

111TH CONGRESS
2D SESSION

H. R. 5268

To provide assistance to improve maternal and newborn health in developing countries, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 11, 2010

Mrs. CAPPS (for herself, Ms. MCCOLLUM, Mrs. CHRISTENSEN, Ms. WOOLSEY, Mrs. MALONEY, Ms. MOORE of Wisconsin, Ms. DELAURO, Ms. CLARKE, Ms. LEE of California, Ms. WASSERMAN SCHULTZ, Mr. LOEBSACK, Mr. GRIJALVA, Ms. SCHAKOWSKY, Ms. SHEA-PORTER, Ms. NORTON, Mrs. DAVIS of California, Mr. CONYERS, and Ms. MATSUI) introduced the following bill; which was referred to the Committee on Foreign Affairs

A BILL

To provide assistance to improve maternal and newborn health in developing countries, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Improvements in Glob-
5 al Maternal and newborn health Outcomes while Maxi-
6 mizing Successes Act” or “Improvements in Global
7 MOMS Act”.

1 **SEC. 2. FINDINGS AND PURPOSES.**

2 (a) FINDINGS.—Congress makes the following find-
3 ings:

4 (1) In 2000, the United States joined 188 other
5 countries in supporting 8 United Nations Millen-
6 nium Development Goals (MDGs), including MDG
7 5, to reduce the maternal mortality ratio by three-
8 quarters by 2015. In 2005, universal access to re-
9 productive health was added as a target for MDG 5.

10 (2) On January 15, 2009, United States Per-
11 manent Representative to the United Nations Susan
12 Rice stated before the Committee on Foreign Rela-
13 tions of the Senate that President Barack Obama is
14 committed to “making the Millennium Development
15 Goals America’s goals.”.

16 (3) With thousands of avoidable maternal
17 deaths still occurring, the United States will need to
18 immediately scale up its funding and delivery of
19 proven low-cost, lifesaving interventions in order to
20 fulfill its commitment to help ensure that MDG 5 is
21 met.

22 (4) Substantial progress in maternal health has
23 been made in some countries and regions: Egypt,
24 Honduras, Malaysia, Sri Lanka, and parts of Ban-
25 gladesh have all halved their maternal mortality ra-
26 tios over the past few decades.

1 (5) However, MDG 5 has made the least
2 progress of all the MDGs. At the current pace,
3 MDG 5 will not be met in Asia until 2076 and much
4 later in Africa.

5 (6) An estimated 8,800,000 children under the
6 age of 5 die each year. Over 40 percent of these die
7 in the first month of life. And mortality rates are in-
8 creasing for those born to young mothers or where
9 pregnancies are less than a year apart.

10 (7) Hundreds of thousands of women die each
11 year from causes related to pregnancy and child-
12 birth. Ninety-nine percent of these deaths occur in
13 the developing world and the vast majority are pre-
14 ventable.

15 (8) In sub-Saharan Africa, a woman's lifetime
16 risk of maternal death is a staggering 1 in 22, com-
17 pared with 1 in 4,800 in the United States, accord-
18 ing to the United Nations Children's Fund
19 (UNICEF).

20 (9) Nine out of 10 women in sub-Saharan Afri-
21 ca will lose a child during their lifetimes.

22 (10) For every maternal death, approximately
23 20 women—or 10,000,000 women per year—suffer
24 complications with severe consequences, including

1 pregnancy-related injuries such as fistula, uterine
2 prolapse, infections, diseases, and disabilities.

3 (11) The number one cause of maternal deaths
4 is hemorrhage. Other primary causes of maternal
5 death include sepsis, unsafe abortion, hypertensive
6 disorder, and prolonged or obstructed labor.

7 (12) Violent acts against pregnant women can
8 lead to poor health outcomes, including preterm
9 labor, preterm delivery, miscarriage, and stillbirths,
10 and even maternal deaths, and the risk for maternal
11 mortality is 3 times as high for abused mothers.

