then be addressed in the reauthorization of the national lunch program in the 108th Congress.

I want to thank Chairman BOEHNER of the Committee on Education and the Workforce and Subcommittee Chairman CASTLE for their efforts in introducing and expediting consideration of H.R. 3216. Without their strong support and the efforts of all the staff that have been extremely helpful, we would not be able to be here on the floor.

As members of the Armed Forces are fighting terrorism abroad and at home, I would urge my colleagues in the House of Representatives to pass H.R. 3216 unanimously. In these difficult times, the least we can do while these people are serving our country is to make sure that we take care of their children and their education.

Once again, I want to thank both chairmen and the gentlewoman from California (Mrs. DAVIS) for helping out in this effort. I think it is something that we have to come back in the 108th and make sure we take care of it completely. In addition to that, I know that there are about 16,000 housing projects that have been implemented. There is an additional 15,000 whose contracts are out. And then in the future we hope to improve the housing quality for all our military. We have over 51,000 housing projects, so it is an area that we really need to look at very seriously.

I once again thank very much both sides for this effort. The children will appreciate it.

Mrs. DAVIS of California. Madam Speaker, I yield myself such time as I may consume.

I want to thank my distinguished colleague from Texas. I know he has worked tirelessly on this issue. I appreciate all of that and so do the children in our school districts.

Madam Speaker, this is important bipartisan legislation that improves the quality of life of our service members, many of whom are deployed overseas in the face of danger, and removes a handicap to education faced by school districts across the Nation. I urge my colleagues to support this bill.

Madam Speaker, I yield back the balance of my time.

Mr. CASTLE. Madam Speaker, I yield myself such time as I may consume.

I thank the gentlewoman from California and the gentleman from Texas for their kind words and the concept of actually going forward with this. I agree with the gentlewoman from California, this is legislation which is of extreme importance, particularly in helping children who need the extra help in an income circumstance.

I would encourage everybody also to support the legislation.

Ms. JACKSON-LEE of Texas. Madam Speaker, I rise in support of H.R. 3216. H.R. 3216 corrects a problem created by the Department of Defense housing allowance policy by exempting military housing allowances as income for the purpose of determining a student's eligibility for the National School Lunch Program. It will prevent the loss of free- and reduced-priced meal eligibility by school-age children of military when their family home becomes privatized, or when the family moves into a new, privatized home. This measure will take effect for two years from the date of enactment and a permanent fix is anticipated in the 2003 National School Lunch Act reauthorization.

Military personnel generally receive in-kind housing or a housing allowance. In-kind housing usually takes the form of housing on a military base. Several years ago, however, the Department of Defense initiated a pilot program that allowed private developers to build military housing on Federal land, or manage existing military base housing.

Currently, the Department of Agriculture treats this privatized housing allowance as income. The result is that a family's income is raised above the level needed to receive free- or reduce-price lunches. There is little distinction between these families and those living in regular civilian housing because military families living in these privatized housing sign their housing allowance over to the developer. Therefore, military families in privatized military housing should remain eligible for the National School Lunch Program.

We must remember that individual directly benefiting from the National School Lunch Program are the children. Mr. Speaker, we cannot take away these children's free- or reduced-price lunches because of some technicality they have no control over. These are innocent children who require the nourishment to get them through the school day just like any other student. Especially now, when many American mothers and fathers are being called to war to defend our safety and freedom, we should not deny this benefit to their deserving children. For these children, I urge my colleagues to support H.R. 3216.

Mr. BOEHNER. Madam Speaker, recently, I was disheartened to learn that some children of the men and women who proudly serve our country in the U.S. armed services are unfairly losing their eligibility to receive free- and reduced-priced school meals. This is occurring for no reason other than that their family home is being privatized or they have been asked to move into a new, privatized military home. Because program eligibility is based on income, the additional compensation in the form of a housing allowance received by military personnel to pay for privatized military housing can result in the loss of meal benefits, although there is no real increase in salary or disposable income. In addition, schools attended by the children of military personnel could lose Federal and State education aid based on free- and reduced-priced meal counts, including their designation and funding as title I schools.

I support the Department of Defenses' plan to improve the standards of military housing through privatization, but Congress must resolve this unintended consequence of the Department of Defense's housing policy before more otherwise qualified children lose access to free- and reduced-priced school meals.

H.R. 3216 addresses and solves this problem for the next two school years at no cost. By excluding housing allowances used to live in privatized military housing from income when determining a child's eligibility to receive a free- and reduced-priced lunch, we can restore and preserve this benefit for qualified military families.

Many of our service men and women take comfort in knowing that their children can receive a nutritious meal in school at little or no cost. Especially now, when many of our service men and women are being called to war to defend our safety and freedom, we should not deny this benefit to their deserving children.

Mr. CASTLE. Madam Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mrs. BIGGERT). The question is on the motion offered by the gentleman from Delaware (Mr. CASTLE) that the House suspend the rules and pass the bill, H.R. 3216.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the bill was passed.

A motion to reconsider was laid on the table.

GLOBAL ACCESS TO HIV/AIDS PREVENTION, AWARENESS, EDUCATION, AND TREATMENT ACT OF 2001

Mr. HYDE. Madam Speaker, I move to suspend the rules and pass the bill (H.R. 2069) to amend the Foreign Assistance Act of 1961 to authorize assistance to prevent, treat, and monitor HIV/AIDS in sub-Saharan African and other developing countries, as amended.

The Clerk read as follows:

H.R. 2069

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Global Access to HIV/AIDS Prevention, Awareness, Education, and Treatment Act of 2001''.

SEC. 2. FINDINGS; SENSE OF CONGRESS.

(a) FINDINGS.—Congress makes the following findings:

(1) According to the Joint United Nations Programme on HIV/AIDS (UNAIDS) more than 58,000,000 people worldwide have already been infected with HIV/AIDS, a fatal disease that is devastating the health and economies in dozens of countries in Africa and increasingly in Asia, the Caribbean region, and Eastern Europe.

(2) The HIV/AIDS pandemic has erased decades of progress in improving the lives of families in the developing world and has claimed 22,000,000 lives since its inception.

(3) More than 17,000,000 individuals have died from HIV/AIDS in sub-Saharan Africa alone.

(4) The HIV/AIDS pandemic in sub-Saharan Africa has grown beyond an international public health issue to become a humanitarian, national security, and developmental crisis.

(5) The HIV/AIDS pandemic is striking hardest among women and girls. According to UNAIDS, by the end of 2000, fifty-five percent of the HIV-positive population in sub-Saharan Africa and 40 percent of such population in North Africa and the Middle East were women, infected mainly through heterosexual transmission. In Africa, 6 out of 7 children who are HIV positive are girls.

(6) An estimated 1,400,000 children under age 15 were living with HIV/AIDS at the end of 2000, of which 1,100,000 were children living

in sub-Saharan Africa. An estimated 500,000 children died of AIDS during 2000, of which 440,000 were children in sub-Saharan Africa. In addition there are an estimated 13,200,000 children worldwide who have lost one or both of their parents to HIV/AIDS, of which 12,100,000 are children in sub-Saharan Africa.

(7) Mother-to-child transmission is the largest source of HIV infection in children under age 15 and the only source for very young children. The total number of births to HIV-infected pregnant women each year in developing countries is approximately 700,000.

(8) Counseling and voluntary testing are critical services to help infected women accept their HIV status and the risk it poses to their unborn child. Mothers who are aware of their status can make informed decisions about treatment, replacement feeding, and future child-bearing.

(9) Although the HIV/AIDS pandemic has impacted the sub-Saharan Africa disproportionately, HIV infection rates are rising rapidly in India and other South Asian countries, Brazil, Russia, Eastern European countries, and Caribbean countries, and pose a serious threat to the security and stability in those countries.

(10) By 2010, it is estimated that approximately 40,000,000 children worldwide will have lost one or both of their parents to HIV/AIDS.

(11) In January 2000, the United States National Intelligence Council estimates that this dramatic increase in AIDS orphans will contribute to economic decay, social fragmentation, and political destabilization in already volatile and strained societies. Children without care or hope are often drawn into prostitution, crime, substance abuse or child soldiery. The Council also stated that, in addition to the reduction of economic activity caused by HIV/AIDS to date, the disease could reduce GDP by as much as 20 percent or more by 2010 in some countries in sub-Saharan Africa.

(12) The HIV/AIDS epidemic is not just a health crisis but is directly linked to development problems, including chronic poverty, food security and personal debt that are reflected in the capacity of affected households, often headed by elders or orphaned children, to meet basic needs. Similarly, heavily-indebted countries are stripped of the resources necessary to improve health care delivery systems and infrastructure and to prevent, treat, and care for individuals affected by HIV/AIDS.

(13) On March 7, 2001, the United States Secretary of State testified before Congress that the United States has an obligation '' . . . if we believe in democracy and freedom, to stop this catastrophe from destroying whole economies and families and societies and cultures and nations''.

(14) A continuing priority for responding to the HIV/AIDS crisis should be to emphasize and encourage awareness, education, and prevention, including prevention activities that promote behavioral change, while recognizing that behavioral change alone will not conquer this disease. In so doing, priority and support should be given to building capacity in the local public health sector through technical assistance as well as through nongovernmental organizations, including faith-based organizations where practicable.

(15) Effective use should be made of existing health care systems to provide treatment for individuals suffering from HIV/AIDS.

(16) Many countries in Africa facing health crises, including high HIV/AIDS infection rates, already have well-developed and high functioning health care systems. Additional resources to expand and improve capacity to respond to these crises can easily be absorbed by the private and public sectors, as well as by nongovernmental organizations, community-based organizations, and faith-based organizations currently engaged in combatting the crises.

(17) An effective response to the HIV/AIDS pandemic must also involve assistance to stimulate the development of sound health care delivery systems and infrastructure in countries in sub-Saharan Africa and other developing countries, including assistance to increase the capacity and technical skills of local public health professionals and other personnel in such countries, and improved access to treatment and care for those already infected with HIV/AIDS.

(18) Access to effective treatment for HIV/AIDS is determined by issues of price, health care delivery system and infrastructure, and sustainable financing and such access can be inhibited by the stigma and discrimination associated with HIV/AIDS.

(19) The HIV/AIDS crisis must be addressed by a robust, multilateral approach such as the one envisioned by the Congress in the Global AIDS and Tuberculosis Relief Act of 2000, which directed the United States Government to seek to negotiate the creation of an international HIV/AIDS trust fund involving the World Bank.

(20) The Secretary General of the United Nations has called for a global fund to halt and reverse the spread of HIV/AIDS and other infectious diseases. The Secretary General has also called for annual expenditures of $7,000,000,000 to $10,000,000,000, financed by donor governments and private contributors, for all efforts to combat the HIV/AIDS pandemic and, equally important, called on leaders from developing countries to give a much higher priority in their budgets to development of comprehensive health systems.

(21) The Administration has advocated a fiduciary role for the World Bank in the Global Fund to Fight AIDS, Tuberculosis, and Malaria and the Transitional Working Group for that fund has decided to invite the World Bank to play such a role.

(22) An effective United States response to the HIV/AIDS crisis must also focus on the development of HIV/AIDS vaccines to prevent the spread of the disease as well as the development of microbicides, effective diagnostics, and simpler treatments.

(23) The innovative capacity of the United States in the commercial and public pharmaceutical research sectors is among the foremost in the world, and the active participation of both these sectors should be supported as it is critical to combat the global HIV/AIDS pandemic.

(24) Appropriate treatment of individuals with HIV/AIDS can prolong the lives of such individuals, preserve their families and prevent children from becoming orphans, and increase productivity of such individuals by allowing them to lead active lives and reduce the need for costly hospitalization for treatment of opportunistic infections caused by HIV.

(25) United States nongovernmental organizations, including faith-based organizations, with experience in healthcare and HIV/AIDS counseling, have proven effective in combatting the HIV/AIDS pandemic and can be a resource in assisting sub-Saharan African leaders of traditional, political, business, and women and youth organizations in their efforts to provide treatment and care for individuals infected with HIV/AIDS.

(26) Most of the HIV infected poor of the developing world die of deadly diseases such as tuberculosis and malaria. Accordingly, effective HIV/AIDS treatment programs should address the growing threat and spread of tuberculosis, malaria, and other infectious diseases in the developing world.

(27) Law enforcement and military personnel of foreign countries often have a high rate of prevalence of HIV/AIDS, and therefore, in order to be effective, HIV/AIDS awareness, prevention, and education programs must include education and related services to such law enforcement and military personnel.

(28) Microenterprise development and other income generation programs assist communities afflicted by the HIV/AIDS pandemic and increase the productive capacity of communities and afflicted households. Microenterprise programs are also an effective means to support the productive activities of healthy family members caring for the sick and orphaned. Such programs should give priority to women infected with the AIDS virus or in HIV/AIDS affected families, particularly women in high-risk categories.

(29) The exploding global HIV/AIDS pandemic has created new challenges for United States bilateral assistance programs and will require a substantial increase in the capacity of the United States Agency for International Development and other agencies of the United States to manage and monitor bilateral HIV/AIDS programs and resources. To meet this challenge, the Agency will need to recruit and retain appropriate technical expertise in the United States as well as in foreign countries to help develop and implement HIV/AIDS strategies in concert with multilateral agencies, host country governments, and nongovernmental organizations.

(b) SENSE OF CONGRESS.—It is the sense of Congress that—

(1)(A) combatting the HIV/AIDS pandemic in countries in sub-Saharan Africa and other developing countries should be a global effort and include the financial support of all developed countries and the cooperation of governments and the private sector, including faith-based organizations; and

(B) the United States should provide additional funds for multilateral programs and efforts to combat HIV/AIDS and also seek to leverage public and private resources to combat HIV/AIDS on a global basis through the Global Development Alliance Initiative of the United States Agency for International Development and other public and private partnerships with an emphasis on HIV/AIDS awareness, education, prevention, and treatment programs;

(2)(A) in addition to HIV/AIDS awareness, education, and prevention programs, the United States Government should make its best efforts to support programs that safely make available to public and private entities in countries in sub-Saharan Africa and other developing countries pharmaceuticals and diagnostics for HIV/AIDS therapy in order—

(i) to effectively and safely assist such countries in the delivery of HIV/AIDS therapy pharmaceuticals through the establishment of adequate health care delivery systems and treatment monitoring programs; and

(ii) to provide treatment for poor individuals with HIV/AIDS in such countries; and

(B) in carrying out such programs, priority consideration for participation should be given to countries in sub-Saharan Africa;

(3)(A) combatting the HIV/AIDS pandemic requires that United States Government programs place a priority on the vulnerable populations at greatest risk for contracting HIV;

(B) these populations should be determined through qualitative and quantitative assessments at the local level by local government, nongovernmental organizations, people living with HIV/AIDS, and other relevant sectors of civil society; and

(C) such assessments should be included in national HIV/AIDS strategies;

(4) the United States should promote efforts to expand and develop programs that support the growing number of children orphaned by the HIV/AIDS pandemic;

(5) in countries where the United States Government is conducting HIV/AIDS awareness, prevention, and education programs, such programs should include education and related services to law enforcement and military personnel of foreign countries to prevent and control HIV/AIDS, malaria, and tuberculosis;

(6) prevention and treatment for HIV/AIDS should be a component of a comprehensive international effort to combat deadly infectious diseases, including malaria and tuberculosis, and opportunistic infections, that kill millions annually in the developing world;

(7) programs developed by the United States Agency for International Development to address the HIV/AID pandemic should preserve personal privacy and confidentiality, should not include compulsory HIV/AIDS testing, and should not be discriminatory;

(8)(A) the United States Agency for International Development should carry out HIV/AIDS awareness, prevention, and treatment programs in conjunction with effective international tuberculosis and malaria treatment programs and with programs that address the relationship between HIV/AIDS and a number of opportunistic diseases that include bacterial diseases, fungal diseases, viral diseases and HIV-associated malignancies, such as Kaposi sarcoma, lymphoma, and squamous cell carcinoma; and

(B) effective intervention against opportunistic diseases requires not only the appropriate drug or other medication for a given medical condition, but also the infrastructure necessary to diagnose the condition, monitor the intervention, and provide counseling services; and

(9) the United States Agency for International Development should expand and replicate successful microenterprise programs in Uganda, Zambia, Zimbabwe, and other African countries that provide poor families affected by HIV/AIDS with the means to care for themselves, their children, and orphans;

(10) the United States Agency for International Development should substantially increase and improve its capacity to manage and monitor HIV/AIDS programs and resources;

(11) the United States Agency for International Development must recruit and retain appropriate technical expertise in the United States as well as in foreign countries to help develop and implement HIV/AIDS strategies in conjunction with multilateral agencies, host country governments, and nongovernmental organizations;

(12) the United States Agency for International Development must strengthen coordination and collaboration between the technical experts in its central and regional bureaus and foreign country missions in formulating country strategies and implementing HIV/AIDS programs;

(13) strong coordination among the various agencies of the United States, including the Department of State, the United States Agency for International Development, the Department of Health and Human Services, including the Centers for Disease Control and the National Institutes of Health, the Department of the Treasury, the Department of Defense, and other relevant Federal agencies must exist to ensure effective and efficient use of financial and technical resources within the United States Government; and

(14) to help alleviate human suffering, and enhance the dignity and quality of life for patients debilitated by HIV/AIDS, the United States should promote, both unilaterally and through multilateral initiatives, the use of palliative and hospice care, and provide financial and technical assistance to palliative and hospice care programs, including programs under which such care is provided by faith-based organizations.

