

CRS Report for Congress

Trends in U.S. Global AIDS Spending: FY2000-FY2007

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Tiaji Salaam-Blyther
Analyst in Foreign Affairs
Foreign Affairs, Defense, and Trade Division



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Summary

According to the Joint United Nations Program on HIV/AIDS (UNAIDS), since AIDS was identified in 1981, about 65 million people have been infected with HIV, and more than 25 million people have died from AIDS. At the end of 2005, some 40 million people were living with HIV/AIDS worldwide, more than 4 million of whom were newly infected; almost 3 million died of AIDS-related illnesses in 2005. More than 2 million of those living with HIV/AIDS at the end of 2005 were children, and some 570,000 of those who died of AIDS that year were under 15 years old. UNAIDS estimates that in each day of 2005, some 1,500 children worldwide became infected with HIV, due in large part to inadequate access to drugs that prevent the transmission of HIV from mother to child. Only 9% of pregnant women in low- and middle-income countries were offered services to prevent HIV transmission to their newborns.

UNAIDS asserts that an effective fight against the global spread of HIV/AIDS would cost \$15 billion in 2006, \$18 billion in 2007, and \$22 billion in 2008. In FY2006, Congress provided almost \$3.4 billion for international HIV/AIDS, tuberculosis (TB), and malaria programs, which included U.S. contributions to international partnerships, such as the Global Fund to Fight AIDS, TB, and Malaria (Global Fund). Most recent statistics indicate that in 2005, some \$8.3 billion was spent on HIV/AIDS globally, though UNAIDS estimated that \$11.6 billion was needed. About \$4.3 billion of those funds were provided by donor governments. The Kaiser Family Foundation asserts that in 2005, the United States provided the largest percent of HIV/AIDS assistance in the world, comprising some 49% of all donor spending.

Although the United States is the leading provider of international HIV/AIDS assistance, some argue that it needs to give more, particularly to the Global Fund. Critics of increased AIDS spending, however, question whether the most affected region — sub-Saharan Africa — can absorb increased revenue flows. Some also contend that additional HIV/AIDS allocations will yield limited results, as poor health care systems and health worker shortages complicate efforts to scale up HIV/AIDS spending. While this report describes how HIV/AIDS, TB, and malaria are interlinked and exacerbate efforts to control each disease, it primarily addresses funding issues related to U.S. global HIV/AIDS initiatives. It provides background information on the key U.S. agencies that implement global HIV/AIDS programs; analyzes U.S. spending on HIV/AIDS by U.S. agency and department; and presents some issues Congress might encounter in the 110th Congress. This report will be updated to reflect the final decision on FY2007 appropriations.

Glossary of Abbreviations and Acronyms

ABC	Abstinence, Be Faithful, Condoms
ARV	Anti-Retroviral medication
CDC	U.S. Centers for Disease Control and Prevention
COP	Country Operation Plan
CSH	Child Survival and Health
DOD	U.S. Department of Defense
DOL	U.S. Department of Labor
FDA	U.S. Food and Drug Administration
GAO	Government Accountability Office
GAP	Global AIDS Program
GHAI	Global HIV/AIDS Initiative
HHS	U.S. Department of Health and Human Services
HIPC	Highly Indebted Poor Countries
HRSA	U.S. Human Resources and Services Administration
IAVI	International AIDS Vaccine Initiative
ILAB	Bureau of International Labor Affairs
ILO	International Labor Organization
IMF	International Monetary Fund
I-TECH	International Training and Education Center on HIV
JLI	Joint Learning Institute
LIFE	Leadership and Investment in Fighting an Epidemic Initiative
MTCT	Mother-to-Child Transmission
NIH	National Institutes of Health
OAR	Office of AIDS Research
OGAC	Office of Global AIDS Coordinator
PEPFAR	President's Emergency Plan For AIDS Relief
PMI	President's Malaria Initiative
PMTCT	Prevention of Mother-to-Child Transmission
TB	Tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS
USAID	U.S. Agency for International Development
USDA	U.S. Department of Agriculture
WHO	World Health Organization

Contents

Introduction	1
History of Funding for U.S. Global HIV/AIDS Efforts	4
LIFE Initiative	4
International Mother and Child HIV Prevention Initiative	7
PEPFAR	7
PEPFAR-Participating Departments and Agencies	10
Department of State: Office of the Global AIDS Coordinator	10
U.S. Agency for International Development (USAID)	11
Department of Health and Human Services	13
Centers for Diseases Control and Prevention	13
National Institutes of Health (NIH)	15
Health Resources and Services Administration (HRSA)	17
U.S. Food and Drug Administration (FDA)	17
Department of Defense (DOD)	18
Department of Labor (DOL)	19
U.S. Department of Agriculture (USDA)	21
Peace Corps	21
U.S. Department of Commerce	21
Issues for the 110 th Congress	22
Consider Outstanding Appropriations	22
Reauthorize PEPFAR?	24
Decrease, Maintain, or Increase HIV/AIDS Funding Levels?	24
Retain U.S. Contributions to the Global Fund?	25
Alter Abstinence-Until-Marriage Stipulation?	26
Emphasize Other HIV Prevention Strategies?	26
Expand the List of Focus Countries?	27
Address Infrastructure Challenges and Health Worker Shortages	28
Appendix	29
HIV/AIDS Bills Not Enacted in the 109 th Congress	30
Legislation Related to Strengthening Health Systems	30
Legislation Related to Integrating Health Services	30
Legislation Related to HIV/AIDS Treatments and Vaccines	31
Legislation Related to Care for those Affected by HIV/AIDS	31
Legislation to Amend P.L. 108-25	31

List of Figures

Figure 1. OGAC HIV/AIDS Appropriations: FY2004-FY2007	11
Figure 2. USAID HIV/AIDS Appropriations: FY2000-FY2007	13
Figure 3. CDC HIV/AIDS Appropriations: FY2000-FY2007	15
Figure 4. Office of AIDS Research Grants: FY2000-FY2007	16
Figure 5. DOD HIV/AIDS Appropriations: FY2000-FY-2007	19
Figure 6. DOL HIV/AIDS Appropriations: FY2000-FY2007	20

List of Tables

Table 1. Global HIV/AIDS, TB, and Malaria Appropriations: FY2000-FY2003	6
Table 2. Global HIV/AIDS, TB, and Malaria Appropriations: FY2004-FY2007	9
Table 3. USAID Global Health Programs: FY2000-FY2007	24
Table 4. Participating Agencies and Departments in U.S. Global HIV/AIDS Initiatives: LIFE and PEPFAR	29

Trends in U.S. Global AIDS Spending: FY2000-FY2007

Introduction

It is estimated that HIV/AIDS, tuberculosis (TB), and malaria together kill more than 6 million people each year.¹ According to the Joint United Nations Program on HIV/AIDS (UNAIDS), at the end of 2005, an estimated 38.6 million people were living with HIV/AIDS, of whom 4.1 million were newly infected, and 2.8 million died in the course of that year.² More than 2 million of those living with HIV/AIDS at the end of 2005 were children, and some 570,000 of those who died of AIDS that year were under 15 years old. Almost 90% of all children infected with HIV reside in sub-Saharan Africa, which is home to 2 million of the estimated 2.3 million children living with HIV worldwide. UNAIDS estimates that on each day of 2005, some 1,500 children worldwide became newly infected with HIV, due in large part to inadequate access to drugs that prevent the transmission of HIV from mother to child. Only 9% of pregnant women in low- and middle-income countries were offered services to prevent HIV transmission to their newborns.

¹ See [http://www.who.int/tb/publications/2006/tb_facts_2006.pdf].

² Unless otherwise indicated, all data on HIV/AIDS infection rates are taken from UNAIDS, *2006 Report on the Global AIDS Epidemic*, at [http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp]. In November 2006, UNAIDS released its *2006 AIDS Epidemic Update* report. However, statistics from the 2006 full report are used, because the full report is more detailed, provides regional data, and reports on HIV infection among children, while the update does not. The update can be found at [http://data.unaids.org/pub/EpiReport/2006/2006_EpiUpdate_en.pdf].

The World Health Organization (WHO) estimates that by the end of 2004, more than 14 million people were infected with TB,³ of whom almost 9 million were newly infected.⁴ More than 80% of those living with TB in 2004 were in southeast Asia and sub-Saharan Africa, with the greatest per capita rate found in Africa. Although most forms of TB are curable, WHO estimates that the disease killed 2 million people in 2004.

According to WHO, each year there are about 300 million acute malaria cases,⁵ which cause more than 1 million deaths annually. Health experts believe that between 85% and 90% of malaria deaths occur in Africa, mostly among children,⁶ killing an African child every 30 seconds.⁷

While HIV/AIDS, TB, and malaria are preventable diseases, their impacts have been catastrophic, particularly in sub-Saharan Africa. Researchers have found that people infected with one of the three illnesses are more likely to contract either of the other two, and the symptoms are more severe in people with two or more of the diseases. According to WHO, 90% of people living with AIDS die within four to

³ Tuberculosis is a contagious disease that is spread like the common cold through the air. Only people who are sick with TB in their lungs are infectious. When infectious people cough, sneeze, talk, or spit, they propel TB germs, known as bacilli, into the air. A person needs only to inhale a small number of these to be infected. Left untreated, each person with active TB disease will infect an average of between 10 and 15 people every year. However, people infected with TB bacilli will not necessarily become sick with the disease. The immune system “walls off” the TB bacilli, which, protected by a thick waxy coat, can lie dormant for years. When someone’s immune system is weakened, the chances of becoming sick are greater. See [<http://www.who.int/mediacentre/factsheets/fs104/en/>].

⁴ WHO Report 2006, *Global Tuberculosis Control: Surveillance, Planning, Financing*, at [http://www.who.int/tb/publications/global_report/en/index.html].

⁵ There are four types of human malaria, *Plasmodium (P.) vivax*, *P. malaria*, *P. ovale*, and *P. falciparum*. *P. vivax* and *P. falciparum* are the most common, and *P. falciparum* is the most deadly type of malaria infection. *P. falciparum* malaria is most common in sub-Saharan Africa, accounting in large part for the extremely high malarial mortality in the region. People contract malaria through bites from infected mosquitos. An infected mosquito spreads the malaria parasite through the bloodstream. Once in the bloodstream, the malaria parasite can evade the immune system and infect the liver and red blood cells. Mosquitos can also contract malaria if they ingest blood from an infected person. See [http://malaria.who.int/cmc_upload/0/000/015/372/RBMInfosheet_1.htm].

⁶ As indicated above, WHO estimates that each year, 300 million acute malaria cases cause some 1 million deaths, 90% of which occur in sub-Saharan Africa. The World Bank estimates that there are more than 500 million cases of malaria each year, and that at least 85% of malarial deaths occur in sub-Saharan Africa. The World Bank believes that 8% of deaths occur in southeast Asia, 5% in the Eastern Mediterranean region, 1% in the Western Pacific, and 0.1% in the Americas. It asserts that there is no accurate count of malaria infections or deaths, due to weaknesses in data collection and reporting systems, inaccurate diagnoses that may result in over- or under-reporting, and an insufficient amount of skilled workers who can accurately make diagnoses, particularly in malaria-endemic areas.

