COUNCIL OF THE CITY OF PHILADELPHIA

COMMITTEE ON PUBLIC HEALTH AND HUMAN SERVICES

Room 400, City Hall
Philadelphia, Pennsylvania
Monday, March 2, 2026
1:10 p.m.

PRESENT:

COUNCILWOMAN NINA AHMAD, CHAIR
COUNCILWOMAN CINDY BASS
COUNCILMAN JIM HARRITY
COUNCILWOMAN RUE LANDAU
COUNCILMAN NICOLAS O'ROURKE

RESOLUTION: 260051

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COUNCILWOMAN AHMAD:

Good afternoon, everyone. Welcome to Philadelphia City Council's Committee on Public Health and Human Services. I now note that the hour has come.

Mr. Sham, would you please call the roll.

THE CLERK: Chair Ahmad.

COUNCILWOMAN AHMAD:

Present.

THE CLERK: Vice-Chair Lozada.

(No response.)

THE CLERK:

Councilmember Thomas.

(No response.)

THE CLERK:

Councilmember Driscoll.

(No response.)

THE CLERK:

Councilmember Bass.

COUNCILWOMAN BASS:

Present.

THE CLERK:

Councilmember Landau.

(No response.)

THE CLERK:

Councilmember O'Rourke.

COUNCILMAN O'ROURKE:

Present.

THE CLERK: And,

Councilmember Harrity.

COUNCILMAN HARRITY:

Present.

COUNCILWOMAN AHMAD:

Thank you. I note for the record that a quorum of this committee is present and this hearing is called to order. This is a public hearing of the Committee on Public Health and Human Services considering testimony on Resolution No. 260051.

Mr. Sham, would you please read the title of the resolution.

THE CLERK: Resolution

No. 260051, authorizing the Committee of Public Health and Human Services to hold hearings examining the current state of Philadelphia's reproductive health care system, the current federal landscape affecting reproductive policy and The city's response to protect reproductive freedom.

COUNCILWOMAN AHMAD:

Before we call up the first panel, I will recognize myself. So good afternoon, everyone. Happy Women's History Month. Thank you to everyone who came out today. I know we had to change our date because of the snow, lots of moving parts, but I appreciate all of you who made the time to come today.

This is personal, as probably it is for many of you. A lot of people do not feel comfortable talking about reproductive health in a public

setting, on camera and on the record. So if you're here to testify or you took time to submit written testimony, thank you. You are helping other people get care with less fear, less stigma and less silence.

We are here today because reproductive health care is not a headline. It is an afterthought and we have to reverse that. It is the appointment you cannot get. It is the prescription you have to stretch. It is trying to find a provider who takes your insurance and is actually accepting new patients. It is someone being pregnant doing everything they're told to and still feeling like the system is stacked against them.

When I say reproductive health care, I mean the whole shebang, sexual violence, birth control, STI care, prenatal visits,

labor and delivery, postpartum care, cancer screenings, fertility care, menopause care, abortion care. This is health care across a person's life. And we should be able to talk about it just the same way we talk about any other health care issues without judgment.

The reason we are holding this hearing is simple. Too many Philadelphians are running into barriers. People are traveling farther than they should have to, waiting longer than they should have to, paying more than they should have to, and it is usually people already carrying most of the burden who get hit the hardest.

We also need to name what too many families in this city already know. Outcomes are not the same for everyone. Black women and birthing people face higher risks,

and too often are not listened to, not taken seriously or sent from one appointment to another without real support. That is not just how it is. That is something we might have to own and we have to fix. And this is not only about what happens inside a clinic. It is also about whether someone has paid leave, a safe space to live, transportation, child care, language access, safety at home, whether they feel comfortable seeking care at all. All of that shows up in health outcomes, whether we talk about it or not.

So here is what I would like to get from today: I would like to get a clear picture of what is happening now. I'd like to know where the gaps are, what is getting harder, what is working and what is not. And as you testify, I'm asking you to help us with three

things: First, what barriers you see every day; second, where people fall through the cracks and who is most at risk; and third, what the city can do that would actually make a difference.

We are obviously limited by resources, limited by what the state does, what the federal government does. However, we have power and let us use it. If we do this right, this hearing is not the end of a conversation. It is the beginning of better follow-through. So I thank all of you again for being here and I look forward to the testimony.

So are there any other members who would like to offer any opening remarks?

COUNCILWOMAN BASS: Madam Chair, I just wanted to thank you for this very important hearing, which is long overdue. I

know that we had to reschedule because of the snow. Unfortunately, due to my scheduling conflicts, I'm not going to be able to stay for the beginning of the hearing. I will be able to return I'm sure before the hearing will be over. But I really just wanted to thank you for addressing this very, very, very, very important topic and look forward to following up with you on this matter. Thank you.

COUNCILWOMAN AHMAD:

Thank you so much, Councilmember, for being here. And I'm sure we will follow up with the outcomes of this hearing and how we proceed after that. We'll have another guest here, another Councilmember who is doing another hearing, an informal setting, not here, because it's hard for all of us to come during the day during work hours.

So I'm very glad and really happy that she's able to hold a hearing in the evening where a lot more people hopefully will be able to come. And so, we are having a continuum of care and conversation about this so we can really make a difference. All right. Thank you, Councilmember Brooks -- Member Bass.

Are there any other members who would like to offer --

COUNCILMAN O'ROURKE: Thank you, Chair Dr. Ahmad, for holding the hearing on this incredibly important topic. As you have lifted up already today, it's vital for us I think as a local governing body to understand the far-reaching effects that cuts in federal funding have on our communities, including on reproductive health care.

I have benefited from

being with you and with others in this body, learning more and more in this lane, this topic, whether it be in hearings or conversations or in other events where other groups, advocate groups, were addressing this matter. I think as we sit here in the people's house to hold a public hearing, advocates with the Philadelphia's Reproductive Freedom Task Force, as you've lifted up, led by Member Kendra Brooks, are organizing a People's Hearing on reproductive health this week. So this is, as she said, a continuum, right, a week long.

So for all of those who are interested in having more discussion, engaging more questions, get as many as you can in here. And if you have anything left over, bring it on down on Thursday the 5th, from 6:00 to

8:00 p.m. at the Friend Center on 15th and Cherry Streets, and look forward to continuing the conversation with you there. I think it'll be very impactful. And thank you again for your foresight and your leadership on this topic.

COUNCILWOMAN AHMAD: And Member Brooks is actually going to be here to reiterate that as well. So thank you again for that.

Are we good? Okay. The Clerk will please call the first panel to testify on this resolution.

THE CLERK: Dr. Aasta Mehta, Director of the Division of Reproductive Adolescent and Child Health, Philadelphia Department of Public Health.

DR. MEHTA: Thank you so much. Good afternoon, Chairperson Ahmad and members of the Committee of Public Health and Human

Services. My name is Dr. Aasta Mehta, and I serve as Director of the Division of Reproductive Adolescent and Child Health or ReACH at the Philadelphia Department of Public Health, and I'm a practicing OB/GYN in Philadelphia.

On behalf of Dr. Raval-Nelson and the Philadelphia Department of Public Health, thank you for the opportunity to testify to Resolution No. 260051 and to provide information about the Philadelphia Department of Public Health's work on reproductive health care from a systems perspective. Reproductive freedom is not a single service. It is infrastructure. It is whether accurate information is available, whether evidence-based providers are accessible, whether individuals

can obtain abortion or prenatal care without delay and whether families have disability needed to thrive. It requires coordinated public health investment across prevention, early pregnancy care, maternal health and economic support. ReACH invests across the full continuum.

In early pregnancy care, we fund evidence-based programs that provide pregnancy confirmation, unbiased options counseling and direct referral to licensed abortion providers when desired as well as a timely connection to prenatal care for those who choose to continue a pregnancy. When Title 10 funding was paused for Planned Parenthood, we stepped in to provide financial support to ensure that Philadelphians did not lose access to essential preventive

reproductive health services such as contraception and cancer screening. That was a public health decision focused on continuity of care during federal instability.

We are preparing to launch a public health campaign focused on early pregnancy. The goal is to support residents in the days immediately following a positive pregnancy test, helping them understand what is normal, what symptoms require medical attention and what steps to take next. The campaign will provide clear, medically accurate guidance and connect individuals to licensed providers and evidence-based programs that can help explore their options, whether that is continuing a pregnancy or seeking abortion care.

It will also help

residents distinguish between regulated medical providers and unregulated facilities that may not offer evidence-based services. Providing accurate, timely information at this early stage is a critical public health intervention. Reproductive freedom also begins long before pregnancy. ReACH operates a youth care team that provides direct services to adolescents, including sexual health counseling and education, behavioral health screenings and care navigation.

We partner with the School District of Philadelphia to support health teachers and provide education upon request, and we collaborate with the elect or education leading to employment and career training program to support pregnant and parenting teens. While there is not currently a

citywide mandate for comprehensive sex education, the evidence is clear that medically accurate, age-appropriate sex education reduces unintended teen pregnancy, improves STI prevention and strengthens young people's ability to make informed choices.

Continued expansion of these partnerships would meaningfully strengthen reproductive health outcomes in Philadelphia. For individuals who continue pregnancies, we invest in maternal and postpartum systems designed to reduce preventable deaths and severe complications. Through the city's health centers, PDPH provides comprehensive, low-barrier prenatal care regardless of insurance status or ability to pay, ensuring that costs and coverage gaps do not prevent residents from accessing care.

At the same time, ReACH houses and leads the city's maternal mortality review committee, conducts one of a handful of locally implemented PRAMS surveys in the country and operates the nation's only city-level active severe maternal morbidity surveillance system. These efforts generate Philadelphia specific realtime data that allows us to identify disparities and design interventions tailored to our population.

Our data consistently demonstrates the intersection between violence, substance use and adverse maternal outcomes. In response, in partnership with the Office of Domestic Violence Strategies, we have implemented universal intimate partner violence screenings across all five Philadelphia birthing hospitals and

trained more than 500 frontline maternal health care professionals to identify and respond to patients experiencing violence.

We have peered screening with immediate resources through Philly Safe, a dedicated concrete goods fund that provides emergency hotel accommodations and transportation support to ensure safety when risk is identified. We are also working across city agencies and community partners to strengthen the coordinated response for individuals who present to care following sexual assault, ensuring access to forensic exams, trauma-informed medical care and linkage to ongoing support services.

In addition, we are in the early planning stages of establishing surveillance of intimate partner violence-related homicides, to better understand

patterns and strengthen prevention strategies. Recognizing that mental health conditions and overdoses are leading contributors to pregnancy-related deaths, we've expanded warm handoff models that connect pregnant and postpartum individuals with substance use disorder to ongoing treatment and community-based care.

We also operate and established a doula support program specifically serving pregnant people with substance use disorder. Across these efforts, we continue to prioritize perinatal workforce stabilization and expansion. We also recognize that economic stability is inseparable from reproductive health. Through Philly Families Can, we provide centralized intake and navigation services to connect families to resources across the city.

The PF CAN concrete goods fund addresses urgent material needs such as rent, essential appliances and furniture, reducing immediate economic stressors that contribute to poor maternal and infant outcomes. Through Philly Joy Bank, we are piloting guaranteed income support for pregnant individuals, acknowledging that financial insecurity is a measurable health risk.

Reproductive freedom includes the material conditions necessary to safely parent. Despite these investments, we face real challenges. Philadelphia has become a major access point for abortion care within Pennsylvania. Clinic and obstetric unit closures across the region have concentrated care in fewer facilities. Workforce instability, particularly

policies that disrupt nursing and reproductive health training pathways, threatens care capacity,

Misinformation and unregulated facilities can delay care and undermine patient autonomy. And economic barriers, including transportation, child care and insurance gaps, continue to limit timely access to both abortion and prenatal care.

Protecting reproductive freedom in Philadelphia therefore requires sustained investment in evidence-based providers, continued public education about available evidence-based services, stabilization of the reproductive health workforce, strengthen navigation and material support systems and continued partnership with schools to ensure young people receive medically accurate information.

Reproductive freedom is not abstract. It is whether someone can access accurate information and evidence-based care when they need it. It is whether they can make decisions about pregnancy and consultation with their provider and it is whether families have the support necessary to thrive once those decisions are made.

Philadelphia has built meaningful infrastructure to support reproductive health across the life course. Sustaining and strengthening that infrastructure will require continued coordination, investment and vigilance. ReACH stands ready to continue leading this work in partnership with Council and our community providers. Thank you for the opportunity to testify on this important topic.

COUNCILWOMAN AHMAD:

Thank you so much, Dr. Mehta. That was a very comprehensive overview, and we want to sort of dig down a little bit on some of the parts of that. But before that, I want to acknowledge my colleague Councilmember Rue Landau who has joined us, who's on the committee. So thank you for being here. Did you want to make any opening remarks because we went through -- we can do that now if you want.

COUNCILWOMAN LANDAU:

(Inaudible).

COUNCILWOMAN AHMAD:

You're okay. You're welcome. I know we have a long list. It's an important issue so we're going to try to be efficient.

So first, I want to acknowledge the department's hard work and broad range of services you provide. What we were looking

for, and maybe you have this already and we would love to share with all our Council offices, what that flow chart looks like, how people contact these resources and for referrals, all of those? So basically, what are the low and no cost services and what are the best contact information for such services and referrals?

And what we would like to do is get something from your office as a resource sheet available that outlines all of this so we can have better information for our constituents. This is a practical thing that we are requesting from you.

The second thing I wanted to ask before I open the floor to my colleagues is, you know, you spoke about we have a lot of cuts going on so there's a lot of places where service is kind of

coagulating and causing backflow problems. So what would you in the Public Health Department recommend we do to address this logjam?

Outside of just the pure funding issues that can come from budgetary requests, what additional supports and entities are out there who maybe we haven't tapped or we can tap some more in order to fill the gaps? What I want to do with this hearing is to really understand those gaps. See if you could speak to that.

DR. MEHTA: So I believe I outlined a lot of places where infrastructure is already built. And I think that sustaining the infrastructure that's already here is important. Where the infrastructure works and then where it doesn't work, changing that specifically. So in terms of you speaking about the federal changes

specifically around Medicaid, right, so Medicaid ensures a large number of pregnant individuals.

And so, as those changes come into place, we're going to have to lean on our Pennsylvania Medicaid partners to better understand what we can do at the grassroots level to ensure continued coverage for both pregnancy and postpartum and in between pregnancies. And so, that's going to have to be whatever infrastructure that they build at the state level, that we would know about it and operationalize that locally to ensure that people know how to continue to access benefits, things like that. But that's like broader, all sorts of care. But it does particularly impact the pregnant population.

Certainly, benefit changes to SNAP and WIC, which

specifically the reproductive health age population will have to -- we'll have to figure out how they can continue receiving those services. But that's things that we're going to have to operationalize once we know what that infrastructure is that we're going to be operating under.

But then I would say that one of our goals as sort of people in the community is to be sure that folks that are most impacted by that have the information and we invest in care navigators to be able to get folks the services that they still qualify for. That's large scale.

COUNCILWOMAN AHMAD:

Yes. Thank you. But we need to do it like ASAP, right, to have this sort of infrastructure built out, because the cuts have already happened and we'll be seeing the

impact. I wanted to ask specifically about partners, philanthropic partners, hospitals. Have we convened these entities who can help us address the gap? And I'm envisioning this is just something I'm thinking outside the box.

Is there a fund that might be created where people, especially for things that are not covered by Medicaid and now are going to become even harder to get, such as abortion care, are we able to set aside resources, along with partners, where we could dip into those to fill those gaps? Do we have anything like this?

And have we convened all our partners around the table to say this is right at our doorstep, what are we doing in an infrastructure perspective?

DR. MEHTA: So we

convene multiple stakeholders often. We meet with the Pennsylvania Medicaid and all of the regional managed care organizations on a monthly basis to talk about shared issues, along with all the health systems. And so, there is a natural convening that we've been meeting since 2020 regularly to talk about shared ways that we can work together. And that's where we get more realtime understanding about what's going on at the state level, and to be able to ensure that folks continue to get access.

I think it's still unclear what that infrastructure looks like. And so, before we operationalize something else, we want to be sure that we're working in tandem with our state partners. And in addition to that, while people might live in Philadelphia

or their insurance might be outside of the county or people outside the county birth in Philadelphia, so we want to be sure that whatever things that we have in line are in collaboration with all the counties around us so we have a more coordinated, cohesive approach in terms of other sorts of convening.

Certainly, we talked to labor and delivery groups. That's how we're able to implement quality improvement initiatives and things like that. But again, I think it's still unclear what is our charge. And we don't want to develop a charge that's not in alignment with the state charge. Because while Philadelphians are here, they're also in Bucks County or in Chester County and they're birthing in different places. So you want to have more of a cohesive approach there.

COUNCILWOMAN AHMAD: One last comment on this whole infrastructure and how we fund the infrastructure. The state has a surplus and we have a Governor who is sympathetic to the issues we are facing and how we leverage that support, first of all, get that support in some kind of a structure, a vehicle that we can use, and then use our other entities who have large endowment funds, other spaces. Healthcare is so fundamental. Without that, you're not going to do anything else, no jobs, no education, nothing if we are not meeting those needs, and particularly for our new residents of Philadelphia who are being born, right.

So maybe we'll do a follow-up to understand how we can do a very concrete kind of convening, concrete results to come

out of a convening that could actually underwrite some of these service providers who are feeling the pinch. Just to think about for -- we can have another conversation, but that's kind of what I'm thinking. What are our solutions, like realtime solutions so real providers can actually get some support in providing these services and what that could look like.

