I

113TH CONGRESS
2D SESSION

H. R. 5862

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

IN THE HOUSE OF REPRESENTATIVES

DECEMBER 11, 2014

Mrs. CAPPS introduced the following bill; which was referred to the Committee on Foreign Affairs

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A BILL

To provide assistance to improve maternal and newborn health 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 ''Improvements in Global Maternal and Newborn Health Outcomes while Maximizing Successes Act'' or ''Improvements in Global MOMS Act''.

SEC. 2. FINDINGS AND PURPOSES.

(a) FINDINGS.—Congress finds the following:

(1) In 2000, the United States joined 188 other countries in supporting the 8 United Nations Millennium Development Goals (MDGs), including MDG 4, which aims to reduce child mortality by two-thirds and MDG 5, which aims to reduce the maternal mortality ratio by three-quarters by 2015. In 2005, universal access to reproductive health was added as a target for MDG 5.

(2) Substantial progress in maternal health has been made. The total number of maternal deaths decreased by over 50 percent from 529,000 maternal deaths in 2000 to 287,000 maternal deaths in 2010. Egypt, Honduras, Malaysia, Sri Lanka, and parts of Bangladesh have all halved their maternal mortality ratios over the past few decades.

(3) While significant progress has been made in reducing maternal mortality, the United Nations reports that current maternal mortality levels are ''far removed from the 2015 target''.

(4) Women in developing countries are nearly 100 times more likely to die of complications during pregnancy or childbirth than in developed countries, with higher rates for women living in rural areas and among poorer communities.

(5) The United States Agency for International Development (USAID) estimates the global economic impact of maternal and newborn mortality at $15 billion in lost productivity every year.

(6) Annually, 287,000 women die from complications during pregnancy or childbirth, with 99 percent of these deaths occurring in developing countries. Six countries—Afghanistan, the Democratic Republic of Congo, Ethiopia, India, Nigeria, and Pakistan—account for almost one-half of all maternal deaths worldwide.

(7) It is estimated that up to 90 percent of these maternal deaths are preventable. With access to medicines and skilled health care providers, most women across the world can expect a successful delivery and a healthy newborn.

(8) The leading cause of maternal deaths is hemorrhage. Other primary causes of maternal death include sepsis, hypertensive disorder (pre-eclampsia/eclampsia), unsafe abortion, and prolonged or obstructed labor.

(9) An essential part of ensuring a woman survives pregnancy and childbirth includes access to maternal health medicines and other supplies. Uterotonics prevent and treat postpartum hemor-

rhage by causing contractions of the uterus during and after childbirth, effectively controlling excessive bleeding. If uterotonic medicines, such as oxytocin and misoprostol, were available to all women giving birth over a 10-year period, approximately 41 million postpartum hemorrhage cases could be prevented and 1.4 million women's lives saved.

(10) Pregnancy is the leading killer of adolescent girls ages 15 to 19 in the developing world. Nearly 70,000 adolescent girls die every year because their bodies are not ready for childbirth. Compared to women in their twenties, adolescent girls aged 15 to 19 are twice as likely to die in childbirth, and girls under 15 are five times as likely to die, and mortality and morbidity rates are also higher among infants born to young mothers.

(11) For every maternal death, approximately 20 women and girls experience serious or long-term negative health consequences. Severe pregnancy-related injuries include fistula, uterine prolapse, infections, diseases, and disabilities. Maternal morbidities accrue an estimated global cost of $6.8 billion.

(12) Healthy timing and spacing of pregnancy has a powerful impact on the chances of survival for women, newborns, infants, and children. Access to

voluntary family planning plays an essential role in improving maternal health.

(13) Delaying a first pregnancy until at least 18 years old, waiting at least 24 months to become pregnant after a live birth, and waiting at least 6 months after a miscarriage or induced abortion, can reduce all maternal mortality by 30 percent and prevent 70,000 deaths per year of women who die from unsafe abortion.

(14) Healthy timing and spacing of birth can also reduce newborn and child death by more than 50 percent. Children born less than two years after the previous birth are approximately 2.5 times more likely to die before the age of five than children born three to five years after the previous birth.

(15) If all women who wanted to delay or avoid pregnancy had access to modern contraception, 26 million abortions would be averted.