⁷ WHO’s Roll Back Malaria website, [http://malaria.who.int/cmc_upload/0/000/015/372/RBMInfosheet_1.htm], accessed on August 31, 2006.

twelve months of contracting TB if they do not receive TB treatment.⁸ TB/HIV co-infection is a considerable burden in sub-Saharan Africa, where 70% of the world's 14 million co-infected people live. As many as half of all HIV-positive people in Africa have TB (and one out of three dies of TB), and up to 80% of all African TB patients have HIV.⁹ Research has demonstrated that treatment of TB or HIV in co-infected patients has positive effects on halting the advancement of both diseases. Studies have shown that HIV replication increases during the active phase of TB and returns to baseline after successful TB therapy. Conversely, anti-retroviral (ARV) treatment may decrease the progression of latent TB to active TB, allowing those infected with HIV to live longer.¹⁰

Some research has also found that malaria contributes to the advancement of HIV replication, greater sexual transmission of HIV, and higher mother-to-child HIV transmission (MTCT) rates among the co-infected. For example, one study in Malawi found that adults with acute malaria had a seven-fold increase in their HIV viral load.¹¹ However, HIV viral loads decreased when malaria treatment was offered to some patients. Conversely, HIV-positive pregnant women were more likely to contract malaria than HIV-negative pregnant women.¹² Additionally, malaria-HIV co-infection was associated with an increased risk of maternal, perinatal, and early infant death compared to infection of either disease alone. Researchers are also beginning to explore whether HIV-positive pregnant women who are co-infected with malaria are more likely to transmit HIV to their children. In Uganda, co-infected women had an HIV-transmission rate of 40%, while HIV-positive women not infected with malaria had an HIV transmission rate of 15.4%.¹³

Drug resistance complicates efforts to halt the spread of TB and malaria. WHO estimates that about 450,000 new multi-drug-resistant TB cases occur each year. In September 2006, WHO expressed concern about an increase in treatment-resistant TB cases, particularly in the Soviet Union, Asia, and South Africa.¹⁴ WHO found

⁸ The Stop TB Partnership, "WHO Calls for Free TB Drugs for HIV Patients," July 16, 2003; see [<http://www.stoptb.org>].

⁹ WHO press release, "WHO Pushing to Rapidly Scale-Up Measures to Fight TB and HIV," January 21, 2004, at [<http://www.who.int/mediacentre/news/releases/2004/pr5/en/>].

¹⁰ "TB-HIV Fueling Each Other." The Stop TB Partnership. June 2001.

¹¹ U.S. Department of Health and Human Services, Centers for Disease Control, National Center for Infectious Diseases, Division of Parasitic Diseases, Malaria Branch, "Interaction of HIV and Malaria," at [http://www.cdc.gov/malaria/pdf/Malaria_HIV_Rick_website.pdf].

¹² Carlo Ticconi, Monica Mapfumo, Maria Dorrucchi, Neela Naha, Elizabeth Tarira, Adalgisa Pietropolli, and Giovanni Rezza, "Effect of Maternal HIV and Malaria Infection on Pregnancy and Perinatal Outcome in Zimbabwe," *Journal of Acquired Immune Deficiency Syndromes*, vol. 34, no. 3 (Nov. 1, 2003), at [<http://www.jaids.com/>].

¹³ H. Brahmabhatt, G. Kigozi, F. Wabwire-Mangen, D. Serwadda, N. Sewankambo, T. Lutalo, M. J. Wawer, C. Abramowsky, D. Sullivan, and R. Gray, "The Effects of Placental Malaria on Mother-to-Child HIV Transmission in Rakai, Uganda," *AIDS: Official Journal of the International AIDS Society*, vol. 17 (Nov. 21, 2003), pp. 2539-2541, at [<http://www.aidsonline.com>].

¹⁴ UN News Center, "Drug-Resistant Strains of Tuberculosis Spark Concern from UN (continued...)"

that Extensive Drug Resistant TB (XDR-TB) is resistant not only to the two main first-line TB drugs — *isoniazid* and *rifampicin* — but also to three or more of the six classes of second-line drugs.¹⁵ Health experts are particularly concerned about the most recent outbreak of XDR-TB in South Africa, which killed 52 out of 53 patients within 25 days on average, including those being treated with anti-retroviral medication.¹⁶ On October 9 and 10, 2006, WHO convened a meeting of a Global Task Force to review available data on XDR-TB incidence, and to develop an emergency XDR-TB action plan focused on containing the deadly strain and advising health practitioners on XDR-TB case management.¹⁷

Some experts believe that a steady rise in malarial deaths in sub-Saharan Africa is due in large part to an increase in treatment resistance. One of the commonly used drugs, *chloroquine*, is quickly becoming ineffective in treating those infected with malaria.¹⁸ *Chloroquine* is affordable to many, as it costs approximately 10 cents per course of treatment. Because it has been used for more than 50 years, however, resistant strains of malaria are rapidly developing, rendering the drug useless in a growing number of cases. Newer treatments that are more effective and have no observable resistance are considerably more expensive. The new drugs, called “artemisinin-based combination therapies” (ACTs), cost about \$2 per treatment course, which is beyond the financial reach of many in the most affected regions.

History of Funding for U.S. Global HIV/AIDS Efforts

LIFE Initiative

In July 1999, then-President Bill Clinton requested that Congress provide an additional \$100 million to fund his Leadership and Investment in Fighting an Epidemic (LIFE) Initiative. The initiative sought to expand U.S. global HIV/AIDS efforts and to target the funds at 13 countries with the highest number of new HIV infections.¹⁹ Specifically, President Clinton proposed that Congress allocate \$48 million to global AIDS prevention, \$23 million to home- and community-based care, \$10 million to children orphaned by AIDS, and \$19 million to infrastructure and capacity development.

¹⁴ (...continued)

Health Agency.” Sept. 5, 2006, at [<http://www.un.org/apps/news/story.asp?NewsID=19727>].

¹⁵ For more information on the spread of drug-resistant TB, see [http://www.cdc.gov/nchstp/tb/pubs/mmwrhtml/mmwr_mdrtb.htm].

¹⁶ “Drug-Resistant TB in South Africa Draws Attention from U.N.,” *New York Times*, September 6, 2006, at [<http://www.nytimes.com>].

¹⁷ UNAIDS, *2006 AIDS Epidemic Update*, p. 12.

¹⁸ Data in this paragraph taken from *Disease News*, “Malaria Mortality Rate in Africa and Asia Could Double in a Few Decades as the Drug Used Most Frequently Is Rendered Useless,” July 23, 2004; see [<http://www.news-medical.net>].

¹⁹ The LIFE target countries were India, Ethiopia, Kenya, Malawi, Mozambique, Nigeria, Rwanda, Senegal, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe.

In FY2000, Congress provided more for global HIV/AIDS programs than President Clinton requested for his LIFE Initiative, directing \$189.3 million²⁰ to USAID for global HIV/AIDS activities; and appropriating \$46.8 million²¹ to the Department of Health and Human Services (HHS) for Centers for Disease Control and Prevention (CDC) global AIDS activities, providing the first bilateral HIV/AIDS appropriation to an agency other than USAID.²²

In FY2001, Congress expanded appropriations for global HIV/AIDS programs to the Departments of Agriculture (P.L. 106-948), Defense (P.L. 106-754), and Labor (P.L. 106-1033); and provided funds for the first U.S. Global Fund contribution (P.L. 106-997 and P.L. 106-1033). Some HIV/AIDS analysts contend that the LIFE Initiative raised congressional awareness about potential implications of a global HIV/AIDS epidemic, led to an increase in U.S. spending on global HIV/AIDS, and enhanced congressional receptivity to President George Bush's Emergency AIDS Plan, which he would announce three years later. While advocating for the LIFE Initiative, U.S. officials argued that HIV/AIDS was more than a health issue. HIV/AIDS, the Clinton administration contended, threatened economic growth, political stability, and civil society, which made it an issue of trade and investment, security and stability, and development.²³

²⁰ This figure includes a 0.38% across-the-board rescission.

²¹ The \$46.7 million includes \$34.8 million directed to CDC through regular FY2000 appropriations, and \$11.9 million provided through FY2000 emergency appropriations.

²² Although in FY2000, CDC was the only agency outside of USAID to which Congress appropriated funds for global HIV/AIDS programs, DOD and DOL websites indicate that each launched HIV/AIDS programs through the LIFE Initiative that fiscal year. Additionally, Congress authorized funds to the National Institutes of Health (NIH) for international research activities (discussed later).

²³ The White House, *Report on the Presidential Mission on Children Orphaned by AIDS in Sub-Saharan Africa: Findings and Plan of Action*, July 19, 1999, at [<http://clinton4.nara.gov/media/pdf/africa2.pdf>].

**Table 1. Global HIV/AIDS, TB, and Malaria Appropriations:
FY2000-FY2003**

(\$ millions)

Program	FY2000	FY2001	FY2002	FY2003
USAID HIV/AIDS assistance (excluding Global Fund)	189.3	280.0	485.0	587.6
USAID contributions to the Global Fund	0.0	120.0	200.0	248.4
USAID HIV/AIDS appropriations from other accounts	0.0	15.0	40.0	38.3
Foreign Military Financing	0.0	0.0	0.0	0.0
Foreign Operations Appropriations Subtotal	189.3	415.0	725.0	874.3
CDC Global AIDS Program	46.8	104.5	143.8	182.5
Global Fund Contribution from HHS	0.0	0.0	100.0	99.3
Department of Labor AIDS in the Workplace	0.0	10.0	10.0	9.9
Labor/HHS Appropriations Subtotal	46.8	114.5	253.8	291.7
Department of Defense HIV/AIDS Prevention	0.0	10.0	14.0	7.0
Section 416(b) Food Aid	0.0	25.0	25.0	25.0
TOTAL	236.1	564.5	1017.8	1198.0

Source: Prepared by CRS from appropriations legislation.

Note: The data includes supplemental appropriations. This table reflects appropriated figures, which may differ from actual spending. Agencies and departments might spend additional funds on global HIV/AIDS efforts that were not specifically appropriated. For example, though Congress does not specifically appropriate funds to NIH's global HIV/AIDS research efforts, the Office of AIDS Research reports that it has allocated some \$160 million, \$218 million, and \$279 million in grants in FY2001, FY2002, and FY2003, respectively.

International Mother and Child HIV Prevention Initiative

In FY2002, President Bush requested that Congress provide \$500 million to fund a new initiative he called the International Mother and Child HIV Prevention (PMTCT) Initiative.²⁴ The initiative sought to prevent the transmission of HIV from mothers to infants and to improve health care delivery in Africa and the Caribbean. Congress provided \$100 million to USAID for the initiative in FY2002 supplemental appropriations (P.L. 107-206); \$100 million to USAID and \$40 million to CDC for the initiative in FY2003 (P.L. 108-7); and \$150 million to CDC for the initiative in FY2004 (P.L. 108-199).

In addition to the \$150 million provided to CDC in FY2004, conferees expressed an expectation that \$150 million would be made available for the initiative from the newly established Global HIV/AIDS Initiative (GHAI; H.Rept. 108-401). Since the initiative expired in FY2004, following the administration's request, Congress has continued to include funds for programs that prevent the transmission of HIV from mother to child in the GHAI account.