So I thank you so much and I'll yield to my colleague. You're good? Okay. She didn't have a question, but I do have a few. I wanted to talk about sex education. I know there are other panels we were going to be talking about. It's not mandated. Can you speak to why that is not part of our school curriculum from a perspective of a health provider?

DR. MEHTA: So in other

states, there's usually a state law that mandates comprehensive sexual education that does not exist in Pennsylvania. And so, the only path to that would be that we would mandate it in Philadelphia County. And I'm not clear of the legislative pathway for how that should occur and also probably a good question for the school district.

COUNCILWOMAN AHMAD: That's why I asked it. Just to go on the record that if the state doesn't do something which allows us to then step up in a legislative manner, because I think it's reprehensible in this day and age we are not preparing our young people to understand what life looks going forward. And this is a fundamental missed opportunity to set up our kids for success. So we will probably look to you to speak

about this in terms of what we can do legislatively, if we can. Those are all those ifs about preemption that come into play.

But since there's nothing, that's when we're not preempting anyone so we need to probably work with you and many of the providers here to move on that as soon as we can. If we can of course, given the legal parameters.

DR. MEHTA: Just for the record, I'm not sure what the pathway is so I don't want to say that I am the expert in that.

COUNCILWOMAN AHMAD: I totally understand. But again, I want to be on the public record that we don't have comprehensive sex education in Philadelphia that could really preempt many of the issues you face downstream because we don't have that.

So if there are no

questions, I want to thank you for your testimony. You're good and we will be in touch. Thank you so much.

DR. MEHTA: Thank you so much.

COUNCILWOMAN AHMAD: Okay. The Clerk will please call the next panel to testify on this resolution.

THE CLERK: Meredith Mattone, Director of Policy Lab, Children's Hospital of Philadelphia; Lila Slovak, Director of the Philadelphia office Woman's Law Project; Laquisha Anthony, Senior Manager of Advocacy, Philadelphia Center Against Sexual Violence; Jabina Coleman, Co-founder BAE Culture; we have Brook Smith reading on behalf of Karla Mendez Lugo, Executive Assistant Oshun Family Center; and last but not least, Jessica Corey,

Director of Family Support Programs, Maternity Care Coalition.

(Witnesses approached witness table.)

COUNCILWOMAN AHMAD: Okay. Big panel here. Thank you everyone for being here. Please state your name and begin your testimony, any one of you.

MS. MATTONE: Good afternoon, Chairperson Ahmad and members of the committee. My name is Meredith Mattone, maternal health researcher here in the city for the past 15 years, also a member of the city's Maternal Mortality Review Committee. Thank you so much for the opportunity to be here today to discuss how we can support the reproductive health of our community.

First and underscoring my testimony today is a call to consider economic security as a

matter of reproductive justice and reproductive freedom. The effects of economic insecurity on health are pervasive and insidious. They span access to care, education, nutrition, concrete goods and they contribute to stigma, bias and environmental exposures that are adverse to health.

The pregnancy and postpartum year are economically fragile periods for birthing people and their infants, with heightened poverty rates in this time that impact health intergenerationally. A policy framework that considers economic security as a matter of health includes policies such as the child tax credit and other income support programs like those that Dr. Mehta mentioned are being piloted in Philadelphia.

It includes nutrition security programs, Medicaid and

also paid family and medical leave. Policies that reduce administrative barriers to access to public benefit programs and increase public awareness of the pathways to eligibility and access to benefits for Philadelphians are of increased importance in this moment, as our protective and proactive outreach to families who are no longer eligible for programs.

I would also encourage Council to use its collective power and voice to advance state action on paid family and medical leave so that all members of our community have access to this health-promoting program. Improving maternal mortality in our city also requires evidence-informed strategies that address structural and economic supports.

To address first two issues, first, we have mobilized on

substance use and mental health as leading contributors to maternal deaths here under the leadership of many amazing people in this room today. However, there are challenges that remain. Pregnant and parenting people wishing to start treatment for substance use disorder face numerous barriers.

One underdiscussed challenge that I'd like to highlight is child care, which is essential for treatment engagement. In our research, we hear repeatedly about child care-related barriers. Exemplar programs from across the country have included prioritized child care placements for postpartum people in recovery as well as investments in respite care models for short-term and walk-in appointments that are supportive of attendance and medical care. We have no such systemized programs in

the city today for respite care, and this is an opportunity.

Moving to the issue of domestic violence as a factor in maternal death. Investments that support survivor safety, including the availability of emergency funds that address survivors' concrete needs that are accessible to all systems and parties that are working with survivors are necessary. And policies that reduce administrative burdens associated with accessing public benefit programs have also been shown to improve survivor health.

Lastly, beyond pregnancy, financial barriers create other disparities in reproductive health across the life course. Economic insecurity results in delays in access to care that can prolong time to diagnosis and treatment, increase pain and

impacts on fertility and also result in missed time from work, school and family. Again, paid leave and access to health insurance are critical for reducing disparities in all reproductive health outcomes.

We know that protecting reproductive and women's health in this precarious policy environment will require bold investments and focused policies, but we're really fortunate to have such fierce advocates and strong thought leadership. Many of these colleagues are in the room today to show us how to move forward. So on behalf of myself and CHOP, I thank the Chairperson and this committee for the opportunity to testify this morning.

COUNCILWOMAN AHMAD: We'll hear from everyone and then we'll do questions.

Would the next person state their name and begin their testimony.

MS. SLOVAK: Good afternoon. Lila Slovak. I'm speaking on behalf of the Women's Law Project today where I am the Director of our Philadelphia office. Thank you for the opportunity to testify. As you know, Women's Law Project is a legal services organization that seeks to advance and defend gender justice here in Pennsylvania and beyond, and we are here today to urge Council, as you're considering the landscape of reproductive needs in the city, to center the needs and experiences of survivors of sexual violence.

I know my colleague, my panelist here Ms. Laquisha Anthony, will be speaking in further detail to the relationship and

intersection between sexual violence and reproductive health, and I'm here today to speak specifically about a gaping hole that is about to open.

You asked, Councilmember, to hear about the gaps in our system. And we are on the precipice of really expanding gaps in the ways that we're servicing the needs of sexual assault survivors here in the city. Survivors of sexual violence are a frequently overlooked aspect of reproductive health and justice. They require specialized services. That could include trauma-informed medical care, so things like emergency contraception, access to abortion services, STI prevention, but also things like forensic examination if they wish, and connection to victim services.

The experience that a

survivor of sexual assault has in accessing those services can have a lifelong impact on their relationship with their health care. For 15 years, the Philadelphia Sexual Assault Response Center, which is known by its acronym PSARC, has been the place in Philadelphia where adult survivors or survivors ages 16 and up, receive these specialized, comprehensive services.

PSARC is at risk of closing in a matter of weeks on June 30th due to a lack of funds. We are asking that Council act now to preserve those essential services and to invest in PSARC to affirm the commitment to reproductive health and to survivors of sexual assault in the city.

Not all members of Council might be familiar with

PSARC, and that is because it is not, in fact, a city program. It is a privately-operated public good that we have in this city that is open to all members of the public in Philadelphia and provides free services. In 2025, PSARC conducted 338 rape kits, which was a 9% increase over the previous year.

While PSARC is housed in a building with all kinds of other city services and, in fact, PSARC pays to the city tens of thousands of dollars a year to sublease that space, the city is not actually involved in either the management or the funding of PSARC. PSARC was the brainchild of a coalition of groups, including a number of city agencies, so the District Attorney's Office, the police, my colleagues of WOAR, Women's Law Project and other organizations here in this city.

It was created back in 2011 to meet the needs of survivors. And when that program was launched, Hahnemann Hospital operated it. In 2019, as you know Hahnemann closed, and at that point Drexel School of Nursing assumed responsibilities for operating PSARC, and that is where we are today. But as I mentioned, there's a funding gap. It's been operating at a deficit and we are looking at a closure on June 30th.

In the words of Shanita Good who's the Clinical Director, PSARC was created to do what traditional systems could not. It offers an intimate setting free from alarms, from the organized chaos, the prolonged waiting times that people might encounter in an emergency room. And unlike an emergency room or in the Philadelphia hospitals, PSARC

caters exclusively to the needs of survivors of sexual assault. And it is staffed by sexual assault nurse examiners known as SANEs, who are credentialed specialists trained specifically in providing these trauma-informed services in the aftermath of a sexual assault.

So to be clear, currently all adult rape kits in Philadelphia are conducted by PSARC SANEs and they're happening either in the office-based clinic, the Office suite at PSARC or PSARC SANEs are dispatched out to area hospitals when somebody is inpatient and they can't travel to PSARC.

If you have not had experience with a rape kit, and I hope that you have not, it's important to understand that it is a multi-hour, intrusive, arduous exam where a patient's body is

essentially being approached as a crime scene for the preservation of evidence. The exam must be completed within the first 24 to 72 hours for the best hope of preserving DNA evidence and the provider of that rape kit of the exam after interviewing a patient about what happens, what they remember. After obtaining consent, they will examine and photograph and document the patient's entire body. They're collecting debris from under their fingernails. They are taking urine samples, blood samples. They are removing foreign debris.

So it could be fibers, it could be hair, it could be other materials from a patient's body, their clothing tangled in their hair. They're swabbing inside their mouth, inside their genitals, their skin, so neck, abdomen,

thighs, anywhere where contact may have occurred, again to try to collect that DNA evidence so that could be foreign semen, blood, saliva, skin cells, and that's all being documented and preserved.

Before PSARC existed, so going back 15 years, the only option for survivors of sexual assault if they wanted to receive a forensic exam was to go to the emergency room. And you could imagine going to an emergency room and encountering a provider who may have never performed a rape kit before. And so, they are actually opening that box, the rape kit box and reading the instructions on the rape kit for the first time as they're performing that exam. They might not have had special training in how to speak to somebody, how to interview somebody after they've been raped.

At PSARC, in contrast it is a small setting that, as I mentioned, is exclusively catering to survivors of sexual assault. And as a result, they are able to really center the human being in front of them. There's not a triage or counting of injuries. And as one patient shared with us while we were preparing for today, a recent patient said that they had been really scared to seek help. But that after going to PSARC, they no longer felt that fear.

On behalf of the Women's Law Project, we are urging you and all members of Council when you are considering the city budget for the coming year to include a line item for PSARC for $300,000. That is all that we are asking, a $300,000 line item so that these high-quality specialized services can continue to be offered to victims

of sexual assault in Philadelphia.

Philadelphia hospitals do not employ SANEs right now and are not prepared to begin conducting sexual assault forensic exams should PSARC close on June 30th. If the city allows PSARC to shut its doors, we will be failing in the mission to protect and support reproductive health in Philadelphia. We ask you to act now. Philadelphia depends on PSARC. PSARC needs to be able to depend on Philadelphia. I certainly welcome your questions on the topic. Thank you for your attention.

COUNCILWOMAN AHMAD: Thank you so much. Will the next witness please state your name and proceed with your testimony.

MS. ANTHONY: Good afternoon, Public Health and Human Services Committee and all of those

that are present today. My name is Laquisha Anthony. I am the Senior Manager of Advocacy at WOAR, Philadelphia's center against sexual violence, the only rape crisis center in Philadelphia. Thank you for the opportunity to testify today.

Every day at WOAR we walk alongside survivors in this city at some of their most vulnerable and life-altering moments in their lives. I'm here to speak about the urgent and inseparable connection between gender-based violence and reproductive health, and to offer an overarching view of why reproductive health access is foundational to safety, dignity and equity.

Reproductive health is not limited to one service or one moment. It encompasses

contraception, emergency contraception, STI testing treatment, abortion care, prenatal and post-partum care, maternal health and trauma-informed gynecological services. At its core, reproductive health is about bodily autonomy, the ability to decide if, when and how to have children and to access the care necessary to protect one's health.

For survivors of gender-based violence, reproductive health care is not separate from safety. It is central to it. Gender-based Violence is both a crime and a public health crisis. It's rooted in unequal power and harmful gender norms, systemic inequities and coercion. It includes sexual violence, intimate partner violence, stalking, trafficking, elder abuse and family violence.

While it can impact

anyone, its consequences are not experienced equally at all. Specifically for survivors of sexual assault, nationally nearly 1 in 5 women have experienced completed or attempted rape in their lifetime. Each year hundreds of thousands of people experience sexual assault. And for many survivors, the violence does not end when the assault ends.

The harm often continues in their bodies. Approximately 5% of rapes result in pregnancy, translating to tens of thousands of rape-related pregnancies in the United States each year. Survivors face risk of sexually transmitted infections, unintended pregnancy, pregnancy complications and long-term reproductive health conditions and severe psychological trauma.

For survivor access to emergency contraception, STI and

abortion care, prenatal care if that's their choice and trauma-informed follow-up services is not elective, it is emergency care. Reproductive health access is violence prevention at its best. We also know that intimate partner violence and pregnancy are deeply connected.

A Philadelphia health report found that roughly 9% of people reported have some form of intimate partner violence during or after pregnancy. Even more alarming, 21% of people who died within a year of pregnancy had documented intimate partner violence in their records. Pregnant people are elevated risk of lethal violence by intimate partners compared to non-pregnant people. That means reproductive health care settings are not just medical spaces. They are critical

safety touchpoints.

We must also name reproductive coercion as a part of this broader view of reproductive health. Reproductive coercion is a form of abuse in which a partner interferes with someone's reproductive autonomy to maintain power and control. Up to 1 in 4 women experiencing intimate partner violence report reproductive coercion. This can look like birth control, sabotage, refusing to use condoms, pressuring or forcing pregnancy, threatening violence if a survivor seeks abortion care or monitoring and restricting medical appointments.

Reproductive coercion directly undermines reproductive health. It increases the risk of unintended pregnancy and further entraps survivors in abusive relationships. When health care

systems fail to provide confidential, discrete, trauma-informed services, they unintentionally reinforce that control.

When access to reproductive services is delayed or denied, harm compounds. Emergency contraceptive is most effective within 72 hours. Abortion care becomes more expensive, more medically complex and more difficult to access. Yet survivors often face insurance restrictions, limited clinic availability and cost barriers, providers who are not trained in trauma-informed care.

In nearly 1 in 3 counties in the United States do not have obstetrics providers. In many states, large regions lack abortion providers entirely. For low-income survivors, missing work

and arranging child care and securing transportation can make timely care nearly impossible. When access is restricted, survivors are more likely to carry unintended pregnancies to term, mental health outcomes worsen and economic instability increases.

Survivors may remain tied to abusive partners because of shared parenthood, and lack of access is not neutral. It increases risks, it deepens trauma, and we must be clear about who is most impacted. We cannot discuss reproductive health without addressing racial disparities. Black women experience higher lifetime rates of sexual violence compared to White women, while also facing systemic barriers in health care rooted in racism and bias.

Black women are three times more likely to die from

pregnancy-related causes than White women. They are more likely to experience unintended pregnancy and more likely to live in areas where limited access to reproductive health services are. Structural racism in health care means that Black women's pain are too often dismissed. Their concerns are underestimated, their autonomy is questioned. And when reproductive access is restricted, Black women are disproportionately impacted economically, medically and generationally, policies that limit care, widening existing inequities and continue a long history of controlling Black women's bodies.

And if we're serious about improving public health in this city, then we must treat reproductive health as comprehensive, essential care and as a violence prevention.

Survivors need immediate access to emergency contraception and abortion care. They need sustained funding for Philadelphia Sexual Assault Response Center, which is known as PSARC, for forensic exams and follow-up reproductive services. They need trauma-informed training and reproductive health providers. They need strong protections for patients' confidentiality and they need investment in community-based serving Black women in marginalized community.

And screenings for reproductive coercion must also be standard practice in healthcare settings. Reproductive autonomy is not a political abstract. It's a safety issue, it's a racial justice issue, it's a public health issue. So when survivors are denied comprehensive reproductive health

care, their trauma is prolonged and their safety is compromised.

When they are supported with timely, compassionate, accessible care, healing becomes possible and cycles of violence can be disrupted. Survivors deserve control over their bodies. They deserve equity and health care and they deserve policies that recognize what we see every day at WOAR. Safety, dignity and reproductive autonomy are inseparable. Thank you for your time and your commitment for protecting the lives and well-being of survivors in Philadelphia.

Thank you.

COUNCILWOMAN AHMAD:

Thank you, Laquisha.

Will the next witness please state their name and begin their testimony.

MS. SMITH: Good

afternoon, Councilmembers. My name is Brooke Smith. I am the Community Impact Specialist for Oshun Family Center, and I'm also the founder of Baby Be Soothed, a Philadelphia-based organization supporting families through infant massage, safety, education, maternal wellness and parenting support.

I am honored to read testimony on behalf of Karla Mendez of Oshun Family Center: My name is Karla Mendez Lugo. I am the daughter of a migrant, the mother to Amelia who was born sleeping, and to my Rainbow Baby Mia. I serve as a leader at Oshun Family Center. I am a mental health advocate and a reproductive justice advocate.

I am here for women who choose not to bear children simply because they do not want to and who

should never have to justify their autonomy. Bearing children does not equal womanhood. Motherhood is sacred, but it is meant to be chosen. Our bodies are not public property. Our wounds are not political battlegrounds. Autonomy over our bodies is a fundamental human right.