12 (13) The spacing of births has a powerful im-
13 pact on a child's chances of survival. Children born
14 less than 2 years after the previous birth are about
15 2.5 times more likely to die before age 5 than chil-
16 dren born 3 to 5 years after the previous birth.

17 (14) Pregnancy is the leading cause of death
18 for young women aged 15 to 19 worldwide. Com-
19 pared to girls in their twenties, girls aged 15 to 19
20 are twice as likely, and girls under 15 five times as
21 likely, to die in childbirth, and mortality and mor-
22 bidity rates are also higher among infants born to
23 young mothers.

24 (15) Globally, 215,000,000 women would like to
25 delay or end childbearing, but do not have access to

1 modern contraceptives. Fully addressing this need
2 would prevent an additional 53,000,000 unintended
3 pregnancies each year and reduce maternal deaths
4 due to unsafe abortion by 82 percent.

5 (16) If family planning and maternal and new-
6 born services were provided simultaneously, the costs
7 of these services would decline by \$1,500,000,000
8 compared with investing in maternal and newborn
9 care alone—this dual investment would result in a
10 70 percent decline in maternal deaths and 44 per-
11 cent decline in newborn deaths.

12 (17) Maternal death rates are inextricably tied
13 to neonatal survival, with the risk of death doubling
14 for newborns in some countries in the developing
15 world following maternal death.

16 (18) In many developing countries, including
17 fragile states and countries affected by conflict, lack
18 of access to quality health care facilities, health serv-
19 ices, and trained providers results in deaths for
20 mothers, newborns, and children—the majority of
21 births in Africa take place without a skilled attend-
22 ant present, increasing the risk of death or disability
23 for both mother and newborn.

24 (19) The experiences of United States Govern-
25 ment-supported and nongovernmental organization

1 maternal and child health programs in countries
2 such as Nepal, Ethiopia, and Senegal have dem-
3 onstrated that community-based approaches, linked
4 to primary and referral care when possible, can de-
5 liver high-impact interventions to prevent or treat
6 many of the life-threatening conditions affecting
7 mothers, newborns, and children under the age of 5.

8 (20) More than half of all children and preg-
9 nant women in developing countries suffer from ane-
10 mia, which is exacerbated by malaria, neglected
11 tropical diseases, and nutritional deficits, causing
12 adverse pregnancy outcomes and even death.

13 (21) According to WHO, women that have un-
14 dergone female genital mutilation are significantly
15 more likely than those who have not undergone fe-
16 male genital mutilation to experience serious
17 postpartum health problems, and children born to
18 mothers who have undergone female genital mutila-
19 tion face higher death rates immediately after birth.

20 (22) According to the Director of National
21 Intelligence's 2009 Annual Threat Assessment, wide-
22 spread poor maternal and child health and malnutri-
23 tion has the potential to weaken central governments
24 and empower non-state actors, including terrorist
25 and paramilitary groups.

1 (23) The United States Agency for Inter-
2 national Development has estimated the economic
3 impact of maternal and newborn mortality to be a
4 global loss of over \$15,000,000,000 due to dimin-
5 ished productivity.

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

7 (1) to authorize assistance to improve maternal
8 and newborn health in developing countries; and

9 (2) to develop a strategy to reduce mortality
10 and improve maternal and newborn health in devel-
11 oping countries.

12 **SEC. 3. ASSISTANCE TO IMPROVE MATERNAL AND NEW-**
13 **BORN HEALTH IN DEVELOPING COUNTRIES.**

14 (a) IN GENERAL.—Chapter 1 of part I of the Foreign
15 Assistance Act of 1961 (22 U.S.C. 2151 et seq.) is amend-
16 ed—

17 (1) in section 102(b)(4)(B), by striking “reduc-
18 tion of infant mortality” and inserting “reduction of
19 maternal and newborn mortality”; and

20 (2) by inserting after section 104C the fol-
21 lowing new section:

22 **“SEC. 104D. ASSISTANCE TO REDUCE MORTALITY AND IM-**
23 **PROVE MATERNAL AND NEWBORN HEALTH.**

24 “(a) AUTHORIZATION.—Consistent with section
25 104(c), the President is authorized to furnish assistance,

1 on such terms and conditions as the President may deter-
2 mine, to reduce mortality and improve maternal health
3 and the health of newborns in developing countries.

