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THE SCOURGE OF AIDS

From winter, plague and pestilence deliver us.

Thomas Nashe, 1592

A new fatal disease of unknown cause threatens blood supplies

I first heard about AIDS early in March 1983, while I was on the National Blood Transfusion Committee. We knew little about a disease that had been taking lives in the US for more than two years. At the time it was thought to be restricted to male homosexuals in California and New York, to injecting heroin addicts and to people from Haiti. Occurrence of the same abnormality in the T lymphocytes of men treated with Factor VIII concentrate for haemophilia strongly suggested a new blood-borne virus that spread in a manner analogous to hepatitis B.[1] The first case of AIDS to be diagnosed in Australia is believed to be that of a gay American man at St Vincent's Hospital, Sydney, late in 1982, but this did not appear in Australian medical literature until April 1983.

I was asked by the Executive of the NBTC to consult with US and international Red Cross contacts and with our own expert Working Party on Coagulation Factors used in treatment of haemophilia. I was to advise on action to be taken by the BTS. There was, at that time, no reason for us to believe that the disease itself was established in Australia.

The Sydney Blood Bank Director, Gordon Archer, subsequently invited a visiting blood specialist from the US to speak there on the topic. On 9 May, Archer unilaterally called on promiscuous male homosexuals and intravenous drug users to refrain from donating blood, and public notices to this effect were posted at the Sydney Blood Bank. The *Sydney Morning Herald* reported this on 11 May, resulting in public fear about the safety of blood transfusion. I had released a statement on 10 May, reassuring the public that there was no evidence at that time of the disease in Australia, apart from the American visitor. It was feared that people in critical need of blood transfusion might refuse treatment.

The community had become aware of AIDS from a dramatic article in *The Australian* on 5 May asserting the advent of a new 'Black Death' about to sweep the world. On 12 May, the Red Cross statement was reissued because of the *Sydney Morning Herald* report but, that very day, a case of AIDS was reported in Melbourne and shortly after another in Sydney. On 13 May Archer's Blood Bank was publicly picketed by members of what was termed the Gay Solidarity Group on the grounds of 'unwarranted and discriminatory action'. Events were moving quickly.

By 26 May, and the meeting of our Working Party on Coagulation Factors, three Australian cases of AIDS had been identified. US reports indicated more clearly the risk of transmission of the disease through transfusion and by blood products in treatment of haemophilia. The US Department of Health and Human Services was, by this time, recommending exclusion of male homosexuals with multiple partners and intravenous drug injectors from blood donation. We decided to do likewise. The reference to 'multiple partners' was intended to minimise social unrest from stigmatisation of all homosexual men, those living in strictly monogamous relationships not being a 'risk'.

On 27 May, as Chair of the NBTC, with advice from the working party, I sent a message to all Australian blood transfusion services and Red Cross divisions, recommending that

> … transfusion services not collect whole blood or any of its components from the following categories of potential donors:
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> 1 Persons with symptoms or signs suggestive of AIDS.
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> 2 Sexually active homosexual or bisexual men with multiple partners.
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> 3 Present or past abusers of intravenous drugs.
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> 4 Sexual partners of persons in the above categories.
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> The Working Party noted that no cases of AIDS in Australia had yet been associated with the administration of blood or blood products. Nonetheless, it considered it prudent to err on the side of caution and to adopt the above recommendations which were based on those of the US Department of Health and Human Services in a form applicable to this country.

In addition to the above, a reassuring public statement was promulgated:

> The transfusion services in this country have taken steps to minimise the likelihood of donation of blood from volunteers belonging to any of the groups in the country known to be at particular risk.

This assumed that my advice as Chairman would be implemented forthwith in all divisions. Sadly, not all took appropriate action. The failure in 1978–82 to gain agreement to adopt national policies left the state divisions to go their own way. A number did just this.

Anonymous testing of all blood donations for syphilis and hepatitis B on blood donation was undoubtedly an attraction for some highly promiscuous gay men to keep a confidential check on their health. We knew there were gay men amongst our donors. The picketing in Sydney, if nothing else, suggested resentment at exclusion. There was much discussion about requiring all donors to complete a declaration form stating that they did not belong to any of the declared risk groups.

The NH&MRC acts

Early in July, I reported to the 95th Session of the Council of the NH&MRC on the likelihood of the new disease representing a public health risk. I was asked to establish a working party on AIDS. Our terms of reference were:

> To consider the available information on AIDS, as it relates to the Australian situation and
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> (i) to recommend appropriate courses of action to enable diagnostic and treatment facilities to be provided for the care of patients at appropriate centres,
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> (ii) to monitor evidence of spread of disease and to recommend measures aimed at its containment, and
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> (iii) to keep health professionals and the public (particularly those associated with blood or blood products) informed as to the situation by reporting to the Director General of Health and the Public Health Advisory Committee.'

Although we were to report to the NH&MRC, because of public concern we were given the right to speak directly to the press—an unusual arrangement for the NH&MRC and the Commonwealth Department of Health.

Those initially appointed to the working party, on my advice, were Dr Bob Beal (Director of Blood Transfusion Services, South Australia), Associate Professor Clem Boughton (Director, Division of Infectious Diseases, Prince Henry's Hospital, New South Wales), Associate Professor Ronald Penny (Head of Immunology at St Vincent's, Sydney), and Dr Peter Schiff (Director, Plasma Fractionation, CSL), with a secretary from the NH&MRC. By our second meeting in October, we had added Professor Ian Gust, Director of the Virus Laboratory at the Fairfield Infectious Diseases

Hospital, a person of international standing in the field of hepatitis viruses, and Dr Julian Gold, at that time with the Commonwealth Institute of Health in Sydney, a person working on data collection on disease—the discipline of epidemiology. We were joined, from time to time, by state public health officers, Dr Graham Rouch of Victoria and Dr Tony Adams, Chief Medical Officer of New South Wales, to maintain links with the Public Health Committee of the NH&MRC. Associate Professor David Cooper was closely associated with Ron Penny in Sydney and linked with our work in a number of ways.

The initial meeting of our committee was on 25 July 1983 at the Faculty of Medicine, University of Melbourne, as were most others over four years. There were now some sixteen men in New South Wales and Victoria suspected of developing AIDS. New South Wales, Victoria and Queensland moved to make AIDS a notifiable disease, following the NH&MRC discussion, providing a means for data collection. State authorities were eager to work closely with us, a consistent pattern over the next four years. Our first task was to access all the information available from the US Center for Disease Control (CDC) in Atlanta, Georgia, and in medical journals. Press interest in the disease became high and remained so over four years.

In 1983, little was known about AIDS beyond a handful of reports in medical journals in 1981 and 1982. The CDC had commenced collecting data on the disease in 1981 and reported its incidence and manifestations. The condition had been recognised in groups of homosexual men, first in California and then in New York, and shortly after in Europe, showing very selective impairment of a particular T cell of the immune system (CD4), a propensity to pneumonia associated with an uncommon germ, *Pneumocystis carinii*, and in some instances, the development of a rare skin cancer, Kaposi's sarcoma. The disease appeared to be rapidly fatal. In addition to gay men, it was identified in people sharing syringes and needles for intravenous injection of drugs, and in immigrants from Haiti.

At first, communicating with the media was assumed to be an occasional event, but requests for information burgeoned. Soon press queries occurred daily, with journalists ringing my home from 6 a.m., seeking comments on the latest statement gleaned from media outlets around the world. Other members of the working party were also frequently asked for comment, which we freely gave, based on evidence as we knew it. It was often a matter of hosing down emotive and inflammatory statements in an avuncular manner, seeking to gain public understanding of issues on the basis of objective evidence and to minimise the stirring of unreasonable fears. We urged use of public health principles to curb the spread of what was clearly an infective disease, presumed by us to be due to a virus rather than due to homosexuality as such. Quarantine was not an option, if for no other reason than that those incubating infection could not be identified. Educating the community about the disease was the best way to allay anxiety and to minimise the consequences of prejudice.

We received every *Morbidity and Mortality Weekly Report* (*MMWR*) issued by the CDC and made a commitment to keep one another fully informed as evidence became available. Ian Gust was an outstanding virologist whose laboratory had been one of two in the world responsible for identifying the hepatitis A virus. He had played a significant role in the World Health Organization (WHO) committees on hepatitis. He became a key contributor in the development of our strategies and the research base we employed to combat the epidemic. His international contacts were invaluable and he shared with me much of the responsibility for keeping the media and community groups informed about scientific and public health evidence.

We recommended establishment of a formal second tier of AIDS advisory committees in each state and territory, convened by public health authorities with input from BTS directors, to include expertise in infectious diseases and to involve community groups affected, particularly the gay community. The Commonwealth Chief Public Health Officer, Dr 'Spike' Langsford, worked with me in 1983–84 to bring these into existence. They played a key role; state governments had the power to rapidly implement recommendations as they saw fit.

