

PEPFAR EXTENSION ACT OF 2018

NOVEMBER 9, 2018.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. ROYCE of California, from the Committee on Foreign Affairs, submitted the following

R E P O R T

together with

ADDITIONAL VIEWS

[To accompany H.R. 6651]

[Including cost estimate of the Congressional Budget Office]

The Committee on Foreign Affairs, to whom was referred the bill (H.R. 6651) to extend certain authorities relating to United States efforts to combat HIV/AIDS, tuberculosis, and malaria globally, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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THE AMENDMENT

The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the “PEPFAR Extension Act of 2018”.

SEC. 2. INSPECTORS GENERAL AND ANNUAL STUDY.

Section 101 of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7611) is amended—

- (1) in subsection (f)(1)—
 - (A) in subparagraph (A), by striking “2018” and inserting “2023”; and
 - (B) in subparagraph (C)(iv)—
 - (i) by striking “four” and inserting “nine”; and
 - (ii) by striking “2018” and inserting “2023”; and
- (2) in subsection (g)—
 - (A) in paragraph (1), by striking “2019” and inserting “2024”; and
 - (B) in paragraph (2)—
 - (i) in the heading, by striking “2018” and inserting “2024”; and
 - (ii) by striking “September 30, 2018” and inserting “September 30, 2024”.

SEC. 3. PARTICIPATION IN THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS, AND MALARIA.

Section 202(d) of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7622(d)) is amended—

- (1) in paragraph (4)—
 - (A) in subparagraph (A)—
 - (i) in clause (i), by striking “fiscal years 2009 through 2018” and inserting “fiscal years 2004 through 2023”; and
 - (ii) in clause (ii), by striking “2018” and inserting “2023”; and
 - (iii) by striking clause (vi); and
 - (B) in subparagraph (B)—
 - (i) by striking clause (ii);
 - (ii) by redesignating clauses (iii) and (iv) as clauses (ii) and (iii), respectively;
 - (iii) in clause (ii) (as redesignated by clause (ii) of this subparagraph)—
 - (I) in the first sentence, by adding at the end before the period the following: “or section 104B or 104C of such Act”; and
 - (II) in the second sentence, by striking “for HIV/AIDS assistance”; and
 - (iv) in clause (iii) (as redesignated by clause (ii) of this subparagraph), by striking “2018” and inserting “2023”; and
- (2) in paragraph (5), by striking “2018” and inserting “2023”.

SEC. 4. 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) in subsection (b), by striking “2018” and inserting “2023”; and
- (2) in subsection (c), in the matter preceding paragraph (1), by striking “2018” and inserting “2023”.

SUMMARY AND PURPOSE

H.R. 6651, the PEPFAR Extension Act of 2018, extends authorities, limitations, and reporting requirements relating to the President’s Emergency Plan for AIDS Relief (PEPFAR), as initially authorized by Congress in 2003 and reauthorized in 2008 and 2013, respectively. The bill extends through Fiscal Year 2023 a requirement for the Inspectors General of the U.S. Department of State, the Department for Health and Human Services (HHS), and the United States Agency for International Development (USAID) to develop joint auditing plans that ensure greater unity of efforts, reduce gaps in program oversight and performance, and eliminate waste. It extends through Fiscal Year 2023 annual reporting re-

quirements relating to HIV/AIDS treatment providers and costs. It also extends two funding directives, including the requirement to allocate at least half of the PEPFAR budget to HIV/AIDS treatment and care, and at least 10 percent of the PEPFAR budget to children orphaned or made vulnerable by HIV/AIDS.

The bill also addresses United States participation in the Global Fund to Fight AIDS, Tuberculosis, and Malaria (the Global Fund). Specifically, the bill extends the existing 33 percent cap on U.S. contributions to the Global Fund and clarifies that the limitation applies to cumulative contributions made between Fiscal Years 2004 and 2023. It extends through Fiscal Year 2023 a requirement to withhold contributions to the Global Fund in an amount equal to any assistance provided to a State Sponsor of Terrorism and clarifies that any funds withheld from the Global Fund for any purpose may be made available for U.S. bilateral HIV/AIDS, tuberculosis, or malaria programs. The bill additionally extends through Fiscal Year 2023 a requirement to withhold 20 percent of planned annual U.S. contributions to the Global Fund until statutory transparency requirements are met.

BACKGROUND AND NEED FOR THE LEGISLATION

PEPFAR, the largest bilateral global health initiative aimed at combatting a single disease in history, was first announced by President George W. Bush during his January 28, 2003, State of the Union Address. The closely held—but welcome—announcement took experts and advocates by surprise, including those leading efforts within USAID and the Centers for Disease Control and Prevention (CDC) to combat the HIV/AIDS pandemic, as well as Members of Congress, many of whom had been advocating for a more effective response for several years.

“Seldom has history offered a greater opportunity to do so much for so many . . . to meet a severe and urgent crisis abroad, tonight I propose an emergency plan for AIDS relief . . . a work of mercy beyond all current international efforts to help the people of Africa.”—President George W. Bush, January 28, 2003.

Congress promptly responded by enacting the “U.S. Global Leadership Against AIDS, Tuberculosis and Malaria Act of 2003” (P.L. 108–25, known as “the Leadership Act”), which was signed by the President on May 27, 2003. The bill—supported by a diverse, bipartisan coalition of Members, advocates, academics, implementers, the faith community, non-governmental organizations, and other leaders from around the globe—authorized a 5-year, \$15 billion initiative to be led by a U.S. Global AIDS Coordinator within the Department of State. This initiative would concentrate resources in 15 “focus” countries to provide life-saving treatment for 2 million people, prevent 7 million new infections, and provide palliative care for 10 million people suffering from AIDS. The U.S. Global AIDS Coordinator was specifically charged with developing and overseeing implementation of a 5-year integrated strategy to meet these ambitious targets by aligning the efforts of relevant Federal departments and agencies (particularly USAID and the Departments of State, Defense, and HHS/CDC/NIH), managing resources, coordinating with other donors and partner countries, eliminating duplication and waste, and managing U.S. participation in the Global Fund. Of the funds made available for combatting HIV/AIDS glob-

ally, the bill required that 55 percent be directed toward treatment, 20 percent toward prevention, 15 percent toward care, and 10 percent toward supporting children orphaned or made vulnerable by HIV/AIDS.

In addition to combatting HIV/AIDS, the bill amended the Foreign Assistance Act of 1961 (22 U.S.C. 2151 et seq.) to establish combatting malaria and tuberculosis as major U.S. foreign policy objectives and authorized “such sums as may be necessary” to carry out related programs. Finally, the bill authorized the United States to participate in the Global Fund—a multilateral financing mechanism established in 2002 to combat AIDS, tuberculosis, and malaria—subject to a 33 percent cap on U.S. contributions and other restrictions.

