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| Shadegg | Tancredo | Weldon (FL) |
| Smith (NE) | Thornberry | |
| Stearns | Tiahrt | |

NOT VOTING—12

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|---|---|---|
| Bishop (UT) | Cannon | LaHood |
| Boehner | Cubin | Ortiz |
| Boswell | Hinojosa | Rush |
| Brown-Waite, Ginny | Hoyer | |
| | Hulshof | |

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members have 2 minutes remaining to cast their votes.

□ 1553

Mr. WELDON of Florida and Mr. HOEKSTRA changed their vote from ''yea'' to ''nay.''

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

## AUTHORIZING THE CLERK TO MAKE CORRECTIONS IN ENGROSSMENT OF H.R. 3999, NATIONAL HIGHWAY BRIDGE RECONSTRUCTION AND INSPECTION ACT OF 2008

Mr. OBERSTAR. Mr. Speaker, I ask unanimous consent that in the engrossment of H.R. 3999, the Clerk be authorized to correct section numbers, punctuation, cross-references, and to make such other technical and conforming changes as may be necessary to accurately reflect the actions of the House.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Minnesota?

There was no objection.

## TOM LANTOS AND HENRY J. HYDE UNITED STATES GLOBAL LEADERSHIP AGAINST HIV/AIDS, TUBERCULOSIS, AND MALARIA REAUTHORIZATION ACT OF 2008

Mr. BERMAN. Mr. Speaker, pursuant to House Resolution 1362, I call from the Speaker's table the bill (H.R. 5501) to authorize appropriations for fiscal years 2009 through 2013 to provide assistance to foreign countries to combat HIV/AIDS, tuberculosis, and malaria, and for other purposes, with a Senate amendment thereto, and ask for its immediate consideration in the House.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The Clerk will designate the Senate amendment.

The text of the Senate amendment is as follows:

Senate amendment:

Strike all after the enacting clause and insert the following:

**SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

(a) SHORT TITLE.—This Act may be cited as the ''Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:



***SEC. 2. FINDINGS.***

*Section 2 of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7601) is amended by adding at the end the following:*

*''(29) On May 27, 2003, the President signed this Act into law, launching the largest international public health program of its kind ever created.*

*''(30) Between 2003 and 2008, the United States, through the President's Emergency Plan for AIDS Relief (PEPFAR) and in conjunction with other bilateral programs and the multilateral Global Fund has helped to—*

*''(A) provide antiretroviral therapy for over 1,900,000 people;*

*''(B) ensure that over 150,000 infants, most of whom would have likely been infected with HIV during pregnancy or childbirth, were not infected; and*

*''(C) provide palliative care and HIV prevention assistance to millions of other people.*

*''(31) While United States leadership in the battles against HIV/AIDS, tuberculosis, and malaria has had an enormous impact, these diseases continue to take a terrible toll on the human race.*

*''(32) According to the 2007 AIDS Epidemic Update of the Joint United Nations Programme on HIV/AIDS (UNAIDS)—*

*''(A) an estimated 2,100,000 people died of AIDS-related causes in 2007; and*

*''(B) an estimated 2,500,000 people were newly infected with HIV during that year.*

*''(33) According to the World Health Organization, malaria kills more than 1,000,000 people per year, 70 percent of whom are children under 5 years of age.*

*''(34) According to the World Health Organization, ⅓ of the world's population is infected with the tuberculosis bacterium, and tuberculosis is 1 of the greatest infectious causes of death of adults worldwide, killing 1,600,000 people per year.*

*''(35) Efforts to promote abstinence, fidelity, the correct and consistent use of condoms, the delay of sexual debut, and the reduction of concurrent sexual partners represent important elements of strategies to prevent the transmission of HIV/AIDS.*

*''(36) According to UNAIDS—*

*''(A) women and girls make up nearly 60 percent of persons in sub-Saharan Africa who are HIV positive;*

*''(B) women and girls are more biologically, economically, and socially vulnerable to HIV infection; and*

*''(C) gender issues are critical components in the effort to prevent HIV/AIDS and to care for those affected by the disease.*

*''(37) Children who have lost a parent to HIV/AIDS, who are otherwise directly affected by the disease, or who live in areas of high HIV prevalence may be vulnerable to the disease or its socioeconomic effects.*

*''(38) Lack of health capacity, including insufficient personnel and inadequate infrastructure, in sub-Saharan Africa and other regions of the world is a critical barrier that limits the effectiveness of efforts to combat HIV/AIDS, tuberculosis, and malaria, and to achieve other global health goals.*

*''(39) On March 30, 2007, the Institute of Medicine of the National Academies released a report entitled 'PEPFAR Implementation: Progress and Promise', which found that budget allocations setting percentage levels for spending on prevention, care, and treatment and for certain subsets of activities within the prevention category—*

*''(A) have 'adversely affected implementation of the U.S. Global AIDS Initiative';*

*''(B) have inhibited comprehensive, integrated, evidence based approaches;*

*''(C) 'have been counterproductive';*

*''(D) 'may have been helpful initially in ensuring a balance of attention to activities within the 4 categories of prevention, treatment, care, and orphans and vulnerable children';*

*''(E) 'have also limited PEPFAR's ability to tailor its activities in each country to the local epidemic and to coordinate with the level of activities in the countries' national plans'; and*

*''(F) should be removed by Congress and replaced with more appropriate mechanisms that—*

*''(i) 'ensure accountability for results from Country Teams to the U.S. Global AIDS Coordinator and to Congress'; and*

*''(ii) 'ensure that spending is directly linked to and commensurate with necessary efforts to achieve both country and overall performance targets for prevention, treatment, care, and orphans and vulnerable children'.*

*''(40) The United States Government has endorsed the principles of harmonization in coordinating efforts to combat HIV/AIDS commonly referred to as the 'Three Ones', which includes—*

*''(A) 1 agreed HIV/AIDS action framework that provides the basis for coordination of the work of all partners;*

*''(B) 1 national HIV/AIDS coordinating authority, with a broadbased multisectoral mandate; and*

*''(C) 1 agreed HIV/AIDS country-level monitoring and evaluating system.*

*''(41) In the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, of April 26–27, 2001 (referred to in this Act*

*as the 'Abuja Declaration'), the Heads of State and Government of the Organization of African Unity (OAU)—*

*''(A) declared that they would 'place the fight against HIV/AIDS at the forefront and as the highest priority issue in our respective national development plans';*

*''(B) committed 'TO TAKE PERSONAL RESPONSIBILITY AND PROVIDE LEADERSHIP for the activities of the National AIDS Commissions/Councils';*

*''(C) resolved 'to lead from the front the battle against HIV/AIDS, Tuberculosis and Other Related Infectious Diseases by personally ensuring that such bodies were properly convened in mobilizing our societies as a whole and providing focus for unified national policymaking and programme implementation, ensuring coordination of all sectors at all levels with a gender perspective and respect for human rights, particularly to ensure equal rights for people living with HIV/AIDS'; and*

*''(D) pledged 'to set a target of allocating at least 15% of our annual budget to the improvement of the health sector'.''.*

***SEC. 3. DEFINITIONS.***

*Section 3 of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7602) is amended—*

*(1) in paragraph (2), by striking ''Committee on International Relations'' and inserting ''Committee on Foreign Affairs of the House of Representatives, the Committee on Appropriations of the Senate, and the Committee on Appropriations'';*

*(2) by redesignating paragraph (6) as paragraph (12);*

*(3) by redesignating paragraphs (3) through (5), as paragraphs (4) through (6), respectively;*

*(4) by inserting after paragraph (2) the following:*

*''(3) GLOBAL AIDS COORDINATOR.—The term 'Global AIDS Coordinator' means the Coordinator of United States Government Activities to Combat HIV/AIDS Globally.''; and*

*(5) by inserting after paragraph (6), as redesignated, the following:*

*''(7) IMPACT EVALUATION RESEARCH.—The term 'impact evaluation research' means the application of research methods and statistical analysis to measure the extent to which change in a population-based outcome can be attributed to program intervention instead of other environmental factors.*

*''(8) OPERATIONS RESEARCH.—The term 'operations research' means the application of social science research methods, statistical analysis, and other appropriate scientific methods to judge, compare, and improve policies and program outcomes, from the earliest stages of defining and designing programs through their development and implementation, with the objective of the rapid dissemination of conclusions and concrete impact on programming.*

*''(9) PARAPROFESSIONAL.—The term 'paraprofessional' means an individual who is trained and employed as a health agent for the provision of basic assistance in the identification, prevention, or treatment of illness or disability.*

*''(10) PARTNER GOVERNMENT.—The term 'partner government' means a government with which the United States is working to provide assistance to combat HIV/AIDS, tuberculosis, or malaria on behalf of people living within the jurisdiction of such government.*

*''(11) PROGRAM MONITORING.—The term 'program monitoring' means the collection, analysis, and use of routine program data to determine—*

*''(A) how well a program is carried out; and*

*''(B) how much the program costs.''.*

***SEC. 4. PURPOSE.***

*Section 4 of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7603) is amended to read as follows:*

***''SEC. 4. PURPOSE.***

*''The purpose of this Act is to strengthen and enhance United States leadership and the effectiveness of the United States response to the HIV/AIDS, tuberculosis, and malaria pandemics and other related and preventable infectious diseases as part of the overall United States health and development agenda by—*

*''(1) establishing comprehensive, coordinated, and integrated 5-year, global strategies to combat HIV/AIDS, tuberculosis, and malaria by—*

*''(A) building on progress and successes to date;*

*''(B) improving harmonization of United States efforts with national strategies of partner governments and other public and private entities; and*

*''(C) emphasizing capacity building initiatives in order to promote a transition toward greater sustainability through the support of country-driven efforts;*

*''(2) providing increased resources for bilateral and multilateral efforts to fight HIV/AIDS, tuberculosis, and malaria as integrated components of United States development assistance;*

*''(3) intensifying efforts to—*

*''(A) prevent HIV infection;*

*''(B) ensure the continued support for, and expanded access to, treatment and care programs;*

*''(C) enhance the effectiveness of prevention, treatment, and care programs; and*

*''(D) address the particular vulnerabilities of girls and women;*

*''(4) encouraging the expansion of private sector efforts and expanding public-private sector partnerships to combat HIV/AIDS, tuberculosis, and malaria;*

*''(5) reinforcing efforts to—*

*''(A) develop safe and effective vaccines, microbicides, and other prevention and treatment technologies; and*

*''(B) improve diagnostics capabilities for HIV/AIDS, tuberculosis, and malaria; and*

*''(6) helping partner countries to—*

*''(A) strengthen health systems;*

*''(B) expand health workforce; and*

*''(C) address infrastructural weaknesses.''.*

***SEC. 5. AUTHORITY TO CONSOLIDATE AND COMBINE REPORTS.***

*Section 5 of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7604) is amended by inserting '', with the exception of the 5-year strategy'' before the period at the end.*

***TITLE I—POLICY PLANNING AND COORDINATION***

***SEC. 101. DEVELOPMENT OF AN UPDATED, COMPREHENSIVE, 5-YEAR, GLOBAL STRATEGY.***

*(a) STRATEGY.—Section 101(a) of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7611(a)) is amended to read as follows:*

*''(a) STRATEGY.—The President shall establish a comprehensive, integrated, 5-year strategy to expand and improve efforts to combat global HIV/AIDS. This strategy shall—*

*''(1) further strengthen the capability of the United States to be an effective leader of the international campaign against this disease and strengthen the capacities of nations experiencing HIV/AIDS epidemics to combat this disease;*

*''(2) maintain sufficient flexibility and remain responsive to—*

*''(A) changes in the epidemic;*

*''(B) challenges facing partner countries in developing and implementing an effective national response; and*

*''(C) evidence-based improvements and innovations in the prevention, care, and treatment of HIV/AIDS;*

*''(3) situate United States efforts to combat HIV/AIDS, tuberculosis, and malaria within the broader United States global health and development agenda, establishing a roadmap to link investments in specific disease programs to the broader goals of strengthening health systems and infrastructure and to integrate and coordinate HIV/AIDS, tuberculosis, or malaria programs with other health or development programs, as appropriate;*

*''(4) provide a plan to—*

*''(A) prevent 12,000,000 new HIV infections worldwide;*

*''(B) support—*

*''(i) the increase in the number of individuals with HIV/AIDS receiving antiretroviral treatment above the goal established under section 402(a)(3) and increased pursuant to paragraphs (1) through (3) of section 403(d); and*

*''(ii) additional treatment through coordinated multilateral efforts;*

*''(C) support care for 12,000,000 individuals infected with or affected by HIV/AIDS, including 5,000,000 orphans and vulnerable children affected by HIV/AIDS, with an emphasis on promoting a comprehensive, coordinated system of services to be integrated throughout the continuum of care;*

*''(D) help partner countries in the effort to achieve goals of 80 percent access to counseling, testing, and treatment to prevent the transmission of HIV from mother to child, emphasizing a continuum of care model;*

*''(E) help partner countries to provide care and treatment services to children with HIV in proportion to their percentage within the HIV-infected population in each country;*

*''(F) promote preservice training for health professionals designed to strengthen the capacity of institutions to develop and implement policies for training health workers to combat HIV/AIDS, tuberculosis, and malaria;*

*''(G) equip teachers with skills needed for HIV/AIDS prevention and support for persons with, or affected by, HIV/AIDS;*

*''(H) provide and share best practices for combating HIV/AIDS with health professionals;*

*''(I) promote pediatric HIV/AIDS training for physicians, nurses, and other health care workers, through public-private partnerships if possible, including through the designation, if appropriate, of centers of excellence for training in pediatric HIV/AIDS prevention, care, and treatment in partner countries; and*

*''(J) help partner countries to train and support retention of health care professionals and paraprofessionals, with the target of training and retaining at least 140,000 new health care professionals and paraprofessionals with an emphasis on training and in country deployment of critically needed doctors and nurses and to strengthen capacities in developing countries, especially in sub-Saharan Africa, to deliver primary health care with the objective of helping countries achieve staffing levels of at least 2.3 doctors, nurses, and midwives per 1,000 population, as called for by the World Health Organization;*

*''(5) include multisectoral approaches and specific strategies to treat individuals infected with HIV/AIDS and to prevent the further transmission of HIV infections, with a particular focus on the needs of families with children (including the prevention of mother-to-child transmission), women, young people, orphans, and vulnerable children;*

*''(6) establish a timetable with annual global treatment targets with country-level benchmarks for antiretroviral treatment;*

*''(7) expand the integration of timely and relevant research within the prevention, care, and treatment of HIV/AIDS;*

*''(8) include a plan for program monitoring, operations research, and impact evaluation and for the dissemination of a best practices report to highlight findings;*

*''(9) support the in-country or intra-regional training, preferably through public-private partnerships, of scientific investigators, managers, and other staff who are capable of promoting the systematic uptake of clinical research findings and other evidence-based interventions into routine practice, with the goal of improving the quality, effectiveness, and local leadership of HIV/AIDS health care;*

''(10) expand and accelerate research on and development of HIV/AIDS prevention methods for women, including enhancing inter-agency collaboration, staffing, and organizational infrastructure dedicated to microbicide research;

''(11) provide for consultation with local leaders and officials to develop prevention strategies and programs that are tailored to the unique needs of each country and community and targeted particularly toward those most at risk of acquiring HIV infection;

''(12) make the reduction of HIV/AIDS behavioral risks a priority of all prevention efforts by—

''(A) promoting abstinence from sexual activity and encouraging monogamy and faithfulness;

''(B) encouraging the correct and consistent use of male and female condoms and increasing the availability of, and access to, these commodities;

''(C) promoting the delay of sexual debut and the reduction of multiple concurrent sexual partners;

''(D) promoting education for discordant couples (where an individual is infected with HIV and the other individual is uninfected or whose status is unknown) about safer sex practices;

''(E) promoting voluntary counseling and testing, addiction therapy, and other prevention and treatment tools for illicit injection drug users and other substance abusers;

''(F) educating men and boys about the risks of procuring sex commercially and about the need to end violent behavior toward women and girls;

''(G) supporting partner country and community efforts to identify and address social, economic, or cultural factors, such as migration, urbanization, conflict, gender-based violence, lack of empowerment for women, and transportation patterns, which directly contribute to the transmission of HIV;

''(H) supporting comprehensive programs to promote alternative livelihoods, safety, and social reintegration strategies for commercial sex workers and their families;

''(I) promoting cooperation with law enforcement to prosecute offenders of trafficking, rape, and sexual assault crimes with the goal of eliminating such crimes; and

''(J) working to eliminate rape, gender-based violence, sexual assault, and the sexual exploitation of women and children;

''(13) include programs to reduce the transmission of HIV, particularly addressing the heightened vulnerabilities of women and girls to HIV in many countries; and

''(14) support other important means of preventing or reducing the transmission of HIV, including—

''(A) medical male circumcision;

''(B) the maintenance of a safe blood supply;

''(C) promoting universal precautions in formal and informal health care settings;

''(D) educating the public to recognize and to avoid risks to contract HIV through blood exposures during formal and informal health care and cosmetic services;

''(E) investigating suspected nosocomial infections to identify and stop further nosocomial transmission; and

''(F) other mechanisms to reduce the transmission of HIV;

''(15) increase support for prevention of mother-to-child transmission;

''(16) build capacity within the public health sector of developing countries by improving health systems and public health infrastructure and developing indicators to measure changes in broader public health sector capabilities;

''(17) increase the coordination of HIV/AIDS programs with development programs;

''(18) provide a framework for expanding or developing existing or new country or regional programs, including—

''(A) drafting compacts or other agreements, as appropriate;

''(B) establishing criteria and objectives for such compacts and agreements; and

''(C) promoting sustainability;

''(19) provide a plan for national and regional priorities for resource distribution and a global investment plan by region;

''(20) provide a plan to address the immediate and ongoing needs of women and girls, which—

''(A) addresses the vulnerabilities that contribute to their elevated risk of infection;

''(B) includes specific goals and targets to address these factors;

''(C) provides clear guidance to field missions to integrate gender across prevention, care, and treatment programs;

''(D) sets forth gender-specific indicators to monitor progress on outcomes and impacts of gender programs;

''(E) supports efforts in countries in which women or orphans lack inheritance rights and other fundamental protections to promote the passage, implementation, and enforcement of such laws;

''(F) supports life skills training, especially among women and girls, with the goal of reducing vulnerabilities to HIV/AIDS;

''(G) addresses and prevents gender-based violence; and

''(H) addresses the posttraumatic and psychosocial consequences and provides postexposure prophylaxis protecting against HIV infection to victims of gender-based violence and rape;

''(21) provide a plan to—

''(A) determine the local factors that may put men and boys at elevated risk of contracting or transmitting HIV;

''(B) address male norms and behaviors to reduce these risks, including by reducing alcohol abuse;

''(C) promote responsible male behavior; and

''(D) promote male participation and leadership at the community level in efforts to promote HIV prevention, reduce stigma, promote participation in voluntary counseling and testing, and provide care, treatment, and support for persons with HIV/AIDS;

''(22) provide a plan to address the vulnerabilities and needs of orphans and children who are vulnerable to, or affected by, HIV/AIDS;

''(23) encourage partner countries to develop health care curricula and promote access to training tailored to individuals receiving services through, or exiting from, existing programs geared to orphans and vulnerable children;

''(24) provide a framework to work with international actors and partner countries toward universal access to HIV/AIDS prevention, treatment, and care programs, recognizing that prevention is of particular importance;

''(25) enhance the coordination of United States bilateral efforts to combat global HIV/AIDS with other major public and private entities;

''(26) enhance the attention given to the national strategic HIV/AIDS plans of countries receiving United States assistance by—

''(A) reviewing the planning and programmatic decisions associated with that assistance; and

''(B) helping to strengthen such national strategies, if necessary;

''(27) support activities described in the Global Plan to Stop TB, including—

''(A) expanding and enhancing the coverage of the Directly Observed Treatment Short-course (DOTS) in order to treat individuals infected with tuberculosis and HIV, including multi-drug resistant or extensively drug resistant tuberculosis; and

''(B) improving coordination and integration of HIV/AIDS and tuberculosis programming;

''(28) ensure coordination between the Global AIDS Coordinator and the Malaria Coordinator and address issues of comorbidity between HIV/AIDS and malaria; and

''(29) include a longer term estimate of the projected resource needs, progress toward greater sustainability and country ownership of HIV/AIDS programs, and the anticipated role of the United States in the global effort to combat HIV/AIDS during the 10-year period beginning on October 1, 2013.''.

(b) REPORT.—Section 101(b) of such Act (22 U.S.C. 7611(b)) is amended to read as follows:

''(b) REPORT.—

''(1) IN GENERAL.—Not later than October 1, 2009, the President shall submit a report to the appropriate congressional committees that sets forth the strategy described in subsection (a).

''(2) CONTENTS.—The report required under paragraph (1) shall include a discussion of the following elements:

''(A) The purpose, scope, methodology, and general and specific objectives of the strategy.

''(B) The problems, risks, and threats to the successful pursuit of the strategy.

''(C) The desired goals, objectives, activities, and outcome-related performance measures of the strategy.

''(D) A description of future costs and resources needed to carry out the strategy.

''(E) A delineation of United States Government roles, responsibility, and coordination mechanisms of the strategy.

''(F) A description of the strategy—

''(i) to promote harmonization of United States assistance with that of other international, national, and private actors as elucidated in the 'Three Ones'; and

''(ii) to address existing challenges in harmonization and alignment.

''(G) A description of the manner in which the strategy will—

''(i) further the development and implementation of the national multisectoral strategic HIV/AIDS frameworks of partner governments; and

''(ii) enhance the centrality, effectiveness, and sustainability of those national plans.

''(H) A description of how the strategy will seek to achieve the specific targets described in subsection (a) and other targets, as appropriate.

''(I) A description of, and rationale for, the timetable for annual global treatment targets with country-level estimates of numbers of persons in need of antiretroviral treatment, country-level benchmarks for United States support for assistance for antiretroviral treatment, and numbers of persons enrolled in antiretroviral treatment programs receiving United States support. If global benchmarks are not achieved within the reporting period, the report shall include a description of steps being taken to ensure that global benchmarks will be achieved and a detailed breakdown and justification of spending priorities in countries in which benchmarks are not being met, including a description of other donor or national support for antiretroviral treatment in the country, if appropriate.

''(J) A description of how operations research is addressed in the strategy and how such research can most effectively be integrated into care, treatment, and prevention activities in order to—

''(i) improve program quality and efficiency;

''(ii) ascertain cost effectiveness;

''(iii) ensure transparency and accountability;

''(iv) assess population-based impact;

''(v) disseminate findings and best practices; and

''(vi) optimize delivery of services.

''(K) An analysis of United States-assisted strategies to prevent the transmission of HIV/AIDS, including methodologies to promote abstinence, monogamy, faithfulness, the correct and consistent use of male and female condoms, reductions in concurrent sexual partners, and delay of sexual debut, and of intended monitoring and evaluation approaches to measure the effectiveness of prevention programs and ensure that they are targeted to appropriate audiences.