PEPFAR

On January 28, 2003, during his State of the Union Address, President Bush proposed that the United States spend \$15 billion over the next five fiscal years to combat HIV/AIDS through an initiative he called the President's Emergency Plan for AIDS Relief (PEPFAR). The initiative, authorized in May 2003 by P.L. 108-25, the U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act, anticipates channeling \$10 billion through the Global HIV/AIDS Initiative (GHAI) to 15 focus countries (nine of the eleven LIFE focus countries are also PEPFAR focus countries); directing \$4 billion to global TB programs, international HIV/AIDS research, and bilateral HIV/AIDS programs in more than 100 additional non-focus countries; and reserving \$1 billion for U.S. Global Fund contributions.²⁵ Between FY2004 and FY2008, PEPFAR programs aim to support care for 10 million HIV-affected people, including children orphaned by AIDS; to support the prevention of 7 million new HIV infections; and to support the provision of ARVs to 2 million people.²⁶

Each fiscal year since the inception of PEPFAR, Congress has allocated more than the Administration has requested for global HIV/AIDS programs. Between FY2004 and FY2006, the United States spent some \$8.6 billion on global HIV/AIDS, TB, and malaria efforts, \$8.3 billion of which was spent on bilateral HIV/AIDS initiatives. During this time period, an estimated \$3.6 billion of the \$8.3 billion was spent on HIV/AIDS programs in the 15 focus countries through GHAI. The remaining amount, which totaled nearly \$5 billion, was spent on U.S. contributions to global partners like the Global Fund, pre-existing programs in 108 additional countries, international HIV/AIDS research, and global TB efforts. The Office of

²⁴ See [<http://www.whitehouse.gov/news/releases/2002/06/20020619-1.html>].

²⁵ White House fact sheet on PEPFAR, [<http://www.state.gov/p/af/rls/fs/17033.htm>].

²⁶ White House Fact Sheet, "The President's Emergency Plan for AIDS Relief," Jan. 29, 2003, at [<http://www.state.gov/p/af/rls/fs/17033.htm>].

Global AIDS Coordinator (OGAC) reports that in FY2004 and FY2005, PEPFAR-participating U.S. agencies and departments have supported:

- the provision of prevention of mother-to-child HIV transmission (PMTCT) services to approximately 3.2 million women, of whom over 248,000 have received ARV treatment, leading to the prevention of an estimated 47,100 new HIV infections;
- the purchase and distribution of ARV medication for an estimated 471,000 people, of whom 401,000 were in the 15 focus countries;
- care for nearly 3 million people in the focus countries, of whom 1.2 million were orphans and vulnerable children; and
- HIV counseling and testing services for over 9.4 million people in the focus countries.²⁷

PEPFAR programs, led by OGAC at the U.S. Department of State and implemented by various U.S. agencies and departments, support initiatives that prevent the contraction of HIV/AIDS, TB, and malaria, as well as care and treatment for people affected by the three diseases. Meanwhile, U.S. agencies and departments implement additional international HIV/AIDS, TB, and malaria programs not funded through PEPFAR. In each fiscal year since PEPFAR was launched, appropriators have included a chart in the foreign operations appropriations conference reports that itemizes how global HIV/AIDS, TB, and malaria funds are authorized to be spent (see **Table 2**). Press accounts of U.S. global HIV/AIDS spending are usually derived from this chart, though it does not include all U.S. global HIV/AIDS, TB, and malaria funds. In FY2007, however, the charts in House and Senate subcommittee reports do not include funding for global malaria efforts. Instead, language indicates that global malaria funds are authorized under the President's Malaria Initiative. While authorizing legislation for PEPFAR requires the President to submit to appropriators an annual report that describes how U.S. funds support the prevention of HIV/AIDS, TB, and malaria, as well as care and treatment for those affected by the three diseases, the two reports submitted by OGAC have only reported on U.S. global HIV/AIDS activities.

²⁷ OGAC, *Second Annual Report to Congress on PEPFAR, 2006*, at [<http://www.state.gov/s/gac/rl/c16742.htm>].

**Table 2. Global HIV/AIDS, TB, and Malaria Appropriations:
FY2004-FY2007**

(\$ millions)

Program	FY2004 Actual	FY2005 Actual	FY2006 Actual	FY2007		
				Request	House	Senate
1. Child Survival Assistance for HIV/AIDS (excluding Global Fund)	513.4	347.2	346.5	325.0	346.6	342.5
2. Child Survival Assistance for TB & Malaria	183.9	168.6	178.2	305.0	257.6	305.0
3. Child Survival Assistance for Global Fund	397.6	248.0	247.5	100.0	200.0	300.0 ^a
4. FY2004 Global Fund Carryover ^b	-87.8	87.8	n/a	n/a	n/a	n/a
5. Other USAID accounts ^c	53.2	53.1	42.6	40.4	33.8	34.1
6. State Department GHAI	488.1	1,373.5	1,775.0	2,794.0	2,528.0	2,494.9
7. GHAI for the Global Fund	0.0	0.0	198.0	100.0	244.5	300.0 ^a
8. Foreign Military Financing ^d	1.5	2.0	1.9	1.6	— ^e	— ^e
9. Subtotal, Foreign Operations Appropriations	1549.9	2280.2	2,789.7	3,666.0	3,610.5	3,776.5
10. CDC Global AIDS Program (GAP)	291.8 ^f	123.8	122.7	121.9	121.9	121.3
11. NIH International Research	317.2	370.0	371.1	368.0	— ^e	— ^e
12. Global Fund contribution NIH	149.1	99.2	99.0	100.0	0.0	100.0
13. DOL AIDS in the Workplace Initiative	9.9	1.9	— ^e	0.0	0.0	—
14. Subtotal, Labor/HHS Appropriations^g	768	594.9	592.8	589.9		
15. DOD HIV/AIDS prevention education, primarily in Africa	4.2	7.5	5.2	0.0	—	— ^e
16. Section 416(b) Food Aid	24.8	24.8	24.8	10.0	— ^e	— ^e
17. TOTAL	2346.9	2907.4	3,412.5	4,265.9		

Source: Prepared by CRS from appropriations legislation figures and interviews with Administration staff.

- a. S.Rept. 109-277, the Senate report to the FY2007 Foreign Operations appropriations, proposes contributing \$600 million to the Global Fund, though it only appropriates \$300 million to the Child Survival and Health (CSH) account. The additional \$300 million U.S. Global Fund contribution on Line 7 should be considered a placeholder. There is no certainty that the funds will be appropriated to this account.
- b. In FY2004, \$87.8 million of the amount provided to the Global Fund was withheld per legislative provisions limiting U.S. contributions to the Global Fund to 33% of the amount contributed by all donors. The FY2005 Consolidated Appropriations legislation provided these withheld funds to the Global Fund, subject to the 33% proviso, like the remainder of the U.S. contribution.
- c. Other USAID accounts include Development Assistance (DA), Economic Support Fund (ESF), Assistance for Eastern Europe and the Baltic States (SEED), and Assistance for the Independent States of the Former Soviet Union (FSA).
- d. Appropriations for Foreign Military Financing are used to purchase equipment for DOD HIV/AIDS programs. DOD HIV/AIDS initiatives are referred to in Line 15.
- e. Not congressionally designated, though funds could be provided at the Administration's discretion.
- f. The funding level for FY2004 GAP activities is significantly higher than subsequent fiscal years because funds for the PMTCT Initiative were included in overall CDC global AIDS funds. However, after FY2004, funds for the Initiative were appropriated to GHAI.
- g. FY2005 was the last year that OGAC tracked spending by CDC on HIV/AIDS research spending, international malaria, and global tuberculosis initiatives. CRS has followed this practice and no longer reports spending on these efforts, though they and other programs contribute to U.S. efforts to curb the global spread of these diseases.

PEPFAR-Participating Departments and Agencies

A number of U.S. departments and agencies are responsible for implementing PEPFAR programs, though OGAC coordinates the distribution of most U.S. global HIV/AIDS spending through the Global HIV/AIDS Initiative (GHAI). After the State Department, USAID and HHS (NIH OAR²⁸ and CDC GAP) receive the largest congressional appropriations for international HIV/AIDS efforts. Other departments that receive global HIV/AIDS funds include Labor (though Congress did not appropriate funds to DOL in FY2006), Defense, and Agriculture. The programs and budgets of each PEPFAR-participating department and agency are detailed below. All budgetary figures in this section are adjusted to reflect rescissions unless otherwise specified.

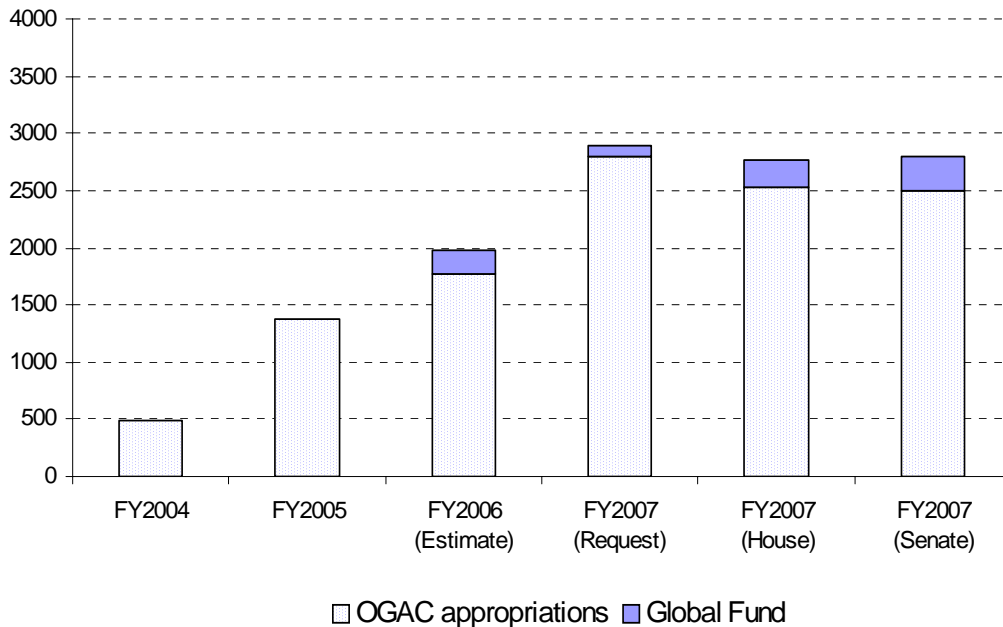
Department of State: Office of the Global AIDS Coordinator

In FY2003, P.L. 108-25 authorized the creation of OGAC. The mission of this office is to coordinate and oversee all global HIV/AIDS spending by U.S. agencies in the 15 focus countries. At the time of selection, these countries were among the world's most severely affected by HIV/AIDS, were home to approximately half of the world's 40 million HIV-positive people, and held almost 8 million children who were orphaned or made vulnerable by HIV/AIDS.

As a coordinating office, OGAC transfers GHAI funds that it receives from Congress for the 15 focus countries to implementing departments and agencies. **Figure 1** illustrates appropriations to OGAC from FY2004 through FY2007. In FY2004, Congress provided OGAC its first appropriation, \$488.1 million. Congress provided a substantially larger amount for GHAI in FY2005, when it appropriated \$1,373.5 million to OGAC. Congress boosted appropriations to GHAI again in FY2006, providing \$1,775.0 million to the effort. In FY2007, the President requested \$2,794.0 million for GHAI, the House Foreign Operations Appropriations Subcommittee proposed providing \$2,528.0 million to GHAI, and the Senate Foreign Relations Appropriations Subcommittee suggested appropriating \$2,476.5 million to the initiative.

