I

111TH CONGRESS
1ST SESSION

H. R. 1410

To provide assistance to improve the health of newborns, children, and mothers in developing countries, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 10, 2009

Ms. MCCOLLUM (for herself, Mr. REICHERT, Mrs. CAPPS, Mr. PAYNE, Mr. BLUMENAUER, Mr. SCHIFF, Mr. MOORE of Kansas, Mr. GRIJALVA, Ms. MOORE of Wisconsin, Ms. JACKSON-LEE of Texas, Mrs. TAUSCHER, Mr. MCDERMOTT, Mr. MCGOVERN, Mr. WALZ, Mr. MORAN of Virginia, Ms. WATSON, Ms. WOOLSEY, Ms. DELAURO, Mr. HINCHEY, Mr. CARSON of Indiana, Mr. YOUNG of Alaska, Ms. LEE of California, Mr. OBERSTAR, Mr. MURPHY of Connecticut, Mrs. CHRISTENSEN, Ms. EDDIE BERNICE JOHNSON of Texas, Ms. HIRONO, Mr. SERRANO, Ms. SLAUGHTER, Mr. FILNER, Ms. DEGETTE, Mr. CROWLEY, Mr. HONDA, Mr. OLVER, Mr. SNYDER, Mr. SHIMKUS, Mr. JACKSON of Illinois, and Mrs. MALONEY) introduced the following bill; which was referred to the Committee on Foreign Affairs

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A BILL

To provide assistance to improve the health of newborns, children, and mothers in developing countries, and for other purposes.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Newborn, Child, and Mother Survival Act of 2009''.

SEC. 2. FINDINGS AND PURPOSES.

(a) FINDINGS.—Congress finds the following:

(1) At least 9,200,000 children under the age of 5 die each year, more than 25,000 children per day, mostly from preventable and treatable causes according to the United Nations Children's Fund (UNICEF).

(2) In poor countries, an estimated 3,700,000 newborns die in the first 4 weeks of life according to the World Health Organization (WHO).

(3) Approximately 536,000 women die every year in developing countries from causes related to pregnancy and childbirth, the equivalent of 1 woman per minute, according to WHO.

(4) For every maternal death some 20 women—or 10 million women per year—suffer complications with severe consequences, including pregnancy-related injuries, infections, diseases, and disabilities.

(5) Worldwide, 68 countries account for 97 percent of all maternal and under-5 child deaths.

(6) Nearly 1 of every 5 children die before the age of 5, more than 2,000,000 child deaths per year, in the ten countries with the highest child mortality rates in the world: Sierra Leone, Afghanistan, Chad,

Equatorial Guinea, Guinea-Bissau, Mali, Burkina Faso, Nigeria, Rwanda, and Burundi.

(7) Nine out of 10 women in sub-Saharan Africa will lose a child during their lifetimes.

(8) In sub-Saharan Africa, a woman's lifetime risk of maternal death is a staggering 1 in 22, compared with 1 in 8,000 in industrialized countries, according to UNICEF.

(9) Pneumonia, diarrhea, low birth weight, sepsis, birth trauma, and malaria, all preventable and treatable, are the top contributors of deaths of children under the age of 5.

(10) Poor nutrition is a major factor in 20 percent of maternal deaths, up to one-third of under-5 child deaths, and 60 to 80 percent of newborn deaths.

(11) Risk factors for maternal death in developing countries include pregnancy and childbirth at an early age, closely-spaced births, infectious diseases, malnutrition, and complications during childbirth.

(12) In Mozambique, the ratio of nongovernmental organizations engaged in HIV/AIDS prevention efforts compared to nongovernmental organizations engaged in maternal and child health efforts is

100 to 1, according to Mozambique's Minister of Health, yet in that country 168 out of every 1,000 children die before the age of 5 and one in every 45 mothers are at risk of death.

(13) Antenatal care coverage for pregnant mothers in developing countries is often low. For example, in sub-Saharan Africa antenatal care coverage is 69 percent yet programs for prevention of maternal to child transmission of HIV reach an average of only 11 percent of those who need them, according to UNICEF.