At the time of enactment, fewer than 50,000 people living with HIV/AIDS in sub-Saharan Africa had access to life-saving antiretroviral treatment (ART). Health systems were collapsing under the strain of new infections and, with no treatment options available, patients were sent home to die. Teachers, factory workers, health care providers, and soldiers were dying faster than they could be replaced. Economies declined. In the hardest hit countries, life expectancy plummeted to just 30 years. Newborns were infected by their mothers and, by 2003, an estimated 13 million children had lost one or both parents. The situation was so dire that, in January 2000, the National Intelligence Estimate identified the AIDS pandemic as a threat to U.S. national security, noting in particular that dramatic declines in life expectancy would heighten the risk of “revolutionary wars, ethnic wars, genocides and disruptive regime transitions” in the developing world. The HIV/AIDS pandemic that was ravaging sub-Saharan Africa and parts of Asia and the Caribbean had evolved from a global health challenge to a national security threat.

PEPFAR changed the course of the HIV/AIDS pandemic. During the “emergency” phase—Fiscal Years 2004 through 2008—Congress provided over \$18.8 billion for PEPFAR¹, including over \$3 billion in contributions to the Global Fund, enabling the program to rapidly scale-up testing, treatment, and care services in the 15 focus countries. An estimated 3.7 million health workers were trained, nearly 57 million people received voluntary testing and counseling (VTC) services, 2.1 million people received ART, and 10.1 million people, including 4 million orphans and vulnerable children (OVC), were supported through care programs. In addition, prevention of mother-to-child transmission (PMTCT) services were provided during nearly 16 million pregnancies, helping to avert at least 240,000 newborn infections.

Building upon the success of the Leadership Act, President Bush signed the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008 (P.L. 110–293, known as “the Lantos-Hyde Act”) on July 30, 2008. The bill was intended to set the stage for a transition from an emergency program to a sustainable response

¹PEPFAR totals include funding for bilateral HIV/AIDS programs, U.S. contributions to the Global Fund, and bilateral tuberculosis programs. Bilateral funding for malaria has been segregated since Fiscal Year 2006, after the launch of the President’s Malaria Initiative (PMI). The cumulative total of funding for bilateral malaria programs under the PMI between Fiscal Years 2006 and 2017 is \$5.65 billion.

that would build partner capacity and better enable focus countries to achieve epidemic control. To that end, it introduced the concept of country and regional “compacts” or “framework agreements” that would more clearly define the commitments and responsibilities of the United States, the Global Fund, other donors, and the partner governments themselves in designing and implementing coordinated national HIV/AIDS strategies. It also established a requirement for the Inspectors General of the Department of State, HHS, and USAID to jointly develop annual oversight plans for the programs authorized under the Act.

More broadly, the Lantos-Hyde Act reauthorized the PEPFAR program for an additional 5 years (Fiscal Years 2009 through 2013), emphasized the importance of combatting malaria and tuberculosis, and increased HIV/AIDS prevention, care, and treatment targets. It increased the level of authorized appropriations from \$15 billion to \$48 billion, adjusted the funding directives for HIV/AIDS treatment and care to not less than 50 percent, and changed the OVC funding directive from a 10 percent minimum requirement to a more permissive Sense of Congress. Finally, the bill reset the timeframe for calculating the 33 percent cap on U.S. contributions to the Global Fund from Fiscal Years 2004 through 2008 to Fiscal Years 2009 through 2013 and added a requirement to withhold 20 percent of planned annual U.S. contributions until the Global Fund adopted certain transparency requirements.

Over the second authorization period following the Lantos-Hyde Act, Congress provided over \$33.4 billion for PEPFAR, including nearly \$6.4 billion in contributions to the Global Fund, enabling the program to significantly expand in size and scope. In Fiscal Year 2013 alone, PEPFAR provided VTC services for 57.7 million people, including 12.8 million pregnant women, nearly 800,000 of whom tested positive and received immediate access to ART in order to prevent mother-to-child transmission of the virus. Over 17 million people, including 5 million OVC, received palliative care and support, and 4.2 million men underwent voluntary medical male circumcisions.

PEPFAR also continued to support a rigorous research agenda that contributed to the discovery of exciting breakthroughs in prevention and treatment. First-line antiretroviral therapies were improved, generics were developed, and supply chains were strengthened, all of which enabled PEPFAR to more than triple the number of people receiving life-saving treatment (from 2.1 million people in 2009 to 6.7 million people in 2013). The expansion of treatment contributed to an overall reduction in HIV/AIDS morbidity and mortality rates and a subsequent decline in the number of HIV/AIDS orphans. Still, there were over 2.3 million new infections in 2012—the year leading up to the PEPFAR Stewardship and Oversight Act—and appropriations had declined from a high of \$6.87 billion in Fiscal Year 2010 to \$6.58 billion in Fiscal Year 2013. The continuing and dire needs abroad and budget constraints in the U.S. would have to be reconciled.

On December 2, 2013, President Obama signed the PEPFAR Stewardship and Oversight Act of 2013 (P.L. 113–56, known as “the Stewardship Act”). While the bill did not specifically authorize appropriations, it sought to enhance the transparency and accountability of PEPFAR and the Global Fund so continued appropria-

tions could be used more efficiently and effectively. It required more rigorous analysis and public disclosure of prevention, treatment, and care needs in partner countries, as well as the costs supported by the United States, the Global Fund, and partner governments. The bill further conditioned U.S. contributions to the Global Fund upon enhanced transparency and improved grants management and pressed the Office of the Global AIDS Coordinator (OGAC) and the Global Fund to more clearly disaggregate and attribute results. It required comprehensive, annual studies on treatment costs and highlighted the need to establish metrics to measure partner country capacity to manage their own epidemics. It also extended through Fiscal Year 2018 the requirement for the Inspectors General for the Department of State, HHS, and USAID to jointly develop coordinated audit plans. Finally, it extended through Fiscal Year 2018 the funding directives for treatment and OVC and adjusted the 33 percent cap on U.S. contributions to the Global Fund to cover cumulative contributions between Fiscal Years 2009 through 2018.

Over this period, following the enactment of the Stewardship Act, Congress provided nearly \$34.19 billion for PEPFAR, including over \$7 billion in contributions to the Global Fund. Thus, the U.S. has enacted a total of \$79.7 billion for PEPFAR since Fiscal Year 2004, including \$14.7 billion for the Global Fund.

According to the latest available data, PEPFAR is supporting over 14 million people on ART and has provided VTC for over 85.5 million people, helped avert 2.2 million infections among babies born to HIV-positive mothers, provided over 15.2 million voluntary medical male circumcisions to help men and boys remain HIV-negative, and provided palliative care for 6.4 million OVC. Additionally, OGAC is pioneering new analytical tools, including Population-Based HIV Impact Assessments (PHIAs), which enable partners to gather data, identify needs, fill gaps, and measure results down to the site-level. By more strategically targeting resources and holding partners accountable for results, PEPFAR is helping reduce the number of new infections among the most vulnerable groups—particularly young women and adolescent girls between the ages of 15 and 24—by as much as 40 percent. These results are remarkable, yet more remains to be done.

