

(2) in the matter preceding paragraph (1)—

(A) by striking “newborn and infant” and inserting “newborn, infant, and young child”; and

(B) by striking “providers,” and inserting “providers (including, as appropriate, education and training of family members);”;

(3) in paragraph (1)—

(A) in the first sentence—

(i) by striking “newborns and infants” and inserting “newborns, infants, and young children (referred to in this section as ‘children’);” and

(ii) by striking “and medical” and all that follows through the period and inserting “medical, and communication (or language acquisition) interventions (including family support), for children identified as deaf or hard-of-hearing, consistent with the following;”;

(B) in the second sentence—

(i) by striking “Early” and inserting the following:

“(A) Early”;

(ii) by striking “and delivery of” and inserting “, and delivery of;”;

(iii) by striking “by schools” and all that follows through “programs mandated” and inserting “by organizations such as schools and agencies (including community, consumer, and family-based agencies), in health care settings (including medical homes for children), and in programs mandated”; and

(iv) by striking “hard of hearing” and all that follows through the period and inserting “hard-of-hearing children.”; and

(C) by striking the last sentence and inserting the following:

“(B) Information provided to families should be accurate, comprehensive, up-to-date, and evidence-based, as appropriate, to allow families to make important decisions for their children in a timely manner, including decisions with respect to the full range of assistive hearing technologies and communications modalities, as appropriate.

“(C) Programs and systems under this paragraph shall offer mechanisms that foster family-to-family and deaf and hard-of-hearing consumer-to-family supports.”;

(4) in paragraph (2), by striking “To collect” and all that follows through the period and inserting “To continue to provide technical support to States, through one or more technical resource centers, to assist in further developing and enhancing State early hearing detection and intervention programs.”; and

(5) by striking paragraph (3) and inserting the following:

“(3) To identify or develop efficient models (educational and medical) to ensure that children who are identified as deaf or hard-of-hearing through screening receive follow-up by qualified early intervention providers or qualified health care providers (including those at medical homes for children), and referrals, as appropriate, including to early intervention services under part C of the Individuals with Disabilities Education Act. State agencies shall be encouraged to effectively increase the rate of such follow-up and referral.”.

(C) TECHNICAL ASSISTANCE, DATA MANAGEMENT, AND APPLIED RESEARCH.—Section 399M(b)(1) of the Public Health Service Act (42 U.S.C. 280g-1(b)(1)) is amended—

(1) in the first sentence—

(A) by striking “The Secretary” and inserting the following:

“(A) IN GENERAL.—The Secretary”;

(B) by striking “to complement an intramural program and” and inserting the following: “or designated entities of States—

“(i) to develop, maintain, and improve data collection systems related to newborn, infant, and young child hearing screening, evaluation (including audiologic, medical,

and language acquisition evaluations), diagnosis, and intervention services;”;

(C) by striking “to conduct” and inserting the following:

“(ii) to conduct”; and

(D) by striking “newborn” and all that follows through the period and inserting the following: “newborn, infant, and young child hearing screening, evaluation, and intervention programs and outcomes;

“(iii) to ensure quality monitoring of hearing screening, evaluation, and intervention programs and systems for newborns, infants, and young children; and

“(iv) to support newborn, infant, and young child hearing screening, evaluation, and intervention programs, and information systems.”;

(2) in the second sentence—

(A) by striking the matter that precedes subparagraph (A) and all that follows through subparagraph (C) and inserting the following:

“(B) USE OF AWARDS.—The awards made under subparagraph (A) may be used—

“(i) to provide technical assistance on data collection and management, including to coordinate and develop standardized procedures for data management;

“(ii) to assess and report on the cost and program effectiveness of newborn, infant, and young child hearing screening, evaluation, and intervention programs and systems;

“(iii) to collect data and report on newborn, infant, and young child hearing screening, evaluation, diagnosis, and intervention programs and systems for applied research, program evaluation, and policy improvement;”;

