Mrs. FEINSTEIN. Will the Senator yield?

Mr. COCHRAN. I am happy to yield to my friend if I have any time.

Mrs. FEINSTEIN. I thank the Senator for those comments. I have just been told we are clear on our side. We can go to the bill. Obviously, there is a request to have amendments and I think we should hear the amendments out and vote on them. I think those of us who participated in this are really dedicated to get this bill passed. We worked for 2 years with your help——

Mr. COCHRAN. Mr. President, let me reclaim the time. I asked unanimous consent on this floor to do just that and there was an objection by the acting leader for the Democratic side, Mr. HARRY REID. If there has been a change in position, that ought to be communicated to the leader. That would be good to know.

Mrs. FEINSTEIN. As a point of clarification, Senator, if I may, I am told there is no objection to going to the bill. There was an objection on the limitation of amendments.

Mr. COCHRAN. Mr. President, there was no limitation of amendments. The provision in the unanimous consent request was that any amendment offered to the bill would be relevant to the bill and any amendment to an amendment be relevant to the amendment to which it was offered. There was no limitation requested in that unanimous consent request.

Mrs. FEINSTEIN. If I may say, through the Chair, for just a moment to the Senator, then I believe we can move to the bill. Because, as I understand it, what you have just stated is exactly the position of this side.

The PRESIDING OFFICER (Mr. SUNUNU). The Senator from Alabama.

## AIDS IN AFRICA

Mr. SESSIONS. Mr. President, as the Senate considers the Foreign Operations bill, we are considering President Bush's proposal to spend $15 billion to deal with the crisis of AIDS in Africa. It is something I believe is a necessary thing. I supported the President on this. It is a tremendous amount of money, but it is a tremendous problem.

There are many aspects of the problem. Not everybody agrees on every single part of it. I would just say I have done some work on it and I have looked at a number of the issues. I believe strongly that there are some things we can do. If we do them correctly and promptly and effectively, we can dramatically impact the transmission of AIDS in Africa and prevent people from becoming infected and thereby serve a great and noble purpose.

I think this: We know thousands of people are infected in Africa every year. According to conservative numbers generated by the World Health Organization, 250,000 to 450,000 Africans each year contract AIDS, a death sentence ultimately, through healthcare routes. They contract that not from dangerous activities, but from seeking to improve their own health by going to a hospital, a doctor's office, a clinic, and getting a shot or receiving a transfusion. One thousand a day at a minimum are infected by these procedures. It is totally preventable. It goes beyond just policy, and it is in my view a moral imperative. There is no doubt we can reduce this problem in Africa. We can do it by good policy and strong leadership and I believe we need to speak as a Congress on this issue.

In March of this year I had occasion to read a newspaper article that was in the Washington Times. It quoted a published article in the International Journal of STD and AIDS, a publication of the British Royal Society of Medicine, that presented evidence that the reuse of needles and syringes has played a major role in the HIV/AIDS epidemic in Africa.

At the time, the article challenged conventional wisdom and the belief in the international public health community that heterosexual sexual contact was the primary route of transmission for HIV in Africa and that medical transmission of the disease did not require the foremost attention of health care specialists.

Dr. David Gisselquist pointed to a number of pieces of evidence supporting his conclusion that medical exposures account for a large proportion of HIV transmissions. He conducted an extensive review of refereed journal articles on the epidemiology—that is the history of the transmission, the people who get it—in the African HIV epidemic. A careful analysis of the data behind these studies enabled him to identify the following trends:

No. 1, multiple studies he reviewed found HIV-infected children whose mothers test negative for the virus. Many of these children are far too young to have contracted the HIV virus through sexual practices or drug use, leaving their infections unexplained by conventional assumptions about the spread of the disease. It was found, however, that these children bearing the HIV virus had, on average, received nearly twice as many injections of vaccines and medicines than their uninfected peers, leading researchers to conclude that there was a strong correlation between the number of injections a child received and that child's chances of contracting HIV.

As we looked at the issue, we found it was not a newly discussed matter but in fact had been out in the field for some time, unfortunately not receiving the kind of attention it should, in my view, have received from the people who were required and authorized to participate in the treatment and prevention of the disease.

Let me just show this article, a blowup from the San Francisco Chronicle dated Tuesday, October 27, 1998, 5 years ago this date. The title of it is ''Fast Track To Global Disaster.''

The subheadline under the top is ''Deadly Needles.'' This is what the subheadline said:

> For decades, researchers have warned that contaminated syringes could transmit deadly viruses with cruel efficiency, but efforts to defuse the crisis failed, and today, it has become an insidious global epidemic, destroying millions of lives every year.

