110TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPT. 110–546
Part 1

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

MARCH 10, 2008.—Ordered to be printed

Mr. BERMAN, from the Committee on Foreign Affairs, submitted the following

R E P O R T

[To accompany H.R. 5501]

[Including cost estimate of the Congressional Budget Office]

The Committee on Foreign Affairs, to whom was referred the bill (H.R. 5501) to authorize appropriations for fiscal years 2009 through 2013 to provide assistance to foreign countries to combat HIV/AIDS, tuberculosis, and malaria, and for other purposes, having considered the same, reports favorably thereon without amendment and recommends that the bill do pass.

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SUMMARY

H.R. 5501, the "Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008," authorizes $50 billion for the United States' bilateral and multilateral programs to combat HIV/AIDS, tuberculosis (TB) and malaria for Fiscal Years 2009 through 2013.

It seeks to continue the bipartisan commitment to aggressively prevent, treat, and care for those living with HIV/AIDS, and prevent and cure those with TB and malaria in the least developed countries by launching a second five-year strategy to achieve these goals.

In the first five years of the U.S. response to the global HIV/AIDS pandemic, U.S. policy was driven by the urgency of an emergency response. Under this Act, the United States will develop and implement strategies to transition from the emergency phase to long-term sustainability that can be maintained by the host countries. The new authorization also seeks to further integrate HIV/AIDS programs with TB and malaria programs. It strengthens health care delivery systems to boost host country capacities to reach and provide HIV/AIDS services to populations that are difficult to reach. In addition, the Reauthorization Act invests in rebuilding the health care workforce through training and the redistribution of tasks among health workers. Lastly, H.R. 5501 includes a provision that employs the expertise of the Department of the Treasury to work with the finance and health ministries of focus countries to establish public finance management systems for greater accountability.

BACKGROUND AND PURPOSE FOR THE LEGISLATION

In his State of the Union address in 2003, President George W. Bush announced the "President's Emergency Plan for AIDS Relief" (PEPFAR), requesting $15 billion to intervene in the worst global health pandemic since the Plague.

In 2003, according to UNAIDS, 3 million people were newly infected with HIV and 2 million died. Worldwide, an estimated 30.9 million people were living with HIV/AIDS. Sub-Saharan Africa, the most severely affected region of the world, accounted for over 2.1 million of these new infections and 1.6 million AIDS deaths. Every day in 2003, an estimated 8,200 people were newly infected with HIV worldwide.[1] At the time, antiretroviral drug treatment regimens in poor settings were viewed by some policy makers as prohibitively expensive and complicated. Primary focus was on the cheaper and more easily administered drugs for the prevention of mother-to-child transmission.

Soon after the President's announcement, Congress passed and the President signed the *"U.S Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003,"* Public Law 108–25 ("the 2003 Act"), authorizing $15 billion in assistance to combat these diseases for Fiscal Years 2004—2008.[2] President Bush signed the Act into law in May 2003.

The 2003 Act established, within the Department of State, a Coordinator of United States Government Activities to Combat HIV/AIDS Globally, appointed by the President with the advice and consent of the Senate. The Office of the Global AIDS Coordinator (OGAC) now leads interagency implementation of and administers U.S. global HIV/AIDS policy. The Reauthorization Act seeks to

[1] UNAIDS, 2007

[2] The efforts were concentrated primarily in 14 "focus countries"—Botswana, Cote d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, and Zambia. Vietnam was later added as a 15th focus country, and PEPFAR also supports bilateral programs in dozens of other countries.

strengthen the Coordinator's role of coordinating the Federal agencies engaged in implementing global HIV/AIDS policy.

The 2003 Act required a five-year emergency plan (2004–2008) designed to coordinate all U.S.-funded bilateral HIV/AIDS programs, including those established by PEPFAR and administered through the seven implementing agencies,[3] to address the emergency. With this new funding, combined with other HIV/AIDS program funding, the U.S. bilateral programs to combat HIV/AIDS, tuberculosis, and malaria were expanded to 114 countries. The U.S. now supports programs in 136 countries, including programs funded by the United States and administered through The Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), an international financing mechanism for collective global funding of programs to combat these three diseases. A major goal of the 2003 Act was to focus the delivery of services through local community and faith-based organizations in the host countries. On World AIDS Day in 2005, the President announced the creation of "The New Partners Initiative" (NPI) to provide technical assistance enabling faith-based and community organizations with little prior experience working with the U.S. Government to administer sustainable HIV/AIDS programs.

The initial "emergency phase" was also designed to scale up HIV/AIDS treatment, care, and prevention programs (including prevention of mother-to-child transmission programs), and extend them to hard-to-reach rural areas and vulnerable populations, including women, girls, orphans and vulnerable children. The three major infectious diseases—HIV/AIDS, TB, and malaria—were covered by the 2003 Act because research demonstrated that co-infection with HIV/AIDS and one or both of the other diseases resulted in more severe symptoms and certain and untimely death. For example, according to the World Health Organization (WHO), 90% of people living with AIDS die within months of contracting TB if they do not receive TB treatment.[4]

For the past five years, the United States has been the leading international provider of global HIV/AIDS support for prevention, treatment, and care. Over this period, Congress appropriated more funds than were initially authorized. In Fiscal Years 2004 through 2008, the U.S. appropriated more than $19 billion for programs to combat HIV/AIDS, tuberculosis and malaria internationally, including more than $3 billion in contributions to The Global Fund.

The U.S. emergency program intervened in this horrific pandemic and performed well in the face of a massive humanitarian disaster, broken infrastructure and a major shortage of health care workers. As of September 30, 2007: the U.S. had supported life-saving antiretroviral treatment for 1,445,500 men, women, and children; supported care for more than 6.6 million, including care for more than 2.7 million orphans and vulnerable children; and supported prevention of an estimated 157,000 infant infections (cumulative for Fiscal Years 2004 through 2007). In virtually every host country, in order to treat and care for individuals, major investment in infrastructure and workforce training has taken place, though there is still much more to be done. Shortages of health

[3] Department of State, USAID, Department of Defense, Department of Commerce, Department of Labor, Department of Health and Human Services and the Peace Corps.

[4] "Frequently Asked Questions About TB and HIV/AIDS," World Health Organization, 2008.

care workers, clinics, hospitals, laboratories, and storage facilities in many areas of host countries have made it incredibly difficult to reach vast numbers of individuals who needed care and treatment.

By 2007, the news, while still grim, was beginning to improve. The HIV/AIDS prevalence rates were leveling off and annual deaths stabilized. According to UNAIDS, in 2007 there were 33.2 million people worldwide living with HIV/AIDS, of whom 2.5 million were children under the age of 15; 2.5 million were newly infected, of whom 420,000 were children under the age of 15; and there were 2.1 million deaths, of whom 330,000 were children under the age of 15. Due to the massive intervention by the U.S. Government, the Global Fund, other bilateral donors, and the governments and people of the countries most affected by the disease, the growth of the pandemic has slowed and the estimates are headed in the right direction.

Host countries that have partnered with the U.S. to fight HIV/AIDS have expressed their deep appreciation of the program. As President Jakaya Kikwete of Tanzania said when talking to President Bush in February 2008, "Today there are thousands of children who have managed to avoid joining the already long list of orphans, and who continue to enjoy the love, guidance and support of their parents who are alive because of the AIDS care and treatment they get with the support of PEPFAR initiative. Mr. President, thank you. Today, as a result of PEPFAR, parents with AIDS are able to take care of their children."[5]

In September 2007, President Festus Mogae of Botswana said, ". . . The modest successes we have recorded in my country . . . and indeed in many African countries, could not have been achieved without United States support under the President Bush's Emergency Fund for AIDS Relief, PEPFAR. . . . The fund has, in addition, provided impetus to other donors and major contributors to contribute to international efforts to fight the scourge of HIV/AIDS around the world. The quantum of resources under PEPFAR, a significant amount from a single source by any standard, has helped translate international consensus into tangible opportunity and hope for millions around the world. . . . PEPFAR has galvanized donor countries and agencies alike to act in concert in the interest of humanity."[6]

While the program has been able to reach a large number of people, the more difficult challenges lie ahead. The number of those receiving prevention, treatment, and care services needs to increase towards the goal of universal access, and host country programs must be strengthened to sustain those on treatment for life. Measures must be taken to create sustainability of host country HIV/AIDS programs far into the future. Research is needed to address further developments of the virus and the disease. Lastly, health care delivery systems strengthening and maintenance and workforce stability must be achieved. Without these improvements, the threat of a rapid expansion of HIV/AIDS in countries where the epidemic has become generalized and into countries that have relatively low prevalence rates remains grave.

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[5] Joint Press Availability with President Kikwete and President Bush in Tanzania, 2/17/08

[6] "Botswana's Future: Reflections on HIV/AIDS, Democratization, and U.S.-Botswana Relations," Center for Strategic & International Studies, Washington, DC, 9/21/2007.

The reauthorization of the Act for FY 2009–2013 is designed with four major priorities to move the U.S. global HIV/AIDS response from the "emergency phase" towards long-term "sustainability." The first priority is to continue to designate and meet ambitious targets for prevention, treatment, and care that will move poor countries toward universal access (defined as providing treatment and other services to 80% of the affected population). The second priority is to strengthen and build the capacity of health care delivery systems, including refurbishing hospital facilities, free-standing clinics, and laboratories; providing supplies; and training and extending the workforce to expand the reach of HIV/AIDS programs to those yet to be serviced. The third priority is to coordinate HIV/AIDS programs closely with programs for tuberculosis, malaria, and, where appropriate, other diseases. The fourth priority is to provide technical assistance to improve the ability of host governments to plan, direct, finance, and manage the programs that the U.S. Government and other donors have helped to put in place. To that end, the reauthorization increases U.S. funding for HIV/AIDS, tuberculosis, and malaria to $50 billion over the next five fiscal years.

Estimates of Funding

The $50 billion five-year authorization will provide a total of $41 billion for HIV/AIDS programs, $5 billion for malaria programs, and $4 billion for tuberculosis programs through bilateral programs and Global Fund contributions combined. According to projections based on the most recent UNAIDS estimates of prevalence, developing country financial needs to fight HIV/AIDS (not including tuberculosis and malaria) will be $28 billion per annum in 2009 and will rise to $45 billion in 2013. The 2009–2013 total projected low and middle-income country need is $198 billion for HIV/AIDS programs. Donors collectively should take on 70% of the total finances required and the host countries should cover 30% of these costs. Assuming the appropriate U.S. contribution to address the global need is the same as the 33% "cap" on contributions to the Global Fund, the U.S. share of developing world HIV/AIDS financing would be $46 billion for five years.

Based on the work of the WHO Commission on Macroeconomics and Health, developed countries need to provide at least one-third of country-level needs identified in the WHO Global Plan to Stop TB, and 50% of the extensively drug resistant tuberculosis (XDR–TB) and multi-drug resistant tuberculosis (MDR–TB) costs. Thirty-three percent of this donor share is $3.85 billion for the Fiscal Years 2009 to 2013. Additional resources are required for research and development of new diagnostics, drugs, and vaccines.

The current best estimate of global need for malaria programs by the World Malaria Report is $4.1 billion ($3.2 billion for implementation; $0.9 billion for research and development) per year. The Reauthorization Act authorizes up to$5 billion as the U.S. Government's contribution to this global effort.

Prevention Policy

The Reauthorization Act continues support for the "Abstinence, Be Faithful, Correct and Consistent Use of Condoms" (ABC) approach that has proven to be effective in combating the spread of HIV/AIDS, with modifications. The Act emphasizes prevention by increasing the importance of abstinence, delay of sexual debut and faithfulness programming. It requires that policy makers further prioritize these approaches in their programming and reporting as part of the integrated ABC prevention approach. The Committee remains committed to each part of this approach, recognizing that the greatest gains have been found when all three components of ABC are used in an integrated approach. The Committee also values the benefit of abstinence and be faithful-only programs, particularly in countries where the epidemic is generalized. The Committee is committed to the enforcement of the "conscience clause" to protect and ensure the participation of organizations that have a religious or moral objection to certain programs or activities.

Reflecting the Committee's continued commitment to the ABC approach, H.R. 5501 removes the one-third "abstinence until marriage" funding directive from the 2003 Act. Instead, it includes a requirement that the Coordinator provide balanced funding for prevention activities for sexual transmission of HIV/AIDS and ensure that behavioral change programs, including abstinence, delay of sexual debut, monogamy, fidelity and partner reduction programs, 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 infection, and in consultation with the government of each host country involved in HIV/AIDS prevention activities. The objective epidemiological evidence to be used for the Coordinator's determination should be primarily the Demographic and Health Surveys, the AIDS Information Service (AIS), and other United States Government supported surveys, including surveys requested by the Congress and other independent, scientifically-sound studies. The modification of the previous abstinence spending requirement should not be interpreted to imply that abstinence and be faithful programs are no longer considered by the Committee to be a priority for prevention funding.

In addition, H.R. 5501 provides that the Coordinator shall establish an HIV sexual transmission prevention strategy governing the expenditure of funds authorized by the Act and used to prevent the sexual transmission of HIV in any host country with a generalized epidemic. In each such host country, if this strategy provides less than 50 percent of such funds for behavioral change programs (defined to include abstinence, delay of sexual debut, monogamy, fidelity, and partner reduction), the Coordinator shall, within 30 days of the issuance of this strategy, report to the appropriate congressional committees on the justification for this decision.

The country-by-country breakout for FY 2008, which indicates current patterns of prevention efforts under the Global HIV/AIDS program, was as follows:

PEPFAR Focus Countries Sexual Prevention Planned Funding—FY 2008

Field & Central Programs (in USD million)

Country	Sexual Prevention Funding	AB Funding	AB as a % of All Sexual Prevention
Botswana	12.4	8.4	67.6%
Cote D'Ivoire	11.9	7.8	65.9%
Ethiopia	36.3	16.9	46.5%
Guyana	3.8	2.3	60.0%
Haiti	8.4	5.1	60.8%
Kenya	64.0	38.0	59.4%
Mozambique	24.1	14.1	58.7%
Namibia	16.6	11.0	66.1%
Nigeria	27.5	18.2	66.1%
Rwanda	12.1	8.0	66.0%
South Africa	60.2	37.5	62.2%
Tanzania	29.6	18.2	61.5%
Uganda	30.3	17.2	56.9%
Vietnam	15.8	2.9	18.3%
Zambia	32.9	20.8	63.3%
All Focus Countries	385.8	226.4	58.7%

Faith-Based Organizations

The Reauthorization Act continues the support of nongovernmental organizations, including faith-based organizations, which have long played a critical role in the provision of heath care services in the poorest countries in the world. In many communities in developing nations, the only medical services available within a reasonable distance from people's homes are those provided by clinics and hospitals run by churches and other nongovernmental organizations. Faith-based organizations have played an important role in providing prevention, treatment and care services for HIV/AIDS since before the passage of the 2003 Act, and have taken the lead in integrating nutrition with treatment and care services, particularly to orphans and vulnerable children.

The Committee applauds the important work of these organizations and encourages the U.S. Government's continued partnership with them. We look forward to continued participation of these organizations in all aspects of HIV/AIDS programming, including, for example, providing services related to abstinence, delay of sexual debut and faithfulness. We expect the Global HIV/AIDS program to continue to provide services through faith-based organizations.

To strengthen the relationship with such organizations, the 2008 Act strengthens the "conscience clause," a provision that has en-

sured that faith-based organizations are not required to endorse or utilize any prevention or treatment method to which they have a religious or moral objection. The 2008 Act strengthens this provision by specifically adding language indicating that faith-based groups are not required to integrate with or refer people to other programs or activities to which the organizations have a religious or moral objection and are not discriminated against in the solicitation or issuance of grants, contracts or cooperative agreements for refusing to do so.

Expanding Program Linkages, Coordination and Cooperation

The Reauthorization Act of 2008 establishes stronger linkages between HIV/AIDS programs and programs in nutrition and education that are vital to improving the success of treatment by enhancing the overall health of the person with HIV/AIDS. The 2008 Act also strengthens prevention activities for women and girls that were missing in the original Act. The Coordinator is charged with developing strategies that will make women and girls less vulnerable to situations that increase their chances of getting HIV/AIDS, including the provision of antiretroviral post-exposure prophylaxis for victims of gender-based violence and rape, the development of microenterprise and job creation programs, and empowering women and youth to avoid cross-generational sex.

The Reauthorization Act calls for ensuring access to HIV/AIDS education and testing in family planning and maternal health programs supported by the United States Government. The 2008 Annual Report to Congress on the implementation of the Global HIV/AIDS program specifically discussed existing "linkages between HIV/AIDS and voluntary family planning programs." The 2008 Act is consistent with the Administration's implementation of the Global HIV/AIDS effort. Currently, the Coordinator is providing grants for HIV/AIDS prevention services in family planning settings in order to reach a wider population. The Committee commends the Coordinator for doing so and the new authorization of assistance in this area is intended to build on existing efforts.

The Reauthorization Act increases and strengthens the linkage between HIV/AIDS and tuberculosis programs. The dual epidemics of HIV/AIDS and tuberculosis are particularly deadly due to widespread stigma, low levels of awareness, and poorly coordinated services. In sub-Saharan Africa, tuberculosis is the most common cause of death and illness for individuals with HIV. Additionally, XDR–TB is particularly dangerous and almost universally fatal for those living with HIV. Responding to the need for greater mobilization and coordination efforts for tuberculosis and HIV/AIDS co-infection, this Act provides stronger linkages for prevention, care, and treatment services to reduce tuberculosis-related illness and death among people living with HIV/AIDS. It provides for tuberculosis diagnostic counseling, testing, and treatment (including for MDR–TB and XDR–TB) to those with HIV/AIDS and HIV/AIDS voluntary counseling, testing, and treatment to those with any form of tuberculosis. The Act supports the linking of individuals with both HIV/AIDS and any form of tuberculosis to HIV/AIDS treatment and care services.

Globally, malaria has become one of the many opportunistic infections afflicting people living with HIV/AIDS. There is a par-

ticular burden on pregnant women, children and those individuals who suffer high HIV viral loads, and those in end stage HIV disease. Pregnant women who experience malaria also risk higher rates of cognitive disability in their newborn children. Malaria is a disease that kills swiftly. According to the World Health Organization, in many cases, the first 48 hours of malaria parasite infection are the most critical. Individuals whose systems have been compromised by HIV/AIDS stand little chance of surviving malaria. This Act establishes strong linkages between HIV/AIDS and malaria programs to prevent the debilitating and deadly effects of malaria on individuals served by this program.

