CHILD SURVIVAL: THE UNFINISHED AGENDA TO REDUCE GLOBAL CHILD MORTALITY

HEARING

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CHILD SURVIVAL: THE UNFINISHED AGENDA TO REDUCE GLOBAL CHILD MORTALITY

THURSDAY, MARCH 13, 2008,

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON AFRICA AND GLOBAL HEALTH,
COMMITTEE ON FOREIGN AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:37 a.m. in room 2200, Rayburn House Office Building, Hon. Donald M. Payne (chairman of the subcommittee) presiding.

Mr. PAYNE. We will call this hearing to order.

Thank you for joining us for this very important hearing of the Subcommittee on Africa and Global Health on Child Survival: The Unfinished Agenda to Reduce Global Child Mortality.

We have with us a panel of experts which include the distinguished former Senate Majority Leader, Bill Frist. I will begin with an opening statement, and we will introduce each of the witnesses before each of the panels.

Every day 27,000 children under the age of 5 die, mostly from preventable disease and conditions. Factors such as malnutrition, unsafe drinking water, and inadequate access to vaccines contribute greatly to global child mortality. We know how to prevent most of these deaths, but we have not spent the resources necessary to do so. It comes as no surprise that most of these are children born into the developing world, those who are dying, nor that half of these children are in Africa.

In 2000, the United Nations adopted the 8 Millennium Development Goals, MDGs, and called on member states throughout the world to provide the necessary resources to reach key targets by 2015. The fourth goal is to reduce child mortality by two-thirds. Given the fact that malnutrition caused by chronic hunger causes the death of more than 5 million children each year, we cannot reach that goal without making strides in the first Millennium Development Goal—halving extreme poverty and hunger. This underscores the need for an integrated approach on these Millennium challenge goals.

The United National Children's Fund, UNICEF, recently released "The State of the World's Children 2008: Child Survival," which reports that annual deaths among children under 5 fell to 9.7 million a year, the first time that this number fell under 10 million since we have been tracking the numbers from 1960.

The fact that 9.7 million children are dying each year of preventable diseases sends a clear message to all of us—we absolutely must do more, it is just that simple. There is no excuse for children

to be dying from preventable diseases. Those figures represent human beings, little children who deserve a shot at life just like children born here in the United States of America. All little children are the same.

This is not to say that the work of countless individuals, groups, and governments are not making a difference. On the contrary, their efforts are critical and have made serious inroads in reducing child mortality. Yet, there are some countries, such as Sierra Leone, which has the highest child and maternal mortality rates in the world. One in every four children will not live to see their first birthday. That is unbelievable.

This means that we must increase our investments in life-saving programs. If there is any good news to report on child survival, it is that according to the World Health Organization, two-thirds of child deaths are preventable, as I mentioned before. Moreover, they can be prevented with a very small investment and that is even better news.

Today, we are joined by Congresswoman Betty McCollum of Minnesota and Congressman Chris Shays of Connecticut because of their leadership on child survival. In May 2007, they introduced H.R. 2266, the United States Commitment to Global Child Survival Act of 2007, of which I am a proud cosponsor, which directs the President to develop a comprehensive strategy to reduce child mortality and establish the Interagency Task Force on Child Survival and Maternal Health in Developing Countries.

The bill also authorizes up to $600 million, ending at $1.6 billion by 2012, to save lives of children around the world.

The significant commitment of the United States in reducing child mortality in the developing world contributes to a 50 percent reduction in the mortality of children under the age of 5 between 1960 and 1990. However, over the past several years funding for child survival and maternal health programs have fluctuated but have remained between $350 million and $450 million. In the Fiscal Year 2009 budget, the administration has requested $369.5 million for child survival and maternal health programs, some $77 million less than the 2008 levels, which is not going in the right direction.

Two weeks ago this committee voted for a bill which would provide $50 billion in reauthorization for the President's Emergency Plan on AIDS Relief, PEPFAR, and this, once passed in both chambers, will be a great victory for the President and for this Congress. PEPFAR will be remembered for years to come as a cornerstone of President Bush's Africa legacy. I mentioned that to him in person last week, and we are hoping that we will be able to have the $50 billion reauthorized. It has created a tremendous amount of good will and, of course, has saved countless lives in Africa. I fully support PEPFAR and will continue to push for its approval.

At the same time, we must take into account that, according to the U.S. Coalition for Child Survival, more than 90 percent of child deaths are caused by preventable, treatable diseases and conditions other than HIV/AIDS and malaria. So as we ramp up PEPFAR, we must also increase funding for programs to address the basic health needs of children and pregnant mothers, such as immuniza-

tions, nutrition assistance, and treatments for diarrhea and other infections.

We can save children's lives. We can prevent nearly 10 million child deaths that will occur unnecessarily this year as called for in the McCollum-Shays bill. But we must begin by providing $600 million for child survival in Fiscal Year 2009 and increase our commitment each year. I urge members of this committee t cosponsor H.R. 2266 and I look forward to hearing from our witnesses.

With that, I will turn to our ranking member who has been very supportive in all of our issues, Mr. Smith from New Jersey.

[The prepared statement of Mr. Payne follows:]

PREPARED STATEMENT OF THE HONORABLE DONALD M. PAYNE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY, AND CHAIRMAN, SUBCOMMITTEE ON AFRICA AND GLOBAL HEALTH

Thank you for joining us for this hearing of the Subcommittee on Africa and Global Health on *Child Survival: The Unfinished Agenda to Reduce Global Child Mortality*. We have with us a panel of expert witnesses which includes the distinguished former Senate Majority Leader, Bill Frist. I will begin with an opening statement and will introduce the witnesses before each panel.

Every day 27,000 children under the age of 5 die, mostly from preventable diseases and conditions. Factors such as malnutrition, unsafe drinking water, and inadequate access to vaccines contribute greatly to global child mortality. We know how to prevent most of these deaths, but we have not spent the resources necessary to do so. It comes as no surprise that most of these are children born into the developing world, nor that half of them occur in Africa.

In 2000, the United Nations adopted the 8 Millennium Development Goals (MDG's) and called on member states to provide the necessary resources to reach key targets by 2015. The 4th goal is to reduce child mortality by two-thirds. Given the fact that malnutrition caused by chronic hunger causes the deaths of more than 5 million children each year, we cannot reach this goal without making strides in the first Millennium Development Goal—halving extreme poverty and hunger. This underscores the need for an integrated approach.

The United Nations Children's Fund (UNICEF) recently released The State of the World's Children 2008: Child Survival, which reports that annual deaths among children under 5 fell to 9.7 million a year, the first time below 10 million since we started tracking this in 1960.

The fact that 9.7 million children are dying each year of preventable diseases sends a clear message to us all—we absolutely must do much more. Those figures represent human beings; little children who deserve a shot at life just as much as children born here in the United States.

This is not to say that the work of countless individuals, groups, and governments are not making a difference. On the contrary, their efforts are critical and have made serious inroads in reducing child mortality. Yet, there are some countries where child survival is not improving, such as Sierra Leone, which has the highest child and maternal mortality rates in the world. One in 4 children will not live to see their first birthday.

This means that we must increase our investments in life-saving programs. If there is any good news to report on child survival, it is that according to the World Health Organization (WHO), two-thirds of child deaths are preventable. Moreover, they can be prevented at with small investments.

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At the same time, we must take into account that, according to the US Coalition for Child Survival, more than 90 percent of child deaths are caused by preventable, treatable diseases and conditions other than HIV/AIDS and malaria. So as we ramp up PEPFAR, we must also increase funding for programs to address the basic health needs of children and pregnant mothers—such as immunizations, nutrition assistance, and treatments for diarrhea and other infections.

We can save children's lives. We can prevent the nearly 10 million child deaths that will occur unnecessarily this year. We must begin by providing significantly increased funding for child survival in FY'09 and then increase our commitment each year, as called for in the McCollum-Shays bill. I urge members of this committee to cosponsor HR 2266 and look forward to hearing from our witnesses.

Mr. SMITH OF NEW JERSEY. Thank you very much, Mr. Chairman, and I thank you for calling this important hearing on child survival and the related issue of maternal health.

Mr. Chairman, as we know, reducing child and maternal mortality and providing quality health care and nutrition to ensure the well-being of both mother and baby has been one of my top legislative priorities throughout my tenure here in Congress. As early as 1985, I sponsored the child survival legislation that led to providing $50 million for what we then called The Child Survival Fund.

Members might recall that David Stockman, who was then the OMB director under Ronald Reagan, had zeroed out a new program that had begun just 1 year before sponsored by Gus Yatron and Tony Hall at $25 million. When that happened we were able to not just say no way, but we doubled it and I offered the amendment to make it $50 million. It put a very heavy emphasis on oral rehydration therapy, breast feeding, growth monitoring, and of course, on immunizations.

In 1989, I introduced legislation and proposed amendments that led to additional increased appropriations of $245 million, specifically for child survival activities and health, plus 10 percent for sub-Saharan Africa with a special emphasis on maternal and child health.

In the 1990s, Chairman Sonny Callahan did yeoman's work and boosted the Child Survival Fund even further, and he deserves an enormous amount of credit for his leadership as well.

Saving the lives of children is an issue that unites and can even stop wars, as we saw during the conflict in El Salvador. I will never forget what Jim Grant said in meeting in New York with President Duarte, "Why don't you hold a vaccination day?" President Duarte of El Salvador said, "Okay," and he did so, and the FLMN, despite the blood-letting that was occurring during those years, had a day of tranquility. Hundreds of thousands of kids, some put it as high as 200,000, were vaccinated against the five leading killers of children.

I went down with Jim Grant for that vaccination day. Experiencing it firsthand, I went to several vaccination sites. I saw the

church where many of the venues were, the boy scouts, and a whole mobilization of volunteers. The only shots heard that day were those immunization shots going into the hands of little children. It was a remarkable day and was followed by several other days, and then it was Central America-wide, and so many kids were saved from preventable diseases.

There is a universal recognition that children are a nation's most precious citizens, most vulnerable, most at risk citizens, and they demand every protection and safeguard society can provide.

In the latest State of the World's Children, UNICEF cites several important reasons why investing in the health of children is important. Besides the primary and most obvious reason of wanting to spare every child and his or her family unnecessary pain and suffering, there are societal considerations as well. A child who lacks basic health care and adequate nutrients is less likely to survive, will have more disease and illness, and be unable to develop thinking, language, emotional and social skills. Such a child is less likely to succeed in school and become a creative and productive member of his or her community.

Too many children lack not only what is necessary for them to thrive in life, but even what is necessary to survive in the first place.

Although UNICEF reports significant decreases in the number of neonatal and under-5 mortality rates between 1980 and 2000, the extremely high numbers of avoidable deaths still occurring give no reason to celebrate this outcome. The latest evidence indicates that some 4 million babies die each year during the neonatal period and that half of these infants die within their first 24 hours after birth. A baby is about 500 times more likely to die in the first day after birth than during the first month.

If we are to address these newborn and maternal death issues and go even further to ensure the healthy development of the baby throughout adolescence and the long-term health of the mother, the baby and the mother must be provided adequate nutrition and health care from the earliest stages of life prior to birth. Birth is not the start of life. It is an event that happens in the baby's existence as part of a continuum from the moment of conception.

We need to recognize this biological fact in terms of policy, funding, and programming, and treat both mother and unborn baby as two patients whose survival and well-being are mutually interdependent. This would significantly increase the baby's chances of survival following birth, and also reduce the risk of maternal mortality and morbidity.

Child survival revolution, in my opinion, must recognize, embrace, protect, and tangibly assist unborn children from all threats, including disease, trauma and abortion. Abortion is the antithesis of child survival, and is violence against unborn children. More children die from abortion, whether it be legal or illegal, than from any other cause. Dismembering an unborn child with sharp knives, pulverizing a child with powerful suction machines or devices, or chemically poisoning a baby with any number of toxic chemicals is child abuse no matter how many euphemisms are employed to sanitize this child violence. Any consistent definition of child survival must include the vulnerable child in the womb.

I am pleased to note that UNICEF recognizes that unborn children require care and nurturing, stating that "Significant improvement in the early neonatal period will depend on essential interventions from mother and babies before, during, and immediately after birth."

According to the latest estimates for 2000 to 2006, one-quarter of pregnant women in the developing world do not receive even a single visit from a skilled health personnel, doctor, nurse, or midwife, and only 59 percent of births take place with the assistance of a skilled attendant, and just over half take place in a health facility.

Yet, care for the unborn child cannot be restricted to medical consultations as important as they are. For example, in its child survival series, The Lancet identified fetal malnutrition and low maternal body mass index as likely factors in neonatal mortality rates and fetal growth retardation. Just as under nutrition is the underlying cause of a substantial percentage of all child deaths, so the mother's nutritional status has a direct bearing on the unborn child's development and ability to survive and develop normally following birth.

The Lancet stated that all countries need sound epidemiological information to prioritize, plan, and implement public health interventions. It added that neonatal deaths have only recently been identified as a global priority and concluded there was urgent need for further research in this area.

I would strongly suggest that such epidemiological information and research must be extended to the development needs of the unborn child addressed in conjunction with the needs of the mother in order to determine how prenatal care can be expanded and improved upon to care for both mother and baby prior to birth.

The United Nations Convention on the Rights of the Child in its preamble recognizes, and I quote:

> "The child by reason of his physical and mental immaturity needs special safeguards and care, including appropriate legal protection before as well as after birth."

The global survival bills that have been introduced in the House and Senate must provide significantly greater protection and have greater impact if they are to expressly include this right to health care. The draft legislation already references The Lancet and its finding that "maternal health is an important determinant of neonatal survival with maternal death increasing death rates for newborns to as high as 100 percent in poor countries." The purposes of the legislation should be expanded to include assistance not only to reduce mortality and improve the health of newborn children and mothers, but that of unborn children as well.

The Child Survival Revolution is not just for some children, it must be for all children, including those unborn. With this improvement, I think this legislation will speed itself through the Congress, and be signed into law.

I yield back.

Mr. PAYNE. Thank you very much.

Ms. Watson?

Ms. WATSON. Thank you so much, Mr. Chairman, for holding today's hearing in particular. It is very important because every day we have heard about 27,000 children between birth and age 5 die, mostly because of preventable diseases and conditions such as diarrhea and pneumonia. Factors such as malnutrition, unsafe drinking water, and inadequate access to vaccines contribute greatly to global child mortality.

Mr. Chairman, we know how to prevent most of these deaths, so we need to spend the necessary resources to do just that. We need to coordinate aggressive, accountable systems to address this global tragedy. The Global Child Survival Act of 2007 is about legislation which strengthens the United States Government's role in saving the life of children and mothers in poor countries. This act will continue the U.S. leadership in developing an integrated strategy for supporting the improvement and coordinating activities directed toward achieving child and maternal health goals.

The U.S. Government naturally needs to be cautious with its development policy because it is entrusted with the wise stewardship of taxpayers' dollars. However, if we were able to find new creative strategies to save children in poor countries, we need to sometimes be tolerant. What policies and systems can we put in place to encourage our foreign policy professionals, particularly our development professionals, to innovate?

Mr. Chairman, this hearing is essentially important because we are going to hear from the people on the ground responsible. So we need to be able to measure the results of our development aid so that we can ensure that all of the goals are met and lives are saved. So thank you so much.

Mr. PAYNE. Thank you very much.

One of the cosponsors of the legislation, Mr. Shays from Connecticut.

Mr. SHAYS. Mr. Chairman, could you defer to the sponsor, chief sponsor, and also I think a member of the committee.

Mr. PAYNE. Well, we are doing Democrat/Republican, so we will not do boy/girl too. [Laughter.]

But we will hear from the sponsor, Ms. McCollum from Minnesota.

Ms. MCCOLLUM. Well, I thank the gentleman from Connecticut for his allowing me to speak on this, but I think we speak with one voice on this issue, and so it is an honor to have Mr. Shays as a coauthor.

Chairman Payne, I want to thank you once again for inviting me to join this Subcommittee on Africa for this important hearing, and for all the great work you do. It is wonderful to be here with all of you.

Today's hearing is about children. It is about newborns, infants, toddlers; it is about hope, opportunity. As a caring nation, we have the responsibility to help moms and dads in the world's poorest countries keep their children alive. The United States has been a global leader in child survival for decades, and I commend USAID for its remarkable record. Investments in basic, low-cost interventions like antibiotics, oral rehydration solution, immunizations, micro nutrients, basic nutrition, health education, and maternal health have resulted in millions of children being alive today.

Many of us here today are parents, and we know every one of our children is precious. The parents in Liberia, Afghanistan, Haiti or Yemen, their child's life is just as precious to them, and they are in need of our help because many of their children are dying.

I am very proud to be the sponsor of H.R. 2266, The United States Commitment to Global Child Survival Act. Chairman Payne, thank you for being an original cosponsor. I thank the other cosponsors here today, Shays and Watson, and other subcommittee members, Jackson-Lee, Woolsey and Miller. And I would respectfully ask the other members of the subcommittee to seriously look for cosponsoring this legislation.

The goal of H.R. 2266 is not complicated. It increases the U.S. investment in child survival and directs the President to develop a comprehensive strategy to reduce mortality and improve the health of newborn children and mothers in developing countries.

H.R. 2266, if it becomes law, will save hundreds of thousands of newborns, infants, and toddlers. It will save their lives because they will not die from preventable diseases, diseases that are easily treatable.

Congress's commitment to invest in PEPFAR and the President's malaria and TB initiative is making a significant global health impact on killer diseases, but we must have balance. We must have a balanced approach to global health. Balance, in my opinion, is not minimizing or neglecting our investments in the lives of children and their mothers in poor countries because they are not dying of HIV/AIDS, and they are not HIV positive.

Last year around the world 2.5 million children died of AIDS. Diarrhea alone killed almost 2 million children last year. The cost is about 6 cents to treat and cure a child with diarrhea. In total, 10 million children under the age of 5 died last year, as many as two-thirds of those deaths were totally preventable. Eighty percent of America's global health investment is for HIV/AIDS. This investment is important, but it does not reflect the global disease burden or the mortality rates in poor countries.

For example, let me draw a stark comparison. Nigeria is a PEPFAR country in which 220,000 people died of AIDS in 2005. Yet in 2006, according to UNICEF, 1.12 million deaths of Nigerian children under the age of 5 were reported. Still, in 2009, the United States is proposing to spend 12 times more on HIV/AIDS than on all the other health interventions combined.

