



Trends in U.S. Global AIDS Spending: FY2000-FY2008

(name redacted)

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Summary

It is estimated that HIV/AIDS, TB, and malaria together kill more than 6 million people each year. According to the Joint United Nations Program on HIV/AIDS (UNAIDS), at the end of 2007, an estimated 33.2 million people were living with HIV/AIDS, of whom 2.5 million were newly infected, and 2.1 million died in the course of that year. More than 2 million of those living with HIV/AIDS at the end of 2007 were children, and some 290,000 of those who died of AIDS that year were under 15 years old. On each day of 2007, some 1,000 children worldwide became newly infected with HIV, due in large part to little access to drugs that prevent the transmission of HIV from mother to child. An estimated 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 about \$3.1 billion for international HIV/AIDS programs and U.S. contributions to the Global Fund to Fight HIV/AIDS, TB, and Malaria, \$4.3 billion in FY2007, and \$5.7 billion in FY2008. 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 percentage 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 consider, particularly as debate on PEPFAR reauthorization ensues. This report will not be updated; PEPFAR authorization expires in FY2008. Subsequent reports will analyze additional funding should the initiative be reauthorized.

Contents

Introduction	1
History of Funding for U.S. Global HIV/AIDS Efforts	4
LIFE Initiative	4
International Mother and Child HIV Prevention Initiative.....	5
PEPFAR	5
PEPFAR-Participating Departments and Agencies.....	8
Department of State: Office of the Global AIDS Coordinator.....	9
U.S. Agency for International Development (USAID)	9
Department of Health and Human Services	11
Centers for Diseases Control and Prevention	11
National Institutes of Health (NIH)	13
Health Resources and Services Administration (HRSA)	14
U.S. Food and Drug Administration (FDA)	14
Department of Defense (DOD).....	15
Department of Labor (DOL).....	17
Peace Corps	19
U.S. Department of Commerce.....	19
Issues for the Second Session of the 110 th Congress.....	19
Reauthorize PEPFAR	19
Determine Appropriate Amount of Support for PEPFAR Reauthorization	20
Consider U.S. Contributions to the Global Fund	20
Reconsider Abstinence-Until-Marriage Provisions.....	21
Consider Impact of Abstinence-Until-Marriage Provision on Gender	22
Emphasize Other HIV Prevention Strategies.....	22
Consider Access to Condoms	23
Integrate Family Planning Services Into PEPFAR Programs	23
Increase Anti-Retroviral Treatments for Children	23
Expand the List of Focus Countries?	24
Address Infrastructure Challenges and Health Worker Shortages	24
Integrate Food and HIV/AIDS Services.....	25
Boost Support for Research and Innovative Technology	26

Figures

Figure 1. OGAC HIV/AIDS Appropriations: FY2004-FY2008.....	9
Figure 2. USAID HIV/AIDS Appropriations: FY2000-FY2008.....	11
Figure 3. CDC HIV/AIDS Appropriations: FY2000-FY2008.....	13
Figure 4. Office of AIDS Research Grants: FY2000-FY2008	14
Figure 5. DOD HIV/AIDS Appropriations: FY2000-FY2008	17
Figure 6. DOL HIV/AIDS Appropriations: FY2000-FY2008.....	18

Tables

Table 1. Appropriations to Bilateral HIV/AIDS Programs and the Global Fund: FY2000-FY2003.....	5
Table 2. U.S. Spending on Global HIV/AIDS, TB, and Malaria: FY2004-FY2008.....	7

Appendixes

Appendix A. Glossary of Abbreviations and Acronyms	28
Appendix B. Participating Agencies and Departments in U.S. Global HIV/AIDS Initiatives: LIFE and PEPFAR.....	29

Contacts

Author Contact Information	30
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Introduction

It is estimated that HIV/AIDS, 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 2007, an estimated 33.2 million people were living with HIV/AIDS, of whom 2.5 million were newly infected, and 2.1 million died in the course of that year.² More than 2 million of those living with HIV/AIDS at the end of 2007 were children, and some 290,000 of those who died of AIDS that year were under 15 years old.³ On each day of 2007, some 1,000 children worldwide became newly infected with HIV, due in large part to little access to drugs that prevent the transmission of HIV from mother to child. An estimated 9% of pregnant women in low- and middle-income countries were offered services to prevent HIV transmission to their newborns.

Although tuberculosis (TB)⁴ is curable, the World Health Organization (WHO) estimates that by the end of 2005 (the year for which the most current data are available), the disease killed 1.6 million people, including 195,000 who were also infected with HIV/AIDS.⁵ Some 8.8 million people were estimated to have contracted the disease in 2005, with about 84% of the cases having occurred in 22 countries.⁶ All but three of those high-burden countries were found in Africa or Asia.⁷ About half of all new TB cases were in six countries: Bangladesh, China, India, Indonesia, Pakistan, and the Philippines. More than 80% of those living with TB in 2005 were in southeast Asia and sub-Saharan Africa, with the greatest per capita rate found in Africa.⁸

¹ World Health Organization. "2006 TB Factsheet." At http://www.who.int/tb/publications/2006/tb_facts_2006.pdf, visited on December 5, 2007.

² Unless otherwise indicated, all data on HIV/AIDS infection rates were taken from UNAIDS. *2007 AIDS Epidemic Update*. December 2007. At http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf, visited December 5, 2007.

³ Estimates for HIV infection among children were revised after the publication of UNAIDS' report, *2007 AIDS Epidemic Update*. On its website, UNAIDS indicated that an "in-depth review of HIV estimates among children published in the 2007 AIDS Epidemic Update report in November 2007 has revealed inaccuracies in processing some of the data." HIV infection estimates for children reflect those changes. See UNAIDS website: <http://www.unaids.org/en/KnowledgeCentre/HIVData/EpiUpdate/EpiUpdArchive/2007/default.asp>, visited on January 29, 2008.

⁴ 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/>.

⁵ Data in this section was compiled from WHO, *2007 Global Tuberculosis Control Report*, http://www.who.int/tb/publications/global_report/2007/pdf/full.pdf.

⁶ The 22 high-burden countries were: Afghanistan, Bangladesh, Brazil, Burma, Cambodia, China, Democratic Republic of Congo, Ethiopia, India, Indonesia, Kenya, Mozambique, Nigeria, Pakistan, Philippines, Russia, South Africa, Tanzania, Thailand, Uganda, Vietnam, and Zimbabwe.

⁷ Of the high burden-countries, Afghanistan, Brazil, and Russia are not in Africa or Asia.

⁸ For more information on tuberculosis, see CRS Report RL34246, *Tuberculosis: International Efforts and Issues for Congress*, by (name redacted).

According to WHO, each year there are about 300 million acute malaria cases,⁹ 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,¹⁰ killing an African child every 30 seconds.¹¹

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 twelve months of contracting TB if they do not receive TB treatment.¹² 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.¹³ 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.¹⁴

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.¹⁵ 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.¹⁶ Additionally, malaria-HIV

⁹ 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 mosquitoes. 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. Mosquitoes 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.

¹⁰ 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.

¹¹ WHO's Roll Back Malaria website, http://malaria.who.int/cmc_upload/0/000/015/372/RBMInfosheet_1.htm, accessed on August 31, 2006.

¹² The Stop TB Partnership, "WHO Calls for Free TB Drugs for HIV Patients," July 16, 2003; see <http://www.stoptb.org>.

¹³ 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/>.

¹⁴ For more information on TB and HIV co-infection, see WHO, *Frequently asked questions about TB and HIV/AIDS*, <http://www.who.int/tb/hiv/faq/en/>.

¹⁵ 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.

