and understanding of the significance of the Declaration of Independence, the United States Constitution, and the Federalist Papers; and

''(2) State and local governments and local educational agencies are encouraged to include a requirement that, before receiving a certificate or diploma of graduation from secondary school, students be tested on their competency in understanding the Declaration of Independence, the United States Constitution, and the Federalist Papers.''

AMENDMENT NO. 625

(Purpose: To provide a technical correction)

On page 648, strike lines 4 through 8 and insert the following:

''(1) to carry out chapter 1—

''(A) $150,000,000 for fiscal year 2002; and

''(B) such sums as may be necessary for each of the 6 succeeding fiscal years; and ''(2) to carry out chapter 2—

''(A) $150,000,000 for fiscal year 2002; and

''(B) such sums as may be necessary for each of the 6 succeeding fiscal years.''.

AMENDMENT NO. 631

(Purpose: To allow literacy grant funds to be used for humanities-based family literacy programs)

On page 189, between lines 17 and 18, insert the following:

''(6) PRIME TIME FAMILY READING TIME.—A State that receives a grant under this section may expend funds provided under the grant for a humanities-based family literacy program which bonds families around the acts of reading and using public libraries.

Mr. BENNETT. Mr. President, I rise in support of an amendment to the Better Education for Students and Teachers Act that will make a minor but important technical change to the Rural Education Initiative, located in Title V of the bill. The Rural Education Initiative directs funds to school districts that lack the personnel and resources needed to compete for Federal competitive grants and often receive formula allocations in amounts too small to be effective in meeting their intended purposes.

As the bill is currently drafted, districts must meet two requirements to qualify for grants under this program. One of these requirements is that the district must have less than 600 students. This requirement poses a problem for many States that have geographically large districts. For instance, in my home State of Utah, there are only 40 school districts. Compare this to States of similar or smaller geographic size, some of which have more than 500 districts. The result is that many districts in States like Utah have more than 600 students and therefore fail to qualify for rural assistance, despite the fact that these districts may be in the most rural parts of the State. I have been to these districts. If the members of this body were to travel with me to Beaver School District in Beaver, Utah, they would find it hard to dispute the fact that Beaver is a rural district. But the students in Beaver School District will not receive any assistance under the Rural Education Initiative as it is currently written.

I do not wish to argue the merits of large districts versus small districts. The way a State chooses to run its educational system is rightly left up to State and local education authorities. However, Congress should not be in the business of penalizing States based on their educational systems.

My amendment alters the Rural Education Initiative to include an either/or provision that will allow districts to qualify in one of two ways: a district must have less than 600 students or must have a total population density of less than ten people per square mile. This minor change will allow a handful of school districts that do not currently qualify to become eligible for funding under this provision. It is important to note that no school district currently qualifying under the Rural Education Initiative will be disqualified by my amendment. However, this change will have a serious impact on places like Beaver, Utah, and on many other rural school districts around the country.

I encourage my colleagues to support this amendment.

Mr. KENNEDY. Mr. President, I thank colleagues for their cooperation.

We are going to continue to work closely with our Members to try to move this process forward, and to do it in a timely way that will permit our colleagues, obviously, to speak to these measures where necessary and permit us to dispose of the amendments where necessary. But we do want to move ahead. I have every expectation we will have an opportunity to clear additional amendments tomorrow as well.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. GREGG. It is my understanding, therefore, that for the balance of the evening we will simply participate in general debate on the bill and that tonight no more amendments will be offered to the bill. Tomorrow, as the Senator from Massachusetts has represented, there will be 20 minutes of debate equally divided when we go back to the bill, at which time there will be a vote on the Wellstone amendment, followed by the Senator from Maine, Ms. COLLINS, offering an amendment.

The PRESIDING OFFICER. Is there a unanimous consent request?

Mr. GREGG. That is not a unanimous consent request. That is just a summary of where we are. We are waiting for the formal written document to make it clear that I did not make any mistakes, and pending that, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. GREGG. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

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

Mr. GREGG. Madam President, I ask unanimous consent that when the Senate resumes consideration of the education bill on Wednesday, there be 20 minutes of debate on the Wellstone amendment equally divided with no amendments in order to the amendment. I further ask unanimous consent that following the use or yielding back of the time, the Senate proceed to a vote in relationship to the amendment. I further ask unanimous consent that following that vote, the Senate then begin consideration of the Collins amendment No. 509.

