

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:

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Good afternoon, everyone. Welcome

4

to Philadelphia City Council's

5

Committee on Public Health and

6

Human Services. I now note that

7

the hour has come.

8

Mr. Sham, would you

9

please call the roll.

10

THE CLERK: Chair Ahmad.

11

COUNCILWOMAN AHMAD:

12

Present.

13

THE CLERK: Vice-Chair

14

Lozada.

15

(No response.)

16

THE CLERK:

17

Councilmember Thomas.

18

(No response.)

19

THE CLERK:

20

Councilmember Driscoll.

21

(No response.)

22

THE CLERK:

23

Councilmember Bass.

24

COUNCILWOMAN BASS:

1 Present.

2 THE CLERK:

3 Councilmember Landau.

4 (No response.)

5 THE CLERK:

6 Councilmember O'Rourke.

7 COUNCILMAN O'ROURKE:

8 Present.

9 THE CLERK: And,
10 Councilmember Harrity.

11 COUNCILMAN HARRITY:

12 Present.

13 COUNCILWOMAN AHMAD:

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

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

24 THE CLERK: Resolution

1 No. 260051, authorizing the
2 Committee of Public Health and
3 Human Services to hold hearings
4 examining the current state of
5 Philadelphia's reproductive health
6 care system, the current federal
7 landscape affecting reproductive
8 policy and The city's response to
9 protect reproductive freedom.

10 COUNCILWOMAN AHMAD:

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

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

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

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

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

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

9 The reason we are
10 holding this hearing is simple.
11 Too many Philadelphians are running
12 into barriers. People are
13 traveling farther than they should
14 have to, waiting longer than they
15 should have to, paying more than
16 they should have to, and it is
17 usually people already carrying
18 most of the burden who get hit the
19 hardest.

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

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

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

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

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

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

21 COUNCILWOMAN BASS:

22 Madam Chair, I just wanted to thank
23 you for this very important
24 hearing, which is long overdue. I

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

14 COUNCILWOMAN AHMAD:

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

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

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

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

24 I have benefited from

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

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

1 8:00 p.m. at the Friend Center on
2 15th and Cherry Streets, and look
3 forward to continuing the
4 conversation with you there. I
5 think it'll be very impactful. And
6 thank you again for your foresight
7 and your leadership on this topic.

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

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

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

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

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

9 On behalf of
10 Dr. Raval-Nelson and the
11 Philadelphia Department of Public
12 Health, thank you for the
13 opportunity to testify to
14 Resolution No. 260051 and to
15 provide information about the
16 Philadelphia Department of Public
17 Health's work on reproductive
18 health care from a systems
19 perspective. Reproductive freedom
20 is not a single service. It is
21 infrastructure. It is whether
22 accurate information is available,
23 whether evidence-based providers
24 are accessible, whether individuals

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

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

1 reproductive health services such
2 as contraception and cancer
3 screening. That was a public
4 health decision focused on
5 continuity of care during federal
6 instability.

7 We are preparing to
8 launch a public health campaign
9 focused on early pregnancy. The
10 goal is to support residents in the
11 days immediately following a
12 positive pregnancy test, helping
13 them understand what is normal,
14 what symptoms require medical
15 attention and what steps to take
16 next. The campaign will provide
17 clear, medically accurate guidance
18 and connect individuals to licensed
19 providers and evidence-based
20 programs that can help explore
21 their options, whether that is
22 continuing a pregnancy or seeking
23 abortion care.

24 It will also help

1 residents distinguish between
2 regulated medical providers and
3 unregulated facilities that may not
4 offer evidence-based services.

5 Providing accurate, timely
6 information at this early stage is
7 a critical public health
8 intervention. Reproductive freedom
9 also begins long before pregnancy.
10 ReACH operates a youth care team
11 that provides direct services to
12 adolescents, including sexual
13 health counseling and education,
14 behavioral health screenings and
15 care navigation.

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

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

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

1 At the same time, ReACH
2 houses and leads the city's
3 maternal mortality review
4 committee, conducts one of a
5 handful of locally implemented
6 PRAMS surveys in the country and
7 operates the nation's only city-
8 level active severe maternal
9 morbidity surveillance system.

10 These efforts generate Philadelphia
11 specific realtime data that allows
12 us to identify disparities and
13 design interventions tailored to
14 our population.

15 Our data consistently
16 demonstrates the intersection
17 between violence, substance use and
18 adverse maternal outcomes. In
19 response, in partnership with the
20 Office of Domestic Violence
21 Strategies, we have implemented
22 universal intimate partner violence
23 screenings across all five
24 Philadelphia birthing hospitals and

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

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

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

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

11 We also operate and
12 established a doula support program
13 specifically serving pregnant
14 people with substance use disorder.
15 Across these efforts, we continue
16 to prioritize perinatal workforce
17 stabilization and expansion. We
18 also recognize that economic
19 stability is inseparable from
20 reproductive health. Through
21 Philly Families Can, we provide
22 centralized intake and navigation
23 services to connect families to
24 resources across the city.

1 The PF CAN concrete
2 goods fund addresses urgent
3 material needs such as rent,
4 essential appliances and furniture,
5 reducing immediate economic
6 stressors that contribute to poor
7 maternal and infant outcomes.

8 Through Philly Joy Bank, we are
9 piloting guaranteed income support
10 for pregnant individuals,
11 acknowledging that financial
12 insecurity is a measurable health
13 risk.

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

1 policies that disrupt nursing and
2 reproductive health training
3 pathways, threatens care capacity,
4 Misinformation and
5 unregulated facilities can delay
6 care and undermine patient
7 autonomy. And economic barriers,
8 including transportation, child
9 care and insurance gaps, continue
10 to limit timely access to both
11 abortion and prenatal care.

12 Protecting reproductive
13 freedom in Philadelphia therefore
14 requires sustained investment in
15 evidence-based providers, continued
16 public education about available
17 evidence-based services,
18 stabilization of the reproductive
19 health workforce, strengthen
20 navigation and material support
21 systems and continued partnership
22 with schools to ensure young people
23 receive medically accurate
24 information.

1 Reproductive freedom is
2 not abstract. It is whether
3 someone can access accurate
4 information and evidence-based care
5 when they need it. It is whether
6 they can make decisions about
7 pregnancy and consultation with
8 their provider and it is whether
9 families have the support necessary
10 to thrive once those decisions are
11 made.