Reproductive justice means the right to have a child and the right not to have a child and the right to raise children in a safe, healthy community. Anything other than that is an equal in -- inequality. I'm sorry, y'all. Having experienced both profound loss and profound joy in motherhood, I know pregnancy decisions are deeply personal and often painful.

They require support, health care and trust, not stigma and political interference.

Stories like mine matter. When they are on record, they create space for other women to share their truths and advocate for themselves, and for those who can and cannot.

I strongly support Councilmember Nina Ahmad's resolution. Real change requires community and collaboration. We invite her to join us at the People's Hearing on March 5 with the Reproductive Justice Task Force. We have a wealth of data. We know people are dying. We know families need care.

The question is not whether the problem exists. It is what we will do about it. Data without action is delay. We need solutions, investment and policy that reflect the dignity of people that we serve. Protect our autonomy. Protect our health care.

Move from documentation to decisive action. Thank you. Karla Mendez Lugo.

COUNCILWOMAN AHMAD: Thank you so much. Just before we go to the rest of our witnesses, I wanted to recognize my colleague Kendra Brooks who's here. She's on a bit of a tight schedule. As I said in my opening, we are creating a continuum of speaking about reproductive health care and justice, and she's here to speak about an initiative that she's undertaking.

So if you bear with me, we'll make sure she gets to say her piece before we go back to the rest of the panel. Thank you. The floor is yours.

COUNCILWOMAN BROOKS: Thank you so much, colleague.

Good afternoon, everyone. And I want to thank

Councilmember Ahmad for making some time for me to be able to give a few remarks this afternoon during a hearing. Over the last two years, it's been a pleasure leading the Reproductive Health Task Force, working with patients, doctors and providers on how to shape public health and particularly reproductive health care policy here in Philadelphia, and I'm so very proud of the work.

The task force consists of 20 organizations, administration officials and my office as well as Councilmember Landau's office. We meet quarterly throughout the year and discuss issues of the day as it relates to reproductive health care, with particular focus on local policy. Philadelphia has been a national leader following the Dobbs decision in ensuring reproductive health care is

protected and remains a human right here in our city.

The ongoing attacks on public health from the Trump administration make us all less safe. They are implementing the most anti-public health agenda this country has ever seen, from attacks on Medicaid and the Affordable Care Act, to doctors' gag orders to funding freezes and cuts. It is imperative that municipalities and states are doing all that they can to fight back. This is what the task force has been focused on since our launch in October 2023. I appreciate everyone for being here today for this very important hearing, because City Council and the Administration need to hear from you directly.

During last year's budget cycle, Philadelphia took steps backwards. After years of

continuing funding for organizations like The Spot, Abortion Liberation Fund and Planned Parenthood, these organizations were left on the cutting floor during budget negotiation. That's not acceptable. And we are going to fight this budget to change that.

I also want to take a moment to plug the People's Hearing that my office and the Reproductive Health Task Force is holding later this week. We plan to continue this important conversation outside of City Hall because we know that it is going to take people power to win this funding back.

So the People's Hearing will take place this Thursday, March 5th from 6:00 p.m. to 8:00 p.m. It will be hosted at the Friends Center at 1501 Cherry Street. But I think we're packed

in full over capacity. So I would implore people, we would love for you to be a part of it. So I would suggest that you follow us on Facebook. We'll be livestreaming so you guys can see the Facebook page. It's Councilmember Kendra Brooks.

I want to thank all the task force members that are here. We've worked really hard to get to this point and let's continue to push this journey forward. And thank you. I'm sorry to interrupt you guys' testimony, but I just wanted to make sure that I show up for the work and we show up wherever we are. So thank you all for the work.

Thank you so much, Dr. Ahmad, for moving this forward. And I look forward to seeing and meeting you on Thursday.

COUNCILWOMAN AHMAD:

Thank you so much, Member Brooks. As we said at the beginning, we are creating a continuum, a landscape where we're going to fight from every angle to make sure reproductive health care, reproductive freedom is a household topic, that we don't push it as a second class issue. This needs to be at the forefront. We have to look at funding. We have to normalize this conversation.

I recently passed a bill on workplace accommodations for menstruation, perimenopause and menopause. That was to address the real issues people face in any one of these three issues, conditions. However, part of the issue was to actually normalize the conversation. We're a 17 member body. We are 10 men and 7 women, and we needed to have a conversation where everybody had to

read those words and vote on that, right. So that's part of the conversation.

That's why having this continuum is so important to message to Philadelphia, to the state and to the nation and to the world. The world is watching us. The world is watching what we are doing. We are supposed to be at the forefront of women's rights, but we certainly are not there now. We have slipped way back and I think we need to keep emphasizing that, keep amplifying it.

And so, I'm very grateful to all of you. That's enough of my speech. We'll go back to our panel. The next person, would you please state your name and begin your testimony. And thank you, Jabina, for being here. Yay.

MS. COLEMAN: Good

afternoon, Councilmember Ahmad and fellow Councilmembers. My name is Jabina Coleman. I'm a licensed Clinical Social Worker, Reproductive Psychotherapist, International Board Certified Lactation Consultant and an Adjunct professor teaching public policy of breastfeeding.

I'm here today because infant feeding is a public health imperative. And in Philadelphia, we cannot talk about reproductive health without talking about lactation care, human milk access and the conditions that shape feeding outcomes. I also come as the co-founder of Breastfeeding Awareness and Empowerment, also known as BAE Culture, now in our 10th year of breastfeeding, building community with Black women and birthing people, creating peer support, lactation education and

systems navigation when families can't find support, where they should be able to, in perinatal, at birth and in the weeks after.

As a city and health system, there has been real progress. More hospitals have adopted evidence-based maternity practices that support breastfeeding, including reducing formula marketing and improving early feeding support, which really matters. But we can't confuse hospital policy with the full lactation system.

The moment families leave the hospital, many enter what I call a maternity care desert or the first food desert, places where support required to meet feeding goals is unevenly available. A first food desert has been defined as the geographic area where social and economic conditions unequally

constrain breast feeding compared to other places. That's what many places in Philadelphia neighborhoods still experience.

Human milk is the biological norm. Breastfeeding is not a lifestyle. It's a choice. Families deserve the truth. Feeding human milk is one of the most evidence-based ways to protect infant health and to protect the health of mothers and birthing people. Philadelphia's own public health reporting shows breastfeeding initiation increased over time with the implementation of the programs within hospitals. However, local reporting highlights that there still remain gaps, even with initiation and relatively high by the eight weeks postpartum.

About 59% of Black parents are breastfeeding compared to 79% of White parents in

Philadelphia. This is not about motivation. This is about systems. Inconsistent prenatal education, fragmented postpartum follow-up, lack of accessible inhome support, return-to-work pressures and too few culturally-responsive providers in the right places at the right time.

What I see in practice and what community programs have been forced to patch is a simple gap. Prenatal education is inconsistent. Many families are meeting lactation support for the first time after birth, and postpartum support is hard to access. And so, with that we encourage the voice of our patients to stand out, especially because in the hospital the reasons why they're not breastfeeding is not just because they made a choice as soon as they walked through the

door when they were in labor. It was a choice because they didn't have access to reasonable, reasonable resources before pregnancy and after pregnancy.

Breastfeeding is not only a family issue, it's a city budget and health-care cost issue. Breastfeeding is not only a family issue because research has estimated that if breast feeding rates improve substantially, the United States would have billions in pediatric health costs and other economic impacts.

There are important policy levers already in motion. At the federal level, workers have rights to break time and an appropriate place to pump, enforced under federal labor standards strengthened through the Pump Act, which many of us are already familiar with. At the Pennsylvania

level, Owen's Law expand Medicaid access to medically necessary donor human milk for vulnerable infants, especially those in the NICU in premature babies.

A current proposal would expand state protections to include pumping in public by updating the Freedom to Breastfeed framework. In Philadelphia schools, we have Policy 234, which includes the requirement for reasonable accommodations for our lactating students. And some folks mentioned that earlier.

In Philadelphia government workplaces, there is an executive framework addressing worksite lactation support policies. These are the pieces, but policy without implementation is just paper. If we want equitable breastfeeding outcomes, we need equitable access to the

people who make outcomes possible.

For the last decade, I've been building workforce development through community-based mentorship, including support aligned with Pathway 3 Clinical and realworld readiness, because we know we need the people on the ground to do the work, to support what folks are and are not saying.

What I'm asking City Council to do is to fund universal prenatal breastfeeding education. It's not optional, not dependent on provider preference, expand postpartum lactation support that reaches families at home, including within the first 72 hours and first two weeks when outcomes are most fragile. Integrate lactation into existing maternal home visiting, community doula and public nursing pathways so it's not siloed. Breastfeeding and mental health are

not mutually exclusive.

And so, as much as we talk about reproductive justice and reproductive health, we have to also uplift lactation, as lactation is the key to how our babies and our mothers survive. And so, as we integrate reproductive justice, we have to also allow people to make the choice, but make the choice with informed decisions.

COUNCILWOMAN AHMAD: Thank you. Will the next witness please state their name and begin their testimony.

MS. COREY: Good afternoon. My name is Jessica Corey and I'm the Director of Family Support Programs at Maternity Care Coalition. Maternity Care Coalition is a community-based nonprofit organization founded here in Philadelphia. We have over four

decades of commitment to improving maternal and child health in early care and education.

It has been widely demonstrated that pregnant and postpartum people from underresourced communities, particularly communities of color, have disproportionately higher rates of life challenges. Many of the clients we serve experience significant past or current trauma, domestic violence, histories of discrimination, poverty and other life stressors, all of which can contribute to increased rates of perinatal depression and substance abuse. And we also know that behavioral health conditions are a leading cause of maternal mortality in the state and in Philadelphia.

The last Philadelphia Maternal Mortality Review Report indicated that 58% of maternal

deaths had substance use histories and 45% had mental health conditions. Most pregnancy-related deaths are preventable, which means there is an opportunity for providers to intervene with resources and recovery-oriented support to prevent deaths and to improve long-term outcomes for families.

The need for rapid engagement and holistic support for pregnant and parenting people with substance use disorder cannot be overstated. Furthermore, without treatment these conditions can impact a person's ability to parent effectively and subsequently contribute to adverse childhood experiences and persistent intergenerational social, emotional and behavioral challenges, so at a very high cost to our communities.

Just as maternal

mortality is complex and multifaceted, the solutions to the issues of perinatal behavioral health must be as well. General priorities should include increased outreach and enhanced access to behavioral health treatment, destigmatization of mental health and substance dependence, increased access to harm reduction education and resources, and an investment in the sectors impacting our families, such as affordable housing and child care, education and employment opportunities.

Maternity Care Coalition is committed to partnering with Councilmember Ahmad, City Council, the Philadelphia Department of Public Health and other community organizations to find and implement these types of interventions. Thank you for your time.

COUNCILWOMAN AHMAD:

Thank you so much. I think that's the last witness for this panel. I know two of our witnesses who have testified have a time crunch so we'll begin with Dr. Mattone. Just a few questions before you have to leave, and then I'll yield the floor to my colleagues as well.

I'll be specific in my question. In addition to my work in public health, one of my key priorities is strengthening Philadelphia's child welfare system, particularly for vulnerable children and families. You mentioned that access to child care is a significant barrier for birthing people with substance use disorder, especially during treatment and the postpartum period, and this can lead to a lot of child abandonment issues and such.

From your perspective,

what type of collaboration between the city hospitals, community-based organizations or NGOs would be most effective in addressing this gap and building a coordinated system that supports parental recovery and child stability?

DR. MATTONE: Thank you for this question and a focus on child care. I think that the engagement of city government in terms of coordination and sort of a call to action and resources for a collaborative of community-based organizations with involvement of the Health Department is a model that other jurisdictions have taken on.

We know that the child care sector right now is very underresourced. Some of that is federal, some of that is state, although in the Governor's recent budget there was a small increase

for child care. It doesn't meet the need, certainly not in Philadelphia. I think the other sort of framework for this is thinking about prioritized subsidy. We also know that the subsidy program does not have sort of any distinctions for caregivers under sort of special considerations.

I would say involvement in treatment could be one of those. And that's also a framework that other jurisdictions have used to sort of allocate subsidy slots specifically for caregivers in recovery. We had a respite care provider in Philadelphia for a long time and that is no longer the case. And so, I know that members of the Health Department are sort of looking into what type of respite care model, looking at a model that was used in Texas that sort of mobilized community

providers to come together to form a collaborative to make child care available in sort of this respite walk-in, short-term scheduling availability, because we know sort of that is a barrier to engagement in medical care.

COUNCILWOMAN AHMAD:

Thank you for that. I'll follow up and then open the floor to my colleagues. In medical care, now there's an ability to prescribe good food, right, healthy food options. If somebody is undergoing substance use disorder treatment and if they have a child, we should have a check box for child care so that they can do their treatment with sane mind because they're not worrying about child care for a child.

You might have heard about the Joy Bank work that was done by the Health Department, so

we actually know how to do this. Obviously, that was a pilot. And for those who are like, oh, you're giving money away, awful, awful, awful, my perspective to them is look at the long-term economic outcome that happens because we're reducing much more problematic care, which is expensive after the fact if we don't intervene early.

So we're going to look at the Texas model and see what we can implement. As I mentioned before, implementing things at our city level is always a question of preemption of the state and federal. However, I think what I mentioned to Dr. Mehta in the first panel was there are ways for our philanthropic sector, including those entities with large endowments, to really have something set aside like our Joy Bank to supplement what we're

doing. There are solutions to this and people just have to deeply care to want to do this, right.

So I thank you for your testimony. And I know you have to leave, but we'll do some follow-up with all of our folks who are testifying here. As I said, this is the beginning because we're not going to come up with all the answers just in one hearing, and we're going to take what Councilmember Brooks' event does, kind of put it all together to see what legislative priorities can we do and then how do we put a landscape together for others to participate in a real fashion, right. So thank you.

Do you have questions for Dr. Mattone?

COUNCILMAN O'ROURKE: Yes. Thank you, Madam Chair.

Dr. Mattone, first of

all, thank you for being here. Thank you to the entire panel for providing testimony today, all very important information. I had stepped out for a minute and I believe that was when you began your testimony. But based off of the testimony that was submitted, I did have a question that I wanted to raise with you.

You described how supporting new parents' economic security is a matter of reproductive justice. As a new parent myself and a Councilman here in this body focusing on affordability, I couldn't agree more with you on that. You mentioned Medicaid as one form of support. As Medicaid requirements shift and health care premiums increase across the board, could you speak a little more to the effects those barriers will have on

reproductive justice in the city?

DR. MATTONE: Yeah, it's a great question. Also, congratulations.

COUNCILMAN O'ROURKE: Thank you.

DR. MATTONE: I think Medicaid is probably on all of our minds. We know that the cuts to Medicaid that were put forward in H.R. 1 are largely the sort of direct cuts to the expansion population and those caregivers not sort of eligible through pregnancy. However, we know that there are populations of immigrant families who will be directly impacted by changes to H.R. 1 and my colleague Dr. Montoya Williams can speak more directly to that when she provides her testimony.

But we also know that indirectly cuts to Medicaid can destabilize health systems and

community organizations that provide other services to pregnant and parenting people. And so, I think understanding and providing an action plan early prior to when the cuts start on what services are most likely to be impacted in terms of community organizations that disproportionately rely on Medicaid.

And so, we know substance use treatment facilities, for example, rely on Medicaid and run on low margins. And so, I think those are a place of focus. We also know that pediatric health systems have a disproportionate share of Medicaid coverage for our patient panels. Medicaid was a program designed for the coverage of children, for example. And so, I think that there are places to look and conversations to start to have as we think about loss of

Medicaid coverage.

And the last thing I'll say is that we know that the policy is confusing. All of these policy changes are confusing for families. And so, proactive outreach and messages from leadership in our city about coverage and clarity on coverage so that everyone who is still eligible is not confused about that and maintaining access to their benefits will be extremely important. Because we know that when policy changes happen, people unnecessarily leave Medicaid rolls out of fear or out of confusion. And so, those are two things that we can do something about.

COUNCILMAN O'ROURKE:

Thank you so much. Thank you, Madam Chair.

COUNCILWOMAN AHMAD:

Councilmember Landau.

COUNCILWOMAN LANDAU:

Thank you. To open up for -- first of all, thank you all for such incredible testimony. This is extremely important and you are absolutely the experts, and we need to hear from you. I was curious about the funding for PSARC, $300,000, how far does that take us? Does that only fund one year or will that continue the funding for longer?

COUNCILWOMAN AHMAD: Just one second before -- we can let Dr. Mehta go. You don't have a question for her?

COUNCILWOMAN LANDAU: No.

COUNCILWOMAN AHMAD: She has to leave. Okay. Thank you so much.

MS. SLOVAK: Thank you for the question. And before I answer, let me just reiterate I'm with the Women's Law Project. I am

not with PSARC or with Drexel, but have had the opportunity to speak with them. So the funding right now -- well, really only the revenue that comes in is from a rape kit by rape kit, person-by-person reimbursement, so up to $1,000 from the State Victims Compensation Program. So part of the challenge is that can vary year to year while we've got all these fixed costs.

So my understanding from the current expense budget is that 300,000 would close the gap for a year, right. So that sort of investment is what would be needed year over year.

COUNCILWOMAN LANDAU: Okay. Thank you so much. I appreciate you. And my apologies to everyone, but I have to leave early too. But thank you. We are listening upstairs without a doubt.