In Uganda, another PEPFAR country, 91,000 AIDS deaths were reported in 2005. The next year 188,000 Ugandan children died from diarrhea, pneumonia, malaria, and lack of immunizations and malnutrition.

In Afghanistan, there were 327,000 child deaths in 2006, that is one death for every four persons.

If this Congress invests in child survival, parents will watch their children grow, and they will know that the U.S. is a caring partner in their child's development. If we do not, if we allow the child survival budget to be cut in half, as it has been proposed in 2009, then we can be assured more children will die needlessly.

Chairman Payne, thank you for your commitment to all children around the world, and especially to the children on the African continent. I look forward to working closely with you and the Foreign

Affairs Committee on the markup of H.R. 2266. The Senate Foreign Relations Committee has marked up the companion legislation so we have a real opportunity to move this legislation forward and put it on President Bush's desk. In the year 2008, it is shameful that millions of children are dying needlessly. Let us all work together here in Congress and with moms and dads around the world to make sure that those lives are saved.

Thank you again, Mr. Chairman.

Mr. PAYNE. Thank you very much, and now Mr. Shays from Connecticut.

Mr. SHAYS. Thank you, Chairman Payne, and Ranking Member Smith, and Ambassador, as well as the chief sponsor of this legislation. I want to thank you for allowing me to participate in this hearing.

This legislation is one of the main reasons why I wanted to serve in Congress. It is so sensible. It is so logical, and it will mean so much to so many. As a former Peace Corps volunteer, I can speak to the benefit of a program that cares about children, that spends a minimal amount of dollars to save literally hundreds and hundreds of thousands of lives, if not millions, and I am just grateful that you are moving forward with this legislation.

You all have talked about the statistics. I will just align myself with the comments made. I hope that this legislation will not be viewed as an issue dealing with abortion or not. There is nothing in this legislation that would be promoting abortion, and so I hope that that is not the issue. What I hope is the issue is that we can spend 6 cents to save a life dying of diarrhea or pneumonia or malaria or measles, and that we would have the good sense to do that.

I want to particularly thank the One Campaign for what it is doing. I was in New Hampshire during the elections, and there was one somewhere in that audience and there certainly was in the John McCain events that I went to, and you helped educate a lot of people about this legislation. So I want to thank that grass root effort. I want to thank the U.S. Coalition for Child Survival, and I want to particularly thank Save the Children that is in our district, the 4th District, the district I am grateful to represent. It is an amazing organization. CARE, Mercy Corps, Catholic Relief Service, IRI, and so many others, there are literally hundreds of nongovernment organizations that, frankly, are accomplishing a lot more than we in Congress are accomplishing, and I just thank them for this effort.

So for me, this is a real special privilege to be able to listen to our witnesses, and thank the Majority Leader for his effort to bring attention to this issue, and all our panelists. Thank you again.

Mr. PAYNE. Thank you very much. Let me thank all of you for your opening statements. It shows that there is a tremendous amount of interest in this subject.

Our first panel we will have as our witness Dr. Kent Hill. Dr. Kent Hill was sworn in on November 2 of 2005 as Assistant Administrator for the Bureau for Global Health, U.S. Agency for International Development.

Mr. Hill had served as acting Assistant Administrator from January 21, 2005 until his confirmation by the Senate on October 7. USAID is the government agency that administers economic and

humanitarian assistance around the world. From November 2001 to October 2005, Mr. Hill served as Assistant Administrator for the Bureau for Europe and Eurasia at USAID.

As Assistant Administrator for the Bureau for Global Health, Mr. Hill is responsible for a bureau that in Fiscal Year 2006 managed or co-managed health programs all over the world with funding of more than $1.8 billion, estimated to be over $2 billion in Fiscal Year 2007. The bureau seeks to provide global leadership in the effort to improve the quality, availability, and use of essential health services. USAID focuses its efforts on HIV/AIDS, avian influenza, other infectious diseases such as tuberculosis and malaria, maternal and child health, family planning, environmental health, and nutrition.

Thank you for your service and your commitment, and we look forward to hearing your testimony.

STATEMENT OF THE HONORABLE KENT R. HILL, ASSISTANT ADMINISTRATOR, BUREAU FOR GLOBAL HEALTH, U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

Mr. HILL. Thank you, Chairman Payne, Congressman Smith, other distinguished members of the committee. I want to thank you very much for convening this important hearing, and let me just as a personal side note say that serving the administration now going on 7 years and having testified on many topics, but none, none is more important than what we are addressing this morning.

We want to commend and thank, from USAID, all of the Members of the Congress who have been so gracious and supportive of our work, including our work in child survival and maternal health programs. And we came here to witness to you, but I believe I could say on behalf of the audience here, we are already inspired by the compassionate pleas for involvement in this area by the committee itself. So thank you very much for that.

The support you have given us has enabled USAID to play a leadership role in an international child survival effort that has yielded some of the greatest improvements in global health ever seen, and this would not have been possible apart from your help.

Now let me put this in perspective. Because the revolution really began in the early 1980s, when USAID and UNICEF launched the Child Survival Revolution with the support of Congress, and at that point an estimated 15 million children in the developing world were dying every single year, and had there been no action in the early 1980s the number of deaths today, we estimate, would be about 17 million a year. And of course, with the larger population, that is part of the answer.

Instead, as you yourself have reported, a result of the global survival efforts by the United States and by others throughout the world by 2006 is that the estimated number of child deaths in the world was not 17 million, but had fallen below 10 million to 9.7 million. Something about the way this revolution has unfolded has worked and worked very well.

But I do not want to dwell there very long. What is particularly tragic about the remaining deaths is that most are preventable. Two-thirds are preventable. Every year 3.7 million newborns fail to survive even the first month of life. Each year .5 million mothers

lose their lives in the process of giving birth, and millions more suffer complications that produce life-long disabilities.

Because the survival and health of young children, especially newborns, starts with the health of their mothers and the care those mothers receive during pregnancy and childbirth, USAID integrates our programming to the fullest extent possible—an approach that increases the affordability and sustainability of our global efforts to tackle these important public health challenges.

Most of our missions, for example, already support integrated maternal and child health, and family planning, and malaria programs all together, and this helps to build broad-based health systems. Yet, there is an urgent unmet need to improve the survival and well-being of mothers, newborns, and children. USAID's continuing role in this effort focuses on three key elements to address this unmet need.

First, we support research to develop high-impact, low-cost interventions, such as ways to manage low-weight birth babies and to prevent and treat life-threatening infections of newborns.

Second, we support programs that deliver life-saving, high-impact, cost-effective interventions, such as immunizations, vitamin A, treatment of child illness, and essential newborn care.

Third, we help countries build the essential elements of health systems and human capacity they will need to sustain progress.

But I do not want to just talk in generalities. I want to be very specific about what we do and why it makes a difference. Let us start with Bolivia. As the government implemented a national health insurance system that covered maternity services, USAID trained health care providers in obstetric care and promoted culturally-appropriate birth practices and quality 24-hour-a-day care of women, and the results are as follows: From 1990 to 2004, maternal mortality dropped by 45 percent in Bolivia.

Or take the example of Ethiopia. Here we are supporting the government in extending access to basic maternal and child health care through training and deployment of thousands of new community health workers. The result: Ethiopia has seen under-5 deaths decline by almost 30 percent since 1998.

Or take the example of Nepal. We have been developing and scaling up a program that links female community health volunteers with a health system to bring vitamin A, immunizations, and the treatment of child illness to villages that in the past had no health care at all. The result: This program now reaches more than half the population of Nepal, and Nepal has recorded a decline in under-5 mortality of 41 percent since 1998.

Let us take a look at Afghanistan. After the Taliban fell in 2001, Afghanistan registered some of the most horrific health statistics in the world. They are: One in every four children in Afghanistan died before their first birthday, and one in six of every mother giving birth died in that childbirth.

USAID and its partners started immediately with measles immunizations and then set in place a program that provided a basic package of health services to mothers and children in rural Afghanistan. I visited those places. I have seen places where we were there to open a health care clinic, and Afghan militia were killed

trying to protect the health clinic we had just opened because they did not want to see the success of the program.

The program also paid attention to rebuilding key elements of the health system, including management, drug supply, and training. Here is the result of this: Since then, under harsh and insecure conditions, skilled attendants at birth in Afghanistan has tripled, and under-5 mortality has been reduced by 26 percent, saving the lives of 80,000 children per year. We are waiting for the results now of what it means that we tripled the attendance at birth of skilled attendants, but we believe it is going to show a similar decline in maternal mortality.

The written testimony, by the way, has other examples and those of you who really care about this, I think you will find them there, including ones in Indonesia.

These countries demonstrate that it is possible to make real progress despite continuing poverty, instability, and even conflict. As shown in the display chart, this progress also is occurring more broadly in USAID-assisted countries in the world, and I want to mention these charts. I am sorry you cannot see them, but you have the charts in the materials that you were given. But the audience does not have them.

This one here which shows the percent declines in under-5 mortality from 1998 to 2006, even if you cannot read the fine print, you can see which way the bars are going.

Mr. SHAYS. Could you hold up a chart there to show us which one is——

Mr. HILL. Sure.

Mr. SHAYS. This one here?

Mr. HILL. It is the one with the bars. That is exactly right. And it lists them where the decline has been as much as 50 percent in Cambodia, going down through Malawi and Indonesia, and it varies between 50 percent and 20 percent, averaging about 33 percent between these years 1998 and 2006. That is a decline in under-5 mortality using, as I think Madam McCollum noted, the interventions that work that we know how to do. We do not have to invent.

The 15 countries that are on that chart show that 33 percent decline. Now, I want to insert something here before I talk about this chart. I want to put this in perspective for us.

We talk about things coming down. But we do not often make the comparison we ought to make between what it is like to be lucky enough to live in the industrialized world and what is not so lucky to be living someplace else in the developing world. Let us start with the maternal mortality ratio.

If you are lucky enough to be in the developed regions of the world, out of every 100,000 live births, nine mothers will die. And in the United States, it would be 11 mothers would die out of 100,000 births. The average ratio in the developing world is 533—a huge increase in the risk of dying if you do not happen to be in the developed world.

Or take the WHO, UNICEF, World Bank, UNFPA numbers that have to do with the under-5 mortality rate. What is it like if you live in the United States? It would be eight out of every 1,000 would die before their 5th birthday, where in most industrialized countries on average would be 6. What is it in the rest of the

world? Well over 10 times that many. Seventy-nine out of every 1,000 die in the developing countries. That is what these charts are talking about.

If you look at this chart, you can see that the lines are going down, and it shows you the maternal mortality in those 10 countries is going down steadily over a period of years. We find it more difficult to bring the lines down here. We need to do more. We need to do more copious work to get that done.

But in those 10 countries, even there, 10 of those USAID-assisted countries had a decline of 32 percent. This progress is the result of USAID working hand in hand with many partners, combined with commitment and leadership by countries themselves. Much, much, more remains to be done.

We at USAID believe that there is now an important opportunity to reach more newborn children and mothers to accelerate the progress. New resources are appearing from partners like the Gates Foundation, the U.K. and Norway, and we are seeing increased attention to reaching the Millennium Development Goals for child survival and maternal health.

Countries like India are substantially increasing their own investments in maternal and child health. These new developments and resources provide an important opportunity for the United States to help reach more children through leveraging non-USAID resources and co-investments by USAID. We have a recognized leadership role in the global child survival and maternal health arena. USAID is unique among international partners in child survival and maternal health. Let me tell you why.

We have the technical expertise to support ground-breaking research and to guide development of solid evidence-based programming. We have the missions on the ground that can adapt this evidence to each country's situation, and coordinate our support with other donors and with other government strategies. And we have the strength of our partnership with NGOs, with faith-based and other civil society organizations, and with the private sector of both the international and the country levels. And now with the support of Congress, we have additional resources to apply these strengths. I am pleased to share with you how we intend to maximize the use of any funds that can be appropriated after they are authorized.

We plan to focus the major share of these resources in approximately 30 USAID-assisted countries that represent 50 percent of the maternal and child deaths worldwide. We will work with these priority countries to achieve and sustain the greatest possible reduction of maternal and child mortality and malnutrition through programs.

What do they do? They identify and scale up high impact interventions that are relevant to each country. They will strengthen the health systems and human capacity. They will link the water and sanitation investments to improve children's health. They will complement USG donor and other host country resources, and in difficult settings, post-conflict settings like Liberia or the Democratic Republic of Congo or Southern Sudan, we will expand basic services as quickly as possible while rebuilding the foundations of the health systems.

Now, what is this actually going to mean? One of you made the comment, "We have to be accountable." What is the goal and are we going to be able to reach it? By 2013, we believe we can aim to achieve at least an average 25 percent reduction of maternal and under-5 mortality in those 30 priority countries, as well as an average 15 percent reduction of child malnutrition in at least 10 of those countries. And at the same time, we recognize the critical human resource constraints toward progress in many countries.

Therefore, as part of the plan, we are making a commitment to increase, by at least 100,000, the number of trained, equipped, and supervised community health workers and volunteers. In this work, we will continue the successful collaboration we have with other U.S. agencies in our work in family planning, water and sanitation, immunizations, polio eradication with the CDC, new vaccine development with NIH, PEPFAR, and the President's Malaria Initiative.

As I conclude, I just want to emphasize how much we appreciate this opportunity to share with this committee the work of USAID in this vitally important area of maternal and child health. USAID shares your commitment to make a difference. I want to end with some words that I learned long ago when I was in college, and remember reading the works of Albert Camus, although Albert Camus is often a depressing writer and I acknowledge that. I think I was quite depressed in college myself. But one of the phrases that he used that I have never forgotten and I have used in speeches ever since, and it is a paraphrase of Albert Camus here: He said, "Perhaps we can do nothing about living in a world where children suffer, but we can lessen the number that do."

Thank you very much.

[The prepared statement of Mr. Hill follows:]

PREPARED STATEMENT OF THE HONORABLE KENT R. HILL, ASSISTANT ADMINISTRATOR, BUREAU FOR GLOBAL HEALTH, U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

Chairman Payne, Congressman Smith, and other distinguished members of the Committee, I would like to thank you for convening this important hearing. I especially thank you and the Congress for the sustained support provided through the years for our Child Survival and Maternal Health programs. That support has enabled USAID to play a leadership role in an international effort that has made significant improvements in maternal and child health. And, we greatly appreciate your recognition of USAID's contribution to this effort.

I first want to acknowledge the importance of the theme that you have set for this hearing, the "unmet need" for progress in child survival. I will tell you about some of the important successes of USAID's child survival and maternal health programs because these successes are what give us confidence that we can meet this "unmet need." I then will briefly discuss why this is a good time to hold this hearing and the special opportunities that exist to accelerate progress in child survival. In closing, I will describe our strategic approach to achieving the greatest impact on maternal and child mortality with the resources we have. Our goal is for our programs to build sustainability.

Despite significant progress in reducing child deaths, almost 10 million pre-school children die each year, almost all of them in poor countries. What is particularly tragic is that most of these deaths are preventable. Almost four million deaths are newborn infants who do not survive beyond the first week or month of life. By the time many children reach school age, the effects of illness and malnutrition have reduced permanently their potential to learn, grow, and be productive citizens of their countries.

We appreciate your recognition of the urgent need to improve the survival and well-being of mothers. USAID's approach to child survival and maternal health is integrated because we know that the survival and health of young children, especially newborns, starts with the health of their mothers and the care those mothers

receive during pregnancy and childbirth. Each year, half a million mothers still make the ultimate sacrifice, losing their lives in the process of giving birth. Millions more suffer complications that produce lifelong disability.

For a quarter of a decade, with the support of Congress, USAID has been working to improve the survival of mothers and children. When the U.S. Child Survival program began in the early 1980s, almost 15 million children died each year in the developing world. If the global community had done nothing, with the increasing number of children born each year, that number now would have reached 17 million. USAID and UNICEF, however, chose to launch the "Child Survival Revolution" that has become a global collaboration with other donors, multilateral organizations, U.S. private voluntary organizations and NGOs, researchers, the private sector, and, especially, country governments. As a result of all these efforts UNICEF announced in 2007 that the estimated number of child deaths in the world had fallen below 10 million annually. That number is still far too high, but the drop does mean that our efforts have made a real difference.

USAID works to address the "unmet need" in child survival and maternal health through discovery, diffusion and scale-up, and long term sustainability of effective health interventions.

- We support research to develop high impact, low cost interventions, for example, ways to treat low birth weight babies, prevent and treat life-threatening infections of newborns, and save mothers from bleeding to death after giving birth.
- We support countries to expand their use of new and existing high impact, cost-effective interventions, for example, vaccines, vitamin A, treatments for sick children and mothers in pregnancy and childbirth, newborn care, breastfeeding and improved nutrition for children and pregnant women, and improved household water quality.
- We help countries build the essential elements of health systems and human capacity they will need to sustain progress in maternal and child health.

I would like to provide some successful examples of USAID's programs.

1. In Indonesia, USAID has a long history of supporting the Government of Indonesia's maternal health program, focusing primarily on strengthening the capacity of skilled birth attendants to provide basic essential obstetric care, including prevention of bleeding immediately after birth, the leading cause of maternal mortality. According to a global survey, Indonesia had the highest use of active management of the third stage of labor to prevent bleeding. From 1992 to 2000, maternal mortality dropped by 21 percent.
2. In Bolivia, as the government implemented a national health insurance system that covered maternity services, USAID trained health care providers in obstetric care and promoted culturally appropriate birth practices and 24-hour-a-day quality care of women. From 1990 to 2004, maternal mortality dropped by 44 percent.
3. In Bangladesh, home-based essential newborn care, coupled with successful identification and treatment or referral of newborn infections by trained community health workers, reduced newborn mortality by 33 percent in a pilot program supported by USAID. The Government of Bangladesh now has developed a newborn health strategy to scale up lessons learned from this pilot. USAID has replicated this low-cost, high impact approach of reducing newborn mortality in several other countries.
4. In Ethiopia, we are supporting the government in extending access to basic maternal and child health care through training and deployment of thousands of new community health workers. At the same time, we are helping to strengthen Ethiopia's health system through a new national drug logistic system, an improved health information system, and a strengthened ability to estimate costs and budget for basic health services. Ethiopia has seen under-five deaths decline by almost 30 percent since 1998, supported by these changes.
5. In Nepal, we have been developing and scaling up a program that links female community health volunteers with the health system to bring vitamin A, immunization, and treatment of child illness to villages that in the past had no health care. This program now reaches more than half the population of Nepal. Nepal has recorded a decline in under-five child mortality of 41 percent since 1998.
6. After the fall of the Taliban in 2001, Afghanistan registered some of the worst health statistics in the world: 1 in 4 children died before his/her first

birthday and 1 in 6 women died in childbirth in her lifetime. USAID and its partners started immediately with measles immunizations and then launched a program that provided a basic package of health services to mothers and children in rural Afghanistan. The program also paid attention to rebuilding key elements of the health system, including management, drug supply, and training. Since then, under harsh and insecure conditions, skilled attendance at birth has tripled and under-five mortality has been reduced by 26 percent, saving the lives of 80,000 children per year.

