

Showdown over AIDS is coming in California

by Warren J. Hamerman, director
EIR Biological Holocaust Task Force

A full-scale international showdown is unfolding in California on the true nature of the threat of AIDS to the general population outside of the so-called High Risk Groups. In November, the electorate will vote on California Ballot Proposition 64, an initiative which calls upon the state to apply the same standard public health measures to stop the spread of AIDS which have traditionally been applied to the list of other deadly communicable diseases. Nearly 700,000 California citizens had signed petitions to qualify Ballot Proposition 64.

Proposition 64 was filed by the Prevent AIDS Now Initiative Committee—or PANIC. The proposition has been identified internationally as the “LaRouche measure.”

On July 30, California Secretary of State March Fong Eu went into California Superior Court to strike sections of arguments filed by proponents of Proposition 64, whose certification on the ballot is not challenged. Those arguments, which outline the magnitude of the health crisis already caused by AIDS in the general population, and describe the dangers of transmission of the disease, had been prepared for publication in the *California Voters' Handbook*.

Fong Eu filed the case under a procedure which permits the Secretary of State to prevent publication in such pamphlets, copy which she or he claims to be false, misleading, or inconsistent with the requirements of the Elections Code. The outcome of the case will have no bearing on the ballot status of Proposition 64, and concerns only the information which reaches the public through the *California Voters' Handbook*.

The entirety of the evidence upon which Fong Eu's case

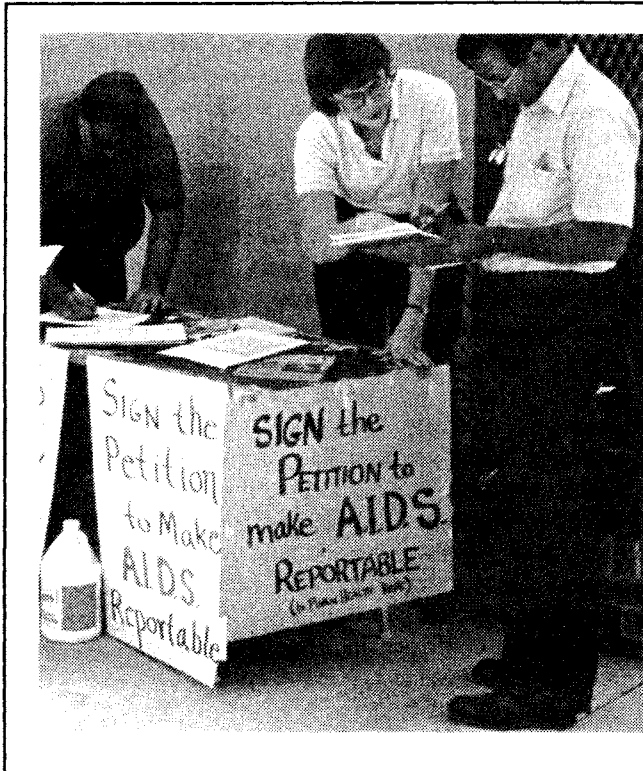
is based, is a sworn statement from Dr. Mervyn Silverman, who was health director for the City and County of San Francisco for over a decade and the man whose incompetent policies made San Francisco an AIDS necropolis. In his statement, Dr. Silverman advances fraudulent and preposterous arguments concerning AIDS.

We are printing below some of the declarations by internationally renowned medical experts submitted as testimony to counter Silverman's lies for the hearing, scheduled for Aug. 8.

In his arguments, Silverman denies known realities about AIDS, just as evidence from medical authorities throughout the world is becoming overwhelming. Silverman claims it is false to say that AIDS is easy to get: “It is hard to get, because it requires the exchange of blood, blood products, or bodily fluids for infection to occur.” The truth is otherwise. As supporters of the PANIC Initiative make clear, there are now 500,000 people infected with AIDS in California, and millions are infected worldwide.