12 Philadelphia has built
13 meaningful infrastructure to
14 support reproductive health across
15 the life course. Sustaining and
16 strengthening that infrastructure
17 will require continued
18 coordination, investment and
19 vigilance. ReACH stands ready to
20 continue leading this work in
21 partnership with Council and our
22 community providers. Thank you for
23 the opportunity to testify on this
24 important topic.

1 COUNCILWOMAN AHMAD:

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

14 COUNCILWOMAN LANDAU:
15 (Inaudible).

16 COUNCILWOMAN AHMAD:
17 You're okay. You're welcome. I
18 know we have a long list. It's an
19 important issue so we're going to
20 try to be efficient.

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

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

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

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

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

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

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

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

4 And so, as those changes
5 come into place, we're going to
6 have to lean on our Pennsylvania
7 Medicaid partners to better
8 understand what we can do at the
9 grassroots level to ensure
10 continued coverage for both
11 pregnancy and postpartum and in
12 between pregnancies. And so,
13 that's going to have to be whatever
14 infrastructure that they build at
15 the state level, that we would know
16 about it and operationalize that
17 locally to ensure that people know
18 how to continue to access benefits,
19 things like that. But that's like
20 broader, all sorts of care. But it
21 does particularly impact the
22 pregnant population.

23 Certainly, benefit
24 changes to SNAP and WIC, which

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

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

19 COUNCILWOMAN AHMAD:

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

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

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

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

24 DR. MEHTA: So we

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

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

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

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

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

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

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

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

24 DR. MEHTA: So in other

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

12 COUNCILWOMAN AHMAD:

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

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

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

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

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

24 So if there are no

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

5 DR. MEHTA: Thank you so
6 much.

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

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

1 Director of Family Support
2 Programs, Maternity Care Coalition.
3 (Witnesses approached
4 witness table.)

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

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

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

1 matter of reproductive justice and
2 reproductive freedom. The effects
3 of economic insecurity on health
4 are pervasive and insidious. They
5 span access to care, education,
6 nutrition, concrete goods and they
7 contribute to stigma, bias and
8 environmental exposures that are
9 adverse to health.

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

23 It includes nutrition
24 security programs, Medicaid and

1 also paid family and medical leave.
2 Policies that reduce administrative
3 barriers to access to public
4 benefit programs and increase
5 public awareness of the pathways to
6 eligibility and access to benefits
7 for Philadelphians are of increased
8 importance in this moment, as our
9 protective and proactive outreach
10 to families who are no longer
11 eligible for programs.

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

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

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

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

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

3 Moving to the issue of
4 domestic violence as a factor in
5 maternal death. Investments that
6 support survivor safety, including
7 the availability of emergency funds
8 that address survivors' concrete
9 needs that are accessible to all
10 systems and parties that are
11 working with survivors are
12 necessary. And policies that
13 reduce administrative burdens
14 associated with accessing public
15 benefit programs have also been
16 shown to improve survivor health.

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

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

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

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

1 Would the next person
2 state their name and begin their
3 testimony.

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

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

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

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

24 The experience that a

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

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

23 Not all members of
24 Council might be familiar with

1 PSARC, and that is because it is
2 not, in fact, a city program. It
3 is a privately-operated public good
4 that we have in this city that is
5 open to all members of the public
6 in Philadelphia and provides free
7 services. In 2025, PSARC conducted
8 338 rape kits, which was a 9%
9 increase over the previous year.

10 While PSARC is housed in
11 a building with all kinds of other
12 city services and, in fact, PSARC
13 pays to the city tens of thousands
14 of dollars a year to sublease that
15 space, the city is not actually
16 involved in either the management
17 or the funding of PSARC. PSARC was
18 the brainchild of a coalition of
19 groups, including a number of city
20 agencies, so the District
21 Attorney's Office, the police, my
22 colleagues of WOAR, Women's Law
23 Project and other organizations
24 here in this city.

1 It was created back in
2 2011 to meet the needs of
3 survivors. And when that program
4 was launched, Hahnemann Hospital
5 operated it. In 2019, as you know
6 Hahnemann closed, and at that point
7 Drexel School of Nursing assumed
8 responsibilities for operating
9 PSARC, and that is where we are
10 today. But as I mentioned, there's
11 a funding gap. It's been operating
12 at a deficit and we are looking at
13 a closure on June 30th.

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

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

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

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

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

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

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

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

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

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

1 of sexual assault in Philadelphia.

2 Philadelphia hospitals
3 do not employ SANEs right now and
4 are not prepared to begin
5 conducting sexual assault forensic
6 exams should PSARC close on June
7 30th. If the city allows PSARC to
8 shut its doors, we will be failing
9 in the mission to protect and
10 support reproductive health in
11 Philadelphia. We ask you to act
12 now. Philadelphia depends on
13 PSARC. PSARC needs to be able to
14 depend on Philadelphia. I
15 certainly welcome your questions on
16 the topic. Thank you for your
17 attention.

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

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

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

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

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

1 contraception, emergency
2 contraception, STI testing
3 treatment, abortion care, prenatal
4 and post-partum care, maternal
5 health and trauma-informed
6 gynecological services. At its
7 core, reproductive health is about
8 bodily autonomy, the ability to
9 decide if, when and how to have
10 children and to access the care
11 necessary to protect one's health.

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

24 While it can impact

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

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

23 For survivor access to
24 emergency contraception, STI and

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

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

1 safety touchpoints.

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

19 Reproductive coercion
20 directly undermines reproductive
21 health. It increases the risk of
22 unintended pregnancy and further
23 entraps survivors in abusive
24 relationships. When health care

1 systems fail to provide
2 confidential, discrete, trauma-
3 informed services, they
4 unintentionally reinforce that
5 control.

6 When access to
7 reproductive services is delayed or
8 denied, harm compounds. Emergency
9 contraceptive is most effective
10 within 72 hours. Abortion care
11 becomes more expensive, more
12 medically complex and more
13 difficult to access. Yet survivors
14 often face insurance restrictions,
15 limited clinic availability and
16 cost barriers, providers who are
17 not trained in trauma-informed
18 care.

