Mr Kerin
Dr Hunt
Mrs Hewlett-Davies
Mr Hulme
Dr Harris
Dr Ower
Dr Smithies
Mrs Firth
Mr James
Mr Harris
Dr Sibellas
Mr Murray
Mrs Gorvin

CONFIDENTIAL

DRAFT LETTER TO THE MINISTER OF STATE, HOME OFFICE

ACQUIRED IMMUNE DEFICIENCY SYNDROME [AIDS[: WIDER ISSUES

You will of course be well aware of the considerable public concern about AIDS. This serious disease presents us with a major public health problem which I believe has implications for many Government Departments.

The problems are certain to increase in the next few years. We have already taken a number of urgent measures to prevent and control the spread of AIDS, and have set up an Expert Advisory Group under the Chairmanship of the Chief Medical Officer. But the disease has wider implications - for employers and employees, life insurance, education, certain occupational groups, and so on. So I have it in mind to propose an Inter-Departmental Group of senior officials to advise Ministers on the development of a co-ordinated strategy towards these wider issues, and on the measures needed to implement such a strategy.

As a first step, I thought it would be helpful to invite you, together with a senior official, to a presentation on AIDS to be given by the Chief Medical Officer. This might I think serve to separate the facts from the legends about AIDS, and to give you a chance to make a first assessment of the implications for your Department. I am extending the same invitation to [Ministers of State in Environment,

/Employment...

Employment, Trade and Industry, Education, Foreign and Commonwealth Office, Defence, Treasury and from Scotland, Wales and Northern Ireland] to whom I am copying this letter. Perhaps you, and they, would let my office know if you would wish to attend, or be represented at, a presentation. We will then look for a suitable date.

I am also copying this to Sir Robert Armstrong.

Di T PRESS RELEASE

GOVERNMENT PUTS IN EXTRA £ FOR FIGHT AGAINST AIDS

Barney Hayhoe Minister for Health, today announced that the Government is contributing an extra £ towards the fight against AIDS in the current financial year.

The money will be used to provide extra resources for a national public education campaign, for counselling, diagnosis and treatment particularly in London.

[This should be expanded to spell out the allocations to each or say that the exact allocations are being worked out.]

Mr Hayhoe said: "AIDS is a very serious disease. Although the number of cases in this country is still small - by the end of August this year 206 patients had been confirmed as AIDS cases of whom 114 had died - we know that the number of new cases is bound to increas steadily over the next few years. Some 10,000 people may already have been exposed to the virus, but only a small proportion of these will go on to develop clinical AIDS. It is vital to do all we can to control the further spread of the disease and to help those who have already been exposed to the virus.

"In this country we have had the benefit of learning from the experience of the United States where more than 12,000 cases have occurred. Knowledge of the disease is progressing rapidly and much has already been achieved but much remains to be done. In the absence of a cure for AIDS or a vaccine which protects against the virus we must take all the precautions indicated in the light of current knowledge and experience.

"Health education must be at the centre of our strategy to control the spread of the disease. We are urgently considering what new initiatives are available to improve understanding of the disease by those most at risk of contracting AIDS and also by the general public and the way in which its spread can be controlled.

"We are also considering what services need to be provided for those who are infected with the virus and how these services should be funded. The Government has already given nearly £1 million towards combatting the disease. With the prospect of increasing numbers of cases over the next few years we need to estimate what the future burden on health authorities will be.

"We are also setting up an Inter-Departmental Group on AIDS to advise Ministers on the development of a co-ordinated strategy towards the wider issues arising out of the infection with the HTLVIII virus.

"The Government is keenly aware of public concern about AIDS. We are tackling the disease on a broad front and, with the continuing co-operation of those in the main at-risk groups, I am hopeful that we will be able to control the spread of the disease and prevent the appalling suffering which accompanies it."

NOTES FOR EDITORS

Listed below are the major measures already taken to control the spread of AIDS in the areas of:

*Funding
*Health education
*Screening of blood donations
*Other blood testing and confidentiality
*Heat treatment of blood products
*Counselling
*Research
*Information for health professionals
*Co-operation with the voluntary sector
*Setting up an advisory group of experts

Health Education

The main at-risk groups are homosexual and bisexual men; intravenous drugs abusers; haemophiliacs who have received contaminated blood products; and the sexual contacts of people in these groups. Information leaflets have been produced by the Health Education Council, the Haemophilia Society and the Terrence Higgins Trust. A leaflet warning those in the at-risk groups not to give blood has also been produced for the National Blood Transfusion Service (NBTS).