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

MORNING BUSINESS

Mr. GREGG. Madam President, I ask unanimous consent that there now be a period of morning business.

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

Mr. GREGG. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The senior assistant bill clerk proceeded to call the roll.

Mr. ENZI. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

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

The Senator from Wyoming is recognized.

Mr. ENZI. I thank the Chair.

(The remarks of Mr. ENZI pertaining to the introduction of S. 984 are located in today's RECORD under ''Statements on Introduced Bills and Joint Resolutions.'')

Mr. ENZI. I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. SMITH of Oregon). The clerk will call the roll.

The assistant bill clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent the order for the quorum call be rescinded.

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

THE HIV/AIDS VIRUS

Mr. FRIST. Mr. President, I rise to speak on the 20-year anniversary of a truly remarkable event which, at the time, no one in the world would have envisioned its impact—its impact on people throughout the United States and on people throughout the world—indeed, its impact on impact. No one could have foreseen an impact which, from a public health perspective, has resulted in the single worst public health crisis since the bubonic plague ravaged Europe more than 600 years ago.

That event occurring 20 years ago today was the publication of a brief description of the first five cases of a disease that could not be explained. The five people mentioned happened to have been infected with a virus that had never previously been described, and which at the time had no name. The five people had been infected with what was later called the HIV virus,

and they died of complications associated with AIDS.

It was a case study. It was published by the CDC. At the time I was a third year surgical resident at the Massachusetts General Hospital in Boston. I remember very vaguely 20 years ago those first case reports being talked about. And it was vague. It was obscure. Nobody had any idea because that virus had never been described in the history of mankind. Nobody had ever before talked about a virus with such power to destroy—to destroy cells, to destroy cellular function, to destroy life itself: the HIV/AIDS virus.

During my surgical residency, I was involved in operating every day. At the time, we had no earthly idea that this virus would infect much of our blood supply. No one knew that it would ultimately be transformed, 5 or 6 years later, into what became known as ''universal precautions,'' where, for the first time, we began to treat all blood in the operating room as potentially infected or potentially toxic. We started to wear double gloves. We started to wear a mask when we operated. We took these precautions to protect ourselves—not our patients This all occurred within a few years after these initial five cases were described. It changed the practice of medicine.

I had the opportunity earlier today to meet a wonderful person, a person whom I had previously only heard about. Her name is Denise Stokes. She has a wonderful voice and a wonderful story. The story was told to me and many others today.

Denise was infected with the HIV virus at the age of 13. Shortly after her infection was identified, she became active in the struggle against the virus. She described her many experiences in an intensive care unit. She described what it was like not to have access to available drugs. She talked about watching, in the depth of her illness, as policymakers talked about AIDS on television. She wondered whether at any point they would be able to respond to what has become the largest, most significant public health challenge in our lifetimes, in the last century—perhaps in the history of the world.

She talked about saying a silent prayer that hopefully there would be a cure someday. She talked about her hopes that someday she, by sharing her experiences, could become a catalyst for ultimately discovering a cure for HIV/AIDS.

Denise helped to put a face on heterosexual HIV infection in the 1980s. She was instrumental in gaining access to African-American churches in the early 1990s. As I said, she was infected when she was 13 years old. She is now 31. She talks to college students, community groups, and professional organizations sharing her story, a story that is powerful, a story that puts a face on HIV/AIDS.

No one 20 years ago, or even 15 years ago, would have ever guessed that this disease would become the single worst public health crisis in over 700 years.

People ask: What do we think about this virus now 20 years later? The Kaiser Family Foundation, in a very recent survey, showed two things about Americans' thinking: No. 1, they see AIDS is the most urgent international health issue; and, No. 2, after cancer, Americans view HIV/AIDS is the most urgent health issue here at home.

And the American public is right on target. We have learned a great deal about this disease over the last 20 years. We know how to prevent it. We have fairly effective drugs and treatment therapies today for treating HIV and AIDS-related infections. They work in most cases if they are available and if they are taken properly.