On 15 August 1983, at the request of the Sydney gay community, Ron Penny and I attended a large public meeting in Paddington Town Hall chaired by [redacted] former mayor of Paddington. More than 600 people were in attendance, and we had a lively meeting, the audience including such oddities as the very male Sisters of Perpetual Indulgence, resplendent in exotic nuns' habits. There was hostility towards the Sydney Blood Bank, but there was also eagerness to hear what was known scientifically about the disease and our view as to how to handle it in terms of reducing risk of transmission by the use of condoms. I reiterated the need for gay men with multiple partners to refrain from donating blood and made a commitment to provide minutes of our working party meetings to the recently formed Sydney AIDS Action Committee (AAC). The meeting ended positively and I anticipated good relations with the gay community.

The formal AIDS Advisory Committees in each state became the major conduits for liaison between health authorities, blood transfusion services and with the gay community. In Victoria this worked well, with support from the state Department of Health, which formed its own AIDS Unit. It employed the very responsible Philip Carswell, previously an education union official and long-standing counsellor on gay issues, who was to become an important player in national committees. There was also a very able journalist, Adam Carr, editor of the gay journal *OutRage*, which played an important educational role. Dr David Bradford, head of the Victorian STD clinic, was a former surgeon who had given up operating [redacted]; he became a highly responsible influence, seeking rational plans rather than those heavily tainted by the political priorities of 'gay rights'. The same cohesion was not enjoyed in New South Wales, however, where gay groups tended to compete with one another. The politics of 'gay law reform' was potent and was, in many ways, their over-riding concern.

Learning about the gay culture

In 1983, I was on a steep learning curve on issues of gay lifestyle and was given valuable advice by [redacted]. I visited a Melbourne bath house with him—out of hours—and was amazed both by the variety of devices and situations used and his account of patterns of sexual behaviour. I was astonished at the huge number of sexual partners of some these men—their sexual energy was prodigious. Whilst journalists loved to make much of all of such matters, the reality was that very many men in male homosexual relationships led quiet, stable, monogamous lives and would also be at risk of victimisation. Conservative social and religious views (strongly condemning homosexuality) had wide currency in newspapers and on radio, identifying homosexuality itself as the cause of the epidemic.

Leaders of the gay community, particularly in Sydney, had been lobbying vigorously for homosexual law reform and campaigning against discrimination, which was still rife. Male homosexual intercourse was still illegal in New South Wales, although such legislation had been rescinded in Victoria in 1978. They felt threatened by AIDS, not only in terms of health, but also had reason to fear discrimination and that their new-found rights could be in jeopardy. I am still, to this day, struck by the hostility expressed by some community and religious leaders in their public denunciation of male homosexuality. There is no doubt some adolescent boys go through a period of ambiguous sexual orientation, later becoming resolutely heterosexual. I often wonder whether the behaviour of some men prone to extravagant attacks on gay men might represent the consequence of suppressed feelings of guilt due to such adolescent ambiguity. This was, however, the context in which we had to work. We had to get the public to accept calm, rational and open discussion of sex and sexuality.

Many male homosexuals lead constructive lives in stable, long-term relationships. They are often sensitive and creative people, perhaps less curbed than others by conventional views. Leonardo de Vinci was almost certainly gay! We had no treatment to offer against the spread or cure of this new illness, and the epidemic would have to be handled through public education. If male homosexuality was represented as the 'cause' of the disease, we would not get effective cooperation. I came to play a significant role in this public debate over several years, urging in a calm manner, again and again, that the disease be handled as a limited viral epidemic rather than as a 'gay plague'. Even in recent years I am identified and thanked by gay men in stable relationships for the contribution I made.

The initial Haiti connection was not well understood. It was a common vacation venue for New York gay men, but very probably its Afro-American community had been infected through contacts in Angola, to which many had been recruited as mercenaries in that country's long-running civil war. In 1983 little was known of the huge reservoir of HIV infection in central Africa, from which we were later to learn the pandemic had originated.[2] The disease had arisen from a closely related virus carried by African chimpanzees.

At the time of our first working party meeting, Peter Schiff had returned from a meeting on AIDS at the US National Institutes of Health. American public health authorities had decided not to impose mandatory withdrawal of blood products (Factor VIII) to which AIDS patients had contributed. Companies involved in supplying blood products considered the issue and decided: 'The unquantifiable but very small risk of transmitting AIDS to hemophiliacs through blood products must be weighed carefully against risk of sub-optimal treatment of their underlying disease'. There was always pressure to supply more Factor VIII than was readily available, particularly for home therapy. Any significant reduction in supply was represented as withdrawal of life-saving support for men with haemophilia. The decision, we learned subsequently, was consistent with that expressed by the World Federation of Hemophilia Congress in Stockholm in June 1983, a body comprising both medical and haemophilia family interests worldwide. Factor VIII concentrate from large pools of plasma, including donations from AIDS sufferers, continued to be used in many countries for a time.

At our second meeting in September 1983 we received a passionate submission from Lex Watson, a Sydney University academic then leading the Sydney AAC explaining their deep concern over social discrimination arising from 'media hysteria', which would lead to serious erosion of gay rights. He was also concerned about lack of knowledge about the nature of the disease and about negative attitudes of many members of the medical profession, who lacked understanding of the gay lifestyle. These concerns were acknowledged as real.

First steps to safeguard blood supplies and to limit the spread of disease

Australia was not the only country having difficulty in making appropriate decisions to exclude 'at risk' people from blood donation. The US Food and Drug Administration (FDA) heard both from companies involved in human plasma processing and a physician representing the gay community urging that such donors should not be excluded, despite strong advice to the contrary from public health officers of the CDC. A gay physician is documented as asserting that exclusion of gay men represented 'scape-goating', a term I was to hear many times in the following years. In September 1983 we followed CDC advice on developing donor declaration forms, seeking to firmly exclude male homosexuals with multiple partners and intravenous drug users. There was no other tool at the time to protect against transmission of the virus through blood. We passed this advice through the NBTC of Red Cross, from which I was in the process of stepping down. I have no doubt many responsible gay men did withdraw from donating blood, but others failed to do so, as became clear in the next year.

In Sydney, there were media releases, some purporting to be from the 'Gay Army', and others from the Sydney AAC, more concerned about gay rights. I was told by one of the AAC leaders: 'You don't understand. This is not an infectious disease, it is a social and political disease and we must be part of any decision about what is to be done'. They strongly opposed what they saw as our 'medical model' in dealing with an epidemic—that of attempting to identify the causative virus, monitoring its spread, finding out how to inactivate it outside the body based on experience with other viruses, and recognising special responsibility of those likely to carry the infection not to put others at risk without their knowledge.

The Sydney AAC demanded membership of our committee which, under NH&MRC processes, I was not in a position to offer. We recommended they liaise through the state advisory body. Lex Watson proposed that no research of any kind related to AIDS be undertaken without their oversight and approval, project by project, to which I could not agree. In 1984 we sought funds for research from the NH&MRC, and the Council allocated more than we requested. In due course these funds were disbursed by a formal NH&MRC AIDS Research Committee, which I chaired.

In retrospect, we were unwise to accept the US formulation of 'male homosexuals with multiple partners', however well intended, as it turned out that donors with 'a few' partners considered themselves as 'not excluded', by comparison with some who might have a dozen or more sexual partners in one night. To us, 'multiple' meant having had more than one. A group styled as the Sydney Gay Army reported to us in September 1984 that gay men were continuing to donate. This was hotly contested by the AAC, in which Lex Watson continued to play the lead role; he insisted that the Gay Army consisted of only one man and should not be taken seriously.

We hoped that Australia's blood transfusion service would fare better than the US through having only volunteer donors. We knew of active educational initiatives through gay publications to prevent spread of the virus with use of condoms, and to dissuade gay blood donors. These were excellent initiatives. Whilst they were encouraging, further discussions with gay groups began to be difficult.

In September 1983, we released a publication entitled *Facts about AIDS*, based primarily on information from the US. The *MMWR* from the CDC was invaluable. They also gave advice on infection control, which we modified for Australian conditions in another publication. We worked closely with the health reporters of major city papers so they would understand emerging information. This contributed greatly to avoiding inappropriate 'scare' stories likely to fuel antipathy towards the gay community or others carrying the infection, and the risk of social disruption.

In a meeting in Geneva in the middle of 1983, Ian Gust sat with Luc Montagnier, Director of the Institut Pasteur, who spoke of finding what they termed 'Lymphadenopathy Associated Virus' or LAV, from a patient with AIDS. His report was met with scepticism by the Americans present. We were satisfied that such a virus, if confirmed, would prove to be the cause of the disease.

