examination of the details of the bill call that claim into question. For one thing, the oftencited assertion that H.R. 1 reduces spending by $99 billion is misleading as the $99 billion figure represents the amount that H.R. 1 reduces spending from the President's proposed Fiscal Year 2011 budget, not reductions in actual spending. Trying to claim credit for a reduction in spending based on cuts in proposed spending is like claiming someone is following a diet because he had 5 pieces of pizza when he intended to have 10 pieces.

In fact, H.R. 1 reduces federal spending by $66 billion. This may seem like a lot to the average American but in the context of an overwhelming trillion-dollar budget and a national debt that could exceed 100 percent of GNP in September, this cut is barely even a drop in the bucket.

One reason that H.R. 1 does not cut spending enough is that too many fiscal conservatives continue to embrace the fallacy that we can balance the budget without reducing spending on militarism. Until Congress realizes the folly of spending trillions in a futile attempt to impose democracy on the world we will never be able to seriously reduce spending.

Congress must not only reject the warfare state, it must also reject the welfare state. H.R. 1 is more aggressive in ending domestic spending than foreign spending, and does zero out some objectionable federal programs such as AmeriCorps. However, H.R. 1 leaves most of the current functions of the federal government undisturbed. This bill thus continues the delusion that we can have a fiscally responsible and efficient welfare state.

Mr. Chair, the failure to even attempt to address the serious threat the welfare-warfare state poses to American liberty and prosperity is the main reason why supporters of limited government and individual liberty should ultimately find H.R. 1 unsatisfactory. Only a rejection of the view that Congress can run the economy, run our lives, and run the world will allow us to make the spending reductions necessary to avert a serious financial crisis. This does not mean we should not prioritize and discuss how to gradually transition away from the welfare state in a manner that does not harm those currently relying on these programs. However, we must go beyond balancing the budget to transitioning back to a free society, and that means eventually placing responsibility for social welfare back in the hands of individuals and private institutions. Despite the overheated rhetoric heard during the debate, H.R. 1 is a diversion from the difficult task of restoring constitutional government and a free economy and society.

CONGRATULATIONS GORDY FAMILY

HON. JOE WILSON

OF SOUTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Friday, February 18, 2011

Mr. WILSON of South Carolina. Mr. Speaker, I am happy to congratulate my good friend, Thomas Gordy and his wife, Theresa on the birth of their daughter, Trenton Talmadge Gordy. Trenton was born on Tuesday, February 15, 2011, in Manassas, Virginia. She is welcomed home by her sister, Sarah Gordy.

Trenton Talmadge Gordy is seven pounds and one ounce of pride and joy to her loving grandparents, Timmy and Kay Gordy of Monroe, Louisiana, Toni and Michael LeBlanc of Shreveport, Louisiana, and Canoy and Lynn Mayo of West Monroe, Louisiana.

I am so excited for this new blessing to the Gordy family and wish them all the best.

CONGRATULATING THE WINNERS OF THE MEDAL OF FREEDOM

HON. CHRIS VAN HOLLEN

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Friday, February 18, 2011

Mr. VAN HOLLEN. Mr. Speaker, I rise to honor this week's recipients of the Presidential Medal of Freedom, our nation's highest civilian honor. All of the honorees have led extraordinary lives and made enormous contributions in their fields. They come from a range of backgrounds—arts, sports, public service—and have enriched our nation and improved our world.

I particularly want to recognize my friend, Congressman JOHN LEWIS, who received this honor. JOHN has given a lifetime of service to this nation, from his leadership in the Civil Rights Movement to his 26 years as the ''Conscience of the Congress.'' A few years ago, I had the privilege to join JOHN on a trip to Alabama, where we retraced the steps of the courageous civil rights activists who changed the face of America. JOHN's passion has never wavered and he remains a voice for the voiceless—strongly advocating for opportunity for all Americans. I congratulate him on this much-deserved honor and look forward to working with him for many years to come.