²⁸ Staff of OAR have indicated that they do not believe that OAR funds should be included in overall PEPFAR funds, as the office does not receive funds through OGAC and its spending decisions are independently made. Authorizing language in HHS appropriations since FY2000 has enabled the Office of the Director at NIH to independently determine the appropriate spending level for international HIV/AIDS research. Nonetheless, NIH international HIV/AIDS research spending is included here as part of PEPFAR spending, following the practice of OGAC.

Figure 1. OGAC HIV/AIDS Appropriations: FY2004-FY2007
(\$ in millions, current)



Source: Compiled by CRS from appropriations legislation.

U.S. Agency for International Development (USAID)

USAID implements global HIV/AIDS programs in 50 countries and reaches an additional 48 countries through regional programs. The programs largely focus on the following objectives:

- strengthening primary health care systems;
- providing training, technical assistance, and commodities, including pharmaceuticals that reduce HIV transmission;
- providing care and support to people infected with HIV/AIDS;
- reducing high-risk behaviors; and
- supporting international partnerships, such as the International AIDS Vaccine Initiative (IAVI), UNAIDS, and the Global Fund.

Prior to the launching of the LIFE Initiative, USAID was the sole agency through which Congress supported bilateral HIV/AIDS programs, though other agencies or departments might have implemented global HIV/AIDS initiatives. In FY2000, Congress appropriated \$189.3 million to USAID for its global HIV/AIDS programs. In FY2001, appropriators provided \$295 million to the agency for global HIV/AIDS projects, and an additional \$120.0 million for a U.S. contribution to the Global Fund.²⁹ Appropriations for USAID's bilateral programs rose in FY2002 to \$525 million, which included \$100 million for the PMTCT Initiative. When the additional \$200.0 million that Congress appropriated for a U.S. contribution to the

²⁹ In FY2000, Congress provided \$20 million for a U.S. contribution to the Global Fund in regular appropriations, and an additional \$100 million in supplemental appropriations.

Global Fund are added, total appropriations to USAID reached \$725.0 million in FY2002.³⁰ In FY2003, Congress slightly increased appropriations to the agency, providing \$526.5 million for its HIV/AIDS projects, including \$99.3 million for the PMTCT Initiative and an additional \$248.4 million for the Global Fund.

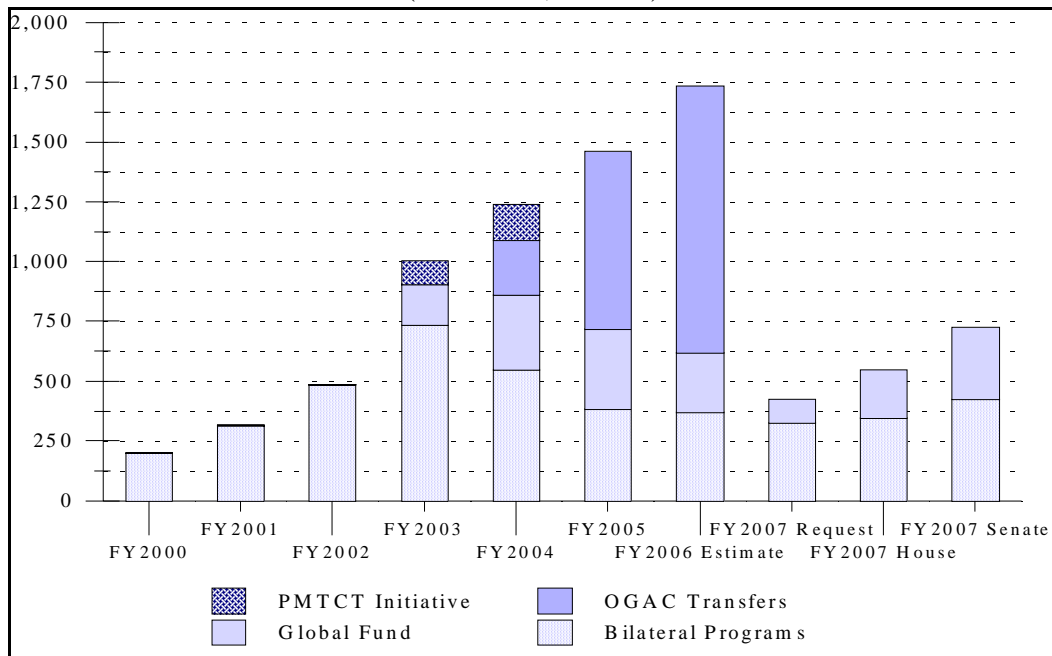
Some analysts have asserted that since Congress began funding GHAI in earnest, support for USAID-managed HIV/AIDS programs has declined. In FY2004, when PEPFAR was first funded, appropriations to USAID's bilateral programs reached \$549.2 million and appropriations to GHAI for the 15 Focus Countries were \$488.1. In FY2005 and FY2006, when appropriations to GHAI were ramped up to \$1.4 billion and \$1.8 billion, respectively, support for USAID's bilateral programs fell to \$382.8 million and \$371.2 million, respectively.³¹ In FY2007, the President requested \$325.0 million for USAID's bilateral HIV/AIDS initiatives, while the House proposed providing \$346.6 million for USAID's HIV/AIDS programs, and the Senate suggested appropriating \$342.5 million to the projects. Proposed spending levels from the administration and appropriating subcommittees are lower for FY2007 than FY2006 appropriations.

Although appropriations for USAID HIV/AIDS programs have declined since FY2003, overall spending by USAID on global HIV/AIDS initiatives has increased. In FY2004 and in subsequent fiscal years, some of the funds that were appropriated to OGAC for GHAI were transferred to USAID (see **Figure 2**). As a coordinating body, OGAC does not implement HIV/AIDS programs; it transfers funds to the implementing agencies and departments as needed. Most of the funds appropriated to USAID are spent on global HIV/AIDS programs in non-focus countries; while the majority of funds transferred to the agency from OGAC are spent on HIV/AIDS efforts in the 15 focus countries. This practice has expanded USAID's funding streams, so that it receives support for its global HIV/AIDS programs from congressional appropriations and from OGAC transfers. With OGAC transfers, total USAID HIV/AIDS spending has increased substantially since FY2003.

³⁰ In FY2002, Congress provided \$100 million to USAID for a Global Fund contribution in regular appropriations and an additional \$100 million in supplemental appropriations. The FY2002 supplemental appropriations also included \$100 million for the PMTCT Initiative.

³¹ Includes appropriations to other accounts for USAID's bilateral HIV/AIDS programs.

Figure 2. USAID HIV/AIDS Appropriations: FY2000-FY2007
(\$ millions, current)



Source: Compiled by CRS from appropriations legislation and interviews with OGAC staff.

Department of Health and Human Services

Centers for Diseases Control and Prevention. A number of HHS agencies participate in PEPFAR activities. The CDC Global AIDS Program (GAP) operates in 25 countries³² and includes regional programs in Asia, the Caribbean, Central America, and Southern Africa. CDC initiated its international HIV/AIDS programs in FY2000 under the LIFE Initiative. CDC sends clinicians, epidemiologists, and other medical experts to assist foreign governments, health institutions, and other entities that work on a range of HIV/AIDS-related activities. The key objectives of GAP are to help resource-constrained countries prevent HIV infection; improve treatment, care, and support for people living with HIV; and build health care capacity and infrastructure. Specific activities within the projects include:

- conducting HIV lab tests;
- supporting ARV drug therapy for HIV/AIDS patients;
- preventing mother-to-child transmission (PMTCT);
- supporting HIV counseling and testing;
- strengthening national blood transfusion services to ensure safe blood supplies;

³² The 25 GAP countries (with PEPFAR focus countries italicized) are Angola, *Botswana*, Brazil, Cambodia, China, *Côte d'Ivoire*, D.R. Congo, *Ethiopia*, *Guyana*, *Haiti*, India, *Kenya*, Malawi, *Mozambique*, *Namibia*, *Nigeria*, *Rwanda*, Senegal, *South Africa*, *Tanzania*, Thailand, *Uganda*, *Vietnam*, *Zambia*, and Zimbabwe.

- supporting medical injection safety programs; and
- building in-country surveillance, monitoring, and evaluation capacity.

In FY2000, for the first time, Congress provided \$34.8 million for CDC global HIV/AIDS programs, and an additional \$11.9 million for global HIV prevention and research through FY2000 emergency supplemental appropriations. In FY2001, Congress appropriated \$104.5 million to CDC (of which \$3 million was committed to Health Resources and Services Administration (HRSA)'s International Training and Education Center on HIV. In FY2002, funding increased again to \$143.7 million. Congress provided about the same level of funding for GAP programs in FY2003, providing \$142.6 million for GAP programs and an additional \$40 million for the PMTCT Initiative. Funding for GAP remained about the same in FY2004; that year the initiative received \$142.7 million and an additional \$149.1 million for the PMTCT Initiative.

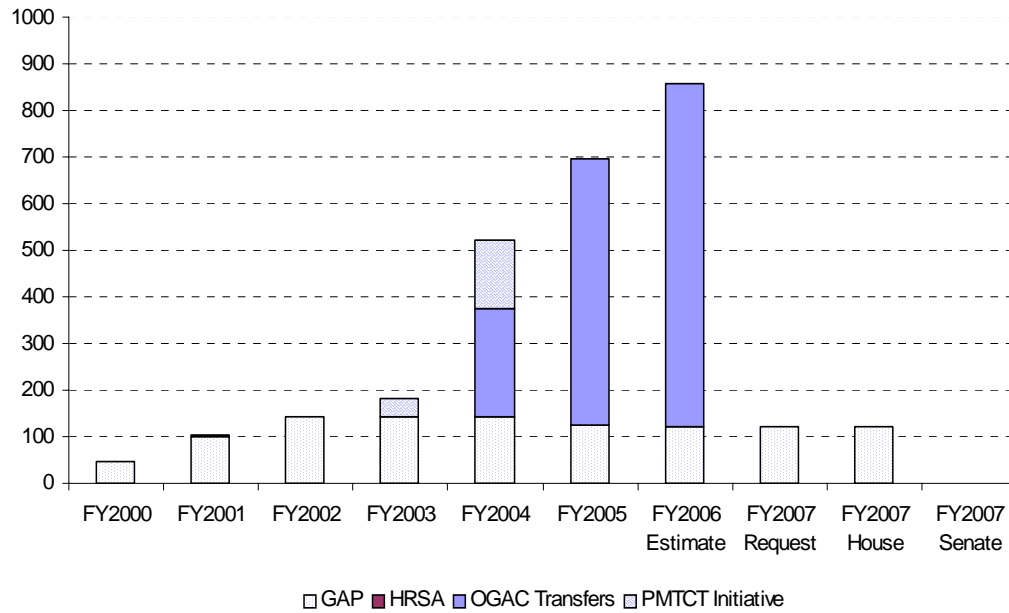
In FY2005, when the PMTCT Initiative expired, Congress stopped including funds for the effort in CDC GAP appropriations. Nonetheless, preventing mother-to-child HIV transmission remains a critical part of CDC GAP activities. Funds for the PMTCT Initiative are included in GHAI appropriations, and OGAC transfers funds to CDC to continue PMTCT activities. GAP funding fell slightly in FY2005 and FY2006, when Congress provided \$123.8 million and \$122.6 million, respectively. The Administration requested \$121.9 million for CDC HIV/AIDS programs in FY2007. The House Labor, HHS, Education Appropriations Subcommittee proposed fully funding the President's request, while the Senate subcommittee did not indicate a specific amount for CDC global HIV/AIDS programs.

