The second estimate put out by CBO was, if we froze all domestic spending for the next 10 years, that would give us a non-Social Security surplus of $1.8 trillion. Again, how realistic is that? Are we really going to freeze for the next 10 years all the spending on education? Are we going to freeze for the next 10 years all the spending on defense? Are we going to freeze for the next 10 years all the spending on law enforcement? Are we going to freeze for the next 10 years all the spending on parks in this country, roads, and highways? That is not a realistic projection. That is not an honest projection.

The third estimate put out by the Congressional Budget Office is if we adjusted for inflation each of the years going forward for the next 10 years. That resulted in a non-Social Security budget surplus of $838 billion. In order to evaluate how reasonable that forecast is, I think you have to look at what has happened the last 2 years. This Republican-controlled Congress has been increasing spending by higher than the rate of inflation, which would reduce this number even further. That means instead of a $1.9 trillion Social Security surplus that has been bandied about in the press, or a $1.8 trillion surplus over the next 10 years that has been discussed in some circles, we are much more likely to face a surplus over the next 10 years in the non-Social Security accounts of about $800 billion. That is reality, that is facing the most likely prospect, instead of the kind of dreamworld anticipations we have had in the first two scenarios.

In the proposal of Governor Bush and the Republican side over the next 10 years, he is proposing a tax cut of $1.3 trillion, when we only likely will have a non-Social Security surplus of $800 billion. That means Governor Bush would have to take $500 billion out of Social Security to pay for his tax cut scheme, a tax cut scheme that gives 60 percent of the benefit to the wealthiest 10 percent in this country. That is a dangerous plan for this Nation's economy.

Instead of further reducing the debt with this non-Social Security surplus, he would devote every penny of it to a tax cut disproportionately going to the wealthiest 10 percent in this country. That is a dangerous plan.

It is especially dangerous in light of what Chairman Greenspan has told us, which is that the highest priority ought to be to pay down the debt—not to have a massive tax cut scheme, not to have a massive new spending scheme, but to have our first priority being to pay down the debt. Goodness knows, our generation ran up this debt. We have a responsibility to pay it down. Not only do we have a moral obligation, but it is the best economic policy for this country. It will take pressure off interest rates. It will mean greater economic growth. It will mean we are preparing for the baby boom generation, which all of us know is coming.

I am a baby boomer; many of us are. We know there is a huge bulge in the population. When these baby boomers start to retire, they are going to put enormous pressure on Social Security spending, on Medicare spending, and we ought to get ready for that day. We ought to be responsible. The responsible thing to do is not to engage in some big new spending scheme, not to engage in some massive tax cut scheme, but to have a balanced approach, one that puts the priority on paying down this debt, one that puts a priority on strengthening Social Security, extending the solvency of Medicare, and also addressing certain high-priority domestic needs such as education and defense, which I think many of us in this Chamber believe needs to be strengthened.

I come from agriculture country. I come from a farm State. Agriculture needs attention. That is a domestic priority for many of us.

Finally, yes, we can have tax reduction as well, but we certainly shouldn't put that as the highest priority. We certainly should not take all of the non-Social Security surplus and devote it to that purpose. We absolutely must not take money out of Social Security to provide a tax cut. That is irresponsible. That is dangerous. That threatens our economic security and our economic expansion.

Over 5 years, the Bush tax cut plan is even more dramatic in terms of its effect on Social Security. I talked about a non-Social Security surplus over 10 years of just over $800 billion. Over 5 years, it is about $150 billion. Yet the Bush tax cut plan over 5 years approaches $500 billion. Let me say that again. Over the next 5 years, the most realistic projection of surpluses is just under $150 billion. Yet the Bush tax cut plan over 5 years is over $480 billion. Where is the difference coming from? It can only come from one place. That is the Social Security surplus. That is profoundly mistaken, profoundly wrong. That is exactly what we should not do in terms of the fiscal policy of this country. The last thing we should do is put this thing back in the old ditch of deficits and debt.

I end as I began. Chairman Greenspan has advised us that what we ought to do as the highest priority is pay down this debt—$5.6 trillion of total debt, $3.6 trillion of publicly held debt. Let us keep our eye on the ball. Let us put as our highest priority the paying down of this national debt. Our generation ran it up. We have an obligation to pay it down.

I thank the Chair and yield the floor.

Mrs. FEINSTEIN addressed the Chair.

The PRESIDING OFFICER (Mr. VOINOVICH). The Senator from California.

Mrs. FEINSTEIN. Mr. President, I ask unanimous consent to speak for such time as I may require as in morning business and that, by unanimous consent, Senator FEINGOLD be recognized to speak directly following the conclusion of my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

HIV/AIDS IN AFRICA

Mrs. FEINSTEIN. Mr. President, this afternoon Senators will come to the floor to speak about a problem we believe is a very serious one; that is, the HIV/AIDS epidemic in Africa. I know the distinguished Senator from Illinois, Mr. DURBIN, will speak, and the Senator from Wisconsin, Mr. FEINGOLD will speak. I believe others will as well.

Mr. President, I rise to join my colleagues here this afternoon to address what I consider to be one of the most pressing and important national security and international health issues that we will face in the coming decades: The HIV/AIDS pandemic, which is currently sweeping Africa.

I wish to begin by giving my colleagues a sense of the scope and scale of this problem.

Sub-Saharan Africa has been far more severely affected by AIDS than any other part of the world. Today, 23.3 million adults and children are infected with the HIV virus in Africa, which only has about 10 percent of the world's population, but nearly 70 percent of the worldwide total of infected people.

Worldwide, about 5.6 million new infections will occur this year, with an estimated 3.8 million in sub-Saharan Africa—3.8 million people will contract HIV. Every day, 11,000 additional people are infected—1 every 8 seconds.

All told, over 34 million people in Africa—the population of my State of California—have been infected with HIV since the epidemic began, and an estimated 13.7 million Africans have lost their lives to AIDS, including 2.2 million who died in 1998.

Each day, AIDS buries 5,500 men, women, and children. We saw a very compelling documentary made by the filmmaker Rory Kennedy, which showed the burials of some of these children as well as the enormous cultural problems that exist in Africa because of HIV/AIDS. By 2005, if policies do not change, the daily death toll will not be 5,500, it will be 13,000—double what it is now—with nearly 5 million AIDS deaths that year alone, according to the White House Office of AIDS Policy.

AIDS has surpassed malaria as the leading cause of death in Africa, and it kills many times more people on that continent than war.