(14) In many poor countries, a lack of access, including transportation to quality health care facilities, results in deaths for newborns, children, and mothers.

(15) No skilled birth attendant is present at 34 percent of deliveries worldwide which means 45,000,000 births each year are occurring at home without skilled health personnel, according to WHO.

(16) Due to an estimated 50 percent shortfall in skilled birth attendants, 700,000 skilled and trained birth attendants are needed worldwide to ensure universal coverage to maternity care, while an additional 47,000 doctors with emergency obstetric

skills are required, particularly in rural areas, according to WHO.

(17) Expansion of clinical care for newborns and mothers, such as clean delivery by skilled birth attendants, emergency obstetric care, and neonatal resuscitation can save the lives of mothers, and can also avert 50 percent of newborn deaths.

(18) Maternal, newborn, and child health services should include interventions along the continuum of care from before pre-pregnancy to early childhood period and should be provided at home, community, and clinics.

(19) An effective household to hospital continuum of care is especially important for maternal survival, since timely linkage to referral-level obstetric care is necessary to reduce maternal mortality.

(20) A package of 32 affordable interventions, including skilled care at birth, emergency obstetric care, breastfeeding, vaccinations, antibiotics, and micro-nutrients, could save 6,000,000 children per year at a cost of only $25 per child or $1.62 per person in 60 priority countries.

(21) Millions of children's lives can be saved by high-impact, low-cost, feasible interventions like oral rehydration therapy (ORT) for diarrhea ($0.07 per

treatment), antibiotics to treat respiratory infections ($0.25 per treatment), and anti-malaria tablets ($0.29 per treatment).

(22) Exclusive breastfeeding—giving only breast milk for the first 6 months of life—could help prevent an estimated 1,400,000 newborn and infant deaths each year, primarily by protecting again diarrhea and pneumonia.

(23) Three million children die each year due to lack of access to low-cost antibiotics and anti-malarial drugs.

(24) Two million children die from diarrheal diseases unnecessarily due to lack of access to ORT prepared with clean water.

(25) Between 1999 and 2004, distribution of low-cost vitamin A supplements saved an estimated 2,300,000 lives, yet the unmet need for vitamin A supplements results in an estimated 250,000 to 500,000 children becoming blind each year, with 70 percent of such children dying within 12 months of losing their sight.

(26) Studies suggest that high coverage and quality of proven health interventions could avert about 67 percent of neonatal and child deaths in 60 priority countries worldwide.

(27) Maternal and child mortality rates are an important indicator of a government's commitment to women and children, as well as a barometer of a country's healthcare system and overall development performance.

(28) It is estimated that an additional $850,000,000 invested in newborn and child health could save the lives of nearly 1,000,000 children every year.

(29) Investments in child survival have contributed to a major decline in the rate of child mortality, even in poor countries such as Indonesia, Nepal, Laos, Bangladesh, and Bolivia, which have all reduced their under-5 child mortality by more than one-half since 1990.

(30) Under-five child mortality has decreased by 20 to 50 percent in 15 United States Agency for International Development-assisted countries over the past ten years.

(31) In 2000, the United States joined 188 other countries in supporting eight United Nations Millennium Development Goals to reduce the mortality rate of children under the age of 5 by two-thirds (goal 4) and to reduce maternal deaths by three-quarters (goal 5).

(32) In 2008, of the 68 priority countries representing 97 percent of newborn and child mortality, only 16 of these countries are on track to achieve Millennium Development Goal (MDG) 4 of reducing child mortality by two-thirds.

(b) PURPOSES.—The purposes of this Act are to—

(1) authorize assistance to reduce mortality and improve the health of newborns, children, and mothers in developing countries, including strengthening the capacity of health systems and health workers;

(2) develop and implement a strategy based on a continuum of care to reduce mortality and improve the health of newborns, children, and mothers in developing countries; and

(3) assess, monitor, and evaluate the progress and contributions of relevant departments and agencies of the Government of the United States in achieving reductions of newborn, child, and maternal mortality in developing counties as well as contributions in achieving the United Nations Millennium Development Goals through the establishment of an interagency task force.