COUNCILWOMAN AHMAD:

Thank you, Councilmember Landau. And, yes, it's all recorded, transcripts, so we'll be digging deep.

I wanted to ask you, Ms. Slovak, about this issue that Councilmember Landau touched on. How is it that -- and we've talked about this, but I want to go on public record. How is it that this is a privately managed space, when there's a crime in our city, the city services go out, police, you know, prosecution, all of those things happen, victim services, how is this not included in that continuum?

MS. SLOVAK: Well, I can't speak to why the city hasn't invested before. I can certainly speak to the evolution and it sort of being placed at this intersection between health care

and victim services, right, as a forensic exam. It is certainly the case by state law that if a victim presents at a hospital and that is where they want to receive a forensic exam, that the hospitals are required to do so.

But it's my understanding that victims, by and large, are being cared for at PSARC now because of the reasons I described for that. It really is well set up to provide these specialized services and alleviate some of the barriers somebody might face in an emergency room. So I think it's a mixture of really good intentions and some unusual history in what was put in motion 15 years ago and then it sort of took on a life of its own, as I mentioned, Hahnemann closed.

PSARC is in this space that is city-leased. It is

co-located next to SVU, so there's a lot of collaboration with the city. But it has I think kind of fallen under the radar as a city service.

COUNCILWOMAN AHMAD: It seems most logical, if they're already working with SVU, they're already in city-owned space, that this should be potentially underwritten by the city. And in addition, I do think hospitals who are not having to provide this care, so I could see a mixed model where one hospital is providing this care and this 300,000, if it were allocated, they would continue to provide this care at that location?

MS. SLOVAK: So that's really a question for Drexel, but I certainly agree with you that hospitals need to be at the table too. This is a shared

responsibility, particularly when we think about what's best for victims and wanting to sort of have a no wrong door of entry, right. Some victims want to be making a report to police and want to have both the forensic exam, the care and the report to police and some want to stay anonymous.

But things like prescription drug costs, so prophylactic medication for HIV is extraordinarily expensive and that could be provided in an emergency room where if that's being provided out of PSARC's pocket for many patients, that's really a budget change. So I agree, I think having the hospitals at the table, having the city at the table and the current operators of PSARC at the table is really what we need to maybe not fully reimagine, but consider what the next steps are.

COUNCILWOMAN AHMAD: And we need it to be a sustainable model --

MR. SLOVAK: Absolutely.

COUNCILWOMAN AHMAD: -- because we can't go year-to-year putting people at risk. Until rape culture is eradicated from this globe, we're going to need these services sadly.

MS. SLOVAK: Unfortunately.

COUNCILWOMAN AHMAD: And you said there was a 5% increase that you saw in the services provided by PSARC, which could be because more people are coming forward. Hopefully, that's it and not because there's actually been an increase. But the goal here is to reduce and eliminate rapes. This is the power dynamic we have to level.

But up until that point,

we have to have resources in a sustainable manner, and I look forward to potentially getting PSARC at the table to divvy up how we get participation from sort of a multi-factorial way to address not only this budget gap, but to put this on the front burner instead of the back burner, right.

This is the goal for this entire hearing, is to push things to the forefront. Because it again, speaking just economically, it makes more sense to do that and we benefit economically from that when we have a victim who has gotten all the services they need and make sure they're whole and they're moving forward, right. We are all economic entities. So it just boggles my mind how this has not been a part of what we do if police services or all these other things

are already in place, so we are definitely going to be focusing on that.

Do you have any questions for Lila?

COUNCILMAN O'ROURKE: No.

COUNCILWOMAN AHMAD: She also has to leave, I believe. Thank you so much for your testimony and your questions.

Are you leaving, Laquisha?

MS. ANTHONY: No. I wanted to add to that.

COUNCILWOMAN AHMAD: Okay. I was going to wrap this up with speaking about this with Laquisha Anthony who is from WOAR, as you've all heard. And also, I wanted to understand the continuum of PSARC, that work that happens, and then where you guys pick up or how that whole ecosystem looks

like, if you could elaborate on that.

MS. ANTHONY: Thank you for giving me the opportunity to explain that. I was actually coming to do so. We also have advocates that are housed at PSARC. So when a survivor comes in to PSARC, they will get a forensic exam done. But in the process, they have an advocate to support them through their process, to tell them what's going to happen and also to care for their physical needs as well as to see if they would like to actually go report to SVU, which is next door. That also is the insert channel for them to obtain therapeutic counseling care through us at WOAR. So therefore, we are met there. They are given the option to connect with our advocates, then put into our system for intake to be able to get

counseling or therapeutic services, which is also free of charge.

COUNCILWOMAN AHMAD: So in other words, this continuum of care for getting your rape kit done and then potentially getting the support from WOAR, which is like victim services, right. We already do that for gunshot violence victims and their survivors and their families, so we're already expending dollars to do that. I don't know why this crime in itself doesn't rise to the level of needing this.

So your services are not paid for either from any city entity?

MS. ANTHONY: So we do have some specific contracts around our services, but not specific outright. It's just specific programs under our jurisdiction.

COUNCILWOMAN AHMAD: So

it seems to me because we have a very prevalent rape culture -- and I keep using this word to normalize the fact that people need to deal with it, right -- we need to actually have sustainable set-up systems that address it, and it seems like we don't at the moment. So there's a contract here and a thing here and a building there and maybe somebody will -- the clouds shall part and the sun shall shine maybe. So we really need to do way better in this area. And I thank you all for advocating for that and there will be follow-up on this. So thank you very much.

MS. ANTHONY: Thank you.

COUNCILWOMAN AHMAD: Quickly, I wanted to thank Brooke for reading the testimony. And I want to thank Ms. Mendez Lugo for trusting us with your story and your loss and joy in motherhood.

And I know she's not here, but maybe you are able to do a little bit of perspective on what would being truly supported and respected look like in those moments, if you're able to. You don't have to speak to that but if you are, we would appreciate that.

MS. SMITH: So being truly supported and respected. Sometimes what happens is we are not respected and supported in the sense of it's you'll be okay. A lot of times you need more support. You need to have some mental health behind it and you need support because it doesn't just go away. You had a huge loss. And now, you're expected to deal with it every day, get back to normal. It doesn't work like that. I had a baby, the baby's not here, I don't have the joy. Everybody's asking where is the baby and it gets to

you. It's a lot. So the mental health component behind that for a significant period of time is helpful. It's just like any other postpartum. We need to have it taken care of because it's huge. And sometimes it's greater than when you actually do have a baby. So those are some of the supports that are necessary.

COUNCILWOMAN AHMAD:

Yeah. Again, I go back to the postpartum care when you actually have your baby, as you said, this is similar postpartum care when you lost your baby. And I think this should be part and parcel of our health care continuum, right. Our hospitals should know who's impacted, right, in this space.

And working with our Department of Behavioral Health and Intellectual Disabilities sector is a place I'm thinking of how this

gap is filled, not just for parents who have lost their children, but also those who are facing other postpartum issues as well. So it seems to me that mental health care needs to be like that.

All the care we check off, it needs to be one and a consistent and sustained one. Again, better outcomes for our families. They do better, their economic units. We have more tax revenue if our children do better, so if nobody else cares about anything else. Thank you for your input and thank you for reading that.

I wanted -- did you have a question for Ms. Brooke Smith?

COUNCILMAN O'ROURKE: (Shaking head).

COUNCILWOMAN AHMAD: I wanted to actually go to Jabina. And if you could show us the

intersection of lactation services. You talked about the prenatal education in this space and the fact that some people choose not to do breastfeeding. And there was a time in history when women just didn't do it, right. They were advised not to do it and it was cooler not to do it.

We've come a long way understanding the immunological benefits you get for the child and also the mother, the bonding and all of that. I remember having the hardest time learning football hold with my daughter and you needed help. For me, I could not figure this out on my own. Even if people told me in my ear, I needed someone to come and actually show me what that looked like, right.

It was there minimally. My community, my neighbors actually taught me more about being a parent

than the hospital support did, right. And I'm not saying that shouldn't happen, but I think sometimes people don't have family. I'm an immigrant to this city, right. And so, I don't have family. My mother did come to help me out and then she had to leave, and my neighbors stood in. But we need to have a very defined system of where people go.

And I know there are some, but we need to -- if you could speak to what would make that a smooth process for people not to be shamed, people not to have to beg for services or people to not even have to ask. It should be there before they even ask for it. So if you could speak to that about that gap.

MS. COLEMAN:

Absolutely. So your experience mimics my own. I'm a mother of two

and I breastfed for a total of five years. And the first experience wasn't the greatest because just lack of social support and that support not coming from medical providers, pediatricians at that time.

But what the support looks like in prenatal education supports people to make informed decisions. And when you have the information, you have the resources before delivery, that allows you to know where to access, where to pivot, where to get the support. And it's also important that people have support that's also culturally aligned and culturally relevant from providers who speak your language, understand your community dynamics and your setup.

BAE Culture offers that for the community in Philadelphia. For the last 10 years, we've been

able to support moms to initiate breastfeeding at a higher rate than our national average and also to sustain breastfeeding past one year for most of our participants. And so, what that prenatal education looks like is being embedded in prenatal care through our federally qualified health centers, through our outpatient services during the prenatal period and contracting and supporting other community-based organizations that are able to do that work.

It shouldn't be a decision that parents have to make as soon as they deliver a baby without having the information to make that informed decision. And then when asked to mix feed or bottle feed, then the data looks different. And then it also appears that people aren't interested in breastfeeding and

aren't making a decision to best nourish their babies, so being able to connect to organizations to sustain and fund these organizations that are on the ground providing prenatal breastfeeding education.

You mentioned that we can't put the onus on all the hospital systems, and that is true. And that's why it's important that community-based organizations, lactation professionals have access to supporting the parents and the families that need it the most.

COUNCILWOMAN AHMAD: I also wanted to just speak to when mothers go back to work and they have to pump. I remember the machine I used. It was called the Mercedes of machines and it was awful. However, I just wondered how people can afford that, right. So I just wondered if you're

looking for people to be employed and come back to a family-friendly space, what is the policy about providing breast pumps and making sure you can refrigerate your milk while you're at work?

All of those things, until you're in it, you don't think about those things, right. So that's why we need people like you advising our systems what are those gaps and what we need to do to continue to allow a parent to come back to work and yet still breastfeed their children. So these are some gaps that we don't articulate, like I had to go find my own thing and rent it and all of that. And if you're someone struggling with a low-income job and you barely can make ends meet, I think there should be a requirement, that if you're a lactating mother, you should have

access if you're going back to work to a pump. How does that sound?

MS. COLEMAN:

Absolutely. You should have access to all the resources necessary to be able to have a successful breastfeeding experience or being able to provide human milk in any way that fits your family structure.

COUNCILWOMAN AHMAD: I mean, a child really benefits from that. Anyway, I mean these are all things that bubble to the surface and we need to have to connect the dots to see all these gaps that we are hearing about today and we kind of know them already, but putting it in the record of saying if we truly want to take care of our next generation, these are some of the things we need to invest in and do. So thank you for your testimony.

And I think we have just

Maternal Care left here. Thank you again for being here. You have some of the overlap with this lactation space. And I don't know if you have anything further to add that you can see to make this a sustainable postpartum experience for the mother and child going into, you know, as the child grows up. What would your perspective be on that since you're a big organization that handles a lot of these issues?

MS. COREY: Yes. I do feel that Maternity Care Coalition does an excellent job in having their hand in lots of different topics and issues. I would say overall, just education, education and also having those advocates. We have home-visiting advocates in various different spaces to be able to go out into the community to provide advocacy for clients, to

provide that education, to provide resources and referrals to help address some of these barriers that were addressed today.

COUNCILWOMAN AHMAD: Thank you. Do you have any questions?

COUNCILMAN O'ROURKE: (Shaking head).

COUNCILWOMAN AHMAD: I want to thank the panel for their participation and ask the Clerk to call up the next panel please.

THE CLERK: Signe Espinoza, Executive Director of Planned Parenthood. And then we have Audrey Ann Ross, Senior Manager Communications and Policy Access Matters, and then we're adding Diana Montoya-Williams, Assistant Professor of Pediatrics, Perelman School of Medicine.

(Witnesses approached witness table.)

COUNCILWOMAN AHMAD: Thank you. Please have a seat and state your name and start your testimony. Let's start with you, Signe.

MS. ESPINOZA: Good afternoon, Councilmembers. Thank you for having me. As it was mentioned, my name is Signe Espinoza and I serve as the Vice-President of Public Policy and Advocacy at Planned Parenthood Southeastern Pennsylvania. And I also serve as the Executive Director of our statewide (c)(4) Planned Parenthood Pennsylvania advocates.

As we sit here today, I'm just relieved to say that our providers and staff are caring for patients at our centers in Center City, Castor Avenue and the Far Northeast. They're showing up the way they always do, and I want to

acknowledge that in such turbulent times. But I need to be clear, a Philadelphia without Planned Parenthood is no longer a hypothetical. It is a very real possibility.

More than 20,000 patients in Philadelphia rely on Planned Parenthood health centers for health care, and that care is very much beyond at risk. Last year's federal reconciliation package effectively stripped Planned Parenthood affiliates across the country of Medicaid reimbursement. 37 affiliates have been defunded and 45 health centers have already closed across the country.

Here in Philadelphia, we are still seeing patients. We are not able to be reimbursed. Our affiliate is absorbing that cost. That is just simply unsustainable

and the stakes are incredibly high. We know that in Philadelphia, nearly 1 in 5 Philadelphians lives in poverty, one of the highest poverty rates among major U.S. cities.

66% of our patients live below 250% of the federal poverty level. 44% identify as Black or African American and 15% as Hispanic or Latino, communities that already face deep health inequities. At the same time, Philadelphia also has some of the highest STI rates in the country. Black women in Pennsylvania die at more than twice the rate of White women from pregnancy-related causes. This is where safety net providers really come in like Planned Parenthood.

Planned Parenthood really is the first entry point of care for many people. Funding

Planned Parenthood is simply funding birth control, cancer screenings, STI testing and treatment, pregnancy care and preventative services. We know, and we will say this over and over again, that there is no health care provider in Philadelphia that can absorb 20,000 patients if our services are to be reduced or we were to close our doors. The infrastructure does not exist.

Other cities like New York, Atlanta, Baltimore, Columbus and St. Louis have stepped up now that federal funding completely falls short and they created local funding streams to protect access streams. We're hoping for Philadelphia to do the same. And without city investment, sustaining care for tens of thousands of patients is just not feasible long-term.

One of our neighboring affiliates, Planned Parenthood Keystone, just actually stopped seeing Medicaid patients as of last week. This is truly about whether Philadelphia will protect its public health infrastructure and the communities that rely on it. Our providers will continue to show up, but we need this body to also show up and we are asking you to invest in Planned Parenthood to protect access to basic health care for 20,000 Philadelphians. Thank you.

COUNCILWOMAN AHMAD: Thank you. We'll ask questions when the entire panel is done. Please state your name and begin your testimony.

MS. ROSS: Hello. Good afternoon. My name is Audrey Ann Ross and I'm the Senior Manager for Communications and Policy at Access

Matters, a public health nonprofit based in and serving Philadelphia for over 50 years. We protect, expand and enhance access to sexual and reproductive health care and information.

At Access Matters, we are acutely aware of the substantial barriers that prevent many Philadelphians from accessing the sexual and reproductive health care they seek. These barriers are especially pronounced in communities that face stigma and who have been historically excluded from health care services.

Access matters and our partners are critical in reducing barriers. Many of the people we serve who face challenges to getting connected to services, including cost, difficulty navigating insurance coverage, lack of transportation or simply just

not knowing what resources are available.

Through Access Matters information hotline and our Title 10 Family Planning Program, we directly interface with people throughout Philadelphia, identifying nearby resources and connecting people to care. As my colleagues have outlined today, there have been significant threats to access in the past several years that have impacted the ways Philadelphians access and think about care.

After the overturning of Roe v. Wade, Access Matters information hotline saw an increase in callers asking about options available to them. This is particularly true and remains true when there's increased media attention around restrictions to abortion care and other

reproductive health services in other states. This really, truly speaks to the fear that many people in our city face and have, fear that their reproductive health care services and their access may disappear.

We are particularly concerned about protecting adolescent services and access. Adolescents face their own unique barriers to accessing sexual and reproductive health care, including transportation barriers and fears around confidentiality. School-based health centers are an evidence-based approach that address many of these barriers. For 35 years, Access Matters Health Resource Center program has provided school-based, sexual and reproductive health centers that provide counseling and education as well as referrals to community-

based health services, including primary care, mental health, sexual health and social services.

There are 22 health resource centers serving adolescents, located in schools in eight Philadelphia City Council Districts, that together served over 3000 adolescents last year. These spaces are greatly beneficial for adolescents, positively impacting health and wellness and their well-being. But some schools do not have health resource centers or there are centers that are located in schools that are now slated to close.

This program has historically been supported through federal and state funding, but we strongly encourage the city to invest $500,000 in the budget to protect and expand this important program. We are grateful that City

Council is committed to the health of our city and has demonstrated interest in leading the way to transform access to sexual and reproductive health.

Access Matters supports Councilmember Ahmad's Resolution No. 260051, by identifying where barriers to care intersect. This review will assist the city to develop a comprehensive approach towards improving access to vital sexual and reproductive health care services, and we are grateful and stand ready to be a partner in that. Thank you for the opportunity to provide testimony today.