The PEPFAR Extension Act of 2018 has been informed by 15 years of implementation and seeks to ensure that PEPFAR resources are used efficiently, effectively, and for the purposes specified by law so partner countries can achieve epidemic control. The bill supports efforts by OGAC and the Global Fund to expand access to treatment and prevent new infections; reasserts the 33 percent cap on U.S. contributions to the Global Fund while taking into account previous errors in calculating compliance; clarifies Congressional intent on how funds withheld from the Global Fund may be used; and continues support for OVC while directing implementers to adapt programs to better reflect current needs.

Ensuring PEPFAR Resources are Used Efficiently, Effectively, and for the Purposes Specified by Law. A combination of budget realities, a change of leadership within OGAC, and the enactment of the Stewardship Act brought renewed emphasis to data and evidence-based programming within the PEPFAR program. Today, the Coordinator is using Country Operational Plans (COPs, influenced

in part by the framework agreements envisioned in the Lantos-Hyde Act), the PHIA, and other strategic planning tools to restore program discipline and ensure resources are being concentrated in the areas of greatest need. The committee notes that this shift has been met by episodic resistance in several partner countries and among implementers that take an expanded view of PEPFAR. The committee further notes that both PEPFAR and the Global Fund were established to combat three diseases: AIDS, tuberculosis, and malaria. While goals such as strengthening health systems, combatting non-communicable diseases, and establishing social safety nets for children in adversity are worthy objectives—and PEPFAR and the Global Fund clearly have had corollary, net-positive effects on these and other global health and development priorities—these objectives can and should be addressed through different initiatives. PEPFAR’s past and future success is contingent on remaining focused upon the three core diseases.

The committee supports the efforts of OGAC to align budgets with priorities, strategically target resources, and enhance coordination among Federal departments and agencies, the Global Fund, other donors, partner countries, and implementers, including through the annual COP process. The committee notes that the COP process is labor intensive and appreciates the efforts of participants to ensure that it serves as an effective planning tool that enhances transparency and accountability. The committee directs all participating Federal departments and agencies to strictly adhere to the COPs and to seek specific authority from OGAC if a deviation becomes necessary. Similarly, the committee directs all participating Federal departments and agencies to obtain explicit approval from OGAC prior to initiating research projects to be funded with PEPFAR resources. OGAC shall report patterns of noncompliance to the Committees on Foreign Affairs and Appropriations in the House and Foreign Relations and Appropriations in the Senate.

The coordinated Inspectors General audit plans, studies on treatment providers and costs, and annual reporting requirements that are extended in this Act are critical to effective oversight and enhance the ability of OGAC to stretch resources farther, program for impact, and eliminate duplication and waste. The committee notes that execution of the coordinated audit plans has been inconsistent. The committee directs the Inspectors General to improve coordination and pursue a robust audits and investigations agenda, including by scrutinizing supply chains² and OGAC’s efforts to expand utilization of local partners to ensure resources continue to be used as efficiently and effectively as possible. The committee also recommends enhanced coordination with the Inspector General for the Peace Corps to ensure program integrity.

Expanding Access to Treatment as a Form of Prevention. In 2011, a study by the HIV Prevention Trials Network (HPTN), known as HPTN 052, began showing evidence that early initiation of ART could reduce the chances of transmission from an HIV-positive per-

²See “Committee on Foreign Affairs Oversight Investigation: USAID Global Health Supply Chain Contract”, October 2018, available at <https://foreignaffairs.house.gov/wp-content/uploads/2018/10/Oversight-Investigation-USAID-Global-Health-Supply-Chain-Contract.pdf>.

son to an HIV-negative partner by more than 96 percent.³ The Joint United Nations Program on HIV/AIDS (UNAIDS) seized upon these findings and, in 2014, launched ambitious “90–90–90” targets—whereby, by 2020, 90% of people living with HIV will know their status; 90% of those who know their status will be on treatment; and 90% of those accessing treatment will be virally suppressed. To reach these targets, the World Health Organization (WHO) recommended in 2015 that all countries move to a “test-start-retain” model—whereby all people diagnosed with HIV immediately start ART regardless of their CD-4 count (i.e., the measure of white blood cells, or T cells, in a patient’s bloodstream) and strictly adhere to the treatment regime in order to achieve viral suppression. According to the WHO, universal adoption of “test-start-retain” policies and related progress toward the 90–90–90 targets would help avert 28 million new infections by 2030.

On July 24, 2018, UNAIDS reported that considerable progress has been made—by the end of 2017, an estimated 75 percent of people living with HIV knew their status, of which 79 percent were receiving treatment, of which 81 percent were virally suppressed—but entire populations and regions in eastern Europe, central Asia, central and western Africa, and the Middle East and North Africa are still being left behind. Key populations, adolescents, and men are not being reached by traditional testing approaches, and adolescent girls in particular remain extremely vulnerable to infection. Moreover, gaps in political will, societal stigma and discrimination—especially against key populations—and the imposition of user fees on HIV services remain significant barriers to progress.

The committee is encouraged by progress in meeting the 90–90–90 targets and encourages all partner countries to adopt effective test-start-retain policies and approaches. At the same time, the committee recognizes that flat budgets will make it increasingly difficult for OGAC and partner countries to expand access to treatment and prevent new infections.

The committee expects OGAC to continue to collect, refine, and apply data so PEPFAR resources can be targeted to the areas of greatest need. The committee encourages OGAC, the Global Fund, and other partners to work with the private sector to develop and deploy cost-effective innovations in testing and treatment for hard-to-reach populations. The committee also urges partner countries to lower barriers to testing and treatment, including by eliminating user fees, strengthening supply chains, fighting stigma and discrimination, and enacting policies that allow for early adoption and transition to improved testing and treatment regimens.

The Global Fund Cap. The Leadership Act of 2003 established a 33 percent cap on U.S. contributions to the Global Fund for each of the Fiscal Years 2004 through 2008, and the Lantos-Hyde Act of 2008 extended that cap for each of the Fiscal Years 2009 through 2013. During negotiations over the Stewardship Act, the Administration indicated that they were having difficulty calculating the cap on a year-to-year basis because the Global Fund operates on a 3-year “replenishment cycle” and the fiscal years of other donors do not necessarily align with those of the United States. To that

³The results of the HPTN 052 study were finalized and published in the *New England Journal of Medicine* on September 1, 2016.

end, OGAC requested that they be allowed to apply the cap to cumulative contributions over the authorization period rather than annual contributions. Congress consented and extended the cap in the Stewardship Act so that it would apply to cumulative contributions between Fiscal Year 2009 through 2018.

In late 2015, OGAC reported that they had misinterpreted how compliance with the cap was to be calculated. Rather than limiting U.S. contributions to the Global Fund to 33 percent of the cumulative contributions received between Fiscal Years 2009 and 2018 as the Stewardship Act stipulated, OGAC had been applying the cap to cumulative contributions received between Fiscal Years 2004—rather than 2009—and 2018. Since total U.S. contributions to the Global Fund prior to 2008 were below 33 percent, this calculation allowed OGAC to provide additional U.S. funding to the Global Fund. By the time the new Global AIDS Coordinator detected and reported the error in December 2015, the United States had provided more than \$500 million in excess contributions to the Global Fund. Without statutory relief, the consequence of this miscalculation meant that OGAC would have to pull back over \$500 million from signed Global Fund agreements, potentially resulting in patients losing access to treatment.