Screening of Blood Donations

The risk of contracting AIDS from a blood transfusion is already extremely small, but the planned introduction of a screening test within the NBTS will reduce this risk still further. All the commercially available screening tests have been evaluated by the Public Health Laboratory Service (PHLS) and two kits are now being tested in the NBTS. Routine screening of all blood donations should be introduced by mid-October.

Other Blood Testing

Health authorities are also making arrangements for blood samples to be taken in sexually transmitted disease clinics so that people who are worried that they may have been exposed to the virus can have their blood tested to discover whether they are antibody positiv

Confidentiality

A letter has been sent to all health authorities reminding them that anyone who goes for a blood test at a sexually transmitted disease clinic must be treated under terms of strict confidentiality. AIDS patients and people who are antibody positive tested or treated at STD clinics are protected by the venereal disease regulations. A doctor may only pass on information about such persons to a third party (other than another doctor involved in the patient's treatment) with the permission of that patient. This applies equally to male and female aptients. In all cases, however, every attempt will be made to persuade the patient to give his or her permission to enable contacts of either sex to be informed of their risk and given appropriat medical advice. If confidentiality is not guaranteed people may not come forward for testing, which defeats the object of making the test available.

Heat Treatment of Blood Products

All Factor VIII - a blood clotting agent needed by haemophiliacs - is not being heat-treated. The major redevelopment, costing over £35 million, of the blood products laboratory in Elstree will come on stream at the beginning of 1986 with the capacity for achieving self-sufficiency in blood products by the end of that year.

Counselling

Anyone whose blood is found to contain antibodies to the AIDS virus will be offered counselling. The counselling will also extend to families and friends. A counselling training course has been developed at St Mary's Hospital, Paddington, and over 180 people will be trained by the time the blood test becomes available in October.

Research

The Government-funded Medical Research Council is co-ordinating a number of important research projects costing nearly £370,000. The MRC also maintains valuable links with researchers working in the United States and elsewhere.

Information for Health Professionals

Special guidance has been produced for groups of health professionals who are involved in caring for AIDS patients. This has included:

- general information for doctors on the diagnosis of the disease and infection control measures
- information for nurses on the care of patients living in the community
- guidelines of safety measures for health workers and those working in the emergency services

Co-operation with the Voluntary Sector

The voluntary sector has a major role to play in offering advice, support and counselling. The Government has given £25,000 to the Terrence Higgins Trust to support its work on AIDS and £15,000 to the Haemophilia Society.

E xpert Advisory Group on AIDS

The introduction of all these measures in such a short time has been made possible by the setting up of an advisory group of experts on AIDS (EAGA). Sub-groups of EAGA work on various topics such as counselling and blood testing and give advice on the policies to adopt.

Monitoring

The Communicable Disease Surveillance Centre (CDSC), which is part of the PHLS, began national surveillance of AIDS in 1982. They have close contacts with similar centres in other countries including the Center for Disease Control (CDC) in the United States and the WHO AIDS Collaborating Centre for Europe in Paris.

Overall Funding

The Government has so far contributed nearly £1 million directly towards the fight against AIDS. Besides funding various research projects it has contributed:

£50,000	for the training programme for counsellors
£58,000	for evaluating screening tests at PHLS
£80,000	for evaluating screening tests in the NBTS
£750,000	for testing blood samples at PHLS
£25,000	for the Terrence Higgins Trust
£15,000	for the Haemophilia Society
£978,000	

HTLV3 infection,

the AIDS epidemic

and

the control of its spread

in the

UK

June 1985

1. SUMMARY

1. AIDS is the principal end stage of infection with HTLV3/ virus. It is estimated that at least 10,000 people mostly men have been infected with the virus in the UK the majority in London and the number is increasing rapidly; the equivalent number in USA has been estimated at about 500,000.

2. The results of the infection are potentially fatal and there is no effective treatment for it. A vaccine is unlikely to be developed in the foreseeable future.

3. There is usually a prolonged incubation period after infection (average 2½ years) during which the person is unaware of the infection, and feels well, but is infectious.

4. Infection is transmitted during sexual intercourse particularly but not exclusively between homosexual males, and by means of blood, blood products, contaminated needles and syringes. Infected mothers may pass on the virus to their babies during pregnancy or at birth.

5. In the United Kingdom most cases of infection that have occurred so far have been in homosexual males and patients with haemophilia treated with infected Factor VIII from pooled plasma. A few persons who use contaminated needles and syringes for drug abuse have also been infected, as have persons receiving blood for transfusion.