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

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

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

23 Black women are three
24 times more likely to die from

1 pregnancy-related causes than white
2 women. They are more likely to
3 experience unintended pregnancy and
4 more likely to live in areas where
5 limited access to reproductive
6 health services are. Structural
7 racism in health care means that
8 Black women's pain are too often
9 dismissed. Their concerns are
10 underestimated, their autonomy is
11 questioned. And when reproductive
12 access is restricted, Black women
13 are disproportionately impacted
14 economically, medically and
15 generationally, policies that limit
16 care, widening existing inequities
17 and continue a long history of
18 controlling Black women's bodies.

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

1 Survivors need immediate access to
2 emergency contraception and
3 abortion care. They need sustained
4 funding for Philadelphia Sexual
5 Assault Response Center, which is
6 known as PSARC, for forensic exams
7 and follow-up reproductive
8 services. They need trauma-
9 informed training and reproductive
10 health providers. They need strong
11 protections for patients'
12 confidentiality and they need
13 investment in community-based
14 serving Black women in marginalized
15 community.

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

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

3 When they are supported
4 with timely, compassionate,
5 accessible care, healing becomes
6 possible and cycles of violence can
7 be disrupted. Survivors deserve
8 control over their bodies. They
9 deserve equity and health care and
10 they deserve policies that
11 recognize what we see every day at
12 WOAR. Safety, dignity and
13 reproductive autonomy are
14 inseparable. Thank you for your
15 time and your commitment for
16 protecting the lives and well-being
17 of survivors in Philadelphia.
18 Thank you.

19 COUNCILWOMAN AHMAD:

20 Thank you, Laquisha.

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

24 MS. SMITH: Good

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

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

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

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

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

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

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

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

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

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

4 COUNCILWOMAN AHMAD:

5 Thank you so much. Just before we
6 go to the rest of our witnesses, I
7 wanted to recognize my colleague
8 Kendra Brooks who's here. She's on
9 a bit of a tight schedule. As I
10 said in my opening, we are creating
11 a continuum of speaking about
12 reproductive health care and
13 justice, and she's here to speak
14 about an initiative that she's
15 undertaking.

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

21 COUNCILWOMAN BROOKS:

22 Thank you so much, colleague.

23 Good afternoon,

24 everyone. And I want to thank

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

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

1 protected and remains a human right
2 here in our city.

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

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

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

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

19 So the People's Hearing
20 will take place this Thursday,
21 March 5th from 6:00 p.m. to
22 8:00 p.m. It will be hosted at the
23 Friends Center at 1501 Cherry
24 Street. But I think we're packed

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

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

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

24 COUNCILWOMAN AHMAD:

1 Thank you so much, Member Brooks.

2 As we said at the beginning, we are
3 creating a continuum, a landscape
4 where we're going to fight from
5 every angle to make sure
6 reproductive health care,
7 reproductive freedom is a household
8 topic, that we don't push it as a
9 second class issue. This needs to
10 be at the forefront. We have to
11 look at funding. We have to
12 normalize this conversation.

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

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

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

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

24 MS. COLEMAN: Good

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

10 I'm here today because
11 infant feeding is a public health
12 imperative. And in Philadelphia,
13 we cannot talk about reproductive
14 health without talking about
15 lactation care, human milk access
16 and the conditions that shape
17 feeding outcomes. I also come as
18 the co-founder of Breastfeeding
19 Awareness and Empowerment, also
20 known as BAE Culture, now in our
21 10th year of breastfeeding,
22 building community with Black women
23 and birthing people, creating peer
24 support, lactation education and

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

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

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

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

5 Human milk is the
6 biological norm. Breastfeeding is
7 not a lifestyle. It's a choice.
8 Families deserve the truth.
9 Feeding human milk is one of the
10 most evidence-based ways to protect
11 infant health and to protect the
12 health of mothers and birthing
13 people. Philadelphia's own public
14 health reporting shows
15 breastfeeding initiation increased
16 over time with the implementation
17 of the programs within hospitals.
18 However, local reporting highlights
19 that there still remain gaps, even
20 with initiation and relatively high
21 by the eight weeks postpartum.

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

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

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

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

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

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

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

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

16 In Philadelphia
17 government workplaces, there is an
18 executive framework addressing
19 worksite lactation support
20 policies. These are the pieces,
21 but policy without implementation
22 is just paper. If we want
23 equitable breastfeeding outcomes,
24 we need equitable access to the

1 people who make outcomes possible.

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

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

1 not mutually exclusive.

2 And so, as much as we
3 talk about reproductive justice and
4 reproductive health, we have to
5 also uplift lactation, as lactation
6 is the key to how our babies and
7 our mothers survive. And so, as we
8 integrate reproductive justice, we
9 have to also allow people to make
10 the choice, but make the choice
11 with informed decisions.

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

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

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

4 It has been widely
5 demonstrated that pregnant and
6 postpartum people from
7 underresourced communities,
8 particularly communities of color,
9 have disproportionately higher
10 rates of life challenges. Many of
11 the clients we serve experience
12 significant past or current trauma,
13 domestic violence, histories of
14 discrimination, poverty and other
15 life stressors, all of which can
16 contribute to increased rates of
17 perinatal depression and substance
18 abuse. And we also know that
19 behavioral health conditions are a
20 leading cause of maternal mortality
21 in the state and in Philadelphia.

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

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

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

24 Just as maternal

1 mortality is complex and
2 multifaceted, the solutions to the
3 issues of perinatal behavioral
4 health must be as well. General
5 priorities should include increased
6 outreach and enhanced access to
7 behavioral health treatment,
8 destigmatization of mental health
9 and substance dependence, increased
10 access to harm reduction education
11 and resources, and an investment in
12 the sectors impacting our families,
13 such as affordable housing and
14 child care, education and
15 employment opportunities.

16 Maternity Care Coalition
17 is committed to partnering with
18 Councilmember Ahmad, City Council,
19 the Philadelphia Department of
20 Public Health and other community
21 organizations to find and implement
22 these types of interventions.

23 Thank you for your time.

24 COUNCILWOMAN AHMAD:

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

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

24 From your perspective,

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

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

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

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

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

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

8 COUNCILWOMAN AHMAD:

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

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

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

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

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

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

20 Do you have questions
21 for Dr. Mattone?

22 COUNCILMAN O'ROURKE:

23 Yes. Thank you, Madam Chair.

24 Dr. Mattone, first of

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

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

1 reproductive justice in the city?