COUNCILWOMAN AHMAD: Thank you so much.

Please go ahead and state your name and start your testimony.

DR. MONTOYA-WILLIAMS:

Good morning, Chair and members of the Council. My name is Dr. Diana Montoya-Williams. I'm a neonatologist or a baby doctor and also an immigrant health researcher. I study the health of mothers and infants in this country. I work at the Children's Hospital of Philadelphia's Policy Lab and the Leonard Davis Institute of Health Economics at the University of Pennsylvania. I'm also an immigrant mother. Thank you all for creating the space today to discuss these issues.

I'd like to speak to you about the health of Hispanic and Latina women in Philadelphia and more globally, immigrant women. Recent data shows that about 1 in 4 births here in Philadelphia are to Hispanic Latina mothers. And while not all Hispanic Latina women in our city are immigrants, many are

and many live in mixed documentation status families. That reality has profound implications for the reproductive health of Hispanic women and thus, the public health of our city.

For years, we have known that immigrant women face incredible barriers to health care, insurance eligibility gaps, language barriers and fear tied to immigration status. But as you know, we are living in a period of heightened risk. A large body of research shows that punitive immigration policies or aggressive enforcement can create what's called a chilling effect on health care use and the use of other critical health-promoting benefits. This has profound consequences on pregnant individuals and their babies.

When families fear

deportation or separation or do not have legal recourses to citizenship, pregnant women may delay prenatal care, and some may avoid it entirely. In areas of the country that have experienced increased immigration enforcement or heightened anti-immigrant rhetoric, research shows higher rates of maternal anemia in pregnancy and even lower birth weight among the babies born to Hispanic mothers. This is a measurable impact on public health, but it's also not abstract data to me.

Over the past months, I have been working alongside community organizations in our city as they support families trying to navigate this moment, families struggling to decide whether to bring their babies to their new follow-up appointments. A pregnant

refugee woman worried about how she will access postpartum health care when her Medicaid eligibility disappears later this year because of federal policy changes, parents afraid to visit their own baby in my NICU because they fear immigration enforcement on the way to the hospital.

And I want to let that last one sink in. A woman recovering from childbirth afraid to come see her hospitalized sick newborn because of credible fears about the safety of her entire family. That is the level of stress that we are living and talking about and we also know that toxic stress is biologically harmful. It increases the risk of many conditions that pregnant women and women of reproductive potential can face, like hypertensive disorders of pregnancy, preterm

birth, postpartum depression.

Right now many immigrant women are navigating pregnancy and early motherhood under this acute, destabilizing, toxic stress. I worry about what happens when a pregnant or postpartum woman with severe hypertension is hesitating before going to the emergency department or when she has postpartum depression and stays home because she fears being targeted or can't access contraception.

When mothers don't feel safe seeking care, it is not only a personal crisis, it is a public health issue for our city. But I do think there are solutions. First, trusted messengers really matter. In my own research, we have found that culturally and linguistically concordant community health workers, doulas, peer

navigators, other support roles like these are especially essential. Women need accurate information from people that they trust, and sometimes they need literal accompaniment, whether that is virtual or in person, to buffer that fear with support.

We have to advocate and support those existing doula and community health worker programs that exist within our health department and our local communities, many who are represented here today and maybe create special funds to sustain this workforce. We also have to advocate for telemedicine infrastructure. Telehealth is not a replacement for inperson, reproductive care, but it is a powerful supplement. It can provide blood pressure monitoring, lactation support, mental health

services and pediatric follow-up when families are fearful of travel, but it has to be accessible. Language appropriate and digital navigation can help, and that really requires strong policy advocates.

And finally, we must stabilize and fund the community-based organizations already doing this work. They are really the backbone. If we want Latina and immigrant mothers to continue to access care, we have to ensure the organizations that are guiding them right now are resource-protected and sustained. They are working really hard under very scary conditions.

The health of immigrant mothers is inseparable from the health of Philadelphia. When mothers receive timely reproductive prenatal and postpartum care, we

reduce complications. When babies are born healthy and full-term, we reduce their costly NICU admissions. And when families feel safe engaging with health care, including traveling to and from health care, our city will benefit.

So I'm very grateful to Councilmember Ahmad in this body for approaching these issues in a solutions-oriented way and I am ready to partner with City Council to ensure that every woman and mother in Philadelphia can safely seek the care they deserve regardless of where they were born.

COUNCILWOMAN AHMAD:

Thank you so much for all your testimony. Critical, you know, we know these things, but when we put this into the public record, which is why we're doing this hearing, it is important. It is in the annals for us to know. We heard and did

we do something or not do something. That's the accountability piece that is so important.

So hearing from Planned Parenthood and knowing that 20,000 people are at risk, even though we kind of know this, it makes a difference to actually hear numbers and what we are facing. So question about -- let me just bring up my questions. So in terms of other best practices, are there best practices in other municipalities around your specific thing, because you do multi-dimensional care. Any other best practices we can look to who are stepping up? You mentioned a couple of the cities.

MS. ESPINOZA: Yeah, we can totally follow up and send -- we're monitoring municipalities across the country. A lot of folks

are obviously stepping in to supplement for Medicaid loss, but they are also supplementing for some campaigns as well. I think there's a lot of confusion even within the public health space that folks are like, you know, we'll have to wait until after the midterms for Medicaid to be impacted. That actually wasn't the way the provision was written and the reconciliation package.

The big, beautiful bill actually targeted Planned Parenthood immediately, and that's something that often times gets lost in conversation. So I think a lot of providers and a lot of advocates are talking about what's ahead of a midterm, when in reality for our providers in particular, the impact was immediate.

And on top of that, I think messaging, right, like if

there's anything that this body can do or together to really combat the misinformation and disinformation, people don't know the difference between Planned Parenthood Keystone, Western, Southeastern Pennsylvania Action Fund, Federation of America, right, like there's a lot of entities here.

And so, when one affiliate and another region is being impacted, that could really contribute to a lot of confusion around whether or not folks can be seen. And we want to make sure that folks know that they can go to Planned Parenthood if they're on Medicaid, if they're underinsured, uninsured and even undocumented, right. We want to make sure that folks are getting through the door despite the fact that we continue to face this financial crisis.

And so, I think just the

level of trying to combat some of that is some of the ways that we're seeing so many municipalities come together with some educational campaigns to let folks know what resources are available to them with so much confusion and headlines.

COUNCILWOMAN AHMAD:

That is doable, right. Before you go, in terms of because a lot of states have become draconian in what they can do in terms of caring for these services that you provide, are you getting a lot of influx from outside of Philadelphia, from outside the state as well as from other parts of the state, because that's part of the burden that is in addition to everything else, I just wanted to kind of get a sense of that?

MS. ESPINOZA:

Certainly. We can follow up with

some of the data. I know that, particularly after the overturning of Roe v. Wade, we certainly did. I think Western Pennsylvania was certainly most impacted just because of where they are geographically. But what I will say is we're obviously going to be monitoring data right now in realtime. One of our affiliates, Planned Parenthood Keystone, I know there were some headlines last week regarding the fact that because of the situation we are all in, that they are no longer able to see Medicaid patients.

And so, we're going to be monitoring data in realtime to see if some of the patients that cover some of those counties, probably Bucks County being because they do have centers in Bucks, we could see maybe some patients coming into Philly or from some of

the other counties, they cover Reading, Lancaster, Allentown, Harrisburg area. And so, that decision was very recent. So we'll certainly have some data in realtime.

COUNCILWOMAN AHMAD: And finally, what is the role the state is playing?

MS. ESPINOZA: That's the million dollar question. I think the dynamics of the legislature have made this fundamentally difficult. We've continued to have conversations with the Administration and the Governor. A lot of times that response is, let's wait and see what happens after an election. And my response to that is, sexual and reproductive health care cannot wait.

I try to be a little bit, you know, protective in my

remarks and sharing that we know what the potential outcomes are, right. When we talk about the services that we provide, they're timely services. And so, purposely --

COUNCILWOMAN AHMAD: I ask because we were able to suddenly get some money into SEPTA when the legislature --

MS. ESPINOZA: There are certainly --

COUNCILWOMAN AHMAD: We have a surplus.

MS. EPINOZA: Oh, yeah. There are certainly ways that this can be done. I think that we are in a moment right now where we truly cannot protect a status quo, right. I think we need folks to step up because we are certainly in the most difficult position we've ever been. And on top of that, the hits just keep on coming, right.

We know that opposition has realized and touched grass and realized that abortion is deeply popular, right. So they're not coming out Planned Parenthood or abortion, you know, coming for abortion bans outright. They know they're unpopular across the electorate. They know they're unpopular in every state where it's been on the ballot, right.

And so, the way that they're going to come for Planned Parenthood and abortion is through a backdoor abortion ban, bankrupt Planned Parenthood. And without Planned Parenthood, right, without those providers how are we going to talk about -- where are abortion seekers really going to go without the nation's largest provider of abortion care in the country.

COUNCILWOMAN AHMAD: Operationally, when we think about

grants and programmatic support versus operational support is really they're trying to hamstring you there and I think we should know this. And again, as I said this hearing is part of making reproductive health care a priority, not an after-fact, not if we can, not oh, they don't like it so I shouldn't say anything, I should wait. There's no guarantee for what our elections are going to do or not do.

There's no guarantee that we're having elections, by the way. So we cannot wait. And I think that advocacy piece is really important, which is why I was asking how all the other counties might be, you know, we're one county. And obviously when they hear Philadelphia, they're already like, oh, they get too much already, but we have more people

than anybody else and we have more needs.

So we just need a coalition of pushing our state coffers because there is money. And I just watched it with SEPTA. Obviously, I want SEPTA to be funded and other resources to be funded, but this is life and death literally. There's no other way around this. So we'll talk some more about what that could look like with so many partners in the room.

Do you have a question for Planned Parenthood?

COUNCILMAN O'ROURKE: (Shaking head).

COUNCILWOMAN AHMAD: I wanted to move on to Access Matters and I'm trying to hurry up because we have one more panel, and it's been a long day. I wanted to ask about transportation and the

barriers to transportation and confidentiality for our young people. You heard about me saying why we don't have proper sex education as a school curriculum, right. I don't know if there's a lot of pushback from parents or this has been tried or not, but that's all connected to the next piece of actual service delivery and what impedes the children to get them. So if you can speak to that sort of holistically as well as specifically.

MS. ROSS: Sure. So as we discussed earlier, as folks discussed, there are efforts at the state level and have been for some time to implement or to establish standards for comprehensive sex education, unsuccessfully. Thus far, we absolutely recognize and understand that this is a key component for folks, for

adolescents and people. Parents overwhelmingly typically support access to comprehensive sex ed. We do know that adolescents have varying access to these resources at home, outside of school and there's varying level of comfortability to having these conversations.

And so, this is one of the key reasons why school-based health resource centers are critical, access to Title 10 Family Planning Centers, including Planned Parenthood and our other partners are vital. And transportation is absolutely a barrier for adolescents for a number of reasons, certainly cost as well as we certainly know that health centers try to have accessible hours for adolescents as well, but there is a confidentiality piece still that remains. And although

the services are available confidentially, that education and awareness around the availability is still something that, you know, we continue to work to make sure adolescents know that these services are available in a confidential way.

COUNCILWOMAN AHMAD: So if we had the continuum of sex ed. into the school-based health care center, which also then backed up what you just learned in the class, is what we would want, right. So we both need sex education mandated in our curriculum and also to have health care provided in the school setting where they could. I hear you.

MS. ROSS: Absolutely.

COUNCILWOMAN AHMAD: I've been hearing you for a while now.

All right. Do you have

any questions for Audrey?

COUNCILMAN O'ROURKE: No questions, but just thank you for your work and your care.

COUNCILWOMAN AHMAD: And finally, I will move to Dr. Montoya Williams. Thank you for saying what we know is true is happening, and not a lot of people are speaking up about that. And so, I appreciate that you are making sure those voices are heard and the concerns are voiced. We are in unprecedented times.

My children, even though they're born here, are required to carry their passports, and, you know, they look like me. Doesn't matter if you're born and brought up here, which I'm not, they are, and they have told me I'm not to travel outside the country. They've put a ban on me and my husband going anywhere. This is

like the light part of this, right.

When this is health care, we're talking about particularly giving birth and having no resources or being so afraid, it's just inhumane. This is inhumane. And that's again why we need to be on the record with a physician like you talking about what you're actually seeing. Even though we know it anecdotally, we need it in our record, the public record that this is causing harm to other people too. Not just in the small unit, this is impacting the community at large.

So in terms of practical ways, you talked about telemedicine. What about -- I know it's hard, but home visits, right. Is there a way to stratify at least maybe in -- I don't know the capacity of our health care centers to be able to and we have only five

to eight birthing centers. I can't remember the number right off the top in the City of Philadelphia.

Could there be sort of what it used to be when doctors came to your house to give you care? At least we can do it in a limited fashion for specific communities.

DR. MONTOYA-WILLIAMS: I think that's really -- I really appreciate your creativity in thinking about how we navigate this moment and offer care to families who might go completely without. I think some of the issues that we are discussing and debating within the immigrant health advocacy space is first making sure that the people who continue to be eligible for health care and continue to be eligible for insurance and for taking their children understand the truth and the truth of the

information and eligibility versus the misinformation that is very much circulating because of these policy changes.

I think it is important to think about alternate ways to deliver health care while also keeping in mind what is the standard of care, what is the gold standard in terms of maternal care and pediatric care and making sure that we don't inadvertently create a different level of care that's substandard for our immigrant families because of this moment.

I think that is one of the things that I worry about. And how do we navigate offering good, gold standard maternal and infant care while understanding the very real risks that families may have to navigate as they choose to go or not go. That is partly why I think telemedicine is so important.

There may be opportunities for home visits too, but I think that'll be individual and family decisions with their medical providers. But I want to make sure that we're balancing those and keeping in mind what is true and appropriate health care for these families, and thinking about ways that we can create safety as families make those decisions, create accurate information, create trusted messengers and perhaps allow for more people to be accompanied. That's why I think community --

COUNCILWOMAN AHMAD:

Yeah, that was my next question.

DR. MONTOYA-WILLIAMS:

-- health workers will support people, have an especially important role to play in this issue, and we have these roles already within and outside of our health care systems. So how can

we ensure those support personnel, those jobs are sustained and really that workforce has grown because we know they have a role to play in this moment of uncertainty and fear and lack of safety.

COUNCILWOMAN AHMAD: So you're talking about sort of navigators in this space, who would --

DR. MONTOYA-WILLIAMS: There can be many roles, right. We know that doulas often play this role. Community health workers can play this role. Sometimes we have patient navigators, but it's support personnel that come from the community, maybe speak the same language if possible and are trusted. Our community-based organizations have this workforce. Our health department has workforce like this, but they are also in this moment of uncertain funding

and sustainability, but they have a role to play for our immigrant families and can be deployed very strategically and targeted to allow for some improved safety risk profiles as families seek the care they still are eligible for.

COUNCILWOMAN AHMAD: And finally before you go, about hospitals themselves in terms of what they allow, who they allow to come in, kind of, how strict are they? I mean, I thought the public space outside kind of access was there, but what about making sure we created boundaries of what was a private versus a public space? Those are creative ways to escort people into spaces that no one else except for medical personnel has access to.

DR. MONTOYA-WILLIAMS: Absolutely. I think you're speaking to some of the policies

that can be put into place and that health care systems, small and large, can start to remind their staff around which is creating the safe, confidential spaces during which health care occurs, versus the public waiting room spaces. And certainly within our institutions, we're having those conversations and re-upping that information. I think it gets tricky depending on how immigration enforcement chooses to act and chooses to carry out their enforcement activities, but we certainly can create policies and increase our education and awareness of what is allowable within our health care spaces, and that's certainly work that is happening.

The other thing that can happen in that space is families being informed of those policies,

right. Families need to know that these spaces may be able to be protected unless there are warrants that are judicially signed. So we get into the legalities of immigration enforcement and what those warrants do and do not allow which gets beyond my payroll.

But there are policies that hospitals can consider bringing to the forefront, and we have done that within my institution families need to be aware of and public health campaigns can be created around that.

COUNCILWOMAN AHMAD: Yeah, I think, not doctors, but we have a whole -- Philadelphia is full of lawyers everywhere. So we could have partnerships in order to figure out how to do it because health is primary for people. So we don't have to talk all details

right now, but we definitely have pathways to rethink this and be creative about how we address many, all of the issues we're talking about, not just this particular one. But I thank you all for -- if you have no questions further, thank you for your testimony.

As I said to the panels before, we're going to be in touch because we're just gathering all this to see what are some through-lines we can follow up on to do more. So thank you again.

COUNCILWOMAN AHMAD: The Clerk will call up the next and last panel, correct?

THE CLERK: No, we have two more.

COUNCILWOMAN AHMAD: Oh, two more. The next panel please.

THE CLERK: Alice Abernathy, Assistant Professor Obstetrics and Gynecology,

University of Pennsylvania; Elizabeth Kukura, Associate Professor of Law, Drexel University; and Abigail Wolf, Professor of Clinical Obstetrics and Gynecology; University of Pennsylvania.

(Witnesses approached witness table.)

COUNCILWOMAN AHMAD: Thank you so much. Please state your name and begin your testimony, Dr. Abernathy.

