S. 1966 Global Child Survival Act of 2009: Analysis and Recommendations

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Executive Summary

The escalating rates of infant, child, and maternal mortality in developing countries are a significant problem both for the developing world and for developed countries that are capable of initiating and sustaining cost-efficient interventions. In 2000, the U.S. and 188 other countries committed to achieve 8 Millennium Development Goals which aim to reduce global infant, child, and maternal death rates by 2015. Given that the goals are still far from reach, the passing and implementation of a revised U.S. Senate Bill 1966, the Global Child Survival Act of 2009, would guide the U.S. in developing a strategy and task force to support the international community in reducing disparities in maternal and child mortality around the world.

Context of Child and Maternal Health

The state of child health and overall development in countries around the world is largely measured by the under-5 mortality rate [1]. More than 11 million children under the age of five die every year and an overwhelming majority of these cases arise from preventable or easily treatable conditions [2]. In fact, over 70% of global child deaths can be attributed to diarrhea, malaria, neonatal infection, pneumonia, preterm delivery, or lack of oxygen at birth. [3] Most child deaths occur in developing countries, which play host to contributing factors such as

marginalization, conflict, HIV/AIDS, malnutrition, and lack of safe drinking water and sanitation. Children in the developing world are ten times more likely to die before age five as compared to their counterparts in developed countries [2]. In fact, in the ten countries with the highest child mortality rates, almost 1 of every 5 children dies before age five [2].

Maternal mortality is directly connected to neonatal mortality. About 20% of the disease burden in children under age 5 is tied to poor maternal health and nutrition, as well as the quality of care children receive in the first year of life [3]. Every year, 8 million babies die before or during delivery and during the newborn period, while others left motherless have a 10-fold risk of dying within 2 years of their mothers' death. Maternal mortality is also at a critical level as nearly 550,000 women die each year from causes related to pregnancy and childbirth, including hemorrhage, infection, obstructed labor, hypertensive disorders, and unsafe abortion practices [4]. The vast majority of these maternal deaths occur in the developing world. Sadly, they are also due to preventable causes including pregnancy and childbirth at an early age, closely spaced births, infectious diseases, malnutrition, and complications during child birth [5]. When it comes to the indicator of mortality risk, women in developing countries experience the largest disparity of any health indicator when contrasted to women in richer, developed countries. Compared to a 1 in 4,000 risk of dying during pregnancy or childbirth in the developed world, a woman in sub-Saharan Africa, for example, faces a 1 in 16 chance of death [3].

The issues of infant, child, and maternal death are pervasive and expected to grow without deliberate intervention. As these problems continue to escalate naturally, strategic, cost-efficient programs are necessary to curb them and to improve the state of global child and maternal

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health. In fact, research demonstrates that with the use of cost-effective, evidence-based healthcare interventions, 6 million child deaths can be prevented [3]. Examples include immunization programs, antibiotics, insecticide-treated bed net distribution, micronutrient supplementation, and improved family care and breastfeeding practices [3]. In order to design, implement, and evaluate such programs that purport to decrease the under-5 mortality rate and achieve improvements in overall health in the developing world, public policy is needed. Legislating international strategy will mobilize stakeholders and appropriate funding in order to implement effective programs for sustainable change. This is precisely the task of Senate Bill 1966 (S. 1966) which seeks to improve the health of infants, children, and mothers in the world's poorest nations [6].

Policy Background

While U.S. health policy pertaining specifically to global child and maternal health is a relatively recent development, several significant policies preceded S. 1966 in an attempt to create foreign assistance structures for the improvement of international health. After World War II, Europe's requests for assistance resulted in the international community's establishment of the International Monetary Fund and the International Bank for Reconstruction and Development in 1945. The U.S. responded in 1948 with the enactment of the Economic Cooperation Act and creation of the Marshall Plan which sought to stabilize Europe through temporary emergency assistance [7]. After the end of the Marshall Plan in 1951, Congress passed the first Mutual Security Act which paired military and economic programs with technical assistance as new foreign aid policy. In 1953, the Foreign Operations Administration was established as an independent government agency to consolidate international assistance. This agency merged into the International Cooperation Administration in 1954, which gave aid for the purposes of economic, political, and social development but remained quite limited in autonomy. In response to this shortcoming, the second Mutual Security Act was passed in 1954 while the Food for Peace Program introduced food aid in the same year [7]. Congress approved a revised Mutual Security Act in 1957 and despite great development of foreign aid policy by this time, there remained a need for a long-term foreign development program. This gap in policy contributed to the increasing dissatisfaction among the public and Congress with the U.S. foreign assistance structures already in place [7].