SEC. 3. ASSISTANCE TO REDUCE MORTALITY AND IMPROVE THE HEALTH OF NEWBORNS, CHILDREN, AND MOTHERS IN DEVELOPING COUNTRIES.

(a) IN GENERAL.—Chapter 1 of part I of the Foreign Assistance Act of 1961 (22 U.S.C. 2151 et seq.) is amended—

(1) in section 101(a)(1), by inserting at the end before the semicolon the following: ", with particular focus on children and mothers";

(2) in section 102(b)(4)(B), by striking "reduction of infant mortality" and inserting "reduction of newborn, child, and maternal mortality";

(3) in section 104(c)—

(A) by striking paragraphs (2) and (3); and

(B) by redesignating paragraph (4) as paragraph (2);

(4) by redesignating sections 104A, 104B, and 104C as sections 104B, 104C, and 104D, respectively; and

(5) by inserting after section 104 the following new section:

"SEC. 104A. ASSISTANCE TO REDUCE MORTALITY AND IMPROVE THE HEALTH OF NEWBORNS, CHILDREN, AND MOTHERS.

"(a) AUTHORIZATION.—Consistent with section 104(c), the President is authorized to furnish assistance, on such terms and conditions as the President may determine, to reduce mortality and improve the health of newborns, children, and mothers in developing countries.

"(b) ACTIVITIES TO PREVENT MORTALITY AND IMPROVE NEWBORN AND CHILD HEALTH.—Assistance provided under subsection (a) shall, to the maximum extent practicable, be used to—

"(1) improve newborn care and treatment, including educating families about proper antenatal and skilled delivery care, drying and warming with the mother, immediate and exclusive breastfeeding, handwashing, clean cord care, prompt recognition and care seeking for danger signs, and treatment of neonatal infections; and

"(2) increase access to and utilization of appropriate interventions to treat life-threatening childhood illnesses, including—

"(A) to prevent and mitigate the severity of and treat diarrhea, including point of use water treatment, improvements in hygienic behavior, oral rehydration therapy (ORT), zinc,

exclusive breastfeeding in the first six months of life, and adequate and young child feeding during the first 6 to 24 month period;

''(B) to prevent deaths due to pneumonia with a focus on community-based treatments using antibiotics and effective recognition of severe illness with appropriate referral;

''(C) to achieve the delivery of full immunization services, including efforts to eliminate polio and introduce new vaccines as available; and

''(D) to prevent and treat malaria through increased use of insecticide-treated nets, indoor residual spraying, and timely and appropriate treatment of malaria.

''(c) ACTIVITIES TO PREVENT MORTALITY AND IMPROVE MATERNAL HEALTH.—Assistance provided under subsection (a) shall, to the maximum extent practicable, be used to—

''(1) improve birth preparedness, including quality antenatal care throughout pregnancy; and

''(2) expand access and improve quality of maternity services, including—

''(A) skilled birth attendants;

''(B) recognition and treatment of obstetric complications and disabilities, such as postpartum hemorrhage;

''(C) quality emergency obstetric care;

''(D) activities to treat and repair injuries resulting from pregnancy and childbirth; and

''(E) activities to lower or remove financial barriers to maternal healthcare services.

''(d) ACTIVITIES TO PROMOTE HEALTHY NEWBORNS, CHILDREN, AND MOTHERS.—Assistance provided under subsection (a) shall, to the maximum extent practicable, be used to—

''(1) improve child and maternal nutrition, including the delivery of iron, folic acid, zinc, vitamin A, iodine, and other key micronutrients;

''(2) promote breastfeeding, appropriate complementary feeding, and the management of acute severe malnutrition, including the use of ready to use therapeutic food;

''(3) improve access to clean water and improved sanitation through community-based hygiene education programs, the use of personal water purification tools and devices, and latrine construction;

''(4) reduce exposure to environmental toxins and indoor smoke from cooking fires;

''(5) address antimicrobial resistance in children and mothers;

''(6) ensure access to transportation for newborns, children, and mothers in need of emergency clinical care;

''(7) ensure access to comprehensive post-natal newborn and maternal care, including services during the immediate post-partum period; and

''(8) increase access to low- or no-cost deworming products.

