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International HIV/AIDS, Tuberculosis, and Malaria: Key Changes to U.S. Programs and Funding

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Summary

The United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (P.L. 108-25) authorizes $15 billion for U.S. global efforts to combat HIV/AIDS, tuberculosis (TB), and malaria from FY2004 through FY2008. It also authorizes the Office of the Global AIDS Coordinator (OGAC) to oversee U.S. government efforts to combat HIV/AIDS internationally. These efforts to combat HIV/AIDS implement the President's Emergency Plan for AIDS Relief (PEPFAR), a program proposed by President Bush in January 2003.

President Bush requested $30 billion for the reauthorization of PEPFAR from FY2009 through FY2013, estimating it would support HIV/AIDS treatments for 2.5 million people, the prevention of more than 12 million new HIV infections, and care for more than 12 million HIV-affected people, including 5 million orphans and vulnerable children.

On July 24, 2008, Congress reauthorized $48 billion for U.S. international HIV/AIDS, tuberculosis, and malaria programs through FY2013 in H.R. 5501, the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008 (hereafter referred to as the Reauthorization Act). The President signed H.R. 5501 into law (P.L. 110-293) on July 30, 2008.

The Reauthorization Act makes a number of changes to U.S. international HIV/AIDS, tuberculosis, and malaria programs. It increases funding for U.S. efforts to fight HIV/AIDS, tuberculosis, and malaria and for U.S. contributions to the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund). It adds Vietnam to the list of PEPFAR Focus Countries; proposes the use of compacts or framework agreements between the United States and each country receiving HIV/AIDS funds under the reauthorization; and removes the 33% spending requirement on abstinence prevention efforts, as well as the 20% spending recommendation on prevention efforts overall. It establishes a Global Malaria Coordinator within the U.S. Agency for International Development (USAID) and supports the sustainability of health care systems in affected countries. It eliminates Immigration and Nationality Act (INA) language that statutorily bars foreign nationals with HIV/AIDS from entering the United States.

This report discusses changes in coordination and funding for HIV/AIDS, tuberculosis, and malaria programs as directed in the Reauthorization Act. It provides background on PEPFAR implementation including results and funding through FY2008. It then discusses similarities and differences between H.R. 5501 as passed by the House on April 2, 2008, and H.R. 5501 as passed by the Senate on July 16, 2008. Finally, it details key outcomes in the legislation as enacted. This report will be updated as events warrant.

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International HIV/AIDS, Tuberculosis, and Malaria: Key Changes to U.S. Programs and Funding

Introduction

On May 30, 2007, President Bush announced that he would request $30 billion for the reauthorization of the President's Emergency Plan for AIDS Relief (PEPFAR), which is the coordinated U.S. government effort to combat HIV/AIDS globally.[1] The President estimated PEPFAR would support HIV/AIDS treatments for 2.5 million people, the prevention of more than 12 million new HIV infections, and care for more than 12 million HIV-affected people, including 5 million orphans and vulnerable children.[2] In 2003, Congress authorized $15 billion for U.S. efforts to combat global HIV/AIDS, tuberculosis, and malaria from FY2004 through FY2008 with the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (P.L. 108-25) (hereafter referred to as the Leadership Act).

On July 24, 2008, Congress authorized $48 billion for U.S. global efforts to fight HIV/AIDS, tuberculosis, and malaria and for U.S. contributions to the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund)[3] from FY2009 through FY2013 through H.R. 5501, the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008 (hereafter referred to as the Reauthorization Act). The Reauthorization Act (P.L. 110-293) was signed into law on July 30, 2008.

This report describes U.S. efforts to combat international HIV/AIDS through PEPFAR including an overview of its implementation structure, key program elements, results, and funding from FY2004 through FY2008. It also details funding for tuberculosis, malaria, and U.S. contributions to the Global Fund during that time. This report discusses similarities and differences between H.R. 5501 as passed by the House on April 2, 2008, and H.R. 5501 as passed by the Senate on July 16, 2008,

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[1] Office of the Global AIDS Coordinator (OGAC), U.S. Department of State, "President Bush Announces Five-Year, $30 Billion HIV/AIDS Plan," at [http://www.pepfar.gov/85811.htm].

[2] Ibid.

[3] The Global Fund to Fight AIDS, Tuberculosis, and Malaria, headquartered in Geneva, Switzerland, is an independent foundation that seeks to attract and rapidly disburse new resources in developing countries aimed at countering the three diseases. The Fund is a financing vehicle, not an implementing agency. For more information on the Global Fund, see CRS Report RL33396, *The Global Fund to Fight AIDS, Tuberculosis, and Malaria: Progress Report and Issues for Congress*, by Tiaji Salaam-Blyther.

including proposed changes in program authorities and funding for HIV/AIDS, tuberculosis, and malaria programs. Finally, it details key outcomes in the legislation as enacted. It does not describe U.S. efforts to combat tuberculosis and malaria.[4]

PEPFAR: Implementation, Results, and Funding

On January 28, 2003, President Bush proposed the President's Emergency Plan for AIDS Relief (PEPFAR) in his State of the Union address, requesting $15 billion over five years to combat HIV/AIDS.[5] Congress authorized $15 billion for U.S. efforts to combat global HIV/AIDS, tuberculosis (TB), and malaria from FY2004 through FY2008 with the Leadership Act, which the President signed into law (P.L. 108-25) on May 27, 2003.

Implementation Structure

OGAC and PEPFAR Countries. The Leadership Act created the Office of the Global AIDS Coordinator (OGAC) in the Department of State and outlined its role.[6] OGAC directly approves all U.S. activities and funding related to combating HIV/AIDS in the 15 PEPFAR Focus Countries. In addition to the Focus Countries, OGAC has primary responsibility for the oversight and coordination of all U.S. government resources and international activities to combat HIV/AIDS. This role extends to ensuring program and policy coordination among the relevant executive branch agencies and non-governmental organizations (NGOs), including auditing, monitoring, and evaluating all such programs including activities conducted in non-Focus Countries.[7]

In 2003, the 15 PEPFAR Focus Countries accounted for over 50% of all HIV-infected people in the world. The 15 Focus Countries are Botswana, Cote d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam, and Zambia.[8] OGAC estimates that from

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[4] For more information on U.S. efforts to combat tuberculosis, see CRS Report RL34246, *Tuberculosis: International Efforts and Issues for Congress*, by Tiaji Salaam-Blyther. For more information on U.S. efforts to combat malaria, see CRS Report RL33485, *U.S. International HIV/AIDS, Tuberculosis, and Malaria Spending: FY2004-FY2008*, by Tiaji Salaam-Blyther.

[5] For more information on PEPFAR, see CRS Report RL33771, *Trends in U.S. Global AIDS Spending: FY2000-FY2008*, by Tiaji Salaam-Blyther, and CRS Report RL34192, *PEPFAR: From Emergency to Sustainability*, by Tiaji Salaam-Blyther.

[6] Section 102 of P.L. 108-25, the Leadership Act.

[7] OGAC, "FY 2006 Countries of the President's Emergency Plan for AIDS Relief (PEPFAR)," at [http://www.pepfar.gov/countries/84362.htm].

[8] These Focus Countries, except Vietnam, were specified in the Leadership Act (P.L. 108-25). Section 102(B)(ii)(VII) of the Leadership Act also authorizes the President to designate Focus Countries. President Bush announced that Vietnam would be added to the group of Focus Countries on June 23, 2004. See The White House, "Vietnam to Receive U.S.

(continued...)

FY2004 through FY2008, 58% of PEPFAR funds will have been spent on the 15 Focus Countries.[9] OGAC transfers funds to PEPFAR-participating agencies that administer HIV/AIDS programs in Focus Countries.

