that discriminates solely on the basis of an HIV/AIDS diagnosis is long past due.

I would like to take a moment now to highlight a couple of key provisions included in this bill that were drawn from legislation I introduced earlier this year with my colleague, Senator GORDON SMITH. Our bill, the Global Pediatric HIV/AIDS Prevention and Treatment Act, and the bill before us today set a target for the prevention and treatment of mother-to-child transmission of HIV that, within 5 years, will reach 80 percent of pregnant women in those countries most affected by HIV/AIDS in which the U.S. has such programs.

The bill also calls for integrating care and treatment with prevention of mother-to-child transmission programs, increasing access of women in these programs to maternal and child health services, and a timeline for expanding access to prevention of mother-to-child regimes. The ultimate goal of these policy improvements is to improve the health outcomes of HIV-affected women and their families and to improve followup and continuity of care.

I also want to thank the chairman and ranking member of the Foreign Relations Committee for including an amendment I offered in committee that will convene a prevention of mother-to-child expert panel which will report to the Office of the Global AIDS Coordinator and the public within a year on a plan for the scale-up of mother-to-child transmission prevention services. This provision was not included in the House-passed bill but I urge my colleagues to maintain it in the bill that is sent to the President.

We can prevent the transmission of HIV mother-to-child. We know how to do it. In the industrialized world, the standard of care involving a complex drug regimen has reduced mother-to-child transmission rates to as low as 2 percent. By the end of 2007, 34 percent of HIV-infected pregnant women around the world received the medicines they need to prevent transmission of HIV to their babies, a substantial increase from 14 percent in 2005. While this is considerable progress, still almost two-thirds of HIV-positive pregnant women did not receive the medicines necessary to prevent the transmission of HIV to their baby. That is why the target in the bill is so crucial.

I am in the unique position of serving on both the Foreign Relations Committee and the Health, Education, Labor and Pensions Committee where I have spent many years working to improve the health and welfare of children and families. We have made great strides through the Ryan White CARE Act program in this country toward ensuring that children and their families receive adequate, family-centered care and treatment for HIV/AIDS. In the United States, we have reached a point where a child living with HIV/AIDS no longer faces certain death. Thanks to antiretroviral, ARV, therapy, many children born infected with HIV/AIDS now have the opportunity to grow up healthy. However, long-term survival remains a dream that eludes most of the 2.5 million HIV-infected children around the world.

Globally, HIV/AIDS infection rates in children continue to outpace the rate at which they are treated. Every day approximately 1,100 children across the globe are infected with HIV, the vast majority through mother-to-child transmission during pregnancy, labor or delivery or soon after through breastfeeding. Approximately 90 percent of these infections occur in Africa.

With no medical intervention, HIV-positive mothers have a 25 to 30 percent chance of passing the virus to their babies during pregnancy and childbirth. Without proper care and treatment, half of these newly-infected children will die before their second birthday and 75 percent will die before their fifth. Sadly, although children represent close to 16 percent of HIV infections, they are only 10 percent of those receiving treatment.

That is why the bill before us today also includes a 5-year target that the number of children receiving care and treatment for HIV/AIDS is proportionate to their infection rate in each country funded under this program. One cannot lag behind the other and, with passage of this bill, they won't.

I thank the chairman and ranking member again for working with me to include these vital provisions for children and families. I believe they will have an enormous impact on the long-term health and survival of the millions of men, women and children affected by HIV/AIDS.

I would be remiss if I did not take a moment to highlight an area where I believe the bill regrettably does not incorporate the lessons learned over the past 5 years about addressing HIV/AIDS, and that is the lack of language in the bill facilitating linkages between HIV/AIDS activities and family planning activities.

I recognize that Members have strong feelings on this issue. But family planning providers serve millions of women in developing countries that are now at the center of the global HIV/AIDS pandemic. Moreover, it is critical that this program continue to support voluntary family planning counseling and referral as a core component of prevention of mother-to-child transmission and other HIV-service programs. I look forward to working to ensure that this program links HIV/AIDS activities and family planning activities.

With that, I urge my colleagues to act quickly to pass this bill to reauthorize a program that has helped save the lives of millions of men, women and children. The President has asked Congress to pass the bill. The leading organizations advocating for reauthorization of this program have called on Congress to pass the bill. The House has already passed the bill. It is time for the Senate to do the same. I implore my colleagues to put aside their differences and support passage of this bill.