Although appropriations to CDC GAP have declined since FY2004, when OGAC transfers are included, as was the case for USAID, total provisions have increased (**Chart 3**).³³ In FY2004, OGAC transferred \$230.6 million to CDC for GAP programs. In FY2005 and FY2006, OGAC transferred \$573.5 million and \$734.0 million to CDC, respectively.³⁴

³³ This chart does not include funding for other HHS global HIV/AIDS efforts, such as CDC overseas applied HIV prevention research, and National Institutes of Health (NIH) international HIV/AIDS research. The chart also does not include U.S. Global Fund contributions, as the contribution is not funded through the CDC bilateral programs.

³⁴ Correspondence with OGAC staff in June 2006.

Figure 3. CDC HIV/AIDS Appropriations: FY2000-FY2007
(\$ in millions, current)



Source: Compiled by CRS from appropriations legislation and interviews with

OGAC.

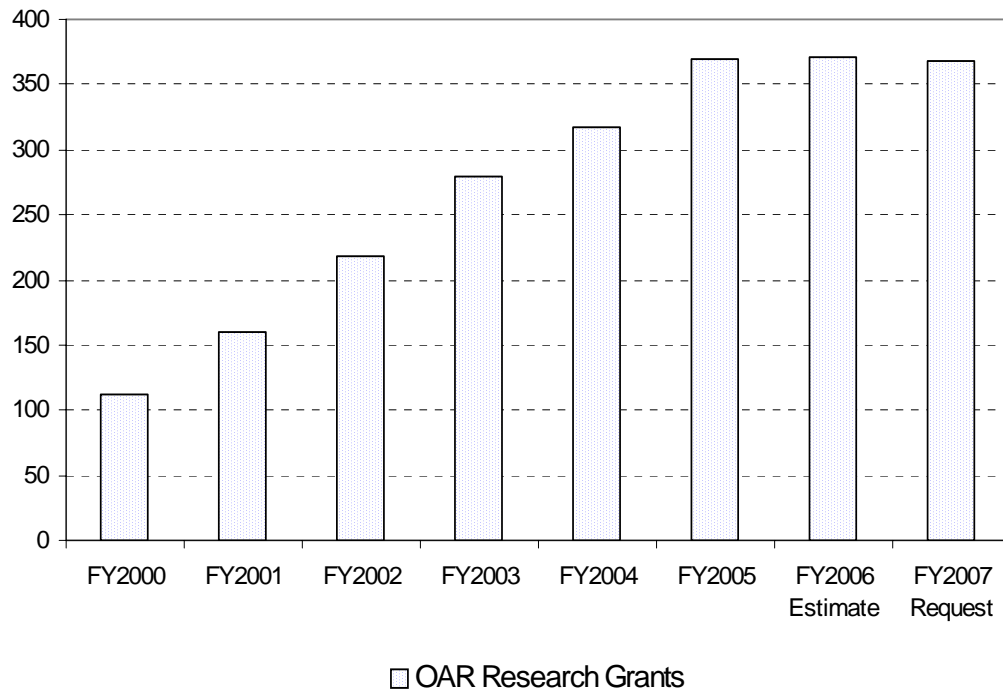
National Institutes of Health (NIH). NIH has long implemented international HIV prevention efforts. In 1984, NIH initiated its global HIV research in Haiti; today NIH's global HIV research is conducted in 90 countries around the world. NIH-sponsored international research includes efforts to:

- develop an HIV vaccine;
- develop chemical and physical barrier methods for HIV prevention, including microbicides;
- prevent sexually transmitted diseases, including HIV;
- encourage behavior change to lessen risky behaviors;
- identify drug and non-drug strategies to prevent mother-to-child HIV transmission;
- develop therapeutics for HIV-related co-infection; and
- strengthen approaches to treating HIV in resource-poor settings.

NIH staff assert that although PEPFAR draws on expertise from NIH's Office of AIDS Research (OAR) international HIV/AIDS research activities, OAR spending on global AIDS research is not determined by PEPFAR priorities.³⁵ OAR's international HIV/AIDS research spending is driven by research activities conducted in the field. NIH staff explain that its program spending fluctuations represent the funding phases of multi-year grants that support the research activities. Through competitively bid grants, OAR directs most of its funds to U.S.-based investigators who conduct HIV/AIDS research in collaboration with international scientists. However, some investigators based in foreign research institutions have also received OAR grants. In FY2007, OAR estimates that it will award \$368 million in grants for global AIDS research activities (see **Figure 4**); and, as in previous fiscal years, neither chamber appropriated a specific amount for NIH international HIV/AIDS research.

³⁵ CRS interview with OAR staff, July 5, 2006.

**Figure 4. Office of AIDS Research Grants: FY2000-FY2007
(\$ in millions, current)**



Source: NIH, Office of the Director.

Health Resources and Services Administration (HRSA). HRSA, which has experience expanding HIV/AIDS and other health services in resource-poor settings in the United States, helps PEPFAR focus countries to develop HIV care and treatment plans.³⁶ Much of the training is conducted through International Training and Education Centers on HIV (I-TECH). In 2002, HRSA and CDC established I-TECH to share lessons learned from U.S. domestic AIDS education and training efforts. I-TECH programs offer health experts in PEPFAR focus countries and other resource-poor countries technical assistance on effective HIV/AIDS program expansion. The assistance focuses on developing training programs, advising health managers, producing health education materials, and providing guidance on HIV awareness and education messages.

U.S. Food and Drug Administration (FDA). As OGAC began to establish guidelines for the purchase of HIV treatment, the Bush Administration expressed skepticism about broad-based use of generic ARV medication. The Administration asserted that WHO's prequalification process was not sufficient, and that generic drugs purchased with PEPFAR funds had to pass FDA inspection.³⁷ The Administration's position was that the WHO is not a regulatory body, and thus its adherence to stringent FDA standards was uncertain.³⁸ Observers contended that the U.S. position was shaped by then-Global AIDS Coordinator, Randall Tobias. When President Bush selected Randall Tobias as the Global AIDS Coordinator in July 2003, some had opposed his appointment, fearing that he would oppose the use of generic ARV medications in PEPFAR programs because of his long-standing relationship with the pharmaceutical industry.³⁹ The Bush Administration responded that Mr. Tobias's experience in the private sector was what made him a good candidate.

Debate about the use of generic ARVs in PEPFAR-supported programs continued — though it was somewhat muted — after the FDA approved the first generic ARV for use in PEPFAR programs in December 2004. Although the generic drug was approved less than a year after FDA launched an expedited review process, critics contended that the process was unnecessary and delayed the distribution of ARVs.⁴⁰ The FDA contended that the process was necessary to ensure that ARV

³⁶ For more on HRSA's global HIV/AIDS training efforts, see [<http://www.go2itech.org/>].

³⁷ The WHO prequalifying process includes an assessment of product files (lasting approximately two to four months); site inspections; and the procurement of data on all active pharmaceutical ingredients, specifications, product formulas, and manufacturing methods. After the products and manufacturing sites meet the required standards, the medicine is added to the list of prequalified products. For more information, see [<http://www.who.int/3by5/publications/briefs/amds/en/>].

³⁸ Interviews with staff at the Office of the AIDS Coordinator, April 1, 2004.

³⁹ Randall Tobias is no longer the U.S. Global AIDS Coordinator. For a summary of the debate on his selection for the position, see the Kaisernetwork website at [http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=1&DR_ID=18625].

⁴⁰ David Brown and Ellen Nakashima, "U.S. Rule on AIDS Drugs Criticized," *Washington Post*, July 14, 2004. Steve Sternberg, "Bush's AIDS plan could be tough to implement," *USA Today*, July 14, 2004. "The end of the beginning? AIDS," *The Economist*, July 17, (continued...)

treatments used in the PEPFAR programs were safe, effective, and of high quality.⁴¹ The expedited review process can take between two and six weeks. Since FDA began reviewing generic drug applications, more than 30 generic versions of patented ARVs have been approved or tentatively approved for use in PEPFAR treatment plans.⁴²

Department of Defense (DOD)

The Department of Defense also joined the U.S. global fight against HIV/AIDS under the LIFE initiative. DOD HIV prevention programs develop and implement military-specific HIV prevention activities. DOD efforts:

- help foreign militaries to establish HIV/AIDS-specific policies for their personnel;
- assist foreign militaries in adapting and providing HIV prevention programs;
- train foreign military personnel to implement, maintain, and evaluate HIV prevention programs;
- assist foreign countries in developing military-specific interventions that address high-risk HIV attitudes and behaviors; and
- integrate with and make use of foreign military contacts, other U.S. government programs, and those managed by allies and the United Nations.

In FY2000, the department received \$10.0 million through the LIFE Initiative, though Congress did not appropriate funds to the department.⁴³ In FY2001, Congress provided \$10.0 million to DOD for its HIV prevention efforts. In FY2002, Congress provided \$14.0 million. Appropriations to the department fell in FY2003 to \$7.0 million. In FY2004, Congress did not provide any funds for DOD HIV prevention activities. However, through FY2005 appropriations, Congress amended FY2004 Defense appropriations to add \$4.2 million for FY2004 DOD global HIV programs, and provided \$7.5 million for FY2005 DOD HIV prevention efforts. Finally, in FY2006, Congress appropriated \$5.3 million to DOD for global HIV prevention activities. The FY2007 budget request did not include funds for DOD global HIV/AIDS efforts, and the FY2007 Defense appropriations did not include funds for DOD global HIV/AIDS programs. As with other U.S. agencies and departments, DOD spending on global HIV prevention has been significantly boosted by OGAC transfers (see **Figure 5**).

⁴⁰ (...continued)

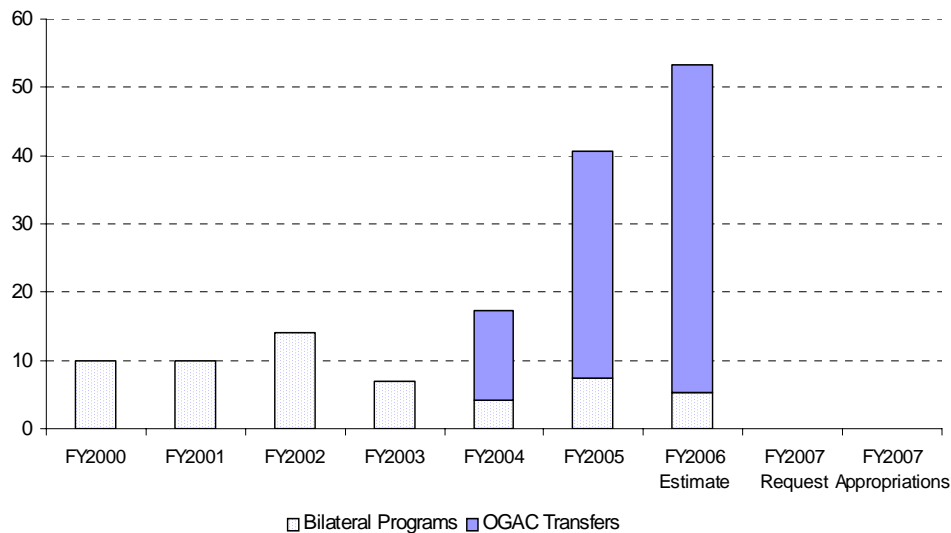
2004. For more on the debate about the FDA review process, see the Kaisernetwork website at [http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=1&DR_ID=27788].