Participating U.S. Agencies. PEPFAR-participating agencies and departments, which receive funding transfers from OGAC, include the U.S. Agency for International Development (USAID); the Department of State (State); the Department of Health and Human Services (HHS) through the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), the Health Resources and Services Administration (HRSA), the Food and Drug Administration (FDA), and the Substance Abuse and Mental Health Services Administration (SAMHSA); the Department of Labor (DOL); the Department of Commerce; the Peace Corps; and the Department of Defense (DoD). These agencies may allocate their own agency funds for global HIV/AIDS, tuberculosis, and malaria programs.

International Organizations and International Initiatives. The Leadership Act authorizes funds to support U.S. contributions to some multilateral organizations and international research initiatives including the Global Fund to Fight AIDS, Tuberculosis, and Malaria (hereafter referred to as the Global Fund),[10] the United Nations Joint Programme on HIV/AIDS (UNAIDS), and the International AIDS Vaccine Initiative (IAVI). OGAC reports that 16% of PEPFAR funds will support the Global Fund from FY2004 through FY2008.[11]

Restrictions on Spending and Programs. Though Focus Countries receive the bulk of PEPFAR funding, individual Focus Countries may not necessarily receive more funds than non-Focus Countries: for example, India, which is not a Focus Country, receives more funding than Guyana, a Focus Country.[12] OGAC determines annual funding allocations for each Focus Country based on past funding allocations and provides an initial budget estimate to U.S. staff in each PEPFAR country to help them formulate a Country Operational Plan (COP). A COP provides data that informs OGAC's final funding decision. OGAC uses the COP to evaluate country-based information on the extent of the HIV/AIDS epidemic, absorptive

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[8] (...continued)
Emergency HIV/AIDS Assistance," June 22, 2004, at [http://vietnam.usembassy.gov/pepfar040622.html].

[9] OGAC figures do not include funding for U.S. international malaria programs. OGAC, "Making A Difference: Funding," at [http://www.pepfar.gov/press/80064.htm].

[10] For more information on the Global Fund, see CRS Report RL33396, *The Global Fund to Fight AIDS, Tuberculosis, and Malaria: Progress Report and Issues for Congress*, by Tiaji Salaam-Blyther.

[11] OGAC figures do not include funding for U.S. international malaria programs. OGAC, "Making A Difference: Funding," at [http://www.pepfar.gov/press/80064.htm].

[12] OGAC, "2008 PEPFAR Country Profiles: India," and "2008 PEPFAR Country Profiles: Guyana," at [http://www.pepfar.gov/press/c19558.htm].

capacity for funding, effectiveness of PEPFAR efforts to date, and country team projections of need.[13]

In the Leadership Act, Congress outlined both funding distribution guidelines and "spending directives" for HIV/AIDS assistance. Congress recommended that 20% of HIV/AIDS funds should be spent on prevention. It required that from FY2006 through FY2008 at least 33% of these prevention funds must be spent on abstinence-until-marriage programs.[14] In addition, Congress directed that from FY2006 through FY2008 not less than 55% of HIV/AIDS funds must be spent on treatment, and of these, it recommended that 75% should support the purchase and distribution of antiretroviral (ARV) drugs, while the remaining 25% should be spent on related care for treatment patients. Congress also recommended that 15% of HIV/AIDS funds should be spent on palliative care of HIV-affected people. Finally, it required that from FY2006 through FY2008 the remaining 10% of HIV/AIDS funds must be spent on orphans and vulnerable children (OVC).[15] It required that at least 50% of these OVC funds must be provided through non-profit NGOs, including faith-based organizations (FBOs), that implement programs on the community level.

Results

When President Bush proposed PEPFAR in 2003, he projected that the five-year initiative to combat HIV/AIDS globally would prevent 7 million new HIV infections, would provide antiretroviral treatment for 2 million people, and would support care for 10 million HIV-affected people.[16]

As of September 30, 2007, OGAC reports that it has accomplished the following:[17]

- **Prevention**: supported over 33 million HIV counseling and testing sessions; supported prevention of mother to child [HIV] transmission (PMTCT) services in more than 10 million pregnancies; and prevented an estimated 157,000 infant infections.

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[13] For more information on the OGAC allocation process, see Government Accountability Office (GAO), *Global HIV/AIDS: A More Country-Based Approach Could Improve Allocation of PEPFAR Funding*, April 2008, at [http://www.gao.gov/new.items/d08480.pdf].

[14] OGAC defines abstinence-until-marriage activities as programs that address both abstinence and faithfulness, according to GAO, *Global Health: Spending Requirement Presents Challenges for Allocating Prevention Funding Under the President's Emergency Plan for AIDS Relief*, April 2006, at [http://www.gao.gov/new.items/d06395.pdf].

[15] For more information on OVC, see CRS Report RL32252, *AIDS Orphans and Vulnerable Children (OVC): Problems, Responses, and Issues for Congress*, by Tiaji Salaam-Blyther.

[16] The White House, "Fact Sheet: The President's Emergency Plan for AIDS Relief," January 29, 2003, at [http://www.whitehouse.gov/news/releases/2003/01/20030129-1.html].

[17] OGAC has updated some but not all of these statistics through March 31, 2008; CRS has included statistics available through September 30, 2007, in order to provide more detailed information. Data in this section was compiled by CRS from OGAC, "Latest Results," at [http://www.pepfar.gov/about/c19785.htm].

- **Treatment**: provided antiretroviral treatment for about 1.45 million people, including 86,000 children.

- **Care**: supported care for more than 6.6 million HIV-affected people, including more than 2.7 million orphans and vulnerable children (OVC).

Funding

The Leadership Act authorizes $15 billion to address HIV/AIDS, tuberculosis, and malaria globally and to provide U.S. contributions to the Global Fund from FY2004 through FY2008. OGAC calculates PEPFAR funding as the total of enacted funding for U.S. efforts to combat HIV/AIDS globally, U.S. efforts to combat tuberculosis internationally, and U.S. contributions to the Global Fund.[18] Prior to FY2006, PEPFAR funding also included U.S. efforts to combat malaria. Then in June 2005 the President introduced the President's Malaria Initiative (PMI) to expand U.S. government efforts to combat malaria globally.[19] As a result, OGAC excluded malaria funding from PEPFAR calculations beginning in FY2006.[20] Since that time, U.S. government spending on malaria has been reported separately.[21] Since the Leadership Act authorization included malaria programs, the funding data in this report includes malaria and PMI funding. This report details funding separately for HIV/AIDS, TB, malaria, and U.S. contributions for the Global Fund.

FY2004-2008 Appropriations. From FY2004 through FY2008, Congress appropriated $15.3 billion to U.S. programs to combat global HIV/AIDS, of which $10.6 billion was spent in the 15 PEPFAR Focus Countries through the Global HIV/AIDS Initiative (GHAI); $530 million to U.S. programs to combat TB; and

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[18] OGAC, "Making A Difference: Funding," at [http://www.pepfar.gov/press/80064.htm].

[19] For more information on PMI, see CRS Report RL33485, *U.S. International HIV/AIDS, Tuberculosis, and Malaria Spending: FY2004-FY2008*, by Tiaji Salaam-Blyther.

[20] OGAC, "Appendix 1: The President's Emergency Plan for AIDS Relief Sources of Funding," *The Power of Partnerships: Third Annual Report to Congress on PEPFAR (2007)*, at [http://www.pepfar.gov/documents/organization/81019.pdf].