''(L) Within the analysis required under subparagraph (K), an examination of additional planned means of preventing the transmission of

*HIV including medical male circumcision, maintenance of a safe blood supply, public education about risks to acquire HIV infection from blood exposures, promotion of universal precautions, investigation of suspected nosocomial infections and other tools.*

*''(M) A description of efforts to assist partner country and community to identify and address social, economic, or cultural factors, such as migration, urbanization, conflict, gender-based violence, lack of empowerment for women, and transportation patterns, which directly contribute to the transmission of HIV.*

*''(N) A description of the specific targets, goals, and strategies developed to address the needs and vulnerabilities of women and girls to HIV/AIDS, including—*

*''(i) activities directed toward men and boys;*

*''(ii) activities to enhance educational, microfinance, and livelihood opportunities for women and girls;*

*''(iii) activities to promote and protect the legal empowerment of women, girls, and orphans and vulnerable children;*

*''(iv) programs targeted toward gender-based violence and sexual coercion;*

*''(v) strategies to meet the particular needs of adolescents;*

*''(vi) assistance for victims of rape, sexual abuse, assault, exploitation, and trafficking; and*

*''(vii) programs to prevent alcohol abuse.*

*''(O) A description of strategies to address male norms and behaviors that contribute to the transmission of HIV, to promote responsible male behavior, and to promote male participation and leadership in HIV/AIDS prevention, care, treatment, and voluntary counseling and testing.*

*''(P) A description of strategies—*

*''(i) to address the needs of orphans and vulnerable children, including an analysis of—*

*''(I) factors contributing to children's vulnerability to HIV/AIDS; and*

*''(II) vulnerabilities caused by the impact of HIV/AIDS on children and their families; and*

*''(ii) in areas of higher HIV/AIDS prevalence, to promote a community-based approach to vulnerability, maximizing community input into determining which children participate.*

*''(Q) A description of capacity-building efforts undertaken by countries themselves, including adherents of the Abuja Declaration and an assessment of the impact of International Monetary Fund macroeconomic and fiscal policies on national and donor investments in health.*

*''(R) A description of the strategy to—*

*''(i) strengthen capacity building within the public health sector;*

*''(ii) improve health care in those countries;*

*''(iii) help countries to develop and implement national health workforce strategies;*

*''(iv) strive to achieve goals in training, retaining, and effectively deploying health staff;*

*''(v) promote the use of codes of conduct for ethical recruiting practices for health care workers; and*

*''(vi) increase the sustainability of health programs.*

*''(S) A description of the criteria for selection, objectives, methodology, and structure of compacts or other framework agreements with countries or regional organizations, including—*

*''(i) the role of civil society;*

*''(ii) the degree of transparency;*

*''(iii) benchmarks for success of such compacts or agreements; and*

*''(iv) the relationship between such compacts or agreements and the national HIV/AIDS and public health strategies and commitments of partner countries.*

*''(T) A strategy to better coordinate HIV/AIDS assistance with nutrition and food assistance programs.*

*''(U) A description of transnational or regional initiatives to combat regionalized epidemics in highly affected areas such as the Caribbean.*

*''(V) A description of planned resource distribution and global investment by region.*

*''(W) A description of coordination efforts in order to better implement the Stop TB Strategy and to address the problem of coinfection of HIV/AIDS and tuberculosis and of projected challenges or barriers to successful implementation.*

*''(X) A description of coordination efforts to address malaria and comorbidity with malaria and HIV/AIDS.''.*

*(c) STUDY.—Section 101(c) of such Act (22 U.S.C. 7611(c)) is amended to read as follows:*

*''(c) STUDY OF PROGRESS TOWARD ACHIEVEMENT OF POLICY OBJECTIVES.—*

*''(1) DESIGN AND BUDGET PLAN FOR DATA EVALUATION.—The Global AIDS Coordinator shall enter into a contract with the Institute of Medicine of the National Academies that provides that not later than 18 months after the date of the enactment of the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008, the Institute, in consultation with the Global AIDS Coordinator and other relevant parties representing the public and private sector, shall provide the Global AIDS Coordinator with a design plan and budget for the evaluation and collection of baseline and subsequent data to address the elements set forth in paragraph (2)(B). The Global AIDS Coordinator shall submit the budget and design plan to the appropriate congressional committees.*

*''(2) STUDY.—*

*''(A) IN GENERAL.—Not later than 4 years after the date of the enactment of the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008, the Institute of Medicine of the National Academies shall publish a study that includes—*

*''(i) an assessment of the performance of United States-assisted global HIV/AIDS programs; and*

*''(ii) an evaluation of the impact on health of prevention, treatment, and care efforts that are supported by United States funding, including multilateral and bilateral programs involving joint operations.*

*''(B) CONTENT.—The study conducted under this paragraph shall include—*

*''(i) an assessment of progress toward prevention, treatment, and care targets;*

*''(ii) an assessment of the effects on health systems, including on the financing and management of health systems and the quality of service delivery and staffing;*

*''(iii) an assessment of efforts to address gender-specific aspects of HIV/AIDS, including gender related constraints to accessing services and addressing underlying social and economic vulnerabilities of women and men;*

*''(iv) an evaluation of the impact of treatment and care programs on 5-year survival rates, drug adherence, and the emergence of drug resistance;*

*''(v) an evaluation of the impact of prevention programs on HIV incidence in relevant population groups;*

*''(vi) an evaluation of the impact on child health and welfare of interventions authorized under this Act on behalf of orphans and vulnerable children;*

*''(vii) an evaluation of the impact of programs and activities authorized in this Act on child mortality; and*

*''(viii) recommendations for improving the programs referred to in subparagraph (A)(i).*

*''(C) METHODOLOGIES.—Assessments and impact evaluations conducted under the study shall utilize sound statistical methods and techniques for the behavioral sciences, including random assignment methodologies as feasible. Qualitative data on process variables should be used for assessments and impact evaluations, wherever possible.*

*''(3) CONTRACT AUTHORITY.—The Institute of Medicine may enter into contracts or cooperative agreements or award grants to conduct the study under paragraph (2).*

*''(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out the study under this subsection.''.*

*(d) REPORT.—Section 101 of such Act, as amended by this section, is further amended by adding at the end the following:*

*''(d) COMPTROLLER GENERAL REPORT.—*

*''(1) REPORT REQUIRED.—Not later than 3 years after the date of the enactment of the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008, the Comptroller General of the United States shall submit a report on the global HIV/AIDS programs of the United States to the appropriate congressional committees.*

*''(2) CONTENTS.—The report required under paragraph (1) shall include—*

*''(A) a description and assessment of the monitoring and evaluation practices and policies in place for these programs;*

*''(B) an assessment of coordination within Federal agencies involved in these programs, examining both internal coordination within these programs and integration with the larger global health and development agenda of the United States;*

*''(C) an assessment of procurement policies and practices within these programs;*

*''(D) an assessment of harmonization with national government HIV/AIDS and public health strategies as well as other international efforts;*

*''(E) an assessment of the impact of global HIV/AIDS funding and programs on other United States global health programming; and*

*''(F) recommendations for improving the global HIV/AIDS programs of the United States.*

*''(e) BEST PRACTICES REPORT.—*

*''(1) IN GENERAL.—Not later than 1 year after the date of the enactment of the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008, and annually thereafter, the Global AIDS Coordinator shall publish a best practices report that highlights the programs receiving financial assistance from the United States that have the potential for replication or adaption, particularly at a low cost, across global AIDS programs, including those that focus on both generalized and localized epidemics.*

*''(2) DISSEMINATION OF FINDINGS.—*

*''(A) PUBLICATION ON INTERNET WEBSITE.—The Global AIDS Coordinator shall disseminate the full findings of the annual best practices report on the Internet website of the Office of the Global AIDS Coordinator.*

*''(B) DISSEMINATION GUIDANCE.—The Global AIDS Coordinator shall develop guidance to ensure timely submission and dissemination of significant information regarding best practices with respect to global AIDS programs.*

*''(f) INSPECTORS GENERAL.—*

*''(1) OVERSIGHT PLAN.—*

*''(A) DEVELOPMENT.—The Inspectors General of the Department of State and Broadcasting Board of Governors, the Department of Health and Human Services, and the United States Agency for International Development shall jointly develop 5 coordinated annual plans for oversight activity in each of the fiscal years 2009 through 2013, with regard to the programs authorized under this Act and sections 104A, 104B, and 104C of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b–2, 2151b–3, and 2151b–4).*

*''(B) CONTENTS.—The plans developed under subparagraph (A) shall include a schedule for financial audits, inspections, and performance reviews, as appropriate.*

*''(C) DEADLINE.—*

*''(i) INITIAL PLAN.—The first plan developed under subparagraph (A) shall be completed not later than the later of—*

*''(I) September 1, 2008; or*

*''(II) 60 days after the date of the enactment of the Tom Lantos and Henry J. Hyde United*

States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008.

''(ii) SUBSEQUENT PLANS.—Each of the last four plans developed under subparagraph (A) shall be completed not later than 30 days before each of the fiscal years 2010 through 2013, respectively.

''(2) COORDINATION.—In order to avoid duplication and maximize efficiency, the Inspectors General described in paragraph (1) shall coordinate their activities with—

''(A) the Government Accountability Office; and

''(B) the Inspectors General of the Department of Commerce, the Department of Defense, the Department of Labor, and the Peace Corps, as appropriate, pursuant to the 2004 Memorandum of Agreement Coordinating Audit Coverage of Programs and Activities Implementing the President's Emergency Plan for AIDS Relief, or any successor agreement.

''(3) FUNDING.—The Global AIDS Coordinator and the Coordinator of the United States Government Activities to Combat Malaria Globally shall make available necessary funds not exceeding $15,000,000 during the 5-year period beginning on October 1, 2008 to the Inspectors General described in paragraph (1) for the audits, inspections, and reviews described in that paragraph.''.

(e) ANNUAL STUDY; MESSAGE.—Section 101 of such Act, as amended by this section, is further amended by adding at the end the following:

''(g) ANNUAL STUDY.—

''(1) IN GENERAL.—Not later than September 30, 2009, and annually thereafter through September 30, 2013, the Global AIDS Coordinator shall complete a study of treatment providers that—

''(A) represents a range of countries and service environments;

''(B) estimates the per-patient cost of antiretroviral HIV/AIDS treatment and the care of people with HIV/AIDS not receiving antiretroviral treatment, including a comparison of the costs for equivalent services provided by programs not receiving assistance under this Act;

''(C) estimates per-patient costs across the program and in specific categories of service providers, including—

''(i) urban and rural providers;

''(ii) country-specific providers; and

''(iii) other subcategories, as appropriate.

''(2) PUBLICATION.—Not later than 90 days after the completion of each study under paragraph (1), the Global AIDS Coordinator shall make the results of such study available on a publicly accessible Web site.

''(h) MESSAGE.—The Global AIDS Coordinator shall develop a message, to be prominently displayed by each program receiving funds under this Act, that—

''(1) demonstrates that the program is a commitment by citizens of the United States to the global fight against HIV/AIDS, tuberculosis, and malaria; and

''(2) enhances awareness by program recipients that the program is an effort on behalf of the citizens of the United States.''.

**SEC. 102. INTERAGENCY WORKING GROUP.**

Section 1(f)(2) of the State Department Basic Authorities Act of 1956 (22 U.S.C. 2651a(f)(2)) is amended—

(1) in subparagraph (A), by inserting '', partner country finance, health, and other relevant ministries,'' after ''community based organizations)'' each place it appears;

(2) in subparagraph (B)(ii)—

(A) by striking subclauses (IV) and (V);

(B) by inserting after subclause (III) the following:

''(IV) Establishing an interagency working group on HIV/AIDS headed by the Global AIDS Coordinator and comprised of representatives from the United States Agency for International Development and the Department of Health and Human Services, for the purposes of coordination of activities relating to HIV/AIDS, including—

''(aa) meeting regularly to review progress in partner countries toward HIV/AIDS prevention, treatment, and care objectives;

''(bb) participating in the process of identifying countries to consider for increased assistance based on the epidemiology of HIV/AIDS in those countries, including clear evidence of a public health threat, as well as government commitment to address the HIV/AIDS problem, relative need, and coordination and joint planning with other significant actors;

''(cc) assisting the Coordinator in the evaluation, execution, and oversight of country operational plans;

''(dd) reviewing policies that may be obstacles to reaching targets set forth for HIV/AIDS prevention, treatment, and care; and

''(ee) consulting with representatives from additional relevant agencies, including the National Institutes of Health, the Health Resources and Services Administration, the Department of Labor, the Department of Agriculture, the Millennium Challenge Corporation, the Peace Corps, and the Department of Defense.

''(V) Coordinating overall United States HIV/AIDS policy and programs, including ensuring the coordination of relevant executive branch agency activities in the field, with efforts led by partner countries, and with the assistance provided by other relevant bilateral and multilateral aid agencies and other donor institutions to promote harmonization with other programs aimed at preventing and treating HIV/AIDS and other health challenges, improving primary health, addressing food security, promoting education and development, and strengthening health care systems.'';

(C) by redesignating subclauses (VII) and VIII) as subclauses (IX) and (XII), respectively;

(D) by inserting after subclause (VI) the following:

''(VII) Holding annual consultations with nongovernmental organizations in partner countries that provide services to improve health, and advocating on behalf of the individuals with HIV/AIDS and those at particular risk of contracting HIV/AIDS, including organizations with members who are living with HIV/AIDS.

''(VIII) Ensuring, through interagency and international coordination, that HIV/AIDS programs of the United States are coordinated with, and complementary to, the delivery of related global health, food security, development, and education.'';

(E) in subclause (IX), as redesignated by subparagraph (C)—

(i) by inserting ''Vietnam,'' after ''Uganda,'';

(ii) by inserting after ''of 2003'' the following: ''and other countries in which the United States is implementing HIV/AIDS programs as part of its foreign assistance program''; and

(iii) by adding at the end the following: ''In designating additional countries under this subparagraph, the President shall give priority to those countries in which there is a high prevalence of HIV or risk of significantly increasing incidence of HIV within the general population and inadequate financial means within the country.'';

(F) by inserting after subclause (IX), as redesignated by subparagraph (C), the following:

''(X) Working with partner countries in which the HIV/AIDS epidemic is prevalent among injection drug users to establish, as a national priority, national HIV/AIDS prevention programs.

''(XI) Working with partner countries in which the HIV/AIDS epidemic is prevalent among individuals involved in commercial sex acts to establish, as a national priority, national prevention programs, including education, voluntary testing, and counseling, and referral systems that link HIV/AIDS programs with programs to eradicate trafficking in persons and support alternatives to prostitution.'';

(G) in subclause (XII), as redesignated by subparagraph (C), by striking ''funds section'' and inserting ''funds appropriated for HIV/ AIDS assistance pursuant to the authorization of appropriations under section 401 of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7671)''; and

(H) by adding at the end the following:

''(XIII) Publicizing updated drug pricing data to inform the purchasing decisions of pharmaceutical procurement partners.''.

**SEC. 103. SENSE OF CONGRESS.**

Section 102 of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7612) is amended by adding at the end the following:

''(d) SENSE OF CONGRESS.—It is the sense of Congress that—

''(1) full-time country level coordinators, preferably with management experience, should head each HIV/AIDS country team for United States missions overseeing significant HIV/AIDS programs;

''(2) foreign service nationals provide critically important services in the design and implementation of United States country-level HIV/AIDS programs and their skills and experience as public health professionals should be recognized within hiring and compensation practices; and

''(3) staffing levels for United States country-level HIV/AIDS teams should be adequately maintained to fulfill oversight and other obligations of the positions.''.

## TITLE II—SUPPORT FOR MULTILATERAL FUNDS, PROGRAMS, AND PUBLIC-PRIVATE PARTNERSHIPS

**SEC. 201. VOLUNTARY CONTRIBUTIONS TO INTERNATIONAL VACCINE FUNDS.**

Section 302 of the Foreign Assistance Act of 1961 (22 U.S.C. 2222) is amended—

(1) by inserting after subsection (c) the following:

''(d) TUBERCULOSIS VACCINE DEVELOPMENT PROGRAMS.—In addition to amounts otherwise available under this section, there are authorized to be appropriated to the President such sums as may be necessary for each of the fiscal years 2009 through 2013, which shall be used for United States contributions to tuberculosis vaccine development programs, which may include the Aeras Global TB Vaccine Foundation.'';

(2) in subsection (k)—

(A) by striking ''fiscal years 2004 through 2008'' and inserting ''fiscal years 2009 through 2013''; and

(B) by striking ''Vaccine Fund'' and inserting ''GAVI Fund''.

(3) in subsection (l), by striking ''fiscal years 2004 through 2008'' and inserting ''fiscal years 2009 through 2013''; and

(4) in subsection (m), by striking ''fiscal years 2004 through 2008'' and inserting ''fiscal years 2009 through 2013''.

**SEC. 202. PARTICIPATION IN THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA.**

(a) FINDINGS; SENSE OF CONGRESS.—Section 202(a) of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7622(a)) is amended to read as follows:

''(a) FINDINGS; SENSE OF CONGRESS.—

''(1) FINDINGS.—Congress makes the following findings:

''(A) The establishment of the Global Fund in January 2002 is consistent with the general principles for an international AIDS trust fund first outlined by Congress in the Global AIDS and Tuberculosis Relief Act of 2000 (Public Law 106–264).

''(B) The Global Fund is an innovative financing mechanism which—

''(i) has made progress in many areas in combating HIV/AIDS, tuberculosis, and malaria; and

''(ii) represents the multilateral component of this Act, extending United States efforts to more than 130 countries around the world.

''(C) The Global Fund and United States bilateral assistance programs—

''(i) are demonstrating increasingly effective coordination, with each possessing certain comparative advantages in the fight against HIV/AIDS, tuberculosis, and malaria; and

''(ii) often work most effectively in concert with each other.

''(D) The United States Government—

''(i) is the largest supporter of the Global Fund in terms of resources and technical support;

''(ii) made the founding contribution to the Global Fund; and

''(iii) is fully committed to the success of the Global Fund as a multilateral public-private partnership.

''(2) SENSE OF CONGRESS.—It is the sense of Congress that—

''(A) transparency and accountability are crucial to the long-term success and viability of the Global Fund;

''(B) the Global Fund has made significant progress toward addressing concerns raised by the Government Accountability Office by—

''(i) improving risk assessment and risk management capabilities;

''(ii) providing clearer guidance for and oversight of Local Fund Agents; and

''(iii) strengthening the Office of the Inspector General for the Global Fund;

''(C) the provision of sufficient resources and authority to the Office of the Inspector General for the Global Fund to ensure that office has the staff and independence necessary to carry out its mandate will be a measure of the commitment of the Global Fund to transparency and accountability;

''(D) regular, publicly published financial, programmatic, and reporting audits of the Fund, its grantees, and Local Fund Agents are also important benchmarks of transparency;

''(E) the Global Fund should establish and maintain a system to track—

''(i) the amount of funds disbursed to each subrecipient on the grant's fiscal cycle; and

''(ii) the distribution of resources, by grant and principal recipient, for prevention, care, treatment, drug and commodity purchases, and other purposes;

''(F) relevant national authorities in recipient countries should exempt from duties and taxes all products financed by Global Fund grants and procured by any principal recipient or subrecipient for the purpose of carrying out such grants;

''(G) the Global Fund, UNAIDS, and the Global AIDS Coordinator should work together to standardize program indicators wherever possible;

''(H) for purposes of evaluating total amounts of funds contributed to the Global Fund under subsection (d)(4)(A)(i), the timetable for evaluations of contributions from sources other than the United States should take into account the fiscal calendars of other major contributors; and

''(I) the Global Fund should not support activities involving the 'Affordable Medicines Facility-Malaria' or similar entities pending compelling evidence of success from pilot programs as evaluated by the Coordinator of United States Government Activities to Combat Malaria Globally.''.

(b) STATEMENT OF POLICY.—Section 202(b) of such Act is amended by adding at the end the following:

''(3) STATEMENT OF POLICY.—The United States Government regards the imposition by recipient countries of taxes or tariffs on goods or services provided by the Global Fund, which are supported through public and private donations, including the substantial contribution of the American people, as inappropriate and inconsistent with standards of good governance. The Global AIDS Coordinator or other representatives of the United States Government shall work with the Global Fund to dissuade governments from imposing such duties, tariffs, or taxes.''.

(c) UNITED STATES FINANCIAL PARTICIPATION.—Section 202(d) of such Act (22 U.S.C. 7622(d)) is amended—

(1) in paragraph (1)—

(A) by striking ''$1,000,000,000 for the period of fiscal year 2004 beginning on January 1, 2004'' and inserting ''$2,000,000,000 for fiscal year 2009,''; and

(B) by striking ''the fiscal years 2005–2008'' and inserting ''each of the fiscal years 2010 through 2013'';

(2) in paragraph (4)—

(A) in subparagraph (A)—

(i) in clause (i), by striking ''fiscal years 2004 through 2008'' and inserting ''fiscal years 2009 through 2013'';

(ii) in clause (ii)—

(I) by striking ''during any of the fiscal years 2004 through 2008'' and inserting ''during any of the fiscal years 2009 through 2013''; and

(II) by adding at the end the following: ''The President may waive the application of this clause with respect to assistance for Sudan that is overseen by the Southern Country Coordinating Mechanism, including Southern Sudan, Southern Kordofan, Blue Nile State, and Abyei, if the President determines that the national interest or humanitarian reasons justify such a waiver. The President shall publish each waiver of this clause in the Federal Register and, not later than 15 days before the waiver takes effect, shall consult with the Committee on Foreign Relations of the Senate and the Committee on Foreign Affairs of the House of Representatives regarding the proposed waiver.''; and

(iii) in clause (vi)—

(I) by striking ''for the purposes'' and inserting ''For the purposes'';

(II) by striking ''fiscal years 2004 through 2008'' and inserting ''fiscal years 2009 through 2013''; and

(III) by striking ''prior to fiscal year 2004'' and inserting ''before fiscal year 2009'';

(B) in subparagraph (B)(iv), by striking ''fiscal years 2004 through 2008'' and inserting ''fiscal years 2009 through 2013''; and

(C) in subparagraph (C)(ii), by striking ''Committee on International Relations'' and inserting ''Committee on Foreign Affairs''; and

(3) by adding at the end the following:

''(5) WITHHOLDING FUNDS.—Notwithstanding any other provision of this Act, 20 percent of the amounts appropriated pursuant to this Act for a contribution to support the Global Fund for each of the fiscal years 2010 through 2013 shall be withheld from obligation to the Global Fund until the Secretary of State certifies to the appropriate congressional committees that the Global Fund—

''(A) has established an evaluation framework for the performance of Local Fund Agents (referred to in this paragraph as 'LFAs');

''(B) is undertaking a systematic assessment of the performance of LFAs;

''(C) has adopted, and is implementing, a policy to publish on a publicly available Web site—

''(i) grant performance reviews;

''(ii) all reports of the Inspector General of the Global Fund, in a manner that is consistent with the Policy for Disclosure of Reports of the Inspector General, approved at the 16th Meeting of the Board of the Global Fund;

''(iii) decision points of the Board of the Global Fund;

''(iv) reports from Board committees to the Board; and

''(v) a regular collection and analysis of performance data and funding of grants of the Global Fund, which shall cover all principal recipients and all subrecipients;

''(D) is maintaining an independent, well-staffed Office of the Inspector General that—

''(i) reports directly to the Board of the Global Fund; and

''(ii) compiles regular, publicly published audits of financial, programmatic, and reporting aspects of the Global Fund, its grantees, and LFAs;

''(E) has established, and is reporting publicly on, standard indicators for all program areas;

''(F) has established a methodology to track and is publicly reporting on—

''(i) all subrecipients and the amount of funds disbursed to each subrecipient on the grant's fiscal cycle; and

''(ii) the distribution of resources, by grant and principal recipient, for prevention, care, treatment, drugs and commodities purchase, and other purposes;

''(G) has established a policy on tariffs imposed by national governments on all goods and services financed by the Global Fund;

''(H) through its Secretariat, has taken meaningful steps to prevent national authorities in recipient countries from imposing taxes or tariffs on goods or services provided by the Fund;

''(I) is maintaining its status as a financing institution focused on programs directly related to HIV/AIDS, malaria, and tuberculosis;

''(J) is maintaining and making progress on—

''(i) sustaining its multisectoral approach, through country coordinating mechanisms; and

''(ii) the implementation of grants, as reflected in the proportion of resources allocated to different sectors, including governments, civil society, and faith- and community-based organizations; and

''(K) has established procedures providing access by the Office of Inspector General of the Department of State and Broadcasting Board of Governors, as cognizant Inspector General, and the Inspector General of the Health and Human Services and the Inspector General of the United States Agency for International Development, to Global Fund financial data, and other information relevant to United States contributions (as determined by the Inspector General in consultation with the Global AIDS Coordinator).

''(6) SUMMARIES OF BOARD DECISIONS AND UNITED STATES POSITIONS.—Following each meeting of the Board of the Global Fund, the Coordinator of United States Government Activities to Combat HIV/AIDS Globally shall report on the public website of the Coordinator a summary of Board decisions and how the United States Government voted and its positions on such decisions.''.

**SEC. 203. RESEARCH ON METHODS FOR WOMEN TO PREVENT TRANSMISSION OF HIV AND OTHER DISEASES.**

(a) SENSE OF CONGRESS.—Congress recognizes the need and urgency to expand the range of interventions for preventing the transmission of human immunodeficiency virus (HIV), including nonvaccine prevention methods that can be controlled by women.

(b) NIH OFFICE OF AIDS RESEARCH.—Subpart 1 of part D of title XXIII of the Public Health Service Act (42 U.S.C. 300cc–40 et seq.) is amended by inserting after section 2351 the following:

**''SEC. 2351A. MICROBICIDE RESEARCH.**

''(a) FEDERAL STRATEGIC PLAN.—The Director of the Office shall—

''(1) expedite the implementation of the Federal strategic plans required by section 403(a) of the Public Health Service Act (42 U.S.C. 283(a)(5)) regarding the conduct and support of research on, and development of, a microbicide to prevent the transmission of the human immunodeficiency virus; and

''(2) review and, as appropriate, revise such plan to prioritize funding and activities relative to their scientific urgency and potential market readiness.

''(b) COORDINATION.—In implementing, reviewing, and prioritizing elements of the plan described in subsection (a), the Director of the Office shall consult, as appropriate, with—

''(1) representatives of other Federal agencies involved in microbicide research, including the

Coordinator of United States Government Activities to Combat HIV/AIDS Globally, the Director of the Centers for Disease Control and Prevention, and the Administrator of the United States Agency for International Development;

''(2) the microbicide research and development community; and

''(3) health advocates.''.

