

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

A BILL

To provide assistance to improve the health of newborns, children, and mothers 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 “Newborn, Child, and
5 Mother Survival Act of 2009”.

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

2 (a) FINDINGS.—Congress finds the following:

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

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

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

15 (4) For every maternal death some 20
16 women—or 10 million women per year—suffer com-
17 plications with severe consequences, including preg-
18 nancy-related injuries, infections, diseases, and dis-
19 abilities.

20 (5) Worldwide, 68 countries account for 97 per-
21 cent of all maternal and under-5 child deaths.

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

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

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

5 (8) In sub-Saharan Africa, a woman's lifetime
6 risk of maternal death is a staggering 1 in 22, com-
7 pared with 1 in 8,000 in industrialized countries, ac-
8 cording to UNICEF.

9 (9) Pneumonia, diarrhea, low birth weight, sep-
10 sis, birth trauma, and malaria, all preventable and
11 treatable, are the top contributors of deaths of chil-
12 dren under the age of 5.

13 (10) Poor nutrition is a major factor in 20 per-
14 cent of maternal deaths, up to one-third of under-
15 5 child deaths, and 60 to 80 percent of newborn
16 deaths.

17 (11) Risk factors for maternal death in devel-
18 oping countries include pregnancy and childbirth at
19 an early age, closely-spaced births, infectious dis-
20 eases, malnutrition, and complications during child-
21 birth.

22 (12) In Mozambique, the ratio of nongovern-
23 mental organizations engaged in HIV/AIDS preven-
24 tion efforts compared to nongovernmental organiza-
25 tions engaged in maternal and child health efforts is

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

5 (13) Antenatal care coverage for pregnant
6 mothers in developing countries is often low. For ex-
7 ample, in sub-Saharan Africa antenatal care cov-
8 erage is 69 percent yet programs for prevention of
9 maternal to child transmission of HIV reach an av-
10 erage of only 11 percent of those who need them, ac-
11 cording to UNICEF.

12 (14) In many poor countries, a lack of access,
13 including transportation to quality health care facili-
14 ties, results in deaths for newborns, children, and
15 mothers.

16 (15) No skilled birth attendant is present at 34
17 percent of deliveries worldwide which means
18 45,000,000 births each year are occurring at home
19 without skilled health personnel, according to WHO.

20 (16) Due to an estimated 50 percent shortfall
21 in skilled birth attendants, 700,000 skilled and
22 trained birth attendants are needed worldwide to en-
23 sure universal coverage to maternity care, while an
24 additional 47,000 doctors with emergency obstetric

1 skills are required, particularly in rural areas, ac-
2 cording to WHO.

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

8 (18) Maternal, newborn, and child health serv-
9 ices should include interventions along the con-
10 tinuum of care from before pre-pregnancy to early
11 childhood period and should be provided at home,
12 community, and clinics.

13 (19) An effective household to hospital con-
14 tinuum of care is especially important for maternal
15 survival, since timely linkage to referral-level obstet-
16 ric care is necessary to reduce maternal mortality.

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

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

1 treatment), antibiotics to treat respiratory infections
2 (\$0.25 per treatment), and anti-malaria tablets
3 (\$0.29 per treatment).

4 (22) Exclusive breastfeeding—giving only
5 breast milk for the first 6 months of life—could help
6 prevent an estimated 1,400,000 newborn and infant
7 deaths each year, primarily by protecting against diar-
8 rhea and pneumonia.

9 (23) Three million children die each year due to
10 lack of access to low-cost antibiotics and anti-malar-
11 ial drugs.

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

15 (25) Between 1999 and 2004, distribution of
16 low-cost vitamin A supplements saved an estimated
17 2,300,000 lives, yet the unmet need for vitamin A
18 supplements results in an estimated 250,000 to
19 500,000 children becoming blind each year, with 70
20 percent of such children dying within 12 months of
21 losing their sight.

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

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

6 (28) It is estimated that an additional
7 \$850,000,000 invested in newborn and child health
8 could save the lives of nearly 1,000,000 children
9 every year.

