

This issue has had a significant impact on a large portion of the congressional district that I have the honor of representing in the House, which is the Second Congressional District of Florida. It is a largely rural district in Florida's panhandle that encompasses 19 counties and two national forests, the Apalachicola and the Osceola. On May 18, 1999, Hal Summers, Superintendent of Schools in Liberty County, Florida, testified before the House Agriculture Subcommittee on Department Operations, Oversight, Nutrition, and Forestry about the various effects that the loss of timber revenue from the Apalachicola National Forest has had on the children of Liberty County.

Liberty County is a rural county with a population of about 7,000 including 1,300 schoolchildren. That is the smallest county population of schoolchildren in the entire state of Florida. It has a total land area of 525,000 acres, 97% of which is forested, with half of that owned by the U.S. Forest Service within the Apalachicola. Until recently, the forest was the mainstay of a strong local forest product-based economy, and through sharing 25% of the revenue from timber sales, provided substantial support for the local schools and government.

In 1989, the Forest Service began to manage its land in a different way, mostly to protect the habitat for the endangered red-cockaded woodpecker. It is interesting to note that Liberty County has the only recovered population of this bird in the world. Perhaps the most significant thing about these changes is not the decline in harvest, but rather the fact that in 1998 the net annual growth of timber on the Apalachicola National Forest was about 800% greater than the volume harvested. The sawtimber growth is approximately 50 times greater than the volume harvested.

The effects of timber harvest reduction on forest revenues to the 4 counties and schools districts within the Apalachicola is that the 25% payments have declined in value from a 1987-93, 5 year average (in 1998 dollars) of \$1,905,000 to \$220,000 in 1998; a loss of 89%. Due to this reduction, the Liberty County School District was forced to take several painful steps. These steps included reducing school staffing by 11 positions out of a total of 151; increasing the average class size from 23 to 28 students; discontinuing the enrichment programs in health, computer education, and humanities; discontinuing vocational programs in industrial arts, small engine repair, and electronics (80% of the graduates do not attend college); curtailing the school media center; eliminating certified art and music teachers from the elementary school staffs; reducing the Pre-K program, formerly the only program in the state to serve all four-year olds; and terminating a new program in technology acquisition, which would have placed the county on par with other Florida school districts.

The impacts on county government have also been very significant. The County road crew was reduced from 23 to 18 positions. This staff reduction, plus equipment obsolescence and the inability to purchase needed supplies and materials, has resulted in the deterioration of the rural road system. In 1994, the County was forced to float a \$1,780,000 bond issue in order to meet current road

needs. It is unclear how the county will meet its future road responsibilities in the absence of a substantial increase in the 25% payments from timber sale receipts. County employees suffered a 10% salary cut, which was partially restored following the imposition of a 1% local option sales tax and 7 cents per gallon gas tax. Finally, the Sheriff's Office and Emergency Medical Service have been forced to curtail hours and reduce services. As a result of this action, Liberty County remains the only county in Florida without an advanced life support system as part of the county emergency response organization.

However, the most far-reaching and devastating impact of these declining revenues is the adverse effect on the future of our children. An education system crippled by such funding cuts cannot train our young people in the skills needed to join tomorrow's society as contributing, functioning citizens.

In 1993, the Congress enacted a law which provided an alternative annual safety net payment system for 72 counties in the northwest region of the country, where federal timber sales had been restricted or prohibited to protect the northern spotted owl. This authority for the 1993 safety net program will expire in 2003. No comparable protection has been provided for the other 730 counties across the nation which receive forest payments. An equitable system of payments for all forest counties nationwide is needed to protect the ability of these counties to provide quality schools and roads and to allow the federal government to uphold its part of the compact.

It is clear to me that the compact of 1908 is broken and needs to be fixed immediately. That is why I have introduced the County Schools Funding Revitalization Act of 1999. H.R. 2389 contains two main provisions. First, it would restore stability to the 25% payment compact by ensuring a predictable payment level to federal forest communities for an interim 5-year period. This temporary five-year payment program would be based on the average of the three highest payments received by a state in fiscal years from 1985 until this bill is enacted. This is obviously a necessary step to arrest the current destructive downward spiral. Secondly, the bill requires the federal government to collaborate with local community and school representatives as part of the Forest Counties Payment Committee to develop a permanent solution that will fix the 1908 compact for the long term.