''(e) ACTIVITIES TO STRENGTHEN COMMUNITIES AND HEALTH SYSTEMS.—Assistance provided under subsection (a) shall, to the maximum extent practicable, be used to—

''(1) improve capacity for health governance, finance and workforce, including support for the training and supervision of clinicians, nurses, midwives, skilled birth attendants, nutritionists, technicians, sanitation and public health workers, community-based health workers, peer educators, volunteers, and private sector enterprises;

''(2) recruit, train, and supervise providers of comprehensive emergency obstetric and newborn care services;

''(3) establish and support management information systems in host country institutions and the development and use of tools and models to collect, analyze, and disseminate information relating to newborn, child, and maternal health, including registration of all births and deaths, along with cause of death, at district and country levels;

''(4) develop and conduct needs assessments, baseline studies, targeted evaluations, and other information-gathering efforts for the design, monitoring, and evaluation of newborn, child, and maternal health programs; and

''(5) implement tailored programs in priority countries in political transition or post conflict settings to extend newborn, child, and maternal services as quickly as possible to assist in rebuilding of fragile health systems.

''(f) ACTIVITIES TO PROMOTE INTEGRATION, COORDINATION, AND MAXIMUM UTILIZATION OF HEALTH AND DEVELOPMENT RESOURCE ASSISTANCE.—Assistance provided under subsection (a) shall, to the maximum extent practicable, be used to—

''(1) carry out activities in host countries, including—

"(A) the prevention of the transmission of HIV from mother-to-child and other HIV/AIDS counseling, care, and treatment;

"(B) the prevention of malaria and other malaria counseling, care, and treatment;

"(C) the prevention of tuberculosis and other tuberculosis counseling, care, and treatment;

"(D) child spacing;

"(E) nutrition;

"(F) education and microfinance activities that facilitate increasing access to and use of critical health services or practices; and

"(G) water and sanitation activities; and

"(2) carry out activities linked to United States Government programs to reduce poverty and improve health and development, including—

"(A) title II of the Agricultural Trade Development and Assistance Act of 1954 (7 U.S.C. 1721 et seq.);

"(B) the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7601 et seq.) and the amendments made by that Act (commonly known as

the 'President's Emergency Plan for HIV/AIDS Relief' or 'PEPFAR');

''(C) the Presidential Malaria Initiative (PMI);

''(D) global health programs administered by the United States Agency for International Development (USAID);

''(E) programs administered by USAID's Office of U.S. Foreign Disaster Assistance programs (OFDA); and

''(F) global health programs administered by the Department of Health and Human Services.

''(g) GUIDELINES.—To the maximum extent practicable, programs, projects, and activities carried out using assistance provided under this section shall be—

''(1) carried out through private and voluntary organizations, including faith-based organizations, and relevant international and multilateral organizations, including the GAVI Alliance (formerly known as the Global Alliance for Vaccines and Immunization) and the United Nations Children's Fund (UNICEF), the World Health Organization (WHO), the World Food Programme (WFP), and the Global Fund to Fight AIDS, Tuberculosis and Malaria, giv-

ing priority to organizations that demonstrate effectiveness and commitment to preventing mortality and improving the health of newborns, children, and mothers;

''(2) carried out with input by host countries, including civil society and local communities, as well as other donors and multilateral organizations;

''(3) carried out with input by beneficiaries and other directly-affected populations, especially women and marginalized communities; and

''(4) designed to build the capacity of host country governments and civil society organizations.

''(h) ANNUAL REPORT.—Not later than February 1 of each year, the President shall transmit to Congress a report on the implementation of this section for the prior fiscal year.

''(i) DEFINITIONS.—In this section:

''(1) AIDS.—The term 'AIDS' has the meaning given the term in section 104B(g)(1) of this Act.

''(2) HIV.—The term 'HIV' has the meaning given the term in section 104B(g)(2) of this Act.

''(3) HIV/AIDS.—The term 'HIV/AIDS' has the meaning given the term in section 104B(g)(3) of this Act.''.