You ask why, perhaps, did we not deal with that back in 1998 when these matters were being raised. Apparently, there was a debate and a concern that panic would ensue and maybe people wouldn't seek medical care, or that it would deflect attention from WHO's primary view that sexual transmission was the way AIDS was transmitted.

I note this statement by Mike Zaffran of the World Health Organization. You can tell they were wrestling with it, although they did not take action. The subject quote is:

> We want to avoid creating a panic. But maybe there is a need to create that panic to solve this problem.

According to WHO, 10 percent of the AIDS transmissions in Africa come from reused needles or contaminated transfusions, both of which are totally preventable, as I will discuss shortly. But I just want to say right now that there is evidence to suggest that the true figure is far larger than 10 percent. Remember, people who contract AIDS and who have no reason to believe they have AIDS are then in a position to unwittingly transmit that disease to their spouses and to others with whom they come in contact. Those who ultimately pass the disease by those contacts may not have done so had they known they had been exposed. I think it has a multiplier effect on the crisis in Africa, clearly affecting and involving the infection of millions of Africans.

I have hosted two hearings in the Health, Education, Labor, and Pensions Committee on this issue. We have had witnesses from the World Health Organization, from USAID, and from private groups such as Physicians for Human Rights. They have presented evidence. At the conclusion of that testimony, I am even more concerned that the numbers the WHO has acted on or not acted on are low, that more than 10 percent of these HIV cases are being transmitted through unsafe healthcare. Certainly, that is the conclusion Dr. Gisselquist reached after extensive study.

Let me talk about a couple of things: The good news and the bad news.

Injection safety is a critical issue in America. Our health care community has long recognized the risks associated with unsafe injections.

At the outset of the HIV epidemic in America, one of the top priorities in this country was to quickly ensure that patients and health care workers were educated about these risks and that steps were taken to provide ample supplies of single-use syringes—syringes that could not be used again—with safety features to ensure that

both patients and providers were protected.

In fact, one thing we dealt with in this Congress was the Ryan White Act that was passed in response to the infection of young Ryan White as the result of a tainted blood products that he received to treat his hemophilia. In fact, long before the HIV virus emerged as a significant epidemic in the United States, health care workers and policymakers were well aware that unsafe injection practices could spread many dangerous diseases and posed a public health hazard. There was ample evidence that unsafe practices can kill.

From the 1950s through 1982, the Egyptian Government carried out an ambitious program to eliminate schistosomiasis, a serious parasitic disease. Infected Egyptians received multiple injections to kill this parasite—up to 16 injections over 3 months. The needles used in these campaigns were rarely sterilized sufficiently to kill viruses such as hepatitis C.

By the 1980s, it became clear that Egypt was in the grip of a tremendous epidemic of hepatitis C, a disease that frequently leads to liver failure, cancer, and death. In a country of 67 million people, it was estimated that 20 percent of the population had been exposed to hepatitis C. Neighboring Sudan, in comparison, had a rate of less than 5 percent.

This is still thought to represent ''the world's largest iatrogenic transmission event.'' The World Health Organization's data suggests that unclean needles contributed to an appalling 18.9 percent prevalence rate of the deadly hepatitis C virus in the Egyptian population. Altogether, over 12 million people were exposed to this virus and 7.2 million infected. Those are stunning numbers, and they are the result of using dirty needles.

One of the University of Maryland researchers who chronicled this disaster stated emphatically that the practice of reusing inadequately sterilized or unsterilized syringes ''before the danger of exposure to blood was so well known, and before the availability of disposable needles and syringes provided a very potent means for the transmission of blood-borne infections.''

That is something we don't doubt in America today. Unfortunately, however, the same conditions that permitted this tragedy to occur continue to exist in Africa and other areas of the world, and these unsafe practices spread not only hepatitis but also the HIV virus, leading to AIDS and leading to death.

Health care workers around the world continue to devote time and resources to treating medically transmitted infections, many of which remain incurable even by the best medical science.

Since the recognition that unsafe injections pose an unacceptable risk in vaccination campaigns, international vaccination programs now almost universally include adequate injection safety training and supplies. These limited efforts are commendable but much more needs to be done.

To understand the proportion of the problem that remains to be addressed, one must note the distinction between injections given for vaccination and therapeutic injections, or injections given for the purpose of treating infections or other diseases.

It has been estimated that worldwide, therapeutic injections outnumber vaccinations by 9 to 1, totaling approximately 12 billion injections administered each year in the developing world, including the African nations of the Global AIDS Initiative.

Despite this fact and the demonstrated risks associated with unsafe injections, researchers and leaders in the field of HIV prevention have warned that ''little attention has been paid to the systematic correction of widespread unsafe practices resulting in disease transmission through therapeutic injections''—the very problem referenced in this chart where, at the beginning, it says ''Deadly Needles''—dated October 27, 1998—5 years ago today.