There are other options that have been proposed to address this problem, from decoupling forest receipt payments from forest management activities to legislating or mandating timber harvest. My view is that the welfare of schools and county governments cannot be artificially disconnected from the economic stability and social vitality of rural counties. I do not feel that either one of those options is a starter in this Congress. However, I truly believe that the consensus compromise that H.R. 2389 represents is the one possibility that could be passed.

We, the federal government, must fulfill the promise made to these communities in 1908. In the part of the country where I come from, a man's word is his bond. Together, we can fix the compact and restore long-term stability to our rural schools and governments and the families that depend on them.

## AIDS EPIDEMIC IS CRISIS IN SOUTHERN AFRICA

HON. ROSA L. DeLAURO

OF CONNECTICUT

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 1, 1999

Ms. DELAURO. Mr. Speaker, I want to draw the attention of my colleagues to the AIDS epidemic which sub-Saharan Africa faces today. In all, 11.5 million people have died in sub-Saharan Africa since the disease emerged in the 1980's, and 22.5 million people now living with the HIV virus are expected to die in the next ten years. By the end of 1997, at least 7.8 million children in this area of Africa alone were left orphans by the age of 14 due to AIDS.

I am submitting for the RECORD these articles from the May 29th issue of the USA Today, which detail the problem.

[From the USA Today, May 24, 1999]

TIME BOMB SOUTH OF SAHARA—U.S. URGED TO CONFRONT REALITY: 20% COULD DIE

(By Steve Sternberg)

SOWETO, SOUTH AFRICA.—When the AIDS virus detonates in this black township of 3 million in a decade or so, the disease will wipe out about 600,000 souls—almost six times as many people as the atomic bombs killed in Hiroshima and Nagasaki.

But unlike a nuclear blast or world war, the AIDS crisis is an explosion in slow motion, a creeping chain reaction with no end in sight. There is no sound, no searing heat, no mushroom cloud, no buildings reduced to rubble. Just one mute death after another.

Sandra Thurman has come here—to the country where AIDS is spreading faster than in any other on Earth—to break that silence.

Director of President Clinton's Office of National AIDS Policy, Thurman hopes to bring home to the American people and to Clinton the immensity of the crisis in South Africa and the other countries south of the Sahara that form the epicenter of AIDS.

To this end, Thurman and a small team of U.S. officials recently traveled through South Africa and three other countries at the heart of Africa's AIDS epidemic: Zambia, Zimbabwe and Uganda. A USA TODAY reporter and photographer accompanied them to document the ravages of what is now the No. 1 cause of death in Africa.

In all, 11.5 million people have died in sub-Saharan Africa since the epidemic emerged in the early 1980s, and 22.5 million now living with the virus are expected to die in the next 10 years, according to UNAIDS, the United Nations' AIDS agency.

Staggering as the numbers are, Thurman believes that the sub-Saharan epidemic has been met with indifference by Americans and, to some extent, by their government, which spends \$74 million a year on AIDS programs in the region. In contrast, Congress this month voted to spend \$1.1 billion to assist roughly 750,000 Kosovo refugees.

"When you're looking at whole generations of adults and children in jeopardy—we ought to be able to hold hands and sing Kumbaya around that," Thurman says. "We can't do anything if we can't do this."

To gauge the social and political costs of AIDS here, Thurman visited cities and shantytowns, orphanages and hospitals, taking in scenes from an epidemic.

One of Thurman's first stops was at the Javabu clinic, headquarters of the Soweto

Project—an effort to unite medical care, social support and AIDS prevention.

The project is the brainchild of Mark Ottenweller, 10 years ago a prosperous internist in a leafy suburb of Atlanta. Today, at 47, he works in Johannesburg as a medical director of Hope Worldwide, the relief arm of the International Church of Christ.