(b) CONFORMING AMENDMENTS.—The Foreign Assistance Act of 1961 (22 U.S.C. 2151 et seq.) is amended—

(1) in section 104(c)(2) (as redesignated by subsection (a)(2)(B) of this section), by striking ''and 104C'' and inserting ''104C, and 104D'';

(2) in section 104B (as redesignated by subsection (a)(3) of this section)—

(A) in subsection (c)(1), by inserting ''and section 104A'' after ''section 104(c)'';

(B) in subsection (f)(2)(A), by striking ''section 104B, and section 104C'' and inserting ''section 104C, and section 104D''; and

(C) in subsection (g), by striking ''section 104(c), this section, section 104B, and section 104C'' and inserting ''section 104(c), section 104A, this section, section 104C, and section 104D'';

(3) in subsection (c) of section 104C (as redesignated by subsection (a)(3) of this section), by inserting ''and section 104A'' after ''section 104(c)'';

(4) in subsection (c) of section 104D (as redesignated by subsection (a)(3) of this section), by inserting ''and section 104A'' after ''section 104(c)'';

(5) in the first sentence of section 119(c), by striking ''section 104(c)(2), relating to Child Survival Fund'' and inserting ''section 104A''; and

(6) in section 135(b)—

(A) in paragraph (1), by striking ''section 104A(g)(1)'' and inserting ''section 104B(g)(1)''; and

(B) in paragraph (3), by striking ''section 104A(g)(3)'' and inserting ''section 104B(g)(3)''.

SEC. 4. STRATEGY TO REDUCE MORTALITY AND IMPROVE THE HEALTH OF NEWBORNS, CHILDREN, AND MOTHERS IN DEVELOPING COUNTRIES.

(a) STRATEGY REQUIRED.—The President shall develop and implement a comprehensive United States Government strategy to reduce mortality and improve the health of newborns, children, and mothers in developing countries.

(b) COMPONENTS.—The comprehensive United States Government strategy developed pursuant to subsection (a) shall include the following:

(1) An identification of not less than 60 countries with priority needs for the 5-year period beginning on the date of the enactment of this Act based on—

(A) the number and rate of neonatal deaths;

(B) the number and rate of child deaths;

(C) the number and ratio of maternal deaths;

(D) the number and rate of malnourished women of reproductive age; and

(E) the number and rate of malnourished infants and children under the age of 5.

(2) For each country identified in paragraph (1)—

(A) an assessment of the most common causes of newborn, child, and maternal mortality;

(B) a description of the host country's overall health strategy and expenditures, including an assessment of components to specifically reduce newborn, child, and maternal mortality rates;

(C) a description of the programmatic areas and interventions providing maximum health benefits to populations at risk as well as maximum reduction in newborn, child, and maternal mortality;

(D) an assessment of the investments needed in identified programs and interventions to achieve the greatest results;

(E) a description of how United States assistance complements and leverages efforts by other donors, as well as builds capacity and self-sufficiency among recipient countries;

(F) a description of goals and objectives for improving newborn, child, and maternal health, including, to the extent feasible, objective and quantifiable indicators; and

(G) a description of the host government's commitment to working with partners and civil society to achieve accelerated reductions in newborn, child and maternal mortality.

(3) With respect to the 30 countries identified in paragraph (1) that have the highest newborn, child, and maternal mortality rates, a plan to—

(A) reduce the mortality rate among newborns, children, and mothers in each of those countries by 25 percent by 2013;

(B) address the human resources crisis in each of those countries by increasing by at least 100,000 the number of functional (trained, equipped, and supervised) community health

workers and volunteers serving at primary care and community levels in those countries by 2013; and

(C) achieve an average reduction in child and maternal malnutrition in at least 10 of those countries by 15 percent by 2013.

(4) With respect to the countries identified in paragraph (1) without a United States Agency for International Development (USAID) mission or in conflict, post-conflict, or in a condition of political transition and at risk of increased newborn, child, and maternal mortality, a plan to prevent newborn, child, and maternal deaths in each of those countries through coordination with and support from multilateral organizations.

(5) An expansion of the Child Survival and Health Grants Program of USAID, at a minimum proportionate to any increase in newborn, child, and maternal health assistance, to provide additional support programs and interventions determined to be efficacious and cost-effective in improving health and reducing mortality.

