any security assistance provided for the Government of Mexico from, any practices described in subparagraph (B); and

(D) to assess, prior to removal, how the Government of Mexico would treat people who are not citizens of Mexico but have been removed to Mexico by the United States Government, including—

(i) conducting individualized assessments of such individuals to determine whether the Government of Mexico may send that person to their country of origin or last residence, and if so, whether the Government of Mexico would provide them with meaningful opportunity before their removal to show that they may be persecuted, tortured, or otherwise harmed; and

(ii) ensuring that the Government of Mexico would provide such individuals with legal immigration status, should they wish to remain in Mexico, and would be treated humanely; and

(3) other information, including—

(A) an assessment from the Secretary of State of the likelihood that United States security assistance (as defined in section 502B(d) of the Foreign Assistance Act of 1961 (22 U.S.C. 2304(d))) provided to Mexico could be used in support of activities by government officials related to the rendition, trafficking, detention, or imprisonment of people who are not citizens of Mexico but have been removed to Mexico by the United States Government;

(B) any analysis conducted by the United States Government of the conditions to be faced in Mexico by people who are not citizens of Mexico but have been removed to Mexico by the United States Government, prior to the rendition, removal, trafficking, detention, or imprisonment of such individuals to Mexico;

(C) an assessment from the Secretary of State of the conditions in any detention centers or prisons in Mexico that may hold people who are not citizens of Mexico but have been removed to Mexico by the United States Government, including an assessment of allegations of torture and other gross violations of human rights;

(D) a description of any actions that the United States Government is taking to ensure that the Government of Mexico returns people who are not citizens of Mexico but have been removed to Mexico by the United States Government, in compliance with United States court orders regarding their return to the United States;

(E) a description of any actions that the United States Government is taking to address the risk of detention, torture, or forced disappearances of people who are not citizens of Mexico but have been removed to Mexico by the United States Government, or efforts to facilitate the detention, torture, or forced disappearances of such people;

(F) a description of any actions the United States Government is taking to protect people who are not citizens of Mexico but are within the United States' jurisdiction or effective control from unlawful rendering, trafficking, or other means of removal to Mexico;

(G) all information regarding any agreement or financial transaction between the United States Government and the Government of Mexico related to the rendition, removal, trafficking, detention, or imprisonment of individuals who are not citizens of Mexico but have been removed to Mexico by the United States Government;

(H) all information regarding any individuals sent to Mexico by the United States Government in 2025;

(I) a description of any actions that the United States Government is taking to facilitate the release or return of people who are not citizens of Mexico but have been wrongfully removed to Mexico by the United States Government;

(J) all information regarding any assurances the United States Government sought or received regarding the treatment of people who are not citizens of Mexico but have been removed to Mexico by the United States Government, prior to the rendition, removal, or trafficking of such individuals to Mexico;

(K) all information regarding assurances the United States Government sought or received regarding the further rendition, trafficking, removal, or transfer of people who are not citizens of Mexico but have been removed to Mexico by the United States Government to countries that are not Mexico, including the human rights conditions for such individuals in those countries; and

(L) a summary of all meetings in 2025 between Government of Mexico officials and Washington-based officials of the United States Government.

SENATE RESOLUTION 357—RECOGNIZING THE 20TH ANNIVERSARY OF HURRICANE KATRINA

Mr. CASSIDY (for himself and Mr. KENNEDY) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 357

Whereas, on August 29, 2005, Hurricane Katrina inflicted catastrophic damage as a Category 3 hurricane and caused damage exceeding $200,000,000,000 in the States of Louisiana, Mississippi, Alabama, and Florida, making it one of the costliest storms in the history of the United States;

Whereas Hurricane Katrina was one of the deadliest hurricanes in the history of the United States, with a recorded 1,822 fatalities, including 1,577 in Louisiana, 238 in Mississippi, 14 in Florida, 2 in Georgia, and 2 in Alabama, according to the National Hurricane Center;