These countries demonstrate that it is possible to make real progress despite continuing poverty, instability, and sometimes conflict. As shown in the displayed chart, this progress also is occurring more broadly in USAID-assisted countries throughout the world. The 15 countries show an average 33 percent reduction in under-five child deaths.

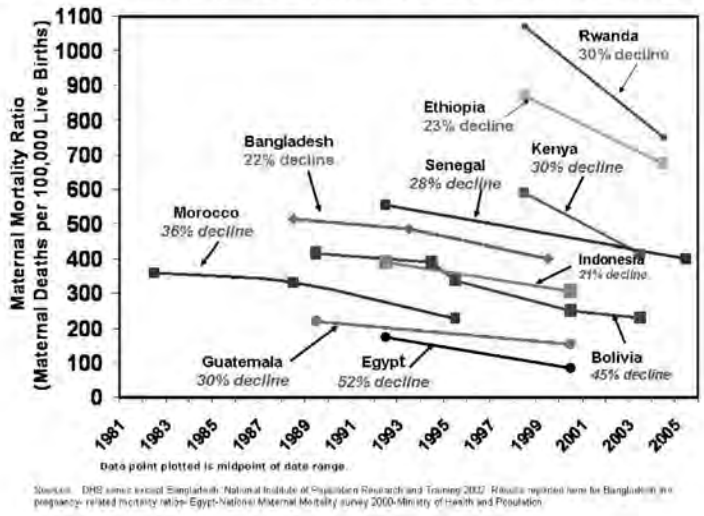
15 USAID- Assisted Countries Achieving 20-50% Reductions in U5 MR in the Last Ten Years:

Country	Under-5 Mortality (deaths/1,000 births)	Year	To	Under-5 Mortality (deaths/1,000 births)	Year	Percent Reduction
Bangladesh	106	1998	→	69	2006	35 %
Bolivia	85	1998	→	61	2006	28 %
Cambodia	163	1998	→	82	2006	50 %
Ethiopia	173	1998	→	123	2006	29 %
Guatemala	52	1998	→	41	2006	21 %
Haiti	130	1998	→	80	2006	39 %
India	105	1998	→	76	2006	28 %
Indonesia	56	1998	→	34	2006	39 %
Madagascar	157	1998	→	115	2006	27 %
Malawi	213	1998	→	120	2006	44 %
Mozambique	206	1998	→	138	2006	33 %
Nepal	100	1998	→	59	2006	41 %
Pakistan	136	1998	→	97	2006	29 %
Philippines	44	1998	→	32	2006	27 %
Sudan	115	1998	→	89	2006	23 %

Source: State of the World's Children reports, 2000 & 2008

Similarly, this graph shows that within relatively short periods of time maternal mortality has declined on average 32 percent in 10 USAID-assisted countries.

10 USAID- Assisted Countries Achieving 20-50% Reductions in Maternal Mortality



Sources: DHS surveys except Bangladesh: National Institute of Population Research and Training 2002. Results reported here for Bangladesh are pregnancy-related mortality ratio• Egypt-National Maternal Mortality survey 2000-Ministry of Health and Population

This progress is the result of USAID working hand-in-hand with many partners, including the private sector and civil society, other international bilateral partners, and the country governments. Nevertheless, much remains to be done. In countries where infant and child mortality has declined, newborn mortality still remains high. Globally, newborn mortality now accounts for almost 40 percent of under-five mortality.

Some countries, particularly in Africa, have made slow or no progress toward the child mortality and maternal health Millennium Development Goals (MDGs). Countries in Asia and the Americas show progress at the national level on meeting these MDGs, yet this progress often masks growing health disparities within countries.

We at USAID believe it is possible to reach more newborns, children, and mothers and accelerate progress toward the respective MDGs. In the past few years, new resources and commitments have appeared, which we believe can lead to a "second wave" of global efforts to increase child survival:

- New resources are available from private sector partners like the Bill and Melinda Gates Foundation, bilateral donors such as the U.K. and Norway, and multilateral partners, including UNICEF.
- The MDGs are stimulating increased international and country-level attention to the need for accelerated progress to reach the child and maternal survival goals.
- This attention is producing new international cooperation such as the interagency "Countdown 2015," which will monitor and report on progress toward these goals in 60 priority countries.
- The African Union recently approved a new "Framework for Accelerated Progress in Child Survival." Work on a similar regional collaboration for maternal and child health is beginning in Asia.
- In response to these MDGs and countries' commitment to accelerate social development, some countries are substantially increasing their own investments in maternal and child health. India is an impressive example where a Prime Ministerial "National Rural Health Mission" represents the commitment of more than two billion dollars a year to improve health status among the underserved poor.

These new developments and resources provide an important opportunity for USAID to leverage non-USAID resources to provide more assistance. We have a recognized leadership role in the global child survival and maternal health effort. USAID is unique among international partners in child survival and maternal health:

- We have the technical expertise to support ground-breaking research and to guide development of solid, evidence-based programming;
- We have Missions on the ground that can adapt this evidence to each country's situation and coordinate our support with other donors and with government strategies, and
- We have the strong partnerships with NGOs, faith-based and other civil society organizations, and the private sector at both international and country levels.

We see USAID's approach as supportive of the recently endorsed Paris Declaration principles that promote:

- leadership in development activities by countries themselves;
- alignment of foreign assistance with countries' own priorities, systems, and approaches;
- harmonization among external partners to reduce the complex burden of assessments, plans, monitoring approaches, and reporting; and
- results-oriented investments by both countries and their donor partners.

Now with the support of Congress, we have additional resources to apply these strengths. USAID focuses its strategic approach in child survival and maternal health to achieve the greatest possible health and development impact with our maternal and child health resources.

We plan to use the major share of those resources in approximately 30 USAID-assisted countries that represent at least 50 percent of maternal and child deaths worldwide. These countries are characterized by:

- the highest numbers and rates of child deaths;
- commitment of the host country government to work with partners and civil society for accelerated reduction of maternal and under-five mortality;
- capacity of the USAID mission and the country to manage and program increased resources, and
- opportunities to interact with other resources, including other USG investments such as PL 480 Title II, the President's Malaria Initiative, the President's Emergency Plan for AIDS Relief (PEPFAR), and our own emergency programs as well as the investments of other donors, multilateral agencies, the Global Fund, and others.

Given the political, cultural, and epidemiological context as well as the available resources and infrastructure, a deliberate process to determine the best mix of key interventions must occur for each priority country. Through our Missions and Regional Bureaus, we will work with these priority countries to achieve and sustain the greatest possible reduction of maternal and child mortality and malnutrition with programs that:

- identify and scale up the high impact interventions most relevant to the country;
- strengthen health systems and the human capacity to support and sustain improved child and maternal health outcomes;
- link water and sanitation investments to improved children's health;
- complement other USG, donor, and host country resources, and
- in post-conflict settings such as Liberia, Democratic Republic of Congo, and southern Sudan, extend basic services as quickly as possible while rebuilding the foundations of health systems.

By 2013, we aim to achieve an average 25 percent reduction of maternal and under-five mortality in these 30 priority countries as well as an average 15 percent reduction of child malnutrition in at least ten of these countries.

At the same time, we recognize the critical human resource constraints on progress in many countries. Therefore, as part of our plan, we are making a commitment to increase by at least 100,000 the number of trained, equipped, and supervised community health workers and volunteers serving at the primary care and community levels in these priority countries. This measurable health system change will provide and extend critical health services in the countries and communities which need them most. The success of these community health workers and volunteers will depend upon a health system that can deliver the necessary interventions and commodities and also ensure quality of care and retention of these workers.

In this work we will continue the successful collaborations we have with other USG agencies. This includes our work with CDC on family planning, water and sanitation, immunizations, and polio eradication, and our work with NIH and others on new vaccine development as well as our collaboration with PEPFAR and the President's Malaria Initiative.

Thank you again for this opportunity. We at USAID share the commitment you have demonstrated to the continuing needs of children and families in poor countries.

Mr. PAYNE. Thank you very much for that very comprehensive testimony. I understand you have to leave. I wonder how soon you have to leave.

Mr. HILL. I can take a few questions. I am headed to Lansing to give a speech.

Mr. PAYNE. Well, let me just ask a quick question and then we will see if we can get each person to answer a question. This year there has been a request in the budget for $369.5 million, $77 million less than 2008. We have fluctuated between 350 and 450 throughout the years, and I just wonder if you have any rationale why the President requested a decrease in the funding of these programs.

Mr. HILL. It is an important question, and I will answer it in two ways. One, I think the most delicate and difficult process for all the bureaucrats who are responsible for trying to make something happen is what happens with OMB and the administration, and eventually with Congress about how you divide up whatever pot of money you think you dare ask for in a given year. And there are a lot of competing priorities, and there are some major concerns about the debt and priorities overall in the budget, and even priorities within the health budget.

Personally, I wish the number could have been higher. I suppose most of my colleagues and other representatives of the program would say the same thing, and we're never completely satisfied.

I would point out one thing that is often missed, though, in the discussions. If you look just at the account within child survival and health that has to do with child and maternal health, you are right to point out that it goes down. But it would be a mistake to believe that the only parts of the budget that affect child and maternal health are in that account.

Since about 1 million die every year of malaria, the President's goal and the President's Malaria Initiative is to have 85 percent coverage, and then have a 50 percent mortality reduction success in the huge ramp-up of the President's Malaria Initiative. When I came to work at the Global Health Bureau, we were going to spend $35 million that first year on the President's Malaria Initiative. It is up to $300 million this year. We could not touch most of those debts. Now we have the opportunity to make a big difference. It is child and maternal health working on malaria, and the HIV and the PEPFAR, and I fully accept the observation that a lot of money is going into PEPFAR. You do not always give credit to PEPFAR for its impact on child and maternal health.

The reason that Congress, in a bipartisan way, became so exercised to try to do the most they could, why they have increased the amount from $30 billion to $50 billion in the President's draft, is because they are so afraid of what will happen if the pandemic expands dramatically. The impact would be in terms of children, in

terms of orphans, in terms of the deaths of children and mothers, and the vulnerability of mothers to all sorts of things if their immune system is impacted. That means that if PEPFAR succeeds, the impact on children and mothers will be dramatic.

So do not just look at the number that has to do with child and maternal health within the budget. It is impacted by lots of other things as well.

Recently on his trip to Africa, the President announced the new initiative of $350 million on neglected tropical diseases over 5 years. This will have a huge impact on children and on mothers. There are whole villages in Africa where everybody is blind. The burden on society, the suffering of children—all of these things are impacted. So although I would be less than honest if I did not tell you I would like to see that account higher than it is, and I hope that the authorization dreams of this legislation will be fulfilled in subsequent years, and whether I am in government or out of government, I will support that. I hope the appropriations can go up significantly because this is one area we are talking about low-hanging fruit. For every $100,000 more you spend, you can measure it tangibly in terms of lives saved and suffering averted.

Mr. PAYNE. Mr. Smith.

Mr. SMITH OF NEW JERSEY. Thank you very much. I know we are almost out of time.

Just briefly on the sustainability of the immunizations campaigns. There is always concern that there would be fall-off after a heightened focus, and secondly, very important, and I referenced this in my opening comments, the unborn child as a patient. Low birth weight babies do not get that way while they are traversing the birth canal. Obviously, that all happens prenatally. More needs to be done, and we need to get rid of this myth that somehow an unborn child is not human and alive. Ultrasound has shattered that myth, hopefully forever.

So what can we do, should we be doing definition-wise so that no child is left behind, including the unborn child, in child survival programs?

Mr. HILL. I think you are very right to point out that all the global experts in health will say a key to what happens in terms of the health of both the mother and the child is what happens in the 9 months before the child is born, and there is just no question about it. If there was not agreement on that, we would not be doing all the programs we do that have to do with immunizations and nutrition, et cetera.

So the empirical evidence as we understand that something is going on in the womb that is tremendously important, and if it does not develop right, it is going to cause a lot of suffering later on.

So your point to draw a red line between birth and the 3 months before or even before that, I think is on target in terms of the logic of that. We do our best in ante-natal care to deal and help the mothers and the children to be, and so I think you are right. That is part of what we are trying to do in terms of child survival and maternal health—to make sure that all goes well from the time of conception, right up to birth and beyond.

Mr. PAYNE. Thank you. Mr. Shays?

Mr. SHAYS. This could be just a yes answer, and if it is not a yes answer, then it will need an explanation. Does the administration support H.R. 2266, the Global Child Survival Act?

Mr. HILL. I have never been told that I could say one thing or another on that, so I am going to take the liberty of saying this is an authorizing piece of legislation which, as I understand it, says this is the kind of ceiling.

Mr. SHAYS. Right.

Mr. HILL. We think the need is this great, and to the extent future congresses and administrations can find the money to do it, it makes all the sense in the world.

Mr. SHAYS. I am going to cut you off right there.

Mr. HILL. I think the answer is yes. [Laughter.]

Mr. SHAYS. Thank you very much.

Mr. PAYNE. Let me just ask one other quick question. I look at the funding and I just wonder what the criteria would be for how funding is, for example—oh, Mr. Boozman, Dr. Boozman snuck in here. He must have a question. No. Okay, I apologize.

I just wondered, the administration proposes, for example, spending $20 per child per death in Ethiopia, whereas in Jordan, it is $3,500. In other words, for Ethiopia where 389,000 children die under 5, the administration asks for $8.1 million, but in Jordan where 4,000 under 5 die, there is a proposal for $14 million. So you have a disproportion.

How is that criteria determined?

Mr. HILL. Well, there are factors involved in allocating development funds that are not entirely related just to health. That has certainly been the case from the very beginning, and it does turn out sometimes that large sums of money have gone to countries that have been more developed, in one sense, and seem to be less a need than some countries with very large populations.

Sometimes that is because we have wanted to encourage a strategic relationship with the country, and we have done it through some of our development programs. We have done this with Israel. We have done it with Egypt. We have done it with Jordan. And we have done it with other countries in the world, and we will probably continue to do it.

The good news about the topic we are dealing with today is that there is such a wide bipartisan consensus, that in places like Nigeria or Ethiopia or the big countries, Bangladesh, one of the most densely populated in the world, I do not know of people who are not willing to stand up and say, If we could find more money to do this, we should. We have a moral obligation and I would argue that it is in our pragmatic best interest to expand our work in those areas.

Mr. PAYNE. I know that there is a lot of work that needs to be done, but I notice that in a number of programs, for example, Water for the Poor Program, which is supposed to go to the places that need water programs the most, but we find the same thing, that Jordan and Iraq and others receive adequate funding. It seems like there is some rationale that is going into allocating these funds. If we have to fund programs over there, maybe we need to put it into the Defense Department. But if you have a program for

Water for the Poor, you would think that the countries like Nigers, who is practically out of water, would receive adequate funding.

Mr. HILL. Right.

Mr. PAYNE. Chad, they are not even in the program, but it is Afghanistan, Iraq, it is Jordan, and so they need it too but we are really short-changing those places that need it the greatest.

I am going to miss the vote so, unfortunately, I am going to have to leave, and I know you have to go. I might have missed the vote already. But the meeting stands adjourned for a recess until we come back in about 10 minutes, hopefully.

[Recess.]

Mr. PAYNE. We are very pleased to have our second panel. The witnesses on Panel II are Senator William Frist; Mr. David Oot; Dr. E. Anne Peterson, Dr. Pierre-Marie Metangmo; and Dr. Robert Walley.

The Honorable William Frist will be our first witness on this panel, and I will introduce each of the panelists, and then we will start with Senator Frist.

Senator Frist currently serves as a Visiting Professor of International Economic Policy at Princeton University's Woodrow Wilson School of Public and International Affairs where he teaches graduate and undergraduate courses in health-related care, economics, and policy. Senator Frist represented Tennessee in the U.S. Senate in 1995 until his retirement in 2007, serving as Majority Leader from 2003 to 2007.

With his 1994 election to the U.S. Senate, Senator Frist became the first practicing physician to serve in the legislative body since 1938. He rose to the Majority Leader just 8 years after his election, having served less time in the Congress than anyone ever to hold the leadership position on that level.

Senator Frist who strongly advocates executive-level involvement in charitable causes currently serves on numerous prestigious boards. Among them are Africare, the Center for Strategic and International Studies, the U.S. Holocaust Museum's Committee on Conscious, the Clinton Global Initiatives, Global Health Working Group, Save the Children, U.S. Global Leadership Campaign Advisory Committee. We have traveled to Sudan together and he has done medical procedures for many years where he would go during his recess time and is still doing that, so we really appreciate the wonderful work that you have done in your life and continue to do.

Dr. Oot serves as the Associate Vice President for Health at Save the Children, U.S.A. In that capacity is responsible for managing a diverse portfolio of maternal newborn child and adolescent health activities, and oversees the delivery of technical support and assistance to over 40 countries worldwide. David began his career as a Peace Corps volunteer in India in the mid-sixties and subsequently served as a health officer with the U.S. Agency for International Development in Vietnam and Pakistan, Thailand, Kenya and Nepal as Chief of Population Health and Nutrition in USAID's Bureau for Asia and Director of USAID's Global Bureau, Office of Health and Nutrition.

Mr. Oot currently shares the Steering Committee of the U.S. Coalition for Child Survival, and is a member of the International Health Section Council of the American Public Health Association.

He has a graduate degree in public health from the University of Michigan, and I think you join your former Peace Corps volunteer, Mr. Shays.