¹⁶ Carlo Ticconi et al., "Effect of Maternal HIV and Malaria Infection on Pregnancy and Perinatal Outcome in Zimbabwe," *Journal of Acquired Immune Deficiency Syndromes*, vol. 34, no. 3 (November 1, 2003), at (continued...)

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%.¹⁷

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.¹⁸ WHO found 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.¹⁹ 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.²⁰ 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.²¹

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.²² *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.

(...continued)

<http://www.jaids.com/>.

¹⁷ H. Brahmbhatt et al., “The Effects of Placental Malaria on Mother-to-Child HIV Transmission in Rakai, Uganda,” *AIDS: Official Journal of the International AIDS Society*, vol. 17 (November 21, 2003), pp. 2539-2541, at <http://www.aidsonline.com>.

¹⁸ UN News Center, “Drug-Resistant Strains of Tuberculosis Spark Concern from UN Health Agency,” September 5, 2006, at <http://www.un.org/apps/news/story.asp?NewsID=19727>.

¹⁹ For more information on the spread of drug-resistant TB, see http://www.cdc.gov/nchstp/tb/pubs/mmwrhtml/mmwr_mdrtb.htm.

²⁰ “Drug-Resistant TB in South Africa Draws Attention from U.N.,” *New York Times*, September 6, 2006, at <http://www.nytimes.com>.

²¹ UNAIDS, *2006 AIDS Epidemic Update*, p. 12.

²² 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>.

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.²³ 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.

In FY2000, Congress provided more for global HIV/AIDS programs than President Clinton requested for his LIFE Initiative, directing \$189.3 million²⁴ to USAID for global HIV/AIDS activities; and appropriating \$46.7 million²⁵ to the Department of Health and Human Services (HHS) for the Centers for Disease Control and Prevention's (CDC) Global AIDS Program (GAP), providing the first bilateral HIV/AIDS appropriation to an U.S. agency other than the U.S. Agency for International Development (USAID).²⁶

In FY2001, Congress expanded appropriations for global HIV/AIDS programs to the Departments of Agriculture (P.L. 106-387), Defense (P.L. 106-259), and Labor (P.L. 106-554); and provided funds for the first U.S. Global Fund contribution (P.L. 106-429). 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.²⁷

²³ The LIFE target countries were India, Ethiopia, Kenya, Malawi, Mozambique, Nigeria, Rwanda, Senegal, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe.

²⁴ This figure includes a 0.38% across-the-board rescission.

²⁵ The \$46.7 million includes \$34.8 million directed to CDC through regular FY2000 appropriations, and \$11.9 million provided through FY2000 emergency appropriations.

²⁶ 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).

²⁷ 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 I. Appropriations to Bilateral HIV/AIDS Programs and the Global Fund: FY2000-FY2003

(current U.S.\$ millions)

Program	FY2000	FY2001	FY2002	FY2003
USAID HIV/AIDS assistance (excluding Global Fund)	189.3	318.0	424.0	523.8
USAID contributions to the Global Fund	0.0	100.0	50.0	248.4
Foreign Military Financing	0.0	0.0	0.0	0.0
Foreign Operations Appropriations Subtotal	189.3	418.0	474.0	772.2
CDC Global AIDS Program	46.8	104.5	143.8	182.5
Global Fund Contribution from HHS	0.0	0.0	125.0	99.0
Department of Labor AIDS in the Workplace	0.0	10.0	10.0	9.9
Labor/HHS Appropriations Subtotal	46.8	114.5	278.8	291.4
Department of Defense HIV/AIDS Prevention	0.0	10.0	14.0	7.0
Total	236.1	542.5	766.8	1,070.6

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

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.²⁸ 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 that up to \$100 million (excluding rescissions) be made available to USAID for the initiative in FY2003. In FY2004, Congress provided \$150 million (excluding rescissions) to CDC for PMTCT programs. Conferees also 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, Congress has included funds for PMTCT programs 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 President proposed channeling \$10 billion through the Global HIV/AIDS Initiative (GHAI) to 15 Focus Countries (9 of the 11 LIFE Focus Countries are also PEPFAR Focus Countries); directing \$4

²⁸ See <http://www.whitehouse.gov/news/releases/2002/06/20020619-1.html>.

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.²⁹ In May 2003, Congress authorized sufficient funds to support the initiative through P.L. 108-25, the U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act (the Leadership Act).

Each fiscal year since the inception of PEPFAR, Congress has allocated more than the Administration has requested for global HIV/AIDS programs. Congress exceeded the President's five-year spending proposal for PEPFAR by nearly \$5 billion. From FY2004 through FY2008, Congress provided almost \$20 billion to fight the global spread of HIV/AIDS, TB, and malaria, of which \$18.3 billion was appropriated for global HIV/AIDS programs and the Global Fund (**Table 2**). The President's FY2008 budget request included about \$5.8 billion for global HIV/AIDS, TB, and malaria efforts. Congress exceeded the President's request by some \$570 million, providing \$6.3 billion for global HIV/AIDS, TB, and malaria efforts, including \$5.8 billion for global HIV/AIDS programs and a U.S. contribution to the Global Fund.

Between FY2004 and FY2008, PEPFAR programs aimed 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.³⁰ The Office of Global AIDS Coordinator (OGAC) reports that as of September 30, 2007, PEPFAR-participating U.S. agencies and departments have supported

- the provision of prevention of mother-to-child HIV transmission (PMTCT) services during more than 10 million pregnancies, of whom over 827,000 have received ARV treatment, leading to the prevention of an estimated 157,000 new HIV infections;
- the purchase and distribution of ARV medication for an estimated 1.44 million people, 1.35 million of whom lived in Focus Countries and 86,000 of whom were children;
- care for more than 6.6 million people in the Focus Countries, of whom 2.7 million were orphans and vulnerable children; and
- HIV counseling and testing services for over 33 million people.³¹

PEPFAR programs, led by OGAC at the U.S. Department of State and implemented by various U.S. agencies and departments, are authorized to support initiatives that prevent HIV/AIDS, TB, and malaria transmission, 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**). Most public documents refer to this chart as "PEPFAR appropriations."

²⁹ White House Fact Sheet, "The President's Emergency Plan for AIDS Relief," January 29, 2003, at <http://www.state.gov/p/af/rls/fs/17033.htm>, visited on January 29, 2008.

³⁰ Ibid.

³¹ PEPFAR website, "Latest Results." At <http://www.pepfar.gov/about/c19785.htm>, visited January 29, 2008.

Since FY2007, however, Congress has not included appropriations to global malaria efforts in the “PEPFAR appropriations.” Instead, global malaria funds are provided through the President’s Malaria Initiative (PMI). In June 2005, President Bush launched PMI to increase support for U.S. international malaria programs by more than \$1.2 billion between FY2006 and FY2010 in 15 countries. Since launching PMI, the Administration has requested that all support for bilateral malaria efforts be provided to USAID as the coordinating agency for the initiative. When the Administration shifted leadership for bilateral malaria programs to USAID in FY2005, it determined that the Office of the Global AIDS Coordinator (OGAC) would no longer include malaria spending in its annual PEPFAR reports to Congress and that budgetary requests for the disease would be made separately from HIV/AIDS and TB requests.

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 annual reports that OGAC has submitted have reported only on U.S. global HIV/AIDS activities and services provided to those co-infected with HIV/AIDS and TB. There is some debate about whether malaria should be included in PEPFAR spending estimates. U.S. spending on international malaria activities are included herein, because in the first two fiscal years that PEPFAR was implemented, the Administration included spending on HIV/AIDS, TB, and malaria in its reports to Congress; the Leadership Act authorized support for all three diseases; and the act required that the President report on progress made in addressing HIV/AIDS, TB, and malaria.