(B) by redesignating subparagraphs (D), (E), and (F) as clauses (iv), (v), and (vi), respectively, and aligning the margins of those clauses with the margins of clause (i) of subparagraph (B) (as inserted by subparagraph (A) of this paragraph);

(C) in clause (v) (as redesignated by subparagraph (B) of this paragraph)—

(i) by striking “newborn and infant” and inserting “newborn, infant, and young child”; and

(D) in clause (vi) (as redesignated by subparagraph (B) of this paragraph)—

(i) by striking “sharing” and inserting “integration and interoperability”; and

(ii) by striking “with State-based” and all that follows through the period and inserting “across multiple sources to increase the flow of information between clinical care and public health settings, including the ability of States and territories to exchange and share data.”.

(d) COORDINATION AND COLLABORATION.—Section 399M(c) of the Public Health Service Act (42 U.S.C. 280g-1(c)) is amended—

(1) in paragraph (1)—

(A) by striking “consult with” and inserting “consult with—”;

(B) by striking “other Federal” and inserting the following:

“(A) other Federal”;

(C) by striking “State and local agencies, including those” and inserting the following:

“(B) State and local agencies, including agencies”;

(D) by striking “consumer groups of and that serve” and inserting the following:

“(C) consumer groups of, and that serve.”;

(E) by striking “appropriate national” and inserting the following:

“(D) appropriate national”;

(F) by striking “persons who are deaf and” and inserting the following:

“(E) individuals who are deaf or”;

(G) by striking “other qualified” and inserting the following:

“(F) other qualified”;

(H) by striking “newborns, infants, toddlers, children,” and inserting “children.”;

(I) by striking “third-party” and inserting the following:

“(G) third-party”; and

(J) by striking “related commercial” and inserting the following:

“(H) related commercial”; and

(2) in paragraph (3)—

(A) by striking “States to establish newborn and infant” and inserting the following: “States—

“(A) to establish newborn, infant, and young child”;

(B) by inserting a semicolon after “subsection (a)”;

(C) by striking “to develop” and inserting the following:

“(B) to develop”.

(e) RULE OF CONSTRUCTION; RELIGIOUS ACCOMMODATION.—Section 399M(d) of the Public Health Service Act (42 U.S.C. 280g-1(d)) is amended—

(1) by striking “which” and inserting “that”;

(2) by striking “newborn infants or young”; and

(3) by striking “parents” and inserting “parent’s”.

(f) DEFINITIONS.—Section 399M(e) of the Public Health Service Act (42 U.S.C. 280g-1(e)) is amended—

(1) in paragraph (1)—

(A) by striking “(1)” and all that follows through “to procedures” and inserting the following:

“(1) The term ‘audiologic’, when used in connection with evaluation, means procedures—”;

(B) by striking “to assess” and inserting the following:

“(A) to assess”;

(C) by striking “to establish” and inserting the following:

“(B) to establish”;

(D) by striking “auditory disorder”; and inserting “auditory disorder.”;

(E) by striking “to identify” and inserting the following:

“(C) to identify”;

(F) by striking “options,” and all that follows through “linkage” and inserting the following: “options, including—

“(i) linkage”;

(G) by striking “appropriate agencies,” and all that follows through “national” and inserting the following: “appropriate agencies;”

“(ii) medical evaluation;

“(iii) assessment for the full range of assistive hearing technologies appropriate for newborns, infants, and young children;

“(iv) audiology rehabilitation treatment; and

“(v) referral to national”;

(H) by striking “parent, and education” and inserting “parent, family, and education”;

(2) by striking paragraph (2);

(3) by redesignating paragraphs (3) through (6) as paragraphs (2) through (5);

(4) in paragraph (2) (as redesignated by paragraph (3) of this subsection)—

(A) by striking “refers to providing” and inserting the following: “means—

“(A) providing”;

(B) by striking “with hearing loss, including nonmedical services,” and inserting “who is deaf or hard-of-hearing, including nonmedical services.”;

(C) by striking “ensuring that families of the child are provided” and inserting the following:

