COUNCIL OF THE CITY OF PHILADELPHIA

PUBLIC HEARING

COMMITTEE ON PUBLIC HEALTH AND HUMAN SERVICES

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Room 696, City Hall
Philadelphia, Pennsylvania
Tuesday, September 17, 2002
10:15 a.m.

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BILL 010675 - Resolution authorizing the Committee on Public Health and Human Services to hold hearings to investigate the causes and effects of continuing high levels of infant mortality in Philadelphia African American neighborhoods.

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PRESENT:

COUNCILWOMAN MARIAN B. TASCO, Chair
COUNCILWOMAN BLONDELL REYNOLDS BROWN
COUNCILMAN WILSON W. GOODE, JR.
COUNCILMAN RICHARD T. MARIANO
COUNCILWOMAN DONNA REED MILLER
COUNCILMAN ANGEL L. ORTIZ
COUNCILMAN FRANK RIZZO

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I N D E X

9/17/02 - PUBLIC HEALTH - RES. 010675

COUNCILWOMAN TASCO: Good morning. I'd like to call the hearing to order. I'd like to note that we have a quorum in the presence of Councilman Goode, Councilman Ortiz and Councilman Rizzo and Marian Tasco, I am chair the committee.

I call on Brenda Frazier to read the hearing notice.

MS. FRAZIER: Resolution No. 010675, authorizing the Committee on Public Health and Human Services to hold hearings to investigate the cause and effects of continuing high levels of infant mortality in Philadelphia's African American Neighborhoods.

Whereas, infant mortality indicates that a baby dies before a first birthday. Its incidence greatly for white or minority women in the City of Philadelphia; and

Whereas, overall for every 1,000 live births in Philadelphia in 1999 there were 11.6 infant deaths, but for every 1,000 live births in the African American community, the rate of infant deaths was 16.7, while there were 5.8 infant deaths for white babies;

Whereas, a complex set of factors, not

all of which are fully understood, impacts the large discrepancy between white and black communities and the health of mothers and their babies; and

Whereas, many studies have pointed to the general conditions of poverty and unhealthy living conditions, the lack of prenatal care, the use of drugs, alcohol, and tobacco, can precipitate low birthweight of a newborn; and

Whereas, low birthweight can be the single most important indicator of complications for the survival of a baby, it is increasingly being linked to mental, emotional, and physical stress of the mother; and

Whereas, Northwest Philadelphia has not been a recipient of a Healthy Start Program, neither has it been targeted for substantive increases in maternal healthcare or maternal health education; and

Whereas, an infant death produces such a cycle of trauma, depression, grief, and loss within a family that it can negatively influence the society at large; and

Whereas, new initiatives are needed to improve the chances of infant survival and to

decrease infant mortality throughout minority communities.

Therefore, resolved that the Council of the City of Philadelphia authorize the Committee on Public Health and Human Services to hold hearings to investigate the causes and effects of continuing high levels of infant mortality in Northwest Philadelphia's African American neighborhoods.

COUNCILWOMAN TASCO: Thank you very much.

I'd like to add that Councilman Mariano is joining us.

I will have some prepared remarks. And after my remarks, I will invite my colleagues to make any opening statements they would like to make.

There is a greeting in an African village that is not "hello" or "how are you," but "How are the children?"

The strength of a society is measured by how it cares for its young and its old. By today's standard, our society is less than strong because our children are not well.

We are in the middle of a crisis of epidemic proportions. So much attention has been

focused this past summer on child kidnappings, murders, and other violent crimes that not enough people are talking about the number one crisis among children in Philadelphia: Infant mortality.

As a parent and grandparent, learning about the continuing numbers of infant deaths we are going to discuss today shocked me. As a Councilwoman, I have turned this shock into action. We can no longer afford to stay silent. This hearing today is intended to focus attention on Philadelphia's above-average, double-digit death rate and underscore the dire need to make further inroads on reducing it.

According to a recent Morbidity and Mortality Weekly Report from the Centers for Disease Control and Prevention, the CDC published in April 2002, Philadelphia, tied with Buffalo, was ranked as having the 11th highest infant mortality rate among the 60 largest cities for the period 1995 to 1998.

Bringing this closer to home, according to the recent Philadelphia Department of Public Health Report for 1999, Philadelphia resident birth, death, disease and population data by health district, by neighborhood, and by census tract

within health districts, 4 of the 21 neighborhoods with infant death rates above the city-wide rate fall within my Councilmanic district in whole or in part. Of the 10 neighborhoods with the highest infant mortality rates, three fall within my district in whole or in part.

The highest infant mortality rate in Philadelphia in the last reported year, 1999, was in the West Oak Lane-Cedarbrook neighborhood of my Councilmanic District, with 24.9 deaths per 1,000 live births. The number was more than double the infant mortality rate for the City as a whole that year, which was 11.6 per 1,000 live births.

I have been cautioned that we cannot look at just one year's statistics in a vacuum. But the fact remains that the West Oak Lane-Cedarbrook neighborhood has had an infant death rate much higher than the City rate for three of the last four years for which data is available, 1996 through 1999. This City data also shows that the highest infant death rates are occurring in certain neighborhoods year after year. So my concern and alarm is well-founded.

Just last week, the CDC released its

Health, United States 2002 report, the 26th annual statistical report on the nation's health. It reported that the national infant mortality rate dropped to 6.9 in 2000. This is good news of a continuing overall downward trend in infant deaths. But it stands in stark contrast to the 1999 West Oak Lane-Cedarbrook rate which was more than three times higher.

Much effort has been made here in Philadelphia, as well as across the country, to reduce the number of infant deaths. Many of the witnesses we will hear from today play a major role in making this happen. Many of you work hard every day to provide important prenatal care services to pregnant women in our communities. My colleagues on Council and I applaud your effort.

Progress has been made over the years, in part due to increased access to healthcare services for low-income families through federal and state health insurance programs such as Medicaid and the Children's Health Insurance Program known as CHIP. But the sad fact is that too many of our neighborhoods, including the neighborhoods in my own Councilmanic District, infant deaths are still far

above the City and national averages.

Research shows that there are significant racial and ethnic disparities in infant mortality rates. In particular, African American and Hispanic infants are much more likely to die within the first year of life than Caucasian babies are. More women are getting prenatal care earlier in their pregnancies, but, again, racial disparities exist. And racial disparities exist in the percentages of babies with low birthweight which puts them at increased risk of death.

The purpose of today's hearing is to have a meaningful public dialog about this crucial public policy challenge:

Why high infant death rates persist in certain neighborhoods;

What has been the impact of healthy start and other programs;

What can be done to make further headway on reducing the death rate;

Who is best suited or most responsible for taking what actions;

How much will additional corrective or preventative measures cost;

And when can we expect to see some positive results?

To facilitate this dialog, we will hear from several witness panels representing research, healthcare, advocacy, and government communities. These individuals will bring us their expertise and recommendation for moving forward to reduce the infant mortality rate.

I thank each of you for your contribution to this dialog, for helping us better understand the nature of the problem, and for assisting us to identify appropriate policy responses. Again, thank you all for coming.

I call on and invite my colleagues if they have comments to make before we begin with our first panel to do so.

I also would like -- I know you are very busy and you like to stay in contact with your office, but if you could put your phones on low so we won't have the interruption of the telephone, and also ask my colleagues to do the same.

Any of my colleagues have comments?

Councilman Ortiz.

COUNCILMAN ORTIZ: Thank you, Madam

Chair. I want to thank you for bringing these hearings. But it just shows that the more things change, the more things remain the same. As you remember, we were here before on infant mortality in 1987, '88. The Mom Mobile, other aspects were created. We spent money. In fact, we had a pilot program in West Philadelphia which is where Healthy Start began. So we have a history. And the problem is that just like the lead problem in the City of Philadelphia, it seems that the issues that pertain to children and children's health and children's education really seem to take a back seat when public policy is being made and monies are being spent, especially when these children reside in poor neighborhoods or come from families who just migrated to the City of Philadelphia.

So I would hope, because now we have a national government only intent on replacing evildoers across the world, but we have evil that is constant every day in City's such as Philadelphia, and that is disease and bad schools, bad housing.

Today, the Inquirer front page said there are no homes for homeless families in Philadelphia. So when you're born into a homeless

family, you are not going to have a good chance of surviving that first year. And we have to begin to be serious about how we make public policy and where we direct our efforts.

Lead has always been an issue, but we don't address it. And we address it every time every 10 years. Infant mortality is one of those issues. We are coming back to it after 10, 14 years because it's still a problem in the poorest areas of our City.

So I hope that this time around, the following Council in the year 2017 is not talking about infant mortality and lead and so on. I hope that we're able to put into track the solutions and change public policy in the City of Philadelphia so that kids in West Oak Lane and in Fairhill can not die before they reach the age of one. Thank you, Madam Chair.

COUNCILWOMAN TASCO: Thank you. I would like to recognize Councilwomen Blondel Reynolds-Brown and Councilwoman Donna Reed-Miller who have joined us.

Would any other colleagues like to have any opening remarks?

(No response.)

COUNCILWOMAN TASCO: Okay. Certainly, they will join in as we proceed today.

We have several panels. And you all have been given instructions, I understand, about the length of time. What we'll do is ask you to make remarks and then we'll have questions at the end of the last presentation.

I now call on researchers Jennifer Culhane, Mary Harkins-Schwartz, and Linda Hock-Long.

Would you identify yourself for the record and proceed with your testimony? We'd like for you to, in some measure, summarize your testimony, if you can.

MS. ELO: My name is Irma Elo and I'm from the University of Pennsylvania. I work with Jennifer Culhane on a number of studies that examine infant health in Philadelphia. And I will base my remarks mostly on the results of those studies. And I will focus mostly on the role of social and economic context and residential environments in determining infant health. There are a number of other individuals later today who are better equipped to discuss medical care and its role in

reducing infant mortality. But I'm also doing this because we believe that to make further progress in reducing infant mortality, we must also pay attention to non-medical factors and do a better job in integrating medical and non-medical services.

It has been impossible to explain black-white differences in infant mortality by paying attention only to black-white differences in health behaviors or prenatal care used during pregnancy, or by looking only at black-white differences in income and education. That's why there's much more attention now being paid to other factors, such as the potential role of residential context, the role of social support, and exposures to acute and chronic stress. And here, neighborhood context might be particularly important for understanding black-white differences in infant mortality.

Residential segregation and racial discrimination has meant that African Americans are much more likely than whites to live in neighborhoods with poor municipal services, limited access to healthcare, high rates of crime, and poor housing quality. These are all conditions that have

been linked to health outcomes, including infant mortality in a number of studies that have control for individual differences among neighborhood residents. That's why in our studies we integrate social context, health behaviors, exposures to acute and chronic stress in a comprehensive model.

I have a handout with a number of slides on the handout. You should have copies and you can peruse through that. The first three pages of that handout show examples of the integration of these number of different models.

So based on this work, I would like to emphasize four points that we believe are particularly important to keep in mind when you consider policy interventions aimed at reducing infant mortality.

First, we must take a purview of social and economic context and not only consider individual characteristics of mothers. There are a number of mechanisms through which broader community context could influence health outcomes. And these mechanisms are outlined on Figure 4 of our handout, so you can take it with you and look at it later. But they're all related to community, social

service, and physical environments.

The second point I want to raise is that health behaviors and use of medical care do not occur in isolation. They're imbedded in the social context, they are influence by social and economic circumstances. And if we change just one set of health behaviors or we come up with just one other medical intervention but we do not consider the broader context in which these behaviors or health interventions occur, we are only addressing part of the problem.

Third, there are plausible biological mechanisms that link context to birth outcomes through maternal physiology. So focus on the context is not unrelated to the health of the mother. These mechanisms are related to neuroendocrine dysregulation and functioning of the immune system. And there's recent research that suggests that social context may work through these biological mechanisms and that they may be particularly important for understanding pre-term births.

And that leads to my fourth point. The high infant mortality rate in the United States is

mainly due to the high rate of births that are born too early or preterm. Births that are born too early are generally also low birthweight. So to reduce infant mortality, we must reduce low birthweight babies and preterm births. The black-white difference in preterm births and low birthweight in turn is also one of the main reasons for black-white differences in infant mortality. Most infant mortality occurs very shortly after birth. And preterm births and low birthweight babies are largely responsible for that.

So let me now illustrate the points I make with a couple of examples of work that we have done in Philadelphia. The first set of results refer to some work that we did on the Philadelphia Infant Mortality Review, which was part of the Healthy Start Initiative that Councilman Ortiz mentioned earlier. We did a case control study of low-income women in West and Southwest Philadelphia. And we found that among this low-income, mostly African American population, housing problems during pregnancy, individuals who were either homeless or had frequent moves during pregnancy, or the availability of emotional and instrumental support,

having individuals who could help them out at the time of crisis, were important determinants of infant mortality. So housing instability emerged as a very important factor, something that was already mentioned.

At the neighborhood level, when we looked at the determinants at the neighborhood level, we also found that residential stability and neighborhood level economic disadvantage were also related to infant mortality even when we controlled the characteristics for the mother. So over and above the fact that low-income people live in low-income neighborhoods, being in a particularly bad neighborhood was bad for your health.

Among this low-income population we found that health behaviors were not important. They did not add any explanatory power to explaining infant mortality among this low-income population, although there were some differences in use of prenatal and healthcare.

The second set of examples that I want to say that emphasize the potential role of social context from another study that we are doing in Philadelphia which is based on our linked birth and

infant death records where we have women who gave birth in Philadelphia in the early '90s to their neighborhoods so that we can know where the people were living at the time they gave birth.

If we look at the -- in this analysis we focused on birthweight which, as I mentioned earlier, is an important determinant of infant mortality. If we looked only at the individual characteristics of mothers, which is typically done when we try to explain why a certain group has a higher infant mortality than other, we explain only 35 percent of the black-white difference in infant mortality. But when we included measures of context or we took the neighborhood context where the women lived into account in this analysis, we could explain 50 percent of the difference in birthweight.

So these results to us suggest that it's not only the person or the individual, how much education, income, or how much healthcare the person uses that matters, but it's also the residential context where they find themselves. And as I mentioned, there are a number of mechanisms through which these residential contexts could matter, which I outlined in one of those handouts.

So let me briefly end with some concluding comments. In our view, strategies that are designed to reduce preterm births and infant mortality must not be limited to medical interventions alone, but any medical interventions have to be integrated with other service programs and we have to take serious with the role of social context broadly defined.

We also need to do further work in trying to understand the role of neighborhood context. The research in this area is relatively new, and we know some things but we certainly don't have most of the answers at this time. But for understanding black-white differences in infant mortality, the role of context may be particularly important because we know that the residential environments are very different for whites and African Americans, even at the same levels of income and education. Thank you for your time.

COUNCILWOMAN TASCO: Thank you.

MS. HARKINS-SCHWARTZ: Councilwoman Marian Tasco and members of the Committee on Public Health and Human Services, thank you for this opportunity to talk about the infant mortality

today. My name Mary Harkins-Schwartz. I'm the Project Director for Philadelphia's Interdisciplinary Youth Fatality Review Team.

The Youth Fatality Review Team is funded by the Health Department and the Department of Human Services and it's managed by Philadelphia Health Management Corporation. The team conducts a case review of all Philadelphia children that die. So we look at children from birth up to and including age 19. Members of the team represent government agencies as well as local, private, non-profit organizations. Members or representatives include the Health Department, DHS, Philadelphia School District, Fire and Police Departments, private organizations like CHOP and Saint Christopher's Hospital for Children, the Antiviolence Partnership of Philadelphia, and so forth.

Today, I'd like to present findings from our case reviews. I have five years' worth of data, 1985 to 1999. During that time period there were 1,384 deaths to Philadelphia infants. As mentioned earlier, Philadelphia has a higher infant mortality rate than the nation as a whole, and we do see a discrepancy between the black infant mortality rate

and white infant mortality rate. The rates also vary by different sections of the City, as was mentioned earlier. And in the handout I do have a map that shows the infant mortality rate by section of the City, and you can see parts of North and West a Southwest Philadelphia, the darker areas, the infant mortality rate is higher.

We found that leading causes of infant mortality are, as described earlier, related to perinatal conditions, so primarily low birthweight and premature births. SIDS is a second leading cause of death in Philadelphia, followed by congenital anomalies. The cause of death does vary by race. Among white infants, the leading causes of death are perinatal conditions followed by congenital anomalies. And among black infants, the leading cause of death was perinatal related conditions followed by SIDS.

Risk factors that national studies have shown are lack of prenatal care, infants born to teenage mothers are at higher risk for infant mortality, low education, women who smoke during pregnancy, and again, premature and low birthweight births. Recently, we began looking at those factors

by linking birth certificates and death certificates. And for 1999 fatalities, we found that 3 out of 10 mothers of infants that died had inadequate or no prenatal care, almost 20 percent of the mothers were teenagers, one-third of the mothers had not completed high school, almost 25 percent of the mothers said that they smoked during the pregnancy, 3 out 4 of the infants are born premature, and 3 out of 4 of the infants are low birthweight.

I focused this testimony around three recommendations, and those recommendations are around the largest group of infants that die, those with perinatal-related conditions and SIDS and fatal injuries. And those SIDS and fatal injuries we're looking at because from the Youth Team's perspective, many of those deaths have clearly identifiable prevention strategies.