Community concerns

During 1983 the number of deaths from AIDS was small, but through 1984 it doubled approximately every four months. The first case in Australia of the disease being transmitted through blood transfusion was identified in Sydney in July 1984. By this time, there were widespread cases of AIDS in male homosexuals, but some blood banks still refused to require use of donor declaration forms to exclude such men.

By late 1983 there had been confirmation in the US of Institut Pasteur's report of the virus causing the disease. Outside the body, the virus could readily be killed by disinfectant, so it became possible to calm some of the more wild fears. By September 1984, however, the public clearly linked AIDS with blood transfusion after a further case of transfusion-induced disease. People failed to distinguish between the role of blood donor and recipient, leading to a progressive reduction in blood donations.

In October 1984, a very detailed report on the disease from our NH&MRC working party was published in the *Medical Journal of Australia*.[3] It had been written some two months before the publication appeared. Even by October, it was being overtaken by events. The journal included a paper from Lex Watson entitled 'Living with AIDS', one from Terry Goulden and others from the New South Wales Gay Counselling Service entitled 'AIDS and Community Support Services', and from David Cooper and others of Sydney's St Vincent's on contact tracing, important in assessing the epidemic. The consequences of AIDS for the community were becoming better understood. The publication was a turning point, bringing together both the medical evidence and an objective account from the gay community of what they were facing.

There was real fear in the community. Here was a new, fatal disease for which medical science had not initially been able to identify a cause, let alone a cure. It was the first time in many years that a potentially fatal infective disease had arisen for which there was no known treatment.

The community had become complacent, confident that infections could always be treated with current or new antibiotics. Lessons of the 1930s epidemics had been largely forgotten. It had then been accepted that people themselves were responsible for avoiding infection or infecting others. To this was added the potent mixture of sex, of homosexuality, of moral overtones from some prominent fundamentalist Christians implying that the disease was a natural consequence of depravity and that sufferers deserved no sympathy. People with infection other than male homosexuals were frequently referred to as 'innocent victims'.

The male homosexual community was kept well informed from shared experience through their own newspapers, through gay publications from the US, by our committee members and others serving in the state committees, by medical people within their own community or by those providing clinical services. They responsibly advocated use of condoms and the mantra of safe sex.

Some incidents were quite colourful! I remember one morning in 1984 being interviewed on national radio as I ate breakfast, about terms current in the gay lexicon alluding to anal intercourse and other sexual practices. I began to explain the first term offered, but as the reporter went on, I interrupted the flow with the statement, 'I do not think it is appropriate to discuss such matters over breakfast!' Nonetheless, it became critically important to work closely with the major health journalists. Every time allocation of responsibilities for health reporting at a major paper changed, we had to brief an incoming reporter. It was time well spent.

There was public speculation about spread of the disease through brothels, where men were being urged to use condoms. I well remember a call from the madam of a large and 'superior' brothel in Sydney who wanted advice. The only location convenient in my busy program was the Qantas Private Lounge at Melbourne Airport. I arranged use of their small conference room and awaited her arrival. Her entry into the large room attracted the eyes of all the men in the busy lounge! She was a buxom lady, elaborately made up, exotically dressed and coiffured. No one could miss her profession. We retreated to our conference room. She explained that she gave advice to clients about the importance of condoms. She tutored her girls, some of whom, she said, were university students, doing part-time work to assist their finances. They all had a regular check for infections. I commended her on these initiatives and assured her that the risk of transmission of the disease was far less with vaginal intercourse than with anal penetration. She thanked me, and waltzed out through the lounge as, again, every head turned to watch!

Another memorable episode was when I was invited to an urgent meeting of the Airline Pilots Industrial Association. This followed a Qantas pilot setting off on a flight to Los Angeles carrying dinner, prepared by his wife, in a paper bag. He said he could not risk having a gay steward sneeze over his meal as it was carried to the flight deck. I was able to convince a large audience that studies by the CDC in Atlanta, completely ruled out spread by saliva or skin contact. No single health professional had acquired the infection over several years through physical contact in caring for sufferers of the disease. There were, undoubtedly, many male homosexuals amongst the cabin attendants, but only simple safeguards were needed within aircraft.

Another recurring proposition was the possible spread through blood carried by mosquitoes. In reality, the pattern of spread in states like Florida, with its large mosquito population, completely ruled this out. When a mosquito is swatted, the blood it carried rests outside the skin; the injected saliva itself carries no infection. However, this was a recurring scare story on talkback radio.

The cause is confirmed—a virus the villain

Both Institut Pasteur in Paris and at the National Cancer Institute in Baltimore had searched for the virus at speed. Discovery of the virus at Institut Pasteur, under Luc Montagnier, was confirmed. It was classed as a ‘retrovirus’, reading its chemical and reproductive message into the DNA of the cell (the opposite direction from that leading to normal protein production). The cell then reproduced copies of the virus in very large numbers. It was detected in a particular class of lymphocytes (the CD4 subset of T cells) responsible for one aspect of immune protection of the body. It severely depleted these cells, giving rise to the selective immune deficiency for which the disease was named. The discovery was reported simultaneously from the two laboratories in *Science*.[4]

It transpired that Gallo's report from Baltimore used a picture of the virus sent to him by Montagnier. This led to an acrimonious dispute over scientific priority. Montagnier and Barre-Sinoussi from the Institut Pasteur were jointly awarded the 2008 Nobel Prize in Medicine. The virus was variously named Lymphadenopathy Associated Virus (LAV) or HTLV III, because of two other known human T lymphocyte retroviruses. The term Human Immunodeficiency Virus (HIV) was later adopted. Identification of the virus led to a hectic chase to develop a test to screen blood transfusion. Antibodies to the virus could be more readily detected than the virus itself. Contracts were given to five major pharmaceutical and biotech companies to compete in development of an appropriate test and the FDA established a fast track for approval.

Ian Gust liaised with Luc Montagnier, who twice attempted to provide us with lymphoid cells infected with virus to develop our own tests for the antibody; on both occasions the cells died in transit. In August 1984, Ian sent Robert Pringle from his laboratory to visit the CDC and the National Cancer Institute in the Baltimore. He came back with sufficient virus antigen to run some 20 000 tests. The Gust laboratory rapidly developed an 'enzyme-linked immunosorbent assay' (ELISA) as a screening test, and two more sophisticated tests providing more precise and dependable analysis of the antibody with the so-called Western Blot technique, safeguarding against false positive tests. False positives, if they occurred without detection, could have caused mayhem! Ian then sought to develop a network of collaborators with skills in handling viruses in each capital city in Australia.

Ian proposed a three-tiered structure for national testing—the lowest level providing screening tests in the BTS and community clinics, the second being state reference laboratories with confirmatory tests, and the third a national reference laboratory to be the final arbiter for confirmation of doubtful results, for training and for quality control. The Director of Virology at the CDC and the American Red Cross marvelled at what we were able to do. With its diverse delivery of services, it would not have been feasible in the US.

Fairfield, as an internationally recognised virus laboratory for hepatitis, was the obvious site for national leadership in rolling out the network, but when this was proposed at our September meeting the Sydney members of our Task Force were distressed at missing out to Melbourne. They saw themselves as the natural national leaders of anything to do with AIDS, having reported the first case in Australia and having the greatest number of cases. We suggested they have a national role in developing standards for care and in collection of data on case numbers—the field of epidemiology—and Ian's proposal was accepted.

These critical decisions were made in an AIDS working party meeting on 17 September 1984, a few days before final completion and submission to government of our *Report on Private Practice in Public Hospitals*, and twelve days before I remarried!

'Self-exclusion' from blood donation did not work

Fear in the gay community about public hostility and even civil violence against them was understandable. Despite gay opposition, following recognition of its transfusion-transmitted case, the Sydney Blood Bank required signatures on donor forms, indicating that donors did not belong to the identified risk groups. Use of such forms was strongly commended by our working party, but even as late as September 1984, despite endorsement of such action by the Red Cross NBTC, it was stated by the Victorian BTS that use of signed donor declarations 'would not be done in Victoria'. Furthermore, it was noted in their BTS Management Sub-Committee minutes that 'there had been complaints from donors about being asked to sign a form because of concern that if they did transmit a disease to a patient, legal action could be taken against them'. In November 1984 the Victorian BTS committee noted: 'Some donors who have been giving for years feel they are being persecuted'. That there was resistance illustrated the very need for the forms.

Victoria was not alone amongst world blood transfusion services in this matter. Canadian, British, French and many US blood banks had not required use of donor declaration forms and all used the American reference to 'male homosexuals with multiple partners' in their exclusion policies. Anti-discrimination laws continued to impinge on the way male homosexuals might be excluded from blood donation in countries that had well-developed campaigns for gay rights.