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

5 COUNCILMAN O'ROURKE:
6 Thank you.

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

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

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

11 And so, we know
12 substance use treatment facilities,
13 for example, rely on Medicaid and
14 run on low margins. And so, I
15 think those are a place of focus.
16 We also know that pediatric health
17 systems have a disproportionate
18 share of Medicaid coverage for our
19 patient panels. Medicaid was a
20 program designed for the coverage
21 of children, for example. And so,
22 I think that there are places to
23 look and conversations to start to
24 have as we think about loss of

1 Medicaid coverage.

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

19 COUNCILMAN O'ROURKE:

20 Thank you so much. Thank you, Madam
21 Chair.

22 COUNCILWOMAN AHMAD:

23 Councilmember Landau.

24 COUNCILWOMAN LANDAU:

1 Thank you. To open up for -- first
2 of all, thank you all for such
3 incredible testimony. This is
4 extremely important and you are
5 absolutely the experts, and we need
6 to hear from you. I was curious
7 about the funding for PSARC,
8 \$300,000, how far does that take
9 us? Does that only fund one year
10 or will that continue the funding
11 for longer?

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

16 COUNCILWOMAN LANDAU:
17 No.

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

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

1 not with PSARC or with Drexel, but
2 have had the opportunity to speak
3 with them. So the funding right
4 now -- well, really only the
5 revenue that comes in is from a
6 rape kit by rape kit, person-by-
7 person reimbursement, so up to
8 \$1,000 from the State Victims
9 Compensation Program. So part of
10 the challenge is that can vary year
11 to year while we've got all these
12 fixed costs.

13 So my understanding from
14 the current expense budget is that
15 300,000 would close the gap for a
16 year, right. So that sort of
17 investment is what would be needed
18 year over year.

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

1 COUNCILWOMAN AHMAD:

2 Thank you, Councilmember Landau.

3 And, yes, it's all recorded,
4 transcripts, so we'll be digging
5 deep.

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

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

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

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

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

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

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

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

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

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

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

4 MR. SLOVAK: Absolutely.

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

11 MS. SLOVAK:
12 Unfortunately.

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

24 But up until that point,

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

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

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

4 Do you have any
5 questions for Lila?

6 COUNCILMAN O'ROURKE:

7 No.

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

12 Are you leaving,
13 Laquisha?

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

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

1 like, if you could elaborate on
2 that.

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

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

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

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

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

24 COUNCILWOMAN AHMAD: So

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

18 MS. ANTHONY: Thank you.

19 COUNCILWOMAN AHMAD:

20 Quickly, I wanted to thank Brooke
21 for reading the testimony. And I
22 want to thank Ms. Mendez Lugo for
23 trusting us with your story and
24 your loss and joy in motherhood.

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

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

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

11 COUNCILWOMAN AHMAD:

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

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

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

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

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

20 COUNCILMAN O'ROURKE:
21 (Shaking head).

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

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

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

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

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

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

22 MS. COLEMAN:
23 Absolutely. So your experience
24 mimics my own. I'm a mother of two

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

8 But what the support
9 looks like in prenatal education
10 supports people to make informed
11 decisions. And when you have the
12 information, you have the resources
13 before delivery, that allows you to
14 know where to access, where to
15 pivot, where to get the support.
16 And it's also important that people
17 have support that's also culturally
18 aligned and culturally relevant
19 from providers who speak your
20 language, understand your community
21 dynamics and your setup.

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

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

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

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

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

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

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

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

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

3 MS. COLEMAN:

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

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

24 And I think we have just

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

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

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

5 COUNCILWOMAN AHMAD:

6 Thank you. Do you have any
7 questions?

8 COUNCILMAN O'ROURKE:

9 (Shaking head).

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

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

23 (Witnesses approached
24 witness table.)

1 COUNCILWOMAN AHMAD:

2 Thank you. Please have a seat and
3 state your name and start your
4 testimony. Let's start with you,
5 Signe.

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

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

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

7 More than 20,000
8 patients in Philadelphia rely on
9 Planned Parenthood health centers
10 for health care, and that care is
11 very much beyond at risk. Last
12 year's federal reconciliation
13 package effectively stripped
14 Planned Parenthood affiliates
15 across the country of Medicaid
16 reimbursement. 37 affiliates have
17 been defunded and 45 health centers
18 have already closed across the
19 country.

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

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

7 66% of our patients live
8 below 250% of the federal poverty
9 level. 44% identify as Black or
10 African American and 15% as
11 Hispanic or Latino, communities
12 that already face deep health
13 inequities. At the same time,
14 Philadelphia also has some of the
15 highest STI rates in the country.
16 Black women in Pennsylvania die at
17 more than twice the rate of White
18 women from pregnancy-related
19 causes. This is where safety net
20 providers really come in like
21 Planned Parenthood.

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

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

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

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

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

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

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

7 At Access Matters, we
8 are acutely aware of the
9 substantial barriers that prevent
10 many Philadelphians from accessing
11 the sexual and reproductive health
12 care they seek. These barriers are
13 especially pronounced in
14 communities that face stigma and
15 who have been historically excluded
16 from health care services.

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

1 not knowing what resources are
2 available.

3 Through Access Matters
4 information hotline and our Title
5 10 Family Planning Program, we
6 directly interface with people
7 throughout Philadelphia,
8 identifying nearby resources and
9 connecting people to care. As my
10 colleagues have outlined today,
11 there have been significant threats
12 to access in the past several years
13 that have impacted the ways
14 Philadelphians access and think
15 about care.

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

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

8 We are particularly
9 concerned about protecting
10 adolescent services and access.
11 Adolescents face their own unique
12 barriers to accessing sexual and
13 reproductive health care, including
14 transportation barriers and fears
15 around confidentiality. School-
16 based health centers are an
17 evidence-based approach that
18 address many of these barriers.
19 For 35 years, Access Matters Health
20 Resource Center program has
21 provided school-based, sexual and
22 reproductive health centers that
23 provide counseling and education as
24 well as referrals to community-

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

4 There are 22 health
5 resource centers serving
6 adolescents, located in schools in
7 eight Philadelphia City Council
8 Districts, that together served
9 over 3000 adolescents last year.

10 These spaces are greatly beneficial
11 for adolescents, positively
12 impacting health and wellness and
13 their well-being. But some schools
14 do not have health resource centers
15 or there are centers that are
16 located in schools that are now
17 slated to close.