(c) NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES.—Subpart 6 of part C of title IV of the Public Health Service Act (42 U.S.C. 285f et seq.) is amended by adding at the end the following:

**''SEC. 447C. MICROBICIDE RESEARCH AND DEVELOPMENT.**

''The Director of the Institute, acting through the head of the Division of AIDS, shall, consistent with the peer-review process of the National Institutes of Health, carry out research on, and development of, safe and effective methods for use by women to prevent the transmission of the human immunodeficiency virus, which may include microbicides.''.

(d) CDC.—Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.) is amended by inserting after section 317S the following:

**''SEC. 317T. MICROBICIDE RESEARCH.**

''(a) IN GENERAL.—The Director of the Centers for Disease Control and Prevention is strongly encouraged to fully implement the Centers' microbicide agenda to support research and development of microbicides for use to prevent the transmission of the human immunodeficiency virus.

''(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for each of fiscal years 2009 through 2013 to carry out this section.''.

(e) UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT.—

(1) IN GENERAL.—The Administrator of the United States Agency for International Development, in coordination with the Coordinator of United States Government Activities to Combat HIV/AIDS Globally, may facilitate availability and accessibility of microbicides, provided that such pharmaceuticals are approved, tentatively approved, or otherwise authorized for use by—

(A) the Food and Drug Administration;

(B) a stringent regulatory agency acceptable to the Secretary of Health and Human Services; or

(C) a quality assurance mechanism acceptable to the Secretary of Health and Human Services.

(2) AUTHORIZATION OF APPROPRIATIONS.—Of the amounts authorized to be appropriated under section 401 of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7671) for HIV/AIDS assistance, there are authorized to be appropriated to the President such sums as may be necessary for each of the fiscal years 2009 through 2013 to carry out this subsection.

**SEC. 204. COMBATING HIV/AIDS, TUBERCULOSIS, AND MALARIA BY STRENGTHENING HEALTH POLICIES AND HEALTH SYSTEMS OF PARTNER COUNTRIES.**

(a) IN GENERAL.—Title II of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7621) is amended by adding at the end the following:

**''SEC. 204. COMBATING HIV/AIDS, TUBERCULOSIS, AND MALARIA BY STRENGTHENING HEALTH POLICIES AND HEALTH SYSTEMS OF PARTNER COUNTRIES.**

''(a) STATEMENT OF POLICY.—It shall be the policy of the United States Government—

''(1) to invest appropriate resources authorized under this Act—

''(A) to carry out activities to strengthen HIV/AIDS, tuberculosis, and malaria health policies and health systems; and

''(B) to provide workforce training and capacity-building consistent with the goals and objectives of this Act; and

''(2) to support the development of a sound policy environment in partner countries to increase the ability of such countries—

''(A) to maximize utilization of health care resources from donor countries;

''(B) to increase national investments in health and education and maximize the effectiveness of such investments;

''(C) to improve national HIV/AIDS, tuberculosis, and malaria strategies;

''(D) to deliver evidence-based services in an effective and efficient manner; and

''(E) to reduce barriers that prevent recipients of services from achieving maximum benefit from such services.

''(b) ASSISTANCE TO IMPROVE PUBLIC FINANCE MANAGEMENT SYSTEMS.—

''(1) IN GENERAL.—Consistent with the authority under section 129 of the Foreign Assistance Act of 1961 (22 U.S.C. 2152), the Secretary of the Treasury, acting through the head of the Office of Technical Assistance, is authorized to provide assistance for advisors and partner country finance, health, and other relevant ministries to improve the effectiveness of public finance management systems in partner countries to enable such countries to receive funding to carry out programs to combat HIV/AIDS, tuberculosis, and malaria and to manage such programs.

''(2) AUTHORIZATION OF APPROPRIATIONS.—Of the amounts authorized to be appropriated under section 401 for HIV/AIDS assistance, there are authorized to be appropriated to the Secretary of the Treasury such sums as may be necessary for each of the fiscal years 2009 through 2013 to carry out this subsection.

''(c) PLAN REQUIRED.—The Global AIDS Coordinator, in collaboration with the Administrator of the United States Agency for International Development (USAID), shall develop and implement a plan to combat HIV/AIDS by strengthening health policies and health systems of partner countries as part of USAID's 'Health Systems 2020' project. Recognizing that human and institutional capacity form the core of any health care system that can sustain the fight against HIV/AIDS, tuberculosis, and malaria, the plan shall include a strategy to encourage postsecondary educational institutions in partner countries, particularly in Africa, in collaboration with United States postsecondary educational institutions, including historically black colleges and universities, to develop such human and institutional capacity and in the process further build their capacity to sustain the fight against these diseases.''.

(b) CLERICAL AMENDMENT.—The table of contents for the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7601 note) is amended by inserting after the item relating to section 203, as added by section 203 of this Act, the following:

''Sec. 204. Combating HIV/AIDS, tuberculosis, and malaria by strengthening health policies and health systems of partner countries.''.

**SEC. 205. FACILITATING EFFECTIVE OPERATIONS OF THE CENTERS FOR DISEASE CONTROL.**

Section 307 of the Public Health Service Act (42 U.S.C. 242l) is amended—

(1) by amending subsection (a) to read as follows:

''(a) The Secretary may participate with other countries in cooperative endeavors in—

''(1) biomedical research, health care technology, and the health services research and statistical analysis authorized under section 306 and title IX; and

''(2) biomedical research, health care services, health care research, or other related activities in furtherance of the activities, objectives or goals authorized under the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008.''; and

(2) in subsection (b)—

(A) in paragraph (7), by striking ''and'' after the semicolon at the end;

(B) by striking ''The Secretary may not, in the exercise of his authority under this section, provide financial assistance for the construction of any facility in any foreign country.''

(C) in paragraph (8), by striking ''for any purpose.'' and inserting ''for the purpose of any law administered by the Office of Personnel Management;''; and

(D) by adding at the end the following:

''(9) provide such funds by advance or reimbursement to the Secretary of State, as may be necessary, to pay the costs of acquisition, lease, construction, alteration, equipping, furnishing or management of facilities outside of the United States; and

''(10) in consultation with the Secretary of State, through grant or cooperative agreement, make funds available to public or nonprofit private institutions or agencies in foreign countries in which the Secretary is participating in activities described under subsection (a) to acquire, lease, construct, alter, or renovate facilities in those countries.''.

(3) in subsection (c)—

(A) by striking ''1990'' and inserting ''1980''; and

(B) by inserting or ''or section 903 of the Foreign Service Act of 1980 (22 U.S.C. 4083)'' after ''Code''.

**SEC. 206. FACILITATING VACCINE DEVELOPMENT.**

(a) TECHNICAL ASSISTANCE FOR DEVELOPING COUNTRIES.—The Administrator of the United States Agency for International Development, utilizing public-private partners, as appropriate, and working in coordination with other international development agencies, is authorized to strengthen the capacity of developing countries' governmental institutions to—

(1) collect evidence for informed decision-making and introduction of new vaccines, including potential HIV/AIDS, tuberculosis, and malaria vaccines, if such vaccines are determined to be safe and effective;

(2) review protocols for clinical trials and impact studies and improve the implementation of clinical trials; and

(3) ensure adequate supply chain and delivery systems.

(b) ADVANCED MARKET COMMITMENTS.—

(1) PURPOSE.—The purpose of this subsection is to improve global health by requiring the United States to participate in negotiations for advance market commitments for the development of future vaccines, including potential vaccines for HIV/AIDS, tuberculosis, and malaria.

(2) NEGOTIATION REQUIREMENT.—The Secretary of the Treasury shall enter into negotiations with the appropriate officials of the International Bank of Reconstruction and Development (World Bank) and the GAVI Alliance, the member nations of such entities, and other interested parties to establish advanced market commitments to purchase vaccines to combat HIV/AIDS, tuberculosis, malaria, and other related infectious diseases.

(3) REQUIREMENTS.—In negotiating the United States participation in programs for advanced market commitments, the Secretary of the Treasury shall take into account whether programs for advance market commitments include—

(A) legally binding contracts for product purchase that include a fair market price for up to a maximum number of treatments, creating a strong market incentive;

(B) clearly defined and transparent rules of program participation for qualified developers and suppliers of the product;

(C) clearly defined requirements for eligible vaccines to ensure that they are safe and effective and can be delivered in developing country contexts;

(D) dispute settlement mechanisms; and

(E) sufficient flexibility to enable the contracts to be adjusted in accord with new information related to projected market size and other factors while still maintaining the purchase commitment at a fair price.

(4) REPORT.—Not later than 1 year after the date of the enactment of this Act—

*(A) the Secretary of the Treasury shall submit a report to the appropriate congressional committees on the status of the United States negotiations to participate in programs for the advanced market commitments under this subsection; and*

*(B) the President shall produce a comprehensive report, written by a study group of qualified professionals from relevant Federal agencies and initiatives, nongovernmental organizations, and industry representatives, that sets forth a coordinated strategy to accelerate development of vaccines for infectious diseases, such as HIV/AIDS, malaria, and tuberculosis, which includes—*

*(i) initiatives to create economic incentives for the research, development, and manufacturing of vaccines for HIV/AIDS, tuberculosis, malaria, and other infectious diseases;*

*(ii) an expansion of public-private partnerships and the leveraging of resources from other countries and the private sector; and*

*(iii) efforts to maximize United States capabilities to support clinical trials of vaccines in developing countries and to address the challenges of delivering vaccines in developing countries to minimize delays in access once vaccines are available.*

## *TITLE III—BILATERAL EFFORTS*

### *Subtitle A—General Assistance and Programs*

#### *SEC. 301. ASSISTANCE TO COMBAT HIV/AIDS.*

*(a) AMENDMENTS TO THE FOREIGN ASSISTANCE ACT OF 1961.—*

*(1) FINDING.—Section 104A(a) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b–2(a)) is amended by inserting ''Central Asia, Eastern Europe, Latin America'' after ''Caribbean,''.*

*(2) POLICY.—Section 104A(b) of such Act is amended to read as follows:*

*''(b) POLICY.—*

*''(1) OBJECTIVES.—It is a major objective of the foreign assistance program of the United States to provide assistance for the prevention and treatment of HIV/AIDS and the care of those affected by the disease. It is the policy objective of the United States, by 2013, to—*

*''(A) assist partner countries to—*

*''(i) prevent 12,000,000 new HIV infections worldwide;*

*''(ii) support—*

*''(I) the increase in the number of individuals with HIV/AIDS receiving antiretroviral treatment above the goal established under section 402(a)(3) and increased pursuant to paragraphs (1) through (3) of section 403(d); and*

*''(II) additional treatment through coordinated multilateral efforts;*

*''(iii) support care for 12,000,000 individuals infected with or affected by HIV/AIDS, including 5,000,000 orphans and vulnerable children affected by HIV/AIDS, with an emphasis on promoting a comprehensive, coordinated system of services to be integrated throughout the continuum of care;*

*''(iv) provide at least 80 percent of the target population with access to counseling, testing, and treatment to prevent the transmission of HIV from mother-to-child;*

*''(v) provide care and treatment services to children with HIV in proportion to their percentage within the HIV-infected population of a given partner country; and*

*''(vi) train and support retention of health care professionals, paraprofessionals, and community health workers in HIV/AIDS prevention, treatment, and care, with the target of providing such training to at least 140,000 new health care professionals and paraprofessionals with an emphasis on training and in country deployment of critically needed doctors and nurses;*

*''(B) strengthen the capacity to deliver primary health care in developing countries, especially in sub-Saharan Africa;*

*''(C) support and help countries in their efforts to achieve staffing levels of at least 2.3 doctors, nurses, and midwives per 1,000 population, as called for by the World Health Organization; and*

*''(D) help partner countries to develop independent, sustainable HIV/AIDS programs.*

*''(2) COORDINATED GLOBAL STRATEGY.—The United States and other countries with the sufficient capacity should provide assistance to countries in sub-Saharan Africa, the Caribbean, Central Asia, Eastern Europe, and Latin America, and other countries and regions confronting HIV/AIDS epidemics in a coordinated global strategy to help address generalized and concentrated epidemics through HIV/AIDS prevention, treatment, care, monitoring and evaluation, and related activities.*

*''(3) PRIORITIES.—The United States Government's response to the global HIV/AIDS pandemic and the Government's efforts to help countries assume leadership of sustainable campaigns to combat their local epidemics should place high priority on—*

*''(A) the prevention of the transmission of HIV;*

*''(B) moving toward universal access to HIV/AIDS prevention counseling and services;*

*''(C) the inclusion of cost sharing assurances that meet the requirements under section 110; and*

*''(D) the inclusion of transition strategies to ensure sustainability of such programs and activities, including health care systems, under other international donor support, or budget support by respective foreign governments.''.*

*(b) AUTHORIZATION.—Section 104A(c) of such Act is amended—*

*(1) in paragraph (1), by striking ''and other countries and areas.'' and inserting ''Central Asia, Eastern Europe, Latin America, and other countries and areas, particularly with respect to refugee populations or those in postconflict settings in such countries and areas with significant or increasing HIV incidence rates.'';*

*(2) in paragraph (2), by striking ''and other countries and areas affected by the HIV/AIDS pandemic'' and inserting ''Central Asia, Eastern Europe, Latin America, and other countries and areas affected by the HIV/AIDS pandemic, particularly with respect to refugee populations or those in post-conflict settings in such countries and areas with significant or increasing HIV incidence rates.''; and*

*(3) in paragraph (3)—*

*(A) by striking ''foreign countries'' and inserting ''partner countries, other international actors,''; and*

*(B) by inserting ''within the framework of the principles of the Three Ones'' before the period at the end.*

*(c) ACTIVITIES SUPPORTED.—Section 104A(d) of such Act is amended—*

*(1) in paragraph (1)—*

*(A) in subparagraph (A)—*

*(i) by inserting ''and multiple concurrent sexual partnering,'' after ''casual sexual partnering''; and*

*(ii) by striking ''condoms'' and inserting ''male and female condoms'';*

*(B) in subparagraph (B)—*

*(i) by striking ''programs that'' and inserting ''programs that are designed with local input and''; and*

*(ii) by striking ''those organizations'' and inserting ''those locally based organizations'';*

*(C) in subparagraph (D), by inserting ''and promoting the use of provider-initiated or 'opt-out' voluntary testing in accordance with World Health Organization guidelines'' before the semicolon at the end;*

*(D) by redesignating subparagraphs (F), (G), and (H) as subparagraphs (H), (I), and (J), respectively;*

*(E) by inserting after subparagraph (E) the following:*

*''(F) assistance to—*

*''(i) achieve the goal of reaching 80 percent of pregnant women for prevention and treatment of mother-to-child transmission of HIV in countries in which the United States is implementing HIV/AIDS programs by 2013; and*

*''(ii) promote infant feeding options and treatment protocols that meet the most recent criteria established by the World Health Organization;*

*''(G) medical male circumcision programs as part of national strategies to combat the transmission of HIV/AIDS;'';*

*(F) in subparagraph (I), as redesignated, by striking ''and'' at the end; and*

*(G) by adding at the end the following:*

*''(K) assistance for counseling, testing, treatment, care, and support programs, including—*

*''(i) counseling and other services for the prevention of reinfection of individuals with HIV/AIDS;*

*''(ii) counseling to prevent sexual transmission of HIV, including—*

*''(I) life skills development for practicing abstinence and faithfulness;*

*''(II) reducing the number of sexual partners;*

*''(III) delaying sexual debut; and*

*''(IV) ensuring correct and consistent use of condoms;*

*''(iii) assistance to engage underlying vulnerabilities to HIV/AIDS, especially those of women and girls;*

*''(iv) assistance for appropriate HIV/AIDS education programs and training targeted to prevent the transmission of HIV among men who have sex with men;*

*''(v) assistance to provide male and female condoms;*

*''(vi) diagnosis and treatment of other sexually transmitted infections;*

*''(vii) strategies to address the stigma and discrimination that impede HIV/AIDS prevention efforts; and*

*''(viii) assistance to facilitate widespread access to microbicides for HIV prevention, if safe and effective products become available, including financial and technical support for culturally appropriate introductory programs, procurement, distribution, logistics management, program delivery, acceptability studies, provider training, demand generation, and postintroduction monitoring.''; and*

*(2) in paragraph (2)—*

*(A) in subparagraph (B), by striking ''and'' at the end;*

*(B) in subparagraph (C)—*

*(i) by inserting ''pain management,'' after ''opportunistic infections,''; and*

*(ii) by striking the period at the end and inserting a semicolon; and*

*(C) by adding at the end the following:*

*''(D) as part of care and treatment of HIV/AIDS, assistance (including prophylaxis and treatment) for common HIV/AIDS-related opportunistic infections for free or at a rate at which it is easily affordable to the individuals and populations being served;*

*''(E) as part of care and treatment of HIV/AIDS, assistance or referral to available and adequately resourced service providers for nutritional support, including counseling and where necessary the provision of commodities, for persons meeting malnourishment criteria and their families;'';*

*(3) in paragraph (4)—*

*(A) in subparagraph (C), by striking ''and'' at the end;*

*(B) in subparagraph (D), by striking the period at the end and inserting a semicolon; and*

*(C) by adding at the end the following:*

*''(E) carrying out and expanding program monitoring, impact evaluation research and analysis, and operations research and disseminating data and findings through mechanisms to be developed by the Coordinator of United States Government Activities to Combat HIV/AIDS Globally, in coordination with the Director of the Centers for Disease Control, in order to—*

*''(i) improve accountability, increase transparency, and ensure the delivery of evidence-based services through the collection, evaluation, and analysis of data regarding gender-responsive interventions, disaggregated by age and sex;*

''(ii) identify and replicate effective models; and

''(iii) develop gender indicators to measure outcomes and the impacts of interventions; and

''(F) establishing appropriate systems to—

''(i) gather epidemiological and social science data on HIV; and

''(ii) evaluate the effectiveness of prevention efforts among men who have sex with men, with due consideration to stigma and risks associated with disclosure.'';

(4) in paragraph (5)—

(A) by redesignating subparagraph (C) as subparagraph (D); and

(B) by inserting after subparagraph (B) the following:

''(C) MECHANISM TO ENSURE COST-EFFECTIVE DRUG PURCHASING.—Subject to subparagraph (B), mechanisms to ensure that safe and effective pharmaceuticals, including antiretrovirals and medicines to treat opportunistic infections, are purchased at the lowest possible price at which such pharmaceuticals may be obtained in sufficient quantity on the world market, provided that such pharmaceuticals are approved, tentatively approved, or otherwise authorized for use by—

''(i) the Food and Drug Administration;

''(ii) a stringent regulatory agency acceptable to the Secretary of Health and Human Services; or

''(iii) a quality assurance mechanism acceptable to the Secretary of Health and Human Services.'';

(5) in paragraph (6)—

(A) by amending the paragraph heading to read as follows:

''(6) RELATED AND COORDINATED ACTIVITIES.—'';

(B) in subparagraph (B), by striking ''and'' at the end;

(C) in subparagraph (C), by striking the period at the end and inserting ''; and''; and

(D) by adding at the end the following:

''(D) coordinated or referred activities to—

''(i) enhance the clinical impact of HIV/AIDS care and treatment; and

''(ii) ameliorate the adverse social and economic costs often affecting AIDS-impacted families and communities through the direct provision, as necessary, or through the referral, if possible, of support services, including—

''(I) nutritional and food support;

''(II) safe drinking water and adequate sanitation;

''(III) nutritional counseling;

''(IV) income-generating activities and livelihood initiatives;

''(V) maternal and child health care;

''(VI) primary health care;

''(VII) the diagnosis and treatment of other infectious or sexually transmitted diseases;

''(VIII) substance abuse and treatment services; and

''(IX) legal services;

''(E) coordinated or referred activities to link programs addressing HIV/AIDS with programs addressing gender-based violence in areas of significant HIV prevalence to assist countries in the development and enforcement of women's health, children's health, and HIV/AIDS laws and policies that—

''(i) prevent and respond to violence against women and girls;

''(ii) promote the integration of screening and assessment for gender-based violence into HIV/AIDS programming;

''(iii) promote appropriate HIV/AIDS counseling, testing, and treatment into gender-based violence programs; and

''(iv) assist governments to develop partnerships with civil society organizations to create networks for psychosocial, legal, economic, or other support services;

''(F) coordinated or referred activities to—

''(i) address the frequent coinfection of HIV and tuberculosis, in accordance with World Health Organization guidelines;

''(ii) promote provider-initiated or 'opt-out' HIV/AIDS counseling and testing and appropriate referral for treatment and care to individuals with tuberculosis or its symptoms, particularly in areas with significant HIV prevalence; and

''(iii) strengthen programs to ensure that individuals testing positive for HIV receive tuberculosis screening and to improve laboratory capacities, infection control, and adherence; and

''(G) activities to—

''(i) improve the effectiveness of national responses to HIV/AIDS;

''(ii) strengthen overall health systems in high-prevalence countries, including support for workforce training, retention, and effective deployment, capacity building, laboratory development, equipment maintenance and repair, and public health and related public financial management systems and operations; and

''(iii) encourage fair and transparent procurement practices among partner countries; and

''(iv) promote in-country or intra-regional pediatric training for physicians and other health professionals, preferably through public-private partnerships involving colleges and universities, with the goal of increasing pediatric HIV workforce capacity.''; and

(6) by adding at the end the following:

''(8) COMPACTS AND FRAMEWORK AGREEMENTS.—The development of compacts or framework agreements, tailored to local circumstances, with national governments or regional partnerships in countries with significant HIV/AIDS burdens to promote host government commitment to deeper integration of HIV/AIDS services into health systems, contribute to health systems overall, and enhance sustainability, including—

''(A) cost sharing assurances that meet the requirements under section 110; and

''(B) transition strategies to ensure sustainability of such programs and activities, including health care systems, under other international donor support, or budget support by respective foreign governments.''.

(d) COMPACTS AND FRAMEWORK AGREEMENTS.—Section 104A of such Act is amended—

(1) by redesignating subsections (e) through (g) as subsections (f) through (h); and

(2) by inserting after subsection (d) the following:

''(e) COMPACTS AND FRAMEWORK AGREEMENTS.—

''(1) FINDINGS.—Congress makes the following findings:

''(A) The congressionally mandated Institute of Medicine report entitled 'PEPFAR Implementation: Progress and Promise' states: 'The next strategy [of the U.S. Global AIDS Initiative] should squarely address the needs and challenges involved in supporting sustainable country HIV/AIDS programs, thereby transitioning from a focus on emergency relief.'.

''(B) One mechanism to promote the transition from an emergency to a public health and development approach to HIV/AIDS is through compacts or framework agreements between the United States Government and each participating nation.

''(2) ELEMENTS.—Compacts on HIV/AIDS authorized under subsection (d)(8) shall include the following elements:

''(A) Compacts whose primary purpose is to provide direct services to combat HIV/AIDS are to be made between—

''(i) the United States Government; and

''(ii)(I) national or regional entities representing low-income countries served by an existing United States Agency for International Development or Department of Health and Human Services presence or regional platform; or

''(II) countries or regions—

''(aa) experiencing significantly high HIV prevalence or risk of significantly increasing incidence within the general population;

''(bb) served by an existing United States Agency for International Development or Department of Health and Human Services presence or regional platform; and

''(cc) that have inadequate financial means within such country or region.

''(B) Compacts whose primary purpose is to provide limited technical assistance to a country or region connected to services provided within the country or region—

''(i) may be made with other countries or regional entities served by an existing United States Agency for International Development or Department of Health and Human Services presence or regional platform;

''(ii) shall require significant investments in HIV prevention, care, and treatment services by the host country;

''(iii) shall be time-limited in terms of United States contributions; and

''(iv) shall be made only upon prior notification to Congress—

''(I) justifying the need for such compacts;

''(II) describing the expected investment by the country or regional entity; and

''(III) describing the scope, nature, expected total United States investment, and time frame of the limited technical assistance under the compact and its intended impact.

''(C) Compacts shall include provisions to—

''(i) promote local and national efforts to reduce stigma associated with HIV/AIDS; and

''(ii) work with and promote the role of civil society in combating HIV/AIDS.

''(D) Compacts shall take into account the overall national health and development and national HIV/AIDS and public health strategies of each country.

''(E) Compacts shall contain—

''(i) consideration of the specific objectives that the country and the United States expect to achieve during the term of a compact;

''(ii) consideration of the respective responsibilities of the country and the United States in the achievement of such objectives;

''(iii) consideration of regular benchmarks to measure progress toward achieving such objectives;

''(iv) an identification of the intended beneficiaries, disaggregated by gender and age, and including information on orphans and vulnerable children, to the maximum extent practicable;

''(v) consideration of the methods by which the compact is intended to—

''(I) address the factors that put women and girls at greater risk of HIV/AIDS; and

''(II) strengthen elements such as the economic, educational, and social status of women, girls, orphans, and vulnerable children and the inheritance rights and safety of such individuals;

''(vi) consideration of the methods by which the compact will—

''(I) strengthen the health care capacity, including factors such as the training, retention, deployment, recruitment, and utilization of health care workers;

''(II) improve supply chain management; and

''(III) improve the health systems and infrastructure of the partner country, including the ability of compact participants to maintain and operate equipment transferred or purchased as part of the compact;

''(vii) consideration of proposed mechanisms to provide oversight;

''(viii) consideration of the role of civil society in the development of a compact and the achievement of its objectives;

''(ix) a description of the current and potential participation of other donors in the achievement of such objectives, as appropriate; and

''(x) consideration of a plan to ensure appropriate fiscal accountability for the use of assistance.