SEC. 3. ASSISTANCE TO COMBAT HIV/AIDS.

(a) ASSISTANCE.—Section 104(c) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b(c)) is amended—

(1) by striking paragraphs (4) through (6); and

(2) by inserting after paragraph (3) the following:

''(4)(A) Congress recognizes that the alarming spread of HIV/AIDS in countries in sub-Saharan Africa and other developing countries is a major global health, national security, and humanitarian crisis. Accordingly, the United States and other developed countries should provide assistance to countries in sub-Saharan Africa and other developing countries to control this crisis through HIV/AIDS prevention, treatment, monitoring, and related activities, particularly activities focused on women and youth, including mother-to-child transmission prevention strategies.

''(B)(i) The Administrator of the United States Agency for International Development is authorized to provide assistance to prevent, treat, and monitor HIV/AIDS, and carry out related activities, in countries in sub-Saharan Africa and other developing countries.

''(ii) It is the sense of Congress that the Administrator should provide an appropriate level of assistance under clause (i) through nongovernmental organizations in countries in sub-Saharan Africa and other developing countries affected by the HIV/AIDS pandemic.

''(iii) The Administrator shall coordinate the provision of assistance under clause (i) with the provision of related assistance by the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Children's Fund (UNICEF), the World Health Organization (WHO), the United Nations Development Programme (UNDP), other appropriate international organizations, such as the World Bank and the relevant regional multilateral development institutions, national, state, and local governments of foreign countries, and other appropriate governmental and nongovernmental organizations.

''(C) Assistance provided under subparagraph (B) shall, to the maximum extent practicable, be used to carry out the following activities:

''(i) Prevention of HIV/AIDS through activities including—

''(I) education, voluntary testing, and counseling (including the incorporation of confidentiality protections with respect to such testing and counseling), including integration of such programs into women's and children's health programs;

''(II) assistance to ensure a safe blood supply and to provide post-exposure prophylaxis to victims of rape and sexual assault; and

''(III) assistance through nongovernmental organizations, including faith-based organizations, particularly those organizations that utilize both professionals and volunteers with appropriate skills and experience, to establish and implement culturally appropriate HIV/AIDS education and prevention programs.

''(ii) The treatment and care of individuals with HIV/AIDS, including—

''(I) assistance to establish and implement programs to strengthen and broaden indigenous health care delivery systems and the capacity of such systems to deliver HIV/AIDS pharmaceuticals and otherwise provide for the treatment of individuals with HIV/AIDS, including clinical training for indigenous organizations and health care providers;

''(II) assistance aimed at the prevention of transmission of HIV/AIDS from mother to child, including medications to prevent such transmission and access to infant formula and other alternatives for infant feeding; and

''(III) assistance to strengthen and expand hospice and palliative care programs to assist patients debilitated by HIV/AIDS, their families, and the primary caregivers of such patients, including programs that utilize faith-based organizations.

''(iii) The monitoring of programs, projects, and activities carried out pursuant to clauses (i) and (ii), including—

''(I) monitoring to ensure that adequate controls are established and implemented to provide HIV/AIDS pharmaceuticals and other appropriate medicines to poor individuals with HIV/AIDS; and

''(II) appropriate evaluation and surveillance activities.

''(iv) The conduct of related activities, including—

''(I) the care and support of children who are orphaned by the HIV/AIDS pandemic, including services designed to care for orphaned children in a family environment which rely on extended family members;

''(II) improved infrastructure and institutional capacity to develop and manage education, prevention, and treatment programs, including the resources to collect and maintain accurate HIV surveillance data to target programs and measure the effectiveness of interventions;

''(III) vaccine research and development partnership programs with specific plans of action to develop a safe, effective, accessible, preventive HIV vaccine for use throughout the world; and

''(IV) the development and expansion of financially-sustainable microfinance institutions and other income generation programs that strengthen the economic and social viability of communities afflicted by the HIV/AIDS pandemic, including support for the savings and productive capacity of affected poor households caring for orphans.

''(D)(i) Not later than January 31 of each calendar year, the Administrator shall submit to Congress an annual report on the implementation of this paragraph for the prior fiscal year.

''(ii) Such report shall include—

''(I) a description of efforts made to implement the policies set forth in this paragraph;

''(II) a description of the programs established pursuant to this paragraph and section 4 of the Global Access to HIV/AIDS Prevention, Awareness, Education, and Treatment Act of 2001; and

''(III) a detailed assessment of the impact of programs established pursuant to this paragraph, including the effectiveness of such programs in reducing the spread of HIV infection, particularly in women and girls, in reducing HIV transmission from mother to child, in reducing mortality rates from HIV/AIDS, and the progress toward improving health care delivery systems and infrastructure to ensure increased access to care and treatment.

''(iii) The Administrator shall consult with the Global Health Advisory Board established under section 6 of the Global Access to HIV/AIDS Prevention, Awareness, Education, and Treatment Act of 2001 in the preparation of the report under clause (i) and on other global health activities carried out by the United States Agency for International Development.

''(E)(i) There is authorized to be appropriated to the President to carry out this paragraph $485,000,000 for fiscal year 2002.

''(ii) Not more than six percent of the amount appropriated pursuant to the authorization of appropriations under clause (i) for fiscal year 2002, and not more than four percent of the amount made available to carry out this paragraph for any subsequent fiscal year, may be used for the administrative expenses of the Agency in carrying out this paragraph.

''(iii) Amounts appropriated pursuant to the authorization of appropriations under clause (i) are in addition to amounts otherwise available for such purposes and are authorized to remain available until expended.

''(F) In this paragraph:

''(i) The term 'HIV' means infection with the human immunodeficiency virus.

''(ii) The term 'AIDS' means acquired immune deficiency syndrome.''.

(b) AVAILABILITY OF ASSISTANCE UNDER SECTION 104(c).—Section 104(c) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b(c)) is amended—

(1) by redesignating paragraph (7) as paragraph (5); and

(2) by adding at the end the following:

''(6) Assistance made available under any paragraph of this subsection, and assistance made available under chapter 4 of part II of this Act to carry out the purposes of any paragraph of this subsection, may be made available notwithstanding any other provision of law.''.

SEC. 4. ASSISTANCE FOR PROCUREMENT AND DISTRIBUTION OF HIV/AIDS PHARMACEUTICALS AND RELATED MEDICINES.

(a) ASSISTANCE.—The Administrator of the United States Agency for International Development shall provide assistance to countries in sub-Saharan Africa and other developing countries for—

(1) the procurement of HIV/AIDS pharmaceuticals, anti-viral therapies, and other appropriate medicines; and

(2) the distribution of such HIV/AIDS pharmaceuticals, anti-viral therapies, and other appropriate medicines to qualified national, regional, or local organizations for the treatment of individuals with HIV/AIDS in accordance with appropriate HIV/AIDS testing and monitoring requirements and for the prevention of transmission of HIV/AIDS from mother to child.

(b) ADDITIONAL AUTHORITY.—The authority contained in section 104(c)(6) of the Foreign Assistance Act of 1961, as amended by section 3(b) of this Act, shall apply to assistance made available under subsection (a).

(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to the President to carry out this section $50,000,000 for fiscal year 2002.

SEC. 5. INTERAGENCY TASK FORCE ON HIV/AIDS.

(a) ESTABLISHMENT.—The President shall establish an interagency task force (hereafter referred to as the ''task force'') to ensure coordination of all Federal programs related to the prevention, treatment, and monitoring of HIV/AIDS in foreign countries.

(b) DUTIES.—The duties of the task force shall include—

(1) reviewing all Federal programs related to the prevention, treatment, and monitoring of HIV/AIDS in foreign countries to ensure proper coordination and compatibility of activities and policies of such programs;

(2) exchanging information regarding design and impact of such programs to ensure that the United States Government can catalogue the best possible practices for HIV/AIDS prevention, treatment, and monitoring and improve the effectiveness of such programs in the countries in which they operate; and

(3) fostering discussions with United States and foreign nongovernmental organizations to determine how United States Government programs can be improved, including by engaging in a dialogue with the Global Health Advisory Board established under section 6 of this Act.

(c) MEMBERSHIP.—

(1) COMPOSITION.—The task force shall be composed of the Secretary of State, the Administrator of the United States Agency for International Development, the Secretary of Health and Human Services, the Secretary of the Treasury, the Director of the National Institutes of Health, the Director of the Centers for Disease Control, the Secretary of Defense, and the head of any other agency that the President determines is appropriate.

(2) CHAIRPERSON.—The Secretary of State shall serve as chairperson of the task force.

(d) PUBLIC MEETINGS.—At least once each calendar year, the task force shall hold a public meeting in order to afford an opportunity for any person to present views regarding the activities of the United States Government with respect to the prevention, treatment, and monitoring of HIV/AIDS in foreign countries. The Secretary of State shall maintain a record of each meeting and shall make the record available to the public.

(e) AVAILABILITY OF FUNDS.—Amounts made available for a fiscal year pursuant to section 104(c)(4)(E)(ii) of the Foreign Assistance Act of 1961, as amended by section 3(a) of this Act, are authorized to be made available to carry out this section for such fiscal year.

SEC. 6. GLOBAL HEALTH ADVISORY BOARD.

(a) ESTABLISHMENT.—There is established a permanent Global Health Advisory Board (hereafter referred to as the ''Board'') to assist the President and other Federal officials, including the Secretary of State and the Administrator of the United States Agency for International Development, in the administration and implementation of United States international health programs, particularly programs relating to the prevention, treatment, and monitoring of HIV/AIDS.

(b) DUTIES.—

(1) IN GENERAL.—The Board shall serve as a liaison between the United States Government and private and voluntary organizations, other nongovernmental organizations, and academic institutions in the United States that are active in international health issues, particularly prevention, treatment, and care with respect to HIV/AIDS and other infectious diseases.

(2) SPECIFIC ACTIVITIES.—In carrying out paragraph (1), the Board—

(A) shall provide advice to the United States Agency for International Development and other Federal agencies on health and management issues relating to foreign assistance in which both the United States Government and private and voluntary organizations participate;

(B) shall provide advice on the formulation of basic policy, procedures, and criteria for the review, selection, and monitoring of project proposals for United States Government international health programs and for the establishment of transparency in the provision and implementation of grants made under such programs;

(C) shall provide advice on the establishment of evaluation and monitoring programs to measure the effectiveness of United States Government international health programs, including standards and criteria to assess the extent to which programs have met their goals and objectives and the development of indicators to track progress of specific initiatives;

(D) shall review and evaluate the overall health strategy for United States bilateral assistance for each country receiving significant United States bilateral assistance in the health sector;

(E) shall recommend which developing countries could benefit most from programs carried out under United States Government international health programs; and

(F) shall assess the impact and effectiveness of programs carried out under section 104(c)(4) of the Foreign Assistance Act of 1961, as amended by section 3(a) of this Act, in meeting the objectives set out in the HIV/AIDS country strategy established by the United States Agency for International Development.

(c) MEMBERSHIP.—

(1) COMPOSITION.—The Board shall be composed of 12 members—

(A)(i) all of whom shall have a substantial expertise and background in international health research, policy, or management, particularly in the area of prevention, treatment, and care with respect to HIV/AIDS and other infectious diseases; and

(ii) of whom at least one member shall be an expert on women's and children's health issues; and

(B) of whom—

(i) three members shall be individuals from academic institutions;

(ii) five members shall be individuals from nongovernmental organizations active in international health programs, particularly HIV/AIDS prevention, treatment and monitoring programs in foreign countries, of which not more than two members may be from faith-based organizations;

(iii) two members shall be individuals from health policy and advocacy institutes; and

(iv) two members shall be individuals from private foundations that make substantial contributions to global health programs.

(2) APPOINTMENT.—The individuals referred to in paragraph (1) shall be appointed by the President, after consultation with the chairman and ranking member of the Committee on International Relations of the House of Representatives and the Committee on Foreign Relations of the Senate.

(3) TERMS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), each member shall be appointed for a term of two years and no member or organization shall serve on the Advisory Board for more than two consecutive terms.

(B) TERMS OF INITIAL APPOINTEES.—As designated by the President at the time of appointment, of the members first appointed—

(i) six members shall be appointed for a term of three years; and

(ii) six members, to the extent practicable equally divided among the categories described in clauses (i) through (iv) of paragraph (1)(B), shall be appointed for a term of two years.

(4) CHAIRPERSON.—At the first meeting of the Board in each calendar year, a majority of the members of the Commission present and voting shall elect, from among the members of the Board, an individual to serve as chairperson of the Board.

(d) TRAVEL EXPENSES.—Each member of the Board shall receive travel expenses, including per diem in lieu of subsistence, in accordance with applicable provisions under subchapter I of chapter 57 of title 5, United States Code.

(e) AVAILABILITY OF FUNDS.—Amounts made available for a fiscal year pursuant to section 104(c)(4)(E)(ii) of the Foreign Assistance Act of 1961, as amended by section 3(a) of this Act, are authorized to be made available to carry out this section for such fiscal year.

SEC. 7. AUTHORIZATION OF APPROPRIATIONS FOR MULTILATERAL EFFORTS TO PREVENT, TREAT, AND MONITOR HIV/AIDS.

(a) AUTHORIZATION.—There is authorized to be appropriated to the President $750,000,000 for fiscal year 2002 for United States contributions to a global health fund negotiated by the United States consistent with the general principles in the Global AIDS and Tuberculosis Relief Act of 2000 and the initiative of the Secretary General of the United Nations or other multilateral efforts to prevent, treat, and monitor HIV/AIDS in countries in sub-Saharan Africa and other developing countries, including efforts to provide hospice and palliative care for individuals with HIV/AIDS.

(b) CHARACTERISTICS OF GLOBAL HEALTH FUND.—It is the sense of Congress that, consistent with the general principles outlined in the Global AIDS and Tuberculosis Relief Act of 2000, United States contributions should be provided to a global health fund under subsection (a) only if the fund—

(1) is a public-private partnership that includes participation of, and seeks contributions from, governments, foundations, corporations, nongovernmental organizations, organizations that are part of the United Nations system, and other entities or individuals;

(2) has the World Bank serving as the fiduciary agent of the fund and in any other capacity deemed appropriate by the international community;

(3)(A) includes donors, recipient countries, civil society, and other relevant parties in the governance of the fund; and

(B) contains safeguards against conflicts of interest in the governance of the fund by the individuals and entities described in subparagraph (A);

(4) supports targeted initiatives to address HIV/AIDS, tuberculosis, and malaria through an integrated approach that includes prevention interventions, care and treatment programs, and infrastructure capacity-building;

(5) permits strategic targeting of resources to address needs not currently met by existing bilateral and multilateral efforts and includes separate sub-accounts for different activities allowing donors to designate funds for specific categories of programs and activities;

(6) reserves a minimum of 5 percent of its grant funds to support scientific or medical research in connection with the projects it funds in developing countries;

(7) provides public disclosure with respect to—

(A) the membership and official proceedings of the mechanism established to manage and disburse amounts contributed to the fund; and

(B) grants and projects supported by the fund;

(8) authorizes and enforces requirements for the periodic financial and performance auditing of projects and makes future funding conditional upon the results of such audits; and

(9) provides public disclosure of the findings of all financial and performance audits of the fund.

SEC. 8. DEFINITION.

In this Act:

(1) HIV.—The term ''HIV'' means infection with the human immunodeficiency virus.

(2) AIDS.—The term ''AIDS'' means acquired immune deficiency syndrome.

SEC. 9. EXTENSION OF TIME FOR GAO REPORT ON TRUST FUND EFFECTIVENESS.

Section 131(b) of the Global AIDS and Tuberculosis Relief Act of 2000 (22 U.S.C. 6831(b)) is amended by striking ''of the enactment of this Act'' and inserting ''the Trust Fund is established''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Illinois (Mr. HYDE) and the gentleman from California (Mr. LANTOS) each will control 20 minutes.

The Chair recognizes the gentleman from Illinois (Mr. HYDE).

GENERAL LEAVE

Mr. HYDE. Madam Speaker, I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks and include extraneous material on the bill under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Illinois?

There was no objection.

Mr. HYDE. Madam Speaker, I yield myself such time as I may consume.

(Mr. HYDE asked and was given permission to revise and extend his remarks.)

Mr. HYDE. Madam Speaker, once again the United States has an opportunity, and the responsibility, to lead the world in confronting one of the most compelling humanitarian and moral challenges facing us today. I speak of the HIV/AIDS pandemic, a crisis unparalleled in modern times and one that threatens the entire world, embracing developed and developing countries alike.