To avoid having to cut off treatment to patients in need, a bipartisan agreement to provide temporary cap relief was reached in December 2015 with enactment of the Consolidated Appropriations Act, 2016 (P.L. 114–113). This agreement, which simply substituted “2004” for “2009” for the purposes of calculating the Global Fund cap, was extended by the Consolidated Appropriations Act, 2017 (P.L. 115–31) and the Consolidated Appropriations Act, 2018 (P.L. 115–141).

To ensure compliance with existing law and prevent the need to carry temporary relief through annual appropriations bills, the PEPFAR Extension Act of 2018 eliminates any ambiguity about how the cap is to be calculated during the next Global Fund replenishment cycle, by permanently amending the Leadership Act and applying the 33 percent cap to cumulative contributions between Fiscal Years 2004 and 2023. The bill also extends the requirement to withhold contributions to the Global Fund in an amount equal to any assistance provided to a State Sponsor of Terrorism and clarifies that any funds withheld from the Global Fund for any purpose may be made available for U.S. bilateral HIV/AIDS, tuberculosis, or malaria programs.

Together, PEPFAR and the Global Fund have helped save 27 million lives. The number of AIDS-related deaths has been cut in half since 2005, while malaria deaths have decreased by 60 percent since 2000. In 2017 alone, over 79.1 million HIV tests were administered and 17.5 million people were receiving life-saving ART. Nearly 200 million insecticide-treated bed nets were distributed, while 108 million people received treatment for malaria. Unfortunately, progress in combatting tuberculosis remains slow and hampered by significant gaps in case detection. Tuberculosis, while curable, kills more people worldwide than any other infectious disease and is the leading killer of people living with HIV/AIDS. As such, failure to accelerate progress against tuberculosis threatens to undermine the substantial progress achieved through PEPFAR and the Global Fund. Despite these challenges, an estimated 60 percent

of tuberculosis patients know their HIV status and 85 percent of HIV-positive people co-infected with tuberculosis receive treatment for both.

These results could not have been possible absent a laser focus on these three diseases. The committee urges the Global Fund to maintain this focus while exploring innovating testing, treatment, and financing options. The committee also reminds partners that U.S. participation in the Global Fund is voluntary. The committee directs OGAC to continue to condition U.S. contributions to the Global Fund upon performance and compliance with transparency and accountability requirements.

Orphans and Vulnerable Children. In 2003, AIDS was a death sentence that was threatening a generation of caregivers in sub-Saharan Africa. According to UNAIDS and WHO, over 4 million children under the age of 15 had been infected—90 percent of whom had been infected by their mothers at birth or through breastfeeding—and another 13 million children had lost one or both parents to AIDS.⁴ In Zimbabwe alone, life expectancy had dropped to 37 years and 1.32 million children had become “AIDS orphans.”⁵ Traditional communal care norms were broken and an alarming number of children were abandoned, left to raise other children, or forced to adopt negative coping mechanisms to survive. It was against this backdrop that Congress established the requirement under the Leadership Act to direct not less than 10 percent of the PEPFAR budget toward OVC.

Thanks to PEPFAR’s success, the scale and demographics of the OVC crisis have dramatically shifted. With treatment now much more accessible, parents and caregivers are surviving. The worst-case scenario predicted by UNAIDS in 2003—41 million AIDS orphans by 2010—has not come to pass.⁶ Moreover, the OVC of 2003 are now adults and require significantly different types of support than they did when the funding directive was established.

The committee believes it is important to maintain a focus on mitigating the harmful impact HIV/AIDS has on children and adolescents. However, the OVC programming supported by the 10 percent funding directive extended by this Act must continue to evolve to meet the demands of a changing epidemic and its impacts on children and adolescents today. Despite having invested more than \$2 billion in comprehensive OVC programs since Fiscal Year 2004, only 52 percent of children ages 0–14 with HIV have access to ART and 180,000 children were newly infected in 2017. Effective OVC programming must take into account the aging population and, consequently, evolving needs of OVC, the disproportionately high risk of HIV infection and sexual violence for adolescent girls and young women, and the number of HIV-positive orphans yet to be diagnosed and linked to treatment. The committee directs OGAC to report on how PEPFAR—in particular the 10 percent OVC funding directive—is working to prevent new infections among OVC, with a particular emphasis on girls between the ages of 9 and 17, and to expand access to treatment for OVC.

⁴The World Health Organization defines “AIDS orphans” as children under the age of 15 who have lost their mother or both parents to AIDS. See UNAIDS/WHO, “2003 AIDS epidemic update: December 2003.” <https://www.who.int/ceh/risks/otherisks/en/index2.html>.

⁵See UNICEF, “Africa’s Orphaned and Vulnerable Generations: Children Affected by AIDS.”

⁶UNAIDS/WHO, “2003 AIDS epidemic update: December 2003.”

HEARINGS

Over the past 5 years, the committee has continued its active oversight of U.S. development, economic, and global health assistance programs, including 12 hearings related to the PEPFAR program:

July 12, 2018, hearing before the Subcommittee on Africa, Global Health, Global Human Rights, and International Organizations on “Combating Tuberculosis in Southern Africa” (The Honorable Deborah L. Birx, M.D., U.S. Global AIDS Coordinator and U.S. Special Representative for Global Health Diplomacy, U.S. Department of State; Ms. Irene Koek, Deputy Assistant Administrator, Bureau for Global Health, USAID; Rebecca Martin, Ph.D., Director, Center for Global Health, U.S. Centers for Disease Control and Prevention);

May 17, 2018, hearing before the Subcommittee on Africa, Global Health, Global Human Rights, and International Organizations on “Global Health Supply Chain Management: Lessons Learned and Ways Forward” (Ms. Irene Koek, Deputy Assistant Administrator; Bureau for Global Health, USAID; the Honorable Deborah L. Birx, M.D., U.S. Global AIDS Coordinator and U.S. Special Representative for Global Health Diplomacy, U.S. Department of State);

March 21, 2018, hearing before the full committee on “The FY 2019 Foreign Assistance Budget” (The Honorable Mark Green, Administrator, USAID);

October 11, 2017, hearing before the Subcommittee on Africa, Global Health, Global Human Rights, and International Organizations on “The State Department and USAID FY 2018 Africa Budget” (The Honorable Donald Yamamoto, Acting Assistant Secretary, Bureau of African Affairs, U.S. Department of State; Ms. Cheryl Anderson, Acting Assistant Administrator, Bureau for Africa, USAID);

June 14, 2017, hearing before the full committee on “The FY 2018 Foreign Affairs Budget” (The Honorable Rex W. Tillerson, Secretary of State, U.S. Department of State);

