child. And each and every day, law enforcement professionals spend long hours and sleepless nights in search of these children.

May we never forget those children still waiting to be found. May we never forget those families still looking for their missing child. And may we never cease in our efforts to reunite children safely with their families.

CAT OSTERMAN—A TEXAS SOFTBALL LEGEND

HON. TED POE

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 18, 2013

Mr. POE of Texas. Mr. Speaker, today I am honored to recognize a talented Texas woman, Catherine ''Cat'' Osterman, a fast pitch softball legend. Born in Houston, Cat discovered at an early age that she wanted to be a pitcher. There was no denying that she was a natural athlete, but it wasn't until the day that she filled in as a back-up pitcher for her Little League softball team that sparked the fire making her so successful in her sport.

Since that first taste of pitching, Cat's love for the game blossomed. Through her hard work and determination, she became a star on her high school's softball team. Her pitching is incredible: she has mastered six pitches, and she reserves her most famous pitch, the fast pitch, for critical moments on the field.

She graduated from Cypress Springs High School where she earned the Gatorade National Softball Player of the Year Award as well as her now famous nickname ''Cat.'' She went on to play softball for the Longhorns at the University of Texas at Austin when the softball team was only 5 years old. During Cat's time in Austin, she broke every softball record at the University of Texas.

Cat's talent and passion for the game took her and her team to 3 Women's College World Series. She remains the only person to have ever won the national college player of the year 3 times. Because of her incredible talent and statistics, Cat was asked to play for Team USA in the 2004 Olympics in Athens. At only 21 years of age, Cat became an Olympic gold medalist, having pitched nearly 15 innings without allowing a run. Athens was not Cat's only Olympic experience; she returned to the Olympic Games 4 years later in Beijing, once more pitching for the United States national softball team.

After the Olympics, Cat's career in softball continued to be successful. She played for Team USA, winning 2 world championships, and she was the first draft pick for Connecticut Brakettes in the National Pro Fastpitch softball league.

This April, Cat announced that she will be retiring from pitching. But you can't keep her away from the game that she loves. Her passion for the game has driven her all these years, and passion like that doesn't just die. Cat's passion is leading her to coach softball for St. Edwards University in Austin, Texas, and to help others to become passionate about the game themselves. People like Cat Osterman, who dedicate their lives to what they are passionate about, are the reason why this country remains great.

And that's just the way it is.

PERSONAL EXPLANATION

HON. BARBARA LEE

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 18, 2013

Ms. LEE of California. Mr. Speaker, I was not present for rollcall votes 245–247. Had I been able to vote, I would have voted ''yes'' on all three.

COMMEMORATING THE LIFE AND MEMORY OF MR. JOSEPH A. PINNOLA

HON. MICHAEL G. GRIMM

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 18, 2013

Mr. GRIMM. Mr. Speaker, I rise today to commemorate the life and memory of a marvelous Staten Islander, a model citizen, and a devoted family man, Mr. Joseph A. Pinnola, 83, who passed away on May 14th at his Dongan Hills home.

Born in Brooklyn, Joseph Pinnola moved to Great Kills in 1966 and settled in Dongan Hills in 1974. In 1944, at the age of 14, Mr. Pinnola began working at a drugstore to support his family after the death of his father. He started his career with Brooklyn Union Gas Company about three years later, working as a messenger. Mr. Pinnola served in the U.S. Army from 1952 to 1954, attaining the rank of staff sergeant during the Korean War. On guard duty one night, he sounded an alarm that alerted his company to a fire that had broken out in the compound where thousands of his comrades lay sleeping. He was also assigned to the Army Security Agency, working in cryptography and counter intelligence. On at least one occasion, he is said to have cracked a key enemy code.