The statistics are chilling: over 22 million people have already died of AIDS throughout the world. More than 3 million died last year alone. That is over 8,000 deaths each day, or nearly one death every 6 minutes. What is most alarming is that the number of infections and deaths is growing and the pandemic is quickly spreading from sub-Saharan Africa to India, China and Russia. An incredible 36 million people are already infected with HIV; and 15,000 new infections occur every day.

To illustrate the magnitude of the crisis, it is estimated that by the year 2010, over 80 million people may have died from AIDS. By comparison, that is more than all the military and civilian deaths resulting from World War II. If the disease is left unchecked, we have no idea what the statistics will be in 2015 or 2020, less than 20 years from today. The most dramatic increase in infection rates is in the developing world, where education, awareness and access to health care is most seriously lacking. As is too often the case, it is the children who suffer most. Millions are born HIV-infected even though mother-to-child transmission is easily avoided if adequate training and health care is provided. To this is added a widespread mortality among parents: by the end of the decade, 40 million children are likely to be orphaned as a consequence of AIDS. The impact on developing societies, socially, politically and economically, is incalculable and threatens the stability of many countries and societies around the globe.

Contrary to popular conceptions, the pandemic is not limited to Africa, where AIDS continues to sweep forward virtually unchecked. The disease has jumped to every continent. In Europe, last year Russia had the highest rate of increase of new cases of any country on the planet. That impoverished country's medical system is clearly unable to adequately cope with the challenge, ensuring that it will continue to spread. According to the National Intelligence Council, India is on the verge of a catastrophic AIDS epidemic. Closer to home, the Caribbean region has the second highest rate of HIV infections in the world.

The most appropriate comparison of this ever-widening threat is with the 14th century, when the plague repeatedly swept through Europe, killing a quarter of that continent's population, leaving no country untouched, and decimating entire regions. This time, however, it is the entire world that is at risk. If the world is to have a chance of prevailing against this disease, the United States must take a leading role in the efforts to combat it. To do so, we must advance along many fronts, both bilateral and multilateral. The bill we consider today, H.R. 2069, addresses both the bilateral and multilateral pillars of our response to the AIDS crisis.

H.R. 2069 builds upon existing efforts by authorizing the Agency for International Development to carry out a comprehensive program of HIV/AIDS prevention, education and treatment at a level of $485 million during fiscal year 2002. Moreover, Madam Speaker, H.R. 2069 authorizes an additional $50 million pilot program to provide treatment for those infected with HIV/AIDS by helping the public and private sectors of developing countries procure HIV/AIDS pharmaceuticals and antiviral therapies.

The novel bilateral treatment program that my bill authorizes is vitally important, for it gives hope to those already suffering from AIDS. By authorizing a pilot treatment program, we can work to extend the productive lives of those infected by the virus. This is not only the right thing to do, it has beneficial impact on treatment as well. Without some expectation of care, the poor have little reason to be tested for AIDS or to seek help. I am fully cognizant of the challenge posed by treatment programs in developing countries. However, it is my hope that successful treatment programs such as those carried out by the AIDS Healthcare Foundation will be replicated in developing countries. Madam Speaker, there simply is no option other than treatment if we are ever to stem the tide of this pandemic.

Through our bilateral efforts, the United States will demonstrate its commitment to address all facets of the HIV/AIDS challenge and thereby challenge the entire developed world to emulate the example of the United States. It is also my hope that faith-based organizations such as Catholic Relief Services will play a very significant and meaningful role in advising

USAID on the most effective approaches to combat the HIV/AIDS pandemic.

In addition to our bilateral efforts, the President has already signaled our Nation's intention to lead the multilateral campaign by committing at least $200 million to combat HIV/AIDS through a global AIDS war chest that will be designed and implemented in the months to come.

The Global Access to HIV/AIDS Prevention, Awareness, Education, and Treatment Act of 2001 also authorizes the President to contribute to multilateral efforts to combat HIV/AIDS at a level that the administration deems appropriate and at such time as a fund is established and criteria developed to ensure its sound management. America will contribute its fair share as we work to leverage additional funds for this effort from other developed countries.

By providing the President with this flexibility, we can ensure that the contributions made by the United States will be adequate and also yield the commitments from other countries to make this effort a truly global war on AIDS.

As with any problem, however, financial resources cannot serve as the sole answer, and the generosity of the American people must be well managed. We must provide resources at a pace at which these can be absorbed and used wisely. We must continue to encourage and support those faith-based organizations and churches that are on the front lines in the effort to educate the poor about HIV and AIDS and treatment and prevention. We must also insist that any program designed to combat the AIDS pandemic include abstinence as a core component.

In closing, I wish to thank the many Members and staff who have contributed to the passage of this landmark legislation. I am especially grateful to the gentleman from California (Mr. LANTOS) the committee's ranking member, and to the gentlewoman from California (Ms. LEE) for their leadership in crafting this legislation.

I am also appreciative of the invaluable support of the gentleman from New York (Mr. GILMAN), the committee's chairman emeritus; the gentleman from Nebraska (Mr. BEREUTER); and the gentleman from Iowa (Mr. LEACH). I am also very grateful for the generous support offered by the gentleman from Arizona (Mr. KOLBE). I also wish to thank Nisha Desai, David Abramowitz, Pearl Alice Marsh, and Michael Riggs of the Democratic staff for their many contributions and dedication to make this bill come to fruition.

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My greatest appreciation, however, goes to Adolfo Franco, a member of my own staff, whose tireless work made this bill a reality. He is leaving the staff to go to a very important job with the administration, and he will be sorely missed.

Madam Speaker, I wish to reiterate what I think is a consensus in Congress. Simply stated, the AIDS virus is one of the great moral challenges of our era. It is a scourge of unparalleled proportions in modern times. Every citizen has a stake in preventing what otherwise might well become the bubonic plague of the 21st century. We must do all that lies in our power to do if we are to meet this threat, first of all, by reaching out now to those most in need. It is not only the most sensible thing to do, it is the right thing to do for our children, our country and for the world.

I urge all of my colleagues to vote for H.R. 2069.

Madam Speaker, I reserve the balance of my time.

Mr. LANTOS. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, I rise in strong support of this legislation.

Madam Speaker, I first would like to commend my good friend, the distinguished chairman of the Committee on International Relations, for his leadership, his vision and his commitment to help combat the global HIV-AIDS crisis. The gentleman from Illinois (Mr. HYDE) has shown courage and integrity in tackling this issue, when he could have relied upon others to legislate on this front. Many do not see the global HIV–AIDS crisis as a United States priority and question the need to spend significant U.S. funds toward preventing and treating this disease, but the gentleman from Illinois (Chairman HYDE) recognizes not only the severity of the epidemic, but our moral, humanitarian and national security interests in stemming the tide of the HIV–AIDS pandemic.

I would also like to commend my colleague, the gentlewoman from California (Ms. LEE), for her unwavering leadership in the global fight against HIV–AIDS. She has played a critical role in setting this Congress on the right course on this human disaster and in fashioning this legislation.

Madam Speaker, the bill reflects an extraordinary process of consultation that involves not only members of our committee, but advocacy groups, nongovernmental organizations, the administration and the staff of the United Nations. The result is a landmark, bipartisan agreement that outlines both a policy framework and funding levels for U.S. bilateral and multilateral assistance to fight the global AIDS pandemic. I want to join the gentleman from Illinois (Chairman HYDE) in praising members of the Republican and Democratic staffs who played such a key role in bringing us to this point.

Madam Speaker, the bill before us represents a broad consensus, and I urge all of my colleagues to support it. I truly believe that our legislation lays the foundation for a long-term commitment by the United States to eradicate this devastating disease.

Our bill authorizes $535 million in bilateral U.S. assistance to education, prevention, treatment and care of HIV–AIDS and those highly infectious diseases associated with it. In addition, our bill commits $750 million towards a global health fund to coordinate both funding and comprehensive programs in the fight against this disease, to which governments the private sector, foundations and individual philanthropists will contribute.

Madam Speaker, in this post-September 11 world, it is all too easy to lose sight of the HIV–AIDS crisis as we focus on the most pressing problem of global terrorism and the devastating conditions in Afghanistan, but it is precisely in this post-September 11 era that we must strive to maintain our commitment to HIV–AIDS and other crises of global magnitude. AIDS has devastated entire societies, and it is leaving in its wake a generation lost in despair. It is these children, raised without hope, who often provide fertile grounds for the terrorists and criminal networks to sow their evil seeds.

As our Secretary of State, Colin Powell, said at the UN special session on AIDS, ''From this moment on, our response to AIDS must be no less comprehensive, no less relentless, and no less swift than the pandemic itself.''

If we have learned anything through our terrible national tragedy, it is that the world's problems are our problems, and if we do not deal with these problems overseas, we will be dealing with them on our own doorstep.

The resurgence of HIV–AIDS and tuberculosis in some parts of the United States is just one ominous indication of how the problems of the developing world can soon become our own problems if we do not act decisively. The new bilateral program authorized by our legislation will guarantee that the American people are directly engaged in providing education, prevention, treatment and care to those suffering in poor countries. It will improve the quality of the U.S. aid programs in the HIV–AIDS field and provide those who are suffering with AIDS opportunities to live better and more productive lives.

Our proposed 1-year multilateral expenditure of $750 million is a major investment on our part toward a global effort to secure a better future for millions suffering from this deadly disease. It is a signal to the world, and particularly those suffering from this disease, that the United States is a partner in the international battle against HIV–AIDS.

Lastly, Madam Speaker, I want to tell schoolteachers, health workers, women and men, grandparents and orphans in poor countries suffering from the HIV–AIDS pandemic that we are fighting for and with them. Men, women and children in Africa, South Asia, Europe, the Western Hemisphere, are all affected, and we must all work

together to find a solution. I urge my colleagues to support H.R. 2069.

Madam Speaker, I reserve the balance of my time.

Mr. HYDE. Madam Speaker, I am pleased to yield 4 minutes to the distinguished gentleman from Nebraska (Mr. BEREUTER).

Mr. BEREUTER. Madam Speaker, I rise in strong support of this legislation, and I thank the distinguished chairman for yielding me time. I want to thank him also for his leadership in introducing this legislation and for the effort to move it to the House floor so expeditiously. Also I would like to thank the distinguished ranking member of the House Committee on International Relations, the gentleman from California (Mr. LANTOS) and the distinguished gentlewoman from California (Ms. LEE), among others mentioned by the gentleman from Illinois (Chairman HYDE), for their very positive efforts regarding H.R. 2069.

I am pleased to be a member of the Committee on International Relations, but today I speak primarily as a chairman of a subcommittee of the Committee on Financial Services, the Subcommittee on International Monetary Policy and Trade. It is in that respect that I thank the gentleman from Illinois (Mr. HYDE), the chairman, and the gentleman from California (Mr. LANTOS), and others, for working with the distinguished gentleman from Ohio (Chairman OXLEY) and this Member by incorporating into H.R. 2069 language suggested by us to recognize the World Bank's fiduciary role for the Global Health Fund on HIV–AIDS.

The statistics on HIV–AIDS are staggering, as we heard a few minutes ago. According to the joint United Nations Programme on HIV–AIDS, as of December 2001, an estimated 40 million people worldwide live with HIV–AIDS, which includes an estimated 28.1 million people in Sub-Saharan Africa. Furthermore, in the year 2001 alone, there were an estimated 5 million new HIV–AIDS infections worldwide, with 3.4 million of these cases being in Sub-Saharan Africa. In addition to Africa, HIV infection rates are also rising dramatically in India and the other South Asian countries, as well as Russia, the Eastern European countries, Brazil and the Caribbean countries.

As the chairman of the Subcommittee on International Monetary Policy and Trade, this Member conducted a hearing on May 15, 2001, which focused on the activities in Africa of the International Monetary Fund, the World Bank, the African Development Bank and African Development Fund, including their efforts to combat HIV–AIDS. As a result of this hearing, which included testimony from the Joint United Nations Programme on HIV–AIDS, this Member introduced H.R. 2209. This legislation increases the authorization for the multilateral world AIDS trust for FY 2002 from $150 million to $200 million.

The World Bank AIDS Trust Fund was established with American support through what became Public Law 106–264, primarily authored by the distinguished gentleman from Iowa (Mr. LEACH). This law directed the United States Government to seek to negotiate the creation of an international HIV–AIDS trust fund which would be established within the World Bank.

The Global Access to HIV–AIDS Prevention, Awareness, Treatment, and Education Act of 2001, this bill, provides both multilateral and bilateral authorization funding to help prevent, treat and monitor HIV–AIDS. This dual approach is very important as the United States combats the global plague of HIV–AIDS with our neighbors and outer countries throughout the world.

This Member would like to particularly emphasize the $750 million multilateral authorization for FY 2002 to the Global Health Fund to combat HIV–AIDS. This legislation, H.R. 2069, states that this Global Health Fund is consistent with the global AIDS and Tuberculosis Relief Act of 2000, which established the U.S. negotiations for the World Bank AIDS Trust Fund.

The World Bank has the most extensive global infrastructure to provide the multilateral assistance needed to help prevent, treat and monitor HIV–AIDS. This Member fully supports the Bush administration's position to abdicate a fiduciary role for the World Bank in this Global Health Fund to fight HIV–AIDS. It should be noted that the Transitional Working Group, a multilateral institution for this Global Health Fund, has recently invited the World Bank to play that fiduciary role as a trustee for the fund.

I urge support of this legislation. I think the two committees worked well together to merge the two bills together.

Mr. LANTOS. Madam Speaker, I yield 4 minutes to the gentlewoman from California (Ms. LEE). No Member has worked harder and more diligently on this issue than my friend and colleague from California.

Ms. LEE. Madam Speaker, I rise first to thank the gentleman from Illinois (Chairman HYDE), our ranking member, the gentleman from California (Mr. LANTOS), the gentleman from Iowa (Mr. LEACH), and also the gentleman from Nebraska (Mr. BEREUTER), for their commitment and real diligence in working to develop H.R. 2069, legislation that will comprehensively fight the global AIDS, TB and malaria pandemics.

This bipartisan legislation that we are considering today is important because it authorizes the desperately needed resources to address the multifaceted and multigenerational challenges presented by the global AIDS, TB and malaria pandemics.

It has been over 20 years since the first AIDS diagnosis. Since then, HIV and AIDS has infected over 56 million people worldwide and has claimed over 25 million lives, including 4 million children. The events of September 11 have turned the world's attention appropriately on combatting international terrorism. However, we cannot forget the global will scourge of HIV and AIDS. It is a national security threat of staggering proportions. AIDS, like many diseases, knows no borders and discriminates against no one. Each day, AIDS, TB and malaria claim over 17,000 lives. So, just as we fight terrorism, we must also fight these diseases.

According to UN, AIDS left unchecked, it is estimated that over 100 million people will be infected worldwide by 2007.

□ 1445

AIDS is decimating the continent of Africa and leaving millions of orphans in its wake.

Today, the number of orphans in Africa is the equivalent of the total population of children in America's public schools. Left unchecked, Africa will be home to more than 40 million orphans by 2010; and unfortunately, Africa is only the epicenter. We must not sacrifice this generation of children on the alter of indifference.

The AIDS pandemic has cut life expectancy by 25 years in some countries. In Botswana, the population growth due to AIDS is negative. This means that there are more people dying from AIDS than there are being born. The AIDS, TB, and malaria pandemics constitute a crisis of biblical proportions in Africa and puts the very survival of the continent at stake. These pandemics are not only a humanitarian crisis, but they are potentially an economic, political, and social catastrophe. Therefore, it is important that we continue to beat the drum to raise awareness. Our efforts at home must reach far beyond our shores.

When the House Committee on International Relations marked this bill up earlier this year, the gentleman from Illinois (Mr. HYDE), the chairman of the committee, the gentleman from California (Mr. LANTOS), the gentleman from Iowa (Mr. LEACH), and the gentleman from Nebraska (Mr. BEREUTER) worked on this bill day and night to increase bilateral funding for AIDS, TB, and malaria and also to increase the U.S. contribution to our multilateral AIDS program. The program, under this bill's $750 million, includes a contribution to the Global AIDS Trust Fund, which the gentleman from Iowa (Mr. LEACH) and I cosponsored last year. This was actually signed into law as the Global AIDS and TB Relief Act of 2000, which the gentleman from Nebraska (Mr. BEREUTER) earlier referred to.

So today, the House is sending a strong message that America can and must do more.

Also, I want to state for the record that all HIV-infected persons have a basic right to vital medicines for prevention and treatment of AIDS and also must have access to drugs for treatment of opportunistic infections

and to anti-retroviral agents. We have the knowledge and we have the technology to prevent the spread of AIDS. We have the necessary drugs that can substantially reduce the rate of mother-to-child transmission and also prolong the lives of people who are infected.

In addition to all of the barriers we face addressing this global crisis, basic health care infrastructure remains an issue. This bill addresses that also.

So I just once again want to thank my colleagues, the gentleman from Illinois (Mr. HYDE), the chairman of the committee; the gentleman from California (Mr. LANTOS), the ranking member; the gentleman from Iowa (Mr. LEACH); and the gentleman from Nebraska (Mr. BEREUTER) for their commitment, and also for our staffs' work. I want to thank the staff for diligently working on this. Our dedication and their dedication to the future of the human family will surely have a ripple effect.

