

Service and the Founder's Trophy for Extraordinary Leadership and Service to the Electrical Industry by the National Electrical Contractors Association, San Diego Chapter.

Jim is currently the Director of Training for San Diego Electrical Training and has been inducted into the California apprenticeship Hall of Fame on May 4, 2006.

James M. Westfall is very deserving of this award as he has been a driving force in the organized labor movement for the past 30 years.

CONGRATULATING MAGEE RIETER AUTOMOTIVE SYSTEMS OF BLOOMSBURG, PENNSYLVANIA ON BEING NAMED SUPPLIER OF THE YEAR TO GENERAL MOTORS FOR THE 14TH CONSECUTIVE YEAR

HON. PAUL E. KANJORSKI

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, September 7, 2006

Mr. KANJORSKI. Mr. Speaker, I rise today to ask you and my esteemed colleagues in the House of Representatives to pay tribute to Magee Rieter Automotive Systems of Bloomsburg, Pennsylvania, on the occasion of their being named worldwide "Supplier of the Year" to General Motors for the 14th consecutive year.

Of GM's 30,000 suppliers, Magee Rieter Automotive Systems is the only company in North America to achieve this remarkable record, a fact that should make its nearly 800 employees exceedingly proud.

Magee Rieter is the leading supplier of carpets to General Motors in America. The company has been in business in Bloomsburg since 1889 and has been supplying General Motors for more than 90 years, first with hand draped tapestries for Fisher Body carriages and, today, with fully molded carpet floors and integrated acoustical systems.

For more than a century, the company has endured and overcome numerous challenges including floods, fires and the rapidly changing business environment. After World War II, the company received the Army/Navy "E" award for excellence in recognition of its production of high quality materials for the war effort.

Magee Rieter records annual sales in excess of \$175 million and has an annual payroll of more than \$37 million that provides its employees with family sustaining incomes that average about \$39,000 annually. Overall, Magee Rieter is responsible for a \$168 million annual impact to the local economy.

The current employees of Magee Rieter are carrying on traditions of pride and success handed down by their parents, grandparents and great grandparents who worked at this remarkable company.

Mr. Speaker, please join me in congratulating Magee Rieter for demonstrating superior performance and for serving as a shining example for other businesses to emulate.

AIDS IN 2006—MOVING TOWARD ONE WORLD, ONE HOPE?

HON. JANICE D. SCHAKOWSKY

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, September 7, 2006

Ms. SCHAKOWSKY. Mr. Speaker, the International AIDS Society meeting in Toronto last month focused the world's attention on ways to deal with the ongoing AIDS pandemic. Global health experts and advocates came together to discuss effective tactics and comprehensive strategies for improved prevention and therapies and, ultimately, a cure. I am particularly glad that the meeting highlighted the need for microbicides development, treatments that will allow vulnerable women to protect themselves and their families from infection.

As we consider the recommendations made in Toronto, I want to draw my colleagues' attention to a recent article, "AIDS in 2006—Moving toward One World, One Hope?," published in the August 17 edition of *The New England Journal of Medicine*. Written by Dr. Paul Farmer and Dr. Jim Yong Kim, leading medical experts with years of front-line experience through their work at Partners in Health, they offer us important lessons that will help translate the optimism expressed in Toronto into the reality of improved global health.

As they point out, an effective approach to the global AIDS epidemic (and to the global TB and malaria epidemics as well) will require strategies that address the global epidemic of poverty and the inequitable distribution of health care resources. Affordable drugs, viable public health systems, access to trained health care personnel, and the provision of nutrition and other "wrap-around" services that make the difference between life and death are all essential components for success. As Partners in Health has proven in Haiti and Rwanda, this comprehensive approach is not a pie-in-the-sky notion. It is completely achievable given a commitment to make and sustain the necessary investments.

The work of nongovernmental organizations like Partners in Health, the Bill and Melinda Gates Foundation and the Clinton Foundations HIV/AIDS Initiative has allowed us to make incredible strides, but they cannot solve these problems alone. As Dr. Farmer and Dr. Kim caution us, "Only the public sector, not nongovernmental organizations, can offer health care as a right." The U.S. government can and must take the lead in expanding our commitment to defeating the twin dangers of global pandemics and global poverty. By doing so, we will not only make the world healthier, we will make it safer.

[From the *New England Journal of Medicine*, Aug. 17, 2006]

AIDS IN 2006—MOVING TOWARD ONE WORLD, ONE HOPE?

(By Jim Yong Kim and Paul Farmer)

For the past two decades, AIDS experts—clinicians, epidemiologists, policymakers, activists, and scientists—have gathered every two years to confer about what is now the world's leading infectious cause of death among young adults. This year, the International AIDS Society is hosting the meeting in Toronto from August 13 through 18. The last time the conference was held in Canada, in 1996, its theme was "One World, One Hope." But it was evident to conferees

from the poorer reaches of the world that the price tag of the era's great hope—combination antiretroviral therapy—rendered it out of their reach. Indeed, some African participants that year made a banner reading "One World, No Hope."

Today, the global picture is quite different. The claims that have been made for the efficacy of antiretroviral therapy have proved to be well founded: in the United States, such therapy has prolonged life by an estimated 13 years—a success rate that would compare favorably with that of almost any treatment for cancer or complications of coronary artery disease. In addition, a number of lessons, with implications for policy and action, have emerged from efforts that are well under way in the developing world. During the past decade, we have gleaned these lessons from our work in setting global AIDS policies at the World Health Organization in Geneva and in implementing integrated programs for AIDS prevention and care in places such as rural Haiti and Rwanda. As vastly different as these places may be, they are part of one world, and we believe that ambitious policy goals, adequate funding, and knowledge about implementation can move us toward the elusive goal of shared hope.

The first lesson is that charging for AIDS prevention and care will pose insurmountable problems for people living in poverty, since there will always be those unable to pay even modest amounts for services or medications, whether generic or branded. Like efforts to battle airborne tuberculosis, such services should be seen as a public good for public health. Policymakers and public health officials, especially in heavily burdened regions, should adopt universal-access plans and waive fees for HIV care. Initially, this approach will require sustained donor contributions, but many African countries have recently set targets for increased national investments in health, a pledge that could render ambitious programs sustainable in the long run.

As local investments increase, the price of AIDS care is decreasing. The development of generic medications means that antiretroviral therapy can now cost less than 50 cents per day, and costs continue to decrease to affordable levels for public health officials in developing countries. All antiretroviral medications—first-line, second-line, and third-line—must be made available at such prices. Manufacturers of generic drugs in China, India, and other developing countries stand ready to provide the full range of drugs. Whether through negotiated agreements or use of the full flexibilities of the Agreement on Trade-Related Aspects of Intellectual Property Rights, full access to all available antiretroviral drugs must quickly become the standard in all countries.

Second, the effective scale-up of pilot projects will require the strengthening and even rebuilding of health care systems, including those charged with delivering primary care. In the past, the lack of a health care infrastructure has been a barrier to antiretroviral therapy; we must now marshal AIDS resources, which are at last considerable, to rebuild public health systems in sub-Saharan Africa and other HIV-burdened regions. These efforts will not weaken efforts to address other problems—malaria and other diseases of poverty, maternal mortality, and insufficient vaccination coverage—if they are planned deliberately with the public sector in mind. Only the public sector, not nongovernmental organizations, can offer health care as a right.

Third, a lack of trained health care personnel, most notably doctors, is invoked as a reason for the failure to treat AIDS in poor