Mr. SHAYS. Do I look older than he looks? [Laughter.]

Mr. PAYNE. If you go by the hairline. [Laughter]

Mr. SHAYS. No applauding in the audience. [Laughter.]

Mr. PAYNE. Dr. E. Anne Peterson is a long-time public health physician whose career has spanned the globe from teaching doctors in rural African villages to the decision tables of Washington, DC. For almost 6 years in sub-Sahara Africa—Kenya and Zimbabwe—she focused her expertise on community development, public health training, and AIDS prevention. Dr. Peterson consulted for the Centers for Disease Control and Prevention, and the World Health Organization in Haiti and Brazil and served for 3 years as the Health Commissioner for the State of Virginia.

Prior to joining World Vision, Dr. Peterson was Assistant Administrator for the Bureau of Global Health at USAID. She led U.S. Government's international health policies and represented the U.S. on boards such as the Global Fund to fight AIDS, Tuberculosis and Malaria, GAVI, Stop TB, and the Child Survival Partnership.

Currently, she is Director of the Center for Global Health within World Vision's new Strategy Unit, guiding World Vision's refocus and re-invigorated efforts to improve the health and well-being of children.

Dr. Pierre-Marie Metangmo currently serves as Dean of the Future Generations Graduate School and Applied Community Change and Conservation. In this capacity, he guides the development of practical instructional programs and curricula, creates training programs that meets the needs of multiple communities, oversees student practicum and teaches and mentors Research Design and Methods.

He has had over 20 years of international public health and management experience and leadership. Born in Cameroon, West Africa. Dr. Metangmo has worked for the past 10 years in the United States, and worked as Plan International's Senior Child Survival and Health Programs Specialist. In this capacity, he has provided technical management and training in the form of program design, management, implementation, monitoring and evaluation in the technical areas of child survival, maternal and child health, reproductive health, HIV/AIDS, tuberculosis and tropical disease control in over 30 developing countries.

Dr. Walley, Dr. Robert Walley was educated in Pune, India and London, England, and qualified in medicine at London University in 1963. His residency training was in London, and at the University of Toronto. His firsthand experience in West Africa beginning in 1981 prompted him to initiate the formation of the MaterCare International in 1995. This nongovernmental organization is interdisciplinary and made up of obstetricians, gynecologists, midwives, bioethnics, and administrators and many supporters around the world who are dedicated to improving maternal health care worldwide through new initiatives of service training, research and advocacy based on the ethic that all mothers and babies matter.

Dr. Walley has developed new approaches to the delivery of maternal health care in Nigeria and Ghana, and is presently involved

in developing similar projects in Sierra Leone, Rwanda, and Kenya. Dr. Walley was asked to conduct maternal needs assessments of refugees in Albania during the Kosovo crisis and East Timor following the withdrawal of occupying forces there.

Thank you all for being here, and we will start with Senator Frist.

STATEMENT OF THE HONORABLE WILLIAM FRIST, CHAIRMAN, SURVIVE TO 5 CAMPAIGN, SAVE THE CHILDREN (FORMER UNITED STATES SENATE MAJORITY LEADER)

Dr. FRIST. Thank you, Mr. Chairman, Mr. Smith.

Since we have been here today, about 2,000 children have died over the last hour or so, and I think the remarkable thing about that, and really goes right to the heart of why we are here today is that about 1,500 of those kids who an hour ago were alive could be alive today by taking actions that we in some ways celebrate today because we all know it is the right thing to do, but it is ultimately going to take action.

To do that, very different than when I was doing heart transplants or treating people, individuals one on one for cancer. To do it, it is cheap, cheap, inexpensive. It is proven. It has been previously demonstrated, and the techniques and the tools are readily available. You cannot really say that about any other real piece of legislation that we have had to deal with as colleagues, when I was a colleague, or really probably before you as legislators today. And that is the remarkable thing, just putting those two facts together.

Just speaking from the heart, I spent 20 years in medicine healing or doing my best to heal one on one, going back to that individual life that all of this comes back to, and then came to Washington and spent 12 years in the United States Senate, and ultimately leader of that body, and then left. And the fact that I am here today really for my first sort of public/private event, I hope demonstrates to you that based on my observations of 20 years of healing directly one on one, and then 12 years in the United States Senate, trying to do what all of you are really all about today, and that is healing, that it is back at this hearing, back at this legislation, back on this particular issue Dr. Hill mentioned today, there is nothing else that is quite like this, and that is really my observation, that is why I am here.

I appreciate, Mr. Chairman, and all of you, the invitation to be here to share my quick thoughts.

I do come before you today as chairman of the Survive to 5 Campaign, as a product of an initiative with Save the Children who, just like you and I traveled to Africa together, with which I have had the opportunity to travel to Africa, to Bangladesh, looking very directly through the eyes of someone in the position of a policymaker. What can be done? And I conclude that through this bipartisan legislation, pulled together, that we can have a huge impact in reversing this course of humanity, the oneness of humanity.

The goal of our Survive to 5 is basically what it says, and that is to increase the survival where we know that we have now about 10 million deaths, about 27,000 children die every day, to increase that survival and doing that through these cheap, inexpensive, proven and demonstrated tools.

Statistics clearly show that if you get through that first day where you have 2 million deaths every year, and you get through that first month and you get through that milestone year of 5 years of age, then the odds of really blossoming into a productive life, a happy life, a fulfilling life, the dream that we all envision, that all of us who have children of our own, becomes a reality.

Number one, when children die needlessly, when we know we have these effective therapies that are cheap, inexpensive and proven, and easily available, it is clearly a moral imperative. It is the right thing to do as individuals, as communities, as states, and indeed as a nation. And this has been a guiding principle for our country throughout the great history that we have all seen, really an experiment in democracy. And it is this impulse that springs from our conscious, and it is one that represents the highest ideals of what being a person is all about, and clearly what that American flag represents, what being an American is all about.

Secondly, scaling up our child programs, the survival programs, and leading other nations to follow with what we do practically, but also what we represent with this voice also serves our national security interest. And I mention this, not the reason for doing it, but as Chairman Payne said, I have had the opportunity as Majority Leader, as a United States Senator, of going just about every year somewhere in the developing world, and very quietly working on the ground, doing medical procedures, treating young children, older people. And I have seen the trust that is engendered by that mere presence, and in the war-torn zones, whether it is in Southern Sudan, in Northern Uganda, they are working, and you are healing and you are delivering life and helping facilitate life, there is a trust that is built up and all of a sudden fighting stops built on that trust. I call it Currency for Peace. You can call it any number of things, but it is what we have as an opportunity both before us in addition to that moral imperative.

The despair that comes when people die very early, whether the maternal deaths or in that first day of life or that first month or the first 5 years, it breaths despair. And out of that despair we know that the potential for terrorism can come. I put that out there because others probably do not talk about it, but I do think it is important, at least based on my own experience.

The 9/11 Commission concluded that when people lose hope, when societies break down, when countries fragment, the breeding grounds for terrorism are created. Diplomacy undermines that ideological support of terror by shining a light of trust, of compassion on these hate-filled propaganda proposals that are fed into an island of despair.

Last summer I did have the opportunity to visit Bangladesh. We saw Bangladesh on an earlier chart today where there has been huge progress with a 25 to 30 percent improvement in child mortality. I had the opportunity to work side by side with other community health workers, and with some of the doctors doing the very simple things that we know make such a profound impact.

I met with the Minister of Health there who offered his country's profound thanks to the United States of America for assisting in reducing child mortality, a true success story as we saw many success stories, as we worked side by side, NGOs working with our

Government, and most importantly, with the local communities to help deliver focused case, establish this prevention.

A recent PEW global attitude survey shows that Bangladeshis have one of the most favorable views of the United States in the entire Muslim world. This support is due largely to the assistance we have provided Bangladesh since its independence, relatively tiny, relatively modest investment that continues to pay huge dividends by cementing a link with this moderate Muslim nation, and building a bond between its citizens and Americans.

As someone who has served in Congress and wrestled with the whole range of policy issues that you are barraged with every day, I know these global health issues seem daunting. But as Americans, we are a generous people; we are a compassionate people, and now is the time that we can demonstrate that in ways that we absolutely know, we know will work.

I think it is a credit, as we heard a little bit earlier, to this administration, to this Congress and to the American people that the U.S. has made huge efforts in tackling HIV/AIDS and malaria and tuberculosis. I, like all of you, participated aggressively in that regard, and appreciate the contributions of this committee in that regard.

Yet, as much as we have done, we still have 10 million kids, 27,000–28,000 a day dying, 2,000 dying since we started this hearing, all of which underscores that, yes, despite the commitment that we have made thus far with PEPFAR and with the initiatives that were nonexistent 5, 6, 7 years ago, we still have tough, tough battles ahead of us.

What is claiming these young lives? There are two charts that we have and I think on this chart, which is over here, you see, and everyone knows what the preventable deaths are due to. We see pneumonia. We see diarrhea. We see the other newborn complications that are related to sub-optimal prenatal care, care during pregnancy, delivery care, and post-natal care. We see that malnutrition is an underlying condition, contributing to more than one-third of these deaths.

What is interesting, and I think that what is important, at least as a policymaker, people will say, well, you are committing so much to PEPFAR, you are submitting so much to HIV/AIDS, and so much to malaria, all the things we have been fighting for, how can you justify this? It is competitive in many ways.

Well, I think this chart does show part of that. If you look at the cause of death in there, you see that malaria causes 8 percent of these 2,000 deaths over the last hour, and HIV/AIDS cause 3 percent of the deaths. We need to focus and continue to focus on HIV/AIDS and you have done that in this very hearing room I guess a couple of weeks ago. But look at where the other 85 percent of people are dying.

I mentioned that things are simple, they are inexpensive, they are readily available. I think of things just like the little vitamin A that literally one of these little capsules, you just cut it open or put a needle in and you squirt it in the mouth twice a year in certain areas can reduce mortality by 20 percent, a few little pennies.

All of us know in Bangladesh this just happens to be what they used in terms of oral rehydration. From a physiologic standpoint,

whether it is infection, whether it is dirty water out there, this dehydrating diarrhea causes cardiovascular collapse and the heart just simply does not beat anymore. This is life saving. Again, 15 cents can be life-saving for a child today.

Antibiotics, you know, Dad did not have antibiotics when he was practicing medicine in 1945. We got them. We take them for granted today, but antibiotics which can cost, again, less than $1 become life saving.

You know, these interventions, you can go on down the list, immunizations, which again we talked about, the sustainability is so important for $16–17, clearly life saving, and so it really becomes a matter of us stepping up, leading to the world and making sure the distribution of these inexpensive, little tools that we have in our tool box are applied. Little things like a bedcap or a little nightcap, baby cap, they can put on, appropriate color for either boy or girl right here just after birth, because all of us know most of the thermal transfer is through the head is literally life saving. We have had people step up all over the United States of America to make those, these simple things.

The U.S. Commitment to Child Survival Act, which has been introduced by Representatives McCollum and Shays, who are with us today, and over on the Senate side, Chris Dodd and Gordon Smith, will advance this cause. We talked about it being bipartisan legislation, strongly supported. A survey last fall by the U.S. Coalition for Child Survival showed that 93 percent of all American believe saving 27,000 children who die every day should be our responsibility, a government responsibility.

We mentioned the One Campaign earlier, the tremendous leadership of the One Campaign, and really other grassroot organizations, more than 2.4 million Americans seeking to raise awareness of extreme poverty and global disease through this One Campaign that is symbolized by the band that I have on and that you will see all of the Presidential candidates wearing sometimes. I look at these letters before me, and this stack, obviously, is just a sampling of them, but over 200,000 letters just like these have been sent by One members, 200,000 to you. You may not have seen them all, but they are in your offices. [Laughter.] And more will be coming. It really does reflect that support and that understanding of the American people, a moral cause, a national security cause, it is the right thing to do.

We have other countries, and I will just close with that, we have other countries that are stepping forward. The U.S. leadership, we all saw with HIV/AIDS, malaria. As a person in Congress you cannot travel to another country without one of the top three bullet points that they bring up to us because we are leaders on HIV/AIDS, malaria and tuberculosis. Their leaders know that they have got to respond. So the impact of us, once again, leading in this field where we know we can have an impact politically is important. Other countries are standing up. We have countries such as Norway that have undertaken major initiatives to reduce child mortality. The Japanese Government has also placed global health on July's G–8 Summit agenda, which is a tremendous forum for addressing the issues both for the United States and for our G–8 partners to pledge at that time an all-out effort to accelerate the

reduction of child mortality and to boost investment that will be required in order to distribute and make sure that these very simple tools are disseminated appropriately.

Bolstering our action to save these 10 million children is the moral thing to do under America's humanitarian ideals. It is the smart thing for our Nation's long-term security interests. I look forward personally to working with all of you and to working with all of the hundreds of thousands of people who care about this issue across America in promoting our Nation's leadership to save millions of young lives every year.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Frist follows:]

PREPARED STATEMENT OF THE HONORABLE WILLIAM FRIST, CHAIRMAN, SURVIVE TO 5 CAMPAIGN, SAVE THE CHILDREN (FORMER UNITED STATES SENATE MAJORITY LEADER)

Chairman Payne, Ranking Member Smith, distinguished committee members:

Thank you for holding this hearing and for your invitation to share my perspectives on a pressing global health matter. This is my first participation in an official Congressional activity since retiring as Senate Majority Leader, and I can think of no more important issue to address upon returning to Capitol Hill than renewing American leadership in saving millions of children throughout the world.

Why here? Why now? The answer is simple and compelling: We can save up to 10 million young lives throughout the world each year through inexpensive, well known, readily available health interventions. Today 27,000 newborns and children under the age of five will die from preventable and treatable causes. More than 2,000 of those innocent lives will be lost during this hearing alone.

The United States, governments in the developing world and other donors have the means to save these children. We know what to do, and we know how to do it. But we need the political will to achieve that goal. And we need to work with partners throughout the globe, just as we are doing to end the scourge of HIV/AIDS.

I know none of us gathered here today believes nearly 10 million children under the age of five dying every year is an acceptable reality. Each of these children, with access to appropriate care, can become a productive citizen in his or her country, helping those nations advance in health, education and economic development.

I come before you today as chairman of Save the Children's Survive to 5 campaign to give voice to these children. The goal of our campaign is as simple as its name: helping those 10 million children who die each year reach their fifth birthday. Statistics clearly show that if these young people reach that milestone, the odds of them blossoming into happy, healthy, productive citizens—the dream we envision for our own children—are greatly enhanced.

For more than a decade I have participated in medical mission trips to Africa, and my firsthand experiences have led me to believe in the power of using medicine as a currency for peace. I have seen war-torn villages calmed and reunited through the establishment of health clinics. I have seen medicine dissolve hatred as hope filled voids long occupied by despair. And I have seen leery citizens in distant lands develop trust in America as our nation's compassion and generosity provide a helping hand to those in need.

This last point has convinced me that increased support for global child and newborn health is more than a compelling moral or humanitarian issue. It is a national security issue. Health diplomacy undermines the ideological support of terror by shining through hate-filled propaganda to show America's true face. Medicine is truly a force that overpowers division and hatred because people do not go to war with those who have just saved their child. We should harness those truths to strengthen our image abroad and bolster our security for generations to come.

Last summer, for example, I traveled to Bangladesh with Save the Children to work side-by-side with doctors and community health workers. We spent the vast majority of our time working to improve the health of newborns and young children. In a small village outside Sylhet I distributed vitamin A supplements and polio vaccine to dozens of babies, including the child of a young woman named Tahmina. Through the work of Save the Children and the support of USAID, Tahmina received prenatal counseling and continuing education regarding proper newborn care following her son's birth. As a result of that assistance, her child's chances of sur-

viving to the age of five—and the odds he will lead a long, healthy life—have increased dramatically.

When I met with the Bangladeshi Minister of Health in Dhaka last summer, he offered his country's profound thanks for U.S. assistance in reducing child mortality. But average citizens—not just government officials—have taken note of America's support for Bangladesh. Stories such Tahmina's are a driving force behind a recent Pew Global Attitudes survey that shows Bangladeshis have one of the most favorable views of the U.S. in the entire Muslim world. This support is due largely to the assistance we have provided Bangladesh since its independence—a relatively modest investment that continues to pay huge dividends by cementing a link with this moderate Muslim nation and building a bond between its citizens and Americans.

As a doctor, former legislator and now private citizen, I view our efforts to save these 10 million young lives through many lenses. I would like to speak briefly from three of those perspectives: public health, public policy and public opinion.

PUBLIC HEALTH

In the developing world, the first few years of life are the most treacherous. Two million children die each year on the day they are born. Another two million die during the first month of life. In sub-Saharan Africa, one in every six children will die before their fifth birthday. That is the grim reality we face.

In America, pregnancy is a time of joy. Parents decide the name of their child before he or she is even born. In many developing countries, however, that joy is mixed with fear of adverse outcomes. In some countries, parents do not even give their child a name for the first six weeks of life. Try to imagine not naming your newborn because you fear he or she will not survive even six weeks. You have the power to help calm those mothers' fears and provide hope for their children's future.

It is important that we take a few moments to examine what is taking these young lives. The largest portion of preventable deaths is due to pneumonia, diarrhea and a variety of newborn complications related to suboptimal pregnancy and delivery care. Malnutrition is an underlying condition contributing to more than one-third of these deaths. And defying common misperceptions, HIV/AIDS is associated with only three percent of under-five deaths globally while malaria accounts for only another eight percent.

The health interventions to save these children are simple, inexpensive, well known and readily available. Supplements such as vitamin A can—for mere pennies—reduce micronutrient deficiency. A basic antibiotic that costs only 30 cents can treat pneumonia. Oral rehydration therapy can help save the two million children who otherwise perish from dehydrating diarrhea each year. And together with other interventions like immunizations, skilled care at delivery and simple knit caps, we could save most newborn lives.

These live-saving solutions do not require expensive investment in state of the art hospital facilities. They rely instead upon a network of community-level health services, an area in which U.S. government-supported programs can play a critical role in training and supporting community health workers to treat sick children and in teaching parents how to protect the health of their babies.

In short, we know how to deliver these life-saving solutions. The challenge is to scale up our efforts in coordination with other donor nations and enlist the commitment of developing countries to ensure these proven, low-cost health interventions reach every village and each child in need.