On his return to civilian life, Mr. Pinnola continued working for Brooklyn Union while he took night classes at St. John's University. He earned his B.A. in accounting from St. John's in 1954, and was promoted to programmer at Brooklyn Union. He would go on to play a large role in the development and implementation of the company's computer systems throughout the next three decades. In 1982, as he continued moving ahead with his career, Mr. Pinnola graduated from the executive program in business administration at Columbia University. He was named senior vice president and chief information officer at Brooklyn Union in 1991, and retired three years later.

Affiliated with several organizations, Mr. Pinnola served on the board of trustees of Brooklyn Hospital. He was also a member of Community Board 2 and involved with the Jacques Marchais Center for Tibetan Art in Richmond. In his leisure time, he enjoyed jogging, cooking, drawing and playing the piano. Above all, he cherished spending time with his family and he particularly loved taking vacations with his children and grandchildren to Long Beach Island. ''He was happiest around his family and grandchildren,'' said his son Joseph. He courageously supported his family after the tragic death of his grandson, Christopher S. Pinnola, in 2007. He is survived by his wife of 53 years, the former Anita Adinolfi; his sons, Joseph, Steven, Richard and Kenneth; his daughters, Mary Pinnola-Waring and Joyce Pinnola; a sister, Nina Perry, and 10 grandchildren.

In all, Mr. Pinnola led a full life, enjoyed a successful career, but above all, always made time for his greatest of all joys, his beautiful and loving family.

PERSONAL EXPLANATION

HON. DOUG LAMBORN

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 18, 2013

Mr. LAMBORN. Mr. Speaker, I was unavoidably detained due to a family medical situation and was unable to vote on rollcall No. 245, rollcall No. 246, and rollcall No. 247.

Had I been present, I would have voted ''yea'' on rollcall No. 245, ''yea'' on rollcall No. 246, and ''yea'' on rollcall No. 247.

RECOGNIZING THE 10TH ANNIVERSARY OF PEPFAR: A CRITICAL PART OF THE FIGHT AGAINST AIDS

HON. JANICE D. SCHAKOWSKY

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 18, 2013

Ms. SCHAKOWSKY. Mr. Speaker, ten years ago Congress, with the leadership of the Bush Administration, enacted the bipartisan President's Emergency Plan for AIDS Relief (PEPFAR), an initiative which the Institute of Medicine in a Congressionally-requested February 2013 report called ''globally transformative.''

In its 10 years, PEPFAR has saved lives, improved health care delivery systems and, as the IOM concluded, provided a ''lifeline'' that restored hope to areas devastated by the epidemic. Over the course of its existence so far, PEPFAR has spent $46 billion to expand access to prevention, treatment and medical services. Through its contributions, new infections in sub-Saharan Africa, one of the hardest-hit areas, have dropped by 25 percent.

PEPFAR is a success story. It is part of the global effort to prevent, treat, and, soon I hope, find a cure so that we can end AIDS. We should celebrate PEPFAR's decade's worth of achievements, while we must also recommit to its goals. For, as the IOM report stated and all of us know, ''substantial unmet needs remain across HIV services'' both here and abroad.

PEPFAR itself is part of an ongoing effort to respond aggressively and effectively to HIV and AIDS. I would like to draw my colleagues' attention to an article by Dr. Allan Brandt from the June 6, 2013 New England Journal of Medicine, outlining the ways that the effort surrounding HIV/AIDS has reshaped our vision of global health—both what is needed and what is achievable.

As we pause today to recognize the 10th anniversary of PEPFAR, it is also important to recognize the enormous work of AIDS activists and providers who have been leading this fight for decades. Their work, as Dr. Brandt's article details, has had consequences that go far beyond combating AIDS—as critical as that is—

to shape the way we think about the right to medical care, health care justice, and our global relationships and responsibilities. It has also focused on the need to make essential medicines available—a matter of much attention in the ongoing Trans-Pacific Partnership trade discussions—and to build robust networks of medical professionals and community health workers.