At the outset of the AIDS epidemic in the United States, our Government and the public declared that blood supplies must be absolutely safe. The Federal Government and the public health community moved rapidly to ensure that every single unit of blood donated in this country is tested for the HIV virus before it is given to any person.

It is estimated—get this number—that 25 percent of the blood donated in Africa is never tested for HIV—75 percent is but 25 percent is not—and that up to 80 percent of the blood is not tested for hepatitis. It is estimated by the respected group, Safe Blood For Africa—their name indicates their concern about this problem—that as a consequence of this breakdown, approximately 15 percent of the sub-Saharan African blood supply is infected with HIV and 20 percent with hepatitis. Fifteen percent of the blood supply in sub-Saharan Africa is infected with HIV, a deadly disease. People go there and they get transfusions on a regular basis. The World Health Organization estimates that up to 10 percent of new HIV cases in Africa are due to contaminated blood transfusions.

Once again, it is clear that transfusions of contaminated blood represent yet another hidden source of transmission of this disease, fueling the epidemic.

Seventy percent of the recipients of these high-risk transfusions are women and children, making blood safety a critical component of our larger effort to fight HIV/AIDS and to protect the mothers and children. I will repeat that: 70 percent of the recipients of these high-risk transfusions—15 percent of which is contaminated with HIV—are women and children.

So what does that mean? That means that 15 out of every 100 women who go to get a transfusion in Africa—and many of them get transfusions because malaria leads to a lot of transfusions, really more than is needed to be performed but they are performed—and from those transfusions, thousands come home with AIDS. Instead of being healed and cured, they are infected with a deadly disease.

It is important to recognize, too, that in the treatment of anemia, which is related to problems such as malaria, best medical practices would dictate that many of these transfusions are not necessary. So the combination of reducing the number of transfusions is the first step, along with making sure every blood unit that is utilized in Africa is tested for AIDS before being used in a blood transfusion.

We have an HIV rate in the United States of less than 1 percent, and we test our blood supply. In some countries in Africa, the HIV prevalence rate is as high as 40 percent. Every blood donation in the world, and particularly in Africa, should be tested before we do transfusions. This is one more example of the potential ways in which we can reduce the risk of this deadly disease.

I would also like to share some thoughts about why I think this is not just a public policy issue for discussion but why it is a moral imperative.

We will be spending $15 billion over 5 years, on average $3 billion a year. I know there is debate whether we should have the full $3 billion this first year. I have my doubts the money can be assimilated, but we are going to be spending that over 5 years.

Let me talk to you about the cost of completely fixing the medical transmission problem. One of the most startling facts and best news about health care transmissions of HIV in Africa is the fact that injection safety and blood safety have been specifically singled out by researchers as the most cost-effective means of preventing the spread of HIV.

A study by the World Health Organization, in 1999—a year after the San Francisco Chronicle article—suggested that addressing the problem of unsafe injections might well result in actual savings for the governments and organizations financing the fight against AIDS. It can actually save them money. These savings would be generated both by a reduction in the number of unnecessary injections and transfusions, which, amazingly, may account for a majority of the therapeutic injections actually given—and a majority of the therapeutic injections in Africa are probably not necessary and could be handled without any shots or with a pill—and by avoiding the tremendous financial drain that occurs as a result of these infections, including hepatitis.

In testimony before the Health, Education, Labor, and Pensions Committee at a hearing which I chaired in July, one of the leading World Health Organization researchers confirmed both his own conclusion that ending unsafe injection practices would be eminently

cost effective and his projection that blood safety efforts would prove to be similarly cost effective.

In fact, on a day when we are discussing $15 billion for Global AIDS, the benefits of an additional $1 billion here or $289 million there—I think you would all be stunned at the numbers involved in solving this problem. These estimates I am going to give you were provided by the World Health Organization.

Clean, new needles and syringes for every injection, given by medical personnel educated in the proper use of injections in Africa would cost $24 million for all 12 nations included in the Global AIDS initiative. Just $24 million would provide safe and clean needles for every necessary injection in Africa.

Clean, safe blood transfusions, administered by medical personnel trained in the proper indications for transfusions—$46 million for all 12 nations. So for $46 million, we can completely eliminate the problem of transfusions, which WHO admits could be 10 percent of the problem of all the problem of AIDS in Africa.

There are so many tragic aspects to this problem.

Hard-working frontline doctors and nurses inadvertently contribute to the spread of the very diseases they are struggling to prevent.

At the HELP Committee hearing, it was very encouraging to hear the testimony of Dr. John Ssemakula, a physician from Uganda, who was able to describe the great strides his country has made in cleaning up injection practices.