6. The infection has been transmitted to a few female partners of bisexual men and haemophiliacs, and perhaps from infected females to males. Although heterosexual intercourse may be less effective than homosexual intercourse in the transmission of the infection it would be wrong at present for policy to be based on the assumption that HTLV3 infection cannot be transmitted as a result of heterosexual intercourse.

7. A comprehensive campaign to reduce the spread of infection principally by means of education directed at those specially at risk is urgently needed.

8. The personal and social consequences of HTLV3 infection to the infected person and his or her family are calamitous.

/ the full conventional designation is HTLV/LAV3

2. BACKGROUND AND NATURAL HISTORY

The condition referred to as "AIDS" (Acquired Immune Deficiency Syndrome) is the principal end result of an infection by a virus (HTLV3) the action of which is to depress the body's defences against infection and cancer. People with normal body defences rarely contract the conditions from which AIDS patients suffer and these conditions are difficult and expensive to treat.

As the first cases of AIDS occurred as recently as 1979, little can yet be said about the long-term outlook of people infected with HTLV3 virus. Enough is however known to make it possible to conclude that many will become ill and a substantial proportion will develop and die from AIDS. Of a group of American men known to have been infected with the virus in 1980-2, and who are being followed up, about 10 per cent have so far developed 'AIDS' and an additional 30 per cent have developed other symptoms and signs such as fever, loss of weight, enlargement of the lymph glands or diarrhoea. It is not yet clear at what point the effect of the virus on the body's defences becomes irreversible but no sufferer from the fully developed AIDS syndrome has yet recovered. As far as the remainder of the infected me n are concerned changes in their blood suggest that a proportion may yet develop 'AIDS' or other manifestations of infection. The virus has been isolated from the brains of infected persons and can cause various disturbances of the nervous system including dementia.

The virus which is the cause of AIDS was isolated in 1983 in France and in the USA. Although much is already known about its structure, scientists agree that there are grave technical problems in preparing a vaccine and that plans should be based on the assumption that no means will be available to prevent the disease by immunisation in the next five years.

The treatment of the 'opportunistic' infections and tumours from which 'AIDS' patients suffer is sometimes successful and may prolong life but does not tackle the causative virus.

3. FACTS ABOUT THE EPIDEMIC

(a) Cases of AIDS

In the USA there had been 8,495 cases and in the UK 108 cases of fully developed AIDS by the end of 1984. In 1985 a further 10,000 cases are expected to occur in the USA and between 100 and 150 cases in the UK.

	USA	UK
1979	10	1
1980	46	0
1981	252	4
1982	980	9
1983	2,643	36
1984	4,293	58
1985	10,000 (est)	150 (est)

Table 1 Cases of the fully developed AIDS syndrome in USA andUK.

So far cases in both countries have been concentrated in certain big cities eg San Francisco, Los Angeles, New York and London. The prediction of the future trend of cases of AIDS is difficult. As the incubation period is on average 2-3 years it is inevitable that any reduction of incidence of AIDS as a result of recent public education will not be seen for some time so we must plan for a continuing steep increase of cases of AIDS in the immediate future and middle-term. For planning purposes we are assuming that between 1,000-2,000 new cases of AIDS will occur in the UK in 1988 the majority in London. In addition there will be a much larger number of patients with less serious manifestations who will require supervision in outpatients.