For perinatal-related conditions, some recommendations from the team include improving women's health before they become pregnant. In order to have a healthy pregnancy, a woman needs to be healthy before she actually becomes pregnant. Increasing the number of women who obtain and have

consistent prenatal care throughout the pregnancy.

Offering case management to high risk women. Prenatal care is not enough if you have a lot of other factors in the neighborhood or with biologically gestational diabetes, alcohol or substance abuse. These women need something more than simply prenatal care, so case management can help fulfill that need.

And to coordinate services. There are a number of services existing in Philadelphia, and so to help coordinate services for pregnant women.

The next area I'd like to focus on is SIDS. SIDS, as I mentioned, is the second leading cause of death among African American infants. And although the cause of SIDS are unknown, we do know that putting an infant to sleep on their back, as well as some other factors such as reducing soft bedding, avoiding comforters, quilts, other soft materials in the bed, can help reduce the risk for SIDS.

Nationally, there has been a Back to Sleep Campaign. With that campaign, we've seen an increase in the number of infants being put to sleep on their back and a corresponding decrease in the

SIDS rate. Unfortunately, that message has not reached the African American community as much as it has the white community. Today, African American infants are twice as likely to be put to sleep on their stomach rather than their back. And so that message of Back to Sleep really needs to be dispersed to the African American community. We found in Philadelphia that almost 40 percent of the Philadelphia infants that died from SIDS were found sleeping on their stomach.

The National Back to Sleep Campaign, along with the National Black Child Development Institute have come up with free materials. And I'll pass these out at the end of my testimony. They have magnets, brochures, and this is just one way to disseminate the message.

And finally, I'd like to focus on the area of injuries. This is small subset of the infants that died. Between 1995 and 1999, there were 53 Philadelphia infants that died from injuries. However, this is an area where we see some prevention strategies more clearly identifiable. And as well, injuries are the fifth leading cause of death among African American

infants in Philadelphia: 17 of the infants were suffocated, 16 died from being beaten or injuries from being shaken, 7 died from injuries caused by a fire, 4 were killed from motor vehicle accidents, and 3 drowned. 23 of those injuries were ruled unintentional injuries and 19 were homicides. The homicides were primarily caused by a guardian or primary caregiver for the infant.

In order to prevent fatal injuries, the recommendations we propose are to educate parents and caregivers about infant care and safety, and those include suffocation, strategies to prevent suffocation which would be the same message as is proposed in the Back to Sleep Campaign: Ensuring that your infant is sleeping in a safe area, in a crib as opposed to on a bed or on a couch; installing working smoke detectors; installing and using car seats; supervising infants around water, including while bathing, of course; and general care for an infant.

One way to help educate parents is through home visitation programs and parenting classes. In particular, home visitation programs like the David Olds model can also help prevent

abuse and neglect by teaching parents caregiving, as well as we believe they can be useful in helping to identify potential neglect or abuse before it turns into a homicide.

So today, again, I focused on three areas, the perinatal-related deaths because that's the largest group of infants that die; then SIDS and injuries because, from the Youth Team's perspective, we see those as potential areas for prevention strategies.

We find that we only -- for most of these infants, we only have data from the birth and death certificates. A lot of these infants are not necessarily known to the agencies that are sitting around the table, including DHS. So from our perspective, more research is still needed in order to understand what is going on where the families live and what is going on in the context of the family in order to prevent infant mortality.

And that will conclude my testimony. Thank you for this opportunity.

COUNCILWOMAN TASCO: Thank you very much. We'll come back with questions after the presentation.

MS. HOCK-LONG: My name is Linda Hock-Long, and I am Director of Research at the Family Planning Council. Thank you for inviting me to participate in today's hearings on this extremely important public health topic that has profound implications for families who lose a baby and also for our community at large. I'm going to use some overheads to walk us through my testimony.

Just to define issues related to infant mortality, and some of these have already been discussed, I'll be providing an overview of trends nationally and locally in infant mortality. Then I'm going to present one approach that can be used to help cities or communities target infant mortality prevention efforts, and that's called the Perinatal Periods of Risk Model. I'm going to provide an overview of that model, and I am anticipating that Commissioner Domzalski might be providing you with more in-depth information because this is an approach that I know the Health Department has begun to use in examining issues related to infant mortality.

To put it in context, infant mortality is the term used to refer to the death of an infant

that can occur anytime between the day of birth up to 364 days of age or right up until the first birthday. It's often used to guage the health and well-being of communities and to guide public health interventions and social interventions. It is a very complex issue. It's more complex once you start to really look into the issues related to infant morality than you might recognize at first glance. But it represents a complex interplay of biologic, social, economic, environmental factors.

Councilwoman Tasco referred to a study that was recently done by the CDC that looked at infant mortality trends in 60 cities in the United States, the largest cities in the United States. And that study spoke to some of the disparities that we see in Philadelphia related to infant mortality. For example, cities that had the highest infant mortality rates tended to have a larger proportion of African American births related to the total number of births and a smaller proportion of Latino births related to the number of overall births. In Philadelphia in the year 2000, 52 percent of the babies who were born were African American and 12 percent were Latino, just to put our City in context

in relation to the cities included in the study.

Despite similar rates of poverty for African Americans and Latino populations, there are still differences, disparities in terms of infant mortality rate. So while poverty is often referred to as one of the causes or has a strong relationship with infant mortality and race, we see that economics for people who might have the same level of income disparity might have very different outcomes in terms of infant mortality rates for those families experiencing the death of an infant.

Another way that we can look at the complexities involved with infant mortality are the relationship between education and race. We usually think of women who have lower levels of education as being at higher levels of risk for infant mortality, but when you look at African American infants who die and compare parents who have college level educations with white families who have college levels of educations, there is still a disparity between the black and the white infant mortality rate.

In terms of the causes for infant mortality, it's been mentioned that preterm births,

which are births that occur before 37 weeks gestation -- normal pregnancy is 40 weeks -- and infants with low birthweights and very low birthweights are the largest contributors to infant mortality. Given the high low birthweight and preterm birth rates for African Americans, we can begin to get an understanding of what might be related to the high infant mortality rate for that population.

In Philadelphia, some good news is between 1990 and 2000, there was a reduction of 36 percent in the overall infant mortality rate for the City. In terms of looking at trends more recently, between 1994 and 2000, we can see that there's been some change in the infant mortality rates, but there has not been as much change as we would like for any group. The top line, the green line represents African Americans who, for an average between 1994 and 1996, had an infant mortality rate of close to 18 percent. By the year '98 to 2000, the rate was down to about 16 percent for the three-year average. And I did the three-year averages because of in relation to the comments you made, Councilwoman, in terms of when you have a relatively small number of

events, sometimes it's best to collapse a few years to really get a sense of what the true trends are.

The City rate overall has remained relatively stagnant. The Latino infant mortality rate has dropped in relation to the other groups the most, and the white infant mortality rate has remained stable also.

As I mentioned before, one approach that can be used to begin to examine issues related to infant mortality and to target infant mortality reduction efforts is the Perinatal Periods of Risk Model. This is a model that was originally developed by the World Health Organization and the CDC to tackle infant mortality problems in developing countries. More recently it's being used in the United States, and Philadelphia is part of the perinatal health collaborative, which consists of about 14 cities in the United States using this model to look at infant mortality rates in their cities.

So how do you use this model? The top row or the blue row refers to deaths of infants who are under 1500 grams or who have very low birthweights and who die between 0 and 364 days of

age. The bottom row, the pink block, refers to infants who do not have very low birthweights. They might have low birthweights, they might have normal birthweights, who die anywhere between 0 and 364 days of age.

Now, the way you use this model is you can calculate rates for each of the blocks based on a city as a whole. You can calculate rates based on different parts of a city. You can calculate rates based on different racial and ethnic groups.

In general, the maternal health prematurity, the blue block is the block that accounts for most of the infant deaths, as has been described. So that would be deaths of infants with very low birthweights. Again, it can occur anytime from the day of birth up until 364 days of age.

When I did a comparison of Philadelphia infant mortality rates, for example, and New Orleans, both cities had the highest rates in the blue block. However, the next highest rates for Philadelphia were in the maternal care block versus the next highest rates for New Orleans being in the infant health block. These findings have important implications for how we might target infant

mortality reduction efforts.

I'm going to describe how we might use this to do that. If we think of the blue block related to maternal health and prematurity issues, what are the issues that might contribute to a woman having a premature birth? It might be that she has not waited, quote, a long enough time -- and recommended time two years -- to have a second baby or a third baby so that there are short periods of time between pregnancies. Infection has been mentioned as a potential contributor to low birthweight and preterm birth. And unwanted pregnancy might place a woman at higher risk for having adverse birth outcomes.

Well, what can we do about this? How can we use the Perinatal Periods of Risk Model to help us understand the scope of the problem and then to develop some interventions?

And again, I'm going to use the maternity health prematurity category as an example. There's a saying that healthy women have healthy babies. If you go into a pregnancy and you have health problems, health issues, there's probably more of a chance that you're going to have problems

during the pregnancy. It's strongly believed that increased access to family planning and reproductive health services for women might be one of the strategies used to direct activities related to deaths occurring for very low birthweight infants. There's also the management of infections. Making sure that women have access to healthcare so that they can know that they have an infection and get proper treatment. And expansion of Medicaid coverage for women of reproductive age. If you don't have health insurance, you are less likely to be able to utilize healthcare resources.

According to the CDC, family planning has been one of the 10 great public health achievements in the 20th Century. And it's due to reasons like --

COUNCILMAN ORTIZ: Tell George Bush.

MS. HOCK-LONG: We'll send this to him. But longer intervals of pregnancy are related to the use of family planning services and also a reduction in infection due to barrier contraceptives like condoms. So again, this is one strategy if we were going to target the maternal health area as an area for prevention.

Now, one the issues related to Medicaid is that in Pennsylvania, a low-income woman or a woman has an income below 185 percent of the poverty line becomes eligible for Medicaid when she is pregnant. Before that time, she is not eligible for Medicaid. Medicaid coverage continues until 60 days after she has her baby. This is the law in all of the states. The income levels according to state vary, but all states must provide Medicaid coverage to women while they're pregnant and up to 60 days after they're pregnant. Some states, though, have thought 60 days isn't a long enough period if we want to be addressing issues like interconceptional health or health of a woman between pregnancies. So some states, six, had expanded benefits up to two years after delivery, and I've listed those states there. In Delaware, the decision has been made to extend Medicaid for up to two years when a woman discontinues being eligible for Medicaid for any reason. Again, in recognition of the important role that women's health plays along with all of the other factors that have been discussed today in promoting healthy birth outcomes.

So in summary, I think all of us have

spoken to the complex issue of infant mortality and the fact that multiple strategies need to be used to help us tackle this problem. And despite the reduction that we've seen over the decade in infant mortality in Philadelphia we still have a long way to go. Thank you.

COUNCILWOMAN TASCO: Thank you very much.

Are there questions from members of the panel?

Councilman Goode.

COUNCILMAN GOODE: Good morning. This question is to everyone who used the term "socioeconomic" or says that there's a complex mix of social and biological, environmental and economic factors. The question is, first, how you define the term "socioeconomic," and can you actually separate those economic factors from social issues?

MS. ELO: I'm happy to tackle that. I think often when people are thinking socioeconomic conditions, they think of a person's level of schooling or their level of income or how much wealth they have or their housing conditions. I think we have to expand that and think more broadly

about social conditions more generally.

COUNCILMAN GOODE: Could you speak up. I couldn't hear you.

MS. ELO: When most people think of socioeconomic, they think of income, level of income a person has, level of schooling they have.

COUNCILMAN GOODE: I'm very familiar with the term "socioeconomic." I'm talking about for the purposes of your study.

MS. ELO: Social conditions are much more broadly defined. They include things like housing conditions, which we believe are actually quite important, household size, household composition, because all those factors will influence the person's decisions about healthcare, social interactions are important both in terms social support that can be positive or demands on one's resources that might be --

COUNCILMAN GOODE: I guess my question is really -- and the way I posed it was, can you separate those economic factors from other social factors? I guess to pinpoint it more, are you really talking about access to health services and health education and access to affordable housing

and quality housing, or are you actually talking about economic conditions that are persistent?

MS. ELO: I think you can separate them. I think access to housing can be separated from other social conditions. For example, providing stable housing can be separate from your income level and we can separate that housing instability independent influence on infant mortality. I think we can -- and I think that's a separate component from access to healthcare. The biologic mechanisms that have been mentioned, including immune functions, are not necessarily only influenced by access to medical care, but now research suggests that exposure to acute and chronic stress which can be defined by living in high-crime areas, hassles of living in communities where you don't have grocery stores, access to services where daily living is very different -- just getting the food on the table is very different than in neighborhoods where you have access to grocery stores, a broad set of circumstances, influence stress in one's life that can affect biologic mechanism in the body.

COUNCILMAN GOODE: Let me try this a different way. Sense these are a complex set of

intricate, interrelated factors, is there a way to actually improve the economic conditions of the African American or target groups, African American, Latinos, and impact infant mortality rates in Philadelphia?

MS. ELO: I think so. I think there are a number mechanisms. Housing stability is one, providing housing support.

COUNCILMAN GOODE: And how would that impact the infant mortality rate?

MS. ELO: By reducing housing instability it would help people.

COUNCILMAN GOODE: It would help. I'm asking if you actually impact economic condition of the target group, how will it impact infant mortality rates?

MS. ELO: It might not have an impact tomorrow, but it might have an impact -- I would predict that it would have impact in the long-term.

COUNCILMAN GOODE: What type of impact?

MS. ELO: It would reduce infant mortality.

COUNCILMAN GOODE: Reduce it how much?

MS. ELO: I have no idea.

COUNCILMAN GOODE: Thank you.

COUNCILWOMAN TASCO: Ms. Schwartz, you want to comment?

MS. HARKINS-SCHWARTZ: For SES, the Youth Fatality Review Team, we don't have access to that data because we're limited to the birth and death certificates. And so we don't have access. We're not able to look at what the resources are in the communities or the incomes of individual families and so forth. But I do believe that raising incomes, creating stable housing, increasing resources can help reduce infant mortality. And if you compare -- my understanding is if you compare African American infants to African or other black infants, that the infant mortality rates in other communities are higher. And so we still need to look to see what's going on within our community.

Linda, do you add to that or contradict me?

MS. ELO: Maybe I can give you an example about a health campaign and how that interacts with --

COUNCILMAN GOODE: My question was very direct. You helped discussions somewhat by saying

that you studied this upon birth and death statistics as opposed to studying it in terms of group dynamics to try to deal with those complex issues within those communities. And I guess my question really was, really how much of it is economic. And I guess the answer to that question was, you're not really sure.

MS. HARKINS-SCHWARTZ: I'm definitely not sure.

MS. ELO: Can I give one example, and that relates to SIDS which is very high in African American communities. One of the examples given is the Back to Sleep Campaign. We are doing a longitudinal study of African American women before and after their births. We find that many low-income women don't have cribs to put their child into. So that Back to Sleep Campaign may be very important, but if you do not have in your household a crib to put the child to sleep on its back, it's not going to be very effective. So we need to think of ways in which we either through health education campaign that are suited for that particular population reduce SIDS mortality, which would reduce infant mortality in Philadelphia. One SIDS death

would reduce the infant mortality rate in the City, but we need to think of how that health campaign interacts with the social conditions that women find themselves in.

COUNCILMAN GOODE: Thank you.

Thank you, Madam Chair.

COUNCILWOMAN TASCO: Ms. Schwartz, in your testimony on your map you show the areas with a very high infant death per 1,000 live births. And I'm looking at the 19138 and 19126 of the north part of the map. And I'm looking at those two because they're in my district, for one. But, two, they are close to a hospital. But when you look at the neighborhoods, when you talk about low-income housing, you look at those neighborhoods, particularly 19126 which has 15 to 19 percent, that is east Oak Lane area, and of course it could be one street. What I'm concerned about is you looked at just the birth and death certificates. What do you plan to do to follow-up to look at the individual which would give you really the information you need as to why and what happened and put a face on the person? Because one of the discussions I had with Dorothy Mann from Family Planning is that there is

no tracking of these women or supportive services after their babies die. What is it support and what is the statistical information we gather from them other than just reading the death certificate?

MS. HARKINS-SCHWARTZ: I guess I have a few thoughts on that. One thing I'd like to just inform you all about, if you're not aware, Philadelphia Safe and Sound along with the Health Department has worked on a mapping system. I'm not sure of the website, but I'm sure we can find out when John Domzalski speaks or we can find out later. They've worked on a mapping system so you can look at each area of the City and look at what resources are available. And I think that's really important because, as you've noted, this map just shows what the infant mortality rates are in that area of the City and all areas of the City, but it doesn't show what resources are there, like the hospitals. The map that's been done by Safe and Sound chose housing conditions. So there's a lot of information that I think this map is just a starting point for the discussion. But there's a lot more to think about.

The second point I'd like to make is, the Youth Fatality Review Team, we're funded to do

the case reviews, having member agencies come to the table to discuss why children die, to gather any information that we can from those member agencies. So families that have seen, for example, if an infant is part of a family that has been seen by DHS, they'll bring information to the table. And it's a confidential review. I should state that clearly. But my scope with this project, unfortunately, does not go beyond that. And so I don't have resources to actually go out into the community and interview families to find out what the situation is. And I think that's a really great point because we're very limited -- we have some great information, but it does reach a point where there are limits.