DR. ABERNATHY: Good afternoon, Chair Ahmad and members of the committee. Thank you for the opportunity to testify. My name is Dr. Alice Abernathy. I am an obstetrician-gynecologist and health services researcher. I am also a mother and the first person in my family to attend medical school.

My life has benefited

personally from access to abortion and contraception. It has literally shaped the entire trajectory of my career. And now, I practice in and study the intersection of patients navigating structural barriers to reproductive care and the systems responsible for delivering it.

I'm here to discuss the ramifications of the U.S. Supreme Court's Dobbs decision, which reversed Roe v. Wade and how it impacted Philadelphians and why strengthening our reproductive health safety net is an urgent public health imperative. We have a lot of data and now we need to act.

The reproductive health safety net is a central pillar of public health infrastructure. It includes testing and treatment for sexually-transmitted infections,

management of chronic gynecologic conditions and the provision of contraception and abortion care. Frequently, these services are delivered at the same time. My research examining Pennsylvania after Dobbs shows that although the legal status of abortion did not change in our state, health behaviors did. Demand for permanent contraception increased. Patients altered their contraceptive decisions, not in response to a policy change, but in fear that one could occur.

At the same time in Philadelphia, which is home to the majority of abortion providers in the state, we experienced an increased demand for care, including from out-of-state patients. These clinics are not siloed facilities. They're central access points for STI and

contraception care in addition to abortion and contraception care. And we know that when that infrastructure destabilizes, predictable harms follow.

Untreated sexually-transmitted infections lead to pelvic inflammatory disease, infertility, chronic pelvic pain and ectopic pregnancy, which is the leading cause of maternal death in the first trimester. These are all preventable conditions. STI testing and treatment are fertility-preserving and lifesaving and a central aspect of the reproductive health safety net. Contraception is also not simply pregnancy prevention. These medications are used to manage a wide breadth of chronic gynecologic conditions. And we know that when patients cannot access contraception for these concerns,

they experience harms.

We also know that when patients cannot access contraception for birth control, we see more unintended pregnancies, particularly among patients with uncontrolled chronic medical conditions. In my practice in West Philadelphia, nearly every single patient that I see has a comorbidity that makes pregnancy higher risk for them. Contraception is not just pregnancy prevention. It allows patients to optimize their health before becoming pregnant, making pregnancies safer and directly reducing maternal morbidity and mortality.

Finally, abortion access is inseparable from maternal health conditions. Evidence consistently demonstrates that when individuals are denied wanted abortions, they

experience depression, increased exposure to interpersonal violence and long-term financial instability. Post-op, we are seeing increase of service demand, provider strain, financial vulnerability amongst the clinics that anchor the reproductive health safety net with federal changes to Medicaid and Title 10.

We are staring down the barrel of some of the largest cuts to health services in our lifetime at the state and national level. At the city level, booming budget cuts will decimate the reproductive health safety net. The consequences will extend beyond abortion access to STI testing and treatment contraception access and maternal mortality reduction efforts.

These are all measurable post-op outcomes that are already

unfolding across the U.S. But this does not have to be the story of Philadelphia. I'm asking the Council to take meaningful action to safeguard Philadelphians from the known harms of inadequate access to comprehensive reproductive health care.

If we're serious about reducing maternal mortality in Philadelphia, we cannot weaken the very infrastructure that safeguards reproductive health. These are services that are critical for Philadelphians to prosper in the city they love. I ask you to protect this infrastructure so that every Philadelphian, regardless of their zip code or their income, can access the care they need in the city that they call home. Thank you.

COUNCILWOMAN AHMAD:

Thank you so much.

Please state your name and proceed with your testimony.

MS. KUKURA: Good afternoon. My name is Elizabeth Kukura, and I'm an Associate Professor of law at Drexel University, Kline School of Law, where my research focuses on reproductive health. I want to thank you for the opportunity to testify under Resolution No. 260051 as part of the committee's comprehensive review of reproductive health care in Philadelphia.

The resolution identifies a broad array of topics that are important for maximizing the health and well-being of Philadelphia. And so, in my time today I'd like to highlight several specific concerns, mostly related to maternal and perinatal health.

First, we know that

adverse maternal health outcomes are disproportionately high in this country and in this city, especially for Black women. Given the number of hospitals that have eliminated their obstetrics units and the imminent closing of the freestanding birth center life cycle, it's really essential that we understand the current geography of perinatal health care services in Philadelphia, including where pregnant people get prenatal care, where they give birth, where they access postpartum care, including postpartum mental health care, opportunities for the potential for telemedicine to play an increased role in provision of postpartum mental health care and opportunities for midwifery access and community birth as well.

A critical question in this context is how well all of

these care sites are served by public transportation and how SEPTA's operational planning can facilitate or reduce access to prenatal and postpartum care, care that we know is essential to improving maternal health outcomes. My second point is related and has to do with gaps in access to early pregnancy care. There are various reasons why someone may need medical attention early in pregnancy before they've established a relationship with an OB or midwife, including pain or bleeding that could indicate miscarriage or ectopic pregnancy. And many women in this situation end up in the emergency department.

The city should support efforts like those at Penn's Peace Clinic and at Einstein to address gaps in access to early pregnancy care which can be lifesaving, and

to lessen reliance on ED use or on Catholic hospitals that may not provide comprehensive counseling or treatment due to moral objections.

Furthermore, right, and as was discussed in the last panel, as actions of the federal government raise concern about the vulnerability of immigrants in health care facilities, it's even more important to facilitate access to routine pregnancy care in settings where there's less likely to be law enforcement presence.

Third, the research is clear that midwifery care is a great choice for many people experiencing low-risk pregnancies who desire patient-centered, relationship-based care. And it's also clear that how well midwives are integrated into mainstream maternity care is linked to important maternal and infant

outcomes.

The March of Dimes and Temple Center for Health Justice are currently facilitating a team of researchers conducting a landscape analysis of midwifery care across the Commonwealth. Likewise, it's important to understand the role midwives play currently in serving Philadelphians, both in hospitals and in community settings, and to ensure that resources about childbirth-related services made publicly available through the city include midwifery as an option.

And on the topic of midwives, I want to mention a bill that's currently pending in the State legislature, SB 507, which, if passed, would help move the needle forward slightly in terms of enabling midwives to practice to the full extent of their education

and training. Importantly though, the bill would enable licensed midwives to provide medication-assisted therapy for pregnant women with opioid use disorder. This would be an important step in making sure that drug use during pregnancy is addressed as a health concern and not through criminalization, knowing as we do, that criminalizing pregnant women does not improve health outcomes.

Relatedly, my fourth point focuses on understanding ways that the health care system can cause harm to pregnant and postpartum people by facilitating the separation of newborns from their families or interfering with breastfeeding when there are concerns about drug use. Research shows that the city's Community Doula Support Program is a promising model for supporting

people with substance use disorder in the postpartum period.

Under this resolution, the committee should examine how the city can work more broadly to reduce harm within the maternity care system, and particularly to make sure pregnant and parenting people with substance use disorder have access to the services they need.

Finally, the health care needs of women in perimenopause and menopause are grossly underaddressed. Building on its work to prohibit discrimination on the basis of perimenopause and menopause, thank you very much, the committee should look at who is providing this care well currently, including those who have earned the certified practitioner credential from the menopause society. That's a starting place, but not the full

extent of the story, with the goal of promoting more widespread competence in caring for the health needs of people in perimenopause and menopause. And this needs to start with medical education and training, including in relevant fields beyond obstetrics and gynecology.

I close by encouraging the committee to remember, of course, that reproductive health care is not synonymous with women's health care, and that efforts to advance reproductive health in Philadelphia must also account for the reproductive and sexual health of men as well as trans and gender-diverse people who are often poorly served when it comes to cancer screenings, STI prevention and treatment, fertility treatment and pregnancy-related care. Thank you very much.

COUNCILWOMAN AHMAD:

Thank you.

And we'll go on to Dr. Abigail Wolf. Hello. Good to see you.

DR. WOLF: Hello. Nice to see you. Hello. My name is Abigail Wolf and I'm the Department Chair for Obstetrics and Gynecology at Pennsylvania Hospital. I appreciate the opportunity to be here. We've heard a lot today about the statistics that we find in Philadelphia and that impact our patients. And I intended today to come and talk about statistics around menopause. But over the last several weeks, I've had two patients and I can't shake the story, and I want to share those with you.

The first is a 33-year old Black woman. She's pregnant. She was pregnant with her fourth

child. And at 15 weeks of pregnancy, she was admitted to a local hospital. Her story is that she had three children, unfortunately, an abusive partner. She had her meds for her asthma refilled during her early pregnancy and was referred to a pulmonary specialist. However, over the next several weeks she had several admissions to the different emergency room departments for management of her asthma. And then last week, her 6-year-old called 911 because she was having such a severe asthma attack. She was taken to the hospital and in the ambulance she coded. She was admitted to the ICU and unfortunately, she died.

The next several days later I had another patient, a 28-year-old woman, her third pregnancy. She also had an abusive

partner and multiple medical problems. She works in our schools, and her insurance is Medicaid. She told me that she loves being a mother, she loves her children, but she recognizes that she cannot bring another child into her life situation. She doesn't have a -- she can't stay with this partner and continue with the abuse and she understands that pregnancy often increases abuse.

I can't shake the look on her face when I told her what a medication abortion would cost. It is so far out of anything that she could even imagine affording. And since Medicaid doesn't cover medication abortions, we did fortunately get her referred to PEACE, and I believe will be able to move forward with her care.

I work in a big medical system. I've heard you ask about

what the hospitals are doing. And unfortunately, I think the hospitals find ourselves in the same situation. We have a disproportionate number of our patients who receive their insurance through Medicaid. And as we have less and less reimbursement for Medicaid and more and more patients who won't have Medicaid, we're going to be struggling with providing those same resources. My first patient who died, died two days before her appointment in pulmonary medicine.

So thank you very much for letting me come and share those stories. I think that there is so much more that we can do and we can be so much better, and I appreciate the opportunity to share that. Thank you.

COUNCILWOMAN AHMAD:

Well, thank you so much. Thank you

for sharing these stories because that just brings it home. We have to do better, right.

I wanted to start with Dr. Abernathy and your research. One of the things I wanted to do with all of this, and I'm not sure if this is the right place or not, I wanted to have a map, like a geospatial map, and maybe there's one already, for all the reproductive health care that we have in our city. We heard over and over again that people don't know what's out there, right.

This would be sort of you were looking for X, and that was the purple dot. And if you're looking for Y, that's the red dot. And I don't know that we actually have a comprehensive reproductive landscape that has been mapped out in the entire city, but we will need help to do something like that

and we need researchers and we do have some GIS capability.

But I just wanted to know what your feedback would be on something -- would that be useful? Would that be something we could train our communities to actually use and inform themselves about the plethora of things out there and then also work on what is not working?

DR. ABERNATHY: Thank you for that question. As a map lover, I do think that maps can be very helpful in helping people understand what their resources are. There are some publicly available sites for accessing that type of information, specifically around abortion care that are maintained by the Philadelphia Department of Public Health. Those are not always as comprehensive in terms of the full spectrum of

reproductive health care, and sometimes it's difficult to ascertain what services are provided at what clinic.

But I would like to raise a statistic that even when we think about the most traditional forms of accessing reproductive health care, which would be starting prenatal care in the first trimester, what we know about the pregnancy-related deaths that have occurred in Philadelphia is that 30% of those pregnancy-associated deaths started care later, right.

So 11% in the second trimester, 21% had no prenatal care whatsoever, and that is the basement. So when we think about what is available for people from when they first find out that they're pregnant, often when they're at home taking a pregnancy test, we leave people in the lurch

for weeks. We do not adequately support them in their decision-making process, in understanding what their chronic medical conditions are that could reduce morbidity and mortality in a pregnancy should someone desire to continue it.

And so, I think a map is helpful in understanding and sharing with people what resources are available. But I think really streamlining connectivity is another central effort that needs to be undertaken.

COUNCILWOMAN AHMAD: (Inaudible) of all of the care. I mean, to the point of Dr. Wolf's examples of her first patient who sadly died because we didn't have good intersecting care from the very beginning and she had other issues as well. When somebody is pregnant, all of those things they

should have access to, if she's needing help with her domestic abuse issue, if she's -- and all of them are interconnected, right. Even her asthma is probably interconnected to that situation.

I'm just trying to imagine how we do wraparound services for our communities, for them to proactively sort of understand what we need for them to do, right. So it's education, it's changing how we do things. So pulmonology, talking to obstetrics and gynecology, and how well that intersection is working.

I don't know. I'm just thinking we're siloed in general in our world. So those are sort of more philosophical questions, but I think we should put them on the table to say, how is the outcome of somebody who's pregnant, how is it all impacted and what are some of

the things we can fix and change. Even if we can't fix everything, but we can start at some point, some spaces.

In terms of Dr. Kukura, I wanted to ask you about -- I know you didn't touch on it, for -- but Dr. Wolf kind of touched on it a bit as well. She changed her testimony based on her recent experience, which honoring your patients is really important so I thank you for that. But looking at perimenopause and menopause and the lack of information therein and the black box, removal of HRT, all of those things, our communities don't know about these things.

What would you say is -- if you had the perfect world, we got on that continuum for people transitioning into perimenopause and menopause, what should we be doing to prepare, those

experiencing either perimenopause and then menopause?

I know it might be a question for -- yeah.

DR. WOLF: I think that this is information that we should be, providers should be offering in those years between the time when we finish our reproductive years until we get to menopause. You know, I think historically, there just hasn't been enough education in medical schools about managing perimenopause and menopause. And I think that some of it is sort of our historic ability to tolerate suffering in women that allows us to say that's okay for you to feel this way.

COUNCILWOMAN AHMAD: That's just how it is. Suck it up and keep moving.

DR. WOLF: Suck it up. I do think, however, that as much

as I worry about some of the risks of the information that patients and people get in general off of social media, because not all of it is evidence-based, I do think that that is encouraging patients to ask more of their providers and really quite correctly to demand that we should be doing better.

And I'm going to go out on a limb and say all of the residency programs in OB/GYN in the city are really responding to that by increasing the amount of education that we provide to our residents regarding menopause and menopause care.

COUNCILWOMAN AHMAD: So I'm hearing the hospital OB/GYN departments should have their prolific social media platforms, because that's where people are going to get their information. So let's meet the moment and maybe

this is a new branch of outreach to patients. We have brochures when you walk into your office. We have signs, but that's not where people are. So we could be responsible about what we're actually putting on there.

So when somebody puts up some nonsense, people can get go, you know what, I know there's an actual site that is vetted, that has got information. And it's in packets of information that we can sort of absorb, right. That could be a whole new wave of doing business, but that's a global conversation, right.

MS. KUKURA: Like one issue related to this, because I'm not sure that it's come up yet in the conversation today and is relevant to a lot of the issues that you're reviewing, right, which has to do with the dramatic changes

in federal funding for research, right. There's particular research issues that are longstanding as a for treatment for perimenopause and menopause as a horrifically underresearched topic. But there's also a lot of changes happening right now in terms of the changes and priorities of federal funding that are stopping research study that are discouraging researchers in areas that are really critical, not just to perimenopause and menopause, but so many aspects of reproductive health care.

And so, in a situation like this where many of these issues feel like they're at a crisis point, I think it's also important to be thinking about the kind of investment in building knowledge and what the future of this care and the future of the infrastructure looks like and how

there are roadblocks being implemented now that are going to seriously impede that down the line, right, as these issues continue to challenge us in the city.

COUNCILWOMAN AHMAD: Yeah, I think even if you just put out the information we have, with the research we have right now would be really helpful. One topic before I let you go is just about other issues, other health concerns outside of menopause or perimenopause or menstruation, including things like fibroids, PCOS, cancer, cancer screening. Where is that bucket? This is preventive kind of perspective work with also people who actively have any one of those conditions. How do we get our communities to be proactive, the BRCA1 to get screened for breast cancer, to know

your risk, all of those things?

I know there are different buckets of people working on these things, but they all kind of come to a head in your general practitioner's office or some place where we connect you to the right sources, but how do we bring this awareness because our job -- we're not in the actual delivery of your medicine or medical work. We're connecting and helping communicate to our communities how they can be proactive in their own care and how can they be, you know, sort of driving their destiny in this space. That's where we want people to be, to be able to know where to go, what to use, this is where I am in the continuum and this is where I land, perfect case scenario.

But how do we sort of from a policy perspective push that? And this doesn't have to be

answered just now. This could be a further conversation. For example, breast cancer has gone up in Asian women, Asian American women. Why? Colorectal cancer has gone up so much higher in young Black people, both men and women, right. There are some ideas of where all that is coming from, but we kind of have to be proactive about it. And I'm just wondering holistically about reproductive health care, how do we bring people to a place where they know to take the reins and move ahead?

DR. WOLF: Well, I think one of the biggest barriers is the historic racism of medicine in general and of obstetrics and gynecology in particular, and those of us who practice in those fields need to be working harder and harder to make people feel like it's safe to come to us. And I

think as we increase the number of providers in OB/GYN and in medicine in general who are people of color, I hope that that will help. And as we are more honest with ourselves, that more people of color will feel comfortable coming to our practices and accessing that care. But I think that we still have a lot of work to do in that area.

DR. ABERNATHY: I want to add another comment to that, which is that because of the longstanding and historic disincentives or disinvestment in research related to health care related primarily to people who are capable of pregnancy, our tools for managing many of those conditions are extremely limited, so we rely on contraception for its many other benefits outside of birth control to manage the majority of those conditions.