Table 2. U.S. Spending on Global HIV/AIDS, TB, and Malaria: FY2004-FY2008
(\$ millions, current)

Program	FY2004 Actual	FY2005 Actual	FY2006 Actual	FY2007 Actual	FY2008 Estimate	FY2004- FY2008 TOTAL
1. USAID HIV/AIDS (excluding Global Fund)	555.5	384.7	373.8	345.9	371.1	2,031.0
2. USAID Tuberculosis	85.1	92.0	91.5	94.9	162.2	525.7
3. USAID Malaria	79.9	90.8	102.0	248.0	349.6	870.3
4. USAID Global Fund Contribution	397.6	248.0	247.5	247.5	0.0	1,140.6
5. FY2004 Global Fund Carryover ^b	(87.8)	87.8	n/a	n/a	n/a	0.0
6. State Department GHAI	488.1	1,373.5	1,777.0	2,869.0	4,116.4	10,624.0
7. GHAI Global Fund Contribution	0.0	0.0	198.0	377.5	545.5	1,121.0
8. Foreign Military Financing ^c	1.5	1.9	1.9	1.6	—	6.9
9. Subtotal, Foreign Operations Appropriations	1,519.9	2,278.7	2,791.7	4,184.4	5,544.8	16,319.5
10. CDC Global AIDS Program ^d	266.9	123.8	122.6	121.5	119.4	754.2
11. CDC Tuberculosis	2.0	2.3	0.0	0.0	0.0	4.3
12. CDC Malaria	9.2	9.1	9.0	8.9	8.7	44.9
13. CDC International Research	9.0	14.0	0.0	0.0	0.0	23.0
14. NIH International Research ^e	317.2	370.0	373.0	372.0	363.6	1,795.8
15. NIH Global Fund contribution	149.1	99.2	99.0	99.0	294.8	741.1

Program	FY2004 Actual	FY2005 Actual	FY2006 Actual	FY2007 Actual	FY2008 Estimate	FY2004- FY2008 TOTAL
16. DOL AIDS in the Workplace Initiative	9.9	1.9	0.0	0.0	0.0	11.8
17. Subtotal, Labor/HHS Appropriations	763.3	620.3	603.6	601.4	786.5	3,375.1
18. DOD HIV/AIDS prevention education	4.3	7.5	5.2	0.0	8.0	25.0
19. Total HIV/AIDS and Global Fund	2,111.3	2712.3	3,198.0	4,434.0	5,818.8	18,274.4
20. GRAND TOTAL	2,287.5	2,906.5	3,400.5	4,785.8	6,339.3	19,719.6

Sources: Prepared by CRS from appropriations bill figures and interviews with Administration officials.

Note: Agencies and departments might obligate more funds to global HIV/AIDS, TB, and malaria efforts than were appropriated. All figures are at appropriated levels and include rescissions.

- a. Although the Administration asserts operations for PMI began in FY2006, Congress did not appropriate funds to the initiative until FY2007. That fiscal year, it provided \$250.9 million for global malaria programs, including \$149.0 million to expand PMI.
- b. In FY2004, \$87.8 million of U.S. contributions to the Global Fund was withheld per legislative provisions that prohibit U.S. contributions to the Fund to exceed 33% of all contributions. The FY2005 Consolidated Appropriations act released these funds to the Global Fund, subject to the 33% proviso.
- c. Appropriations for Foreign Military Financing are used to purchase equipment for DOD HIV/AIDS programs.
- d. Lower spending levels after FY2004 reflect the shift of funds initially reserved for the International Mother and Child HIV Prevention Initiative to the Global HIV/AIDS Initiative account. When the initiative expired in FY2004, these changes were made permanent and were applied to subsequent fiscal years.
- e. Although appropriations bills do not specify funding for NIH's international HIV research initiatives, sufficient funds are provided to the Office of AIDS Research (OAR) to undertake such efforts. The figures used in Line 11 reflect those amounts reported by OAR in its congressional budget justifications.

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. After the State Department, USAID, and HHS (which includes NIH's Office of AIDS Research [OAR]³² and CDC's GAP) receive the largest congressional appropriations for international HIV/AIDS efforts. The Departments of Defense (DOD) and Labor (DOL) also receive global HIV/AIDS funds, though Congress has not appropriated funds to DOL since FY2006. The section below itemizes obligations by each PEPFAR-participating department and agency to global HIV/AIDS programs. All figures in this section are adjusted to reflect rescissions unless otherwise specified.

³² 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.

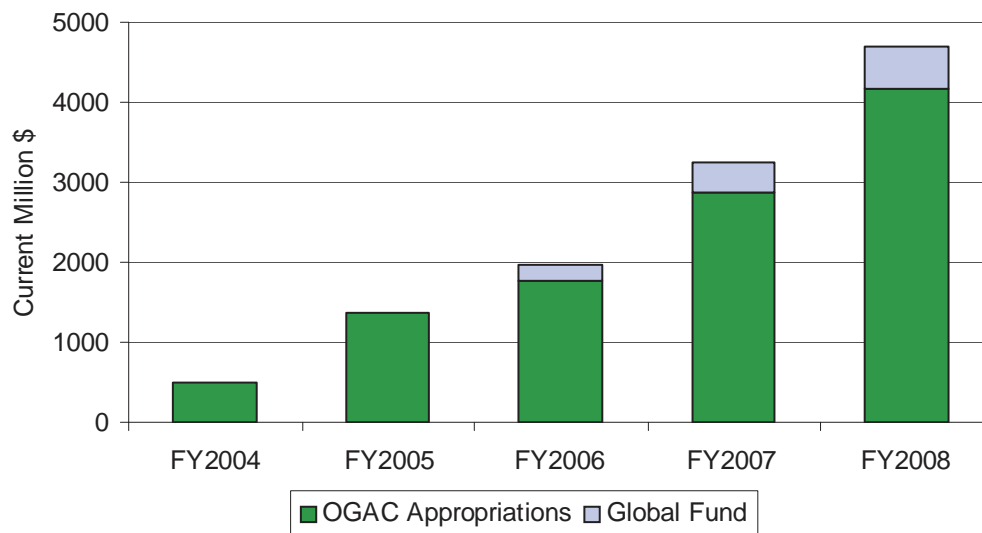
Department of State: Office of the Global AIDS Coordinator

In FY2003, the Leadership Act 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 and other bilateral HIV/AIDS programs to implementing departments and agencies. **Figure 1** illustrates funds appropriated to OGAC from FY2004 through FY2008. 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 and FY2007, providing \$1,777.0 million and \$2,869.0 million, respectively.

In FY2008, Congress funded GHAI through a newly established account entitled "Global Health and Child Survival." The account consolidates the GHAI account and USAID's Child Survival and Health Account. The President's FY2008 budget request included \$4,150.0 million for GHAI; Congress provided slightly less, \$4,116.4 million. From FY2004 to FY2008, total appropriations to GHAI reached \$10.6 billion, some \$1.6 billion more than the Administration proposed for PEPFAR's five-year term.

Figure 1. OGAC HIV/AIDS Appropriations: FY2004-FY2008



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 \$318.0 million to the agency for global HIV/AIDS projects, and an additional \$100.0 million for a U.S. contribution to the Global Fund.³³ Appropriations for USAID's bilateral programs rose in FY2002 to \$424.0 million, which included \$100 million for the PMTCT Initiative. When the additional \$50.0 million that Congress appropriated for a U.S. contribution to the Global Fund are added, total appropriations to USAID reached \$474.0 million in FY2002.³⁴ In FY2003, Congress slightly increased appropriations to the agency, providing \$523.8 million for its HIV/AIDS projects, including \$99.3 million for the PMTCT Initiative and an additional \$248.4 million for the Global Fund.