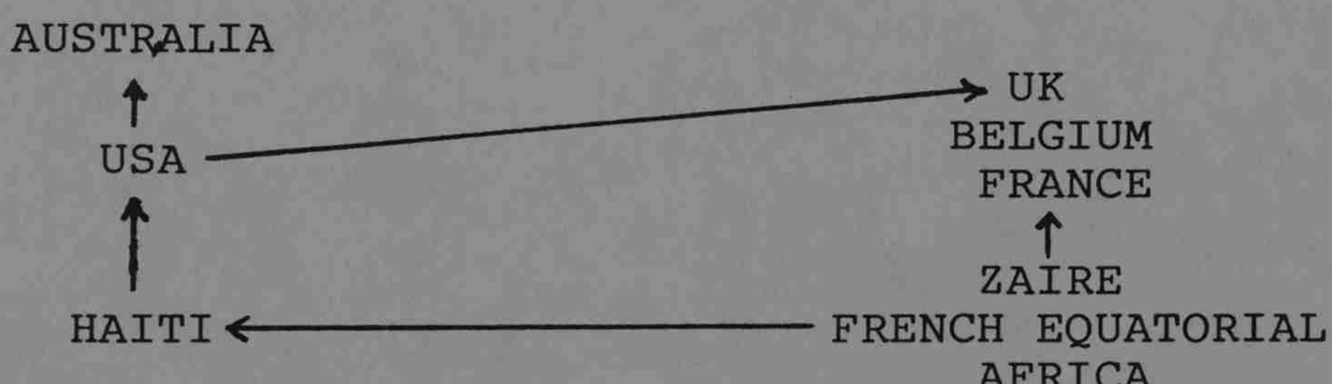
b. Numbers of infected persons

The crucial issue, however, is not the number of cases of AIDS but the number of infected persons. It has been estimated that in the USA there may at present be 500,000 infected persons. In the United Kingdom various estimates have been made of which 10,000 represents the midpoint. The majority of these persons are in London and the number is increasing perhaps at the rate of 50-100 per week. People infected with HTLV3 virus are usually free of symptoms for many months or years, are unaware of their infections, but are nevertheless infectious at least to the same degree as patients with fully developed AIDS. This degree of infectivity may persist indefinitely.

Unless effective means of controlling spread become available, an exponential increase in the number of infected persons can be expected at least in the immediate future.

c. Origin and spread of the epidemic

It has been suggested that the virus originated in Sub-Saharan Africa where infection has recently been discovered to be widespread and equally prevalent in both sexes.



Many of the early UK cases had had sexual contact in the USA. A small number of British cases have had direct or indirect contact with Sub-Saharan Africa.

4. MEANS OF SPREAD

Virus has been recovered from blood, semen and saliva of infected persons. The infection is known to have been transmitted in the following ways:-

a. through infected blood and blood products

b. during sexual intercourse, particularly but not exclusively between homosexual men

c. by use of or injury by contaminated needles and syringes

d. by donation of an infected organ [not in the UK]

e. from infected mother to child at birth or during pregnancy.

The virus is easily destroyed by disinfectants outside the human body. There is no evidence of transmission by social contact or by sharing washing, eating, drinking or toilet facilities, or as a result of living in the same home. In one reported case deep kissing was suggested as the means of transmission.

5. GROUPS AT RISK

a. Male homosexuals

These comprise 72 per cent of the American and 89 per cent of the British cases of AIDS. More than 60 per cent of male homosexuals who attend STD clinics in San Franciso and about 20 per cent in one clinic in London are known

to be HTLV3 seropositive : evidence suggests that the proportion of infected homosexuals attending STD clinics in other parts of England is much lower (5 per cent) and in Scotland lower still. This group is believed to represent the largest pool of infection at present.

b. Female partners of homosexual/bisexual men

Spread by sexual intercourse from males to females has undoubtedly taken place in both categories, although so far the number of documented cases has been small. By the end of February 1985 68 of 8,697 American cases and 1 of 132 cases in the UK were recorded as in female partners of bisexual men.

c. Intravenous drug abusers and persons who use other infected equipment

This constitutes a large group in the United States where it comprises 27 per cent of all cases and provides most of the infected women. Only one British case in this category has occurred so far although there has been one other who is also a homosexual. From the public point of view this is a potentially crucial group for the future because many of the women who abuse intravenous drugs are prostitutes, and also because they provide the largest source of infection in children. There is a theoretical possibility of transmission by tattooing, ear piercing other skin piercing instruments and by use of infected razors.

d. Haemophiliacs

Sufferers from this disease, who are almost exclusively male, are treated by repeated injections of Factor VIII which is a clotting factor derived from pooled human plasma which in recent years has been infected with

HTLV3 virus. More than 50 per cent of these patients have been infected by HTLV3 virus and there are probably about 2,500 haemophiliac men in the UK so infected. A small number have transmitted this infection to spouses, and in the United States also through them to their children.

e. Recipients of blood tranfusions

More than 100 cases of AIDS have occurred in the USA as a result of transfusion of infected blood but so far none has occurred in the UK (although two recipients have been infected with HTLV3 virus). It is almost inevitable that some cases will occur sooner or later.

f. Children of infected mothers

More than 100 cases have occurred in the USA mostly in children of intravenous drug abusers. Transmission of the virus occurs before or during birth or possibly by breast milk. More than 60 per cent of the children have died in infancy or have AIDS and, the long-term outlook for the survivors is uncertain.

g. Health care workers

Transmission to doctors, dentists, nurses and other health workers due to accidents with infected needles and sharp instruments is a possibility and has occurred in one case. In a number of other cases where accidents have occurred transmission has not taken place suggesting that the agent is of relatively low infectivity.