(16) More than 220 million women in developing countries who would prefer to delay or avoid childbearing lack access to safe and effective family planning methods. Less than one-half of married women of reproductive age in South Asia and less than 25 percent of women in sub-Saharan Africa use modern contraceptives. In 2012, an estimated 80

million women in developing countries had an unintended pregnancy.

(17) It is estimated that if 120 million more women had access to family planning information, services and supplies, without coercion or discrimination by 2020, 200,000 fewer girls and women would die during pregnancy and childbirth, there would be 100 million fewer unintended pregnancies, there would be 50 million fewer abortions, and 3 million fewer infants would die in their first year of life.

(18) Violent acts against pregnant women can also lead to poor health outcomes for women and their babies, including miscarriage, pre-term birth, low birthweight, stillbirths, and maternal deaths. The risk for maternal mortality is 3 times as high for abused mothers. In emergency settings, gender-based violence rates continue to increase.

(19) According to the World Health Organization (WHO), women that have undergone female genital mutilation/cutting are significantly more likely to experience serious postpartum health problems than those who have not undergone female genital mutilation, and children born to mothers who have undergone female genital mutilation face higher death rates immediately after birth.

(20) Maternal health is inextricably tied to newborn health and survival. In some countries in the developing world the risk of newborn death doubles following maternal death. The conditions in utero, during labor, delivery, and shortly after birth have a direct relationship on newborn outcomes.

(21) In 2012, 2.9 million newborns or 44 percent of total under-five mortality did not survive the first month of life. One million of these deaths occurred during the first day of life.

(22) The leading causes of newborn mortality include prematurity, intrapartum complications (including birth asphyxia), and neonatal infections. Over two-thirds of these deaths could be prevented through low-cost medicines, products, and interventions that would not require intensive care.

(23) In addition to newborn mortality there are an additional 2.65 million stillbirths each year that are not included in newborn or under-five mortality statistics.

(24) Women in Africa are 24 times more likely to have a stillbirth than women in high-income countries.

(25) In developing countries, nearly one-third of stillbirth babies were alive when labor began. If 99

percent of women in developing countries had comprehensive emergency obstetric care, nearly 700,000 stillbirths could be prevented each year.

(26) In many developing countries, lack of access to quality health care facilities, health services, and trained providers results in deaths for mothers, newborns, and children—the majority of births in Africa take place without a skilled attendant present or the necessary medicines and medical supplies, increasing the risk of death or disability for both mother and newborn.

(27) If family planning and maternal and newborn services were provided simultaneously, the costs of these services would decline by $1.5 billion and would result in a 70 percent decline in maternal deaths and a 44 percent decline in newborn deaths.

(28) More than one-half of all children and pregnant women in developing countries suffer from anemia, which is exacerbated by malaria, neglected tropical diseases, and nutritional deficits, causing adverse pregnancy outcomes and even death.

(29) Maternal deaths worldwide could be reduced by 60,000 per year if women received appropriate HIV diagnosis and treatment.

(30) With proper interventions, the transmission of HIV between women and their infants during pregnancy and breastfeeding can be reduced to 5 percent in the developing world. The WHO recommends early diagnosis and immediate treatment for children identified as HIV positive because, without treatment, half of these children will die before the age of two.

(31) Nine out of ten women in sub-Saharan Africa will lose a child during their lifetimes, and only 30 percent of women in sub-Saharan Africa have contact with a health worker after giving birth.

(32) According to the Director of National Intelligence's 2009 Annual Threat Assessment, widespread poor maternal and child health and malnutrition has the potential to weaken central governments and empower non-state actors, including terrorist and paramilitary groups.

(33) The experiences of United States Government-supported and nongovernmental organization maternal and child health programs in countries such as Nepal, Ethiopia, and Senegal have demonstrated that community-based approaches, linked to primary and referral care when possible, can deliver high-impact interventions to prevent or treat

many of the life-threatening conditions affecting mothers and newborns.

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

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

(2) to develop a strategy to reduce mortality and morbidity and improve maternal and newborn health in developing countries.

SEC. 3. ASSISTANCE TO REDUCE MORTALITY AND IMPROVE MATERNAL AND NEWBORN HEALTH 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 102(b)(4)(B), by striking ''reduction of infant mortality'' and inserting ''reduction of maternal and newborn mortality, morbidity, and stillbirths''; and

(2) by inserting after section 104C the following new section:

''SEC. 104D. ASSISTANCE TO REDUCE MORTALITY AND IMPROVE MATERNAL AND NEWBORN HEALTH.