[21] USAID, *Report to Congress: USAID FY 2006 Malaria Programming Report No. 1*, at [http://pdf.usaid.gov/pdf_docs/PDACH688.pdf]. *Report to Congress: USAID FY 2006 Malaria Programming Report No. 2*, at [http://pdf.usaid.gov/pdf_docs/PDACH689.pdf]. President's Malaria Initiative (PMI), USAID, *PMI First Annual Report: Saving the Lives of Mothers and Children in Africa,* March 2007, at [http://www.pmi.gov/resources/pmi_annual_report.pdf]. PMI, USAID, *PMI Second Annual Report: Progress Through Partnerships: Saving Lives in Africa*, [http://www.pmi.gov/resources/pmi_annual_report08.pdf].

$915 million to U.S. programs to combat malaria (**Table 1**).[22] Congress also appropriated $3.0 billion to the Global Fund (**Table 2**).[23]

Table 1. Global HIV/AIDS, Tuberculosis, and Malaria Appropriations by Disease, FY2004 through FY2008

(Current U.S. $ Millions)

AIDS Program	Amount
USAID HIV/AIDS	2,031.0
State Global HIV/AIDS Initiative (GHAI)	10,624.0
Foreign Military Financing	6.9
CDC Global AIDS Program	754.2
CDC International HIV Research	23.0
NIH International HIV Research	1,795.8
DOL AIDS Initiative	11.8
DOD HIV/AIDS Prevention Education	25.0
Total HIV/AIDS Funding[a]	15,271.7
Tuberculosis Program	**Amount**
USAID Tuberculosis	525.7
CDC Tuberculosis	4.3
Total Tuberculosis Funding	530.0
Malaria Program	**Amount**
USAID Malaria	870.3
CDC Malaria	44.9
Total Malaria Funding[b]	915.2

Source: Derived from data presented in CRS Report RL33485, *U.S. International HIV/AIDS, Tuberculosis, and Malaria Spending: FY2004-FY2008*, by Tiaji Salaam-Blyther.

a. Includes UNAIDS, International AIDS Vaccine Initiative (IAVI), and international microbicide research contributions.

b. Includes President's Malaria Initiative (PMI).

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[22] For more information on GHAI, PEPFAR, TB, and malaria appropriations, see CRS Report RL33485, *U.S. International HIV/AIDS, Tuberculosis, and Malaria Spending: FY2004-FY2008*, by Tiaji Salaam-Blyther; and CRS Report RL33771, *Trends in U.S. Global AIDS Spending: FY2000-FY2008*, by Tiaji Salaam-Blyther.

[23] For more information on the Global Fund, see CRS Report RL33396, *The Global Fund to Fight AIDS, Tuberculosis, and Malaria: Progress Report and Issues for Congress*, by Tiaji Salaam-Blyther.

Table 2. U.S. Contributions to the Global Fund to Fight AIDS, Tuberculosis, and Malaria, FY2004 through FY2008
(Current U.S. $ Millions)

Global Fund Contributions	Amount
USAID	1,140.6
State GHAI	1,121.0
NIH	741.1
Total Global Fund Contribution	3,002.7

Source: Derived from data presented in CRS Report RL33485, *U.S. International HIV/AIDS, Tuberculosis, and Malaria Spending: FY2004-FY2008*, by Tiaji Salaam-Blyther.

Key Reauthorization Proposals and Debates During Consideration of H.R. 5501

On May 30, 2007, President Bush urged Congress to extend PEPFAR from FY2009 through FY2013 with an additional $30 billion authorization.[24] The Administration estimates that $30 billion would support treatment for 2.5 million people, the prevention of more than 12 million new infections, and care for more than 12 million people, including 5 million orphans and vulnerable children.[25]

The Administration's FY2009 budget request included $6 billion for U.S. international HIV/AIDS and tuberculosis programs.[26] Of this $6 billion, $500 million was requested for a U.S. contribution to the Global Fund.[27] The President also separately requested $385 million for the President's Malaria Initiative (PMI) for U.S. global malaria eradication efforts.[28]

The following section focuses on key proposed changes to U.S. programs that combat HIV/AIDS, tuberculosis, and malaria, as suggested by the April 2, 2008, version of H.R. 5501 that was passed by the House and the July 16, 2008, version of H.R. 5501 that was passed by the Senate and that was subsequently voted on and

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[24] OGAC, "President Bush Announces Five-Year, $30 Billion HIV/AIDS Plan," at [http://www.pepfar.gov/85811.htm].

[25] Ibid.

[26] Director of U.S. Foreign Assistance, U.S. Department of State, FY2009 International Affairs (Function 150) Congressional Budget Justification for Foreign Operations: Annex A - President's Emergency Plan for AIDS Relief, at [http://www.state.gov/documents/organization/101458.pdf].

[27] Ibid.

[28] Director of U.S. Foreign Assistance, U.S. Department of State, FY2009 International Affairs (Function 150) Congressional Budget Justification for Foreign Operations: Request by Appropriation Account — Ex-Im Bank, OPIC, USTDA, CSH, DA, IDA, and TI, at [http://www.state.gov/documents/organization/101417.pdf].

passed by the House and enacted into law. This section highlights key proposed requirements and funding allocations included in either version of the bill and discusses the debate surrounding the proposals, including debates about possible policy implementation implications.

Funding Authorization Increase

H.R. 5501 as passed by the House proposed up to $50 billion for U.S. international efforts to combat HIV/AIDS, tuberculosis, and malaria during the reauthorization period of FY2009 through FY2013. It would have authorized $10 billion for each of the five years.[29] The Senate version proposed $48 billion in total over the same period for these activities. Both versions also proposed authorizing higher funding levels for U.S. contributions to the Global Fund and for U.S. efforts to combat tuberculosis and malaria (**Table 3**).

Table 3. Comparison of Proposed Reauthorization Levels from FY2009 through FY2013 in House and Senate Versions of H.R. 5501

Area of Authorization	H.R. 5501 as passed by the House	H.R. 5501 as passed by the Senate
Overall for HIV/AIDS, Tuberculosis, and Malaria	$50 billion ($10 billion each fiscal year over five years)	$48 billion (in total)
U.S. Contribution to Global Fund to Fight AIDS, Tuberculosis, and Malaria	Up to $2 billion for U.S. contributions in each of FY2009 and FY2010; such sums as may be necessary from FY2011 through FY2013.	Up to $2 billion for U.S. contributions in FY2009; such sums as may be necessary from FY2010 through FY2013.
Tuberculosis	$4 billion (in total)	$4 billion (in total)
Malaria	$5 billion (in total)	$5 billion (in total)

Source: Compiled by CRS from April 2, 2008, House-passed version and July 16, 2008, Senate-passed version of H.R. 5501.

The Senate version of H.R. 5501 also proposed authorizing $2 billion for an emergency fund for Indian health and safety from FY2008 through FY2013. The Senate adopted S.Amdt. 5076 to S. 2731, the basis for the substitute amendment to H.R. 5501, and S.Amdt. 5084, which amended S.Amdt. 5076. These amendments added language that requires an emergency plan to address the law enforcement,

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[29] According to *Congressional Quarterly*, the funding level for PEPFAR programs in H.R. 5501 is the result of a compromise reached the night before introduction. Adam Graham-Silverman, "Lawmakers Push Bipartisan Deal on Global AIDS Bill," *CQ Today*, February 26, 2008.

water, and health care needs of Indian tribes and directs the expenditure of the funds for particular purposes.[30]

Critics of the $50 billion and $48 billion authorization levels argued that it would be fiscally irresponsible to spend such levels in light of U.S. military operations in Iraq and Afghanistan, a near economic recession in the United States, and questions about the absorptive capacity of recipient countries. Some analysts suggested that increased disease-specific funding in the foreign operations appropriations would drain available funding from other aid priorities in developing countries, such as agriculture assistance and private sector growth. Others opposed increased funding because they did not want to expand current PEPFAR activities to support additional Focus Countries and to fund activities not directly related to AIDS. Critics of high spending levels were concerned about proposals to increase the number of Focus Countries and to extend PEPFAR funds to support health care infrastructure as well as to enhance nutrition and feeding programs.[31] For example, Senators who placed a hold on H.R. 5501 and S. 2731 had stated that the bills would "transform a targeted and accountable $15 billion dollar AIDS program into an unaccountable, unspecified $50 billion development program."[32]

Proponents of the authorization level argued that access to HIV/AIDS prevention, treatment, and care for all would require greater resources. As a result, debate among bill advocates focused on where the dollars should be spent and what priorities the increased funding should support. Some urged Congress to consider further definition of tuberculosis authorities and targets, improved coordination of tuberculosis activities with HIV/AIDS activities in areas of co-infection, and strengthened reporting requirements for tuberculosis. Backers of the increased authorization argued that the next stage in fighting AIDS, tuberculosis, and malaria must occur alongside the strengthening of health systems. They argued that these activities must be integrated with related development efforts in order to ensure the sustainability of efforts to fight the three diseases.