PUBLIC POLICY

As someone who served in Congress and wrestled with the broad range of policy and funding questions you face, I know these global health issues seem daunting. But Americans are a generous and compassionate people, a truth our nation has demonstrated time after time.

It is a credit to Congress and this Administration that the U.S has made great efforts in recent years to tackle HIV/AIDS, malaria and tuberculosis. As Majority Leader, I—like many of you—devoted significant time and energy to making these initiatives a reality, and I appreciate this committee's many contributions to combating these challenges. Yet as much as we have done, tough battles remain.

If a child in Haiti, for example, escapes infection from HIV thanks to PEPFAR relief but loses her life to pneumonia or diarrhea, should we be satisfied? Can we declare success? Even with the important work this committee has done to reauthorize PEPFAR, our assistance will not help most of the 10 million forgotten children we are discussing today. Saving those young lives requires additional leadership and

investment through an integrated package of basic, cost-efficient health interventions addressing the leading causes of illness and death.

The good news, as I noted earlier, is that we know what needs to be done and how to do it. This challenge, as compared to many others facing Congress, is neither intensely complicated nor all that expensive.

The programs I have described during the course of this testimony work. UNICEF's recent *State of the World's Children* report makes clear that progress has been achieved: the global mortality rate for children under five was cut in half between 1960 and today. And countries need not be flush with cash in order to succeed. Bangladesh and Egypt, for example, have made great gains in recent years thanks to the commitment of their national leaders to make this a priority. Bangladesh reduced under-five child mortality from 149 deaths per thousand live births in 1990 to 73 in 2005. Egypt reduced its figure from 104 in 1990 to 33 in 2005. Even Nepal, a country torn by conflict, has succeeded in reducing child mortality from 145 in 1990 to 74 in 2005.

Nonetheless, reducing the rate by 50 percent over the past half century still means that almost 10 million children die each year of preventable causes. Clearly much work remains to be done. Ninety-four percent of the nearly 10 million children who die each year of preventable causes live in just 60 developing countries, and we need to mount a targeted effort that focuses resources on these high priority countries.

The U.S. Commitment to Global Child Survival Act (H.R. 2266/S. 1418), introduced by Representatives Betty McCollum and Chris Shays in the House and Senators Chris Dodd and Gordon Smith in the Senate, will help advance this cause. This bipartisan legislation, cosponsored by more than 80 House members and more than 20 senators, renews U.S. leadership for child and newborn health programs in developing countries while ensuring greater coordination and accountability in the delivery of these services.

But why should the House Foreign Affairs Committee and Congress take up this issue now?

When children die needlessly, we have a moral and humanitarian imperative to act. For Republicans and Democrats alike, that imperative has long stood as a principle guiding America's role in the world. It is an impulse that springs from our conscience and represents our highest ideals. Our nation has always adopted the common cause of those in need, and at a time when we have the tools and the knowledge to save millions of young lives each year, we should do so with greater urgency and commitment.

But American leadership on child survival does more than convey our humanitarian values. Scaling up our child survival programs and leading other nations to follow suit also serves our national security interest. The investment in saving young lives protects our security by ameliorating conditions that breed extremism and enhancing our standing in the world. When we know basic health care can help bring stability and serve as a currency for peace, we cannot afford to stand pat.

The 9/11 Commission concluded, "[W]hen people lose hope, when societies break down, when countries fragment, the breeding grounds for terrorism are created." Many countries with high child mortality rates are also fragile states, affected by (or recently emerging from) conflicts with the potential to spawn instability and threaten our security. These are precisely the countries where, from the perspective of our national security strategy, we need to engage in a proactive effort to stem extremism and shore up stability. Increased child survival programming can serve as an important component of such an effort.

Although a moral imperative and improved national security are sound reasons for greater U.S. leadership in child survival, responsibility to save these children does not rest with America alone. Other governments such as Norway have undertaken major initiatives to reduce child mortality. The Japanese government has also placed global health on this July's G8 summit agenda, a forum providing a great opportunity for the United States, Japan and other G8 partners to pledge an all-out effort to accelerate the reduction of child mortality and boost international investment in these programs.

PUBLIC OPINION

I would like to close my opening remarks by speaking to you as a private citizen who has traveled throughout our great country and the world. Ours is a tremendous nation, one much admired overseas but often misunderstood. I strongly believe every U.S. effort—public or private, at home or abroad—to ensure each child has an opportunity to achieve his or her potential helps reduce that misunderstanding. And I am pleased to say I do not stand alone.

A survey last fall by the U.S. Coalition for Child Survival showed that 93 percent of all Americans believe saving the 27,000 children who die every day should be a government priority. Many have expressed themselves through organizations such as the ONE Campaign, a grassroots movement of more than 2.4 million Americans seeking to raise awareness of extreme poverty and global disease. ONE members have sent more than 200,000 letters to members of Congress urging support for H.R. 2266, the lifesaving legislation I discussed earlier, and I urge the committee to make this critical bill a priority this session.

Approving the U.S. Commitment to Global Child Survival Act and supporting the appropriation of the funds required to achieve its goals is the right thing to do for children at risk. It is the moral thing to do under America's humanitarian ideals. And it is the smart thing to do for our nation's long-term security interests. I look forward to working together to renew our nation's leadership in the fight to save millions of young lives each year.

Mr. PAYNE. Thank you very much for that testimony.

Mr. Oot.

STATEMENT OF MR. DAVID OOT, M.PH., ASSOCIATE VICE PRESIDENT, OFFICE OF HEALTH, SAVE THE CHILDREN (ALSO CHAIRMAN OF THE STEERING COMMITTEE FOR THE UNITED STATES COALITION FOR CHILD SURVIVAL)

Mr. OOT. Thank you. On behalf of the U.S. Coalition for Child Survival as well as Save the Children, let me also begin by thanking Chairman Payne and Ranking Member Smith for holding this important hearing.

First, I want to say just a word about the Coalition. Our Coalition believes it is simply unacceptable that nearly 10 million children die each year of highly preventable causes, largely unnoticed both here and abroad. We are committed to educating and advocating for increased attention to this issue, and specifically dedicated to mobilizing U.S. and global leadership and resources to save these lives.

Our membership is diverse and made up of more than 40 organizations. It includes representatives of academic and other technical institutions, student groups, faith-based and other nongovernmental organizations. Collectively, our members represent literally hundreds of years of experience working in developing countries delivering life-saving maternal, newborn and child health services.

I would also like to say that our members represent grass roots American constituents who actually care deeply about this issue, and how do we know they care? A very interesting experience on the part of Save the Children. When people were told by Save the Children that a simple knitted cap could help prevent hyperthermia in a newborn, an often fatal condition due to the loss of body heat, over 20,000 knitters from every state in the union got out their knitting needles and produced nearly 300,000 caps. In New Jersey, for example, nearly 1,000 people knitted over 13,000 caps. We literally at Save the Children had to vacate an entire wing of our headquarters to receive these caps, and the heartfelt notes that were attached asking the President and our policymakers to do more to save newborn lives.

So what have we learned? First, the programs work, and I will just reiterate a couple of points made by Dr. Hill. I mean, had there been no change in under-5 mortality since 1985, 17 million children would be dying, instead that number is less than 10 million per annum, and I have to repeat the Nepal experience because

based on nearly four decades of personal experience, nearly 20 of which were spent living in Asia and Africa, I have had a chance to see these programs firsthand, and during the 1990s, early 1990s, I lived and worked in Nepal when this program in fact expanded rapidly.

At that time no one, and believe me, no one could have imagined that a country as poor as Nepal, mired at that time in a widespread internal conflict, could find itself on track to meet the Millennium Development Goal for a two-thirds reduction in under-5 mortality, but it is. Since 1990, under-5 mortality has declined by nearly 50 percent by focusing on a package of proven low-cost interventions delivered through local health facilities, but even more importantly, extended to communities through community health workers, and especially through a national network or cadre of female community health volunteers, which U.S. aid, by the way, helped to train. Immunization coverage increased from 43 to 83 percent since 1996, more than 90 percent of children under-5 routinely receive vitamin A supplementation, and children who previously had little or no access to treatment for pneumonia are seen and treated in or near their homes. Indeed, these semi-literate FCHVs currently deliver more than all, half of all pneumonia treatments in 42 districts in Nepal.

Second, proven low-cost solutions will not save lives if they do not reach people in need, and the basics must be in place. We must have trained and skilled staff. We must have equipment, supplies and the critical operating budgets to support these programs. In many countries, especially in South Asia and sub-Sahara, Africa, millions, and especially the poor, have yet to benefit from these programs, and we must close that gap.

Third, we need to deliver a package of critical services for mothers, newborns and children, so it is not just about children or just about mothers. It really is about mothers, newborns and children, and we need to extend these services beyond health centers to households and communities. We cannot succeed if we do not reach those households and communities where most of these deaths occur, in villages and homes that are often far from any health facility.

Lastly, we need to focus more attention on newborns since nearly 40 percent of deaths of children under 5 occur in that first month of life, and in India, where I began my career as a Peace Corps volunteer in the mid-1960s, that is quite a long time ago.

Mr. SHAYS. You said "mid." [Laughter.]

Mr. OOT. I will not give the exact date. Nearly 1 million deaths to children under 5, 1 million occur in the first month of life. Most of these newborns are born and die at home, and until recently it was thought there was really little that could be done about this problem, and what we have learned working with local nongovernmental institutions in India, Save the Children and our partners, is that a basic package of home-based newborn care delivered by community health workers can prevent as many as half of these deaths.

So clearly, we know these programs work, and more lives, 6 million more each year can be saved. But as others have said, business as usual will not save these lives. We must do much more, and

thanks to Chairman Payne and other cosponsors of the United States Commitment to Global Child Survival Act, we have an unprecedented opportunity, I believe, to provide the leadership and resources needed to make this happen. We applaud the recognition that this is truly a partnership involving governments, civil society and other donor countries. We should not be doing it alone. And in part, due to the USAID-funded Child Survival Grants Programs, there are more than 45 nongovernmental agencies or organizations, rather, poised to deliver these life-saving services to those most in need.

There are other donors, as have been mentioned, Canada, Norway, the United Kingdom, are stepping up to the plate as our multilateral donors and especially UNICEF in working to expand these programs. It will take all of us working together to make this happen.

Finally, the act authorizes increasing funding to support the expansion of programs and using data from a recent expert analysis published in The Lancet Medical Journal, they have estimated that it would cost about $44 to deliver a package of life-saving interventions to one child each year. And if we doubled our funding, or Fiscal Year 2008 funding to $900 million in Fiscal Year 2009, we could deliver these services to over 20 million children, and we could save more than 1 million young lives if we did that.

I want to quote Bill Foege, who is kind of a personal hero of mine, who is now a Senior Fellow at the Bill and Melinda Gates Foundation, and former Director of the U.S. Centers for Disease Control and Prevention who said,

> "We need to change the social norm that we all recognize that it is simply wrong for only the few to have access to the tools for survival because of where they live."

When we have the tools and resources to prevent these needless deaths and we fail to act, we are not only failing those we know we can help, we are failing to live up to the values that we know we cherish as Americans. We know that these programs will be good for those children and the parents of those children who survive, but we firmly believe it will also be good for America.

In closing, I want to inform the chair that 30 organizations committed to this cause have submitted written testimony to be included in the record, and again thank you for the opportunity to speak to this committee.

[The prepared statement of Mr. Oot follows:]

PREPARED STATEMENT OF MR. DAVID OOT, M.PH., ASSOCIATE VICE PRESIDENT, OFFICE OF HEALTH, SAVE THE CHILDREN (ALSO CHAIRMAN OF THE STEERING COMMITTEE FOR THE UNITED STATES COALITION FOR CHILD SURVIVAL)

On behalf of the US Coalition for Child Survival, as well as Save the Children, let me also begin by thanking Chairman Payne and Ranking Member Smith for holding this important hearing. First, let me say a word about the Coalition. Our Coalition believes it is simply unacceptable that nearly 10 million children die each year of highly preventable causes—largely unnoticed both here and abroad. Our Coalition is committed to educating and advocating for increased attention to this issue, and specifically dedicated to mobilizing U.S. and global leadership and resources to save these lives.

Our Coalition membership of 40 organizations is diverse—and includes representatives of academic and other technical institutions, student groups, faith-based and other non-governmental organizations. Collectively, our Coalition members rep-

resent literally hundreds of years of experience working in developing countries delivering life-saving maternal, newborn, and child health services.

Many of our members represent grassroots American constituents who care deeply about this issue. And, how do we know they care? When told by Save the Children that a simple knitted cap could help prevent hypothermia in a newborn (an often fatal condition due to loss of body heat), over 20,000 knitters from every State in the Union got out their knitting needles and produced nearly 300,000 caps. In New Jersey, for example, nearly a thousand people knitted over 13,000 caps. We literally had to vacate an entire floor in our Save the Children headquarters to receive these hats—and the heartfelt notes that were attached asking the President and our policymakers to do more to save newborn lives.

SO, WHAT HAVE WE LEARNED?

First, these programs work. When we hear about the suffering and death of children in developing countries, many assume that is the way it has always been, that little can really be done about it. That perspective is just wrong. Something can be done. Thanks to the efforts of host governments, non-governmental organizations, donors, and the private sector, progress in reducing these needless deaths has been made. The truth is that if there had been no change in under-five mortality rates since 1985, nearly 17 million children would still be dying each year. Instead, that number is now less than 10 million.

Based on four decades of personal experience—and nearly 20 years living and working in Asia and Africa—I have had a chance to see firsthand the difference that these life-saving programs make. During the early 1990s, I lived and worked in Nepal. At that time, no one could have imagined that a country as poor as Nepal—mired in a widespread internal conflict—could find itself on track to meet the Millennium Development Goal 4 of a two-thirds reduction in under-five mortality by 2015. But it is. As noted by Senator First, since 1990, under-five mortality has declined by nearly 50 percent. By focusing on a package of proven, low-cost interventions—delivered through local health facilities and community health workers—and especially through a national cadre of Female Community Health Volunteers (FCHVs), immunization coverage has increased from 43 to 83 percent since 1996, more than 90 percent of children under-five receive vitamin A supplements, and children who previously had little or no access to treatment for pneumonia are seen and treated in or near their homes. Indeed, semi-literate FCHVs currently deliver more than half of all pneumonia treatments in 42 districts.

Second, proven, low-cost solutions won't save lives if they don't reach those most in need. The basics must be in place—trained and skilled staff, equipment, supplies, and critical operating budgets—to support the delivery of services. In many countries—especially in South Asia and sub-Saharan Africa—millions, and especially the poor, have yet to benefit from these life-saving solutions. We must close that gap.

Third, we need to deliver *a package of critical services for mothers, newborns, and children—and extend these services beyond health centers to households and communities.* We cannot succeed if we do not reach those households and communities where most of these deaths occur—in villages and homes that are often far from any health facility.

Lastly, we need to focus more attention on newborns since nearly 40 percent of deaths of children under five occur in that first month of life. In India, (where I began my career as a Peace Corps volunteer in the 1960's) nearly one million deaths to children under-five occur in the first month of life. Most of these newborns are born and die at home. Until recently, it was thought there was little that could be done to prevent these deaths. Working with local non-governmental organizations, Save the Children and our partners have learned that a basic package of home-based newborn care delivered by community health workers can prevent as many as half of these deaths. A local non-governmental organization called SEARCH trained community health workers to promote basic preventive health practices, including warming and drying the newborn, assisting a newborn that was not breathing at the time of delivery, using a clean blade to cut the umbilical cord, promoting immediate breastfeeding, and recognizing and treating common neonatal infections. Collectively, these interventions reduced deaths in the first month of life by more than 60 percent, and the Government of India now plans to replicate home-based newborn care throughout India.

Clearly, these programs work—and more lives—6 million more each year—can be saved. But, "business as usual" will not save these lives. We must do much more. Thanks to Chairman Payne, and other co-sponsors of the United States Commitment to Global Child Survival Act, we have an unprecedented opportunity to provide the leadership and resources needed to make this happen.

Together with other developed and developing countries partners, the US has a critical role to play. Our Coalition strongly believes that the proposed Child Survival legislation is a critical step in re-establishing our leadership and increased investments that are urgently needed to save the lives of babies and young children. We believe that the proposed creation of an inter-agency Task Force will help ensure that this effort gets the high-level policy attention that is needed, and that this initiative will focus on those countries where the need is great and on those proven interventions we know can save lives.

We also applaud the recognition that this is a partnership involving governments, civil society, and other donor countries. In part due to the USAID-funded Child Survival Grants Programs, there are now more than 45 US non-governmental organizations poised to deliver these life-saving programs to those most in need. Bilateral donors, such as Canada, Norway, and the United Kingdom, and multilateral donors, such as UNICEF, have recently made a major commitment to supporting the expansion of these programs. It will take all of us working together to get these services to those in need.

Finally, the Act authorizes increased funding needed to expand access to these life-saving programs, and the establishment of a system of accountability so that Congress and the American people will know the difference we are making. We want to commend USAID for the recent steps taken to focus on those countries where the need is great and on those interventions we know can save lives. We also want to acknowledge USAID's commitment to building a transparent system to monitor and measure the results we know are possible.

WHAT IT WILL ACHIEVE

Using data from a recent expert analysis published in the Lancet medical journal, it is estimated that it would cost about $44 to deliver a package of life-saving interventions to one child each year. Therefore, if we doubled our assistance from $450 million in FY 08 to $900 million in FY 09, we could deliver these services to over 20 million children—and save more than one million young lives. With renewed, strong American leadership, our increased investment would help leverage greater efforts by other donor governments and host governments, thus saving a much larger number of young lives.

To quote Bill Foege, Senior Fellow at the Bill & Melinda Gates Foundation, and former Director of the U.S. Centers for Disease Control and Prevention (CDC), we need to "change the social norm so that we all recognize that it is simply wrong for only the few to have access to the tools for survival because of where they live." When we have the tools and resources to prevent these needless deaths, and fail to act, we are not only failing those we know we can help, we are failing to live up to the values that we know we cherish as Americans. We know that these programs will be good for those children—and the parents of those children—who survive, but we firmly believe that it will also be good for America. In closing, I want to inform the Chair that 30 organizations committed to this cause have submitted written testimony to be included in the record. Again, thank you for the opportunity to speak to this committee.