Mr. HYDE. Madam Speaker, I ask unanimous consent that each side be granted an additional 6 minutes for purposes of debate.

The SPEAKER pro tempore (Mrs. BIGGERT). Is there objection to the request of the gentleman from Illinois?

There was no objection.

Mr. HYDE. Madam Speaker, I yield 3 minutes to the gentleman from Arizona (Mr. KOLBE).

(Mr. KOLBE asked and was given permission to revise and extend his remarks.)

Mr. KOLBE. Madam Speaker, I thank the gentleman for yielding me this time.

When I became chairman of the Subcommittee on Foreign Operations of the Committee on Appropriations, I said that one of my highest priorities was to fund the battle against HIV/AIDS that is becoming a pandemic globally. With that in mind, I want to thank the distinguished chairman of the Committee on International Relations for his leadership and his interest in fighting HIV and other infectious diseases. We share this as a priority, and I am very pleased to work with the chairman on this important matter.

The authorization for bilateral assistance through the United States Agency for International Development is virtually identical to the amount recommended by the House and Senate conferees on the Foreign Operations, Export Financing, and Related Programs Appropriations Act for fiscal year 2002. We hope to file that conference report on the bill in the very near future. We completed the work on our conference in November and are awaiting a signal from the leadership to file that agreement.

Having said that, however, I think it is important to tell the House and Members here that the $750 million authorization that is included in this bill for the multilateral assistance is unlikely to be funded in fiscal year 2002. The chairman indicated in his own remarks that he understood that that was going to be the case.

Members need to know, should know, that the multilateral fund does not yet exist. It is a concept, and we are working on it; but its structure, its objectives, its voting methodology has not yet been determined and is not likely to occur until the middle of next year.

Despite that, the Committee on Appropriations is in the process of providing a total of $250 million in three separate bills for the proposed global fund to fight HIV, tuberculosis, and malaria; and that is an amount that is $50 million greater than had been requested in the President's budget.

Now, more funds are possible; but I do not want anybody to have unrealistic expectations for the FY 2002 budget. First, it is very important that this fund get created and that we begin to demonstrate success. That is not going to happen yet until at least well into this fiscal year. Until the Congress concurs with the proposed terms and conditions under which our initial $250 million could be used, it is not prudent, in my view, to leave the impression that there is another $500 million available or required at this time for the global fund.

Madam Speaker, I support this bill, because we must continue to dedicate an increasing amount of resources to fight the global pandemic of HIV/AIDS, but I do not want my support for the bill to be viewed as an endorsement of the $750 million level authorized for the proposed global fund, at least not at this time. We have more work to do before we are going to be ready to spend any of the funds set aside for the global trust fund, much less an amount as large as $250 million. I know the chairman understands that.

So this is a proactive, leading-the-way authorization, and I appreciate that. I do think that we can carry out the policies and provide for the ongoing and expanded bilateral programs. I thank the chairman for his leadership.

Mr. LANTOS. Madam Speaker, I am delighted to yield 2 minutes to the gentlewoman from California (Ms. PELOSI), the incoming whip of the Democratic Party, my friend and neighbor in San Francisco, who has been a national leader in the fight against HIV/AIDS for years.

Ms. PELOSI. Madam Speaker, I thank the gentleman for yielding me this time, and I thank him for his leadership on this issue. I commend the gentleman from Illinois (Mr. HYDE), the chairman of the committee; the gentleman from Nebraska (Mr. BEREUTER), the gentleman from Iowa (Mr. LEACH), and the gentlewoman from California (Ms. LEE) for their extraordinary leadership in bringing this bill to the floor. I know it was difficult, and I congratulate them in doing it.

I am pleased to follow the gentleman from Arizona (Mr. KOLBE), my distinguished chairman on the Subcommittee on Foreign Operations, a longtime member on that committee. Following the lead of my own constituents, we put the first money for international AIDS into that bill several years ago. We could never get the attention that he is getting here today on this issue. I know how hard it is, and I commend him for it. We tried to get the attention of the G–7 to put AIDS on the agenda a dozen years ago in both Democratic and Republican administrations, and only recently have the ramifications of AIDS been recognized at that level.

So it is with great enthusiasm that I commend all of my colleagues, and I rise in support of H.R. 2069.

Madam Speaker, we must never forget that every single day, 8,000 people die of AIDS; 8,000 people die every day of AIDS. Think of it. It is so staggering. It is unimaginable, almost. But we are concerned about every single one of them and about protecting every single child in the world and person in the world from contracting HIV and AIDS in the future.

The United States must take the lead in the global effort to end the global AIDS pandemic and the havoc it is creating in the developing world. Halting this crisis can only happen with new resources, and the dramatic step that is being taken today is a very, very important and significant step forward.

The social, economic, security, national security, and human rights cost of this crisis are devastating entire nations. Projections show that by 2010, South Africa's GDP will be 17 percent below where it would have been without AIDS, and the United Nations has estimated that AIDS could kill up to 26 percent of the workforce in Africa. India already has more infected people than Africa.

Madam Speaker, I will submit my full statement for the RECORD because, again, the statistics are staggering. Madam Speaker, $750 million is an excellent step forward. We need to do more.

Experts are predicting that without significant prevention and treatment efforts the number of Indians living with HIV/AIDS could surpass the combined number of cases in all African countries within two decades.

Developing countries will be unable to turn the tide on this epidemic if even the most basic health care is unavailable for most of their citizens. People must be educated about HIV and how to prevent its spread. Increased testing and counseling opportunities are desperately needed. Basic care and treatment that can be delivered in homes or makeshift clinics is essential. And the need for support for the growing number of children orphaned by AIDS looms large.

We know that prevention and treatment work. Comprehensive prevention efforts have turned around HIV epidemics in Uganda and Thailand, and averted an epidemic in Senegal. In a small village in Haiti, community health workers have been trained to deliver high quality care, including the advanced medicines used to treat AIDS in our country. The provisions of H.R. 2069 will help impoverished

countries expand and replicate effective programs, and strengthen the capacity of indigenous health care systems to deliver HIV/AIDS pharmaceuticals.

Our investment in the fight against the global AIDS pandemic not only has a direct impact, but is also promises to leverage significant funds from other countries and multilateral institutions. Specifically, the $750 million authorized for multilateral assistance will demonstrate this country's dedication to the new United Nations Global Fund, and other international efforts. Fighting AIDS requires a real, sustained commitment, and the money we provide is a signal to other nations that we will do our part.

The fight ahead of us against the global AIDS pandemic is a long one. We have no choice but to engage in the fight and to prevail. I urge my colleagues to support H.R. 2069.

Mr. HYDE. Madam Speaker, I am pleased to yield 2 minutes to the gentlewoman from Maryland (Mrs. MORELLA).

Mrs. MORELLA. Madam Speaker, I thank the gentleman for yielding me this time.

I rise in strong support of H.R. 2069, the Global Access to HIV and AIDS Prevention Act, to authorize nearly $1.4 billion to combat HIV/AIDS in sub-Saharan Africa and other developing countries.

I certainly want to applaud the leadership of the gentleman from Illinois (Mr. HYDE) and the gentleman from California (Mr. LANTOS) for their efforts in bringing this bill to the floor today. Because of their work and the work of so many of my friends and colleagues here in Congress, we are seeing a vast change in the global AIDS crisis in sub-Saharan Africa and other parts of the world. What I am referring to is a rapidly changing and increased level of awareness and concern, not only about the horrific damage the virus is wreaking, but about the future costs, costs in cultural, political, and economic stability in Africa.

New figures released on December 1, which was World AIDS Day, show that more than 40 million people are now living with the virus. The vast majority of them are in sub-Saharan Africa where the devastation is so acute it has become one of the main obstacles to development. I could go on with the various statistics. An estimated 24.5 million people in sub-Saharan Africa are infected with the HIV virus. That is 71 percent of the world's total.

What can we do? The United States is uniquely positioned to lead the world in the prevention and eradication of HIV and AIDS. This year's House-passed Foreign Operations Appropriations bill provides $474 million for AIDS prevention and control. But we must also pass this bill, H.R. 2069, The Global Access to HIV and AIDS Prevention Act. It authorizes $560 million in bilateral assistance programs for the various AIDS treatment and prevention programs administered by USAID. It also authorizes $750 million in 2002 for the United States contributions to the Global AIDS Fund.

So I would certainly say that this bill is good news. The bad news is it has taken so long.

Mr. LANTOS. Madam Speaker, I am pleased to yield 2 minutes to the gentleman from Texas (Mr. RODRIGUEZ), our distinguished colleague.

Mr. RODRIGUEZ. Madam Speaker, I rise in support of the Global Access to HIV/AIDS Prevention Act, H.R. 2069. I would like to commend the gentlewoman from California (Ms. LEE). I want to thank her for her hard work and her dedication as well. I want to thank her specifically for when she first sent that letter for us to sign to get on board, and I was very pleased to see that. I also want to thank the gentleman from California (Mr. LANTOS) for his efforts and the gentlewoman from California (Ms. PELOSI) and some of the other speakers that have been speaking on this issue, as well as the gentleman from Illinois (Mr. HYDE). I thank him for allowing us this opportunity to move forward on this issue.

This year marks the 20th year of HIV/AIDS, and in that time the virus has taken the lives of more than 25 million people throughout the world. In claiming lives, the virus has destroyed families and communities. It has devastated economies and created instability. It has changed the very way we interact with our neighbors.

The continued spread of the virus calls for a multilateral strategy in the struggle to reduce infections. Domestic and international efforts, prevention as well as treatment, as well as research and development and education, are critical. These are the parts of the equation that will help us change the outcome.

We must remember that disease has no borders and especially infectious diseases. We cannot afford to ignore the plight of our neighbors, because sooner or later, it will come and knock on our door.

By investing in the international efforts to eradicate this virus, we will be assuring and protecting Americans' health and prosperity. We will also show ourselves as a Nation committed to alleviating human sufferings everywhere else. It is the right thing to do for our neighbors and ourselves and for our constituents and for our children, for untreated and mistreated HIV/AIDS can hamper us all. For not treating appropriately, other types of strains can be created that will cause us more harm.

□ 1500

Madam Speaker, I urge my colleagues to support H.R. 2069, the Global Access to HIV/AIDS Prevention Awareness, Education, and Treatment Act of 2001.

Mr. HYDE. Madam Speaker, I am pleased to yield 2 minutes to the distinguished gentleman from Florida, (Mr. WELDON).

Mr. WELDON of Florida. Madam Speaker, I thank the gentleman for yielding time to me.

Madam Speaker, I did my internship and residency in San Francisco in the early eighties when AIDS was ravaging the homosexual community in that city. Prior to coming here to the U.S. House, I practiced infectious diseases and primarily treated AIDS, so I have seen firsthand the devastation that this disease can cause. I certainly commend all those involved with working to bring this bill to the floor.

I am particularly pleased that the chairman was willing to work with me to add language to emphasize the importance of a safe blood supply and the importance of prophylactic drugs for victims of rape and sexual assault; certainly, also, the language to emphasize access to infant formula and other alternatives for infant feeding.

Many babies are born to HIV mothers and survive the birth process without contracting AIDS, to only go on, unfortunately, to contract the disease through the process of breast feeding.

I do remain concerned, Madam Speaker, that the bill does not sufficiently stress abstinence. Abstinence programs have shown to be helpful in Uganda and Senegal; and abstinence, of course, is the only approach that actually guarantees that AIDS will not be spread.

I have served in the past on the board of a faith-based group that has worked in Nigeria on abstinence-based education. I think the bill, as it moves through the conference process and gets signed by the President, should have some stronger language inserted to deal with the importance of abstinence.

Also, I would like to see the makeup of the board, the advisory board, structured in such a way that faith-based organizations will be guaranteed a place at the table. There are currently hundreds of faith-based organizations in Africa. As I said, I have worked with one of them firsthand. They need to be included in this process.

Mr. LANTOS. Madam Speaker, I am pleased to yield 2 minutes to my good friend and my distinguished colleague, the gentlewoman from North Carolina (Mrs. CLAYTON).

Mrs. CLAYTON. Madam Speaker, I thank the gentleman for yielding time to me.

Madam Speaker, I rise in support of the Global to Access HIV/AIDS Prevention, Awareness, Education, and Treatment Act of 2001, H.R. 2069.

I also want to commend the leadership on this bill, the gentleman from Illinois (Chairman HYDE) and the gentleman from California (Mr. LANTOS), and all others involved in sponsoring this, the gentleman from Nebraska (Mr. BEREUTER), the gentlewoman from California (Ms. LEE), and those who have been carrying this fight on and have been strong advocates for ridding the world of this disease.

This legislation provides crucial funding for the prevention, treatment, and monitoring of AIDS in sub-Saharan Africa and other parts of the developing world, and an increased amount

of assistance through education and treatment programs, as well as assistance and aid for the prevention and transmission of HIV/AIDS from mother to child.

Madam Speaker, this legislation is essential to fighting the HIV/AIDS epidemic in many parts of the world, including that part of Africa. HIV is worldwide and actually knows no border, as we said earlier.

Madam Speaker, I include for the RECORD information on the AIDS epidemic provided by the World Health Organization.

The material referred to is as follows:

AIDS EPIDEMIC UPDATE—DECEMBER 2001

GLOBAL OVERVIEW

Twenty years after the first clinical evidence of acquired immunodeficiency syndrome was reported, AIDS has become the most devastating disease humankind has ever faced. Since the epidemic began, more than 60 million people have been infected with the virus. HIV/AIDS is now the leading cause of death in sub-Saharan Africa. Worldwide, it is the fourth-biggest killer.

At the end of 2001, an estimated 40 million people globally were living with HIV. In many parts of the developing world, the majority of new infections occur in young adults, with young women especially vulnerable. About one-third of those currently living with HIV/AIDS are aged 15–24. Most of them do not know they carry the virus. Many millions more know nothing or too little about HIV to protect themselves against it.

Eastern Europe and Central Asia—still the fastest-growing epidemic

Eastern Europe—especially the Russian Federation—continues to experience the fastest-growing epidemic in the world, with the number of new HIV infections rising steeply. In 2001, there were an estimated 250,000 new infections in this region, bringing to 1 million the number of people living with HIV. Given the high levels of other sexually transmitted infections, and the high rates of injecting drug use among young people, the epidemic looks set to grow considerably.

Asia and the Pacific—narrowing windows of opportunity.

In Asia and the Pacific, an estimated 7.1 million people are now living with HIV/AIDS. The epidemic claimed the lives of 435,000 people in the region in 2001. The apparently low national prevalence rates in many countries in this region are dangerously deceptive. They hide localized epidemics in different areas, including some of the world's most populous countries. There is a serious threat of major, generalized epidemics. But, as Cambodia and Thailand have shown, prompt, large-scale prevention programmes can hold the epidemic at bay. In Cambodia, concerted efforts, driven by strong political leadership and public commitment, lowered HIV prevalence among pregnant women to 2.3 percent at the end of 2000—down by almost a third from 1997.

Sub-Saharan Africa—the crisis grows

AIDS killed 2.3 million African people in 2001. The estimated 3.4 million new HIV infections in sub-Saharan Africa in the past year mean that 28.1 million Africans now live with the virus. Without adequate treatment and care, most of them will not survive the next decade. Recent antenatal clinic data show that several parts of southern Africa have now joined Botswana with prevalence rates among pregnant women exceeding 30 percent. In West Africa, at least five countries are experiencing serious epidemics, with adult HIV prevalence exceeding 5 percent. However, HIV prevalence among adults continues to fall in Uganda, while there is evidence that prevalence among young people (especially women) is dropping in some parts of the continent.

The Middle East and North Africa—slow but marked spread

In the Middle East and North Africa, the number of people living with HIV now totals 440,000. The epidemic's advance is most marked in countries (such as Djibouti, Somalia and the Sudan) that are already experiencing complex emergencies. While HIV prevalence continues to be low in most countries in the region, increasing numbers of HIV infections are being detected in several countries, including the Islamic Republic of Iran, the Libyan Arab Jamahiriya and Pakistan.

High-income countries—resurgent epidemic threatens

A larger epidemic also threatens to develop in the high-income countries, where over 75,000 people acquire HIV in 2001, bringing to 1.5 million the total number of people living with HIV/AIDS. Recent advances in treatment and care in these countries are not being consistently matched with enough progress on the prevention front. New evidence of rising HIV infection rates in North America, parts of Europe and Australia is emerging. Unsafe sex, reflected in outbreaks of sexually transmitted infections, and widespread injecting drug use are propelling these epidemics, which, at the same time, are shifting more towards deprived communities.

Latin America and the Caribbean—diverse epidemics

An estimated 1.8 million adults and children are living with HIV in Latin America and the Caribbean—a region that is experiencing diverse epidemics. With an average adult HIV prevalence of approximately 2 percent, the Caribbean is the second-most affected region in the world. But relatively low national HIV prevalence rates in most South and Central American countries mask the fact that the epidemic is already firmly lodged among specific population groups. These countries can avert more extensive epidemics by stepping up their responses now.