⁴¹ HHS Press Release, “HHS Proposes Rapid Process for Review of Fixed Dose Combination and Co-Packaged Products,” May 14, 2004, at [<http://www.hhs.gov/news/press/2004pres/20040516.html>].

⁴² For more information on FDA’s role in reviewing ARVs, see [<http://www.fda.gov/oia/pepfar.htm>].

⁴³ DOD HIV Prevention website, [<http://www.nhrc.navy.mil/programs/dhapp/background/background.html>].

Figure 5. DOD HIV/AIDS Appropriations: FY2000-FY2007 (\$ in millions, current)



Source: Compiled by CRS from appropriation legislation and interviews with OGAC staff.

Department of Labor (DOL)

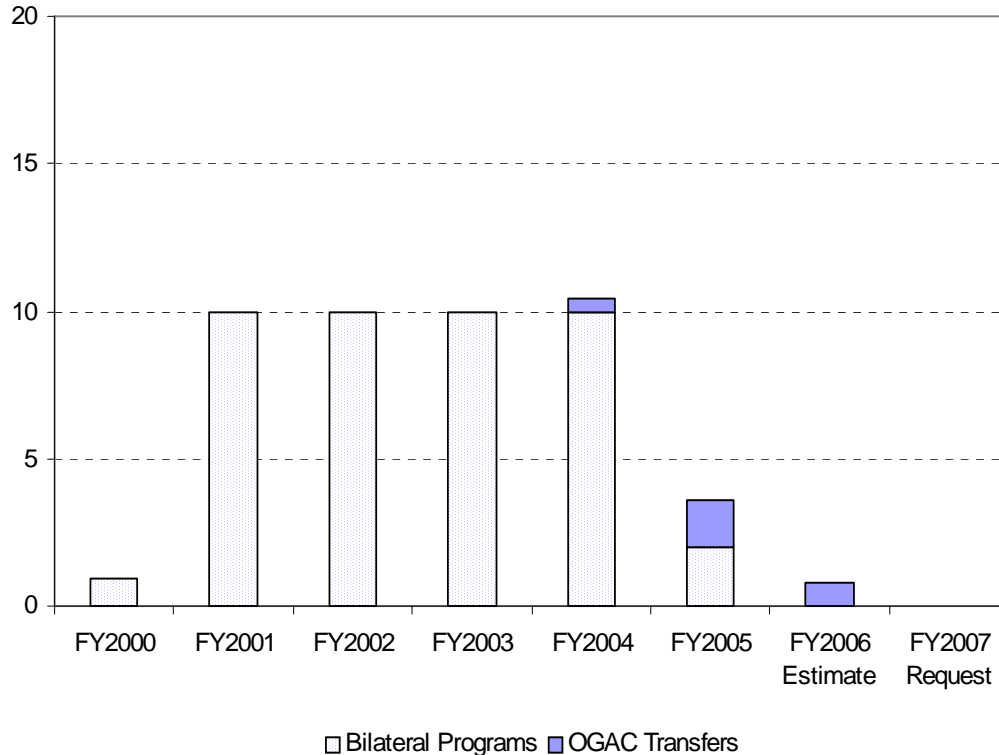
DOL HIV/AIDS-in-the-workplace programs are implemented through the Bureau of International Labor Affairs (ILAB). Key activities include:

- guiding the development of comprehensive workplace-based prevention and education programs;
- assisting governments, employers, and trade unions to develop and disseminate national workplace policy statements that counter stigma and discrimination; and
- supporting the formation of tripartite advisory committees (government, business, and labor).

ILAB initiated its HIV prevention programs under former President Clinton's LIFE Initiative. Although Congress did not appropriate funds to the bureau in FY2000, ILAB reports that it spent \$900,000 on international HIV/AIDS efforts in that fiscal year. In FY2001, ILAB received its first global HIV/AIDS appropriation, \$10 million (excluding rescissions). From FY2001 to FY2004, Congress maintained funding for DOL HIV-prevention in the workplace programs at \$10 million (excluding rescissions). Conference report language to FY2004 Labor, HHS, and Education Appropriations stated that ILAB was to transfer the full balance of its global HIV/AIDS funds to the International Labor Organization's (ILO's) global AIDS programs. In FY2005, appropriations to ILAB HIV programs fell to \$1.9 million; conference report language again included the statement that the funds were to be transferred to the ILO. In FY2006, Congress did not provide any funds to DOL

for HIV-in-the-workplace programs.⁴⁴ The Administration did not request funds for DOL HIV programs in FY2007, and neither House nor Senate subcommittee bills appropriate funds for the programs (see **Figure 6**).⁴⁵

**Figure 6. DOL HIV/AIDS Appropriations: FY2000-FY2007
(\$ in millions)**



Source: Compiled by CRS from appropriation legislation and interviews with OGAC staff.

Some speculate that the Bush administration's opposition to the rapid growth and breadth of ILAB's technical assistance programs led to a decline in congressional support for the bureau's HIV-in-the-workplace programs. Since the administration submitted its first budget request in FY2002, Secretary of Labor Elaine Chao has attempted to minimize the scope of activities undertaken by ILAB. At an FY2002 hearing on DOL's budget, the Secretary asserted that the increase in appropriations from FY2000 to FY2001 was made too quickly and that the bureau was not able to absorb the rapidly increased funding.⁴⁶ At a subsequent budget hearing in FY2003, the Secretary argued that ILAB needed to return its focus to improving core labor

⁴⁴ OGAC transferred some funds to DOL in FY2004, FY2005, and FY2006, providing \$400,000, \$1,600,000 and \$800,000, respectively.

⁴⁵ The \$900,000 illustrated in FY2002 of Figure 6 was not appropriated. DOL reports that it spent that amount on international HIV/AIDS efforts in that fiscal year.

⁴⁶ Senate Labor, HHS, Education Subcommittee hearing on DOL's FY2002 budget request, May, 2, 2001.

standards and combating child labor abuses.⁴⁷ Other activities that the bureau engaged in — including combating HIV/AIDS — the Secretary contended, strayed from the bureau's core mission and duplicated the efforts of other U.S. agencies. Finally, in FY2005, Secretary Chao complained that ILAB spent too much of its budget on overhead through grants to other organizations.⁴⁸

U.S. Department of Agriculture (USDA)

In FY2001, and in each subsequent fiscal year, Congress committed USDA to donate commodities valued at up to \$25 million to foreign countries struggling to counter the effects of HIV/AIDS. Although the funds are appropriated to USDA, USAID manages the provision of the food aid. Neither the House nor the Senate FY2007 Agriculture appropriations bills would provide funds for USDA food assistance.

Peace Corps

The Peace Corps uses its volunteers to support community-based HIV/AIDS care and prevention initiatives in 77 countries around the world, nine of which are PEPFAR focus countries. Currently, some 20% of Peace Corps volunteers are involved in HIV/AIDS and health projects worldwide, and some 800,000 people have benefited from Peace Corps HIV/AIDS training.⁴⁹ In 2003, about 1,000 volunteers worked on HIV/AIDS programs, and in 2004, about 3,100 volunteers engaged in HIV/AIDS activities.⁵⁰ While some of the Peace Corps' HIV/AIDS activities were highlighted in OGAC's *Second Annual Report to Congress*, no agency-specific spending information was included in the report. Appropriations legislation has not provided a specific amount for Peace Corps global HIV/AIDS initiatives since PEPFAR was launched.⁵¹

U.S. Department of Commerce

The Department of Commerce provides in-kind support to PEPFAR aimed at fostering public-private partnerships. The activities focus on informing industry HIV trade advisory committees on how the private sector can help to combat HIV/AIDS; and on creating and disseminating sector-specific strategies for various industries (e.g., consumer goods, oil, and health care). The U.S. Census Bureau, within the Department of Commerce, also contributes to PEPFAR by assisting with data

⁴⁷ House Labor, HHS, Education Subcommittee hearing on DOL's FY2003 budget request, February 13, 2002.

⁴⁸ House Labor, HHS, Education Subcommittee hearing on DOL's FY2005 budget request, February 12, 2004.

⁴⁹ See [<http://www.peacecorps.gov/index.cfm?shell=learn.whatlike.interactivefeatures.hiv>].

⁵⁰ See [<http://www.peacecorps.gov/index.cfm?shell=learn.Whatvol.healthhiv>].

⁵¹ In FY2004, appropriators authorized OGAC to transfer up to \$15 million of GHAI funds to the Peace Corps for global HIV/AIDS efforts. OGAC staff reported in an interview conducted on June 29, 2006, that the office transferred \$1.2 million, \$4.7 million, and \$7.8 million to the Peace Corps for global HIV/AIDS programs in FY2004, FY2005, and FY2006, respectively.

management and analysis, estimating infections averted, and supporting mapping of country-level activities.

Issues for the 110th Congress

Consider Outstanding Appropriations

HIV/AIDS advocates are closely watching how Congress will ultimately fund global HIV/AIDS programs. In FY2007, Congress did not enact any of the outstanding appropriations measures that would provide funds for global HIV/AIDS, TB, and malaria activities. Instead, it amended P.L. 109-289 (Division B), which provides funding at the lesser of FY2006 enacted, FY2007 House-passed, or FY2007 Senate-passed levels until February 15, 2007. H.R. 5522, the FY2007 House Foreign Operations appropriations, would provide some \$3.61 billion for the three diseases, about \$47 million less than the Administration requested for FY2007. H.R. 5647, the FY2007 House Labor, HHS, Education appropriations, would provide \$121.9 million for CDC's Global AIDS Program (GAP), meeting the President's request. For the first time, the House Labor, HHS, Education Appropriations Subcommittee did not propose additional funds for a U.S. Global Fund contribution through Labor, HHS, Education appropriations. Instead, it deemed the \$445 million included in its FY2007 Foreign Operations appropriations proposal to be a sufficient amount for a U.S. Global Fund contribution. With no additional funds provided in H.R. 5647, the House appropriations subcommittees proposed contributing less to the Fund in FY2007 than the preceding fiscal year for the first time since Congress began appropriating contributions to the Global Fund.

The Senate report on FY2007 Foreign Operations appropriations, S.Rept. 109-277, provided much less detail on how global HIV/AIDS, TB, and malaria funds should be spent, but proposes appropriating a larger amount for the three diseases. The Senate Foreign Relations Appropriations Subcommittee proposed nearly \$3.8 billion for global HIV/AIDS, TB, and malaria efforts. Of that amount, the subcommittee wanted to commit \$600 million for a U.S. contribution to the Global Fund, though the bill did not specify to which account \$300 million of the funds would be appropriated. Where specified, the Senate subcommittee proposal meets or exceeds the Administration's requests for the three diseases. S. 3708, FY2007 Labor, HHS, Education appropriations, does not provide a specific amount for global HIV/AIDS, TB, and malaria programs.