Mr. PAYNE. Thank you very much.

Dr. Peterson.

STATEMENT OF E. ANNE PETERSON, M.D., M.PH., DIRECTOR, CENTER FOR GLOBAL HEALTH, WORLD VISION INTERNATIONAL

Dr. PETERSON. Thank you, Chairman Payne, Ranking Member Smith, cosponsors.

I really appreciate you holding this hearing. I had actually been hoping for it for a number of years, and so this is a very special day, and thank you to the press for some of your incredible commitment to save the children of the world.

My name is Dr. Anne Peterson. I am here, not in Kent Hill's spot, but now representing the NGO, World Vision and today to hopefully represent the perspective of faith-based organizations. The U.S. Government has a long and exemplary commitment to effective child and maternal health programs, but much more can be

done. There is no need for the 10 million deaths that you have been hearing about this morning.

But I would like to add that hundreds of millions of more children and mothers suffer on a regular and repeated basis. So what we are talking about is not just the deaths of women and children, it is also the disease and permanent harm that is caused by the exposure to disease.

The United States can provide leadership that keeps global promises, conveys the compassion of the American people, and strengthens U.S. relationships with other countries, and most importantly, does impact the lives of women and children. I would like to highlight four critical areas.

First, we could have far more impact by increasing our support to prevention activities aimed at the household and community level. In rural villages in Africa and pediatric wards, I have seen the ongoing harm of malnutrition, measles, and diarrhea. I have seen children dying needlessly from illnesses that could have been prevented. If we do not address the underlying causes that put children at risk, then hospitals and clinics become revolving doors of death. By implementing the proven cost-effective interventions at the community level, we can actually reduce the occurrence of those diseases and deaths, and promote a healthy environment where children can grow and reach their full potential.

Second, a whole health system includes civil society and the community itself. This community-level focus is not just getting approved outcomes, it empowers parents, as Congresswoman McCollum was talking about. This puts into the hands of parents the power to keep their children healthy. That is sustainable development, and the parents do want to know what to do. It also helps avoid missed opportunities across sectors and the synergy of working with food security and agricultural and micro enterprise. When we take those community perspectives and interventions and purposefully link it with the public sector, whether it is a government or other faith-based organizations or the U.N. agencies, only then do we have a whole health care system that addresses the beginning environment around a child all the way to the clinical care needed when they get sick.

Third, if we truly want to achieve the Millennium Development Goals, we need to focus attention on the forgotten children that Senator Frist talked about, those hardest to reach, that are in the slums, hidden valleys, neglected tribes or in the war zones. We know that for every intervention and for every disease that is before us it is the poor and forgotten who do worse than those who are richer, and that the gaps are getting wider between countries and within countries. They have less access to preventive services and less access to care when they need it.

Children caught in conflict not only face harm directly, but their daily needs are unmet. They die from lack of nutritious food, clean drinking water, a home, nurturing parents or access to care. How can a child not only survive but thrive in such circumstances?

Often the governments in these cases may not be able or want to care for those children, and yet NGOs are often present.

Finally, the U.S. should continue its support of faith-based and community-based organizations, and recognize the role that they

play in addressing child survival. According to the World Health Organization, faith-based and community-based organizations account for as much as 30 to 70 percent of all of health care in sub-Sahara in Africa. They are an important component of health care delivery throughout the world, and their networks are far-reaching. Many faith-based organizations have as their specific mandate to reach the poorest of the poor, the most neglected.

Organizations like World Vision are deeply embedded in the community. They have spent decades providing care, support, treatment, and prevention at the local level. And in many places where no other providers exist, they are trusted partners and work with UNICEF, WHO, Ministries of Health, the New Global Health Partnerships, complementing their work and providing a crucial link between government and civil society. Faith and community-based organizations contribute to more sustainable solutions and help reduce dependence on foreign aid.

Twenty-five years ago I worked with a small mission organization and with the Anglican Church in Kenya doing community-based health programs, thanks in part to a small USAID grant of $25,000. I recently returned and found that the church was not only continuing but had expanded the work with a variety of funding sources, and that new generations of children were still being cared for 20 years later. That is sustainable development.

Americans do care about children as evidenced from the continued growth of child-focused, faith-based organizations. Given that there are inexpensive, proven solutions that exist, partners ready to take action in the places most in need, the reduction by two-thirds of child morbidity and mortality and turning around the maternal mortality problem is the easiest of the Millennium Development Goals to meet.

In conclusion, if we as a nation are serious about achieving the MDGs and wish to do what is right for children representing our constituencies well, then we will support U.S. leadership on child survival and ensure the passage of the Child Survival Act. Please support this bill, champion its funding, and make it a success because it is truly a win/win situation. Thank you.

[The prepared statement of Dr. Peterson follows:]

PREPARED STATEMENT OF E. ANNE PETERSON, M.D., M.PH., DIRECTOR, CENTER FOR GLOBAL HEALTH, WORLD VISION INTERNATIONAL

Thank you Chairman Payne, Ranking Member Smith and members of the Committee for calling for this hearing on child survival. Thank you, too, to Senator Frist for your interest and commitment to the children of the world.

My name is Dr. Anne Peterson, and I am here today to represent the perspective of faith-based organizations. I am the Director for the Global Health Centre at World Vision, a Christian humanitarian organization operational in nearly 100 countries. World Vision provides hope and assistance to millions by joining with local communities to tackle poverty and injustice, ensuring vulnerable children and families reach their full potential.

I respectfully request to submit my longer written testimony for the record.

Today we have an incredible opportunity to keep global promises, convey the compassion of the American people, provide global leadership to help others, and strengthen U.S. relationships with other countries.

You have heard information about the scope of the problem and the interventions that could save two-thirds of the 10 million children who fall ill and die each year. As Congress considers the Child Survival Act, I hope to shed light on four critical areas on which the U.S. should focus to ensure children are rescued from preventable diseases and death. In order to help save some of the more than 10 million

children who die each year, the U.S. should (1) increase support for prevention activities aimed at the household and community level, (2) engage directly with local communities, (3) focus attention on children in conflict zones and in underserved areas, and (4) support the role faith-based and community-based organizations fill in addressing this tragedy.

WHAT SHOULD BE THE FOCUS OF A UNITED STATES GOVERNMENT CHILD HEALTH STRATEGY?

The U.S. Government has long supported effective programs in child and maternal health with interventions that have been confirmed in global medical literature and the public policy arena. The US government should continue to support such activities, but incorporate within this strategy an increased focus on preventive interventions at the household and community level which can save the most number of lives. The Child Survival Act highlights this approach.

I first understood the need for this approach while visiting a small mission hospital in Zaire, now the Democratic Republic of Congo, as a fourth-year medical student. The pediatric ward was full of children, all with measles. I was appalled at how many died of what in the U.S. was a minor and vanishing childhood infection. A few weeks later, I went on an outreach mission into some of the local villages. One child there changed my life. He was about 18 months old, but only the size of a seven month old. He had the red hair and stunting of chronic malnutrition. He had an enlarged spleen and anemia from chronic malaria. He had polio paralysis in both legs and open infected sores from scabies. In the midst of the measles epidemic, his chances of survival were abysmally low. I then realized his problem was the same as that faced by those small children under medical care in the hospital—dying from something that could be prevented with minimal cost. If he had lived, serious malnutrition at his young age would have compromised his intellectual capacity, and the polio would have left him paralyzed for life. So it is for the millions of children who die and for the millions more who survive with less than their God-given potential.

Child survival goes far beyond providing medication for an illness—it means getting serious about the things that keep people healthy. It would be a mistake to think that focusing solely on improving clinical solutions will have the greatest impact on the diseases and illnesses that plague so many young children. For example, Oral Rehydration Salts provided to children with diarrhea are a good thing, yet they fail to address the underlying cause of the diarrhea which can often be traced to the dirty drinking water they consumed in the first place. The inexpensive household interventions that could provide safe drinking water right to the mouths of children aren't provided, and diarrhea often ensues. Other issues such as malnutrition have long been neglected despite knowledge that malnutrition contributes to more than 50 percent of child deaths. Lack of food is not the only problem, though agricultural productivity and poverty play a role. Poor diet, seasonal food insecurity and closely spaced births all contribute to malnutrition. Diseases like diarrhea and malaria take an additional toll.

World Vision is actively involved in addressing the primary underlying causes of child morbidity and mortality across the globe. Our Micah Project, working in five countries in Africa, reached 2.7 million direct beneficiaries and reduced malnutrition by up to 30 percent within 3 years through diet diversification, disease prevention (such as distributing bed-nets and Oral Rehydration Salts), enhancement of food security and education of parents. Similarly, our community-based therapeutic care has moved the emergency treatment of acutely malnourished children from lengthy, expensive inpatient care to community-centered, home-based interventions using a ready-to-eat food, "Plumpy'nut." This approach has shown better results for more children over the course of eight weeks than the previous inpatient programs, at a fraction of the cost. Both programs are being replicated in additional countries in Africa and Asia.

Like us, parents everywhere want their children to stay healthy and grow up to their full potential. The U.S. should increase support for efforts that help families realize this right using proven, cost-effective interventions that prevent disease.

WHERE SHOULD THE U.S GOVERNMENT FOCUS THIS WORK?

You will note from the story I shared earlier that by the time a sick child reaches a clinic it is often too late to undo the harm. Most disease and death occur not at health-care facilities, but at home, and can be prevented there. The Lancet series referred to in the Child Survival Act recommends a package of key interventions. Most of these can be implemented in communities and households, with the exception of simple clinic-based interventions like safe birthing and delivery.

There is considerable global dialogue about the changes needed in policies to address shortfalls in human capacity (too few doctors and nurses) and overburdened or weak health systems—both of which are real concerns. However, this focus ignores the "whole health system" which includes civil society and community level efforts. To truly improve the lives of children, decrease child and maternal mortality, and achieve the Millennium Development Goals, a comprehensive package of interventions to prevent childhood illness and death must be implemented at scale at the community level where disease occurs. Community level perspective and participation helps improve outcomes and avoid what are currently missed opportunities by ensuring better health integration and greater synergy with other sectors such as economic, agricultural and educational development. By focusing at this level, there is greater assurance that child deaths will not only be reduced, but that a healthy environment will ensue where children and families will be able to experience life in all its fullness.

WHO MOST NEEDS OUR ASSISTANCE?

UNICEF and the World Health Organization have identified countries with the worst health indicators. Yet even in countries with better indicators, disparities and inequities are growing. As we seek to finish the "unfinished agenda," we will need to pay increasing attention to the hardest to reach—the poorest, the disenfranchised, the homeless, and those in conflict zones. These are the children and families who live in inaccessible valleys, are caught in deep poverty, are among neglected tribal groups, are disenfranchised or are caught in the cross-fire of conflict zones.

We know that for almost every health indicator or intervention, the poor do worse than the rich and have less access to preventive services or health care. The places with the worst health indicators—those furthest from achieving most of the Millennium Development Goals—are most often war-torn areas. Increasingly, millions of women and children are living in these disaster and conflict zones. They need protection from the harm of conflict, but they also need and have the right to the same things as children everywhere—a healthy diet, clean drinking water, a bed net to keep away mosquito-borne diseases, immunizations, and access to clinical care.

Where there is conflict, it almost always means that the government cannot fulfill its mandate to care for its own people. However, many times NGOs are there, from Medicins Sans Frontieres, to Senator Frist's work with Samaritan's Purse in South Sudan, to World Vision in Afghanistan. At risk to themselves and their families, staff from NGOs and faith-based organizations are often the first to respond in the hardest places and the last to leave. When I visited Afghanistan with USAID in 2004, two local NGO staff had been killed the previous week because of the association with the U.S. government. Yet even as their peers grieved, the head of their organization told me he and his staff were determined to continue bringing hope to their people. And that hope was being realized. Visiting a small clinic outside the town of Herat, Muslim elders thanked USAID saying, "Our women no longer die in childbirth and our children do not get sick and die. This is the 'Peace Dividend.'"

How can we assure the most needy populations are reached? There must be careful measurement of what is happening and solid data to identify systematic inequities. This data will allow better, more purposeful targeting of programs to assist the poorest, the forgotten, and those in harm's way. The links between the work of the Office of Foreign Disaster Assistance and the Child Survival and Health Programs development portfolio should be strengthened by USAID, and the work of U.S. government partners should be geared toward reaching the most needy.

WITH WHOM SHOULD THE U.S. GOVERNMENT BE WORKING?

There are vibrant examples of the role Governments play in aiding their own citizens to prevent childhood illness and death, such as Ethiopia, which has been training 20,000 health outreach workers. However, few Ministries of Health are able to reach deeply into the communities and provide a high level of coverage of preventive interventions. In order to achieve success and increase coverage, there must be a partnership between civil society and government. Faith-based and community-based organizations help provide this crucial link.

We are entering a new era where the divide between government and civil society in development work is being overcome. I have recently seen a new and more intensive level of cooperation between NGOs and governments and a strengthening of public-private partnerships to address these global health challenges. A component of World Vision's health strategy is to facilitate access to quality care through partnerships—mainly with Ministries of Health. These partnerships have raised awareness of immunization's benefits and ensured that vaccines are available for remote

communities where the needs are often greatest. Differences in culture, organizational priority, and even historical competition for resources are now being overcome and synergistic cooperation is now benefiting more children.

Faith-based and community-based organizations are essential partners in the fight to reduce child mortality worldwide and are often the key to mobilizing communities to achieve these ends. Ensuring progress on the Millennium Development Goal of reducing mortality for children under five by two-thirds by 2015 will require the networks, support, trust, and influence that only faith-based and community-based organizations can provide.

According to the World Health Organization, faith-based and community-based organizations account for as much as 30% to 70% of all health care in sub-Saharan Africa, and are an important component of health care delivery throughout the world. Organizations like World Vision are often deeply embedded in the community and have spent decades providing care, support, treatment and prevention at the local level, in many cases where no other provider of care exists. The value of these organizations rests in the influence and support they have in the local community, enabling better mobilization of resources, people and services. They also have built far-reaching networks. Many faith-based organizations have as their specific mandate to reach the poor and intervene when others suffer from poverty, sickness, disease, and death.

Faith-based and community-based organizations also contribute to more sustainable solutions and help reduce dependence on foreign aid. Faith-based institutions, churches, and community groups which have existed for many years empower parents and community elders, ensuring the impact lasts beyond the life of a grant or time-bound funding stream. Twenty-five years ago I served with Mission Moving Mountains, a small mission organization in Kenya working with the local Anglican Church conducting community-based health programs. In three years, the work expanded from zero to 29 villages. A small USAID grant of $25,000, alongside other funding, facilitated this successful growth. More importantly, I went back recently and found that the church had continued to expand the work, obtaining funding from a variety of sources. They were still successfully reaching out to new generations of children 20 years after USAID funding had ceased.

Americans, your constituents, show their care for children by their personal contributions to their favorite charities, many of which, like World Vision, have seen remarkable growth in recent years. There are strong trends among many NGOs, including faith-based organizations, to use best practices and achieve measurable results—something in which both public and private donors increasingly seek to invest. Faith-based and community organizations are better able than ever to deliver results based on clear strategies and strong accountability.

CONCLUSION

If we as a nation are serious about achieving the Millennium Development Goals, then we will support U.S. leadership on child survival and ensure passage of Child Survival Act. Given the inexpensive, proven solutions that exist, the reduction of child morbidity and mortality by two-thirds represents one of the easiest goals to achieve.

However, funding alone will be insufficient. Efforts must be focused on those interventions that make the most difference, targeted where the need is greatest, directed to those who need the most help, and implemented in conjunction with trusted partners who have a track record of success.

Please make this your personal issue. As parents yourselves, as representatives of all the parents in your constituencies, and for the children who lack other representatives, I encourage you to tenaciously pursue justice, health, and hope on their behalf.

I urge you to pass the Child Survival Act. It is the right thing to do for the children. It is good politics, building relationships across the world and with constituencies at home. The cost is small compared with much of what you are asked to fund, yet can show such gain in lives, in hope and in restored relationships. This truly is a win-win situation. Please support this bill and champion the funding to make it a success.

Mr. PAYNE. Thank you very much.

Dr. Metangmo.

STATEMENT OF PIERRE–MARIE METANGMO, M.D., M.PH., M.B.A, DEAN, FUTURE GENERATIONS

Dr. METANGMO. Thank you, Chairman, and Ranking Member Smith, and distinguished member of the African Global Health Subcommittee, for the opportunity and honor to share with you a few reflection on my 20 years of experience working on child health program in rural Africa, Asia, and Latin America.

These experiences are just the tip of the iceberg. The iceberg being more than 20 years of USAID-funded child survival program, supporting millions of models, hundreds of thousands of health workers, committee health workers, nurses, health professional in providing affordable and very simple effective health care to children.

The previous speakers have provided a caricature of where we stand today in our effort to reduce under-5 mortality. Now, I want to bring the perspective of a professional African and committee leader born and raised in Cameroon who had led community-based child survival program all over the world.

After graduation from medical school in France, I worked for the Cameroon Government as district medical officer. I then joined Plan International in the position of West Africa Health Advisor. And 9 years ago, I came to the United States as a senior child survival specialist providing leadership for Plan global child health programs. I most recently joined Future Generations as Dean of the Graduate School for Applied Community Change and Conservation.

However, today I am privileged to speak for the voiceless and powerless mothers and children from Africa and beyond, to those of you who can make it possible for millions of such people to live instead of die.

When I was a child growing up in Cameroon, I had to accompany my mother twice a day to fresh water at the river a half a mile away. I did wonder why the village was not built along the riverside. As a child, this made sense for me, to bring the people close to the river, and beside this had prevent me from one mile walk every day.

And after I graduated from medical school and went back home to work in Hospital de Dschang, I kept wondering why people could not simply move to live closer to the hospital or health centers. It was not until much later that I understood how important it was to take essential services to the people rather than bringing the people to the essential services. This simple task is possible, is affordable, and we should do it.

Indeed, during my years at the Hospital de Dschang, one evening, Ntuma, a young woman whom I had rescued 2 months previously from an obstructed labor pounded at my door crying, "Doctor, save my baby." I quickly took the baby in my arm only to discover that it was too late.

I learned that 5 days earlier, the 2-month-old baby had started coughing and had developed difficulty breathing. The baby's condition gradually worsened and no one realized how serious the situation was.