4 “(b) ACTIVITIES SUPPORTED.—Assistance provided
5 under subsection (a) shall, to the maximum extent prac-
6 ticable, include—

7 “(1) activities to expand access and improve
8 quality of maternal health services, including—

9 “(A) comprehensive voluntary family plan-
10 ning services, integrated into antenatal and
11 postnatal care and in child health services, to
12 support women and men in making informed
13 decisions and having timely, intended, well-
14 spaced pregnancies and to help women with
15 preexisting conditions avoid high-risk, unin-
16 tended pregnancies;

17 “(B) birth preparedness through the provi-
18 sion of quality antenatal care, including—

19 “(i) educating women and families
20 about danger signs to look for, potential
21 complications during pregnancy and child-
22 birth, and where to access care;

23 “(ii) providing counseling about hy-
24 giene, nutrition, and the care and feeding
25 of babies;

1 “(iii) helping women and families de-
2 velop a birth plan that includes skilled de-
3 livery care and a transport plan in case of
4 emergencies;

5 “(iv) screening for complications in-
6 cluding blood pressure screenings;

7 “(v) diagnosis and treatment of exist-
8 ing conditions, such as HIV/AIDS, syphi-
9 lis, malaria, and tuberculosis, and ensuring
10 that women are provided with, or referred
11 to, appropriate care and treatment for
12 those conditions;

13 “(vi) ensuring that women infected
14 with HIV are provided mother-to-child
15 transmission prevention services, including
16 access to voluntary family planning, medi-
17 cations to prevent such transmission, and
18 counseling on infant feeding; and

19 “(vii) making vaccines, micronutri-
20 ents, and treatment for infections and
21 parasites available and accessible;

22 “(C) skilled delivery care, including—

23 “(i) the presence of an accredited
24 health professional, such as midwife, doc-
25 tor, or nurse, who has been educated and

1 trained to proficiency in the skills needed
2 to manage normal or uncomplicated preg-
3 nancies, childbirth, and the immediate
4 postnatal period, and in the identification,
5 management, or referral of complications
6 in women and newborns, including active
7 management of the third stage of labor;
8 and

9 “(ii) an enabling environment that in-
10 cludes access to a referral system, commu-
11 nication and transport, drugs and supplies,
12 and equipment appropriate for a normal
13 delivery;

14 “(D) quality emergency obstetric care, in-
15 cluding—

16 “(i) increasing the technical com-
17 petence of health care providers;

18 “(ii) increasing the essential supplies
19 and equipment including fluids, blood
20 products, and drugs to treat complications
21 such as infection, bleeding, and hyper-
22 tension;

23 “(iii) providing the information and
24 counseling for the client, including quality
25 of client-provider interaction;

1 “(iv) ensuring continuity of com-
2 prehensive, acceptable care, referrals and
3 followup; and

4 “(v) access to cesarean section when
5 necessary;

6 “(E) postpartum care and support, includ-
7 ing—

8 “(i) activities to promote immediate
9 exclusive breastfeeding;

10 “(ii) activities to promote essential
11 care of newborns;

12 “(iii) activities to treat, repair, and
13 provide followup services for injuries re-
14 sulting from pregnancy and childbirth, in-
15 cluding fistula; and

16 “(iv) family planning counseling and
17 service provision; and

18 “(F) postabortion care, including—

19 “(i) emergency treatment of complica-
20 tions of unsafe abortion;

21 “(ii) family planning counseling and
22 services; and

23 “(iii) linkages to other reproductive
24 health services;