“(B) ensuring that the family of the child is—

“(i) provided”;

(D) by striking “language and communication options and are given” and inserting the following: “language acquisition in oral and visual modalities; and

“(ii) given”; and

(B) by striking “their child” and inserting “the child”;

(5) in paragraph (3) (as redesignated by paragraph (3) of this subsection), by striking “(3)” and all that follows through “decision making” and inserting “The term ‘medical evaluation’ means key components performed by a physician including history, examination, and medical decisionmaking”;

(6) in paragraph (4) (as redesignated by paragraph (3) of this subsection)—

(A) by striking “refers to” and inserting “means”;

(B) by striking “and/or surgical” and inserting “or surgical”; and

(C) by striking “of hearing” and all that follows through “disorder” and inserting “for hearing loss or other medical disorders”; and

(7) in paragraph (5) (as redesignated by paragraph (3) of this subsection)—

(A) by striking “(5)” and all that follows through “refers to” and inserting “(5) The term ‘newborn, infant, and young child hearing screening’ means”; and

(B) by striking “and infants” and inserting “, infants, and young children under 3 years of age”.

(g) AUTHORIZATION OF APPROPRIATIONS.—Section 399M(f) of the Public Health Service Act (42 U.S.C. 280g–1(f)) is amended—

(1) in paragraph (1), by striking “such sums” and all that follows through the period and inserting “\$17,818,000 for fiscal year 2018, \$18,173,800 for fiscal year 2019, \$18,628,145 for fiscal year 2020, \$19,056,592 for fiscal year 2021, and \$19,522,758 for fiscal year 2022.”; and

(2) in paragraph (2), by striking “such sums” and all that follows through the period and inserting “\$10,800,000 for fiscal year 2018, \$11,026,800 for fiscal year 2019, \$11,302,470 for fiscal year 2020, \$11,562,427 for fiscal year 2021, and \$11,851,488 for fiscal year 2022.”.

The SPEAKER pro tempore (Mr. WOMACK). Pursuant to the rule, the gentleman from Texas (Mr. BURGESS) and the gentlewoman from Florida (Ms. CASTOR) each will control 20 minutes.

The Chair recognizes the gentleman from Texas.

GENERAL LEAVE

Mr. BURGESS. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and insert extraneous material into the RECORD on the bill.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. BURGESS. Mr. Speaker, I yield 4 minutes to the gentleman from Oregon (Mr. WALDEN), chairman of the Energy and Commerce Committee.

Mr. WALDEN. Mr. Speaker, I really want to thank our Members on both sides of the aisle, and especially the gentleman from Texas (Mr. BURGESS) and the gentleman from Kentucky (Mr. GUTHRIE), who has an identical bill, the House companion bill to this one.

S. 652 revises the Public Health Service Act’s expanding access to critical resources for the deaf and hard-of-hearing newborns and young children. It will boost training of healthcare professionals in helping these young par-

ents and ensure that, in turn, they can help educate the patient’s family members.

This bill will also deliver relief to parents and caretakers of young children that have hearing loss, granting them important resources to aid in their care.

Again, the Health Subcommittee vice chair, BRETT GUTHRIE, is the author of the House companion. When the House today approves this legislation, which I assume it will, that means this bill will go to the President’s desk and be signed into law. This is really important work that the Energy and Commerce Committee is doing, once again, in a big and bipartisan way. It is an important bill that will expand access to critical resources for deaf and hard-of-hearing newborns and young children.

By updating and reauthorizing HRSA and CDC grants to help States treat children with hearing loss, we are doing our work to achieve better outcomes for patients.

I am particularly pleased about the potential to harness new and improved data collection systems to improve access. You know, if we can better understand what is happening with patients on the ground, we can make better decisions about where to allocate resources to help recruit more providers and improve coordination of care for children with hearing loss.

Mr. Speaker, I am delighted with the work of the Health Subcommittee and the Members who have put so much into this legislation, and I look forward to the House passing it.

