

proposed an amendment to amendment SA 1542 proposed by Mr. SPECTER to the bill H.R. 2660, making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2004, and for other purposes; as follows:

On page 61, between lines 14 and 15 insert the following:

SEC. ____ From the amounts appropriated under the heading OFFICE OF THE SECRETARY, GENERAL DEPARTMENTAL MANAGEMENT there may be made available an additional \$2,000,000 to the Health Resources and Services Administration for the purchase of automatic external defibrillators and the training of individuals in cardiac life support in rural areas.

SA 1640. Mr. SPECTER submitted an amendment intended to be proposed to amendment SA 1542 proposed by Mr. SPECTER to the bill H.R. 2660, making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2004, and for other purposes; as follows:

On page 61, between lines 14 and 15, insert the following:

"SEC. . Notwithstanding any other provisions of law, funds made available under this heading may be used to continue operating the Council on Graduate Medical Education established by Section 301 of Public Law 102-408."

SA 1641. Mr. SPECTER (for Mr. CHAMBLISS) proposed an amendment to amendment SA 1542 proposed by Mr. SPECTER to the bill H.R. 2660, making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2004, and for other purposes; as follows:

On page 28, line 6, strike "\$250,000,000" and insert "\$260,000,000" in lieu thereof.

On page 28, line 5, insert after "; and" the following: "purchase."

SA 1642. Mr. SPECTER (for Mr. ROBERTS (for himself and Mr. CONRAD)) proposed an amendment to amendment SA 1542 proposed by Mr. SPECTER to the bill H.R. 2660, making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2004, and for other purposes; as follows:

On page 27, line 2, insert before the period the following: " Provided further, That up to \$15,000,000 may be made available to carry out the rural emergency medical service training and equipment assistance program under section 330J of the Public Health Service Act (42 U.S.C. 254c-15)".

SA 1643. Mr. SPECTER proposed an amendment to amendment SA 1542 proposed by Mr. SPECTER to the bill H.R. 2660, making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2004, and for other purposes; as follows:

At the appropriate place in Section 515(a): Increase the amount by \$37,455,000.

SA 1644. Mr. SPECTER (for himself and Mr. BYRD) proposed an amendment to amendment SA 1542 proposed by Mr. SPECTER to the bill H.R. 2660, making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2004, and for other purposes; as follows:

On page 23, between lines 15 and 16, insert the following:

SEC. ____ (a) FINDINGS.—Congress finds that—

(1) it is projected that the Department of Labor, in conjunction with labor, industry, and the National Institute for Occupational Safety and Health, will be undertaking several months of testing on Personal Dust Monitor production prototypes; and

(2) the testing of Personal Dust Monitor prototypes is set to begin (by late May or early June of 2004) following the scheduled delivery of the Personal Dust Monitors in May 2004.

(b) RE-PROPOSAL OF RULE.—Following the successful demonstration of Personal Dust Monitor technology, and if the Secretary of Labor makes a determination that Personal Dust Monitors can be effectively applied in a regulatory scheme, the Secretary of Labor shall re-propose a rule on respirable coal dust which incorporates the use of Personal Dust Monitors, and, if such rule is re-proposed, the Secretary shall comply with the regular procedures applicable to Federal rulemaking.

SA 1645. Mr. HARKIN (for himself and Mr. DASCHLE) proposed an amendment to amendment SA 1542 proposed by Mr. SPECTER to the bill H.R. 2660, making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2004, and for other purposes; as follows:

Add at the appropriate Place:

SECTION 1. DESIGNATION OF SENATOR PAUL D. WELLSTONE NIH MDCRC PROGRAM.

(a) FINDINGS.—Congress finds the following:

(1) On December 18, 2001, Public Law 107-84, otherwise known as the Muscular Dystrophy Community Assistance, Research and Education Amendments of 2001, or the MD CARE Act, was signed into law to provide for research and education with respect to various forms of muscular dystrophy, including Dechenne, Becker, limb girdle, congenital, facio-scapulothoracic, myotonic, oculopharyngeal, distal, and EmeryDreifuss muscular dystrophies.