10 (29) Investments in child survival have contrib-
11 uted to a major decline in the rate of child mor-
12 tality, even in poor countries such as Indonesia,
13 Nepal, Laos, Bangladesh, and Bolivia, which have
14 all reduced their under-5 child mortality by more
15 than one-half since 1990.

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

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

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

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

7 (1) authorize assistance to reduce mortality and
8 improve the health of newborns, children, and moth-
9 ers in developing countries, including strengthening
10 the capacity of health systems and health workers;

11 (2) develop and implement a strategy based on
12 a continuum of care to reduce mortality and improve
13 the health of newborns, children, and mothers in de-
14 veloping countries; and

15 (3) assess, monitor, and evaluate the progress
16 and contributions of relevant departments and agen-
17 cies of the Government of the United States in
18 achieving reductions of newborn, child, and maternal
19 mortality in developing countries as well as contribu-
20 tions in achieving the United Nations Millennium
21 Development Goals through the establishment of an
22 interagency task force.

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

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

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

10 (2) in section 102(b)(4)(B), by striking “reduc-
11 tion of infant mortality” and inserting “reduction of
12 newborn, child, and maternal mortality”;

13 (3) in section 104(e)—

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

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

18 (4) by redesignating sections 104A, 104B, and
19 104C as sections 104B, 104C, and 104D, respec-
20 tively; and

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

1 **“SEC. 104A. ASSISTANCE TO REDUCE MORTALITY AND IM-**
2 **PROVE THE HEALTH OF NEWBORNS, CHIL-**
3 **DREN, AND MOTHERS.**

4 “(a) **AUTHORIZATION.**—Consistent with section
5 104(c), the President is authorized to furnish assistance,
6 on such terms and conditions as the President may deter-
7 mine, to reduce mortality and improve the health of
8 newborns, children, and mothers in developing countries.

9 “(b) **ACTIVITIES TO PREVENT MORTALITY AND IM-**
10 **PROVE NEWBORN AND CHILD HEALTH.**—Assistance pro-
11 vided under subsection (a) shall, to the maximum extent
12 practicable, be used to—

13 “(1) improve newborn care and treatment, in-
14 cluding educating families about proper antenatal
15 and skilled delivery care, drying and warming with
16 the mother, immediate and exclusive breastfeeding,
17 handwashing, clean cord care, prompt recognition
18 and care seeking for danger signs, and treatment of
19 neonatal infections; and

20 “(2) increase access to and utilization of appro-
21 priate interventions to treat life-threatening child-
22 hood illnesses, including—

23 “(A) to prevent and mitigate the severity
24 of and treat diarrhea, including point of use
25 water treatment, improvements in hygienic be-
26 havior, oral rehydration therapy (ORT), zinc,

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

4 “(B) to prevent deaths due to pneumonia
5 with a focus on community-based treatments
6 using antibiotics and effective recognition of se-
7 vere illness with appropriate referral;

8 “(C) to achieve the delivery of full immuni-
9 zation services, including efforts to eliminate
10 polio and introduce new vaccines as available;
11 and

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

16 “(c) ACTIVITIES TO PREVENT MORTALITY AND IM-
17 PROVE MATERNAL HEALTH.—Assistance provided under
18 subsection (a) shall, to the maximum extent practicable,
19 be used to—

20 “(1) improve birth preparedness, including
21 quality antenatal care throughout pregnancy; and

22 “(2) expand access and improve quality of ma-
23 ternity services, including—

24 “(A) skilled birth attendants;

1 “(B) recognition and treatment of obstetric
2 complications and disabilities, such as post-
3 partum hemorrhage;

4 “(C) quality emergency obstetric care;

5 “(D) activities to treat and repair injuries
6 resulting from pregnancy and childbirth; and

7 “(E) activities to lower or remove financial
8 barriers to maternal healthcare services.