Ms. CASTOR of Florida. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in support of the Early Hearing Detection and Intervention Act authored by two of my Energy and Commerce Committee colleagues, Mr. BRETT GUTHRIE from Kentucky and Ms. DORIS MATSUI from California. I thank Chairman WALDEN and Chairman BURGESS for their help. I also thank Senators Portman and Kaine from the Senate.

It is vital that the House reauthorize the early hearing detection and intervention initiative for an additional 5 years because it provides the all-important newborn and infant hearing screening, evaluation, and intervention.

The bill will provide vital resources to the Health Resources and Services Administration to run a grant initiative and allow the Centers for Disease Control to conduct hearing loss research.

According to data from the CDC, 1.4 babies out of every—I don’t know how you get 1.4—but 1.4 babies out of 1,000 that were screened were found to have a prevalence of hearing loss. And as a mother, I know how important it is to determine if your child has any level of hearing loss as early as possible so that a parent can determine the best treatment to allow their child to live a full and happy life.

My home State of Florida has required newborn screening since October 1, 2000. We need to keep this going. According to the most recent State data in Florida, 98 percent of all newborns in Florida will be screened within the first month. That is absolutely vital to detect any problem early in their lives.

So let’s work together. Extending this newborn screening initiative for another 5 years ensures that babies will continue to have access to this vital hearing screening, and we can make sure that kids across America get the healthcare that they need.

Mr. Speaker, I would like to again thank my colleagues, Representatives GUTHRIE and MATSUI and Senators PORTMAN and KAINA, for leading the charge on this important effort. I encourage my colleagues to support this bipartisan S. 652.

Mr. Speaker, I reserve the balance of my time.

Mr. BURGESS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I also want to be in strong support of S. 652, the Early Hearing Detection and Intervention Act of 2017, sponsored by Senator PORTMAN from Ohio. This legislation has been championed in the House by my friend, the vice chair of the Health Subcommittee, Representative BRETT GUTHRIE, as H.R. 1539.

The bill does have strong bipartisan support and, in fact, passed this House unanimously in the last Congress. Federal support for early hearing detection and intervention programs across the country help identify children with hearing loss and directs them to early intervention services.

This program is a model of how government at different levels and public and private agencies can and should work together. In addition to improving upon current programs, this legislation improves the recruitment, retention, education, and training of qualified personnel and health providers to identify and assist young children with hearing loss.

This bill emphasizes the importance of the Health Resources and Services Administration, Centers for Disease Control and Prevention, and the National Institutes of Health partnering together to improve outcomes and strengthen the early hearing detection intervention program. I commend Representative GUTHRIE for spearheading this initiative on the House side.

Mr. Speaker, I reserve the balance of my time.

Ms. CASTOR of Florida. Mr. Speaker, I yield the balance of my time to the gentlewoman from California (Ms. MATSUI), the primary cosponsor of the bill. And I thank her for championing the healthcare of children across America.

Ms. MATSUI. Mr. Speaker, I rise in support of H.R. 1539, the Early Hearing Detection and Intervention Act of 2017, which I coauthored with my colleague, Congressman GUTHRIE.

The Newborn Hearing Screening and Intervention Program established almost 2 decades ago has been life-changing for those born deaf or hard of hearing. A member of my staff in Sacramento, Devin, was born hard of hearing but didn't receive a screening at birth. For the first few years of her life, she appeared to be struggling to keep up with her peers.

It wasn't until Devin reached the middle of kindergarten that her teacher suggested she get her hearing tested. After receiving her diagnosis, Devin's family was able to seek out tools and resources to help her catch up to her classmates in school.

Devin's story illustrates the importance of early detection and intervention. We know that a child's development in the first few years of their life can have a major impact on their well-being later on.

By extending this program through our legislation, we are ensuring that infants continue to have access to hearing screenings at birth so their parents can make informed choices about their care and management early on.

We have come so far in increasing the number of babies who are screened every year. By passing this legislation, we are continuing that progress.

Mr. Speaker, I thank my colleague, Congressman GUTHRIE, for his leadership on this issue, and I ask for everyone's support.