That was the turning point in my life. I knew that if Ntuma and her family had learned about the danger sign of pneumonia in

young children, they might have sought medical care earlier and the child might not have died. I also knew that if in Ntuma's village, this remote village, there was a health worker, committee health worker who were trained in identifying and treating pneumonia in children, he or she may have saved the life of this baby.

The experience opened my eyes to the importance of community-based programs that seek synergy between simple, effective health intervention and empowerment of local people. That is what non-governmental organizations such as Plan, Future Generations, and thousands of others are doing to save the lives of millions of children who otherwise will have died from pneumonia, diarrhea, measles, neonatal tetanus, and malnutrition.

Plan is one of the world's largest community development organizations, working at present in 46 countries, and dedicated to improving the lives of destitute children.

Future Generations, another organization working in Afghanistan, China, India and in Nepal, is also interested in advancing community empowerment. In 2002, Future Generations founded an international graduate school offering a master's degree in applied community change and conservation. This school teaches processes for equitable social change, community empowerment, and its application to maternal and child health.

In my village in Cameroon, the number of child deaths has drastically decreased as a result of community-based health activities. Safe water is provided. Children are regularly immunized and diseases such a malaria and pneumonia are detected and treated earlier.

For this life-saving important fact to occur, a three-way partnership has been essential, involving the community, the local administration, and external funding. Another important variable was the training of community health workers.

Expanding this intervention to reach the hard-to-reach requires a sustained and high level of funding from the U.S. Government, and from other donors contribution. Also, this requires new partnership and alliances that ensure that more children in impoverished communities live to their 5th birthday and beyond.

In conclusion, Chairman Payne, Ranking Member Smith, and distinguished member of the African Global Health Subcommittee, your leadership and continued support is crucial to ensure adequate resources are mobilized to save the lives of millions of children in Africa, Asia, and Latin America when we act now, and yes, we can.

Thank you.

[The prepared statement of Dr. Metangmo follows:]

PREPARED STATEMENT OF PIERRE-MARIE METANGMO, M.D., M.PH., M.B.A., DEAN, FUTURE GENERATIONS

Good morning Chairman Payne, Ranking Member Smith, and distinguished members of the House Subcommittee on Africa and Global Health. Thank you for this opportunity and honor to share with you a few reflections on my 20 years of experience working on child health programs to improve health conditions in rural Africa, Asia, and Latin America.

My experiences represent just the tip of a massive iceberg—that iceberg being 20 years of Child Survival programs funded by the U.S. government through its Child Survival and Health Grant Program. This program gives support to U.S.-based private voluntary organizations (PVOs) to work with millions of mothers and hundreds

of thousands of community health workers, midwives, and health professionals in impoverished communities to provide simple interventions that save children's lives.

The previous speakers have provided a clear picture of where we stand today in our global effort to reduce under-5 mortality by two-thirds by the year 2015. I would like to bring the perspective of an African professional and community leader born and raised in Cameroon who has led community-based child survival programs all over the world. After graduation from the medical school of Lille in France, I first worked seven years with the Cameroonian government as district medical officer in Dschang in the Western Province.

I then joined Plan International in the position of West Africa Regional Health Advisor, working in Senegal for two years. Nine years ago, I came to the United States as Plan global child survival specialist providing leadership for child health programs in 46 countries. I most recently joined Future Generations as Dean of its new Graduate School for Applied Community Change and Conservation.

Today, I am privileged to speak for the voiceless and the powerless mothers and children from Africa—and indeed from impoverished communities all around the world—to those of you who can make it possible for millions of such people to live instead of die.

When I was a child growing up in the village of Bafou, Cameroon, as the first-born I had to accompany my mother twice a day to fetch water at the river half a mile away. The question I had then was, "Why didn't the leaders build the village along the river side?" And, after I graduated from medical school in France and went back home to work in the *Hôpital de Dschang* (10 Km from Bafou), I kept wondering why people couldn't simply move to live closer to a hospital or health center for easy access to quality health services. It was not until much later that I had to switch my focus to the essential services moving to the people rather than the people moving to the services.

Indeed, during my years at the *Hôpital de Dschang*, one evening as my family and I were having dinner, Ntuma, a young woman whom I had rescued two months previously from an obstructed labor and who had left the maternity ward with a healthy baby, pounded at our door crying, *"Doctor, save my baby, please save my baby!"* I quickly took the baby in my arms only to discover that it was too late.

I learned that five days earlier, the two-month-old baby had started coughing and had developed difficulty breathing. The baby's condition gradually worsened and no one realized how serious the situation was. Ntuma's husband decided to wait until the next morning to seek advice from the elders. It was not until the following afternoon that Ntuma and her mother-in-law gathered some money from their family members and walked five hours down a path, wading through a big river, to finally reach me at my house next to the hospital.

That was the turning point in my life. I knew that, if Ntuma and her family had learned about the danger signs of pneumonia in young children, they might have sought medical care earlier and the child might not have died. I also knew that if a local community health worker was trained to diagnose and treat pneumonia in children in that village where mothers have no medical care available to them, he/she might have provided care to save the baby's life. The scientific research is conclusive: the lives of millions of children like Ntuma's baby can be saved through readily affordable community-based programs that Ntuma's community did not have.

This experience opened my eyes to the importance of community-based programs that seek synergy between simple, effective health interventions and empowerment of local people. Through the grassroots work of non-governmental organizations such as Plan, Future Generations, and thousands of similar NGO's working with governments and international donors, community-based primary health care programs are saving the lives of millions of children who otherwise would have died from pneumonia, diarrhea, measles, neonatal tetanus, and malnutrition.

Plan is one of the world's largest community development organizations, working at present in 46 countries, and dedicated to improving the lives of destitute children around the world. Plan currently has three U.S. government-funded child survival grants in Cameroon, Kenya and Nepal that benefit 613,285 children and 875,000 women of reproductive age. Through these grants, the women and children benefit from interventions which promote nutrition, immunizations and family planning. The children are treated for childhood pneumonia, and death by malaria is prevented through insecticide-treated bed nets and access to early and proper treatment.

In Plan's USAID-funded Child Survival project in Nepal, the percentage of children in our project area whose mothers gave them oral rehydration solution when they had diarrhea increased from 34% to 67% in three years. The Pregnant Women's Group initiative which brings together 10 to 15 pregnant women for weekly

self-help activities with counseling from community health workers has reduced the under-5 child mortality by 50 percent as compared with control groups.

Future Generations is another non-governmental organization committed to communities. Based in Franklin, WV, Future Generations works in Afghanistan, China, India and Peru to empower communities and women to improve their health and quality of life. In 2002, Future Generations also founded an international graduate school, offering a master's degree in Applied Community Change and Conservation. This school teaches processes for equitable social change, community empowerment, and its application to maternal and child health.

In Afghanistan, which has the third-highest under-5 mortality rate in the world, Future Generations work has transformed numerous communities and countless mothers by the knowledge of simple and practical approaches. These approaches include the promotion of exclusive breastfeeding during the first six months of life, handwashing, the use of oral rehydration solution for childhood diarrhea, and other simple and readily affordable activities. As a result, lives are saved.

In my village in Cameroon, the number of child deaths has drastically decreased as a result of community-based health activities. Safe water is now provided by hand pumps from wells. Through the efforts of the local health center, children are regularly immunized and diseases such as malaria and pneumonia are detected and treated earlier. Community health education has resulted in better sanitation and hygiene as well as more informed breast-feeding practices among women.

For these village improvements impacting child health to occur, a three-way partnership has been essential involving the community, the local government administration, and external funding support. Another important element has been the training and support of local health workers.

Child survival programs played an important role in reducing the number of children dying around the world each year from 20 million in 1960 to less than 10 million now in spite of the fact that the number of children born annually has risen from 96 million in 1960 to 135 million currently. However, in order to reach the global goal of reducing under-5 mortality by two-thirds by the year 2015, we will need to achieve the following:

1. Reach the hard-to-reach and the poorest-of-the-poor through programs that ensure equity;
2. Expand coverage of simple and effective child survival interventions on a much larger scale than is currently possible; and,
3. Ensure that funding is available to make these programs sustainable in the long-term as poor countries and poor communities gradually absorb the cost of these programs.

Achieving this will require a sustained and higher level of funding from the U.S. government and from other donor countries around the world than has been available to date. Achieving this will also require a stronger engagement of communities and their creativity and resources. It will require new partnerships and alliances. And it will require a higher level of commitment to first-class operations' research to ensure the effectiveness of large-scale programs. Only these partnerships will ensure that more children in Africa, Asia, and Latin America live to their fifth birthdays and beyond.

The world has the resources and the technical "know how" to ensure that fewer and fewer children in the poorest countries of the world die from readily preventable or treatable conditions. Now is the time for the American people and the United States government to expand their support and contribute their fair share to make this possible. Because of the generosity of the American people, much has been achieved for the world's children. But much more is still left to do.

In conclusion, Chairman Payne, Ranking Member Smith, and distinguished members of the Subcommittee on Africa and Global Health, I appreciate your interest in and attention to this critical matter of saving children's lives throughout the world. All of us who work on behalf of mothers and children around the world look forward to your continued strong support.

Your leadership is crucial to ensure adequate resources for this great and historic global effort to combat child mortality in the poorest countries of the world. Just as Ntuma's baby could have been saved with more resources and community-based health education, millions of other babies will be saved when we act now!

Mr. PAYNE. Thank you very much.

Dr. Walley.

STATEMENT OF ROBERT L. WALLEY, M.D., EXECUTIVE DIRECTOR, MATERCARE INTERNATIONAL

Dr. WALLEY. Mr. Chairman, Mr. Smith, distinguished members of the committee, please excuse my voice. It was the air conditioner on the aircraft has done this to me.

This is a unique experience for me. You know, 20 years ago Dr. Rosenfield and Deborah Maine published a paper in The Lancet entitled "Where is the M in MCH?," "Where is the Mother in Maternal and Child Health?" I am pleased that I am here as the obstetrician and a gynecologist to put the M into your deliberations.

Mothers in the developing world are experiencing unimaginable suffering due to the scandalous lack of effective care during pregnancy and child birth with a consequence that many thousands are dying. The World Health Organization claims that there are 600,000 maternal deaths annually, of which 99 percent occur in developing countries. However, there is no actual data to substantiate these numbers. The reason being that most developing countries do not report information on births, deaths, the sex of dead people, or the cause of death.

However, figures from my experience at a mission hospital in Nigeria where the in-hospital maternal mortality ratio was 1,700 per 100,000 live births illustrates the enormity of the situation. Some 200 million women are pregnant worldwide each year. Most mothers deliver in villages without access to safe, clean facilities in which to deliver and without a trained person to assist them. Most maternal deaths occur during the last trimester and the first week following delivery.

Prior to going to Nigeria in 1991, I had never been present or had a mother die under my care from a direct obstetrical cause, and in 35 years I have never experienced one. Maternal deaths in Canada are on the level of what is called "irreducible minimums," at one, maybe two per 100,000 live births. However, in the mission hospital maternal deaths are almost a daily event, and I recall one weekend during which there were four deaths of mothers who had arrived in the hospital in extremis, one from hemorrhage, one in agony from obstructed labor, and another after days in labor with a ruptured uterus as she was young and consequently her pelvis was too small. Others would arrive unconscious due to pregnancy-induced hypertension or suffering from malaria or severe anemia resulting from malnutrition.

Most mothers in Africa die alone and in terror in the villages as they have no way of getting to the hospital. Not only are the lives of these mothers abruptly ended, but also the lives of their babies and in the aftermath the chances of survival of their younger children decreases dramatically resulting in the disintegration of their families.

Thirdly, these deaths represent only the tip of the iceberg. It is estimated that for every death, 30 more suffer long-term damage to their health; for example, from obstetric fistulae. These arise in young mothers, as a consequence of neglected obstructed labor—lack of Caesarean section—and also from cultural practices, for example, Gisiri cuts and female circumcision. The result is because of damage to the bladder and rectum these mothers become incontinent of urine and feces.

Consequently, they are complete outcasts and are treated worse than lepers by husbands, partners, families and societies simply because they are wet, filthy and offensive. They suffer pain, humiliation, and lifelong debility if not treated. Worldwide perhaps 2 million of these poor, young and forgotten mothers are living with this problem mostly in Africa. Reliable hospital data in Ghana gives the incidence of obstetric fistulae as 2 percent of all births. These deaths of mothers and babies are the greatest tragedies of our times, especially since they are readily preventable and the cause is treatable. Obstetric fistulae can be treated surgically but at present there are insufficient trained doctors, nurses or specialized hospitals.

The problems of maternal health and the need for improved health care has been discussed by the international community for years, most recently as the Millennium Development Goal No. 5, the improvement of maternal health by reducing maternal mortality and morbidity by 75 percent. It is admitted by the U.N. and the international health community that this goal is the most neglected of all the MDGs.

A report in the British Medical Journal in July of last year commented that at the present rate of progress the MDGs will not be met for 275 years, that is, 2282, and not 2015 as intended. The reasons are poverty, lack of compassion, lack of political and professional wills, a conspiracy of silence, and a lack of imagination.

The consensus of the obstetrical community is that mothers need essential prenatal care, skilled attendants at all deliveries and specialist care for life threatening complications. While billions of dollars have been spent on so-called reproductive health programs and more is demanded, only a small fraction is focused on providing the services that ensures mothers and their babies survive pregnancies.

In my experience, mothers in Africa are optimistic and want to have babies as they know they are the future of their families, communities and countries. Mothers in developing countries do not expect to die or suffer birth injuries, and those who die obviously have no voice, only ours, to plead their causes for adequate care, care of the sort which mothers have access to in the United States of America and Canada, which is second to none, but which is frequently taken for granted.

MaterCare International was established by obstetricians concerned by the tragic state of maternal health in developing countries. We have worked in Nigeria and Ghana, Sierra Leone, and Rwanda and Kenya, working with local churches that provide 30 to 40 percent of the beds. We work with our local colleagues. In addition to providing most of the health care in rural areas in African countries, these faith-based hospitals have for many years enjoyed the confidence and trust of many mothers and their families.

MCI's approach has been to put into practice the old obstetrical adage that live health mothers produce live healthy babies. As a consequence, MCI has developed a model of comprehensive rural maternal health care based on local causes of mortality and the circumstances under which they occur.

This model is similar to the one we have had in Newfoundland for 70 years where it was one of the, and still is, the poorest prov-

inces in the whole of North America. It is a way of taking essential obstetrical services, found usually in hospitals, closer to the mother. It provides at around small 30-bed mission hospital, full prenatal care with treatment for common medical conditions, for example, malaria, HIV, severe anemia, with immunization against tetanus and specialist management of life threatening obstetrical complications; for example, Caesarean section, blood transfusion.

The hospital is linked by radio to an emergency obstetrical transport which can go to the mother with life threatening complications with the equipment needed to resuscitate her and then to transfer her to the hospital in a safe and timely manner. The hospital is linked to rural clinics, staffed by trained midwives, also providing pre and postnatal care, safe delivery and early referral.

A training program for doctors, midwives in emergency obstetrics, is provided. Traditional birth attendants are taught to identify and refer mothers at risk to the nearest clinic early. It is known that at least 15 percent of normal pregnancies and labors may run into complications, so the radio and transport system is able to meet these emergency needs.

This model was developed in Nigeria in the early 1990s and has been functioning now in Ghana since 1997. Evaluation has shown an increase in referrals to the hospital of mothers with complications and thus an inference can be made that maternal deaths have been reduced. The cost of that sort of program for 5 years is $2.5 million, Canadian or United States dollars, a mere pittance compared with the cost of hospitals in our own countries. Our funding proposals for projects in Sierra Leone, Rwanda and Kenya to government agencies, however, have been turned down.

That any mother in the 21st century should die having her baby or sustain a birth injury is an international disgrace. This tragedy will only be solved one mother at a time with appropriate obstetrical care to which she has a fundamental right, and this year is the 60th anniversary of the Universal Declaration of Human Rights.

I would like to add a plea in particular for refugee mothers who seem to be left out of the discussion and whose suffering is immense. We obstetricians know what we have to do and for whom, and I think your legislation is a generous way of providing the how. I thank you very much. Thank you.

[The prepared statement of Dr. Walley follows:]

PREPARED STATEMENT OF ROBERT L. WALLEY, M.D., EXECUTIVE DIRECTOR, MATERCARE INTERNATIONAL

Mothers, in the developing world, are experiencing "unimaginable suffering" due to scandalous lack of effective care during pregnancy and childbirth with the consequence that many thousands are dying. The World Health Organization claims that there are 600,000 maternal deaths annually of which ninety-nine per cent occur in developing countries. However, there is no accurate data to substantiate these numbers, the reason being that most developing countries do not report information on births, deaths, the sex of dead people or the cause for death. However, figures from my own experience at a mission hospital in Nigeria where the in-hospital maternal mortality ratio was 1,700/100,000 live births illustrates the enormity of the situation.

Some 200 million women are pregnant world-wide each year. Most mothers deliver in villages without access to safe, clean facilities in which to deliver and without a trained person to assist them. Most maternal deaths occur during the last trimester and in the first week following delivery. Prior to going to Nigeria in 1981,

I had never been present or had a mother die under my care from a direct obstetrical cause. Maternal deaths in Canada are at the level of what is called irreducible minimums, 1/100.000 live births. However, in the mission hospital maternal deaths were almost a daily event and I recall one weekend during which there were four deaths of mothers who had arrived at the hospital in extremis from haemorrhage, one in agony from obstructed labour, and another after days in labour with a ruptured uterus as she was young and consequently her pelvis was too small. Others would arrive unconscious due to pregnancy induced hypertension or suffering from malaria, or severe anaemia resulting from malnutrition. Many more mothers die in Africa alone and in terror in the villages as they have no way of getting to the hospital. Not only are the lives of these mothers abruptly ended but also the lives of their babies, and in the aftermath the chances of survival of their young children decreases dramatically resulting in the disintegration of their families.