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[30] For further information, see CRS Report RL34461, *Interior, Environment, and Related Agencies: FY2009 Appropriations,* by Carol Hardy Vincent, et al.; and CRS Report RL32198, *Indian Reserved Water Rights: An Overview*, by Yule Kim.

[31] Adam Graham-Silverman, "Despite Efforts, Senate Global AIDS Legislation Stalled Over Cost Concerns," *CQ Today*, June 13, 2008.

[32] Seven Senators placed a hold on H.R. 5501 and S. 2731 on March 31, 2008. See Senators Tom Coburn, Jim DeMint, Jeff Sessions, Richard Burr, Saxby Chambliss, Jim Bunning, and David Vitter, "Letter to Senator Mitch McConnell," March 31, 2008, at [http://coburn.senate.gov/ffm/index.cfm?FuseAction=Files.View&FileStore_id=82a33c04-4833-4a00-9895-4ff924bd9b04]. Senators Coburn and Burr subsequently withdrew their objection to a motion to proceed to S. 2731; see "Letter to Senator Mitch McConnell," July 1, 2008, at [http://coburn.senate.gov/ffm/index.cfm?FuseAction=Files.View&FileStore_id=de6535c6-c151-4717-89ff-26c399bf3024]. An agreement to limit amendments to S. 2731 to those identified and agreed to as first degree by the bill's managers (10 amendments) was reached with most of the Senators. Shortly thereafter, the Senate invoked cloture on a motion to proceed to the bill.

Some opponents used the Congressional Budget Office's (CBO) cost estimates to justify a lower authorization funding level. CBO estimated that implementing either H.R. 5501 or S. 2731, which was the bill from which language for the Senate-passed version of H.R. 5501 was drawn, would cost $35 billion from FY2009 through FY2013 and that most of the additional amounts of authorized funding would be spent by FY2018.[33] Some argued that the CBO cost estimates assumed that outlays will follow historical spending patterns for existing programs and did not reflect the proposed increases in authorization levels for tuberculosis and malaria spending and for the U.S. contribution to the Global Fund.

Global Malaria Coordinator

Both bills would have established a Coordinator of United States Government Activities to Combat Malaria Globally (Global Malaria Coordinator) at USAID. The Global Malaria Coordinator would oversee and coordinate all U.S. resources for international activities related to combating malaria. The bills also would have authorized the Global Malaria Coordinator to provide financial assistance to multilateral efforts such as the Roll Back Malaria Partnership (RBM).[34] The proposed authorization of a Global Malaria Coordinator was related to the creation of the President's Malaria Initiative (PMI), which President Bush announced in June 2005 and has been operational since FY2006. PMI is located at USAID.

Some observers opposed a disease-specific approach. They argued that it ignored the interconnected nature of health care challenges, and in resource-poor countries, it would create competition for limited human capacity such as doctors, public health specialists, and U.S. program managers. Supporters believed PMI would focus attention on malaria, which is a major killer in sub-Saharan Africa and some parts of Asia.

Others contended that directed efforts on specific diseases should occur simultaneously with efforts to build health capacity and infrastructure. While they applauded the initial emphasis on HIV/AIDS, which helped to build health system capacity in resource-poor settings, observers contended that the next stage of disease response under PEPFAR should integrate efforts to combat HIV/AIDS with the provision of basic healthcare and the prevention of childhood illness.

Some urged Congress to consider questions related to the establishment of PMI, including how PMI should coordinate its activities with PEPFAR; the further definition of authorities over the three diseases in the Leadership Act; the possibility of competing priorities between PMI and PEPFAR, especially where they operate in

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[33] Congressional Budget Office (CBO), *Cost Estimate: H.R. 5501*, March 5, 2008, at [http://www.cbo.gov/ftpdocs/90xx/doc9029/hr5501.pdf]. CBO, *Cost Estimate: S. 2731*, April 11, 2008, at [http://www.cbo.gov/ftpdocs/91xx/doc9126/s2731.pdf].

[34] The Roll Back Malaria Partnership (RBM) is a partnership of organizations that aims to provide a coordinated global approach to fighting malaria. RBM was launched in 1998 by the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP) and the World Bank. For more information on RBM, see [http://www.rollbackmalaria.org/].

the same Focus Countries; and the implications of different initiative timetables for strategic planning, funding authorizations, and implementation.

List of Focus Countries Expansion

On February 6, 2007, Representative Luis Fortuño introduced H.R. 848, a bill to amend the State Department Basic Authorities Act of 1956 to authorize assistance to combat HIV/AIDS in certain countries in the Caribbean. The bill would add 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, and the Dominican Republic to the list of Focus Countries. When introduced, H.R. 5501 proposed adding Vietnam as a Focus Country as well as those countries listed in H.R. 848. Representative Betty McCollum proposed adding Malawi, Swaziland and Lesotho to the list of Focus Countries in H.R. 5501 through H.Amdt. 975, which was adopted. While the House-passed version of H.R. 5501 would have added these additional Focus Countries, the Senate version proposed adding only Vietnam as a Focus Country. Vietnam has been a Focus Country in practice since 2004 at the direction of President Bush; this language would have updated the list of 14 Focus Countries that was included in the Leadership Act. The new language in the Senate-passed version also specified that in designating additional Focus Countries priority shall be given to those countries in which there is a high prevalence of HIV or risk of significantly increasing incidence of HIV within the general population and inadequate financial means within the country.

Some observers questioned why the above-named countries were selected, particularly since OGAC did not put forth these countries for consideration. Proponents of the addition of these new Focus Countries argued that the designation would direct more HIV/AIDS funding to these areas. Debate about the Focus Countries list also centered on how authorized funds in excess of the President's $30 billion PEPFAR reauthorization proposal would be distributed across PEPFAR countries. It was not clear whether the proposed, newly-designated Focus Countries would have received more support than they did previously or whether they would have been funded at higher levels than non-Focus Countries for HIV/AIDS activities. Some would have liked the final reauthorization bill to clarify this issue.

Opponents of the proposed list argued that incidence rates — the rates of new infections — have been growing in East Asia and Oceania, while incidence rates appeared to have stabilized in the Caribbean. They also argued that prevalence rates — the percentages of given populations that are infected with HIV/AIDS — have been growing in Eastern Europe and Central Asia, while prevalence rates in the Caribbean appeared to have stabilized and in some countries have even declined.[35] As new infections worldwide continued to outpace the numbers of infected persons placed on treatment, others asserted that a more complex analysis of need should be used in naming Focus Countries. Still others argued that Focus Countries should no

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[35] For more information on incidence and prevalence rates, see United Nations Joint Programme on HIV/AIDS (UNAIDS), *2007 AIDS Epidemic Update*, November 17, 2007, at [http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf].

longer be used to apportion funding and that distribution of funds should be based on country needs and recipient countries' access to other funding sources for HIV/AIDS programs.