(6) A description of the measured or estimated impact on newborn, child, and maternal morbidity

and mortality of each project or program carried out.

(c) REPORT.—Not later than 180 days after the date of the enactment of this Act, the President shall transmit to Congress a report that contains the strategy described in this section.

SEC. 5. INTERAGENCY TASK FORCE ON NEWBORN, CHILD, AND MATERNAL HEALTH IN DEVELOPING COUNTRIES.

(a) ESTABLISHMENT.—There is established a task force to be known as the Interagency Task Force on Newborn, Child, and Maternal Health in Developing Countries (in this section referred to as the ''Task Force'').

(b) DUTIES.—

(1) IN GENERAL.—The Task Force shall assess, monitor, and evaluate the progress and contributions of relevant departments and agencies of the Government of the United States in achieving the United Nations Millennium Development Goals by 2015 for reducing the mortality of children under the age of 5 by two-thirds (Millennium Development Goal 4) and reducing maternal mortality by three-quarters (Millennium Development Goal 5) in developing countries, including by—

(A) identifying and evaluating programs and interventions that directly or indirectly contribute to the reduction of newborn, child, and maternal mortality rates;

(B) assessing effectiveness of programs, interventions, and strategies toward achieving the maximum reduction of newborn, child, and maternal mortality rates;

(C) assessing the level of coordination among relevant departments and agencies of the Government of the United States, the international community, international organizations, faith-based organizations, academic institutions, and the private sector;

(D) assessing the level of coordination of United States bilateral programs and the host country government in implementing the host country's health strategy to reduce newborn, child, and maternal mortality rates;

(E) assessing the contributions made by United States-funded programs toward achieving the Millennium Development Goals 4 and 5;

(F) identifying the bilateral efforts of other nations and multilateral efforts toward achiev-

ing the Millennium Development Goals 4 and 5; and

(G) preparing the annual report required by subsection (f).

(2) CONSULTATION.—To the maximum extent practicable, the Task Force shall consult with individuals with expertise in the matters to be considered by the Task Force who are not officers or employees of the Government of the United States, including representatives of United States-based nongovernmental organizations (including faith-based organizations and private foundations), academic institutions, private corporations, the United Nations Children's Fund (UNICEF), and the World Bank.

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Task Force shall be composed of the following members:

(A) The Administrator of the United States Agency for International Development.

(B) The Assistant Secretary of State for Population, Refugees and Migration.

(C) The Coordinator of United States Government Activities to Combat HIV/AIDS Globally (commonly known as the ''U.S. Global AIDS Coordinator'').

(D) The Coordinator of the United States Government Presidential Malaria Initiative (PMI).

(E) The Director of the Office of Global Health Affairs of the Department of Health and Human Services.

(F) The Under Secretary for Food, Nutrition and Consumer Services of the Department of Agriculture.

(G) The Chief Executive Officer of the Millennium Challenge Corporation.

(H) The Director of the Peace Corps.

(I) Other officials of relevant departments and agencies of the Federal Government who shall be appointed by the President.

(J) Two ex-officio members appointed by the Speaker of the House of Representatives in consultation with the minority leader of the House of Representatives.

(K) Two ex-officio members appointed by the majority leader of the Senate in consultation with the minority leader of the Senate.

(2) CHAIRPERSON.—The Administrator of the United States Agency for International Development shall serve as chairperson of the Task Force.

(d) MEETINGS.—The Task Force shall meet on a regular basis, not less often than quarterly, on a schedule to be agreed upon by the members of the Task Force, and starting not later than 90 days after the date of the enactment of this Act.

(e) DEFINITION.—In this section, the term ''Millennium Development Goals'' means the key development objectives described in the United Nations Millennium Declaration, as contained in United Nations General Assembly Resolution 55/2 (September 2000).

(f) REPORT.—Not later than 120 days after the date of the enactment of this Act, and not later than April 30 of each year thereafter, the Task Force shall submit to Congress and the President a report on the implementation of this section.

SEC. 6. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—There are authorized to be appropriated to carry out this Act, and the amendments made by this Act, such sums as may be necessary for each of the fiscal years 2010 through 2014.

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

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