I think with other speakers here today who actually do meet with clients, hopefully, they will be able to answer some of your questions, because I don't have that one-on-one contact.

The Pennsylvania SIDS Coalition was a member of our team, and they actually did meet with families of infants that died from SIDS. They would be able to share with us a lot of pertinent information. And they also were involved in the

grief counseling. And I understand that that now is being done from -- the grief counseling, at the medical examiners office. And so we're hoping that they will be able to share similar information with the team. And I think that's a really good point.

COUNCILWOMAN TASCO: Linda.

MS. HOCK-LONG: To make a comment in relation to that, several things. As Mary mentioned, the way that the death reviews are organized are that they're confidential. So we don't know if some families would want to be contacted. Some families might not want to be contacted, so that would take much thinking in terms of how to do follow-up, I think, in a sensitive kind of way for families who have gone through a loss and something that we might want to think about further.

I'm going to put another plug in for the Perinatal Periods of Risk Model. In doing an analysis, and, again, I imagine it might be discussed in more detail today of your area, one of issues that seem to come up was really a high rate in that maternal health prematurity category of deaths. In looking deeper -- and deeper is being able to use some birth certificate data to find out,

well, you know, were there health problems with the mothers, that was one of the areas of the City with the highest rates of high blood pressure among women who were pregnant. So if we can't get to the individual level, we might be able to use some of these methodologies to get at some of the potential areas that we could target interventions to try to make a reduction. So that if hypertension, high blood pressure, is a problem, what does that say about some of the health needs of women who live in your area? Are they getting the service they need? Are they women who might be considered, quote, working poor who don't have Medicaid because their incomes are too high but they're not pregnant so that they don't qualify to get those services? So that's another way that we might approach some of those issues.

COUNCILWOMAN TASCO: The other thing, do you look at the age of the mother? Do you have a higher rate of infant mortality in younger women, particularly teenage pregnancies, as opposed to the older woman? Where does the higher category fall?

MS. HOCK-LONG: It varies by race. It varies by geography. You can't, I think, state

emphatically that, yes, if you're younger you're going to be more likely to experience a death; it varies.

COUNCILWOMAN TASCO: That's not what I'm saying. As you look at the statistics, do you look at the age categories? If you're looking at West Oak Lane and you see that there's a high rate of infant mortality, what is the age category?

MS. HOCK-LONG: Not for the City as a whole, but to look at different parts of the City, because we know that there are going to be different issues in different parts of the City. We've done analysis that tell us that. So it would be targeting an area that you're interested in.

MS. ELO: Can I add that the age issue is actually quite important because the African American pattern in the infant mortality by age is different from the white pattern. The increase in infant mortality by young mothers is much less for African Americans than it is for white women. The increase in infant mortality for African Americans at old ages is much more rapid than for white women. And that gets back to the issue of maternal health. It has been suggested that because of health

conditions among African Americans, the health of African American women deteriorates more rapidly than white women and it gets to the issues of maternal health more generally rather than just in infancy and that the additional risk of living in low-income circumstances is actually an additional risk factor for African American women at older ages. Teenage pregnancy is a problem, but it's not -- the high level of teen infant mortality is not much higher than among 20- to 24-year-olds.

COUNCILMAN ORTIZ: So the older you get, the weaker you get?

MS. ELO: The older you get, the more your health deteriorates and infant mortality rates goes up faster for African American than whites. So it's a whole age range that is quite reflective of the maternal health issue that she mentioned more generally.

COUNCILWOMAN TASCO: Anymore questions?

Councilwoman Miller.

COUNCILWOMAN MILLER: Thank you. Good morning. I was wondering, what services are available to mother, particularly in this risk category, while they're still hospitalized after

birth? And how long do they actually stay now in the hospital?

MS. HARKINS-SCHWARTZ: I think I'd like to defer that question for later panelists. Maybe JoAnne Fischer or some of our other panelists can answer that later or some of the physicians.

COUNCILWOMAN MILLER: I have another question. What are you defining as good birthweight and low birthweight?

MS. ELO: The normal definition people consider low birthweight is a baby that's born less than about 5 1/2 pounds. And very low birthweight is 1500 grams which translates to about 2.2 pounds -- 3.3 pounds.

COUNCILWOMAN MILLER: We have know weights in pounds, not in grams.

MS. ELO: Yes, I know. 3.2 pounds. And anything about 5 1/2 pounds is considered normal weight birth.

COUNCILWOMAN MILLER: Five and a half to what, seven?

MS. ELO: Maybe the neonatologists panel can address the issue of whether a very high weight can also be problematic.

COUNCILWOMAN MILLER: Because I know a lot of young ladies who have had babies recently, and most of their babies are 8 pounds and up. And we're saying, my goodness, that's big baby. Thank you.

COUNCILMAN ORTIZ: To me, it's just very frustrating because we live in a society where none of this should be existing, in the United States at least. You have a federal government -- are there any federal policies, for example, that inhibit the ability of cities such as Philadelphia to be able to put forward public policy that would go towards alleviating or bettering the issue of infant mortality? Does the family planning policies of the federal administration impact on the ability of cities such as ours to be able to develop policies that make sense?

MS. HOCK-LONG: I can give an example in the area of reproductive health. Certainly, federal policies tell us things we can and can't do around the kind of reproductive health services we can provide. The amount of funding that goes in reproductive health services tell us the amount of service that we can provide. For example, the

Family Planning Council has experienced dramatic increases in the patient population over the past couple years without increases in money to support increases in services.

At the state level, the Medicaid issue is something that the state takes action on. For example, the state could apply for a waiver to the federal government to extend Medicaid coverage for women beyond that 60-day period after they're pregnant if the state chose to do that. So that that's an area that we could look to the state government for some intervention, because if the regulations were changed and, for example, Medicaid were expanded to two years like in Virginia and Maryland and some of the other states that I mentioned, women would have greater access to health services for that group of women where their health status impacts on the health of their child.

COUNCILMAN ORTIZ: Something we've got to talk to Ed Rendell about then.

MS. HOCK-LONG: Yes.

COUNCILWOMAN TASCO: Thank you very much.

We'll call on our next panel. Endla

Anday from St. Christopher's; Angelo Giardino, St. Christopher's; Jay Greenspan, March of Dimes; Valerie Whiteman, Temple University. If you're here, please come forward. And Dr. Ron Wapner, Drexel University of Medicine. This is our physicians panel.

While we're setting up, why don't we begin with you, young lady. Would you identify yourself for the record and proceed?

DR. ANDAY: Good morning. I am Dr. Endla Anday. I'm a neonatologist at Drexel University, School of Medicine at St. Christopher's Hospital and at Hahnemann University Hospital. And good morning, Councilwoman Tasco and committee members. As a neonatologist, I will focus most of my comments on infant mortality as it relates to the first month of life.

Over the past 50 years, a number of significant changes have resulted in improvement in infant health and reduction of infant mortality in this country. Certain fundamental factors have clearly influenced infant mortality, including the provision of maternal prenatal and postnatal services, the use of hospital-based deliveries, and

the development of regional perinatal service and medical subspecialty disciplines that address the care of the high-risk mother and fetus. This approach has a yielded a continued improvement in perinatal outcome and survival of the infant at risk.

However, prematurity or those births that are at less than 37 weeks gestation, while they account for less than 25 percent of all the live births, the risk of premature birth is significantly increased with regard to morbidity and mortality. And I think we've had a number of presentations this morning that would certainly attest to that. However, the highest incidence of neonatal mortality is in the extremely low birthweight category of babies who are born at less than 28 weeks gestation, approximately 3.3 pounds. Infants in this category, although they comprise less than 5 percent of all live births, do account for approximately 95 percent of all the neonatal deaths. In spite of this, neonatal survival in the extremely low birthweight infant category has improved over the past decade with more than 75 percent of these very fragile babies actually surviving to be discharged to home.

However, despite the improved survival, the extremely low birthweight infant is at risk for significant morbidity. This includes chronic lung disease, poor growth, and neurodevelopmental outcome. And further, they are at higher risk for post-discharge death in the first year of life. There are many factors that account for preterm delivery, including, as we have seen this morning, maternal medical diseases, perinatal infection, just to mention a few. Teen pregnancy, however, and poor prenatal care and risk behaviors such as drugs and smoking are definitely contributory to preterm delivery. So clearly, the identification of risk for adverse pregnancy outcome and early intervention are key to preventing a significant number of the preterm births and, therefore, neonatal mortality and morbidity.

As part of the recommendations of the American Academy of Pediatrics and the American College of Obstetrics and Gynecology, emphasis was placed on recognizing potential problems before or early during pregnancy and to ensure that access to care for all women is available. This was in order to better utilize our resources to improve the

outcome of pregnancy.

So the primary goal of early identification of risk assessment is to provide the appropriate referral for a subspecialty consultation, psychosocial support, childbirth education, and care coordination for such basic services as transportation, food, and housing, again, to mention a few. And these issues have been brought up earlier this morning.

So although advance in at least the biomedical technology have revolutionized the state-of-the-art of healthcare for the pregnant women, fetus and newborn infants, there continues to be a gap in the organization and delivery of that care. Specifically, rural areas tend to be underserved medically; whereas, poorer urban areas such as certain areas of the City of Philadelphia are underserved because of insufficient funding to support perinatal services. The disparity of black versus non-black infant deaths in the City of Philadelphia is in part related to the points raised in the previous section of this report. In spite of the availability of some of the very finest medical care in the academic centers that this City has to

offer, we have not been able to increase the number of visits that women who are pregnant and seek care early in pregnancy at the Hahnemann University Hospital. We do service an underprivileged patient population. About 80 percent of the patients who deliver at the hospital are African American, about 70 percent have some prenatal care, but the majority of the women do not have regular prenatal visits during their pregnancy. As a neonatologist, I can tell you it's frustrating to be able to pull an infant through some of the most difficult respiratory distress and other medical complications that these infants have, only to have the baby discharged and then to later find out they have succumbed as infants in a less-than-optimal social environment.

It is important to identify areas of risk and to then subsequently strategize such that we can decrease the high infant mortality and morbidity that we do see in the City. Thank you.

COUNCILWOMAN TASCO: Thank you very much.

DR. GIBSON: Good morning. My name is Eric Gibson. I'm substituting for Dr. Jay

Greenspan. I'm from Thomas Jefferson University. I'm a neonatologist and also here working on some issue with prematurity with the March of Dimes. Thank you very much for having me here.

I want to just review quickly a couple of quick take-home points because you had so many outstanding presentations and you've been inundated with a lot of material. A couple of things are important. The first slide that was up there before had a picture of a premature infant and I have seen several Councilmembers who have come through our nursery at Jefferson Hospital and I cordially invite any or all of you to come back at any time to really look firsthand at some of the issues dealing with prematurity.

The first important point is that premature infant isn't just small. A lot of people think of that as just a small baby, but it's really a very early, underdeveloped baby, and prematurity is obviously one of the major problems that contribute to infant mortality.

The second thing is a real important take-home point, is infant mortality that most people have been talking about, which is death in

the first year of life, has two very important components. The first is what we call the neonatal mortality. That's the mortality and death in the first 28 days or the first month of life. That's the area in which prematurity is a really major contributor. The second part is what we call postneonatal mortality, and that's mortality from the first month of life until the end of the first year of life. And generally, about 60 to 70 percent of all infant mortality is neonatal mortality, mortality in the first month. Whereas, the postneonatal mortality is mortality from the first month to the first year. And that's what we talked about, things like SIDS, accidents, many of the homicides, the other issues having to do with infant mortality or the postneonatal mortality issues.

As a neonatologist, I'm particular interested in prematurity, although I've done a lot of work with SIDS and worked with child abuse and so forth. And prematurity is really a major risk factor as we've said, and it's the second highest cause of infant death and it's a very costly problem as Dr. Anday had highlighted to you. And it is the leading cause of date, that neonatal mortality in

the first month of life. And birth defects, which is another problem -- congenital anomalies are later on.

And also, as Dr. Anday highlighted, we've made a lot of progress in neonatal and infant mortality over the years, but as she noted, it's come as a very high cost because a lot of the survivors of these very preterm infants are very high cost to society with all the problems as she mentioned, cerebral palsy, mental retardation, chronic respiratory problems. And so many of these survivors, although we have decreased mortality, the morbidity and the problems continue.

This is an interesting picture because this shows the rate of preterm and very preterm births. The last two bars are the goals, the March of Dime goals for 2007 and 2010. Now, I have to say that when you look at this chart, there's not a lot of reason to expect that we're going to achieve those goals. We hope to, but certainly there has not been a change in the rate of prematurity in this country in very many years. Throughout many different objectives, reaching back to the '60s and '70s where people have tried all sorts of strategies

to reduce prematurity, by and large it has not been that successful. So a lot of the success we've had in surviving prematurity has come after babies are born, again, many with a high cost.

Again, as many people have highlighted the problem of race, and I want to emphasize that it seems very specific to African Americans. Many people have said that here looking at African Americans and Latinos, but particularly in Philadelphia, every racial group has lower infant mortality, prematurity and other issues having to do with childhood illness than African Americans: Latinos, Asians, even the newest Asian immigrants seem to have much lower rates of infant mortality and prematurity than African Americans. So in Philadelphia in particular, it's an African American problem.

This is the infant death rate in Philadelphia. Just taking representative years from '60 to 2000, you can see overall there's been tremendous progress, and I've divided into the neonatal and postneonatal death rates. And you can see the neonatal death rate has dropped by almost 75 percent. Whereas, the postneonatal death rate have

dropped by about 50 percent. So we've made a lot more progress in this neonatal death rate.

And when we look at by race, the infant mortality -- the third column is non-white infant mortality and the last one is the Caucasian infant mortality. And you can see that despite improvements, a tremendous disparity still exists between African Americans and non-African Americans.

I do want to say at the bottom of the slide, I have written there 2000 VS, Page 13-14. I'm sure you've all seen this, but this is the Vital Statistics Report that the Health Department puts out every year. This has tremendous value. That's a very important document that you can get a lot of information from. It shows births, deaths, and all sorts of trends over many years, and shows racial and ethnic comparisons as well and can really be helpful for you all in thinking about how you as individuals and a group want to look at the problem of infant mortality.

Again, another thing that people have said. This just shows Philadelphia in relationship to many metropolitan areas. And we certainly lag behind in our infant death rate, although it's now

10. 3 so we've moved up a little bit, but we're certainly far behind many metropolitan areas with very similar demographics to us.

Now, you can skip this. We've talked a lot about the lack of prenatal care.

Again, another emphasis cost of prematurity. Tremendous estimated cost of care of babies who are born very premature, half a million dollars or more, big-time cost to top health plans and so on and so forth. And, again, just highlighting some of the expenses of prematurity.

Again, many speakers have talked about the etiology of preterm birth. The emphasis I want to make here is that there's a lot of opportunities for research and there are a lot of places that are doing great research. The first group of people we've talked about some are the social aspects of prematurity is very, very important, new pioneering research that really no one else is doing anywhere else. The March of Dimes exists with tremendous funding for research on prematurity. We've been able to start a campaign that's going to begin in 2000 that's funded mostly through private donations that's really going to be a very important effort

looking at some of the causes of prematurity. So this is another resource that already exists for the community to use. We have a hot line, we have phone numbers, people can call, pregnant women can call to get information on prematurity, so it's good research as well to look at in terms of what can be done that's outside the resources of the City. And so we want to really increase the awareness of problems with prematurity and decrease the rates of preterm birth over the next five years, if we can.

I hope that you all can take home some of these points in thinking about how you're going to formulate your own approach to the issue. Thank you very much.

COUNCILWOMAN TASCO: Thank you very much.

DR. WAPNER: Ron Wapner, I'm Chairman of the OB-GYN Department at now Drexel University and I'm also a subspecialist in maternal fetal medicine. I just want to emphasize a few of the points that were made with some Philadelphia-specific data. And the handout that you've just received demonstrates what we've heard a lot about this morning, and that is that infant mortality in Philadelphia is high and

there is a significant difference in racial distribution. The encouraging information from that is that in all groups, African Americans, Asians, Latinos, and whites, there has been since 1990 to 1996 a decrease in the overall infant mortality, but the staggering oblivious thing is the difference between African Americans and other groups.