Compacts With Recipient Countries

Some observers expressed concern about the long-term commitment that PEPFAR may require, particularly in the Focus Countries. As an alternative to adding Focus Countries, some suggested using compacts between the U.S. government and PEPFAR-recipient governments to clearly outline the scope and terms of U.S. involvement in AIDS prevention, treatment and care and to elicit recipient government involvement, ownership, and investment. Supporters asserted that compacts may have been helpful in outlining expectations for broader development efforts and investments that have been shown to have a significant impact on health. Some compacts, for example, might have included an agreement that aid recipient countries would reform property laws and inheritance laws. Such reforms have been shown to reduce the vulnerability of widows and orphans to HIV infection by providing them with greater financial security.[36] The Senate-passed version of H.R. 5501 supported this idea, stating that compacts and framework agreements were "one mechanism to promote the transition from an emergency to a public health and development approach to HIV/AIDS" and could be "tailored to local circumstances to promote host government commitment to deeper integration of HIV/AIDS services into health systems, contribute to the health systems overall, and enhance sustainability."[37] The language required that cost-sharing assurances from PEPFAR-recipient governments and transition strategies be included in compacts. The House-passed version of H.R. 5501 did not include similar language.

Role of Spending Directives

H.R. 5501 as passed by the House maintained funding distribution guidelines and spending directives of 20% for HIV prevention activities, 15% for HIV/AIDS care activities, and 10% for orphans and vulnerable children (OVC) activities, but it did not include the spending directive for HIV/AIDS treatment. The Senate-passed version maintained the spending directive for OVC and modified the spending directives for treatment and care by requiring that over half of bilateral HIV/AIDS assistance be spent on treatment, care, and nutritional and food support for HIV/AIDS-infected people. It did not include the funding distribution guidelines and spending directives for HIV/AIDS prevention. Both versions required balanced funding for HIV prevention activities, stating that a report to Congress must be provided to justify any decision to spend less than 50% of prevention funds on behavioral change programs, including abstinence and be faithful activities, in any PEPFAR recipient country with a generalized epidemic.

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[36] U.N. Millennium Project Task Force on Education and Gender Equality, *Taking Action: Achieving Gender Equality and Empowering Women*, 2005, at [http://www.unmillenniumproject.org/documents/Gender-complete.pdf].

[37] See Section 310(c)(6) and Section 301(d).

There was considerable debate about the effectiveness of congressional spending directives. Some observed that the spending directives limited Focus Country teams' ability to tailor budgets to local HIV transmission patterns.[38] Critics contended that the spending directives also complicated efforts to address the specific nature of the HIV/AIDS epidemic in each country. HIV/AIDS rates among the Focus Countries ranged from 1% to over 33%. The current and proposed Focus Countries had epidemics that varied in nature and prevalance: some epidemics were concentrated among drug users or prostitutes while others were spread throughout the population. Some argued that Congress might consider eliminating some or all prevention, treatment, and care spending directives to promote operational planning that was responsive to the nature of the epidemic in each country and reflected the cost of implementation in that area. The Government Accountability Office (GAO) found that the spending restrictions did not account for the costs of particular HIV/AIDS activities that may vary from country to country or for changes in costs over time.[39]

Some encouraged Congress to maintain its spending directives, particularly those related to orphans and vulnerable children (OVC). Supporters cited a GAO report that stated that without the spending directive, programs for OVC might not have been protected.[40] Others stressed the importance of the spending directive that requires at least 55% of HIV/AIDS funds be spent on HIV/AIDS treatment, to maintaining support for the purchase and distribution of antiretroviral drugs and related care for those receiving treatment. Senator Tom Coburn introduced S. 2749, the Save Lives First Act of 2008, on March 12, 2008, which maintains protections for AIDS treatment funding. Senator Coburn also signed a letter that requested a hold on H.R. 5501 and S. 2731, noting the removal of the treatment spending directive. *Congressional Quarterly* subsequently reported that, after negotiating for changes to S. 2731 — which was the basis for the Senate-passed version of H.R. 5501, Senator Coburn was "satisfied with language that would require more than half the money go to treatment, including antiretroviral drugs."[41] Senator Coburn subsequently withdrew his objection to a motion to proceed to S. 2731.[42]

Program Objectives

Program objectives are goals that establish the number of people that U.S. HIV/AIDS activities, such as prevention, treatment, and care, will reach within a

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[38] Institute of Medicine of the National Academies (IOM) Committee for the Evaluation of the President's Emergency Plan for AIDS Relief (PEPFAR) Implementation, *PEPFAR Implementation: Progress and Promise*, The National Academies Press: 2007.

[39] GAO, *Global HIV/AIDS: A More Country-Based Approach Could Improve Allocation of PEPFAR Funding*, April 2008, at [http://www.gao.gov/new.items/d08480.pdf].

[40] Ibid.

[41] Adam Graham-Silverman, "Deal Could Pave Way for Quick Senate Passage of Global AIDS Aid Measure," *CQ Today*, June 25, 2008.

[42] Senators Tom Coburn and Richard Burr, "Letter to Senator Mitch McConnell," July 1, 2008, at [http://coburn.senate.gov/ffm/index.cfm?FuseAction=Files.View&FileStore_id=de6535c6-c151-4717-89ff-26c399bf3024].

specified period. In 2003, for example, the PEPFAR five-year global program objective for treatment was to provide antiretroviral treatment for 2 million people.[43] Some suggested that one alternative to spending directives was to allow U.S. staff in PEPFAR Focus Countries to set annual program objectives for prevention, treatment, and care that, in turn, would be added up to become the five-year country prevention, treatment, and care objectives. These then would have been totaled across countries to calculate the U.S. global program objectives for these program areas. At the time of consideration of H.R. 5501, OGAC determined five-year country prevention, treatment, and care goals for the 15 Focus Countries, and then U.S. staff in PEPFAR Focus Countries set annual program objectives with the goal of reaching five-year country goals but with consideration for the challenges of the country's HIV/AIDS epidemic. OGAC then calculated global program objectives by adding up the five-year country targets.[44]

Some supporters of program targets being determined entirely by U.S. staff in PEPFAR Focus Countries contended that country teams have the greatest awareness of each country's needs and should establish prevention, treatment, and care targets. However, some PEPFAR country team members expressed concern about difficulties country teams might face in reaching a consensus about such targets.[45] Critics of program targets being determined this way asserted that Congress could specify global targets as a way of guiding policy implementation and priorities without hampering the ability of country-based teams to respond flexibly to in-country realities and to coordinate with national health plans. They pointed to language in both versions of H.R. 5501 as examples: both bills proposed establishing a target for prevention of mother to child [HIV] transmission (PMTCT) activities that at least 80% of pregnant women would be reached in affected countries by 2013.[46] The Senate version also proposed setting a target that the proportion of children receiving care and treatment would be proportionate to their numbers within the population of HIV-infected individuals in each country by 2013, while the House-passed version of H.R. 5501 proposed setting a target requiring that by 2013 up to 15% of those receiving treatment and care must be children.

Balance Between Prevention, Treatment, and Care

Debate about spending directives and program targets was closely related to debate about how to prioritize or balance HIV/AIDS prevention, treatment, and care activities. Some experts maintained that prevention should remain a focus of global efforts, because there is no cure for AIDS at this time and preventing new infections

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[43] The White House, "Fact Sheet: The President's Emergency Plan for AIDS Relief," January 29, 2003, at [http://www.whitehouse.gov/news/releases/2003/01/20030129-1.html].

[44] GAO, *Global HIV/AIDS: A More Country-Based Approach Could Improve Allocation of PEPFAR Funding*, April 2008, at [http://www.gao.gov/new.items/d08480.pdf].