In more recent history, novel therapies have emerged that are extremely costly and difficult for people who have day-to-day life things come up to access, because of the number of hoops they have to jump through and their providers have to jump through to guarantee access to those costly medications. So secondary to keeping the doors open for places where people can access contraceptions, I think we need to take a holistic approach around how we talk to patients about what their options are and ensuring they can access them.

In my practice, I find many people actually know that they have these conditions, but the therapies that they could use to manage them are consistently out of reach. So it's a mix always. But I think that there are two barriers at play. One may be lack of trust

or inability to access knowledgeable providers outside of Internet forums like social media, etc, where many people get their information. The second is being able to reliably, consistently access the medications that keep them out of emergency departments and preserve their health in the long run.

COUNCILWOMAN AHMAD: Well, thank you.

My colleague, do you have any questions of this wonderful panel?

COUNCILMAN O'ROURKE: (Shaking head).

COUNCILWOMAN AHMAD: Thank you so much. We're not -- this is the beginning. As I told every panel, we are going to be coming back because you're the experts, we're not. And we also of course want to hear from people

with lived experience. I mean, the patients you described are powerful reminders of why we need to do this work. So thank you so much.

Clerk, would call up the next and final panel.

THE CLERK: Jordan Garvey Guy, reading on behalf of Saleemah McNeil, Executive Director Oshun Family Center; Katia Perez, Interim Executive Director Abortion Liberation Fund of PA; Jenne Johns, President of Once Upon a Preemie; and Jessica Schwarz, Midwife and Director of Clinical Services at Life Cycle Wellness and Birth Center.

(Witnesses approached witness table.)

COUNCILWOMAN AHMAD: Thank you so much. Please state your name and begin your testimony.

MS. GARVIN GUY: My name is Jordan Garvin Guy. I am a

licensed -- thank you. My name is Jordan Garvin Guy. I am a licensed marriage and family therapist in the state of Pennsylvania. I happily and passionately serve as the Clinical Director for Oshun Family Center, providing psychotherapy to individuals, couples, families and then supervising and training our amazing team of trauma-informed clinicians as well as informing the community about perinatal mood and anxiety disorders.

I have the pleasure to read the testimony of my Executive Director Saleemah O'Neill. But before I do, I do want to share my experience in the therapy room of seeing parents and treating parents as they navigate parenthood for the first time or for the fifth time.

Just last week, one of my clients actually returned to

treatment, which I'm very glad that she did, because in our sessions she thought she was just stressed, and I was able to educate her that you're actually experiencing depression and depression on a severe scale. She hadn't been eating properly, she was not getting sleep and did not recognize how that impacted her mental health. And this is not a rare case.

A lot of times people do not know the signs of these perinatal mood and anxiety disorders as it affects you as a parent. And so, when they come in, this is sometimes the only place, one, they get to tell people that they're struggling and someone can listen but, two, that they get the information that they need to even go in to take care of their physical health to even be able to

advocate for themselves in hospitals and to build that confidence. So this work is so, so, so important and so sacred. And so, I just ask for your continued support of our organization and other organizations that support perinatal mood and anxiety disorders. And I will read her testimony now:

Good afternoon, Chairwoman Ahmad and members of the Council. My name is Saleemah McNeil. I am the founder and Executive Director of Oshun Family Center. I am here in support of this resolution and in strong support of continued public hearings on reproductive health in Philadelphia. Let me begin with the data.

Black women in Philadelphia continue to experience

disproportionately high rates of maternal morbidity and mortality. We know that pregnancy-related complications, untreated perinatal mood disorders, cardiovascular conditions and postpartum gaps in care are not isolated events. These are systemic failures.

At Oshun, 61% of our psychotherapy clients enter care with moderate to severe anxiety. Nearly 39% enter with moderate to severe depression, 40% screened in the clinically significant range for trauma, and over 27% met criteria consistent with probable PTSD. These are not fringe cases. These are mothers, partners and families navigating pregnancy and postpartum in our city.

In 2025 alone, we delivered over 1300 therapy sessions to more than 160 unduplicated clients. Through the

Change of Heart study, 324 participants enrolled and 146 babies were born within that program. These numbers tell us something clear, families are seeking support beyond the hospital walls.

Reproductive health cannot be addressed in fragments. We cannot examine abortion access without addressing postpartum mental health. We cannot discuss fertility without continuity of care after birth. We cannot pass resolutions about equity while community-based providers are left building infrastructure without sustained policy alignment.

My own birth experience sits at the center of this work. I was educated. I had insurance. I had professional training in maternal health. And still, I left the hospital destabilized. I

remember sitting at home thinking if this is my experience with resources, what is happening to women with less protection. That moment became the Oshun Family Center.

On April 1, 2025, we closed on a building in Kensington that will become Philadelphia's Maternal Wellness Village, a trauma-informed, community-rooted center designed to serve families across the reproductive spectrum not just pregnancy, not just the crisis, the full continuum. This resolution is important, but hearings must move beyond documentation of disparities. They must create a coordinated strategy, community providers, researchers, policymakers and families must be aligned at the same table before decisions are made, not only called in to testify after.

So I invite Chairwoman Ahmad and members of the Council, to join us during Black Maternal Health Week, April 11th through 17th and for the People's Hearing on March 5, 2026. Come into spaces where families speak freely, hear from our clinicians, doulas and birth workers who are carrying the weight of fragmented systems every day. Let's build policy that reflects lived reality. Reproductive justice requires infrastructure, not intention alone. Thank you for winning this conversation and for the opportunity to stand here today. I look forward to working collectively to ensure that every family in Philadelphia experiences safety, dignity and sustained care. Thank you.

COUNCILWOMAN AHMAD:

Thank you so much for your

testimony.

Would the next witness please state your name and begin your testimony.

MS. PEREZ: Hello, everyone. And thank you, Councilmember Ahmad, for holding this hearing to examine the current state of reproductive health care in Philadelphia. It's critical that those with decision-making power in our city understand the real impacts of not funding reproductive health care in this current fiscal year and beyond.

COUNCILWOMAN AHMAD: Please state your name.

MS. PEREZ: My name is Katia Perez, and I am the Interim Executive Director of the abortion liberation fund of Pennsylvania. I'm here today to share what we witness every day on a help line where people call seeking support

covering the cost of their abortion care, people like Lynn, a 41-year-old who was excited to continue her pregnancy until she received devastating news about a fetal anomaly or Sierra, a 19-year-old who fled an abusive relationship and was moving between friends and relatives' homes. When she discovered she was further along in her pregnancy than expected, she called us, our helpline for support.

At ALF, we serve everyone who can become pregnant and needs help covering abortion care, regardless of gender, race, age or immigration status, and most of our callers identify as mothers. Philly mothers are the backbone of the city. They are workers, caregivers, leaders and constituents. They keep this city running.

For Fiscal Years '23 and '24, ALF received $500,000 in municipal funding last year. That amount was reduced to 250,000. Even with that reduction, because the average pledge to help cover abortion care is around for $245, that funding allowed us to support more than 1000 callers. That's 1000 people with different circumstances, some facing health complications, some navigating financial hardship and others who know it's simply not the right time. That is the direct measurable impact of city investment in the stability of families and the strength of our city.

At ALF, we do everything we can to fund every caller, but demand exceeds what we can provide. The city needs to step up for Philadelphia mothers. Thank you.

COUNCILWOMAN AHMAD:

Thank you.

Would the next witness please state your name and begin your testimony.

MS. JOHNS: Good afternoon. Thank you for having me, Councilwoman Ahmad and Councilmembers. I'm Jenne Johns, micropreemie mom and President of Once Upon a Preemie, Inc. Today marks the meaningful expansion of my journey with this Council, building upon the advocacy work we began together in 2021 and 2025 for the Black Maternal Health Week resolutions. I return today with a renewed commitment and excitement to ensure that these resolutions, coupled with today's resolution translate into lasting protections for Black birthing women in the City of Philadelphia, in particular preterm infants.

With budget season upon us, we are called to confront a profound moral and financial crossroads. To address the systemic health disparities in our city's birthing people, we must bridge our funding gaps with a budget that treats maternal well-being not as a line item, but as a non-negotiable investment in our city's future.

Across the Greater Philadelphia region, reproductive and neonatal health facilities are facing massive funding gaps, estimated in the millions needed to sustain lifesaving operations and community-based contributions. While the philanthropic sector plays a vital role in bridging these funding gaps, private charity cannot be the sole solution for our public health crisis. We need a budget that reflects the values of

Black birthing lives in this city.

Operationalizing maternal health equity is not just about the brick-and-mortar access. While physical facilities are one level of access, the deeper barrier is the quality of care within those walls. Our local reproductive health facilities face immense pressure to serve high patient volumes while navigating systemic underfunding. This evidence is undeniable.

Our maternal health outcomes are a direct reflection of our systemic limitations. For instance, when our city-operated health centers offer prenatal clinics only one to two days per week, we aren't managing a schedule. We are rationing care. Our birthing mothers deserve a health care infrastructure that is available every day, not just

occasionally.

However, there is an operational solution that is both avoidable and preventable, which is the elimination of medical bias. Respectful bias-free care is not an extra. It's a clinical necessity. Through the Once Upon a Premium Academy's City of Philadelphia, maternal implicit bias training, which launched a pivotal $100,000 initial investment from the City Council, we're transforming Philadelphia's health care workforce. We're equipping our clinicians with the tools to deliver the bias-free care, respectful care, that our families deserve.

And I may also pivot and add, we're also providing the mental and emotional support that a lot of our clinicians need because they too are Black birthing women

in this city and face the same biased level of care. Today our city health centers' administrators are demanding more training, recognizing it as an essential lifesaving operational solution for our birthing populations and for their families themselves.

The data is very clear. Black women account for 73% of Philadelphia's maternal deaths, and our preterm birth rates remain a harrowing outlier. To meet this crisis, Once Upon a Preemie requests a $500,000 line item in the municipal budget allocation to expand the city's initial commitment and investment in maternal health. This funding must be leveraged to continue and expand the maternal implicit bias training that we started this year so that our work does not die on the vine.

More importantly, it is

helping to address the recurring request that we receive every time we show up for a one-hour maternal implicit bias training at our city's health centers. In addition, when we survey Black preemie families in Philadelphia, many still report experiencing medical racism and discrimination.

When we support hospitals to complete our accredited e-learning courses, many of which who have completed our program, report improved quality of care delivered to families, better patient-provider relationships, and to build upon some of the lactation conversation we heard earlier. Many of our neonatal institutions are improving and increasing initiation and continuation of breastfeeding for all moms, which is significant for Black preemie moms.

In closing, Philadelphia has the opportunity to lead this nation. Every birthing person has the fundamental right to prenatal, postpartum and neonatal care, deeply rooted in a fully-funded reproductive justice framework. By investing in robust accountability and community-based partnerships, we ensure that Philadelphia's mothers and babies do not just survive the birthing experience, but thrive within it. I stand in absolute full support of adopting Resolution No. 260051 to transform birth outcomes in our city. Thank you.

COUNCILWOMAN AHMAD: Thank you so much for your testimony. We'll ask questions all at once.

MS. SCHWARZ: Hi. Good afternoon. Thanks for the opportunity to speak. My name is

Jesse Schwarz. I'm a certified nurse midwife and the Executive Director and Clinical Director of Lifecycle Wellness and Birth Center, Pennsylvania's first birth center, the largest and longest continuously operating birth center in the country.

We opened our doors in 1978 and we will be closing next week permanently. Birth centers care for low-risk childbearing people in community-based settings rooted in the midwifery model of care. In this state, they are licensed by the Pennsylvania Department of Health and in all states they are accredited by a national accrediting body.

The Federal Strong Start initiative demonstrated that birth center care significantly reduces disparities in preterm birth, low birth weight and cesarean rates for

Black and Brown birthing people. When we close birth centers, we are not simply reducing options. We are removing one of the few settings where BIPOC people have been shown to receive measurably safer care. Narrowing the spectrum of safe community birth makes birth less safe for everyone.

Lifecycle's clinical outcomes over the 47 years we operated have been excellent. Our cesarean rate over the past five years is under 14%. In December of 2025, our second to last month attending births, we welcomed 65 babies, the second highest monthly total in our history. We had a waiting list of over 200 people for a GYN visit.

We were not failing for lack of need or lack of quality. Tragically, we are closing because the financial architecture of

reproductive health care in this country prioritizes profits above all else, particularly Black and Brown lives. Despite the established evidence that independent, community-based practices like Lifecycle improve outcomes and reduce disparities and in the setting of tremendous community support, our closure has been forced by financial pressures.

The reasons are not unique to us. Our malpractice insurance costs have doubled between 2024 and 2025. And since Pennsylvania repealed its venue shopping restriction, malpractice cases in Philadelphia County have increased 40%. Despite the fact that 100% of the births we attend occur in Delaware and Montgomery County, 100% of Lifecycle's open cases have been filed in the last five years in Philadelphia County.

Reimbursements do not increase nearly as fast as the cost of doing business, and there is no ability to negotiate with payers.

We are closing with nearly $1 million in accounts receivable on a $6 million budget, most of it owed by payers under contract. Community-based midwifery is not designed to generate surplus. It is built for safety, trust, time and human connection, things essential to good maternity outcomes that cannot be scaled or monetized.

In 47 years, Lifecycle cared for over 16,000 birthing families and educated generations of midwives. We welcomed babies, but we also did countless first pelvic exams, served menopause clients, cared for people grieving lost pregnancies and provided safe, accessible and evidence-based

reproductive health care to tens of thousands. When we close, that care does not simply move elsewhere. Much of it disappears.

The city can act. Help restore the venue shopping restriction, support payer accountability, invest in funding mechanisms that allow independent reproductive health practices to survive. Listen to the voices of childbearing people. This loss reveals what our system chooses to reward and what it chooses not to sustain. Philadelphia has the opportunity to make a different choice.

COUNCILWOMAN AHMAD:

Thank you. I'm so sorry that this is the testimony you had to share with us. Could you ex -- and we'll go backwards with you. Could you explain the venue shopping restriction a little more,

elaborate?

MS. SCHWARZ: Yeah. Historically, there was a restriction that there was a law that required that if you were going to bring a malpractice case, you had to bring it in the county where the care had been rendered. And that restriction on venue shopping, meaning shopping cases around to a place where the jury payouts would be higher, was repealed.

And so, because Philadelphia County has historically had much higher jury awards for malpractice cases, it makes for an incentive for plaintiff's attorneys. So Lifecycle had not had a malpractice case in 20 years. We've had five in the last five years, all of which have been brought in Philadelphia --

COUNCILWOMAN AHMAD: The cases happened elsewhere but they --

MS. SCHWARZ: All of the births happened in Delaware, Montgomery County. They are the only places we do births. So cases that might have not even been worth a plaintiff's attorney's time if they had had to be brought in the county in which they occurred, you know, I'm sorry to say the predatory nature of plaintiff's attorneys make it such that they are highly motivated to encourage clients to bring lawsuits if they think that there's a chance that they can get a big payout.

I was hesitant to talk specifically about this because I think in the general public, there's a sense that if you are facing a lawsuit, it must mean that you did something wrong. And I

think that we've heard a lot of very, very thoughtful testimony today about how difficult it is to provide good care. And I think that part of the nature of being a health care provider is that sometimes you have bad outcomes. And when you insert a predatory plaintiff attorney into the mix with between the family and their providers who are trying to work through a hard situation like that, it does not improve outcomes for anyone.

COUNCILWOMAN AHMAD: So this is a state --

MS. SCHWARZ: It's a state-level thing. So it is, you know, definitely beyond the scope of pure City Council oversight. But it's definitely something that has impacted all of the birth providers in this area.

COUNCILWOMAN AHMAD:

Yeah. I know OB/GYN in general has a very high malpractice rate, and that's a whole other ball of wax. And I think there needs to be -- maybe there's a fund these people can put together that can offset because it's millions and millions of dollars from --

MS. SCHWARZ: I mean, it's absolutely prohibitive for community-based providers. And honestly, we saw that the University of Pennsylvania had a $200 million-plus verdict against it. So at that scale, it threatens the whole system.

COUNCILWOMAN AHMAD: Do you know what is -- how are our smaller centers that do doula care and other things are then indemnified against all this because they're not giving actual service, actual birthing service?

MS. SCHWARZ: I mean, I

think that they're -- a doula was named in one of our cases. I don't think that they're as likely to be sued, because typically they don't carry malpractice insurance that has, you know, they might carry a very small professional liability policy, but it's not a very deep pocket. I don't know. Other people could probably speak more to that than I can.

COUNCILWOMAN AHMAD: Well, listen, we hear you. This is probably a more global conversation in general, not just even in Pennsylvania.

MS. SCHWARZ: Absolutely.

COUNCILWOMAN AHMAD: But how do we balance care with poor care. I mean, there are times when there is poor care. How do we distinguish between that and a predatory, you know, effort, right.

That's why we have judges to be able to discern which case to keep and which case to throw out, right. And maybe there's that's a separate conversation, but I think it's a conversation worth having globally because soon, there'll be no OB/GYNs and then what, what are you going to do then?

When you have a complication and you need a C-section or you need something, what's going to happen, because that's going to impact preterm births and all of that, the entire space. So there has to be a balance of some sort. So I hear you and I'm so sorry that you are facing this closure. Is there any room for going back to actually having you operate?