Congress and the Eisenhower Administration were spurred to reorganize U.S. foreign assistance programs and focus U.S. aid on the developing world, which led to the

enactment of the Foreign Assistance Act (FAA) of 1961 [8]. The FAA separated military and non-military aid and mandated the creation of the U.S. Agency for International Development (USAID) to promote and administer long-term assistance programs for the economic and social growth of developing countries [7]. The impact of current programs run by USAID is significant and has undoubtedly worked for the improvement of infant, child, and maternal health around the world. The U.S. has invested over \$6 billion over the past 20 years in child survival programming run by USAID which has had great impact on child health [5]. For example, 15 countries in Africa, Asia, and Latin America, that USAID provided with assistance, experienced a decline in under-5 mortality by an average of 33% between 1996 and 2006, while some countries experienced as much as a 50% decrease in under-5 mortality [5]. While the FAA remains the prevailing and most effective foreign assistance legislation, disparities in child and maternal health in developing countries persist.

To continue combating the grave disparities faced by women and children in developing nations in the spirit of previous policy development, the U.S. joined 188 countries at the United Nations Millennium Summit in 2000 in committing to achieve 8 Millennium Development Goals (MDGs) [3]. The leaders declared that by 2015, the state of global health would be measurably improved with active progress by the international community towards the 8 key goals that are geared mainly towards children. Commitments to improving infant, child, and maternal health are reflected in MDG 4, to reduce child mortality by two thirds and MDG 5, to reduce maternal mortality by three quarters, between 1990 and 2015 [3]. With the deadline fast-approaching, maternal mortality has only declined by 5% between 1990 and 2005, while 91 developing countries are far behind their target of reducing child mortality and many have actually experienced a rise in rates since 1990 [3]. These troubling findings indicate that the international community must do more to accelerate progress.

Efforts to reform the FAA in order to address increasing health disparities faced by the developing world have been numerous yet largely unsuccessful, and this is the climate into which S. 1966 enters. The first bill to propose amendments to the FAA was the House of Representatives Bill 4222 (H.R. 4222) for the Child Investment for Long-Term Development (CHILD and Newborn) Act of 2005 [9]. This bill proposed various activities to improve the health of newborns, children, and mothers in developing countries but expired in the 109th session of Congress and never became law. Senate Bill 2765 (S. 2765) for the CHILD and Newborn Act of 2006 also died while under review in the 109th session of Congress [10]. House of Representatives Bill 2266 and Senate Bill 1418 (S. 1418) were both versions of the U.S. Commitment to Global

Child Survival Act of 2007, which proposed similar amendments to the FAA as did H.R. 4222 and S. 2765 and died in the 110th session of Congress [11, 12]. S. 1418 progressed the furthest in the legislative process having been reported by the Senate Committee on Foreign Relations. It was placed on the Senate Legislative Calendar but eventually met the same fate as previous versions of the bill [12].