The overall rate of infection among adults is about 8 percent, compared with a 1.1-percent infection rate worldwide. In some countries of southern Africa, 20 to 30 percent of the adults are infected.

AIDS has cut life expectancy by 4 years in Nigeria, 18 years in Kenya, and 26 years in Zimbabwe. As these numbers suggest, AIDS is devastating Africa.

AIDS is swelling infant and child mortality rates, reversing the declines that had been occurring in many countries during the 1970s and 1980s. Over 30 percent of all children born to HIV-infected mothers in sub-Saharan Africa will themselves become HIV infected. Let me say again, 30 percent of all of the children born to HIV-infected mothers will become HIV infected.

There are many explanations for why this epidemic is sweeping across sub-Saharan Africa. Certainly the region's poverty, which has deprived much of Africa from effective systems of health information, health education and health care, bears much of the blame. Cultural and behavioral patterns, which have led to sub-Saharan Africa becoming the only region in which women are infected with HIV at a higher rate than men, may also play a role.

HIV/AIDS is becoming a major woman's issue. AIDS has largely impacted the heterosexual community in Africa, and it has established itself in such a way that it sweeps across and wipes out entire villages.

Because of the region's poverty, all too often treatment of AIDS sufferers with medicines that can result in long-term survival has not been widely used in Africa.

But I strongly believe that if the international community is to be successful, we must make every effort to get appropriate medicine into the hands of those in need.

For too many years there were no effective drugs that could be used to combat HIV/AIDS, but now, thanks to recent medical research, we do have effective drugs. For example, some recent pilot projects have had success in reducing mother-to-child transmission by administering the anti-HIV drug AZT, or a less expensive medicine, Nevirapine, during birth and early childhood.

New studies indicate that Nevirapine can reduce the risk of mother-to-child transmission by as much as 80 percent. NVP is given just once to the mother during labor, once to the child within 3 days of birth. Taking three or four pills can mean that a child is prevented from being born with HIV. In fact, for $4 a tablet—a little more than the cost of a large latte at Starbuck's, which is not a lot here, but a great deal in Africa—this drug regime has created an unprecedented opportunity for international cooperation in the fight against AIDS. I, frankly, believe it is the single most cost-effective thing that can be done. Currently, however, less than 1 percent of HIV-infected pregnant women have access to interventions to reduce mother-to-child transmission.

Administered in a treatment regimen known as HAART—highly active antiretroviral therapy—antiretroviral drugs can allow people living with AIDS to live a largely normal life and use of the drugs can lead to long-term survival rather than early death. Such treatment is proven highly effective in developed countries, including our very own.

My understanding is that most antiretrovirals are relatively inexpensive to produce. AIDS Treatment News recently reported:

> AZT in bulk can be purchased for 42 cents for 300 milligrams from the worldwide suppliers; this price reflects profits not only to the manufacturer, but also to the middleman bulk buyer. The same drug retails at my local pharmacy for $5.82 per pill. This ridiculous price bears no relation to the cost of production.

Unfortunately—and inexplicably, in my view—access for poor Africans to costly combinations of AIDS medications, or antiretrovirals, is perhaps the most contentious issue surrounding the response to the African epidemic.

As the U.S. Development Program head, Mark Brown, said at the U.N. Security Council meeting on AIDS in Africa last month:

> We cannot lapse into a two-tier treatment regime: drugs for the rich, no hope for the poor. While the emphasis must be on prevention, we cannot ignore treatment, despite its costs.

I agree with that. Although it is true that the cost of combination therapy is beyond the means of most people living with HIV/AIDS and governments in sub-Saharan Africa—combination therapy in South Africa, incidentally, was estimated at $334 a month, or $4,000 per individual per year, and UNAIDS reports that Brazil treated 75,000 people with antiretrovirals in 1999 at a cost of $300 million—or, again, $4,000 a person.

I believe we have a strong moral obligation to try to save lives when the medications for doing so exist. There are several things the United States can do to increase access to lifesaving drugs.

First, the U.S. should work with others in the international community to provide support to make these drugs affordable and to strengthen African health care systems so that drug therapies can be effectively administered. The plan for combating HIV/AIDS in Africa recently put forward by the President and Vice President goes a long way towards seeing that the U.S. meets its commitment to this goal.

Second, it should be possible for African governments and donor agencies to achieve reductions in the cost of antiretrovirals through negotiated agreements with drug manufacturers. The British pharmaceutical firm Glaxo Wellcome, a major producer of antiretrovirals, has already stated that it is committed to ''differential pricing,'' which would lower the cost of AIDS drugs in Africa.

Third, I strongly believe that the United States must work to advocate ''parallel imports'' of drugs and ''compulsory licensing'' by African governments to lower the price of patented medications so that HIV/AIDS drugs are more affordable, and more people in Africa will be able to have access to them.

Through parallel importing, patented pharmaceuticals could be purchased from the cheapest source, rather than from the manufacturer. Under ''compulsory licensing'' an African government could order a local firm to produce a drug and pay a negotiated royalty to the patent holder.

Both parallel imports and compulsory licensing are permitted under the World Trade Organization agreement for countries facing health emergencies. There can be little doubt that Africa is facing a health emergency of monumental proportions.

That is why I, along with my colleague from Wisconsin, introduced an Amendment to the Africa Growth and Opportunity Act last year to allow the countries of Sub-Saharan Africa to pursue ''compulsory licensing''.

Without ''compulsory licensing'', which would allow access to cheaper generic drugs, more people in Sub-Saharan African will suffer and die.

For those of my colleagues who may be concerned that this Amendment may undermine wider Intellectual Property Rights, this Amendment acknowledges that the World Trade Organization (WTO) Agreement on Trade Related Aspects of Intellectual Property (TRIPS) is the presumptive legal standard for intellectual property rights (IPR).

The WTO, however, allows countries flexibility in addressing public health concerns, and the compulsory licensing process under this Amendment is consistent with the WTO's approach to balancing the protection of intellectual property with a moral obligation to meet public health emergencies such as the HIV/AIDS epidemic in Africa.

In other words, this Amendment does not create new policy or a new approach on IPR issues under TRIPS, nor does it require IPR rights to be rolled back or weakened. All it asks is that in approaching HIV/AIDS in Africa, U.S. policy on compulsory licensing remains consistent with what is accepted under international trade law.

By doing so, this Amendment will allow the countries of Sub-Saharan Africa to continue to determine the availability of HIV/AIDS pharmaceuticals in their countries, and provide their people with affordable HIV/AIDS drugs.

These drugs exist. We need to get them to where this epidemic is reaching monumental proportions.