The clinic is housed in a small cluster of brick buildings on a broad lawn, bordered by the brilliant splashes of jacaranda and bougainvillea. To its beneficiaries, it's a lifeline.

Mary Mudzingwa, 35, mother of Chipo, 9, and Gift, 5, credits the Soweto Project for helping her adapt to life with HIV.

"I lost my job. I lost a place to stay. Now I stay with friends, but there's no toilet, no water. Maybe that's why my 9-year-old is always sick."

She says that one of the most difficult things about having the virus is the way it changes how people respond to you.

"Some people, I told them I am HIV-positive. They were afraid. I said, 'Don't be afraid. We look like other people.'"

Many of the people Mudzingwa was preaching to probably are infected themselves, though they don't know it.

Ninety-five percent of HIV carriers in sub-Saharan Africa have not been tested because tests are in short supply and many people deny they are at risk.

Consider the men Ottenweller comes across a few days later, on an AIDS-prevention foray into the shantytown of Klipstovon, near Soweto. They grow silent as Ottenweller approaches.

"I'm Dr. Mark," he says, half in Zulu, half in English. "How many of you guys wear condoms?"

Quizzical smiles bloom on embarrassed faces. Half the men raise their hands; half seem indifferent. "I never use a condom," one man says defiantly. "I stick to one partner."

"But does she stick to you?" the doctor asks. "Come see me at the clinic when you get sick."

"Ten years from now, one-fifth of these people will be dead," Ottenweller says later. "HIV is going to hit this place like an atom bomb."

Tests of women in prenatal clinics, a group believed to reflect the infection rate in the general population, show that at least one of every five people in South Africa, Zimbabwe, Zambia and Botswana is infected with the AIDS virus.

That means those nations stand to lose at least one-fifth of their populations, a death toll that rivals the Black Plague in Medieval Europe.

In some places, the infection rates are much higher.

In South Africa, between 1991 and 1997, the infection rate on average soared from 2% to almost 18%. And in South Africa's most populous province, KwaZulu-Natal, the rate has reached 37%.

Alan Paton, in the classic 1948 novel *Cry, the Beloved Country*, described the province's rolling green hills as "lovely beyond any singing of it." Those lovely jade hills outside Pietermaritzburg are still there.

But there also stands a massive brick building that is overflowing with human misery beyond any lamenting of it.

The building is a hospital known as Edendale.

During apartheid, it was for blacks only. That soon will change, as part of a massive South African health reform program under way.

For now, the battered wooden benches lined up in corridors and the large anterooms

in the hospital's wards are packed with black people. Some are waiting to deliver babies—8,000 are born here each year, although there is just one obstetrician on the staff.

On average, 20 children are admitted to Edendale each day. More than 60% are infected with the AIDS virus, says pediatrician Johnny Ahrens, and they often are brought in by their grandmothers or aunts because their mothers have died.

The nurses in the pediatric HIV ward, once accustomed to returning children to health, now are so over-whelmed with dying infants that they are on the brink of cynicism.

Many nurses, Ahrens says, are beginning to think: "If there's nothing you can do to help, why bother? It's just one more dying child."

Ahrens himself is furious because he thinks the government should have done something, anything to stop HIV before it took hold.

"We all knew that HIV was going to hit South Africa. It was coming down through Africa like a red tide. People were trying to warn us. But nothing ever happened."

#### ZAMBIA: THE CRADLE OF AFRICA'S ORPHAN CRISIS

LUSAKA, ZAMBIA.—Fountain of Hope resembles nothing so much as a refugee camp for children. And it is nearly that for 1,500 of the 128,000 orphans who live on the streets of this lush capital, with its broad boulevards and spreading trees.

This informal day school in a shabby recreation center downtown was the first stop outside South Africa for Sandra Thurman, the White House's top AIDS official, on a recent fact-finding mission to see the AID's crisis in Africa.

Each morning, the youngest victims of AIDS, ranging in age from 3 to 15, straggle in from the streets. They don't come for the books or the playground or the toys. There aren't any. And there's nothing distinctive about the rec center, built of unadorned concrete.