1 “(2) working with communities and health care
2 providers to identify and remove barriers to mater-
3 nal health care services, including barriers such as
4 financial, sociocultural, transportation, gender dis-
5 crimination, and stigma based on preexisting health
6 concerns, and ensure that those services are based in
7 individual human rights, as recognized by inter-
8 national agreements and instruments;

9 “(3) comprehensive sexuality education pro-
10 grams and services for youth that provide adoles-
11 cents with information, skills, and materials nec-
12 essary to postpone childbearing;

13 “(4) promotion of activities that focus on em-
14 powering women and girls and engaging men and
15 boys at the individual, household, and community
16 levels to improve the health outcomes of women,
17 newborns, and children including education and
18 awareness programs about gender-based violence,
19 the health risks of female genital mutilation, and
20 shared responsibility for and benefits of family plan-
21 ning;

22 “(5) activities to improve essential newborn
23 care and treatment, including educating families and
24 communities about proper antenatal and skilled de-
25 livery care, tetanus toxoid immunization during

1 pregnancy, immediate and exclusive breastfeeding,
2 keeping the newborn warm, such as by providing
3 skin-to-skin care, keeping the cord clean, resuscita-
4 tion of newborns who are not breathing properly,
5 and treatment of infections;

6 “(6) activities to prevent and treat childhood ill-
7 ness, including early infant diagnosis of HIV infec-
8 tion and increasing access to appropriate prevention
9 and treatment for diarrhea, pneumonia, malaria,
10 HIV/AIDS, and other life-threatening childhood ill-
11 nesses;

12 “(7) activities to improve child and maternal
13 nutrition, including the delivery of iron, zinc, vita-
14 min A, iodine, and other key micronutrients, the
15 promotion of breastfeeding and appropriate com-
16plementary feeding, and the utilization of Ready to
17 Use Therapeutic Foods (RUTF) that, to the extent
18 practicable, are developed, purchased, or produced in
19 the country or region that they are utilized;

20 “(8) activities to strengthen the delivery of im-
21munization services, including efforts to strengthen
22 routine immunization, introduce new vaccines for
23 diseases such as rotavirus and pneumococcal disease,
24 and eliminate polio;

1 “(9) activities to improve household-level behav-
2 ior related to safe water, hygiene, safe and hygienic
3 food preparation and storage, exposure to indoor
4 smoke, and environmental toxins such as lead;

5 “(10) activities to improve capacity for health
6 governance, health finance, and the health work-
7 force, including in the private sector, and support
8 for training clinicians, nurses, technicians, sanitation
9 and public health workers, community-based health
10 workers, midwives, birth attendants, peer educators,
11 volunteers, and private sector enterprises to provide
12 integrated health services and referrals that meet
13 the needs of patients across a continuum of care;

14 “(11) activities to address antimicrobial resist-
15 ance in treating maternal health infections;

16 “(12) activities to establish and support man-
17 agement of host country institutions’ information
18 systems and the development and use of tools and
19 models to collect, analyze, and disseminate informa-
20 tion related to maternal and newborn health;

21 “(13) activities to develop and conduct needs
22 assessments, baseline studies, targeted evaluations,
23 or other information-gathering efforts for the design,
24 monitoring, and evaluation of maternal and newborn
25 health efforts, including—

1 “(A) studying the availability and effects
2 of critical medicines, particularly those of im-
3 portance in the developing world, on pregnant
4 women and newborns;

5 “(B) collection, evaluation, and use of data
6 on the medical and socioeconomic factors that
7 led to a maternal or newborn death or ‘near
8 miss’ at the community and health facility lev-
9 els; and

10 “(C) sociocultural barriers, influencers,
11 and enhancers of health and nutrition behav-
12 iors;

13 “(14) activities to integrate and coordinate as-
14 sistance provided under this section with existing
15 health programs for—

16 “(A) the prevention of the transmission of
17 HIV from mother to child and other HIV/AIDS
18 prevention, care, treatment, and counseling ac-
19 tivities;