In FY2004, when PEPFAR was first funded, appropriations to USAID's bilateral programs reached \$555.5 million and appropriations to GHAI for the 15 Focus Countries were \$488.1million. In FY2005 and FY2006, when appropriations to GHAI were ramped up to \$1,373.5 million and \$1,777.0 million, respectively, support for USAID's bilateral programs fell below FY2004 levels to \$384.7 million and \$373.8 million, respectively.³⁵ In FY2007, appropriations to USAID bilateral HIV/AIDS programs fell again to \$345.9 million, but nearly reached FY2006 levels in FY2008 with Congress providing an estimated \$371.1 million; the President requested \$346.3 million.

Although appropriations for USAID's HIV/AIDS programs have declined since FY2004, overall obligations to USAID for global HIV/AIDS efforts have 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 by OGAC are sent to USAID for 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.

³³ 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.

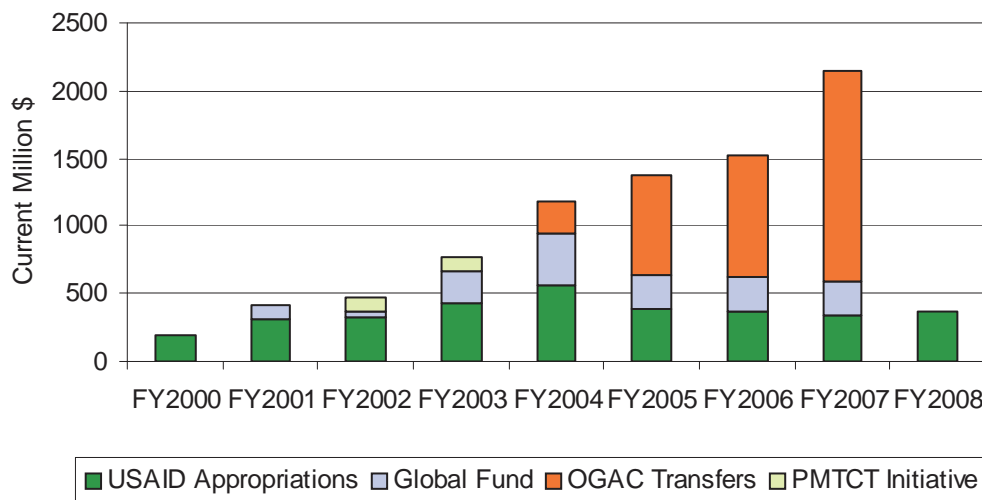
³⁴ In FY2002, Congress provided \$100 million to USAID for a Global Fund contribution in regular appropriations and an additional \$100 million in supplemental appropriations. The FY2002 supplemental appropriations also included \$100 million for the PMTCT Initiative.

³⁵ Includes appropriations to other accounts for USAID's bilateral HIV/AIDS programs.

With OGAC transfers, total USAID HIV/AIDS spending has increased substantially since FY2003.

OGAC transferred \$230.0 million to USAID for HIV/AIDS projects in FY2004.³⁶ In FY2004, USAID received a total of \$785.0 million for its HIV/AIDS projects (\$230.0 million from OGAC and \$555.0 million from Congress), some \$258.5 million more than in FY2003. Transfers to USAID continued to increase with each fiscal year. In FY2005, OGAC obligated \$743.0 million to USAID, \$900.0 million in FY2006, and \$1,552.0 million in FY2007.

Figure 2. USAID HIV/AIDS Appropriations: FY2000-FY2008



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's Global AIDS Program (GAP) operates in 25 countries³⁷ 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:

³⁶ Data in this paragraph was compiled from correspondence with Karin Fenn, Program Support Officer, OGAC on January 23, 2008.

³⁷ 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.

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

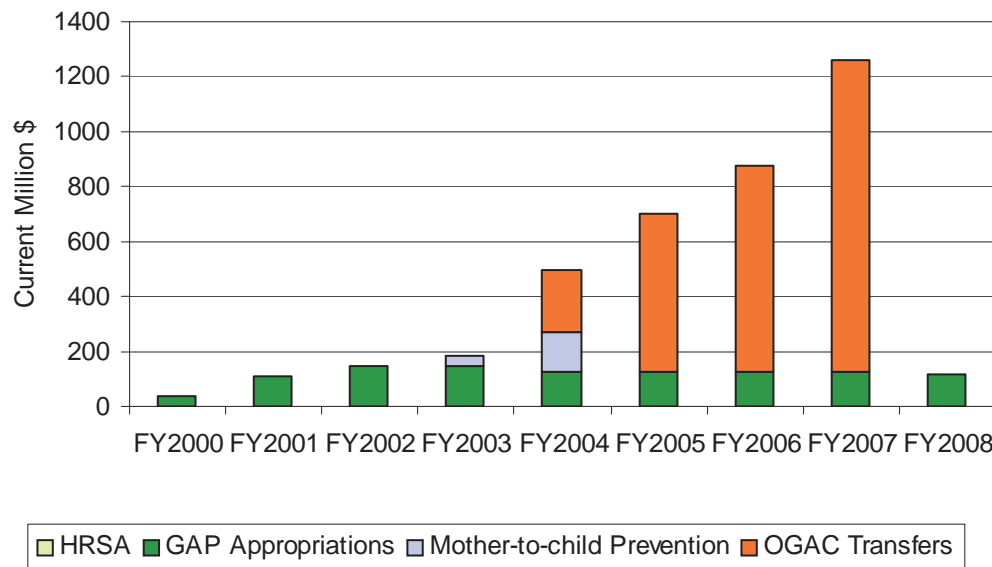
In FY2000, for the first time, Congress provided \$34.8 million for CDC's global HIV/AIDS programs, and an additional \$11.9 million for global HIV prevention and research through FY2000 emergency supplemental appropriations. In FY2001, Congress appropriated \$104.5 million to CDC (of which \$3 million 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 dropped slightly in FY2004; that year the initiative received \$124.9 million and an additional \$142.0 million for the PMTCT Initiative.

In FY2005, when the PMTCT Initiative expired, Congress stopped including funds for the effort to CDC. 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. In FY2007, Congress provided \$121.0 million to GAP. The Administration requested \$121.2 million for CDC HIV/AIDS programs in FY2008; Congress appropriated \$118.7 million.

Although appropriations to CDC GAP have declined since FY2004, when OGAC transfers are included, as was the case for USAID, total provisions have increased (**Figure 3**).³⁸ In FY2004, OGAC transferred \$231.0 million to CDC for GAP programs, \$574.0 million in FY2005, \$753.0 million in FY2006, and \$1,147.0 million in FY2007.³⁹

³⁸ 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.

³⁹ Data in this paragraph was compiled from correspondence with Karin Fenn, Program Support Officer, OGAC on January 23, 2008.