Stronger commitment

Greater and more effective prevention, treatment and care efforts need to be brought to bear. During the year 2001, the resolve to do so became stronger than ever.

History was made when the United Nations General Assembly Special Session on HIV/AIDS in June 2001 set in place a framework for national and international accountability in the struggle against the epidemic. Each government pledged to pursue a series of many benchmark targets relating to prevention, care, support and treatment, impact alleviation, and children orphaned and made vulnerable by HIV/AIDS, as part of a comprehensive AIDS response. These targets include the following: To reduce HIV infection among 15–24-year-olds by 25 percent in the most affected countries by 2005 and, globally, by 2010; by 2005, to reduce the proportion of infants infected with HIV by 20 percent, and by 50 percent by 2010; by 2003, to develop national strategies to strengthen health-care systems and address factors affecting the provision of HIV-related drugs, including affordability and pricing. Also, to urgently make every effort to provide the highest attainable standard of treatment for HIV/AIDS, including antiretroviral therapy in a careful and monitored manner to reduce the risk of developing resistance; by 2003, to develop and, by 2005, implement national strategies to provide a supportive environment for orphans and children infected and affected by HIV/AIDS; by 2003, to have in place strategies that begin to address the factors that make individuals particularly vulnerable to HIV infection, including under-development, economic insecurity, poverty, lack of empowerment of women, lack of education, social exclusion, illiteracy, discrimination, lack of information and/or commodities for self-protection, and all types of sexual exploitation of women, girls and boys; and by 2003, to develop multisectoral strategies to address the impact of the HIV/AIDS epidemic at the individual, family, community and national levels.

Increasingly, other stakeholders, including nongovernmental organizations and private companies worldwide, are making clear their determination to boost those efforts.

New resources are being marshalled to lift spending to the necessary levels, which UNAIDS estimates at US$7–10 billion per year in low- and middle-income countries. The global fund called for by United Nations Secretary-General Kofi Annan has attracted about US$1.5 billion in pledges. In addition, the World Bank plans major new loans in 2002 and 2003 for HIV/AIDS, with a grant equivalency of over US$400 million per year. All the while, more countries are boosting their national budget allocations towards AIDS responses. Several ''least developed countries'' have received, or are in line for, debt relief that could help them increase their spending on HIV/AIDS.

More private companies are also stepping up their efforts. Guiding some of their interventions is a new international code of conduct on AIDS and the workplace, which was ratified earlier this year by members of the International Labour Organization (the new, eighth cosponsoring organization of UNAIDS).

The challenge now is to build on the newfound commitment and convert it into sustained action—both in the countries and regions already hard hit, and in those where the epidemic began later but is gathering steam.

Beyond complacency

The diversity of HIV's spread worldwide is striking. But in many regions of the world, the HIV/AIDS epidemic is still in its early stages. While 16 sub-Saharan African countries reported overall adult HIV prevalence of more than 10 percent by the end of 1999, there remained 119 countries of the world where adult HIV prevalence was less than 1 percent.

Low national prevalence rates can, however, be very misleading. They often disguise serious epidemics that are initially concentrated in certain localities or among specific population groups and that threaten to spill over into the wider population.

Nationwide prevalence in Myanmar, for instance, has been put at 2 percent. Yet, national HIV rates as high as 60 percent are being registered among injecting drug users and almost 40 percent among sex workers. Moreover, in vast populous countries such as China, India and Indonesia (where individual provinces or states often have more inhabitants than most countries), national prevalence all but loses meaning. The Indian states of Maharashtra, Andhra Pradesh and Tamil Nadu (each with at least 55 million inhabitants), have registered HIV prevalence rates of over 2 percent among pregnant women in one or two sentinel sites and over 10 percent among sexually transmitted infection patients—rates far higher than the national average of less than 1 percent. In the absence of vigorous prevention efforts, there is considerable scope for further HIV spread.

Even HIV prevalence rates as low as 1 percent or 2 percent across Asia and the Pacific (which is home to about 60 percent of the world's population) would cause the number of people living with HIV/AIDS to soar.

All countries have, at some point in their epidemic histories, been low-prevalence countries. HIV prevalence among pregnant women attending antenatal clinics in South Africa was less than 1 percent in 1990 (almost a decade after the first HIV diagnosis there in 1982). Yet, a decade later, the country was experiencing one of the fastest growing epidemics in the world, with prevalence among pregnant women at 24.5 percent by the end of 2000.

Low-prevalence settings present special challenges. At the same time, they offer opportunities for averting large numbers of future infections. Today, we are seeing rapidly emerging epidemics in several countries that had previously recorded relatively low rates of HIV infection—proof that the epidemic can emerge quickly and unexpectedly, and that no society is immune. In Indonesia, where recorded infection rates were negligible until very recently (even among some high-risk groups), there is new evidence of striking increases in the infection rates of HIV. Prevalence has risen significantly among female sex workers in three cities at opposite ends of the Indonesian archipelago, with similar increases also evident at other sites. Among women working in massage parlours in the capital, Jakarta, HIV prevalence was measured at 18 percent in 2000. Blood donor data now show a tenfold rise in HIV prevalence since 1998.

Elsewhere, longer-standing epidemics could be on the verge of spreading more rapidly and widely. Nepal and Viet Nam, for example, have registered marked increases in HIV infection in recent years, while in China—home to a fifth of the world's people—the virus seems to be moving into new groups of the population.

In other areas of the world, too, time is fast running out if much larger AIDS epidemics are to be averted. For instance, in the Russian Federation, only 523 HIV infections had been diagnosed by 1991. A decade later, that number had climbed to more than 129,000. In a country where injecting drug use among young people is rife (and there are higher levels of sexually transmitted infections in the wider population), there is an urgent need for action to avoid an even larger number of new infections.

Prompt, focused prevention

Countires that still have low levels of HIV infection should avert the epidemic's potential spread, rather than take comfort from current infection rates. The key to success in low-prevalence settings where HIV is not yet at risk to the wider population is to enable the most vulnerable groups to adopt safer sexual and drug-injecting behaviour, interrupt the virus's spread among and between those groups, and buy time to bolster the wider population's ability to protect itself against the virus.

This means, first, determining which population groups are at highest risk of infection and, second mustering the political will to safeguard them against the epidemic. At the same time, it is vital to defuse the stigma and blame so often attached to vulnerable groups and to deepen the wider public's knowledge and understanding of the epidemic.

Young people are a priority on this front. Twenty years into the epidemic, millions of young people know little, if anything, about HIV/AIDS. According to UNICEF, over 50 percent of young people (aged 15–24) in more than a dozen countries, including Bolivia, Botswana, Côte d'Ivoire, the Dominican Republic, Ukraine, Uzbekistan and Viet Nam, have never heard of AIDS or harbour serious misconceptions about how HIV is transmitted. Providing young people with candid information and life skills is a prerequisite for success in any AIDS response.

Reclaiming the future

The impact of the AIDS epidemic is being increasingly felt in many countries across the world. Southern Africa continues to be the worst affected area, with adult prevalence rates still rising in several countries. But elsewhere, also, in countries often already burdened by huge socioeconomic challenges, AIDS threatens human welfare, developmental progress and social stability on an unprecedented scale.

The AIDS epidemic has a profound impact on growth, income and poverty. It is estimated that the annual per capita growth in half the countries of sub-Saharan Africa is falling by 0.5–1.2 percent as a direct result of AIDS. By 2010, per capita GDP in some of the hardest hit countries may drop by 8 percent and per capita consumption may fall even farther. Calculations show that heavily affected countries could lose more than 20 percent of GDP by 2020. Companies of all types face higher costs in training, insurance, benefits, absenteeism and illness. A survey of 15 firms in Ethiopia has shown that, over a five-year period, 53 percent of all illnesses among staff were AIDS-related.

Devastating cycles

An index of existing social and economic injustices, the epidemic is driving a ruthless cycle of impoverishment. People at all income levels are vulnerable to the economic impact of HIV/AIDS, but the poor suffer most acutely. One quarter of households in Botswana, where adult HIV prevalence is over 35 percent can expect to lose an income earner within the next 10 years. A rapid increase in the number of very poor and destitute families is anticipated. Per capita household income for the poorest quarter of households is expected to fall by 13 percent, while every income earner in this category can expect to take on four more dependents as a result of HIV/AIDS.

In sub-Saharan Africa, the economic hardships of the past two decades have left three-quarters of the continent's people surviving on less than US $2 a day. The epidemic is deepening their plight. Typically, this impoverished majority has limited access to social and health services, especially in countries where public services have been cut back and where privatized services are unaffordable. In hard-hit areas, households cope by cutting their food consumption and other basic expenditures, and tend to sell assets in order to cover the costs of health care and funerals.

Studies in Rwanda have shown that households with a HIV/AIDS patient spend, on average, 20 times more on health care annually than households without an AIDS patient. Only a third of those households can manage to meet these extra costs.

According to a new United Nations Food and Agricultural Organization (FAO) report, seven million farm workers have died from AIDS-related causes since 1985 and 16 million more are expected to die in the next 20 years. Agricultural output—especially of staple products—cannot be sustained in such circumstances. The prospect of widespread food shortages and hunger is real. Some 20 percent of rural families in Burkina Faso are estimated to have reduced their agricultural work or even abandoned their farms because of AIDS. Rural households in Thailand are seeing their agricultural output shrink by half. In 15 percent of these instances, children are removed from school to take care of ill family members and to regain lost income. Almost everywhere, the extra burdens of care and work are deflected onto women—especially the young and the elderly.

Families often remove girls from school to care for sick relatives or assume other family responsibilities, jeopardizing the girls' education and future prospects. In Swaziland, school enrollment is reported to have fallen by 36 percent due to AIDS, with girls most affected. Enabling young people—especially girls—to attend school and, hopefully, complete their education, is essential. South Africa's and Malawi's universal free primary education systems point the way. Schemes to provide girls with second-chance schooling are another option.

Development and stability threatened

Meanwhile, the epidemic is claiming huge numbers of teachers, doctors, extension workers and other human resources. In some countries, health-care systems are losing up to a quarter of their personnel to the epidemic. In Malawi and Zambia, for example, five-to-six-fold increases in health worker illness and death rates have reduced personnel, increasing stress levels and workload for the remaining employees.

Teachers and students are dying or leaving school, reducing both the quality and efficiency of educational systems. In 1999 alone, an estimated 860,000 children lost their teachers to AIDS in sub-Saharan Africa. In the Central African Republic, AIDS was the cause of 85 percent of the 300 teacher deaths that occurred in 2000. Already, by the late 1990s, the toll had forced the closure of more than 100 educational establishments in that country. In Guatemala, studies have shown that more than a third of children orphaned by HIV/AIDS drop out of school. In Zambia, teacher deaths caused by AIDS are equivalent to about half the total number of new teachers the country manages to train annually.

Replacing skilled professionals is a top priority, especially in low-income countries where governments depend heavily on a small number of policy-makers and managers for public management and core social services. In heavily affected countries, losing such personnel reduces capacity, while raising the costs of recruitment, training, benefits and replacements. A successful response to AIDS requires that essential public services, such as education, health, security, justice and institutions of democratic governance, be maintained. Each sector has to take account of HIV/AIDS in its own development plans and introduce measures to sustain public sector functions. Such actions might include fast-track training, as well as the recruitment of key civil servants and the reallocation of budgets towards the most essential services. Countries that explore innovative ways of maintaining and rebuilding capacity in government will be better equipped to contain the epidemic. Equally valuable are labour and social legislation changes that boost people's rights, more effective and equitable ways of delivering social services, and more extensive programmes that benefit those worst hit by the epidemic (especially women and orphans).

Coping with crisis

In the worst-affected countries, steep drops in life expectancies are beginning to occur, most drastically in sub-Saharan Africa, where four countries (Botswana, Malawi, Mozambique and Swaziland) now have a life expectancy of less than 40 years. Were it not for HIV/AIDS, average life expectancy in sub-Saharan Africa would be approximately 62 years; instead, it is about 47 years. In South Africa, it is estimated that average life expectancy is only 47 years, instead of 66, if AIDS were not a factor. And, in Haiti, it has dropped to 53 years (as opposed to 59).

The number of African children who had lost their mother or both parents to the epidemic by the end of 2000—12.1 million—is forecast to more than double over the next decade. These orphans are especially vulnerable to the epidemic, and the impoverishment and precariousness it brings.

As more infants are born HIV-positive in badly affected countries, child mortality rates are also rising. In the Bahamas, it is estimated that some 60 percent of deaths among children under the age of five are due to AIDS, while, in Zimbabwe, the figure is 70 percent.

Unequal access to affordable treatment and adequate health services is one of the main factors accounting for drastically different survival rates among those living with HIV/AIDS in rich and poor countries and communities. Public pressure and UN-sponsored engagements with pharmaceutical corporations (through the Accelerating Access Initiative), along with competition from generic drug manufacturers, has helped drive antiretroviral drug prices down. But prices remain too high for public-sector budgets in low-income countries where, in addition, health infrastructures are too frail to bring life-prolonging treatments to the millions who need it.

Backed by a strong social movement, Brazil's government has shown that those barriers are not impregnable and that the use of cheaper drugs can be an important element of a successful response. Along with Brazil, countries such as Argentina and Uruguay also guarantee HIV/AIDS patients free antiretroviral drugs. In Africa, several governments are launching programmes to provide similar drugs through their public health system, albeit on a limited scale, at first.

In all such cases, though, clearing the hurdle of high prices is essential but not enough. Also indispensable are functioning and affordable health systems. Massive international support is needed to help countries meet that challenge.

EASTERN EUROPE AND CENTRAL ASIA

HIV incidence is rising faster in this region than anywhere else in the world. There were an estimated 250,000 new infections in 2001, raising to 1 million the number of people living with HIV.

In the Russian Federation, the startling increase in HIV infections of recent years is continuing, with new reported diagnoses almost doubling annually since 1998. In 2001, more than 40,000 new HIV-positive diagnoses were reported in the first six months. The total number of HIV infections reported since the epidemic began came to more than 129,000 in June 2001—up from the 10,993 reported for the end of 1998. The actual number of people now living with HIV in the Russian Federation is estimated to be many times higher than these reported figures.

At 1 percent, the adult HIV prevalence rate in Ukraine is the highest in the region. While injecting drug use is currently responsible for three-quarters of HIV infections in Ukraine, the proportion of sexually transmitted HIV infections is increasing. In Estonia, reported HIV infections have soared from 12 in 1999 to 1,112 in the first nine months of 2001. Outbreaks of HIV-related injecting drug use are also being reported in several Central Asian republics, including Kazakhstan and, most recently, Kyrgyzstan, Tajikistan and Uzbekistan.

Given the current evidence, a much larger and more generalized epidemic is a real threat. However, the epidemic is still at an early stage in the region and massive prevention efforts could curtail its scale and extent. Such efforts would require a comprehensive response to reduce risky sexual and drug-injecting behaviour among young people, and tackle the socioeconomic and other factors that promote the spread of the virus.

In the Russian Federation and other parts of the former Soviet Union, the vast majority of reported HIV infections are related to injecting drug use, which has become unusually widespread among young people, especially young men. An estimated 1 percent of the population of those countries is injecting drugs. Given the high odds of transmission through needle sharing, the fact that the young people are also sexually active, and the high levels of sexually transmitted infections in the wider population, a huge epidemic may be imminent. As well, the male-female ratio among newly detected HIV cases has narrowed from 4:1 to 2:1, indicating that young women are increasingly at risk of HIV infection.

Several factors are creating a fertile setting for the epidemic; mass unemployment and economic insecurity beset much of the region; social and cultural norms are being increasingly liberalized; and public health services are steadily disintegrating.

Reported rates of other sexually transmitted infections are very high and compound the odds of HIV being transmitted through unprotected sex. The incidence of syphilis (the reported number of infections in a given year) in the Russian Federation in 2000 stood at 157 per 100,000 persons, compared to 4.2 per 100,000 persons in 1987. Similar general trends are visible in the Baltic States, Belarus, the Central Asian republics, the Republic of Moldova, and Ukraine.

Unprecedented numbers of young people are not completing their secondary schooling. With jobs in short supply, many are at special risk of joining groups of vulnerable populations, by resorting to injecting drug use and (regular or occasional) sex work. Among young people in the Russian Federation, for instance, drug use is almost three times more prevalent than it was five years ago. Drug use is steadily becoming a more frequent feature of secondary school life in many cities. Needle sharing is common practice among injecting drug users—and a common cause of HIV transmission. Surveys in some cities in the Russian Federation show that most sex workers are 17–23 years old and that condom use in the sex industry is erratic, at best.

HIV risk is high among men who have sex with men, among whom multiple partners and unprotected sex are widespread. While laws penalizing homosexual activities with imprisonment have been struck off the statute books in the Russian Federation and in most (though not all) other countries of the former Soviet Union, men who have sex with men remain highly stigmatized socially. Currently, there are very few examples of HIV prevention activities targeting this group.