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

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

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

19 COUNCILWOMAN AHMAD:
20 Thank you so much.

21 Please go ahead and
22 state your name and start your
23 testimony.

24 DR. MONTOYA-WILLIAMS:

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

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

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

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

24 When families fear

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

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

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

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

1 birth, postpartum depression.

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

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

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

9 We have to advocate and
10 support those existing doula and
11 community health worker programs
12 that exist within our health
13 department and our local
14 communities, many who are
15 represented here today and maybe
16 create special funds to sustain
17 this workforce. We also have to
18 advocate for telemedicine
19 infrastructure. Telehealth is not
20 a replacement for inperson,
21 reproductive care, but it is a
22 powerful supplement. It can
23 provide blood pressure monitoring,
24 lactation support, mental health

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

8 And finally, we must
9 stabilize and fund the community-
10 based organizations already doing
11 this work. They are really the
12 backbone. If we want Latina and
13 immigrant mothers to continue to
14 access care, we have to ensure the
15 organizations that are guiding them
16 right now are resource-protected
17 and sustained. They are working
18 really hard under very scary
19 conditions.

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

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

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

17 COUNCILWOMAN AHMAD:
18 Thank you so much for all your
19 testimony. Critical, you know, we
20 know these things, but when we put
21 this into the public record, which
22 is why we're doing this hearing, it
23 is important. It is in the annals
24 for us to know. We heard and did

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

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

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

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

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

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

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

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

24 And so, I think just the

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

9 COUNCILWOMAN AHMAD:

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

23 MS. ESPINOZA:

24 Certainly. We can follow up with

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

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

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

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

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

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

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

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

11 MS. ESPINOZA: There are
12 certainly --

13 COUNCILWOMAN AHMAD: We
14 have a surplus.

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

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

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

23 COUNCILWOMAN AHMAD:
24 Operationally, when we think about

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

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

1 than anybody else and we have more
2 needs.

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

15 Do you have a question
16 for Planned Parenthood?

17 COUNCILMAN O'ROURKE:
18 (Shaking head).

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

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

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

1 adolescents and people. Parents
2 overwhelmingly typically support
3 access to comprehensive sex ed. We
4 do know that adolescents have
5 varying access to these resources
6 at home, outside of school and
7 there's varying level of
8 comfortability to having these
9 conversations.

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

1 the services are available
2 confidentially, that education and
3 awareness around the availability
4 is still something that, you know,
5 we continue to work to make sure
6 adolescents know that these
7 services are available in a
8 confidential way.

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

20 MS. ROSS: Absolutely.

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

24 All right. Do you have

1 any questions for Audrey?

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

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

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

1 like the light part of this, right.

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

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

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

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

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

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

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

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

1 There may be opportunities for home
2 visits too, but I think that'll be
3 individual and family decisions
4 with their medical providers. But
5 I want to make sure that we're
6 balancing those and keeping in mind
7 what is true and appropriate health
8 care for these families, and
9 thinking about ways that we can
10 create safety as families make
11 those decisions, create accurate
12 information, create trusted
13 messengers and perhaps allow for
14 more people to be accompanied.

15 That's why I think community --

16 COUNCILWOMAN AHMAD:

17 Yeah, that was my next question.

18 DR. MONTOYA-WILLIAMS:

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

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

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

11 DR. MONTROYA-WILLIAMS:
12 There can be many roles, right. We
13 know that doulas often play this
14 role. Community health workers can
15 play this role. Sometimes we have
16 patient navigators, but it's
17 support personnel that come from
18 the community, maybe speak the same
19 language if possible and are
20 trusted. Our community-based
21 organizations have this workforce.
22 Our health department has workforce
23 like this, but they are also in
24 this moment of uncertain funding

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

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

22 DR. MONTROYA-WILLIAMS:
23 Absolutely. I think you're
24 speaking to some of the policies

1 that can be put into place and that
2 health care systems, small and
3 large, can start to remind their
4 staff around which is creating the
5 safe, confidential spaces during
6 which health care occurs, versus
7 the public waiting room spaces.

8 And certainly within our
9 institutions, we're having those
10 conversations and re-upping that
11 information. I think it gets
12 tricky depending on how immigration
13 enforcement chooses to act and
14 chooses to carry out their
15 enforcement activities, but we
16 certainly can create policies and
17 increase our education and
18 awareness of what is allowable
19 within our health care spaces, and
20 that's certainly work that is
21 happening.

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

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

9 But there are policies
10 that hospitals can consider
11 bringing to the forefront, and we
12 have done that within my
13 institution families need to be
14 aware of and public health
15 campaigns can be created around
16 that.

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

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

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

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

18 THE CLERK: No, we have
19 two more.

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

22 THE CLERK: Alice
23 Abernathy, Assistant Professor
24 Obstetrics and Gynecology,

1 University of Pennsylvania;
2 Elizabeth Kukura, Associate
3 Professor of Law, Drexel
4 University; and Abigail Wolf,
5 Professor of Clinical Obstetrics
6 and Gynecology; University of
7 Pennsylvania.

8 (Witnesses approached
9 witness table.)

10 COUNCILWOMAN AHMAD:

11 Thank you so much. Please state
12 your name and begin your testimony,
13 Dr. Abernathy.

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

24 My life has benefited

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

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

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

1 management of chronic gynecologic
2 conditions and the provision of
3 contraception and abortion care.
4 Frequently, these services are
5 delivered at the same time. My
6 research examining Pennsylvania
7 after Dobbs shows that although the
8 legal status of abortion did not
9 change in our state, health
10 behaviors did. Demand for
11 permanent contraception increased.
12 Patients altered their
13 contraceptive decisions, not in
14 response to a policy change, but in
15 fear that one could occur.

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

1 contraception care in addition to
2 abortion and contraception care.

3 And we know that when that
4 infrastructure destabilizes,
5 predictable harms follow.

6 Untreated sexually-
7 transmitted infections lead to
8 pelvic inflammatory disease,
9 infertility, chronic pelvic pain
10 and ectopic pregnancy, which is the
11 leading cause of maternal death in
12 the first trimester. These are all
13 preventable conditions. STI
14 testing and treatment are
15 fertility-preserving and lifesaving
16 and a central aspect of the
17 reproductive health safety net.
18 Contraception is also not simply
19 pregnancy prevention. These
20 medications are used to manage a
21 wide breadth of chronic gynecologic
22 conditions. And we know that when
23 patients cannot access
24 contraception for these concerns,

1 they experience harms.