Policy Analysis

Senate Bill 1966, sponsored by Senators Dodd, Durbin, and Corker, is the current bill purporting to amend the FAA and specifies two key goals. First, it proposes to “develop a strategy to reduce mortality and improve the health of newborns, children, and mothers, and authorize assistance for its implementation” [13]. This first component will be carried out by activities to improve essential newborn care and treatment, prevent childhood illness, improve maternal nutrition, and improve access to clean water and proper sanitation among many others. Another component of this first goal calls for President Barack Obama to “develop and implement a comprehensive strategy to reduce mortality and improve the health of newborns, children, and mothers in developing countries” [5]. This part of the bill would be accomplished by compiling mortality data, assessing causes of mortality, assessing necessary investments for programs, and describing specific goals and objectives for improving infant, child, and maternal health among many more activities. Secondly, the bill aims to “establish a task force to assess, monitor, and evaluate the progress and contributions of relevant departments and agencies of the U.S. Government in achieving MDG 4” [5]. To accomplish this second goal of creating the Interagency Task Force on Child Survival in Developing Countries, activities such as identifying and evaluating programs, assessing coordination among the U.S. Government and international communities, and preparing an annual report, are outlined. S. 1966 has currently been read twice and referred to the Committee on Foreign Relations, the first step in the legislative process [13].

Groups in favor of S. 1966 are practitioners including physicians and nurses, organizations working for child health, including the World Health Organization and United Nations Children’s Fund, as well as the bill sponsors, Senators Dodd, Durbin, and Corker. These bill supporters advocate for improvements in child and maternal health and for the use of low-cost interventions to reduce mortality. The bill sponsors hold that the U.S. must follow through with its commitment to reduce infant, child, and maternal mortality and increase funding and delivery of cost-efficient interventions to ensure that MDG 4 is met [5].

In accordance with this stance, U.S. Permanent Representative to the United Nations, Susan Rice, presented to the Senate Committee on Foreign Relations on January 15, 2009 and stated that President Barack Obama is committed to “making the Millennium Development Goals America’s goals” [5]. In statements to the Senate, Senator Dodd conceded that the U.S. takes part in many activities to combat child mortality but that “We can do more, we have committed to do more, and we must do more” [6]. Senators Dodd, Durbin, and Corker have gained support of S. 1966 by Save the Children, the U.S. Coalition for Child Survival, and the U.S. Fund for UNICEF [6].

When examining S. 1966 alongside its previous version, S. 1418, it is evident that there are a few key differences. While both of the bills sought “to provide assistance to improve the health of newborns, children, and mothers in developing countries, and for other purposes,” they differ in how they plan to provide assistance [5, 14]. While S. 1418 does not focus at all on preventive care in order to improve health outcomes, S. 1966 details strategies to prevent childhood illness and disease, the onset of tropical diseases, as well as postpartum complications [5, 14]. Another key difference is that S. 1966 fails to list its appropriations of funds per fiscal year whereas S. 1418 outlines its estimated funding per fiscal year within the bill [5, 14]. In essence, S. 1966 and S. 1418 are very similar. The most crucial difference is that S. 1966 does not state the estimated financial requirements to carry out all the outlined activities, an aspect of the bill that makes it less likely to pass through Congress.

Policy Critiques

In analyzing S. 1966, one of the weaknesses can be ascertained by understanding its financial implications. As S. 1966 does not detail funding appropriations by fiscal year, this information can be extrapolated from S. 1418, the U.S. Commitment to Global Child Survival Act of 2007. This bill mandated an increase in funding to expand child and maternal health interventions including \$600 million for fiscal year 2008, \$900 million for 2009, \$1.2 billion for 2010, and \$1.6 billion each for 2011 and 2012 [14, 15]. As S. 1966 is very similar to its counterpart in 2007, it is reasonable to expect that the cost of the activities outlined in it will be similar to these figures. The lack of this type of information in the bill document poses a great barrier to its comprehensiveness and acceptance by Congress. Another issue concerning the authorization of appropriations is that the bill does not delineate possible sources of funding for the activities it describes. Along with the lack of funding context, the omission of funding sources and strategies weakens the persuasive power of the bill.

A second critique of S. 1966 is that the activities outlined in the bill seem too extensive to gain the support needed to progress to the next step of the legislative process. The bill outlines sixteen broad categories of activities to help reduce mortality and improve health, in addition to the numerous components of the strategy and task force development sections of the bill. While there is no doubt that U.S. leadership in improving maternal and child health in developing countries will eventually require a multifaceted and complex approach, it is reasonable to expect that a bill that is too comprehensive may not appear feasible. Taking a lesson from the recent health care reform process, Congress tends to deal with smaller-scale bills more openly while maintaining transparency and wide-ranging input in the committee and floor procedures [16]. Taking smaller, more incremental steps that allow for experimentation and evaluation of results may be the only feasible approach to big problems such as global health disparities [16]. The current version of S. 1966, with its numerous activities, may very well be deliberated upon in committee for a long period of time and expire by the end of the current session of Congress just as its previous versions did.