[45] Ibid.

[46] In the Leadership Act, Congress required that the U.S. government strategy to combat the global HIV/AIDS pandemic must "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."

is the only way to stop the epidemic in the long term. In 2001 the U.N. General Assembly adopted the Declaration of Commitment on HIV/AIDS, which stated that "prevention must be the mainstay of our response."[47] Some organizations, such as the Bill and Melinda Gates Foundation and the Global AIDS Prevention Working Group, focused their efforts on strategies and prevention research in an effort to "prevent the HIV epidemic from becoming generalized in countries with emerging epidemics" and to prevent millions of new infections.[48]

On the other hand, some contended that focusing on prevention and neglecting treatment and care would ignore the economic and social impacts of the disease on those already infected, on the children and families of infected persons, and on countries with high prevalence rates. Some asserted that treatment and care were investments in hope and stability, preventing children from being orphaned and people from suffering the ravages of the disease when treatment to prolong life and improve its quality is available. Some argued that treatment costs were dropping very rapidly for not only first-line treatment regimens but also second-line antiretroviral therapies, a trend that was expected to continue as treatment expanded to cover more infected people in low and middle income countries and as more international donors negotiated for lower prices.[49] Others maintained that combating HIV/AIDS required a combination of prevention, treatment, and care rather than a choice between these strategies.

HIV/AIDS Activities and Family Planning

H.R. 5501 as passed by the House included language that addressed U.S. HIV/AIDS activities' links and referral to family planning and maternal health programs. Section 101(a)(4) of H.R. 5501 proposed amending Section 101 of P.L. 108-25, the Leadership Act. It stated that a comprehensive five-year global strategy to combat HIV/AIDS, tuberculosis, and malaria shall:

> include specific plans for linkage to, and referral systems for non-governmental organizations that implement multisectoral approaches, including faith-based and community-based organizations, for ... access to HIV/AIDS education and testing in family planning and maternal health programs supported by the United States Government.[50]

The Senate-passed version of H.R. 5501 did not include family planning program language.

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[47] U.N. Document, A/RES/S-26/L.2, June 27, 2001, at [http://data.unaids.org/publications/irc-pub03/aidsdeclaration_en.pdf].

[48] Bill and Melinda Gates Foundation, "Grantmaking Priorities for HIV/AIDS," [http://www.gatesfoundation.org/GlobalHealth/Pri_Diseases/HIVAIDS/HIV_Grantmaking.htm]. Global HIV Prevention Working Group, [http://www.globalhivprevention.org/].

[49] First-line treatment regimens are initial drugs used to treat infected people. When patients become resistant to these drugs they may require second-line and third-line drugs.

[50] This language is the proposed Section 101(a)(5)(D) in P.L. 108-25.

Opponents of the language in the House version of H.R. 5501 argued that the language was ambiguous and might have applied the Mexico City policy to programs that receive PEPFAR funding.[51] The Mexico City policy denies U.S. funds to foreign non-governmental organizations (NGOs) that perform or promote abortion as a method of family planning — even if the activities are undertaken with non-U.S. funds.[52] Others opposed the language because they did not believe that it sufficiently supported the integration of family planning services in U.S.-supported HIV prevention programs.[53] Proponents of the family planning program language in the House version of H.R. 5501 maintained that it would limit PEPFAR funding for family planning groups based on their compliance with the Mexico City policy.[54] Other groups reserved endorsement or opposition until such as time as Congress

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[51] For example, the Center for Health and Gender Equity states, "The bill restricts funding to U.S.-funded family planning programs — ensuring that restrictive U.S. policies such as the Mexico City Policy could extend to PEPFAR-funded programs that seek to link family planning and HIV prevention." Center for Gender Health and Equity, "U.S. Congress Introduces New PEPFAR Bill: Two Steps Forward, Three Steps Back," February 27, 2008, [http://www.genderhealth.org/pubs/PR2008BermanPEPFAR.pdf]. Pathfinder International, an NGO, states that the bill "adopts an ambiguous provision stating that only family planning organizations 'supported by the U.S. government' will be eligible for PEPFAR funds for HIV/AIDS testing and education purposes," which "potentially paves the way for the Mexico City Policy ... to be applied for the first time to the receipt of global HIV/AIDS funds." Pathfinder International, "Pathfinder International's Response to Recent Senate PEPFAR Reauthorization," March 19, 2008, [http://www.pathfind.org/site/PageServer?pagename=News_Pathfinder_Response_PEPFAR_Reauthorization_Senate08].

[52] For more information on the Mexico City policy, see CRS Report RL33250, *International Population Assistance and Family Planning Programs: Issues for Congress*, by Luisa Blanchfield.

[53] See, for example, EngenderHealth, "Action Alert: Global Funding for AIDS, TB, and Malaria," March 4, 2008, at [http://engenderhealth.org/media/press-releases/2008-03-04-hiv-funding.php]. Physicians for Human Rights, "PHR's Position on PEPFAR Reauthorization Bills," March 27, 2008, at [http://physiciansforhumanrights.org/library/news-2008-03-27.html]. Nandini Oomman, Center for Global Development, "PEPFAR Reauthorization Responds to Some Evidence from First Five Years," March 19, 2008, at [http://blogs.cgdev.org/globalhealth/2008/03/pepfar_reauthorizati_1.php]. Health GAP, "Comparison of House and Senate PEPFAR Legislation and Suggested Changes," March 24, 2008, at [http://www.pepfar2.org/ legislationsuggestions.html#FP].

[54] The Southern Baptist Convention's Ethics & Religious Liberty Commission, for example, is "encouraged by the changes that have taken place in the [House Foreign Affairs] committee that would keep funding from going to pro-abortion organizations." Southern Baptist Convention's Ethics & Religious Liberty Commission, "House Panel OKs Revised AIDS Funding," March 3, 2008, at [http://erlc.com/article/house-panel-oks-revised-aids-funding]. The Family Research Council states, "Unlike previous versions, this House bill doesn't fund 'family planning' services, although there's no explicit ban preventing it." Tony Perkins, Family Research Council, "Washington Update: FRC's PEP Talk Improves AIDS Bill," April 3, 2008, at [http://www.frc.org/get.cfm?i=WA08D15].

might further clarify the language. Some expressed concern, however, that the family planning language might contradict their beliefs and principles.[55]

Health Systems and the Single Disease Approach

Section 501 of the House version of H.R. 5501 proposed the development of five-year health workforce strategies by countries that receive assistance under the reauthorization. It directed the Global AIDS Coordinator and the Secretary of the Treasury to work to reform International Monetary Fund (IMF) policies that result in limitations on national and donor investments in health. It also directed the Global AIDS Coordinator to work with relevant stakeholders to develop effective public sector procurement and supply chain management systems for supplies and drugs in countries receiving assistance under the reauthorization. The Senate-passed version of H.R. 5501 included similar language through the use of compacts and actions required of the Administrator of USAID.

H.R. 5501 as passed by the House also would have required OGAC and USAID to create and implement a plan to combat HIV/AIDS by strengthening health policies and health systems of PEPFAR countries as part of USAID's Health Systems 20/20 project.[56] The plan, in part, would have aimed to encourage post-secondary institutions in host countries, especially in Africa, to develop human and institutional capacity to support the health care system in those countries. This included collaboration with U.S. post-secondary educational institutions including historically black colleges and universities.[57] The Senate-passed version included similar language.