The Act calls for the training of health care workers to diagnose, treat, and provide care for individuals with HIV/AIDS and tuberculosis. According to the United Nations Development Programme, Human Development Report 2003, approximately 3 out of 4 countries in sub-Saharan Africa have fewer than 20 physicians per 100,000 people, the minimum ratio recommended by the World Health Organization, and 13 countries have 5 or fewer physicians per 100,000 people. Nurses play particularly important roles in sub-Saharan African health care systems, but approximately one-quarter of sub-Saharan African countries have fewer than 50 nurses per 100,000 people or less than 1/2 the staffing levels recommended by the World Health Organization. Paraprofessionals and community health workers can be trained more quickly than nurses or doctors and are critically needed in sub-Saharan Africa to meet immediate health care needs. While the scope of the problem of dire shortfalls of personnel and inadequacies of infrastructure in the sub-Saharan African health systems is immense, effective and targeted interventions to improve working conditions, management, and productivity will yield significant dividends in improved health care.

To empower host countries to sustain these programs, the Reauthorization Act of 2008 invests in strengthening health care delivery systems and building health workforce capacities through recruitment and training. The Committee has encouraged stronger linkages between the Global HIV/AIDS programs and initiatives to increase the capacity of the health care delivery systems. For example, instead of equipping laboratories with equipment that can only be used to test and manage HIV/AIDS testing, through this Act laboratories will be designed and equipped to handle general medical and public health care. Also, the Act authorizes the Department of the Treasury to carry out a public finance management program to work with host countries to create policy environments that will support the modernization of the health sector.

Since 1999, the International Monetary Fund (IMF) has provided concessional loans to national governments with the goal of reducing poverty and supporting economic growth in developing countries. As a condition of receiving these loans, national governments are required to develop Poverty Reduction Strategy Papers which frequently prevent national governments from increasing health sector spending to address urgent and emerging health epidemics such as HIV/AIDS, tuberculosis, or malaria. In response, this Act directs the Coordinator to work with the Secretary of the Treasury to reform existing IMF macroeconomic and fiscal policies that result in limitations on health sector spending by national govern-

ments receiving assistance from the IMF. The Act further directs the Secretary of the Treasury to instruct the United States Executive Director at the IMF to oppose all IMF programs that do not exempt increased health sector spending by national governments from any loan conditions set by the IMF.

THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS, AND MALARIA [7]

In addition to our bilateral programs, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (the Global Fund) is a vehicle through which the U.S. Government extends its support even more broadly. The Global Fund is a public-private partnership dedicated to raising and disbursing large amounts of funding to prevent and treat the pandemics of HIV/AIDS, malaria and tuberculosis. As a financing organization with no regional or country offices, the Global Fund is unable (and not intended) to provide hands-on technical support to improve grant performance; this becomes the responsibility of international and bilateral partners.[8]

The U.S. Government, as a founding member of the Global Fund and its first and largest contributor, continues to play a leadership role in ensuring the success of this essential international effort. Though the Fund was not established until 2002, President Bush made the founding contribution to the Global Fund of $200 million in May 2001. As of February 2008, donors have pledged more than $18 billion to the Fund, of which nearly $10 billion has been paid. The funds have been used to support nearly 500 grants totaling $8.3 billion for projects in 136 countries, of which $5.2 billion has been disbursed. To date, the U.S. has appropriated and pledged $3.5 billion for contributions to the Global Fund.

The 2003 Act included a provision that limits the U.S. contribution to the Global Fund to 33% of overall contributions. This policy was adopted to ensure other public and private donors made substantial contributions to the Global Fund and has allowed the leaders of the Global Fund to use the U.S. funds as matching for others. Many believe that without this restriction, other donor countries would not have stepped forward to make significant contributions. Increased investments by the Organization for Economic Development and Cooperation's Development Assistance Committee (OECD/DAC) countries have kept pace with the U.S. increases.[9]

In the Reauthorization Act, the authorized U.S. contribution to the Global Fund doubles from $1 billion to $2 billion per year. This level anticipates the growing demand on funding from the Global Fund and increased bilateral funding from other donor countries. The "1/3 cap" on the U.S. Government contribution limits the total amount contributed in any given year. The Reauthorization Act retains the "1/3 cap" as a demonstration of the Committee's commit-

[7] A United Nations General Assembly *Special Session on AIDS* in June 2001 concluded with a commitment to create a global fund. The commitment was endorsed by the G8 that helped finance it at their meeting in Genoa in July 2001. Following that commitment, a *Transitional Working Group* was formed to develop a framework for how the Global Fund would be structured and operate on an ongoing basis and in January 2002, a permanent secretariat was established in Geneva. Three months later the Global Fund Board approved the first round of grants to 36 countries. The U.S. was a leader in the creation of the Global Fund and continues to be its largest contributor.

[8] http://www.pepfar.gov/coop/c18962.htm

[9] Kates, J. et al., "Financing the response to AIDS in the low- and middle income countries: International assistance from the G8, European Commission and other donor governments". 2006.

ment to multilateral funding for the enormous challenges that lie ahead for HIV/AIDS, tuberculosis and malaria programs. The "1/3 cap" expresses our intention to call on other donor countries to make substantial contributions. In addition, the Committee expects increased transparency and accountability for the Fund, particularly in light of the authorization for increased funding, and has provided a set of benchmarks to help improve the Global Fund's operations.

HEARINGS

The Committee held five hearings directly related to the subject matter of the bill. On March 21, 2007, the Subcommittee on Africa and Global Health held a hearing entitled "The Global Threat of Drug-Resistant TB: A Call to Action for World TB Day." On April 24, 2007, the full committee held a hearing entitled "PEPFAR: An Assessment of Progress and Challenges." On April 25, 2007, the Subcommittee on Africa and Global Health held a hearing entitled "Malaria Awareness Day: Leveraging Progress for Future Advances." On September 25, 2007, the full committee held a hearing entitled "PEPFAR Reauthorization: From Emergency to Sustainability." On October 9, 2007, the Subcommittee on Africa and Global Health held a hearing entitled "The President's Emergency Plan for AIDS Relief: Is It Fulfilling the Nutrition and Food Security Needs of People Living with HIV/AIDS?"

COMMITTEE CONSIDERATION

On February 27, 2008, the Full Committee held a markup on H.R. 5501, the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008, and it was favorably reported to the House, by voice vote, a quorum being present.

VOTES OF THE COMMITTEE

There were no recorded votes on H.R. 5501.

COMMITTEE OVERSIGHT FINDINGS

In compliance with clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee reports that the findings and recommendations of the Committee, based on oversight activities under clause 2(b)(1) of rule X of the Rules of the House of Representatives, are incorporated in the descriptive portions of this report.

NEW BUDGET AUTHORITY AND TAX EXPENDITURES

In compliance with Clause 3(c) (2) of House Rule XIII, the Committee adopts as its own the estimate of new budget authority, entitlement authority, or tax expenditures or revenues 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

In compliance with clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the Committee sets forth, with respect to the bill, H.R.5501, the following estimate and comparison prepared by the Director of the Congressional Budget Office under section 402 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, Month 5, 2008.

Hon. HOWARD L. BERMAN, *Acting 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. 5501, the Tom Lantos and Henry J. Hyde U.S. Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008.

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

Sincerely,

PETER R. ORSZAG.

Enclosure

cc: Honorable Ileana Ros-Lehtinen
Ranking Member

H.R. 5501—Tom Lantos and Henry J. Hyde U.S. Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008.

SUMMARY

H.R. 5501 would reauthorize several assistance programs aimed at preventing and treating HIV/AIDS, tuberculosis, and malaria in other countries. For those programs, the bill would authorize the appropriation of $10 billion a year over the 2009–2013 period. CBO estimates that implementing H.R. 5501 would cost $1.5 billion in 2009 and $35 billion over the 2009–2013 period, assuming appropriation of the authorized amounts. Enacting the bill would not affect direct spending or receipts.

H.R. 5501 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA) and would not affect the budgets of state, local, or tribal governments.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 5501 is shown in the following table. The costs of this legislation fall within budget functions 150 (international affairs) and 550 (health). For this estimate, CBO assumes that the bill will be enacted by September 30, 2008, that the authorized amounts are appropriated for each year, and that outlays will follow historical spending patterns for the existing programs.

By Fiscal Year, in Millions of Dollars

	2009	2010	2011	2012	2013
CHANGES IN SPENDING SUBJECT TO APPROPRIATION					
HIV/AIDS, Tuberculosis, and Malaria Programs					
Authorization Level	10,000	10,000	10,000	10,000	10,000
Estimated Outlays	1,392	6,392	8,262	9,082	9,482
Contributions to Vaccine Funds					
Estimated Authorization Level	108	108	108	158	158
Estimated Outlays	108	108	108	158	158
Total Changes					
Estimated Authorization Level	10,108	10,108	10,108	10,158	10,158
Estimated Outlays	1,500	6,500	8,370	9,240	9,640

BASIS OF ESTIMATE

Section 401 of H.R. 5501 would authorize the appropriation of $10 billion each year from 2009 through 2013. Those funds would be used to operate and expand the existing assistance programs that provide grants and contributions to organizations and global funds devoted to treating the effects of HIV/AIDS, tuberculosis, and malaria, and to preventing the transmission of those diseases. Those programs, which received a total of $3 billion in appropriations for 2008, are run by the Department of State, the United States Agency for International Development (USAID), and the Department of Health and Human Services.

Section 203 would authorize the appropriation of such sums as may be necessary to make contributions for research and development of various vaccines. Based on information from USAID on the current amount of contributions to those funds (about $100 million in 2008) and the amount needed to fund the final stages of development for a tuberculosis vaccine, CBO estimates that implementing section 203 would cost $640 million over the 2009–2013 period.

Based on information from the Department of State, CBO estimates that the amount authorized to be appropriated is sufficient to fund the expanded requirements. Because it will take some time to expand existing programs and develop new procedures and activities, CBO estimates that implementing this bill would cost $1.5 billion in 2009 and about $35 billion over the 2009–2013 period. Most of the additional amounts from the authorized funding would be spent by 2018.

INTERGOVERNMENTAL AND PRIVATE–SECTOR IMPACT

H.R. 5501 contains no intergovernmental or private-sector mandates as defined in UMRA and would not affect the budgets of state, local, or tribal governments.

ESTIMATE PREPARED BY:

Federal Costs: Michelle S. Patterson (226–2840)
Impact on State, Local, and Tribal Governments: Neil Hood (225–3220)
Impact on the Private Sector: MarDestinee C. Perez (226–2940)

ESTIMATE APPROVED BY:

Peter H. Fontaine

Assistant Director for Budget Analysis

PERFORMANCE GOALS AND OBJECTIVES

Pursuant to clause (3)(c) of House rule XIII, upon enactment of this legislation, assistance should be expanded to reach more people around the world with HIV/AIDS prevention, treatment and care programs and should provide integrated food and nutrition programs. Special attention should be given to women, youth and mother-to-child transmission, and more expansive programming to reduce the tuberculosis and malaria pandemics.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 3(d) (1) of rule XIII of the Rules of the House of Representatives, the Committee finds the authority for this legislation in article I, section 8 of the Constitution.

NEW ADVISORY COMMITTEES

H.R. 5501 does not establish or authorize any new advisory committees.

CONGRESSIONAL ACCOUNTABILITY ACT

H.R. 5501 does not apply to the Legislative Branch.

EARMARK IDENTIFICATION

H.R. 5501 does not include any earmarks, and does not include limited tax benefits, or limited tariff benefits as defined in clause 9(d), 9(e), or 9(f) of rule XXI.

SECTION-BY-SECTION ANALYSIS AND DISCUSSION

Sec. 1. Short Title and Table of Contents.

The short title of this Act is the "Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008".

Sec. 2. Findings.

This section amends the findings in the United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003 (22 U.S.C. 7601) ("the 2003 Act") by adding to the end of that Act's findings, additional findings with updated data on human immunodeficiency virus (HIV) and the acquired immunodeficiency syndrome (AIDS), hereinafter collectively referred to as HIV/AIDS, tuberculosis and malaria around the world and the impact of U.S. assistance in combating these diseases since the 2003 Act was passed. The findings also identify ongoing and growing challenges in meeting the needs for treatment, care, prevention, cure and research of and related to these diseases in coming years.

Sec. 3. Definitions.

This section amends the 2003 Act by updating the title of the Committee to the "Committee on Foreign Affairs."

Sec. 4. Purpose.

This section amends the purpose of the 2003 Act by adding the creation of five-year plans for tuberculosis and malaria; calling for increased resources for bilateral efforts for prevention, treatment and care; expanding this assistance to cover nutrition assistance, heath system and workforce development, monitoring and evaluations and operations research; and including efforts to develop research for tuberculosis and other prevention technologies.

TITLE I—POLICY PLANNING AND COORDINATION

Sec. 101. Development of a Comprehensive, Five-Year, Global Strategy.

This section amends section 101 of the 2003 Act by providing additional guidance to the President on the development of the second five-year plan to combat HIV/AIDS globally. It instructs the President to expand the strategic approach to behavioral risks related to transmission of HIV/AIDS. It instructs the President to provide for linkages and referral systems to nutrition and food support for individuals with HIV/AIDS, child health services and development programs, and other social service programs related to HIV/AIDS. It also calls on the President to provide access to HIV/AIDS education and testing in family planning and maternal health programs supported by the United States Government, and to maximize host country capacity for HIV/AIDS training and research in the five-year strategy.

Sec. 102. HIV/AIDS Response Coordinator.

This section amends section 1(f)(2) of the State Department Basic Authorities Act of 1956 (22 U.S.C. 2651a(f)(2)) to strengthen and expand the duties of the HIV/AIDS Response Coordinator, including enhancing the role of the Coordinator in consulting and coordinating with foreign governments, nongovernmental organizations and other U.S. Government agencies.

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

Sec. 201. Sense of Congress on Public-Private Partnerships.

This section amends section 201 of the 2003 Act by updating the purpose of public-private partnerships to address easily preventable and treatable infectious diseases.

Sec. 202. Participation in the Global Fund to Fight AIDS, Tuberculosis and Malaria.

This section amends section 202 of the 2003 Act relating to U.S. contributions to the Global Fund. Subsection (a) updates findings in that Act. Subsection (b) increases the annual authorization for the U.S. contribution to the Global Fund from $1 billion to $2 billion for Fiscal Years 2009 and 2010 of the amounts authorized to be appropriated under section 401 of the 2003 Act. It also moves the deadline after which funds appropriated for such contribution can be transferred to the U.S. bilateral programs from July 1 to December 31 of the year after the funds are appropriated (if they are available for more than one fiscal year) and provides new

benchmarks designed to improve the accountability and transparency of the Global Fund's activities.

Sec. 203. Voluntary Contributions to International Vaccine Funds.

This section amends section 302 of the Foreign Assistance Act of 1961 to reauthorize the existing programs for the vaccine fund authorized under section 302(k) of that Act, the International AIDS Vaccine authorized by section 302(l) of such Act and the malaria vaccine development program authorized by section 302(m) of such Act. Section 203 also adds a new section 302(n) relating to authorizing a U.S. contribution to research and development of a tuberculosis vaccine.

Sec. 204. Program to Facilitate Availability of Microbicides to Prevent Transmission of HIV and Other Diseases.

Subsection (a) expresses the sense of Congress recognizing the need and urgency to expand the range of interventions for preventing the transmission of HIV, including non-vaccine prevention methods that can be controlled by women.

Subsection (b) authorizes the Administrator of USAID, in coordination with the Coordinator of U.S. Government Activities to Combat HIV/AIDS Globally, to develop and implement a program to facilitate wide scale availability of microbicides that prevent the transmission of HIV after such microbicides are proven safe and effective.

Subsection (c) authorizes of the amounts authorized by section 401 of the 2003 Act, such sums as may be necessary for Fiscal Years 2009 through 2013 to carry out this section.

Sec. 205. Plan to Combat HIV/AIDS, Tuberculosis, and Malaria by Strengthening Health Policies and Health Systems of Host Countries.

This section amends Title II of the 2003 Act by adding a new section 204 relating to strengthening health policies and health systems of host countries. Subsection (a) provides findings on the need for strengthening of such health policies and systems. Subsection (b) provides for a statement of policy directed to this need. Subsection (c) requires the Coordinator to develop and implement a plan to combat HIV/AIDS by strengthening such policies and systems as part of the United States Agency for International Development's "Health Systems 2020 Project." Subsection (d) authorizes the appropriation of funds authorized under section 401 of the Act to the Department of the Treasury to provide technical assistance to host countries to improve the public finance management systems of such countries to enable them to receive HIV/AIDS assistance, collect revenue and manage their own programs.

TITLE III—BILATERAL EFFORTS

Subtitle A—General Assistance and Programs

Sec. 301. Assistance to Combat HIV/AIDS.

This section amends section 104A of the Foreign Assistance Act of 1961 and section 301 of the 2003 Act, both of which relate to bilateral U.S. HIV/AIDS assistance.

Subsection (a) amends section 104A by updating and sharpening the focus on certain assistance activities. In particular, the amendments to section 104A create new targets for U.S. HIV/AIDS assistance by 2013 of preventing 12 million infections, treating 3 million persons with HIV/AIDS and caring for 12 million individuals (including 5 million HIV/AIDS orphans and vulnerable children), and training health workers and professionals for HIV/AIDS prevention, treatment and care; widening U.S. efforts to regions such as Central and Eastern Europe and South and Southeast Asia; and creating a new focus on support for host countries.

Subsection (a) also expands the activities for which U.S. HIV/AIDS assistance can be used for prevention, including an increased focus on counseling, delay of sexual debut, abstinence, fidelity, life skills, prevention of mother-to-child HIV transmission, and the use of safe and effective microbicides when they become available. It also expands activities for treatment, including assistance to support treatment for one-third of all individuals in clinical need of treatment in the poorest countries worldwide, assistance to reduce barriers to treatment, and assistance for psycho-social treatment for youth to ensure adherence to treatment. It also provides for a more integrated approach to HIV/AIDS by supporting referral of individuals with HIV/AIDS to relevant services and enhanced support of related programs that can improve the effectiveness of HIV/AIDS programs, such as nutrition, education, and programs that improve the livelihood of individuals with HIV/AIDS. Subsection (a) also expands the annual report required by section 104A(e) to address a number of the new approaches described in this Act.

Subsection (b) amends section 301 of the 2003 Act to expand the authorization to Fiscal Years 2009 through 2013.

Subsection (c) amends section 301(c) of the 2003 Act to create an enhanced focus on food and nutrition assistance as critical to an integrated approach to treatment of individuals with HIV/AIDS.