Figure 3. CDC HIV/AIDS Appropriations: FY2000-FY2008

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:

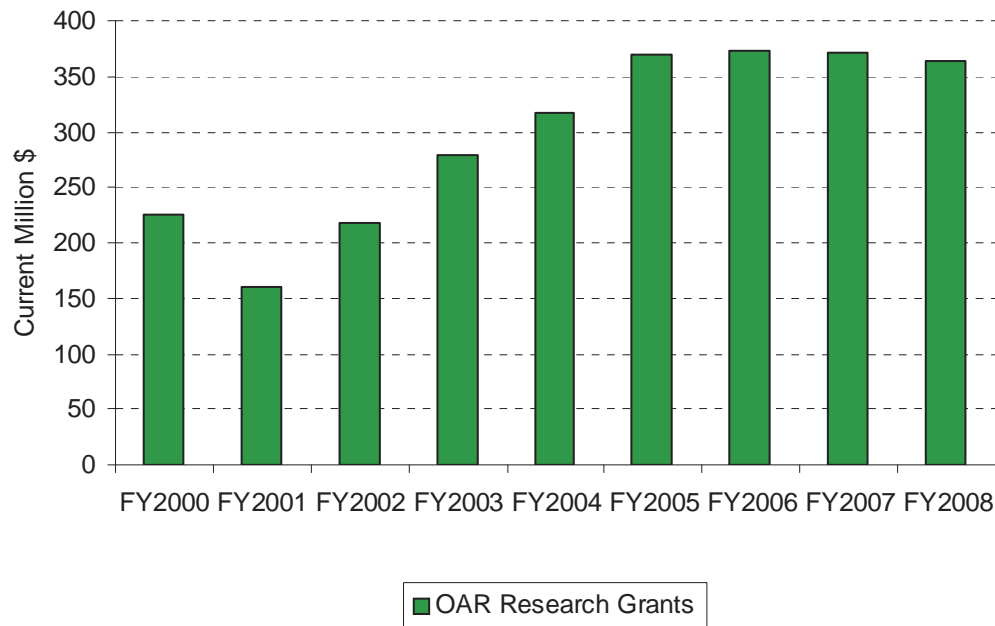
- develop an HIV vaccine;
- develop chemical and physical barrier methods for HIV prevention, including microbicides;
- prevent sexually transmitted diseases, including HIV;
- encourage behavior change to lessen risky behaviors;
- identify drug and non-drug strategies to prevent mother-to-child HIV transmission;
- 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.⁴⁰ 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.

⁴⁰ CRS interview with Wendy Wertheimer, Senior Advisor, Office of the Director, Office of the AIDS Research, on July 5, 2006.

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 provided an estimated \$372.0 million in grants for global AIDS research activities (see **Figure 4**) and anticipates providing \$363.6 million in FY2008.

Figure 4. Office of AIDS Research Grants: FY2000-FY2008



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.⁴¹ 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

⁴¹ For more on HRSA's global HIV/AIDS training efforts, see <http://www.go2itech.org/>.

Administration asserted that WHO's prequalification process was not sufficient, and that generic drugs purchased with PEPFAR funds had to pass FDA inspection.⁴² The Administration's position was that the WHO is not a regulatory body, and thus its adherence to stringent FDA standards was uncertain.⁴³ 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.⁴⁴ 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.⁴⁵ The FDA contended that the process was necessary to ensure that ARV treatments used in the PEPFAR programs were safe, effective, and of high quality.⁴⁶ The expedited review process can take between two and six weeks. Since FDA began reviewing generic drug applications, more than 50 generic versions of patented ARVs have been approved or tentatively approved for use in PEPFAR treatment plans.⁴⁷

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;

⁴² 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/>.

⁴³ Interviews with staff at the Office of the AIDS Coordinator, April 1, 2004.

⁴⁴ 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.

⁴⁵ 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, 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.

⁴⁶ 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>.

⁴⁷ OGAC, "FDA Grants Tentative Approval for 50th and 51st Anti-Retroviral Drugs Under President's AIDS Relief Plan." Press Release. August 13, 2007. At <http://www.pepfar.gov/press/91018.htm>, visited on January 29, 2008. For more information on FDA's role in reviewing ARVs, see <http://www.fda.gov/oia/pepfar.htm>.

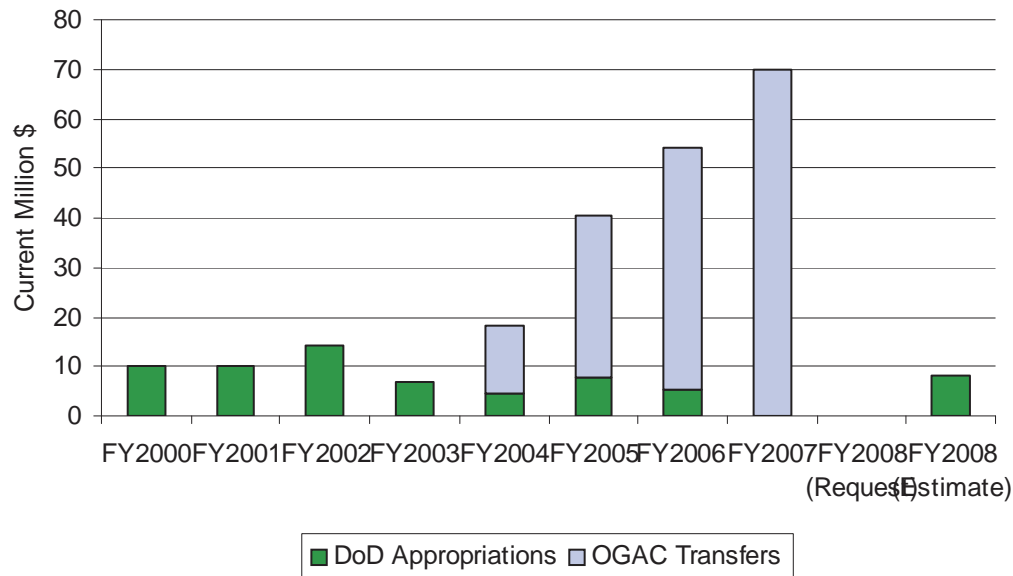
- train foreign military personnel to implement, maintain, and evaluate HIV prevention programs;
- assist foreign countries in developing military-specific interventions that address high-risk HIV attitudes and behaviors; and
- integrate with and make use of foreign military contacts, other U.S. government 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.⁴⁸ 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 \$4.3 million for FY2004 DOD global HIV programs and provided \$7.5 million for FY2005 DOD HIV prevention efforts. In FY2006, Congress appropriated \$5.2 million to DOD for global HIV prevention activities. The FY2007 Defense Appropriations (P.L. 109-289) did not provide funds for DOD's HIV/AIDS programs, though OGAC did transfer funds to the department in that fiscal year. The President did not request funds for DOD's HIV/AIDS prevention efforts in FY2008, though Congress provided \$8.0 million.

As with other U.S. agencies and departments, DOD spending on global HIV prevention has been significantly boosted by OGAC transfers (see **Figure 5**). In FY2004, OGAC transferred \$14.0 million to DOD, \$33.0 million in FY2005, \$49.0 million in FY2006, and \$70.0 million in FY2007.⁴⁹

⁴⁸ DOD HIV Prevention website. At <http://www.nhrc.navy.mil/programs/dhapp/background/background.html>.

⁴⁹ Data in this paragraph was compiled from correspondence with Karin Fenn, Program Support Officer, OGAC on January 23, 2008.

Figure 5. DOD HIV/AIDS Appropriations: FY2000-FY2008

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).