(2) In response to the MD CARE Act of 2001, in September 2002, NIH announced its intention to direct \$22.5 million over five years to its newly created Muscular Dystrophy Cooperative Research Centers (MDCRC) program.

(3) Senator Paul D. Wellstone was a driving force behind enactment of the MD CARE Act, which led to the establishment of the MDCRC program.

(b) DESIGNATION.—The NIH Muscular Dystrophy Cooperative Research Centers (MDCRC) program shall be known and designated as the "Senator Paul D. Wellstone Muscular Dystrophy Cooperative Research Centers," in honor of Senator Paul D. Wellstone who was deceased on October 25, 2002.

(c) REFERENCES.—Any reference in a law, regulation, document.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON FINANCE

Mr. GREGG. Mr. President, I ask unanimous consent that the Committee on Finance be authorized to meet in open Executive Session during the session on Wednesday, September 10, 2003, at 10 a.m., to consider a substitute to H.R. 4, to reauthorize and improve the program of block grants to States for temporary assistance for needy families, improve access to quality child care and for other purposes; and S. 622, the Family Opportunity Act of 2003.

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

SUBCOMMITTEE ON TERRORISM, TECHNOLOGY, AND HOMELAND SECURITY

Mr. GREGG. Mr. President, I ask unanimous consent that the Committee on the Judiciary Subcommittee on Terrorism, Technology and Homeland Security be authorized to meet to conduct a hearing on "Terrorism: Two Years After 9/11, Connecting the Dots," on Wednesday, September 10, 2003, at 10 a.m., in room 226 of the Dirksen Senate Office Building.

Witness List:

Panel I: Mr. Simon Henderson, Founder Saudi Strategies, London, UK; Mr. Matthew Epstein, Attorney, Terrorism Analyst and Assistant Director of Research for the Investigative Project, Washington, DC; Mr. Nihad Awad, Director, Council on American Islamic Relations; or Mr. Omar Ahmed, Chairman of the Board, Council on American Islamic Relations, Washington, DC.

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

SUBCOMMITTEE ON OVERSIGHT OF GOVERNMENT MANAGEMENT, THE FEDERAL WORKFORCE AND THE DISTRICT OF COLUMBIA

Mr. GREGG. Mr. President, I ask unanimous consent that the Committee on Governmental Affairs Subcommittee on Oversight of Government Management, the Federal Workforce and the District of Columbia be authorized to meet on Wednesday, September 10, 2003 at 9 a.m. for a hearing entitled, "The 2003 Blackouts: The Federal Response."

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

PRIVILEGE OF THE FLOOR

Ms. LANDRIEU. I ask unanimous consent that Kathleen Stottman be granted the privilege of the floor.

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

AIDS

The PRESIDING OFFICER. The Senator from Alabama.

Mr. SESSIONS. Mr. President, I ask unanimous consent to speak for 2 minutes.

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

Mr. SESSIONS. Mr. President, in part of this bill was language that requires the CDC to develop a plan to deal with the medical transmission of AIDS in Africa. The science is coming in clearer and clearer that a substantial portion of the infections in Africa result from transmissions from blood transfusions or the reuse of needles for injections.

In fact, we believe the World Health Organization numbers say that 10 percent are caused by it. That means as many as 300,000 infections in Africa are, in fact, a death sentence caused by unsafe medical practices. We need to end that. We can end that.

We have had two hearings I have conducted. It is a moral crisis. It should not be allowed to continue. Our medical agencies, including Health and Human Services, CDC, and particularly WHO, have been slow to respond. My remarks go into great detail about the science behind this. It has raised the concern of human rights groups as well as health groups. We will continue to proceed. We will be discussing in more depth the need for focus.

By WHO's own number, they can virtually eliminate this problem for less than \$100 million a year. We will be spending \$3 billion a year when the AIDS program in Africa is rolling. We can fund this. We can eliminate this and 300,000 people a year being infected would be stopped. There are even studies that show 670,000 Africans in South Africa from the age of 2 to 14 are now infected by HIV, much of that from unsafe health practices. It is a dilemma for us. We have to act quickly and not delay.