Subsection (d) clarifies that not only are groups receiving funds under the Act not required to endorse or utilize any activities or programs to which they have a moral or religious objection, they are also not required to integrate with or refer to programs to which they have a moral or religious objection.

Subsection (e) repeals a sense of Congress that is superfluous in light of the amendment made by subsection (c).

Subsection (f) requires the Coordinator to provide a report identifying a target for the number of additional health professionals and workers needed in host countries to provide HIV/AIDS prevention, treatment and care.

Sec. 302. Assistance to Combat Tuberculosis.

Subsection (a) makes amendments to section 104B of the Foreign Assistance Act of 1961 relating to assistance to combat tuberculosis, drawing from the House-passed version of H.R. 1567, the Stop Tuberculosis (TB) Now Act of 2007. These amendments include additional findings and an amended statement of policy; a requirement to provide assistance to combat tuberculosis; and a list of activities to be carried out, including diagnostic testing and counseling, treatment, and integration of HIV/AIDS and tuberculosis training. The amendments also include providing for a new

U.S. strategy to combat tuberculosis and an authorization to provide increased resources to the World Health Organization.

Subsection (b) amends section 302 of the 2003 Act to authorize up to a total of $4 billion for Fiscal Years 2009 to 2013 from the overall amounts authorized by section 401 of the 2003 Act (as amended by this Act) for assistance to combat tuberculosis.

Sec. 303. Assistance to Combat Malaria.

Subsection (a) amends section 104C of the Foreign Assistance Act of 1961 to ensure that treatment is part of the U.S. effort to combat malaria.

Subsection (b) amends section 303 of the 2003 Act to authorize up to a total of $5 billion for Fiscal Years 2009 to 2013 from the overall amounts authorized by section 401 of the 2003 Act (as amended by this Act) for assistance to combat malaria.

Subsection (c) further amends section 303 of the 2003 Act by adding a requirement for a comprehensive strategy to combat malaria and to establish within USAID a malaria coordinator. It also provides for contributions to the Roll Back Malaria Partnership and the World Health Organization; for research by relevant U.S. agencies to address prevention, treatment and care of malaria; and for an annual report on the prevention, treatment, control and elimination of malaria.

Sec. 304. Health Care Partnerships to Combat HIV/AIDS.

This section supports the development of partnerships between institutions based in the United States and foreign institutions, including national and local health agencies, medical facilities, health education and training institutions, and faith- and community-based organizations involved in prevention, treatment and care of individuals with HIV/AIDS.

Subtitle B—Assistance for Women, Children, and Families

Sec. 311. Policy and Requirements.

This section amends section 312 of the 2003 Act to provide for additional policy and other requirements. Subsection (a) provides for collaboration among all relevant actors that combat HIV/AIDS. Subsection (b) revises section 312(b) of the 2003 Act to provide for requirements regarding the five-year strategy required by section 101 of the 2003 Act, including establishing targets for reaching 80 percent of pregnant women for prevention of mother-to-child transmission (PMTCT) of HIV; for requiring that up to 15 percent of those receiving treatment and up to 15 percent of those receiving care from U.S. HIV/AIDS assistance are children; for integrating care and treatment with PMTCT programs; and for expanding programs to care for children orphaned by HIV/AIDS.

Sec. 312. Annual Reports on Prevention of Mother-to-Child Transmission of the HIV Infection.

This section amends section 313 of the 2003 Act by extending the duration of the annual PMTCT report required by such section and requires that such report include additional information on the number of women who receive various types of assistance related to PMTCT.

Sec. 313. Strategy to Prevent HIV Infections Among Women and Youth.

This section provides for a comprehensive, integrated and culturally appropriate global HIV/AIDS prevention strategy that addresses the vulnerabilities of women and youth. Subsection (a) provides a statement of policy regarding this matter. Subsection (b) requires the strategy and describes its elements. Subsection (c) provides, in formulating and implementing the strategy required by subsection (b), coordination with relevant actors involved in combating HIV/AIDS. Subsection (d) provides for guidance to field missions based on the strategy described in subsection (b). Subsection (e) requires a report on the implementation of the strategy.

Sec. 314. Clerical Amendment.

This section makes a clerical amendment to the 2003 Act.

TITLE IV—AUTHORIZATION OF APPROPRIATIONS

Sec. 401. Authorization of Appropriations.

This section increases the authorization under section 401(a) of the 2003 Act to $10 billion for each of the Fiscal Years 2009 to 2013.

Sec. 402. Sense of Congress.

This section amends the sense of Congress language included in section 402(b) of the 2003 Act to eliminate specific spending directives in the legislation, including the 55% directive, expressed as a sense of Congress, for treatment, and the directive, again expressed as a sense of Congress, that one-third of prevention funds be used for abstinence programs.

Sec. 403. Allocation of Funds.

This section amends section 403(a) of the 2003 Act to maintain focus on balanced prevention programming. In particular, the new subsection (a) provides that 20 percent of all funds authorized for HIV/AIDS programs by the Act shall be used to support HIV prevention programs. In addition, the revised section 403(a) includes a requirement that the Coordinator provide balanced funding for prevention activities for sexual transmission of HIV/AIDS and ensure that behavioral change programs, including 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 infection and in consultation with the government of each host country involved in HIV/AIDS prevention activities. The new subsection also provides that the Coordinator shall establish a HIV sexual transmission prevention strategy governing the expenditure of funds authorized by the Act used to prevent the sexual transmission of HIV in any host country with a generalized epidemic. In each such host country, if this strategy provides less than 50 percent of such funds for behavioral change programs (defined to include abstinence, delay of sexual debut, monogamy, fidelity, and partner reduction), the Coordinator shall, within 30 days of the issuance of this strategy, report to the appropriate congressional committees on the justification for this deci-

sion. Finally, this section extends the focus of the Act relating to orphans and vulnerable children.

Sec. 404. Prohibition on Taxation by Foreign Governments.

Subsection (a) provides that none of the funds appropriated pursuant to the authorization of the 2003 Act, as amended by this Act, may be made available to provide assistance for a foreign country under a new bilateral agreement governing the terms and conditions under which such assistance is to be provided unless such agreement includes a provision stating that assistance provided by the United States shall be exempt from taxation, or reimbursed, by the foreign government, and the Secretary of State shall expeditiously seek to negotiate amendments to existing bilateral agreements, as necessary, to conform with this requirement.

Subsection (b) provides for a de minimus exception to this section.

Subsection (c) authorizes that any funds withheld pursuant to subsection (a) shall be reprogrammed for HIV/AIDS assistance to another country.

Subsection (d) provides that subsection (a) shall not apply if the Secretary of State determines that a country does not assess such taxes, has a mechanism for reimbursement of such taxes, or that U.S. foreign policy interests outweigh the purposes of subsection (a).

Subsection (e) provides for the issuance of regulations regarding this section.

Subsection (f) provides definitions.

TITLE V—SUSTAINABILITY AND STRENGTHENING OF HEALTH CARE SYSTEMS

Sec. 501. Sustainability and Strengthening of Health Care Systems.

This section amends the 2003 Act by adding a new title relating to sustainability and strengthening of health care systems in countries as part of overall efforts to combat HIV/AIDS. The new title also directs U.S. representatives to relevant international financial institutions to support the exemption of health expenditures from any proposed national budget caps or other limits.

Sec. 502. Clerical Amendment.

This section makes a clerical amendment to the 2003 Act to reflect the new title.

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 omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

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

AN ACT To provide assistance to foreign countries to combat HIV/AIDS, tuberculosis, and malaria, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) * * *

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

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) * * *

* * * * * * *

(29) The HIV/AIDS pandemic continues to pose a major threat to the health of the global community, from the most severely-affected regions of sub-Saharan Africa and the Carib-

bean, to the emerging epidemics of Eastern Europe, Central Asia, South and Southeast Asia, and Latin America.

(30) According to UNAIDS' 2007 global estimates, there are 33.2 million individuals with HIV/AIDS worldwide, including 2.5 million people newly-infected with HIV. Of those infected with HIV, 2.5 million are children under 15 who also account for 460,000 of the newly-infected individuals.

(31) Sub-Saharan Africa continues to be the region most affected by the HIV/AIDS pandemic. More than 68 percent of adults and nearly 90 percent of children with HIV/AIDS live in sub-Saharan Africa, and more than 76 percent of AIDS deaths in 2007 occurred in sub-Saharan Africa.

(32) Although sub-Saharan Africa carries the heaviest disease burden of HIV/AIDS, the HIV/AIDS pandemic continues to affect virtually every world region. While prevalence rates are relatively low in Eastern Europe, Central Asia, South and Southeast Asia, and Latin America, without effective prevention strategies, HIV prevalence rates could rise quickly in these regions.

(33) By world region, according to UNAIDS' 2007 global estimates—

(A) in sub-Saharan Africa, there were 22.5 million adults and children infected with HIV, up from 20.9 million in 2001, with 1.7 million new HIV infections, a 5 percent prevalence rate, and 1.6 million deaths;

(B) in South and Southeast Asia, there were 4 million adults and children infected with HIV, up from 3.5 million in 2001, with 340,000 new HIV infections, a 0.3 percent prevalence rate, and 270,000 deaths;

(C) in East Asia, there were 800,000 adults and children infected with HIV, up from 420,000 in 2001, with 92,000 new HIV infections, a 0.1 percent prevalence rate, and 32,000 deaths;

(D) in Eastern and Central Europe, there were 1.6 million adults and children infected with HIV, up from 630,000 in 2001, with 150,000 new HIV infections, a 0.9 percent prevalence rate, and 55,000 deaths; and

(E) in the Caribbean, there were 230,000 adults and children infected with HIV, up from 190,000 in 2001, with 17,000 new HIV infections, a 1 percent prevalence rate, and 11,000 deaths.

(34) Tuberculosis is the number one killer of individuals with HIV/AIDS and is responsible for up to one-half of HIV/AIDS deaths in Africa.

(35) The wide extent of drug resistant tuberculosis, including both multi-drug resistant tuberculosis (MDR–TB) and extensively drug resistant tuberculosis (XDR–TB), driven by the HIV/AIDS pandemic in sub-Saharan Africa, has hampered both HIV/AIDS and tuberculosis treatment services. The World Health Organization (WHO) has declared the prevalence of tuberculosis to be at emergency levels in sub-Saharan Africa.

(36) Forty percent of the world's population, mostly poor, live in malarial zones, and malaria, which is highly preventable, kills more than 1 million individuals worldwide each year. Ninety percent of malaria's victims are in sub-Saharan

Africa and 70 percent of malaria's victims are children under the age of 5. Additionally, hunger and malnutrition kill another 6 million individuals worldwide each year.

(37) Assistance to combat HIV/AIDS must address the nutritional factors associated with the disease in order to be effective and sustainable. The World Food Program estimates that 6.4 million individuals affected by HIV will need nutritional support by 2008.

(38) Women and girls continue to be vulnerable to HIV, in large part, due to gender-based cultural norms that leave many women and girls powerless to negotiate social relationships.

(39) Women make up 50 percent of individuals infected with HIV worldwide. In sub-Saharan Africa, where the HIV/AIDS epidemic is most severe, women make up 57 percent of individuals infected with HIV, and 75 percent of young people infected with HIV in sub-Saharan Africa are young women ages 15 to 24.

(40) Women and girls are biologically, socially, and economically more vulnerable to HIV infection. Gender disparities in the rate of HIV infection are the result of a number of factors, including the following:

(A) Cross-generational sex with older men who are more likely to be infected with HIV, and a lack of choice regarding when and whom to marry, leading to early marriages and high rates of child marriages with older men. About one-half of all adolescent females in sub-Saharan Africa and two-thirds of adolescent females in Asia are married by age 18.

(B) Studies show that married women and married and unmarried girls often are unable or find it difficult to negotiate the frequency and timing of sexual intercourse, ensure their partner's faithfulness, or insist on condom use. Under these circumstances, women often run the risk of being infected by husbands or male partners in societies where men in relationships have more than one partner. Behavior change is particularly important in societies in which this is a common practice.

(C) Because young married women and girls are more likely to have unprotected sex and have more frequent sex than their unmarried peers, and women and girls who are faithful to their spouses can be placed at risk of HIV/AIDS through a husband's infidelity or prior infection, marriage is not always a guarantee against HIV infection, although it is a protective factor overall.

(D) Social and economic inequalities based largely on gender limit access for women and girls to education and employment opportunities and prevent them from asserting their inheritance and property rights. For many women, a lack of independent economic means combines with sociocultural practices to sustain and exacerbate their fear of abandonment, eviction, or ostracism from their homes and communities and can leave many more women trapped within relationships where they are vulnerable to HIV infection.

(E) A lack of educational opportunities for women and girls is linked to younger sexual debut, earlier childhood marriage, earlier childbearing, decreased child survival, worsening nutrition, and increased risk of HIV infection.

(F) High rates of gender-based violence, rape, and sexual coercion within and outside marriage contribute to high rates of HIV infection. According to the World Health Organization, between one-sixth and three-quarters of women in various countries and settings have experienced some form of physical or sexual violence since the age of 15 within or outside of marriage. Women who are unable to protect themselves from such violence are often unable to protect themselves from being infected with HIV through forced sexual contact.

(G) Fear of domestic violence and the continuing stigma and discrimination associated with HIV/AIDS prevent many women from accessing information about HIV/AIDS, getting tested, disclosing their HIV status, accessing services to prevent mother-to-child transmission of HIV, or receiving treatment and counseling even when they already know they have been infected with HIV.

(H) According to UNAIDS, the vulnerability of individuals involved in commercial sex acts to HIV infection is heightened by stigmatization and marginalization, limited economic options, limited access to health, social, and legal services, limited access to information and prevention means, gender-related differences and inequalities, sexual exploitation and trafficking, harmful or non-protective laws and policies, and exposure to risks associated with commercial sex acts, such as violence, substance abuse, and increased mobility.

(I) Lack of access to basic HIV prevention information and education and lack of coordination with existing primary health care to reduce stigma and maximize coverage.

(J) Lack of access to currently available female-controlled HIV prevention methods, such as the female condom, and lack of training on proper use of either male or female condoms.

(K) High rates of other sexually transmitted infections and complications during pregnancies and childbirth.

(L) An absence of functioning legal frameworks to protect women and girls and, where such frameworks exist, the lack of accountable and effective enforcement of such frameworks.

(41) In addition to vulnerabilities to HIV infection, women in sub-Saharan Africa face a 1-in-13 chance of dying in childbirth compared to a 1-in-16 chance in least-developed countries worldwide, a 1-in-60 chance in developing countries, and a 1-in-4,100 chance in developed countries.

(42) Due to these high maternal mortality rates and high HIV prevalence rates in certain countries, special attention is needed in these countries to help HIV-positive women safely deliver healthy babies and save women's lives.

(43) Unprotected sex within or outside of marriage is the single greatest factor in the transmission of HIV worldwide and

is responsible for 80 percent of new HIV infections in sub-Saharan Africa.

(44) Multiple randomized controlled trials have established that male circumcision reduces a man's risk of contracting HIV by 60 percent or more. Twelve acceptability studies have found that in regions of sub-Saharan Africa where circumcision is not traditionally practiced, a majority of men want the procedure. Broader availability of male circumcision services could prevent millions of HIV infections not only in men but also in their female partners.

(45)(A) Youth also face particular challenges in receiving services for HIV/AIDS.

(B) Nearly one-half of all orphans who have lost one parent and two-thirds of those who have lost both parents are ages 12 to 17. These orphans are in particular need of services to protect themselves against sexually-transmitted infections, including HIV.

(C) Research indicates that many youth benefit from full disclosure of medically accurate, age-appropriate information about abstinence, partner reduction, and condoms. Providing comprehensive information about HIV, including delay of sexual debut and the ABC model: "Abstain, Be faithful, use Condoms", and linking such information to health care can help improve awareness of safe sex practices and address the fact that only 1 in 3 young men and 1 in 5 young women ages 15 to 24 can correctly identify ways to prevent HIV infection.

(D) Surveys indicate that no country has succeeded in fully educating more than one-half of its youth about the prevention and transmission of HIV.

(46) According to the United Nations High Commissioner for Refugees (UNHCR), HIV/AIDS prevalence rates among refugees are generally lower than the HIV/AIDS prevalence rates for their host communities, though perceptions run counter to this fact. However, peacekeeping operations that no longer deploy HIV/AIDS-positive troops still face vulnerabilities to sexual transmission of HIV with HIV-positive individuals in refugee camps. Host countries generally do not provide HIV/AIDS prevention, treatment, and care services for refugees.

(47) Continuing progress to reach the millions of impoverished individuals who need voluntary testing, counseling, treatment, and care for HIV/AIDS requires increased efforts to strengthen health care delivery systems and infrastructure, rebuild and expand the health care workforce, and strengthen allied and support services in countries receiving United States global HIV/AIDS assistance.

(48) While HIV/AIDS poses the greatest health threat of modern times, it also poses the greatest development challenge for developing countries with fragile economies and weak public financial management systems that are ill equipped to shoulder the burden of this disease. International donors will have to play a critical role in providing resources for HIV/AIDS programs far into the future.

(49) The emerging partnerships between countries most affected by HIV/AIDS and the United States must include stronger coordination between HIV/AIDS programs and other

United States foreign assistance programs, and stronger collaboration with other donors in the areas of economic development and growth strategies.

(50) The future control of HIV/AIDS demands coordination between international organizations such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNAIDS, the World Health Organization (WHO), the World Bank and the International Monetary Fund (IMF), the international donor community, national governments, and private sector organizations, including community and faith-based organizations.

(51) The future control of HIV/AIDS further requires effective and transparent public finance management systems in developing countries to advance the ability of such countries to manage public revenues and donor funds aimed at combating HIV/AIDS and other diseases.

(52) The HIV/AIDS pandemic contributes to the shortage of health care personnel through loss of life and illness, unsafe working conditions, increased workloads for diminished staff, and resulting stress and burnout, while the shortage of health care personnel undermines efforts to prevent and provide care and treatment for individuals with HIV/AIDS.

(53) The shortage of health care personnel, including doctors, nurses, pharmacists, counselors, laboratory staff, paraprofessionals, trained lay workers, and researchers is one of the leading obstacles to combating HIV/AIDS in sub-Saharan Africa.

(54) Since 2003, important progress has been made in combating HIV/AIDS, yet there is more to be done. The number of new HIV infections is still increasing at an alarming rate. According to the United States National Institute of Allergy and Infectious Diseases, globally, for every 1 individual put on antiretroviral therapy, 6 individuals are newly infected with HIV.

(55) The United States Government continues to be the world's leader in the fight against HIV/AIDS and the unsurpassed partner with developing countries in their efforts to control this disease.