Silverman also claims that it is false that the vast majority of AIDS cases, when viewed worldwide, lie outside the “high risk” categories of homosexuals and intravenous drug users. But medical authorities supporting the initiative have pointed out that the majority of AIDS sufferers are not in high-risk categories, once data for Africa and other Third World nations are taken into account. In Haiti three years ago, 70% of AIDS cases were in “high risk” groups. Today, over 70% are *not* in “high risk” groups.

Silverman also states categorically that no cases of insect-borne or respiratory-aerosol transmission have been reported



Court upholds censorship in AIDS voter education

California State Court Judge Ford in Sacramento on Aug. 8 made four rulings on the wording of the Proposition 64 Voter Education Pamphlet which will be printed for the California electorate. The judge made a gross error by upholding the precedent-setting request of Secretary of State March Fong Eu to "censor" key sentences from the Ballot Education Pamphlet and thereby keep the public from receiving critical public health information. Specifically, the Judge ruled to strike the reference to numerous studies of the "potential transmission of AIDS" by insects and the respiratory route and other formulations, despite the massive scientific documentation supplied in the affidavits of Dr. Whiteside, Gus Sermos, Dr. Seale, and Dr. Grauerholz.

or documented and even denies that they are "potentially possible." As supporters of Proposition 64 point out, potential insect and respiratory transmission has been established by numerous studies (see affidavits below).

A similar point can be made with regard to Silverman's assertions that "casual contact" cannot transmit AIDS. In an amended statement, initiative supporters point out that there is *no* scientific evidence for the assertion that AIDS *cannot* be transmitted by casual contact.

Who is Dr. Silverman?

On Dec. 12, 1984, Silverman, then public-health director of San Francisco, resigned under a cloud of controversy, as scandals and political disagreements rocked his administration. The first scandal concerned his administration of San Francisco General Hospital. Control of the hospital was taken from him in June 1984, after state investigations revealed problems in medical practices there.

Commentators at the time noted that Silverman was believed to spend more time on the "gay"-dominated politics of the city, than on administering the hospital. For much of his career in San Francisco, Silverman had basked in the praise of the deviant community for his willingness to tailor health-care and outreach programs to its needs. He was also known as the darling of City Hall, much admired and trusted by San Francisco's liberal Democratic Mayor Dianne Feinstein.

Nonetheless, Silverman balked at Feinstein's order that he outlaw the city's "gay" bathhouses, which public health officials knew to be promoting the spread of AIDS. At that

time, Silverman stated, "It was important that we be seen as protectors rather than policemen. If we had closed the bathhouses, we would have lost that relationship." Silverman ultimately lost on the bath house issue.

Silverman currently serves as president of the American Foundation for AIDS Research, whose founder and co-chairman is Dr. Mathilde Krim.

Krim was born into a wealthy Swiss family and attended the University of Geneva, where she came into contact with the terrorist organization known as the Irgun, and worked with them smuggling guns in southern France. She married American lawyer Arthur Krim, a top figure in the "Hollywood Mafia." The well-known Russophile and fellow traveler of the Soviet KGB, Armand Hammer, a close friend of Krim, is one of the leading figures operating on behalf of The Trust, the coordinating body which links networks of the Western financial oligarchy to the Soviet state and Soviet interests. Hammer personally provides significant funding to the American Foundation for AIDS Research, which Silverman heads, and Hammer's Occidental Petroleum provides corporate funding as well.

Silverman-associate Krim has been one of the leading "experts" opposing the use of traditional public-health measures for AIDS carriers, and also supports the giving of free needles to drug addicts, supposedly to prevent the spread of AIDS.

EIR has long maintained that only individuals seeking to undermine the United States or promote organized crime would oppose the use of traditional public-health measures

to stop the spread of AIDS.

As the irrefutable medical judgment contained in the affidavits of Sermos, Seale, and Whiteside below proves, on the scientific merits, there is no doubt but that AIDS is a deadly threat to the general population. We call attention to the conception developed in Dr. Whiteside's affidavit, that the issue in tropical areas such as Africa or southern Florida is not "high risk individuals," but that these poverty areas themselves are "high risk areas."