I was pleased to work with the Managers of this bill when the African Growth and Opportunity Act was on the floor of the Senate last November, to modify my Amendment to meet some of their concerns, and to have their support in seeing it included in the final Senate-passed version of this bill.

Unfortunately, several pharmaceutical manufacturers are strongly opposed to this measure, and, as I understand it, there are efforts to have this Amendment taken out of the final bill that will be reported out of Conference.

I believe that such efforts are reprehensible, and I am determined not to allow this to happen.

And if, behind closed doors, this amendment is indeed removed from this bill, I intend to do all I can to—I hope I will be joined by my colleagues—make sure that an African Growth and Opportunity bill without this provision does not pass this Congress.

What good is an African trade bill if Africa is going to get wiped out from AIDS?

It is clearly in the interest of the United States to prevent the further spread of HIV/AIDS in Africa, and I believe that the ''compulsory licensing'' amendment was a necessary addition to the Africa Growth and Opportunity Act if we are to continue to assist the countries of this region in halting the number of premature deaths from AIDS. Antiretroviral drugs can do much to improve quality and length of life. The United States has the power to make these life-saving drugs more affordable and accessible to Africans. We cannot turn our backs on Africa. Our assistance is truly a matter of life and death.

I thank the Chair. I yield the floor.

The PRESIDING OFFICER. The Senator from Wisconsin.

Mr. FEINGOLD. Mr. President, I ask unanimous consent that the Senator from Illinois, Mr. DURBIN, be recognized after my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. FEINGOLD. Thank you, Mr. President.

Let me first thank my colleague from California, Senator FEINSTEIN, for her comments and leadership on this issue, and in particular the work we started together last fall and her determination with regard to the amendment that we are quite determined to make sure stays in the African Growth and Opportunity Bill.

I also especially thank Senator DURBIN, who came back from Africa in December with a tremendous passion on this issue, for using his enormous leadership skills to bring us together on a bipartisan basis to try to help fight this problem. I am grateful for his leadership and for his having the idea that we should come together in the Chamber to make some comments.

As the ranking member of the Subcommittee on Africa, I have always felt very strongly about the issue of AIDS in Africa. I have raised it in the context of the African debate. I have had success in some areas but not in others. I had a chance to raise it in December in personal meetings in their own countries with 10 different African Presidents.

I applaud the United Nations Security Council's decision to address the crisis last month. I want to especially mention our Ambassador to the U.N., Richard Holbrooke, whose idea it was to have such a session, and I support the administration's call to increase the resources directed at the crisis. I am especially pleased to stand with my colleagues to raise the issue again today.

I have heard some of the statistics, but I think they bear repetition.

In 1998 alone, AIDS killed 2 million Africans. At least 12 million Africans have been killed by AIDS since the onset of the crisis. Africa accounts for over half of the world's cases of HIV. According to World Bank President James Wolfensohn, the disease has left 10 million African children in its wake.

In Botswana, Namibia, Zambia, and Zimbabwe, 25 percent of the people between the ages of 15 and 19 are HIV positive.

By 2010, sub-Saharan Africa will have 71 million fewer people than it would have had if there has been no AIDS epidemic.

My recent trip to 10 African countries only renewed my resolve to address this matter with the urgency and seriousness it deserves.

In Namibia, HIV-positive citizens pulled up to a meeting in a van with curtained windows, and they hurried to the safety of the meeting room as soon as they arrived. They feared that their identity would be revealed, and that the stigma still attached to the disease would cause them to lose their jobs and perhaps even to be disowned by their families. It was shocking—in a country gripped by the epidemic, people are still afraid to acknowledge the crisis.

In Zambia I visited an orphanage of sorts, where 500 children, many of them orphaned when AIDS killed their parents, gathered by day. At night, there is only room for 50 of them—the rest must make their own arrangements, and many end up sleeping on the streets, sometimes prostituting themselves—thereby risking exposure to HIV in their struggle to survive.

In Zimbabwe, life expectancy has dropped from 65 to 39. Let me repeat that: life expectancy in Zimbabwe dropped from 65 to 39. Walking past the Parliament building one day, I asked how old one had to be to become a legislator there. The answer was 40. That exchange helped me to grasp how far-reaching the consequences of this disease really are—no society is structured in a way that prepares it to deal with an unchecked epidemic like AIDS.

In July 1999, the National Institutes of Health released a report on the effectiveness of a drug called nevirapine, the drug Senator FEINSTEIN mentioned, in preventing mother-to-child transmission of HIV. Studies indicate that this drug can reduce the risk of mother-to-child transmission by as much as 80 percent.

As she said, NVP costs $4 per tablet. This relatively simple and inexpensive drug regimen has created an unprecedented opportunity for international cooperation in the fight against the vertical transmission of HIV.

It should be recognized that Uganda is making real headway with regard to prevention. Since 1992, the Ugandan government's very frank and high-profile public education efforts have helped to reduce the incidence of HIV infection by more than 15 percent.

But despite these positive signs, there are many fronts on which there has been very little progress. Virtually no one has access to drugs to treat the disease. Prevention is unquestionably the most important element of the equation, but treatment cannot be ignored. Poverty should not be a death sentence—not when the infectious disease that is destroying African society can be treated.

Again, because Senator FEINSTEIN and I, and I know Senator DURBIN, are determined on this, we offered an amendment to the African Growth and Opportunity Act that was accepted into the Senate version of that legislation. It prohibits federal money from being used to lobby governments to change TRIPS-compliant laws allowing access to HIV/AIDS drugs. Basically, it just says that taxpayer money shouldn't be used to prevent countries from taking international legal measures in this AIDS emergency. I strongly urge the conferees to support that amendment.

The AIDS crisis in Africa is just what the TRIPS agreement was meant to address. This is a crisis, an emergency on an incomprehensibly vast scale. This is the rare and urgent situation that calls for something beyond a dogmatic approach to intellectual property rights.

If allowing for a TRIPS-compliant response seems expensive, think how expensive it will be, in the long run, not to do so. Even beyond the human tragedy, there are vast economic costs to this epidemic. AIDS affects the most productive segment of society. It is turning the future leaders of the region into a generation of orphans.

It is simply unconscionable for the U.S. government to fight the legal efforts of African states to save their people from this plague. I cannot imagine why any of my colleagues would support such action. Those dissatisfied with the TRIPS agreement should focus their efforts on changing it—not on twisting the arms of countries in crisis who comply with international law.