By October 1984, the Gust laboratory was able to demonstrate the presence of the AIDS antibody in a batch of Factor VIII concentrate made at CSL from plasma derived from Sydney. Positive tests were then found in Melbourne patients with haemophilia whose serum samples had been stored over a period of two years. The proportion with the infection had risen from 14 per cent in 1983 to 36 per cent in 1984, indicating continuing contamination of the blood supply. The corresponding figure in Sydney haemophiliacs in 1984 was 47 per cent.

The testing of stored haemophiliac blood samples was carried out in October under circumstances we judged to be a public health crisis. It was done without the usual consultation and signed consent from each individual, which would have delayed us for months. The doctors responsible for care of the subjects were kept fully informed. Tight confidentiality was observed over all individual information. It was vital information for the development of policies that could prevent many more deaths.

We had clear evidence that gay men had continued to donate blood in both Melbourne and Sydney. Many in the gay organisations clung to the hope that 'surrogate' testing for 'core antibody' to hepatitis B would suffice. Although suggested in the US, the American Red Cross blood banks had rejected such testing and the FDA had required several plasma fractionators to desist from using this as a safety indicator in labelling their products. In reality, both the 'core' and the more usual 'surface antibody' hepatitis B tests were positive in a very significant proportion of both heterosexuals and in gay men who did not have HIV infection and would not necessarily be positive in those with HIV.

Late in 1984, in a survey of a cohort of sexually active male homosexuals conducted at the WEHI, it was noted that 10 to 20 per cent of the subjects had continued to donate blood in 1983 and 1984. When blood samples from 1983 and 1984 were tested for the antibody in Gallo's

US laboratory, the number infected rose steadily through that period.[5] Despite this evidence and the dramatic news that subsequently broke from Queensland, I was accused of 'distrust of gay men' when I urged mandatory signed declarations for donors. It was subsequently stated that I 'clearly believed gay men to be irresponsible and unwilling to consider the health of others'.[6]

In mid-November, there was a remarkable discovery that the AIDS virus had infected four Queensland babies. It transpired that a single unit of blood from a male homosexual donor, who had no symptoms, had been used to transfuse four babies in a neonatal ward in Queensland, with devastating outcomes. In one case, paediatrician Dr John O'Duffy saw a very sick 8½-month-old baby with severe thrush and an uncommon form of pneumonia; he found unusual changes in the child's immune system. A pathologist friend, with whom he was sailing one weekend, commented that he had earlier carried out an autopsy on a child, with similar findings. When clinical records were checked, the single transfusion unit was identified as the common factor. A third child, also a recipient, had died in a similar way. A fourth recipient was still alive, but subsequently died. All four babies had been in the neonatal ward at the Brisbane Mater Hospital at the same time. O'Duffy contacted Ian Gust who, over a weekend, confirmed the presence of the antibody to HIV in the blood of two babies and the gay donor, who had been a regular contributor to the BTS for some years.

Once the Queensland government was notified that the donor was a male homosexual who had donated despite the policy of exclusion, on 15 November the state Health Minister called for legislative penalties for donation of blood by people in the high-risk groups. This triggered a national hue and cry.

A national crisis recognised

The Queensland announcement about the four babies let loose an avalanche of community protest against male homosexuals, and by them against the proposed legislation. A federal election was due on 1 December

1984. There was extravagant denunciation of 'gays', particularly of the gay man who had donated the blood, but also of male homosexuals in general. The next day there was an outbreak of violence against gay men in Sydney, and outcries from homosexual groups about 'scape-goating'.

There were protests from the AIDS Action Committees against the proposed penalty for false donor declarations in Queensland. It soon became known that there had been other recipients of blood from this donor, and his plasma had also contributed to a plasma pool for Factor VIII. There was an immediate further drop in blood donations and patients were refusing to be transfused with blood. The situation demanded action despite the imminent election. Neal Blewett, campaigning in South Australia for the election, called an urgent national meeting of Health Ministers in Melbourne for Sunday, 18 November; it became designated by the media as a national AIDS summit.

Ian Gust and I happened to be in Canberra on Friday, 16 November and held an urgent meeting with Spike Langsford, the senior public health officer of the Commonwealth Department of Health. Ian laid out his plan for the national three-tiered structure of laboratories and processes for testing for the AIDS antibody both in the transfusion services and in the community, with carefully planned processes for quality control. We agreed that it was urgent to proceed with all the necessary steps to prepare the BTS to handle screening tests when they became available. Testing needed to be available simultaneously in public health clinics so that high-risk people would not go to the blood banks to be confidentially tested through donating blood. Each state was to have an expert reference laboratory, with Gust's lab recognised as the National Reference Laboratory, responsible for organising evaluation of test kits, for training the staff for the state labs and the BTS, and for oversight of testing across Australia.

We recommended that the kits be imported subject to specific health-related customs control (ordinarily used for therapeutic substances) so that they would only be accessed by approved laboratories with appropriate quality control, with testing to be linked with an obligation for confidentiality and counselling for any persons with positive tests. This was all to be put to the 'summit' two days later, with a provisional price tag of $300 000 to develop the National Reference Laboratory and its network. This was crisis planning in huge detail at high speed!

Neal Blewett's Principal Private Secretary, Bill Bowtell, GRO-C GRO-C, had been instrumental in making all the arrangements for the meeting on the Sunday. I knew little of what was to come except that every state would be represented by its Health Minister and senior health officials. The Queensland Minister refused to attend if the two established gay state AIDS Action Committees were present as Bowtell intended, and they were reduced to making written submissions protesting against penalties for falsely signed donor declarations.

Prior to commencement of the meeting, I had an hour over coffee in the Windsor Hotel with Neal Blewett and Bill Bowtell. The latter explained they had already recruited Ita Buttrose to head a new national committee with responsibility for community relationships and education about AIDS, which would report directly to Blewett. She was rightly seen as a popular and trusted community figure with a proven record of public communication. I supported the proposal. It was suggested by the Minister that the NH&MRC working party's work was important and should have a higher profile as the National AIDS Task Force. He proposed expanding our Commonwealth and state public health expertise, and the inclusion of a male homosexual person, each of which I welcomed, providing the latter was a person capable of contributing constructively in planning research and strategies, rather than a nominee of gay organisations, with which we were having difficulties. We were to report to the NH&MRC, and to state and federal governments, through their public health authorities. I briefed the Minister on our previous discussions about developing testing and the need for urgent decisions, including approval of financial support, if we were to secure access to the testing facilities being developed in the US. Neal Blewett subsequently negotiated with the US authorities to use our network of laboratories and the BTS as a test-bed for the kits, in parallel with FDA trials in the US.

Bill Bowtell had already negotiated with Ita Buttrose, providing an appropriate part-time salary and personal secretarial support. It was to be styled the National AIDS Advisory Committee (soon known as 'NACAIDS'). It would have representation of community groups, including the gay community, the Australian Red Cross Society, the ACTU, the AMA and the haemophilia community, the last position being filled by [redacted], an able person who headed the Haemophilia Foundation of Australia and consistently made thoughtful and responsible contributions. I was to be a member, bringing the knowledge base of the National AIDS Task Force, and Bowtell would represent the Minister. Ita, a former publisher of *Australian Women's Weekly*, was to recruit some high-profile women, including the wives of the Prime Minister and Leader of the Opposition, to become blood donors. I agreed to all of this, and saw clear advantages in there being a different body to handle liaison with the gay community groups and with haemophiliacs, who now faced huge problems.

The Ministers agreed with the entire package, including the proposed funding of a National Reference Laboratory at Fairfield. Queensland, in particular, was keen to see state legislation with penalties for false donor declarations across Australia. Bowtell was strongly opposed to this, as were the gay organisations in written submissions. The Task Force was requested to develop a uniform national donor declaration form, in consultation with Red Cross, and to advise the Health Ministers on the desirability of legislation providing penalties for false declarations. We were to continue national data collection on cases. Blewett proposed inviting an expert from the CDC to visit and advise, to which we willingly agreed.

Ita Buttrose, as Chair of NACAIDS, had no knowledge of AIDS or public health strategies. She was to be assisted by Bowtell, who would report to the Minister, and could speak for the Minister as the head of his office. He and I, and two representatives of the gay organisations, would be the only members with real knowledge of the disease. Bowtell clearly saw NACAIDS as the key committee to control the national agenda, with himself providing advice to Ita. In reality, the work of the National AIDS Task Force was able to continue over the next three years without interruption, with support from Neal Blewett and the state Ministers. That Bowtell regretted our NH&MRC working party continuing is now on the public record.[7] We had secured our future, with a complex organisational plan and the commitment to fund the testing, in just 48 hours!