On the generalized risk of getting AIDS Affidavit #1: Gus Sermos

I, Gus G. Sermos, declare as follows:

1) I am a former Public Health Advisor with the Centers for Disease Control, which is located in Atlanta, Georgia.

2) My experiences are detailed in my curriculum vitae, which is attached as Exhibit A.

3) During my two and a half years of performing AIDS surveillance in Florida for the Centers for Disease Control, I reported between 775 and 825 diagnosed and well documented AIDS cases to my superiors at the CDC.

4) Dr. Silverman states that, "There are no medical studies or clinical data that support this assertion." He was referring to the assertion that AIDS may be transmitted by insects. In April 1985, I attended the International AIDS Symposium in Atlanta, Georgia. At that meeting, Dr. Jonathan Mann of the CDC stated during his presentation that, while working in Zaire, he had seen evidence of insect transmission of

HTLV-III among villagers living in crowded huts.

5) A number of the approximately 800 cases that I investigated in Florida do not fall in a known risk group. For example, in two different cases, female nurses contracted AIDS. In both situations, we tested sex partners and live-in relatives for antibodies to HTLV-III and found no sex partners or family members to be infected. Neither one of the nurses were intravenous drug users. Their method of contracting is unknown. Additionally, a female married to a transfusion-associated AIDS case developed AIDS shortly after her husband expired. They reportedly had not engaged in sexual relations for several years. The female was not an intravenous drug user. In another case, a male sewer worker contracted AIDS; we have never been able to establish that he was either gay or an intravenous drug user.

6) In my opinion, too many AIDS cases fall into unknown risk groupings for any of us to state that modes of transmission other than intimate sex contact or intravenous drug use are neither possible, plausible, nor viable.

I declare under penalty of perjury that the foregoing is true and correct and that, if called upon as a witness, I could testify competently thereto.

On the potential of insect transmission Affidavit #2: Mark Whiteside, M.D.

1) I, Mark Whiteside, M.D., hereby declare that, although I do not endorse California Proposition 64, I do feel obligated to express my opinion about the role of environmental factors in the transmission of Acquired Immunodeficiency Syndrome. I personally believe that AIDS is an environmental (probably insect-transmitted) disease of the tropics with secondary transmission via other blood means, i.e., transfusion, contaminated needles, and sexual practices that lead to breaks in the skin and mucosa. The role of environmental factors, for example, blood-sucking insects, sores rubbing together in crowded places, etc., has been unfortunately neglected. These issues have great significance for prevention and control of AIDS today.

2) AIDS is becoming a worldwide disease, with an increase in Africa, the Caribbean, South America, especially Brazil, among those persons with a risk factor for blood contamination in the United States and Europe. The national figures on the breakdown of AIDS by "risk group" are not applicable to the state of Florida. Percentages of "unknowns" or "no identifiable risk" (NIR) AIDS ranges from 22% of cases in Florida to 30% of cases in Miami to 50% of cases in Belle Glade, Florida. In this subtropical environment we are seeing men and women, heterosexuals without the usual risk factors associated with AIDS. It is my opinion that most of the NIR AIDS is not explained by sexual contact with members of high risk groups.

3) The coming debate is over how much disease, AIDS, will be transferred between men and women. Heterosexual transmission of AIDS has been uncommon in the United

EIR

Special Report

An Emergency War Plan to Fight AIDS

\$250.00. Order from: EIR News Service, P.O. Box 17390, Washington, D.C. 20041-0390. Order #85020

States, accounting for 1-2% of cases. There are approximately 300 female "heterosexual contact" AIDS and 200 female NIAID cases in the United States. Most of the female AIDS is concentrated in poor blacks and Hispanics on the eastern and southern coasts of the United States (Reference 1). We don't know if AIDS can be transmitted from women to men. Although heterosexual spread of AIDS needs further investigation, I don't think it explains the pattern of AIDS in the tropics (for example, equal sex ratio in Central Africa).