I thank my colleague from Illinois and I look forward to all the efforts we will take on together on this issue, and I look forward to working with Members of the other party on this as well.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, I thank my colleagues, Senators FEINSTEIN and FEINGOLD, for joining me to speak about AIDS today. I might add there are others who were not able to be here because of scheduling problems.

I, too, have just returned from a trip to Africa. Let me say at the outset there are some who question the value of Congressional travel. I wish they would look at it from a different perspective. I think the Senators who spoke on the floor on this issue, Senator FEINGOLD included, have benefited greatly from traveling to Africa, not just because we have seen firsthand

this epidemic and its devastation, but frankly because it is energizing. Seeing people, real people and their travails, their hardships because of this epidemic, causes many of us to dedicate ourselves to do something.

In an epidemic of such Biblical proportions as the AIDS epidemic in Africa, many of us are humbled, as we should be. I came back and met up with Senator FEINGOLD, whom I know had a similar interest, and Senator FEINSTEIN, who helped introduce the amendment which was discussed earlier, and I spoke with Senator ORRIN HATCH, a Senator from Utah, who has a similar passion on this issue. I have spoken to Senator BILL FRIST, a Senator from Tennessee, chairman of the Foreign Relations Subcommittee on African Affairs. I sincerely believe on this issue, more than any other issue, we should put party labels aside. I think we are dealing with not merely another political issue, and certainly not any political agenda; when we speak of AIDS in Africa we are dealing with a Holocaust without a Hitler. We are dealing with the greatest moral challenge of our time. Those are large statements, I understand. But as you listen to the statistics that have been noted in earlier debate about the epidemic, I do not believe I am overstating it at all.

Sub-Saharan Africa has been far more severely affected by AIDS than any other part of the world. Approximately 23 million adults and children are infected with HIV in that part of the world. They have about 10 percent of the world's population, 70 percent of the world's HIV-infected people. Though an estimated 13.7 million Africans have already lost their lives to AIDS, including 2.2 million who died in 1998, we are going to see these numbers increase dramatically.

This was my first trip to Africa. I tried to make an earlier trip with a Congressional delegation 10 years ago, and I was denied a visa by the South African Government. Those were the days of apartheid, and as a Congressman I had voted consistently against apartheid. They obviously had read my voting record and said they wanted me to stay home; they did not want me to visit their country.

Things have changed. Apartheid is over. There is majority rule in South Africa. Under the inspired leadership of Nelson Mandela and now President Mbeki, this country has a great future. They offered a visa and an invitation to come visit, and I did. I visited Kenya and Uganda as well.

I started out this trip thinking I would focus on issues I am familiar with such as food aid. I have been involved in agriculture and food assistance for as long as I have been in the House of Representatives and the Senate. I think these programs are so essential, where America takes its bounty and shares it with people who are hungry, people who are starving, around the world.

I also wanted to focus on microcredit. Ten years ago in Bangladesh, I learned of the Grameen Bank and similar microcredits that were producing miraculous results. These are small loans, $50, $100, $200, primarily to women to give them a chance to buy a cow or some chickens or some goats or some tools or to expand their stall at the marketplace. Mr. President, 98 percent of these microcredit loans are repaid. It is a wonderful program, and it elevates people to a much higher level in terms of their living standards.

So I went looking for food and microcredit programs, realizing I would be discussing the AIDS issue as part of it. I quickly came to the realization that AIDS is an issue which is overwhelming the continent of Africa. Every other issue takes second tier to the AIDS issue. That became the focal point of the trip.

The three countries we visited, South Africa, Kenya, and Uganda, represent such different attitudes and different approaches when it comes to the AIDS epidemic.

South Africa: I have a photo I took and have blown up. This is a rural health clinic in Ndwedwe, which is right outside of Durban, South Africa. This was a lovely young mother and her beautiful little boy who sat in the front row of this clinic which I visited.

Americans help this clinic stay open. Americans help this clinic have a nurse come in each day and have a doctor come in once a month. These villagers walk sometimes hours to bring their children and members of their families in for medical care.

This beautiful little boy, as you can see—maybe you cannot see on the television—has the traditional Zulu bracelet made out of hair. His mother has the scarring on the cheeks, which is part of the ceremony of the Zulu tribes. They invited me to this clinic to meet some of the people being served.

There was a lady sitting right behind this mother and child, and she came up to speak. When she stood up, you could tell she was nervous. She had on a T-shirt and, over that, a long-sleeved shirt. This was a few weeks ago, and it was very warm in South Africa at that time.

As she came forward, she was clearly nervous about speaking with us. She very calmly buttoned every button on her shirt all the way up to her neck. She stood in front of this assembled group, and she was very quiet. Then she said in Zulu: Unity, unity, unity, unity; in unity there is strength. Every time she said the word, the crowd answered her. Then she summoned her courage and told her story about how 2 years ago she was diagnosed with tuberculosis and has heart problems and may need surgery and how important this clinic is to her.

At the very end of her talk, she said: And I have AIDS, and I don't know what will happen to my children. And she started crying.

The man who was the master of ceremonies at this little gathering asked her to sit down on a bench next to me as she was crying. I reached up and put my arm on her shoulder, and this audience, wide-eyed, gasped that I would touch her. A doctor who traveled with us stood up and said to the people assembled on this porch: Do you see this? Do you see this American politician? He is touching her. You will not get this AIDS epidemic if you just touch someone.

That reflects the level of ignorance, the level of denial in South Africa about an epidemic that has reached and touched 4 million people out of some 40 million. They do not understand the basics.

In 1998 on World AIDS Day, a South African woman stood up and said: I have AIDS. She returned to her village that evening and was beaten to death because they believed that was how you could end the scourge.

The Chicago Tribune did an amazing series about the AIDS epidemic, one that I took out of the paper recently. They talked about another town in South Africa, Esidubwini, and they told a story about a lady, Thandiwe Mwandla, who was diagnosed with AIDS, and after the diagnosis, no one would buy her sugarcane, her bananas, her peaches. They would not buy anything she touched. She said at one point that her neighbors walked a broad circle around her. She had the stigma of AIDS. She said: We get sick, and we get poor, and we die lying to ourselves.

The Tribune wrote in this story what I consider to be a very inspiring paragraph:

> Staring into the abyss of an incomprehensibly brutal epidemic, it is plain how the 23 million people who live with HIV in Africa can drift easily into numbing fatalism, or a fierce, hardening shell of denial.

We saw that shell of denial in South Africa, a country which looks more like Europe than any other part of Africa, a country which accounts for 30 percent of the economy of sub-Saharan Africa, a country where many people are pinning their hopes that they see the rebirth of Africa in the 21st century. Yet, devastated by this disease, it has been unwilling to face it.