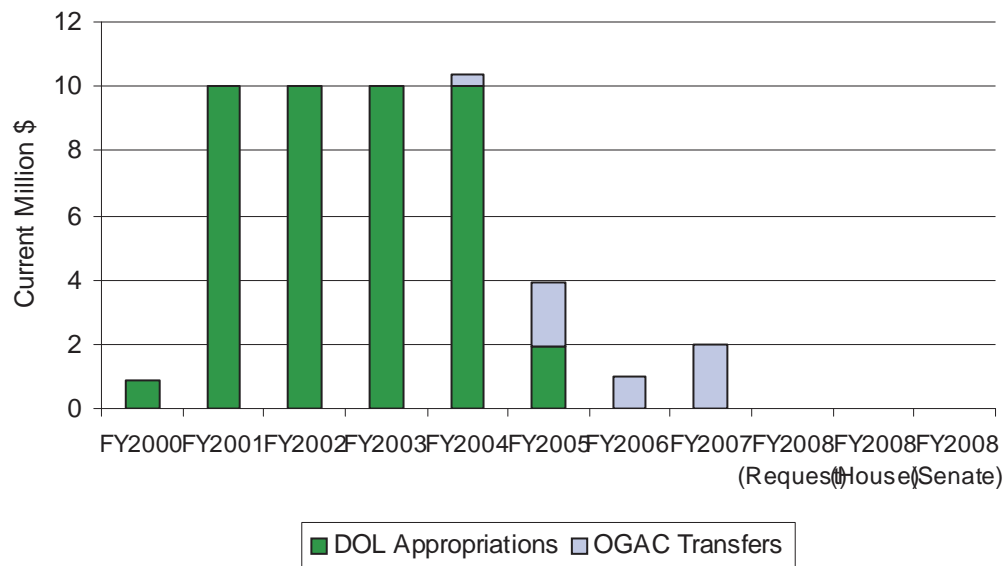
ILAB initiated its HIV prevention programs under former President Clinton's LIFE Initiative. Although Congress did not appropriate funds to the bureau in FY2000, ILAB reports that it spent \$900,000 on international HIV/AIDS efforts in that fiscal year.⁵⁰ In FY2001, ILAB received its first global HIV/AIDS 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

⁵⁰ Correspondence with Celeste Helm, HIV/AIDS Coordinator, Bureau of International Labor Affairs, DOL, on June 30, 2003.

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.⁵¹

The Administration did not request funds for DOL HIV programs in FY2007 or FY2008, though OGAC transferred funds to the department from FY2005 to FY2007. OGAC did not allocate funds to the department in FY2004, but provided \$2.0 million in FY2005, \$1.0 million in FY2006, and \$2.0 million in FY2007 (see **Figure 6**).

Figure 6. DOL HIV/AIDS Appropriations: FY2000-FY2008



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.⁵² At a subsequent budget hearing in FY2003, the Secretary argued that ILAB needed to return its focus to improving core labor standards and combating child labor abuses.⁵³ 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

⁵¹ OGAC transferred some funds to DOL in FY2004, FY2005, and FY2006, providing \$400,000, \$1,600,000 and \$800,000, respectively.

⁵² U.S. Congress, Senate Committee on Appropriations, Subcommittee on Labor, HHS, Education Subcommittee, *FY2002 Department of Labor Budget*, May 2, 2001.

⁵³ U.S. Congress, House Committee on Appropriations, Subcommittee on Labor, HHS, Education Subcommittee, *FY2003 Department of Labor Budget*, February 13, 2002.

complained that ILAB spent too much of its budget on overhead through grants to other organizations.⁵⁴

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.⁵⁵ In 2003, about 1,000 volunteers worked on HIV/AIDS programs, and in 2004, about 3,100 volunteers engaged in HIV/AIDS activities.⁵⁶ Congress has not appropriated funds to the Peace Corps for international HIV/AIDS activities since PEPFAR was launched. OGAC reports having transferred \$1 million to Peace Corps for its international HIV/AIDS efforts in FY2004, \$5 million in FY2005, \$8 million in FY2006, and \$16 million in FY2007.

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

Issues for the Second Session of the 110th Congress

Reauthorize PEPFAR

Congressional debate about reauthorizing PEPFAR began in the first session of the 110th Congress. One reauthorization bill has been introduced, and Members have begun to debate at what level to fund a second five-year phase of PEPFAR. 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 combat effectively the global spread of HIV/AIDS. The section below analyzes some of the key issues that Congress might consider as it debates PEPFAR reauthorization.

⁵⁴ U.S. Congress, House Committee on Appropriations, Subcommittee on Labor, HHS, Education Subcommittee, *FY2005 Department of Labor Budget*, February 12, 2004.

⁵⁵ See Peace Corp's website on HIV/AIDS. At <http://www.peacecorps.gov/index.cfm?shell=learn.whatlike.interactivefeatures.hiv>, visited on January 29, 2008.

⁵⁶ See Peace Corp's website, "What Do Volunteers Do?" At <http://www.peacecorps.gov/index.cfm?shell=learn.Whatvol.healthhiv>, visited on January 29, 2008.

Determine Appropriate Amount of Support for PEPFAR Reauthorization

The Leadership Act authorized the appropriation of the \$15 billion that the President requested to fund PEPFAR through FY2008. Ultimately, Congress supported the plan in excess of nearly \$5 billion, providing \$19.7 billion for global HIV/AIDS, TB, and malaria initiatives from FY2004 through FY2008.

On May 30, 2007, President Bush requested that Congress authorize \$30 billion to extend PEPFAR an additional five years. The President anticipates that from FY2009 through FY2013, the plan would support treatment for 2.5 million people, prevent more than 12 million new infections, and care for more than 12 million people, including 5 million orphans and vulnerable children (OVC). In August 2007, Senator Richard Lugar introduced the HIV/AIDS Assistance Reauthorization Act of 2007 (S. 1966) to authorize \$30 billion for FY2009 through FY2013. The bill maintains the five-year approach to addressing HIV/AIDS, the Global AIDS Coordinator position, and reporting requirements.

Some HIV/AIDS advocates would like Congress to provide more than the \$30 billion that the President requested. On November 30, 2007, Senator Joseph Biden, Chair of the Senate Foreign Relations Committee, issued a press release that urged Congress to provide \$50 billion for a five-year PEPFAR reauthorization.⁵⁷ Representative Tom Lantos, Chair of the House Foreign Relations Committee, announced that he intended to support efforts to increase funding for PEPFAR “dramatically over current levels” and that the House Foreign Affairs Committee would consider reauthorization of the initiative “as [the] first major order of business in 2008.”⁵⁸

Consider 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. Congress 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.⁵⁹

Some question whether U.S. contributions to the Fund are provided at the expense of U.S. bilateral HIV/AIDS 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 [HIV/AIDS] programs.⁶⁰ While proposing PEPFAR, the

⁵⁷ Senator Joseph Biden, “Biden Issues Statement on Eve of World AIDS Day.” Press Release. November 30, 2007. At http://biden.senate.gov/press/press_releases/release/?id=bf310f9e-a173-4c46-bedd-12105bed5e61, visited January 29, 2008.

⁵⁸ Representative Tom Lantos, “Observing World AIDS Day, Lantos Calls Congressional Commitment to Ending Scourge of HIV/AIDS Higher Than Ever.” Press Release. November 30, 2007. At http://foreignaffairs.house.gov/press_display.asp?id=451, visited January 29, 2008.

⁵⁹ For more on this debate, see CRS Report RL33396, *The Global Fund to Fight AIDS, Tuberculosis, and Malaria: Progress Report and Issues for Congress*, by (name redacted).

⁶⁰ U.S. Congress, Senate Committee on Appropriations, *FY2005 Appropriations*, May 18, 2004.

Administration announced that it would seek \$1 billion for the Global Fund over the five-year term of the initiative. In total, the Administration requested \$1.3 billion for the Fund from FY2004 to FY2008, \$200 million in each of FY2004 and FY2005 and \$300 million in each of FY2006 through FY2008. Congress has consistently provided more to the Fund than the Administration has requested, appropriating some \$3 billion from FY2004 through FY2008. In FY2008, Congress provided \$840.3 million to the Fund, the largest U.S. contribution in a fiscal year to date.