4) AIDS corresponds to the insect belt in many parts of the world. Before modern day AIDS, the region of greatest density of Kaposi's sarcoma (a tumor associated with AIDS) was on the border of Zaire and Uganda. Such tropical tumors as Kaposi's sarcoma and Burkitt's lymphoma were always linked to environmental conditions of climate, rainfall, and altitude (Reference 2). The distribution of these tumors correlated with malaria and the insect-borne virus (arbovirus) infections. Even more recent studies show a correlation of antibodies to HTLV-III/LAV (HIV) and antibodies to malaria (References 3, 4).

5) Today AIDS is increasing in men and women in Central Africa with some spread to both East and West Africa. Potential co-factors in African AIDS include malaria, parasites, malnutrition, genetic factors, poor sanitation, and hepatitis-B. Many scientists accept hepatitis-B (serum hepatitis) as a model of the transmission of AIDS. Several studies suggest insect transmission (mosquitos, bedbugs) of hepatitis-B in the tropics (References 5, 6). A significant percentage (15-22%) of AIDS in Africa is found in children (Reference 7). How can this possibly be called a sexually transmitted disease?

6) The introduction of AIDS into the Caribbean in the late 1970s corresponds with epidemics of mosquito-transmitted virus infection. For example, Dengue type I (mosquito virus) was introduced for the first time in 1977, causing hundreds of thousands of people to get sick, and in 1981-82, several hundred people died from dengue hemorrhagic fever. There is every indication that AIDS has a broad base in the Caribbean from Cuba on over to Puerto Rico. AIDS was never limited to Haiti, although Haiti happens to be the poorest country in the Caribbean.

7) Several years ago, we began to see Haitian patients at Jackson Memorial Hospital in Miami with unusual tropical diseases. Many people have never heard of these unusual parasitic infections, but they are all described in textbooks of tropical medicine. Studies showed that the Haitians were heterosexual, with relatively few lifetime sexual partners and no obvious means of acquisition of AIDS. We noticed that most of the Haitians we interviewed came from poor conditions in their own country to poor conditions in the United States. We visited the homes of our patients in Little Haiti (in Miami) and documented serious public health problems, for example, inadequate housing, overcrowding, open waste, and high mosquito and rat populations. We conducted our

first environmental survey in Miami and brought this technique with us to Belle Glade.

8) Belle Glade is the best example of the tropical pattern of AIDS in the United States. Belle Glade has the highest rate of AIDS in the United States (2.5 per 1,000 population). Over one-half of the AIDS in Belle Glade is in men and women born in the United States (20%) or in the Caribbean (30%) who do not fit into the usual risk groups. The final striking observation is that nearly all persons with AIDS and persons with tuberculosis live in the central economically depressed (slum) sections of Belle Glade (Reference 8). An untreatable sexually transmitted disease (like herpes) does not confine itself to single poor neighborhoods.

9) There are more than 50 confirmed AIDS cases in Belle Glade, but, because of lack of diagnostic facilities and few autopsies in the past, AIDS is assumed to be underreported by a factor of three to one. We will know what the "iceberg" is in Belle Glade, since we are keeping track of persons with AIDS, ARC (AIDS-related complex or illness) and sick, HTLV-III/LAV antibody-positive individuals. Independent surveys (by CDC and Institute of Tropical Medicine) have documented a 9-11% seroprevalance of antibodies to HTLV-III/LAV among the largely heterosexual control population living in one of two central depressed neighborhoods in Belle Glade. The majority (60-70%) of these antibody-positive individuals do not have an identifiable "risk factor" for AIDS (Reference 9). Results of studies in Belle Glade will affect all communities in south Florida, and, hopefully, will be used to help prevent the disease.

