businesses providing child care to their employees. The credit would be available to businesses for building or expanding on-site child care facilities, operating existing on-site child care facilities, or contracting with a licensed child care facility.

Finally, this legislation recognizes the need for more after-school care. Research from the FBI indicates that children between the age of 12 and 17 are most at risk for committing or being victims of violent crime between 3 and 6 pm. Other menacing issues, including teenage pregnancy, also become a problem during this interval between the school bell and the work whistle when an estimated 5 million children go without adult supervision. To provide constructive educational and recreational programs for more children during these perilous hours, the legislation would increase funding for after school programs by almost $4 billion over the next five years. Three billion dollars of this new funding would be sent to the states as a capped entitlement to help them promote a variety of after-school programs. Additionally, the five-year authorization level for the Department of Education's 21st Century Community Learning Center Program, which provides grants to local schools or after-school care, would be increased to $1 billion.

Before I conclude, let me remind all of my colleagues that providing additional tax relief for middle-income families to help them afford day care or care for their children at home will be drastically undercut unless we reform the Alternative Minimum Tax (ATM). Without changes, the AMT will rob 8 million families of the current $500 Child Tax Credit over the next ten years, not to mention any potential new tax credits. The Investment in Children Act therefore includes a provision that would prevent the AMT from hitting middle-income families depending on tax credits.

Taken as a whole, the provisions in the Investment in Children Act would improve the accessibility, safety and quality of child care in America and that represents nothing less than an investment in our future. I urge all of my colleagues to support this effort to provide better care for millions of children across our great nation.

TRIBUTE TO JOHN L. ''JACK'' SMITH, DISTRICT DIRECTOR, CHICAGO DISTRICT OFFICE, U.S. SMALL BUSINESS ADMINISTRATION

HON. BOBBY L. RUSH

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, February 26, 1998

Mr. RUSH. Mr. Speaker, I rise today to honor John L. ''Jack'' Smith, who is retiring as the District Director, Chicago District Office, of the U.S. Small Business Administration. An event will be held in his honor on Thursday, February 26, 1998, in Chicago, Illinois. Jack began his service to his country in 1951 when he joined the Navy. From 1967 to 1970, Jack worked as a loan specialist for the Economic Development Administration after two years as Director of Financial Assistance for the Business and Job Development Corp. in Pittsburgh. In October, 1973, Jack joined the Office of Minority Business Enterprise of the Department of Commerce as the Midwest Regional Director in Chicago. Jack joined the SBA in November, 1975. As District Director, Jack was responsible for the administration of SBA's loan management assistance, government contract, and advocacy programs for small businesses throughout Illinois. Jack's efforts as Chicago District Director have resulted in several billion dollars in loans and federal contracts on behalf of Illinois' small business community.

Jack's 23 years as District Director and 34 years of federal service have greatly benefited Illinois' small business concerns. However, his service did not end there. Jack has volunteered his considerable expertise to benefit the Heart Association, the Kiwanis Club, United Fund and Boy Scouts of America.

I ask that my colleagues join me in honoring John L. Smith, an outstanding community and business leader and role model. I wish him the best of luck in his retirement. May he continue to share his talent and love of community that he has given to the federal government and the community at large.

WITNESS PROTECTION AND INTERSTATE RELOCATION ACT OF 1997

SPEECH OF

HON. LOUIS STOKES

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, February 25, 1998

The House in Committee of the Whole House on the State of the Union had under consideration the bill (H.R. 2181) to ensure the safety of witnesses and to promote notification of the interstate relocation of witnesses by States and localities engaging in the relocation, and for other purposes:

Mr. STOKES. Mr. Chairman, I rise in opposition to H.R. 2181, the Witness Protection and Interstate Relocation Act of 1997. Although I support the witness notification and relocation provision in this bill as well as the goals of the witness intimidation provisions, I object strongly to the inclusion of the death penalty for witness intimidation that results in death. It is also troubling that the death penalty is again applied for conspiracy offenses. This subjects a defendant to be sentenced to death without tangible evidence of guilt of murder and substantially increases the risk of a mistaken conviction and execution. I cite the report from the Death Penalty Information Center, ''Innocence and the Death Penalty: The Increasing Danger of Mistaken Executions,'' which reports 69 instances since 1973 in which condemned prisoners were released from death row because of wrongful convictions. It did not have figures on how many innocent people were actually executed.

I concur with the American Bar Association's resolution that the system for administering the death penalty in the United States is unfair and lacks adequate safeguards. The Bar Association resolution goes on to declare that a moratorium should be imposed on executions until a greater degree of fairness and due process is in place.

There is compelling evidence from many jurisdictions that the race of the defendant is the primary factor governing the imposition of the death sentence. In the Ocmulgee judicial circuit in Georgia, the district attorney sought the death penalty in 29 cases between 1974 and 1994; in 23 of those 29 cases—79 percent—the defendant was black, although blacks make up only 44 percent of the circuit's population. Another instance of the distorted effect of the death sentence is the evidence emerging under the Federal death penalty for drug kingpins. Of 37 defendants against whom the death penalty was sought between 1988 and 1994, 4 defendants were white, 4 were Hispanic, and 29 were black.