Today, PEPFAR continues to partner with countries that rely on the United States to show leadership in meeting ongoing needs and challenges. While we can celebrate its successes today, we cannot be complacent. The fight against AIDS is a fight for global health, and it is one that we must continue to support.

[From the New England Journal of Medicine, June 6, 2013]

HOW AIDS INVENTED GLOBAL HEALTH

(By Allan M. Brandt, Ph.D.)

Over the past half-century, historians have used episodes of epidemic disease to investigate scientific, social, and cultural change. Underlying this approach is the recognition that disease, and especially responses to epidemics, offers fundamental insights into scientific and medical practices, as well as social and cultural values. As historian Charles Rosenberg wrote, ''disease necessarily reflects and lays bare every aspect of the culture in which it occurs.''

Many historians would consider it premature to write the history of the HIV epidemic. After all, more than 34 million people are currently infected with HIV. Even today, with long-standing public health campaigns and highly active antiretroviral therapy (HAART), HIV remains a major contributor to the burden of disease in many countries. As Piot and Quinn indicate in this issue of the Journal (pages 2210–2218), combating the epidemic remains a test of our expanding knowledge and vigilance.

Nonetheless, the progress made in addressing this pandemic and its effects on science, medicine, and public health have been far-reaching. The changes wrought by HIV have not only affected the course of the epidemic: they have had powerful effects on research and science, clinical practices, and broader policy. AIDS has reshaped conventional wisdoms in public health, research practice, cultural attitudes, and social behaviors. Most notably, the AIDS epidemic has provided the foundation for a revolution that upended traditional approaches to ''international health,'' replacing them with innovative global approaches to disease. Indeed, the HIV epidemic and the responses it generated have been crucial forces in ''inventing'' the new ''global health.''

This epidemic disrupted the traditional boundaries between public health and clinical medicine, especially the divide between disease prevention and treatment. In the 1980s, before the advent of antiretroviral therapies, public health officials focused on controlling social and behavioral risk factors; prevention was seen as the only hope. But new treatments have eroded this distinction and the historical divide between public health and clinical care. Clinical trials have shown that early treatment benefits infected patients not only by dramatically extending life expectancy, but by significantly reducing the risk of transmission to their uninfected sexual partners. Essential medicines benefit both patients and populations, providing a critical tool for reducing fundamental health disparities. This insight has encouraged the integration of approaches to prevention and treatment, in addition to behavioral change and adherence.

The rapid development of effective antiretroviral treatments, in turn, could not have occurred without new forms of disease advocacy and activism. Previous disease activism, for example, had established important campaigns supporting tuberculosis control, cancer research, and the rights of patients with mental illness. But AIDS activists explicitly crossed a vast chasm of expertise. They went to Food and Drug Administration meetings and events steeped in the often-arcane science of HIV, prepared to offer concrete proposals to speed research, reformulate trials, and accelerate regulatory processes. This approach went well beyond the traditional bioethical formulations of autonomy and consent, As many clinicians and scientists acknowledged, AIDS activists, including many people with AIDS, served as collaborators and colleagues rather than constituents and subjects, changing the trajectory of research and treatment. These new models of disease activism, enshrined in the Denver Principles (1983), which demanded involvement ''at every level of decision-making,'' have spurred new strategies among many activists focused on other diseases. By the early 2000s, AIDS activists had forged important transnational alliances and activities, establishing a critical aspect of the ''new'' global health.

Furthermore, HIV triggered important new commitments in the funding of health care, particularly in developing countries. With the advent of HAART and widening recognition of HIV's potential effect on the fragile progress of development in resource-poor settings, HIV spurred substantial increases in funding from sources such as the World Bank. The growing concern in the United Nations and elsewhere that the epidemic posed an important risk to global ''security'' elicited new funding from donor countries, ultimately resulting in the establishment of the Global Fund to Fight AIDS, Tuberculosis, and Malaria. In 2003, it was joined by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), which, with bipartisan support, initially pledged $15 billion over 5 years. Since PEPFAR's inception, Congress has allocated more than $46 billion for treatment, infrastructure, and partnerships that have contributed to a 25% reduction in new infections in sub-Saharan Africa.