Mr. COLEMAN. Madam President, I strongly support the reauthorization of the President's emergency plan for AIDS relief. The fight against pandemic AIDS is an important international priority, and I am very pleased that we can work toward a bipartisan consensus on this legislation. We have the benefit of 5 years of lessons learned to integrate into this bill, and the resources that we are putting into action through this measure will deliver lifesaving medicines, basic health care infrastructure and hope to millions of people around the global who face the threat of HIV/AIDS, malaria and tuberculosis.

I have had a particular interest in the area of health care infrastructure in Africa, and have worked closely with my colleagues Senators DURBIN and FEINGOLD on legislation relating to this. I am very pleased that some of our language and ideas have been integrated into the current PEPFAR bill. The fact of the matter is that we face great challenges in the area of health infrastructure in Africa, including serious shortages of health care workers, clinics, and hospitals in many areas of the host countries that limit our ability to reach the millions of people who need care and treatment. It is my view that at least some of the answers may be found in the private sector, and it is my hope that U.S. agencies will reach out to the private sector to help us meet the overwhelming needs of the affected countries.

I would like to share with my colleagues the success of one unique nonprofit from my home State that has harnessed the powerful force of franchising to establish a sustainable network of health clinics and pharmacies in two PEPFAR countries. This program, run by the HealthStore Foundation, was established more than a decade ago to "prevent needless death and illness by sustainably improving access to essential medicines." Since that time, the HealthStore Foundation has established a network of more than 65 franchises in Kenya, serving roughly 525,000 patients and customers in 2007. Currently, the program is expanding to Rwanda, and the first franchise should be open within a few weeks. By 2012, the HealthStore Foundation plans to expand its network to over 14 countries serving millions of patients per year.

Each HealthStore franchise is locally owned and operated by a licensed nurse or by a community health worker. Some hire employees, creating still more jobs, mostly for women. HealthStore operates as a typical franchisor, and franchises are licensed under the Child and Family Wellness Shops, CFW shops, brand name. The model incorporates key elements of any successful franchise network:

strong branding, proven operating systems and training; strict quality controls enforced through regular inspections; and well-chosen locations. It is worth noting that franchising the distribution of health care and pharmaceuticals has also helped to curtail incentives for corruption, as franchisees risk losing their business if they fail to comply with franchise system standards.

I describe the HealthStore Foundation program as a "microfranchise" model, because this model shares many of the unique characteristics of the microlending efforts led by the Grameen Bank. In Kenya, clinics are easily accessible, located within an hour's walk of the communities they serve. Each clinic offers a range of government-approved, tested medicines and products along with basic health care services from licensed nurses. Up front costs for each franchise unit are modest, and the stores generate a steady income for their owners. To ensure that capital is available, the HealthStore Foundation provides financing for up to 88 percent of the required initial capital, although many owners raise funds through family and friends. Most importantly, these clinics operate to turn a profit, and it is the long-term maintenance of this profit that sustains the system.

Franchising delivers certain competitive advantages, including economies of scale, centralized distribution of high-quality drugs, central management of regulatory and legal issues, and a critical mass of locations that can share best practices and leverage resources. Apart from the benefits accrued through these competitive advantages, franchise owners also receive extensive training, marketing and promotions support, technical advice, and an established, trusted brand name.

The genius of the HealthStore Foundation's strategy for building a sustainable infrastructure of health care delivery in Kenya and Rwanda is the adoption of the franchise business model. Franchising is such a tried and true business strategy in this country that most Americans take it for granted, but franchising is taking place all around us. In fact, a recent report by the International Franchise Association Educational Foundation shows that roughly 909,000 franchise businesses in the United States account for 21 million jobs and more $2.3 trillion in annual economic activity, and franchising has been growing at a faster pace than the overall economy. In the United States, franchising is a business strategy that works because an entrepreneur with a great idea or great product can quickly and efficiently develop a network of businesses to deliver a consistent, high quality product in every State, city and town across the Nation.

