DEPARTMENT OF HEALTH & SOCIAL SECURITY
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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.

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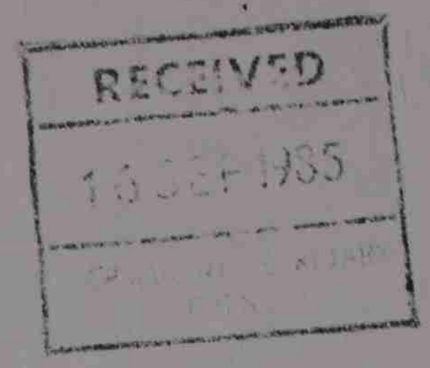

Ms Bateman

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

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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.

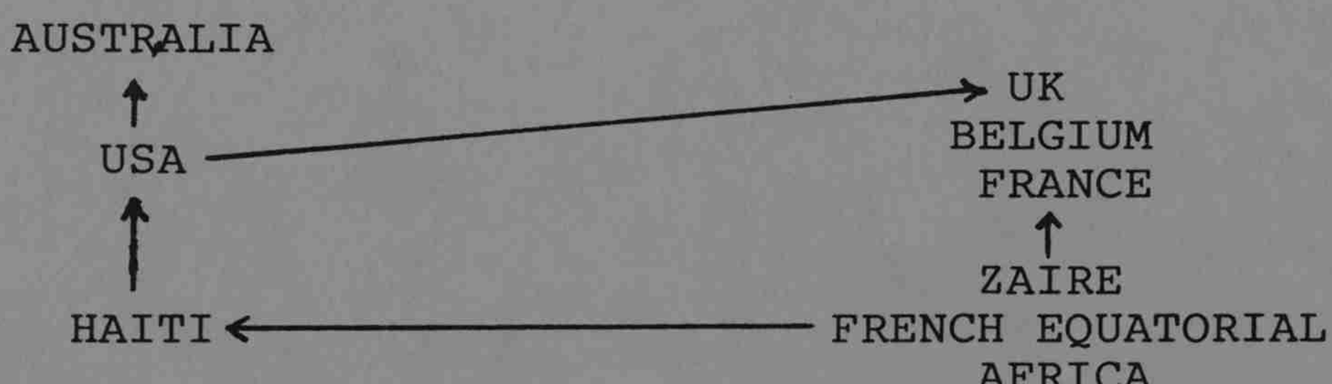
b. Numbers of infected persons

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.