''(F) For regional compacts, priority shall be given to countries that are included in regional funds and programs in existence as of the date of the enactment of the Tom Lantos and Henry J. Hyde United States Global Leadership

*Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008.*

*''(G) Amounts made available for compacts described in subparagraphs (A) and (B) shall be subject to the inclusion of—*

*''(i) cost sharing assurances that meet the requirements under section 110; and*

*''(ii) transition strategies to ensure sustainability of such programs and activities, including health care systems, under other international donor support, and budget support by respective foreign governments.*

*''(3) LOCAL INPUT.—In entering into a compact on HIV/AIDS authorized under subsection (d)(8), the Coordinator of United States Government Activities to Combat HIV/AIDS Globally shall seek to ensure that the government of a country—*

*''(A) takes into account the local perspectives of the rural and urban poor, including women, in each country; and*

*''(B) consults with private and voluntary organizations, including faith-based organizations, the business community, and other donors in the country.*

*''(4) CONGRESSIONAL AND PUBLIC NOTIFICATION AFTER ENTERING INTO A COMPACT.—Not later than 10 days after entering into a compact authorized under subsection (d)(8), the Global AIDS Coordinator shall—*

*''(A) submit a report containing a detailed summary of the compact and a copy of the text of the compact to—*

*''(i) the Committee on Foreign Relations of the Senate;*

*''(ii) the Committee on Appropriations of the Senate;*

*''(iii) the Committee on Foreign Affairs of the House of Representatives; and*

*''(iv) the Committee on Appropriations of the House of Representatives; and*

*''(B) publish such information in the Federal Register and on the Internet website of the Office of the Global AIDS Coordinator.''.*

*(e) ANNUAL REPORT.—Section 104A(f) of such Act, as redesignated, is amended—*

*(1) in paragraph (1), by striking ''Committee on International Relations'' and inserting ''Committee on Foreign Affairs''; and*

*(2) in paragraph (2)—*

*(A) in subparagraph (B), by striking ''and'' at the end;*

*(B) by striking subparagraph (C) and inserting the following:*

*''(C) a detailed breakdown of funding allocations, by program and by country, for prevention activities; and*

*''(D) a detailed assessment of the impact of programs established pursuant to such sections, including—*

*''(i)(I) the effectiveness of such programs in reducing—*

*''(aa) the transmission of HIV, particularly in women and girls;*

*''(bb) mother-to-child transmission of HIV, including through drug treatment and therapies, either directly or by referral; and*

*''(cc) mortality rates from HIV/AIDS;*

*''(II) the number of patients receiving treatment for AIDS in each country that receives assistance under this Act;*

*''(III) an assessment of progress towards the achievement of annual goals set forth in the timetable required under the 5-year strategy established under section 101 of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 and, if annual goals are not being met, the reasons for such failure; and*

*''(IV) retention and attrition data for programs receiving United States assistance, including mortality and loss to follow-up rates, organized overall and by country;*

*''(ii) the progress made toward—*

*''(I) improving health care delivery systems (including the training of health care workers, including doctors, nurses, midwives, pharmacists, laboratory technicians, and compensated community health workers, and the use of codes of conduct for ethical recruiting practices for health care workers);*

*''(II) advancing safe working conditions for health care workers; and*

*''(III) improving infrastructure to promote progress toward universal access to HIV/AIDS prevention, treatment, and care by 2013;*

*''(iii) a description of coordination efforts with relevant executive branch agencies to link HIV/AIDS clinical and social services with non-HIV/AIDS services as part of the United States health and development agenda;*

*''(iv) a detailed description of integrated HIV/AIDS and food and nutrition programs and services, including—*

*''(I) the amount spent on food and nutrition support;*

*''(II) the types of activities supported; and*

*''(III) an assessment of the effectiveness of interventions carried out to improve the health status of persons with HIV/AIDS receiving food or nutritional support;*

*''(v) a description of efforts to improve harmonization, in terms of relevant executive branch agencies, coordination with other public and private entities, and coordination with partner countries' national strategic plans as called for in the 'Three Ones';*

*''(vi) a description of—*

*''(I) the efforts of partner countries that were signatories to the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases to adhere to the goals of such Declaration in terms of investments in public health, including HIV/AIDS; and*

*''(II) a description of the HIV/AIDS investments of partner countries that were not signatories to such Declaration;*

*''(vii) a detailed description of any compacts or framework agreements reached or negotiated between the United States and any partner countries, including a description of the elements of compacts described in subsection (e);*

*''(viii) a description of programs serving women and girls, including—*

*''(I) HIV/AIDS prevention programs that address the vulnerabilities of girls and women to HIV/AIDS;*

*''(II) information on the number of individuals served by programs aimed at reducing the vulnerabilities of women and girls to HIV/AIDS and data on the types, objectives, and duration of programs to address these issues;*

*''(III) information on programs to address the particular needs of adolescent girls and young women; and*

*''(IV) programs to prevent gender-based violence or to assist victims of gender based violence as part of, or in coordination with, HIV/AIDS programs;*

*''(ix) a description of strategies, goals, programs, and interventions to—*

*''(I) address the needs and vulnerabilities of youth populations;*

*''(II) expand access among young men and women to evidence-based HIV/AIDS health care services and HIV prevention programs, including abstinence education programs; and*

*''(III) expand community-based services to meet the needs of orphans and of children and adolescents affected by or vulnerable to HIV/AIDS without increasing stigmatization;*

*''(x) a description of—*

*''(I) the specific strategies funded to ensure the reduction of HIV infection among injection drug users;*

*''(II) the number of injection drug users, by country, reached by such strategies; and*

*''(III) medication-assisted drug treatment for individuals with HIV or at risk of HIV;*

*''(xi) a detailed description of program monitoring, operations research, and impact evaluation research, including—*

*''(I) the amount of funding provided for each research type;*

*''(II) an analysis of cost-effectiveness models; and*

*''(III) conclusions regarding the efficiency, effectiveness, and quality of services as derived from previous or ongoing research and monitoring efforts;*

*''(xii) building capacity to identify, investigate, and stop nosocomial transmission of infectious diseases, including HIV and tuberculosis; and*

*''(xiii) a description of staffing levels of United States government HIV/AIDS teams in countries with significant HIV/AIDS programs, including whether or not a full-time coordinator was on staff for the year.''.*

*(f) AUTHORIZATION OF APPROPRIATIONS.—Section 301(b) of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7631(b)) is amended—*

*(1) in paragraph (1), by striking ''fiscal years 2004 through 2008'' and inserting ''fiscal years 2009 through 2013''; and*

*(2) in paragraph (3), by striking ''fiscal years 2004 through 2008'' and inserting ''fiscal years 2009 through 2013''.*

*(g) RELATIONSHIP TO ASSISTANCE PROGRAMS TO ENHANCE NUTRITION.—Section 301(c) of such Act is amended to read as follows:*

*''(c) FOOD AND NUTRITIONAL SUPPORT.—*

*''(1) IN GENERAL.—As indicated in the report produced by the Institute of Medicine, entitled 'PEPFAR Implementation: Progress and Promise', inadequate caloric intake has been clearly identified as a principal reason for failure of clinical response to antiretroviral therapy. In recognition of the impact of malnutrition as a clinical health issue for many persons living with HIV/AIDS that is often associated with health and economic impacts on these individuals and their families, the Global AIDS Coordinator and the Administrator of the United States Agency for International Development shall—*

*''(A) follow World Health Organization guidelines for HIV/AIDS food and nutrition services;*

*''(B) integrate nutrition programs with HIV/AIDS activities through effective linkages among the health, agricultural, and livelihood sectors and establish additional services in circumstances in which referrals are inadequate or impossible;*

*''(C) provide, as a component of care and treatment programs for persons with HIV/AIDS, food and nutritional support to individuals infected with, and affected by, HIV/AIDS who meet established criteria for nutritional support (including clinically malnourished children and adults, and pregnant and lactating women in programs in need of supplemental support), including—*

*''(i) anthropometric and dietary assessment;*

*''(ii) counseling; and*

*''(iii) therapeutic and supplementary feeding;*

*''(D) provide food and nutritional support for children affected by HIV/AIDS and to communities and households caring for children affected by HIV/AIDS; and*

*''(E) in communities where HIV/AIDS and food insecurity are highly prevalent, support programs to address these often intersecting health problems through community-based assistance programs, with an emphasis on sustainable approaches.*

*''(2) AUTHORIZATION OF APPROPRIATIONS.—Of the amounts authorized to be appropriated under section 401, there are authorized to be appropriated to the President such sums as may be necessary for each of the fiscal years 2009 through 2013 to carry out this subsection.''.*

*(h) ELIGIBILITY FOR ASSISTANCE.—Section 301(d) of such Act is amended to read as follows:*

*''(d) ELIGIBILITY FOR ASSISTANCE.—An organization, including a faith-based organization, that is otherwise eligible to receive assistance under section 104A of the Foreign Assistance Act of 1961, under this Act, or under any amendment made by this Act or by the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008, for HIV/AIDS prevention, treatment, or care—*

''(1) shall not be required, as a condition of receiving such assistance—

''(A) to endorse or utilize a multisectoral or comprehensive approach to combating HIV/AIDS; or

''(B) to endorse, utilize, make a referral to, become integrated with, or otherwise participate in any program or activity to which the organization has a religious or moral objection; and

''(2) shall not be discriminated against in the solicitation or issuance of grants, contracts, or cooperative agreements under such provisions of law for refusing to meet any requirement described in paragraph (1).''.

***SEC. 302. ASSISTANCE TO COMBAT TUBERCULOSIS.***

(a) POLICY.—Section 104B(b) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b–3(b)) is amended to read as follows:

''(b) POLICY.—It is a major objective of the foreign assistance program of the United States to control tuberculosis. In all countries in which the Government of the United States has established development programs, particularly in countries with the highest burden of tuberculosis and other countries with high rates of tuberculosis, the United States should support the objectives of the Global Plan to Stop TB, including through achievement of the following goals:

''(1) Reduce by half the tuberculosis death and disease burden from the 1990 baseline.

''(2) Sustain or exceed the detection of at least 70 percent of sputum smear-positive cases of tuberculosis and the successful treatment of at least 85 percent of the cases detected in countries with established United States Agency for International Development tuberculosis programs.

''(3) In support of the Global Plan to Stop TB, the President shall establish a comprehensive, 5-year United States strategy to expand and improve United States efforts to combat tuberculosis globally, including a plan to support—

''(A) the successful treatment of 4,500,000 new sputum smear tuberculosis patients under DOTS programs by 2013, primarily through direct support for needed services, commodities, health workers, and training, and additional treatment through coordinated multilateral efforts; and

''(B) the diagnosis and treatment of 90,000 new multiple drug resistant tuberculosis cases by 2013, and additional treatment through coordinated multilateral efforts.''.

(b) PRIORITY TO STOP TB STRATEGY.—Section 104B(e) of such Act is amended to read as follows:

''(e) PRIORITY TO STOP TB STRATEGY.—In furnishing assistance under subsection (c), the President shall give priority to—

''(1) direct services described in the Stop TB Strategy, including expansion and enhancement of Directly Observed Treatment Short-course (DOTS) coverage, rapid testing, treatment for individuals infected with both tuberculosis and HIV, and treatment for individuals with multidrug resistant tuberculosis (MDR–TB), strengthening of health systems, use of the International Standards for Tuberculosis Care by all providers, empowering individuals with tuberculosis, and enabling and promoting research to develop new diagnostics, drugs, and vaccines, and program-based operational research relating to tuberculosis; and

''(2) funding for the Global Tuberculosis Drug Facility, the Stop Tuberculosis Partnership, and the Global Alliance for TB Drug Development.''.

(c) ASSISTANCE FOR THE WORLD HEALTH ORGANIZATION AND THE STOP TUBERCULOSIS PARTNERSHIP.—Section 104B of such Act is amended—

(1) by redesignating subsection (f) as subsection (h); and

(2) by inserting after subsection (e) the following:

''(f) ASSISTANCE FOR THE WORLD HEALTH ORGANIZATION AND THE STOP TUBERCULOSIS PARTNERSHIP.—In carrying out this section, the President, acting through the Administrator of the United States Agency for International Development, is authorized to provide increased resources to the World Health Organization and the Stop Tuberculosis Partnership to improve the capacity of countries with high rates of tuberculosis and other affected countries to implement the Stop TB Strategy and specific strategies related to addressing multiple drug resistant tuberculosis (MDR–TB) and extensively drug resistant tuberculosis (XDR–TB).''.

(d) ANNUAL REPORT.—Section 104B of such Act is amended by inserting after subsection (f), as added by subsection (c) of this section, the following:

''(g) ANNUAL REPORT.—The President shall submit an annual report to Congress that describes the impact of United States foreign assistance on efforts to control tuberculosis, including—

''(1) the number of tuberculosis cases diagnosed and the number of cases cured in countries receiving United States bilateral foreign assistance for tuberculosis control purposes;

''(2) a description of activities supported with United States tuberculosis resources in each country, including a description of how those activities specifically contribute to increasing the number of people diagnosed and treated for tuberculosis;

''(3) in each country receiving bilateral United States foreign assistance for tuberculosis control purposes, the percentage provided for direct tuberculosis services in countries receiving United States bilateral foreign assistance for tuberculosis control purposes;

''(4) a description of research efforts and clinical trials to develop new tools to combat tuberculosis, including diagnostics, drugs, and vaccines supported by United States bilateral assistance;

''(5) the number of persons who have been diagnosed and started treatment for multidrug-resistant tuberculosis in countries receiving United States bilateral foreign assistance for tuberculosis control programs;

''(6) a description of the collaboration and coordination of United States anti-tuberculosis efforts with the World Health Organization, the Global Fund, and other major public and private entities within the Stop TB Strategy;

''(7) the constraints on implementation of programs posed by health workforce shortages and capacities;

''(8) the number of people trained in tuberculosis control; and

''(9) a breakdown of expenditures for direct patient tuberculosis services, drugs and other commodities, drug management, training in diagnosis and treatment, health systems strengthening, research, and support costs.''.

(e) DEFINITIONS.—Section 104B(h) of such Act, as redesignated by subsection (c), is amended—

(1) in paragraph (1), by striking the period at the end and inserting the following: ''including—

''(A) low-cost and effective diagnosis, treatment, and monitoring of tuberculosis;

''(B) a reliable drug supply;

''(C) a management strategy for public health systems;

''(D) health system strengthening;

''(E) promotion of the use of the International Standards for Tuberculosis Care by all care providers;

''(F) bacteriology under an external quality assessment framework;

''(G) short-course chemotherapy; and

''(H) sound reporting and recording systems.''; and

(2) by redesignating paragraph (5) as paragraph (6); and

(3) by inserting after paragraph (4) the following:

''(5) STOP TB STRATEGY.—The term 'Stop TB Strategy' means the 6-point strategy to reduce tuberculosis developed by the World Health Organization, which is described in the Global Plan to Stop TB 2006–2015: Actions for Life, a comprehensive plan developed by the Stop TB Partnership that sets out the actions necessary to achieve the millennium development goal of cutting tuberculosis deaths and disease burden in half by 2015.''.

(f) AUTHORIZATION OF APPROPRIATIONS.—Section 302 (b) of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7632(b)) is amended—

(1) in paragraph (1), by striking ''such sums as may be necessary for each of the fiscal years 2004 through 2008'' and inserting ''a total of $4,000,000,000 for the 5-year period beginning on October 1, 2008.''; and

(2) in paragraph (3), by striking ''fiscal years 2004 through 2008'' and inserting ''fiscal years 2009 through 2013.''.

***SEC. 303. ASSISTANCE TO COMBAT MALARIA.***

(a) AMENDMENT TO THE FOREIGN ASSISTANCE ACT OF 1961.—Section 104C(b) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151–4(b)) is amended by inserting ''treatment,'' after ''control,''.

(b) AUTHORIZATION OF APPROPRIATIONS.—Section 303 of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, and Malaria Act of 2003 (22 U.S.C. 7633) is amended—

(1) in subsection (b)—

(A) in paragraph (1), by striking ''such sums as may be necessary for fiscal years 2004 through 2008'' and inserting ''$5,000,000,000 during the 5-year period beginning on October 1, 2008''; and

(B) in paragraph (3), by striking ''fiscal years 2004 through 2008'' and inserting ''fiscal years 2009 through 2013''; and

(2) by adding at the end the following:

''(c) STATEMENT OF POLICY.—Providing assistance for the prevention, control, treatment, and the ultimate eradication of malaria is—

''(1) a major objective of the foreign assistance program of the United States; and

''(2) 1 component of a comprehensive United States global health strategy to reduce disease burdens and strengthen communities around the world.

''(d) DEVELOPMENT OF A COMPREHENSIVE 5-YEAR STRATEGY.—The President shall establish a comprehensive, 5-year strategy to combat global malaria that—

''(1) strengthens the capacity of the United States to be an effective leader of international efforts to reduce malaria burden;

''(2) maintains sufficient flexibility and remains responsive to the ever-changing nature of the global malaria challenge;

''(3) includes specific objectives and multisectoral approaches and strategies to reduce the prevalence, mortality, incidence, and spread of malaria;

''(4) describes how this strategy would contribute to the United States' overall global health and development goals;

''(5) clearly explains how outlined activities will interact with other United States Government global health activities, including the 5-year global AIDS strategy required under this Act;

''(6) expands public-private partnerships and leverage of resources;

''(7) coordinates among relevant Federal agencies to maximize human and financial resources and to reduce duplication among these agencies, foreign governments, and international organizations;

''(8) coordinates with other international entities, including the Global Fund;

''(9) maximizes United States capabilities in the areas of technical assistance and training and research, including vaccine research; and

''(10) establishes priorities and selection criteria for the distribution of resources based on factors such as—

''(A) the size and demographics of the population with malaria;

''(B) the needs of that population;

''(C) the country's existing infrastructure; and

''(D) the ability to closely coordinate United States Government efforts with national malaria control plans of partner countries.''.

***SEC. 304. MALARIA RESPONSE COORDINATOR.***

*Section 304 of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7634) is amended to read as follows:*

***"SEC. 304. MALARIA RESPONSE COORDINATOR.***

''(a) IN GENERAL.—There is established within the United States Agency for International Development a Coordinator of United States Government Activities to Combat Malaria Globally (referred to in this section as the 'Malaria Coordinator'), who shall be appointed by the President.

''(b) AUTHORITIES.—The Malaria Coordinator, acting through nongovernmental organizations (including faith-based and community-based organizations), partner country finance, health, and other relevant ministries, and relevant executive branch agencies as may be necessary and appropriate to carry out this section, is authorized to—

''(1) operate internationally to carry out prevention, care, treatment, support, capacity development, and other activities to reduce the prevalence, mortality, and incidence of malaria;

''(2) provide grants to, and enter into contracts and cooperative agreements with, nongovernmental organizations (including faith-based organizations) to carry out this section; and

''(3) transfer and allocate executive branch agency funds that have been appropriated for the purposes described in paragraphs (1) and (2).

''(c) DUTIES.—

''(1) IN GENERAL.—The Malaria Coordinator has primary responsibility for the oversight and coordination of all resources and international activities of the United States Government relating to efforts to combat malaria.

''(2) SPECIFIC DUTIES.—The Malaria Coordinator shall—

''(A) facilitate program and policy coordination of antimalarial efforts among relevant executive branch agencies and nongovernmental organizations by auditing, monitoring, and evaluating such programs;

''(B) ensure that each relevant executive branch agency undertakes antimalarial programs primarily in those areas in which the agency has the greatest expertise, technical capability, and potential for success;

''(C) coordinate relevant executive branch agency activities in the field of malaria prevention and treatment;

''(D) coordinate planning, implementation, and evaluation with the Global AIDS Coordinator in countries in which both programs have a significant presence;

''(E) coordinate with national governments, international agencies, civil society, and the private sector; and

''(F) establish due diligence criteria for all recipients of funds appropriated by the Federal Government for malaria assistance.

''(d) ASSISTANCE FOR THE WORLD HEALTH ORGANIZATION.—In carrying out this section, the President may provide financial assistance to the Roll Back Malaria Partnership of the World Health Organization to improve the capacity of countries with high rates of malaria and other affected countries to implement comprehensive malaria control programs.

''(e) COORDINATION OF ASSISTANCE EFFORTS.—In carrying out this section and in accordance with section 104C of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b–4), the Malaria Coordinator shall coordinate the provision of assistance by working with—

''(1) relevant executive branch agencies, including—

''(A) the Department of State (including the Office of the Global AIDS Coordinator);

''(B) the Department of Health and Human Services;

''(C) the Department of Defense; and

''(D) the Office of the United States Trade Representative;

''(2) relevant multilateral institutions, including—

''(A) the World Health Organization;

''(B) the United Nations Children's Fund;

''(C) the United Nations Development Programme;

''(D) the Global Fund;

''(E) the World Bank; and

''(F) the Roll Back Malaria Partnership;

''(3) program delivery and efforts to lift barriers that would impede effective and comprehensive malaria control programs; and

''(4) partner or recipient country governments and national entities including universities and civil society organizations (including faith- and community-based organizations).

''(f) RESEARCH.—To carry out this section, the Malaria Coordinator, in accordance with section 104C of the Foreign Assistance Act of 1961 (22 U.S.C. 1151d–4), shall ensure that operations and implementation research conducted under this Act will closely complement the clinical and program research being undertaken by the National Institutes of Health. The Centers for Disease Control and Prevention should advise the Malaria Coordinator on priorities for operations and implementation research and should be a key implementer of this research.

''(g) MONITORING.—To ensure that adequate malaria controls are established and implemented, the Centers for Disease Control and Prevention should advise the Malaria Coordinator on monitoring, surveillance, and evaluation activities and be a key implementer of such activities under this Act. Such activities shall complement, rather than duplicate, the work of the World Health Organization.

''(h) ANNUAL REPORT.—

''(1) SUBMISSION.—Not later than 1 year after the date of the enactment of the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008, and annually thereafter, the President shall submit a report to the appropriate congressional committees that describes United States assistance for the prevention, treatment, control, and elimination of malaria.

''(2) CONTENTS.—The report required under paragraph (1) shall describe—

''(A) the countries and activities to which malaria resources have been allocated;

''(B) the number of people reached through malaria assistance programs, including data on children and pregnant women;

''(C) research efforts to develop new tools to combat malaria, including drugs and vaccines;

''(D) the collaboration and coordination of United States antimalarial efforts with the World Health Organization, the Global Fund, the World Bank, other donor governments, major private efforts, and relevant executive agencies;

''(E) the coordination of United States antimalarial efforts with the national malarial strategies of other donor or partner governments and major private initiatives;

''(F) the estimated impact of United States assistance on childhood mortality and morbidity from malaria;

''(G) the coordination of antimalarial efforts with broader health and development programs; and

''(H) the constraints on implementation of programs posed by health workforce shortages or capacities; and

''(I) the number of personnel trained as health workers and the training levels achieved.''.

***SEC. 305. AMENDMENT TO IMMIGRATION AND NATIONALITY ACT.***

*Section 212(a)(1)(A)(i) of the Immigration and Nationality Act (8 U.S.C. 1182(a)(1)(A)(i)) is amended by striking '', which shall include infection with the etiologic agent for acquired immune deficiency syndrome,'' and inserting a semicolon.*

***SEC. 306. CLERICAL AMENDMENT.***

*Title III of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7631 et seq.) is amended by striking the heading for subtitle B and inserting the following:*

***"Subtitle B—Assistance for Women, Children, and Families".***

***SEC. 307. REQUIREMENTS.***

*Section 312(b) of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7652(b)) is amended by striking paragraphs (1), (2), and (3) and inserting the following:*

''(1) establish a target for the prevention and treatment of mother-to-child transmission of HIV that, by 2013, will reach at least 80 percent of pregnant women in those countries most affected by HIV/AIDS in which the United States has HIV/AIDS programs;

''(2) establish a target that, by 2013, the proportion of children receiving care and treatment under this Act is proportionate to their numbers within the population of HIV infected individuals in each country;

''(3) integrate care and treatment with prevention of mother-to-child transmission of HIV programs to improve outcomes for HIV-affected women and families as soon as is feasible and support strategies that promote successful follow-up and continuity of care of mother and child;

''(4) expand programs designed to care for children orphaned by, affected by, or vulnerable to HIV/AIDS;

''(5) ensure that women in prevention of mother-to-child transmission of HIV programs are provided with, or referred to, appropriate maternal and child services; and

''(6) develop a timeline for expanding access to more effective regimes to prevent mother-to-child transmission of HIV, consistent with the national policies of countries in which programs are administered under this Act and the goal of achieving universal use of such regimes as soon as possible.''.