''(a) AUTHORIZATION.—Consistent with section 104(c), the President is authorized to furnish assistance, on such terms and conditions as the President may deter-

mine, to reduce maternal and newborn mortality and morbidity and improve maternal health and the health of newborns in developing countries.

''(b) ACTIVITIES SUPPORTED.—Assistance provided under subsection (a) shall, to the maximum extent practicable, include—

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

''(A) birth preparedness through the provision of quality pre-pregnancy and antenatal care with a skilled provider (midwife, nurse, or doctor), which should consist of, at minimum—

''(i) iron and folic acid supplementation;

''(ii) tetanus vaccine;

''(iii) smoking cessation;

''(iv) prevention and management of sexually transmitted infections and HIV, including access to Preventing Mother-to-Child Transmission;

''(v) screening, diagnosis, and treatment of existing conditions, such as syphilis, HIV/AIDS, malaria, and tuberculosis, and ensuring that women are provided with, or referred to, appropriate care and

treatment and prophylaxis for those conditions, including access to antiretrovirals (ARVs);

''(vi) magnesium sulfate and low-dose aspirin to prevent pre-eclampsia and calcium supplementation to prevent hypertension;

''(vii) screening for complications, including blood pressure screenings;

''(viii) magnesium sulfate for eclampsia; antihypertensive medication;

''(ix) corticosteroids to prevent respiratory distress syndrome;

''(x) induction of labor at term to manage pre-labor rupture of membranes;

''(xi) nutrition treatment of malnourished pregnant women; and

''(xii) antibiotics for pre-term labor;

''(B) expanding access to skilled childbirth and postnatal care, particularly in areas with low utilization of skilled delivery, including—

''(i) the presence of a skilled health professional (nurse, midwife, or doctor) who has been educated and trained to proficiency in the skills needed to manage nor-

mal or uncomplicated pregnancies or referral of complications in women and newborns,

"(ii) clean delivery;

"(iii) uterotonics and active management of third stage of labor to prevent postpartum hemorrhage;

"(iv) social support during childbirth;

"(v) screening for HIV, linkages to HIV care and treatment services, and follow up tracking;

"(vi) induction of labor for prolonged pregnancy;

"(vii) nutrition counseling;

"(viii) management of postpartum hemorrhage;

"(ix) caesarean section for maternal/fetal indication with prophylactic antibiotics;

"(x) treating maternal anemia; and

"(xi) postpartum family planning methods;

"(C) comprehensive voluntary family planning services, integrated into antenatal and postnatal care, to support women and men in

making informed decisions and having timely, intended, well-spaced pregnancies, and to help women with pre-existing conditions avoid high-risk, unintended pregnancies, including—

''(i) provision of family planning/birth spacing counseling and services; and

''(ii) emergency treatment of complications of unsafe abortions and linkages to other reproductive health services;

''(2) activities to expand access to and improve quality of services that reduce newborn and infant mortality, including—

''(A) immediate thermal care;

''(B) initiation of early, exclusive, and continued breastfeeding;

''(C) hygienic cord and skin care;

''(D) kangaroo mother care;

''(E) extra support for feeding small and preterm infants;

''(F) antibiotic therapy for newborns at risk of bacterial infection;

''(G) use of surfactant in pre-term infants;

''(H) initiate prophylactic antiretroviral therapy for infants exposed to HIV;

"(I) neonatal resuscitation with a bag and mask for infants suffering from birth asphyxia;

"(J) continuous positive airway pressure to manage respiratory distress syndrome;

"(K) case management of neonatal sepsis, neonatal meningitis, and pneumonia;

"(L) case management of meningitis, malaria, diarrhea, pneumonia, and severe acute malnutrition; and

"(M) comprehensive care of HIV, including ARVs, cotrimoxazole, nutrition support, and psychosocial support;

"(3) activities to support communities and health care providers in identifying and removing barriers to maternal health care services, including—

"(A) financial and sociocultural barriers;

"(B) child marriage;

"(C) transportation;

"(D) gender discrimination and gender-based violence;

"(E) stigma based on pre-existing health concerns; and

"(F) female genital mutilation/cutting;