As this Congress takes up the task of funding a landmark global effort to combat HIV/AIDS, it is imperative that lawmakers consider an aspect of this crisis that has consistently not received the prominence it deserves.

I would like to thank Senator SPECTER for his help in bringing this issue to light during our consideration of appropriations for the Departments of Labor and HHS.

While we are all aware of many excellent programs that seek to treat this virus or prevent its transmission, it is widely unrecognized that, even by conservative estimates, each day 1,000 Africans who go to hospitals, clinics, or local doctors seeking treatment come away infected with a deadly disease.

They contract this virus through unsafe injections given with needles and syringes that are often reused again and again, or through contaminated transfusions with blood that is never screened for HIV, hepatitis B, hepatitis C, or other potentially deadly diseases.

In March of this year, the Washington Times reported that Dr. David Gisselquist and his colleague John Potterat had published an article in the International Journal of STD & 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 African HIV/AIDS epidemic.

This article challenged the conventional wisdom in the international public health community that heterosexual contact is the primary route of transmission for HIV in Africa and that medical transmission of the disease did not require its foremost attention.

Dr. Gisselquist pointed to a number of pieces of evidence supporting his conclusion that medical exposures account for a large proportion of HIV transmission.

Dr. Gisselquist conducted an extensive review of refereed journal articles on the epidemiology of the African HIV epidemic. A careful analysis of the data behind these studies enabled him to identify the following trends:

Multiple studies found HIV-infected children whose mothers test negative for the virus. Many of these children are far too young to have contracted HIV through sexual practices or drug use, leaving their infections unexplained by conventional assumptions about the spread of this 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.

International groups involved in large-scale vaccination campaigns have long realized that injection safety is an indispensable element of their work. This realization followed events such as the tremendous epidemic of hepatitis C in Egypt following a nationwide effort to vaccinate against schistosomiasis.

This is still thought to represent "the world's largest iatrogenic transmission event," contributing to an appalling 18 percent prevalence of the deadly hepatitis C virus in the Egyptian population.

Since the recognition that unsafe injections pose an unacceptable risk in vaccination campaigns, international efforts now almost universally include adequate injection safety training and supplies. These limited efforts are commendable but 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 vaccinations and therapeutic injections, or injections given for the purpose of treating infections or other disease processes.

It has been estimated that worldwide, therapeutic injections outnumber vaccinations by about nine to one, 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, leaders in the field of HIV prevention have warned that "little attention has been paid to the systematic correction of widespread unsafe prac-

tices resulting in disease transmission through therapeutic injections."

There are so many tragic aspects of this problem:

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

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

Citizens come to trusted institutions for medical treatment for themselves, or for their children, and are unknowingly infected.

Ironically, these people do not, based on present AIDS prevention education, have any reason to view themselves as high-risk. They have not engaged in unsafe sex or intravenous drug use—they have merely acted responsibly and gone to the doctor.

Subsequently, these victims go home and, again unknowingly, pass HIV or other deadly diseases to their own families—husbands to wives, wives to husbands, mothers to children.

In this manner, this "hidden" source of disease transmission continues to fuel the epidemic, capitalizing on a large blind spot in the current HIV prevention orthodoxy.

At the outset of the AIDS epidemic in the United States, both the U.S. Government and the public declared that the blood supply must be rendered 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.

It is estimated that 25 percent of blood donated in Africa is never tested for HIV and that up to 80 percent is never tested for hepatitis.

It is estimated by the respected group, Safe Blood for Africa, 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.

The World Health Organization estimates that up to 10 percent of new HIV cases in Africa may be due to contaminated blood transfusions.

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

Seventy percent of the recipients of these high-risk transfusions are women and children, making blood safety a crucial component of our larger effort to fight HIV/AIDS in mothers and children.