The next slide demonstrates preterm births in Philadelphia by year and race. This just demonstrates, it's a mirror image, it's actually the same image of infant mortality, and that is, just as you've heard, that 60 to 70 percent of infant mortality is directly related to neonatal mortality and that's directly to preterm birth. So that if you look at the incidents of preterm births in Philadelphia, it dramatically mimics infant mortality. Again, we can see that the African American population has twice the incidents of preterm birth. It did in 1990. It's improved in 1998, but it still is significantly higher. The question that we've all been struggling this morning is, "Why?" Why would one racial group have a significantly higher incidence of a very severe complication, preterm birth. The answer is, "I

don't know." The answer is that nobody knows. We've heard that there are differences that could be related to socioeconomic factors, it could be related to stress, it could be related to environment, it could be related to infection. What's missing in our knowledge, what's missing in my ability or any of our abilities to sit here and tell you how to solve this problem is the understanding of the trigger between what it is in an environment, how that can interact with the pregnancy and cause a preterm birth. We don't know. We thought it was infection for the last 10 years. And we've done a number of research trials treating people, particularly high risk African American populations at risk with antibiotics, thinking that would resolve it. No difference whatsoever. We're very fortunate in Philadelphia that we're part of what's called the Maternal Fetal Medicine Network. Now, this is an NIH-funded project that pays about $9 million a year, and it funds somewhere between 10 and 14 centers around the country to actually study ways to improve or decrease the incidence of preterm birth. Fortunately, Philadelphia has one of these centers. It's housed with myself at Drexel, but we

also subcontract with Jefferson and the University of Pennsylvania. So really, there's a large number already of patients in all of our university centers who are being recruited into research projects in order to try to answer this problem. And we're studying, not only new innovations like antibiotics, but we're also trying to understand the susceptibility. And that's what we're talking about, why would some groups be more susceptible to stress, why would some groups be more susceptible to infection. So I think one important thing, and where Philadelphia is making a major difference is that we already are one of the major participating centers in the country trying to answer this question.

The next demonstrates what I think is the most depressing slide, but it also points out what we've just heard, and that's the incidents of preterm birth by year. And if you look at all the columns, but notice the ones on the right because those are the very premature babies. Those are the ones that are likely to die. Those are the ones also that, if they survive, have significant morbidity. There's absolutely no change in the

incidence of preterm birth from 1990 to 1998, which is the last year I have here. More importantly, there has not been a change in the incidence of preterm birth in any group, a significant change, in the last 40 years. So when I demonstrate or say that we don't know the answer to this problem, part of it is we haven't known it for almost four decades now.

The last overhead, again, demonstrate severe preterm births in Philadelphia. Again, these are the babies that are likely to die; and if they survive, they're likely to have significant handicaps. The difference there is clearly illustrated. There's been no change between '90 and now, but there's still a significant difference based on race and ethnic group.

There are, however, a few question. Obviously, well, gee, is this so depressing that we should sit here, throw our hands up and say there's no way to solve the problem? Of course not. As I pointed out already, there's active research already ongoing in the City. The March of Dimes is about to embark on more research. But we have to do something between now and when we get the critical

answers to the question.

One of the things we can do is already look at the problem of preterm birth we have and decide the best way to serve these patients. We have lots of university hospitals that are best taking care of small premie babies. But the question is, do we have those babies delivering so that they're immediately cared for in those hospitals. If a woman today in Philadelphia calls with an episode of labor, whether she's in preterm labor and at term, she goes to the nearest hospital. Frequently, these are patients that don't have transportation, high risk patients preterm, they don't wind up at the hospitals that are best prepared to serve a woman in preterm labor.

We have very are poor data system. Many of our patients start prenatal care in one hospital, they wind up having delivery in another. Right now in the City of Philadelphia, we have no way to transmit that patient information from hospital to hospital, from city health district to city health district. And for those of us that are on the frontline, so to speak, that have to care for these patients, this is a major, major problem.

We also have very poor statistics. I think the people, the epidemiologist that showed you the data today, should be congratulated but the amount of work that needed to go into finding this information is astronomical. And there are cities that have obstetrical data systems so that we can get this, not four years from now when we link the birth certificates, but in real-time so that we can identify changes.

So this isn't a hopeless situation. Again, I just want to emphasize, none of us -- unless somebody is going come up with something I'm not aware of -- is going to be able to give you the answer that you want today because 70 percent of our problem is from preterm birth, and we don't even understand exactly what the causes are.

One last comment, and actually I think this probably is the most important thing. And I just want to emphasize what other people have said. Infant mortality is a significant problem, but it's just a marker for preterm birth. And preterm babies have incredible long-term risks of handicaps. They have cerebral palsy, they have blindness, they have a number of other things. So as we try to solve the

problem of decreasing infant mortality, we also have to address the problem of do we have the resources in place to follow-up for those parents that have preterm babies so that when those babies need to be in early intervention programs, they need to be in other social systems, they need to be available so that these babies get the best start in life that they possibly can. Thank you for your time.

COUNCILWOMAN TASCO: Thank you for your information.

MR. GIARDINO: Thank you for asking us to speak with you. I come to you as a primary care pedestrian who has served on the Child Fatality Review Team that you've heard about.

COUNCILWOMAN TASCO: Did you say your name?

MR. GIARDINO: Yes, Angelo Giardino, and I'm the Associate Chairman of Pediatrics at St. Christopher's Hospital.

I can't really add anything to the expertise that's been discussed here related to preterm children. But what I would like to offer to you is a perspective from someone who tries to serve the children after they're past their prematurity.

And what pedestrians in general experience for children who are at risk for a number of these preventable causes of death are a lot of barriers. And the reason why I was interested in coming before you today is because I think you're the people who can help tear down barriers. And I'll give you some examples.

Again, all of the causes of death that you see before you in Ms. Schwartz's report are preventable. We know how to help prevent SIDS. You've heard that we know that we could reduce prematurity if we have good systems of care and that people can get to the right place at the right time. Injuries are preventable. But what we seem to find as practicing pedestrians are very short-term episodic programs that try to solve one little problem and they don't try to solve the whole problem. And this became very clear to me that you need a comprehensive approach. And then as soon as I said that, then I said, okay, then you need a really expensive approach, so that requires long-term thinking and that's hard to do.

But you may have heard of the David Olds model. The David Olds model is a program where

high-risk teens are linked up with a nurse for two years and the nurse comes out to that person's house for two years. And this program is over 15 years old, has great data attached to it. And what we found with that program is that it didn't target one specific problem. It literally linked a nurse with a teen mom. And what happened is the teen mom's life course changed. She now had a professional friend, if you will, who gave her advice on how to rear her child, so the children's number of injuries went down. The number of times the child had to go an emergency room for an injury went down. The nurse gave the mom advice about life course, jobs, delaying second pregnancies; and as you heard, that causes health deterioration. The number births to the moms in a very short period of time after the first birth went down. The mom's economic situation went down. And what was fascinating was the number of children who were abused and neglected went down. The people that did the David Olds study 15 years ago, using the Internet were able to able to find all of those mom's except two of them 15 years later. And all of those findings remain consistent.

Now, most people aren't elected for

15-year terms. Most program officers don't have a 15-year horizon. But that program was long-term in its view and it was comprehensive and it didn't try to do one little thing. It tried to do a lot and it was comprehensive in its design and it worked. But it's very expensive. However, for every dollar spent on the program, $4 are saved to the society. And I look at you and I realize you're the people that have the society's pocketbook. So I'm hoping that you can take some of the information you learn here and really advocate for comprehensive programs that aren't episodic, that get all of us in this room together at a table and we can all deposit our expertise. And there are some wonderful programs represented here, but they all have to be stitched together and there has to be a comprehensive view or else we're going to be here in 2016 talking about these preventable causes of death that we failed to prevent. Thank you.

COUNCILWOMAN TASCO: Thank you very much.

DR. WHITEMAN: Good morning. I'm Dr. Valerie Whiteman from Temple University Health Systems. My apologies for the delay, however, my

first and last patient for the morning would have been a perfect candidate for any type of program that we're talking about this morning.

In terms of the issue of infant mortality, I think all of the people who have spoken before me have very nicely demonstrated that the recent changes in perinatal and neonatal medicine have reduced the infant mortality to a plateau, however, that has not significantly decreased over the past several years. Despite the decrease in infant mortality that are seen in other well-established and first-world countries.

When you look at things that will affect infant mortality, classically we look at prenatal care as the first thing, the first issue. However, prenatal care as it is known at this point in time has not significantly reduced our infant mortality rates beyond that which we are experiencing at this point in time. We do see that there have been several programs similar one that was implemented at Temple University Hospital several years ago, which was the Temple Infant and Parent Support System Program which significantly reduced the infant mortality within the first year of life. This

program had various incentives towards prenatal care and also more so than that, addressed several of the social problems that our patients see. The expenditure for that program was not small. However, the amount of healthcare cost that was reduced was very significant and certainly improved the long-term health status for those patients that were involved in that program.

We know that the Women and Infant Children's Program, the WIC Program, reduces low birthweight significantly. However, in terms of reducing infant mortality ,that still is debatable.

So what can we do? We know that the social stressors that seen in the environment similar to where I practice in North Philadelphia are known to severely affect health status, not just in pregnancy, but even beyond pregnancy. And therefore, any kind of program that will be formulated to reduce infant mortality has to look at ways to affect the financial and socioeconomic status of patients. Now, the recent social and economic changes notwithstanding has been documented various times in the literature that low socioeconomic status is associated with adverse

health outcomes as well as an increase in infant mortality. And therefore, it is only intuitive that the suggestion that some type of a program that will address the disparity between the patients and the population in some of our areas in Philadelphia will also have as a secondary effect a reduction in infant mortality.

Lastly, there's been various studies done in the literature, some of them by people in the general local area that have looked at ways to reduce infant mortality in terms of, not just the prenatal care but also non-prenatal care, meaning some of the social situations. And their conclusions very simply are that prenatal care as we know it may not necessarily be enough and some of the social problems, specifically stress, finances, low socioeconomic status, jobs, other stressors of life need to be addressed for there to be a significant impact in the infant mortality that we're experiencing in many of the communities in North Philadelphia. Certainly any kind of program that will be formulated has to look at those things because as medical professionals we've done about as much as we can do in terms of reducing infant

mortality, and it's time to look at some of the secondary social programs to be addressed for that to be further significantly reduced. Thank you.

COUNCILWOMAN TASCO: Thank you very much. We appreciate your comments. We certainly know that the issue of the economy and the stress and the things that cause stress, poor housing, low incomes, inadequate incomes, because we have a lot of neighborhood, particularly in the area of the West Oak Lane area, we have the working poor. They work, have jobs, but don't necessarily have the level of income that we'd like nor access to the healthcare that is needed. So we are certainly aware of that and in our role as policy-makers try to address those issues as we deliberate what to do here in the City about those things.

The question I have for you -- earlier a comment was made that even with the of same economic level, you can take a black college graduate and a white college graduate, the same socioeconomic conditions, the infant mortality is still higher with the African American. Do you have any comments about that? Same stress, I guess.

DR. WHITEMAN: Yes, just because we've

graduated from medical school or any other higher education certainly doesn't necessarily mean that we don't have stressors in life. I could continue this conversation outside of these walls. The socioeconomic status notwithstanding, there still are certain stressors with being a person in this society that my counterpart who, all do respect for the non-African Americans in this room, don't necessarily have to experience. And those stressors can certainly impact on pregnancy outcomes as well as other aspects of life.

COUNCILWOMAN TASCO: Okay. Dr. Anday, you talked about the some of the mothers who are discharged from Hahnemann and you find later that maybe they have died -- maybe she said that, but what programs do you have at Hahnemann to have prenatal outreach program and post-delivery programs to stay in touch with these parents?

DR. ANDAY: My comment was that infants who have been rescued who are extraordinarily fragile medically will be discharged to an environment where continued stress in terms of socioeconomic, risk of infection and so on will increase the risk of those infants who are fragile

medically because of usually chronic lung disease, neurological problems and so on, and will wind up in the first year of life not surviving.

So with regard to what programs we have, certainly with -- and maybe Dr. Wapner can speak to what maternal programs are available with linking a mother into a support system early, encouraging things like adequate nutrition, caring for one's self properly, and decreasing risk behavior to try to optimize pregnancy. Outcome, we have follow-up clinics both at 231 North Broad Street and certainly St. Christopher's Hospital for Children has a high risk neonatal follow-pu clinic that we refer all of our graduates from neonatal intensive care unit to this program. And when there is lack of -- if the patient does not show up for their appointment, we do call and try to have social work, case management, and so on, assist us in trying to get the patient back. But, again, the amount of resources and time expenditure to have the successful return for your appointment visit is extraordinary. And a number of patients do follow through, so it may be several months before a baby comes back for its post discharge follow-up care.

And I think that we can certainly improve overall what we do in that area, but it will require a number of additional resources to be able to have a successful program.

COUNCILWOMAN TASCO: Let me ask you a question that has been on my mind, since all of you are connected with hospitals -- well, let me talk about Temple and Thomas Jefferson. What impact will you see or have you seen on the medical malpractice issue and the doctors leaving the City? And I understand that Jefferson is closing its OB-GYN clinic, is that something I've heard?

DR. GIBSON: I'm sure you brought that up. I'm sure it's something that you've heard but it's something that's not true. As a matter of fact, for several reasons it seems as though the OB-GYN clinic is probably busier than it's been in several years. So we hear the rumors all the time, but so far nothing like that is happening. Our births are higher at Jefferson in the last six months than they've been in the last five years. So I've not -- we've heard rumors. We hear lots of rumors about lots of different things, that that one has not been confirmed at all. As a matter of fact,

it seems as though at this point just the opposite.

COUNCILWOMAN TASCO: Well, do you have complement of doctors that you need to provide services that's required?

DR. GIBSON: Certainly from our end, you know, I'm a neonatologist and we take care of the babies after they're born. We certainly have enough there. They have a sizable residency program and attending physicians that train the residents and fellowship programs. So it seems as though it's very well staffed at this point.

COUNCILWOMAN TASCO: Councilman Ortiz, you have any questions?

DR. WAPNER: Excuse me. Could I add something to his answer.

COUNCILWOMAN TASCO: Yes.

DR. WAPNER: I think there are two incredibly important issues dealing with the impact that malpractice has had on us. One is there's no question that there are hospitals. And actually Methodist Hospital which was part of the Jefferson system recently in South Philly did close and Misericordia has closed their obstetrical services. The question, I think -- and these are directly

related to the impact of malpractice. The question we have to start asking ourselves is when is the last time we asked as a City how many hospitals do we need to be doing deliveries? What resources do we need to have at those particular hospitals? Is the bad the two hospitals closed?

Certainly there down sides. The people that live in that community have to travel further, but certainly obstetrics and neonatology take incredible resources. And we haven't done -- I've been here 30 years and, to my knowledge, we haven't really done a resource evaluation of the best way to provide maternity care in the City of Philadelphia. So before anybody can give you the information of what the impact is, we really need some basics.

The second thing, there are some incredibly more subtle impacts of the malpractice crisis issues than just not enough doctors, and you' touched on one yourself when you asked about the follow-up. Numbers of years ago, every clinic was loaded with social workers, loaded with nutritionists. We had all the ancillary care that we needed to provide this. That's gone, and it's gone because the dollars that we were using to pay

for those additional important healthcare issues have gone to malpractice insurance. So the doctors, to be honest, are the last to go because they absolutely need to be there. But what has gone slowly but really surely has been all the important ancillary services. I doubt any university clinic in the City has a full-time nutritionist in their clinic. That was routine. The numbers of his social workers are less. The ability to do follow-up for these patients -- we'd love to do it, we know how important. But when we're paying between 100 and 250,000 a year per doctor for malpractice, that money's just money that's not in the system anymore. So those are the really critical parts of the malpractice situation that kind of aren't really said as much as the loss of doctors.

COUNCILWOMAN TASCO: Do you have any questions?

COUNCILMAN ORTIZ: I agree. The aspect of the analysis of resources. When Episcopal closed the obstetrics, it had a great impact in terms of the Puerto Rican community around Episcopal. I still think the effects of that closing of

obstetrics Episcopal services is still being felt and still having a very negative impact. But it was done and it was closed without having any data as to the social and health consequences that it was going to have. It was done basically on a profit aspect of Temple deciding that they wanted to centralize its services and making the obstetrics over at Episcopal were no economically feasible. And those are the way decisions are being made. So it's a tragedy, but that's the reality of what we have today.

DR. WHITEMAN: We have seen an increase in our deliveries. Part of the reason why a lot of decisions are made, and I'm certain that the decision to close several other facilities in Philadelphia are made is because of the fiscal strain that the medical malpractice situation has brought upon many institutions, including Methodist and Temple and so forth. These are all problems that aren't necessarily going to make the headlines when people look at medical malpractice cost going up, but they're still going to affect medical care one way or the other.

COUNCILMAN ORTIZ: Somebody said that

we're probably the only large city, large urban city in the country without a city hospital. I don't think you can take the 10 largest Cities in this country and I think you can go to each one of them and they will have a City hospital. But we are one of those that -- again, that was a political decision made way before our time here. But it was a bad political decision. It was a bad health decision that was made. Maybe we should look at how we can restore that.

DR. WAPNER: Arnie Keller, who is the Chairman of OB-GYN at Einstein Hospital and along with myself are two of the grayest-haired obstetricians in the area, while this whole thing was going on, he leaned over to me and he said, "Well, there's a solution to this. Why don't we build one City hospital and maybe we should call it PGH." And I think you're absolutely correct, although he beat you to the punch.

COUNCILMAN ORTIZ: I think that's one of the things that we got to look at if we're serious about making an investment in terms of the health of the citizens of Philadelphia.

COUNCILWOMAN TASCO: Thank you very

much. It's been very informative. And, certainly, the purpose of this hearing is to gather information, to get your thoughts, your comments. And then the follow-up will be something that we will figure out once we gather all this information and do a report. And solve your suggestions have been quite interesting and creative, and we appreciate your participation.