Over the last 20 years—remember, this virus was not around 21 years ago—AIDS has become a very effective killer. About 8,000 people will die somewhere in the world today from this virus, this single little virus that 21 years ago, to the best of our knowledge, had killed no one.

Its impact has been tremendous. Consider the research field—speaking as a physician and medical scientist, I can say that in 1981 we had no drugs to treat this virus. About 6 years later, we had six or seven drugs. Now, we have about 65 drugs to treat this virus. In spite of that, as I said, it is killing about 8,000 people a day.

One thing that gives us some hope is the great boldness, the genius of our research industry—both the public sector through NIH and the private sector through the pharmaceutical companies—where there are today over 100 drugs in the pipeline to combat HIV/AIDS.

Our successes have been many. We have reduced the incidence of mother-to-child transmission thanks to counseling, voluntary testing, and AZT for pregnant women. New HIV infections have declined sharply. The Ryan White CARE Act, which originated in the Congress, supports care for over 100,000 people who otherwise would not be able to afford therapy. The drugs have doubled their life expectancies. That's a tremendous success. It has cut in half the average length of stay for HIV-related hospitalizations.

This body, I am proud to say, has responded to the changing face of HIV/AIDS, in the communities where it appears. For example, last year Congress expanded the reach of the Ryan White CARE Act to include a wider range of communities. We created supplemental grants for emerging metropolitan communities that previously had not been affected and in the past did not qualify for such funding.

The expansion in the program will benefit such places as Nashville, TN, where the Comprehensive Care Center, led by Dr. Steve Raffanti, has served more than 3,000 patients over the last 6 years, and is currently following almost 1,900 patients, 40 percent of whom fall below the poverty level.

How? The Congress first authorized the Ryan White CARE Act ten years ago and we reauthorized it five years ago and then again last year.

Congress has also responded with increased funding. Ryan White funding is now at a level of $1.8 billion a year. That is not double what it was when we started, or tripled, or quadrupled. It is 7 times what we initially put into the funding of the Ryan White Care Act.

But there is so much more to be done. There are 500,000 to 600,000 Americans living with the HIV infection and another 320,000 people with AIDS. We have reduced the number of new infections from 150,000 a year down to 40,000 a year. That is tremendous progress, but it is not acceptable. 40,000 new infections per year is one new infection every 13 minutes, 24 hours a day, 365 days a year.

Our loved ones are at risk. Even worse, there are some new danger signs on the horizon. The progress and the advances that have been made appear to have created an element of complacency. Surveys indicate today that 80 percent of our young people do not believe they are at risk for HIV infection. Such ignorance and complacency breeds incaution, less prevention, and, ultimately, more infections.

Last week, the CDC featured a report which cited a frightening increase in HIV incidence for young African-American gay and bisexual males. In Tennessee, the number of HIV/AIDS infections increased by a startling 35 percent over the 2-year period of 1998 to the year 2000. We simply cannot allow this increase in the number of infections. We cannot allow a new wave of infections in our country. All of this is a call to arms, a call to arms for all of us as citizens of our communities, as Americans, and as citizens of the world.

As we were talking this morning, Denise talked about initially withdrawing within herself as the virus infected her at age thirteen. As she grew older, she started to reach out—first, to her community; later, to policy makers.

Denise should be an example for all of us. We have a moral obligation to reach out within our communities and beyond, to the United States of America and beyond. We need to reach out to the entire world. Indeed, as troubling as the trends are in this country, they pale beside the staggering disaster of HIV/AIDS in the developing world, especially in sub-Saharan Africa.

The historical enemies of human beings—and we all know what they are: war, famine, natural disasters, persecution—today are dwarfed by the global epidemic of HIV/AIDS. The crisis is one of public health. The crisis is one of developmental economies. The crisis is one of humanitarian outreach.

The global statistics of HIV/AIDS are chilling. I just mentioned that an American is infected with HIV/AIDS every 13 minutes. During that same 13 minutes, 72 people will die of HIV/AIDS somewhere in the world. Twice that number will become newly infected.