The formal conclusions of the AIDS summit had a strategy in three parts—the need to deliver:

- information to high-risk groups and the community generally
- steps to safeguard the integrity of the blood supply
- practical efforts, free of prejudice, to modify sexual and other behaviour that may transmit the disease.

In addition to the above, all positive antibody tests were to be reported within our epidemiological framework.

We had terms of reference including the need to advise on 'urgent coordinated national action to combat the spread of AIDS'. We were to liaise with NACAIDS, but had a different reporting track. We were to continue to function as an advisory body, rather than controlling policy or resources. Our recommendations would go directly to NH&MRC, and to Commonwealth and state heads of health administration. Our advice carried weight, and recommendations were rapidly put into effect by governments around the country.

The Task Force acts

Ian Gust moved rapidly to establish his National Reference Laboratory. Space at Fairfield was expanded forthwith, including an animal house converted to laboratories over Christmas. He created a national panel of serum specimens. Five panels of 2000 randomised samples, positive and negative, were used in five different laboratories (including three BTS services) to evaluate the screening kits as soon as they became available from the US late in February 1985.

We met on 14 December as the Task Force, retaining our dual role as the NH&MRC working party. Dr Michael Ross, a very able clinical and research psychologist from Flinders University, GRO-C added to our number, and he made valuable and constructive contributions in our work over several years. Dr Ken Donald, a senior executive from Queensland, added to our skill set in public health administration and took on a number of tasks over the next two years. Public health officers in the states and territories were corresponding members, receiving copies of all papers. Representation of the Commonwealth Department of Health changed many times over the years. Professor John Dwyer, of the Prince of Wales Hospital in Sydney, joined us later (in 1986) on return from working with AIDS patients in the US. All were people of high ability and knowledge of public health issues.

At our first meeting, we confirmed the establishment of the National Reference Laboratory at Fairfield, which was subsequently recognised as a WHO Collaborating Centre for HIV. (I was to hear later that one of our Sydney members personally lobbied the Prime Minister seeking to block that recognition!) We confirmed that all tests were to be voluntary. Positive tests were to be notifiable throughout Australia, with appropriate safeguards for individual confidentiality. All testing outside the BTS was to be linked with counselling.

We finalised the national blood donor form, forwarding it to Red Cross for agreement, and recommended that all states and territories introduce legislation providing penalties for false declarations. We noted that CSL was working through technical problems with heat treatment of Factor VIII preparations for haemophilia. We recommended all restrictions to condom advertising across Australia be revoked to assist the gay community organisations in their safe-sex programs. We approved revised versions of *Facts on AIDS* and *Infection Control Guidelines*, which were then released. The risk of spread of disease in prisons was also considered.

By the time of our January meeting we had, with telephone and fax communications, embarked on a long series of public *AIDS Bulletins*, which continued through 1985. These advised the community, professionals and other employment groups about the reality or otherwise of dangers of AIDS or the way in which it should be handled, with antibody testing where necessary. Topics of individual bulletins through that year covered tissue and organ transplantation, artificial insemination from anonymous donors, dental care, risks associated with first aid and resuscitation work, health-care workers with positive antibody tests, colonic irrigation, the work of plumbers, ear piercing, acupuncture, tattooing, hair removal by electrolysis and the conduct of coronial autopsies. There were fears of risk in schools from any child carrying the infection and unreasonable fears about swimming pools that might be frequented by gay men. I had a number of meetings with representatives of life-insurance bodies. It was an exhausting process, but very necessary in hosing down unrealistic anxieties and to put in place necessary safeguards.

The program of bulletins and associated media comment did much to allay fear in the community and to give confidence that things were in hand for all those in situations or occupations thought to be at risk. Reporters and groups other than those associated with the male homosexual community tended to turn to us for advice rather than to NACAIDS, which was not as Bowtell had envisaged.

The prototype kits from the five American manufacturers arrived and were evaluated. The coded data, from testing at five different centres, was all returned to Fairfield. After decoding, two products gave outstanding results, the data being analysed on Friday, 8 March. The Task Force considered the findings in a national teleconference on Tuesday, 12 March. The outcome was formally approved by the Task Force on Tuesday, 19 March, recommending the immediate issuing of tenders by government and the Red Cross the following day, closing at 5 p.m. on Friday, 22 March! Kits from the two outstanding performers were imported. On 29 April 1985 and thereafter, every single blood donation in Australia was tested for the AIDS antibody, with simultaneous availability of free and confidential voluntary testing through authorised community-based clinics in every state and territory—the first country in the world to achieve this! Blood transfusion in the US was not controlled by a single authority, and took longer to gain total coverage.

Of the first 500 000 blood donations tested over six months, only seven were confirmed as positive. Each of these donors had a recognised risk factor; two were people validly not conscious of this at the time of their donation. This was very different from the situation in the US, which continued to rely on voluntary self-exclusion of high-risk donors and had a much higher number of positive donations. They experienced thirty-eight confirmed positive tests per 100 000 donations[8] compared with our 1.2. The transmission of disease through transfusion had all but ceased with the decision to introduce legal penalties for false declarations, foreshadowed in December 1984, even before legislation and testing were in place. This was further confirmed by a subsequent review of dates of infection in transfusion-infected recipients.[9]

It remained critical to continue to have sanctions against false donor declarations as it became clear that people with early infection would not have a positive antibody test for a matter of weeks, but could still transmit the disease. Protection of haemophiliacs through heat inactivation of HIV in Factor VIII concentrates was very important. In October 1984 CSL had commenced trials, based on experience with inactivation of hepatitis B virus. Significant loss of Factor VIII activity was overcome with a new fractionation process based on research from the Sydney BTS. From early February 1985, all Factor VIII and Factor IX concentrate (used for the two forms of haemophilia) was heat treated and safe. Australia had done well compared with many other countries following the decisions at the end of 1984; many lives were saved.

The review of our policies by Dr James Curren of the CDC in 1985 was full of praise for Australia's coordinated national response.

The tasks broaden

Neal Blewett made a major statement to Parliament on 23 May 1985, declaring that AIDS was 'potentially one of the most serious and expensive public health problems to face Australia since Federation'. He mobilised a bipartisan parliamentary liaison committee, which did useful work to gain rational and responsible public support for the necessary strategies and was supportive in mobilising financial resources. At his request, I met with the Commonwealth parliamentary committee several times. He ensured appropriate funding was available for all the necessary initiatives and provided strong leadership.

As testing became more widely used, it was always voluntary and associated with strict confidentiality and counselling. In February 1986, we adopted a formal policy statement that testing of all persons in the high-risk groups was desirable and that anyone knowing they had a positive test had an obligation not to put others at risk without their knowledge and consent. This was not intended to replace the safe-sex campaign, but to supplement it. To us, it was the logical way to further curb the epidemic once those with the infection had identified themselves.

Our stance was strongly supported by GRO-C, our gay member. GRO-C lived in a monogamous relationship with another academic. He brought to our attention surveys indicating that use of condoms was not invariable, even amongst men fully aware of their importance. Clearly in the heat of sexual passion they might not be used or might break. In an exchange of letters with Neal Blewett, his response to our call for testing, although carefully worded, was clearly supportive.

Early in 1986 the several AIDS Action Committees came together to form the Australian Federation of AIDS Organisations (AFAO), facilitating sharing of information and interaction with NACAIDS and the Commonwealth. A negative, however, was cohesion of opposition to our strategy of voluntary testing associated with counselling. In a meeting on 19–20 April they opposed testing, taking the view that it was discriminatory. 'Safe sex' for everyone, with use of condoms, was all that was necessary. They were opposed to the proposition that people carrying the infection had a special responsibility not to put others at risk and complained that we were seeking to divide their community between those with and without the infection. AFAO passed these views to NACAIDS.

The number of men coming forward for testing in the first eleven months from May 1985 was around 1750 per month, with a mean of some 150 confirmed positives each month. The number coming for tests then dropped suddenly, to less than 100 in April 1986, and then less than 20 per month. This followed the AFAO meeting. On 2 June 1986, the Commonwealth Health Department issued a press release stating that in NACAIDS 'there had been concern expressed that widespread AIDS screening is to be introduced without proper medical and counselling support'. We had made no such recommendation. It proposed a meeting between the Task Force and the Minister.

The meeting took place on 15 July, involving Blewett and myself, representatives from NACAIDS and AFAO. The Minister gave strong support for the Task Force position that testing should be an important adjunct to counselling. This was agreed by the meeting, subject to testing being underpinned by 'informed consent'. NACAIDS established a committee headed by Dr David Bradford to develop guidelines for informed consent and for counselling. The Task Force welcomed the outcome.