Other healthcare providers, we'll have Pamela Clarke, Shelah Harper, and Dr. Herbert Kean.

We're going to get started. We're running a little behind time. And for the advocates panel, I think we've asked you to allow our Health Commissioner to come next because he has a 2 o'clock appointment. And an after this panel, we'll call forth the Health Commissioner.

To this panel, we have no intentions of shortchanging you, but we would like for you to summarize your comments. We do have the entire -- if you have prepared written comments, those statements will be made part of the record. So a summary would be quite helpful for us as we move along in our day. Thank you.

Dr. Kean, good morning.

DR. KEAN: I appreciate the opportunity of being here. My name is Herbert Kean. I'm a physician. I'm the Chairman of the Philadelphia County Medical Society Public Health Committee. I passed out a review of what I'm going to talk about.

Our committee represents many organizations in the City, City organizations. We also have the block captain program within our committee. The block captain program is something that the City is well aware of. These are the barefoot doctors who go around the community, every block, every neighborhood has block captains.

Now, we have heard testimony about preterm birth, the problems connected with it because these people don't get prenatal care, they don't know about it, they don't know about programs. We are dealing with maybe a medically indigent population, a socially indigent population.

What I'd like to say to really sum my testimony is, we don't know the reason for all these problems, but my committee has part of the cure. The patients like to know the cures. Doctors like to know the reasons. We have 5,000 volunteers. We have essentially one volunteer in every block in the

City. And these volunteers know their people, they know the people on their block, they know which youngsters are sexually active, they know who might be pregnant, they know who might need prenatal care, and they also might know who's afraid to go to organizations to get prenatal care. Maybe they're immigrants who are afraid of the system. Maybe they are people who not citizens who are afraid. Whatever the reason is, our 5,000 people know the people who need the care. Our people, our 5,000 volunteers can get to these people one-on-one. And it's my feeling, like with so many good programs, one-on-one is the way to go. We can find these people. We can seek them, ferret them out. We can bring them to the organizations which will provide the care, provide the answers.

We have meetings every three or four months. We have the block captains coming to our meetings. We get overflow at the Philadelphia County Medical Society meetings. There's standing room only. These are people who are interested in their blocks, interested in the people who live on their streets. These people come to our meetings and they are given instruction as to what to look

for, what to do. We've instructed them on diabetes. We've instructed them on hypertension. Some of the follow-up, I understand from our health czar, has been amazing in the weight reduction people who are in our program, in diabetes reduction, hypertension reduction. One-and-one it works.

And what I am expressing to Council is to try to find all the reasons for these things, but when you want to get to these people who need the prenatal care, who have the preterm births, the block captains are an approach that you should consider. It costs the City nothing, which is a major factor. It may cost you lunch, but this an important issue. We talk about money, there's no money. Well, we don't need money to do it. We have volunteers, 5,000 volunteers who will go to every home in the City if need be and get these people to the proper care.

I don't want to belabor that point, but this is a program that's available through the Philadelphia County Medical Society. It really has nothing to do with the malpractice crisis, although all the doctors in the society are aware of it. It has nothing to do with City funds. It has to do

with volunteerism at its best.

We've heard a lot from the present administration nationally about volunteerism. We have it right here in the City, and we're doing an outstanding job. And I would like to make this available to Council in whatever way they want to use it. Thank you.

COUNCILWOMAN TASCO: Thank you. We certainly appreciate the offer. I'm sure that some of us will contact you relative to making contacts with the block captains because, unlike you, we don't have access to that information even though it belongs to the City.

Next.

MS. CLARKE: Good morning, Councilwoman Tasco. I want to introduce myself. I'm Pamela Clarke from the Delaware Valley Healthcare Council and Hospital Association of Pennsylvania. I am here speaking on behalf of Andrew Wigglsworth, the President of DVHC who unfortunately was unable to attend.

DVHC is a membership organization representing over 150 healthcare organizations in southeastern Pennsylvania, southern New Jersey, and

northern Delaware. We appreciate the opportunity to present our views on infant mortality in Northwest Philadelphia's African American neighborhoods.

Infant mortality is a tragic public health problem. Although the rates have been declining, high rates persist in the Philadelphia neighborhoods and are greater for the African American community than for the white population. In Philadelphia, the infant mortality rate for African American infants is more than twice that for the rate for the white infants. The disparities are unacceptable.

As has already been mentioned this morning, infant mortality has many causes, birth defects, preterm deliveries and low birthweight. Birth defects as a cause does not demonstrate differences from the African Americans and the whites; however, preterm delivery and low birthweight do have differences between the African Americans and the whites. Infant mortality related to low birthweight occurs four times more frequently for the African American population than for whites.

An analysis was conducted by the Philadelphia Department of Health which examined

birth and death data for infants in the West Oak Lane neighborhood from 1998 to 2000. This analyses showed that greater than 75 percent of infant deaths could be a attributed to low birthweight and preterm deliveries. So DVHC believes that it is important to focus on strategies for reducing preterm deliveries and low birthweight deliveries.

Data from the Philadelphia Department of Public Health show that while the infant death rates in Olney and West Oak Lane neighborhoods are not as high as in North and West Philadelphia, the rates in these neighborhoods are higher than the norm for the City as a whole. In these areas, there are hospital-based programs that exist that address the problems of infant mortality. In particular, the programs tend to be outreach programs. Albert Einstein Medical Center has a program called A Better Start Program that provides health education, prenatal, and parenting education. In addition, Albert Einstein Medical Center works with the City to provide care to uninsured mothers in a program called The Maternity Services Program. They also offer Healthy Beginnings Plus services to mothers on Medicaid.

You had raised the question earlier about what type of aftercare services are provided for mothers who deliver babies at the hospitals. Albert Einstein has a program that ensures that mothers who deliver their babies in their facility receive new-baby visits within five days post discharge. These particular visits focus on providing information about newborn care, health education, and they make an assessment as to whether or not the mother needs additional support services post hospitalization.

Chestnut Hill hospital also has community based outreach programs to address the problem of infant mortality. Chestnut Hill Hospital provides prenatal and parenting classes both at their hospital and in the community. They work with teen mothers at Martin Luther King High School and Germantown High School. They work with churches to provide community health fairs for pregnant mothers. Likewise, Chestnut Hill Hospital also is concerned about aftercare services for mothers who deliver their infants in their facility. They ensure that every baby born at the hospital has a medical home post discharge.

Temple University, although it is not directly in the Councilmanic District No. 9, is in close proximity. And it has a program called Temple Select High Risk OB Program. In this program, case management outreach services are provided for high risk pregnant women. Temple University provides educational and transportation programs for these high risk pregnant women.

Programs such as the ones that I have mentioned focus on addressing maternal and preconception care, and these are the types of programs that are usually cited as promising strategies for attacking high rates of infant mortality. These programs are designed to address some of the factors contributing to the disparities in preterm deliveries such as the social, cultural, and environmental stressors that have been mentioned today.

However, it is also important to explore access to and use of quality prenatal and hospital care. DVHC has engaged in initiatives to address the problem of access to care. In particular, DVHC and its members have spearheaded enrollment programs throughout the region. In partnership with the

Philadelphia Citizens for Children and Youth, the School District and others, DVHC has participated in a program called First Step for Healthy Kids. These agencies work together to get health care coverage for children and their families and to provide linkages for low-income families to a medical home or regular source of care. In particular, in 2001, DVHC and Einstein partnered with the Germantown area schools to enroll more than 200 children who are eligible for medical assistance or CHIP.

Despite these efforts to provide greater access to care through enrollment programs, DVHC has testified on numerous occasions before in the state legislature that we are faced with medical liability insurance crisis that threatens access to care. And of course, you raised this as a question earlier.

Access to quality obstetrical care is in jeopardy due to this growing liability insurance crisis. The American College of Obstetrics and Gynecology has issued a red alert on the condition of obstetrical care in nine states, one of which Pennsylvania. They warn that liability insurance is becoming unaffordable or even unavailable. Without insurance, OB/GYNs are forced to stop delivering

babies, stop surgical services, and close their doors. They warn that with fewer obstetric providers, women's access to care will be greatly reduced. High liability cost has resulted in the closing of units and the layoffs of hundreds of employees. Seven out of 39 maternity units have closed in Philadelphia and two closed most recently this summer.

Einstein delivers about 30 percent of the babies from West Oak Lane, and they lost 17 positions including two obstetricians since 2001. Chestnut Hill Hospital delivers 20 percent of the babies from West Oak Lane, and they decreased the number of OB/GYNs from 14 to 6. Einstein malpractice costs have increased from 14 million in Fiscal Year 2002 to 36 million in Fiscal Year 2003, a third of the amount is related to obstetrics. Einstein has tried to fill the void of physicians by increasing employed positions. They've increased the numbers of employed positions from 100 to 400. However, physician recruitment in Philadelphia is becoming increasingly difficult, especially in the minority communities.

In addition to these costs, there have

been increases in other healthcare costs such as the cost for nursing, which has increased 40 percent; the cost of blood products, which has increased 50 percent; and the cost of drug costs, which has increased 25 percent. All of these costs have an impact on the provision of neonatal intensive care unit services as well as obstetric services.

In 2001, more than 3100 babies were delivered in Northwest area hospitals. Almost 500 of the babies were treated in Northwest Philadelphia Neonatal Intensive Care Units or NICUs. In the past two decades, NICUs have been a major contributor to the decline in infant mortality. As was mentioned earlier, before NICUs, 70 percent of babies born prematurely with low birthweight, birth defects, or other serious problems die. However, today, with the provision of service through the NICUs, over 90 percent will survive. We need to work to keep NICU care fully available to infants throughout Philadelphia by making sure we continue to have the doctors and nurses to provide the care.

Equally important, however, is the focus on prevention strategies so that newborn babies will not need that level of care. Healthy Start programs

have provided these prevention programs for the past seven years in North and West Philadelphia and Chester, Pennsylvania. The national evaluation of the Philadelphia program outcomes completed in 2000 documented that the program had statistically significant impact on the number of prenatal care visits and on the preterm birth rates in those neighborhoods. The Healthy Start Program resulted in decline in infant mortality rates, but those particular results were not statistically significant.

COUNCILWOMAN TASCO: Would repeat that again?

MS. CLARKE: Sure. Although there was a decline in the infant mortality rates of the areas that participated in the Healthy Start Program, the results were not found to be statistically significant.

In the Olney West Oak Lane neighborhood, there is no City health center or federally-qualified health center. There are no structured coordinated services such as those provided by the Healthy Start funds. The Healthy Start Initiative funding is available to communities

with infant mortality rates above 10.8 deaths per thousand live births. The rate in Northwest Philadelphia is 50 percent above the Healthy Start criteria.

In conclusion, it seems evident the hospitals and health systems are already devoting enormous resources to this problem. DVHC stands ready to work with the City, community-based and neighborhood organizations and maternal and child care experts to explore further ways to address this continuing community human tragedy.

We should all be working together to seek state and federal resources to augment and coordinate health and supportive social services for women and children and families in Northwest Philadelphia. However, I have to emphasize that left unresolved, the continuing medical liability insurance crisis will cripple the ability of hospitals to help address this deep-rooted public health problem. It will severely limit access to needed services. Across this region, hospitals have been faced with the doubling and tripling of liability costs as well as the growing loss of physicians to other areas and the inability to

recruit new physicians in our City. Some hospitals are now spending more money on liability coverage than for medicines for their patients. Moreover, hospitals in this City provided 273 million in uncompensated care in 2001. In the context of years of low reimbursements, high work force shortages, government cutbacks, growing uncompensated care, and increased responsibilities related to disaster preparedness, the City's healthcare system is very fragile with virtually no capacity to absorb new challenges without new resources.

As we work together to solve the problems in Northwest Philadelphia, we must do so in the context of working together to address some of the system issues undermining vitality of our region's healthcare system. To confront the challenges related to infant mortality, it will require effort by all of us. We need to work together and be in the game together as a team working toward a unified goal of reducing infant mortality. Thank you.

COUNCILWOMAN TASCO: Thank you very much.

Ms. Harper.

MS. HARPER: Good afternoon, Council, it's a pleasure to be here on behalf of Health Center No. 9. I am Vice Chair of Health Center No. 9's Citizens Advisory Board, and I'm here today with a sincere interest with regard to the infant mortality rate.

My concern is when I look at the numbers and the statistics that deal with the infant death rates, the low birth rates, it is like really clear that the population for Health Center No. 9's district along with Health Center No. 8, which I question because there is no Health Center No. 8. Health Center No. 8 was closed years ago, so was Health Center No. 7. When I look at those numbers, a lot of the patients that have -- once they closed, came over to Health Center No. 9, particularly 8. 8 was -- if you can hold on one second I can give you a picture. This is 9, this is 8, this is 7. When I start looking at those numbers and I start seeing that Health Center No. 8 had 378 deaths and then I look at No. 7 and I see that they had a hundred and something deaths, I'm like, okay, where are these people being seen because there are no health centers in that particular district? Therefore, if

a large percentage of those people are coming over to No. 9, when I look at the numbers, 9 is off of the hook. Excuse my mouth, but that's the way I have to put it.

For example, in terms of infant deaths, if I combined 8 and 9, I have 73 infant deaths in that particular area. If I add 7 on, I have 21 more, that's almost a hundred. Now, granted some of those people are being seen at Health Center No. 10. However, a significant number are coming over to us. My concern is how resources are allocated. If I see numbers that look like, okay, we had let's say in Health District No. 4 in West Philadelphia we had 24 infant deaths; if I look at 3, I see we had 38. Well, I look at 7, 8, and 9 and I see we almost had a hundred; and then I look at 5 and I see we had 15. And I'm saying to myself, This doesn't make any sense. A lot of the resources are being placed -- I think the most recent Healthy Start resources were placed in Health Center No. 5's area. I'm concerned. What is the criterion for allocating resources when you have numbers that are off the hook, particularly when you're looking at areas that don't have health centers. So that's one of my

concerns. I think that in terms of how we prioritize our funding and allocation of resources, whether it's the Maternity Care Coalition, whether it's Healthy Start money, I think we have to look at those numbers and we have to base our allocation of resources on the mere numbers.

Secondly, as a behavior specialist, I do work on the side as a behavior specialist, a lot of the houses that I go into have a major roach problem. I have seen roaches in babies' cribs. I have roaches in babies' car seats. I got a roach infestation in my car because of the fact that I took a baby's car seat and placed it in my car. I had to spray my car. Now, we're talking about babies who -- I know it's gross and most of us in this room never see this. This is like stuff that we don't want to see. However, there is a direct correlation -- and I think some of our physicians and stuff here could probably deal with the issue of roaches and asthma. There's a high correlation. I literally had some social workers from DHS and every place else looking for some sort of program that could go into some of these households to spray for roaches. The response that I got all the way around

was, Well, you know they deal with roach infestations on the street, but there's nothing that deals with roach infestations in the house.

There's a relation between roaches and salmonella poisoning. If you have roaches crawling around -- I guess some of the whatever they leave behind when they're crawling, if they're crawling through things of cereal and through people's cabinets, there's a relationship.

So I'm looking at some sort of program that the City can fund to go into low-income houses where it's like really infestation issue, because I'm not even going to talk about the behavioral issues of a child laying in a crib with a bunch of roaches. A program where you can go in and exterminate. Now, I understand that years ago, I think it was kind of like before my time, but years ago there was something like this.

So I basically summary would ask that Council demand of whoever allocates these resources in terms of preventative issues for infant mortality, basically take a look at the numbers. Please consider that Health Center No. 7 and Health Center No. 8 do not exist. They come to Health

Center No. 9 and some of them probably go to 10 also. But the mere numbers jump off the of me.

Now, I haven't been able to -- and I will submit this information to you in a more written format because I have the specific statistical numbers in terms of the numbers of 7 and 8 and this that and the other. So I'd ask that you please demand that those resources be allocated based on the prevalence of the problem and also look at some sort of a program that deals with this roach infestation and it's impact on asthma and salmonella, et cetera. Thank you.

COUNCILWOMAN TASCO: Thank you very much. One of the concerns I've had over the years, it's sad that we have to pit one community against the other when you have the problems pretty much City-wide, but certainly in targeted areas, and how the decision is made to fund one community and not fund another or find programs for one community. And so that is one of the reasons also for this hearing is to talk about the allocations resources, what public policies we set as a City in handling the issue of infant mortality and what we have to do to set those priorities. I don't want one community

to suffer because another community has received all of the funding. How do we fund everyone? How do we address the issue in those communities that have problems? And certainly through the years I've tried to seek funding for my community up in the northwest area for the Healthy Start Program, for the Mom Mobile, and I'm constantly told, Well, the numbers don't show it or we have funded the program in West Philadelphia or North Philadelphia. Well, when the news story hit and said that West Oak Lane had the highest, I thought it was about time for us to address that issue because it's not just West Philadelphia and North Philadelphia. I want those resources sent to our community also. And not at the expense of West Philadelphia or North Philadelphia. We have to find to address the issue city-wide and particularly in those areas the highest rate. And that's why we're today because we have to have some action taken on that. Thank you very much.

Any other questions?

Councilwoman Blondel Reynolds-Brown.

COUNCILWOMAN BROWN: Good afternoon. Not having the benefit of having heard all of the

testimony, at what point did District 9 no longer exist?

MS. HARPER: It's No. 8 and 7.