(56) By September 2007, the United States, through the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7601 et seq.), had provided services to prevent mother-to-child-transmission of HIV to women during 10 million pregnancies; provided antiretroviral prophylaxis for women during over 827,300 pregnancies; prevented an estimated 157,240 HIV infections in infants; cared for over 6.6 million individuals, including over 2.7 million orphans and vulnerable children; supported lifesaving antiretroviral therapies for approximately 1.4 million men, women, and children in sub-Saharan Africa, Asia, and the Carribean; and provided counseling and testing to over 33.7 million men, women, and children in developing countries.

(57) These numbers were achieved because of the commitment of substantial resources and support of the United States Government to our partners on the front lines—the dedicated and committed women and men, communities, and nations who

are taking control of the HIV/AIDS epidemics in their own countries.

SEC. 3. DEFINITIONS.

In this Act:

(1) * * *

(2) APPROPRIATE CONGRESSIONAL COMMITTEES.—The term "appropriate congressional committees" means the Committee on Foreign Relations of the Senate and the [Committee on International Relations] *Committee on Foreign Affairs* of the House of Representatives.

* * * * * * *

[SEC. 4. PURPOSE.

[The purpose of this Act is to strengthen United States leadership and the effectiveness of the United States response to certain global infectious diseases by—

[(1) establishing a comprehensive, integrated five-year, global strategy to fight HIV/AIDS that encompasses a plan for phased expansion of critical programs and improved coordination among relevant executive branch agencies and between the United States and foreign governments and international organizations;

[(2) providing increased resources for multilateral efforts to fight HIV/AIDS;

[(3) providing increased resources for United States bilateral efforts, particularly for technical assistance and training, to combat HIV/AIDS, tuberculosis, and malaria;

[(4) encouraging the expansion of private sector efforts and expanding public-private sector partnerships to combat HIV/AIDS; and

[(5) intensifying efforts to support the development of vaccines and treatment for HIV/AIDS, tuberculosis, and malaria.]

SEC. 4. PURPOSE.

The purpose of this Act is to strengthen and enhance United States global leadership and the effectiveness of the United States response to the HIV/AIDS, tuberculosis, and malaria pandemics and other related and preventable infectious diseases in developing countries by—

(1) establishing a comprehensive, integrated five-year, global strategy to fight HIV/AIDS, tuberculosis, and malaria that encompasses a plan for continued expansion and coordination of critical programs and improved coordination among relevant executive branch agencies and between the United States and foreign governments and international organizations;

(2) providing increased resources for United States bilateral efforts to combat HIV/AIDS, tuberculosis, and malaria, particularly for prevention, treatment, and care (including nutritional support), technical assistance and training, the strengthening of health care systems, health care workforce development, monitoring and evaluations systems, and operations research;

(3) providing increased resources for multilateral efforts to combat HIV/AIDS, tuberculosis, and malaria;

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

(5) intensifying efforts to support the development of vaccines, microbicides, and other prevention technologies and improved diagnostics treatment for HIV/AIDS, tuberculosis, and malaria.

* * * * * * *

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, five-year strategy [to combat] *to develop efforts further to combat* global HIV/AIDS that strengthens the capacity of the United States to be an effective leader of the international campaign against HIV/AIDS. Such strategy shall maintain sufficient flexibility and remain responsive to the ever-changing nature of the HIV/AIDS pandemic and shall—

(1) * * *

* * * * * * *

[(4) provide that the reduction of HIV/AIDS behavioral risks shall be a priority of all prevention efforts in terms of funding, educational messages, and activities by promoting abstinence from sexual activity and substance abuse, encouraging monogamy and faithfulness, promoting the effective use of condoms, and eradicating prostitution, the sex trade, rape, sexual assault and sexual exploitation of women and children;]

(4) provide that the reduction of HIV/AIDS behavioral risks shall be a priority of all prevention efforts in terms of funding, scientifically-accurate educational services, and activities by—

(A) designing prevention strategies and programs based on sound epidemiological evidence, tailored to the unique needs of each country and community, and reaching those populations found to be most at risk for acquiring HIV infection;

(B) promoting abstinence from sexual activity and substance abuse;

(C) encouraging delay of sexual debut, monogamy, fidelity, and partner reduction;

(D) promoting the effective use of male and female condoms;

(E) promoting the use of measures to reduce the risk of HIV transmission for discordant couples (where one individual has HIV/AIDS and the other individual does not have HIV/AIDS or whose status is unknown);

(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) promoting the rapid expansion of safe and voluntary male circumcision services;

(H) promoting life skills training and development for children and youth;

(I) supporting advocacy for child and youth community-based protective social services;

(J) eradicating trafficking in persons and creating alternatives to prostitution;

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

(L) promoting services demonstrated to be effective in reducing the transmission of HIV infection among injection drug users without increasing illicit drug use;

(M) promoting policies and programs to end the sexual exploitation of and violence against women and children; and

(N) promoting prevention and treatment services for men who have sex with men;

(5) include specific plans for linkage to, and referral systems for nongovernmental organizations that implement multisectoral approaches, including faith-based and community-based organizations, for—

(A) nutrition and food support for individuals with HIV/AIDS and affected communities;

(B) child health services and development programs;

(C) HIV/AIDS prevention and treatment services for injection drug users;

(D) access to HIV/AIDS education and testing in family planning and maternal health programs supported by the United States Government; and

(E) medical, social, and legal services for victims of violence;

[(5)**]** *(6)* improve coordination and reduce duplication among relevant executive branch agencies, foreign governments, and international organizations;

[(6)**]** *(7)* project general levels of resources needed to achieve the stated objectives;

[(7)**]** *(8)* expand public-private partnerships and the leveraging of resources;

[(8)**]** *(9)* maximize United States capabilities in the areas of technical assistance and training and research, including vaccine research;

(10) maximize host country capacities in training and research, particularly operations research;

[(9)**]** *(11)* establish priorities for the distribution of resources based on factors such as the size and demographics of the population with HIV/AIDS, tuberculosis, and malaria and the needs of that population and the existing infrastructure or funding levels that may exist to cure, treat, and prevent HIV/AIDS, tuberculosis, and malaria; and

[(10)**]** *(12)* include initiatives describing how the President will maximize the leverage of private sector dollars in reduction and treatment of HIV/AIDS, tuberculosis, and malaria.

(b) REPORT.—

(1) IN GENERAL.—Not later than 270 days after the date of enactment of [this Act] *the Tom Lantos and Henry J. Hyde Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008*, the President shall submit to the appropriate congressional committees a report setting forth the strategy described in subsection (a).

* * * * * * *

(3) REPORT ELEMENTS.—The elements referred to in paragraph (2) are the following:

(A) * * *

* * * * * * *

[(C) A description of the manner in which the strategy will address the fundamental elements of prevention and education, care, and treatment (including increasing access to pharmaceuticals and to vaccines), the promotion of abstinence, monogamy, avoidance of substance abuse, and use of condoms, research (including incentives for vaccine development and new protocols), training of health care workers, the development of health care infrastructure and delivery systems, and avoidance of substance abuse.]

(C) A description of the manner in which the strategy will address the following:

(i) The fundamental elements of prevention and education, care and treatment, including increasing access to pharmaceuticals, vaccines, and microbicides, as they become available, screening, prophylaxis, and treatment of major opportunistic infections, including tuberculosis, and increasing access to nutrition and food for individuals on antiretroviral therapies.

(ii) The promotion of delay of sexual debut, abstinence, monogamy, fidelity, and partner reduction.

(iii) The promotion of correct and consistent use of male and female condoms and other strategies and skills development to reduce the risk of HIV transmission.

(iv) Increasing voluntary access to safe male circumcision services.

(v) Life-skills training.

(vi) The provision of information and services to encourage young people to delay sexual debut and ensure access to HIV/AIDS prevention information and services.

(vii) Prevention of sexual violence leading to transmission of HIV and assistance for victims of violence who are at risk of HIV transmission.

(viii) HIV/AIDS prevention, care, and treatment services for injection drug users.

(ix) Research, including incentives for HIV vaccine development and new protocols.

(x) Advocacy for community-based child and youth protective services.

(xi) Training of health care workers.

(xii) The development of health care infrastructure and delivery systems.

(xiii) Prevention efforts for substance abusers.

(xiv) Prevention, treatment, care, and outreach efforts for men who have sex with men.

(D) A description of the manner in which the strategy will promote the development and implementation of national and community-based multisectoral strategies and programs, including those designed to enhance leadership capacity particularly at the community level*, including through faith-based and other nongovernmental organizations*.

(E) A description of the specific strategies developed to meet the unique needs of women, including *access to HIV/AIDS education and testing in family planning and maternal and child health programs supported by the United States Government and* the empowerment of women in interpersonal situations, young people and children, including those orphaned by HIV/AIDS and those who are victims of the sex trade, rape, sexual abuse, assault, and exploitation.

(F) A description of the specific strategies developed to encourage men to be responsible in their sexual behavior *(including by accessing voluntary clinical circumcision services)*, child rearing and to respect women including the reduction of sexual violence and coercion.

(G) A description of the specific strategies developed to increase women's *and men's* access to employment opportunities, income, productive resources, and microfinance programs.

* * * * * * *

(M) A description of efforts to be undertaken to strengthen the public finance management systems of selected host countries to ensure transparent, efficient, and effective management of national and donor financial investments in health.

[(M)**]** *(N)* The level of resources that will be needed on an annual basis and the manner in which those resources would generally be allocated among the relevant executive branch agencies.

[(N)**]** *(O)* A description of the mechanisms to be established for monitoring and **[**evaluating programs,**]** *evaluating programs to ensure medical accuracy, operations research,* promoting successful models, and for terminating unsuccessful programs.

[(O)**]** *(P)* A description of the manner in which private, nongovernmental entities will factor into the United States Government-led effort and a description of the type of partnerships that will be created to maximize the capabilities of these private sector entities and to leverage resources.

[(P)**]** *(Q)* A description of the ways in which United States leadership will be used to enhance the overall international response to the HIV/AIDS pandemic*, strengthen national health care delivery systems, and increase national health workforce capacities,* and particularly to heighten the engagement of the member states of the G-

8 and to strengthen key financial and coordination mechanisms such as the Global Fund and UNAIDS.

[(Q)] *(R)* A description of the manner in which the United States strategy for combating HIV/AIDS relates to and supports other United States assistance strategies in developing countries*, including strategies relating to agricultural development, trade and economic growth, and education*.

[(R)] *(S)* A description of the programs to be carried out under the strategy that are specifically targeted at women and girls to educate them about the spread of HIV/AIDS.

[(S)] *(T)* A description of efforts being made to address the unique needs of families with children with respect to HIV/AIDS, including *efforts of intergenerational caregivers and* efforts to preserve the family unit.

[(T)] *(U)* An analysis of the emigration of critically important medical and public health personnel, including physicians, nurses, and supervisors from sub-Saharan African countries that are acutely impacted by HIV/AIDS, including a description of the causes, effects, and the impact on the stability of health infrastructures, as well as a summary of incentives and programs that the United States could provide, in concert with other private and public sector partners and international organizations, to stabilize health institutions by encouraging critical personnel to remain in their home countries.

(V) A plan to strengthen and implement health care workforce strategies to enable countries to increase the supply and retention of all cadres of trained professional and paraprofessional health care workers by numbers that move toward global health program needs and toward targets established by the World Health Organization, while enabling health systems to expand coverage consistent with national and international targets and goals.

[(U)] *(W)* A description of the specific strategies developed to promote sustainability of HIV/AIDS pharmaceuticals (including antiretrovirals) and the effects of drug resistance on HIV/AIDS patients.

[(V)] *(X)* A description of the specific strategies to ensure that the extraordinary benefit of HIV/AIDS pharmaceuticals (especially antiretrovirals) are not diminished through the illegal counterfeiting of pharmaceuticals and black market sales of such pharmaceuticals.

[(W) An analysis of the prevalence of Human Papilloma Virus (HPV) in sub-Saharan Africa and the impact that condom usage has upon the spread of HPV in sub-Saharan Africa.]

(Y) A description of the specific strategies, developed in coordination with existing health programs, to prevent mother-to-child transmission of HIV, including the extent to which HIV-positive women and men in treatment, care, and support programs and HIV-negative women and men are counseled about methods of preventing HIV transmission and the extent to which HIV prevention methods

are provided on-site or by referral in treatment, care, and support programs.

(Z) A description of the specific strategies developed to maximize the capacity of health care providers, including faith-based and other nongovernmental organizations, and family planning providers supported by the United States Government to ensure access to necessary and comprehensive information about reducing sexual transmission of HIV among women, men, and young people, including strategies to ensure HIV/AIDS prevention training for such providers.

(AA) A strategy to work with international and host country partners toward universal access to HIV/AIDS prevention, treatment, and care programs.

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

SEC. 201. SENSE OF CONGRESS ON PUBLIC-PRIVATE PARTNERSHIPS.

(a) FINDINGS.—Congress makes the following findings:

(1) * * *

(2) Public-private sector partnerships multiply local and international capacities to strengthen the delivery of health services in developing countries and to accelerate research for vaccines and other pharmaceutical products that are essential to combat [infectious diseases] *easily preventable and treatable infectious diseases* decimating the populations of these countries.

* * * * * * *

(4) Sustaining existing public-private partnerships and building new ones are critical to the success of the international community's efforts to combat HIV/AIDS and other [infectious diseases] *easily preventable and treatable infectious diseases* around the globe.

* * * * * * *

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

(a) FINDINGS.—The Congress finds as follows:

(1) The Global Fund to Fight AIDS, Tuberculosis and Malaria is the multilateral component of this Act, extending United States efforts to a total of 136 countries around the world.

(2) Created in 2002, the Global Fund has played a leading role in the fight against HIV/AIDS, tuberculosis, and malaria around the world and has grown into an organization that currently provides nearly a quarter of all international financing to combat HIV/AIDS and two-thirds of all international financing to combat tuberculosis and malaria.

(3) By 2010, it is estimated that the demand for funding by the Global Fund will grow in size to between $6 and $8 billion

annually, requiring significant contributions from donors around the world, including at least $2 billion annually from the United States.

(4) The Global Fund is an innovative financing mechanism to combat HIV/AIDS, tuberculosis, and malaria, and has made progress in many areas.

(5) The United States Government is the largest supporter of the Global Fund, both in terms of resources and technical support.

(6) The United States made the initial contribution to the Global Fund and is fully committed to its success.

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

[(2)**]** *(8)* Section 2, Article 5 of the bylaws of the Global Fund provides for the International Bank for Reconstruction and Development to serve as the initial collection trustee for the Global Fund.

[(3)**]** *(9)* The trustee agreement signed between the Global Fund and the International Bank for Reconstruction and Development narrows the range of duties to include receiving and investing funds from donors, disbursing the funds upon the instruction of the Global Fund, reporting on trust fund resources to donors and the Global Fund, and providing an annual external audit report to the Global Fund.

* * * * * * *

(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 **[**$1,000,000,000 for the period of fiscal year 2004 beginning on January 1, 2004,**]** *$2,000,000,000 for each of the fiscal years 2009 and 2010,* and such sums as may be necessary for **[**the fiscal years 2005–2008**]** *each of the fiscal years 2011 through 2013*, for contributions to the Global Fund.

* * * * * * *

(4) LIMITATION.—

(A)(i) At any time during **[**fiscal years 2004 through 2008**]** *fiscal years 2009 through 2013*, 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 2004 through 2008**]** *fiscal years 2009 through 2013*, the President determines that the Global Fund has provided assist-

ance 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.

* * * * * * *

(vi) [for the purposes] *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 2004 through 2008] *fiscal years 2009 through 2013* that are not contributed to fulfill a commitment made for a fiscal year prior to [fiscal year 2004] *fiscal year 2009*.

(B)(i) * * *

* * * * * * *

(iv) Notwithstanding clause (i), after July 31 of each of the [fiscal years 2004 through 2008] *fiscal years 2009 through 2013*, any amount made available under this subsection 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*), unless such amount is made available for more than one fiscal year, in which case such amount is authorized to be made available for such purposes after December 31 of the fiscal year following the fiscal year in which such funds first became available.*.

(C)(i) * * *

(ii) The President shall notify the [Committee on International Relations] *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) * * *

* * * * * * *

SEC. 204. PLAN TO COMBAT HIV/AIDS, TUBERCULOSIS, AND MALARIA BY STRENGTHENING HEALTH POLICIES AND HEALTH SYSTEMS OF HOST COUNTRIES.

(a) FINDINGS.—Congress makes the following findings:

(1) One of the most significant barriers to achieving universal access to HIV/AIDS treatment and prevention in developing countries is the lack of health infrastructure, particularly in sub-Saharan Africa.

(2) In addition to HIV/AIDS programs, other treatable and preventable infectious diseases could be treated concurrently and easily if health care delivery systems in developing countries were significantly improved.

(3) More public investment in basic primary health care should be a priority in public spending in developing countries.

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

(1) to invest appropriate resources authorized under this Act and the amendments made by this Act to carry out activities to strengthen HIV/AIDS health policies and health systems and provide workforce training and capacity-building consistent with the goals and objectives of this Act and the amendments made by this Act; and

(2) to support the development of a sound policy environment in host countries to increase the ability of such countries to maximize utilization of health care resources from donor countries, deliver services to the people of such host countries in an effective and efficient manner, and reduce barriers that prevent recipients of services from achieving maximum benefit from such services.

(c) PLAN REQUIRED.—The Coordinator of United States Government Activities to Combat HIV/AIDS Globally, in collaboration with the Administrator of the United States Agency for International Development, shall develop and implement a plan to combat HIV/AIDS by strengthening health policies and health systems of host countries as part of the United States Agency for International Development's "Health Systems 2020" project.

(d) ASSISTANCE TO IMPROVE PUBLIC FINANCE MANAGEMENT SYSTEMS.—

(1) IN GENERAL.—The Secretary of the Treasury, acting through the head of the Office of Technical Assistance, is authorized to provide assistance for advisors and host country finance, health, and other relevant ministries to improve the effectiveness of public finance management systems in host countries to enable such countries to receive funding to carry out programs to combat HIV/AIDS, tuberculosis, and malaria and to manage such programs.

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

TITLE III—BILATERAL EFFORTS

Subtitle A—General Assistance and Programs

SEC. 301. ASSISTANCE TO COMBAT HIV/AIDS.

(a) * * *

(b) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—In addition to funds available under section 104(c) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b(c)) for such purpose or under any other provision of that Act, there are authorized to be appropriated to the President, from amounts authorized to be appropriated under section 401, such sums as may be necessary for each of the **[**fiscal years 2004 through 2008**]** *fiscal years 2009 through 2013* to carry out

section 104A of the Foreign Assistance Act of 1961, as added by subsection (a).