Whereas Hurricane Katrina's storm surge, which exceeded 20 feet in some places, caused 53 breaches in the levee system of New Orleans, and the levee failure resulted in the flooding of 80 percent of the city;

Whereas more than 1,200,000 individuals were under some type of evacuation order, including the first mandatory evacuation in the history of New Orleans;

Whereas non-emergency medical employees sheltered in place at hospitals to provide care and help move patients to higher ground;

Whereas tens of thousands of homes and businesses from Louisiana to Florida were destroyed by the flooding;

Whereas 3,000,000 individuals were left without electricity for weeks;

Whereas major highways were destroyed, including the Interstate 10 Twin Span Bridge connecting the cities of New Orleans and Slidell in Louisiana;

Whereas the Louisiana Superdome sheltered 26,000 evacuees and suffered roof leaks and other significant damage from strong winds;

Whereas Hurricane Katrina affected every part of Louisiana, and thousands of survivors sheltered in the Baton Rouge River Center, the Bossier City Civic Center, and the Monroe Civic Center, and additionally, many evacuees sheltered with friends and family;

Whereas, following the devastation of Hurricane Katrina, medical residents and faculty, as well as grassroots organizations, quickly mobilized to provide immediate health care services to hurricane evacuees;

Whereas neighboring cities and States took in thousands of displaced residents and provided medical care and shelter at makeshift hospitals, such as the Katrina Clinic at the Astrodome in Houston, Texas;

Whereas the American Red Cross, Habitat for Humanity, the Salvation Army, America's Second Harvest (now known as Feeding America), Emergency Communities, Catholic Charities, Pastors Resource Council Compassion, Southern Baptist Disaster Relief, and other charitable organizations provided crucial food, water, and hygiene products to victims;

Whereas more than 70 countries and international organizations pledged monetary donations in excess of $854,000,000;

Whereas improved levees are an essential aspect of providing Category 5-equivalent hurricane protection;

Whereas, in 2009, the Army Corps of Engineers delivered a plan for providing coastal Louisiana with Category 5-equivalent hurricane protection;

Whereas, in the aftermath of Hurricane Katrina, more than $15,000,000,000 was invested into Louisiana's levee system, and the Army Corps of Engineers constructed stronger levees by replacing failed I-Wall design floodwalls with stronger T-wall or L-wall design floodwalls and reinforced the most vulnerable undamaged I-Walls and surge protection closures;

Whereas the investment in Louisiana's levees paid off, and Louisiana's levees have held through multiple storms since their improvement following Hurricane Katrina;

Whereas Louisiana has improved evacuation routes, hardened its electric grid, and secured coastal resiliency grants and flood mitigation assistance grants to be better prepared for the next major hurricane;

Whereas enhancing flood mitigation measures and ensuring the affordability of flood insurance will strengthen the resiliency of vulnerable communities and the broader Gulf Coast region, in particular; and

Whereas the resiliency of the residents of New Orleans and the people of Louisiana allowed their culture, heritage, and identity to endure: Now, therefore, be it

Resolved, That the Senate—

(1) commemorates the victims of Hurricane Katrina;

(2) commends the courageous efforts of those who assisted in the recovery efforts;

(3) recognizes the contributions of the communities in Louisiana and across the United States for providing shelter and assistance to survivors; and

(4) reaffirms its commitment to protecting the Gulf Coast region from future storms.

SENATE RESOLUTION 358—HONORING THE LIFE OF DR. PAUL FARMER BY RECOGNIZING THE DUTY OF THE FEDERAL GOVERNMENT TO ADOPT A 21ST CENTURY GLOBAL HEALTH SOLIDARITY STRATEGY AND TAKE ACTIONS TO ADDRESS PAST AND ONGOING HARMS THAT UNDERMINE THE HEALTH AND WELL-BEING OF PEOPLE AROUND THE WORLD

Mr. MARKEY (for himself and Ms. WARREN) submitted the following resolution; which was referred to the Committee on Foreign Relations:

S. RES. 358

Whereas Dr. Paul Farmer, who pioneered novel community-based strategies for the delivery of high-quality health care in impoverished settings, inspired a paradigmatic shift in global health, including inspiring robust United States leadership to address the

global HIV/AIDS epidemic in the early 2000s through the United States President's Emergency Plan for AIDS Relief and the Global Fund to Fight AIDS, Tuberculosis, and Malaria;

Whereas, in spite of progress made in global health, weak health systems continue to cause millions of people, primarily the global poor, to die tragic and unnecessary deaths, including—

(1) annually, approximately—

(A) 680,000 deaths from HIV/AIDS;

(B) 1,500,000 deaths from tuberculosis;

(C) 627,000 deaths from malaria;

(D) 295,000 deaths of mothers during and following pregnancy and childbirth;

(E) 9,560,000 deaths among children under the age of 15; and

(F) 560,000 deaths of children and young adults, living among the poorest billion people in the world, from non-communicable diseases and injuries; and

(2) a SARS–CoV–2 case-fatality rate of up to 300 percent greater in low-income countries than in high-income countries during the first 2 years of the COVID–19 pandemic;

Whereas progress against unnecessary deaths in impoverished countries is being made, but progress is occurring so slowly that—

(1) based on rates of decline from 2013 to 2022, it will take approximately a century for core mortality statistics in low-income countries to converge with those of high-income countries, including—

(A) 92 years for the tuberculosis death rate;

(B) 109 years for the maternal mortality rate; and

(C) 88 years for the under-15 child mortality rate; and

(2) the death rate in low- and middle-income countries from non-communicable diseases and injuries, which make up 40 to 60 percent of the disease burden of those countries, will never converge with that of high-income countries based on rates of reduction from 2013 to 2022;

Whereas weak health systems that fail to prevent unnecessary deaths also lack the staff, health facility infrastructure, and medical technologies required for effective care delivery and disease containment, placing all countries at increased risk of pandemic disease;

Whereas essential medical technologies, such as diagnostics, treatments, and vaccines for diseases that affect the global poor, are frequently unavailable or inaccessible to health systems in developing countries, because—

(1) investing in research and development of technologies for diseases that disproportionately affect the global poor is often unprofitable for pharmaceutical corporations;

(2) costly intellectual property licensing fees from originator companies to generic manufacturers frequently leave the global poor unable to purchase or access medical technologies; and

(3) originator technology companies often refuse to share or license intellectual property to generic manufacturers, which results in limited supply and high prices, as was the case with the COVID–19 vaccine;

Whereas, according to the Lancet Commission on Investing in Health, preventing most avertable deaths and conferring ''essential universal health coverage'' in low- and lower-middle income countries requires an increase in annual health systems resources in those countries of $75,000,000,000 and $293,000,000,000 (in United States dollars as of 2016), respectively;

Whereas, historically, the United States and other global North-supported global health programs have inadvertently entrenched standards of care in low-income countries that would be unacceptable in rich countries by funding only health services narrowly defined as ''sustainable'', ''cost-effective'', or ''appropriate'' in poor settings;

Whereas the effectiveness and efficiency of current United States overseas development assistance for health is often undermined by—

(1) misalignment with the national health plans of the host country;

(2) bypassing delivery systems with parallel inputs, leading to—

(A) fragmentation of care delivery;

(B) poor donor coordination across partners; and

(C) weak health systems;

(3) favoring technical assistance from consultants from high-income countries, especially the United States, over funding health service delivery in beneficiary countries; and

(4) promoting privatization of health services, which weakens—

(A) the public health system;

(B) health care access;

(C) health equity; and

(D) financial risk protection;

Whereas 98 percent of the annual $1,500,000,000,000 in health spending in aid-eligible low- and middle-income countries is mobilized domestically by the countries themselves, and only 2 percent of this spending comes from overseas development assistance for health;

Whereas many of the poorest developing countries lack the tax capacity to mobilize the necessary resources to close the universal health coverage financing gap, meaning unnecessary deaths will continue in the poorest developing countries for the foreseeable future without external donor financing or dramatic increases in domestic tax capacity;