There were two episodes in 1985 in which I had reason to believe that Bill Bowtell had intervened on his own initiative using the Minister's name. On 1 February, an article had appeared in a major Sydney newspaper with statements attributed to Neal Blewett attacking me and the AIDS Task Force as 'being alarmist' and likely to 'cause anxiety in the community'.[10] This was stated to be both Blewett's view and that of the Department of Health. We had released an estimate of the number of gay men in Sydney likely to have the infection, based on Julian Gold's testing of a sample. It went on to assert that 'any move calculated to shock gay and bisexual men into changing their sexual practices will backfire and damage close co-operation between the task force and homosexuals'. The Department of Health was quoted as being of the view 'that carriers of AIDS might not necessarily have the disease or be capable of passing it on'. The Minister, at the time, was travelling in the US, with Bill Bowtell and the department head, Bernie McKay. Blewett telephoned me personally that day from Washington saying he had never made those statements, and expressed regret that someone had attributed them to him. Bowtell must have taken the call from Sydney; the views attributed to Blewett were identical with those of a Sydney gay spokesman also cited by the journalist.

Late in April, I took several weeks of much-needed leave after an exhausting twelve months. Sonay and I first visited Cyprus, Turkey and then England, to meet her family. When we arrived at Heathrow on 12 May, I was met by an officer of the Australian High Commission saying that Dr Neal Blewett needed to speak with me urgently. The link was made forthwith. Neal said that a move had been made by an officer of the Department of Health to call a special meeting of the AIDS Task Force in my absence, with the intention that it be wound up. He wanted my view! I did not ask how this had come about, but assured him such a move would be disastrous for the programs and he immediately assured me that he would stop it happening. No senior officer of the department would have initiated such action on his own authority, contravening decisions by his Minister and the Health Minister's summit, without believing he had received specific direction from the Minister. I have no doubt Bill Bowtell had seen an opportunity to act for the gay organisations in my absence.

Late in 1985, Neville Wran, Premier of New South Wales, asked whether it would be possible to test every individual in his state. I advised strongly against this approach, supporting the view that testing needed to be voluntary, confidential and associated with counselling.

Interactions with NACAIDS

I attended the first meeting of NACAIDS in Sydney on 29 November 1984 and monthly thereafter. Bill Bowtell played the major role, advising Ita in every meeting. Liaison with the several community groups, including through the Haemophilia Foundation's GRO-A was important. Red Cross, initially represented by its able female Deputy Secretary General, Noreen Minogue, found attendance of little value after initial consideration of recruitment of blood donors, and withdrew. An important joint statement from NACAIDS and the Task Force on care of patients with AIDS in their homes was developed and released in 1985—a positive outcome. The gay community received appropriate support for education programs. They were now at the centre of policy.

In June 1986, I was asked to join a NACAIDS sub-committee on legal and social issues, chaired by Marcus Einfeld QC. It comprised a group of highly articulate and aggressive young gay Sydney barristers who pushed hard the view that our strategies for testing and sanctions against false declarations were discriminatory and wrong. In two meetings in July 1986 it was clear that gay organisations were committed to the most optimistic possible analysis of emerging scientific data, such that many gay men with positive blood tests were physically well, so perhaps only a minority would develop AIDS or could transmit it. They asserted that we could not 'prove', to the degree that would be required as proof in a court of law, that the blood or plasma of each of these people would transmit the disease. Perhaps the presence of the antibody would make the virus inactive.

It must be said in their defence that a leading Australian research immunologist, at the end of 1984, was cited as saying that 'of 100 people who get the AIDS virus only a small proportion come down with the disease, but the exact proportion is not yet known. It is more than 1 per cent and less than 30 per cent'.[11] In reality there was no such evidence and sadly, time proved this to be very wrong. We did not wish to wait for further deaths to prove our point. We had to take a public health stance based on probabilities and experience with the hepatitis virus, rather than arguing as to what could, at that time, be proved in a court of law.

I was almost shouted down over several hours in the second of the NACAIDS sub-committee meetings when attempting to put these views. A letter from Marcus Einfeld after the first meeting had implied that I was advocating widespread, mandatory community testing without informed consent. He subsequently apologised in writing. After the second meeting, I was sure I could not change the views of those lined up against me and resigned. The committees of NACAIDS were restructured shortly thereafter at Neal Blewett's initiative, as set out in a joint press release by Blewett and Buttrose on 13 August 1986. The very able Professor Marcia Neave, Dean of Law at Flinders University, became advisor to NACAIDS on complex legal issues. She had previously completed a landmark report for the Victorian Government on prostitution, resulting in legalisation and regulation of brothels, with safeguards, for the first time, for sex workers.

The agenda of representing AIDS as an equal threat to the whole community began to gather momentum in order to relieve social pressure on male homosexuals. There was repeated mention of a 'second wave' of disease expected to sweep across the heterosexual community. Certainly at an international conference in Paris in July 1986, which I attended, evidence of heterosexual spread in Africa was clear, as I communicated to Blewett, but the pattern in Western countries differed. At one NACAIDS meeting, Phil Carswell, who had been helpful to me earlier, proposed we should declare that every man in Australia should use a condom whenever having sexual intercourse, with no reference to homosexuals or other groups! I suggested that this could only be a very short-term solution, but he did not seem to understand. I then asked whether it was being proposed that there should never be another generation of Australians. After a moment's reflection, he said he had not thought of that!

Through 1985 and 1986 we continued to monitor the number of AIDS cases, which mounted steadily. Following much discussion of the anticipated 'second wave' in the general community, Ita Buttrose had been sent on a visit to Africa in 1986 to witness evidence of heterosexual spread.

The Grim Reaper and his scythe

Late in 1986, NACAIDS established a committee, in which Bill Bowtell played the lead role but also included Ron Penny, to develop, with an advertising agency, the very graphic Grim Reaper advertisements designed to represent AIDS as an equal risk to every section of society. The Task Force was not consulted. Clearly it was based on the grounds of the expected 'second wave'. I was shown the film within twenty-four hours of its going to air and the Minister indicated he hoped I would be supportive. It was too late to object. Bowtell is cited as having regarded it as necessary to represent the disease as a major threat to society at large in order to secure continuing funding from the government.[12]

The Grim Reaper and related advertisements were launched on 6 April 1987. The gruesome figure of the Grim Reaper was depicted in a bowling alley with a ball hurtling down to knock over pins made up of men and women of all ages, children and a woman with a baby in her arms. In my view this was a dishonest representation of the facts when at that time more than 85 per cent of the Australian cases were male homosexuals, with very small numbers in the categories of intravenous drug injectors, blood transfusion recipients and haemophiliacs. No heterosexual cases acquiring the disease through sexual intercourse had been identified in Australia.

It was, of course, a dramatic change in Bowtell's position from that of 1 February 1985, when it had been seen as inappropriately 'alarmist' to release evidence of positive antibody tests in the Sydney gay community in the hope of altering sexual behaviour. Now it was OK to be 'alarmist' to the whole community.

Philip Adams, writing for *The Australian,* was highly critical of the Grim Reaper.[13] Others were also vocal in their criticism. The advertisements were followed in Sydney by a flood of people at no risk coming forward for testing, with virtually no increase in testing amongst those at risk of the disease.[14] Similar reports came from other states. There was a real question as to whether any useful purpose had been served in terms of reducing spread of the virus amongst those at risk of the disease.

Ian Gust made a comment to a journalist that 'if the Grim Reaper advertisement had been produced by business rather than by an arm of government, it would be likely that they would be prosecuted for misleading advertising'.[15] Ian records that when this appeared in print, without his name noted, he received a telephone call from Bowtell, now an advisor to the Deputy Prime Minister, 'that he would go to the Deputy Prime Minister and to the Prime Minister and have me removed from the AIDS bodies I was on'. I intervened through my contacts in the Department of Health, outside the AIDS Unit built up by Bowtell. Ian subsequently received a telephoned apology from Neal Blewett, who said Bowtell had been 'a naughty boy' and that 'he was out of order'.[16]

Injecting drug users and other potential spread

On 1 July 1985, the Pharmaceutical Society of Australia asked government whether it was appropriate for pharmacists to supply syringes and needles to intravenous drug injectors, following national adoption of principles of harm minimisation for illicit drugs. Enquiries we made revealed very variable understanding of the issue in several states, one denying any sharing of needles was occurring. There was, however, clear evidence of rapid spread of HIV through sharing of syringes and needles by drug-dependent people in New York. The minutes of our meeting record: 'The Task Force recommended that needles and syringes be made available on an unrestricted basis and that pharmacists should feel free to so supply'. The Communicable Diseases Committee of NH&MRC subsequently endorsed this view.