May 18, 2017, hearing before the full committee on “U.S. Interests in Africa” (General William E. Ward, USA, Retired, President and Chief Operating Officer, SENTEL Corporation and Former Commander, U.S. Africa Command; Mr. Bryan Christy, Explorer and Investigative Reporter, National Geographic Society; Mr. Anthony Carroll, Adjunct Professor, School of Advanced International Studies, Johns Hopkins University; the Honorable Reuben E. Brigety II, Dean, Elliott School of International Affairs, the George Washington University and former U.S. Representative to the African Union, U.S. Department of State);

March 28, 2017, hearing before the full committee on “The Budget, Diplomacy, and Development” (Stephen D. Krasner, Ph.D., Senior Fellow, Hoover Institution; Ms. Danielle Pletka, Senior Vice President, Foreign and Defense Policy Studies, American Enterprise Institute; the Honorable R. Nicholas Burns, Roy and Barbara Goodman Family Professor of Diplomacy and International Relations, Belfer Center for Science and International Affairs, John F. Kennedy School of Govern-

ment, Harvard University and former Under Secretary for Political Affairs, U.S. Department of State);

December 8, 2015, hearing and briefing before the Subcommittee on Africa, Global Health, Global Human Rights, and International Organizations on “Drug-Resistant Tuberculosis: The Next Global Health Crisis” (Tom Frieden, M.D., Director, CDC; the Honorable Ariel Pablos-Mendez, M.D., Assistant Administrator Bureau for Global Health, USAID; the Honorable Eric P. Goosby, M.D., Special Envoy on Tuberculosis, United Nations and former Global AIDS Coordinator, U.S. Department of State);

March 17, 2015, hearing before the full committee on “The FY 2016 Budget Request: Assessing U.S. Foreign Assistance Effectiveness” (Hon. Alfonso E. Lenhardt, Acting Administrator, USAID; Hon. Dana J. Hyde, CEO, Millennium Challenge Corporation);

September 17, 2014, hearing before the Subcommittee on Africa, Global Health, Global Human Rights, and International Organizations on “Global Efforts to Fight Ebola” (Anthony S. Fauci, M.D., Director, National Institute of Allergy and Infectious Diseases, HHS; Luciana Borio, M.D., Director, Office of Counterterrorism and Emerging Threats, Office of the Chief Scientist, U.S. Food and Drug Administration, HHS; the Honorable Nancy Lindborg, Assistant Administrator, Bureau for Democracy, Conflict and Humanitarian Assistance, USAID; Beth P. Bell, M.D., Director, National Center for Emerging and Zoonotic Infectious Diseases, CDC; Kent Brantly, M.D., Medical Missionary, Samaritan’s Purse; Chinua Akukwe, M.D., Chair, Africa Working Group, National Academy of Public Administration; Mr. Ted Alemayhu, Founder & Executive Chairman, U.S. Doctors for Africa; Dougbeh Chris Nyan, M.D., Director of the Secretariat, Diaspora Liberian Emergency Response Task Force on the Ebola Crisis); and

August 7, 2014, hearing before the Subcommittee on Africa, Global Health, Global Human Rights, and International Organizations on “Combatting the Ebola Threat” (Tom Frieden, M.D., Director, CDC; Ariel Pablos-Méndez, M.D., Assistant Administrator, Bureau for Global Health, USAID; the Honorable Bisa Williams, Deputy Assistant Secretary, Bureau of African Affairs, U.S. Department of State; Mr. Ken Isaacs, Vice President of Program and Government Relations, Samaritan’s Purse; Frank Glover, M.D., Missionary, SIM);

April 9, 2014, hearing before the full committee on “U.S. Foreign Assistance in FY 2015: What Are the Priorities, How Effective?” (The Honorable Rajiv Shah, Administrator, USAID).

COMMITTEE CONSIDERATION

On September 22, 2018, the Foreign Affairs Committee marked up H.R. 6651 pursuant to notice, in open session. The chairman obtained unanimous consent to consider the bill *en bloc* with Smith 113, an amendment offered by Rep. Smith. The items considered *en bloc* were agreed to by voice vote. The committee ordered H.R. 6651, as amended, favorably reported by unanimous consent.

COMMITTEE OVERSIGHT FINDINGS

In compliance with clause 3(c)(1) of rule XIII of Rules of the House of Representatives, the committee reports that findings and recommendations of the committee, based on oversight activities under clause 2(b)(1) of House Rule X, are incorporated in the descriptive portions of this report, particularly in the section on “Background and Need for the Legislation.”

NEW BUDGET AUTHORITY, TAX EXPENDITURES, AND FEDERAL MANDATES

In compliance with clause 3(c)(2) of House Rule XIII and the Unfunded Mandates Reform Act (P.L. 104–4), the committee adopts as its own the estimate of new budget authority, entitlement authority, tax expenditure or revenues, and Federal mandates contained in the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 11, 2018.

Hon. EDWARD R. ROYCE, *Chairman,*
Committee on Foreign Affairs,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 6651, the PEPFAR Extension Act of 2018.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Ann E. Futrell, who can be reached at 226–2840.

Sincerely,

KEITH HALL,
Director.

Enclosure

cc: Honorable Eliot L. Engel
Ranking Member

H.R. 6651—PEPFAR Extension Act of 2018.

As ordered reported by the House Committee on Foreign Affairs on September 27, 2018.

H.R. 6651 would reauthorize, through 2023, certain expired provisions of foreign assistance programs to combat HIV/AIDS, malaria, and tuberculosis (commonly known as the U.S. President’s Emergency Plan for AIDS Relief or PEPFAR). CBO estimates that implementing the bill would cost \$15 million over the 2019–2023 period, assuming appropriation of the necessary amounts.

Section 2 would extend through 2023 a requirement for the Inspectors General (IGs) of the Department of State and Broadcasting Board of Governors, the Department of Health and Human

Services, and the U.S. Agency for International Development to coordinate and conduct oversight of PEPFAR programs. Under current law, that directive expired at the end of fiscal year 2018. According to the Office of the U.S. Global AIDS Coordinator (OGAC)—the office within the Department of State that coordinates all PEPFAR activities—the IGs spent roughly \$15 million on such oversight over the past 5 years. CBO expects that each of the three IGs would require appropriations of roughly \$1 million per year to continue such oversight. Thus, implementing that provision would cost \$15 million over the 2019–2023 period, CBO estimates.

Section 2 also would extend through 2024 an annual requirement to provide a report on HIV/AIDS treatment providers. OGAC plans to collect and analyze the necessary information in the absence of this statutory requirement. CBO estimates that the additional costs of preparing the report would be less than \$500,000 over the 2019–2023 period.

Enacting H.R. 6651 would not affect direct spending or revenues; therefore, pay-as-you-go procedures do not apply.

CBO estimates that enacting H.R. 6651 would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2029.

H.R. 6651 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act.

On October 2, 2018, CBO transmitted a cost estimate for S. 3476, the PEPFAR Extension Act of 2018, as ordered reported by the Senate Committee on Foreign Relations on September 26, 2018. H.R. 6651 is similar to S. 3476, and their estimated costs are the same.