OPPOSITION TO AMENDMENT NO. 262

HON. DONALD M. PAYNE

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Friday, February 18, 2011

Mr. PAYNE. I rise today in opposition to Amendment No. 262, introduced by our colleague Representative LATTA of Ohio, should it be offered during floor consideration of H.R. 1. Amendment No. 262 would eliminate all funding for international family planning programs in the proposed FY 2011 Continuing Resolution. This devastating cut would have severe immediate and long term impacts on women and their families in the world's poorest countries.

Contrary to the rhetoric we are hearing from some of our colleagues, U.S. international family planning assistance in fact helps to reduce unintended pregnancies and abortions in the developing world. According to Population Action International, cutting this funding would result in: 7.8 million more unintended pregnancies; 3.7 million more abortions; 87,000 additional newborn deaths; and 12,000 additional maternal deaths.

Moreover, this amendment would turn back the clock on U.S. investments in the global fight against HIV/AIDS. The integration of family planning and HIV/AIDS services is a vital and cost-effective way to prevent HIV infection, including through mother-to-child transmission. At the same cost, family planning services can avert nearly 30 percent more HIV-positive births than use of the nevirapine prophylaxis by HIV-positive pregnant women. A recent study found that, although PEPFAR has been associated with a reduction in HIV-related deaths, trends of increasing adult prevalence rates continue unabated. However, preventing unintended pregnancies, which is an international pillar of preventing mother to child transmission (PMTCT) programming, continues to receive insufficient attention in AIDS programs. The Guttmacher Institute noted in their report Hiding in Plain Sight: The Role of Contraception in Preventing HIV that helping HIV-positive women avoid unwanted pregnancies not only lowers the rate of new infections, but does so at a relatively low cost.

I hope that you will join me in opposing this amendment, should it be offered.

[From the Guttmacher Policy Review, Winter 2008]

HIDING IN PLAIN SIGHT: THE ROLE OF CONTRACEPTION IN PREVENTING HIV

(By Susan A. Cohen)

As Congress embarks on the process of reauthorizing the U.S. program to fight HIV and AIDS, and as other global donors recalibrate levels and allocations of funding for HIV/AIDS programs, prevention seems to be making a comeback. At the inception of the President's Emergency Plan for AIDS Relief (PEPFAR) five years ago, both the funding and the programmatic emphasis tilted heavily toward treatment. Yet, the rate of new HIV infection continues to outpace the world's ability to deliver antiretroviral therapy, despite recent advances in access to such medications. A public health consensus is emerging, therefore, in favor of realigning the balance between treatment and prevention efforts.

Refocusing the priority on prevention is long overdue, as is an acknowledgment, especially within Congress, that HIV prevention cannot be accomplished with a disproportionate emphasis on abstinence. Indeed, preventing the sexual transmission of HIV requires going beyond the necessary but hardly sufficient strategy of ABC: abstain, be faithful, use condoms. It also requires increasing AIDS awareness through counseling and testing programs, investing in programs promoting the empowerment of women and girls, and increasing access to male circumcision. Other critical prevention interventions include ensuring a clean blood supply and clean medical injections, needle exchange programs for intravenous drug users and preventing the ''vertical'' transmission of HIV from a pregnant woman to her newborn infant.

Largely overlooked as an HIV prevention strategy, however, is the simple and low-cost act of helping HIV-positive women who do not want to have a child to avoid an unintended pregnancy through increased access to contraceptive services. Ward Cates, president for research of Family Health International (FHI), has dubbed contraception the ''best-kept secret in HIV prevention,'' and certainly, the significant contribution of unintended pregnancy prevention toward reducing the perinatal transmission of HIV has gone virtually unrecognized. Yet, a revitalized and more robust effort focused on HIV prevention cannot afford not to fully capitalize on the critical role of contraceptive services in fighting AIDS.

THE NEED FOR PROGRESS ON PREVENTION

Women of reproductive age comprise more than half of the 33 million people currently living with HIV around the world. The vast

majority of these women live in Sub-Saharan Africa, and thus, it is not surprising that 90% of the 2.5 million children younger than 15 living with HIV live there as well. Almost all of these children became infected through their mothers during pregnancy, birth or breastfeeding.