***SEC. 308. ANNUAL REPORT ON PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV.***

*Section 313(a) of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7653(a)) is amended by striking ''5 years'' and inserting ''10 years''.*

***SEC. 309. PREVENTION OF MOTHER-TO-CHILD TRANSMISSION EXPERT PANEL.***

*Section 312 of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7652) is amended by adding at the end the following:*

''(c) PREVENTION OF MOTHER-TO-CHILD TRANSMISSION EXPERT PANEL.—

''(1) ESTABLISHMENT.—The Global AIDS Coordinator shall establish a panel of experts to be known as the Prevention of Mother-to-Child Transmission Panel (referred to in this subsection as the 'Panel') to—

''(A) provide an objective review of activities to prevent mother-to-child transmission of HIV; and

''(B) provide recommendations to the Global AIDS Coordinator and to the appropriate congressional committees for scale-up of mother-to-child transmission prevention services under this Act in order to achieve the target established in subsection (b)(1).

''(2) MEMBERSHIP.—The Panel shall be convened and chaired by the Global AIDS Coordinator, who shall serve as a nonvoting member. The Panel shall consist of not more than 15 members (excluding the Global AIDS Coordinator), to be appointed by the Global AIDS Coordinator not later than 1 year after the date of the enactment of this Act, including—

''(A) 2 members from the Department of Health and Human Services with expertise relating to the prevention of mother-to-child transmission activities;

''(B) 2 members from the United States Agency for International Development with expertise relating to the prevention of mother-to-child transmission activities;

''(C) 2 representatives from among health ministers of national governments of foreign countries in which programs under this Act are administered;

''(D) 3 members representing organizations implementing prevention of mother-to-child transmission activities under this Act;

''(E) 2 health care researchers with expertise relating to global HIV/AIDS activities; and

''(F) representatives from among patient advocate groups, health care professionals, persons living with HIV/AIDS, and non-governmental organizations with expertise relating to the prevention of mother-to-child transmission activities, giving priority to individuals in foreign countries in which programs under this Act are administered.

''(3) DUTIES OF PANEL.—The Panel shall—

''(A) assess the effectiveness of current activities in reaching the target described in subsection (b)(1);

''(B) review scientific evidence related to the provision of mother-to-child transmission prevention services, including programmatic data and data from clinical trials;

''(C) review and assess ways in which the Office of the United States Global AIDS Coordinator collaborates with international and multilateral entities on efforts to prevent mother-to-child transmission of HIV in affected countries;

''(D) identify barriers and challenges to increasing access to mother-to-child transmission prevention services and evaluate potential mechanisms to alleviate those barriers and challenges;

''(E) identify the extent to which stigma has hindered pregnant women from obtaining HIV counseling and testing or returning for results, and provide recommendations to address such stigma and its effects;

''(F) identify opportunities to improve linkages between mother-to-child transmission prevention services and care and treatment programs; and

''(G) recommend specific activities to facilitate reaching the target described in subsection (b)(1).

''(4) REPORT.—

''(A) IN GENERAL.—Not later than 1 year after the date on which the Panel is first convened, the Panel shall submit a report containing a detailed statement of the recommendations, findings, and conclusions of the Panel to the appropriate congressional committees.

''(B) AVAILABILITY.—The report submitted under subparagraph (A) shall be made available to the public.

''(C) CONSIDERATION BY COORDINATOR.—The Coordinator shall—

''(i) consider any recommendations contained in the report submitted under subparagraph (A); and

''(ii) include in the annual report required under section 104A(f) of the Foreign Assistance Act of 1961 a description of the activities conducted in response to the recommendations made by the Panel and an explanation of any recommendations not implemented at the time of the report.

''(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Panel such sums as may be necessary for each of the fiscal years 2009 through 2011 to carry out this section.

''(6) TERMINATION.—The Panel shall terminate on the date that is 60 days after the date on which the Panel submits the report to the appropriate congressional committees under paragraph (4).''.

## TITLE IV—FUNDING ALLOCATIONS

### SEC. 401. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—Section 401(a) of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7671(a)) is amended by striking ''$3,000,000,000 for each of the fiscal years 2004 through 2008'' and inserting ''$48,000,000,000 for the 5-year period beginning on October 1, 2008''.

(b) SENSE OF CONGRESS.—It is the sense of the Congress that the appropriations authorized under section 401(a) of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, as amended by subsection (a), should be allocated among fiscal years 2009 through 2013 in a manner that allows for the appropriations to be gradually increased in a manner that is consistent with program requirements, absorptive capacity, and priorities set forth in such Act, as amended by this Act.

### SEC. 402. SENSE OF CONGRESS.

Section 402(b) of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7672(b)) is amended by striking ''an effective distribution of such amounts would be'' and all that follows through ''10 percent of such amounts'' and inserting ''10 percent should be used''.

### SEC. 403. ALLOCATION OF FUNDS.

Section 403 of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7673) is amended—

(1) by amending subsection (a) to read as follows:

''(a) BALANCED FUNDING REQUIREMENT.—

''(1) IN GENERAL.—The Global AIDS Coordinator shall—

''(A) provide balanced funding for prevention activities for sexual transmission of HIV/AIDS; and

''(B) ensure that activities promoting abstinence, delay of sexual debut, monogamy, fidelity, and partner reduction are implemented and funded in a meaningful and equitable way in the strategy for each host country based on objective epidemiological evidence as to the source of infections and in consultation with the government of each host county involved in HIV/AIDS prevention activities.

''(2) PREVENTION STRATEGY.—

''(A) ESTABLISHMENT.—In carrying out paragraph (1), the Global AIDS Coordinator shall establish an HIV sexual transmission prevention strategy governing the expenditure of funds authorized under this Act to prevent the sexual transmission of HIV in any host country with a generalized epidemic.

''(B) REPORT.—In each host country described in subparagraph (A), if the strategy established under subparagraph (A) provides less than 50 percent of the funds described in subparagraph (A) for activities promoting abstinence, delay of sexual debut, monogamy, fidelity, and partner reduction, the Global AIDS Coordinator shall, not later than 30 days after the issuance of this strategy, report to the appropriate congressional committees on the justification for this decision.

''(3) EXCLUSION.—Programs and activities that implement or purchase new prevention technologies or modalities, such as medical male circumcision, public education about risks to acquire HIV infection from blood exposures, promoting universal precautions, investigating suspected nosocomial infections, pre-exposure pharmaceutical prophylaxis to prevent transmission of HIV, or microbicides and programs and activities that provide counseling and testing for HIV or prevent mother-to-child prevention of HIV, shall not be included in determining compliance with paragraph (2).

''(4) REPORT.—Not later than 1 year after the date of the enactment of the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008, and annually thereafter as part of the annual report required under section 104A(e) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b–2(e)), the President shall—

''(A) submit a report on the implementation of paragraph (2) for the most recently concluded fiscal year to the appropriate congressional committees; and

''(B) make the report described in subparagraph (A) available to the public.'';

(2) in subsection (b)—

(A) by striking ''fiscal years 2006 through 2008'' and inserting ''fiscal years 2009 through 2013''; and

(B) by striking ''vulnerable children affected by'' and inserting ''other children affected by, or vulnerable to,''; and

(3) by adding at the end the following:

''(c) FUNDING ALLOCATION.—For each of the fiscal years 2009 through 2013, more than half of the amounts appropriated for bilateral global HIV/AIDS assistance pursuant to section 401 shall be expended for—

''(1) antiretroviral treatment for HIV/AIDS;

''(2) clinical monitoring of HIV-seropositive people not in need of antiretroviral treatment;

''(3) care for associated opportunistic infections;

''(4) nutrition and food support for people living with HIV/AIDS; and

''(5) other essential HIV/AIDS-related medical care for people living with HIV/AIDS.

''(d) TREATMENT, PREVENTION, AND CARE GOALS.—For each of the fiscal years 2009 through 2013—

''(1) the treatment goal under section 402(a)(3) shall be increased above 2,000,000 by at least the percentage increase in the amount appropriated for bilateral global HIV/AIDS assistance for such fiscal year compared with fiscal year 2008;

''(2) any increase in the treatment goal under section 402(a)(3) above the percentage increase in the amount appropriated for bilateral global HIV/AIDS assistance for such fiscal year compared with fiscal year 2008 shall be based on long-term requirements, epidemiological evidence, the share of treatment needs being met by partner governments and other sources of treatment funding, and other appropriate factors;

''(3) the treatment goal under section 402(a)(3) shall be increased above the number calculated under paragraph (1) by the same percentage that the average United States Government cost per patient of providing treatment in countries receiving bilateral HIV/AIDS assistance has decreased compared with fiscal year 2008; and

''(4) the prevention and care goals established in clauses (i) and (iv) of section 104A(b)(1)(A) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b–2(b)(1)(A)) shall be increased consistent with epidemiological evidence and available resources.''.

## TITLE V—MISCELLANEOUS

### SEC. 501. MACHINE READABLE VISA FEES.

(a) FEE INCREASE.—Notwithstanding any other provision of law—

(1) not later than October 1, 2010, the Secretary of State shall increase by $1 the fee or surcharge authorized under section 140(a) of the Foreign Relations Authorization Act, Fiscal Years 1994 and 1995 (Public Law 103–236; 8 U.S.C. 1351 note) for processing machine readable nonimmigrant visas and machine readable combined border crossing identification cards and nonimmigrant visas; and

(2) not later than October 1, 2013, the Secretary shall increase the fee or surcharge described in paragraph (1) by an additional $1.

(b) DEPOSIT OF AMOUNTS.—Notwithstanding section 140(a)(2) of the Foreign Relations Authorization Act, Fiscal Years 1994 and 1995 (Public Law 103–236; 8 U.S.C. 1351 note), fees collected under the authority of subsection (a) shall be deposited in the Treasury.

## TITLE VI—EMERGENCY PLAN FOR INDIAN SAFETY AND HEALTH

### SEC. 601. EMERGENCY PLAN FOR INDIAN SAFETY AND HEALTH.

(a) ESTABLISHMENT OF FUND.—There is established in the Treasury of the United States a

*fund, to be known as the ''Emergency Fund for Indian Safety and Health'' (referred to in this section as the ''Fund''), consisting of such amounts as are appropriated to the Fund under subsection (b).*

*(b) TRANSFERS TO FUND.—*

*(1) IN GENERAL.—There is authorized to be appropriated to the Fund, out of funds of the Treasury not otherwise appropriated, $2,000,000,000 for the 5-year period beginning on October 1, 2008.*

*(2) AVAILABILITY OF AMOUNTS.—Amounts deposited in the Fund under this section shall—*

*(A) be made available without further appropriation;*

*(B) be in addition to amounts made available under any other provision of law; and*

*(C) remain available until expended.*

*(c) EXPENDITURES FROM FUND.—On request by the Attorney General, the Secretary of the Interior, or the Secretary of Health and Human Services, the Secretary of the Treasury shall transfer from the Fund to the Attorney General, the Secretary of the Interior, or the Secretary of Health and Human Services, as appropriate, such amounts as the Attorney General, the Secretary of the Interior, or the Secretary of Health and Human Services determines to be necessary to carry out the emergency plan under subsection (f).*

*(d) TRANSFERS OF AMOUNTS.—*

*(1) IN GENERAL.—The amounts required to be transferred to the Fund under this section shall be transferred at least monthly from the general fund of the Treasury to the Fund on the basis of estimates made by the Secretary of the Treasury.*

*(2) ADJUSTMENTS.—Proper adjustment shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or less than the amounts required to be transferred.*

*(e) REMAINING AMOUNTS.—Any amounts remaining in the Fund on September 30 of an applicable fiscal year may be used by the Attorney General, the Secretary of the Interior, or the Secretary of Health and Human Services to carry out the emergency plan under subsection (f) for any subsequent fiscal year.*

*(f) EMERGENCY PLAN.—Not later than 1 year after the date of enactment of this Act, the Attorney General, the Secretary of the Interior, and the Secretary of Health and Human Services, in consultation with Indian tribes (as defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b)), shall jointly establish an emergency plan that addresses law enforcement, water, and health care needs of Indian tribes under which, for each of fiscal years 2010 through 2019, of amounts in the Fund—*

*(1) the Attorney General shall use—*

*(A) 18.5 percent for the construction, rehabilitation, and replacement of Federal Indian detention facilities;*

*(B) 1.5 percent to investigate and prosecute crimes in Indian country (as defined in section 1151 of title 18, United States Code);*

*(C) 1.5 percent for use by the Office of Justice Programs for Indian and Alaska Native programs; and*

*(D) 0.5 percent to provide assistance to—*

*(i) parties to cross-deputization or other cooperative agreements between State or local governments and Indian tribes (as defined in section 102 of the Federally Recognized Indian Tribe List Act of 1994 (25 U.S.C. 479a)) carrying out law enforcement activities in Indian country; and*

*(ii) the State of Alaska (including political subdivisions of that State) for carrying out the Village Public Safety Officer Program and law enforcement activities on Alaska Native land (as defined in section 3 of Public Law 103–399 (25 U.S.C. 3902));*

*(2) the Secretary of the Interior shall—*

*(A) deposit 15.5 percent in the public safety and justice account of the Bureau of Indian Affairs for use by the Office of Justice Services of the Bureau in providing law enforcement or detention services, directly or through contracts or compacts with Indian tribes under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.); and*

*(B) use 50 percent to implement requirements of Indian water settlement agreements that are approved by Congress (or the legislation to implement such an agreement) under which the United States shall plan, design, rehabilitate, or construct, or provide financial assistance for the planning, design, rehabilitation, or construction of, water supply or delivery infrastructure that will serve an Indian tribe (as defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b)); and*

*(3) the Secretary of Health and Human Services, acting through the Director of the Indian Health Service, shall use 12.5 percent to provide, directly or through contracts or compacts with Indian tribes under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)—*

*(A) contract health services;*

*(B) construction, rehabilitation, and replacement of Indian health facilities; and*

*(C) domestic and community sanitation facilities serving members of Indian tribes (as defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b)) pursuant to section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a).*

MOTION OFFERED BY MR. BERMAN

Mr. BERMAN. Mr. Speaker, I offer the motion at the desk.

The SPEAKER pro tempore. The Clerk will designate the motion.

The text of the motion is as follows:

Motion offered by Mr. BERMAN:

Mr. BERMAN moves that the House concur in the Senate amendment.

The SPEAKER pro tempore. Pursuant to House Resolution 1362, the gentleman from California (Mr. BERMAN) and the gentlewoman from Florida (Ms. ROS-LEHTINEN) each will control 30 minutes.

The Chair recognizes the gentleman from California.

Mr. BERMAN. Mr. Speaker, I rise in strong support of this bill, and I yield myself 7 minutes.

Mr. Speaker, a few short months ago the House gave its strong bipartisan approval to H.R. 5501, the Tom Lantos and Henry J. Hyde Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008. Last Thursday, the Senate followed suit, approving its amendment to the House bill by an overwhelming margin of 80–16.

We meet today to take up the Senate amendments and to send this bipartisan legislation to the President for his signature. The measure before the House today is a compromise, a compromise between Democrats and Republicans, between the House and the Senate, and between Congress and the executive branch. The fact that compromise was achievable in this highly politicized era is a testament to the bipartisan roots of this legislation.

Five years ago, Tom Lantos and Henry Hyde, our dear deceased colleagues, working closely with the White House, crafted a global HIV/AIDS bill that enjoyed broad bipartisan support. This groundbreaking legislation had a clear and achievable goal, to respond with compassion to those who were dying of AIDS, dramatically increase our Nation's efforts to stop the spread of HIV virus, provide care to children orphaned by AIDS, and get lifesaving medications immediately to those in need.

As a result, our Nation has provided lifesaving antiretroviral medicines to nearly 1½ million men, women and children, supported care for nearly 7 million people, including nearly 3 million orphans and vulnerable children, and prevented an estimated 150,000 infant infections around the world.

Most importantly, the United States has given hope to millions infected with the HIV virus, which just a few short years ago was tantamount to a death sentence.

This law worked well as an emergency intervention to deal with the rapidly expanding HIV/AIDS crisis. But the nature of that disease has changed significantly since then. We now have 5 years of experience in grappling with this pandemic on a global scale, and the reauthorization bill before us reflects what we have learned.

The law we passed in 2003 was designed to deal with the emergency phase of the HIV/AIDS crisis. This legislation moves our programs towards long-term sustainability that will keep the benefit of U.S. global HIV/AIDS programs flowing to those in need. With this reauthorization, host governments will also gain the ability to plan, direct and manage prevention, treatment and care programs that were originally established with U.S. assistance.

The reauthorization bill authorizes nearly $50 billion over 5 years for these three pandemics. These additional funds allow us to significantly boost the health care workforce in those countries hard hit by HIV/AIDS with new professional and paraprofessional training programs, and to increase the number of HIV positive individuals receiving lifesaving medicine.

The 2003 law focused on creating new programs to tackle the crisis. The reauthorization bill increases the number of individuals receiving prevention treatment and care services. It builds stronger linkages between the global HIV/AIDS initiative and existing programs designed to alleviate hunger among those treated. It helps to improve health care and bolster HIV education in schools.

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The 2003 law began to address the needs of women and girls. But given the changing nature of the epidemic, we clearly did not go far enough to meet these needs.

The new legislation remedies this situation by strengthening prevention and treatment programs aimed at this extremely vulnerable population. The Lantos-Hyde bill eliminates the one-third abstinence-only earmark, but requires a balanced approach to sexual

transmission programs and a report regarding this approach in countries where the epidemic has become generalized.

In an effort to ensure that our contributions to the global fund are being wisely spent, the bill provides for certain benchmarks to improve the transparency and the accountability of the fund. The bill incorporates tuberculosis prevention from H.R. 1567 sponsored by Congressman ENGEL. It seeks to further integrate HIV/AIDS programs with TB and malaria programs and create linkages and referrals between these programs for patients.

H.R. 5501 heightens U.S. efforts to combat malaria by requiring the development of a comprehensive 5-year strategy to combat this disease. It creates a new U.S. Government Malaria Coordinator, and it enhances support for clinical research for new diagnostics, treatments, and interventions to prevent, cure, and control malaria.

The Senate made several changes in our bill. It overturned the existing visa ban on HIV-positive individuals. It targeted $2 billion of the $50 billion authorization for Indian health care, water resources, and law enforcement issues. It modified the goal for people living with AIDS and removed a linkage between the global HIV/AIDS program and family planning.

Despite these changes, the language before the House today is very close to what we approved last April. With passage of this reauthorization bill, Congress signals to the world that the United States would exercise continued leadership in the global battle against malaria, tuberculosis, and HIV/AIDS.

So what we have here is a bipartisan bill providing nearly $50 billion for the battle against HIV/AIDS, tuberculosis, and malaria, a bill that has strong bipartisan support, and one that the President has indicated he will sign into law.

I urge my colleagues to support this legislation, and I want to take special note that in the short time that I have been chairing this committee, I want to mention two particular people who have both helped educate me, two Members, colleagues on the committee who have played a major role in helping to guide this legislation and the earlier legislation: the chairman of the Africa Subcommittee, DON PAYNE, and Congresswoman BARBARA LEE, both of whom have been involved in this legislation and the previous legislation from the beginning and were pushing for this even long before that passed.

With that, I reserve the balance of my time.

Ms. ROS-LEHTINEN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, many of us seek a place in this hallowed institution to serve our country and our constituents, to make a difference, to help change the world for the better. Mr. Speaker, today we are given an opportunity to edge ever closer to the accomplishment of these goals.

Today we have an opportunity to positively impact the lives of countless human beings worldwide by recommitting ourselves to fighting and eliminating a great threat to our international security, and that is the global AIDS pandemic.

The bill before us reauthorizes the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003. Before this bill was enacted, known as PEPFAR, only 55,000 people living in sub-Saharan Africa were receiving life-saving treatment, but according to the Office of the Global AIDS Coordinator, through PEPFAR, the United States now has supported treatment for 1.68 million people in Africa and 1.73 million people worldwide.

Further, the United States has provided prevention of mother-to-child HIV transmission services for women enduring nearly 12.7 million pregnancies. We have also prevented an estimated 194,000 infant infections. We have supported care for more than 6.6 million people in need, including more than 2.7 million orphans and vulnerable children. We have supported over 33 million counseling and testing sessions to date for men, women, and children.

These successes are truly remarkable and serve as a testament that all can be accomplished when Members from the House and the Senate on both sides of the aisle work together to find solutions to one of the world's most pressing challenges.

The 2008 reauthorization seeks to consolidate and advance the successes of the past 5 years by providing the funding and the framework to transform this from an emergency program to a sustainable program. It stands as a noble legacy of the late Henry J. Hyde and Tom Lantos who spearheaded this mission of mercy 5 years ago, and I am proud that the bill bears their names.

The stakes for this initiative, Mr. Speaker, are higher than ever. Despite the best efforts of responsible nations to confront the global AIDS pandemic, there are now over 33 million people around the world living with this disease. An estimated 7,000 new infections occur every day. In its wake, the HIV/AIDS pandemic is leaving a trail of poverty, of despondency, of death, which has destabilized societies and undermined the security of entire regions.

Our former House colleague and current ambassador to Tanzania, the Honorable Mark Green, wrote to me highlighting the threat that HIV/AIDS poses to the security of our country. And he said, ''In tearing apart the social fabric and leaving a generation of orphans, the scourge of HIV/AIDS could create a long-term breeding ground for radicalism.''

So it is therefore incumbent upon us, Mr. Speaker, to advance this critical program which not only saves lives and exemplifies the generous humanitarian nature of the American people, but it also helps to preserve our national security.

It is important to note that even in the most remote areas of Kenya or Haiti, for example, people know about the PEPFAR program. They know from where the test kits, the medicines, and other life-saving support is coming. They recognize the leadership and the resources that the United States has provided in an effort to fight this deadly disease, and they are deeply appreciative. This is not just a health program. This is a public diplomacy program as well, and it has greatly enhanced global understanding of the true nature and the essence of the American people at a critical time in our Nation's history. We have led by example, and our success has been measured in human lives saved.

Now, the House has debated and adopted this bill by an overwhelming margin in April of this year. This House text was the product of a bipartisan compromise that preserved the spirit of the 2003 Act while balancing a number of congressional imperatives. Just as in the House, our Senate colleagues sought to produce legislation that would capitalize and expand upon the success of the energy plan while maintaining the bipartisan political consensus that has guided this program from its inception.

After 3 months of negotiations, the amendment before us was approved in the Senate by a margin of 80–16, demonstrating the strong bipartisan commitment of the Senate of their own carefully constructed compromise.

The Senate amendment contains numerous modifications to the text approved by the House in April. It reduces the authorization of HIV/AIDS, tuberculosis, and malaria programs from $50 billion to $48 billion. It allows for a gradual increase of resources over time rather than authorizing $10 billion for each of the fiscal years 2008 through 2013. It requires more than half of all funding appropriated for bilateral HIV/AIDS assistance be expended for treatment and care. It replaces the hard target for treatment with a sliding scale whereby the treatment target will increase over $3 million in direct proportion to increased appropriations. And further, it authorizes the use of compacts as further vehicles for HIV/AIDS assistance in an effort to promote sustainability.

Mr. Speaker, the Senate amendment preserves and strengthens other critical provisions that were at the heart of the House compromise overwhelmingly adopted in April. For example, it corrects an unintended omission by including care under the conscience clause which allows faith-based organizations to disassociate themselves from any program or activity to which they have a religious or moral objection. Also, it amends the abstinence and fidelity language contained in section 403 by striking behavior change programs including abstinence and fidelity, and inserting activities promoting

abstinence and fidelity. This modification provides clarity to the compromise reached in the House last spring.

The Senate amendment also includes two provisions that have raised some concern, including the establishment of a $2 billion emergency plan for Indian safety and health, and the lifting of certain restrictions under the Immigration and Nationality Act.

The first provision, the Indian Safety and Health title of the Senate amendment initially raised concerns about mandatory spending and unfunded mandates. However, the Congressional Budget Office has verified that the language in question is an authorization and does not have implications for direct spending.

It also bears mentioning that the health programs will be implemented through the Indian Health Service which is subject to the rules and regulations of the Department of Health and Human Services.

With respect to the second item, Mr. Speaker, lifting the ban is largely symbolic because the authority to waive the restriction already exists and is routinely exercised, albeit on a case-by-case basis. Furthermore, an alien with HIV would still be inadmissible under current HHS recommendations on communicable diseases of public health significance, and this would continue to be the case until and unless the regulations are changed. The Senate amendment includes offsets for the estimated additional costs involved with the processing of these new visas.

Throughout this process, Members on both sides of the aisle have been forced to make difficult choices to arrive at a consensus that carefully balances U.S. priorities and the range of congressional concerns. The challenges have been great and at times have seemed insurmountable. But a failure to act now would imperil our ability to provide life-saving support to millions of people in need around the world and will ultimately undermine what is arguably the most successful United States foreign assistance and public diplomacy program today.