In south-eastern Europe, rates of sexually transmitted infections and injecting drug use are also on the rise, although still at considerably lower levels than elsewhere in the region. Drug trafficking, along with the economic and psychological aftermath of recent conflicts, are increasing the likelihood that HIV epidemics will emerge in this region.

In Central Europe, there is cause for tempered optimism. There is little indication, at this stage, of a potential rise in HIV infections. By mounting a strong national response, the Polish Government has successfully curtailed the epidemic among injecting drug users and prevented it from gaining a foothold in the general population. Prevalence remains low in countries such as the Czech Republic, Hungary and Slovenia, where well-designed national HIV/AIDS programmers are in operation.

More than 150 HIV/AIDS prevention projects among injecting drug users have been set up across the region in the past five years, along with projects focusing on other vulnerable populations such as prison inmates, sex workers and men who have sex with men. Although comparatively few in number, many of these projects are laying the foundations for larger, more extensive prevention work.

At the same time, there are signs of growing political commitment in the region. Following the UN General Assembly Special Session on HIV/AIDS, countries of the Commonwealth of Independent States are developing a special declaration on the epidemic and are preparing a regional work plan to guide a coordinated response. In countries such as Bulgaria, Romania, the Russian Federation and Ukraine, the budgets of national AIDS programmes have increased substantially. The strong partnerships being forged between the government, private sector and nongovernmental organizations in Ukraine are setting a positive example for the rest of the region. In June 2001, the President of Ukraine declared 2002 the year of the fight against AIDS.

Vigorous prevention efforts are needed to equip young people with the knowledge and services (such as HIV/AIDS information, condom promotion, life-skills training) they need to protect themselves against the virus. Given that young people (especially women) are bearing the brunt of the economic transitions in the region, socioeconomic programmes that can reduce the vulnerability of young men and women are also vital.

Special steps are needed to include HIV-related life-skills education in school curricula and to extend peer education to vulnerable young people who are in institutions or out of school and employment. Much more comprehensive efforts are needed to address the complex issues related to HIV and injecting drug use among young people.

ASIA AND THE PACIFIC

HIV/AIDS was late coming to Asia. Until the late 1980s, no country in the region had experienced a major epidemic and, in 1999, only Cambodia, Myanmar and Thailand had documented significant nationwide epidemics. This situation is now rapidly changing. In 2001, 1.07 million adults and children were newly infected with HIV in Asia and the Pacific, bringing to 7.1 million the total number of people living with HIV/AIDS in this region. Of particular concern are the marked increases registered in some of the world's most heavily populated countries.

Surveillance data on China's huge population are sketchy, but the country's health ministry estimates that about 600,000 Chinese were living with HIV/AIDS in 2000. Given the recently observed rises in reported HIV infections and infection rates in many sub-populations in several parts of the country, the total number of people living with HIV/AIDS in China could well have exceeded one million by late 2001. Reported HIV infections rose by 67.4 percent in the first six months of 2001, compared with the previous year, according to the country's ministry of health. Increasing evidence has emerged of serious epidemics in Henan Province in central China, where many tens of thousands (and possibly more) of rural villages have become infected since the early 1990s by selling their blood to collecting centres that did not follow basic blood donation safety procedures.

HIV levels in specific groups are known to be rising in several other areas. Seven Chinese provinces were experiencing serious labor HIV epidemics in 2001, with prevalence higher than 70 percent among injecting drug

users in a number of areas, such as Yili Prefecture in Xinjiang and Ruili Country in Yunnan. Another nine provinces are possibly on the brink of HIV epidemics among injecting drug users because of very high rates of needle sharing. There are also signs of heterosexually transmitted HIV epidemics in at least three provinces (Yunnan, Guangxi and Guangdong), with HIV rates reaching 4.6 percent (up from 1.6 percent in 1999) in Yunnan and 10.7 percent in Guangxi (up from 6 percent) among sentinel sex worker populations in 2000.

Vast and populous India faces similar challenges. At the end of 2000, the national adult HIV prevalence rate was under 1 percent, yet this meant that an estimated 3.86 million Indians were living with HIV/AIDS—more than in any other country besides South Africa. Indeed, median HIV prevalence among women attending antenatal clinics was higher than 2 percent in Andhra Pradesh and exceeded 1 percent in five other states (Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu) and in several major cities (including Bangalore, Chennai, Hyderabad and Mumbai). India's epidemic is also strikingly diverse, both among and within states.

Indonesia—the world's fourth-most populous country—offers an example of how suddenly a HIV/AIDS epidemic can emerge. After more than a decade of negligible rates of HIV, the country is now seeing infection rates increase rapidly among injecting drug users and sex workers, in some places, along with an exponential rise in infection among blood donors (an indication of HIV spread in the population at large). HIV infection in injection drug users was not considered worth measuring until 1999/2000, when it had already reached 15 percent. Within another year, 40 percent of injectors in treatment in Jakarta were already infected. In Bogor, in West Java Province, 25 percent of injecting drug users tested were HIV-infected, while among drug-using prisoners tested in Bali, prevalence was 53 percent.

Behaviours that bring the highest risk of infection in Asia and the Pacific are unprotected sex between clients and sex workers, needle sharing and unprotected sex between men. But infections do not remain confined to those with higher-risk behaviour. Many countries have been major epidemics grow out of initially relatively contained rates of infection in these populations. Northern Thailand's epidemic in the late 1980's and early 1990s was primed in this way. Over 10 percent of young men became infected before strong national and local prevention efforts, including the ''100 percent programme'', reduced high-risk behaviour, encouraged safer sex and lowered HIV prevalence.

Commercial sex provides the virus with considerable scope for growth. The limited national behavioural data collected in the region to date show that, over the past decade, the percentage of surveyed adult men who reported having visited a sex worker in a given year ranged from 5 percent in some countries to 20 percent in others. India and Viet Nam are countries where levels of infection among clients and sex workers are rising. In Ho Chi Minh City, the percentage of sex workers with HIV has risen sharply since 1998, reaching more than 20 percent by 2000.

Few countries are acting vigorously enough to protect sex workers and clients from the HIV virus. Yet, it is from the comparatively small pool of sex workers first infected by their clients that HIV steadily enters the larger pool of still-uninfected clients who eventually transmit the virus to their wives and partners. Although recent behaviour surveillance surveys show that, in 11 out of 15 Asian countries and Indian states, over two-thirds of sex workers report using a condom with their last client, the need to boost condom use remains. In Bangladesh, Indonesia, Nepal and the Philippines, for instance, fewer than half of sex workers report using condoms with every client.

Sharing injecting equipment is a very efficient way of spreading HIV, making prevention programmes among injecting drug user populations another top priority. Upwards of 50 percent of injecting drug users have acquired the virus in Myanmar, Nepal, Thailand, China's Yunnan Province and Manipur in India. Recent surveys show that a third of injecting drug users in Viet Nam said they recently shared needles with other users, while 55 percent of male injecting drug users in northern Bangladesh and 75 percent in the central region report sharing injecting equipment at least once in the week prior to being questioned.

Extensive harm reduction programmes can and do work. By the 1980s, Australia had prevented a major epidemic from occurring among injecting drug users and, quite likely, from spreading beyond them. Such examples are being followed by several other countries, but in an isolated fashion. The SHAKTI Project in Dhaka, Bangladesh, offers injecting drug users needle exchange, safer injecting options and safer sex education, as well as condoms. IKHLAS, in the Malaysian capital of Kuala Lumpur, provides peer support services, but the estimated 5000 injecting drug users reached are only a fraction of the country's drug-injecting population.

The need to expand such programmes nationally is patent is these concentrated epidemics are to be brought under control before they spill into the wider population. Many injecting drug users are sexually active young men. Many have steady partners; others buy sex. The overlap between injecting drug use and buying sex is striking. In some Vietnamese cities, 17 percent of male injecting drug users reported having recently bought unprotected sex. Between half and three-quarters of male injecting drug users in several cities of Bangladesh have reported buying sex from women during the past year, with fewer than one-quarter of them saying they had used a condom the last time they paid for sex. There also is increasing evidence of female sex workers taking up injecting drug use in Viet Nam.

Some self-identified ''gay'' communities exist throughout the region but, in most of Asia, many additional categories of men engage in same-sex intercourse. Many men who prefer sex with men also have sex with women. Indeed, many marry and raise families. This creates a huge potential for men who have unprotected sex with men to act as ''bridges'' for the virus in the wider population. In Cambodia, for instance, some 40 percent of men who have sex with men reported also having had sex with women in the month prior to being surveyed.

At the same time, there is ample evidence that early, large-scale and focused prevention programmes, which include efforts directed at both those with higher-risk behavior and the broader population, can keep infection rates lower in specific groups and reduce the risk of extensive HIV spread among the wider population. Cambodia's prevention measures, which began in earnest in 1994–95, saw high-risk behavior among men fall and condom use rise consistently in the late 1990s. As a consequence, HIV prevalence among pregnant women declined from 3.2 percent in 1997 to 2.3 percent at the end of 2000, suggesting that the country is beginning to bring its epidemic under control.

Thailand's well-funded, politically-supported and comprehensive prevention programmes, which accelerated in the early 1990s have trimmed annual new HIV infections to about 30,000, from a high of 140,000 a decade ago. Although an estimated 700,000 Thais are living with HIV today, Thailand's prevention efforts probably averted millions of HIV infections. Nonetheless, one-in-60 Thais in this country of 62 million people is infected with HIV, and AIDS has become the leading cause of death, despite the country's prevention successes. There are indications that transmission between spouses is now responsible for more than half of new infections—a reminder that mainly targeting high-risk groups is inadequate, and that countries need to carefully track patterns of HIV spread and adapt their responses accordingly. Furthermore, ongoing high rates of HIV infection through needle sharing in Thailand highlight the need to sustain prevention efforts as the epidemic evolves.

In large parts of Asia and the Pacific, prevention programmes are poorly funded and resourced. Typically, small projects are scattered across countries and do not acquire the scale or coherence that is needed to halt the epidemic's spread. Because many high-risk practices are frowned upon and even criminalized, there are serious political hurdles to prevention.

SUB-SAHARAN AFRICA

Sub-Saharan Africa remains the region most severely affected by HIV/AIDS. Approximately 3.4 million new infections occurred in 2001, bringing to 28.1 million the total number of people living with HIV/AIDS in this region.

The region is experiencing diverse epidemics in terms of scale and maturity. HIV prevalence rates have risen to alarming levels in parts of southern Africa, where the most recent antenatal clinic data reveal levels of more than 30 percent in several areas. In Swaziland, HIV prevalence among pregnant women attending antenatal clinics in 2000 ranged from 32.3 percent in urban areas to 34.5 percent in rural areas; in Botswana, the corresponding figures were 43.9 percent and 35.5 percent. In South Africa's KwaZulu-Natal Province, the figure stood at 36.2 percent in 2000.

At least 10 percent of those aged 15–49 are infected in 16 African countries, including several in southern Africa, where at least 20 percent are infected. Countries across the region are expanding and upgrading their responses. But the high prevalence rates mean that even exceptional success on the prevention front will now only gradually reduce the human toll. It is estimated that 2.3 million Africans died of AIDS in 2001.

This notwithstanding, in some of the most heavily affected countries there is growing evidence that prevention efforts are bearing fruit. One new study in Zambia shows urban men and women reporting less sexual activity, fewer multiple partners and more consistent use of condoms. This is in line with earlier indications that HIV prevalence is declining among urban residents in Zambia, especially among young women aged 15–24.

According to the South African Ministry of Health, HIV prevalence among pregnant women attending antenatal clinics reached 24.5 percent in 2000. About one-in-nine South Africans (or 4.7 million people) are living with HIV/AIDS. Yet, there are possibly heartening signs that positive trends might be increasingly taking hold among adolescents, for whom prevalence rates have dropped slightly since 1998. Large-scale information campaigns and condom distribution programmes appear to be bearing fruit. In South Africa, for instance, free male condom distribution rose from 6 million in 1994 to 198 million five years later. In recent surveys, approximately 55 percent of sexually active teenage girls reported that they always use a condom during sex. But these

developments are accompanied by a troubling rise in prevalence among South Africans aged 20–34, highlighting the need for greater prevention efforts targeted at older age groups, and tailored to their realities and concerns.

Progress is also being made on the treatment and care front. In the southern African region, relatively prosperous Botswana has become the first country to begin providing antiretroviral drugs through its public health system, thanks to a bigger health budget and drug price reductions negotiated with pharmaceutical companies.

Within the context of a public/private partnership between five research-and-development pharmaceutical companies and five United Nations agencies, there is increasing access to antiretroviral therapy in Africa. As of the end of 2001, more than 10 African countries were providing antiretroviral therapy to people living with HIV/AIDS.

In five West African countries—Burkina Faso, Cameroon, Côte d'Ivoire, Nigeria and Togo—national adult prevalence rates already passed the 5 percent mark in 2000. Countries such as Nigeria are boosting their spending on HIV/AIDS and extending their responses nationwide. This year, Nigeria launched a US $240-million HIV/AIDS Emergency Action Plan. Determined prevention efforts in Senegal continue to bear fruit, thanks to the prompt political support for its programmes.

On the eastern side of the continent, the downward arc in prevalence rates continues in Uganda—the first African country to have subdued a major HIV/AIDS epidemic. HIV prevalence in pregnant women in urban areas has fallen for eight years in a row, from a high of 29.5 percent in 1992 to 11.25 percent in 2000. Focusing heavily on information, education and communication, and decentralized programmes that reach down to village level, Uganda's efforts have also boosted condom use across the country. In the Masindi and Pallisa districts, for instance, condom use with casual partners in 1997—2000 rose from 42 percent and 31 percent, respectively, to 51 percent and 53 percent. In the capital, Kampala, almost 98 percent of sex workers surveyed in 2000 said they had used a condom the last time they had sex.

But despite such success, huge challenges remain. New infections continue to occur at a high rate. Most people with HIV do not have access to antiretroviral therapy. Already, by the end of 1999, 1.7 million children had lost a mother or both parents to the disease. Providing them with food, housing and education will test the resources and resolve of the country for many years to come.

Uganda's experience underlines the fact that even a rampant HIV/AIDS epidemic can be brought under control. The axis of any effective response is a prevention strategy that draws on the explicit and strong commitment of leaders at all levels, that is built on community mobilization, and that extends into every area of the country.

Although they are exceptionally vulnerable to the epidemic, millions of young African women are dangerously ignorant about HIV/AIDS. According to UNICEF, more than 70 percent of adolescent girls (aged 15–19) in Somalia and more than 40 percent in Guinea Bissau and Sierra Leone, for instance, have never heard of AIDS. In countries such as Kenya and the United Republic of Tanzania, more than 40 percent of adolescent girls harbor serious misconceptions about how the virus is transmitted. One of the targets fixed at the UN General Assembly Special Session on HIV/AIDS in June 2001 was to ensure that at least 90 percent of young men and women should, by 2005, have the information, education and services they need to defend themselves against HIV infection. As in other regions of the world, most countries in sub-Saharan Africa are a considerable way from fulfilling that pledge.

The vast majority of Africans living with HIV do not know they have acquired the virus. One study has found that 50 percent of adult Tanzanian women know where they could be tested for HIV, yet only 6 percent have been tested. In Zimbabwe, only 11 percent of adult women have been tested for the virus. Moreover, many people who agree to be tested prefer not to return and discover the outcome of those tests. However, other obstacles remain. A study in Abidjan, Côte d'Ivoire, shows that 80 percent of pregnant women who agree to undergo a HIV test return to collect their results. But of those who discover they are living with the virus, fewer than 50 percent return to receive drug treatment for the prevention of mother-to-child transmission of the virus.

More than half of the women who know they have acquired HIV, and who were surveyed by Kenya's Population Council this year, said they had not disclosed their HIV status to their partners because they feared it would expose them to violence or abandonment. Not only are voluntary counselling and testing services in short supply across the region, but stigma and discrimination continue to discourage people from discovering their HIV status.

Accumulating over the past year have been many encouraging developments. Thirty-one countries in the region have now completed a national HIV/AIDS strategic plan and another 12 are developing such a plan. Several regional initiatives to roll back the epidemic are under way. Some, such as those grouping countries in the Great Lakes region, the Lake Chad Basin and West Africa, are concentrating their efforts on reducing the vulnerability of refugee and other mobile populations. The political commitment to turn the tide of AIDS appears stronger than ever. Gatherings such as the 200 African Development Forum meeting last December, and the Organization of African Unity Summit HIV/AIDS, Tuberculosis and Other Related Infectious Diseases in April 2001, appear to be cementing that resolve. At the latter meeting, Heads of State agreed to devote at least 15 percent of their countries' annual budgets to improving health sectors. Fewer than five countries had reached that level in 2000.

AIDS has become the biggest threat to the continent's development and its quest to bring about an African Renaissance. Most governments in sub-Saharan Africa depend on a small number of highly skilled personnel in important areas of public management and core social services. Badly affected countries are losing many of these valuable civil servants to AIDS. Essential services are being depleted at the same time as state institutions and resources come under greater strain and traditional safety nets disintegrate. In some countries, health-care systems are losing up to a quarter of their personnel to the epidemic. People at all income levels are vulnerable to these repercussions, but those living in poverty are hit hardest. Meanwhile, the ability of the state to ensure law and order is being compromised, as the epidemic disrupts institutions such as the courts and the police. The risks of social unrest and even socio-political instability should not be underestimated.