COUNCILWOMAN BROWN: 1987?

MS. HARPER: No, no. District 8 and District No. 7 no longer exists.

COUNCILWOMAN BROWN: Since when?

MS. HARPER: I really don't know. It was before I started looking at these numbers. Maybe someone else could tell me. I don't know.

COUNCILWOMAN BROWN: That's helpful to me in terms of getting a handle on --

MS. HARPER: In the '70s, in the late '70s.

COUNCILWOMAN BROWN: And so given that fact coupled with the allocation for dollars for Mom Mobiles and Healthy Start in West Philadelphia, I'd be curious to know is that the point that dollars for those programs in that area of the City were on the incline, did that match the need. And now we look at today's reality where the great in the Northwest and, again, the interest is to match the need, match the dollars where the greatest need is. So that's why I asked when those centers closed in

the Northwest section and was it at the same time that the need and the presence of infant mortality was on a severe rise in West and North Philadelphia. So can anyone give any insight with that? Because we're sure the reality has changed now because it's Northwest and Olney section of the City that has the greatest need.

COUNCILWOMAN TASCO: We're going to ask the Health Commissioner to come. We're going to ask in terms of protocol, Dr. Robinson, if you would stick around. We want to have your information which is really repeating some of the stuff that's already given. I would like to have the Commissioner come forth and present his testimony before he has to go, and then well certainly incorporate your testimony with his, if you don't mind.

Thank you very much, all of you for your comments.

Good afternoon, Commissioner. Thank you for coming. Why don't you identify yourself for the record and you may proceed.

MR. DOMZALSKI: Good afternoon. My name is John Domzalski, and that's D-O-M-Z-A-L-S-K-I.

I'm the Health Commissioner for the City of Philadelphia.

First off, Councilwoman Tasco and Madam Chair, I'd like to thank you so very much for making an accommodation in your testimony schedule for me this afternoon. I very much appreciate that.

Second thing I'd like to say is, this hearing may well be one of the most important that occurs in this Chamber from a public health perspective. There is no indicator, in my view, of the health of the community than the indicator of infant mortality. While I have prepared testimony that I have submitted, I would like to share some thoughts with you in a summary fashion concerning how I and we in the Department of Public Health now look at the issue of infant mortality.

When we look at infant mortality, one of the first things we usually give is a rate. We usually define infant mortality as the number of babies who die prior to the age of one year per 1000 live births. As we define it that way, almost immediately we take the humanity out of it and take a step back and start looking at it in statistical terms. I think it's critically important that we

understand that, while in my testimony you will see and the record will show that we have made progress in infant mortality in Philadelphia, it's not enough and it's not city-wide and it isn't at all representative of what's going on in our neighborhoods.

Even from a year ago we've been able to post about a 10 percent improvement city-wide in infant mortality. Unfortunately, what that means is that even with those better numbers in the last year for which we have data, that means that there were 224 babies who died. It is imperative that we as a community and we as the Department of Public Health identify that the true measure of success in infant mortality must be bottomed on the principle that one death of a child, one preventable death, is too many. We need to adopt a zero tolerance policy with regard to infant mortality. And the way we need to do that is to begin understanding it from the only way, in my view, that infant mortality can be understood, and that's from the neighborhood community level.

When we talk about infant mortality, it is very, very deceptive for us to focus on that 10.1

deaths of children per 1000 live births, because what it fails to show is that in some parts of the City, that infant mortality rate is as low as two deaths per 1000 live births, which is still too many. But what it doesn't get at is that in too many other neighborhoods in this City, it isn't 10 deaths per 1000 live births. It's more like 19.5 per 1000 live births. And so we need to look -- there was a discussion just in the last testimony about resources. And that's extraordinarily important in terms of how we allocate those resources. I think from the standpoint of how we approach, I believe that with all of the intellectual capital resources that exist in this City, that we in the Department of Public Health need to take a leadership role, and in some cases be the lead, in some cases be part of the team on other issues, but in addressing this issue of infant mortality on a neighborhood-by-neighborhood basis across the City.

There is an awful lot that we understand about infant mortality. I need to say that because when we get in discussions about this, we also get into the discussion that, one, infant mortality is

very complex and we don't understand a lot about it. And there are parts of the phenomena of the infant mortality that we do not understand, that medical science and public health science just hasn't caught up with. But that doesn't mean we don't understand everything. We understand a lot. One of the things that comes very, very clear as we look at the phenomena of infant mortality is the need for us to focus on the health of women. We need to start there because healthy -- unless we have woman who are healthy, unless we have health needs of women that are thoroughly, consistently addressed we'll never get a handle on the issue of infant mortality.

As we look at it, we can break down infant mortality in the periods of risk. There's the preterm period of risk. There's the newborn period of risk and there is -- rather the fetal period of risk. And then there's the infant period of risk. And so, many of the issues that have to do with babies being born too soon and babies being born too small have to do and focus directly in on the health of women. And so that is a paramount focus that we need to have as we deliberate on this issue.

I've been Health Commissioner for seven months, and one of the things that we've identified clearly in our administration is that we need to focus on and bring together all of the things we, in fact, know about the issue of infant mortality and create a process where we can begin to share information and come to understand better those things that we don't know.

On July 15 of this year, we were blessed to be able to appoint a medical director for the Department of Public Health. She's one of the few people in my department that you have not met as Council. She's with us this afternoon. Her name is Dr. Joanne Godley.

Dr. Godley, if you would just raise your hand for folks to see you.

Dr. Godley comes with a -- she's a Philadelphian. She has practiced -- she's worked in public health. She's been an epidemic intelligence officer for the Centers for Disease Control and Prevention. She's worked -- practiced medicine in our health centers a number of years ago. She's worked in managed care, and her last tour of duty was a two-and-a-half year tour with the Peace Corps.

And so on her return back to the United States we were fortunate to recruit Dr. Godley.

I've asked Dr. Godley to head up an effort that begins in the Department of Public Health of looking at infant mortality in a different, more coordinated and more inclusive way than we ever have before. Dr. Godley, in looking at this charge that I have given her, has identified some models that work from the perspective of looking at infant mortality community-wide. And one of them is called a FIMR, F-I-M-R, which is Fetal and Infant Mortality Review. And what that process is, it brings together both the medical players, the social players, the public health players, the neonatologists, everyone who has an understanding about the issue and can bring to bear information on the issue of infant deaths together to begin to change the way we address this. And what we see happening is, one, pulling all the pieces together that now exist in our department, and there are many of them, and I'll touch on a few of them, but also then to extend this out from the department to bring the players in from the rest across this City.

We have a City that has a tremendous

number of medical, academic and academic medical resources when we bring them together that can be brought to bear and understand this. We heard testimony just moments ago from the Philadelphia County Medical Society about resources that they have to offer. We, in fact, heard testimony earlier on from some of our partners, who are talking about a need for some services in their communities which, in fact, exist. And what that indicates is a failing on our part in the Department of Public Health in not being able to communicate that. So we need to make the table larger and bring folks to the table to look at this.

We also need to look at how we do research in this City because more research does need to be done. When we organize research we have to exercise leadership in the Department of Public Health so that we don't allow and we don't encourage our academic partners to get into the habit of going into a community and researching and then going home and writing about it and then running from that community. What we need to do is be able to bring those research efforts together. And through our IRB, our Institutional Review Board Process, where

we approve all research and studies that go on on a community-wide basis or elsewhere in the department, an obligation for people to look at this and help us to understand, to direct the research in areas that are most productive in understanding this.

I'll touch a little bit on the fact that we do have -- some of my comments might be understood to say that, certainly, I don't think we're doing enough. But I think that there has been a lot of very thoughtful effort given by the professionals in the Department of Public Health to structure new ways of looking at and preventing infant deaths across the City. One of them is the David Olds model. And I'll tell you that we have a phenomenon going on in this government where we're able to do things across departments that we have not been able to do before. We're able to sit at tables. I'm in the social services component. And in the social services component under a Deputy Managing Director we bring together all of the services that have to do with health and social services in the government. Public health is at the table. Department of Human Services is at the table, Recreation, Prison System. We're all there

together. And I mention this in relation to the David Olds partnership, and that's because it consists of a partnership with the Department of Public Health, with the Department of Human Services and with Philadelphia Safe and Sound to better be able to get out the issue of if we were to focus resources and effort on women who are first term, who are first-time mothers, and follow, and follow those mothers from the time early on in their pregnancy through the first year or two after the delivery, we believe we can have a substantial impact on the issue of infant mortality.

The David Olds model is one that we have to buy into. It's a licensed model. It's been proven to work. And one of our challenges, that tease out all the ingredients in that that make that successful, so that replicates that across the communities, across neighborhoods.

Since Memorial Day I've had the privilege of going out in the neighborhoods probably four or five times a week across the City. And it's part of the Mayor's Initiative on Safe Streets, but it's more than that. I mean, you would think, why is the Health Commissioner going out with the Police

Commissioner at a Safe Streets rally. Because when we look at the issue from a Safe Streets standpoint, we have to look at it from the standpoint of the comprehensive thrust that it represents. The whole issue of neighborhood transformation has very little to do -- has something to do, but very little to do in the long-term with just the physical aspects of neighborhoods. It has to do with all of us who sit around that social service table bringing in services that can support communities, support community building, help communities grow.

And when I get out there and I'm given the opportunity for a few minutes to talk a little bit, sometimes I talk about things that are relevant to that particular community. I did a couple stops last night and I had the chance to talk about our flu shots because we were talking about, you know, in some of neighborhoods where we have a predominance of elderly people. But it's this neighborhood focus that's so magical that gives us an opportunity and gives us hope that we can do something about this.

I don't think we can any longer have the permissive attitude that we have to have a certain

amount of infant mortality. We just don't. We can do something about that. I think that's the first step. If we say, one, that we must; and two, that we can; and three, that we put some action behind those words. And the beginning of that action, in my view, is for us to begin in the Department of Public Health to build on what we've done. But don't rest there. Okay. We're confident about this, but we're not complacent about where we've been. And then to add, to build on to that, to build our colleagues from Maternity Coalition, to build with PCCY, to build with the County Medical Society, to build with every one of the academic medical centers, and to build with the representatives of the people, the councilpeople in the district to craft programs that make sense in those neighborhoods. I think when we do that and we pull this business together, I just think there's a tremendous amount that we have left undone, but that yet we can accomplish. And that if we set that task for ourselves and people are very cautious -- and this is, I think, where for some of my staff will probably want to run up here and maybe say, don't say any more -- but I think what we need to do is

actually lay the challenge before ourselves to come back a year from now and say, just what have we accomplished. Not just with that city-wide number, not just with that city-wide number, but what does it look like? What does it look like in the neighborhoods where we post infant mortality rates such as the following: Strawberry Mansion, 19.0 per thousand; Ogontz, 18.3 per thousand live births; Sharswood Stanton, 19.5 infant deaths per thousand live births; what have we accomplished in those neighborhoods? And I think that's the task that's before us. And I think there's nothing but optimism that we can do this. It's going to take a concerted effort and it's going to take a willingness for us, not only to partner and to lead, but to lead and to partner when it's appropriate in those circumstances.

Councilwoman Tasco, I thank you again for the opportunity to come here and talk a little bit about the things that have been driving us in the past several months in the department that do seem to fit in with this concern and focus. And I'd be happy to answer some questions now.

COUNCILWOMAN TASCO: Thank you very

much. And certainly we will ask you to come here next year at this time and offer a report on what plans you established, your goals, and what action. I think the bottom line for us will be, what has been done in the year more than just planning and discussion.

I do think the coordination -- the gentleman from Drexel was clear on that. We have to establish a coordinated effort to address this. We have all these wonderful hospitals in the City. And with the City's charge, the Health Department's charge, through the Charter to be mindful and be responsible for the health and welfare of its citizens. It seems to me the Health Department is the appropriate department or agency to spearhead and provide the leadership to get the ball rolling to bring everybody to the table because I'm curious to know -- and you may or may not have the information today -- if you're planning to fund new programs for the targeted areas. And if you decide to fund new programs, how did you determine the targeted areas? I'm interested in that. Because I've been on Council since 1988 and I haven't been able to get a targeted dollar for the Northwest

area. And so that bothers me and troubles me. So a new approach is required. It's an approach that we have to figure out what is the broader picture and how we deal with it.

The other thing we also have to look at, and I am disturbed about, is the possibility of the cutdown on the hours of the health centers. We have been in the past very fortunate to have the health centers open maybe in the evenings, sometimes on Saturdays because women are working now. They are pregnant and they are working and sometimes until they go into the delivery room and may not be able to get to the health center during the day, but may need that evening hour. Certainly the Councilmembers have some real concern. We don't want to go back to the days when the health centers were marching on us to make sure that they stay open or that the prescription medicines were available for the patients. We don't want to go back. We don't want to regress. We made great strides in providing access to the health centers in those off hours. I hope that what I'm reading is not true.

MR. DOMZALSKI: I can tell you unequivocally, Councilwoman Tasco, that there are no

plans to curtail hours in the health centers. None. I will tell you more than that. What we are looking at, and your point is right on target, that the hours that we operate do definitely need to be looked at because women are working. And women are working in greater, greater numbers. And it's not just in the past years. It's been since 1997 and before. And we've had -- not more than eight days ago, not more than eight days ago, I sat with each of our health center directors and directed them to assess the hours in those centers in terms of their applicability to the patients that we now serve. Are these the most convenient hours, 8:00 to 5:00? We know they're convenient for somebody; they're convenient mostly for us. But the issue is, are they convenient for our customers? Are they convenient for people who need those services? So no. In fact, our goal and our objective -- and we believe that we will achieve this, no question -- is to not only not curtail services, but improve them across the board.

One of the big pieces with this, and I'll just take a moment if you'll permit me, but we have some partners on that are helping us that are

right in this room right now on an issue that is of paramount importance that we've neglected for too long, and that's the issue of insurance for people in our health center. We have taken on an initiative of making sure that every eligible person who comes to the health centers has access to insurance. Access to insurance. Why is that important? Certainly revenue is an issue with that, but it's not the paramount issue. We know that the people who suffer the most from disparities in health care are the uninsured. The Institute of Medicine has just completed a report about the severe health deficits that accrue to people who do not have health insurance.

And so that's the focus of getting everyone insured. Everyone insured that is eligible in those health centers. That began on October 28th in force and it's going to be ratcheted up in the weeks ahead to make sure that we have an opportunity -- and not just to send people from the health centers to the county assistance office, but to help them right there on site. Enroll right there. Complete the application and help them. That's the kind of thing that's going to also go a long way.

These are small pieces, but they're all related. If we can work and focus on that and never lose sight of the goal, I believe we're going to be successful.

COUNCILWOMAN TASCO: Well, we certainly hope so. And we look forward to your report of next year, but we will be working with you in the interim.

MR. DOMZALSKI: I appreciate that, Councilwoman Tasco. And just for me and for my staff, I want to just say that we've already lost a half a day. All right. We only have 364 1/2 days left to make good on this promise.

COUNCILWOMAN TASCO: Well, we welcome the new -- how did you spell the new doctor's name?

MR. DOMZALSKI: It's Joanne Godley, G-O-D-L-E-Y, M.D.

COUNCILWOMAN TASCO: Well, we welcome you to Philadelphia. And we certainly will be calling you to meet with you to sit down and discuss your plans for moving this whole issue forward. Members of the Committee, Councilwoman Miller and then Councilwoman Brown.

MR. DOMZALSKI: Good afternoon,

Councilwoman.

COUNCILWOMAN MILLER: I just have a couple questions. In hearing the testimony, in particular reading the testimony, I see that smoking cessation programs are a big plus. Do we have those within the Health Department, or you refer elsewhere? Certainly the alcohol and the drug -- well, I know we have plenty of drug treatment programs. What's happening with smoking cessation for pregnant women?

MR. DOMZALSKI: We have cessation programs now that are part of our prenatal clinic operation, but we're going to have many, many more. We've been fortunate to secure tobacco funding out of the tobacco dollars. What we're doing is we're putting those dollars out on a community-wide basis so that we can get community-based organizations to help us deliver smoking cessation programs to also be able to support nicotine substitutes, so this is a critical part and, Councilwoman Miller, the smoking piece impacts so heavily on pregnancy outcomes that we can't afford not to have this. We'll be -- in fact, we're almost at the end of our award with community-based organizations now and so

we'll be rolling those out, I would say, over the next 30 to 60 days.

COUNCILWOMAN MILLER: A couple other questions. Thank you. Do you have data on planned versus unplanned, in particular, first pregnancies? Because when I read some of the education stuff here and read recommendations, they're all talking about, two years prior to conceiving that the woman should do X, Y, and Z. Well, I just have a feeling, and maybe it's just a feeling, that a whole bunch of women are not thinking two years ahead because they're not planning pregnancies. I worked in family planning. In fact, my tenure in family planning was actually my first job. I worked in family planning probably for about 10 or 12 years during my 20s and into my 30s. I've counseled a lot of women and held lots of workshops on the whole issue of planned versus unplanned parent. And it just seems a little bit unrealistic that -- it might be a recommendation and maybe it's true. But it seems a little bit unrealistic that we're going to find women two years out to say this is what you have to do in order to two years from now -- and I'm not just talking about the Health Department,

because most of the groups that were up here today made that kind of reference about reaching women when they're planning pregnancies. And I just really would like to know how many people have actually sat down and planned a pregnancy, if you have data on that.