From there we went to Kenya. In Kenya, there is a different circumstance—some positive, some not so positive. First, this is a photo we took of this little fellow in a slum in Nairobi, Kenya. It is called Kibera. It is a squatters slum in the middle of the city. People from the rural countryside who cannot make a living pile into this slum. They squat, set up their huts, and try to create a life and existence.

I asked how many people live in this slum. They said: Somewhere between 500,000 and 800,000; we are not sure, it changes so quickly. There is virtually no sanitation, no water. It all has to be brought in. And there certainly is no health care.

Kenya is ravaged by AIDS as well. Sadly, for a long period of time they denied it. They did little about it. Just

recently there was an indication that they are going to start admitting it and dealing with it. This political denial is part of the problem, and we in the United States have to be part of the solution in convincing these governments in Africa that what is at stake is not just this little boy but the future of a continent.

From Kenya we went to Uganda, and thank God it was the last stop on the trip because what we saw in Uganda suggested to me that there is no reason to despair, we should keep our hope alive, there is a chance to deal with this epidemic.

The reason Uganda is so far ahead of many other Third World countries is an interesting story.

About 10 years ago, President Museveni of Uganda sent some of his Ugandan soldiers to Cuba to be trained to fight rebels in the countryside. After a few weeks, he received a message from the Cuban Government. They said: We are sending your soldiers home. Of course, his Government asked why. And they said: Because half your soldiers you sent to Cuba have HIV.

That was 10 years ago. It was stunning for them to realize that what they thought was an isolated disease now infected half of the military.

We met some of the soldiers—in fact, some were HIV positive—in each of these countries who have now come forward and dealt with this in a more open and forthright way.

When those soldiers came back from Cuba to Uganda, at about that same time, one of the more prominent figures in music in Uganda, a man by the name of Philly Lutaaya, announced publicly that he had AIDS. By going public and talking to the people of Uganda, he achieved, in many ways, what Magic Johnson achieved in the United States. He suddenly raised our eyes from our other life's undertakings to look straight into the eyes of someone whom we knew and admired and thought this would never happen to.

Uganda then set out on a program to reduce the incidence of HIV infection, and when they tested the pregnant women of that country, they found that 30 percent of them were HIV positive. They started pushing for abstinence, faithfulness, and condoms as an effort to reduce the incidence of HIV infection. Ten years later, they cut that down from 30 percent of pregnant women to 15 percent—a dramatic improvement. Yet, in this country of 17 million people, there are some 1.7 million AIDS orphans today.

If you travel around Uganda and see how they have dealt with this epidemic and the success they have achieved, you come to understand human nature and the strengths of people who are facing the worst possible outcome: an early death from an incurable disease.

We went to a clinic called The AIDS Support Organization, TASO. It started many years ago with a handful of people and has grown into tens of thousands of HIV-positive people who come there when they have a problem, when they are fighting off an infection. They do not have the AZT cocktail. They can never dream of that. Countries which spend $2, $3 per capita annually on public health cannot even imagine spending $1,000 to treat AIDS. It is beyond their comprehension.

How do they get by? With the basics: With some antibiotics to try to get through each infection. They talk about nutrition and improving their lifestyle, eliminating alcohol and all sorts of things to make them stronger so they can cope with these infections.

There is another element that is equally, if not more, important. At TASO, there is a choir, a group of about 30, who perform for those who visit. They are all men and women, mothers and fathers, who have AIDS themselves. They sing when you come by.

In Africa, it is not unusual that when you go to a group, they will sing, hello; when you leave, they sing, good-bye. When you are there, they sing about what they are thinking about. It is an African style that really grows on you.

But the TASO choir sang some songs they had written. Some of them are very basic—''When We Come Together We Feel Strong.'' This support group keeps the people going, day in and day out, to know that others suffer from this disease and that they can rely on one another for consoling and for strength. I am proud that the U.S. Government, through the US Agency for International Development, helps support this TASO clinic.

As I watched this choir and listened to them sing—and they were very good—I looked into their eyes and thought: There must be some anger or resentment about this.

There is almost a resignation to this disease, this HIV. One of the songs, which a young lady named Grace had written for the TASO choir is entitled ''Why Me?'' It just breaks your heart to hear them sing: ''Why me? Why him? Why her? Why you? Why me?''

We went to another project, which I think is a good investment, a support group called NACWOLA, the National Community of Women Living with AIDS. It is a group that counsels women with AIDS and children. They have a little house in which they come together and meet on a regular basis. They talk to one another and try to help one another.

They have a special project. It is called the ''Memory Book.'' Mothers sit down and try to write their life's story in this book, with family photos, and they talk about where they came from and who their parents were and experiences they have had. And they talk about their children because, you see, they want to leave these books for their kids, so that when they are gone—and they know that day is coming—their children will have this memory book to look at.

I sat on the porch there at the NACWOLA house in Kampala, Uganda, as two of the mothers, Beatrice and Jackie, read to me from their books. I realized then that I was in a nation that had turned into a hospice. These people were not crying. They were not angry. They were doing all they could do. They were trying to get by every day and leave a legacy for the kids who were playing in the yard.

The kids gathered around us and started singing. When they started singing, they talked about their future. They know their parents have AIDS. They know their lives are uncertain. They said: We hope we don't end up with cruel stepparents. We hope we don't end up on the streets. As they were singing, I looked behind me, and there were the mothers holding the Memory Books.

That is the state of Africa today. Some people ask: Why should we care? It is half a world away. We will never see these people. Of course, a lot of things have devastated Africa through the generations. I think there is more to the story.

The AIDS epidemic, most people believe, started in Africa. It is questionable when it started, but most people think it started there. It is now a worldwide epidemic. It is naive to believe that you can contain this kind of health problem and believe that it is not going to travel beyond other countries' borders.

Equally important, I think we understand, as Americans, one of the things that makes us different from some other people in the world is that we do care and we do try to make a difference. I think we can make a significant difference when it comes to this AIDS epidemic in Africa.

Let me tell you some of the things we can do and some of the things we are doing.

Senator FEINGOLD talked about the medical research going on in Africa. It is not at the same level as medical research in the United States. You do not have drug companies that are inspired by huge profits and think if they can find the cure to AIDS they are going to make billions of dollars. That isn't going to happen. These folks are looking at medical research at a much different level.