The Senate version of H.R. 5501 also proposed requiring the U.S. strategy to combat global AIDS to "situate United States efforts to combat HIV/AIDS, tuberculosis, and malaria within the broader United States global health and development agenda, establishing a roadmap to link investments in specific disease programs to the broader goals of strengthening health systems and infrastructure and to integrate and coordinate HIV/AIDS, tuberculosis, or malaria programs with other health or development programs, as appropriate." This language required greater

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[55] Concerned Women for America stated that it "must watch carefully as funding is implemented" due to the "risk posed by the 'family planning' language in the bill." Sarah Griffith, Concerned Women for America, "A Series of Positive Events for AIDS Relief," March 28, 2008, at [http://www.cwalac.org/article_670.shtml].

[56] According to USAID's Health Systems 20/20 website, "health system weaknesses are among the most important factors contributing to the suboptimal use of priority health services. Health Systems 20/20 applies new and proven interventions in financing, governance, operations, and capacity building to strengthen health systems in order to increase use of priority services. . . . Health Systems 20/20 is working at the country level to conduct comprehensive analysis of available and required human resources to scale up and sustain HIV/AIDS services and to facilitate solutions to address human resource shortages." For more information please see USAID Health Systems 20/20, "What We Do," at [http://www.healthsystems2020.org/section/topics/].

[57] See H.Amdt. 976 to H.R. 5501, introduced by Representative Carson and agreed to with a 415-10 vote in the House.

strategic planning across U.S. global health and development programs to coordinate efforts across program areas.

Some health experts were concerned about the single disease approach to global health and how it focused limited resources in high burden countries on one disease while, they contended, the overall health infrastructure and workforces in resource-poor countries minimally improved. Some also were concerned about the possible long term implications of the increased funding levels if the funds were spent on treatment and care of individuals who are infected with AIDS. One study pointed out that treatment of infected individuals is a lifelong commitment and that treatment itself prolongs that length of time; it estimated that if scale-up of treatment continued at the historical rate since FY2004 and drug prices and treatment costs remained the same, maintenance of treatment funding levels would necessitate either a 20% increase in total U.S. overseas development assistance by FY2016 or a reallocation of 20% of the current overseas development assistance budget of $23 billion to AIDS treatment funding alone. It argued this might raise questions about how funding for other global health programs and development efforts might be adversely affected.[58]

Supporters of language that addressed issues of coordination of U.S. global health and development programs with disease-specific initiatives like PEPFAR and PMI argued that the more comprehensive development of health infrastructure and training of health workforces in these areas would increase the effectiveness of PEPFAR and other single-disease programs and decrease the need for disease-specific efforts in the future by building local capacity to address disease and basic health. Critics argued that such investment was outside the scope of PEPFAR and would distract from the program's focus on HIV/AIDS.

HIV/AIDS Activities and Nutrition Programs

Both versions of H.R. 5501 encouraged the integration of HIV/AIDS activities with nutrition programs through linkages and referrals to ensure that treated individuals receive the needed daily caloric intake to support effective treatment. Where such linkages and referrals were not possible, the Senate-passed version of H.R. 5501 proposed establishing additional services to provide nutritional support directly, and it also encouraged support for programs that address the intersections between food insecurity and health problems like HIV/AIDS. The House version of H.R. 5501 included similar language that authorized the direct provision of food and nutritional support to HIV/AIDS-infected individuals receiving antiretroviral treatment through PEPFAR where referrals were not possible. Both bills encouraged providing food and nutritional support for children affected by HIV/AIDS.

Language in both versions of H.R. 5501 addressing health system infrastructure and nutrition did not differ greatly from language included in the Leadership Act. The new language in both versions went into greater detail about the nature of the

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[58] Mead Over, "Prevention Failure: The Ballooning Entitlement Burden of U.S. Global AIDS Treatment Spending and What To Do About It," Center for Global Development Working Paper 144, April 2008, at [http://www.cgdev.org/content/publications/detail/15973].

infrastructure and nutrition challenges in certain regions. Both encouraged greater integration of U.S. HIV/AIDS efforts with broader pre-existing and parallel efforts by U.S. agencies and others, such as non-governmental organizations (NGOs), and promoted linking affected individuals through referrals with such services. Programs that might have been coordinated with or linked to include those that strengthen health care infrastructure, nutrition programs, safe drinking programs, income security programs, and programs that offer technical assistance in health care capacity building and public finance management.

Immigration and Nationality Act Amendment

H.R. 5501 as passed by the Senate proposed eliminating the language in the Immigration and Nationality Act (INA) that statutorily bars foreign nationals with HIV/AIDS from entering the United States.[59] The House-passed version of H.R. 5501 did not include similar language.

Supporters of the amendment argued that maintaining the restrictions on entry into the United States of AIDS-infected people was "discriminatory and unnecessary."[60] They also argued that major international conferences on health and AIDS should not be held in countries that have laws restricting the entry of people living with AIDS. Opponents to the amendment contended that the amendment would add too many costs by increasing U.S. spending on health programs for HIV/AIDS-infected people. Others disputed this would be a significant amount.

Additional Oversight Activities

The Senate version of H.R. 5501 proposed requiring additional reporting, including a report by the Comptroller General that would discuss the coordination of U.S. global AIDS efforts and the impact of global HIV/AIDS funding and programs on other U.S. global health programming. It also required the dissemination of an annual report by OGAC on best practices that might be replicated or adapted by other AIDS programs. In addition, it provided for the Inspectors General of the Department of State, the Broadcasting Board of Governors (BBG), HHS, and USAID to jointly develop five coordinated annual plans for oversight activity in each of the fiscal years 2009 through 2013. The House version of H.R. 5501 did not include similar language.

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[59] See Section 305 of S. 2731 (Reported in Senate) for further information and referral to information about current U.S. law. Immigration and Nationality Act of June 27, 1952, ch. 477; 66 Stat. 163; codified as amended at 8 U.S.C. §§1101 *et seq.* The INA is the basis of current immigration law. For further information, see CRS Congressional Distribution Memorandum, *U.S. Immigration Policy on Foreign Nationals with HIV/AIDS*, by Ruth Ellen Wasem, July 11, 2008, available from author.

[60] United Nations News Center, "UN programme to work toward elimination of HIV travel restrictions," March 5, 2008, [http://www.un.org/apps/news/story.asp?NewsID=25860&Cr=hiv&Cr1=unaids].

Taxation of Assistance Funds by Foreign Governments Prohibited

H.R. 5501 as passed by the House prohibited funds appropriated under the legislation from being made available to a foreign country unless the agreement provided that such assistance funds were exempt from taxation or otherwise reimbursed by the foreign government.[61] The Senate-passed version of S. 2731 did not include similar language.

Prevention of Mother to Child HIV Transmission (PMTCT) Panel

H.R. 5501 as passed by the Senate directed the Global AIDS Coordinator to establish an advisory panel of experts on prevention of mother to child HIV transmission (PMTCT) that would be known as the PMTCT Panel. The panel would review PMTCT efforts and make recommendations to OGAC and Congress on how to scale-up PMTCT services to ensure that, by 2013, such programs would provide access to counseling, testing, and treatment for at least 80% of pregnant women in those countries most affected by HIV/AIDS in which the United States has HIV/AIDS programs. The House version of H.R. 5501 did not include similar language.

Conscience Clause Expansion

Both versions of H.R. 5501 expanded "conscience clause" language included in the Leadership Act. The conscience clause in the Leadership Act stated that organizations that receive funding 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 combating 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. The new language in each version of H.R. 5501 referred to any HIV/AIDS program or activity to which an organization may have a religious or moral objection, whereas language in the Leadership Act referred only to any HIV/AIDS prevention method or treatment program to which the organization has a religious or moral objection. It further stated that organizations who opt-out of the above activities for religious or moral reasons shall not be discriminated against in the solicitation or issuance of grants, contracts, or cooperative agreements.