Reconsider Abstinence-Until-Marriage Provisions

Some health experts assert that the spending requirements for HIV prevention activities are not well-balanced, place too much emphasis on abstinence until marriage, and hinder 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.⁶¹ 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.

Congress has already begun to introduce legislation to uphold, modify, or eliminate the abstinence-until-marriage spending requirement. In the 110th Congress, Members have enacted legislation that requires the Administration to follow the funding guidelines of Congress for prevention activities in FY2008, notwithstanding the 33% spending requirement for abstinence-until-marriage activities.⁶² Members have also introduced the HIV/AIDS Assistance

⁶¹ 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>.

⁶² Department of State, Foreign Operations and Related Programs Appropriations Act, 2008 (Division J of the Consolidated Appropriations Act, 2008; P.L. 110-161; 121 Stat. 2277), paragraph relating to Global Health and Child Survival (121 Stat. 2292). The Senate Committee on Appropriations reported out the House-passed foreign operations appropriations (H.R. 2764) with language stating that funds the Act appropriated for Global Health and Child Survival would be made available notwithstanding a requirement in the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (P.L. 108-25, Sec. 403(a); 22 U.S.C. 7673(a)) that "For fiscal years 2006 (continued...)"

Reauthorization Act (S. 1966), which would increase the portion of prevention funds to be spent on abstinence-until-marriage and fidelity activities to 50%. Other bills seek to strike the provision altogether, such as Protection Against Transmission of HIV for Women and Youth Act of 2007 (H.R. 1713 and S. 2415) and HIV Prevention Act of 2007 (S. 1553).

Consider Impact of Abstinence-Until-Marriage Provision on Gender

The 33% spending requirement is particularly troubling to some HIV/AIDS experts. They contend that the provision does not consider gender dynamics in some of the most affected countries. Research has shown that in Africa, married girls and women are more likely to contract HIV than their single counterparts.⁶³ For example, 30% of married adolescents' spouses were HIV-positive in Kenya, while 11.5% of the partners of their unmarried counterparts were infected with HIV. Similarly, in Zambia, 31.6% of married girls' partners were found to carry HIV, while 16.8% of unmarried girls' boyfriends were HIV-positive.⁶⁴ In response to these findings, some Members have introduced legislation that aims to make PEPFAR responsive to gender inequities. For example, the Protection Against Transmission of HIV for Women and Youth Act of 2007 (H.R. 1713 and S. 2415) requires 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 gender disparities in HIV infection rates.

Emphasize Other HIV Prevention Strategies

Some HIV advocates argue that a disproportionate percentage of prevention funds are spent on abstinence-only programs, effectively limiting the amount of funds available for other HIV prevention strategies. Many health experts advocate for greater spending on the prevention of mother-to-child HIV transmission (PMTCT).⁶⁵ UNAIDS estimates that 1,800 children worldwide become infected with HIV each day, the vast majority of whom are newborns. More than 85% of children infected with HIV live in sub-Saharan Africa, although MTCT rates are rapidly rising in Eastern Europe and Central Asia.⁶⁶ 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

(...continued)

through 2008, not less than 33 percent of the amounts appropriated ...shall be expended for abstinence-until-marriage programs."

⁶³ "Early Marriage and HIV Risks in Sub-Saharan Africa." *Studies in Family Planning*, Volume 35, Number 3, September 2004. Also, "Protecting Young Women from HIV/AIDS: The Case Against Child and Adolescent Marriage." *International Family Planning Perspectives*, Volume 32, Number 2, June 2006. <http://www.jstor.org/journals/01622749.html>

⁶⁴ *The Implications of Early Marriage for HIV/AIDS Policy*. Population Council, 2004. <http://www.popcouncil.org/pdfs/CM.pdf>

⁶⁵ Most children living with HIV contract 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.

⁶⁶ UNAIDS 2006 Global AIDS Report, p.132.

transmission of HIV to their babies.⁶⁷ The Global Pediatric HIV/AIDS Prevention and Treatment Act of 2007 (S. 2472) amends PEPFAR authorizing legislation to ensure that by 2013, 80% of pregnant women in the Focus Countries receive HIV counseling and testing and all those who test positive receive PMTCT services.

Consider Access to Condoms

A number of HIV/AIDS advocates argue that if PEPFAR is reauthorized, the guidelines on condom usage should be expanded. Critics contend that the PEPFAR policy, which advises implementing partners to distribute condoms to “high risk groups”⁶⁸ has limited effectiveness. 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 experts urge Congress to enact legislation that includes language similar to that proposed in HIV Prevention Act of 2007 (S. 1553), which expands the definition of “high risk” individuals to include married and young people.

Integrate Family Planning Services Into PEPFAR Programs

A growing number of health analysts are calling for better integration of family planning and HIV/AIDS programs. Supporters of this strategy assert that adding family planning services to PMTCT programs can achieve the same effect as increasing drug coverage but at a lower cost. According to the Ensuring Access to Contraceptives Act of 2007 (H.R. 2367)—a bill which aims to expand access to contraceptives—at equal funding levels, family planning services can avert nearly 30% more HIV-positive births than ARVs.⁶⁹ The Focus on Family Worldwide Act of 2007 (H.R. 1225) also aims to integrate family planning and HIV/AIDS activities.

Increase Anti-Retroviral Treatments for Children

According to UNAIDS, some 2.1 million children and infants are living with HIV/AIDS worldwide. In 2007, the virus killed an estimated 290,000 children.⁷⁰ Without treatment and care, approximately 50% of all HIV-positive children will die before age two and 75% will die before age five.⁷¹ OGAC estimates that in FY2006, it allocated 9% of all spending on ARVs to

⁶⁷ Ibid, p. 133.

⁶⁸ 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.

⁶⁹ Ensuring Access to Contraceptives Act of 2007, H.R. 2367.

⁷⁰ According to the UNAIDS website, “[an] in-depth review of HIV estimates among children published in the 2007 AIDS Epidemic Update report in November 2007 has revealed inaccuracies in processing some of the data. As a result, the figures used in this paragraph reflect the corrected data and differ from those in the 2007 AIDS Epidemic Update. At the UNAIDS homepage on the 2007 AIDS Epidemic Update: <http://www.unaids.org/en/KnowledgeCentre/HIVData/EpiUpdate/EpiUpdArchive/2007/default.asp>, visited on January 29, 2008.

⁷¹ Elizabeth Glaser Pediatric AIDS Foundation, “In the Battle Against HIV/AIDS, Equal Treatment for Children.” October 19, 2007. At <http://www.pedaids.org/News/Publications/Fact%20Sheet/PEPFAR%20Fact%20Sheets.aspx>

children.⁷² Some advocates for children urge Congress to increase spending on pediatric HIV/AIDS ARVs so that funding meets the needs of children currently without access to treatment. The Global Pediatric HIV/AIDS Prevention and Treatment Act of 2007 (S. 2472) amends PEPFAR authorizing legislation to require that by 2013, children account for at least 15% of those receiving treatment.

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). Administration critics 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, including the fact that the United States was already providing the country more than \$20 million in HIV/AIDS assistance.⁷³ In January 2007, U.S. Representative Barbara Lee introduced H.R. 175, to provide assistance to combat HIV/AIDS in India. The bill would add India as to the list of Focus Countries.