8. TRANSMISSION BETWEEN SEXUALLY ACTIVE HETEROSEXUAL ADULTS

The key issue which will determine the eventual scale of the epidemic in the absence of effective preventive action is the facility with which transmission of infection takes place as a result of heterosexual intercourse. A small number of the female partners of bisexual males and of haemophiliacs (see 4(b) and (d) above) are known to have become infected which suggests that transmission of infection from male to female presumably by semen in the course of vaginal intercourse can take place.

As far as transmission from female to male is concerned the evidence is at present conflicting. In New York City, in spite of a large number of AIDS cases in female prostitutes (who abuse intravenous drugs) only 28 out of a total of 3,354 cases have occurred in males who did not admit either homosexual intercourse or i-v drug abuse or belong to another high risk group. However, a number of cases have been reported in men in the US Army in which it is claimed that the only relevant risk factor was promiscuous heterosexual intercourse. The epidemic of HTLV3 infection in Sub-Saharan Africa affects male and females almost equally. While it is not certain to what extent transmission has been due to tribal scarification and dirty needles in this region, heterosexual intercourse cannot be excluded as a possible means of transmission.

Although the American data suggests that homosexual intercourse is the most important means of sexual spread of HTLV3 infection in our present state of knowledge, it would be wrong for policy to be based on the assumption that heterosexual intercourse will not in the long run assume a significant role. This point should be taken into account in formulating a preventive strategy.

9. CONTROL OF SPREAD OF INFECTION

In the absence of effective immunisation of susceptibles, control of the epidemic must depend upon reducing the frequency of transmission of infection. This will require the urgent development of a properly surveyed and evaluated programme of health education and counselling with the assistance of experts and the active co-operation of the groups at risk.

a. Male homosexuals

The object must be to reduce the spread of infection within this group. A programme of education and advice must be evolved for the gay community throughout the UK; this will require their co-operation. A favourable point is that the infection is at present largely centred in London and there is still an opportunity to curtail its spread to the provinces. The possibility of offering immunisation against Hepatitis B as part of a package of health education should be considered.

b. IV drug abusers

With the assistance of narcotics anonymous and others every effort should be made to get the message across in clinics, and elsewhere that AIDS is a serious potential risk of IV drug abuse.

c. Haemophiliacs

Check that all Factor VIII and Factor IX used in UK is now heat treated. Provide health education and advice for infected haemophiliacs and their families.

d. Blood transfusion

Introduce at the earliest opportunity an effective test for all donated blood simultaneously with a similar service for STD clinic. Introduce counselling and education for donors with HTLV +ve tests. Train an appropriate number of counsellors.

e. Organ and sperm donors

Introduce at the earliest opportunity an effective test for all donors and counselling and education for HTLV +ve donors as in (d).

f. Health care and other workers

Revise interim guidelines for Health Care Workers; extend advice to surgeons, dentists, acupuncturists, tattooists, chiropodists, etc. Introduce indemnification for health workers infected as a result of work.

g. General

Provide education directed at the general population and secondary schools (as part of sex education) on the nature and risks of AIDS.

10. SOCIAL IMPLICATIONS

The personal and social implications of HTLV3 infection for the infected person are calamitous. In the present state of knowledge a male must accept the likelihood of being infective sexually for an indefinite period, possibly for life, in addition to suffering from a potentially fatal condition for which there is no treatment and for which there is an uncertain but extended latent period. An infected

female must accept in addition the probability of infecting any subsequently conceived children. An HTLV infected child has the prospect of life-long infectivity if he survives childhood. All infected persons face the risk of stigma and of being ostracised; thus children have been refused entrance to school and adults may lose jobs or be refused employment without justification from the public health point ofview.

Very difficult issues arise in relation to tests which may reveal a condition for which there is no treatment particularly when it may have a fatal outcome. These issues are relevant to HTLV3 testing and will arise first in relation to the tests which will shortly be introduced for blood donors. Similar issues may also arise if it were suggested that testing should take place on entry to employment in certain jobs, into the Armed Services or as a precondition for life insurance or even for marriage. There are also difficult questions which have to be solved in relation to who has a right to know the result of a positive test apart from the person concerned.

JS

Prime Minister. (4)
For information
MEA 28/8

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Parliamentary Under Secretary of State for Health

Mark Addison Esq
10 Downing Street
LONDON SW1

Dear Mark

28 AUG 85

ACQUIRED IMMUNE DEFICIENCY SYNDROME

In view of the renewed interest in the media recently, you may wish to be aware of the current state of play on AIDS.