Outcomes Under H.R. 5501/P.L. 110-293

On July 24, 2008, the House passed the Senate version of H.R. 5501, the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008 (hereafter referred to as the Reauthorization Act). The Reauthorization Act (P.L. 110-293) was enacted on July

[61] This prohibition applies to funds being made available to a foreign country under a new bilateral agreement.

30, 2008. The outcomes of key proposals are described in **Table 4**. These key proposals and debates surrounding them are discussed in more detail in the previous section of this report. The funding levels authorized from FY2009 through FY2013 for U.S. programs to combat HIV/AIDS, tuberculosis, and malaria internationally are described in **Table 5**.

Table 4. Outcomes of Key Proposals to Change International HIV/AIDS, Tuberculosis, and Malaria Programs Under P.L. 110-293

Key Proposals	P.L. 110-293
Funding Authorization Increase	Authorizes $48 billion for HIV/AIDS, tuberculosis, and malaria from FY2009 through FY2013; authorizes $2 billion for Indian Health and Safety Emergency Fund from FY2009 through FY2013.
Global Malaria Coordinator	Established within USAID to oversee and coordinate U.S. government efforts to combat malaria globally.
List of Focus Countries Expansion	Vietnam added as Focus Country in U.S. government efforts to combat HIV/AIDS globally.
Compacts With Recipient Countries	Promotes the use of compacts between the U.S. government and country and regional programs on HIV/AIDS in order to promote host government commitment to deeper integration of HIV/AIDS services into health systems, contribute to health systems overall, and enhance sustainability.
Role of Spending Directives	OVC: Requires 10% of HIV/AIDS funds to be spent on orphans and other children affected by or vulnerable to HIV/AIDS (OVC). Prevention: Requires the Global AIDS Coordinator to provide balanced funding for prevention activities for sexual transmission of HIV/AIDS; and to ensure that activities promoting abstinence, delay of sexual debut, monogamy, fidelity, and partner reduction are implemented and funded in a meaningful and equitable way in the strategy for each host country based on objective epidemiological evidence as to the source of infections and in consultation with the government of each host county involved in HIV/AIDS prevention activities. Also requires a report to the appropriate congressional committees within 30 days to justify a decision to provide less than 50 percent of the sexual transmission prevention funds for activities promoting abstinence, delay of sexual debut, monogamy, fidelity, and partner reduction. Treatment and Care: For each of the fiscal years 2009 through 2013, more than half of the amounts appropriated for bilateral global HIV/AIDS assistance pursuant to section 401 shall be expended for

Key Proposals	P.L. 110-293
	antiretroviral treatment for HIV/AIDS; clinical monitoring of HIV-seropositive people not in need of antiretroviral treatment; care for associated opportunistic infections; nutrition and food support for people living with HIV/AIDS; and other essential HIV/AIDS-related medical care for people living with HIV/AIDS.
Program Objectives	Prevention Goal: To prevent 12 million new HIV infections worldwide. Treatment Goal: To support the increase in the number of individuals with HIV/AIDS receiving antiretroviral treatment above the 2 million person goal previously established under the Leadership Act for achievement by the end of FY2006 and increased pursuant to the following: for each of the fiscal years 2009 through 2013, the treatment goal shall be increased above 2 million people by at least the percentage increase in the amount appropriated for bilateral global HIV/AIDS assistance for such fiscal year compared with FY2008. Additionally, any increase in the treatment goal above this specified level shall be based on long-term requirements, epidemiological evidence, the share of treatment needs being met by partner governments and other sources of treatment funding, and other appropriate factors. The treatment goal also shall be increased above the number calculated above by the same percentage that the average U.S. government cost per patient of providing treatment in countries receiving bilateral HIV/AIDS assistance has decreased compared with FY2008. Care Goal: To support care for 12 million individuals infected with or affected by HIV/AIDS, including 5 million orphans and vulnerable children affected by HIV/AIDS (OVC), with an emphasis on promoting a comprehensive, coordinated system of services to be integrated throughout the continuum of care. The Reauthorization Act also states that the prevention and care goals described above shall be increased consistent with epidemiological evidence and available resources.
Balance Between Prevention, Treatment, and Care	Prioritizes prevention while preserving and increasing the treatment component of HIV/AIDS efforts as bilateral funding for HIV/AIDS increases relative to FY2008 levels.
HIV/AIDS Activities and Family Planning	Does not mention family planning.

Key Proposals	P.L. 110-293
Health Systems and the Single Disease Approach	Provides for helping partner countries to train and support the retention of health care professionals and paraprofessionals. It sets a target of training and retaining at least 140,000 new health care professionals and paraprofessionals with an emphasis on training and in-country deployment of critically needed doctors and nurses. This assistance is intended to strengthen the capacity of developing countries, especially in sub-Saharan Africa, to deliver primary health care. It has an objective to help countries achieve staffing levels of at least 2.3 doctors, nurses, and midwives per 1,000 population, as called for by the World Health Organization (WHO). Required OGAC and USAID to create and implement a plan to combat HIV/AIDS by strengthening health policies and health systems of PEPFAR countries as part of USAID's Health Systems 20/20 project.[1] The plan, in part, would aim to encourage post-secondary institutions in host countries, especially in Africa, to develop human and institutional capacity to support the health care system in those countries. This includes collaboration with U.S. post-secondary educational institutions including historically black colleges and universities. Required the U.S. strategy to combat global AIDS to situate United States efforts to combat HIV/AIDS, tuberculosis, and malaria within the broader United States global health and development agenda, establishing a roadmap to link investments in specific disease programs to the broader goals of strengthening health systems and infrastructure and to integrate and coordinate HIV/AIDS, tuberculosis, or malaria programs with other health or development programs, as appropriate. This language requires greater strategic planning across U.S. global health and development programs to coordinate efforts across program areas.
HIV/AIDS Activities and Nutrition Programs	Provides for linkages between HIV/AIDS activities and nutrition programs.
Immigration and Nationality Act (INA) Amendment	Amends the INA to statutorily allow foreigners infected with HIV/AIDS to enter the United States.
Additional Oversight Activities	Requires additional reporting, including a report by the Comptroller General that would discuss the coordination of U.S. global AIDS efforts and the impact of global HIV/AIDS funding and programs on other U.S. global health programming. Requires the dissemination of an annual report by OGAC on best practices that might be replicated or adapted by other AIDS programs.

Key Proposals	P.L. 110-293
	Provides for the Inspectors General of the Department of State, the Broadcasting Board of Governors (BBG), HHS, and USAID to jointly develop five coordinated annual plans for oversight activity in each of the fiscal years 2009 through 2013.
Taxation of Assistance Funds by Foreign Governments Prohibited	Language not included.
Prevention of Mother to Child HIV Transmission (PMTCT) Panel	Establishes a 15-person expert panel to review PMTCT activities and to provide recommendations for PMTCT scale-up to the Global AIDS Coordinator.
Conscience Clause Expansion	Expands definition to state that organizations that receive funding 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 combating HIV/AIDS, or to endorse, utilize, or participate in any HIV/AIDS program or activity to which an organization may have a religious or moral objection.

Source: Compiled by CRS from P.L. 110-293, the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008.

Table 5. Key Authorization Levels from FY2009 through FY2013 in P.L. 110-293, the Reauthorization Act of 2008

Area of Authorization	P.L. 110-293
Overall for HIV/AIDS, Tuberculosis, and Malaria	$48 billion (in total)
U.S. Contribution to Global Fund to Fight AIDS, Tuberculosis, and Malaria	Up to $2 billion for U.S. contributions in FY2009; and such sums as may be necessary from FY2010 through FY2013.
Tuberculosis	$4 billion (in total)
Malaria	$5 billion (in total)
Indian Health and Safety Emergency Fund	$2 billion (in total)

Source: Compiled by CRS from P.L. 110-293, the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008.