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(3) ALLOCATION OF FUNDS.—Of the amount authorized to be appropriated by paragraph (1) for the [fiscal years 2004 through 2008] *fiscal years 2009 through 2013*, such sums as may be necessary are authorized to be appropriated to carry out section 104A(d)(4) of the Foreign Assistance Act of 1961 (as added by subsection (a)), relating to the procurement and distribution of HIV/AIDS pharmaceuticals.

[(c) RELATIONSHIP TO ASSISTANCE PROGRAMS TO ENHANCE NUTRITION.—In recognition of the fact that malnutrition may hasten the progression of HIV to AIDS and may exacerbate the decline among AIDS patients leading to a shorter life span, the Administrator of the United States Agency for International Development shall, as appropriate—

[(1) integrate nutrition programs with HIV/AIDS activities, generally;

[(2) provide, as a component of an anti-retroviral therapy program, support for food and nutrition to individuals infected with and affected by HIV/AIDS; and

[(3) provide support for food and nutrition for children affected by HIV/AIDS and to communities and households caring for children affected by HIV/AIDS.

[(d) ELIGIBILITY FOR ASSISTANCE.—An organization that is otherwise eligible to receive assistance under section 104A of the Foreign Assistance Act of 1961 (as added by subsection (a)) or under any other provision of this Act (or any amendment made by this Act) to prevent, treat, or monitor HIV/AIDS shall not be required, as a condition of receiving the assistance, to endorse or utilize a multisectoral approach to combatting HIV/AIDS, or to endorse, utilize, or participate in a prevention method or treatment program to which the organization has a religious or moral objection.]

(c) FOOD SECURITY AND NUTRITION SUPPORT.—

(1) FINDINGS.—Congress finds the following:

(A) The United States provides more than 60 percent of all food assistance worldwide.

(B) According to the United Nations World Food Program and other United Nations agencies, food insecurity of individuals with HIV/AIDS is a major problem in countries with large populations of such individuals, particularly in sub-Saharan African countries.

(C) Individuals infected with HIV have higher nutritional requirements than individuals who are not infected with HIV, particularly with respect to the need for protein. Also, there is evidence to suggest that the full benefit of therapy to treat HIV/AIDS may not be achieved in individuals who are malnourished, particularly in pregnant and lactating women.

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

(A) malnutrition, especially for individuals with HIV/AIDS, is a clinical health issue with wider nutrition, health, and social implications for such individuals, their families, and their communities that must be addressed by

United States HIV/AIDS prevention, treatment, and care programs;

(B) food security and nutrition directly impact an individual's vulnerability to HIV infection, the progression of HIV to AIDS, an individual's ability to begin an antiretroviral medication treatment regimen, the efficacy of an antiretroviral medication treatment regimen once an individual begins such a regimen, and the ability of communities to effectively cope with the HIV/AIDS epidemic and its impacts;

(C) international guidelines established by the World Health Organization (WHO) should serve as the reference standard for HIV/AIDS food and nutrition activities supported by this Act and the amendments made by this Act;

(D) the Coordinator of United States Government Activities to Combat HIV/AIDS Globally and the Administrator of the United States Agency for International Development should make it a priority to work together and with other United States Government agencies, donors, and multilateral institutions to increase the integration of food and nutrition support and livelihood activities into HIV/AIDS prevention, treatment, and care activities funded by the United States and other governments and organizations;

(E) for purposes of determining which individuals infected with HIV should be provided with nutrition and food support—

(i) children with moderate or severe malnutrition, according to WHO standards, shall be given priority for such nutrition and food support; and

(ii) adults with a body mass index (BMI) of 18.5 or less, or at the prevailing WHO-approved measurement for BMI, should be considered "malnourished" and should be given priority for such nutrition and food support;

(F) programs funded by the United States should include therapeutic and supplementary feeding, food, and nutrition support and should include strong links to development programs that provide support for livelihoods; and

(G) the inability of individuals with HIV/AIDS to access food for themselves or their families should not be allowed to impair or erode the therapeutic status of such individuals with respect to HIV/AIDS or related comorbidities.

(3) STATEMENT OF POLICY.—It is the policy of the United States to—

(A) address the food and nutrition needs of individuals with HIV/AIDS and affected individuals, including orphans and vulnerable children;

(B) fully integrate food and nutrition support into HIV/AIDS prevention, treatment, and care programs carried out under this Act and the amendments made by this Act;

(C) ensure, to the extent practicable, that—

(i) HIV/AIDS prevention, treatment, and care providers and health care workers are adequately trained

so that such providers and workers can provide accurate and informed information regarding food and nutrition support to individuals enrolled in treatment and care programs and individuals affected by HIV/AIDS; and

(ii) individuals with HIV/AIDS who, with their households, are identified as food insecure are provided with adequate food and nutrition support; and

(D) effectively link food and nutrition support provided under this Act and the amendments made by this Act to individuals with HIV/AIDS, their households, and their communities, to other food security and livelihood programs funded by the United States and other donors and multilateral agencies.

(4) INTEGRATION OF FOOD SECURITY AND NUTRITION ACTIVITIES INTO HIV/AIDS PREVENTION, TREATMENT, AND CARE ACTIVITIES.—

(A) REQUIREMENTS RELATING TO GLOBAL AIDS COORDINATOR.—Consistent with the statement of policy described in paragraph (3), the Coordinator of United States Government Activities to Combat HIV/AIDS Globally shall—

(i) ensure, to the extent practicable, that—

(I) an assessment, using validated criteria, of the food security and nutritional status of each individual enrolled in antiretroviral medication treatment programs supported with funds authorized under this Act or any amendment made by this Act is carried out; and

(II) appropriate nutritional counseling is provided to each individual described in subclause (I);

(ii) coordinate with the Administrator of the United States Agency for International Development, the Secretary of Agriculture, and the heads of other relevant executive branch agencies to—

(I) ensure, to the extent practicable, that, in communities in which a significant proportion of individuals with HIV/AIDS are in need of food and nutrition support, a status and needs assessment for such support employing validated criteria is conducted and a plan to provide such support is developed and implemented;

(II) improve and enhance coordination between food security and livelihood programs for individuals infected with HIV in host countries and food security and livelihood programs that may already exist in such countries;

(III) establish effective linkages between the health and agricultural development and livelihoods sectors in order to enhance food security; and

(IV) ensure, by providing increased resources if necessary, effective coordination between activities authorized under this Act and the amendments made by this Act and activities carried out under other provisions of the Foreign Assistance Act of

1961 when establishing new HIV/AIDS treatment sites;

(iii) develop effective, validated indicators that measure outcomes of nutrition and food security interventions carried out under this section and use such indicators to monitor and evaluate the effectiveness of such interventions; and

(iv) evaluate the role of and, to the extent appropriate, support and expand partnerships and linkages between United States postsecondary educational institutions with postsecondary educational institutions in host countries in order to provide training and build indigenous human and institutional capacity and expertise to respond to HIV/AIDS, and to improve capacity to address nutrition, food security, and livelihood needs of HIV/AIDS-affected and impoverished communities.

(B) REQUIREMENTS RELATING TO USAID ADMINISTRATOR.—Consistent with the statement of policy described in paragraph (3), the Administrator of the United States Agency for International Development, in coordination with the Coordinator of United States Government Activities to Combat HIV/AIDS Globally and the Secretary of Agriculture, shall provide, to the extent practicable, as an essential component of antiretroviral medication treatment programs supported with funds authorized under this Act and the amendments made by this Act, food and nutrition support to each individual with HIV/AIDS who is determined to need such support by the assessing health professional, based on a body mass index (BMI) of 18.5 or less, or at the prevailing WHO-approved measurement for BMI, and the individual's household, for a period of not less than 180 days, either directly or through referral to an assistance program or organization with demonstrable ability to provide such support.

(C) REPORT.—Not later than October 31, 2010, and annually thereafter, the Coordinator of United States Government Activities to Combat HIV/AIDS Globally, in consultation with the Administrator of the United States Agency for International Development, shall submit to the appropriate congressional committees a report on the implementation of this subsection for the prior fiscal year. The report shall include a description of—

(i) the effectiveness of interventions carried out to improve the nutritional status of individuals with HIV/AIDS;

(ii) the amount of funds provided for food and nutrition support for individuals with HIV/AIDS and affected individuals in the prior fiscal year and the projected amount of funds to be provided for such purpose for next fiscal year; and

(iii) a strategy for improving the linkage between assistance provided with funds authorized under this subsection and food security and livelihood programs

under other provisions of law as well as activities funded by other donors and multilateral organizations.

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

(d) ELIGIBILITY FOR ASSISTANCE.—An organization, including a faith-based organization, that is otherwise eligible to receive assistance under section 104A of the Foreign Assistance Act of 1961 (as added by subsection (a)) or under any other provision of this Act (or any amendment made by this Act or the Tom Lantos and Henry J. Hyde Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008) to prevent, treat, or monitor HIV/AIDS—

(1) shall not be required, as a condition of receiving the assistance, to endorse or utilize a multisectoral approach to combating HIV/AIDS, or to endorse, utilize, make a referral to, become integrated with or otherwise participate in any program or activity to which the organization has a religious or moral objection; and

(2) shall not be discriminated against in the solicitation or issuance of grants, contracts, or cooperative agreements under such provisions of law for refusing to do so.

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[(g) SENSE OF CONGRESS RELATING TO FOOD ASSISTANCE FOR INDIVIDUALS LIVING WITH HIV/AIDS.—

[(1) FINDINGS.—Congress finds the following:

[(A) The United States provides more than 60 percent of all food assistance worldwide.

[(B) According to the United Nations World Food Program and other United Nations agencies, food insecurity of individuals infected or living with HIV/AIDS is a major problem in countries with large populations of such individuals, particularly in African countries.

[(C) Although the United States is willing to provide food assistance to these countries in need, a few of the countries object to part or all of the assistance because of fears of benign genetic modifications to the foods.

[(D) Healthy and nutritious foods for individuals infected or living with HIV/AIDS are an important complement to HIV/AIDS medicines for such individuals.

[(E) Individuals infected with HIV have higher nutritional requirements than individuals who are not infected with HIV, particularly with respect to the need for protein. Also, there is evidence to suggest that the full benefit of therapy to treat HIV/AIDS may not be achieved in individuals who are malnourished, particularly in pregnant and lactating women.

[(2) SENSE OF CONGRESS.—It is therefore the sense of Congress that United States food assistance should be accepted by countries with large populations of individuals infected or living with HIV/AIDS, particularly African countries, in order to help feed such individuals.]

SEC. 302. ASSISTANCE TO COMBAT TUBERCULOSIS.

(a) * * *

(b) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—In addition to funds available under section 104(c) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b(c)) for such purpose or under any other provision of that Act, there are authorized to be appropriated to the President, from amounts authorized to be appropriated under section 401, ⟦such sums as may be necessary for each of the fiscal years 2004 through 2008⟧ *$4,000,000,000 for fiscal years 2009 through 2013* to carry out section 104B of the Foreign Assistance Act of 1961, as added by subsection (a).

* * * * * * *

(3) TRANSFER OF PRIOR YEAR FUNDS.—Unobligated balances of funds made available for fiscal year 2001, 2002, or 2003 under section 104(c)(7) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b(c)(7) (as in effect immediately before the date of enactment of this Act) shall be transferred to, merged with, and made available for the same purposes as funds made available for ⟦fiscal years 2004 through 2008⟧ *fiscal years 2009 through 2013* under paragraph (1).

SEC. 303. ASSISTANCE TO COMBAT MALARIA.

(a) * * *

(b) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—In addition to funds available under section 104(c) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b(c)) for such purpose or under any other provision of that Act, there are authorized to be appropriated to the President, from amounts authorized to be appropriated under section 401, ⟦such sums as may be necessary for fiscal years 2004 through 2008⟧ *$5,000,000,000 for fiscal years 2009 through 2013* to carry out section 104C of the Foreign Assistance Act of 1961, as added by subsection (a), including for the development of anti-malarial pharmaceuticals by the Medicines for Malaria Venture.

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(3) TRANSFER OF PRIOR YEAR FUNDS.—Unobligated balances of funds made available for fiscal year 2001, 2002, or 2003 under section 104(c) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b(c) (as in effect immediately before the date of enactment of this Act) and made available for the control of malaria shall be transferred to, merged with, and made available for the same purposes as funds made available for ⟦fiscal years 2004 through 2008⟧ *fiscal years 2009 through 2013* under paragraph (1).

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(d) DEVELOPMENT OF A COMPREHENSIVE FIVE-YEAR STRATEGY.—The President shall establish a comprehensive, five-year strategy to combat global malaria that strengthens the capacity of the United States to be an effective leader of international efforts to reduce the global malaria disease burden. Such strategy shall maintain sufficient flexibility and remain responsive to the ever-changing nature of the global malaria challenge and shall—

(1) include specific objectives, multisectoral approaches and strategies to treat and provide care to individuals infected with malaria, to prevent the further spread of malaria;

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

(3) clearly explain how proposed activities to combat malaria will be coordinated with other United States global health activities, including the five-year global HIV/AIDS and tuberculosis strategies developed pursuant to section 101 of this Act;

(4) expand public-private partnerships and leveraging of resources to combat malaria, including private sector resources;

(5) coordinate among relevant executive branch agencies providing assistance to combat malaria in order to maximize human and financial resources and reduce unnecessary duplication among such agencies and other donors;

(6) maximize United States capabilities in the areas of technical assistance, training, and research, including vaccine research, to combat malaria; and

(7) establish priorities and selection criteria for the distribution of resources to combat malaria based on factors such as the size and demographics of the population with malaria, the needs of that population, the host countries' existing infrastructure, and the host countries' ability to complement United States efforts with strategies outlined in national malaria control plans.

(e) MALARIA RESPONSE COORDINATOR.—

(1) IN GENERAL.—There should be established within the United States Agency for International Development a Coordinator of United States Government Activities to Combat Malaria Globally, who should be appointed by the President.

(2) AUTHORITIES.—The Coordinator, acting through such nongovernmental organizations and relevant executive branch agencies as may be necessary and appropriate to effect the purposes of section 104C of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b–4), is authorized—

(A) to operate internationally to carry out prevention, treatment, care, support, capacity development of health systems, and other activities for combating malaria;

(B) to transfer and allocate funds to relevant executive branch agencies;

(C) to provide grants to, and enter into contracts with, nongovernmental organizations to carry out the purposes of such section 104C;

(D) to enter into contracts and transfer and allocate funds to international organizations to carry out the purposes of such section 104C; and

(E) to coordinate with a public-private partnership to discover and develop effective new antimalarial drugs, including drugs for multi-drug resistant malaria and malaria in pregnant women.

(3) DUTIES.—

(A) IN GENERAL.—The Coordinator shall have primary responsibility for the oversight and coordination of all resources and global United States government activities to combat malaria.

(B) SPECIFIC DUTIES.—The Coordinator shall—

(i) facilitate program and policy coordination among relevant executive branch agencies and non-governmental organizations, including auditing, monitoring and evaluation of such programs;

(ii) ensure that each relevant executive branch agency has sufficient resources to execute programs in areas in which the agency has the greatest expertise, technical capability, and potential for success;

(iii) coordinate with the Office of the Coordinator of United States Government Activities to Combat HIV/AIDS Globally and equivalent managers of other relevant executive branch agencies that are implementing global health programs to develop and implement program plans, country-level interactions, and recipient administrative requirements in countries in which more than one program operates;

(iv) coordinate relevant executive branch agency activities in the field, including coordination of planning, implementation, and evaluation of malaria programs with HIV/AIDS programs in countries in which both programs are being carried out;

(v) pursue coordinate program implementation with host governments, other donors, and the private sector; and

(vi) establish due diligence criteria for all recipients of funds appropriated pursuant to the authorizations of appropriations under section 401 for malaria assistance.

(f) ASSISTANCE TO WHO.—In carrying out this section, the President is authorized to make a United States contribution to the Roll Back Malaria Partnership and the World Health Organization (WHO) to improve the capacity of countries with high rates of malaria and other affected countries to implement comprehensive malaria control programs.

(g) ANNUAL REPORT.—

(1) IN GENERAL.—Not later than 270 days after the date of the enactment of the Tom Lantos and Henry J. Hyde Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008, and annually thereafter, the President shall transmit to the appropriate congressional committees a report on United States assistance for the prevention, treatment, control, and elimination of malaria.

(2) MATTERS TO BE INCLUDED.—The report required under paragraph (1) shall include a description of—

(A) the countries and activities to which malaria assistance has been allocated;

(B) the number of people reached through malaria assistance programs;

(C) the percentage and number of children and mothers reached through malaria assistance programs;

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

(E) collaboration with the World Health Organization (WHO), the Global Fund to Fight AIDS, Tuberculosis and

Malaria, other donor governments, and relevant executive branch agencies to combat malaria;

(F) quantified impact of United States assistance on childhood morbidity and mortality;

(G) the number of children who received immunizations through malaria assistance programs; and

(H) the number of women receiving ante-natal care through malaria assistance programs.

[SEC. 304. PILOT PROGRAM FOR THE PLACEMENT OF HEALTH CARE PROFESSIONALS IN OVERSEAS AREAS SEVERELY AFFECTED BY HIV/AIDS, TUBERCULOSIS, AND MALARIA.

[(a) IN GENERAL.—The President should establish a program to demonstrate the feasibility of facilitating the service of United States health care professionals in those areas of sub-Saharan Africa and other parts of the world severely affected by HIV/AIDS, tuberculosis, and malaria.

[(b) REQUIREMENTS.—Participants in the program shall—

[(1) provide basic health care services for those infected and affected by HIV/AIDS, tuberculosis, and malaria in the area in which they are serving;

[(2) provide on-the-job training to medical and other personnel in the area in which they are serving to strengthen the basic health care system of the affected countries;

[(3) provide health care educational training for residents of the area in which they are serving;

[(4) serve for a period of up to 3 years; and

[(5) meet the eligibility requirements in subsection (d).

[(c) ELIGIBILITY REQUIREMENTS.—To be eligible to participate in the program, a candidate shall—

[(1) be a national of the United States who is a trained health care professional and who meets the educational and licensure requirements necessary to be such a professional such as a physician, nurse, physician assistant, nurse practitioner, pharmacist, other type of health care professional, or other individual determined to be appropriate by the President; or

[(2) be a retired commissioned officer of the Public Health Service Corps.

[(d) RECRUITMENT.—The President shall ensure that information on the program is widely distributed, including the distribution of information to schools for health professionals, hospitals, clinics, and nongovernmental organizations working in the areas of international health and aid.