Mr. BURGESS. Mr. Speaker, I yield as much time as he may consume to the gentleman from Kentucky (Mr. GUTHRIE), the author of the bill and the vice chairman of the Health Subcommittee.

Mr. GUTHRIE. Mr. Speaker, I thank the gentleman for yielding.

The gentlewoman from California (Ms. MATSUI) and I have worked on a lot of issues together, and it is always a pleasure to work with her and to move important things forward. I know a lot of times you see a lot of big issues need to be addressed, but a lot of things are getting done here in the House.

Today, once we pass this bill, it goes to the President. It is coming back from the Senate, so it goes to the President.

My interest in this is when I was in the General Assembly of Kentucky, the Governor had a big proposal dealing with children in the first 3 years of their life and was looking at a lot of money to be spent. And I remember doing research on a site. I found a report from a doctor from Vanderbilt, and I went down and met with her. So there has been a lot of debate on the research of some of the things that we were looking at moving forward.

She said: In normal stimulation, a child is going to rise to their ability.

But she did say this: If you took a healthy baby and put it into a closet with no light, and it couldn't hear, and pull it out 3 years later—which obviously you couldn't do that—it wouldn't

be able to see and it would never be able to develop its hearing because the brain does start adjusting at a young age.

That is why you can learn a language far better as a child than you can as an adult.

□ 1415

So I was driving back, and part of what Governor Patton of Kentucky had proposed was screening, eyesight screening, and early childhood hearing detection as part of the bill. So a lot of us were saying: "What do you do with mandates?"

I was driving back, and I remember thinking, well, if you were born and you can't see well, if you were born and you can't hear well, then isn't that the same thing as being put in a dark closet? Because if you don't figure out till you show up to school that you can't hear well, then you have lost those first 3 to 5 years of ability and lost language ability for a lifetime.

So for the small amount of money that it actually costs, we passed and authorized, in Kentucky, mandated screenings. One is for eyesight, which my son got caught in going into kindergarten. That is the first time you can really test them, when we gather them, but you can test newborns at birth. If you can find a newborn at birth that has a hearing impairment and get it corrected, it will develop just like all the other healthy children, so why not do it?

So I got to Washington, D.C. It is a national program. It is not something I came up with. It was authored before, so we are here today to reauthorize it.

I just want to point out this program is a success. In 2000, 40 percent of newborns were screened for hearing loss. That number rose to over 86 percent in 2011. In 2015, CDC has reported that roughly 97 percent of infants are screened for hearing loss. Think of the difference that makes in these children's lives when we catch them.

Mr. Speaker, I want to thank Congresswoman MATSUI. I want to thank Senator Kaine from Virginia and Senator PORTMAN from Ohio for taking the bipartisan lead in the Senate. I thank them for their hard work.

I am proud to say, when we take this vote today, it doesn't go back to the Senate. It goes to the President, and we look forward to his signature and continuing this in moving forward. I have been honored to be part of this.

Mr. Speaker, I thank Chairman BURGESS for yielding.

Ms. CASTOR of Florida. Mr. Speaker, once again, I would like to thank my Energy and Commerce colleagues, especially Mr. GUTHRIE and Ms. MATSUI. I urge approval of this bipartisan bill.

Mr. Speaker, I yield back the balance of my time.

Mr. BURGESS. Mr. Speaker, I yield 2 minutes to the gentleman from Florida (Mr. BILIRAKIS).

Mr. BILIRAKIS. Mr. Speaker, I thank the gentleman from Texas for yielding.

Mr. Speaker, I rise today in support of this bipartisan bill to reauthorize the Newborn Hearing Screening and Intervention Program.

If this law were around when I was a newborn, we might have caught my hearing loss at a younger age. I don't want kids to go through what I have gone through. Representative GUTHRIE said it about his child. I had vision problems, too.