9 “(d) ACTIVITIES TO PROMOTE HEALTHY
10 NEWBORNS, CHILDREN, AND MOTHERS.—Assistance pro-
11 vided under subsection (a) shall, to the maximum extent
12 practicable, be used to—

13 “(1) improve child and maternal nutrition, in-
14 cluding the delivery of iron, folic acid, zinc, vitamin
15 A, iodine, and other key micronutrients;

16 “(2) promote breastfeeding, appropriate com-
17 plementary feeding, and the management of acute
18 severe malnutrition, including the use of ready to
19 use therapeutic food;

20 “(3) improve access to clean water and im-
21 proved sanitation through community-based hygiene
22 education programs, the use of personal water puri-
23 fication tools and devices, and latrine construction;

24 “(4) reduce exposure to environmental toxins
25 and indoor smoke from cooking fires;

1 “(5) address antimicrobial resistance in chil-
2 dren and mothers;

3 “(6) ensure access to transportation for
4 newborns, children, and mothers in need of emer-
5 gency clinical care;

6 “(7) ensure access to comprehensive post-natal
7 newborn and maternal care, including services dur-
8 ing the immediate post-partum period; and

9 “(8) increase access to low- or no-cost
10 deworming products.

11 “(e) ACTIVITIES TO STRENGTHEN COMMUNITIES
12 AND HEALTH SYSTEMS.—Assistance provided under sub-
13 section (a) shall, to the maximum extent practicable, be
14 used to—

15 “(1) improve capacity for health governance, fi-
16 nance and workforce, including support for the
17 training and supervision of clinicians, nurses, mid-
18 wives, skilled birth attendants, nutritionists, techni-
19 cians, sanitation and public health workers, commu-
20 nity-based health workers, peer educators, volun-
21 teers, and private sector enterprises;

22 “(2) recruit, train, and supervise providers of
23 comprehensive emergency obstetric and newborn
24 care services;

1 “(3) establish and support management infor-
2 mation systems in host country institutions and the
3 development and use of tools and models to collect,
4 analyze, and disseminate information relating to
5 newborn, child, and maternal health, including reg-
6 istration of all births and deaths, along with cause
7 of death, at district and country levels;

8 “(4) develop and conduct needs assessments,
9 baseline studies, targeted evaluations, and other in-
10 formation-gathering efforts for the design, moni-
11 toring, and evaluation of newborn, child, and mater-
12 nal health programs; and

13 “(5) implement tailored programs in priority
14 countries in political transition or post conflict set-
15 tings to extend newborn, child, and maternal serv-
16 ices as quickly as possible to assist in rebuilding of
17 fragile health systems.

18 “(f) ACTIVITIES TO PROMOTE INTEGRATION, CO-
19 ORDINATION, AND MAXIMUM UTILIZATION OF HEALTH
20 AND DEVELOPMENT RESOURCE ASSISTANCE.—Assistance
21 provided under subsection (a) shall, to the maximum ex-
22 tent practicable, be used to—

23 “(1) carry out activities in host countries, in-
24 cluding—

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

4 “(B) the prevention of malaria and other
5 malaria counseling, care, and treatment;

6 “(C) the prevention of tuberculosis and
7 other tuberculosis counseling, care, and treat-
8 ment;

9 “(D) child spacing;

10 “(E) nutrition;

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

14 “(G) water and sanitation activities; and

15 “(2) carry out activities linked to United States
16 Government programs to reduce poverty and im-
17 prove health and development, including—

18 “(A) title II of the Agricultural Trade De-
19 velopment and Assistance Act of 1954 (7
20 U.S.C. 1721 et seq.);

21 “(B) the United States Leadership Against
22 HIV/AIDS, Tuberculosis, and Malaria Act of
23 2003 (22 U.S.C. 7601 et seq.) and the amend-
24 ments made by that Act (commonly known as

1 the ‘President’s Emergency Plan for HIV/AIDS
2 Relief’ or ‘PEPFAR’);

3 “(C) the Presidential Malaria Initiative
4 (PMI);

5 “(D) global health programs administered
6 by the United States Agency for International
7 Development (USAID);

8 “(E) programs administered by USAID’s
9 Office of U.S. Foreign Disaster Assistance pro-
10 grams (OFDA); and

11 “(F) global health programs administered
12 by the Department of Health and Human Serv-
13 ices.