We have been given a unique opportunity to help make the world a better place for those who have been victimized by the AIDS pandemic while simultaneously enhancing our own Nation's security.

I urge my colleagues to support the Senate amendment to the Tom Lantos and Henry Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008 so that this bill can be signed by the President without further delay and we can get to work on saving even more lives.

With that, Mr. Speaker, I reserve the balance of my time.

Mr. BERMAN. Mr. Speaker, I thank the gentlelady very much for her great words, and more importantly, for her really complete commitment to this project before and now.

GENERAL LEAVE

Mr. BERMAN. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and include extraneous material.

The SPEAKER pro tempore (Mr. ROSS). Is there objection to the request of the gentleman from California?

There was no objection.

Mr. BERMAN. Mr. Speaker, I am now very pleased to yield 5 minutes to the gentleman I referenced earlier, the chairman of the Africa Subcommittee, Mr. PAYNE of New Jersey.

Mr. PAYNE. Thank you very much, Mr. Chairman. And let me begin by thanking you for your strong leadership in bringing this legislation through the House and advocating it through the Senate and our ranking member, Ms. ILEANA ROS-LEHTINEN, for her support, and as you mentioned before, Representative BARBARA LEE and DONNA CHRISTENSEN.

As chairman of the Subcommittee on Africa and Global Health, this bill, the Tom Lantos and Henry Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008, is very timely.

This bill is important. In the 5 years since I have been in Congress, the original legislation authorized by the President's Emergency Plan for Aids Relief, or PEPFAR, as it is known, has become a historical program.

□ 1615

The road toward serious consideration regarding HIV and AIDS was a long journey. The Congressional Black Caucus began advocating for a sound domestic and international effort during the late 1980s with little success. Pressure continued through the executive branch, and in the Clinton years, an office was established headed by Ms. Thurman on the President's initiative on HIV and AIDS. However, adequate funding was still lacking, especially on the international focus.

And so I must say that PEPFAR is destined, in my view, to be remembered as the single most significant achievement of the Bush administration's two terms in office because it was there that we catapulted the funding of this legislation.

Over 800,000 people who would otherwise have no access to treatment are receiving anti-retroviral medication in PEPFAR's 15 focus countries. Twelve of those countries are in sub-Saharan Africa.

Such progress is remarkable. However, we still have a lot of work ahead of us. Despite our best efforts, only 28 percent of Africans needing antiretrovirals are receiving them.

A mere 11 percent of HIV-positive women on the continent who need drugs to prevent mother-to-child transmission is getting it. Shockingly, over 85 percent of Africa's children who need ARVs are going without it.

This is why Congress is taking such an extraordinary step of authorizing close to $50 billion to transform PEPFAR from an emergency response to a sustainable program. It represents the best efforts to turn those statistics around.

The new bill transforms PEPFAR by expanding the program beyond a series of medical interventions. For example, the lack of food and nutrition support for people on ARVs have been, up to now, a major impediment to the adherence to AIDS treatment regimens. The lack of adherence limits PEPFAR's effectiveness.

Fortunately, the new component will help ease the nutrition problem. The Senate bill has incorporated elements of the provision which I authored that were in the original House bill related to addressing the nutrition needs of HIV patients, their families, and communities. When I introduced the nutrition component a year ago, no one could have accurately predicted the tremendous food security problem which besets us today worldwide.

The Senate bill also contains a provision to build and strengthen health systems in developing countries.

Like the House bill, it eliminates cumbersome earmarks that the Government Accountability Office and the Institute of Medicine have said limits program efficacy.

Just as important as the money and programs for HIV and AIDS, the bill we are voting on today also authorizes $9 billion to fight two other diseases that have wrought havoc in the developing world: malaria and tuberculosis.

Malaria kills a child in Africa every 30 seconds. It contributes to the death of an estimated 10,000 pregnant women and up to 200,000 infants each year on the continent. And what is astonishing is that malaria is preventable. With education, providing bed nets and spraying, malaria can be eliminated.

TB is just as deadly. Nearly 20 percent of the people who develop full-blown TB die of the disease. They cannot get a simple, low-cost cure which is available.

And those with HIV and AIDS are very vulnerable to TB infections due to lowered immunity factors. In fact, TB is the number one killer of people with AIDS. With the new cases of MDR and XDR TB, a more radical strain that is much more difficult to treat, the new emphasis on TB is very important. In South Africa in a village, 52 of 53 people who had contracted MDR TB died within a 2-week period.

Mr. Speaker, given the aforementioned toll that AIDS, TB and malaria has taken around the globe, and how much we still need to do to fight all three deadly diseases, it is imperative that we redouble our efforts.

The SPEAKER pro tempore. The time of the gentleman from New Jersey has expired.

Mr. BERMAN. I yield the gentleman an additional 30 seconds.

Mr. PAYNE. As I conclude, we must do so for the obvious reason: U.S.-funded programs save lives. We have a

moral obligation to continue them. We should also do so for a less obvious reason: to counter a growing perception in the world that the United States does not care about anything but counterterrorism.

Fairly or not, I think that this bill will go far to continue to uplift the image of the United States. It's saving lives, and it's doing the right thing.

I urge my colleagues to support the bill.

Ms. ROS-LEHTINEN. Mr. Speaker, I yield 3 minutes to the gentleman from California (Mr. ROHRABACHER), the ranking member of the Subcommittee on International Organization, Human Rights, and Oversight.

Mr. ROHRABACHER. Mr. Speaker, I rise in strong opposition to H.R. 5501.

During this time of economic difficulty, this bill is humanitarianism gone wild. It's irrational benevolence that we cannot afford.

Where are we going to get the $48 billion for combating AIDS and the $2 billion for Native American programs? Well, we can get it out of programs by gutting programs that are for our own people. We can raise taxes, which would likely throw us into a recession that would leave us with even less of a tax base for our people at home, or of course, we can borrow it and let our grandchildren pay for it in some way. And yes, if we borrow it, it will probably come from Communist China, making ourselves even more vulnerable to their pressure.

Mr. Speaker, we have big hearts, but we need to use our brains. We cannot afford $50 billion of generosity to foreigners. This will cost the American people. It will cost them their health care and the education for their children. It will cost the veterans, and it will cost our seniors.

Our economy is facing a catastrophic setback because of the irresponsible spending and taxing policies of the Federal Government, and now we're going to exacerbate that problem with a $50 billion commitment to provide a health care package to Africa.

Concerning my friends on my side of the aisle, Mr. Speaker, I say to those who oppose earmarks in the name of fiscal responsibility, they should not be expected to be taken seriously if they support this enormously expensive, feel-good spending. This $50 billion burden will be shouldered by our veterans, by our elderly, and by our children.

My friends on the other side of the aisle often remind us America does not spend enough on our own people. More funds are needed, we are repeatedly told, for our veterans, our elderly, and yes, for our children. When we are already at a high level of deficit spending, how then can we advocate spending an additional $50 billion overseas?

And we're not fooling anybody. When we have spending like this, it comes right out of the pot of limited resources that are available to Americans.

This expenditure is not going to cure AIDS in the end. I wish I could say that I was very confident that it would succeed in that, but I'm not confident with that. What I am confident is that it will break our back. This could well be the 2-ton tree trunk that broke the camel's back, the item that finally destroyed the hope for responsible spending policies by Congress.

I ask my colleagues to vote against this kind of generosity that is perhaps good-hearted but totally irrational. I say our number one job here is to watch out for the well-being of the American people. This bill is not in the well-being of our people. It will undermine the well-being of our people.

Mr. BERMAN. I yield myself 30 seconds.

Mr. Speaker, without joining issue with the gentleman on his other comments, the suggestion that this is not curing AIDS is directly contrary to the evidence I saw firsthand in Africa earlier this month. There are huge numbers of people there who would now be dead, who are alive simply because of the drugs that this money allowed them to get. I don't know what the definition of the gentleman's cure is, but they are living normal, active lives as a result of the drug therapies.

I insert a Statement of Legislative Intent regarding nutrition into the RECORD at this time.

On behalf of Chairman PAYNE, Mr. MCGOVERN, and Mrs. EMERSON, I would like to make the following statement regarding the intent of the House on H.R. 5501.

H.R. 5501 and the Senate amendment to H.R. 5501 provide clear and specific instructions to the USAID Administrator and the Global AIDS Coordinator to address the food and nutrition needs of individuals with HIV/AIDS and other affected individuals, including orphans and vulnerable children; and to fully integrate food and nutrition support in HIV/AIDS prevention, treatment, and care programs carried out under this act.

We are concerned about the negative effect rising costs are having on our long-term and emergency food aid programs. This is a matter that affects a wide array of our food aid and development programs, including the effectiveness and success of our Global HIV/AIDS programs.

On behalf of the Committee on Foreign Affairs and members who have been very involved in international nutrition, we wish to state that it is the legislative intent of H.R. 5501 and the Senate amendment to H.R. 5501 that food security and nutrition programs, especially those referred to as wrap-around services, are not to be funded with monies diverted from other standing commitments to address food insecurity elsewhere in the world or in these countries.

I'm very pleased to yield 5 minutes to my friend, just a major architect of this whole program, the gentlelady from California (Ms. LEE).

Ms. LEE. Mr. Speaker, first, let me thank Chairman BERMAN for your leadership and for your commitment to addressing this very devastating public health crisis, humanitarian crisis, and national security crisis.

I also want to thank Ranking Member ROS-LEHTINEN, Chairman PAYNE, Ranking Member SMITH, Chairman WAXMAN, and Congresswoman DONNA CHRISTENSEN for working together to bring this bipartisan bill to the floor.

Our Speaker, NANCY PELOSI, has been such a leader early on in addressing the HIV and AIDS crisis, and without her support, we would not have such an important bill before us today.

As an original coauthor of both the initial legislation establishing PEPFAR and of this new bill reauthorizing PEPFAR, I am pleased that today we will complete action on this important initiative and send it to the President for his signature.

Each of us has witnessed, as Mr. BERMAN indicated earlier, the devastation that AIDS has caused in Africa and in the developing world, and we've seen the very dramatic impact of our AIDS programs over the last 5 years in actually saving lives. And this bill will save millions more in terms of life-saving drugs and treatment and care.

And, yes, to the gentleman from California (Mr. ROHRABACHER), I believe that spending $50 billion to address a global health emergency makes more sense than spending over 600–700 billion dollars on a war, quite frankly, that did not have to be fought.

Quite simply, by enacting this bill, we will help change the lives of millions of people around the world for the better.

This bill is a model of compromise and stands as a testament to what true bipartisanship can accomplish.

Let me remind this body that it is the latest in a long string of initiatives on HIV and AIDS that have been born out of a willingness to work together and put the United States on the right side of history when it comes to this global pandemic.

First, in 2000, we passed and President Clinton signed into law the Global AIDS and Tuberculosis Relief Act. This important bill provided the founding contribution and framework for the Global Trust Fund. It was inspired, really, by my colleague, my predecessor, Congressman Ron Dellums, now-Mayor Ron Dellums of Oakland, California, and supported by former Chairman Jim Leach of Iowa.

In 2001, working with both former Chairman Hyde and Chairman Lantos, we drafted H.R. 2069, the Global Access to HIV/AIDS Prevention, Awareness, Education and Treatment Act. This was the first bill that dared to provide a large scale antiretroviral therapy to people living in the developing world. Unfortunately, it wasn't enacted because we couldn't reach a conference agreement with the Senate.

At the end of 2002, the Congressional Black Caucus, along with practically every advocacy group in the United States, sent a letter to President Bush urging him to create a presidential initiative to fight AIDS in Africa.

In January of 2003, the President stepped up to the plate and promised $15 billion to fight AIDS during his State of the Union address.

Within 5 months, working with Chairman Hyde and Chairman Lantos, we passed H.R. 1298, the United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003, which created PEPFAR.

In 2005, we took yet another step forward when we passed H.R. 1409, the Assistance for Orphans and Vulnerable Children in Developing Countries Act, again with Chairman Hyde and Chairman Lantos and Chairman BERMAN and Chairman PAYNE. This bill fine-tuned our programs to meet the needs of children orphaned and made vulnerable by AIDS.

So, Mr. Speaker, I lay out some of the history of our work on this very important issue because it speaks volumes about what is possible when we come together in the spirit of bipartisan compromise.

□ 1630

It is that bipartisan spirit that is again on display today as we honor the legacy of both Chairman Lantos and Chairman Hyde through this legislation. I'm saddened that both of them are not with us, like all of us are, to witness this moment, but I know that they would have been very, very pleased.

As I have said, this bill is a compromise. And as in all compromises, each side did not get everything it wanted, but that's what compromise is about.

I want to mention just a few important items that I worked on which have been included in this bill. First, it takes language from H.R. 1713, the PATHWAY Act, to strike the 33 percent abstinence-until-marriage and helps address the needs of women and girls in a comprehensive fashion—abstinence, be faithful, use condoms. Comprehensive.

It includes language taken from H.R. 3812, the African Health Capacity and Investment Act, to build health capacity by recruiting, training and retaining health professionals and strengthening health care systems.

The SPEAKER pro tempore. The time of the gentlewoman from California has expired.

Mr. BERMAN. I am pleased to yield the gentlelady an additional minute.

Ms. LEE. Thank you, Mr. Chairman, very much.

I am also very grateful that the Senate added language that I originally authored in H.R. 3337, the HIV Nondiscrimination in Travel and Immigration Act, to remove this, quite frankly, unjust and discriminatory statutory ban on travel and immigration for people living with HIV/AIDS. I'm especially pleased that we are lifting this statutory ban just prior to this year's International AIDS Conference in Mexico City. As a delegate to the last four conferences, I look forward to bringing this good news to Mexico City.

While I support the underlying compromise, there are many, many items that I wish had been included: Eliminating the prostitution pledge loyalty oath, recognizing the public health benefits of linking our HIV/AIDS programs with family services, recognizing the need to engage with communities that are at the forefront of this pandemic, such as men who have sex with men, and injection drug users, and clearly committing to provide life-saving AIDS drugs to no less than 3 million people. So let me just thank you again, Chairman BERMAN.

I want to thank our staff, especially Christos Tsentas of my office. And I would like to insert for the the RECORD all of our staff members' names who worked on this bill.

LIST OF STAFF WHO WORKED ON PEPFAR

HOUSE

Dr. Pearl Alice Marsh, Kristin Wells, David Abramowitz, Peter Yeo, and Bob King from Chairman BERMAN's staff of the House Foreign Affairs Committee.

Yleem Poblete, Mark Gage, Sarah Kiko and Joan Condon from Ranking Member ROS-LEHTINEN's staff on the House Foreign Affairs Committee.

From the Subcommittee on Africa and Global Health, Heather Flynn with Chairman DONALD PAYNE and Sheri Rickert with Ranking Member CHRIS SMITH.

Naomi Seiler and Jesseca Boyer from Mr. WAXMAN's staff on Oversight and Government Reform Committee.

And Christos Tsentas of my staff.

SENATE

Shannon Smith, Brian McKeon with Chairman BIDEN's staff on the Senate Foreign Relations Committee.

Shellie Bressler, Paul Foldi, and Dan Diller from Senator LUGAR's staff on the Senate Foreign Relations Committee.

Alexandra Nunez with Senator KERRY's office.

Ms. ROS-LEHTINEN. Mr. Speaker, I yield 3 minutes to the gentleman from Indiana (Mr. PENCE), the ranking member of the Subcommittee on the Middle East and South Asia.

(Mr. PENCE asked and was given permission to revise and extend his remarks.)

Mr. PENCE. Mr. Speaker, I rise today in support of H.R. 5501, the Tom Lantos and Henry Hyde Global AIDS bill. As Congresswoman BARBARA LEE just eloquently stated, it is poignant to those of us who knew these two great legislators to see the important expansion of this legislation occur after both of them have gone home to be with the Lord. But I can think of no better tribute to these men of character and vision and compassion than this legislation.

I commend Chairman BERMAN and Ranking Member ROS-LEHTINEN for their strong leadership. I also want to commend my colleague, CHRIS SMITH, for his yeoman's work in preserving a delicate balance of this bill. Also Mr. Speaker, let me publicly acknowledge the work of our President, George W. Bush. Mr. President, because of your moral leadership and compassion, Africa will never be the same, and history will record your work.

The Bible tells us, ''To whom much is given much is expected.'' I believe the United States has a moral obligation to lead the world in confronting the pandemic of HIV/AIDS.

The dimensions of this crisis are truly staggering. The HIV/AIDS pandemic has infected more than 60 million people worldwide, killed more than 25 million, a number that grows grievously every day by nearly 9,000. HIV/AIDS has orphaned some 14 million children. And today, 70 percent of the people in the world with HIV/AIDS reside in Africa. More startling, if current infection rates continue, new epicenters for the disease are likely to arise out of India, China and eastern Europe.

The threat this pandemic poses to our security is real. If not addressed, this plague will continue to undermine the stability of nations throughout the third world, leaving behind collapsing economies, tragedy, and desperation, which we all know is a breeding ground for extremist violence and terrorism. This is truly a global crisis. And because the United States of America can render timely assistance, I believe we must.

You know, every so often in this place we have the opportunity to do something, not just for the American people, but for humanity, and this is such a time. And this global AIDS bill seeks to address this crisis not only by providing medicine and health care to those in need, but also by providing funding resources for evidence-based programs that have been successful in preventing infection.

It's imperative, I believe, that we not only send our resources, but that we send them in a manner that is consistent with our values. We cannot send billions of dollars to Africa without sending values-based safeguards and techniques that work to fight the spread of HIV/AIDS by changing behavior, and this current version of the global AIDS bill includes those safeguards.

It was essential that we preserve these prevention methods that focus on behavioral change, and that we continue to work with faith-based, nongovernmental organizations that promote programs, including the ABC model, which has produced such undeniable results.

But as a conservative let me say, as we tend to the suffering abroad, we also have to figure out how to pay for it. The Federal budget, I believe, is filled with opportunities to responsibly fund this program, and I look forward to finding the right priorities to do just that.

Mr. Speaker, I rise today in support of H.R. 5501, the "Tom Lantos and Henry J. Hyde Global AIDS Bill."

The Bible tells us, 'to whom much is given, much is expected," and I believe the United States has a moral obligation to lead the world in confronting the pandemic of HIV/AIDS.

The dimensions of this crisis are truly staggering. The HIV/AIDS pandemic has infected more than 60 million people worldwide. It has killed more than 25 million, a number which grows grievously every day by more than

8,500. HIV/AIDS has orphaned some 14 million children. And today, 70 percent of the people in the world with HIV/AIDS reside in Africa. Within that continent there are entire countries where more than one-third of the adult population is infected.

More startling, if current infection rates continue, new epicenters for the disease are likely to arise out of India, China and Eastern Europe, with numbers that could surpass Africa in a few short years.

And the threat that this pandemic poses to our security is also real. If not addressed, this plague will continue to undermine the stability of nations throughout the third world, leaving behind collapsing economies and tragedy and desperation—a breeding ground for extremist violence and terrorism.

This is truly a global crisis and because the United States can render timely assistance, I believe we must.

You know, every so often in this place, we have the opportunity to do something for humanity and serve the American people—and this is such a time.

I thank Chairman BERMAN and Ranking Member ROS-LEHTINEN for their strong leadership. I commend my colleague, Mr. CHRIS SMITH, in particular for his yeoman's work on carefully preserving the delicate balance of this legislation.

And I'd also like to publicly acknowledge the work of our President, George W. Bush. Mr. President, because of your moral leadership and compassion, Africa will never be the same, and history will record your work.

And this Global AIDS bill seeks to address the crisis, not only by providing medicine and health care to those in need, but also by providing funding resources for evidence-based programs that have been successful in preventing infection. It is imperative, I believe, that we not only send our resources but also that we send them in a manner that is consistent with our values. We cannot send billions of dollars to Africa without sending values-based safeguards and techniques that work to fight the spread of HIV/AIDS by changing behavior.

Within the current version the Global AIDS bill that the Senate recently passed, these pivotal provisions exist in the form of a requirement to provide 'balanced funding for prevention activities for sexual transmission of HIV/AIDS,' and to ensure that abstinence and faithfulness programs 'are implemented and funded in a meaningful and equitable way.' This is enforced by requiring the Global AIDS Coordinator to report to the appropriate Congressional committee if funding for abstinence, delay of sexual debut, monogamy, or fidelity programs drops below 50 percent of the total sexual prevention program funding.

It was essential that we preserve prevention methods that focus on behavioral change, and that we work with faith-based and non-governmental organizations at the local level, in particular through the ABC Model, which has produced undeniable results.

As we tend to the suffering, through, we always have to figure out how we're going to pay for it.

The federal budget, I believe, is packed with wasteful and bloated programs, which could supply more than enough opportunities to cover the cost of the Lantos/Hyde Global AIDS bill.

When it comes time to fund this program in the appropriations process, I believe Congress should make the hard choices necessary to ensure that this global health crisis does not become a crisis of debt for our children and grandchildren.

I believe it is possible to be both responsible to our fiscal constraints while being obedient to our moral calling. The greatest of all human rights is the right to live. America is a nation of great wealth—wealth of resources, but more importantly, a wealth of compassion. The history of the world is filled with telling moments regarding the character of a people. Sometimes we are witness to mankind's great inhumanities. Other times we marvel at the beauty of mankind's selfless acts of compassion, when we rise above politics and raise up those in dire need. Let this be such a day.

I urge my colleagues to join me in support of this legislation.

Mr. PAYNE. I yield 2 minutes to the gentlelady from California, a member of the Africa Subcommittee, Congresswoman WOOLSEY.

Ms. WOOLSEY. Mr. Speaker, I'd like to thank Chairman BERMAN and Chairman PAYNE and Ranking Members ROS-LEHTINEN and SMITH for their excellent leadership on global health issues and on this AIDS bill.

I support H.R. 5501 because it is so very necessary. The statistics are staggering. In 2007, there were nearly 35 million people worldwide living with HIV/AIDS. In that year alone, 2.5 million people became infected with HIV, 420,000 were children under the age of 15. And most tragically, there were 2.1 million deaths, 330,000 children under the age of 15.

But Mr. Speaker, this is not only about statistics. This is about the child who must stay home from school to take care of her siblings when a parent dies of AIDS. We're talking about the mother, the mother who, because she lacked prenatal care, passed the disease onto her unborn child.

Today we can make a difference. We can say that one more diagnosis of HIV, one more AIDS death, one more malaria case is absolutely unacceptable. I urge my colleagues to support this bill and take a strong stand against this horrific pandemic.

Ms. ROS-LEHTINEN. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. SMITH), the ranking member of the Committee on the Judiciary.

Mr. SMITH of Texas. Mr. Speaker, I, in turn, thank the gentlewoman and the ranking member of the Foreign Affairs Committee for yielding me time.

Mr. Speaker, I recognize that there are good arguments for and against this bill, but I want to focus on a provision that many Members may not be aware of.

Under current law, the Secretary of Health and Human Services is required to consider HIV/AIDS a communicable disease of public health significance; as a result, aliens with HIV/AIDS are inadmissible. Section 305 of the bill rescinds the statutory designation of HIV/AIDS as a communicable disease. This change would allow the current or a future administration to decide that HIV/AIDS is not a communicable disease of public health significance, and immigrants with HIV/AIDS would be admitted.

The Congressional Budget Office estimates that this provision will result in the entry of thousands of persons with HIV/AIDS. This change of policy inevitably will threaten the health and lives of many Americans. The CBO also estimates that allowing entry of thousands of persons with HIV/AIDS will cost taxpayers tens of millions of dollars. The cost of health care for each person with HIV/AIDS averages more than $600,000. Mr. Speaker, this provision removes a safeguard that protects the health of Americans and costs many millions of dollars.

Mr. PAYNE. Mr. Speaker, I yield 2 minutes to the gentleman from the State of Washington, the father of the AGOA legislation and a health provider for USAID for many years, Mr. MCDERMOTT.

(Mr. MCDERMOTT asked and was given permission to revise and extend his remarks.)

Mr. MCDERMOTT. Mr. Speaker, today the people's House will say eloquently and unequivocally that America's interest to exert its moral leadership in the world is back, that all Americans stand united in fighting this global epidemic.

As we've done in times of the past in great trial, we set aside our differences and declare that America stands with commitment, compassion and conviction against the HIV/AIDS epidemic.

The Senate has already passed this legislation. And the President has announced that he will sign the legislation, which is one of his top priorities. I give him high credit for that decision.

But beyond the money, beyond the $50 billion, is the fact that we are ending the unspoken fear and discrimination in our own country by eliminating the travel ban restriction that has stopped scientists and others infected with HIV/AIDS from crossing our borders to attend medical or educational conferences, or to visit family and friends.