The first report case of AIDS in the UK occurred in 1979; the total number of cases reported at the end of July this year was 196; 110 of these had died. Most victims were homosexual/bisexual men, with a few cases among the other recognised "at risk" groups - haemophiliacs, intravenous drug misusers and patients receiving blood transfusions. Current estimates by the Chief Medical Officer are that at present there are approximately 10,000 people infected with the AIDS virus and by 1988 there will be 1000-2000 cases of the fully developed illness.

Mr Patten visited the USA - where AIDS is much more widespread with more than 22,000 infected and 12,000 cases - recently in order to discuss the response of Federal government and other organisations to the problem. The American experience indicates that the condition will probably spread more generally to the population at large in the future and that education is the most effective means of fighting further increases in the numbers of people infected. It is important to bear in mind that an increase in the number of cases in the next 3-4 years is inevitable because of the long incubation period - anything from 1-5 years. Mr Patten was advised in America that there is no real prospect of an effective vaccine or drug therapy before 1990.

We have already taken action to deal with AIDS - a list is attached at Annex A and a number of other measures are in hand or about to be undertaken.

EDUCATION/PREVENTION

"At Risk" Groups.

The Chief Medical Officer is involved in discussions with organisations dealing with these groups with a view to launching a research-based advertising campaign later in the year.

E.R.

General Public

We are looking into the possibility of conducting a rapid survey in order to discover the general level of public knowledge about and attitudes to AIDS. This would enable us to judge how best to pitch any further information compaigns aimed at the general public.

TREATMENT

Mr Patten has asked the Chief Medical Officer's Expert Advisory Group on AIDS to look into the possibility of setting up 1 or 2 day care centres for patients who do not require hospital in-patient treatment. The hospitals treating AIDS patients (mainly in the London area) are now under extreme pressure. The main centres are: St Mary's Hospital, Paddington, St Thomas', The Middlesex and St Stephen's Hospitals. We have recently announced that all health authorities have been asked to draw up plans for a nationwide counselling service. We have funded St Mary's Hospital, Paddington to set up a new training course for those involved in counselling at Regional and District level.

SCREENING

Three screening test kits for use in blood donor centres are now being evaluated. We aim to introduce the test nationally in October. We are taking steps to ensure that the United Kingdom is self-sufficient in all blood products as soon as possible. In particular we have invested £35 million in new developments at the Blood Products Laboratory, Elstree which should begin to come into production during 1986. In the meantime all blood clotting products for use in the treatment of haemophiliacs are being heat-treated.

WIDER IMPLICATIONS OF AIDS

Officials here are beginning preliminary action on the formation of an inter-departmental group to be chaired by this Department. This group will consider - at official level - how best to deal with subjects like screening of occupational groups, life insurance, housing and any other questions which cut across the range of Government departments.

Mr Patten is proposing to make a low-key announcement some time in the near future setting out the measures which we have already taken, giving an indication of the action we propose to take in the near future and stressing that no matter what we do now, the numbers of AIDS cases will increase over the next 2-3 years because of the long incubation period of those already infected.

Yours sincerely

Jane

JANE McKESSACK
Private Secretary

MG

ANNEX A

AIDS: MEASURES TAKEN

1. In February 1985 the Expert Advisory Group on AIDS was established consisting of experts on all aspects of the disease.

2. Advisory Committee on Dangerous Pathogens have drawn up guidelines to safeguard the health of medical, nursing and other staff who may come into contact with AIDS. Issued on 16 January 1985.

3. The Health Education Council have produced a leaflet for those in at risk groups or others who have the disease. (Copy attached)

4. The Blood Transfusion Service has issued a leaflet to discourage at risk groups from donating blood. (Copy attached)

5. Tests are being evaluated to screen blood for the AIDS related virus (HTLVIII). It should be in operation on 14 October.

6. Product licences have been issued for heat treated factor VIII for haemophiliacs. Steps are also being taken to ensure that the UK is self-sufficient in blood products as soon as possible eg £35 million investment in new development at Elstree.

7. The Chief Medical Officer has sent a letter to all doctors in England. This provided information on groups at risk, clinical presentation and diagnosis, and measures to prevent the spread of the infection. (Issued on 15 May 1985).

8. The Chief Nursing Officer has sent out a letter to Regional Nursing Officers and the professional nursing organisations on the community care of AIDS patients. (Issued on 15 July 1985).

Some facts about

A.I.D.S.

Acquired Immune Deficiency Syndrome

HEALTH EDUCATION COUNCIL

What is AIDS?

AIDS is a very rare condition which prevents the body's defences from working properly. As a result, people may get illnesses which the body would normally be able to fight off quite easily. Some of these illnesses can become serious or fatal.