14 “(g) GUIDELINES.—To the maximum extent prac-
15 ticable, programs, projects, and activities carried out using
16 assistance provided under this section shall be—

17 “(1) carried out through private and voluntary
18 organizations, including faith-based organizations,
19 and relevant international and multilateral organiza-
20 tions, including the GAVI Alliance (formerly known
21 as the Global Alliance for Vaccines and Immuniza-
22 tion) and the United Nations Children’s Fund
23 (UNICEF), the World Health Organization (WHO),
24 the World Food Programme (WFP), and the Global
25 Fund to Fight AIDS, Tuberculosis and Malaria, giv-

1 ing priority to organizations that demonstrate effec-
2 tiveness and commitment to preventing mortality
3 and improving the health of newborns, children, and
4 mothers;

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

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

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

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

17 “(i) DEFINITIONS.—In this section:

18 “(1) AIDS.—The term ‘AIDS’ has the meaning
19 given the term in section 104B(g)(1) of this Act.

20 “(2) HIV.—The term ‘HIV’ has the meaning
21 given the term in section 104B(g)(2) of this Act.

22 “(3) HIV/AIDS.—The term ‘HIV/AIDS’ has
23 the meaning given the term in section 104B(g)(3) of
24 this Act.”.

1 (b) CONFORMING AMENDMENTS.—The Foreign As-
2 sistance Act of 1961 (22 U.S.C. 2151 et seq.) is amend-
3 ed—

4 (1) in section 104(c)(2) (as redesignated by
5 subsection (a)(2)(B) of this section), by striking
6 “and 104C” and inserting “104C, and 104D”;

7 (2) in section 104B (as redesignated by sub-
8 section (a)(3) of this section)—

9 (A) in subsection (c)(1), by inserting “and
10 section 104A” after “section 104(c)”;

11 (B) in subsection (f)(2)(A), by striking
12 “section 104B, and section 104C” and inserting
13 “section 104C, and section 104D”; and

14 (C) in subsection (g), by striking “section
15 104(c), this section, section 104B, and section
16 104C” and inserting “section 104(c), section
17 104A, this section, section 104C, and section
18 104D”;

19 (3) in subsection (c) of section 104C (as red-
20 igned by subsection (a)(3) of this section), by in-
21 sserting “and section 104A” after “section 104(c)”;

22 (4) in subsection (c) of section 104D (as red-
23 igned by subsection (a)(3) of this section), by in-
24 sserting “and section 104A” after “section 104(c)”;

1 (5) in the first sentence of section 119(c), by
2 striking “section 104(c)(2), relating to Child Sur-
3 vival Fund” and inserting “section 104A”; and

4 (6) in section 135(b)—

5 (A) in paragraph (1), by striking “section
6 104A(g)(1)” and inserting “section
7 104B(g)(1)”; and

8 (B) in paragraph (3), by striking “section
9 104A(g)(3)” and inserting “section
10 104B(g)(3)”.

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

14 (a) STRATEGY REQUIRED.—The President shall de-
15 velop and implement a comprehensive United States Gov-
16 ernment strategy to reduce mortality and improve the
17 health of newborns, children, and mothers in developing
18 countries.

19 (b) COMPONENTS.—The comprehensive United
20 States Government strategy developed pursuant to sub-
21 section (a) shall include the following:

22 (1) An identification of not less than 60 coun-
23 tries with priority needs for the 5-year period begin-
24 ning on the date of the enactment of this Act based
25 on—

1 (A) the number and rate of neonatal
2 deaths;

3 (B) the number and rate of child deaths;

4 (C) the number and ratio of maternal
5 deaths;

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

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

10 (2) For each country identified in paragraph

11 (1)—

12 (A) an assessment of the most common
13 causes of newborn, child, and maternal mor-
14 tality;