Dr Alex Wodak attended the Task Force meeting on 30 July 1986 to discuss syringe and needle exchanges. Alex was a former student and resident of mine at St Vincent's, Melbourne, and was working with drug-dependent people at St Vincent's, Sydney, with strong and pragmatic support from the Sisters of Charity. He expressed pleasure at the previous support of the Task Force for availability of needles and syringes, and told us of his informal group distributing needles and syringes in Sydney, which needed funding. He proposed formal needle and syringe exchange programs at a time when some regarded such activity as illegal. We supported the initiative and I wrote in these terms to senior officers in all states and territories, though acknowledging its political sensitivity, so that it should be handled carefully. In the coming months I was personally involved in negotiations with the Pharmaceutical Society of Australia and through them with the Pharmacy Guild for local pharmacists to provide the syringes and needles. Establishment of a national program of syringes and needle exchange to minimise HIV spread was approved by the Australian Health Ministers Advisory Council (AHMAC) at its second meeting on 2 October 1986. Alex has continued to play a distinguished role in harm minimisation and drug treatment services, and in national and international campaigns for drug law reform. The needle and syringe exchange program still minimises the spread of HIV in Australia.

During 1986 we became very concerned about the possibility of the virus spreading to the Aboriginal community, some sections of which were known to have a high incidence of untreated sexually transmitted disease, making them susceptible to rapid heterosexual spread, as in Africa. We talked of testing to see if spread had occurred. Criticism of testing by AFAO became very public at an AIDS Conference in Sydney in November. I was told in the course of the public meeting that NACAIDS was forming a committee to handle the Aboriginal issue, to be chaired by a gay doctor who was strongly opposed to any testing. I protested to no avail and decided to resign from NACAIDS. There was no way the problems of Aboriginal people could be assessed to identify communities at risk without some testing. Fred Hollows, who had done wonderful work in Aboriginal health, including with the eye disease trachoma, gave me strong and very public support. AHMAC shared my concern over the proposed NACAIDS committee. Later, outstanding work with local Aboriginal communities was done by Ken Donald's Inter-governmental Committee on AIDS, established in 1987. He formed a working group with Fred Hollows and an Aboriginal man, which tackled many situations. Further important work was done by Grace Smallwood, GRO-C GRO-C Mercifully there has been little spread.

In order to keep the link between the Task Force and NACAIDS, it was agreed with Neal Blewett in November 1986 that Dr Michael Ross would take my place on the latter, and that I would become a 'corresponding member'. Michael was having a hard time from his courageous public support of the Task Force's position on testing.

The Task Force under challenge

Reports from the US about the response of AIDS patients to treatment with azydothymidine (AZT), a drug previously used in other diseases involving the immune system, appeared by mid-1986. Several other drugs were also claimed to give encouraging results. We agreed the Sydney group should play the lead role in clinical trials once we could gain access to the drug. Their group was formally established as the National Centre for HIV Epidemiology and Clinical Research (NCHECR), led by David Cooper, as had been agreed in principle in September 1984.

Subsequently, public lobbying against the Task Force and against me personally occurred early in 1987 at an AFAO meeting attended by Bill Bowtell and Michael Clarke, GRO-C appointed head of the infectious diseases and health promotion section of the Commonwealth Department of Health. They called publicly for restructuring of the AIDS committees, which we took to mean reducing the influence of the Task Force.

Following these events, however, we were informed that

> at the Health Ministers Conference in Fremantle, there was strong support from ministers for the role of the Task Force and the need for there to be independent national medical and scientific advice on public health aspects of AIDS. Further there was support for the view that the Task Force ought not to be under direct political control, but should have a measure of independence as has been the case until now.[17]

Neal Blewett was in an increasingly difficult position.

I attended a two-day meeting of the NH&MRC in Hobart in June 1987, to be followed the next day by a meeting of AHMAC, the federal body of health officers. A Victorian member had given me a copy of a letter from Blewett to all Labor Ministers of Health requesting that they instruct their senior officers attending AHMAC to vote to change the committees in such a way as to significantly change the membership of the Task Force. There had been no discussion with us. I reported to the Council of the NH&MRC on the progress of the epidemic and strategies we were following. I expressed concern that our body, which was also an NH&MRC committee, might be substantially changed the next day by AHMAC. The NH&MRC was chaired by Bernie McKay, Secretary of Blewett's Department of Health, who flatly denied there was any such proposal and that as he would be chairing AHMAC the next day, he should know. Sadly for him, as an exercise in 'open government' to which he proudly professed, there was a row of journalists sitting in on the meeting, who were fascinated as I drew a copy of the letter from my pocket and read it out! He offered no response.

Next morning, I was on the television at 7.30 a.m. speaking of the important role of the Task Force, and then got to the AHMAC meeting ahead of time. Several members from Labor states agreed they had been given the foreshadowed advice, but assured me it was only 'advice' and that they would make their own judgments, which they did. The Task Force survived unchanged.

By June 1987, I was already Vice Chancellor–elect of the University of Melbourne, and felt that the repeated confrontation with the gay organisations had become counter-productive. I had decided to step down from the Task Force, and gained agreement with Blewett that Tony Basten from Sydney, an immunologist of high international standing, should succeed me in the Chair. Tony had previously been involved in the allocation of AIDS research grants.

Late in 1987, the Commonwealth was developing a detailed White Paper addressing the longer-term issues and policies for managing the AIDS epidemic. After my departure, there were repeated discussions and disagreements about the extent to which public health principles should be embedded in the policy and to the extent that social prejudice and potential discrimination against gay men was the over-riding issue. Sadly, Tony Basten resigned within a year because of continuing difficulties over these matters.

At the end of this personal saga, I received a generous letter from Neal Blewett. The letter said:

> Whilst there were some regrettable differences between us, I think you would agree these were minimal in comparison to the overall achievements made in the AIDS area during the period of your chairmanship … Thank you for your valuable contribution in halting the spread of AIDS in Australia.

The life of the Task Force

At every meeting, the Task Force had to review rapidly evolving scientific evidence, particularly all the information gained from the CDC in their *MMWR* publication and other reports in the world scientific literature. With some six or eight highly intelligent people in the room keen to impress others with their level of knowledge and expertise, chairing meetings in such a way as to rapidly gain consensus and agreement on urgently needed policy was always a challenge. As time went on, I summarised developments and proposals for action or publications, and left it for members to express disagreement as necessary or to suggest any change to what was being put forward. We released nineteen bulletins over two years in

1985–86, covering a wide range of occupations and situations as to how spread of the virus could be avoided. We covered a huge amount of information in every meeting and achieved full agreement on all decisions, even as difficulties emerged with the gay community and with NACAIDS. Every single member of the Task Force made valuable contributions.

The secretaries of the Task Force, Steve McGuiness early on and John Wanless from December 1984, did a superb job. They were based in the AIDS Unit of the Infectious Disease Section of the department in Canberra, and had to liaise with me and other members, to handle minutes and a large flow of papers, including the continuing stream of bulletins we produced between November 1984 and October 1985. As tensions with Bill Bowtell and the gay community mounted, they had a difficult time within the department. [redacted] The atmosphere towards the Task Force became quite hostile. We owe them a real debt.

Our remuneration throughout was something like a hundred dollars per person with travel expenses for any full day spent in formal meetings of the AIDS Task Force, several times a year, whilst we all got on with our busy full-time jobs. [redacted] and others in our group came from an Eastern European Jewish immigrant background—that of the Hassidic tradition and its great commitment to contribution to the community. We all saw AIDS as a significant challenge to public health. The general community needed dispassionate information and advice. Our professional and scientific expertise was much needed. In reality, it took hours out of every day, particularly for [redacted] and for me, over four years. However, we felt that we achieved much. This was, in itself, the real reward.

How did Australia perform?

Australia did well in curbing the spread of the disease, both in the community and through blood transfusion, in a timely manner. The number of persons in Australia identified as infected with HIV per year has been estimated in the national surveillance data to have peaked at somewhat over 2500 new infections per year in 1984, but the rate of new infections per year dropped with the vigorous campaigns for safe sex, testing and counselling, reaching an estimated low of 550 by 1994.[18]

On a population basis, Australia now has a substantially lower occurance of infection with HIV than the US, which has a ten-fold greater incidence. Ours is similar to that of Canada and the UK. In Australia, of those infected, more than 85 per cent are in the community of 'men who have sex with men' or MSM, the term now adopted internationally. The incidence of infection is far higher in most central and southern African countries, in India and Myanmar, in Thailand and Cambodia and in Papua New Guinea where, in each of these countries, heterosexual transmission is predominant.[19]

By the time the two key initiatives for blood transfusion were in place—legislative penalties for false donor declarations and then testing of all blood donations—over 260 haemophiliacs had become infected through use of coagulation factor concentrates produced locally from large pools of plasma. These figures were all tightly validated once questions of compensation from the Commonwealth arose.[20] Initially, 189 people were reported as having been infected through blood transfusion[21], but some of these were subsequently found not to have acquired infection through transfusion. Very little spread occurred in Australia through sharing of needles and syringes in drug-dependent people following the successful development of needle-exchange programs.