An HIV-positive woman about to give birth can dramatically reduce the likelihood of transmitting the virus to her newborn by delivering in a hospital or a primary care setting where she and her infant can receive even a single dose of the anti-retroviral drug nevirapine. However, the challenges to delivering even this seemingly simple prevention of mother-to-child transmission (PMTCT) service are substantial, especially in Sub-Saharan Africa. Pregnancy itself does not usually drive women, especially those in rural areas, to facilities where they could receive pre-natal care and, potentially, an HIV test. In addition, many pregnant women may not want to know their HIV status for fear of public disclosure and the stigma that often results. Considering the difficulties of delivering services to HIV-positive pregnant women, and the simple fact that most women who are HIV-positive do not know it, it is not entirely surprising that only 11% of all theoretically eligible women in poor countries are benefiting from any PMTCT intervention. And without intervention, about one-third of babies born to HIV-positive women likely will become infected.

A long-standing goal of global prevention efforts, therefore, is to ramp up PMTCT efforts so that more pregnant women are tested and that those who are positive receive the treatment that they and their infant will need. PMTCT programs justifiably enjoy broad political support and are certain to continue to be a funding priority within the U.S. global AIDS effort.

The United States does recognize the importance of at least establishing linkages between PMTCT and family planning programs, since PEPFAR requires family planning counseling and referral as one of four elements comprising the minimum package of services for preventing mother-to-child transmission. However, a high-level consultation sponsored by the World Health Organization (WHO} and the United Nations Population Fund in 2004 went considerably further, concluding that investing solely in narrowly defined PMTCT programs will not succeed in dramatically reducing the incidence of perinatal transmission. Rather, the Glion [Switzerland] Call to Action on Family Planning and HIV/AIDS in Women and Children emphasized that all four elements of the WHO approach to preventing HIV infection in infants are essential. PMTCT programs are key, but so are primary prevention of HIV infection in women; the provision of care, treatment and support for women living with HIV and their families; and prevention of unintended pregnancies among women living with HIV. Of these, the significant role that unintended pregnancy prevention already plays—and the much greater role it potentially could play—in averting new cases of HIV has been least recognized and supported.

According to a 2007 Guttmacher Institute study, one in four married women in Sub-Saharan Africa is sexually active and does not want to have a child or another child in the next two years, but is not using any method of contraception. As a result, unintended births are common, and occur in the very countries that are a focus of PEPFAR—countries in which HIV prevalence is high and 60% of all adults living with HIV are women (see table).

Indeed, research into the HIV/AIDS health care system reveals that the unmet need for contraception among HIV-positive women and women at high risk of HIV is even greater than among women in the general population. According to a study published in JAMA in 2006, 84% of the pregnancies among women in three PMTCT programs in South Africa were unintended. Similarly, the Centers for Disease Control and Prevention reported earlier this year that 93% of the pregnancies among pregnant women receiving antiretroviral therapy in Uganda were unintended. And according to FHI research from 2006 of women in HIV counseling and testing clinics (where most women are HIV-negative but are at high risk for HIV), substantial majorities in Kenya (59%), Tanzania (66%), Zimbabwe (77%) and Haiti

HIV AND UNINTENDED PREGNANCY

[In PEPFAR countries, high HIV/AIDS rates coexist with a high unmet need for contraceptive services and a high incidence of unplanned births.]

PEPFAR Focus Countries (selected)	Unmet Need for Contraception, Married Women	Unplanned Births (as % of total births)	HIV/AIDS Prevalence (ages 15–49)
Cote d'Ivoire	28	28	7
Ethiopia	34	35	1–3
Kenya	25	44	6
Mozambique	18	19	16
Namibia	22	45	20
Nigeria	17	14	4
Rwanda	38	39	3
South Africa	15	53	19
Tanzania	22	22	7
Uganda	35	38	7
Zambia	27	39	17

Source: Guttmacher Institute, 2007, and PEPFAR, 2007.

(92%) said they did not want another child in the next two years.

CONTRACEPTION AS HIV PREVENTION

To be sure, many women living with HIV do want to have a child or another child, notwithstanding pressure to forego childbearing from family members, people in their community and health care providers. And, in fact, HIV-positive women are likely to be able to sustain a healthy pregnancy and safely deliver a healthy baby if they can avail themselves of appropriate therapy (related article, Fall 2006, page 17). Nonetheless, many HIV-positive women who know their HIV status seek out contraceptive services specifically because of their status—because they fear infecting their baby if they become pregnant or leaving behind children, whether HIV-positive or not, as orphans. And many more women seeking contraceptives services are, in fact, HIV-positive but do not know it.