[(e) PLACEMENT OF PARTICIPANTS.—

[(1) IN GENERAL.—To the maximum extent practicable, participants in the program shall serve in the poorest areas of the affected countries, where health care needs are likely to be the greatest. The decision on the placement of a participant should be made in consultation with relevant officials of the affected country at both the national and local level as well as with local community leaders and organizations.

[(2) COORDINATION.—Placement of participants in the program shall be coordinated with the United States Agency for International Development in countries in which that Agency is conducting HIV/AIDS, tuberculosis, or malaria programs. Overall coordination of placement of participants in the pro-

gram shall be made by the Coordinator of United States Government Activities to Combat HIV/AIDS Globally (as described in section 1(f) of the State Department Basic Authorities Act of 1956 (as added by section 102(a) of this Act)).

[(f) INCENTIVES.—The President may offer such incentives as the President determines to be necessary to encourage individuals to participate in the program, such as partial payment of principal, interest, and related expenses on government and commercial loans for educational expenses relating to professional health training and, where possible, deferment of repayments on such loans, the provision of retirement benefits that would otherwise be jeopardized by participation in the program, and other incentives.

[(g) REPORT.—Not later than 18 months after the date of enactment of this Act, the President shall submit to the appropriate congressional committees a report on steps taken to establish the program, including—

[(1) the process of recruitment, including the venues for recruitment, the number of candidates recruited, the incentives offered, if any, and the cost of those incentives;

[(2) the process, including the criteria used, for the selection of participants;

[(3) the number of participants placed, the countries in which they were placed, and why those countries were selected; and

[(4) the potential for expansion of the program.

[(h) AUTHORIZATION OF APPROPRIATIONS.—

[(1) IN GENERAL.—In addition to amounts otherwise available for such purpose, there are authorized to be appropriated to the President, from amounts authorized to be appropriated under section 401, such sums as may be necessary for each of the fiscal years 2004 through 2008 to carry out the program.

[(2) AVAILABILITY OF FUNDS.—Amounts appropriated pursuant to the authorization of appropriations under paragraph (1) are authorized to remain available until expended.]

SEC. 304. HEALTH CARE PARTNERSHIPS TO COMBAT HIV/AIDS.

(a) SENSE OF CONGRESS.—It is the sense of Congress that the use of health care partnerships that link United States and host country health care institutions create opportunities for sharing of knowledge and expertise among individuals with significant experience in health-related fields and build local capacity to combat HIV/AIDS and increase scientific understanding of the progression of HIV/AIDS and the HIV/AIDS epidemic.

(b) AUTHORITY TO FACILITATE HEALTH CARE PARTNERSHIPS TO COMBAT HIV/AIDS.—The President, acting through the Coordinator of United States Government Activities to Combat HIV/AIDS Globally, shall facilitate the development of health care partnerships described in subsection (a) by–

(1) supporting short- and long-term institutional partnerships, including partnerships that build capacity in ministries of health, central- and district-level health agencies, medical facilities, health education and training institutions, academic centers, and faith- and community-based organizations involved in prevention, treatment, and care of HIV/AIDS;

(2) supporting the development of consultation services using appropriate technologies, including online courses, DVDs,

telecommunications services, and other technologies to eliminate the barriers that prevent host country professionals from accessing high quality health care services information, particularly providers located in rural areas;

(3) supporting the placements of highly qualified individuals to strengthen human and organizational capacity through the use of health care professionals to facilitate skills transfer, building local capacity, and to expand rapidly the pool of providers, managers, and other health care staff delivering HIV/AID services in host countries; and

(4) meeting individual country needs and, where possible, insisting on the implementation of a national strategic plan, by providing training and mentoring to strengthen human and organizational capacity among local health care service organizations.

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

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Subtitle B—Assistance for Children and Families

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SEC. 312. POLICY AND REQUIREMENTS.

(a) POLICY.—[The United States Government's]

(1) IN GENERAL.—The United States response to the global HIV/AIDS pandemic should place high priority on the prevention of mother-to-child transmission, the care and treatment of family members and caregivers, and the care of children orphaned by AIDS. To the maximum extent possible, the United States Government should seek to leverage its funds by seeking matching contributions from the private sector, other national governments, and international organizations.

(2) COLLABORATION.—The United States should work in collaboration with governments, donors, the private sector, nongovernmental organizations, and other key stakeholders to carry out the policy described in paragraph (1).

[(b) REQUIREMENTS.—The 5-year United States Government strategy required by section 101 of this Act shall—

[(1) provide for meeting or exceeding the goal to reduce the rate of mother-to-child transmission of HIV by 20 percent by 2005 and by 50 percent by 2010;

[(2) include programs to make available testing and treatment to HIV-positive women and their family members, including drug treatment and therapies to prevent mother-to-child transmission; and

[(3) expand programs designed to care for children orphaned by AIDS.]

(b) REQUIREMENTS.—The 5-year United States strategy required by section 101 of this Act shall—

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

(2) establish a target requiring that by 2013 up to 15 percent of individuals receiving care and up to 15 percent of individuals receiving treatment under this Act and the amendments made by this Act are children;

(3) integrate care and treatment with prevention of mother-to-child transmission of HIV programs in order to improve outcomes for HIV-affected women and families as soon as is feasible, consistent with the national government policies of countries in which programs under this Act are administered, and including support for strategies to ensure successful follow-up and continuity of care;

(4) expand programs designed to care for children orphaned by HIV/AIDS;

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

(6) ensure that women receiving voluntary contraceptive counseling, services, or commodities in programs supported by the United States Government have access to the full range of HIV/AIDS services; and

(7) ensure that women in prevention of mother-to-child transmission of HIV programs are provided with appropriate maternal and child services, either directly or by referral.

SEC. 313. ANNUAL REPORTS ON PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF THE HIV INFECTION.

(a) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, and annually thereafter for a period of [5 years] *10 years*, the President shall submit to appropriate congressional committees a report on the activities of relevant executive branch agencies during the reporting period to assist in the prevention of mother-to-child transmission of the HIV infection.

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SEC. 316. STRATEGY TO PREVENT HIV INFECTIONS AMONG WOMEN AND YOUTH.

(a) STATEMENT OF POLICY.—In order to meet the United States Government's goal of preventing 12,000,000 new HIV infections worldwide, it shall be the policy of the United States to pursue a global HIV/AIDS prevention strategy that emphasizes the immediate and ongoing needs of women and youth and addresses the factors that lead to gender disparities in the rate of HIV infection.

(b) STRATEGY.—

(1) IN GENERAL.—The President shall formulate a comprehensive, integrated, and culturally-appropriate global HIV/AIDS prevention strategy that, to the extent epidemiologically appropriate, addresses the vulnerabilities of women and youth to HIV infection and seeks to reduce the factors that lead to gender disparities in the rate of HIV infection.

(2) ELEMENTS.—The strategy required under paragraph (1) shall include specific goals and targets under the 5-year strategy outlined in section 101 and shall include comprehensive HIV/AIDS prevention education at the individual and national level including the ABC ("Abstain, Be faithful, use Condoms") model as a means to reduce HIV infections and shall include the following:

(A) Specific goals under the five-year strategy outlined in section 101.

(B) Empowering women and youth to avoid cross-generational sex and to decide when and whom to marry in order to reduce the incidence of early or child marriage.

(C) Dramatically increasing access to currently available female-controlled prevention methods and including investments in training to increase the effective and consistent use of both male and female condoms.

(D) Accelerating the de-stigmatization of HIV/AIDS among women and youth as a major risk factor for the transmission of HIV.

(E) Addressing and preventing post-traumatic and psycho-social consequences and providing post-exposure prophylaxis to victims of gender-based violence and rape against women and youth through appropriate medical, social, educational, and legal assistance and through prosecutions and legal penalties to address such violence.

(F) Promoting changes in male attitudes and behavior that respect the human rights of women and youth and that support and foster gender equality.

(G) Supporting the development of microenterprise initiatives, job training programs, and other such efforts to assist women in developing and retaining independent economic means.

(H) Supporting universal basic education and expanded educational opportunities for women and youth.

(I) Protecting the property and inheritance rights of women.

(J) Coordinating inclusion of HIV/AIDS prevention information and education services and programs for individuals with HIV/AIDS with existing health care services targeted to women and youth, such as ensuring access to HIV/AIDS education and testing in family planning programs supported by the United States Government and programs to reduce mother-to-child transmission of HIV, and expanding the reach of such HIV/AIDS health services.

(K) Promoting gender equality by supporting the development of nongovernmental organizations, including faith-based and community-based organizations, that support the needs of women and utilizing such organizations that are already empowering women and youth at the community level.

(L) Encouraging the creation and effective enforcement of legal frameworks that guarantee women equal rights and equal protection under the law.

(M) Encouraging the participation and involvement of women in drafting, coordinating, and implementing the national HIV/AIDS strategic plans of their countries.

(N) Responding to other economic and social factors that increase the vulnerability of women and youth to HIV infection.

(3) TRANSMISSION TO CONGRESS AND PUBLIC AVAILABILITY.—Not later than 180 days after the date of the enactment of the Tom Lantos and Henry J. Hyde Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008, the President shall transmit to the appropriate congressional committees and make available to the public the strategy required under paragraph (1).

(c) COORDINATION.—In formulating and implementing the strategy required under subsection (b), the President shall ensure that the United States coordinates its overall HIV/AIDS policy and programs with the national governments of the countries for which the United States provides assistance to combat HIV/AIDS and, to the extent practicable, with international organizations, other donor countries, and indigenous organizations, including faith-based and community-based organizations specifically for the purposes of ensuring gender equality and promoting respect of the human rights of women that impact their susceptibility to HIV/AIDS, improving women's health, and expanding education for women and youth, and organizations, including faith-based and other nonprofit organizations, providing services to and advocating on behalf of individuals with HIV/AIDS and individuals affected by HIV/AIDS.

(d) GUIDANCE.—

(1) IN GENERAL.—The President shall provide clear guidance to field missions of the United States Government in countries for which the United States provides assistance to combat HIV/AIDS, based on the strategy required under subsection (b).

(2) TRANSMISSION TO CONGRESS AND PUBLIC AVAILABILITY.—The President shall transmit to the appropriate congressional committees and make available to the public a description of the guidance required under paragraph (1).

(e) REPORT.—

(1) IN GENERAL.—Not later than 1 year after the date of the enactment of the Tom Lantos and Henry J. Hyde 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 transmit to the appropriate congressional committees and make available to the public a report on the implementation of this section for the prior fiscal year.

(2) MATTERS TO BE INCLUDED.—The report required under paragraph (1) shall include the following:

(A) A description of the prevention programs designed to address the vulnerabilities of women and youth to HIV/AIDS.

(B) A list of nongovernmental organizations in each country that receive assistance from the United States to carry out HIV prevention activities, including the amount and the source of funding received.

TITLE IV—AUTHORIZATION OF APPROPRIATIONS

SEC. 401. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—There are authorized to be appropriated to the President to carry out this Act and the amendments made by this Act [$3,000,000,000] *$10,000,000,000* for each of the [fiscal years 2004 through 2008] *fiscal years 2009 through 2013*.

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SEC. 402. SENSE OF CONGRESS.

(a) * * *

(b) EFFECTIVE DISTRIBUTION OF HIV/AIDS FUNDS.—It is the sense of Congress that, of the amounts appropriated pursuant to the authorization of appropriations under section 401 for HIV/AIDS assistance, an effective distribution of such amounts would be—

[(1) 55 percent of such amounts for treatment of individuals with HIV/AIDS;]

[(2)] *(1)* 15 percent of such amounts for palliative care of individuals with HIV/AIDS;

[(3)] *(2)* 20 percent of such amounts for HIV/AIDS prevention consistent with section 104A(d) of the Foreign Assistance Act of 1961 (as added by section 301 of this Act)[, of which such amount at least 33 percent should be expended for abstinence-until-marriage programs]; and

[(4)] *(3)* 10 percent of such amounts for orphans and vulnerable children.

SEC. 403. ALLOCATION OF FUNDS.

[(a) THERAPEUTIC MEDICAL CARE.—For fiscal years 2006 through 2008, not less than 55 percent of the amounts appropriated pursuant to the authorization of appropriations under section 401 for HIV/AIDS assistance for each such fiscal year shall be expended for therapeutic medical care of individuals infected with HIV, of which such amount at least 75 percent should be expended for the purchase and distribution of antiretroviral pharmaceuticals and at least 25 percent should be expended for related care. For fiscal years 2006 through 2008, not less than 33 percent of the amounts appropriated pursuant to the authorization of appropriations under section 401 for HIV/AIDS prevention consistent with section 104A(d) of the Foreign Assistance Act of 1961 (as added by section 301 of this Act) for each such fiscal year shall be expended for abstinence-until-marriage programs.]

(a) HIV/AIDS PREVENTION ACTIVITIES.—

(1) IN GENERAL.—For each of the fiscal years 2009 through 2013, not less than 20 percent of the amounts appropriated pursuant to the authorization of appropriations under section 401 for HIV/AIDS assistance for each such fiscal year shall be expended for HIV/AIDS prevention activities consistent with section 104A(d) of the Foreign Assistance Act of 1961.

(2) BALANCED FUNDING REQUIREMENT.—(A) The Coordinator of United States Government Activities to Combat HIV/AIDS Globally shall provide balanced funding for prevention activities for sexual transmission of HIV/AIDS and shall ensure that behavioral change programs, including 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.

(B) In fulfilling the requirement under subparagraph (A), the Coordinator shall establish a HIV sexual transmission prevention strategy governing the expenditure of funds authorized by the Act used to prevent the sexual transmission of HIV in any host country with a generalized epidemic. In each such host country, if this strategy provides less than 50 percent of such funds for behavioral change programs, including abstinence, delay of sexual debut, monogamy, fidelity, and partner reduction, the Coordinator shall, within 30 days of the issuance of this strategy, report to the appropriate congressional committees on the justification for this decision.

(C) Programs and activities that implement or purchase new prevention technologies or modalities such as medical male circumcision, pre-exposure prophylaxis, 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 this paragraph.

(3) REPORT.—Not later than 1 year after the date of the enactment of the Tom Lantos and Henry J. Hyde 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 transmit to the appropriate congressional committees and make available to the public a report on the implementation of paragraph (2) for the prior fiscal year.

(b) ORPHANS AND VULNERABLE CHILDREN.—For [fiscal years 2006 through 2008] *fiscal years 2009 through 2013*, not less than 10 percent of the amounts appropriated pursuant to the authorization of appropriations under section 401 for HIV/AIDS assistance for each such fiscal year shall be expended for assistance for orphans and vulnerable children affected by 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.

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TITLE VI—SUSTAINABILITY AND STRENGTHENING OF HEALTH CARE SYSTEMS

SEC. 601. FINDINGS.

Congress makes the following findings:

(1) The shortage of health personnel, including doctors, nurses, pharmacists, counselors, laboratory staff, and paraprofessionals, is one of the leading obstacles to fighting HIV/AIDS in sub-Saharan Africa.

(2) The HIV/AIDS pandemic aggravates the shortage of health workers through loss of life and illness among medical staff, unsafe working conditions for medical personnel, and increased workloads for diminished staff, while the shortage of health personnel undermines efforts to prevent and provide care and treatment for individuals with HIV/AIDS.

(3) Failure to address the shortage of health care professionals and paraprofessionals, and the factors forcing such individuals to leave sub-Saharan Africa, will undermine the objectives of United States development policy and will subvert opportunities to achieve internationally-recognized goals for the prevention, treatment, and care of HIV/AIDS and other diseases, the reduction of child and maternal mortality, and for economic growth and development in sub-Saharan Africa.

SEC. 602. NATIONAL HEALTH WORKFORCE STRATEGIES AND OTHER POLICIES.

(a) NATIONAL HEALTH WORKFORCE STRATEGIES.—

(1) STATEMENT OF POLICY.—It shall be the policy of the United States Government to support countries receiving United States assistance to combat HIV/AIDS, tuberculosis, and malaria, and other health programs in developing, strengthening, and implementing 5-year health workforce strategies.

(2) TECHNICAL AND FINANCIAL ASSISTANCE.—The Administrator of the United States Agency for International Development, in coordination with the Coordinator of United States Government Activities to Combat HIV/AIDS Globally, is authorized to provide technical and financial assistance to countries described in paragraph (1) to enable such countries, in conjunction with other funding sources, to develop, strengthen, and implement health workforce strategies.

(3) ACTIVITIES SUPPORTED.—Assistance provided under paragraph (2) shall, to the maximum extent practicable, be used to carry out the following:

(A) Activities to promote an inclusive process that includes nongovernmental organizations and individuals with HIV/AIDS in developing health workforce strategies.

(B) Activities to achieve and sustain a health workforce sufficient in numbers, skill, and capacity to meet United States and host-country international health commitments, including the Millennium Development Goals and universal access to HIV/AIDS prevention, treatment, and care. In particular, such health workforce strategies should include plans for progress toward achieving the minimum ratio of health professionals required to achieve these goals by 2015, estimated by the World Health Organization to require at least 2.3 doctors, nurses, and midwives per 1,000 population, and additional health workers such as pharmacists and lab technicians.

(C) Activities to ensure that health workforce strategies are aimed at creating appropriate distribution of health workers and prioritizing activities required to ensure rural, marginalized, and other underserved populations are able to access skilled and equipped health workers.

(D) Activities to expand the capacity of public and private medical, nursing, pharmaceutical, and other health training institutions.

(b) POSITIVE BROADER HEALTH IMPACT.—It shall be the policy of the United States to ensure to expand the capacity of the health workforce engaged in HIV/AIDS programming in ways that contribute to, and do not detract from, the capacity of countries to meet other health needs, particularly child survival and maternal health.

(c) SAFETY FOR HEALTH WORKERS.—It is the sense of Congress that the United States should ensure that all health workers participating in programs that receive assistance under this Act and the amendments made by this Act have the proper training to create safe and sanitary working conditions in accordance with universal precautions and other forms of infection prevention and control.

(d) HEALTH CARE FOR HEALTH WORKERS.—The Coordinator of United States Government Activities to Combat HIV/AIDS Globally shall ensure that comprehensive and confidential health services shall be provided to all health workers participating in programs that receive assistance under this Act and the amendments made by this Act, including—

(1) testing and counseling for all such employees;

(2) providing HIV/AIDS treatment to HIV-positive employees; and

(3) taking measures to reduce HIV-related stigma in the workplace.

(e) TRAINING AND COMPENSATION FINANCE.—Where the Coordinator determines such financial support is essential to fulfill the purposes of this Act, the Coordinator shall finance training and provide compensation or other benefits for health workers in order to enhance recruitment and retention of such workers.