While considering the appropriate level to provide for global HIV/AIDS programs, some Members expressed concern that requests for complementary health programs had fallen from FY2006 appropriated levels. Congresswoman Nita Lowey questioned the effectiveness of increasing spending on the Millennium Challenge Corporation (MCC) and PEPFAR, while proposing a reduction or no change in spending for other development assistance and non-AIDS programs. Representative Lowey stated, "I have serious concerns that as resources to these two programs have increased, funding for traditional development initiatives managed by USAID have either flatlined or decreased. [It] makes no sense to put money into ARV therapy for HIV/AIDS patients if they are so malnourished that they cannot absorb the drugs. A budget that addresses one aspect of the problem while neglecting another related

aspect will not achieve the desired impact.”⁵² Global health experts argue that the skewed investment in HIV/AIDS is pulling in-country resources and health workers away from government-run health clinics and toward foreign-funded HIV/AIDS programs. This movement, health analysts argue, exacerbates the current health worker shortage and limits the number of health professionals capable of treating other afflictions.

Although some Members in both chambers criticized the Administration’s proposal to lower funding for most global health programs, appropriations subcommittees in the House and Senate suggested spending less than the President requested in some areas (see **Table 3**).⁵³ The House Foreign Operations subcommittee sought less than was requested for USAID’s child survival and maternal health programs and for initiatives that address other infectious diseases. However, it proposed more than requested for USAID vulnerable children initiatives, HIV/AIDS programs, and family planning/reproductive health efforts. The Senate Foreign Relations subcommittee allocated less than requested for USAID bilateral HIV/AIDS programs and other infectious diseases initiatives. Nonetheless, the Senate proposed more than requested for the remaining programs.

⁵² FY2007 House Foreign Operations Appropriations Subcommittee hearing on USAID’s FY2007 budget request, April 26, 2006.

⁵³ Data in this table is meant for comparative purposes only. The figures were compiled by USAID budget office, and differ somewhat from appropriated figures.

Table 3. USAID Global Health Programs: FY2000-FY2007
(\$ millions)

Program	FY2000 Enacted	FY2001 Enacted	FY2002 Enacted	FY2003 Enacted	FY2004 Enacted	FY2005 Enacted	FY2006 Enacted	FY2007 Request	FY2007 House	FY2007 Senate
CS/MH	\$461.5	\$361.1	\$391.7	\$389.7	\$442.9	\$450.7	\$461.4	\$421.8	\$356.4	\$468.4
VC	\$0.0	\$36.7	\$32.3	\$34.3	\$36.0	\$35.3	\$37.7	\$13.4	\$25.0	\$30.0
HIV/AIDS	\$200.0	\$417.8	\$501.3	\$871.9	\$972.9	\$634.5	\$625.9	\$453.9	\$546.6	\$443.9
Other ID	\$70.4	\$140.2	\$182.0	\$173.1	\$200.5	\$216.0	\$310.2	\$396.6	\$287.6	\$367.3
FP/RH	\$372.5	\$424.0	\$446.5	\$443.6	\$429.5	\$437.0	\$435.0	\$357.3	\$350.0 ^a	\$465.3
TOTAL	\$1,104.4	\$1,379.7	\$1,553.9	\$1,912.5	\$2,081.8	\$1,773.5	\$1,870.2	\$1,643.0	\$1,565.6	\$1,774.9

Source: USAID, Bureau for Policy and Program Coordination. FY2007 House, and Senate columns prepared by CRS from appropriations legislation.

Abbreviations:

CS/MH = Child Survival and Maternal Health

VC = Vulnerable Children

Other ID = Other Infectious Diseases

FP/RH = Family Planning and Reproductive Health

Note:

- a. The committee proposed the provision of additional funds for this program through other accounts, bringing the total for reproductive health and family planning to \$432 million.

Reauthorize PEPFAR?

In the 110th Congress, Members might decide whether to reauthorize PEPFAR, which expires in FY2008. While there appears to be strong support for the reauthorization of the initiative, a number of Members and advocates have proposed some changes to the authorizing legislation. Still other HIV/AIDS analysts suggest that health infrastructure challenges and health worker shortages in many countries will have to be resolved if the United States is to effectively combat the global spread of HIV/AIDS. Some global health advocates are urging Congress to reintroduce bills similar to those that were not enacted in the 109th Congress, but sought to address a range of issues related to the global HIV/AIDS pandemic (see Appendix).

Decrease, Maintain, or Increase HIV/AIDS Funding Levels? P.L. 108-25 authorized the appropriation of \$15 billion to fund PEPFAR through FY2008. If current trends continue, it appears that appropriations will exceed that amount. Some are concerned that competing domestic and international priorities might threaten future congressional spending on foreign assistance, which includes global HIV/AIDS efforts. In June 2006, Representative Jim Kolbe, Chair of the Foreign Operations Subcommittee, warned that the growth in spending on domestic entitlement programs could squeeze out foreign aid allocations.⁵⁴ From FY2003 to FY2004, Congress increased global HIV/AIDS appropriations by about \$700 million,

⁵⁴ Cited from a speech Representative Kolbe gave at the Center for Global Development on June 26, 2006, at [<http://www.cgdev.org/content/article/detail/8495>].

and between FY2004 and FY2006 by about \$500 million per fiscal year. If Congress fully funds the Administration's request, global HIV/AIDS spending in FY2007 will exceed FY2006 spending levels by about \$800 million, reaching approximately \$4.3 billion. Though the virus continues to spread, some proponents of greater HIV/AIDS spending believe that congressional support for global HIV/AIDS programs may soon peak, as suggested by the House Foreign Operations Appropriations Subcommittee's decision not to exceed the President's request for global HIV/AIDS funding for the first time.

Retain U.S. Contributions to the Global Fund? Some HIV/AIDS analysts predict that debate on PEPFAR reauthorization might include whether to set spending limits for U.S. contributions to the fund and at what levels. P.L. 108-25 stipulates that U.S. contributions to the fund for FY2004 through FY2008 may not exceed 33% of contributions from all sources. U.S. Representatives instituted the contribution limit to encourage greater global support for the Global Fund. Some supporters of the fund argue that the 33% should represent the amount the United States contributes annually. Others argue that the statute serves as a ceiling and does not commit the United States to providing 33% of all contributions.⁵⁵ Senate-passed S.Amdt. 3052 to S.Con.Res. 83, the FY2007 Senate budget bill, supported the 33% provision and increased the U.S. FY2007 Global Fund contribution by \$566 million.

Some question whether U.S. contributions to the fund are provided at the expense of U.S. bilateral programs. At an FY2005 Senate Appropriations Committee hearing, then-Global AIDS Coordinator Randall Tobias argued that the "incremental difference between what the Administration requested and what was appropriated to the Fund is money that might have been available" for use in U.S. bilateral programs.⁵⁶ While proposing PEPFAR, the Administration announced that it would seek \$1 billion for the Global Fund over the five-year term of the initiative. Congress has already exceeded that proposal, providing more than \$2 billion to the fund from FY2004 to FY2006. The House Foreign Operations Subcommittee proposed an additional \$444.5 million for the fund in FY2007, while the Senate Foreign Relations Subcommittee proposed \$600 million.

⁵⁵ For more 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.

⁵⁶ Senate Appropriations Committee hearing on FY2005 Appropriations, May 18, 2004.

Alter Abstinence-Until-Marriage Stipulation? Some health experts assert that PEPFAR's HIV prevention stipulations are not well-balanced, place too much emphasis on abstinence until marriage, and limit countries' ability to utilize prevention funds in a manner that is most relevant to local conditions. P.L. 108-25, which delineates how PEPFAR funds should be allocated, stipulates that between FY2006 and FY2008:

- 55% of global HIV/AIDS funds are to be used to treat people infected with HIV/AIDS, of which 75% should be spent on the purchase and distribution of ARV medication;
- 15% of global HIV/AIDS funds are to be used for palliative care;
- 20% of global HIV/AIDS funds are to be used for prevention efforts, of which at least 33% should be expended for abstinence-until-marriage programs; and
- 10% of global HIV/AIDS funds should be reserved for children orphaned or affected by HIV/AIDS.

Opponents of the 33% abstinence-until-marriage provision cite an April 2006 Government Accountability Office (GAO) report, which concluded that the stipulation places a burden on prevention spending. GAO found that PEPFAR's spending requirements limit the flexibility with which prevention funds could be spent.⁵⁷ GAO estimated that in order to meet the 33% proviso, between FY2004 and FY2006, OGAC increased spending on prevention by almost 55% and mandated that country teams spend half of prevention funds on sexual transmission prevention and two-thirds of those funds on abstinence/faithfulness (AB) activities. Additionally, GAO found that OGAC applied the 33% spending requirement to all PEPFAR prevention funding, even though P.L. 108-25 specifies application to the 15 focus countries funded through GHAI. Some expect that in the 110th Congress Members might introduce legislation that amends the 33% provision, as was proposed in the 109th Congress (H.R. 5674 and S. 3656).

Emphasize Other HIV Prevention Strategies? Some HIV advocates argue that since a disproportionate percentage of prevention funds are spent on abstinence-only programs, spending on other HIV prevention strategies is limited. Many health experts advocate for greater spending on the prevention of mother-to-child HIV transmission PMTCT.⁵⁸ UNAIDS estimates that 1,800 children worldwide become infected with HIV each day, the vast majority of whom are newborns. More

⁵⁷ GAO, *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>].

⁵⁸ Most children living with HIV acquire the disease through mother-to-child transmission (MTCT), which can occur during pregnancy, labor and delivery, or breastfeeding. In the absence of any intervention, the risk of such transmission is 15%-30% in non-breastfeeding populations. Breastfeeding by an infected mother can increase the risk to 45%. The risk of MTCT can be reduced to under 2% by interventions that include the provision of ARV treatments. Elective caesarean delivery and complete avoidance of breastfeeding can also reduce the risk of HIV transmission. In many resource-constrained settings, elective caesarean delivery is seldom feasible, and mothers often lack access to enough clean water or formula to refrain from breastfeeding. Research is ongoing to evaluate several new approaches to preventing HIV transmission during breastfeeding.

than 85% of children infected with HIV live in sub-Saharan Africa, although MTCT rates are rapidly rising in Eastern Europe and Central Asia.⁵⁹ UNAIDS estimates that in 2005, just less than 8% of pregnant women in low- and middle-income countries had access to services that could prevent the transmission of HIV to their babies.⁶⁰ Advocates of greater PMTCT spending argue that while proposed bills such as H.R. 5674, H.R. 4188, and S. 2765 support PMTCT initiatives by calling for greater coordination of women's health and HIV/AIDS programs, they could be strengthened by specifying how much HIV/AIDS funding should be spent on PMTCT activities.

A number of HIV/AIDS advocates argue that if PEPFAR is reauthorized, the guidelines on condom usage should be expanded. Critics contend that targeting condom distribution in PEPFAR programs to "high risk groups"⁶¹ limits the effectiveness of the strategy. Other observers complain that although research has demonstrated that married women are particularly at risk of contracting HIV in Africa and India, U.S. condom distribution strategies do not include married women, unless their husbands test positive for HIV. Supporters of U.S. condom distribution guidelines counter that the definition of "high risk" individuals is broad enough to include the most vulnerable groups. Some HIV/AIDS proponents advocate that Congress should introduce legislation that includes language similar to that in S. 3656, which expands the definition of "high risk" individuals to include married young people. Advocates hope that an expanded definition might enable young married people to access condoms through U.S.-supported programs.