FHI researchers estimate that if the HIV-positive women in Sub-Saharan Africa who are currently using modern contraceptive methods to prevent unintended pregnancy were not able to do so, the number of HIV-positive births in the region would be 31% higher than it is now. This would translate to 153,000 more HIV-infected unplanned births each year—or 419 more per day. Researchers at the Johns Hopkins University Bloomberg School of Public Health and WHO published an analysis in AIDS in 2004 demonstrating that even a modest decline in the number of unintended pregnancies among HIV-positive women in Botswana, Cote d'Ivoire, Kenya, Rwanda, Tanzania, Uganda, Zambia and Zimbabwe could lead to the prevention of the same number of births of HIV-positive infants as prevented by the current PMTCT programs in these countries. ''It is clear from this analysis,'' they wrote, ''that only a combined approach utilizing all three intervention components simultaneously [reducing HIV infection among women, reducing unintended pregnancy and increasing the reach of PMTCT programs] will result in significant reductions'' in new HIV infections among infants.

Helping HIV-positive women avoid unwanted pregnancies not only lowers the rate of new infections, but does so at a relatively low cost. The U.S. Agency for International Development (USAID) examined PMTCT programs in the 14 countries comprising the Bush administration's original initiative starting in 2002 aimed at preventing mother-to-child transmission. USAID projected that over a five-year period, adding family planning services to PMTCT programs could prevent almost twice the number of infections to children, and nearly four times the number of deaths to children, as PMTCT alone could prevent (see chart). In addition, a 2006 analysis by FHI concluded that for the same cost, voluntary family planning services can avert not nearly 30% more HIV-positive births—that would have been unintended—than averted by identifying HIV-positive women during their pregnancy and providing nevirapine.

Greater access to contraceptive services then—whether among women in HIV treatment programs, PMTCT programs or counseling and testing programs, or among women in traditional family planning programs in high-HIV-prevelence countries—is a ''win-win-win situation.'' it increases the chances that women living with HIV can prevent future pregnancies they do not want, thereby reducing the incidence of perinatal transmission and the number of potential child deaths, and it achieves these humanitarian ends in a highly cost-effective way.

IMPLICATIONS FOR PREVENTION POLICY

Outside the context of HIV prevention, it is indisputable that the health, social and economic benefits of investing in contraceptive services—for women, their families and their communities—are multiple and varied. By preventing pregnancies that are too early, too late or too closely spaced, contraception reduces the likelihood of infant mortality. And by helping women to avoid high-risk pregnancies and the need for unsafe abortions, it decreases the risk of maternal death or disability. A woman who can determine the timing and spacing of her children increases her own and her existing family's opportunities for educational, social and economic advancement. Moreover, the evidence is compelling that increasing access to family planning programs also amplifies the overall effort to slow the rate of new HIV infection.

Yet, despite the ever-rising demand for contraceptive services and the fact that a woman's ability to control her own fertility is integrally linked to almost all other aspects of health and development, U.S. funding for family planning has been lagging. Funding for family planning programs in developing countries through USAID peaked at about $550 million at the time of the international Conference on Population and Development in Cairo in 1994 and early 1995. It dropped precipitously in 1997, after control of Congress shifted to lawmakers hostile to sexual and reproductive health programs, plummeting to below $400 million. By 2001, the final year of the Clinton administration, funding had regained some ground ($446 million), but that level has remained essentially constant ever since.

Clearly, USAID funding for family planning programs should be increased—both on their traditional merits and, in high-prevalence countries, as an HIV strategy. At the same time, as global donors to the fight against AIDS reconsider the new priority emphasis on prevention, particularly the United States through the reauthorization of PEPFAR, it would be an opportune moment to legitimize contraceptive services as the core HIV prevention intervention they are. This would mean ensuring that HIV treatment programs, where women already predominate, also provide contraceptive services directly or by referral to make it easier for HIV-positive women to coordinate their

treatment regimen with their pregnancy prevention goals. Similarly, it would mean making family planning services more widely available through PMTCT programs, because many HIV-positive new mothers wish to delay or prevent a subsequent pregnancy. Finally, in high-prevalence countries, it would mean promoting greater integration of HIV counseling and testing services into family planning programs, so that more sexually active women at risk of HIV are likely to be tested and to receive appropriate counseling and treatment.