They come because it's better to be here than in the lonely streets, where food is scarce and companionship often involves sex with an older child. Here volunteers teach reading, arithmetic and music. And there's food—though only every other day.

Zambia once was one of the richest countries in sub-Saharan Africa. It supplied copper for the bullets the United States used during the Vietnam War.

Now this country of 11.5 million is one of the poorest—and bears the distinction of having one of Africa's largest orphan populations. In 1990, Zambia had roughly 20,000 orphans. By next year, says UNAIDS, the United Nations' AIDS organization, there will be 500,000.

"The numbers of orphans are increasing by the day," Zambian President Frederick Chiluba tells Thurman. "Street kids are everywhere, and we don't have the funding to care for them."

And they're not just concentrated in the cities. For example, the shantytowns called St. Anthony's and Mulenga's compounds, in Kitwe near the Congolese border 150 miles from Lusaka, have huge numbers of orphans—about 20% of each town's 10,000 residents.

Eventually, many orphans find their way here to Lusaka.

In 1996, when the Fountain of Hope school started, there were 50 children, outreach coordinator Goodson Mamutende says. Just three years later, 30 times that many attend classes in two shifts. Fountain of Hope staffers estimate that half the children have been

abandoned; the other half have lost parents to HIV.

And with 700 HIV-related deaths each week in Lusaka along—a number so large it has caused weekend traffic jams and day-long waits in the cemeteries—the number of orphans and abandoned children continues to multiply.

Dirty-faced, wearing the cast-off clothes that are their only possessions, the children eagerly cluster around a makeshift blackboard to learn arithmetic and the alphabet. They learn to sing in unison, acting out the songs enthusiastically. "Fight child labor with an AK 47," they shout, thrusting their arms as if they were firing guns.

Nicholas Mwila, 23, who has written the words for many of their songs, is the art director.

"I take them as they are, the way I find them," he says. "I want them to dress as they do on the street. I don't encourage them to take a bath."

These "gutter kids," Mwila says, project a message to Thurman and the visiting foreigners: "The problem is real."

After school, when they return to the streets, the children beg, steal and, in many cases, sell sexual favors for food. At night, they sleep in culverts along a thoroughfare called Cairo Road.

Most prized, especially in winter, are the culverts across from a gas station. On cold nights, volunteers say, the children fight the chill by getting high on gasoline fumes or on methane inhaled from bottled, fermented excrement.

Jack Phiri, 14, traveled 150 miles to Lusaka from Ndola, in the copper belt, where statistics show that 46% of young pregnant women are infected with HIV.

Jack says his mother died in 1996 of tuberculosis—the leading killer of people with AIDS in Africa. He says he doesn't know what killed his father; staffers at Fountain of Hope are convinced the culprit was HIV.

Fiddling with the ragged edges of his cut-off jeans, Jack says he has lived on the streets since 1997. His brother has been taken in by relatives and has vanished from Jack's life. The "auntie" who took Jack refused to feed him and made him sleep outside her hut. So he stowed away aboard a train and ended up here.

The other kids in the street told him about Fountain of Hope.

"I like being here because I can go to the school," he says. "And they give you food."

Asked whether he remembers what it's like to have a family, Jack's eyes flood with tears. "He cries very easily," Fountain of Hope staffer Rogers Mwewa says. "He hasn't developed the survival skills of most of the other kids."

When he grows up, will he have a big family?

"I don't know if I'll live that long," Jack says.

Jack spends most of his nights sleeping near fast-food restaurants on Cairo Road. After dark, children clog the sidewalks, chasing anyone who might be persuaded to part with money for food.

One night recently, staffers from Fountain of Hope and an official from the Dutch Embassy dug into their pockets for money to feed 78 starving children.

Buoyed by the prospect of a meal, the children waited patiently on the sidewalk while an older child counted them. Tomorrow night, they knew, they might not be so lucky.