And the other thing that I'd like to know, particularly as it relates to the African American community, that we just seem to be a little bit -- it's not really decreasing in numbers in terms of infant mortality. Has there been any data collected and published that talks about the profile of these mothers or these babies and the living situation, the mother, et cetera? For example, you come into my house -- let me just use myself as an example real quick. I have two children. My first daughter was definitely unplanned at age 20. I had another daughter later in life who was little bit planned, just a little bit planned. Okay. I have a Master's degree in administration. So I'm just connecting me with all the stuff that I've read here day. But in the meantime, so you come over and say, Okay, well, Donna, what were you doing at age 20? What happened here? How was your diet? I hate

fruits. I hate vegetables. I like them a little bit now because I'm older and I know the value and somebody showed me how to cook them. Way back I just grew up hating vegetables. So I know that all that has an impact on my ability to have a healthy baby. Both of my children were healthy and well. So are we -- but if they weren't, are we taking the information that we're collecting to do prevention?

For example, too, when I read this brochure here from, "Reduce the Risk of SIDS, place your baby on a firm mattress such as in a safety approved crib". All right. Good. I just read that. But one of the other speakers today said in the African American community, people don't have cribs. It needs to be plain. I had no idea that people didn't have cribs. Now, maybe that's something that we can mobilize around. So we hear things plain and direct. I mean, the language on flyers and brochures are fine. But when we knew the senior citizens didn't have air conditioners, didn't have fans, people started to do what they needed to do to help to deal with that issue of the deaths of the senior population from the heat. So sometimes things have to be in real plain language for people

to understand it. We don't need to be trying to figure out what the sentence is inferring. We just need to know what it is. Maybe someone may not throw their crib on the trash; they may give it away to somebody or some organization. I never really thought about the fact that people don't have cribs. I don't know what a safety approved crib is, but I do know what a crib is. So I guess I just wanted to ask the question about the profiling, but then kind of make some of those statements. Because sometimes we as professionals, to me, just get too far out with language and we're not really reaching people.

MR. DOMZALSKI: You couldn't be more right. We do this all the time.

COUNCILWOMAN MILLER: Right.

MR. DOMZALSKI: We talk as though we're talking to each other, and half the time we don't understand each other.

COUNCILWOMAN MILLER: That's right.

MR. DOMZALSKI: But your point about unplanned and planned, I mean, in my testimony I think I have about six or eight bullets and I think bullet number four might be access to contraception. But it doesn't get to the point. Here's, I think,

what might get to the point in terms of planned and unplanned. In the last year there were 119 babies born to women under the age of 15. There were 1,412 babies born to women under the age of 18 in Philadelphia. And what this gets to is when I talked about the social services component and the fact that we get in a room and we're all able to talk to each other, one of the big components that we're looking at is the investment in children. I have a button on that says, "Hey, what about the kids?" And that's the focus that we're on. And when the Mayor talks about the children's investment strategy and we talk about needing to provide after-school programs for a hundred thousand children, one of the things we're talking about, this whole business of health and looking at women's health from the standpoint of women other than baby makers, the entire women spectrum of health. And that has to be part of it. The nutrition, the planning of becoming a parent and the entire process. But when children don't have access to those kinds of continuous services -- I mean, I think the after-school programs and those beacon schools are going to be part of this strategy

because it's the way we get to the people that we need, the children that we need to get to. Those figures I just recited, they're children. They're babies having babies, and so that's an avenue to get there. You're so right, Councilwoman. And we'll clean up our language.

COUNCILWOMAN MILLER: Thank you.

COUNCILWOMAN TASCO: Councilwoman Brown.

COUNCILWOMAN BROWN: Thank you, Madam Chair.

To underscore Chairwoman Tasco's remarks regarding an action plan or a plan of action, as you move forward to craft the plan, that sort of draws a strong link between areas of need that which have been highlighted through this hearing and provision of services that address those needs. Is it reasonable to draw a relationship between a lack of a presence of a health center or some coordinated level of service and the rise of the issue we've been talking today that has been happening in a remarkable way the past number of years? Is it reasonable to draw a relationship between the two?

MR. DOMZALSKI: I think we have to draw a relationship between the indicator, infant

mortality, and access to services.

COUNCILWOMAN BROWN: Okay.

MR. DOMZALSKI: Access to service is critically important. One of the things that I think all of the data indicate when we look at some of the household surveys that we have, is that Philadelphia, from the standpoint of having services available, does pretty well in terms of just where they are. In terms of -- I mean, we've got federally qualified health centers. We've got the City health centers. We've got academic medical centers offering service. We've got nursing services. I'm going to a program, I think, tomorrow night where we're opening another community health center associated with one of the academic medical centers. So we have these services there. The question is, who knows about them, to whom are they targeted, and is the constellation of services appropriate? When I mean, the constellation of services is appropriate, I mean appropriate to Philadelphia and to that particular neighborhood.

One of the things that we have going on in Philadelphia right now, we talk about health of young people. We have an epidemic going on among

15- to 19-year-olds of sexually transmittable diseases, specifically chlamydia and gonorrhea. And what ought to be a standard of care in this City is that when any practitioner sees an adolescent between the ages of 15 and 19, that a screening test for chlamydia and gonorrhea be done. And so this is the kind of thing where the Health Department can bring this information out, talk to the care providers and say, these ought to be standards of care.

To talk about -- when we have nurse home visiting. I was to a case conference in West Philadelphia with one of our home visiting teams and I listened to the various services that we were bringing together to help this family. There were three families talked about. And, you know, that team did not know what the infant mortality rate was in -- it's that neighborhood where they were working in. So we've got to bring this together. So it's access. We've got to have care. We've got to have access. And we've got to make sure that people know where those services are and where they're not. Maybe someone wants to opens a health center, you know, right next to where there might already one.

And if there's some flexibility, we might say, hey, what about this area. I think that's the kind of thing that we can do as a community.

COUNCILWOMAN BROWN: Okay. Is it fair to say that we can anticipate a plan that speaks to accessibility which you've addressed, availability of information? Because oftentimes it doesn't get to the people who deserve it most, and then the targeting or marketing of that information to those communities who also need it most.

MR. DOMZALSKI: Exactly. Exactly. And that's what's so special about getting the Health Commissioner out to those neighborhoods as we go through and we've gone through the safe streets and neighborhood transformation. There's going to be more of that. We're going out there all the time and that's where our focus is going to be.

Just as Councilwoman Miller indicated, we've got to make sure we're understood, that the information is understandable that we get out there, and that we don't tell people, you know, something that just is so incomprehensible that it doesn't make any difference whether we told them or not.

COUNCILWOMAN BROWN: Thank you very much

for your testimony. Thank you, Madam Chair.

COUNCILWOMAN TASCO: Thank you so much for your testimony. We appreciate it very much and we look forward to working with you in the next coming months on some of the things you've outlined.

MR. DOMZALSKI: Thank you, Madam Chair.

COUNCILWOMAN TASCO: Just for those people who might be here for the public property hearing planned for today at two o'clock regarding the airport competition hearing, that meeting has been rescheduled to Wednesday, October 9th at 10:00 a.m. That's on the airport.

While we're on the government issue, we have the Physician General of Pennsylvania here. We're going to ask him to come forward and we'll complete the government panel and we'll go into the advocates panel, because they have all the answers. And those of you who can stay, we appreciate your staying.

They're here from Harrisburg and we know they have to take whatever train they can get. There might not be a train. They might have to walk to Harrisburg.

Good afternoon.

DR. MUSCALUS: Good afternoon.

COUNCILWOMAN TASCO: Speak directly into the mike, please. We're glad you've come day.

DR. MUSCALUS: Thank you. Councilwoman Tasco and members of the City Council, I'm Dr. Rob Muscalus, and I have the privilege of serving as Pennsylvania's Physician General. With me today are Darlene Sampson and Stacy Schwartz, both from the State Department of Health.

One of my roles as the State's Physician General is to be an advisor to the Governor and to the Secretary of Health on a variety of public health and public policy issues. I have a great interest in activities that are related to health promotion and disease prevention and I greatly appreciate the opportunity to be here this afternoon and to address you to discuss the topic of infant mortality.

At the outset, though, I must express some frustration. Within blocks of where we are sitting right now, we find some of the most prestigious medical institutions in the United States and, for that matter, the world. And within those same blocks we find many of our citizens,

Philadelphia residents, who do not have access to medical services for some of their most basic health care needs.

Now, the reasons, as you know, are varied. They're complex, and oftentimes involve disparity issues among certain racial and ethnic minorities. And I think we all realize there is no single solution. Today provides an excellent opportunity to evaluate the issue of infant mortality and to discuss ways in which all of us can work together to do what we can to give our youngest citizens the best possible start in life that they can experience.

I want to start my discussion by emphasizing several points. First, the US Department of Health and Human Services has acknowledged that the issue of infant mortality is an important measure of our nation's health. And according to Healthy People 2010 objectives, the issue of infant mortality is one of the six primary health focus areas in which minority groups experience serious disparities in health outcomes. And, therefore, it's important to integrate all of the Healthy People 2010 related target areas when

addressing this issue. Now, target areas include, but they're not limited to, the following: Reducing pregnancies among adolescent females, increasing the proportion of women who receive care beginning in the first trimester of pregnancy, and also, reducing low birth weight.

The second item I would like to emphasize is that the State Department of Health has been and continues to provide financial support to the City of Philadelphia for health services; services specific to maternal, infant, child, and also children with special health needs. The total amount for the current fiscal year, 2002-2003, is projected to be at almost $3.7 million with almost $2 million directed to provide primary and preventative maternal and infant services.

And third, building on the administration's commitment to healthier communities, our Health Secretary, Robert Zimmerman, appointed members to a Minority Health Task Force in the spring of 2001. This was developed to assist in the preparation of a special report on the health status of minorities in Pennsylvania. The report, which recognized the value of getting a broad-based

community perspective, was released in April of 2002. I have a copy with me and we did bring additional copies with us. And if you or anyone, frankly, in the audience would like additional copies, we'll be happy to make them available. We believe that it's an excellent planning tool for communities, as well as a strategic guide for public and private collaboration. Now, the information and recommendations address specific health actions, health data and Healthy People 2010 goals and objectives directed at minority groups and health issues. We believe that this report should be used by counties, cities, townships and municipalities in order to provide baseline information that will help in developing programs and strategies to address a variety of health care needs, including those related to infant mortality.

Now, as indicated in the reports, the infant mortality rate for African American infants in Pennsylvania was three times greater than white infants. And the infant death rate for Latino infants was one-and-a-half times higher than it was for white infants.

Now, if we study the statistics we will

note that we have made some progress. From 1996 to 2000 the infant death rate per 1,000 live births in Philadelphia dropped from 12.2 to 10.3. Despite the steady decline in infant death rates over the last few years, and despite the impressive growth in community health improvement partnerships across Pennsylvania, minority communities remain under-represented and there is still much more that needs to be done.

Now, I would like to sit here today and hand you a prescription that tells you exactly what you should do to make things better, but unfortunately, I do not have such a prescription. However, it's important to point out that ultimately this issue must be addressed at the very local level and that personal responsibility must be combined with community support.

While leadership and financial support can be provided by the federal, state and county government, as well as by the City, the answer does not rest alone in dollars, nor does it rest alone in the construction of more facilities. It goes beyond that and includes a variety of other factors. Things like personal health habits. For example,

the use of tobacco, drugs, and alcohol and the effects they can have on our children. Another factor may involve access to care and increasing a person's awareness and knowledge of certain practices or habits that may have a cultural basis, but may also be based on incorrect information. Such as a simple thing as making sure our infants are placed on their backs when they sleep as opposed to lying on their stomachs. Clearly, it's up to individual communities to work hard to identify and assess what specific issues exist that impact infant mortality and then develop strategies for improving outcomes.

Some strategies may, in fact, require additional dollars, more transportation. Others may only require changes to a program structure, in addition to on-hand educational activities. What you are doing today is certainly a step in the right direction. You're getting as much information as you can to more clearly understand the issues. Having done this, I believe you will be better able to define what the problem areas are and then be able to address them in a practical manner.

I want to thank you for the opportunity

to be here. I'll be happy to address any questions you might have.

COUNCILWOMAN TASCO: Thank you very much. Do you have any questions? Let me ask you -- in all of this discussion today you just kind of hit home to me. We have all the statistical data. I think what's missing is that we're not talking to the people. We need to go into the community and have sit-down chitchats with folk and just say, "What's going on with you? What's the real deal? What's the problem?" Because we gather the information from the health records, however you gather that, but have we really said to a person who -- maybe a mother who has lost her baby. We talked earlier about providing postnatal support to the mother who has lost a baby. What happens to her? How does she feel? What does she feel happened? Maybe, what did she do? Again, that's very sensitive and some people may or may not want to share. But where we can, we might need to find there's another piece to all of this, that we need to go out into the community. The African American community is very closed-mouthed. They don't want to talk a lot about themselves or what's going on.

And we might find a lot of information by doing that.

DR. MUSCALUS: Well, I can't agree with you more. First of all, as I said, I don't think Harrisburg can prescribe what should be done. And in many ways I don't think City Hall can prescribe what should be done in a specific area. It doesn't do us any good to send out questionnaires if the people that we're trying to reach have difficulty reading them. It doesn't do us good to construct a facility in an area that's designed to treat young children if most of the people that live in that area are senior citizens. And I think you're exactly right. It is important for individuals who are trusted and respected in certain communities to be in a leadership role, to be able to communicate with members of that community to better identify what the issues are and how they best can be addressed.

The comments earlier about a crib or no crib, those are the types of things that can only be obtained through a dialogue at the local level. Now, I certainly believe that there is a need for leadership and support from the state and federal

levels. But ultimately it is a local issue that must be addressed.

COUNCILWOMAN TASCO: Identify yourself for the record, please.

MS. SAMPSON: I'm Darlene Sampson. As Dr. Muscalus said, I also work for the Health Department. I'm the Special Assistant to the Secretary of Health on matters related to minority health. And I just want to say, Councilwoman Tasco, that your point is well taken. And just to give you some idea of some other things the Health Department has done that really speak to the question you just asked, when we were developing our special report on minority health we actually went out -- Dr. Muscalus mentioned in his remarks that we wanted to get a broad-based perspective on what the health issues were in minority communities. We actually did a series of ethnic community forums across the state. And, in fact, we had three of those forums here in Philadelphia. Dr. Robinson, who is a member of our task force, participated in that as well.

But we went into communities and we did exactly what you said. We went in, we asked the communities what they perceived their health threats

were in their communities, and we got a lot of good input from communities. In fact, that's how we got a lot of the recommendations that we have in our report. We went and we talked to communities and heard firsthand what they thought some of the issues were. And we plan to continue to have that kind of dialogue with communities.

COUNCILWOMAN TASCO: Okay. Thank you. Earlier, Dr. Muscalus, we talked about -- one of the witnesses talked about Medicaid only being provided to women in Pennsylvania up to 60 days after birth. What is the possibility to get the state to extend that to beyond that, to two years as has been done in some states?

DR. MUSCALUS: That would certainly be an issue that would have to be looked at by the Department of Public Welfare, the General Assembly and the Governor's Office. My office has a peripheral role with regard to that. But we'll be very pleased to take any messages back to Secretary Houston and Secretary Zimmerman with regard to that.

COUNCILWOMAN TASCO: Okay. You stated that the City gets about $3 million from the state. Is that for targeted programs or is that Medicare?

DR. MUSCALUS: My understanding is that's for a variety of health care services with almost $2 million going specifically for women, infants, and children with special needs. We would be more than happy to provide you with a more specific breakdown if you would like that.

COUNCILWOMAN TASCO: Okay. Well, thank you very much. Dr. Robinson, since you participated in this panel, do you want to have some brief comments? Don't leave yet. There may be other questions. Just some brief comments about --

DR. ROBINSON: Thank you very much, Councilwoman Tasco. I did work on this task force. I was a member of the panel and made a lot of the suggestions that you see inside of the report here.

But not only did I work on that panel, but I've also worked on the issue of infant mortality going back to when I first came here as Deputy Health Commissioner. And also I'm a member of the Philadelphia County Medical Society, which is why I'm here today to speak, and I help with the development of the block captains programs. That was one of the programs that came out of, you know, our program.

But I think I do have some answers or some suggestions for you in terms of what's really happening with infant mortality. I think that there are some things that we can do which would actually have an impact on infant mortality. It was very important what Councilwoman Donna Reed-Miller said, and I wish she was here to hear this, when she talked about the issue of unplanned pregnancies here in Philadelphia. I actually went back and looked further back at what was actually going on. I said, well, we have this infant mortality, but what about the babies who died who are not born. And then I went back even further and what I found out, which is very interesting, which I'm sure a lot of people don't realize this, but there were over 14,000 abortions in Philadelphia in 1999. 14,158 was the exact number. There's only 21,000 babies born. So if you look at the issue of unplanned pregnancies, that's 14,000 babies obviously that weren't planned for or were not wanted if they're being aborted. So this is an issue also which is having an impact on that. But also --

COUNCILWOMAN TASCO: That goes to part of my issue of family planning and access to birth

control.