A third critique of S. 1966 is that there is no evidence provided for its potential benefit to the United States. While plenty of evidence is given in the bill text for maternal and child mortality rates worldwide along with the potential impact of cost-efficient preventive strategies, there is no relationship drawn between improvements in global health and the health and well-being of Americans, which would present a strong argument in favor of the bill. Although the U.S. is responsible for following through on its commitment to the MDGs and helping to improve the health of the international community, the bill sponsors do not describe any immediate or long-term benefits that would be experienced on home soil if S. 1966 were passed into law.

Policy Recommendations

After reviewing S. 1966, we offer support for this important policy along with some recommendations to improve the bill's anticipated success. The first suggestion is that the cost per fiscal year of the bill activities be clearly stated. Sponsors of S. 1966 should provide a broader funding context as well as articulate possible sources of funding in order to increase the bill's likelihood of passing into law.

It is evident that if developing countries, which bear most of the total disease burden, are to reach the recognized health-related MDGs by 2015, they will need increased and sustained foreign assistance for health services from economically advanced countries [17]. In order to increase U.S.

commitment to improve global health, the Obama administration is investing \$63 billion between 2009 and 2014 through the Global Health Initiative, a comprehensive whole-of-government approach to help partner countries in bolstering the health of women, newborns and children [18]. In a recent announcement, U.S. Secretary of State Hillary Clinton described the initiative as focused on "maternal and child health, family planning and programs to fight infectious diseases such as malaria, tuberculosis and HIV/AIDS" [19]. While \$51 billion of the initiative's \$63 billion budget will go to the President's Emergency Plan for AIDS Relief, the other \$12 billion will be channeled into programming to fight tropical diseases and other health problems [20]. We recommend that S. 1966 be financed through the Global Health Initiative because the goals of the bill correspond directly to those of the overarching strategy already in place.

We also suggest that S. 1966 sponsors investigate other funding opportunities including raised funds through programs and organizations, both for-profit and non-profit, such as the March of Dimes, the Child Health Foundation, and the Boys & Girls Club of America. A revolutionary and flexible tax on air travel, such as that which funds the international drug purchase facility known as UNITAID, may also be an option to help fund S. 1966 [17]. The Committee on the U.S. Commitment to Global Health reports that in 2009, an opinion poll showed that 57% of Americans would support the U.S. joining France, Chile, the Republic of Korea, and several African countries in charging an additional \$1 to \$2 on international flights to fund UNITAID [17]. Employing innovative financing approaches to support the activities of S. 1966 would not only improve child and maternal health, but also address long-term funding needs and enhance collaboration with the private sector [17].

The second suggestion is based on the complexity of the bill. As it currently stands with its multiple activities towards achieving MDGs 4 and 5, S. 1966 may meet more success through more focused and incremental change. We suggest that the bill be revised to focus on a few key areas to help reduce infant, child, and maternal mortality. The areas of interest should be limited to breast feeding education initiatives, supplement distribution, and immunization programs. These three critical components have proven to positively impact maternal and child health. Breast feeding education initiatives are imperative for expecting and new mothers. In fact, the World Health Organization (WHO) states that "if all babies and young children were breastfed exclusively for their first 6 months of life and then given nutritious complementary food with continued breastfeeding up to 2 years of age, the lives of an additional 1.5 million children under five would be saved every year" [21]. With regards to low-cost supplements,

the Global Action for Children notes that “supplements given two to three times per year can prevent blindness and lower the risk of death from diarrhea, malaria and measles” [22]. Although each capsule costs only two cents, an alarming 28 percent of children in developing countries are not receiving this preventive treatment [22]. Immunization programs are also cost-efficient and can drastically improve the lives of infants, children, and mothers by protecting them from diseases such as measles, mumps, rubella, hepatitis, tetanus, and polio. According to the WHO, “more widespread use of low-cost vaccines could prevent 1.6 million deaths a year among children under the age of five” [23]. By focusing the goals of S. 1966 on these three main components, it is more likely that it will progress through Congress successfully so that the U.S. can partner with developing countries to make significant improvements to health.