We want to give these children an opportunity to succeed. That is why we are here in this Congress. That is why it makes it worthwhile to make a difference in a person's life. All they are asking for is an opportunity to succeed. So now as a user of hearing aids myself, I was proud to cosponsor the bipartisan bill, the House version introduced by my colleagues, Mr. GUTHRIE and Ms. MATSUI.

Studies have shown that important language development skills are learned prior to a child's third birthday, as hearing and language are closely linked. According to the American Academy of Pediatrics, 33 children are born every day with hearing impairment, making it the most common congenital condition in the United States. If left undiagnosed, a child can risk developmental challenges and setbacks.

Since its inception in 1999, the Newborn Hearing Screening and Intervention Program has improved the lives of numerous children. Over its first 15 years, the percentage of newborn babies screened every year increased from 40 percent in 2000 to approximately 96 percent of infants in 2015.

The bill builds on this legacy of success, allowing for vital screenings and monitoring to continue, while improving timely follow-up for infants to receive the care they need—key to healthy development.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. BURGESS. Mr. Speaker, I yield the gentleman an additional 30 seconds.

Mr. BILIRAKIS. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, all these children are asking for is an opportunity to succeed.

I had difficulty hearing in the classroom. I don't know how I got through, but I did. I had a hard time seeing the blackboard. I don't know how I got through my math, but I did.

Again, this is why we are here: to make a difference.

Mr. BURGESS. Mr. Speaker, I urge all Members to vote in favor of this important legislation.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Texas (Mr. BURGESS) that the House suspend the rules and pass the bill, S. 652.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill was passed.

A motion to reconsider was laid on the table.

PROTECTING GIRLS' ACCESS TO EDUCATION IN VULNERABLE SETTINGS ACT

Mr. ROYCE of California. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 2408) to enhance the transparency, improve the coordination, and intensify the impact of assistance to support access to primary and secondary education for displaced children and persons, including women and girls, and for other purposes.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 2408

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 “Protecting Girls’ Access to Education in Vulnerable Settings Act” or the “Protecting Girls’ Access to Education Act”.

SEC. 2. FINDINGS.

Congress finds the following:

(1) At the start of 2017, more than 65,000,000 people have been displaced by disasters and conflicts around the world, the highest number recorded since the end of World War II, of which more than 21,000,000 people are refugees.

(2) More than half of the population of displaced people are children and, according to the United Nations High Commissioner for Refugees, nearly 4,000,000 school-aged displaced children lack access to primary education.

(3) Education offers socioeconomic opportunities, psychological stability, and physical protection for displaced people, particularly for women and girls, who might otherwise be vulnerable to severe forms of trafficking in persons (as such term is defined in section 103(9) of the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7103(9))), child marriage, sexual exploitation, or economic disenfranchisement, and contributes to long-term recovery and economic opportunities for displaced people and for the communities hosting them.

(4) Displaced children face considerable barriers to accessing educational services and, because the duration of such displacement is, on average, 20 years, such children may spend the entirety of their childhood without access to such services.

(5) Despite the rising need for such services, less than two percent of global emergency aid was directed toward educational services in 2016.

SEC. 3. SENSE OF CONGRESS.

It is the sense of Congress that—

(1) it is critical to ensure that children, particularly girls, displaced by conflicts overseas are able to access educational services because such access can combat extremism and reduce exploitation and poverty; and

(2) the educational needs of vulnerable women and girls should be considered in the design, implementation, and evaluation of related United States foreign assistance policies and programs.

SEC. 4. STATEMENT OF POLICY.

It is the policy of the United States to—

(1) partner with and encourage other countries, public and private multilateral institutions, and nongovernmental and civil society organizations, including faith-based organizations and organizations representing par-

ents and children, to support efforts to ensure that displaced children have access to safe primary and secondary education;

(2) work with donors to enhance training and capacity-building for the governments of countries hosting significant numbers of displaced people to design, implement, and monitor programs to effectively address barriers to such education;

(3) incorporate into the design and implementation of such programs measures to evaluate the impact of the programs on girls, with respect to the reduction of child marriage, gender-based violence, and severe forms of trafficking in persons (as such term is defined in section 103(9) of the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7103(9)); and

(4) coordinate with the governments of countries hosting significant numbers of displaced people to—

(A) promote the inclusion of displaced children into the educational systems of such countries; and

(B) develop innovative approaches to providing safe primary and secondary educational opportunities in circumstances in which such inclusion is not possible or appropriate, such as schools that permit more children to be educated by extending the hours of schooling and expanding the number of teachers.