The CBO staff contact for this estimate is Ann E. Futrell. The estimate was reviewed by Leo Lex, Deputy Assistant Director for Budget Analysis.

DIRECTED RULE MAKING

Pursuant to clause 3(c) of House Rule XIII, as modified by section 3(i) of H. Res. 5 during the 115th Congress, the committee notes that H.R. 6651 contains no directed rule-making provisions.

NON-DUPLICATION OF FEDERAL PROGRAMS

Pursuant to clause 3(c)(5) of House Rule XIII, the committee states that no provision of this bill establishes or reauthorizes a program of the Federal Government known to be duplicative of another Federal program, a program that was included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111-139, or a program related to a program identified in the most recent Catalog of Federal Domestic Assistance.

PERFORMANCE GOALS AND OBJECTIVES

The objective of this legislation is to extend and enhance U.S. efforts to combat AIDS, tuberculosis, and malaria through implementation of PEPFAR and participation in the Global Fund. Section 2 requires the Inspectors General of the U.S. Department of State, HHS, and USAID to develop joint auditing plans and requires the U.S. Global AIDS Coordinator to conduct annual studies of HIV/

AIDS treatment providers and costs. These audits and studies will enable Congress to conduct effective oversight of performance and results.

CONGRESSIONAL ACCOUNTABILITY ACT

H.R. 6651 does not apply to terms and conditions of employment or to access to public services or accommodations within the legislative branch.

NEW ADVISORY COMMITTEES

H.R. 6651 does not establish or authorize any new advisory committees.

EARMARK IDENTIFICATION

H.R. 6651 contains no congressional earmarks, limited tax benefits, or limited tariff benefits as described in clauses 9(e), 9(f), and 9(g) of House Rule XXI.

SECTION-BY-SECTION ANALYSIS

Section 1. Short Title. States that the Act may be cited as the “PEPFAR Extension Act of 2018.”

Section 2. Inspectors General and Annual Study. Amends Section 101 of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7611) to: (1) extend through Fiscal Year 2023 the requirement for the Inspectors General of the U.S. Department of State, HHS, and USAID to develop joint auditing plans; and (2) to extend through September 31, 2024 the requirement for the U.S. Global AIDS Coordinator to conduct annual studies of treatment providers and costs.

Section 3. Participation in the Global Fund to Fight AIDS, Tuberculosis, and Malaria. Amends Section 202(d) of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7622(d)) to: (1) extend through Fiscal Year 2023 the 33 percent cap on U.S. contributions to the Global Fund and clarify that the limitation applies to cumulative contributions between Fiscal Years 2004 and 2023; (2) extend through Fiscal Year 2023 a requirement to withhold contributions to the Global Fund in an amount equal to any assistance provided to a State Sponsor of Terrorism; and (3) clarify that any funds withheld from the Global Fund for any purpose may be made available for U.S. bilateral HIV/AIDS, tuberculosis, or malaria programs

Section 4. Allocation of Funds. Amends Section 403 of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7673) to extend through Fiscal Year 2023 the requirement to allocate at least 10 percent of the PEPFAR budget to programs that support children orphaned or made vulnerable by HIV/AIDS and at least half of the PEPFAR budget to HIV/AIDS treatment and care.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omit-

ted is enclosed in black brackets, new matter is printed in italic, and existing law in which no change is proposed is shown in roman):

**UNITED STATES LEADERSHIP AGAINST HIV/AIDS,
TUBERCULOSIS, AND MALARIA ACT OF 2003**

* * * * *

TITLE I—POLICY PLANNING AND COORDINATION

SEC. 101. DEVELOPMENT OF A COMPREHENSIVE, FIVE-YEAR, GLOBAL STRATEGY.

(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 multi-lateral 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 re-

ceiving 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.—

(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 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) **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 coordinated annual plans for oversight activity in each of the fiscal years 2009 through **[2018]** 2023, 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) 2010 THROUGH 2013 PLANS.—Each of the plans for fiscal years 2010 through 2013 developed under subparagraph (A) shall be completed not later than 30

days before each of the fiscal years 2010 through 2013, respectively.

(iii) 2014 PLAN.—The plan developed under subparagraph (A) for fiscal year 2014 shall be completed not later than 60 days after the date of the enactment of the PEPFAR Stewardship and Oversight Act of 2013.

(iv) SUBSEQUENT PLANS.—Each of the last **four** *nine* plans developed under subparagraph (A) shall be completed not later than 30 days before each of the fiscal years 2015 through **2018** *2023*, 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.

(g) ANNUAL STUDY.—

(1) IN GENERAL.—Not later than September 30, 2009, and annually thereafter through September 30, **2019** *2024*, 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) 2013 THROUGH **2018** *2024* STUDIES.—The studies required to be submitted by September 30, 2014, and annually thereafter through **September 30, 2018** *September 30, 2024*, shall include, in addition to the elements set forth under paragraph (1), the following elements:

(A) A plan for conducting cost studies of United States assistance under section 104A of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b–2) in partner countries, taking into account the goal for more systematic collection of

data, as well as the demands of such analysis on available human and fiscal resources.

(B) A comprehensive and harmonized expenditure analysis by partner country, including—

(i) an analysis of Global Fund and national partner spending and comparable data across United States, Global Fund, and national partner spending; or

(ii) where providing such comparable data is not currently practicable, an explanation of why it is not currently practicable, and when it will be practicable.

(3) 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.

(4) PARTNER COUNTRY DEFINED.—In this subsection, the term “partner country” means a country with a minimum United States Government investment of HIV/AIDS assistance of at least \$5,000,000 in the prior fiscal year.

(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.

* * * * *

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

* * * * *

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

(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 sub-recipient 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) AUTHORITY FOR UNITED STATES PARTICIPATION.—

(1) UNITED STATES PARTICIPATION.—The United States is hereby authorized to participate in the Global Fund.

(2) PRIVILEGES AND IMMUNITIES.—The Global Fund shall be considered a public international organization for purposes of section 1 of the International Organizations Immunities Act (22 U.S.C. 288).

(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) REPORTS TO CONGRESS.—Not later than 1 year after the date of the enactment of this Act, and annually thereafter for the duration of the Global Fund, the President shall submit to the appropriate congressional committees a report on the Global Fund, including contributions pledged to, contributions (including donations from the private sector) received by, and projects funded by the Global Fund, and the mechanisms established for transparency and accountability in the grant-making process.

(d) UNITED STATES FINANCIAL PARTICIPATION.—

(1) AUTHORIZATION OF APPROPRIATIONS.—In addition to any other funds authorized to be appropriated for bilateral or multilateral HIV/AIDS, tuberculosis, or malaria programs, of the amounts authorized to be appropriated under section 401, there are authorized to be appropriated to the President up to \$2,000,000,000 for fiscal year 2009, and such sums as may be necessary for each of the fiscal years 2010 through 2013, for contributions to the Global Fund.

(2) AVAILABILITY OF FUNDS.—Amounts appropriated under paragraph (1) are authorized to remain available until expended.