10) Poor people in the tropics suffer from multiple infections. We have hypothesized that repeated exposures to certain insect-borne viruses (which might be found "in one in a few thousand mosquitoes") are one of the things that leads to weakening of the body's defenses over time. Tuberculosis, which is more common in poor environments, is associated with milder degrees of immunosuppression and weakened immunity (Reference 10). When the cellular immune apparatus is broken beyond repair, certain opportunistic infections and cancers come along which are called AIDS. I am often asked, "What proof do you have of this theory?" I don't claim to have proof, but the pattern of AIDS in the tropics strongly implicates an environmental factor, and preliminary data support this observation. The majority of AIDS patients we tested in south Florida have antibodies in their blood to viruses known to be carried by insects. For example, many of our patients have antibodies to Maguari, a Bunyamwera serogroup arbovirus (insect virus) endemic to the Caribbean and South America and not previously reported in the United States (Reference 11). Most people understand that AIDS is blood-to-blood contact and that blood-sucking insects are a logical means of transfer of blood-borne agents in the tropics.

11) We can turn this question around and ask you, "What proof do you have that AIDS is primarily a sexual disease in the tropics?" I understand the popular (or prevailing) view-

point about AIDS is that there is (bi-directional) heterosexual transmission of the disease that is somehow more common in the tropics. However, it is my opinion that studies implicating heterosexual transmission of AIDS in the tropics (for example, Africa, the Caribbean) were seriously flawed by overwhelming bias, inadequate controls, and lack of prospective data. Until better studies are carried out and more is known, the conviction that AIDS is due to sexual habits ("promiscuity") among poor people in the tropics or in south Florida seems to me to be a narrow and quite prejudiced attitude.

12) Most scientists think AIDS is caused by a single agent, the retrovirus named human immune-deficiency virus (HIV), formerly HTLV-III/LAV. It should be pointed out that this virus has not been proved to be the cause of AIDS. Ultimately, reduction of the incidence of AIDS must result from prevention of HIV infection. In the test tube, the HIV must be switched on or activated to enter cells and cause disease. The insect-borne viruses (arboviruses) we are studying as co-factors in AIDS are known to activate retroviruses in animals (Reference 12). I think AIDS results from interaction of more than one virus agent.

13) Veterinarians have known for a long time that the closest relatives to HIV in animals can be carried on the mouth parts of blood-sucking insects. Animal retroviruses, including bovine leukemia (in cows) and equine infectious anemia (in horses) are transmitted "mechanically" by insects under conditions of crowding and abundance of insects, and when the animals have a high level of virus in their bloodstream (References 13, 14). Although you don't hear much about it, a number of researchers from around the world are just beginning to examine the role of insect transmission of the human retrovirus (HIV). A report was recently published in *Lancet* (British journal), showing survival of the "AIDS virus" (HIV) in the common bedbug (Reference 15).

14) Since I work in the highest risk areas of the nation, I am painfully aware of the relentless course of this epidemic. For several years, we have counseled people about sexually transmitted diseases and environmental health risks. Our programs in Miami and Key West for gay men emphasize safe sexual practice. We warn heterosexuals to be more careful (when in doubt, either don't do it, or use a condom). Intravenous drug-users should know there is only one solution, and that is to stop. Blood products have already been made safer by testing for antibodies to HIV. However, in some of our poorest neighborhoods, we would not be doing a proper job unless we counseled about environmental hazards, for example, fixing things at home and asking for help, protective clothing in the field, cleaning the home and yard of refuse and containers of water that breed urban mosquitoes, etc.

15) It is crucial to recognize the importance of environmental factors because that is the first step to begin to control them. We have documented a parallel distribution of AIDS and tuberculosis in several "poverty pockets" in south Flori-

da, for example, neighborhoods in Belle Glade, Delray Beach, and Little Haiti. Our best chance to slow the progression of these epidemics is by prevention and public education. I believe that part of prevention relates directly to classic public health measures, providing adequate housing, sanitation, control of insect and rat populations, etc. During a public health emergency, we must take action even before all the questions have been answered. Public health is no longer the top priority in the United States. We must make it the top priority.

16) I declare, under penalty of perjury, that the foregoing is what I believe to be true and, if called upon as witness, I could testify competently thereto.

Sincerely,
Mark E. Whiteside, M.D.