2 We also know that when
3 patients cannot access
4 contraception for birth control, we
5 see more unintended pregnancies,
6 particularly among patients with
7 uncontrolled chronic medical
8 conditions. In my practice in West
9 Philadelphia, nearly every single
10 patient that I see has a
11 comorbidity that makes pregnancy
12 higher risk for them.

13 Contraception is not just pregnancy
14 prevention. It allows patients to
15 optimize their health before
16 becoming pregnant, making
17 pregnancies safer and directly
18 reducing maternal morbidity and
19 mortality.

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

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

11 We are staring down the
12 barrel of some of the largest cuts
13 to health services in our lifetime
14 at the state and national level.
15 At the city level, booming budget
16 cuts will decimate the reproductive
17 health safety net. The
18 consequences will extend beyond
19 abortion access to STI testing and
20 treatment contraception access and
21 maternal mortality reduction
22 efforts.

23 These are all measurable
24 post-op outcomes that are already

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

9 If we're serious about
10 reducing maternal mortality in
11 Philadelphia, we cannot weaken the
12 very infrastructure that safeguards
13 reproductive health. These are
14 services that are critical for
15 Philadelphians to prosper in the
16 city they love. I ask you to
17 protect this infrastructure so that
18 every Philadelphian, regardless of
19 their zip code or their income, can
20 access the care they need in the
21 city that they call home. Thank
22 you.

23 COUNCILWOMAN AHMAD:

24 Thank you so much.

1 Please state your name
2 and proceed with your testimony.

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

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

24 First, we know that

1 adverse maternal health outcomes
2 are disproportionately high in this
3 country and in this city,
4 especially for Black women. Given
5 the number of hospitals that have
6 eliminated their obstetrics units
7 and the imminent closing of the
8 freestanding birth center life
9 cycle, it's really essential that
10 we understand the current geography
11 of perinatal health care services
12 in Philadelphia, including where
13 pregnant people get prenatal care,
14 where they give birth, where they
15 access postpartum care, including
16 postpartum mental health care,
17 opportunities for the potential for
18 telemedicine to play an increased
19 role in provision of postpartum
20 mental health care and
21 opportunities for midwifery access
22 and community birth as well.

23 A critical question in
24 this context is how well all of

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

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

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

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

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

1 outcomes.

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

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

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

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

1 people with substance use disorder
2 in the postpartum period.

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

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

1 extent of the story, with the goal
2 of promoting more widespread
3 competence in caring for the health
4 needs of people in perimenopause
5 and menopause. And this needs to
6 start with medical education and
7 training, including in relevant
8 fields beyond obstetrics and
9 gynecology.

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

1 COUNCILWOMAN AHMAD:

2 Thank you.

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

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

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

1 child. And at 15 weeks of
2 pregnancy, she was admitted to a
3 local hospital. Her story is that
4 she had three children,
5 unfortunately, an abusive partner.
6 She had her meds for her asthma
7 refilled during her early pregnancy
8 and was referred to a pulmonary
9 specialist. However, over the next
10 several weeks she had several
11 admissions to the different
12 emergency room departments for
13 management of her asthma. And then
14 last week, her 6-year-old called
15 911 because she was having such a
16 severe asthma attack. She was
17 taken to the hospital and in the
18 ambulance she coded. She was
19 admitted to the ICU and
20 unfortunately, she died.

21 The next several days
22 later I had another patient, a
23 28-year-old woman, her third
24 pregnancy. She also had an abusive

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

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

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

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

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

23 COUNCILWOMAN AHMAD:

24 Well, thank you so much. Thank you

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

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

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

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

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

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

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

5 But I would like to
6 raise a statistic that even when we
7 think about the most traditional
8 forms of accessing reproductive
9 health care, which would be
10 starting prenatal care in the first
11 trimester, what we know about the
12 pregnancy-related deaths that have
13 occurred in Philadelphia is that
14 30% of those pregnancy-associated
15 deaths started care later, right.

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

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

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

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

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

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

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

1 the things we can fix and change.

2 Even if we can't fix everything,
3 but we can start at some point,
4 some spaces.

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

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

1 experiencing either perimenopause
2 and then menopause?

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

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

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

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

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

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

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

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

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

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

1 in federal funding for research,
2 right. There's particular research
3 issues that are longstanding as a
4 for treatment for perimenopause and
5 menopause as a horrifically
6 underresearched topic. But there's
7 also a lot of changes happening
8 right now in terms of the changes
9 and priorities of federal funding
10 that are stopping research study
11 that are discouraging researchers
12 in areas that are really critical,
13 not just to perimenopause and
14 menopause, but so many aspects of
15 reproductive health care.

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

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

7 COUNCILWOMAN AHMAD:

8 Yeah, I think even if you just put
9 out the information we have, with
10 the research we have right now
11 would be really helpful. One topic
12 before I let you go is just about
13 other issues, other health concerns
14 outside of menopause or
15 perimenopause or menstruation,
16 including things like fibroids,
17 PCOS, cancer, cancer screening.
18 Where is that bucket? This is
19 preventive kind of perspective work
20 with also people who actively have
21 any one of those conditions. How
22 do we get our communities to be
23 proactive, the BRCA1 to get
24 screened for breast cancer, to know

1 your risk, all of those things?

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

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

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

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

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

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

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

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

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

11 COUNCILWOMAN AHMAD:

12 Well, thank you.

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

16 COUNCILMAN O'ROURKE:

17 (Shaking head).

18 COUNCILWOMAN AHMAD:

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

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

5 Clerk, would call up the
6 next and final panel.

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

18 (Witnesses approached
19 witness table.)

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

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

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

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

23 Just last week, one of
24 my clients actually returned to

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

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

1 advocate for themselves in
2 hospitals and to build that
3 confidence. So this work is so,
4 so, so important and so sacred.
5 And so, I just ask for your
6 continued support of our
7 organization and other
8 organizations that support
9 perinatal mood and anxiety
10 disorders. And I will read her
11 testimony now:

12 Good afternoon,
13 Chairwoman Ahmad and members of the
14 Council. My name is Saleemah
15 McNeil. I am the founder and
16 Executive Director of Oshun Family
17 Center. I am here in support of
18 this resolution and in strong
19 support of continued public
20 hearings on reproductive health in
21 Philadelphia. Let me begin with
22 the data.