THE EPICENTER OF AIDS—UGANDA: DEADLY TRADITIONS PERSIST AMID PROGRESS, VACCINE TEST

(By Steve Sternberg)

KAMPALA, UGANDA.—Tom Kityo, the tall, animated manager of the AIDS Service Organization, stands before a map of his country, gesturing to one area after another, railing about the traditions that spread HIV.

"Here," Kityo says, "The groom's father can have sex with the bride, and that's accepted. Here, other clan members may have sex with someone's wife, and no one says anything."

Kityo blames these and other cultural practices for much of Uganda's AIDS problem. It's a situation that, while showing great improvement, still is marking this country with tragic consequences.

A year ago, U.S. officials estimated that 10% of Uganda's 20 million people are HIV-positive—with 67,000 of those infected younger than 15.

Nearly 2 million people have died nationwide since what some call "slim disease" emerged here in 1982, leaving thousands of orphans. Government statistics suggest that 600,000 children have lost one parent—and that 250,000 have lost both parents—to AIDS.

"We are fighting a lot of complex problems," Kityo says. "There are wars, cultural beliefs, a gender imbalance—these are very difficult things to change."

But change is under way in Uganda, which has done more than almost any other country in the world to slow the spread of HIV.

The evidence lies no farther away than a palm-shaded hilltop above the crush of populous Kampala, inside a sprawling white stucco compound enclosed by a tall white wall.

Once it was part of the palace of the Bagandan king, now a largely ceremonial figure whose domain straddles the equator and borders the legendary source of the Nile.

Today it serves a vastly different purpose. Known as the Joint Clinical Research Center, it is the site of the first HIV vaccine trial in Africa.

On Feb. 8, a nurse guided the first hypodermic into a volunteer's arm—the first of 40 in the trial. The man, whose name was withheld to protect his privacy, isn't just anybody.

He is a medical orderly on the staff of Ugandan President Yoweri Museveni, the most outspoken of the world's leaders on the threat posed by HIV.

Museveni's AIDS awakening came in 1986. Some after he seized power from dictator Milton Obote, Museveni get a call from Cuban military authorities who were training Ugandan troops. They told him that 25% of the men had HIV.

For Museveni, fresh from a civil war, the news was alarming. An army hobbled by disease can't fight, and Museveni had yet to consolidate his power. By the end of 1986, he had established the nation's first AIDS Control Program.

Museveni also issued an international call for help from AIDS researchers and public health organizations. And he declared his intention that Uganda play a key role in any African AIDS vaccine trials.

Five years ago, Museveni's prevention efforts began to pay off. Behavior surveys showed that Ugandans were reporting fewer casual sex partners, more frequent condom use and longer delays before young people became sexually active.

More recent studies of pregnant women demonstrate that infection rates have begun to drop. In Kampala, the infection rate among 15- to 19-year-old women fell to 8% in 1997 from 26% in 1992.

But traditional practices still exact a steep toll. Indeed, they cost Justine Namuli her life. Today, in a small family graveyard in a village two hours from Kampala, she will be laid to rest.

Hillary Rodham Clinton met Namuli, then 25, two years ago while visiting Uganda.

During the visit, Clinton planted a tree to commemorate the opening of the AIDS Information Center's headquarters. There, Elizabeth Marum, a former director of the information and HIV testing center, introduced Namuli to Clinton and Ugandan first lady Janet Museveni. "Justine was so beautiful," Marum says. "And so excited to meet Mrs. Clinton."

Clinton and Museveni listened as Namuli told her life story.

In Bagandan tradition, Namuli said, she was "heir to her aunt," meaning she was to take her aunt's place if anything happened to her.

When her aunt died of tuberculosis, Namuli was forced to drop out of school, marry her uncle and care for his children. She was 16.

At the time, she didn't know that her aunt was infected with HIV or that her uncle was infected, too. Eventually, Namuli's husband died, but not before he infected her. She, in turn, unwittingly infected one of her two sons.

Namuli quickly sought an HIV test at the information center. Learning that she was infected, she joined the Post-Test Club, a support group that emphasizes safe sex, good nutrition and "living positively." And she joined the Philly Lutaya Initiative, an AIDS education and prevention program named for a local rock star who acknowledged publicly he was HIV-positive—the Magic Johnson of Uganda. Like others in the group, Namuli spoke out about HIV and how to guard against infection.