I have had the opportunity to serve on the Foreign Relations Committee. In that committee, I chair the Africa subcommittee. I have had the opportunity to travel to Uganda, to Kenya, to the Congo, to the Sudan. I have had the opportunity to perform surgery in hospitals in the last several years where HIV infections among patients run as high as 50 percent. When you travel to Africa, just as Secretary Powell did 2 weeks ago, you see that Africa is losing an entire generation. It is that middle generation that is being wiped out. It is that working generation that is being wiped out. It is the parenting generation that is being wiped out.

How many orphans result? How many devastated families? How many impoverished villages? How many ruined economies?

The good news is we know a lot about how to reverse the epidemic through a combination of political commitment—I am speaking to my colleagues and to the political leadership of others around the world—of donor support—again, I am speaking to those both inside and outside government who are in a position to contribute—and of newly committed leadership in countries being devastated by the disease. Those three elements, in places such as Uganda, Senegal, and Thailand, have had remarkable successes.

On the ground in these countries, work by community-based organizations, both religious and secular, has been the linchpin of success.

It is very important that we not separate prevention from care and treatment. Science has not yet found a cure. There is no vaccine for HIV/AIDS. Not yet. It will be 5 years, or 7 years, or 10 years maybe more. I am not sure if it will even be a vaccine. It may be a highly effective treatment. One of the many problems of this virus is, once it gets into the memory system of the cells of the human body, those cells stay there for decades, 60 and 70 years. That's just one of the challenges for our research community.

Recent action by the pharmaceutical companies to slash prices on antiretrovirals for poor countries has done two things. First, it sends the message of hope. Second, it puts a spotlight on the necessity of establishing an infrastructure of health care to be able to engage in prevention and care and treatment.

Access to treatment and drugs for opportunistic infections such as tuberculosis is also critical. For all the damage that HIV/AIDS does, tuberculosis kills more people in Africa with AIDS than any other opportunistic infection.

Creation and ongoing support of public health infrastructure, of health care delivery systems, including personnel training, is essential to effective treatment and education programs.

What more should we do to address this challenge?

The reason I am discussing this tonight is that 21 years ago, before the first case studies, we had no idea of the catastrophe of this pandemic which now travels across the world. I have spoken a lot about Africa in the last few minutes; and there is increasing public awareness of the magnitude of the disaster there. When I ask which single country in the world has more HIV/AIDS cases than any other, most of my colleagues and those listening would guess a country in Africa. That's wrong. It is believed that India now has more cases than any other country.

If I ask what country in the world has the fastest growth rate in HIV/AIDS, again, most would guess an African country. That's also probably wrong. We think it's Russia. Frankly, we're not sure because public health information is so poor in most of these places.

There is no debate that no region of the world is more affected than Africa. But guess which region is second; it's the Caribbean.

This is truly a global challenge. The price tag for an effective response is staggering. Billions of dollars are going to be required. The United Nations estimates that $3 to $5 billion will be required in Africa alone. $3 to $5 billion to develop an appropriate human and physical infrastructure to address this challenge. Governments must respond. Legislatures like ours, the executive branch, and the governments of the world are the only ones able to commit the resources needed.

New public-private partnerships that draw on our creativity must be developed to implement the strategies that are put forward.

The United States has taken real leadership on this issue. Although we often are criticized by other nations, we need to make it clear that the United States right now is contributing about half the funds that the entire world is currently spending internationally to fight the problem.

We spend more than anyone on research and on education. We spend more than anyone on treatment of HIV/AIDS. We spend more than anyone to help the rest of the world deal with this problem. Indeed, U.S. foundations alone have contributed more money to attack this problem than most other governments.

This does not mean that we are the only ones doing our part. Other nations, the United Nations, the World Bank, corporations, and philanthropies have been joining together, particularly over the past year.

President George W. Bush, just 3 or 4 weeks ago, took a real leadership position, committing $200 million, the first country to do so, to a global fund to combat AIDS.

Secretary of State Colin Powell, on his recent return from Africa, said:

> There is no war that is causing more death and destruction . . . that is more serious . . . than the war in sub-Saharan Africa against HIV/AIDS.

I will close with seven steps we can take to engage this war:

No. 1. United leadership. We should ask the political, religious, and business leaders of the world to unite in joining the international commitment to halt the spread of HIV/AIDS and to help those afflicted with the disease. They should commit both financial and human resources to the fight.