It has been 25 years since the U.S. Supreme Court invalidated the death penalty in *Furman* v. *Georgia;* there is now a large body of evidence to indicate that the death penalty is still imposed in a manner that goes beyond the words of the law. It targets African-Americans in a totally unacceptable way and although I strongly support improving the safety of witnesses and increasing the coordination between the Federal and State governments in protecting and relocating witnesses, I cannot support legislation which imposes an overtly prejudicial death penalty. I urge my colleagues to defeat this bill.

THE PERSIAN GULF VETERANS ACT OF 1998

HON. LANE EVANS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, February 26, 1998

Mr. EVANS. Mr. Speaker, I am today introducing the Persian Gulf Veterans Act of 1998. This important legislation offers a framework for compensating veterans suffering from Gulf War illnesses, responds to the need many veterans have expressed for identifying effective models to treat hard-to-define diseases, and addressed other problems Congress has investigated since 1992. Joining with me, as original cosponsors of the Persian Gulf War Veterans Act of 1998, are my distinguished colleagues, Representatives ABERCROMBIE, BISHOP, BLAGOJEVICH, BROWN, CARSON, CLYBURN, FILNER, GUTIERREZ, KENNEDY(MA), MASCARA, ORTIZ, PETERSON, REYES, RODRIGUEZ, and UNDERWOOD. I am also pleased the Persian Gulf Veterans Act of 1998 has the support of the major groups advocating on behalf of Persian Gulf veterans. The American Legion, Veterans of Foreign Wars of the U.S. and Vietnam Veterans of America have all expressed support for this measure.

Seven years ago this week, allied ground forces, with air and naval support, countered Iraq's invasion of its neighbor Kuwait. Of the nearly 700,000 American troops who served in the Persian Gulf theatre, about 100,000 have signed onto registries maintained by the Departments of Defense and Veterans Affairs. The Departments' estimates of those registered who have diagnoses which are not easily treated vary from 10–25 percent. Meeting the needs of those suffering from illnesses, including those which defy ready diagnoses and treatments, is a continuing obligation of our nation—an obligation we must honor. With the current buildup of American troops in the Persian Gulf region, the need for enacting the Persian Gulf Veterans Act of 1998 is even more compelling.

The Persian Gulf Veterans Act of 1998 calls for an independent agency to advise the Department of Veterans Affairs on the appropriateness of the federal research agenda on

the numerous illnesses suffered by Gulf vets and the probable causes of these illnesses. The research review would lay the foundation for compensating Persian Gulf War veterans by determining where associations can be made between specific exposures and illnesses and where other information must be considered.

It may take years to determine why so many veterans are sick, but we know one thing for sure. Our veterans are suffering and many share similar symptoms that are not attributable to any particular cause. It seems fair to use these symptoms, rather than some yet-to-be-determined causes as the basis for compensation. While this approach would require scientist to determine which conditions are most likely the result of Gulf War service, veterans would not have to prove that a certain exposure caused an adverse health outcome. That would require some science that simply does not exit.

Determining the ''prevalence'' of the illnesses Gulf War veterans experience more often than other veterans from the same era, is an epidemiologic approach endorsed by scientists from the President's Gulf War advisory panel. On February 5th, Dr. Arthur Caplan, a member of the Presidential Advisory Committee on Gulf War Veterans' Illnesses, stated that his Committee felt that a prevalence model gave the veterans the greatest benefit of the doubt. According to Dr. Caplan, ''Gulf War Illness is a very real phenomena. No one on this committee should doubt that for a moment . . . What should be forthcoming . . . is an unwavering commitment from this Congress and this administration to provide the health and disability benefits to all those who became sick when they came back from the Gulf.''

The Persian Gulf Veterans Act of 1998 would also require the Institute of Medicine of the National Academy of Sciences (NAS/IOM) to review emerging technologies to assess exposure to agents that may have been present in the Gulf or to identify new diagnostic tools for some conditions. It would ask the NAS/IOM to assess the most effective treatment protocols for illnesses like those from which Persian Gulf veterans suffer and to review the research undertaken by the federal government and offer its own assessment of the research to date along with identifying research that should be done to fill the knowledge gaps. This would provide the ''third-party'' perspective sought by many Persian Gulf veterans, as well as the American public. The Persian Gulf Veterans Act of 1998 would also require the information infrastructure VA, DOD and Congress need to review the extent of veterans' health care problems and monitor these agencies' abilities to address them with adequate compensation and health care services.

We must never give up on our efforts to learn why many of our Gulf vets are sick, but we must also use the best available means to treat their symptoms and to compensate them for their disabilities. Our veterans deserve the benefit of the doubt on this issue, and that's what the Persian Gulf Veterans Act of 1998 is designed to give them.