''(4) activities that focus on empowering women and girls and engaging men and boys at the individual, household, and community levels to improve the health outcomes of women, newborns, and children, including education and awareness programs about gender-based violence, the health risks of female genital mutilation, and shared responsibility for, and benefits of, family planning;

''(5) activities to improve the supply of critical maternal and newborn health commodities, including lifesaving medicines and supplies, such as activities designed to strengthen regulatory systems to ensure the quality of commodities in circulation and those related to strengthening supply chain systems so that these commodities reach the women and children who need them;

''(6) activities supporting country-led efforts to improve capacity for health governance, health finance, and the health workforce, including in the private sector, and support for training clinicians, nurses, technicians, sanitation and public health workers, community-based health workers, midwives, birth attendants, peer educators, volunteers, and private sector enterprises to provide integrated health

and nutrition services and referrals that meet the needs of patients across a continuum of care;

''(7) activities that support country-led plans to reduce maternal and newborn mortality and morbidity and stillbirths, including—

''(A) management of host country institutions' information systems and the development and use of tools and models to collect, analyze, and disseminate information related to maternal and newborn health; and

''(B) activities to develop and conduct needs assessments, baseline studies, targeted evaluations, or other information-gathering efforts for the design, monitoring, and evaluation of maternal and newborn health efforts, including—

''(i) the study of the availability and effects of critical medicines and devices, particularly those of importance in developing countries, on pregnant women and newborns;

''(ii) the collection, evaluation, and use of data on the medical and socioeconomic factors that led to a maternal or

newborn death or stillbirths at the community and health facility levels; and

"(iii) the improvement of vital registries to capture live births, neonatal deaths, and the number of stillbirths; and

"(8) activities to integrate and coordinate assistance provided under this section with existing health programs for the prevention of the transmission of HIV from mother to child and other HIV/AIDS prevention, care, treatment, and counseling activities, including better integration with programs addressing—

"(A) malaria;

"(B) tuberculosis;

"(C) family planning and reproductive health;

"(D) counseling for survivors of sexual- and gender-based violence;

"(E) neglected tropical diseases;

"(F) nutrition; and

"(G) child survival.

"(c) 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 community and faith-based organizations, local organizations, and relevant international and multilateral organizations that demonstrate effectiveness, including the United Nations Population Fund, the United Nations Children's Fund, and the Global Alliance for Vaccines and Immunizations, and that demonstrate commitment to improving the health and rights of mothers and newborns and reducing the number of stillbirths;

''(2) carried out in the context of country-driven plans in whose development the United States Government participates along with other donors and multilateral organizations, nongovernmental organizations, and civil society;

''(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.

''(d) ANNUAL REPORT.—Not later than January 31, 2016, and annually thereafter for 4 years, the President shall transmit to Congress a report on the implementation of this section for the prior fiscal year.

''(e) DEFINITIONS.—In this section:

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

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

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

SEC. 4. DEVELOPMENT OF STRATEGY TO REDUCE MORTALITY AND MORBIDITY AND IMPROVE MATERNAL AND NEWBORN HEALTH IN DEVELOPING COUNTRIES.

(a) DEVELOPMENT OF STRATEGY.—The President shall develop and implement a comprehensive strategy to reduce mortality and morbidity and improve the health of mothers and newborns in developing countries that integrates all current United States Government efforts on improving maternal and newborn health, including strategies with respect to HIV/AIDS, gender, child survival.

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

(1) An identification of not less than 24 countries, including fragile states and countries affected by conflict, 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 near-miss morbidity for women and newborns;

(C) the number and rate of maternal deaths;

(D) the number and rate of caesarean sections;

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

(F) the number of individuals with an unmet need for family planning.

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

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

(B) a description of the programmatic areas and interventions providing maximum health benefits to populations at risk and maximum reduction in mortality and morbidity;

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

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

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

(3) Enhanced coordination among relevant departments and agencies of the United States Government engaged in activities to improve the health and well-being of mothers and newborns in developing countries.

(4) A description of the measured or estimated impact on maternal and newborn morbidity and mortality of each project or program receiving assistance under section 104D of the Foreign Assistance Act of 1961 (as added by section 3 of this Act).

(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. 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 fiscal years 2016 through 2020.

(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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