SEC. 603. EXEMPTION OF INVESTMENTS IN HEALTH FROM LIMITS SOUGHT BY INTERNATIONAL FINANCIAL INSTITUTIONS.

(a) COORDINATION WITHIN THE UNITED STATES GOVERNMENT.—The Coordinator of United States Government Activities to Combat HIV/AIDS Globally shall work with the Secretary of the Treasury to reform International Monetary Fund macroeconomic and fiscal policies that result in limitations on national and donor investments in health.

(b) POSITION OF THE UNITED STATES AT THE IMF.—The Secretary of the Treasury shall instruct the United States Executive Director at the International Monetary Fund to use the voice, vote, and influence of the United States to oppose any loan, project, agreement, memorandum, instrument, plan, or other program of the International Monetary Fund that does not exempt increased government spending on health care from national budget caps or restraints, hiring or wage bill ceilings, or other limits sought by any international financial institution.

SEC. 604. PUBLIC-SECTOR PROCUREMENT, DRUG REGISTRATION, AND SUPPLY CHAIN MANAGEMENT SYSTEMS.

(a) IN GENERAL.—The Coordinator of United States Government Activities to Combat AIDS Globally shall work with the Partnership for Supply Chain Management Systems, host countries, and nongovernmental organizations to develop effective, reliable host country-owned and operated public-sector procurement and supply chain management systems, including regional distribution, with

ongoing technical assistance and sustained support to ensure the function of such systems, as well as the function of existing non-public sector supply chains, including those operated by faith-based and other humanitarian organizations that procure and distribute medical supplies.

(b) AVAILABILITY OF EQUIPMENT AND SUPPLIES.—The public-sector procurement and supply chain management systems developed pursuant to subsection (a) should ensure that adequate laboratory equipment and supplies commonly needed to fight HIV/AIDS, including diagnostic tests for CD4 and viral load counts, x-ray machines, mobile and facility-based rapid HIV test kits and other necessary assays, reagents and basic supplies such as sterile syringes and gloves, are available and distributed in a manner that is accessible to urban and rural populations.

(c) DRUG REGISTRATION.—The Coordinator shall work with host country partners and development partners to support efficient and effective drug approval and registration systems that allow expeditious access to safe and effective drugs, including antiretroviral drugs.

(d) REPORT.—The Coordinator shall submit to the appropriate congressional committees an annual report on the implementation of this section, including progress toward specific benchmarks established by the Partnership for Supply Chain Management Systems, and the projection of when host countries can fully sustain their own procurement and supply chain management and distribution systems at a scale necessary for national primary health needs.

SEC. 605. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—Of the amounts authorized to be appropriated under section 401 for HIV/AIDS assistance, there are authorized to be appropriated to the President such sums as may be necessary for each of the fiscal years 2009 through 2013 to carry out this title.

(b) AVAILABILITY.—Amounts appropriated pursuant to the authorization of appropriations under subsection (a) are authorized to remain available until expended.

STATE DEPARTMENT BASIC AUTHORITIES ACT OF 1956

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TITLE I—BASIC AUTHORITIES GENERALLY

SECTION 1. (a) * * *

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(f) HIV/AIDS RESPONSE COORDINATOR.—

(1) * * *

(2) AUTHORITIES AND DUTIES; DEFINITIONS.—

(A) AUTHORITIES.—The Coordinator, acting through such nongovernmental organizations (including faith-based and community-based organizations*), host country finance, health, and other relevant ministries* and relevant executive branch agencies as may be necessary and appropriate to effect the purposes of this section, is authorized—

(i) * * *

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(iii) to provide grants to, and enter into contracts with, nongovernmental organizations (including faith-based and community-based organizations) *and host country finance, health, and other relevant ministries* to carry out the purposes of section.

(B) DUTIES.—

(i) * * *

(ii) SPECIFIC DUTIES.—The duties of the Coordinator shall specifically include the following:

(I) * * *

* * * * * * *

[(IV) Ensuring coordination of relevant executive branch agency activities in the field.

[(V) Pursuing coordination with other countries and international organizations.**]**

(IV) Establishing an interagency working group on HIV/AIDS that is comprised of, but not limited to, representatives from the United States Agency for International Development, the Department of Health and Human Services (including the Centers for Disease Control and Prevention, the National Institutes of Health, and the Health Resources and Services Administration), the Department of Labor, the Department of Agriculture, the Millennium Challenge Corporation, the Department of Defense, and the Office of the Coordinator of United States Government Activities to Combat Malaria Globally, for the purposes of coordination of activities relating to HIV/AIDS. The interagency working group shall—

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

(bb) participate in the process of identifying countries in need of increased assistance based on the epidemiology of HIV/AIDS in those countries; and

(cc) review policies that may be obstacles to reaching objectives set forth for HIV/AIDS prevention, treatment, and care.

(V) Coordinating overall United States HIV/AIDS policy and programs with efforts led by host countries and with the assistance provided by other relevant bilateral and multilateral aid agencies and other donor institutions to achieve complementarity with other programs aimed at improving child and maternal health, and food security, promoting education, and strengthening health care systems.

* * * * * * *

(VII) Holding annual consultations with host country nongovernmental organizations providing services to improve health, and advocating on behalf of the individuals with HIV/AIDS and those at particular risk of contracting HIV/AIDS.

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

(aa) maternal and child health care;

(bb) services for other neglected and easily preventable and treatable infectious diseases, such as tuberculosis;

(cc) treatment and care services for injection drug users; and

(dd) programs and services to improve legal, social, and economic status of women and girls.

[(VII)**]** *(IX)* Directly approving all activities of the United States (including funding) relating to combatting HIV/AIDS in each of Botswana, Cote d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Zambia, *Vietnam, Antigua and Barbuda, the Bahamas, Barbados, Belize, Dominica, Grenada, Jamaica, Montserrat, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Saint Lucia, Suriname, Trinidad and Tobago, the Dominican Republic* and other countries designated by the President, which other designated countries may include those countries in which the United States is implementing HIV/AIDS programs as of the date of the enactment of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 *and other countries in which the United States is implementing HIV/AIDS programs. In designating countries under this subclause, the President shall give priority to those countries in which there is a high prevalence of HIV/AIDS and countries with large populations that have a concentrated HIV/AIDS epidemic.*

(X) Working, in partnership with host countries in which the HIV/AIDS epidemic is prevalent among injection drug users, to establish, as a national priority, national HIV/AIDS prevention programs, including education, and services demonstrated to be effective in reducing the transmission of HIV infection among injection drug users without increasing drug use.

(XI) Working, in partnership with host countries in which the HIV/AIDS epidemic is prevalent among individuals involved in commercial sex acts, to establish, as a national priority, national prevention programs,

including education, voluntary testing, and counseling, and referral systems that link HIV/AIDS programs with programs to eradicate trafficking in persons and create alternatives to prostitution.

[(VIII)**]** *(XII)* Establishing due diligence criteria for all recipients of **[**funds section**]** *funds appropriated pursuant to the authorization of appropriations under section 401 of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 for HIV/AIDS assistance* and all activities subject to the coordination and appropriate monitoring, evaluation, and audits carried out by the Coordinator necessary to assess the measurable outcomes of such activities.

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

(XIV) Working in partnership with host countries in which the HIV/AIDS epidemic is prevalent among men who have sex with men, to establish, as a national priority, national HIV/AIDS prevention programs, including education and services demonstrated to be effective in reducing the transmission of HIV among men who have sex with men.

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FOREIGN ASSISTANCE ACT OF 1961

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PART I

CHAPTER 1—POLICY; DEVELOPMENT ASSISTANCE AUTHORIZATIONS

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SEC. 104A. ASSISTANCE TO COMBAT HIV/AIDS.

(a) FINDING.—Congress recognizes that the alarming spread of HIV/AIDS in countries in sub-Saharan Africa, the Caribbean, *South and Southeast Asia, Central and Eastern Europe*, and other developing countries is a major global health, national security, development, and humanitarian crisis.

(b) POLICY.—**[**It is a major**]**

(1) GENERAL POLICY.—It is a major objective of the foreign assistance program of the United States to provide assistance for the prevention, treatment, and **[**control**]** *care* of HIV/AIDS. The United States and other developed countries should provide assistance to countries in sub-Saharan Africa, the Caribbean, and other countries and areas to control this crisis through HIV/AIDS prevention, treatment, monitoring, and related activities, particularly activities focused on women and youth, including strategies to protect women and prevent mother-to-child transmission of the HIV infection *and to fulfill United States commitments to move toward the goal of uni-*

versal access to prevention, treatment, and care of HIV/AIDS. The United States and other developed countries should provide assistance for the prevention, treatment, and care of HIV/AIDS to countries in sub-Saharan Africa, the Caribbean, South and Southeast Asia and Central and Eastern Europe, addressing both generalized epidemics and epidemics concentrated among populations at high risk of infection.

(2) SPECIFIC POLICY.—It is therefore the policy of the United States, by 2013, to—

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

(B) support treatment of at least 3,000,000 individuals with HIV/AIDS with the goal of treating 450,000 children;

(C) provide care for 12,000,000 individuals affected by HIV/AIDS, including 5,000,000 orphans and vulnerable children in communities affected by HIV/AIDS, including orphans with HIV/AIDS; and

(D) train at least 140,000 new health care professionals and workers for HIV/AIDS prevention, treatment and care.

(c) AUTHORIZATION.—

(1) IN GENERAL.—Consistent with section 104(c), the President is authorized to furnish assistance, on such terms and conditions as the President may determine, for HIV/AIDS, including to prevent, treat, and monitor HIV/AIDS, and carry out related activities, in countries in sub-Saharan Africa, the Caribbean*, South and Southeast Asia, Central and Eastern Europe*, and other countries and areas*, and particularly with respect to refugee populations in such countries and areas*.

(2) ROLE OF NGOS.—It is the sense of Congress that the President should provide an appropriate level of assistance under paragraph (1) through nongovernmental organizations (including faith-based and community-based organizations) in countries in sub-Saharan Africa, the Caribbean*, South and Southeast Asia, Central and Eastern Europe*, and other countries and areas affected by the HIV/AIDS pandemic*, and particularly with respect to refugee populations in such countries and areas*.

(3) ROLE OF PUBLIC HEALTH CARE DELIVERY SYSTEMS.—It is the sense of Congress that—

(A) the President should provide an appropriate level of assistance under paragraph (1) to help strengthen public health care delivery systems financed by host countries; and

(B) the President, acting through the Coordinator of United States Government Activities to Combat HIV/AIDS Globally, should support the development of a policy framework in such host countries for the long-term sustainability of HIV/AIDS prevention, treatment, and care programs, and for strengthening health care delivery systems and increasing health workforces through recruitment, training, and policies that allows the devolution of clinical responsibilities to increase the work force able to deliver prevention, treatment, and care services, as necessary, with clearly identified objectives and reporting strategies for such services.

[(3)**]** *(4)* COORDINATION OF ASSISTANCE EFFORTS.—The President shall coordinate the provision of assistance under

paragraph (1) with the provision of related assistance by the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Children's Fund (UNICEF), the World Health Organization (WHO), the United Nations Development Programme (UNDP), the Global Fund to Fight AIDS, Tuberculosis and Malaria and other appropriate international organizations (such as the International Bank for Reconstruction and Development), relevant regional multilateral development institutions, national, state, and local governments of [foreign countries] *host countries and donor countries*, appropriate governmental and nongovernmental organizations, and relevant executive branch agencies.

(5) SENSE OF CONGRESS.—

(A) IN GENERAL.—It is the sense of Congress that the Coordinator of United States Government Activities to Combat HIV/AIDS Globally and the heads of relevant executive branch agencies (as such term is defined in section 3 of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003) should operate in a manner consistent with the "Three Ones" goals of UNAIDS.

(B) "THREE ONES" GOALS OF UNAIDS DEFINED.—In this paragraph, the term "'Three Ones' goals of UNAIDS" means—

(i) the goal of one agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners in host countries;

(ii) the goal of one national HIV/AIDS coordinating authority, with a broad-based multisectoral mandate; and

(iii) the goal of one agreed country-level data-collection, monitoring, and evaluation system.

(d) ACTIVITIES SUPPORTED.—Assistance provided under subsection (c) shall, to the maximum extent practicable, be used to carry out the following activities:

(1) PREVENTION.—Prevention of HIV/AIDS through activities including—

(A) programs and efforts that are designed or intended to impart knowledge with the exclusive purpose of helping individuals avoid behaviors that place them at risk of HIV infection, including *efforts by faith-based and other nongovernmental organizations and* integration of such programs into health programs*, including access to such programs and efforts in family planning programs supported by the United States Government,* and the inclusion in counseling programs of information on methods of avoiding infection of HIV, including delaying sexual debut, abstinence, fidelity and monogamy, reduction of casual sexual partnering, reducing sexual violence and coercion, including child marriage, widow inheritance, and polygamy, and where appropriate, use of *male and female* condoms;

(B) assistance to establish and implement culturally *relevant and* appropriate HIV/AIDS education and prevention programs that focus on helping individuals avoid infection of HIV/AIDS, implemented through nongovernmental organizations, including faith-based and commu-

nity-based organizations, particularly those organizations *and programs* that utilize both professionals and volunteers with appropriate skills, experience*, level of scientific and fact-based knowledge*, and community presence;

* * * * * * *

(D) assistance for the purpose of providing voluntary testing and counseling (including the incorporation of confidentiality protections *and nonjudgmental approaches* with respect to such testing and counseling);

[(E) assistance for the purpose of preventing mother-to-child transmission of the HIV infection, including medications to prevent such transmission and access to infant formula and other alternatives for infant feeding;]

(E) assistance to achieve the target of reaching 80 percent of pregnant women for prevention and treatment of mother-to-child transmission of HIV in countries in which the United States is implementing HIV/AIDS programs by 2013, as described in section 312(b)(1) of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, and to promote infant feeding options that meet the criteria described in the World Health Organization's Global Strategy for Infant and Young Child Feeding;

* * * * * * *

(G) assistance to help avoid substance abuse and intravenous drug use that can lead to HIV infection*, including education and services demonstrated to be effective in reducing the transmission of HIV infection without increasing illicit drug use*; [and]

(H) assistance for the purpose of increasing women's access to employment opportunities, income, productive resources, and microfinance programs, where appropriate[.]*; and*

(I)(i) assistance for counseling, testing, treatment, care, and support programs for prevention of re-infection of individuals with HIV/AIDS;

(ii) counseling to prevent sexual transmission of HIV, including skill development for practicing abstinence, reducing the number of sexual partners, and providing information on correct and consistent use of male and female condoms;

(iii) assistance to provide male and female condoms;

(iv) diagnosis and treatment of other sexually-transmitted infections;

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

(vi) assistance to facilitate widespread access to microbicides for HIV prevention, as safe and effective products become available, including financial and technical support for culturally appropriate introductory programs, procurement, distribution, logistics management, program delivery, acceptability studies, provider training, demand generation, and post-introduction monitoring; and

(J) assistance for HIV/AIDS education targeted to reach and prevent the spread of HIV among men who have sex with men.

(2) TREATMENT.—The treatment and care of individuals with HIV/AIDS, including—

(A) * * *

(B) assistance to strengthen and expand hospice and palliative care programs to assist patients debilitated by HIV/AIDS, their families, and the primary caregivers of such patients, including programs that utilize faith-based and community-based organizations[; and]*;*

(C) assistance for the purpose of the care and treatment of individuals with HIV/AIDS through the provision of pharmaceuticals, including antiretrovirals and other pharmaceuticals and therapies for the treatment of opportunistic infections, nutritional support, and other treatment modalities[.]*;*

(D) assistance specifically to address barriers that might limit the start of and adherence to treatment services, especially in rural areas, through such measures as mobile and decentralized distribution of treatment services, and where feasible and necessary, direct linkages with nutrition and income security programs, referrals to services for victims of violence, support groups for individuals with HIV/AIDS, and efforts to combat stigma and discrimination against all such individuals;

(E) assistance to support comprehensive HIV/AIDS treatment (including free prophylaxis and treatment for common HIV/AIDS-related opportunistic infections) for at least one-third of individuals with HIV/AIDS in the poorest countries worldwide who are in clinical need of antiretroviral treatment; and

(F) assistance to improve access to psychosocial support systems and other necessary services for youth who are infected with HIV to ensure the start of and adherence to treatment services.

* * * * * * *

(4) MONITORING.—[The monitoring]

(A) IN GENERAL.—The monitoring of programs, projects, and activities carried out pursuant to paragraphs (1) through (3) *and paragraph (8)*, including—

[(A)] *(i)* monitoring to ensure that adequate controls are established and implemented to provide HIV/AIDS pharmaceuticals and other appropriate medicines to poor individuals with HIV/AIDS;

[(B)] *(ii)* appropriate evaluation and surveillance activities;

[(C)] *(iii)* monitoring to ensure that appropriate measures are being taken to maintain the sustainability of HIV/AIDS pharmaceuticals (especially antiretrovirals) and ensure that drug resistance is not compromising the benefits of such pharmaceuticals; [and]

[(D)] *(iv)* monitoring to ensure appropriate law enforcement officials are working to ensure that HIV/AIDS pharmaceuticals are not diminished through illegal coun-

terfeiting or black market sales of such pharmaceuticals[.]*; and*

(v) carrying out and expanding program monitoring, impact evaluation research, and operations research (including research and evaluations of gender-responsive interventions, disaggregated by age and sex, in order to identify and replicate effective models, develop gender indicators to measure both outcomes and impacts of interventions, especially interventions designed to reduce gender inequalities, and collect lessons learned for dissemination among different countries) in order to—

(I) improve the coverage, efficiency, effectiveness, quality and accessibility of services provided under this section;

(II) establish the cost-effectiveness of program models;

(III) assess the population-level impact of programs, projects, and activities implemented;

(IV) ensure the transparency and accountability of services provided under this section;

(V) disseminate and promote the utilization of evaluation findings, lessons, and best practices in the implementation of programs, projects, and activities supported under this section; and

(VI) encourage and evaluate innovative service models and strategies to optimize functionality of programs, projects, and activities.

(B) DEFINITIONS.—For purposes of subparagraph (A)(v)—

(i) the term "impact evaluation research" means the application of research methods and statistical analysis to measure the extent to which a change in a population-based outcome can be attributed to a program, project, or activity as opposed to other factors in the environment;

(ii) the term "program monitoring" means the collection, analysis, and use of routine data with respect to a program, project, or activity to determine how well the program, project, or activity is carried out and at what cost; and

(iii) the term "operations research" means the application of social science research methods and statistical analysis to judge, compare, and improve policy outcomes and outcomes of a program, project, or activity, from the earliest stages of defining and designing the program, project, or activity through the development and implementation of the program, project, or activity.