Many AIDS patients have one or both of two rare diseases:

Kaposi's sarcoma - a type of cancer mainly of the skin, but also affecting other organs.

Pneumocystis carinii pneumonia - a serious infection of the lungs.

Why is it called AIDS?

AIDS stands for Acquired Immune Deficiency Syndrome.

Acquired - means that it's caught from someone or something as opposed to inherited.

Immune Deficiency - you've got an immune deficiency when your body can't defend itself against certain illnesses.

Syndrome - the illnesses you can get as a result.

Who gets AIDS?

By October 1984 there had been about 7000 cases of AIDS reported worldwide. The USA was the country most affected: 6250 of the cases were reported there.

Nearly three quarters of all AIDS patients are gay men.

About a fifth are drug addicts, both men and women, who shared needles.

The others include:

people from Haiti

Africans from Central Africa

patients who had received blood transfusions from infected donors

women who had bisexual partners or partners who were intravenous drug users

the newborn babies of mothers who had AIDS

haemophiliacs (people who need to be treated with blood products from donated blood, to make their blood clot normally).

In the UK, 88 cases of AIDS had been reported by October 1984 -more than three quarters of them gay men.

It is *extremely* rare to find a case of AIDS in people who do not belong to any of the "high risk" groups listed.

Is AIDS catching?

Recent evidence suggests that AIDS is caused by a virus that can be passed on in two ways:

1 during sex (in much the same way as hepatitis B is passed on), or

2 if a person comes into contact with blood that is already infected. Some intravenous drug users who use other people's needles may have got AIDS in this way, as the used needles would have been in contact with someone else's blood.

There is absolutely no reason to think that AIDS can be spread through the air, or by touch.

What are the symptoms?

Now hang on … as you begin to read this list of symptoms, you might start thinking "Yes, I've got that … and that … and that … Oh no, I've got it." Well, perhaps, but most probably not. Remember:

☐ AIDS is extremely rare even among people in the "high risk" groups

☐ it's only if you have many of these symptoms together and if they last for a long time that AIDS might possibly be the cause

☐ there can be lots of other reasons for nearly all these symptoms. For example, swollen glands can be a sign of glandular fever, and tiredness, fever and weight loss are much more likely to be signs of worry or going without sleep, or a sign of a cold coming on.

The symptoms which may *suggest* AIDS are:

Swollen glands, especially in the neck and armpits.

Profound fatigue, which lasts for several weeks, with no obvious cause.

Unexpected weight loss - more than 10 pounds (4.5 kg) in two months.

Fever and night sweats, lasting for several weeks.

Diarrhoea which lasts for more than a week, with no obvious cause.

Shortness of breath and a dry cough lasting longer than it would if it were just from a bad cold.

Skin disease - new painless, flat or raised, pink to purple blotches, hard in texture, getting bigger, like a bruise or a blood blister. These may appear anywhere on the skin, including on the mouth or eyelids.

Thrush - a thick whitish coating in the mouth or throat. In men, thrush may also appear as irritating little white spots on the end of the penis or as a white discharge from the rectum. In women, thrush is a very common infection which causes an irritating white discharge from the vagina.

If you're worried

Go to your GP or to a clinic which specialises in genito-urinary infections. Depending on where you live, these clinics may be called a sexually transmitted disease (STD) clinic, a Special Clinic or a GU (genito-urinary) clinic. You don't need to take a letter from your GP and you don't usually need to make an appointment for a visit, but check with the clinic first.

To find your nearest clinic, look in the phone book under VD (Venereal Disease). If you have any trouble finding it, Gay Switchboard (tel: 01-837 7324) can tell you where your nearest clinic is.

For further information about AIDS, you can contact the Terrence Higgins Trust AIDS Information Line on (01) 278 8745 from 8 p.m. - 10 p.m., Mondays to Fridays or you can write to Terrence Higgins Trust, BM/AIDS, London WC1 3XX.

Is there a test for AIDS?

There's no quick and easy test which will tell you yes or no. AIDS can only be diagnosed by medical examination and repeated laboratory tests.
If you go to see a doctor, he or she will

☐ take details of any past illnesses

☐ give you a complete medical examination

☐ take a small sample of your blood and test it to see if there are any signs of lowered resistance. Even if there are, this doesn't necessarily mean that you've got AIDS. There are lots of other reasons for lower resistance.

If you are at all concerned, the best thing you can do is to see your doctor or go to your clinic.

What happens if it is suspected that you have AIDS?

You will probably be admitted to hospital for a full check-up and for treatment of any serious infections.