At Mulago Hospital in Kampala, Uganda, they have a project underway where they are testing this drug, Nevirapine. Nevirapine has been mentioned on the floor a couple times. A dosage of this drug to a mother at the time she goes into labor, and then a dose to the baby, basically cuts in half the transmission of AIDS from mother to child. This is a simple drug, at $4 a dose, which can make a big difference. It is not likely to be a big seller in the United States because no drug company will get rich at $4 a dose. But it works. It appears to work very well.

Thank goodness the Centers for Disease Control—part of our Government—Johns Hopkins University in Baltimore, and this hospital have come together. They are showing how it can make a difference.

They are looking for supplements to diet—for example, whether additional vitamin A can mean that a person with HIV can live longer and be healthier.

They are operating at a lower level because that is all they have to work with. It is a survivalist approach. But it is making life better and longer for a lot of people. It is working. We are helping it to work. I am glad the United States is part of that.

There is a woman who has become somewhat legendary. Anyone who has not seen this I hope will get a chance to see this Newsweek cover story: ''10 Million Orphans.'' It talks about the AIDS epidemic in Africa. Her name is Bernadette Nakayima, and she lives near Kampala, Uganda. She had 11 children. Ten of her children died of AIDS. They are buried on a hillside by their home. The one surviving daughter lives nearby.

This 69-year-old grandmother, after her 10 children died, brought in the orphans to her home. She has 35 orphans in her home. How does she get by? Well, according to the Newsweek story, at one point she did not think she could. She gathered all the children in a room and said: Close the doors and lock them. We're just going to starve to death here. We can't make it. But luckily somebody knocked on the door and said: Come out. We're going to try to help you. People are trying to help.

As I speak here on the floor today, Sandra Thurman, who is the head of the effort to deal with AIDS, is in the gallery. I was in Africa with her. She has visited Bernadette many times. She draws the same inspiration, as everyone who goes there, to think of the strength of this woman who, in advancing years, is trying to raise 35 grandchildren, one of whom, incidentally, is HIV positive.

How is she getting by? It points to another thing at which we should look; that is the fact that she is part of something called FINCA. FINCA is a microcredit program in Africa. Microcredit, as I mentioned earlier, is a small loan, primarily to women where they can dramatically improve their lives by having a little additional income.

Women like Bernadette are able to bring in AIDS orphans and help them lead normal lives in a family setting rather than on the streets.

One of the meetings I had with a FINCA group was in Lugazi, Uganda. I will not soon forget where we had the meeting. Our meeting of 20 women, who were coming to report on their loans and to seek additional credit assistance, took place in a little hut that a few days before had been a chicken coop. The chickens, who had been moved out of that coop to the adjoining room, squawked during the whole meeting. But these ladies were not going to be deterred by a few angry roasters. They were there to get on with the business. The business was borrowing money to improve their lives.

I asked one of the ladies: What have these microcredit loans meant to you? She said, through an interpreter: Because of these loans, my knees have gone soft. I had no idea what she was talking about. She explained. She said: Before I had microcredit, before I had more income, I used to have to crawl on my knees to my husband to beg for money for food for the children and to send the kids to school. Now I have some money. I don't have to crawl. My knees are going soft.

That story was repeated over and over again by the 20 women gathered there. I said: How many of you who are borrowing this money, by these small loans that make such a difference, have brought in AIDS orphans to your home? Half of them raised their hand—two children here, and four here, and six here. They had the wherewithal to do it.

In countries where people survive on 30 cents a day, it does not take much to dramatically improve the quality of life and keep these children within the extended family. It can help. It can work.

The second thing that is helping is food assistance. We are directing food assistance in areas where we know that we have serious problems with AIDS orphans. We need to do more in this regard.

I use these examples so that people who might otherwise want to throw up their hands and say: Well, it is a problem we should worry about, but how can we possibly address it if there are so many people victimized by it? There are things we can do, small things for a great nation to do, that can make a great difference, small things that can save lives and give families a chance.

I am going to introduce legislation today which is entitled: ''The AIDS Orphans Relief Act of 2000.'' It addresses microcredit to try to increase it as an effort to help AIDS orphans find homes and to increase food assistance for that same purpose.

This is not going to solve the problem, by a long shot. There is so much we need to do in the areas of research and prevention, creating an infrastructure for distributing the medicines that are available in Africa. I hope this will be one part of an agenda, that we can gather together and speak, as Senator FEINGOLD and Senator FEINSTEIN did, about the pharmaceutical side of it, address the larger issues that the World Bank might be able to help us with, through Senator JOHN KERRY's bill and Congressman JIM LEACH'S bill, and invite all of the Members of the Senate to focus on this issue in a bipartisan fashion. I believe sincerely we can make a difference.

It has been said earlier that this devastating disease is lowering the life expectancy of people in Africa. You find, when you go to some countries, such as South Africa, that employers will hire two people for a skilled position because they know one is not going to survive. Those are the odds. That is what they are up against. It calls on us to focus on what we can do to help.

A little while ago we had a meeting of Democratic Senators not far from the floor, and Sandy Thurman, our AIDS director, was there, as well as a young woman named Rory Kennedy. She is the daughter of Robert Kennedy. She has been recognized for her skill as a producer of documentary films. She presented for us a 12-minute documentary film on the AIDS epidemic in Africa. It is a film she put together when she visited with a group not that long ago. It really does put in human terms what I am trying to say in words.

You see the faces of those little children. You see the trips to the graveyard to bury babies who have died because of HIV. You go down the road, as you would in Kampala, Uganda, and you notice the stalls of produce. Then at the end, you see the huge sign that says ''coffins.''

When I spoke to the Ambassador, Martin Brennan, he told of going to a village outside of Kampala and seeing in the town square stacks and stacks of coffins. It, unfortunately, is a big growth industry in Africa. It calls on us to address this in so many different ways.

Let me tell you another way that may not seem obvious that is part of this as well. While we were traveling in Uganda, we went to an agricultural research station. This is a station which brought together some ag research which the United States has supported for years. Cassava is a basic root crop used as a staple for the diet of many people in central and eastern Africa. Not that long ago, there was this virus that affected this crop and dramatically reduced it. People were going hungry and starving to death. Because of this research at this station they have found ways to end this so-called mosaic virus. People are now seeing this cassava grow, and they are once again feeding their families.

It was a little thing, lost in the budget of the Department of Agriculture, which means that millions have a chance to live. Some people will question ag research from time to time, even mock it. Yet we see day to day in Africa and in the United States that it pays off. This is a part of the world that has been ravaged by civil war, ravaged by famines as bad as the potato famine, ravaged by epidemic, now as bad as the bubonic plague, all of these things are coming down on central Africa like four horsemen of the apocalypse. They are coping with it every single day.