References

1. CDC (Centers for Disease Control) AIDS surveillance, personal communication, 1985-86.
2. Harris, R.J.C.: Etiology of central African lymphomata. *British Medical Bulletin*, Volume 20 (2), pp. 149-153, 1964.
3. Biggar R.J., Melbye, M., Sarin, T.S., et al.: ELISA HTLV-III retrovirus antibody reactivity associated with malaria and immune complexes in healthy Africans. *Lancet* 2:520-523, 1985.
4. Volsky D.J., Wu Y.T., Stevenson, M., et al: Antibodies to HTLV-III/LAV in Venezuelan patients with acute malarial infection. *NEJM* 314, p. 647-8, 1986.
5. Cook, I.F.: Hepatitis-B and AIDS in Africa. *Medical Journal of Australia*, V. 142, 661, 1985.
6. Blumberg, B.F., in *Advances in Hepatitis Research* (FU Chisari, editor, Masson Publishing Company, N.Y., 1984), Chapter 1, "Background and Prospective Advances in Hepatitis Research," pp. 1-8.
7. Clumeck, N., "Overview of the AIDS Epidemic and Its African Connection," International Symposium on African AIDS, Brussels, Belgium, Nov. 22-23, 1985.
8. Whiteside, M.E., Witham, D., Tavis, D., MacLeod, C.L.: Outbreak of No-Identifiable-Risk AIDS in Belle Glade, Florida, International Conference on AIDS, Atlanta, Georgia, April 17, 1985.
9. Lieb, S., Castro, K., Witham, D., et al.: "AIDS in a Rural Community: Seroepidemiologic Pilot Studies." American Public Health Association Meeting, Washington, D.C., November 1985.
10. CDC *Morbidity and Mortality Weekly Report (MMWR)*, "Diagnosis and Management of Mycobacterial Infections and Disease in Persons with Human T-Lymphotropic Virus-III/Lymphadenopathy-Associated Virus." 35 (28), 448-452.
11. MacLeod, C.L., Whiteside, M.E., deMedina, M.D., et al.: "Antibodies to Maguari in Patients with AIDS." American Society of Tropical Medicine and Hygiene, 34th Annual Meeting, Miami, Florida, November 1985.
12. Harrison, A.K., Murphy, F.A.: "Murine Oncornavirus Activation in the Pancreas During Infection with Venezuelan Equine Encephalitis." *Journal of the National Cancer Institute*, 55, 917-919, 1975.
13. Bech-Nielsen, S., Piper, C.E., Ferrer, J.F.: "Natural Mode of Transmission of the Bovine Leukemia Virus—Role of Blood-Sucking Insects." *American Journal of Veterinary Research*, 39, 1089-1092, 1978.

14. Sissel, C.J., Foil, L.D.: "Studies on Equine Infectious Anemia Virus Transmission by Insects," *JAVMA*, 184, 293-297, 1984.

15. Lyons, S.F., Jupp, P.J., Schoub, B.D.: "Survival of HIV in the Common Bedbug," *Lancet* 2, July 5, 1986, page 45.

On the potential of respiratory transmission of AIDS

Affidavit #3: John Seale, M.D.

I, John Richard Seale, hereby make oath and say as follows:

1) I am a registered Medical Practitioner of the United Kingdom and have been since 1951.

2) I have been a Bachelor of Medicine (Cambridge) since 1951, a Doctor of Medicine (Cambridge) since 1955, A Fellow of the Royal Society of Medicine (London) since 1967, A Fellow of the Medical Society of London since 1968, a member of the Medical Society for the Study of Venereal Diseases (London) since 1963, and a member of the Royal College of Physicians (London) since 1953.

3) I studied medicine from 1945 to 1951 at Cambridge University and St. Thomas Hospital, London, and spent the year 1958-59 in study and research at Harvard University in the U.S.A.