The striking difference in spread of the disease in Australia and in Africa, or more recently in much of Asia, is important. The big difference in incidence of HIV in MSM and in heterosexual people in Western countries continues. As early as 1985, the low incidence of infection with HIV in wives of haemophiliacs was first reported in the US (9.5 per cent at that time).[22] The figure was less than 17 per cent in regular female partners of haemophiliac men in the UK. A higher frequency of infection was noted in the female partners of male intravenous drug users.[23] A further study in Italy analysed factors that increased the risk of heterosexual transmission from known HIV-infected men. In this group only 15 per cent of long-term partners of haemophiliacs with HIV became infected, despite a number with long-term and frequent intercourse without use of condoms. Within the 15 per cent, the major risk factors associated with HIV infection were practice of anal intercourse and the presence of vaginitis or of genital warts[24]—presumed to indicate papilloma virus infection. Gonorrhoea, chlamydia and trichomonas—all common sexually transmitted infections—predispose to heterosexual transmission of HIV with a relative increase of between 60 and 340 per cent.[25] It appears that inflamed vaginal tissues readily admit the virus, whilst healthy tissues are quite resistant to heterosexual transmission. Few wives of HIV-infected Australian haemophiliacs became infected, up to the end of 2006.[26] In Africa, with minuscule expenditure on health care compared with the West (often $2 to $3 per head of population per annum), sexually transmitted disease is seldom treated, and inflamed genital tissues readily permit entry of the virus.

On viewing the horrific spread of HIV in Africa, Asia and now in Papua New Guinea, the glaring issue is what can be done cheaply and readily in prevention. The outstanding issue is the need for widespread use of condoms. Persistent opposition from the Catholic Church to this strategy worldwide, with huge consequences in terms of human suffering affecting not only men but women and children, is little short of scandalous. This, to me, is the over-riding moral issue. It results from the preoccupation of a male-controlled church with conventional sexual morality based on traditional suppositions of marriage and fidelity. It ignores the reality that most of the women and children infected in regions like Africa have not become so as a consequence of their own infidelity. I believe the Church must change its stance to recognise its responsibility to those at risk. The parable of the good Samaritan is very relevant; the Church is passing by on the other side, preoccupied with its rules rather than with human suffering.

Infection with HIV through blood transfusion is a field in which we did well on international comparison. The date of transfusion of the contaminated blood, as distinct from the date of onset of AIDS, has now been carefully documented by Red Cross, with identification of asserted transfusion episodes and tracing of donors. A number of cases had originally been based only on claims by men with infection, attributing this to a more socially acceptable origin than homosexual intercourse. The first two cases of transfusion-acquired HIV infection in Australia, we now know, were in 1980, before the disease had been medically identified in the US. The revised total of cases of HIV infection confirmed as via blood transfusion in Australia between 1980 and 1995 is 151. New South Wales cases were 73 per cent of the national total.[27]

National figures of cases of infection through blood transfusion, with verified dates of infection, show:

1980	2
1981	18
1982	34
1983	47
1984	45 to end of November
1985	1 between November 1984 and May 1985
1998	1

In 1998, there was a further case with infection from a donor during the 'window period' following infection, so that the antibody test was not positive, but otherwise no HIV has been transmitted by blood transfusion in Australia since 1985.

Reducing the 1983 and 1984 totals (to late November 1984) to a monthly rate, there were four infections per month. If infected donations had continued at the same rate for the five months between the 1984 Health Ministers summit and the implementation of screening at the end of April 1995, a further twenty people would have been infected with HIV through blood transfusion. After the AIDS summit only one became infected in those five months. The impact of the decisions at and following the summit are clear.

From a significant initial occurrence of *transfusion-transmitted disease*, Australia moved suddenly to having probably the best figures for transfusion disease of any developed country with a substantial community incidence of AIDS. The total of 9.3 per million people (as at 1986) was well below that in other countries in which gay rights took priority over public health considerations. The figure in Canada was 1148 infected recipients or 45.2 per million population.[28] There were a stated 23.3 per million for the whole of the US, but this figure covered a wide range, with between 40 and 60 per million in California, Florida and Maryland, and between 20 and 40 per million in several other states. Very low figures in the Midwest, where the incidence of AIDS in the community was very low, brought the national total down.[29] There were lower figures for transfusion-acquired disease in the UK, and even lower in many northern European countries in which there was little AIDS in the community.[30]

By the end of 2005, there were 102 AIDS deaths in Australia amongst people infected through treatment with coagulation factors[31], but this was not high compared with incidence of such HIV infection in many other countries. The figure for HIV infection in haemophiliacs in the US is estimated to be 9200 (38 per million population)[32], and in Canada 660 were infected (26 per million).[33] A British study reported 1227 cases (or 21.6 per million).[34] These figures are high when compared with Australia's incidence of 264 cases, taking the higher of the two published figures, which translates to 16.4 per million population.[35] In Europe, figures for HIV infection in haemophiliacs are influenced by a relatively high incidence in Spain, in Germany, in France and in Japan associated with Factor VIII concentrate imported from the US and delay in requiring heat treatment of concentrates.[36] There were between 3 and 5 per million population in most continental European countries that had a low incidence of HIV in their communities. There was a somewhat higher figure of 6 to 8 per million in Germany, France, Belgium and Greece, which had imported unheated US Factor VIII concentrate. Spain had a figure of 13.6 per million for the same reason.[37]

In 1992, the Director of the French Red Cross Blood Transfusion Service and a senior medical advisor went to prison for failing to introduce, in a timely manner, necessary precautions in blood transfusion services. Their Director General of Health and the head of the Public Health Laboratory were both given suspended sentences.[38] A similar court case involving the Director of the Canadian National Red Cross Transfusion Service was before their Supreme Court in 2008 on a charge of criminal negligence in failing to protect Canada against transfusion-transmitted HIV and hepatitis C. Transfusion was taken out of the hands of Canadian Red Cross. The court case was withdrawn in 2009.

Neal Blewett deserves full credit for the leadership he gave. In Australia, the gay community acted quickly in advocating safe-sex programs in 1983 and 1984 and in supporting people suffering from the disease. They were repeatedly at risk from social hostility, and gay rights were certainly under great threat at a time when we needed their cooperation in strategies to minimise spread. Nonetheless they did take their responsibility seriously in seeking to minimise spread, including spread through transfusion.[39]

I summarised the work of the AIDS Task Force in an article in the *Medical Journal of Australia*[40] and from 1 September 1987 refused to accept calls from journalists and others relating to AIDS as I focused on the coming university task. Ita Buttrose and NACAIDS, supported by Blewett's office and the Commonwealth Health Department, played an important role at the interface with the gay community, and also with the Haemophilia Foundation. NACAIDS and the Task Force had complementary roles that were both important. Unfortunately, hostility from some sections of the male homosexual community towards the AIDS Task Force led to a number of publications containing fabricated statements about our decisions or actions, of which I give but one example, much based on unverified statements and assertions drawn from other gay writings.[41]

In reality, most gay groups acted responsibly. Claims that public health principles (the so-called medical model) were unimportant do not match the facts noted above. The principal bone of contention, despite our common ground on education and the use of condoms, was our position that those carrying the infection had a special responsibility not to put others at risk without their knowledge and consent. This remains an issue. Between 1998 and 2007 there has been an increase of 60 per cent in HIV infections acquired in the previous year.[42] Of new cases, 86 per cent have had male-to-male sexual contact. No doubt the availability of treatment has lessened concern in some quarters, but the infection still carries serious life-long consequences. HIV still needs serious attention, including further education programs and responsible action by those carrying the infection.[43]

After an exhausting four years, with many concurrent responsibilities at St Vincent's, in the university and elsewhere, I was ready to step down from dealing with the scourge of AIDS. Little did I foresee that following the July 1987 federal election and the appointment of John Dawkins to the education portfolio as I was preparing to take up the Vice Chancellorship, I was exchanging dealing with one form of pestilence for dealing with another! Some of the lessons I had learned about dealing with government, with the media and with the public were, however, to stand me in good stead.

At the start of 1987, I became a Companion of the Order of Australia in recognition of contributions in medical education and health care. No doubt efforts with AIDS played a significant part. The former Deputy Chancellor of the University of Melbourne, Ninian Stephen, was Governor General when he hung the medal around my neck at the investiture saying, 'I think you will need this to take on the University of Melbourne'. It certainly helped!