(5) PHARMACEUTICALS.—

(A) * * *

* * * * * * *

(C) MECHANISMS TO ENSURE COST-EFFECTIVE DRUG PURCHASING.—Mechanisms to ensure that pharmaceuticals, including antiretrovirals and medicines to treat opportun-

istic infections, are purchased at the lowest possible price at which such pharmaceuticals may be obtained in sufficient quantity on the world market.

[(C)**]** *(D)* DISTRIBUTION.—The distribution of such HIV/AIDS pharmaceuticals, antiviral therapies, and other appropriate medicines (including medicines to treat opportunistic infections) to qualified national, regional, or local organizations for the treatment of individuals with HIV/AIDS in accordance with appropriate HIV/AIDS testing and monitoring requirements and treatment protocols and for the prevention of mother-to-child transmission of the HIV infection.

* * * * * * *

(8) REFERRAL SYSTEMS AND COORDINATION WITH OTHER ASSISTANCE PROGRAMS.—

(A) REFERRAL SYSTEMS.—Assistance to ensure that a continuum of care is available to individuals participating in HIV/AIDS prevention, treatment, and care programs through the development of referral systems for such individuals to community-based programs that, where practicable, are co-located with such HIV/AIDS programs, and that provide support activities for such individuals, including HIV/AIDS treatment adherence, HIV/AIDS support groups, food and nutrition support, maternal health services, substance abuse prevention and treatment services, income-generation programs, legal services, and other program support.

(B) COORDINATION WITH OTHER ASSISTANCE PROGRAMS.—

(i)(I) Assistance to integrate HIV/AIDS testing with testing for other easily detectable and treatable infectious diseases, such as malaria, tuberculosis, and respiratory infections, and to provide treatment if possible or referral to appropriate treatment programs.

(II) Assistance to provide, whenever possible, as a component of HIV/AIDS prevention, treatment, and care services, and co-treatment of curable diseases, such as other sexually transmitted diseases.

(III) Assistance and other activities to ensure, through interagency and international coordination, that United States global HIV/AIDS programs are integrated and complementary to delivering related health services.

(ii) Assistance to support schools and related programs for children and youth that increase the effectiveness of programs described in this subsection by providing the infrastructure, teachers, and other support to such programs.

(iii) Assistance and other activities to provide access to HIV/AIDS prevention, treatment, and care programs in family planning and maternal and child health programs supported by the United States Government.

(iv) Assistance to United States and host country nonprofit development organizations that directly support livelihood initiatives in HIV/AIDS-affected countries that provide opportunities for direct lending to microentrepreneurs by United States citizens or opportunities for United States

citizens to purchase livestock and plants for families to provide nutrition and generate income for individual households and communities.

(v) Assistance to coordinate and provide linkages between HIV/AIDS prevention, treatment, and care programs with efforts to improve the economic and legal status of women and girls.

(vi) Technical assistance coordinated across implementing agencies, offered on a regular basis, and made available upon request, for faith-based and community-based organizations, especially indigenous organizations and new partners who do not have extensive experience managing United States foreign assistance programs, including for training and logistical support to establish financial mechanisms to track program receipts and expenditures and data management systems to ensure data quality and strengthen reporting.

(vii) In accordance with the World Health Organization's Interim Policy on TB/HIV Activities (2004), assistance to individuals with or symptomatic of tuberculosis, and assistance to implement the following:

(I) Provide opt-out HIV/AIDS counseling and testing and appropriate referral for treatment and care to individuals with or symptomatic of tuberculosis, and work with host countries to ensure that such individuals in host countries are provided such services.

(II) Ensure, in coordination with host countries, that individuals with HIV/AIDS receive tuberculosis screening and other appropriate treatment.

(III) Provide increased funding for HIV/AIDS and tuberculosis activities, by increasing total resources for such activities, including lab strengthening and infection control.

(IV) Improve the management and dissemination of knowledge gained from HIV/AIDS and tuberculosis activities to increase the replication of best practices.

(e) ANNUAL REPORT.—

(1) IN GENERAL.—Not later than January 31 of each year, the President shall submit to the Committee on Foreign Relations of the Senate and the [Committee on International Relations] *Committee on Foreign Affairs* of the House of Representatives a report on the implementation of this section for the prior fiscal year.

(2) REPORT ELEMENTS.—Each report shall include—

(A) * * *

(B) a description of the programs established pursuant to such sections; [and]

(C) a detailed assessment of the impact of programs established pursuant to such sections, [including] *including——*

[(i)(I) the effectiveness of such programs in reducing the spread of the HIV infection, particularly in women and girls, in reducing mother-to-child transmission of the HIV infection, and in reducing mortality rates from HIV/AIDS; and

[(II) the number of patients currently receiving treatment for AIDS in each country that receives assistance under this Act.

[(ii) the progress made toward improving health care delivery systems (including the training of adequate numbers of staff) and infrastructure to ensure increased access to care and treatment;]

(i)(I) the effectiveness of such programs in reducing the transmission of HIV, particularly in women and girls, in reducing mother-to-child transmission of HIV, including through drug treatment and therapies, either directly or by referral, and in reducing mortality rates from HIV/AIDS, including through drug treatment, and addiction therapies;

(II) a description of strategies, goals, programs, and interventions to address the specific needs and vulnerabilities of young women and young men; the progress toward expanding access among young women and young men to evidence-based, comprehensive HIV/AIDS health care services and HIV prevention and sexuality and abstinence education programs at the individual, community, and national levels; and clear targets for integrating adolescents who are orphans, including adolescents who are infected with HIV, into programs for orphans and vulnerable children; and

(III) the amount of United States funding provided under the authorities of this Act to procure drugs for HIV/AIDS programs in countries described in section 1(f)(2)(B)(IX) of the State Department Basic Authorities Act of 1956 (22 U.S.C. 2651a(f)(2)(B)(VIII)), including a detailed description of anti-retroviral drugs procured, including—

(aa) the total amount expended for each generic and name brand drug;

(bb) the price paid per unit of each drug; and

(cc) the vendor from which each drug was purchased; and

(ii) the progress made toward improving health care delivery systems (including the training of adequate numbers of health care professionals) and infrastructure to ensure increased access to care and treatment, including a description of progress toward—

(I)(aa) the training and retention of adequate numbers of health care professionals in order to meet a nationally-determined ratio of doctors, nurses, and midwives to patients, based on the target of the 2.3 per-thousand ratio established by the World Health Organization (WHO);

(bb) increases in the number of other health care professions, such as pharmacists and lab technicians, as necessary; and

(cc) the improvement of infrastructure needed to ensure universal access to HIV/AIDS prevention, treatment, and care by 2015;

(II) national health care workforce strategy benchmarks, as required by section 202(d)(5)(B) of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, United States contributions to developing and implementing the benchmarks, and main challenges to implementing the benchmarks;

(III) ensuring, to the extent practicable, that health care workers providing services under this Act have safe working conditions and are receiving health care services, including services relating to HIV/AIDS;

(IV) activities to strengthen health care systems in order to overcome obstacles and barriers to the provision of HIV/AIDS, tuberculosis, and malaria services;

(V) improving integration and coordination of HIV/AIDS programs with related health care services and supporting the capacity of health care programs to refer individuals to community-based services; and

(VI) strengthening procurement and supply chain management systems of host countries;

(iii) with respect to tuberculosis, the increase in the number of people treated and the increase in number of tuberculosis patients cured through each program, project, or activity receiving United States foreign assistance for tuberculosis control purposes*, including the percentage of such United States foreign assistance provided for diagnosis and treatment of individuals with tuberculosis in countries with the highest burden of tuberculosis, as determined by the World Health Organization (WHO)*; and

(iv) with respect to malaria, the increase in the number of people treated and the increase in number of malaria patients cured through each program, project, or activity receiving United States foreign assistance for malaria control purposes**[**.**]***;*

(D) a description of efforts to integrate HIV/AIDS and tuberculosis prevention, treatment, and care programs, including—

(i) the number and percentage of HIV-infected individuals receiving HIV/AIDS treatment or care services who are also receiving screening and subsequent treatment for tuberculosis;

(ii) the number and percentage of individuals with tuberculosis who are receiving HIV/AIDS counseling and testing, and appropriate referral to HIV/AIDS services;

(iii) the number and location of laboratories with the capacity to perform tuberculosis culture tests and tuberculosis drug susceptibility tests;

(iv) the number and location of laboratories with the capacity to perform appropriate tests for multi-drug

resistant tuberculosis (MDR–TB) and extensively drug resistant tuberculosis (XDR–TB); and

(v) the number of HIV-infected individuals suspected of having tuberculosis who are provided tuberculosis culture diagnosis or tuberculosis drug susceptibility testing;

(E) a description of coordination efforts with relevant executive branch agencies (as such term is defined in section 3 of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003) and at the global level in the effort to link HIV/AIDS services with non-HIV/AIDS services;

(F) a description of programs serving women and girls, including—

(i) a description of HIV/AIDS prevention programs that address the vulnerabilities of girls and women to HIV/AIDS; and

(ii) information on the number of individuals served by programs aimed at reducing the vulnerabilities of women and girls to HIV/AIDS;

(G) a description of the specific strategies funded to ensure the reduction of HIV infection among injection drug users, and the number of injection drug users, by country, reached by such strategies, including medication-assisted drug treatment for individuals with HIV or at risk of HIV, and HIV prevention programs demonstrated to be effective in reducing HIV transmission without increasing drug use; and

(H) a detailed description of monitoring, impact evaluation research, and operations research of programs, projects, and activities carried out pursuant to subsection (d)(4)(A)(v).

(3) PUBLIC AVAILABILITY.—The Coordinator of United States Government Activities to Combat HIV/AIDS Globally shall make publicly available on the Internet website of the Office of the Coordinator the information contained in paragraph (2)(H) of each report and, in addition, the individual evaluations and other reports that were the basis of such information, including lessons learned and collected in such evaluations and reports.

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SEC. 104B. ASSISTANCE TO COMBAT TUBERCULOSIS.

(a) FINDINGS.—Congress makes the following findings:

[(1) Congress recognizes the growing international problem of tuberculosis and the impact its continued existence has on those countries that had previously largely controlled the disease.

[(2) Congress further recognizes that the means exist to control and treat tuberculosis through expanded use of the DOTS (Directly Observed Treatment Short-course) treatment strategy, including DOTS-Plus to address multi-drug resistant tuberculosis, and adequate investment in newly created mechanisms to increase access to treatment, including the Global Tuberculosis Drug Facility established in 2001 pursuant to the

Amsterdam Declaration to Stop TB and the Global Alliance for TB Drug Development.]

(1) Tuberculosis is one of the greatest infectious causes of death of adults worldwide, killing 1.6 million individuals per year—one person every 20 seconds.

(2) Tuberculosis is the leading infectious cause of death among individuals who are infected with HIV due to their weakened immune systems, and it is estimated that one-third of such individuals have tuberculosis. Tuberculosis is also a leading killer of women of reproductive age.

(3) Driven by the HIV/AIDS pandemic, incidence rates of tuberculosis in sub-Saharan Africa have more than doubled on average since 1990. The problem is so pervasive that in August 2005, African health ministers and the World Health Organization (WHO) declared tuberculosis to be an emergency in sub-Saharan Africa.

(4)(A) The wide extent of drug resistance, including both multi-drug resistant tuberculosis (MDR–TB) and extensively drug resistant tuberculosis (XDR–TB), represents both a critical challenge to the global control of tuberculosis and a serious worldwide public health threat.

(B) XDR–TB, which is a form of MDR–TB with additional resistance to multiple second-line anti-tuberculosis drugs, is associated with worst treatment outcomes of any form of tuberculosis.

(C) XDR–TB is converging with the HIV/AIDS epidemic, undermining gains in HIV/AIDS prevention and treatment programs and requires urgent interventions.

(D) Drug resistance surveillance reports have confirmed the serious scale and spread of tuberculosis, with XDR–TB strains confirmed on six continents.

(E) Demonstrating the lethality of XDR–TB, an initial outbreak in Tugela Ferry, South Africa, in 2006 killed 52 of 53 patients with hundreds more cases reported since that time.

(F) Of the world's regions, sub-Saharan Africa, faces the greatest gap in capacity to prevent, treat, and care for individuals with XDR–TB.

[(b) POLICY.—It is a major objective of the foreign assistance program of the United States to control tuberculosis, including the detection of at least 70 percent of the cases of infectious tuberculosis, and the cure of at least 85 percent of the cases detected, not later than December 31, 2005, in those countries classified by the World Health Organization as among the highest tuberculosis burden, and not later than December 31, 2010, in all countries in which the United States Agency for International Development has established development programs.]

(b) POLICY.—It is a major objective of the foreign assistance program of the United States to control tuberculosis. In all countries in which the Government of the United States has established development programs, particularly in countries with the highest burden of tuberculosis and other countries with high rates of tuberculosis, the United States Government should prioritize the achievement of the following goals by not later than December 31, 2015:

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

(2) Sustain or exceed the detection of at least 70 percent of sputum smear-positive cases of tuberculosis and the cure of at least 85 percent of such cases detected.

* * * * * * *

(d) ACTIVITIES SUPPORTED.—Assistance provided under subsection (c) shall, to the maximum extent practicable, be used to carry out the following activities:

(1) Provide diagnostic counseling and testing to individuals with HIV/AIDS for tuberculosis (including a culture diagnosis to rule out multi-drug resistant tuberculosis (MDR–TB) and extensively drug resistant tuberculosis (XDR–TB) and provide HIV/AIDS voluntary counseling and testing to individuals with any form of tuberculosis.

(2) Provide tuberculosis treatment to individuals receiving treatment and care for HIV/AIDS who have active tuberculosis and provide prophylactic treatment to individuals with HIV/AIDS who also have a latent tuberculosis infection.

(3) Link individuals with both HIV/AIDS and tuberculosis to HIV/AIDS treatment and care services, including antiretroviral therapy and cotrimoxazole therapy.

(4) Ensure that health care workers trained to diagnose, treat, and provide care for HIV/AIDS are also trained to diagnose, treat, and provide care for individuals with both HIV/AIDS and tuberculosis.

(5) Ensure that individuals with active pulmonary tuberculosis are provided a culture diagnosis, including drug susceptibility testing to rule out multi-drug resistant tuberculosis (MDR–TB) and extensively drug resistant tuberculosis (XDR–TB) in areas with high prevalence of tuberculosis drug resistance.

[(d)**]** *(e)* COORDINATION.—In carrying out this section, the President shall coordinate with the World Health Organization, the Global Fund to Fight AIDS, Tuberculosis, and Malaria, and other organizations with respect to the development and implementation of a comprehensive tuberculosis control program.

[(e) PRIORITY TO DOTS COVERAGE.—In furnishing assistance under subsection (c), the President shall give priority to activities that increase Directly Observed Treatment Short-course (DOTS) coverage and treatment of multi-drug resistant tuberculosis where needed using DOTS-Plus, including funding**]**

(f) *PRIORITY TO STOP TB STRATEGY.—*

(1) PRIORITY.—In furnishing assistance under subsection (c), the President shall give priority to—

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

(B) funding for the Global Tuberculosis Drug Facility, the Stop Tuberculosis Partnership, and the Global Alliance for TB Drug Development. [In order to meet the requirement of the preceding sentence, the President should ensure that not less than]

(2) AVAILABILITY OF AMOUNTS.—In order to meet the requirements of paragraph (1), the President—

(A) shall ensure that not less than 75 percent of the amount made available to carry out this section for a fiscal year should be expended for antituberculosis drugs, supplies, direct patient services, and training in diagnosis and treatment [for Directly Observed Treatment Short-course (DOTS) coverage and treatment of multi-drug resistant tuberculosis using DOTS-Plus,] *to implement the Stop TB Strategy; and* [including substantially increased funding for the Global Tuberculosis Drug Facility.]

(B) should ensure that not less than $15,000,000 of the amount made available to carry out this section for a fiscal year is used to make a contribution to the Global Tuberculosis Drug Facility.

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

[(f)] *(h)* DEFINITIONS.—In this section:

(1) DOTS.—The term "DOTS" or "Directly Observed Treatment Short-course" means the World Health Organization-recommended strategy for treating tuberculosis*, including low cost and effective diagnosis and evaluation of treatment regimes, vaccines, and monitoring of tuberculosis, as well as a reliable drug supply, and a management strategy for public health systems, with health system strengthening, promotion of the use of the International Standards for Tuberculosis Care by all care providers, bacteriology under an external quality assessment framework, short-course chemotherapy, and sound reporting and recording systems*.

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(6) STOP TB STRATEGY.—The term "Stop TB Strategy" means the six-point strategy to reduce tuberculosis developed by the World Health Organization. The strategy is described in the Global Plan to Stop TB 2007–2016: Actions for Life, a comprehensive plan developed by the Stop Tuberculosis Partnership that sets out the actions necessary to achieve the millennium development goal of cutting tuberculosis deaths and disease burden in half by 2016.

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SEC. 104C. ASSISTANCE TO COMBAT MALARIA.

(a) * * *

(b) POLICY.—It is a major objective of the foreign assistance program of the United States to provide assistance for the prevention, [control, and cure] *treatment, and care* of malaria.

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TITLE XII—FAMINE PREVENTION AND FREEDOM FROM HUNGER

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CHAPTER 3—INTERNATIONAL ORGANIZATIONS AND PROGRAMS

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SEC. 302. AUTHORIZATION.—(a) * * *

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(k) In addition to amounts otherwise available under this section, there is authorized to be appropriated to the President such sums as may be necessary for each of the [fiscal years 2004 through 2008] *fiscal years 2009 through 2013* to be available only for United States contributions to the Vaccine Fund.

(l) In addition to amounts otherwise available under this section, there is authorized to be appropriated to the President such sums as may be necessary for each of the [fiscal years 2004 through 2008] *fiscal years 2009 through 2013* to be available only for United States contributions to the International AIDS Vaccine Initiative.

(m) In addition to amounts otherwise available under this section, there are authorized to be appropriated to the President such sums as may be necessary for each of the [fiscal years 2004 through 2008] *fiscal years 2009 through 2013* to be available for United States contributions to malaria vaccine development programs, including the Malaria Vaccine Initiative of the Program for Appropriate Technologies in Health (PATH).

(n) In addition to amounts otherwise available under this section, there are authorized to be appropriated to the President such sums as may be necessary for each of the fiscal years 2009 through 2013 to be available for United States contributions to research and development of a tuberculosis vaccine.

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