These strategies are more than academic. The Elizabeth Glaser Pediatric AIDS Foundation, the largest provider of PMTCT services under PEPFAR, has been striving to incorporate contraceptive services into its programs because ''care and treatment staff members are uniquely positioned to address HIV-positive women's needs concerning future pregnancy plans and counsel them based on their social circumstances, health status, and ART regimen.'' Indeed, as negotiations in Congress got underway last month to reauthorize PEPFAR, the Foundation wrote to the House Foreign Affairs Committee to urge broadening the use of PEPFAR funds in order to support these ''essential prevention services. . . . As implementers, we cannot overstate the importance of [integration] to the work we do on the ground to prevent the spread of HIV.''

For individual women who live where HIV is rampant, the interrelatedness of HIV prevention and unintended pregnancy prevention is a practical reality. Yet most international program donors, including the United States government, have viewed them as complementary goals but separate and unrelated outcomes. All along, the fact of contraception as HIV prevention has been hiding in plain sight. It is time to seek it.

FULL-YEAR CONTINUING APPROPRIATIONS ACT, 2011

SPEECH OF

HON. LAURA RICHARDSON

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 15, 2011

The House in Committee of the Whole House on the State of the Union had under consideration the bill (H.R. 1) making appropriations for the Department of Defense and the other departments and agencies of the Government for the fiscal year ending September 30, 2011, and for other purposes:

Ms. RICHARDSON. Mr. Chair, I move to strike the last word.

I rise to oppose any effort, including the Paul Amendment (No. 523), which would terminate International Security Assistance Funding. I oppose any such attempt because cutting international security funding is unwise and short-sighted, and would undercut U.S. interests in the Middle East.

Given the turmoil in the Middle East, it is essential that the United States keep its commitment to Israel's security by fully funding the $3 billion in U.S. aid pledged to Israel for Fiscal Years 2011 and 2012.

The dramatic events in Egypt and Tunisia underscore the importance of Israel to the United States and the fragility of Israel's security situation. At a time when Israel is facing increased security threats, cutting U.S. aid to Israel would send exactly the wrong message to Israel and its potential adversaries about the strength and reliability of America's commitment to Israel's security.

Mr. Chair, international security assistance funding is not a ''handout'' or ''giveaway'' to Israel, Egypt, Jordan, or to Pakistan. Rather, this investment provides several tangible benefits to the United States: by helping Israel maintain its qualitative military edge, QME, American assistance has promoted peace with Egypt and Jordan, and made Israel secure enough to make significant concessions in peace agreements with these countries and dramatic peace overtures to the Palestinians and to Syria; Israel's battlefield use of American equipment and shared know-how has helped the United States improve both its equipment and tactics especially while fighting two wars in Iraq and Afghanistan; aid to Israel also fuels economic growth here at home since Israel is required to spend 74 percent of U.S. aid in the United States, which helps create American jobs.

Mr. Chair, while other countries in the Middle East wrestle with change and instability, the United States can count on Israel as our trusted, reliable, and democratic ally. Israel in turn must be able to count on the United States. Nothing will send a clearer message to Israel and any potential adversaries of America's unshakeable commitment than defeating any and all attempts to terminate security funding for Israel.

GAO DOCUMENT ON PORT OF BELLINGHAM

HON. JIM McDERMOTT

OF WASHINGTON

IN THE HOUSE OF REPRESENTATIVES

Friday, February 18, 2011

Mr. McDERMOTT. Mr. Speaker, I submit the following Report for the RECORD which I referenced during debate on my Amendment No. 99 to H.R. 1.

DECISION

Matter of: Port of Bellingham.
File: B–401837.
Date: December 2, 2009.