The third recommendation is that some evidence be cited in support of the bill’s anticipated benefits to the United States, an argument that would increase its likelihood of being passed into law. The first clear benefit of enacting S. 1966 and investing in global health is that it would work to protect national security [24]. This is especially true when it comes to the spread of infectious diseases as demonstrated by the threat of recent outbreaks of SARS and H1N1 virus [24]. The Global Health Council describes disease as being potentially broad and borderless, as increased travel and trade mean that people and goods are carrying endemic pathogens to new places and populations [25]. Trade in agricultural products is just as high as international travel and has made foodborne illnesses and illnesses of animal origin more prevalent [25]. Stopping an outbreak when it emerges is more efficacious and cost-efficient than allowing it to become a global threat, and that requires stronger health services in developing countries where infectious disease is highest [24]. Another benefit to the U.S. that will result from enacting S. 1966 is that, just like the activities under the Global Health Initiative, it would be a “tool of public diplomacy” [24]. By giving mothers and children in developing countries care and support through the activities of S. 1966, the United States will send a more powerful message about the country’s values and commitment to the international community.

By helping to reduce health disparities in infant, child, and maternal mortality through the actions of S. 1966, the U.S. will demonstrate sensitivity to other countries’ needs in addition to those at home. When it comes to assisting developing countries, President Obama holds that “We cannot simply confront individual preventable illnesses in isolation” and that the interconnected world “demands an integrated approach to global health” [20]. S. 1966 calls for the development and establishment of a comprehensive

strategy and a task force that will provide such an integrated approach to improvements in maternal and child health. The revisions suggested by the authors including clarity in funding options, a more narrowed focus, and evidence of local as well as global impact, will lead to S. 1966 being more likely to pass into law and leave a lasting legacy of collaboration and compassion. Bob Corker, a member of the Senate Foreign Relations Committee, believes that “We have an opportunity through [S. 1966] to save the lives of more children and improve the health of mothers in developing nations” [26]. Corker also holds that “Maintaining U.S. investment in proven, cost-effective programs to combat poverty and disease overseas helps bring stability to unstable and often dangerous regions of the world, ultimately supporting our security interests both at home and abroad” [26]. A revised S. 1966 will therefore empower the U.S. to improve international health and strengthen the global community.

References

1. World Health Organization. (2010b). *Child mortality*. Retrieved from <http://www.who.int/healthinfo/statistics/mortchildmortality/en/index.html>.
2. World Health Organization. (2010c). *Children: reducing mortality*. Retrieved from <http://www.who.int/mediacentre/factsheets/fs178/en/>.
3. UNICEF. (2010). *Millennium development goals*. Retrieved from <http://www.unicef.org/mdg/index.html>.
4. World Health Organization. (2010d). *Maternal mortality*. Retrieved from http://www.who.int/making_pregnancy_safer/topics/maternal_mortality/en/index.html.
5. Thomas. The Library of Congress, (2009). *Global child survival act of 2009 (S. 1966)*. Washington, DC: Retrieved from http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:s1966is.txt.pdf. (pg. 4, 2, 16, 19, 7, 6, 1, 10, 13, 14, 22).
6. Global Network. (2010) *Dodd, Durbin, and Corker introduce the global child survival act*. Retrieved from <http://globalnetwork.org/press/2009/10/29/dodd-durbin-and-corker-introduce-global-child-survival-act>.
7. USAID. (2010b). *USAID History*. Retrieved from http://www.usaid.gov/about_usaid/usaidhist.html.
8. Kaiser Family Foundation. (2009) U.S. global health policy. Retrieved from <http://globalhealth.kff.org/Policy-Tracker/Congress/Background/Legislations/1961-FAA.aspx>.
9. GovTrack: a civic project to track congress. (2006). *H.R. 4222: Child Health Investment for Long-Term Development (CHILD and Newborn) Act of 2006*. Retrieved from <http://www.govtrack.us/congress/bill.xpd?bill=h109-4222>.
10. GovTrack: a civic project to track congress. (2006). *S. 2765: Child Health Investment for Long-Term Development (CHILD and Newborn) Act of 2006*. Retrieved from <http://www.govtrack.us/congress/bill.xpd?bill=s109-2765>.
11. GovTrack: a civic project to track congress. (2007). *H.R. 2266: United States Commitment to Global Child Survival Act of 2007*. Retrieved from <http://www.govtrack.us/congress/bill.xpd?bill=h110-2266>.