4) I have been engaged in the practice of clinical medicine since 1951; at St. Thomas Hospital, London (1951-53), Internal Medicine and Clinical Pathology; in the Royal Army Medical Corps (1953-55) Internal and Military Medicine; at the Brockton Hospital, London (1955), Thoracic Medicine and Tuberculosis; at the National Hospital for Nervous Diseases, London (1956), Neurology; at St. Mary's Hospital, London (1957-61), Internal Medicine; and at the Middlesex and St. Thomas' Hospitals, London (1962-76), as Consultant Physician in the Departments of Venereology and Genito-Urinary Medicine. Since 1976 till the present, I have been in private consultant practice in London, specializing in Genito-Urinary Medicine and Sexually Transmitted Diseases. Since 1982, several of my patients have suffered and died from AIDS and several others are infected with the AIDS virus.

5) Early in 1983, I started studying the epidemiology, pathogenesis, prognosis, and transmission of AIDS virus infection. I have since published articles and letters on AIDS in the *Journal of the Royal Society of Medicine*, *Nature*, the *Canadian Medical Association Journal*, *New Scientist*, *The Economist*, and a German journal of dermatology (*Zeitschrift für Hautkrankheiten* in German).

6) On third April, 1986, my letter entitled "Infectious AIDS" was published in *Nature* (Exhibit 1). It includes the words, "Under special circumstances, the AIDS virus is highly infectious. . . . Once a critical mass of people have been infected rapidly by highly efficient means of transmitting the virus, then transmission by a far less efficient means will inevitably occur increasingly often. These include blood transfusions, perinatal transmission, biologically normal

sexual intercourse, needle-stick injuries, sharp contact of sores or abrasions with contaminated blood, saliva, or sputum, mechanical transmission by blood-sucking insects and flies, and routine dental procedures."

The letter concludes with the words, "If the long-term mortality of infection also turns out to be similar (to *maedivisna*), the AIDS epidemic is more than a serious problem of public health; it is the start of a pandemic slow virus disease with the potential to decimate mankind within a couple of decades."

In the four months since the letter was published in *Nature*, no letter has been published in the journal by any scientist or public health official indicating that any of my conclusions were erroneous. It is my belief that *Nature* is one of the most highly respected scientific journals, with an international standing, comparable to the American journal *Science*. Many of the fundamental scientific papers relating to the AIDS virus and the epidemic have been published in *Nature*, including the first description, in January 1985, of the full nucleotide sequence of the AIDS virus, by Dr. Robert Gallo, Dr. William Haseltine, and seventeen other American scientists.

7) On first August, 1985, the *Journal of the Royal Society of Medicine* published an editorial, *sans ami*, entitled "AIDS Virus Infection: Prognosis and Transmission" (Exhibit 2). In the ensuing correspondence published in the journal on first February, 1986 (Exhibit 3), the potential for respiratory transmission of the AIDS virus, in association with pulmonary tuberculosis, was discussed.

8) On first August, 1986, the *Journal of the Royal Society of Medicine* published further correspondence on the origins of the AIDS virus, from the exiled Soviet biologist, Dr. Zhores A. Medvedev and myself (manuscripts Exhibit 4).

9) Dr. Medvedev and myself have submitted for publication, to the *Journal of the Royal Society of Medicine*, a more detailed analysis of the origins of the AIDS epidemic and the role of the multi-use hypodermics (Exhibit 5). The date of publication has not yet been cited.

10) The manuscript entitled "The AIDS Coverup" (Exhibit 6), written by me, will be published in *Travel Medicine International* on first October, 1986.

11) On the 28th of May, 1986, at the invitation of Dr. David Axelrod, Commissioner for Health for New York State, I delivered a paper at the International Symposium, "AIDS—Impact on Public Policy," held in New York City on 28-30 May, 1986. The paper, "International Cooperation and Competition in Scientific Research in AIDS," is scheduled for publication by the AIDS Foundation of New York later in 1986.

I declare, under penalty of perjury, that the foregoing is true and correct, and, if called upon as a witness, will repeat this testimony, sworn by the above-named John Richard Seale on this first day of August, 1986, for a chap, Mr. Hapcote, who is a Commissioner for Oaths in Leicester.