23 Black women in
24 Philadelphia continue to experience

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

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

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

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

8 Reproductive health
9 cannot be addressed in fragments.
10 We cannot examine abortion access
11 without addressing postpartum
12 mental health. We cannot discuss
13 fertility without continuity of
14 care after birth. We cannot pass
15 resolutions about equity while
16 community-based providers are left
17 building infrastructure without
18 sustained policy alignment.

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

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

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

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

23 COUNCILWOMAN AHMAD:
24 Thank you so much for your

1 testimony.

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

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

16 COUNCILWOMAN AHMAD:
17 Please state your name.

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

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

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

1 For Fiscal Years '23 and
2 '24, ALF received \$500,000 in
3 municipal funding last year. That
4 amount was reduced to 250,000.
5 Even with that reduction, because
6 the average pledge to help cover
7 abortion care is around for \$245,
8 that funding allowed us to support
9 more than 1000 callers. That's
10 1000 people with different
11 circumstances, some facing health
12 complications, some navigating
13 financial hardship and others who
14 know it's simply not the right
15 time. That is the direct
16 measurable impact of city
17 investment in the stability of
18 families and the strength of our
19 city.

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

1 COUNCILWOMAN AHMAD:

2 Thank you.

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

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

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

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

1 Black birthing lives in this city.

2 Operationalizing

3 maternal health equity is not just
4 about the brick-and-mortar access.

5 While physical facilities are one
6 level of access, the deeper barrier
7 is the quality of care within those
8 walls. Our local reproductive
9 health facilities face immense
10 pressure to serve high patient
11 volumes while navigating systemic
12 underfunding. This evidence is
13 undeniable.

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

1 occasionally.

2 However, there is an
3 operational solution that is both
4 avoidable and preventable, which is
5 the elimination of medical bias.
6 Respectful bias-free care is not an
7 extra. It's a clinical necessity.
8 Through the Once Upon a Premium
9 Academy's City of Philadelphia,
10 maternal implicit bias training,
11 which launched a pivotal \$100,000
12 initial investment from the City
13 Council, we're transforming
14 Philadelphia's health care
15 workforce. We're equipping our
16 clinicians with the tools to
17 deliver the bias-free care,
18 respectful care, that our families
19 deserve.

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

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

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

24 More importantly, it is

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

10 When we support
11 hospitals to complete our
12 accredited e-learning courses, many
13 of which who have completed our
14 program, report improved quality of
15 care delivered to families, better
16 patient-provider relationships, and
17 to build upon some of the lactation
18 conversation we heard earlier.

19 Many of our neonatal institutions
20 are improving and increasing
21 initiation and continuation of
22 breastfeeding for all moms, which
23 is significant for Black preemie
24 moms.

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

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

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

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

9 We opened our doors in
10 1978 and we will be closing next
11 week permanently. Birth centers
12 care for low-risk childbearing
13 people in community-based settings
14 rooted in the midwifery model of
15 care. In this state, they are
16 licensed by the Pennsylvania
17 Department of Health and in all
18 states they are accredited by a
19 national accrediting body.

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

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

10 Lifecycle's clinical
11 outcomes over the 47 years we
12 operated have been excellent. Our
13 cesarean rate over the past five
14 years is under 14%. In December of
15 2025, our second to last month
16 attending births, we welcomed 65
17 babies, the second highest monthly
18 total in our history. We had a
19 waiting list of over 200 people for
20 a GYN visit.

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

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

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

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

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

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

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

5 The city can act. Help
6 restore the venue shopping
7 restriction, support payer
8 accountability, invest in funding
9 mechanisms that allow independent
10 reproductive health practices to
11 survive. Listen to the voices of
12 childbearing people. This loss
13 reveals what our system chooses to
14 reward and what it chooses not to
15 sustain. Philadelphia has the
16 opportunity to make a different
17 choice.

18 COUNCILWOMAN AHMAD:
19 Thank you. I'm so sorry that this
20 is the testimony you had to share
21 with us. Could you ex -- and we'll
22 go backwards with you. Could you
23 explain the venue shopping
24 restriction a little more,

1 elaborate?

2 MS. SCHWARZ: Yeah.

3 Historically, there was a
4 restriction that there was a law
5 that required that if you were
6 going to bring a malpractice case,
7 you had to bring it in the county
8 where the care had been rendered.
9 And that restriction on venue
10 shopping, meaning shopping cases
11 around to a place where the jury
12 payouts would be higher, was
13 repealed.

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

1 COUNCILWOMAN AHMAD: The
2 cases happened elsewhere but they
3 --

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

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

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

15 COUNCILWOMAN AHMAD: So
16 this is a state --

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

24 COUNCILWOMAN AHMAD:

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

9 MS. SCHWARZ: I mean,
10 it's absolutely prohibitive for
11 community-based providers. And
12 honestly, we saw that the
13 University of Pennsylvania had a
14 \$200 million-plus verdict against
15 it. So at that scale, it threatens
16 the whole system.

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

24 MS. SCHWARZ: I mean, I

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

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

17 MS. SCHWARZ:
18 Absolutely.

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

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

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

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

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

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

20 COUNCILWOMAN AHMAD:

21 Well, thank you.

22 Do you have any
23 questions for her?

24 COUNCILMAN O'ROURKE:

1 Not for you a question. Thank you.

2 But --

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

6 COUNCILMAN O'ROURKE:

7 Thank you, Madam Chair.

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

15 But, Katia Perez, it is
16 good to see you. And I want to
17 thank you for the work that you do.
18 Thank you, panelists, for all of
19 you for the work that you have done
20 here in the world. Thank you.