(3) REPROGRAMMING OF FISCAL YEAR 2001 FUNDS.—Funds made available for fiscal year 2001 under section 141 of the Global AIDS and Tuberculosis Relief Act of 2000—

(A) are authorized to remain available until expended; and

(B) shall be transferred to, merged with, and made available for the same purposes as, funds made available for fiscal years 2004 through 2008 under paragraph (1).

(4) LIMITATION.—

(A)(i) At any time during [fiscal years 2009 through 2018] *fiscal years 2004 through 2023*, no United States contribution to the Global Fund may cause the total amount of United States Government contributions to the Global Fund to exceed 33 percent of the total amount of funds contributed to the Global Fund from all sources. Contributions to the Global Fund from the International

Bank for Reconstruction and Development and the International Monetary Fund shall not be considered in determining compliance with this paragraph.

(ii) If, at any time during any of the fiscal years 2009 through ~~2018~~ 2023, the President determines that the Global Fund has provided assistance to a country, the government of which the Secretary of State has determined, for purposes of section 6(j)(1) of the Export Administration Act of 1979 (50 U.S.C. App. 2405(j)(1)), has repeatedly provided support for acts of international terrorism, then the United States shall withhold from its contribution for the next fiscal year an amount equal to the amount expended by the Fund to the government of each such country.

(iii) If at any time the President determines that the expenses of the Governing, Administrative, and Advisory Bodies (including the Partnership Forum, the Foundation Board, the Secretariat, and the Technical Review Board) of the Global Fund exceed 10 percent of the total expenditures of the Fund for any 2-year period, the United States shall withhold from its contribution for the next fiscal year an amount equal to the average annual amount expended by the Fund for such 2-year period for the expenses of the Governing, Administrative, and Advisory Bodies in excess of 10 percent of the total expenditures of the Fund.

(iv) The President may waive the application of clause (iii) if the President determines that extraordinary circumstances warrant such a waiver. No waiver under this clause may be for any period that exceeds 1 year.

(v) If, at any time during any of the fiscal years 2004 through 2008, the President determines that the salary of any individual employed by the Global Fund exceeds the salary of the Vice President of the United States (as determined under section 104 of title 3, United States Code) for that fiscal year, then the United States shall withhold from its contribution for the next fiscal year an amount equal to the aggregate amount by which the salary of each such individual exceeds the salary of the Vice President of the United States.

[(vi) For the purposes of clause (i), “funds contributed to the Global Fund from all sources” means funds contributed to the Global Fund at any time during fiscal years 2009 through 2018 that are not contributed to fulfill a commitment made for a fiscal year before fiscal year 2009.]

(B)(i) Any amount made available that is withheld by reason of subparagraph (A)(i) shall be contributed to the Global Fund as soon as practicable, subject to subparagraph (A)(i), after additional contributions to the Global Fund are made from other sources.

[(ii) Any amount made available that is withheld by reason of subparagraph (A)(iii) shall be transferred to the Activities to Combat HIV/AIDS Globally Fund and shall remain available under the same terms and conditions as funds appropriated to carry out section 104A of the Foreign Assistance Act of 1961 for HIV/AIDS assistance.]

[(iii)] *(ii)* Any amount made available that is withheld by reason of clause (ii) or (iii) of subparagraph (A) is authorized to be made available to carry out section 104A of the Foreign Assistance Act of 1961 (as added by section 301 of this Act) *or section 104B or 104C of such Act* . Amounts made available under the preceding sentence are in addition to amounts appropriated pursuant to the authorization of appropriations under section 401 of this Act **[for HIV/AIDS assistance]**.

[(iv)] *(iii)* Notwithstanding clause (i), after July 31 of each of the fiscal years 2009 through **[2018]** 2023 , any amount made available that is withheld by reason of subparagraph(A)(i) is authorized to be made available to carry out sections 104A, 104B, and 104C of the Foreign Assistance Act of 1961 (as added by title III of this Act).

(C)(i) The President may suspend the application of subparagraph (A) with respect to a fiscal year if the President determines that an international health emergency threatens the national security interests of the United States.

(ii) The President shall notify the Committee on Foreign Affairs of the House of Representatives and the Committee on Foreign Relations of the Senate not less than 5 days before making a determination under clause (i) with respect to the application of subparagraph (A)(i) and shall include in the notification—

(I) a justification as to why increased United States Government contributions to the Global Fund is preferable to increased United States assistance to combat HIV/AIDS, tuberculosis, and malaria on a bilateral basis; and

(II) an explanation as to why other government donors to the Global Fund are unable to provide adequate contributions to the Fund.

(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 **[2018]** 2023 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 in an open, machine readable format—

(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, analysis, and reporting of performance data and funding of grants of the Global Fund, which covers all principal recipients and all subrecipients on the fiscal cycle of each grant, and includes the distribution of resources, by grant and principal recipient and subrecipient, for prevention, care, treatment, drugs, and commodities purchase, and other purposes as practicable;

(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, in an open, machine readable format, of financial, programmatic, and reporting aspects of the Global Fund, its grantees, and LFAs;

(E) has established, and is reporting publicly, in an open, machine readable format, 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;

(ii) all principal recipients and subrecipients and the amount of funds disbursed to each principal recipient and subrecipient on the fiscal cycle of the grant;

(iii) expenditure data—

(I) tracked by principal recipients and subrecipients by program area, where practicable, prevention, care, and treatment and reported in a format that allows comparison with other funding streams in each country; or

(II) if such expenditure data is not available, outlay or disbursement data, and an explanation of progress made toward providing such expenditure data; and

(iv) high-quality grant performance evaluations measuring inputs, outputs, and outcomes, as appropriate, with the goal of achieving outcome reporting;

(G) has published an annual report on a publicly available Web site in an open, machine readable format, that includes—

(i) a list of all countries imposing import duties and internal taxes on any goods or services financed by the Global Fund;

(ii) a description of the types of goods or services on which the import duties and internal taxes are levied;

(iii) the total cost of the import duties and internal taxes;

(iv) recovered import duties or internal taxes; and

(v) the status of country status-agreements;

(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.

(e) INTERAGENCY TECHNICAL REVIEW PANEL.—

(1) ESTABLISHMENT.—The Coordinator of United States Government Activities to Combat HIV/AIDS Globally, established in section 1(f)(1) of the State Department Basic Authorities Act of 1956 (as added by section 102(a) of this Act), shall establish in the executive branch an interagency technical review panel.

(2) DUTIES.—The interagency technical review panel shall serve as a “shadow” panel to the Global Fund by—

(A) periodically reviewing all proposals received by the Global Fund; and

(B) providing guidance to the United States persons who are representatives on the panels, committees, and boards of the Global Fund, on the technical efficacy, suitability, and appropriateness of the proposals, and ensuring that such persons are fully informed of technical inadequacies or other aspects of the proposals that are inconsistent with the purposes of this or any other Act relating to the provision of foreign assistance in the area of AIDS.