15 (B) a description of the host country's
16 overall health strategy and expenditures, includ-
17 ing an assessment of components to specifically
18 reduce newborn, child, and maternal mortality
19 rates;

20 (C) a description of the programmatic
21 areas and interventions providing maximum
22 health benefits to populations at risk as well as
23 maximum reduction in newborn, child, and ma-
24 ternal mortality;

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

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

8 (F) a description of goals and objectives
9 for improving newborn, child, and maternal
10 health, including, to the extent feasible, objec-
11 tive and quantifiable indicators; and

12 (G) a description of the host government's
13 commitment to working with partners and civil
14 society to achieve accelerated reductions in new-
15 born, child and maternal mortality.

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

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

22 (B) address the human resources crisis in
23 each of those countries by increasing by at least
24 100,000 the number of functional (trained,
25 equipped, and supervised) community health

1 workers and volunteers serving at primary care
2 and community levels in those countries by
3 2013; and

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

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

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

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

1 and mortality of each project or program carried
2 out.

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

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

10 (a) ESTABLISHMENT.—There is established a task
11 force to be known as the Interagency Task Force on New-
12 born, Child, and Maternal Health in Developing Countries
13 (in this section referred to as the “Task Force”).

14 (b) DUTIES.—

15 (1) IN GENERAL.—The Task Force shall assess,
16 monitor, and evaluate the progress and contributions
17 of relevant departments and agencies of the Govern-
18 ment of the United States in achieving the United
19 Nations Millennium Development Goals by 2015 for
20 reducing the mortality of children under the age of
21 5 by two-thirds (Millennium Development Goal 4)
22 and reducing maternal mortality by three-quarters
23 (Millennium Development Goal 5) in developing
24 countries, including by—

1 (A) identifying and evaluating programs
2 and interventions that directly or indirectly con-
3 tribute to the reduction of newborn, child, and
4 maternal mortality rates;

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

9 (C) assessing the level of coordination
10 among relevant departments and agencies of
11 the Government of the United States, the inter-
12 national community, international organiza-
13 tions, faith-based organizations, academic insti-
14 tutions, and the private sector;

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

20 (E) assessing the contributions made by
21 United States-funded programs toward achiev-
22 ing the Millennium Development Goals 4 and 5;

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

1 ing the Millennium Development Goals 4 and 5;
2 and

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

5 (2) CONSULTATION.—To the maximum extent
6 practicable, the Task Force shall consult with indi-
7 viduals with expertise in the matters to be consid-
8 ered by the Task Force who are not officers or em-
9 ployees of the Government of the United States, in-
10 cluding representatives of United States-based non-
11 governmental organizations (including faith-based
12 organizations and private foundations), academic in-
13 stitutions, private corporations, the United Nations
14 Children’s Fund (UNICEF), and the World Bank.

15 (c) MEMBERSHIP.—

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

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

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

22 (C) The Coordinator of United States Gov-
23 ernment Activities to Combat HIV/AIDS Glob-
24 ally (commonly known as the “U.S. Global
25 AIDS Coordinator”).

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

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

7 (F) The Under Secretary for Food, Nutri-
8 tion and Consumer Services of the Department
9 of Agriculture.

10 (G) The Chief Executive Officer of the Mil-
11 lennium Challenge Corporation.

12 (H) The Director of the Peace Corps.

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

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

20 (K) Two ex-officio members appointed by
21 the majority leader of the Senate in consulta-
22 tion with the minority leader of the Senate.

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

1 (d) MEETINGS.—The Task Force shall meet on a reg-
2 ular basis, not less often than quarterly, on a schedule
3 to be agreed upon by the members of the Task Force, and
4 starting not later than 90 days after the date of the enact-
5 ment of this Act.

6 (e) DEFINITION.—In this section, the term “Millen-
7 nium Development Goals” means the key development ob-
8 jectives described in the United Nations Millennium Dec-
9 laration, as contained in United Nations General Assembly
10 Resolution 55/2 (September 2000).

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

16 **SEC. 6. AUTHORIZATION OF APPROPRIATIONS.**

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

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

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