HIV/AIDS analysts are beginning to advocate that other countries where the virus is rapidly spreading be included in GHAI. Some HIV/AIDS advocates would like Congress to increase support in areas where HIV has become more entrenched, particularly in Eastern Europe and Central Asia. UNAIDS estimates that the number of people living with HIV in those regions has increased by 150% since 2001, when about 630,000 people were living with the virus. At the end of 2007, about 1.6 million people were living with HIV in the two regions, 90% of whom were in Ukraine and Russia. While Eastern Europe and Central Asia has demonstrated significant increases in HIV prevalence, Members have introduced legislation to boost support in other areas, namely India and the Caribbean. In February 2007, Representative Luis Fortuno introduced H.R. 848 to amend the State Department Basic Authorities Act of 1956 to authorize assistance to combat HIV/AIDS in certain countries of the Caribbean region. Latest estimates indicate that the average HIV/AIDS prevalence rate for the Caribbean is 1%. Nearly 75% of the 230,000 people living with HIV/AIDS in the region reside in Haiti or the Dominican Republic.

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.

⁷² PEPFAR webiste, "Pediatric Treatment and Care," June 2007, <http://www.pepfar.gov/pepfar/press/86524.htm>.

⁷³ For more on this discussion, see the White House press release at <http://www.whitehouse.gov/news/releases/2004/06/20040622-12.html>.

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.⁷⁴ 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.⁷⁵

The African Health Capacity Investment Act of 2007 (H.R. 3812 and S. 805) aims to address some of these issues. The bill authorizes funds to improve health care capacity on the continent. Related activities include training for African health care workers, provision of incentive to encourage health worker retention, and establishment of off-site HIV/AIDS testing and treatment facilities for health care providers. The bill also requires the President to develop a strategy that would coordinate health-related strategies with other donors. Some bills aim to improve health care capacity by integrating HIV/AIDS programs with other key health services, such as child survival and maternal health. The United States Commitment to Global Child Survival Act of 2007 (H.R. 2266 and S. 1418) authorizes funds to integrate and coordinate activities related to PMTCT, HIV/AIDS prevention, care and treatment, malaria, TB, and family planning.

Integrate Food and HIV/AIDS Services

The United Nations' Food and Agriculture Organization (FAO) estimates that in 2001-2003 there were 854 million undernourished people in the world.⁷⁶ Most of the world's undernourished were in Asia (162 million, excluding India and China), India (221 million), and China (142 million), though Africa (206 million) had the greatest proportion; one in three people in Africa were undernourished. Poor nutrition in HIV-positive people is particularly detrimental because poor nutrition weakens the body's immune response to the HIV virus and a number of HIV-associated opportunistic infections. HIV-positive people with weak immune systems become sick more frequently and develop AIDS more rapidly. Malnutrition may also be associated with increased risk of HIV transmission from mother to child.

If patients are not well nourished, they can suffer significant side effects while taking anti-retroviral medication (ARVs), and the drugs can be less effective. Studies have demonstrated that a person with HIV requires 10% to 15% more energy and 50% to 100% more protein a day than a non-infected adult.⁷⁷ Researchers in Singapore found that patients who are malnourished when

⁷⁴ 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>.

⁷⁵ 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.

⁷⁶ The causes of food insecurity and poor nutrition are complex, as are the range of possible health effects. For statistics and more discussion on this issue, see FAO, *The State of Food Insecurity in the World 2006*, <ftp://ftp.fao.org/docrep/fao/009/a0750e/a0750e00.pdf>.

⁷⁷ USAID website on HIV/AIDS and nutrition. At http://www.usaid.gov/our_work/global_health/aids/TechAreas/nutrition/nutrfactsheet.html, visited on October 2, 2007.

they start ARV therapy are six times more likely to die than well-nourished patients and are more likely to suffer side-effects, which often caused them to stop taking the treatments.⁷⁸

A growing number of HIV/AIDS advocates are urging Congress to mandate OGAC to integrate nutritional support in PEPFAR programs. OGAC maintains that it supports limited therapeutic feeding for malnourished AIDS patients, particularly malnourished HIV-positive pregnant and lactating women, as well as malnourished orphans and vulnerable children born to HIV-positive parents, who are clinically malnourished and have no other food resources. Further, the Administration contends that “[t]he Emergency Plan has a clear responsibility to prevent, treat and care for people with HIV and AIDS, but comprehensively addressing issues of food insecurity is beyond the scope of the Emergency Plan.”⁷⁹ At an April 2007 House Foreign Affairs Committee hearing on the progress of PEPFAR, Global AIDS Coordinator Mark Dybul testified that OGAC had contributed \$2.45 million to the World Food Program (WFP) and would contribute an additional \$4.27 million in FY2007. According to the Administration, the United States provides nearly half of all WFP’s resources, when all sources of U.S. funding are included.⁸⁰

In the House report (H.Rept. 109-265) accompanying the FY2006 Foreign Operations Appropriations (P.L. 109-102), Members urged OGAC to develop and implement a strategy to address the nutritional requirements of those taking ARVs. In Division J—the explanatory section for Department of State and Foreign Operations Appropriations—of the FY2008 Consolidated Appropriations, Congress directed that OGAC allocate no less than \$100 million of PEPFAR funds to “address short-term and long-term approaches to food security as components of a comprehensive approach to fighting HIV/AIDS.” Additionally, in December 2007, Representative Donald Payne introduced the Global HIV/AIDS Food Security and Nutrition Support Act of 2007 (H.R. 4914) to amend the PEPFAR authorization to integrate food security and nutrition activities into HIV/AIDS activities.

Boost Support for Research and Innovative Technology

Some HIV/AIDS advocates oppose congressional spending requirements, in part because they limit the ability of implementers to explore emerging technologies. A growing number of health experts are increasingly optimistic about the possible development of a microbicide.⁸¹ HIV/AIDS proponents urge Congress to increase support for microbicide research and development. Members have introduced legislation in support of microbicide research, such as House and Senate versions of The Microbicide Development Act (H.R. 1420 and S. 823). The bills amend the Public Health Service Act (42 U.S.C. 300cc-40 et seq.) and direct 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 mandate the

⁷⁸ World Food Program website on HIV/AIDS. At http://www.wfp.org/food_aid/food_for_hiv/nutrition.asp?section=12&sub_section=2, visited on October 3, 2007.

⁷⁹ OGAC, Report on Food and Nutrition for People Living with HIV/AIDS. May 2006. At <http://www.pepfar.gov/documents/organization/91983.pdf>, visited on January 29, 2008.

⁸⁰ U.S. State Department, “U.S. HIV/AIDS Program Blending Food Aid, Antiretroviral Therapy.” Press Release. April 24, 2007. And OGAC, “Care for People Living with HIV/AIDS,” Press Release. January 2008. At <http://www.pepfar.gov/pepfar/press/84749.htm>, visited on January 29, 2008.

⁸¹ Microbicides are compounds that can be applied inside the vagina or rectum to protect against sexually transmitted infections (STIs), including HIV.

Director of the National Institute of Allergy and Infectious Diseases to establish, within the Division of AIDS, an organizational unit that would conduct microbicide research and development. The bills direct the head of the Office of HIV/AIDS at USAID to develop and implement a program that would support the development of microbicides products and facilitate their wide-scale availability.

Some researchers recommend that Congress expand support for HIV/AIDS vaccine research and development. Supporters of this idea argue that vaccine identification should be an intractable part of U.S. international HIV/AIDS assistance. A key concern for many vaccine proponents is that the cost of U.S. international HIV/AIDS initiatives will continue to rise as more people receive treatment. An HIV/AIDS vaccine could prevent new infections and ultimately save the U.S. government billions of dollars. In February 2007, Senator Richard Lugar introduced the Vaccines for the Future Act of 2007 (S. 569). The bill, and its House companion (H.R. 1391), authorizes 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.

Appendix A. 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
GHAJ	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

Appendix B. 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
		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
		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			
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

Notes: 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.

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