(3) MEMBERSHIP.—The interagency technical review panel shall consist of qualified medical and development experts who are officers or employees of the Department of Health and Human Services, the Department of State, and the United States Agency for International Development.

- (4) CHAIR.—The Coordinator referred to in paragraph (1) shall chair the interagency technical review panel.
- (f) MONITORING BY COMPTROLLER GENERAL.—
- (1) MONITORING.—The Comptroller General shall monitor and evaluate projects funded by the Global Fund.
- (2) REPORT.—The Comptroller General shall on a biennial basis shall prepare and submit to the appropriate congressional committees a report that contains the results of the monitoring and evaluation described in paragraph (1) for the preceding 2-year period.
- (g) PROVISION OF INFORMATION TO CONGRESS.—The Coordinator of United States Government Activities to Combat HIV/AIDS Globally shall make available to the Congress the following documents within 30 days of a request by the Congress for such documents:
- (1) All financial and accounting statements for the Global Fund and the Activities to Combat HIV/AIDS Globally Fund, including administrative and grantee statements.
- (2) Reports provided to the Global Fund and the Activities to Combat HIV/AIDS Globally Fund by organizations contracted to audit recipients of funds.
- (3) Project proposals submitted by applicants for funding from the Global Fund and the Activities to Combat HIV/AIDS Globally Fund, but which were not funded.
- (4) Progress reports submitted to the Global Fund and the Activities to Combat HIV/AIDS Globally Fund by grantees.
- (h) SENSE OF THE CONGRESS REGARDING ENCOURAGEMENT OF PRIVATE CONTRIBUTIONS TO THE GLOBAL FUND.—It is the sense of the Congress that the President should—
- (1) conduct an outreach campaign that is designed to—
- (A) inform the public of the existence of—
- (i) the Global Fund; and
- (ii) any entity that will accept private contributions intended for use by the Global Fund; and
- (B) encourage private contributions to the Global Fund; and
- and
- (2) encourage private contributions intended for use by the Global Fund by—
- (A) establishing and operating an Internet website, and publishing information about the website; and
- (B) making public service announcements on radio and television.

* * * * *

TITLE IV—AUTHORIZATION OF APPROPRIATIONS

* * * * *

SEC. 403. ALLOCATION OF FUNDS.

- (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.

(b) ORPHANS AND VULNERABLE CHILDREN.—For fiscal years 2009 through ~~2018~~ 2023, not less than 10 percent of the amounts appropriated or otherwise made available to carry out the provisions of section 104A of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b–2) for HIV/AIDS assistance for each such fiscal year shall be expended for assistance for orphans and other children affected by, or vulnerable to, HIV/AIDS, of which such amount at least 50 percent shall be provided through non-profit, nongovernmental organizations, including faith-based organizations, that implement programs on the community level.

(c) FUNDING ALLOCATION.—For each of the fiscal years 2009 through ~~2018~~ 2023, more than half of the amounts appropriated or otherwise made available to carry out the provisions of section

104A of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b-2) 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.

* * * * *

ADDITIONAL VIEWS

I concur with the views expressed in the full Committee report accompanying H.R. 6651, the PEPFAR Extension Act of 2018 and recommend that the bill as amended do pass.

The President's Emergency Plan for AIDS Relief (PEPFAR) has brought about tremendous progress across the Bush and Obama Administrations in the global fight to end HIV/AIDS, as detailed in the full Committee report. However, the Trump Administration has threatened this progress by asking Congress to enact deep funding cuts and impeding health care access through the reinstatement and expansion of the Mexico City Policy, or Global Gag Rule.

Draconian Cuts to PEPFAR and the Global Fund Jeopardize 15 Years of Progress

The Administration proposed an 11 percent cut to PEPFAR funding and a 17 percent cut to the Global Fund for Fiscal Year (FY) 2018, relative to FY 2017 levels. While Congress rejected this proposal and maintained level funding for both PEPFAR and the Global Fund, the Trump Administration subsequently requested an even deeper 20 percent cut to PEPFAR and 31 percent cut to the Global Fund for FY 2019.

If enacted, the Trump Administration's budget would jeopardize America's tremendous success in the fight against HIV/AIDS, likely leading to hundreds of thousands of additional HIV/AIDS patients and thousands of deaths. According to a report issued by the ONE Campaign:

Conservative estimates project that implementing the FY 2018 budget proposal would have led to the first global increase in new HIV infections since 1995, with nearly 200,000 additional HIV infections in the first year. If these cuts were maintained, nearly 600,000 additional people could be infected by 2020, dragging the world back to levels of new infections last seen in 2011. Slowing U.S. efforts to fight HIV/AIDS for three years could set the global response back nine years and squander much of the \$64 billion that the U.S. has invested over that time.¹

I urge the Administration to return to the bipartisan consensus and accelerate the progress that PEPFAR and the Global Fund have allowed by prioritizing the fight against HIV/AIDS in the FY 2020 budget request.

¹ "Red Ribbon or White Flag? The Future of the U.S. Global AIDS Response." The ONE Campaign. November 29, 2017. https://s3.amazonaws.com/one.org/pdfs/ONE_WAD_Report_2017.pdf.

The Expanded Global Gag Rule Hampers the Fight to End HIV/AIDS

On January 23, 2017, President Donald Trump reinstated the Global Gag Rule. Previous iterations of this policy barred foreign nongovernmental organizations (NGOs) from receiving U.S. bilateral family planning funds if they used private, non-U.S. funds to perform legal abortions, offer counseling regarding abortion services, or advocate for access to safe, legal abortion. This policy is unwise, but the Trump Administration has made it even worse, expanding it to all foreign NGOs that receive U.S. global health assistance, including PEPFAR implementers.

The effects of the Global Gag Rule are antithetical to the goals of the PEPFAR program. For example, a Mozambican Association for Family Development clinic in Mozambique's Xai-Xai district tested nearly 6,000 patients for HIV over a three-month period between July and September of 2017.² During the next three-month period, the Global Gag Rule forced the clinic to forego U.S. funding, and just 671 patients were tested for HIV—a drop of more than 88 percent.³

I urge the Administration to immediately rescind the Global Gag Rule and ensure that those served by U.S. global health assistance can continue to receive comprehensive care from the providers they trust. If the Global Gag Rule remains in effect, health care providers will continue to dramatically scale back essential services, like HIV tests, or close their doors altogether.⁴ This will endanger 15 years of progress in the global effort to end HIV/AIDS, much of which has been achieved with U.S. support.

ELIOT L. ENGEL.



²“Prescribing Chaos in Global Health: The Global Gag Rule from 1984–2018.” Center for Health and Gender Equity. June 2018. http://www.genderhealth.org/files/uploads/change/publications/Prescribing_Chaos_in_Global_Health_full_report.pdf.

³See 2.

⁴Anna, Cara. “Trump’s global gag rule goes far beyond abortion, groups say.” *AP*. January 23, 2018. <https://www.apnews.com/868c8211b4f948d8b7f7ce58ab08a78b/Trump-s-global-gag-rule-goes-far-beyond-abortion-groups-say>.