PREVENTING THE TRANSMISSION OF HIV

HON. TOM LANTOS

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, February 26, 1998

Mr. LANTOS. Mr. Speaker, earlier this month the Subcommittee on Health and Environment of the Commerce Committee held a hearing on ''Preventing the Transmission of the Human Immunodeficiency Virus (HIV),'' at which a number of witnesses discussed the problems related to this serious health issue facing our nation. The subcommittee also considered legislation that has been introduced in the House relating to HIV transmission. I requested the opportunity to present a statement for inclusion in the record of the hearing, Mr. Speaker, because of the importance of this issue to my congressional district and because of the serious national importance of this health problem. Unfortunately, there is considerable misunderstanding of the issue and the best way to deal with it.

Mr. Speaker, I ask that my statement to the Subcommittee on Health and Environment be placed in the RECORD, and I urge my colleagues to give thoughtful consideration to this important issue. It is probable that the House will be considering legislation involving the transmission of HIV later this year, and it is important that all of us here in this body be well informed on this issue.

STATEMENT OF CONGRESSMAN TOM LANTOS

HEARING OF THE SUBCOMMITTEE ON HEALTH AND ENVIRONMENT ON PREVENTING THE TRANSMISSION OF THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)

HOUSE COMMITTEE ON COMMERCE

Mr. Chairman, I thank you for conducting this hearing on HIV transmission and prevention and for this opportunity to express my support of our country's public health efforts in dealing with this serious epidemic.

As you know, the Center for Disease Control (CDC) reports over 600,000 AIDS cases reported nationally since the outbreak of the AIDS epidemic. Annually, 40,000 new HIV infections are reported and approximately 650,000–900,000 Americans are diagnosed HIV-positive. According to the San Francisco AIDS Foundation, California alone currently reports over 100,000 cases which accounts for nearly 18% of all AIDS cases in the U.S. Only New York reports a larger total number of AIDS cases. These figures indicate precisely why the fight against HIV transmission and infection is a top public health priority.

Despite these overwhelming numbers associated with HIV infection, I am greatly encouraged by the fact that California has recently reported a 60% decline in AIDS-related deaths in the first six months of 1997, as compared to the first six months of 1996. And it is especially urgent that we understand what has enabled California to dramatically decrease its number of AIDS deaths and cases so that we may reproduce these efforts and continue to successfully combat the disease. Federal funding has been a main impetus through which we have developed new drug therapies, and we cannot underestimate the significance of improved access to medical care and increased prevention efforts in reducing AIDS transmission and fatalities.

Our country needs to take an intelligent approach to the AIDS epidemic. By intelligent approach, I mean that we need to take into account how different populations are affected by this disease. We now know that new HIV infections in the U.S. occurs among people between the ages of 13 and 20. Young gay and bisexual men experience disproportionately high numbers of AIDS cases and HIV infections. We know that the proportion of AIDS cases has risen among women and among several minority groups, despite declining in several other populations. The facts are compelling, and rather than ignore these facts, we should direct our attention to specific populations that have been specifically affected.

Research and science are our tools; we should use them to guide us in our federal policies. Because the scientific and statistical findings in regards to HIV transmission indicate significantly different proportions of HIV infection in different population groups, I am fully supportive and a proud cosponsor of H.R. 1219, the Comprehensive HIV Prevention Act of 1997, introduced by my esteemed colleagues Representative Nancy Pelosi (D-CA) and Representative Constance Morella (R-MD). Their legislation will promote targeted, primary prevention programs that effectively consider the increasing challenge for high risk populations such as people of color and women. H.R. 1219 would enhance federal coordination and planning by giving authority and responsibility for developing a strategic HIV prevention and appropriations plan to the Secretary of HHS, in consultation with an Advisory Committee. In addition, the bill will authorize further research for investigating possible new HIV infection sites. With its provisions for community-based prevention programs, counseling and testing programs, treatment and related services for rape victims, funding for AIDS/HIV education and information dissemination, as well as adolescent and school-based programs—the Pelosi-Morella act is a thorough and natural extension of current HIV prevention programs in the United States. It will approach HIV prevention through methods that are locally defined, community-based, and that utilize at-risk population targeting.

In contrast, the HIV Prevention Act of 1997 (H.R. 1062) is based upon a belief that identifying individuals who are HIV positive, in and of itself, can prevent new infections. It is a major setback to the progress we have been making in implementing effective HIV prevention programs. Despite the fact that no other disease is required to be reported by federal mandate, and despite the fact that the CDC has not requested that Congress create such an unprecedented mandate for HIV, H.R. 1062 still calls for mandatory partner notification.

Furthermore, H.R. 1062 mandates reporting of HIV infected people to the State public health officer and the CDC. Not only should HIV reporting remain a state responsibility, but this mandate is a coercive measure which would discourage people at risk for HIV from seeking treatment and testing at a time when we are making impressive breakthroughs in new treatments. This measure would only hurt our efforts to slow HIV transmission, a public health concern. There is no reason for us to isolate and differentiate HIV from other sexually transmitted diseases, nor to stigmatize HIV infected citizens.

The creation of a national partner notification program as would be mandated by H.R. 1062 would also be an unnecessary waste of resources. Furthermore, the Ryan White CARE Act Amendments of 1996 already requires states to administer partner/spousal notification programs as a condition of receiving HIV care funding. The HIV Prevention Act of 1997 would prevent state and local officials from effectively targeting their programs and making decisions to meet the needs of their individual, unique