You may then be able to go home but will need to be carefully checked and will probably need further treatment for other infections.

There is, *as yet*, no treatment for the basic disease.

Reducing the risks for gay men

The best advice for gay men is to keep down the number of different sexual partners you have and to be as sure as you can that your partners are restricting the number of partners that they have, too.

It's not yet known whether the way you have sex affects your risk of getting AIDS. Until more is known, the only completely safe type of sex is masturbation.

Using a condom *may* help to reduce your risk of getting AIDS, and in any case it can protect you against other sexually transmitted diseases.

Should you give blood?

Some gay men have the AIDS virus in their body, but do not know that they've got it. So to avoid the risk of spreading the virus, gay men are asked not to give blood.

For further information, see *AIDS and how it concerns blood donors*, a free leaflet available from the National Blood Transfusion Service and from STD clinics.

What is being done

Research is being done in the USA and other countries and there have been major developments in finding the cause of AIDS, and in recognising the early signs of the disease. There has also been some progress in methods of treating the resulting illnesses.

For further information

Gay Switchboard: (01)-837 7324 (open 24 hours) can answer general queries about AIDS. They can also give you details of your local clinics and can put you in touch with local gay support groups.

Terrence Higgins Trust (BM/AIDS, London WC1N 3XX) runs an AIDS Information Line (01) 278 8745 from 8 p.m. - 10 p.m. Mondays to Fridays and runs a support group for people with AIDS, and their friends and families.

Books

AIDS - Your questions answered, Richard B. Fisher, Gay Men's Press.

The AIDS handbook, Kenneth H Mayer MD and H F Pizer, Bantam Books (Toronto, New York, London and Sydney).

HEALTH EDUCATION COUNCIL
78 New Oxford Street London WC1A 1AH

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Designed by Information Design Workshop

STD 21

A.I.D.S.

IMPORTANT NEW ADVICE FOR BLOOD DONORS

National Blood Transfusion Service

January 1985

WHAT IS AIDS?

AIDS is short for Acquired Immune Deficiency Syndrome, a rare disease that has been recognised only recently. It is a serious disease which depresses the body's normal resistance to infections and other illnesses. AIDS is caused by a virus. But it does not seem to be transmitted by ordinary day-to-day contact.

WHO IS AT RISK FROM AIDS?

1. Practising homosexual and bisexual men.
2. Drug abusers, both men and women, who inject drugs.
3. Sexual contacts of people in these groups.

AIDS has also occurred in a small number of haemophiliac patients who are treated with blood products.

There is evidence that some people who have lived in Haiti or Central Africa, particularly Zaïre and Chad, may be at risk from AIDS.

HOW CAN THE RISKS TO OTHERS BE REDUCED?

Donors in the risk groups must **not** give blood. Some people in these groups may unknowingly carry the AIDS virus in their bodies.

CAN PATIENTS GET AIDS BY TRANSFUSION OF BLOOD?

Yes, but there is only a remote chance of this happening with ordinary blood transfusions given in hospital.

CAN PATIENTS GET AIDS BY TRANSFUSION OF BLOOD PRODUCTS?

Yes. A very small number of patients suffering from haemophilia, an illness in which the blood will not clot, have developed AIDS. Haemophiliacs are more susceptible to AIDS because they need regular injections of a product called Factor VIII. This is made from plasma obtained from many donors. If even one of the donors has AIDS virus, then the Factor VIII would transmit the disease.

CAN BLOOD DONORS GET AIDS BY DONATING BLOOD?

No. Neither AIDS nor any other disease can be contracted from giving blood. All the materials used for collecting blood are sterile and are used only once.

WHERE CAN DONORS GET MORE INFORMATION ABOUT AIDS?

Donors can discuss in confidence whether to give blood

- with a doctor at the blood collection session
- with their own doctor
- with the Director of their Blood Transfusion Centre
- at any Sexually Transmitted Disease (STD) Clinic.

To find your nearest clinic look in the phone book under VD Clinics (Venereal Diseases).

There is also a leaflet 'Some Facts About AIDS' available from your local Health Education Unit. The address is in the 'phone book under local Health Authority.

REMEMBER, AIDS IS A SERIOUS DISEASE

Please do **not** give blood

- if you are a practising homosexual or bisexual man
- if you are a drug abuser who injects drugs
- if you are a sexual contact of any of these people.

We know that all donors are responsible people who give blood for the benefit of others and we thank you for your continuing help.

Prepared by the Department of Health and Social Security and the Central Office of Information for the National Blood Transfusion Service 1985.

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