This figure is linked to the high incidence in Africa of malaria, which frequently causes severe anemia, particularly in children, and of severe postpartum bleeding. It is important to recognize, too, that even in the treatment of anemia related to these common conditions, best medical practices

would dictate that many of these transfusions are unnecessary.

This is just one more example of the potential to decrease the risk to people of deadly infection, as well as the considerable cost of these unnecessary transfusions through educating providers on simple guidelines for transfusion.

This administration, and our respected majority leader, Dr. BILL FRIST, have declared that ending the mother-to-child transmission of HIV is of the utmost importance in the overall global AIDS initiative.

One of the most startling facts about the healthcare transmission 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 published by the WHO in 1999 suggested that addressing the problem of unsafe injections might well result in actual savings for the governments and organizations financing the fight against AIDS. These savings would be generated both by a reduction in the number of unnecessary injections, which, amazingly, may account for a majority of therapeutic injections actually given in the developing world, and by avoiding the tremendous financial drain associated with the averted infections.

In testimony before the HELP committee at a hearing I chaired in July, one of the leading WHO 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 so.

As noted previously, the World Health Organization's Department of Blood Safety and Clinical Technology has, working with a variety of groups, produced a strong body of research on both injection safety and blood safety in Africa.

At my urging, the Department of Health and Human Services has undertaken the task of reviewing all of the available data to better define the true magnitude of health care transmission through unsafe injections. At this very moment, the Research Triangle Institute, the private clinical research organization awarded the contract for this study, is working toward this goal.

The results of this study will be reviewed by an independent panel of experts in the field, and I am pleased to note that we do anxiously await the results of this analysis, which is due to be completed next month.

My eagerness to see action on this problem is fueled by evidence that there have been some real successes on the ground in Africa, in some of the poorest nations in the world:

In Burkina Faso, where in 1995 it was estimated that injection equipment was reused at rates ranging from 20 percent in urban areas to an appalling 90 percent in rural regions, the answer was supply. When adequate disposable

injection equipment was available through community pharmacies, the rate of reuse dropped 92 percent within 5 years.

At the HELP committee hearing I chaired on July 31, 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, well-educated, well-intentioned people and they simply want enough syringes to provide their patients with safe care.

I have been pleased, over the past several months, to have had the opportunity to express my concerns to Randall Tobias, the incoming Global AIDS Coordinator at the State Department, and to Dr. Joe O'Neill, director of the White House Office of National AIDS policy and the new deputy coordinator and chief medical officer in the office of the coordinator.

I hope that these gentlemen came away with a good understanding of the crucial importance of addressing the healthcare transmission of HIV, and I look forward to continuing to work with the administration and other key parties to the global AIDS effort.

One of the greatest disappointments I have encountered in my effort to draw attention and resources to this problem has been the response of the leadership of the World Health Organization.

That being said, groups within the World Health Organization continue to do commendable work in the area of healthcare transmission, including Department of Blood Safety and Clinical Technology, which has made progress in the area of blood safety and, within this department, the Safe Injection Global Network, which is a pioneer in the field of injection safety.

The disconnect between the good work being done by committed people within this organization and the determined resistance of leadership to even acknowledging that this is a substantial problem is really appalling.

The World Health Organization and a number of other major public health entities responded to Dr. Gisselquist's conclusions not as an invitation to reassess their data, but instead mounted a defensive response that consisted of an unyielding insistence on their own, admittedly conservative figures and a campaign to discredit Dr. Gisselquist.

At the very World Health Organization conference where its own researchers were presenting evidence that healthcare transmission is a more substantial problem that prior WHO numbers would suggest, the leadership insisted on releasing a public statement that the organization stands by its own previous numbers—even in light of its

own latest research suggesting otherwise.

At the HELP Committee hearing I chaired on this subject in July, Holly Burkhalter of Physicians for Human Rights joined a host of respected witnesses in testifying that the healthcare transmission of HIV is a problem that must be addressed within the Global AIDS initiative. Ms. Burkhalter and her colleague Dr. Eric Friedman subsequently authored an opinion piece that was run in the Washington Post following the hearing that eloquently reiterated this point.