Lee P. Curtis, Esq., Troy E. Hughes, Esq., and Maggie L Croteau, Esq., Perkins Coie LLP, for the protester.

James H. Roberts, III, Esq., Van Scoyoc Kelly PLLC, for Port of Newport, an intervenor.

Mark Langstein, Esq., Lynn W. Flanagan, Esq., and Diane M. Canzano, Esq., Department of Commerce, for the agency.

Glenn G. Wolcott, Esq., and Ralph O. White, Esq., Office of the General Counsel, GAO, participated in the preparation of the decision.

DIGEST

1. Agency had no reasonable basis to determine that awardee's proposed pier was located outside a designated floodplain area and therefore complied with the solicitation's limitations regarding lease of property located within a base floodplain.

2. Where awardee's proposed pier construction was within a designated floodplain area, agency failed to properly consider whether there was any practicable alternative to selecting awardee's proposal, as was required by the terms of the solicitation.

DECISION

Port of Bellingham, of Bellingham, Washington, protests the award of a lease by the Department of Commerce, National Oceanic and Atmospheric Administration (NOAA), to Port of Newport, of Newport, Oregon, pursuant to solicitation for offers (SFO) No. 09WSA0200C to provide office, warehouse, and related space for NOAA's Marine Operations Center-Pacific (MOC–P).

We sustain the protest.

BACKGROUND

The SFO at issue here was published in November 2008, and contemplated the award of a long-term operating lease to support the activities of NOAA's MOC-P.[1] Among other things, the solicitation sought offers to provide 31,000 square feet of office, warehouse and related space, 1,960 linear feet of pier space, and 20,000 square feet of equipment laydown space. Agency Report (AR), Tab 7, SFO, at 5. The solicitation provided that the lease award would be based on the offer determined to be most advantageous to the government based on application of the following evaluation factors: location of site; site configuration and management; quality of building and pier, availability; past performance and project financing; quality of life; and price. AR, Tab 7, SFO amend. 3, at 2. The solicitation also provided that: ''An award of contract will not be made for a property located within a base flood plain or wetland unless the Government has determined that there is no practicable alternative.'' SFO at 7.

In February 2009, five offers were submitted by four offerors, including Newport and Bellingham.[2] Upon review and evaluation of the offers, the agency determined that four of the five offers were in the competitive range.[3] By letters dated April 20, 2009, the agency advised each of the offerors of their inclusion in the competitive range and identified various issues for discussions.

Concurrent with its ongoing evaluation of proposals, the agency contracted with an engineering firm to perform an environmental assessment (EA) of the various offers, as required by the National Environmental Policy Act of 1969 (NEPA).[4] In June 2009, the agency published a draft EA that provided in-depth environmental analysis regarding each of the four offered sites; the final EA was published in July with no substantive changes. Among other things, both the draft and final EA stated, under the heading ''Floodplains,'' as follows:

[Newport's] proposed dock would be within the 100-year [base] flood plain[5] (Zone A2),[6] and is therefore likely to be impacted by flooding, particularly if the finished level of the dock is below an elevation of nine feet NGVD [National Geodetic Vertical Datum].[7] Additionally, there is some potential for the structure to affect the characteristics of flooding in the area, by trapping debris against the piles of the dock and/or altering the way in which floodwaters circulate/flow within the bay.[8]

AR, Tab 20, Final EA, at 5–96.

During discussions with Newport, the agency brought the floodplain matter to Newport's attention, stating:

It appears that the offered site and pier are in the 100 year flood plain.[9] This would be all parts of the site lower than 9 feet National Geodetic Vertical Datum (NVGD) . . . are within the 100-year floodplain (Zone A2 on the FEMA map, base flood elevation of 9 feet NVGD). Please confirm in your Final Revised Proposals (FRP's) that the finished site level and structures will be above the 100 year flood plain (see SFO Section 1.7).

AR, Tab 15, Letter from Contracting Officer to Newport, May 14, 2009, at 1.

In response, Newport did not alter the location of its proposed pier, nor did it provide any meaningful explanation as to why the pier should be considered to be outside of the floodplain area.[10] Nonetheless, Newport concluded its response to the agency by stating: ''all proposed facilities and structures will be