MS. SCHWARZ: I mean, Lifecycle won't. But there is another birth center that's working

to open in the spring, the Philadelphia Midwife Collective, or own a building and are planning to open a birth center in Germantown this year. And so, we are very supportive of them and I hope that they will find success.

I have a lot of concerns and I think it's a very, very difficult landscape for a small community-based birth center frankly. But I think that they would be an organization that would very much benefit from some of the gap funding that we're talking about and philanthropic support and partnership with some of these other community-based organizations that we've heard from today.

COUNCILWOMAN AHMAD:

Well, thank you.

Do you have any questions for her?

COUNCILMAN O'ROURKE:

Not for you a question. Thank you.
But --

COUNCILWOMAN AHMAD: Go ahead. Ask it. I'll come around to the other people.

COUNCILMAN O'ROURKE: Thank you, Madam Chair.

What piqued my interest immediately was the direct reference to a policy that needed to be repealed. And thank you for raising that. I guess we have some state partners to talk to, to address that matter.

But, Katia Perez, it is good to see you. And I want to thank you for the work that you do. Thank you, panelists, for all of you for the work that you have done here in the world. Thank you. Thank you for your work. Thank you for your work, Katia, particularly with supporting Philly's mothers.

You gave a couple of

figures. You had 500k and it got ducked down to 250, right?

MS. PEREZ: Yes, for 2022 and 2023. The --

COUNCILMAN O'ROURKE: That was through the budget or through grants?

MS. PEREZ: Budget. It was a line item in the budget.

COUNCILMAN O'ROURKE: Okay. Will you be asking for additional funds from the municipal budget this year?

THE CLERK: Yes. We're working with -- we're a member of the Reproductive Freedom Task Force and that's part of the work that we're doing there.

COUNCILMAN O'ROURKE: The who task force -- oh, yeah, yeah.

MS. PEREZ: Reproductive Freedom Task Force, yes.

COUNCILMAN O'ROURKE:

What's the figure that you're asking for this year?

MS. PEREZ: I mean, it would be amazing to be able to get 500,000 again because like -- so last year, like I said we were able to get 250,000. That was a line item in the budget for Fiscal Year '25. With that, we were able to help 1000, right --

COUNCILMAN O'ROURKE: And you ran up to like 500 -- sorry, good grief, voice of God, 245 was your actual --

MS. PEREZ: Is the average pledge. So when people call our helpline -- people call our helpline, we're the last line when they're about to, you know, they still need to get the money together for the abortion care. The clinic, whether it's Planned Parenthood, Women's Center, any other clinic in Philadelphia, they

have their own funding that they're able to give them. And if they still don't have any, we're who they call. And then we just provide the direct money for the abortion care to the clinic. We make that pledge.

The average pledge is 245. With the 500,000, the last year that we got that, that year we were able to serve over 3500 people, right, overall that called our helpline, which is amazing. Last year though when there was -- well, we're very thankful for the 250,000 because we were still able to help support folks.

But that also came when there was a lot of national cuts, right, and cuts to Planned Parenthood and cuts to a lot of the local clinics, so there was just less that we were able to give them. We had to prioritize folks

who were just under extreme circumstances, right, facing homelessness, intimate partner violence, drug addiction, things like that. So that means there were a lot of people who when they called our helpline, they were self-selecting out, right.

So now, we're in a place where there seems to be funding that has increased in the abortion access world. I know there's just so much happening in reproductive health overall. That slowly increased. I'm talking about the last couple of months, but we still have a lot of folks that -- we're not able to meet the demands of folks that are calling our helpline. So it would be amazing if we could get again 500,000. That's just like over 2000 people that were directly with that Philadelphia funding that we're

able to support with that money.

COUNCILMAN O'ROURKE: Okay. You'll also be at the hearing on Thursday?

MS. PEREZ: Yes, I will be.

COUNCILMAN O'ROURKE: Okay. The more that we can hear figures, facts and figures --

MS. PEREZ: And we share our client stories every single time because these are Philly mothers, right, every day.

COUNCILMAN O'ROURKE: A thousand percent. Thank you so much for your testimony. Much appreciated.

Thank you, Madam Chair.

COUNCILWOMAN AHMAD: Thank you for that. Quickly before we move on to another witness, are you also seeing -- and I asked this question of Planned Parenthood -- influx of people from elsewhere or

are you serving mostly Philadelphians?

MS. PEREZ: So, yes, Pennsylvania is a receiving state and Philadelphia specifically is a receiving city, because there's people coming in from states that have bans, right. A lot of people coming in from Florida because of Philadelphia International Airport. So what we have seen in our helpline also is that there have been longer wait times for even Philly residents here in our city, because there's out-of-state folks coming and they're having to travel to the outer counties, Montgomery County, Chester, Delaware County to receive abortion care. So, yes, that has incrementally been increasing.

Pennsylvania is one of the receiving states, as is. What is it like -- Illinois, for all the

states out there. But we are one of them here on the East Coast.

COUNCILWOMAN AHMAD: The reason I ask is because of all these changes in our national landscape and the cuts and all. I think it's time for our state to sort of, and I said this before, to step up. We don't have the ability to absorb all of this, right. Because you're treating people not just from Philadelphia, you're treating people from outside. I think it behooves our state government to sort of see how they can plug some of the holes.

I don't know if your asks have gone there or we are happy to advocate to have that conversation or start not just for you, but other institutions as well, because we are under a lot more stress just because of the federal landscape changing. So

thank you for your testimony.

I wanted to ask, Janae, I'm so happy the 100,000 is now in operation and the training has begun and you're already seeing impact from medical bias being addressed. Medical bias is an independent variable outside of all these other things, whether it's financial insecurity or other predisposing things you come with, it's separate. And so, that's one of the reasons why I started with that small amount of money to see is there a way to make this work, right.

So we would love to get some sort of a report on this in order for the next steps because this is like a proof of concept, right, of how that was done.

MS. JOHNS: We greatly appreciate the initial investment. As you know, $100,000 is a seed

that's being planted where we're going to see water. And allowing those seeds to blossom into beautiful flowers is continued investment, not just in training. Training alone will not eliminate medical bias. Training alone will not eliminate disparities, but medical bias partnered off with quality improvement initiatives and a strategic plan where our health centers and our health department are held accountable to track, monitor and trend, measures and data over time will help us get there. But I hope that this will not be the City Council's first opportunity with this training opportunity.

Because above and beyond what we want to see at Once Upon a Preemie, our health center staff are demanding more. They're asking if we can come back the next day,

the next week for a three-hour inservice. And although we would love to be able to respond to that request, we don't have the internal resources at Once Upon A Preemie to do.

COUNCILWOMAN AHMAD: So listen, that's exactly what I wanted to hear. We were afraid that health centers and others would be too overwhelmed to say, oh, one more training, one more thing. And I was told that before I put out that money, and they were like, oh, no one's going to want to do it because it's one more thing. But their outcomes become better.

To the whole point of what was said about malpractice, right. You have less cases of that when you have good care from the get-go and your people are being heard and seen in real terms. And to your point from -- I'm sorry, I

was calling you Saleemah. You're not Saleemah, I know. The fact of having people live with lived experience at the table, which includes those giving this sort of care, which is why all of you are here, right, this is important, including Lifecycle, even though you're not going to be in existence, maybe you will, there's a lot of learned experience that we could help shape going forward in some of the other spaces.

I just want to ask Katia one more question about medically-induced abortions. Do you provide that service as well?

MS. PEREZ: We send the funding to the medical center itself. So whichever type of abortion procedure that the person is seeking, there is no limits, right. There are times where unfortunately sometimes people --

there's a something we call chasing the fee, where people wait so long because they can't afford it and it just increases the cost.

And in PA, as people know there's a 24-week ban. After that, we cancel. Some people have to go to New Jersey or other surrounding states. And we still will pledge, will pay for that funding that they need to those states as well.

COUNCILWOMAN AHMAD: Even though it's outside.

MS. PEREZ: Yes.

COUNCILWOMAN AHMAD: The reason I asked that is we had talked about making sure our communities know everything that is out there. That seems to be one of the biggest barriers to care, is just knowing where to go, what to do, who's giving what. And so, we will need to work with all of you

to see what does that look like, what does that education, information-sharing look like. It has to be redundant. More than one place has to do it. They have to get it over and over again, you know, like when we got the whole -- you guys, some of you are much too young. When we had the whole smoking cessation thing, it was redundant. It was everywhere. It was everywhere.

So even though this is something else, we need to have it everywhere talking about it so it's a health care issue that is prevalent. And this is again changing the conversation about making this a priority is really what we hope to come out of this hearing is some steps, some things we can do.

For example, this implicit bias thing investing in

care where budgetary allocations, those are all good, but we need to actually take all of that and have our communities know what these are, because understanding how the money flows will tell them what the priority is, right. The budget is a moral document, as they say. So we need to actually explain that to our communities to see this is what you should look for and where is this coming and how much is it. So I appreciate all your testimony.

Colleague, do you have any more questions?

COUNCILMAN O'ROURKE: (Shaking head).

COUNCILWOMAN AHMAD: We learned a lot. And I think we have public testimony. How many?

THE CLERK: One.

COUNCILWOMAN AHMAD: One. Okay. So I want to thank you. We will definitely do follow-

up. And again, thank you for your testimony. Very powerful for all of us to listen to. And we will excuse you and ask our last witness to come forward in public testimony. I'm supposed to say something, right -- what am I -- okay.

Will you call the next panel, and you'll say --

THE CLERK: There are no additional panels, Madam Chair.

COUNCILWOMAN AHMAD: Okay. Would you then call up those who are here to do public testimony?

THE CLERK: The first speaker on the public comment list is Ali Groves.

(Witness approached witness table.)

MS. GROVES: Thank you. I'm mindful of the fact that I'm the last commenter before this and

the break and you guys have been listening to folks for the last four hours. Thank you so much for this opportunity. My name is Ali Groves, and I am a public citizen and also a researcher and a professor at a local university of public health, who examines the effects of cash transfers on health during and after pregnancy.

Pregnancy in the first months of a baby's life are critical for a child's development. And as we've heard from all my colleagues who are on their way out today, there are significant inequities in health, both in infant and maternal health outcomes here in Philadelphia. Local innovative programs like the Philly Joy Bank, which you've referenced earlier, Councilmember, can protect infinite maternal health, ensuring the health of children and families

for years to come.

So launched in 2024, the Philly Joy Bank provides pregnant individuals with cash payments of $1,000 a month during pregnancy and the first 12 months postpartum, and recipients can use this money however they most need it. But the current program is small. It serves only 250 people in just three of our city's neighborhoods. Now is the time to expand it. Having a baby is expensive.

A recent survey of pregnant Philadelphians found that financial stress was the most common stressor in the 12 months before giving birth. And we also know from our research that pregnant individuals who applied for the Philly Joy Bank were experiencing significant financial insecurity at the time of their application. That is only 20% of

our participants felt confident that they could find the money to pay for a financial emergency that costs about $1,000.

Moreover, nearly 1 in 10 reported being evicted in the last three months, which is nearly double the rate of eviction in Philadelphia. These financial stressors are concerns given that household income typically decreases by about 10% during the months surrounding childbirth, and around 40% of Black and Hispanic mothers fall into poverty during these months, often due to lower wages or the need to leave their jobs, especially in states like ours that don't guarantee paid family leave.

Such financial instability can have devastating health consequences for birthing mothers and their children. Stress

related to this financial instability can increase anxiety and depression. It can prevent expecting parents from getting the needed health care that so many of my colleagues have talked about, and it also increases health care spending down the line, poverty, and the stress that it causes has also been linked to poor birth outcomes for infants with ripple effects into early childhood through these cash payments.

The Philly Joy Bank works to counter the stress and improve infant health for people living three of the neighborhoods that experience the worst birth outcomes in the city. However, there are thousands more who could benefit from it in nearly 25% of Philadelphia's neighborhoods.

More than 1 in 7 babies are born with low birth weight, a

troubling sign of deep-rooted health disparities. That's roughly 33% higher than the citywide average and a staggering 65% higher than the national rate with cuts to SNAP and other federal programs. These numbers may climb. There's growing evidence that cash can improve pregnancy and birth outcomes in North America.

A recent study by researchers at the CHOP Policy Lab found that the expanded Child Tax Credit decreased risk of poor birth outcomes among Medicaid-insured pregnant women in Pennsylvania. Another cash transfer that was started in Flint, Michigan and has since expanded across the state, has published peer-reviewed findings that mothers who receive the cash had higher financial stability, including fewer evictions and better mental health

given that federal cuts to Medicaid, SNAP and other public benefit programs are expected to widen health disparities in the coming years.

Local policy solutions to protect and promote health and health equity are more essential than ever in the current moment. Cities like Philadelphia have a powerful opportunity and responsibility to improve the health of babies and their parents. Guaranteed income programs are proving to be just one effective way to do that. We need that same bold leadership and visionary investment that launched the Philly Joy Bank to expand this work. And the world is watching us. Thanks.

COUNCILWOMAN AHMAD:

Thank you so much for your testimony. We already understand the value of the Joy Bank, and I

believe they are increasing the number of zip codes. That is the next iteration, but I could be wrong.

MS. GROVES: We don't have funding for it yet. I mean, I work really closely with my colleagues at the Department of Public Health.

COUNCILWOMAN AHMAD: So I will check into that because I had asked about it, and it could be a budget issue we are getting into our budget years. But clearly again, as I said the economic benefits can justify this kind of investment, because down the road we spend much less when we have that early investment. So I thank you for your testimony and stay tuned with what's happening with this. I don't know how -- I thought it was additional three zip codes, but I could be wrong. We

will check and --

MS. GROVES: I would love for that news.

COUNCILWOMAN AHMAD: We'll check and make sure. I'll check with the Health Department to see when and where that might be coming. They might be just trying to figure out how to do this. But clearly, the value is there. That's been proven over and over, not just here, but in other spaces.

MS. GROVES: Yes, there are other places in the U.S. that have expanded from the city to the broader, you know, to other neighborhoods in the cities and also to the statewide initiative, so we could be one of those places as well. It'd be fantastic.

COUNCILWOMAN AHMAD: Yeah, I think rural spaces would benefit a lot. Anyway, if this was a statewide issue, it should become

a statewide issue and then it could be a different sort of funding pattern that would just help us. We are just so strapped ourselves, but the state has a surplus and there are other revenue streams supposedly coming on.

MS. GROVES: Absolutely.

COUNCILWOMAN AHMAD: We should put our dibs in for what you're going to do with that.

MS. GROVES: In Michigan and in California State, there's these beautiful public-private partnerships where they're drawing on TANF dollars and other sort of state-funded programs alongside --

COUNCILWOMAN AHMAD: Those are good models.

MS. GROVES: They are good models.

COUNCILWOMAN AHMAD: Thank you very much for your testimony.

MS. GROVES: Thank you.

COUNCILWOMAN AHMAD:

Thank you.

Mr. Sham, would you call the next speaker.

THE CLERK: There are no other speakers on the public comment list, Madam Chair.

COUNCILWOMAN AHMAD:

Okay. Did you want to make a note for the record about Dr. Hillary Rosenstein?

THE CLERK: Yeah. We would like to note for the record that Dr. Hillary Rosenstein with the Mazzoni Center and Dr. Robin Fay submitted written testimony.

COUNCILWOMAN AHMAD:

Okay. Thank you. I would like to thank all of our witnesses for joining us today. This concludes the business before the Committee on Public Health and Human Services today. Thank you very much for

your attendance.

I want to especially thank you to my colleague who sat through this whole thing. You know, being a new father, I'll tell your son when he's older that your dad sat and listened to everything because he's on an educational curve here as well. I understand.

But before we end, I want to say thank you to my team who did a lot of work, particularly my youngest member, Nakaja Weaver --

(Applause.)

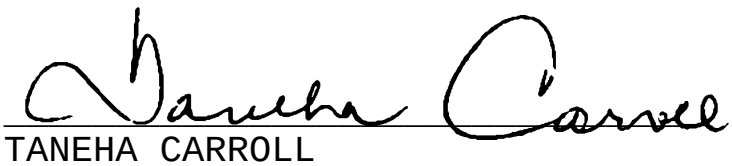
COUNCILWOMAN AHMAD: -- who has worked extremely hard at pivoting here, there and everywhere to make this happen under the guidance of Julian Sham, our Legislative Director. Thank you very much and to the entire team for helping us get here.

(Committee on the Public

Health and Human Services concluded at 4:37 p.m.)

C E R T I F I C A T I O N

I, hereby certify that the proceedings and evidence noted are contained fully and accurately in the stenographic notes taken by me in the foregoing matter, and that this is a correct transcript of the same.



TANEHA CARROLL
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City of Philadelphia

Public Hearing Notice

The **Committee on Public Health and Human Services** of the Council of the City of Philadelphia will hold a Public Hearing on **Monday, March 2, 2026**, at **1:00 PM**, in **Room 400, City Hall**, to hear testimony on the following items:

260051 Resolution authorizing the Committee of Public Health and Human Services to hold hearings examining the current state of Philadelphia's reproductive health care system, the current federal landscape affecting reproductive policy, and the City's response to protect reproductive freedom.

Immediately following the public hearing, a meeting of the Committee on Public Health and Human Services, open to the public, will be held to consider the action to be taken on the above listed items.

Copies of the foregoing items are available in the Office of the Chief Clerk of the Council, Room 402, City Hall.