We need to do all we can to make sure that our country, working with other countries, can try to stop this crisis from getting any worse. The lessons we will learn in Africa will help us save lives there. It will help us take the message to other parts of the world, such as India and other parts of Asia, that are threatened with this epidemic. But there is something else we will learn. We will learn from the courage and compassion of the people who

live in this area that there is strength in the darkest hour.

I came back from this trip determined to do something. I hope that with this meeting today of several Senators on the floor of the Senate we can start this dialog. I think we cannot only reach across the aisle to my friends on the Republican side and share our feelings, but reach out beyond this Chamber and beyond this Government. I think we can reach out to churches across America.

I have written a letter to the Catholic bishops in my home State of Illinois. There, as a little boy growing up, I used to give pennies and nickels every day to the missions. It was something they did automatically in Catholic schools when you were growing up. I didn't know where that money was going. I barely knew what the missions were. But when I went to Sunday Mass at the basilica in Nairobi, Kenya, and saw 2,000 people, standing room only, I found out where that money went. It converted a lot of people to Catholicism, as the Anglican Church converted a lot of people to their religion. Now we have a chance to say to some of these religions, such as Catholicism and others: We made an investment in Africa at a time when they needed our help, and now they need it again. Can we bring together the religions of the United States that have focused on Africa and try to cope with this crisis?

The head of the National AIDS Commission in Uganda is a retired Catholic bishop. I think that says a lot. It says that they are crossing religious boundaries in an attempt to deal with this epidemic and this crisis.

When it comes to the security side of this issue, I have spoken about the military in Uganda, and I am afraid it is the case in so many other countries. They, too, are infected, and that is a source of concern for all of us. If your military cannot respond to a crisis in the country, it fosters instability. It creates security problems which reach far beyond that country, that may even involve the United States, as in the past 10 years we have been to Africa on peacekeeping missions, some with tragic results.

So if we can work, and I hope we can, through our skills and our military to help them cope with this disease in the ranks of the militaries in Africa, it is good for them and their countries. It is good for our world. I will be working with my colleagues to see if we can achieve that.

Let me close by thanking the Chair for this opportunity to speak. I have gone beyond the usual allotment of time. I thank the Chair for his patience in that regard. I hope in this session of Congress we can come together as they do at TASO in Kampala, Uganda, and find the strength and support to care for people halfway around the world, people perhaps of different color from some of us, but people who are our brothers and sisters.

I yield the floor.

Mr. KENNEDY. Mr. President, HIV/AIDS in Africa has become a global emergency unlike anything that public health has seen in this century. According to Archbishop Desmond Tutu of South Africa, ''AIDS in Africa is a plague of biblical proportions. It is a holy war that we must win.''

The number of HIV-infected individuals in Africa has now reached 22.5 million. As a nation, America is all too familiar with the devastation that AIDS causes. Nearly 10 years ago, Senator HATCH and I sponsored the Ryan White CARE act, the legislation that helped begin the long battle to deal with the AIDS epidemic in this country. The situation has steadily improved in the United States, because extensive efforts have been made and needed systems of care have been put in place. The CARE Act has helped us make great progress.

We began our fight against AIDS in the United States with the advantage of having the world's most advanced health care infrastructure, but the situation in the developing world is much different. Resources are scarce, infrastructure is limited, and the people of Africa face a situation that is not improving but is steadily growing worse.

Officials at UNICEF have described the situation that many nations in sub-Saharan Africa face as a ''tripod of deprivation'' that involves poverty, debt and AIDS. Any of these three crises would be severe on its own. Taken together they are devastating. The result for the African continent is enormous pain, suffering, and death. Decades of progress on economic growth, infant mortality, and life expectancy are all threatened. The AIDS virus is infecting every aspect of life for the people of Africa, from work and family to education and even national stability.

The effect on the African workforce is especially ominous. African nations have worked hard for the economic development that is emerging. But HIV is striking vast numbers of individuals during their most productive years, and all of this recent progress is being placed in jeopardy. AIDS directly undermines productivity by increasing absenteeism. It raises the cost of business through increased need for benefits. Costs of recruiting and training employees are rising, as current employees die or become disabled. Higher costs also threaten international investment in Africa, which is essential for future economic development.

Over 8 million children have already been orphaned by AIDS in Africa. In the next decade, that number will reach 40 million, a number equal to the total number of children in the United States who live east of the Mississippi River. Children are forced to leave their schools in order to care for dying parents and put food on the table for themselves and their family. Many of these children are already suffering emotionally from the loss of one or both of their parents, and now they are losing the vital educational opportunities they need and deserve.

HIV infection rates are as high as 80 percent in some African military forces, and the disease is threatening the security and stability of these nations. Forces that have been weakened by disease are less capable of defending their nations, maintaining order, or protecting citizens. The concern is immediate. A 1998 UNAIDS study reported that in both Zimbabwe and Cameroon, HIV infection rates were three to four times higher in the military than in the civilian population.

While new therapies have begun to offer hope in the fight against AIDS in the United States, the cost of these treatments has put them out of reach for developing countries, where the epidemic is raging out of control. During the past six years, there has been a 300 percent increase in annual cases of HIV/AIDS in sub-Saharan Africa. Yet until this year, U.S. funding for AIDS programs overseas had remained level-funded at $125 million. When inflation is taken into account, level funding means a 25 percent decrease between 1993 and 1999.

Last year, many of us in Congress and the administration worked hard to obtain an additional $100 million to fight the HIV/AIDS epidemic in Africa. This funding was a vital first step towards turning the tide, but it is not nearly enough. This money will be used for prevention efforts, counseling and testing, direct medical services, and also to assist the millions of children orphaned by AIDS in the region. The additional $100 million that President Clinton has included in his FY2001 budget will enable us to reach an even greater proportion of people infected with HIV in Africa.

Yesterday I cosponsored the bipartisan legislation introduced by Senator BARBARA BOXER and Senator GORDON SMITH that extends the U.S. commitment to sub-Saharan Africa through 2005. We know that increased U.S. aid for Africa is essential. In partnership with other donors, the U.S. invested $46 million in HIV prevention and care in Uganda, and helped cut the HIV rates by more than half.

Prevention is effective, but it costs money. Treatment and care also cost money. Yet the nations of sub-Saharan Africa are among the poorest in the world, and they cannot and should not bear this burden alone. The U.S. is the leading donor of development assistance for HIV/AIDS prevention and control in the developing world, but our response to this crisis has so far been inadequate. The United States currently ranks ninth in terms of the percentage of GNP devoted to international AIDS programs. This is not the leadership that this country has shown in the past, when nations have been torn apart by tragedy.