THE MIDDLE EAST AND NORTH AFRICA

In the countries of the Middle East and North Africa, the visible trend is also towards increasing HIV infection rates, though still at very low levels. Existing surveillance systems remain inadequate, but it is estimated that 80,000 people acquired the virus in 2001, bringing to 440,000 the number of people living with HIV/AIDS. The need for early, effective prevention is becoming manifest throughout this region.

Unfortunately, factors driving the epidemic are still too seldom systematically analysed in most countries in the region. As a result, HIV/AIDS responses are rarely based on a clear understanding of infection patterns or knowledge of particular high-risk groups.

Based on current knowledge, however, factors putting people at risk are varied, though sexual intercourse remains the dominant route of transmission. A local study in Algeria has revealed prevalence rates of 1 percent among pregnant women. Outbreaks now appear to be occurring elsewhere, including in the Libyan Arab Jamahiriya, where all but a fraction of the 570 new HIV infections reported in 2000 were among drug users. Djibouti and the Sudan are facing growing epidemics that are being driven by combinations of socioeconomic disparities, large-scale population mobility and political instability.

The rate of HIV infection is increasing significantly in other vulnerable groups. Among prisoners in the Islamic Republic of Iran, rates of HIV infection have risen from 1.37 percent in 1999 to 2.28 percent in 2000. Besides the Sudan and the Republic of Yemen, all countries in the region have reported HIV transmission through injecting drug use. Unless addressed promptly through harm reduction and other prevention approaches, the epidemic among these subpopulations of injecting drug users could grow dramatically and spread into the wider population.

There are also signs that the double disease burden of HIV and tuberculosis is growing in some countries. Rates of HIV infection among tuberculosis patients are rising and, by mid-2001, stood at 8 percent in the Sudan, 4.8 percent in Oman, 4.2 percent in the Islamic Republic of Iran and 2.1 percent in Pakistan.

At the same time, the political will to mount a more potent response to the epidemic is visible in several countries, some of which are introducing innovative approaches. Examples include the mobilization of nongovernmental organizations around prevention programmes in Lebanon, and harm reduction work among injecting drug users in the Islamic Republic of Iran.

HIGH-INCOME COUNTRIES

Unless averted with renewed and more effective prevention efforts, resurgent epidemics will continue to threaten high-income countries, where over 75,000 people became infected with HIV in 2001.

In Australia, Canada, the United States of America (USA) and countries of Western Europe, a pronounced rise in unsafe sex is triggering higher rates of sexually transmitted infections and, in some cases, higher levels of HIV incidence among men who have sex with men. The prospect of rebounding HIV/AIDS epidemics looms as a result of widespread public complacency and stalled, sometimes inappropriate, prevention efforts that do not reflect changes in the epidemic. In Japan, meanwhile, HIV infections are also on the rise.

The rise in new HIV infections among men who have sex with men is striking. In Vancouver, Canada, HIV incidence among young men who have sex with men rose from an average of 0.6 percent in 1995–1999 to 3.7 percent in 2000. In London, United Kingdom, reported HIV infections among gay men are also on the rise. In Madrid, reported HIV infections rose almost twofold (from 1.16 percent to 2.16 percent in 1996–2000, whereas, in San Francisco, it rose from 1.1 percent in 1997 to 1.7 percent in 2000 and appears to be rising still, according to recent studies. Among gay men

who inject drugs in that city, the infection rate climbed from 2 percent in 1997 to 4.6 percent in 2000.

Rising incidence of other sexually transmitted infections among men who have sex with men (in Amsterdam, Sydney, London and southern California, for instance) confirms that more widespread risk-taking is eclipsing the safer-sex ethic promoted so effectively for much of the 1980s and 1990s. Similar trends are being detected among the heterosexual populations of some countries, especially among young people. Diagnoses of gonorrhea and syphilis among men and women have hit their highest levels for 13 years in England and Wales, for instance.

Part of the explanation could lie in the visibly life-saving effects of antiretroviral therapy, introduced in high-income countries in 1996. Deaths attributed to HIV in the USA, for instance, fell by a remarkable 42 percent in 1996–97, since the decline has levelled off. However, this wide access to antiretroviral therapy has encouraged misperceptions that there is now a cure for AIDS and that unprotected sex poses a less daunting risk. High-risk behaviour is increasing, as a result.

Prevention efforts, as well as treatment and care strategies, have to contend with other, significant shifts in the epidemic, such as its slow but apparently inexorable shift towards other vulnerable populations. At play appears to be an overlap of racial discrimination with income, health and other inequalities. In high-income countries there is evidence that HIV is moving into poorer and more deprived communities, with women at particular risk of infection. Young adults belonging to ethnic minorities (including men who have sex with men) face considerably greater risks of infection than they did five years ago in the USA. African-Americans, for instance, make up only 12 percent of the population of the USA, but constituted 47 percent of AIDS cases reported there in 2000. As elsewhere in the world, young disadvantaged women (especially African-American and Hispanic women) in the USA are being infected with HIV at higher rates and at younger ages than their male counterparts.

In the USA, men having sex with men is still the main mode of transmission (accounting for some 53 percent of new HIV infections in 2000), but almost one-third of new HIV-positive diagnoses were among women in 2000. In this latter group, an overlap of injecting drug use and heterosexual intercourse appears to be driving the epidemic. Indeed, injecting drug use has become a more prominent route of HIV infection in the USA, where an estimated 30 percent of new reported AIDS cases are related to this mode of transmission. In Canada, women now represent 24 percent of new HIV infections, compared to 8.5 percent in 1995.

The HIV epidemic in western and central Europe is the result of a multitude of epidemics that differ in terms of their timing, their scale and the populations they affect. Portugal faces a serious epidemic among injecting drug users. Of the 3733 new HIV infections reported there in 2000, more than half were caused by injecting drug use and just under a third occurred via heterosexual intercourse. Reports of new HIV infections also indicate that sex between men is an important transmission route in several countries, including Germany, Greece and the United Kingdom. Unfortunately, HIV reporting data are uneven in several of the more affected countries, including some of those believed to be most affected by the epidemic among injecting drug users.

In Japan, the number of HIV infections detected in men who have sex with men has risen sharply in recent years, with male-male sex now accounting for more than twice as many infections in men as heterosexual sex. This is a major departure from past patterns: until two years ago, the number of new infections reported in both groups was roughly equal.

There are also signs that the sexual behavior of youth in Japan could be changing significantly and putting this group at greater risk of HIV infection. Higher rates of Chlamydia among females and gonorrhoea infections among males, as well as a doubling of the number of induced abortions among teenage women in the past five years, suggest increased rates of unprotected sexual intercourse. Behavioral data, meanwhile, show low condom use, both in the general population and among sex workers.

LATIN AMERICA AND THE CARIBBEAN

Major differences in epidemic levels and patterns of HIV transmission are evident in Latin America and the Caribbean, where an estimated 1.8 million adults and children are living with HIV—including the 190,000 people who acquired the virus in the past year. Some 1.4 million people are living with HIV/AIDS in Latin America and 420,000 in the Caribbean.

In Central America and the Caribbean, HIV is mainly heterosexually transmitted, with unsafe sex and frequent partner exchange among young people high among the factors driving the epidemic. Other powerful dynamics are abetting the spread of HIV, notably the combination of socioeconomic pressures and high population mobility (including tourism).

The Caribbean is the second-most affected region in the world, with adult HIV prevalence rates only exceeded by those of sub-Saharan Africa. In several Caribbean countries, HIV/AIDS has become a leading cause of death. Worst affected are Haiti and the Bahamas, where adult HIV prevalence rates are above 4 percent. But the epidemic is by no means concentrated only in the Caribbean.

Along with Barbados and the Dominican Republic, several Central American and Caribbean countries had adult HIV prevalence rates of at least 1 percent at the end of 1999, including Belize, Guyana, Honduras, Panama and Suriname. By contrast, prevalence is lowest in Bolivia, Ecuador and other Andean countries. Almost three-quarters of AIDS cases reported in Central America are the result of sex between men and women. On some Caribbean islands, the phenomenon of young women having sex with older men is especially prominent, and is reflected in the fact that the HIV rate among girls aged 15–19 is up to five times that of boys in the same age group. Research among sex workers in Guyana's capital, Georgetown, has found that 46 percent of surveyed sex workers were living with HIV/AIDS, that more than one-third of them never used a condom with their clients, and that almost three-quarters did not use condoms with their regular partners. The probability of the virus passing into the wider population is therefore high.

In Costa Rica, Mexico, Nicaragua and parts of the Andean region, sex between men is the more prominent route of HIV transmission. Recent studies among men who have sex with men in Mexico have shown that just over 14 percent were HIV-positive. Prevalence rates among heterosexual sex workers and sexually transmitted infection patients in Mexico, meanwhile, appear still to be low. Injecting drug use is a main route of HIV transmission in Argentina, Chile and Uruguay, and also plays a major role in Brazil. Patterns of transmission can also differ markedly within countries—a reminder that universal national programmes are inappropriate. In Colombia's highlands, for instance, unprotected sex between men accounts for most HIV infections, while, on the coast, heterosexual intercourse is the main route of transmission.

Countries' commitment to stem the epidemic and limit its effects has grown markedly. Several countries have launched or are developing government programmes to distribute antiretroviral drugs to HIV/AIDS patients. But there are wide disparities in the quality and scope of different countries' antiretroviral treatment programmes. The wide access to treatment that people living with HIV/AIDS have in countries such as Argentina, Brazil and Uruguay is not yet matched in most other countries of the Americas. Up to recently, Central America experienced a large gap in access to treatment. Now, however, countries such as Costa Rica and Panama are providing treatment access. Caribbean countries are currently developing a regional strategy to speed up and expand access to treatment and care for people living with HIV/AIDS. Countries such as Barbados and Trinidad and Tobago are preparing to implement new national programmes.

In Brazil, a substantial decline in HIV prevalence among injecting drug users has been observed recently in several large metropolitan areas. This suggests that HIV/AIDS prevention and harm reduction programmes in those cities have made possible safer injection habits among these populations. Brazil's prevention efforts are being balanced with an extensive treatment and care programme that guarantees state-funded antiretroviral therapy for those living with HIV/AIDS. The number of people living with the virus in Brazil has reached about 600,000, according to the country's Health Ministry—up from 540,000 in 1999. An estimated 105,000 Brazilians are receiving antiretrovial drugs through the public health system.

A new political resolve is also apparent in several regional initiatives. Launched in February 2001, the Pan-Caribbean Partnership against HIV/AIDS, for instance, links the resources of governments and the international community with those of civil society to boost national and regional responses. It is being coordinated by the Caribbean Community Secretariat (CARICOM). On the basis of the Nassau Declaration issued in July 2001, as follow-up to the UN General Assembly Special Session on HIV/AIDS, Caribbean Heads of Government are also devising ways to support each other's national HIV/AIDS programmes and jointly negotiate affordable prices for antiretrovial drugs.

Meanwhile, protecting vulnerable populations on the move is now the focus of a regional initiative in Central America. Argentina, Chile, Paraguay and Uruguay are collaborating in harm-reduction schemes for injecting drugs users. National AIDS programmes have also joined a collaborative scheme to share technical assistance throughout Latin America and the Caribbean. Known as the Horizontal Technical Cooperation Group, it brings together more than 20 countries of the region.

EXPLANATORY NOTE ABOUT UNAIDS/WHO ESTIMATES

The UNAIDS/WHO estimates in this document are based on the most recent available data on the spread of HIV in countries around the world. They are provisional. UNAIDS and WHO, together with experts from national AIDS programmes and research institutions, regularly review and update the estimates as improved knowledge about the epidemic becomes available, while also drawing on advances made in the methods for deriving estimates.

The estimates and data provided in the graphs and tables are given in rounded numbers. However, unrounded numbers were used

in the calculation of rates and regional totals, so there may be small discrepancies between the global totals and the sum of the regional figures.

In 2001, new software was developed to model the course of HIV/AIDS around the world and to further enhance the quality of estimates of HIV/AIDS prevalence and impact. As a result, this year's estimates incorporate, in particular, new knowledge and assumptions about survival times for adults and children living with HIV/AIDS. Because of this, some of the new estimates cannot be compared directly with estimates from previous years.

UNAIDS and WHO will continue to work with countries, partner organizations and experts to improve data collection. These efforts will ensure that the best possible estimates are available to assist governments, nongovernmental organizations and others in gauging the status of the epidemic and monitoring the effectiveness of their considerable prevention and care efforts.

HIV/AIDS accounts for 70 percent of all cases of AIDS worldwide. Since its inception, more than 58 million individuals have been infected with HIV/AIDS, while 22 million have lost their lives, 17 million alone in sub-Saharan Africa. It is clearly the leading cause of death in sub-Saharan Africa. Further, 90 percent of the world's orphans reside in this region.

Given the loss of life AIDS has caused, the destruction of entire communities, and the long-term impact of economic growth, we must step up our efforts to fight this devastating disease. I have worked with the officials in Botswana who are struggling to combat the impact of HIV on their young adults, their most productive sector of their community. Therefore, we must do all we can.

I want to commend all involved and ask that we not only pass this bill, but do other things to fight this global pandemic.

Mr. HYDE. Madam Speaker, I am pleased to yield 2 minutes to the distinguished gentleman from Iowa (Mr. LEACH).

Mr. LEACH. Madam Speaker, I thank the gentleman for yielding time to me.

Let me first express my appreciation for the leadership of the gentleman from Illinois (Chairman HYDE), the gentleman from California (Mr. LANTOS), the gentleman from Nebraska (Mr. BEREUTER), and of course the gentlewoman from California (Ms. LEE) on this issue.

There should be no doubt that the United States confronts two wars simultaneously. One is the war on terrorism, waged with the scourge of biological weapons. The other is war on the devastating disease that is pandemic in so many poor parts of the world.

Einstein once said that splitting the atom has changed everything save our mode of thinking. Atom-splitting produced the potential for great good through nuclear energy, and the potential for great harm through weapons of mass destruction.

Now, the splitting of genes has come to symbolize an even greater change: the biological discoveries that promise to enrich and lengthen life on the one hand, and the possibility of biological weapons on the other that jeopardize life itself on the planet.

What we must be about is constraining the forces of evil and expanding the forces of life. We cannot win the war that terrorism has brought to our shore without waging with equal vigor the war on disease everywhere that it exists.

Mr. LANTOS. Madam Speaker, I am very pleased to yield 2 minutes to my dear friend and distinguished colleague, the gentlewoman from California (Ms. WATSON), who served our Nation with great distinction as a United States ambassador.

Ms. WATSON of California. Madam Speaker, we have already heard the figures of the number of Africans infected with HIV and AIDS. They are staggering, but deserve to be repeated once again: sub-Saharan Africa has only 10 percent of the world's population, but accounts for 70 percent of all HIV/AIDS cases and 80 percent of all HIV/AIDS-related deaths. The infection rate in some African nations now exceeds 30 percent; and in a few countries, it is approaching 40 percent of the total population.

Finally, the United States National Intelligence Council estimates that the disease could reduce the gross domestic product in some sub-Saharan Africa countries by as much as 20 percent or more by 2010. The social and economic consequences of this disease are not like any other public health threat that the world has faced in modern times. Important and hard-won economic gains made by African nations could be wiped out in less than a decade. Moreover, social dislocation caused by the high rates of death among HIV-infected mothers and fathers is already straining the outer bounds of fragile African nation states.

H.R. 2069, and I commend the sponsors, authorizes additional spending levels in excess of $1 billion for bilateral and multilateral HIV/AIDS assistance to African nations that is more in keeping with our international assistance obligations.

Madam Speaker, the HIV/AIDS pandemic in Africa not only presents us with a profoundly humanitarian, economic, and social dilemma, it also, in the very near term, if more is not done, may challenge the very notion of law-based nation states.

I support this legislation, and I would urge everyone else to do so.

Mr. HYDE. Madam Speaker, I am pleased to yield 2 minutes to the distinguished gentleman from New Jersey (Mr. SMITH).

Mr. SMITH of New Jersey. Madam Speaker, I thank my good friend for yielding time to me.

Madam Speaker, I rise in strong support of H.R. 2069 and believe the gentleman from Illinois (Chairman HYDE) deserves special recognition and thanks for his persistence on behalf of all who are weak and vulnerable, including AIDS victims.

As my colleagues know, and has been said on the floor today, the scourge of AIDS around the globe has reached catastrophic proportions, particularly in sub-Saharan Africa. A December report by U.N. AIDS indicated that nearly 25.3 million adults and children are infected with the HIV virus in sub-Saharan Africa. To put this in perspective, this region has about 10 percent of the world's population, but more than 70 percent of the HIV/AIDS patients.