HIV has also attracted remarkable levels of private philanthropy, most notably from the Bill and Melinda Gates Foundation. HIV funding led to new public private partnerships that have become a model for funding of scientific investigation, global health initiatives, and building of crucial health care delivery infrastructure in developing countries. These funding programs have fomented contentious debates about priorities, efficiency, allocation processes, and broader strategies for preventing and treating many diseases, especially in poorer countries. Nonetheless, they offered new approaches to identifying critical resources and evaluating their effect on the burden of disease. The success of future efforts will depend on maintaining and expanding essential funding during a period of global economic recession, as well as new strategies for evaluating the efficacy of varied interventions.

AIDS also spurred another related debate that continues to roil global health about the cost of essential medicines. Accessibility of effective and preventive treatments has relied on the availability of reduced-cost drugs and their generic equivalents. A recent decision by the Indian Supreme Court upheld India's right to produce inexpensive generics, despite the multinational pharmaceutical industry's claims for stronger recognition of patents.

Another central aspect of the new activism was an insistence that the AIDS epidemic demanded the recognition of basic human rights. Early on, lawyers, bioethicists, and policymakers debated the conditions under which traditional civil liberties could be abrogated to protect the public from the threat of infection. Such formulations reflected traditional approaches to public health and the ''police powers'' of the state, including mandatory testing, isolation, detention, and quarantine. Given the stigma attached to HIV infection at the time, as well as ungrounded fears of casual transmission, affected people often suffered the double jeopardy of disease and discrimination. As a result, Jonathan Mann, the first director of the World Health Organization's Global Program on AIDS, explained, ''To the extent that we exclude AIDS infected persons from society, we endanger society, while to the extent that we maintain AIDS infected persons within society, we protect society. This is the message of realism and of tolerance.'' Mann argued that HIV could never be successfully addressed if impositions on human rights led people to hide their infections rather than seek testing and treatment. Only policy approaches that recognized and protected human rights (including the rights to treatment and care, gender equality, and education) would permit successful clinical and population-based interventions.

These complementary innovations are at the core of what we now call ''global health'' which has demonstrated its capacity to be far more integrative than traditional notions of international health. It draws together scientists, clinicians, public health officials, researchers, and patients, while relying on new sources of funding, expertise, and advocacy. This new formulation is distinct, first of all, in that it recognizes the essential supranational character of problems of disease and their amelioration and the fact that no individual country can adequately address diseases in the face of the movement of people, trade, microbes, and risks. Second, it focuses on deeper knowledge of the burden of disease to identify key health disparities and develop strategies for their reduction. Third, it recognizes that people affected by disease have a crucial role in the discovery and advocacy of new modes of treatment and prevention and their equitable access. Finally, it is based on ethical and moral values that recognize that equity and rights are central to the larger goals of preventing and treating diseases worldwide.

For more than the past decade, major academic medical centers, schools of public health, and universities have created global health programs and related institutes for multidisciplinary research and education. Thus, the institutionalization of this formulation is not only affecting services worldwide, but also changing the training of physicians, other health professionals, and students of public health. When the history of the HIV epidemic is eventually written, it will be important to recognize that without this epidemic there would be no global health movement as we know it today.

HONORING MRS. JOSEPHINE TILLMAN SINGLETON

HON. BENNIE G. THOMPSON

OF MISSISSIPPI

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 18, 2013

Mr. THOMPSON of Mississippi. Mr. Speaker, I rise today to honor a remarkable civil servant and extraordinary educator, Mrs. Josephine Tillman Singleton. Her service to education and the community spans over 35 years.

Mrs. Josphine Tillman Singleton was born October 1, 1940 to Mr. Earnest and Mrs.