Dr. Ssemakula was also able to convey the plea of the dedicated men and women on the frontlines of health care in Uganda, that they be provided with the equipment they need to provide safe injections.

These are intelligent, educated, well-intentioned people, and they simply want enough syringes to provide patients with safe health care.

The health care system in developing nations frequently does not provide either necessary education in proper injection procedures or, for those providers who are striving to follow model practices, the relatively inexpensive supplies necessary to succeed.

We are dealing with, frankly, with our health care providers worldwide, a double standard that is indefensible. You are tempted to say, it is an immoral double standard. Let me tell you about this troubling aspect of the problem. In developed nations, the general public has been made aware of the risk associated with unsafe medical care. We know in America you want safe health care. We insist on it. We spend what it takes to do it. We have needles that are safe to protect nurses and doctors from accidental pricks, much less the patient who goes to get a shot.

When the use of contaminated blood and blood products results in the spread of HIV here, we act. The health community, the Federal and State regulators, and the American public immediately demand guaranteed safety, and very quickly we see that they get this. The safety of blood and blood products is now something Americans take for granted.

Every unit of blood in this country is screened for HIV, hepatitis B, and hepatitis C. When it became clear that the reuse of contaminated needles put patients at risk, we acted. It is clear that many developing nations, including those in Africa within the President's Global AIDS initiative, have not yet been able to achieve similar results.

This is where a disturbing double standard arises. The World Health Organization, the U.S. Government's Centers for Disease Control, and other organizations with employees in the developing nations openly caution their travelers to these areas, including their own workers, that blood is likely unscreened and needles likely reused. This is described as posing a risk of infection of hepatitis B, C, and HIV.

Numerous workers, including our own embassy employees and AIDS workers in Africa, can tell of being instructed to ask for plasma expanders rather than dangerous blood transfusions or being cautioned to purchase and provide their own new, clean syringes when they go to the doctor.

When formulating public statements and policy for these very same African nations, however, many of these organizations continue to maintain that contaminated blood and reused needles are not significant problems and do not pose substantial health risks to African patients.

We have made some progress. We have had a number of hearings on this subject. I have become more convinced than I was when we started that this is an unacceptable practice. It is an unacceptable situation in Africa and one that can be fixed for less than $100 million a year. We can provide tested, safe blood for every transfusion in Africa, and we can provide clean, unused needles for every injection at a cost of less than $100 million a year. That is tremendous news. We are on the road to making some progress.

I have talked to top officials in the World Health Organization and the U.S. Government. We believe that with Director Tobias' new position in the State Department as sort of an American global AIDS czar that he is attuning himself to this issue, that the CDC, at my request, is conducting research to develop a plan to attack this problem. Health and Human Services is conducting a study which we expect to receive back in a matter of weeks that will review independently all the other existing studies of AIDS transmission in Africa to attempt to determine just how big a problem this really is. And now we are at a point where we are putting this new money into the program.

I urge my colleagues to act now to ensure that a certain amount of this money—it would be less than 5 percent, probably closer to 2 percent—be dedicated to dealing with the medical transmission problem. We need to do that. Sure, they can spend more than that if they want to, but this is the minimum amount that virtually guarantees tremendous success against medical transmissions.

Let's do that as part of our legislation. We can go home and know that we made a difference.

Some say: Well, JEFF, we are picking up on this issue. We really don't need any direction on how to spend our money. Just give it to us, and we will spend it like we want. I generally am sympathetic to agencies not being micromanaged. But with the resistance we continue to see from the World Health Organization and American organizations that deal with this issue, we need to ensure that this much money gets spent.

There was a conference in September in Africa. Thousands of people attended who deal with the AIDS epidemic. The WHO entity issued a press release after that meeting—again just a matter of weeks ago—WHO issued a news release dismissing the significance of medical transmission. This caused a group of scientists who were at the meeting to issue a statement of their own contracting it. They said in effect, WHO continues to reject evidence that stopping HIV transmission through unsterile health care could slow the spread of disease.

So we have a continuing problem, continuing to stick with numbers that do not appear to be justified and policies that need to be changed. It is time for us to take a step to save lives. The very thought that we could knock down maybe in 18 months' time, instead of 1,000 people being infected a day by the health care transmission of HIV in Africa, why it could be down to 200; and then in 2 or 3 years down to virtually zero? That is possible. Which would we rather do? Prevent the contraction of a deadly disease or try to deal with the consequences of the disease once a person is infected?

This is the right step. I thank Senator MCCONNELL for his interest and the President for his leadership.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

## HABITAT FOR HUMANITY

Mr. DASCHLE. Mr. President, 13 years ago, Habitat for Humanity International, HFHI, decided to expand its services to include projects in my State. Today, I would like to congratulate HFHI's 14 South Dakota affiliates