I was at the United Nations a few months ago, and Members of Parliaments all over the world said, how can we end the stigma of AIDS if you, in the United States, will not allow someone with AIDS to come in? We know how to treat AIDS, we know how to diagnose it, but the United States is the example: Today, we are making a statement that we want to end the stigma of AIDS. That makes it possible for people to come in and be tested, for people to come forward and receive medication. As long as people have to keep AIDS in the background or hide it, we will not end this epidemic. So this provision alone makes it possible.

Representative GRANGER and I have some legislation in here that ends some of the problems with mother-to-child transmission. These provisions will make it possible for us to prevent AIDS spread and have a generation without AIDS in the future.

This legislation will provide the resources policies necessary to take the fight against HIV/AIDS to the next level. An increase in funding to $48 billion over 5 years will provide the resources to sustain the fight on so many fronts in so many countries especially hard hit by the pandemic.

Our provisions included in this legislation will provide training and education, integrate services into maternal health care and ensure that women and children have access to early screening and life-saving drug therapies.

We know that providing a short regimen of anti-retroviral drugs to the mother and newborn reduces transmission by 50 percent. And now we will have the means to do it.

H.R. 5501 also includes my provision to establish two 5-year targets to protect the next generation. The first goal is that 16 percent of those receiving treatment under PEPFAR be children, which is significantly higher than the children receiving treatment under current PEPFAR programs.

The second goal is that 80 percent of pregnant women in the most affected countries receive HIV counseling and testing and where necessary, antiretroviral treatment to prevent mother to child transmission.

We know how to stop transmission and, over time, we can achieve the goal of a generation born free of HIV/AIDS.

This legislation addresses the fatal connection between HIV and TB, which itself has claimed 1.7 million lives directly or through HIV-associated TB. I'm proud that the Bill and Melinda Gates Foundation in Seattle is a leader in the fight against TB as it is in reversing other global medical crises.

My community rightly swells with pride over the local leadership and resources being devoted to fighting on behalf of all humanity.

We have come a long way in a short period of time. H.R. 5501 will build on the systems and success we have had so far by integrating additional services and providing the vital funding needed to train health care professionals and community workers.

Trained medical personnel, on the ground in country, are the front line in this fight and this legislation gives us the ability to send in reinforcements to help fight a war against this disease. There is so much to say about what this day means. Above all, it means we are going to save lives.

We are going to provide global leadership and real hope. The day will come when medical science will discover a vaccine that will end this scourge once and for all. Until then, let us stand together as one Nation and one world, united in one common goal—in the fight against HIV/AIDS.

I cast my vote for passage on behalf of every person in Seattle, in Africa, China, India and elsewhere who lives with or is threatened by the HIV/AIDS pandemic. I urge my colleagues to support this legislation.

Ms. ROS-LEHTINEN. Mr. Speaker, I'm proud to yield 5 minutes to the gentleman from New Jersey (Mr. SMITH), the ranking member of the Subcommittee on Africa and Global Health.

Mr. SMITH of New Jersey. I want to thank my good friend for yielding, and thank her for her great work on this legislation, as well as Chairman BERMAN and my good friend, DON PAYNE, and so many others who have made this day possible in this launching of a new initiative, building on the old.

Mr. Speaker, H.R. 5501, as amended, will literally mean the difference between life or death to millions, especially in Sub-Saharan Africa. As Members know, close to 70 percent of the estimated 33 million people with HIV live in Sub-Saharan Africa. Of the 2.5 million children afflicted with this dreaded disease, 90 percent of them live in Africa as well.

When combined with opportunistic infections like tuberculosis—the number one killer of individuals with HIV—and malaria, which kills at least one million people a year—again, mostly in Africa—the HIV/AIDS pandemic compares among humanity's worst.

Our distinguished late chairman, Henry Hyde, prime sponsor of the original PEPFAR program, frequently compared the sickness to the bubonic plague—the black death—an epidemic that claimed the lives of over 25 million during the mid-1300s.

So with that much at stake, I want to remind my colleagues how important it is that we get this right. And I think, after a lot of hard work, we have managed to come to a consensus, first in the House, and now also in the Senate, and I hope it will be a sustainable consensus.

I want to note that Congress has unequivocally rejected the attempts of abortion-promoting organizations who wanted to hijack the Global AIDS program and link their abortion agenda to the compassionate effort to prevent this illness or to relieve the deleterious effects of HIV/AIDS.

Look at the progression of this bill. The congressional intent is clear with respect to diverting HIV funding to reproductive health/family planning programming: It was rejected. In the first House drafts, there were numerous provisions mandating not only ''integration'' and ''linkages'' between HIV programming and reproductive health and family planning services, but even explicit authorization to fund those services. This priority is wrong. We are trying to prevent HIV/AIDS, not children.

I know some Members are likely to wince at the cost of the bill, $48 billion over 5 years. But that sum of money will likely provide treatment for millions suffering from the disease, prevent some 12 million new HIV infections worldwide, support care for 12 million individuals with HIV/AIDS, including five million orphans and vulnerable children, and will help train and deploy at least 140,000 new health care professionals and workers for HIV/AIDS prevention, treatment and care.

On the prevention side, the legislation requires that the Global AIDS Coordinator provide balanced funding for sexual transmission prevention activities that promote abstinence, delay of sexual debut, monogamy, fidelity, and partner reduction. If less than 50 percent of sexual transmission prevention monies are spent on the abstinence and be faithful part of the ABC model, the coordinator must provide a written justification.

Five years after PEPFAR first began, the efficacy and importance of promoting abstinence and be faithful initiatives has been demonstrated beyond any reasonable doubt.

The legislation before us also retains the antiprostitution/sex trafficking pledge, an amendment I sponsored in 2003 designed to ensure that pimps and brothel owners don't become, via an NGO that supports such exploitation, U.S. Government partners.

□ 1645

Current law ensures that the U.S. Government is not in the position of ''promoting or advocating the legalization of prostitution or sex trafficking.'' Prostitution and sex trafficking exploit and degrade women and children and exacerbate the HIV/AIDS pandemic.

Finally, we have come a long way since 2003 when significant opposition materialized against an amendment that I offered to include faith-based providers with conscience clause protection. The conscience clause in H.R. 5501, as amended, restates, improves, and expands conscience protection in a way that ensures that organizations like Catholic Relief Services, which has a remarkable record of HIV/AIDS prevention, treatment, and care, are not discriminated against or in any way precluded from receiving public funds.

This legislation is clearly a great legacy and a great honor to our former Members Tom Lantos and Henry Hyde and certainly to President Bush, who led so ably and so nobly on this initiative.

Mr. Speaker, I rise today to submit several items of clarification for the RECORD concerning a provision in HR 5501, the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008. One of the major differences in this bill today from when we voted on it in April, is an amendment that adds Title VI—an Emergency Plan for Indian Safety and Health. Because it is a new addition and because there has been some confusion about how this Title should be read and how it would be implemented, I wanted to make the intent of Congress clear with these submissions to the RECORD.

First, I have been told by the Congressional Budget Office that this amendment is an authorization of appropriations and consequently has a score of 0 since there is ''no direct spending or revenues implications.'' Since there has been some confusion on this point, I want to restate that Title VI of HR 5501 is exclusively an authorization of appropriations and a further act of Congress would be necessary before any money could be provided to this Emergency Fund.

Second, I also want to clarify that according to the author of this amendment, Senator JOHN THUNE of South Dakota, the Emergency Fund, including all health-related contracts or compacts, programs, or other services authorized in this amendment will be conducted exclusively as programs of the Indian Health Service, subject to all regulations and restrictions that ordinarily apply to the Indian Health

Service. This is what the amendment language means and I want that to be clear, so I'm including the letter I received from Senator THUNE which clarified this point.

Last, I would also like this letter from the Department of Health and Human Services to be included in the RECORD. This letter makes it clear that the Administration and the relevant Department also understand that this amendment does not appropriate funds and that all health-related programs that will later receive appropriations will be administered through the Indian Health Service. They go on to explain that this Emergency Fund is, by legislative requirement, subject to the provisions of the Hyde Amendment, which are currently set forth in section 507 of the FY08 L/HHS/ED appropriations act as referenced by 25 U.S.C. Section 1676.

U.S. SENATE,
*Washington, DC, July 23, 2008.*

Hon. CHRIS SMITH,
*Rayburn House Office Building,*
*Washington, DC.*

DEAR CONGRESSMAN SMITH: Thank you for your interest in my Amendment # 5076 to S. 2731, the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008. As you may know, my amendment, which was accepted by voice vote, authorizes $2 billion in appropriations over the next five years to tribal public safety, health, and water projects.

My amendment requires that the Attorney General, the Secretary of Interior, and the Secretary of Health and Human Services establish an emergency plan to address the law enforcement, health, and safe drinking water needs of Native Americans across the nation. Specifically, the amendment provides an authorization totaling $750 million, to be used by the Attorney General and Secretary of Interior, to address tribal law enforcement, court, and detention facility needs.

Additionally, the Amendment established $250 million in authorization to be used by the Secretary of Health and Human Services, acting through the Director of the Indian Health Service (IHS), to provide IHS contract care, health facility construction and rehabilitation, and sanitation facilities. Finally, $1 billion in authorization is to be used to implement Indian drinking water projects that have been approved by Congress.

Again, thank you for your interest in my amendment. Once enacted, I am hopeful that this modest authorization will begin to meet the critical public safety, health, and water needs that many of our nation's reservations face subject to future appropriations by Congress.

Sincerely.

JOHN THUNE,
*United States Senate.*

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DEPARTMENT OF HEALTH
AND HUMAN SERVICES,
*Washington, DC, July 22, 2008.*

Hon. CHRIS SMITH,
*Rayburn House Office Building,*
*Washington, DC.*

DEAR MR. SMITH: We understand that concerns have been raised regarding whether the Hyde Amendment will attach to funds used for Indian Health purposes under Section 601 of H.R. 5501, the Senate bill that seeks to reauthorize the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003. The Department's position is that the Hyde Amendment will attach to funds appropriated for Indian Health purposes.

Section 601 of H.R. 5501 would establish in the Treasury an Emergency Fund for Indian Safety and Health (the ''Fund''). Under Section 601(t)(3), the Secretary of Health and Human Services shall use 12.5 percent of the Fund to provide health services and improve health and sanitation facilities for members of Indian tribes. The Secretary must act ''through the Director of the Indian Health Service,'' thus, such activities will be conducted as programs of the Indian Health Service. Although Section 601 authorizes the establishment of the Fund, it does not actually appropriate money to the Fund. Subsequent legislation is necessary to appropriate money to the Indian Health Service for Indian Health purposes as authorized by the Fund.

The Hyde Amendment, which is currently set forth in section 507 of the FY08 L/HHS/Ed appropriations act, will attach to money appropriated to the Fund for Indian Health purposes under section 601(f)(3). If the L/HHS/Ed appropriations act contains the Hyde Amendment, and Congress appropriates money to the Fund in another act, then the money used for the Indian Health Service will be subject to the Hyde Amendment because 25 U.S.C. §1676 will apply. 25 U.S.C. §1676 states that ''[a]ny limitation on the use of funds contained in an Act providing appropriations for the Department of Health and Human Services for a period with respect to the performance of abortions shall apply for that period with respect to the performance of abortions using funds contained in an Act providing appropriations for the Indian Health Service.'' Because an act that appropriates money to the Fund would ''provid[e] appropriations for the Indian Health Service,'' the Hyde Amendment contained in the L/HHS/Ed appropriations act would be applicable to money used for Indian health purposes under section 601(f)(3).

Sincerely,

CHARLES E. JOHNSON,
*Assistant Secretary for Resources and Technology.*

Mr. PAYNE. Mr. Speaker, I would like to recognize the gentleman from New York (Mr. ENGEL), chairman of the Western Hemisphere Committee, for 2 minutes.

Mr. ENGEL. I thank the gentleman for yielding to me.

Mr. Speaker, I rise in strong support for H.R. 5501.

While most widely recognized for renewing our commitment to global AIDS relief, the Tom Lantos and Henry J. Hyde Global Leadership against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008 reauthorizes provisions on all three of these deadly diseases of poverty.

The World Health Organization reports that 1.7 million people died of tuberculosis in 2006, with 200,000 dying from HIV-associated TB. The emergence of multidrug-resistant and extensively drug-resistant TB, known as MDR and XDR, pose a grave risk to global health. These strains are far deadlier than normal TB and are much more difficult and expensive to treat. A contagious, airborne disease, TB knows no barriers or borders and can only be successfully controlled in the United States by also controlling it overseas.

The Lantos-Hyde Act declares TB control a major objective of U.S. foreign assistance programs. The legislation requires a 5-year plan to support the treatment of 4.5 million tuberculosis patients and 90,000 new MDR-TB cases.

This bill incorporates substantial portions of my bill, H.R. 1567, the Stop Tuberculosis Now Act. The Lantos-Hyde Act prioritizes the Stop TB Partnership's strategy, including expansion of the successful treatment regimen for both standard TB and drug-resistant TB. It further promotes research and development of new tools.

Recognizing the deadly synergy between tuberculosis, an opportunistic infection, and HIV/AIDS, the Lantos-Hyde Act authorizes assistance to strengthen the coordination of HIV/AIDS and TB programs. TB is the leading killer of people with HIV/AIDS, and the explosion of drug-resistant TB in sub-Saharan Africa threatens to halt and roll back our progress in combating both diseases.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. PAYNE. Mr. Speaker, I yield the gentleman 20 seconds.

Mr. ENGEL. I'll talk fast.

Finally, Mr. Speaker, the legislation authorizes assistance for the development of new vaccines for TB. The current TB vaccine is more than 85 years old and is unreliable against pulmonary TB, which accounts for most of the worldwide disease burden. New TB vaccines have the potential to save millions of lives and would lead to substantial cost savings.

I urge my colleagues to vote ''aye'' on H.R. 5501 today. We can control and win the fight against AIDS and TB.

Ms. ROS-LEHTINEN. Mr. Speaker, I would like to yield 3 minutes to the gentleman from Iowa (Mr. LATHAM), a member of the Committee on Appropriations.

Mr. LATHAM. I thank the gentlewoman for yielding the time.

Mr. Speaker, this bill is very important. Helping people in need overseas has always been a national priority, and I stand in favor of H.R. 5501. However, I must say that helping American taxpayers hurt by natural disasters should be our highest priority. This Congress is letting them down.

According to the House and Senate leadership, there simply isn't enough time for Congress to pass emergency aid to help Midwestern States affected by the devastating floods last month.

Not enough time?

When Hurricane Katrina hit the gulf on Monday, August 29, 2005, Congress began working. On Friday of that same week, the House and Senate introduced, passed, and had a supplemental appropriation bill signed into law that same day. Five days later another supplemental bill was introduced and was signed into law the very next day. And in 2004 after Hurricanes Charlie and Frances landed, the Congress passed a supplemental appropriations bill and had it signed into law in 1 week.

Yet here I stand almost 2 months after the most damaging natural disaster in Iowa's history began and the Democrat leadership in the House and the Senate are telling the people up and down the Mississippi River that

they can wait until there is frost on the beans until we decide on additional aid.

Earlier this week the Governor of Iowa told the leadership of this House that Iowa alone needs an additional $1.2 billion more than FEMA can provide. Iowa has suffered a loss of $10 billion. Now we are told we will be waiting until September for a bill.

Where's the outrage? Well, I will tell you. It's in Iowa. It's with the 25,000 homeless Iowans. It's with the small business owners, the employers, the people who sacrificed their homes to help their neighbors.

This House has had time since the first waters started flowing through Midwestern homes to vote on numerous bills under the suspension calendar. We have had time to designate the ''National Day of the Cowboy'' and the ''National Carriage Driving Month.'' And 348 Members of Congress walked over here to vote to honor the life of a musician who had a number one hit entitled ''What's the Use of Getting Sober, When You're Gonna Get Drunk Again?''

Well, it appears that Congress needs to sober up and help the people of the Midwest. The House should not leave for the August recess until we finish our work and help the victims of the Midwest.

Mr. PAYNE. Mr. Speaker, I yield 2 minutes to the gentlewoman from the State of Texas (Ms. JACKSON-LEE).

(Ms. JACKSON-LEE of Texas asked and was given permission to revise and extend her remarks.)

Ms. JACKSON-LEE of Texas. Let me thank the gentleman from New Jersey for his leadership and the ranking member, the chairperson of the full committee, Mr. BERMAN, and pay tribute to our good friends the late Tom Lantos and Henry J. Hyde, who have captured, in essence, what our war against HIV/AIDS is all about. It has to be comprehensive and expansive. It has to recognize the overlapping impact of tuberculosis and malaria.

Mr. Speaker, I think one of the most telling scenes that I was able to experience, sadly so, was walking into a little hut in Zambia and seeing an emaciated body or person, if you will, being taken care of by a 4 year old. That individual had HIV/AIDS and tuberculosis.

So this legislation is crucial in the overall comprehensive war against the devastating diseases when there is no water, no nutrition, and poverty. This targets 12 million new HIV infections. It is treating millions of people. It's supporting care for 12 million. It has a focus on women and girls. It provides a focus on the anti-retroviral treatment that is so important that goes after opportunistic infections. It provides a certain amount of money, $9 billion, for malaria and tuberculosis over 5 years. It goes to the very essence of a 4 year old being the only remaining healthy person in his family having to care for sick relatives suffering from HIV/AIDS and tuberculosis and many suffering from malaria.

This is an important step forward. And, yes, we have many responsibilities in this Congress. I join my friend from Iowa. We will be working hard to provide the support systems that those individuals need. But at the same time, this is a tribute to great leaders like our former and late chairpersons of this committee, Chairman Hyde and Chairman Lantos, who recognized that to those who are given much, much is expected.

This bill responds to the devastation and need around the world. I ask my colleagues to support this legislation.

Thank you, Mr. Speaker, for allowing me to speak on not only an important issue in this country but around the world. I can only note that it gives me great pause that my colleague, Congressman Tom Lantos, did not live to see the fruit of his hard work on this bill. However, I know his family and his colleague Congressman Henry Hyde have kept this legislation alive and moving through this Congress.

Mr. Speaker, thank you for allowing for H.R. 5501, the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008 on PEPFAR to come to the floor today.

JACKSON-LEE AMENDMENT

I would also like to thank both Chairman BERMAN and the Chairman of the Subcommittee on African and Global Health, Congressman PAYNE, for working with me to include important language in this legislation. My language, in Section 301 of this bill, addresses the necessity of making children a priority among individuals with HIV for proper food and nutritional support. Section 301, with my language included, states that it is the sense of Congress that ''for the purposes of determining which individuals infected with HIV should be provided with nutrition and food support—(i) children with moderate or severe malnutrition, according to WHO standards, shall be given priority for such nutrition and food support; and (ii) adults with a body mass index, BMI, of 18.5 or less, or at the prevailing WHO-approved measurement for BMI, should be considered 'malnourished' and should be given priority for such nutrition and food support;''

Mr. Speaker, as Chair of the Congressional Children's Caucus, I believe that this language is crucial, and I thank the Chairman for including it in the text of the bill. HIV-infected children have been underrepresented among beneficiaries of PEPFAR-supported programs. As this legislation cites in the findings section, ''of those infected with HIV, 2.5 million are children under 15 who also account for 460,000 of the newly-infected individuals.'' And even these large numbers are deceiving, as children die much quicker from AIDS than do adults. I am pleased to see this language, which focuses attention on the plight of these children, and makes serving their needs a priority.

PEPFAR

In January 2003, President Bush announced the President's Emergency Plan for AIDS Relief, or PEPFAR. As its name implies, PEPFAR was envisioned as an emergency response; we are here today to discuss how to transition to a sustainable program to address these global epidemics.

HIV/AIDS continues to represent a serious and large-scale challenge throughout much of the world. It goes far beyond a simple health problem, and it hinders attempts to foster economic development and political stability. As we begin the process of reauthorizing PEPFAR, I believe it is crucial that we emphasize the long-term sustainability of our HIV efforts, and that we integrate AIDS prevention and treatment within our larger-scale development initiatives.

Though we have drugs that are effective in managing infections and reducing mortality by slowing the progression to AIDS in an individual, they do little to reduce disease prevalence and prevent new infections. For this reason, there is growing consensus among health experts that we must put greater emphasis on prevention programs, which are perhaps the most critical aspect of any initiative to combat global HIV/AIDS. Even as increasing numbers of people have access to anti-retroviral drugs, ARVs, an estimated 5.1 million people who needed treatment did not receive it in 2006.

TUBERCULOSIS

The World Health Organization, WHO, estimates that throughout the world someone contracts TB every second and that one third of all people in the world are currently infected with TB. Tuberculosis spreads easily from one person to another: when the infected person coughs, the bacilli or TB germs are spread into the air and another person need only to inhale a small number of the bacilli to be infected. The World Health Organization, WHO, estimates that each person left untreated with active TB will infect, on average, between 10 and 15 people every year. Although the TB bacilli can lie dormant in the body for years and its effects may not be immediately felt, if one has a weakened immune system, such as through HIV/AIDS, the chances of becoming sick will increase.

In 2005, nearly 9 million people contracted tuberculosis, of which 84 percent occurred in high burden countries, with all but two of the high burden countries in Africa and Asia. This demonstrates the necessity for special attention to these high burden countries, particularly in Africa. Among the 15 countries with the highest estimated TB incidence rates, 12 were in Africa, due in part to relatively high rates of HIV co-infection. About 80 percent of all cases in the world were found in 22 countries, all but 4 were found in Africa or Asia.

Some 2.97 million people in Southeast Asia were newly infected with TB and about 2.57 million in sub-Saharan Africa. In 2004, sub-Saharan Africa was the only region in the world where TB prevalence was growing; elsewhere the number of cases was stable or falling. Despite our concerted efforts, we continue to face a serious and persistent health threat. I believe that it is imperative that we ensure that American taxpayer dollars are used to greatest effect, not to bolster ideology.

Current restrictions on PEPFAR mandating that ⅓ of all prevention funds must be used on abstinence-only education neglect the real needs of populations both in America and abroad. These stipulations hurt the ability of PEPFAR to adapt its activities in accordance with local HIV transmission patterns, and they impair efforts to coordinate with national health plans. Though AIDS is clearly a global problem, it does not affect every nation equally or in the same manner. Removing these stipulations would allow PEPFAR to better address

the requirements of each country, making more efficient and effective use of taxpayer dollars in serving the millions affected by this disease.

In addition, I believe it is crucial that we dedicate greater attention to strengthening local health infrastructure. Health experts have expressed concern that the high amount of spending directed toward HIV/AIDS initiatives has drawn health workers away from public health facilities and other important programs. This merely compounds a chronic shortage of qualified health workers, which, according to WHO's 2006 World Health Report, is the single most important health issue facing countries today. This need is felt particularly sharply in Southeast Asia and sub-Saharan Africa.

Many health experts also continue to advocate greater integration between PEPFAR and other health programs, including those focused on nutrition, maternal and child heath, and other infectious diseases. These experts note that HIV is intricately linked to these other areas of concern; for example, malnutrition and lack of food may heighten exposure to HIV, raise the likelihood of engaging in risky behavior, increase susceptibility to infection, and complicate efforts to provide antiretroviral, ARV, medication. Further, an HIV epidemic will likely worsen food insecurity, by depleting the agricultural workforce. I believe it is necessary, to ensure maximum effectiveness, that we integrate PEPFAR with other aspects of our international health outreach and development programs.

Mr. Speaker, if we are to turn the tide of turmoil and tragedy that HIV/AIDS causes to millions around the world, and hundreds of thousands right here in our backyard, it is imperative that we continue to fund and expand medical research and education and outreach programs.

HIV/AIDS

I want to share briefly the importance of continued action in awareness for this virulent disease and the nexus between TB and HIV/AIDS, another issue which I am passionate about and would like to see eradicated as I am sure many of my colleagues would. According to the World Health Organization, there were 33.2 million people living with HIV/AIDS worldwide in 2007.

People living with HIV/AIDS are at a greater risk of becoming infected with TB because of their weakened immunity. In 2004, out of the more than 740,000 people who contracted TB and were co-infected with HIV/AIDS, 600,000 of those co-infected were found in sub-Saharan Africa.

Similar to TB, HIV/AIDS has risen to epidemic levels particularly for our African countrymen. According to UNAIDS, in 2005, there were 3.2 million newly infected Africans and 2.4 million Africans who died of HIV/AIDS related complications. The current life expectancy for a person living with AIDS in Africa is 47 years old.

Such high rates of infection can be prevented. The transmission of HIV can be reduced through proper education and resources. Additionally, proper resources can help the treatment of HIV. We must make these resources more accessible to those who need it most.

MALARIA

Malaria is another disease that must be addressed. According to the World Health Organization, more than 500 million people become severely ill with malaria and more than one million people die of malaria every year, mostly infants, young children and pregnant women. Perhaps most shocking is WHO's estimate that a child dies of malaria every 30 seconds. More than 90 percent of malaria cases occur in sub-Saharan Africa.

Mr. Speaker, malaria is both preventable and curable. Early and effective treatment can shorten its duration and prevent the development of complications and the great majority of deaths.