It was shocking to once again open the paper to find that the World Health Organization again declined to lead on the issue of healthcare transmission, an area in which its own researchers are pioneers. Instead, they opted for a competing opinion piece minimizing the problem and opposing the devotion of any additional resources.

As things stand at present, there is still no comprehensive USAID or administration plan to address the healthcare transmission of HIV. I have not been made aware of any plan to address injection safety at all, outside the context of vaccination programs.

Through appropriations directed to USAID, the Global Fund, and the Department of Health and Human Services, the United States Congress represents the single greatest source of funding for the international effort to combat HIV/AIDS. In this capacity, the Congress must require that these funds are accompanied by a moral commitment to apply resources wisely.

It is clear that doing so requires promptly acknowledging and addressing the issue of the healthcare transmission of HIV.

The CDC, through its Global AIDS Program and a variety of other efforts at home and abroad, has accumulated important experience in the prevention of the healthcare transmission of HIV.

This agency provided leadership in ensuring the safety of the U.S. blood supply during the early days of the HIV epidemic here, contributing to the development of one of the world's finest and safest blood banking systems. The CDC continues to provide expertise and support of a multitude of international efforts to promote blood safety.

In the area of injection safety, the CDC has strongly backed efforts to ensure that every injection given in U.S. hospitals and clinics is a safe injection.

Overseas, the agency has supported groups such as the WHO's Safe Injection Global Network, which has conducted important research on safe injection practices in the developing world and also works to disseminate information essential to the implementation of successful injection safety programs.

At a time when the United States is launching an unprecedented campaign against HIV/AIDS in Africa and the Caribbean, the CDC is thus uniquely

positioned to provide the administration and Congress with important guidance in launching the most effective effort possible to end the healthcare transmission of HIV.

While there are a multitude of programs, many of them CDC-supported, addressing various aspects of the healthcare transmission problem, there has been an ongoing failure to launch a coordinated effort to intervene to change conditions on the ground in the African region.

A hallmark of the President's Global AIDS plan has been a commitment to effective coordination and application of resources. This commitment must be extended to ensuring that we put an end, right now, to the appalling daily toll taken by unsafe injections and contaminated blood transfusions in Africa.

The CDC must again take the lead in moving quickly and energetically to outline a plan to comprehensively address injection safety and blood safety in the African nations included in the Global AIDS initiative.

This plan must reflect our intent to intervene in this problem immediately. It must include an assessment of the status of the health care system and existing programs in these countries,

but it must also move beyond this initial assessment stage to outline the supply and logistical requirements that we will need to understand to move forward with real, on-the-ground interventions.

Experts in the field of injection safety suggest that an effective injection safety program must address not only the provision and distribution of safe injection equipment, preferably nonreusable autodisable syringes, but also national-level planning, the education of providers and the public in the appropriate and safe use of injections, and an appropriate program for waste disposal.

Similarly, a strong blood safety program must not only provide rapid access to accurate test kits, but also staff training, quality assurance, and a national-level program to ensure an effective system of donor selection, blood screening, and appropriate utilization of blood products.

Thankfully, these things have all been done before. Moreover, they have been done before by the Centers for Disease Control. It is time that past lessons be applied to the problem before us today, that of the healthcare transmission of HIV.

While we may eagerly anticipate the CDC's contribution, in the form of a strong plan, to be submitted to Congress within 90 days, the interim must not be marked by inaction.

This issue will be before us again soon, when the Senate considers the Foreign Operations appropriations bill, which includes the bulk of the administration's requested appropriations to fund the global AIDS initiative.

I intend to ensure that at that time, the issue of the healthcare transmission of HIV in Africa is not neglected within the greater war on HIV/AIDS.

We have reached an important historical point in the global AIDS epidemic, a point at which the world's leaders have stepped forward to acknowledge the scope of the problem, and its tragedy.

I would like to offer the caution that this tragedy becomes a travesty when the leaders in the global effort are offered clear evidence that intervention is needed, yet continue to allow death sentences to be handed to 1,000 men, women, and children every day through their inaction.