I recently learned about a couple in Senegal who were both stricken by HIV. They have a small shop that sells newspapers, candy and other goods,

and are economically well-off in comparison to many of their fellow citizens. Their financial situation allowed them to afford some AIDS drugs, but the cost of basic treatment for one person takes thirty percent of their monthly income. They have been forced to choose which one of them will take these life-saving medications. That is a decision that no couple should have to make.

The rate at which AIDS has spread in developing countries should alarm all nations and peoples. The world is too small for us to think that a virus which has infected 34 million people and killed 14 million is under control and will not continue to infect our own country.

This global epidemic has already taken more lives than all but one of the major conflicts of this century. Only World War II surpasses AIDS in terms of human devastation in this century. We cannot stand by and let this level of suffering continue.

We can and must do more as a nation to fight this growing global epidemic. It is estimated that by the year 2005 more than 100 million people worldwide will have become infected with HIV—100 million people. The magnitude of the emergency is immense. What will we tell our children and our grandchildren about how we faced the largest human tragedy of our time? I hope that we can tell them that we reached across the aisle and then across the ocean to help those caught in this relentless epidemic. This is not about Democrats or Republicans.

This is about America, and what we stand for as a nation and as a world leader. I urge my colleagues to do all we can to save lives and ease this tragic suffering.

MICROSOFT AND THE AMICUS BRIEF

Mr. GORTON. Mr. President, this is an appropriate time to bring my colleagues up to speed on the continuing saga that is the Microsoft anti-trust trial. Since I last came to the floor to discuss this issue, the industry, of which Microsoft is a part, has once again changed dramatically. For instance, American Online recently triggered the largest corporate merger in history with the acquisition of Time-Warner. This media giant is now poised to compete vigorously in every aspect of the Internet, from the wires that connect you, to the content you watch. To meet this challenge, Microsoft and a legion of its competitors must be allowed to compete vigorously in the ever-changing landscape of the information technology industry.

My fellow Senators will soon receive a ''dear colleague'' letter endorsing an amicus brief filed on behalf of Microsoft by the Association for Competitive Technology (ACT). ACT is a nonprofit association representing more than 9,000 companies in the information technology industry. ACT's membership is made up mostly of small and medium sized businesses but includes household names such as CompUSA, Excite at Home, Intel, Microsoft and Symantec. These members come from all walks of the industry, unified by the cause of protecting competition and innovation in the industry.

This brief was prepared by a bi-partisan group of legal heavyweights including former White House Counsels Lloyd Cutler and C. Boyden Gray as well as former Attorneys General Griffin Bell and Nicholas Katzenbach. It eloquently reinforces many of the points that I have made on the Senate floor for over a year now. In the end, I think you will agree that this document reveals the glaring weaknesses in the DoJ's case against Microsoft.

The amicus brief reinforces the point that current antitrust laws expressly allow, and even encourage, the kind of competitive activity that the government seeks to stop; the kind of competition that continues to benefit not only consumers, but the hundreds of thousands of high-tech workers and entrepreneurs in the software and hardware industries as well. It also sounds the familiar refrain that the government needs to take a highly pragmatic and cautious approach to antitrust enforcement in this dynamic industry.

Unfortunately, Judge Jackson found last year that Microsoft's Windows holds a lawfully acquired monopoly of the market for ''operating systems'' for Intel-compatible personal computers. Although Microsoft may later challenge this finding, the brief assumes for purposes of argument that the finding is correct.

The plaintiffs (the federal government and several states) charge that Microsoft, in adding the Internet Explorer browser to Windows and marketing the package, violated antitrust laws. The amicus brief—and the Supreme Court cases on which it relies—demonstrates that the purpose of the antitrust laws is to protect consumers and competition—not competitors—and that Microsoft, far from violating the antitrust laws, competed vigorously to the immense benefit of consumers.

Vigorous competition, which antitrust laws are designed to protect, produces innovation, better products, more efficient distribution, and lower prices. All of these results of competition are to the benefit of consumers. The antitrust laws do not require competing firms to be nice to one another, or protect firms against their more powerful rivals. It is not wrong for any company to want to take business away from its rivals.

The antitrust laws encourage a firm that holds a lawfully acquired monopoly to compete hard to keep that monopoly. They also encourage such a firm to enter other fields where, by competing with better and cheaper products, it can benefit consumers.

Judge Jackson found that the widespread use of the Windows operating system has made it is a platform for a vast range of computer applications that consumers now enjoy.

Judge Jackson also found that when Microsoft added a superior Internet browser (Internet Explorer) and offered it to consumers at no extra charge, these actions gave consumers better access to the Internet and spurred its rival Netscape to improve the quality of its ''Navigator'' browser and to distribute it at no charge.

Microsoft did not drive Netscape's Navigator out of the browser market. On the contrary, even Judge Jackson found that Netscape's ''installed base'' has more than doubled since 1995 and will continue to grow in the future. Browser competition remains vigorous.

Microsoft did successfully break into the browser market and did obtain a share of that market for itself. The single most important reason, as even Judge Jackson found, is that Microsoft rival AOL itself chose and re-chose Internet Explorer over Navigator, even though AOL now owns Netscape. AOL made that choice because Microsoft offered a better product, better service, and better marketing support than did Netscape.

Microsoft's agreements with PC manufacturers and Internet access providers to distribute Internet Explorer were lawful agreements designed to help Microsoft break into a browser market in which Netscape was the overwhelmingly dominant firm. It was good for competition and consumers, for Microsoft to introduce competition into that market.

The plaintiff's theory is essentially that Microsoft, once it had a lawful monopoly in the operating systems market, should not have aggressively entered the browser market, because Netscape's dominance of that market might have led to more competition in operating systems. That theory is bad law. Again, the law protects consumers, not competitors. Consumers benefit when any firm, including one holding a lawful monopoly, competes aggressively to challenge another firm's incipient monopoly in a related field.

This competition helped usher in the most important change occurring on earth today. The power of information has been taken from a few large centralized institutions and put directly into the hands of people in every town and village across our globe via the Internet.

Not only is the number of users increasing exponentially, but the amount of information available to them is also growing at an unprecedented rate. The International Data Corporation estimated the number of web pages on the World Wide Web at 829 million at the end of 1998, and projects that the number will be 7.7 billion by 2002.

The explosive growth of the Internet will eventually have a fundamental impact on every aspect of American life, and will introduce a vastly different landscape in high-technology than exists today. Users will not necessarily