CONCLUDING STATEMENTS

Key factors that contribute to continuing high rates of HIV/AIDS, Tuberculosis, and Malaria include: weak health care systems, poor access to health facilities, insufficient staffing and other human resource constraints, ill equipped and substandard laboratory services, and little collaboration between TB and HIV programs.

Mr. Speaker, what is so striking about these factors is that they are all preventable. We must address and work to rectify these human factors that have led to such unnecessarily high fatality rates throughout the world, particularly in African nations. I urge my fellow colleagues to join me in support of PEPFAR and H.R. 5501.

Ms. ROS-LEHTINEN. Mr. Speaker, I would like to yield 1 minute to the gentleman from Illinois (Mr. KIRK), a member of the Committee on Appropriations.

Mr. KIRK. I thank the gentlewoman for yielding.

Mr. Speaker, 23 years as a staff member, I heard from WHO that AIDS was not an epidemic based in New York, San Francisco, or Haiti, as we thought back in 1985, but instead was an epidemic that raged in Zaire for years.

I got my then boss, John Porter, and Democratic Congressman Bob Mrazek to begin the foreign AIDS program. We were told by the leaders of the Appropriations Committee that we could not do this, but we did. We started with just a $25 million funding level, and as recently as 1999, I had a tough time even getting members to show up for a hearing on this subject. I feel a bit like a country music singer who worked in every honky-tonk for years before hitting the big time. But this bill is the big time. It's the largest investment in health of another country from just one country, the United States of America. The original legislation put too many congressional restrictions on this program. This frees up those restrictions.

The SPEAKER pro tempore. The time of the gentleman has expired.

Ms. ROS-LEHTINEN. I yield the gentleman 30 seconds, Mr. Speaker.

Mr. KIRK. Mr. Speaker, this legislation takes us in the right direction by freeing up restrictions because we knew even back in 1985 that to save the most lives this program should be run by doctors and not politicians.

Now, 23 years ago John Porter, Bob Mrazek, and I had no idea how large and successful this program would be. My only wish is the head of the Harvard Public School of Health, our first director of this early program, Dr. Jonathan Mann, could be with us. Dr. Mann was killed in a tragic airline accident, but I wish he could see us now.

Mr. BERMAN. Mr. Speaker, I reserve the balance of my time.

Ms. ROS-LEHTINEN. Mr. Speaker, I am pleased to yield 2 minutes to my good friend from Connecticut (Mr. SHAYS).

Mr. SHAYS. I thank the gentlewoman for yielding.

Mr. Speaker, I rise in support of H.R. 5501, the Tom Lantos and Henry Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act. I am pleased the committee named this bill after two great leaders of the Foreign Affairs Committee, Chairmen Lantos and Hyde, who guided the original 2003 act into law.

An estimated 38.6 million people are infected with HIV/AIDS throughout the world today. The majority of them are women and girls. In sub-Saharan Africa, women and girls make up 60 percent of those infected with HIV/AIDS.

It is impossible to overstate the importance of ensuring we are doing all we can to address the spread of this dreaded disease around the world. It is heart breaking to think of children going to school with no teachers, coming home to no parents.

H.R. 5501 would authorize $48 billion over 5 years to treat AIDS and other global diseases and another $2 billion for Native American health care, law enforcement, and drinking water programs.

America faces a new generation of threats in the 21st century, including global health pandemics, terrorism, and climate change. Today's legislation and other critical foreign assistance programs are absolutely vitally important to our national interests and security. Legislation like this helps make our country more secure and, just as importantly, more humane.

Mr. BERMAN. Mr. Speaker, I continue to reserve the balance of my time.

Ms. ROS-LEHTINEN. Mr. Speaker, I would like to yield myself the balance of my time.

I believe that PEPFAR is the most successful example of American foreign assistance since the Marshall Plan. Just as the Marshall Plan protected American lives by helping to stabilize a continent ravaged by war, PEPFAR is protecting American lives today by helping to stabilize a continent ravaged by disease.

□ 1700

More than just express American compassion, PEPFAR also protects American security. Let us give our strong support to H.R. 5501.

In closing, I would like to thank the following staff members of our Foreign Affairs Committee who have dedicated many long hours to ensuring that this bill is signed into law and we can continue U.S. efforts to save lives. For the

majority, Dr. Bob King, Peter Yeo, Dr. Pearl Alice Marsh, David Abramowitz and Kristin Wells. On our side, the Republican side, Joan Condon, Mark Gage, Doug Anderson, Sarah Kiko, Sam Stratman, Sheri Rickert, and our fabulous GOP staff director, Dr. Yleem Poblete. Thank you so much.

Mr. Speaker, I hope that our colleagues will see the meritorious nature of this proposal, because the HIV/AIDS pandemic is a significant threat to global health. It's also a leading threat to global stability. We can help fill this void. We can help stabilize the continent. We can help save lives by passing this bill today and sending it to the President's desk. As soon as tomorrow, we can have it on the President's desk and have a bill signed by next week.

We are in a position where we can make a difference, because this virus is killing millions of people in the prime of life. These are parents. These are teachers. These are government officials, public health workers and military officers, people who hold the fabric of life together for their community. We have an opportunity to rise to the challenge, pass this bill and save their lives and save a generation of lives around the world.

With that, Mr. Speaker, I yield back the balance of my time.

Mr. BERMAN. Mr. Speaker, I yield myself the remaining time.

The bill has been described, and its consequences have been discussed. But I can't help but come back to the comments from my friend from California (Mr. ROHRABACHER) with respect to the effects of this bill. The notion that there are now pregnant women who, because of new discoveries in medicine, can take drugs which allow their baby to be born without being HIV positive, I call that saving lives and curing the problem. This is happening all over the countries where these programs are working. The notion that the United States is helping to take care of the orphans and other vulnerable children who are left without parents as a result of this epidemic I call saving lives and curing a problem.

And as the ranking member said in her opening comments, the effect on these people and their recognition of the role the United States is playing is having a—it's a secondary question, but it's an important one—it's having a massive impact on how they perceive this country at a time when, for many other reasons, this country has not been perceived well in this world.

This has been a remarkable program that has gone on. And I want to add my compliments to the staff, all the staff on the minority who worked on it, as well as Peter Yeo and Pearl-Alice Marsh and David Abramowitz, Kristin Wells, Heather Flynn with Chairman DON PAYNE, Christos Tsentas with Congresswoman LEE, as well as Mark Synnes with legislative counsel, Naomi Seiler and Jessica Boyer from the Oversight Committee staff, and on the Senate Foreign Relations majority staff, Brian McKeon and Shannon Smith. These are people who not only helped put this bill together, not only invested huge amounts of their time in working with the outside coalition forces, who have been working on the ground on these issues in Africa and other places, and also dealt with the administration, these are people who, when I got thrown into this issue, helped educate me. And I'm very grateful for all they have done to make this happen.

Mrs. CAPPS. Mr. Speaker, I rise in strong support of H.R. 5501.

Every day, 6,000 people become infected with HIV, over 1,000 of whom are babies.

We have made terrific advancements in treating and preventing HIV/AIDS, but they mean nothing unless we ensure that the most vulnerable populations have access to them.

Since its inception, the President's Emergency Plan for AIDS Relief, PEPFAR, has saved countless lives and increasing our investment through this reauthorization will save millions more.

I am especially proud to see that this reauthorization places stronger emphasis on prevention.

Without increased efforts to prevent the transmission of HIV/AIDS, we will never adequately address the long-term needs of the global HIV/AIDS population and global health overall.

This bill takes important steps to increase prevention efforts by overturning the ineffective one-third abstinence-only requirement that currently applies to global HIV/AIDS prevention funding; providing an increased focus on women and girls who are at-risk; and setting a target for PEPFAR to provide 80 percent of pregnant women with the tools they need to prevent maternal-to-child transmission of HIV.

Finally I am thrilled to see an increased investment in helping countries to expand their healthcare workforce as they face drastic shortages in skilled healthcare workers.

During my recent visit to Africa with the House Democracy Assistance Commission, I had the opportunity to visit with doctors, nurses and ministries of health in several countries.

They are desperate for more professionals who can treat individuals affected with HIV/AIDS, especially in countries like Malawi where 15 percent of the population suffers from HIV/AIDS.

Our investments and improvements of PEPFAR fulfill a moral responsibility that we are accountable to.

Our steadfast commitment to PEPFAR is also one of our proudest foreign policy accomplishments over the past few years as we provide the necessary humanitarian assistance required for countries to sustain themselves in the long-term.

Finally, I would like to also applaud the provision removing the ban on visas for HIV-infected individuals wishing to come to the United States. This mean spirited statute should have been repealed long ago and I am glad to see that it is finally being ended. Only a few countries have such a policy and America should not be one of them.

I urge my colleagues to enthusiastically support this legislation and I look forward to the success we are sure to see in addressing the global HIV/AIDS epidemic.

Mr. WAXMAN. Mr. Speaker, as one of the original cosponsors of the House version of this bill, I am happy to see that it is about to become law. This reauthorization affirms to our partners around the world that we are with them for the long haul in the fight against HIV, TB, and malaria.

The bill retains many of the important provisions of the House version. It authorizes strengthening of local health systems and health care workforces. It supports fiscal responsibility by directing the purchase of safe drugs at the lowest available prices. And it encourages operational research and the translation of lessons learned into effective programming.

The bill incorporates Congresswoman BARBARA LEE's legislation to eliminate the HIV travel ban. This is an important policy step. And it is an important message that we reject this relic of a time when fear and stigma drove much of the nation's' response to AIDS.

But unfortunately, fear and stigma around HIV are still very real, particularly when we talk about prevention. This bill notes the importance of supporting healthy behavior change, and encourages the expansion of male circumcision as an effective prevention method. But I think there are parts of this bill where Congress could have spoken more directly to the need for honest, evidence-based prevention programming.

Injection drug users around the world are among the most vulnerable to HIV prevention. This bill makes only brief mention of the need for prevention strategy and other programs for this population. Our implementers should understand how crucial this focus is to fighting the epidemic, not only in countries with HIV driven mainly by drug use, but also in countries with emerging, concentrated drug-related epidemics.

The same applies to men who have sex with men. Due to stigma and denial, the HIV prevention, treatment, and care needs of sexual minorities are often unmet. This bill makes only passing reference to men who have sex with men, but the program should be implemented in a way that truly recognizes the needs of this population.

People involved in sex work are also very vulnerable to HIV infection, along with many other health and social risks. I'm disappointed that we haven't eliminated the current requirement that recipients sign an ''anti-prostitution pledge.'' The requirement has reportedly had the unintended consequence of scaring grantees away from doing effective outreach programs for sex workers. But U.S. officials, and all of our partners, should know that Congress wants this law implemented in a way that best respects the public health needs of this severely marginalized group.

Finally, I have concerns about integration of activities. I am particularly disappointed that the bill does not explicitly encourage the close integration of HIV programs with family planning and other reproductive health services. What's more, language added to the bill's ''conscience clause'' could hinder effective integration, when we should be doing everything we can to encourage referrals to important health services.

All of these concerns do not outweigh my deep respect for what the global AIDS program has accomplished, and my strong support of its reauthorization. They do underscore

the need for ongoing oversight of how the program is designed and implemented, particularly in efforts to reduce HIV transmission.

The first 5 years of PEPFAR showed that a remarkable scale-up of effective treatment was possible in the developing world. It's time to use all of the public health knowledge and resources we have to do the same for prevention.

Mr. SIRES. Mr. Speaker, I rise today in support of H.R. 5501, the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008.

The passage of this bipartisan bill will continue Congress' commitment to the fight against HIV, TB and malaria around the world. This bill will dramatically boost HIV/AIDS and health care programs for women and girls, as well as strengthen health and education systems in nations hard-hit by the HIV virus.

H.R. 5501 also provides funding for orphans and vulnerable children, as well as food and nutrition programs.

The World Health Organization estimates that over 38 million people are living with HIV/AIDS and 95 percent of those people live in the developing world.

We must be leaders in combating the global AIDS crisis and this bill allows maximum flexibility for our staff on the ground. H.R. 5501 provides needed funding and support to transition the very successful PEPFAR program from the emergency phase to the sustainability phase. I urge all my colleagues to support this bill.

Mr. VAN HOLLEN. Mr. Speaker, I rise in strong support of the Senate amendments to the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008.

Five years ago, Congress showed leadership and passed legislation on a bipartisan basis to address the global pandemics of HIV/AIDS, tuberculosis and malaria. While enormous progress has been made since 2003, the number of people who are affected by these diseases is still staggering. The United Nations estimates that thirty-three million people are living with HIV/AIDS worldwide, with AIDS causing approximately 1.6 million deaths in sub-Saharan Africa in 2007.

We have a moral obligation to lead the fight against these global diseases. This legislation will authorize $48 billion over five years for our global HIV/AIDS, tuberculosis and malaria efforts. It will allow the United States to provide continued assistance for these pandemics in developing countries and will strengthen the health systems in host countries by giving them more flexibility to plan, direct, and manage prevention, treatment and care programs. I am also pleased that this legislation includes a provision that authorizes funding for the research and development of new tuberculosis vaccines, which have the potential to save millions of lives.

Mr. Speaker, we still have much work to do. I urge my colleagues to continue and reaffirm America's commitment to combating HIV/AIDS, tuberculosis, and malaria by supporting this much-needed bipartisan and bicameral legislation.

Mr. HOYER. Mr. Speaker, five years ago, the United States made an unprecedented commitment to the people of the world who suffer from HIV/AIDS, malaria, and tuberculosis. We pledged $15 billion—and with that funding, we have: Provided life-saving drugs to almost 1.5 million people; funded care for over 2 million orphans and vulnerable children; and provided mother-to-child transmission prevention services during more than 6 million pregnancies.

For millions, HIV/AIDS has been transformed from a death sentence to a manageable condition—and Congress has played a very real role in making that happen. On this issue, our moral obligation and our self-interest speak with one voice. Not only do we have the opportunity to save millions of lives—failing to do so will help proliferate disease and instability, spreading bloodshed across borders.

Today, with the Tom Lantos and Henry J. Hyde Global LeadershipAgainst HIV/AIDS, Tuberculosis and Malaria Reauthorization Act, we raise our commitment to eradicating those diseases to a total of $48 billion. In addition to expanding our prior efforts, this carefully negotiated legislation will:

Strengthen HIV -related health care delivery systems and increase health workforce capacities;

Foster stronger relationships between HIV/AIDS initiatives and other support programs, including those that promote better nutrition and education;

Allow HIV/AIDS testing and counseling to be provided as part of the U.S. bilateral family planning program; and

Enhance prevention and treatment programs targeting women and girls.

This bill also eliminates a requirement that ⅓ of prevention funds be spent on abstinence—a requirement that has proven ineffective. Instead, we have directed the Administration to create a ''balanced'' approach, requiring behavioral change programs to receive 50 percent of the funds devoted to the prevention of sexual transmission of HIV. In the face of the AIDS pandemic, this bill will show the world, unambiguously, that America accepts its obligation to act.

Last year alone, 2.5 million people contracted HIV—roughly 6,800 every single day. And last year alone, 2.1 million AIDS victims were added to the rolls of the dead. We are confronting a scourge far too pressing, far too powerful, to be made the object of political inaction. We have rarely faced a greater global challenge. We have rarely needed a greater global solution.

I want to thank Congresswoman BARBARA LEE for her hard work to shape that solution. But most of all, I want to honor Tom Lantos. This bill, in many ways, was the culmination of his career, his lifetime of service. I wish he could be here to see it. But how perfect that Tom's work, which began in the fight against tyranny in his homeland, expanded to encompass the whole world, and the world's struggle against the tyrannies of disease and poverty.

Chastened by the vast challenge of AIDS—but inspired by Tom's example, and Henry Hyde's, as well—let us come together across the aisle and join the struggle with all the force America can muster. Let us pass this bill.

Mr. PAUL. Mr. Speaker, I in rise opposition to this irresponsible legislation, which will ship $48 billion overseas as foreign aid at a time when Americans are feeling the pressure of rapidly increasing inflation and a weakened dollar. It is particularly objectionable to ship money to fund healthcare overseas when so many Americans either struggle with high healthcare costs or avoid seeking medical assistance altogether due to lack of insurance or funds.

As we know, the Federal Government does not have $48 billion to send overseas so it will have to print the money. It is a cruel irony that this will add to inflation at home which will increase even further the costs of healthcare in the United States.

Mr. Speaker, I am saddened by the prevalence of disease in impoverished countries overseas. I certainly encourage every American concerned about HIV/AIDS, tuberculosis, and malaria overseas to voluntarily provide assistance to help alleviate the problem. But I do not believe it is appropriate—nor is it constitutional—to forcibly take money from American citizens to send abroad. I urge my colleagues to reject this and all foreign aid legislation.

Ms. ZOE LOFGREN of California. Mr. Speaker, this bill underscores the United States' position as the world leader in the fight against HIV/AIDS, Tuberculosis, and Malaria.

In addition to all that the bill does to fight the three diseases on a global level, the bill finally does away with an outdated and unnecessary provision in immigration law that prevents persons with HIV from visiting or immigrating to the United States.

This provision, in place for over 20 years, has kept parents from children and sisters from brothers. It has slowed research and discourse by preventing many researchers and other experts in the field from entering the country. And it has significantly undermined our leadership in the fight against HIV.

The U.S. is one of only 12 countries in the world to have such harsh HIV-based restrictions on entry. The others include Sudan, Libya, Russia and Saudi Arabia. Even China has recently overturned its ban.

This discriminatory policy has no basis in public health, and it should have been stricken long ago.

Our immigration laws have long prevented the admission of persons who have communicable diseases that HHS believes are of ''public health significance.'' In 1993, HHS sought to remove HIV from this list. But Congress, in a time of fear and ignorance about the disease, kept it in.

HIV is now the only medical condition permanently listed in the INA as a basis for inadmissibility. For any other disease, HHS retains the discretion to determine, with the wealth of medical and public health expertise at its disposal, whether that illness should be a bar to admission.

HHS does not believe that HIV should present such a bar. Neither do the American Medical Association, the Centers for Disease Control, the World Health Organization, and other public health organizations. These experts agree that there is no medical or public health rationale for this policy.

The policy also keeps world-renowned experts, doctors, and researchers from participating in U.S. hosted efforts to combat the epidemic. Indeed, since 1993, the International Conference on AIDS has not been held on U.S. soil.

It is time we end this discriminatory policy.

Mr. GENE GREEN of Texas. Mr. Speaker, I rise today in strong support for H.R. 5501, the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008.

This important piece of legislation outlines the United States' efforts to combat the devastating effects of AIDS, Malaria, and Tuberculosis on our global community.

I am extremely encouraged that this bill declares Tuberculosis control a major objective of U.S. foreign assistance programs—particularly, that this bill will encourage the development of a TB vaccine.

TB is the leading killer of people with HIV/AIDS, and the explosion of drug-resistant TB in sub-Saharan Africa threatens to halt and roll back our progress in combating both diseases.

In fact, the World Health Organization (WHO) reports that 1.7 milion people died of tuberculosis in 2006, with 200,000 dying from HIV-associated TB.

The TB germ is constantly changing and drug resistant strains have been found in 28 countries on 6 continents.

Our current TB Vaccine, BCG, is more than 85 years old and is not compatible against pulmonary TB, which accounts for most TB cases.

Even right here in the United States, it is estimated that 10 to 15 million people in the U.S. have latent TB.

Therefore, developing a vaccine has important implications both internationally and domestically.

Studies also show that the ten year economic benefits of a TB vaccine that was only 75 percent effective could result in an estimated savings of $25 billion; no one can deny that this is a significant amount.

This legislation is a good start in our critical battle against TB and we as a legislative body need to continue to work on TB efforts both internationally and right here at home.

I strongly urge my colleagues to support this bill.

Mr. BLUMENAUER, Mr. Speaker, I'm pleased that Congress has come together in a bipartisan and bicameral way to address the devastating impact ofHIV/AIDS, tuberculosis, and malaria. The Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act reaffirms our commitment to fighting the causes and the spread of these terrible and largely preventable diseases.

Treating HIV/AIDS is more than taking prescription drugs. I applaud my colleagues in the House and Senate, particularly Chairman BERMAN and Ranking Member ROS-LEHTINEN, for recognizing that fighting HIV/AIDS means treating the person and not just the disease. The latest breakthrough medicines are worthless without access to food, water, and security.

This legislation makes the connection and contains an important section to address barriers that limit the start of and adherence to treatment services. There is specific recognition of the direct linkages between efforts to treat HIV/AIDS and nutrition, income security, and drinking water and sanitation programs.

We cannot treat HIV/AIDS without clean water. There is terrible irony in providing patients with advanced antiretroviral agents, and asking them to wash the life-saving pills down with a glass of water that may infect them with a life-threatening, water-bourne illness. I am particularly proud that my simple amendment to add safe drinking water to the list of related activities vital to treatment is included here. This small addition shapes our approach to treatment in a realistic and profoundly positive way.

Much more must be done to deal with the global HIV/AIDS pandemic and the problem of lack of access to safe drinking water and sanitization, the world's leading preventable cause of death. The recognition of these important linkages is a critical step forward in our understanding and treatment of these diseases.

This bill is an important part of the tribute to our late colleagues, Chairman Lantos and Chairman Hyde.

Mr. HONDA. Mr. Speaker, today the House of Representatives will vote on H.R. 5501 the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008.

As the Chairman of the Congressional Ethiopia and Ethiopian American Caucus, I strongly support this critical reauthorization of the President's Emergency Plan for AIDS Relief (PEPFAR). Although PEPFAR supports a global effort, no one can argue against the fact that the African continent has borne the brunt of the HIV/AIDS, TB, and Malaria epidemics. The litany of grim statistics documenting the ravages of HIV/AIDS, TB, and Malaria on dozens of African countries and millions of people is familiar to all of us committed to a morally righteous global war on poverty and disease. I have traveled to Ethiopia and witnessed first-hand the courage of a people nurturing a fledgling democracy in the face of terrible obstacles.

For me, what those statistics come down to is the human cost of disease, countless orphans, hollow-eyed children raising children in villages, cities, and countries devastated economically and spiritually by death and fear. I have seen the resiliency and courage of people who, with access to medicine and food, have raised themselves out of abject poverty. As the wealthiest country in the world we have an obligation to invest in the global community, and I support the passage of this bill.

Mr. BERMAN: I yield back the balance of my time.

The SPEAKER pro tempore. All time for debate has expired.

Pursuant to House Resolution 1362, the previous question is ordered.

Pursuant to section 2 of House Resolution 1362, further proceedings on the motion will be postponed.

## RELATING TO THE HOUSE PROCEDURES CONTAINED IN SECTION 803 OF THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003

Mr. HASTINGS of Florida. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 1368 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 1368

*Resolved*, That section 803 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 shall not apply during the remainder of the 110th Congress.

The SPEAKER pro tempore. The gentleman from Florida is recognized for 1 hour.

Mr. HASTINGS of Florida. For the purpose of debate only, I yield the customary 30 minutes to my good friend, the ranking Republican of the Rules Committee, Representative DREIER.

All time yielded during consideration of the rule is for debate only. I yield myself such time as I may consume.

I also ask unanimous consent, Mr. Speaker, that all Members be given 5 legislative days within which to revise and extend their remarks on House Resolution 1368.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Florida?

There was no objection.

Mr. HASTINGS of Florida. Mr. Speaker, as the Clerk just read, House Resolution 1368 provides that section 803 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 shall not apply during the remainder of the 110th Congress.

This resolution is needed today because of a procedural gimmick which was stuck into the Republican Medicare prescription drug bill in the dead of night shortly before the bill found its way to the floor back in 2003. The provision was a way for Republicans to get conservatives in their party to support an unpopular bill that may very well be the largest campaign donor payback program in the history of this institution. However, even this provision failed to prevent one of the most shameful nights in the history of this institution as arms were twisted and threats delivered into the wee hours of the morning to get the votes needed to pass this bill.

Under current law, when the Medicare trustees project in two consecutive trustee reports that general revenues will exceed 45 percent of Medicare spending within a 7-year window, an expedited process is triggered to reduce the percentage. This expedited process, however, bypasses regular order in the House, as well as the Rules Committee. Once the percentage of Medicare funding coming from general revenues reaches 45 percent, the President is required to send legislation to the House and Senate that will address the matter. That bill must then be introduced by the House majority and minority leaders and referred to the appropriate committees.

The process by which that bill, or any bill meeting the requirements of the trigger, moves through the committee process and is discharged to the floor includes a privileged motion. The privileged motion requires only one-fifth of the House, or just 87 Members, to second the motion and force a vote on that motion that would bring the bill itself to the floor for a vote. Under the trigger, if this small minority of the House is successful and the motion passes the House, the bill would come to the floor within 3 legislative days and can be debated with up to 5 hours of general debate and 10 hours of debate on amendments.

Adding to the unprecedented nature of this provision, amendments are given blanket waivers with the only requirement being certification by the