"Imagine what this girl has gone through," Marum says. "Her mother died of AIDS. Her aunt died of AIDS. Her husband died of AIDS, and for 10 years she lived with the knowledge that she was HIV-positive."

About a dozen information center staffers and volunteers pile into two four-wheel-drive vehicles for the two-hour drive to Namuli's funeral.

The little caravan drives down the truck route, the TransAfrica Highway, connecting Mombasa, Kenya, and Kinshasa, in the Democratic Republic of the Congo.

The highway, which runs across southern Uganda, has spread AIDS here, too: The truckers carried HIV from one end of the road to the other, stopping regularly for paid sex with women who needed the money to feed themselves or their families. The women infected their boyfriends and husbands, who infected their wives and girlfriends.

Today, the villages along this road are outposts in an AIDS wasteland, peopled almost entirely by grandparents and children. The middle generation lies in village graveyards.

One grandmother, Benedete Nakayima, 70, says she has lost 11 of her 12 children to HIV—six daughters and five sons. She now cares for 35 grandchildren with the help of her surviving daughter.

At the Namuli funeral, Marum reads a letter from the U.S. first lady, wishing Namuli a speedy recovery.

Sandra Thurman, the Clinton administration's top AIDS official, who is visiting here in her last stop in a tour of four sub-Saharan countries assaulted by AIDS, was to have delivered the letter to Namuli's bedside at Mulago Hospital on Feb. 7.

She was too late.

Namuli died of pneumonia two days earlier—because Mulago Hospital lacked a working oxygen compressor that might have helped her through her respiratory crisis.

Her two sons, Moses, 5, and Isaac, 7, have joined the ranks of Uganda's orphans.

"We are going to sing a song of thanks that she died in Christ," says the preacher, wearing a black suit in bold defiance of the searing midday sun. He consults a hymnal that has been translated into Lugandan, the Bagandans' native tongue. He leads almost 100 men, women and children in Jesus, I'm Coming.

Soon, it is Lucy Mugoda's turn to speak.

Mugoda, one of Namuli's co-workers at the information center, wastes no time on platitudes or prayers. She has a message: HIV holds no respect for tradition; it seeks simply to perpetuate itself through any means possible.

Namuli died, Mugoda says, not because she was promiscuous or willfully engaged in risky behavior, but because she accepted her traditional obligations as "heir to an auntie."

"Let her death serve as an example that not all the old traditions are good," Mugoda says.

"This tradition is death."

## HEALTH OF THE AMERICAN PEOPLE

SPEECH OF

### HON. DEBORAH PRYCE

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 30, 1999

Ms. PRYCE of Ohio. Mr. Speaker, I rise today to add my voice to those who seek to raise awareness about the importance of biomedical research to call attention to the invaluable benefits of biomedical research and to the necessity of making a sustained, significant commitment to research efforts at NIH, our nation's premier research institution. I encourage all of my colleagues to join me in supporting a doubling of the National Institute of Health's budget, including the budget of the National Cancer Institute, over five years.

The Federal investment in cancer research makes sense and saves dollars by unlocking the answers to how cancer is best detected, treated, and prevented. These answers will reduce health care costs and save lives. The costs, both human and economic, of cancer in this country are catastrophic. The human costs in terms of lives lost are immeasurable, and the economic costs exceed \$107 billion annually. Our national investment in biomedical research is the key to containing spiraling health care costs, as every \$1 invested in research saves \$13 in health care costs. Yet, the amount we invest in cancer research today is equal to only 2 percent of the health care costs attributable to cancer. And while cancer is a greater threat than ever, only 31 percent of approved cancer research projects receive funding. Our goal should be to quicken the pace of research by funding at least 45 percent of research initiatives. A much more aggressive effort is required to combat cancer and to reduce human suffering and lives lost to the many forms of this devastating disease.

According to a 1994 NIH report, approximately \$4.3 billion is invested in clinical and