No. 2. A global fund. I mentioned and commended President Bush's commitment to this global international fund for HIV/AIDS, tuberculosis, and malaria. This should not be an American fund. It should not even be a United Nations fund. It should be a global fund that represents a new way of doing business—transparent and responsive. Traditional donors such as European countries, Japan, and others, as well as the business community, foundations, and other institutions of civil society should all be participants in this fund.

In the very near future, I intend to offer legislation authorizing U.S. contributions to this new global fund, this new way of doing business.

No. 3. Swift funding. We should put nongovernmental and community-based organizations, both religious and secular, at the forefront of the action on the ground by getting funds to them quickly so they can most effectively do their jobs reaching out. We know they have an enormous impact, and speed saves lives.

No. 4. Partnerships. We should encourage and empower coalitions and partnerships of governments, universities, academies, research institutions, multilateral institutions, corporations, and the nongovernmental organizations to come together as partners, as coalitions, to help fill the gap between the available resources and the unmet needs of prevention, care, and treatment. Each member of the partnership brings a unique contribution to the battle.

No. 5. Research. We should make absolutely certain that international research efforts on disease affecting poor countries—and that includes AIDS, malaria, and tuberculosis—are reinforced in a manner that assures the best scientific research in the world can lead to real benefits for the developing world at a cost they can afford.

We should continue to aggressively support and encourage research into vaccines and treatments in both private and public institutions like the National Institutes of Health. The Senate has recently supported the doubling of funding at the NIH over 5 years. We should also give new financial incentives for private research. The pharmaceutical companies are doing tremendous research in the field of HIV/AIDS, but more is needed.

There are numerous vaccines currently under investigation. Their success will be measured in millions of lives saved. Just think of it.

No. 6. Prevention, care, and treatment. I already mentioned that prevention needs to be tied to care and treatment. I am very excited about new low-cost options which can link care and treatment with prevention over time.

No. 7. And I will close with this—is hope. As I talked with Denise Stokes today, I was struck by her remarkable enthusiasm, her optimism, and her commitment to teaching others about this disease which changed her life from the age of 13.

The most remarkable thing to me, as I listened to her and learned that she was just in the emergency room 2 days ago, was the simple fact that here she was talking to a large crowd of people with her story. She was sharing what was inside, reaching out broadly to people from all over the world, bringing her special message which can be summed up in one word: ''hope.''

We should do all we can to provide comfort and care to families all over the world today. We should address the issue of the orphans created by this terribly destructive disease. We have a moral responsibility to give them hope.

Yes, the challenge is before us—a moral challenge, a humanitarian challenge. There has never before been such a challenge in terms of sheer magnitude.

As Americans, it is natural to reach out to those around us, domestically, to give a helping hand. Now we must join with other nations to extend our helping hand further to create a better world, a safer world, and a more fulfilling world. We do that here at home with boldness, genius, and creativity, along with a healthy dose of courage, persistence, and patience. Let us now rise to the global challenge as a compassionate people in a great and compassionate nation.

COMMEMORATING TWENTY YEARS SINCE THE FIRST DIAGNOSES OF AIDS

Mr. DASCHLE. Mr. President, I rise to commemorate the beginning of a tragic chapter in human and medical history. Twenty years ago today the first cases of AIDS were diagnosed. Since that initial diagnosis in 1981, the toll wreaked upon humanity by this disease is mind boggling. Twenty-two million people have already died. And an additional thirty-six million people have become infected with HIV, the virus that causes AIDS.

In 1981, no one imagined the impact HIV/AIDS would have in the ensuing two decades. And, unfortunately, no one would have imagined that the United States would be as slow as it has been to respond to what has become a grave international crisis.

International public health experts estimate that the global fight against AIDS demands at least $7 billion per year. Meanwhile, in the last 15 years combined, the United States has invested only $1.6 billion or a little over $100 million per year to fight this pandemic. In 1999, a year during which nearly five and a half million people in Africa alone were newly infected, the United States invested just $142 million, less than .001 percent, of our foreign assistance budget that year, to fight AIDS.

Too much time has been lost, and too little leadership has been demonstrated by America. President Bush, Vice President CHENEY, and Secretary Powell have indicated they now recognize this pandemic for what it is: a national security threat. It is time that we begin dedicating the resources that such a threat demands.