Expand the List of Focus Countries? On June 22, 2004, the White House belatedly selected Vietnam to be the last of the 15 focus countries. According to a White House press release, U.S. officials chose the country in part because they believed that Vietnam was facing an HIV/AIDS explosion, though the country had about 130,000 infected people at the time. Additionally, U.S. officials decided that Vietnam had demonstrated significant commitment to fighting the disease, as it was spending about \$36 per person for HIV/AIDS care, prevention, and treatment.

Some HIV/AIDS analysts argued that India might have been a better selection, because at the time, it shared the distinction with South Africa of having the highest number of HIV-positive people (about 5.3 million). Some theorized that India was not chosen because at the time it had threatened to develop and distribute generic versions of patented ARVs. The White House responded that India was not chosen for a number of reasons. First, the United States was already providing the country more than \$20 million in HIV/AIDS assistance. Officials also asserted that India was reluctant to accept the gravity of the HIV problem in the country, had invested a relatively small amount of its own resources on HIV/AIDS care, prevention, and

⁵⁹ UNAIDS 2006 Global AIDS Report, p.132.

⁶⁰ Ibid, p.133.

⁶¹ High risk groups are defined as sex workers and their clients; sexually active discordant couples (when one partner is HIV-positive and the other is not infected) or couples with unknown HIV status; substance abusers; mobile male populations; men who have sex with men; and people living with HIV/AIDS.

treatment (about \$6 per person), and had a larger economy that was capable of allocating more to fighting the virus.⁶²

HIV/AIDS analysts are beginning to advocate that other countries where the virus is rapidly spreading be included in GHAI. Since Vietnam was selected, India has become the country with the largest number of HIV-infected people in the world (some 5.7 million HIV-positive people), compared to South Africa's 5.5 million. In other areas, HIV has become more entrenched, particularly in Eastern Europe and Central Asia. According to UNAIDS, the number of people living with HIV in those regions has increased by more than 26% since 2003, when about 1.1 million people were living with the virus. At the end of 2005, about 1.5 million people were living with HIV in the two regions, 90% of whom were in Ukraine and Russia. Ukraine has the highest HIV rate in all of Europe (1.4%), with some 410,000 people living with the virus. Some 80% of the estimated 940,000 people living with HIV in Russia are believed to be between 15 and 30 years old.

Address Infrastructure Challenges and Health Worker Shortages

Global AIDS Coordinator Ambassador Mark Dybul testified at a March 2006 hearing on PEPFAR that ill-equipped health systems compromise the ability of the United States to implement its PEPFAR programs efficiently. Ambassador Dybul stated that building health infrastructure and strengthening health systems are critical components of PEPFAR programs. According to OGAC, in FY2005, an estimated 25% of all PEPFAR-supported activities had components directly related to strengthening health systems, such as quality assurance, financial management and accounting, health networks and infrastructure, and commodity distribution and control. In FY2006, OGAC allocated \$44.8 million to policy analysis and system strengthening. Although OGAC reports that it is allocating funds to strengthen health systems, in a July 2004 report, GAO criticized some aspects of PEPFAR's health system strengthening efforts.⁶³ GAO found that some of OGAC's strategies aimed at increasing the quality and quantity of health care workers in Africa might not be cost-effective or practical for long-term implementation.⁶⁴ Some analysts project that as HIV/AIDS continues to spread, more legislation might be introduced in the 110th Congress to support failing health systems (similar to S. 3775 and S. 850, introduced in the 109th Congress).

Appendix

⁶² For more on this discussion, see the White House press release at [<http://www.whitehouse.gov/news/releases/2004/06/20040622-12.html>].

⁶³ GAO, *U.S. AIDS Coordinator Addressing Some Key Challenges to Expanding Treatment, but Others Remain*, July 2004, at [<http://www.gao.gov/new.items/d04784.pdf>].

⁶⁴ The Institute of Medicine of the National Academies also reviewed PEPFAR health system strengthening strategies and made some recommendations on strengthening African health care systems; see [<http://www.nap.edu/catalog/11270.html>]. Some of the criticisms that GAO made about PEPFAR health strengthening strategies were motivated by the institute's recommendations.

Table 4. Participating Agencies and Departments in U.S. Global HIV/AIDS Initiatives: LIFE and PEPFAR

LIFE INITIATIVE	ROLE	PEPFAR INITIATIVE
Implementing Agency or Department		Implementing Agency or Department
	Encourage public-private partnerships, inform the private sector on how to counter HIV/AIDS, provide HIV/AIDS data	Department of Commerce
DOD	Provide technical assistance in the development and implementation of HIV/AIDS policies and programs for military personnel	DOD
DOL	Provide technical assistance in the development of comprehensive workplace-based HIV-prevention and -education programs, and national workplace HIV policy statements	DOL
HHS:		HHS:
CDC	Work with health experts, governments, and health institutions to provide care and treatment for those infected with HIV; and to prevent new infections	CDC
	Review and approve generic ARV drugs for use in PEPFAR programs	FDA
	Help countries to develop HIV care and treatment plans	HRSA
	Conduct NIH international research activities	NIH
	Coordinate implementation of the \$9 billion GHAI	OGAC
	Support community-based HIV/AIDS care and prevention initiatives	Peace Corps
USAID	Implement programs that provide care and treatment to those affected by HIV/AIDS, and prevent new infections.	USAID

Note: NIH is not included in the column for LIFE Initiative, because the Clinton administration did not include the institute in its proposal. Though the institute does not consider itself part of PEPFAR, the administration does and includes it in its reports to Congress.

HIV/AIDS Bills Not Enacted in the 109th Congress

Legislation Related to Strengthening Health Systems. H.R. 4222 and S. 2765, the Child Health Investment for Long-term Development (CHILD and Newborn) Act, would have authorized \$660 million for FY2007 and \$1.2 billion for each fiscal year from 2008 through 2011 to support activities that strengthen the capacity of health systems in developing countries; improve health care access among under-served and marginalized populations; enhance the supply, logistics, and distribution of essential drugs, vaccines, commodities, and equipment; integrate and coordinate HIV/AIDS, malaria, TB, and child spacing programs; and expand access to safe water and sanitation. The bills also would have required the President to develop a strategy that improves the health of newborns, children, and mothers, and reduces their mortality. The bills would have established a task force to assess, monitor, and evaluate the progress and contributions of relevant U.S. departments and agencies toward achieving the Millennium Development Goals to reduce the mortality of children under the age of five by two-thirds and to reduce maternal mortality by three-quarters in developing countries by 2015. H.R. 4222 was introduced and referred to the House Committee on International Affairs (HIRC) on November 3, 2005. S. 2765 was introduced and referred to the Senate Foreign Relations Committee (SFRC) on May 9, 2006.

S. 3775, African Health Capacity Investment Act, would have provided \$100 million for health systems strengthening in FY2007, \$150 million in FY2008, and \$200 million in FY2009. The bill was introduced and referred to the SFRC on August 2, 2005.

S. 850, the Global Health Corps Act, would have established at HHS an Office of the Global Health Corps to expand the availability of health care personnel, items, and related services to improve the health, welfare, and development of communities in select foreign countries and regions. The office would have been responsible for recruiting a volunteer health corps to serve in foreign countries, and for coordinating the implementation of related efforts by participating U.S. agencies and departments. The bill was introduced and referred to SFRC on April 19, 2005.

Legislation Related to Integrating Health Services. H.R. 4188, the Focus on Family Health Worldwide Act, would have amended the Foreign Assistance Act by expanding the activities that the President is authorized to furnish, which include the coordination of HIV/AIDS and family planning programs, the training of health care providers, and improving supply chain logistics. To support the activities, the bill would have authorized \$600 million for FY2007, \$700 million for FY2008, \$800 million for FY2009, \$900 million for FY2010, and \$1 billion for FY2011. The bill was introduced and referred to HIRC on November 1, 2005.

H.R. 4736, the Ensuring Access to Contraceptives Act, would have amended the Foreign Assistance Act of 1961 to authorize the appropriation of \$150 million in FY2007 and FY2008. The bill proposed that the funds be used to purchase and distribute contraceptives in developing countries that could help prevent unintended pregnancies, abortions, and the transmission of sexually transmitted infections, including HIV/AIDS. The bill was introduced and referred to HIRC on February 8, 2006.

Legislation Related to HIV/AIDS Treatments and Vaccines. H.R. 3854 and S. 550, the Microbicide Development Act, would have amended the Public Health Service Act (42 U.S.C. 300cc-40 et seq.) by directing the Office of AIDS Research to expedite the implementation of a federal microbicide research and development plan; annually review the plan, and prioritize related funding and activities. The bills also would have directed the Director of the National Institute of Allergy and Infectious Diseases to establish within the Division of AIDS, a clearly defined organizational unit charged with carrying out microbicide research and development. At USAID, the bills directed the head of the Office of HIV/AIDS to develop and implement a program to support the development of microbicides products for the prevention of the transmission of HIV and other diseases, and facilitate wide-scale availability of the products. H.R. 3854 was introduced on September 21, 2005, and referred to Health Subcommittee of HIRC on October 7, 2005. S. 550 was introduced and referred to the Senate Health, Education, Labor, and Pensions (HELP) Committee on March 8, 2005.

H.R. 3781 and S. 1698, the Vaccines for the New Millennium Act, proposed implementing a number of strategies to accelerate the development of vaccines for diseases primarily affecting developing countries, including HIV/AIDS. Proposed strategies include encouraging public-private partnerships, supporting research, development, and manufacturing incentives, and providing tax credits for participating researchers and manufacturers. Both bills were introduced on September 14, 2005. H.R. 3781 was referred to the House Subcommittee on Domestic and International Monetary Policy, Trade, and Technology on October 17, 2005. S. 1698 was introduced and referred to the Senate Finance Committee on September 14, 2005.

Legislation Related to Care for those Affected by HIV/AIDS. H.R. 164, the International Pediatric HIV/AIDS Network Act, would have amended the Foreign Assistance Act of 1961 to provide for the establishment of a network of pediatric centers in certain developing countries that treat and care for children with HIV/AIDS. The centers would have been developed and staffed by U.S. and local professionals, and would be modeled after international pediatric HIV/AIDS care and treatment centers already established and operating in Romania and Botswana. The bill was introduced and referred to HIRC on January 4, 2005.

Legislation to Amend P.L. 108-25. H.R. 5674, the Protection Against Transmission of HIV for Women and Youth Act, would have stricken the 33% provision from P.L. 108-25. The bill also required the President to formulate and submit to Congress a comprehensive, integrated, and culturally appropriate global HIV prevention strategy that addresses the vulnerabilities of married and unmarried women and girls to HIV infection and seeks to reduce the factors that lead to gender disparities in the rate of HIV infection. The bill was introduced and referred to HIRC on June 22, 2006. There has been no subsequent action on the legislation.

S. 3656, the HIV Prevention for Youth Act, would have amended P.L. 108-25 so that the 33% provision was limited to preventing the sexual transmission of HIV in FY2006 through FY2008. Currently, P.L.108-25 applies the 33% stipulation to all HIV prevention funds. The draft also proposed adding a definition for “abstinence-until-marriage” to the act. The bill added a definition of a generalized epidemic to the Foreign Assistance Act of 1961, and included married and unmarried sexually active young people in the “high risk” group to be targeted in HIV prevention programs. The bill was introduced and referred to SFRC on July 13, 2006.