Madam Speaker, among the most tragic of the victims are the children who contact HIV via vertical transmission, from mother to child, during or shortly after childbirth. Some estimates place the number of vertical transmission cases at 600,000 babies annually in Africa. Madam Speaker, vertical transmission is specifically addressed in this bill. In an age where we already have proven drug regimens and methods to prevent mother-to-child transmission, and we have had them for sometime now, Madam Speaker, it is outrageous that so many children around the world are still contracting HIV/AIDS in this manner. This could be stopped, and this bill goes a long way to doing so.

I would also point out to my colleagues that during markup I offered an amendment in the area of hospice and palliative care. Madam Speaker, unfortunately, today, when people, particularly in Africa, get AIDS, they are treated as lepers, like we had in Biblical times: People go nowhere near them, even when they are family members.

Thankfully, there is an effort under way in Africa and elsewhere to reach out to these people so they can die in dignity, and hopefully with the least amount of pain as is humanly possible. In South Africa, the Catholic Church and Catholic Relief Services and others are doing incredible jobs of networking, of bringing the news that you can take care of an AIDS patient in your home without the fear of contamination yourself. There are methods and procedures that need to be followed; and thankfully, that word is getting out.

Madam Speaker, this legislation does address that and will target some resources in that direction.

Madam Speaker, this is a great bill. I hope Members will support it, and congratulations to the gentleman from Illinois (Chairman HYDE).

Mr. LANTOS. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, again I want to thank the gentleman from Illinois (Chairman HYDE) for his extraordinary leadership. I want to thank all my colleagues and staff for working on this landmark legislation, and I urge all of my colleagues to support it.

Madam Speaker, I yield back the balance of my time.

Mr. HYDE. Madam Speaker, I yield myself the balance of my time.

Madam Speaker, we got an awful lot done in this committee because of the great cooperation of the gentleman from California (Mr. LANTOS) and his staff; and I deeply appreciate it, particularly on this bill.

Mr. GILMAN. Madam Speaker, I rise in strong support for H.R. 2069, The Global Access to HIV/AIDS Prevention, Awareness, Education, and Treatment Act of 2001.

More than 58 million people worldwide are infected with HIV/AIDS making it more than just a humanitarian issue . . . it has become a national security, and developmental crisis. It is reported that ninety five percent of the world's HIV-infected people live in developing countries. Right next door, infection rates are rising rapidly in Haiti and the Caribbean, where an estimated 5 percent of the population has AIDS or is HIV-infected.

Madam Speaker, our nation has only begun to properly tackle AIDS and HIV infection in our nation. Our friends and neighbors in lesser developed nations are breaking under the pressure of the destruction that this terrible disease has brought to bear on them. H.R. 2069 helps to alleviate some of the suffering and will help to strengthen the social structures that are crumbling under the weight of the burden of carrying for so many.

Secretary Powell said it well when he stated that the United States has an obligation to do more ''if we believe in democracy and freedom (then we must work) to stop this catastrophe from destroying whole economies and families and societies and cultures and nations.''

Accordingly, Madam Speaker, I urge my colleagues to support H.R. 2069.

Ms. SCHAKOWSKY. Madam Speaker, I rise in strong support of H.R. 2069, The Global Access to HIV/AIDS Prevention Act of 2001. I want to commend and thank the distinguished Chairman (Mr. HYDE) and Ranking Member (Mr. LANTOS) of the International Relations Committee, the authors of this important legislation for their efforts and for their leadership. I also want to commend the gentlewoman from California (Ms. LEE) for her continuing leadership and commitment on this critical issue. The bill we have before us today is another step in the right direction for the global struggle against HIV/AIDS.

H.R. 2069 authorizes a total of $1.3 billion for the prevention, treatment, and monitoring of acquired immune deficiency syndrome (AIDS) in sub-Saharan Africa and other developing countries. The bill authorizes $560 million in bilateral assistance for various AIDS treatment/prevention programs administered by the U.S. Agency for International Development (AID), and it authorizes a $750 million U.S. commitment to multilateral efforts to fight the pandemic. The bill also authorizes $50 million for AIDS drug procurement.

Funds in this measure will be used to cover many of the needs created by HIV/AIDS. The bill is directed toward prevention, education, testing and counseling, including strengthening and broadening the capacity of indigenous health care systems. The bill also includes assistance aimed at mother-to-child transmission prevention, and strengthening and expanding hospice and palliative care programs, as well as care for children orphaned by HIV/AIDS, improved infrastructure, and vaccine research. Finally, H.R. 2069 includes funds for income generation programs targeting assistance to HIV/AIDS affected populations, particularly those groups and individuals who are at the highest risk of being infected, including women.

I am particularly pleased that this body has recognized the importance of providing end of life care for those that are losing their struggle with AIDS and that we have acknowledged the particular plight that AIDS means for women and children.

We have all heard some of the staggering statistics about AIDS. However, I believe that at least some of them need to be repeated time and again until necessary results are achieved.

Since the HIV–AIDS pandemic began, it has claimed over 22 million lives. Over 17 million men, women and children have died due to AIDS in sub-Saharan Africa alone. Over 40 million people are infected with the HIV virus today. Over 25 million of them live in sub-Saharan Africa. By 2010, approximately 40 million children worldwide will have lost one or both of their parents to HIV–AIDS.

Each day AIDS kills more than 7,000 people in sub-Saharan Africa alone, and the pandemic continues to escalate in the Caribbean, Asia, Russia and elsewhere with more than 8,000 people around the world perishing from AIDS each day. This human catastrophe is unlike anything the world has known.

While an encouraging symbol of progress, awareness, and compromise, the funding set forth by this bill alone will not be enough. In order to satisfy the demands posed by the AIDS pandemic, it has been estimated that sub-Saharan Africa will need as much as $15 billion a year.

I want to take this opportunity to include for the RECORD a compelling article from the December 6 New York Times. The article goes a long way toward dispelling the myth that robust drug treatment programs cannot be implemented in poor developing nations. I agree with the article that what we can learn from the example of Haiti is that, ''if we do not treat the millions of Africans dying of AIDS, it is because we have chosen not to, not because we can't.'' Indeed, we can and should help Africans and all of those struggling against the scourge of AIDS. The virus knows no bounds and failing to attack it with every resource at our disposal would not only be morally reprehensible, it will leave this nation more vulnerable to perhaps the greatest threat we have ever faced.

Again, I commend all of those who helped to bring this important measure to the floor and urge all members to vote in support of H.R. 2069.

LEARN FROM HAITI

(By Howard Hiatt)

Of the 28 million people in Africa with AIDS, no more than 25,000 have access to medications. Officials of both Western nations and some affected countries—like South Africa, which has millions in immediate need of treatment—have said that poor countries have too few clinics and doctors and that their populations are too poorly educated to allow treatment of all infected people. This contention has become familiar in the debate over international financing to treat H.I.V.

But it is a misconception. At a health center in Haiti, a country at the very bottom of the economic heap, H.I.V. infections are controlled as effectively as in America. And the success at this health center, sponsored by Partners in Health, a non-profit charity affiliated with Harvard Medical School, could be replicated all over the world if the wealthy nations chose to provide the financing. The barrier to the use of AIDS drugs for all H.I.V. patients is not some physical or educational impossibility; it is lack of will.

The center is in Cange, an impoverished village of small houses with corrugated roofs and dirt floors. There and nearby, care is delivered with skill and personal attention comparable to that in American teaching hospitals.

The compound was begun in 1983 by Paul Farmer, a physician and anthropologist now at Harvard Medical School, and the Rev. Fritz Lafontant, a Haitian Episcopal priest. Working with Dr. Farmer and Jim Yong Kim, another American physician-anthropologist, are Haitian doctors and nurses and about 200 community health workers, who make this model of health care succeed.

About 1,400 of the patients have H.I.V.; of these, 100 of the sickest receive the advanced medicines used to treat AIDS in the United States and now function normally. Their care is supervised by the local health workers, who are trained at the clinic. The health center's operations are financed by donations, and the doctors will treat another 100 desperately ill patients with the AIDS drugs if they can persuade drug companies to donate them.

Partners in Health also applies the principles used in Cange at a center in Peru and one in Mexico. In each case, training community health workers allows the development of a system that can offer sustained treatment for people ill with hard-to-cure diseases. The center in Lima has cured more than 80 percent of patients with drug-resistant tuberculosis—something many tuberculosis experts and even the World Health Organization had thought impossible.

What these doctors do to treat H.I.V. infection is a small effort against a huge worldwide problem. But they have shown that if we do not treat the millions of Africans who are dying of AIDS, it is because we have chosen not to, not because we can't.

Mrs. CHRISTENSEN. Madam Speaker, I rise in support of H.R. 2069, the Global Access to HIV/AIDS Prevention, Awareness, Education and Treatment Act of 2001 and I commend my colleagues Chairman HYDE, Ranking Member LANTOS and my friend Congresswoman BARBARA LEE for their work in bringing this bill to the floor today.

Madam Speaker, H.R. 2069 is badly needed, and my only regret is that we didn't pass it sooner. Just 10 days ago we celebrated World Aids Day to call attention to the global scourge of HIV/AIDS which has, to date, claimed an estimated four million children world wide and the news gets worse, every day. Everyday AIDS kills more than 7,000 people in sub-Saharan Africa. The AIDS pandemic continues to escalate in the Caribbean, Asia, and Russia and according to today's New York Times; the Chinese central government is taking steps to address its growing AIDS problem. This pandemic is now projected to infect over 100 million people with a deadly incurable virus by 2007.

We must realize that we are no longer a world where any one country, or even one neighborhood can labor under the impression that they are isolated. The devastation and the disruptive effects of the HIV/AIDS pandemic may be at its very worse in far away, exotic lands but the dire effects will ripple until they reach our shores.

The Global Access to HIV/AIDS Prevention, Awareness, Education and Treatment Act of 2001 is a step in the right direction in this regard, because it urges the United States and

other developed countries to provide assistance to sub-Saharan Africa and other developing countries, with respect to activities supported in connection with health programs, to control the HIV/AIDS pandemic through HIV/AIDS prevention, treatment, monitoring and related activities, particularly focused on women and youth—including mother-to-child transmission prevention strategies.

I urge my colleagues to support this important and badly need bill.

Ms. JACKSON-LEE of Texas. Madam Speaker, I rise in strong support of H.R. 2069, the Global Access to HIV/AIDS Prevention, Awareness, Education and Treatment Act of 2001. This bill authorizes assistance to combat the HIV/AIDS pandemic in countries in sub-Saharan Africa and other developing countries. This pandemic is more than an international public health issue, but also a humanitarian, national security, and development crisis.

Sub-Saharan Africa has been the hardest hit region and has been disproportionately affected by the deadly disease. Only 10 percent of the world's population live south of the Sahara, but the region is home to two-thirds of the world's HIV-positive suffering people, accounting for more than 80 percent of all AIDS deaths. In fact, Botswana has an estimated infection rate of 36 percent the highest in the world. Zimbabwe's infection rate is 25 percent, and South Africa's infection rate is 20 percent.

Today, forty million people around the world live with and suffer from HIV/AIDS. Twenty-eight million of them live in the Sub-Saharan African region alone. On the continent of Africa, there are an estimated 11,000 new infections per day, and by the end of this year, approximately 2.3 million Africans will have died from HIV infection.

AIDS does not discriminate against color, and regrettably, it does not discriminate against age. In Africa, 3.8 million children under the age of 15 have died since the beginning of the epidemic 20 years ago. Throughout Africa, 6 out of 7 children who are HIV positive are little girls. Many children are also being orphaned by HIV; losing their mothers or both parents to AIDS. So far, the AIDS pandemic has left behind 13 million orphans, of whom 9 percent currently live in Africa. By 2010, if we do nothing, an estimated 40 million children will be orphaned by this tragic disease. These numbers will lead to the absolute decay of many African societies. As a consequence to losing their parents, children are drawn into prostitution, crime, substance abuse, and child soldiery, and to the kind of destitution unbelievable to most Americans.

Madam Speaker, I traveled to the South African region in 1999 and in July of this year, and what I witnessed was unbelievable! It was a life-altering event to see and meet with the people infected by this deadly virus. But what affected me the most was witnessing the thousands of orphaned children whose parents had died from AIDS.

On November 28, the Global Health Alliance released a report entitled ''Pay Now or Pay More Later: An Independent Report on the Response to the Global HIV/AIDS Pandemic''. The following day, the African Ambassadors Group and International AIDS Trust sponsored a briefing on Refocusing and Reaffirming our Commitment to AIDS''. This is clearly a global issue and it is everyone's problem. The key to fighting this virus must involve a comprehensive approach that includes prevention, education, and support of a health care infrastructure. H.R. 2069 prescribes such an approach. H.R. 2069 also authorizes funds to improve orphan care, encourage hospice and palliative care, strengthen existing health care systems, and to procure medicines and anti-viral therapies to treat the disease. HIV prevention efforts must take into account social and economic factors, such as poverty, underemployment, and poor access to health care, all of which disproportionately affects African societies.

As Members of Congress, we must continue to fight the struggle and persist in obtaining increased funding for the global AIDS response. This is one of the great challenges of our time and of this generation. H.R. 2069 gives us the tools to help overcome this challenge and I urge my colleagues to support this legislation.

Mr. HYDE. Madam Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mrs. BIGGERT). The question is on the motion offered by the gentleman from Illinois (Mr. HYDE) that the House suspend the rules and pass the bill, H.R. 2069, as amended.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the bill, as amended, was passed.

The title was amended so as to read: ''A bill to amend the Foreign Assistance Act of 1961 and the Global AIDS and Tuberculosis Relief Act of 2000 to authorize assistance to prevent, treat, and monitor HIV/AIDS in sub-Saharan African and other developing countries.''.

A motion to reconsider was laid on the table.

SUPPORT FOR TENTH ANNUAL MEETING OF ASIA PACIFIC PARLIAMENTARY FORUM

Mr. BEREUTER. Madam Speaker, I move to suspend the rules and concur in the Senate concurrent resolution (S. Con. Res. 58) expressing support for the tenth annual meeting of the Asia Pacific Parliamentary Forum.

The Clerk read as follows:

S. CON. RES. 58

Whereas the Asia Pacific Parliamentary Forum was founded by former Japanese Prime Minister Yasuhiro Nakasone in 1993;

Whereas the Tokyo Declaration, signed by 59 parliamentarians from 15 countries, entered into force as the founding charter of the forum on January 14 and 15, 1993, establishing the basic structure of the forum as an interparliamentary organization;

Whereas the original 15 members, one of which was the United States, have increased to 27 member countries;

Whereas the forum serves to promote regional identification and cooperation through discussion of matters of common concern to all member states and serves, to a great extent, as the legislative arm of the Asia-Pacific Economic Cooperation;

Whereas the focus of the forum lies in resolving political, economic, environmental, security, law and order, human rights, education, and cultural issues;

Whereas the forum will hold its tenth annual meeting on January 6 through 9, 2002, which will be the first meeting of the forum hosted by the United States;

Whereas approximately 270 parliamentarians from 27 countries in the Asia Pacific region will attend this meeting;

Whereas the Secretariat of the meeting will be the Center for Cultural and Technical Exchange Between East and West in Honolulu, Hawaii;

Whereas the East-West Center is an internationally recognized education and research organization established by the United States Congress in 1960 largely through the efforts of the Eisenhower administration and the Congress;

Whereas it is the mission of the East-West Center to strengthen understanding and relations between the United States and the countries of the Asia Pacific region and to help promote the establishment of a stable, peaceful and prosperous Asia Pacific community in which the United States is a natural, valued, and leading partner; and

Whereas it is the agenda of this meeting to advance democracy, peace, and prosperity in the Asia Pacific region: Now, therefore be it

Resolved by the Senate (the House of Representatives concurring), That the Congress—

(1) expresses support for the tenth annual meeting of the Asia Pacific Parliamentary Forum and for the ideals and concerns of this body;

(2) commends the East-West Center for hosting the meeting of the Asia Pacific Parliamentary Forum and the representatives of the 27 member countries; and

(3) calls upon all parties to support the endeavors of the Asia Pacific Parliamentary Forum and to work toward achieving the goals of the meeting.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Nebraska (Mr. BEREUTER) and the gentleman from California (Mr. LANTOS) each will control 20 minutes.

The Chair recognizes the gentleman from Nebraska (Mr. BEREUTER).

GENERAL LEAVE

Mr. BEREUTER. Madam Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on the Senate concurrent resolution under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Nebraska?

There was no objection.

(Mr. BEREUTER asked and was given permission to revise and extend his remarks.)

Mr. BEREUTER. Madam Speaker, I yield such time as he may consume to the distinguished gentleman from New York (Mr. HOUGHTON), who is the sponsor of this legislation; and he has been the leading force in the House participation in the Asia Pacific Parliamentary Forum.

Mr. HOUGHTON. Madam Speaker, I thank the gentleman for yielding time to me.

Madam Speaker, I would like to talk very briefly on Senate Concurrent Resolution 58, which really supports the tenth annual meeting of the Asia Pacific Parliamentary Forum.

Madam Speaker, this is a forum, I think it is important to know, that was organized by parliamentarians in the Pacific Rim, including about 27 different nations. The reason we are part of it is because of California, Oregon,