The goal of this legislation is to halt the spread of pandemic diseases in a large part of the world. Certainly, the HealthStore Foundation has proven that microfranchise businesses can be capable partners in this effort, but the ownership opportunities provided by franchising also offer us other benefits. We know that ownership is a powerful incentive. Ownership gives people a stake in the future. In Kenya, owning a HealthStore clinic has become an attractive career choice for health care workers, helping to slow the pace of emigration of these trained professionals. The microfranchise model also supports the development of a strong small business infrastructure in villages and towns throughout the PEPFAR regions, and the lessons learned through franchised health care clinics can be repeated in other kinds of businesses.

For these reasons, the Senate should work with U.S. agencies to consider microfranchise business creation among the strategies for putting these resources to work in the PEPFAR region. In order to continue to raise awareness around this important approach that has been tried by the HealthStore Foundation, I plan to follow up this statement with a colloquy with one of my Senate colleagues.

Mr. ENZI. Madam President, I rise today to reiterate my continued support for the passage of the Tom Lantos and Henry J. Hyde U.S. Global Leadership Against HIV/AIDS, Tuberculosis and Malaria Reauthorization Act of 2008. The compromise that many of my colleagues were able to support is what I call the third way. Many on both sides of the aisle would prefer to have it changed one way or another to assuage some of their concerns with the policies set out in the bill, and I can understand those concerns. However, now is the time to put away our partisan politics and pass a bill that will reach to save over 3 million more lives, care for more than 12 million more people affected by HIV/AIDS and continue to stop the spread of the disease by spreading the messages about prevention. That is the bottom line—it saves lives and it really is a shining example of the generosity and goodness of America and her people. Senators COBURN, BURR and I worked with Senators BIDEN and LUGAR and many other members of the Senate to reach an agreement that we all think is fair, just and conscientious.

As I mentioned the other day, I have been to Africa more than once, so I have seen first hand the tremendous benefit that this program has achieved and I am confident that this bill will allow it to achieve even more. Now I know that some of us are concerned about, and have legitimate disagreements, over the high authorization level attached to this bill. I have always supported having a fair debate on this issue on the Senate floor and I hope to find a fiscally responsible way to address this crisis by having every member vote on a number that is reasonable and get the job done. There is an urgent need to meet this world health crisis, and America has never turned her back when there is such a profound and pressing crisis affecting those who are far less fortunate. I again want to reiterate my support for this discussion and for the continuation of the floor process to have this bill passed as quickly as possible.

I believe that the American people support these humanitarian efforts, and as their elected Representatives, we have the solemn responsibility to see to it that their hard-earned dollars are being spent wisely and effectively. I happen to believe that it is critical that the bulk of these funds are spent for the specific benefit of people who are infected—for their direct medical care and treatment. I personally am satisfied that we have secured a bill that will do just that. In fact, in order to assure that this does happen, we have built in safeguards to ensure transparency and accountability throughout this bill so that we may better monitor the outcomes of this program and easily find the areas that are in need of improvement.

We have come a long way in assuring that over half of these funds will be focused on treating people directly, so that the funds will follow the individuals affected by HIV/AIDS. The more we are focusing our efforts on treatment, the less likely these funds will be spent on so called extraneous provisions that so many of my colleagues are concerned about.

I hope that we can all agree to act on this bill in a timely manner without partisan politics. This is a good bill; it will save lives. As I said the other day, I urge all my colleagues to vote for passage and send a message to the world's nations that America will always be there for those who cannot help themselves—our commitment is to ridding the world of these dread diseases, and we are resolute in our determination to reach that goal.

Ms. MIKULSKI. Madam President, I rise today to applaud the passage of the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act. I am proud to have voted in support of this legislation that reauthorizes the President's Emergency Plan for AIDS Relief, PEPFAR, and provides much-needed foreign aid to countries to combat these devastating diseases.

Currently, more than 33 million people worldwide live with HIV/AIDS. My own dear State of Maryland is one of the hardest hit States in the U.S. Maryland has the ninth highest AIDS rate in the Nation and the Baltimore metropolitan area has the second highest rate of AIDS cases compared to other cities in the country. Today, by providing $50 billion over the next 5 years to 120 countries we are recommitting ourselves to fighting the deadly diseases of HIV/AIDS, tuberculosis, and malaria. These global health problems affect not just patients, but their families and communities.

This act provides funding for education, prevention, research, care, and