21 Thank you for your work. Thank you
22 for your work, Katia, particularly
23 with supporting Philly's mothers.

24 You gave a couple of

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

3 MS. PEREZ: Yes, for
4 2022 and 2023. The --

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

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

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

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

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

22 MS. PEREZ: Reproductive
23 Freedom Task Force, yes.

24 COUNCILMAN O'ROURKE:

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

3 MS. PEREZ: I mean, it
4 would be amazing to be able to get
5 500,000 again because like -- so
6 last year, like I said we were able
7 to get 250,000. That was a line
8 item in the budget for Fiscal Year
9 '25. With that, we were able to
10 help 1000, right --

11 COUNCILMAN O'ROURKE:
12 And you ran up to like 500 --
13 sorry, good grief, voice of God,
14 245 was your actual --

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

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

8 The average pledge is
9 245. With the 500,000, the last
10 year that we got that, that year we
11 were able to serve over 3500
12 people, right, overall that called
13 our helpline, which is amazing.
14 Last year though when there was --
15 well, we're very thankful for the
16 250,000 because we were still able
17 to help support folks.

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

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

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

1 able to support with that money.

2 COUNCILMAN O'ROURKE:

3 Okay. You'll also be at the
4 hearing on Thursday?

5 MS. PEREZ: Yes, I will
6 be.

7 COUNCILMAN O'ROURKE:

8 Okay. The more that we can hear
9 figures, facts and figures --

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

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

18 Thank you, Madam Chair.

19 COUNCILWOMAN AHMAD:

20 Thank you for that. Quickly before
21 we move on to another witness, are
22 you also seeing -- and I asked this
23 question of Planned Parenthood --
24 influx of people from elsewhere or

1 are you serving mostly
2 Philadelphians?

3 MS. PEREZ: So, yes,
4 Pennsylvania is a receiving state
5 and Philadelphia specifically is a
6 receiving city, because there's
7 people coming in from states that
8 have bans, right. A lot of people
9 coming in from Florida because of
10 Philadelphia International Airport.
11 So what we have seen in our
12 helpline also is that there have
13 been longer wait times for even
14 Philly residents here in our city,
15 because there's out-of-state folks
16 coming and they're having to travel
17 to the outer counties, Montgomery
18 County, Chester, Delaware County to
19 receive abortion care. So, yes,
20 that has incrementally been
21 increasing.

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

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

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

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

1 thank you for your testimony.

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

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

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

1 that's being planted where we're
2 going to see water. And allowing
3 those seeds to blossom into
4 beautiful flowers is continued
5 investment, not just in training.
6 Training alone will not eliminate
7 medical bias. Training alone will
8 not eliminate disparities, but
9 medical bias partnered off with
10 quality improvement initiatives and
11 a strategic plan where our health
12 centers and our health department
13 are held accountable to track,
14 monitor and trend, measures and
15 data over time will help us get
16 there. But I hope that this will
17 not be the City Council's first
18 opportunity with this training
19 opportunity.

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

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

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

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

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

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

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

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

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

13 COUNCILWOMAN AHMAD:
14 Even though it's outside.

15 MS. PEREZ: Yes.

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

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

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

23 For example, this
24 implicit bias thing investing in

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

14 Colleague, do you have
15 any more questions?

16 COUNCILMAN O'ROURKE:
17 (Shaking head).

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

21 THE CLERK: One.

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

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

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

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

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

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

20 (Witness approached
21 witness table.)

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

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

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

1 for years to come.

2 So launched in 2024, the
3 Philly Joy Bank provides pregnant
4 individuals with cash payments of
5 \$1,000 a month during pregnancy and
6 the first 12 months postpartum, and
7 recipients can use this money
8 however they most need it. But the
9 current program is small. It
10 serves only 250 people in just
11 three of our city's neighborhoods.
12 Now is the time to expand it.
13 Having a baby is expensive.

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

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

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

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

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

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

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

1 troubling sign of deep-rooted
2 health disparities. That's roughly
3 33% higher than the citywide
4 average and a staggering 65% higher
5 than the national rate with cuts to
6 SNAP and other federal programs.
7 These numbers may climb. There's
8 growing evidence that cash can
9 improve pregnancy and birth
10 outcomes in North America.

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

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

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

21 COUNCILWOMAN AHMAD:
22 Thank you so much for your
23 testimony. We already understand
24 the value of the Joy Bank, and I

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

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

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

1 will check and --

2 MS. GROVES: I would
3 love for that news.

4 COUNCILWOMAN AHMAD:
5 We'll check and make sure. I'll
6 check with the Health Department to
7 see when and where that might be
8 coming. They might be just trying
9 to figure out how to do this. But
10 clearly, the value is there.

11 That's been proven over and over,
12 not just here, but in other spaces.

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

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

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

8 MS. GROVES: Absolutely.

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

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

18 COUNCILWOMAN AHMAD:
19 Those are good models.

20 MS. GROVES: They are
21 good models.

22 COUNCILWOMAN AHMAD:
23 Thank you very much for your
24 testimony.

1 MS. GROVES: Thank you.

2 COUNCILWOMAN AHMAD:

3 Thank you.

4 Mr. Sham, would you call
5 the next speaker.

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

9 COUNCILWOMAN AHMAD:

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

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

18 COUNCILWOMAN AHMAD:

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

1 your attendance.

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

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

15 (Applause.)

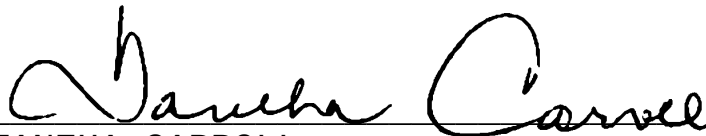
16 COUNCILWOMAN AHMAD: --
17 who has worked extremely hard at
18 pivoting here, there and everywhere
19 to make this happen under the
20 guidance of Julian Sham, our
21 Legislative Director. Thank you
22 very much and to the entire team
23 for helping us get here.

24 (Committee on the Public

1 Health and Human Services concluded
2 at 4:37 p.m.)
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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
Court Reporter - Notary Public

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\$100,000 208:11 232:24	16 45:10	250 225:2 241:10
\$200 220:14	16,000 215:17	250% 120:8
\$245 204:7	160 198:23	250,000 204:4 226:7 227:16
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1000 204:9,10 226:10	2019 47:5	33% 244:3
10th 73:21	2020 30:9	33-year 174:22
11% 180:16	2021 205:15	338 46:8
11th 201:4	2022 225:4	35 125:19
12 241:6,17	2023 68:16 225:4	3500 227:11
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14% 213:14	2025 46:7 198:21 200:7 205:15 213:15 214:15	39% 198:12
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	22 126:4	40% 198:13 214:19 242:14
	23 204:1	41-year- 203:2
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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.