Whereas the inability of many of the poorest developing countries to fully close the financing gap for universal health coverage and the provision of numerous other public goods and services is in part due to the intimate economic links between those countries and high-income countries, including the United States, which have been marked throughout history by acts of violence and coercion;

Whereas these harms have entrenched a global economic architecture of upward wealth redistribution that has resulted in—

(1) depressed wages of workers and artificially low prices of natural resources in developing countries, amounting to an appropriation of tens of billions of tons of raw materials and hundreds of billions of hours of human labor through unequal exchange;

(2) 3,500,000,000 people living under the poverty line of $5.50 from 1993 to 2023, even as global gross domestic product has more than tripled in size during this time;

(3) more financial resources flowing out of developing countries than into developing countries each year, estimated by Global Financial Integrity to total a net negative of $2,000,000,000,000 annually in 2012; and

(4) developing countries bearing nearly all deaths and the vast majority of economic losses attributable to climate change, despite rich countries bearing 92 percent of the responsibility for climate change;

Whereas leadership from the United States to close the financing gaps for essential universal health coverage in low- and lower-middle income countries could precipitate increased global health financing from other donor partners, as evidenced by United States leadership that addressed the HIV/AIDS epidemic in the early 2000s, which spurred a 100-percent increase in global overseas development assistance among all donor partners from 2000 to 2006;

Whereas official United States development assistance to lower-middle income countries is not a supplement for United States action to stop ongoing structural violence and economic injustices preventing countries from financing and delivering universal health care and other social services for their populations; and

Whereas it is the view of the Senate that creating a decent, humane world without tragic, unnecessary deaths requires both a modest but meaningful increase in global health aid funding and a meaningful effort to stop the economic abuse of low- and middle-income countries: Now, therefore, be it

Resolved, That it is the sense of the Senate that—

(1) the Federal Government should adopt a new, 21st century global health solidarity strategy to end medically unnecessary deaths and respond to the full burden of disease in poor countries by—

(A) supporting developing countries to meet the material needs of their health systems by localizing investments in support of national public-sector and local priorities, referred to as ''accompaniment'' by Dr. Paul Farmer, and delivered through what Dr. Paul Farmer called the ''Five S's'', which refers to—

(i) staff, meaning the human resources necessary for high-quality service delivery, including clinical staff, transportation teams, and community health workers, especially by—

(I) supporting long-term training and education systems, including medical schools and teaching hospitals to train the health workforce and improve the quality of care across diseases; and

(II) supporting professionalized community health worker programs whereby community health workers are recruited, adequately compensated, comprehensively trained, supported for long-term retention, positioned as bridges to care, and tasked with undertaking community work with appropriate patient ratios and a manageable scope of work;

(ii) space, meaning the infrastructure needed for service delivery at primary, secondary, and tertiary levels to deliver safe and high-quality care to meet all health care needs;

(iii) stuff, meaning the tools and resources necessary for high-quality care provision, including medical supplies, technologies, and equipment;

(iv) systems, meaning the leadership and governance, health information systems, supply chain systems, logistics, laboratory capacity, and referral pathways required to meet the health needs of the population; and

(v) social support, meaning the resources needed, beyond the direct delivery of health care, to ensure effective care; and

(B) financing the discovery and development of new, urgently needed health technologies, such as diagnostics, treatments, and vaccines, particularly for neglected diseases of poverty, and ensuring their availability as global public goods;

(2) the objectives of adopting a 21st century global health solidarity strategy to end medically unnecessary deaths and responding to the full burden of disease in poor countries will require—

(A) increasing annual global health spending to $125,000,000,000, sufficient—

(i) for the first time, to meet the United Nations development assistance target of spending the equivalent of 0.7 percent gross national income on development assistance, which 6 other countries have previously met; and

(ii) to close over 100 percent of the essential universal health coverage financing gap for low-income countries, and 30 percent of the overall financing gap for low- and lower-middle income countries;