In recent months, some progress has been made in combating AIDS. Governments, foundations, and corporations have begun to pledge donations to the Global Trust Fund to fight AIDS. Drug producers have also begun to make AIDS treatment more affordable for the more than 25 million HIV-positive Africans. But much more remains to be done.

However, the activities of the Global Trust Fund should not and cannot replace our bilateral efforts to bolster the health infrastructure of the countries struggling against this pandemic. Therefore, Congress can take three important steps to bolster our bilateral efforts and invest in the health care workers and researchers needed in the affected countries.

First, Congress must provide the resources needed for increased training of public health workers on the ground.

Second, Congress must increase spending on research in Africa—and insist that research dollars spent in these countries also go to the development of indigenous research capabilities.

And third, Congress must try to create the incentives necessary to stop the steady outflow of African doctors and nurses from these ravaged countries.

It is time to act. We have already lost two decades and tens of millions of lives to this deadly disease. We cannot afford to wait another two decades before we confront this disease with the dedication it demands.

Mr. KENNEDY. Mr. President, today marks the 20th year since the Centers for Disease Control and Prevention first published information in the Morbidity and Mortality Report on this illness we now call HIV/AIDS. The past 20 years have seen immense loss, as well as significant medical advances, and this anniversary is a fitting time to renew the worldwide call for stronger action in the battle against this devastating global epidemic.

Tragically, current reports from the CDC and from the Retrovirus Conference in Chicago indicate that the transmission of HIV is increasing among our youngest citizens. At least 50 percent of new infections in the U.S. occur in those under 25 years of age. Clearly, we can do more to combat this serious challenge that threatens to blight the lives of many of the Nation's youth.

Our concern extends far beyond America's borders. President Bush has pledged $200 million for HIV/AIDS internationally, but we need to do far more, especially to help combat this massive HIV/AIDS crisis in developing nations. From orphaned children, to untrained workforces, to destabilized economies, the realities of HIV/AIDS in third-world nations are harsh. Today, nearly 40 million people worldwide continue to live with HIV/AIDS.

Dealing more effectively with this global epidemic requires a stronger commitment from all of us both in Congress and in the administration, so that medical advances will benefit as many people as possible worldwide. The United States can set a proud example for the world community in dealing with HIV/AIDS by doing all we can to provide the resources needed for effective prevention programs, good treatment for those suffering from HIV/AIDS, and the development of a cure that will finally conquer it and save the lives of millions.

Mr. SMITH of Oregon. Mr. President, I rise today to note the 20th anniversary of the passing of a constituent of mine . . . one of the five original deaths sited by a CDC report published 20 years ago today. Though the 553-word article only outlined a rare type of pneumonia—it also noted that the same strain had struck five gay men in Los Angeles, California. One of those five men in Los Angeles was an Oregonian and I stand here today to mark this somber anniversary.

The world marks this date, June 5, 1981 as ground zero for the AIDS epidemic. Those early days marked a panic among urban populations of gay men, who at first made up the bulk of early AIDS cases. It wasn't until 1984 that researchers identified the AIDS virus, and throughout the 1980s much of the gay community's efforts were focused on organization and education, which became the hallmark for the early fight against AIDS. As this Nation all too slowly wakened to this epidemic, much of the groundwork had been laid by a community devastated by this disease. Slowly funding on the Federal level grew, and by the mid 1990s new drugs slowed but did not stop the progression of the disease.

Today 36 million people are HIV-positive: almost a million in the United States alone, and almost a third of them don't know they have HIV. AIDS is the fourth leading cause of death globally and the leading cause of death in Africa. The statistics in that continent are mind-numbing—in some countries, one of four adults are living with HIV/AIDS. Life expectancies in those countries over the next five years have been slashed from the mid-60s to the early forties. Cumulative deaths attributable to AIDS on that continent numbered over 13 million by 1999, and the number of children orphaned by AIDS is estimated between 7 and 10 million. An estimated 1 million children in Africa are HIV-positive.

There were about 5,000 cases of AIDS in Oregon last year, and the National Institutes of Health allocated over $16 million to universities and other institutions in the state to conduct research for the treatment of HIV/AIDS. In addition the government provided