20 “(B) malaria;

21 “(C) tuberculosis;

22 “(D) family planning and reproductive
23 health;

24 “(E) counseling for survivors of sexual-
25 and gender-based violence;

1 “(F) neglected tropical diseases; and

2 “(G) nutrition;

3 “(15) activities to improve orphan care services
4 and to support innovative orphan and vulnerable
5 children programs;

6 “(16) activities to end harmful traditional prac-
7 tices including female genital mutilation and child
8 marriage;

9 “(17) activities to train health care providers to
10 prevent, identify, and manage cases of gender-based
11 violence as part of family planning and maternal and
12 newborn health services;

13 “(18) activities to support mental health care
14 and provide psychosocial support;

15 “(19) activities to improve access to clean water
16 and improved sanitation through community-based
17 hygiene education programs, access to household-
18 and community-level water purification tools and de-
19 vices, and latrine construction; and

20 “(20) activities to prevent, control, and in some
21 cases eliminate neglected tropical diseases for both
22 newborns and mothers.

23 “(c) GUIDELINES.—To the maximum extent prac-
24 ticable, programs, projects, and activities carried out using
25 assistance provided under this section shall be—

1 “(1) carried out through private and voluntary
2 organizations, including community and faith-based
3 organizations, and relevant international and multi-
4 lateral organizations, including the United Nations
5 Population Fund, the United Nations Children’s
6 Fund, and the Global Alliance for Vaccines and Im-
7 munizations, that demonstrate effectiveness and
8 commitment to improving the health and rights of
9 mothers, newborns, and children;

10 “(2) carried out in the context of country-driv-
11 en plans in whose development the United States
12 Government participates along with other donors
13 and multilateral organizations, nongovernmental or-
14 ganizations, and civil society;

15 “(3) carried out with input by beneficiaries and
16 other directly affected populations, especially women
17 and marginalized communities; and

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

20 “(d) ANNUAL REPORT.—Not later than January 31,
21 2011, and annually thereafter for 4 years, the President
22 shall transmit to Congress a report on the implementation
23 of this section for the prior fiscal year.

24 “(e) DEFINITIONS.—In this section:

1 (B) the number and rate of maternal
2 deaths;

3 (C) the number and rate of malnourished
4 women of reproductive age; and

5 (D) the number of individuals with an
6 unmet need for family planning.

7 (2) For each country identified in paragraph
8 (1)—

9 (A) an assessment of the most common
10 causes of maternal and newborn mortality and
11 morbidity;

12 (B) a description of the programmatic
13 areas and interventions providing maximum
14 health benefits to populations at risk and max-
15 imum reduction in mortality and morbidity;

16 (C) an assessment of the investments need-
17 ed in identified programs and interventions to
18 achieve the greatest results;

19 (D) a description of how United States as-
20 sistance complements and leverages efforts by
21 other donors and builds capacity and self-suffi-
22 ciency among recipient countries; and

23 (E) a description of goals and objectives
24 for improving maternal and newborn health, in-

1 cluding, to the extent feasible, objective and
2 quantifiable indicators.

3 (3) Enhanced coordination among relevant de-
4 partments and agencies of the United States Gov-
5 ernment engaged in activities to improve the health
6 and well-being of mothers and newborns in devel-
7 oping countries.

8 (4) A description of the measured or estimated
9 impact on maternal and newborn morbidity and
10 mortality of each project or program.

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

15 **SEC. 5. AUTHORIZATION OF APPROPRIATIONS.**

16 (a) IN GENERAL.—There are authorized to be appro-
17 priated to carry out this Act, and the amendments made
18 by this Act, such sums as may be necessary for each of
19 fiscal years 2011 through 2015.

20 (b) AVAILABILITY OF FUNDS.—Amounts appro-
21 priated pursuant to the authorization of appropriations
22 under subsection (a) are authorized to remain available
23 until expended.

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