12. GovTrack: a civic project to track congress. (2007). *S.1418: United States Commitment to Global Child Survival Act of 2007*. Retrieved from <http://www.govtrack.us/congress/bill.xpd?bill=s110-1418>.
13. GovTrack: a civic project to track congress. (2009). *S. 1966: Global child survival act of 2009*. Retrieved from <http://www.govtrack.us/congress/bill.xpd?bill=s111-1966>.
14. Thomas. The Library of Congress, (2007). United states commitment to global child survival act of 2007 (S.1418). Washington, DC: Retrieved from http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_bills&docid=f:s1418is.txt.pdf. (pg. 1, 17).
15. U.S. Coalition for Child Survival. (2007). Previous initiatives: the state of global child health. Retrieved on April 3, 2010 from <http://www.child-survival.org/advocacy/gcsa.php>.
16. Hamilton, L. (2010). In congress, going big isn't always the answer. *The Center on Congress at Indiana University*, Retrieved from http://www.centeroncongress.org/radio_commentaries/in_congress_going_big_isnt_always_the_answer.php.
17. Committee on the U.S. Commitment to Global Health; Institute of Medicine. (2009). Increase U.S. Financial Commitments to Global Health. In *The U.S. commitment to global health: recommendations for the public and private sectors* (Chapter 5). Retrieved from <http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=nap12642&part=a2001902dddd00114>.
18. USAID. (2010). *Fact sheet: the U.S. government 's global health initiative*. Retrieved from <http://www.usaid.gov/ghi/factsheet.html>.
19. Sinha, V. (2010). *Obama global health initiative targets maternal, child health, disease*. Retrieved from <http://www.voanews.com/english/news/usa/Maternal-Child-Health-Infectious-Disease-Focus-of-Obama-Administrations-Global-Health-Initiative-102064123.html>.
20. Bohan, C., & Zargham, M. (2009). Obama unveils \$63 billion global health initiative. *Thomson Reuters*. Retrieved from <http://www.reuters.com/article/idUSTRE54457U20090505>.
21. World Health Organization. (2010). *Breastfeeding key to saving children's lives*. Retrieved from http://www.who.int/mediacentre/news/notes/2010/breastfeeding_20100730/en/index.html.
22. Global Action for Children. (2010). *Child survival*. Retrieved from http://www.globalactionforchildren.org/issues/child_survival/.
23. World Health Organization. (1999). Most infectious disease deaths are avoidable at a low cost. In *Removing Obstacles to Healthy Development, World Health Organization Report on Infectious Diseases* (Chapter 4). Retrieved from <http://www.who.int/infectious-disease-report/pages/ch4text.html>.
24. Clinton, H.R. U.S. Department of State, (2010). *The global health initiative: the next phase of American leadership in health around the world*. Washington, DC: Retrieved from <http://www.state.gov/secretary/rm/2010/08/146002.htm>.
25. Global Health Council. (2010). *Global view*. Retrieved from http://www.globalhealth.org/infectious_diseases/global_view/.
26. TimesFreePress. (2010). Press release: corks one of three lawmakers to receive save the children award. *Politics*, Retrieved from <http://www.timesfreepress.com/news/2010/may/06/corker-one-three-lawmakers-receive-save-children-a/>.