SEC. 5. UNITED STATES ASSISTANCE TO SUPPORT EDUCATIONAL SERVICES FOR DISPLACED CHILDREN.

(a) IN GENERAL.—The Secretary of State and the Administrator of the United States Agency for International Development are authorized to prioritize and advance ongoing efforts to support programs that—

(1) provide safe primary and secondary education for displaced children;

(2) build the capacity of institutions in countries hosting displaced people to prevent discrimination against displaced children, especially displaced girls, who seek access to such education; and

(3) help increase the access of displaced children, especially displaced girls, to educational, economic, and entrepreneurial opportunities, including through the governmental authorities responsible for educational or youth services in such host countries.

(b) COORDINATION WITH MULTILATERAL ORGANIZATIONS.—The Secretary and the Administrator are authorized to coordinate with the World Bank, appropriate agencies of the United Nations, and other relevant multilateral organizations to work with governments in other countries to collect relevant data, disaggregated by age and gender, on the ability of displaced people to access education and participate in economic activity, in order to improve the targeting, monitoring, and evaluation of related assistance efforts.

(c) COORDINATION WITH PRIVATE SECTOR AND CIVIL SOCIETY ORGANIZATIONS.—The Secretary and the Administrator are authorized to work with private sector and civil society organizations to promote safe primary and secondary education for displaced children.

SEC. 6. REPORT.

During the five-year period beginning on the date of the enactment of this Act, the Secretary and the Administrator shall include in any report or evaluation submitted to Congress relating to a foreign assistance program for natural or manmade disaster relief or response the following information (to the extent practicable and appropriate):

(1) A breakdown of the beneficiaries of such program by location, age, gender, marital status, and school enrollment status.

(2) A description of how such program benefits displaced people.

(3) A description of any primary or secondary educational services supported by

such program that specifically address the needs of displaced girls.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from California (Mr. ROYCE) and the gentleman from New Jersey (Mr. SIRES) each will control 20 minutes.

The Chair recognizes the gentleman from California.

GENERAL LEAVE

Mr. ROYCE of California. I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks and to include any extraneous material in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

Mr. ROYCE of California. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, first, I would like to recognize Congressman STEVE CHABOT and Congresswoman ROBIN KELLY on the Foreign Affairs Committee for their work on this important issue of protecting girls and protecting their access to education, especially in vulnerable settings.

We all know that education is a critical driver of upward social mobility for these young girls, for economic growth, for overall stability in terms of a society. As we confront an increasing number of conflicts around this globe, education has got to remain a very key component of U.S. foreign assistance.

Around the world today, there are 27 million children who are out of school in conflict zones. Half of all children in refugee camps do not have access to primary education.

With many recent conflicts that have lasted, now, a decade, we are now seeing entire generations of children that fail to receive even the most basic education; and even if they are eventually able to return home, they carry back those deficits in terms of what they have not learned, and those deficits can last a lifetime. So this is a humanitarian crisis with real strategic implications.

In Syria, for example, an estimated 4 million children are out of school in an environment warped by constant violence. Refugee children outside of Syria are placing tremendous strains on the educational systems, and I have seen this in countries like Jordan, in Lebanon, in Turkey.

As we have seen in crisis situations around the world, the lack of stable educational opportunities make these children more vulnerable: more vulnerable, especially for girls, to exploitation; more vulnerable, especially for boys, to radicalization.

Girls face unique barriers to education in conflict zones. In these afflicted countries, girls are 2½ times more likely than young boys to be out of school. They frequently encounter cultural barriers that prevent them from seeking an education, and they often lack safe routes to that little school and back home from that school.