Sadly, these deaths represent only the tip of the iceberg. It is estimated that for every death, 30 more suffer long-term damage to their health, e.g. from obstetric fistulae. These arise in young mothers, as a consequence of neglected obstructed labour (lack of Caesarean section) and also from cultural practices e.g. Gisiri cuts and female circumcision. The result is because of damage to the bladder and rectum these mother become incontinent of urine and/or faeces (obstetric fistulae). Consequently, they are complete outcasts and are treated worse than lepers by husbands/partners, families and societies, simply because they are wet, filthy and offensive. They suffer pain, humiliation, and lifelong debility if not treated. World-wide perhaps 2 million of these poor, young and forgotten mothers are living with the problem mostly in Africa. Reliable hospital data in Ghana gives the incidence of obstetric fistula as 2% of all births. These deaths of mothers and babies are the greatest tragedies of our times especially since they are readily preventable and treatable. Obstetric fistulae can be treated surgically but at present there are insufficient trained doctors, nurses or specialised hospitals.

The problems of maternal health, and the need for improved health care has been discussed by the international community for years, most recently as Millennium Development Goal (MDG) No 5 to improve maternal health by reducing maternal mortality and morbidity. It is admitted by the UN and the international health community that this goal is the most neglected of all the MDG's. A report in the British Medical Journal in July 2007 commented that at the present rate of progress the MDGs will not be met for 275 years i.e. 2282 and not in 2015 as intended. The reasons are poverty, lack of compassion, lack of political and professional wills, a conspiracy of silence, and a lack of imagination.

The consensus of the obstetrical community is that mothers need essential prenatal care, skilled attendants at all deliveries and specialist care for life threatening complications. While billions of dollars have been spent on reproductive health programmes and as more is demanded only a small fraction is focused on providing the services that ensures mothers survive their pregnancies.

In my experience mothers, in Africa are optimistic and want to have babies as they know they are the future of their families, communities and countries. Mother in developing countries do not expect to die or to suffer birth injuries and those who die obviously have no voice, only ours, to plead their cases for adequate care, care of the sort which mothers have access to in the United States of America and Canada which is second to none, but which is frequently taken for granted. I have found that mothers in Africa are becoming aware of what has been done to unborn babies in the rich world. They are becoming increasingly angry and resistant at attempts at coercion by NGOs to make them accept the killing their babies which is totally contrary to their faith and cultural and beliefs. It is egregious that any government or international health agency should suggest that the lives and health of African mothers should be improved by the killing of their unborn babies. We are all too familiar with the violence caused to women by commission e.g. by sexual assault, genital mutilation and torture but this neglect of mothers is violence as the result of omission. The root cause of all this suffering will not be solved by more death and despair.

MaterCare International (MCI) was established in 1995 by obstetricians particular concerned about the tragic state of maternal health in developing countries. MCI has extensive experience in West Africa, in particular Nigeria, Ghana, Sierra Leone, Rwanda and Kenya working with local Churches that provide 30—40 % of the beds and with local colleagues. In addition to providing much of the healthcare in rural African countries, these faith based hospital while for many years enjoyed the trust of mothers and their families, MCI's approach has been to put into practice the old obstetrical adage that live healthy mothers produce live healthy babies. As a consequence, MCI has developed a model of comprehensive, rural, maternal health care based on local causes of mortality and the circumstances under which they

occur. This model is a way of taking essential obstetrical services found usually only in hospitals closer to the mother. It provides, at a small 30 bed mission hospital; full prenatal care, with treatment for common medical conditions e.g. malaria, HIV and severe anaemia, with immunization against tetanus, and specialist management of life threatening obstetrical complications with for example caesarean section, blood transfusion, and manual removal of the placenta; and post-partum care including family planning through fertility awareness. The hospital is linked by radio to an emergency transport which can go to the mother with life threatening complications with the equipment needed to resuscitate her and then to transfer her to the hospital in a safe and timely manner. The hospital is linked to rural clinics, staffed by trained midwives also providing pre and post natal care, safe delivery and early referral of complications. A training programme for doctors and midwives in emergency obstetrics and training is provided and traditional birth attendants (TBAs) are taught to identify and refer mothers at risk to the nearest clinic. It is known that at least 15% of normal pregnancies and labours may run into complications, so the radio and transport system is able to meet these emergency needs.

This model was developed in Nigeria in the early 1990's and refined in Ghana where it has been functioning since 1997. Evaluation has shown an increase in referrals to the hospital of mothers with complications and thus an inference is that maternal deaths have been reduced. The cost of running this sort of programme for 5 years we estimate to be $2.5 million, Canadian or US dollars, a mere pittance compared with the cost hospitals in our countries. Our funding proposals, for projects in Sierra Leone, Rwanda and Kenya to government agencies, however have been turned down.

That any mother in the 21st century should die having her baby or sustain a birth injury is an international disgrace. This tragedy will only be solved one mother and her baby at a time with appropriate obstetrical care to which she has a fundamental right.

Mr. PAYNE. Thank you very much. Let me thank all of the witnesses for the very compelling testimonies. We are all on the same page. We just have to figure out how we move it through.

We talked about the PEPFAR program before, and I wonder if any of you could comment on how you feel that there could be better coordination with PEPFAR—if we can get appropriate funding at the level we are requesting. How much of an impact could that have on the areas that you are interested in child survival?

Dr. PETERSON. Chairman Payne, I would be happy to answer that question. It is something that I struggled with a lot when I was at USAID and part of the reason that I am doing what I am doing now is because I really felt like we had neglected child survival.

One of the lessons we are learning in Africa, not just as PEPFAR goes forward, but the Global Fund and other large amounts of money focused singularly on AIDS, TB and malaria is that the resources then shift to addressing those very needy causes. I have worked in AIDS since 1982. I saw my first AIDS patient in Zaire in 1982. I saw my second one in New York, Long Island, that same year, so I have been back and forth.

But what we are seeing is that the people and resources are shifting and in fact if you look at the UNICEF report on Botswana, which is one of the exemplary countries for having dealt with HIV/AIDS, look at the under-5 mortality rate and it has doubled since 1990. We do not want to address HIV/AIDS at the expense of children, and what one could do is link your PEPFAR and AIDS funding and make sure that as you focus resources on that needful area that the health resources that complement it and keep it intact, the health system also grow with the increases in AIDS. That way you will not have these hydraulic shifting for people and the resources away from one needy area to another.

Mr. PAYNE. Yes?

Dr. WALLEY. I think one of the concerns I always have in dealing with international funding agencies is that their funding comes too compartmentalized, and they are not adaptable. So HIV/AIDS treatment, obviously, is a very important part of prenatal care as is immunization for children. Immunization of mothers is very important against tetanus. And the problem is your country's agencies only fund one particular type of program. So the mother falls through the cracks because at the end we are all trying to make a difference at the village level, not up there in Ottawa.

Mr. PAYNE. So you think that, I guess, there really should be a call for more holistic or comprehensive approach to be able to integrate the needs. What can the U.S. do now to ensure that maternal and child health programs and interventions are being linked and integrated into work? Do you think that PEPFAR needs to perhaps focus a bit more on that, or do you think that the countries themselves—with many of them not having strong health departments—need to focus a bit more on that? I think one of the good results from PEPFAR is that it is helping to establish health departments, units, and ministries in countries to strengthen them, which is certainly needed with the influx. So we are trying to solicit suggestions from you as how that could be better, PEPFAR funds could be better integrated.

Yes, Doctor.

Mr. OOT. It seems to me one of the opportunities is to more clearly define success to include improving maternal newborn child health as part of what we are trying to achieve through PEPFAR.

So in other words, when we do system strengthening, it is not only for that single purpose but it is in fact to improve the lives and the survival of mothers, newborns and children. I think that can be done without diluting the impact. In fact, I think it is necessary in order to be able to deliver effective HIV/AIDS-related interventions as well.

Mr. PAYNE. Yes?

Dr. FRIST. Mr. Chairman, I will just build on that a little bit. It really comes from just the very limited experiences I had in watching PEPFAR funding takeoff. It is really remarkable, just 6 years ago, and how far we have come.

I guess the first point would be that if you save somebody's life from HIV/AIDS and then they die from contaminated water a few years later, the goal of child survival, which is the ultimate goal is health, is not met. It is not a particular virus, it is not a particular entity, but it really is survival, quality of life, productivity, getting them up to this sort of age of 5, at least in this community, we know that milestone, people have that opportunity, and I think that is important, this integration.

The bill that we referred to today, of course, talks about the importance of the strategic planning, bringing people together in an integrated way.

The second point I would like to make, because the most common thing I hear is that we are spending so much money on HIV/AIDS, malaria and tuberculosis, and, yes, some of that comes down to children a lot, but if you take the 10 nations where child survival

is the worst, where mortality is the highest, only one of those 10 are targeted by PEPFAR.

So, again, if you step back and say what is the objective today, maybe in 2003 it was probably the objective, but it was less clear. But I think the objective today is survival. Survive to 5 is the initiative that we are working toward. And if you do that, you look where the problem is, and of those 10 worst countries where it is most challenging, that only one of those 10 is targeted by PEPFAR, it means that we need to refocus, raise the visibility in an integrated way and address the issues before us, Survive to 5.

Mr. PAYNE. Mr. Smith.

Mr. SMITH OF NEW JERSEY. Thank you very much, Mr. Chairman. First of all, let me just say to Dr. Frist how much we miss his leadership over on the Senate side. He is not only an extraordinarily talented surgeon and doctor, but a man who is able to bring disparate factions together time and time again for a very good outcome legislatively and policy-wise and just a totally decent man. It is so good to see you again, and when you hold out that oral rehydration salts, it reminds me of Jim Grant, the former head of UNICEF who never went anywhere without having a packet of salts. And to all of you, thank you for your testimony.

Dr. Walley, I want to especially thank you. Some of you may know this, probably most of you do not, Dr. Walley walked into my office many, many years ago, and asked me what I was doing on fistulae, obstetric fistulae, and I said, I do not even know what it is. This was in the 1990s. And gave me a crash course on what a horrific, preventable, and certainly curable in terms of reconstruction surgery, condition fistulae is; then the attendant psychological counseling that goes along with someone who has been so hurt with such tears. As Dr. Walley knows, I did author legislation, it passed the House, but never got through the Senate. We are working on another bill right now to increase the amount of money for fistulae repairs. And when we did not get it out of the Senate, we went right to Dr. Kent Hill, who was here earlier, and he did almost dollar for dollar exactly what the House legislation would have done, but it all came from Dr. Walley.

Since then I have visited fistulae hospitals and repair centers all over Africa, including the famous one in Addis. I was greatly moved by the work that was done there, and most recently, a few weeks ago, I was in Goma where women were getting fistulae repairs as a result of sexual violence.

So your work, honestly, has been groundbreaking for Africa and has spawned so much wonderful outcomes for women who otherwise had lost their lives. You have given them their lives back.

I know we are going to have to break in a minute, but I do have a number of questions. I would like to start with a few. You mentioned the whole issue of essential obstetrical services. I chaired a hearing when we had control still on the whole issue of safe blood for Africa, and the fact that the lack of it greatly contributed to hemorrhaging of women during child birth who then die because of it. WHO suggested that upwards of 40 to 45 percent, somewhere in that order of magnitude, of the maternal deaths could be done away with with the availability and the accessibility of safe blood.

The Minister of Gender in Uganda told me on one trip, she said, let me tell you Americans something, and this also would go equally for the Europeans, Uganda does not want abortion. We are tired of maternal mortality being misused by the United Nations, by U.S. NGOs, by Marie Stopes International and others to try to put into these countries abortion on demand which kills babies and I believe wounds their mothers. It is a misuse of a horrific tragedy of maternal mortality.

She said, what we want, and you just said it, is essential obstetrical services, trained birth attendants, midwives, if there is an obstructed delivery, to know exactly what to do and to do it quickly for mother and baby's sake so that, like the Canadian number you mentioned, maternal mortality can drop to almost zero.

And if you could elaborate, and maybe Dr. Frist, you as well, because I think the hijacking of the maternal—and let me say parenthetically, when abortion was being considered in the United States, and I know there are a lot of strong advocates for child survival here, and I believe in child survival for all the children, that there is not this artificial line of demarcation that says birth on, we care about them, birth before, only if they are wanted, if they are unwanted, they are dispensable or disposable.

Dr. Bernard Nathanson, founder of NARAL, National Abortion Rights Action League, as it was called then, he and Betty Friedan, founded that organization, ran the largest abortion clinic in New York. He did thousands of them and testified all over the country. He made up the number, 10,000 women in America were dying from illegal abortions every year, right out of thin air, and that got amplified by the media, by Members of Congress and Senators, and the number, according to CDC, was 39. Thirty-nine too many, we want zero, and certainly antibiotics brought down the number precipitously in the sixties, seventies, and eighties, but it was not 10,000.

The same kind of exaggeration and hyperbole and The Lancet article makes a very good point about it, WHO makes a point about it; we do not have hard numbers. But again, if there is one, it is one too many. Large exaggerated numbers do not help either. But this idea of essential obstetrical services, Dr. Walley, that is what Africa is calling for. Why would they want to buy into this, and I consider it a hijacking of the legitimate concerns we all have for ending the maternal mortality tragedy of Africa and everywhere else. Dr. Walley and Dr. Frist.

Dr. WALLEY. I am sitting next to somebody who knows things better than I do. Africa is his home we are talking about. I think the most important thing we should do but we are not, i.e., governments, international organizations, funding agencies, is to listen to the people that we are imposing solutions on. We must ask them what they want, ask the mother what she wants.

You know, I have heard it said and inferred many times by mothers in Africa, "We have not got much hope here. All we have is hope in our children, and it seems the rich world wants to take them away as well. If you do not want to directly do that, you just neglect us."

So this is all about our not listening or neglecting it to help provide technical interventions and so on. There are many things that

one can do both by training traditional birth attendants in the village to know how to rub up a contraction to make the uterus contract, to stimulate the breast with the baby if it is still alive or to rub the breast to induce endogenous oxytocin, which makes the womb contract after the baby is born, other treatments and so on.

But if the only solution is to come in with manual vacuum aspiration, with the early morning after pills and the abortion pills, this is an insult, and I do not know how people would take it if people came and imposed these kind of values on us, or maybe they have seen the way we treat our own babies in Canada or the United States, and that we have almost a despair and death to offer whereas what we are trying to offer with essential obstetrics is life and hope.

Mr. PAYNE. Thank you. Go ahead.

Dr. FRIST. Well, I will just very briefly comment. I appreciate the comments made, and clearly the focus of anything that we do in terms of policy needs to be on that fundamental grounding of respect for life, both before birth and after birth, and I want to make sure that in whatever legislation or policy comes forward that that is very clear.

I will have to say from my experience, and most recently in Bangladesh with Save the Children, what we witnessed up in Sylhet in terms of the postnatal care, in terms of vitamin A administration, vaccine work in the field, back in Dhaka, the prenatal care and respect, four visits that are an instrumental part of the program, the respect for the mother, the education that goes on, and in during birth has been the focus of what I have observed.

I do not have the fear, quite the fear of a hijacking of the agenda, I guess, just based on my experience working with the sort of groups that are represented at this table. I see the focus on that individual, the mother, the unborn baby as well as the baby after birth, and then on up to the age of 5. I think those basic principles need to be reflected again and again and again. Programmatically, that is what I have witnessed.

Mr. PAYNE. Thank you very much. Yes?

Mr. OOT. Is it possible to comment just a little bit more on that? I think the issue of comprehensive emergency obstetrical care is absolutely critical. What we have learned in listening to people and mothers in particular is that many of them either cannot or do not get to those facilities, and so moving those services that could help save lives closer to communities is absolutely critical, as Dr. Walley was referring to.

Mr. PAYNE. Ms. McCollum.

Ms. MCCOLLUM. Thank you. I thank all the witnesses for their testimony. Just a brief comment, Dr. Walley.

I had the opportunity to travel with CARE in Peru where they were identifying high-risk pregnancies through USAID and doing a lot of the interventions that you are talking about, and I think there is much work to be done, so thank you for your efforts in speaking up for women who needlessly suffer during delivery because we know the child needs the mom in order to be successful.

I would just ask all of you if you would comment on the child survival account being cut, and the concerns that we have about bringing balance to this, your perspective why this is important,

and Doctor, you are going to have a very unique perspective on this, so I would ask you to go first. Thank you for coming all this way.

Dr. METANGMO. Thank you. I think really for the longest we have used very effectively the interventionist approach that really focus on training people, on really bringing a very good solution to problem that we identify. But people who are working at community level have been for the past time really starting to discover how important the empowerment approach, where we really listen to people as Dr. Walley was saying, where really you understand and try to seek what exactly is the motive behind the behavior, what really do they want. When you bring them to the table and start talking to them, not only this empowerment and assistance ability, but to really opens door to a lot of other things that we could not have even expected.

So I think really it is very important for people who really want vertical intervention and rapid result. I think it was very easy to take this interventionist approach, but the limit that we are hitting now show that if we listen more to those models, if we really go down there and try to bring stronger the community component of each of those programs, each program, as we said, really has its positive side, but where is the voice of the community in that? As much as we put all that, I am sure that will get down to really a program that not only solve the problem, but solve it in a durable and a long lasting way.

Ms. MCCOLLUM. Mr. Chair, if I may.

Senator Frist, your position, you are a parent, you have been on both front lines. These types of interventions can empower communities and parents to take more active role in saving their own child's life, working in partnership with organizations such as Save the Children, and USAID. But does that also then begin to create part of the health care infrastructure platform that the good doctor was talking about from Cameroon?

Dr. FRIST. Well, it most certainly does, and I think one of the things we have learned really from the PEPFAR, the PEPFAR investment very directly is that coming in and imposing either Western ways or the practice of medicine the way that we practice it in the country is doomed to failure. And it does come back to the sort of empowerment on the ground, initiatives coming from within and supporting those, and supporting them with the inexpensive technologies that we know do work today and applying it. If we marry those together we end up being successful, and that is indeed the way infrastructure must develop overall. It is not going to be just an investment in a single drug or a single treatment or a single virus. It is going to require that broader investment, incorporating and assimilating interest from within, coupled with education and the very simple technologies we have today.

Mr. PAYNE. Let me thank the panel. Unfortunately, our time has expired, and I know you have a 1:30 press conference. We normally come back and ask for another round, but we will not, but let me thank you again, and I ask unanimous consent that written statements submitted by the United States Child Survival Coalition be a part of this hearing record. No objection. So ordered.

The meeting is adjourned.

[Whereupon, at 1:08 p.m., the subcommittee was adjourned.]

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