DR. ROBINSON: That's right.

COUNCILWOMAN TASCO: And education.

DR. ROBINSON: That's right. But that's having the impact even on the numbers also. But also look at the number of fetal deaths. These are the number of babies who are born in utero. That's you know -- which is like 16 weeks on. That number is twice the number of the neonatal deaths. You've got like about 500-something of them. I have the exact number here. In 2000 it was 476. And in 1999, there were 526 fetal deaths. So these are all numbers which you're really looking at when you talk about the health of about babies, you know, being born here. These are very important numbers as well.

Now, there's some other issues, too, we really didn't address so much. But there are some things which we know from a medical standpoint which are responsible for having low birth weight or preterm babies. And some of them were mentioned, but not all of them. Maternal obesity has been linked to fetal death. Poor nutrition during pregnancy. Cigarette smoking, I'm glad somebody

finally mentioned that. Of course, that's one of my big areas. I worked with the federal government on doing the book on smoking cessation, which was a very popular book. Hypertension, which we didn't mention, previous to pregnancy. A person with hypertension is four times as likely to result in inadequate fetal growth. Sexually transmitted diseases and vaginal infections. The use of alcohol during pregnancy. And also the issue of drug abuse, which was not addressed. The use of cocaine and heroin and other drugs and -- we actually did a study where we actually did an overlay of the communities that had high rates of infant mortality. And what you find is that they have high murder rates in those areas, high rates of HIV and high rates of other diseases, which are also associated to things like drug abuse and, you know, sales of drugs in those neighborhoods. That's what those murders are over, over people fighting for drug turfs and things like that.

Now, another thing too which was interesting, because Councilman Goode asked this question and I really have the answer to it, because he was asking, you know, if it's purely a matter of

socioeconomics. Back in about 1992 or '93 when we first started our Healthy Start Program, I looked at the issue of infant mortality and about the economic or socioeconomic conditions that were resolved. What I found out was that it's not totally economics. What I did was I compared Haiti. As you know, Haiti is the poorest country on the continent. And Haiti has a population, an African American population, which is very similar to the African population here. You know, it's just a matter of who basically got off the boat first. But Haiti, being very poor, actually had a lower infant mortality rate than in North Philly and Southwest Philadelphia at that time, even though it was the poorest country on the continent. And I think that that shows, points out, that it's not purely an economic or the amount of money that you spend. Because people in Haiti, they're eating better foods. They don't have the same types of stresses that we have here. Also the family situation is much different and so forth. So, you know, just because you're poor, I tell people, that does not mean that you have to be unhealthy.

Now, the final thing that I'd like to

say was we had a meeting as a member of the County Medical Society. I called together all the doctors. Dr. Kean was part of that committee. There was a Dr. Hernandez, he wasn't here, but he was also part of that team. He's from Temple, the head of their program there. We got together and we said, Well, what is it that is needed to be done to have an impact on this area? And we decided that the medical community could not solve this problem. We've made many advances in the medical community by having intensive care units, by having prenatal clinics and all of this. This has made a dramatic difference. But this is not going to make the difference between those numbers that we have, because now we've already reached the top of that technology. And you heard that also from the guy from Jefferson and the other doctor said that. What do we need? We decided that what we need is education, and that education is going to be the key to us solving this problem.

I really wish that there were someone here from the school system because I think that that is also one of the areas that we need to make it mandatory, that these issues are addressed in the

schools. And I'm not talking about in high school. I'm talking about in middle school because what we're finding is that women 13, 14, 15 are having babies. In fact, I did a study -- I was working with a Dr. Johnson, Leonard Johnson, who has this youth adolescent clinic. Sayre Middle School has the highest rate of teenage pregnancy. That's the middle school. And I actually went to that school and talked to the gym class and gave them, you know, an education and so forth about these issues. And I think that that's really where we need to spend more focus. I know that we can have some impact in the schools. And it should be mandatory that all children in the school get this type of education. And these are the things which I think that they should specifically be given in public schools. They should be taught early nutrition, exercise, substance abuse, Responsible sexual behavior and sexually transmitted diseases, the issues of abstinence and contraception, appropriate pre- and postnatal care, what you have to do to plan pregnancies. They have to be taught about the issue of breast-feeding. This is something that we didn't mention, but do you know that babies who are not

breast-fed are five times more likely to die than babies who are breast-fed? And breast-feeding is not as high in the black African American community and that's not natural. Because in Haiti, all babies are breast-fed. And also the issue of SIDS, Sudden Infant Death Syndrome. A third of the babies are dying because of this Sudden Infant Death Syndrome.

And there's many things that you've talked about, like a crib and how you lay the baby on its side instead of on its back. There's many things that can be taught to mothers to prevent these types of things as well. So I think that education is what we really need to get out of this. We're going to have to work with the medical institutions and the institutes and the intensive care units, but if we're going to really have an impact, we have to educate our population to make the right choices to prepare for their pregnancies and we can really reduce a lot of these deaths. Thank you.

COUNCILWOMAN TASCO: Thanks very much. Very good. Thank you. Thank you so much. We thank you for coming down from Harrisburg, Dr. Muscalus

and your staff -- well, your associates or staff, and thank you. We'll probably be in touch with you. Thank you.

To my advocate community, thank you for sitting here for so long.

We need about a five-minute break for the stenographer.

(Brief recess.)

MS. FISCHER: Hi, I'm Joanne Fisher and I'm the Executive Director of the Maternity Care Coalition. I am very delighted to be here today and I want to thank Council for hosting these hearings and also for those of you who have hung in these many hours of testimony. And I am very encouraged that, as a result of these hearings, that already our discussion has been elevated and that there will be new approaches and new commitments to these longstanding and persistent issues.

I'd like to say in preparation for today's hearing I went back to the Maternity Care Coalition archives -- and we were here before in 1988 -- and I have, Too Many Babies Are Dying, a piece that we did. And at those hearings I would have been wearing a button that said, "Our Babies

Are Dying," and we did have a room full of our clients here at that point in time. And I have all of the statistics and papers from those hearings. And I want to say some things are the same and some things have changed dramatically. We really have made a tremendous amount of progress, but the disparities persist. And I also want to recall that at those hearings we brought in folks from around the country who had very exciting and interesting approaches to infant mortality and community-based programs. And maybe the next set of hearings we could do that again as well so that we can learn from folks around the country.

I also note that while we continue to talk about infant mortality as having many causes and that we -- and I was so delighted to hear Commissioner Domzalski speak about women's health -- that absent from today's panel are folks speaking specifically about behavioral health, depression, drugs and alcohol. And I think if we are looking at these issues we really have to pay a lot of attention -- Larry Robinson mentioned chronic disease -- but to look at these issues in more depth.

It was out of those hearings back in 1988 that the Mom Mobile was born, and today we have 10 Mom Mobile sites and vehicles throughout the Delaware Valley and eight in Philadelphia. And we have served over 44,000 families in the past 20 years, including 5,000 last year.

COUNCILWOMAN TASCO: You have 10 Mom Mobiles?

MS. FISCHER: Ten Mom Mobiles in the Delaware Valley, eight in Philadelphia.

COUNCILWOMAN TASCO: Do we have one in West Oak Lane?

MS. FISCHER: We do not have one in West Oak Lane. And one of the things that I'd like to say is that Shelah has come to us, you've spoken to us, members of the communities have spoken to us, and we are eager and ready to develop a Mom Mobile in Oak Lane. And the problem is, and I guess I'll jump right to the resource issues, is that right now because of the hospital malpractice situation, we have seen tremendous cuts in our revenue. Right now we are struggling to keep the Germantown Mom Mobile alive, let alone start a new Mom Mobile. Last year as a result of the malpractice crisis Einstein had

to lay a tremendous number of staff off and had to cut a lot of community health services, including their support of the Mom Mobile program in Germantown. So of a $200,000 program we now have lost from their contract an additional -- we lost $90,000.

COUNCILWOMAN TASCO: How much does it cost for a Mom Mobile?

MS. FISHER: About $200,000.

COUNCILWOMAN TASCO: That's for the vehicle and to pay for the service?

MS. FISCHER: The vehicle is minimal. It's really about the program and paying for the staff. You need a minimum of three people for security and basically economy of scale to serve the community.

And I want to say that if we also look at our testimony in 1988, we looked at what percentage of the City's budget went to maternal and child health. I don't have those figures here today, but I urge you to get those figures. I know that in our budget, that in the early '90s, City funds constituted about 60 percent of our budget. Now, City funds are about 24 percent of our budget,

so that we have had to increasingly raise more dollars. The City contracts that we have have been flat for about six years. I have to give staff salary increases, my health insurance goes up and there have not been additional funds even for the sites that we have, let alone developing new sites. And we have had to rely more and more on other grants, contracts and funding from private foundations and individuals. This summer I think we've done something like 27 grant proposals to try to keep existing services funded.

Now, I'd also like to say the City has an opportunity to leverage dollars. Because as we heard, not only are Health Department dollars involved, but DHS dollars are involved and behavioral health dollars are involved and early intervention dollars are involved and drug and alcohol dollars are involved and Medicaid managed care dollars are involved. And we still are thinking about this in, you know, in terms of categorical funding. And programs are being developed by a funding source rather than around the needs of a particular family or a particular community. And one of the things that I would like

to see is for the City to take leadership to try to blend some of those funding streams around the needs of communities. I also want to caution the City because there is no silver bullet here. And there are fads and there are programs -- even the Mom Mobile Program being in East Oak Lane will not solve all the problems.

Now, I can tell you that we've done enough research that we know that more people get into prenatal care in those areas where there is a Mom Mobile than those areas when there is not a Mom Mobile. We do know that we can link people with services. We know that we can increase their knowledge of HIV prevention, lead reduction. And we also have had outside researchers who have indicated that communication between health care providers and families are improved when there is a Mom Mobile program or people participate in a Mom Mobile program.

And finally, that individuals participating in a program like ours can set goals for themselves and feel empowered to take better care of themselves and their children. And that information comes from researchers speaking directly

to the women who have participated in the program pre-test, post-test, et cetera. But we can't do this alone. We can get people into prenatal care where problems can be picked up earlier, but we still need that whole array of intensive services, and particularly drug and alcohol support, mental health services, et cetera.

I also want to say Healthy Start in itself won't do it. Healthy Start can be very valuable for boosting the development and intensity of services in the community. But I want to caution you about relying on one program. Healthy Start has very specific and narrow funding criteria. So, for example, in West Philadelphia now, we're in a situation were we can only serve people in two zip codes. We now have a waiting list for clients from other zip codes in West Philadelphia. And pregnant women can't wait. All right. And we need a program that can be responsive to the specific needs of a specific community. And, you know, I think Healthy Start is a good example of where, you know, policy is set, research is done, policy is set and then finally put into a practice, but it's often based on research that's a few years back. So we have to

constantly be innovating.

We heard a lot today about the David Olds Program, another program I followed for a very long time and has demonstrated some important results. However, it also has very stringent criteria for who can participate. It has to be a first-time pregnancy. It has to be within the first trimester. Well, most teens don't even know they're pregnant in the first trimester. So, you know, how do you translate those kinds of programs into the specific needs of families? One of the other things is that we know the biggest indicator of a preterm birth is having had a previous preterm birth. Well, we're not going to be dealing with those families with the Olds project. So we need a variety of approaches in communities.

I became pregnant for the first time 22 years ago. And my son was one of the last babies born at Presbyterian Hospital and it closed it's OB unit shortly thereafter. In 1983 my daughter was born at Boothe Maternity Center. It closed in 1989. And in both cases Maternity Care Coalition spoke out about the diminishing choices for families. In the past two years Philadelphia and the adjacent

suburban counties have lost seven of the 39 remain maternity units. And Councilman Ortiz was absolutely correct in terms of the impact of the closure of Episcopal within that community. And while this is in South Philadelphia, some folks say, well, it's not that far to Center City. Knowing that community, it's very far from Center City. And it also means that there is not a prenatal care program for folks on Medicaid in South Philadelphia. So Health Center 2 only goes so far into South Philadelphia. So that that community has been left really needing services.

Also, I want to urge the City to take some leadership to get people to sit down and talk about this. Ron Wapner spoke a little bit about how we have not looked at how support services have been cut. He's absolutely right. We get a call from the Mom Mobile from a hospital whose fired all their social workers and said, "Will you come do outreach in our clinic?" You know, we're -- basically, folks are expecting us to take over the jobs of the social workers in those hospitals. And, you know, not pay for it. So there is a lot that needs to be done.

I want to draw your attention to one

other issue. And that is the issue of maternal mortality and morbidity. And I was very happy to hear Commissioner Domzalski talk about the FIMR, the Infant Mortality Review. I would like to suggest that we also look at pregnancy-related death review, and we have begun to do that in the City. I was one of three people who last year attended the Center for Disease Control Summit on safe motherhood in Atlanta, Georgia. It was right around this time last year, and as a result of 9/11, the momentum of that conference was curtailed. However, Maternity Care Coalition did host a meeting on safe motherhood in June of this year and we learned there has been no decline in maternal morbidity since 1982. That nationwide, 7 to 8 per 100,000 births result in a mother's death. And last year there were 12 pregnancy-associated deaths in Philadelphia. And while the numbers are relatively small, African American women are four times as likely to die from a pregnancy-related cause. So this is another area that really deserves our attention.

Finally, I would like to say that we have to look at these programs in the context of women's lives. And we were not the least bit

surprised to hear about the lack of cribs in the African American community. In fact, in Northwest Philadelphia we have a mom/baby closet that we do in conjunction with Saint Martin's Church in Chestnut Hill to try to provide those kinds of concrete services to families. We get calls from people for formula and diapers and basic necessities every day. And we understand that those material goods become more and more important as people get poorer and poorer. And in terms of the availability of services, particularly with the new work requirements under TANF, people are not at home and feeling more and more stressed to get back to work quickly, since there's only one year of a work exemption for someone who is pregnant or has a young child. And that's one year for life. So if you plan to have another baby, you better be getting your schooling and your child care in shape early on if you want to meet the work requirements. So all of the services and the context of providing those services have to be within that context. And then looking at what programs are available to working families.

I think I will let my other colleagues

continue here, but I know that the City can take an important role in terms of bringing people together. And again, I'd like to say that it's so important to not waste our resources on new start-ups of new things and not build on the resources that are already there in the community, the tremendous talent that is here and that exists in the community. Thank you.

COUNCILWOMAN TASCO: Thank you.

MS. FITCHETTE-GORDON: Good afternoon, everyone. I am Karen Fitchette-Gordon. I'm Executive Director of Philadelphia Black Women's Health Project. I'd like to start by giving just a little bit of background of the Project, because I run into people all the time who think that the Project sprung up last year, when actually next year will be our 20th anniversary.

The Project is a private, non-profit, community-based organization whose goal is to provide health education, self help, training and advocacy to black women and their families. It was started when a group of women from Philadelphia attended a historic national conference on women's health in Atlanta, Georgia in 1981. We've

maintained an office in North Philadelphia since our inception, and over five years ago a satellite office was opened in Southwest Philadelphia when the Project was awarded a Healthy Start grant. That office is now at 42nd and Chestnut Street.

The Project strives to promote positive health care outcomes for black women. We, as black women, must define, promote and maintain the physical, mental, emotional and spiritual well-being of black women through education, training and advocacy. That's our mission. That is what we try to do every day. PRIME, Partners in the Reduction of Infant Mortality Efforts, is one of our largest programs and it provides service to teens and women and their families who live in North Central Philadelphia. The targeted population is pregnant and parenting women and teens. We do workshops on various topics and make referrals to other human service organizations for such needed things as disposal diapers, formula for infants, clothing, housing, relief for utilities, all of those things to help a woman live a healthier life and therefore provide a healthier life for her children.

Infant mortality rates among blacks

city-wide are disheartening. In 2000 the infant mortality rate was 14.2 percent compared to the white infant mortality rate of 6.1 percent. The infant mortality statistics in North Central Philadelphia are staggering. Strawberry Mansion, which is in the heart of North Central Philly, has a population of over 47,000. Over 80 percent of the residents in Strawberry Mansion are black. In 1999 the infant mortality rate was 16.9 percent. The percentage of low birth weight babies was 15.6 percent and the percentage of women who received little or no prenatal care was 11.9 percent. However, we cannot let those statistics color the fact that infant mortality rates are rising in parts of the City other than North Central.

According to Neighborhood Watch 2001, which was recently published by the Department of Public Health, Division of Early Childhood, Youth and Women's Health, infant mortality rates in the City are 12.7 and 11.1 percent of babies are born with low birth weight. In the Olney, Oak Lane, Germantown section of the City, infant mortality rate is 16.7 percent and low birth weight is 11.5. District Health Center 9, which serves Germantown,

Olney and Oak Lane, reports that of 2,809 births, the infant mortality rate was 12.6; low birth weight was 10.4.

To go back to what Commissioner Domzalski said is let's take away the percentages and look at it as a baby. That's 325 deaths and approximately 300 low birth weight babies out of a thousand. That's 625 babies out of 1,000 babies. That is horrendous. Despite support services that are available in many parts of the City, residents of one of the most densely populated and most underserved areas are not getting the support they need that will increase their chances of better health outcomes. There seems to be an impression that women in a neighborhood like Germantown, Olney and Oak Lane, all served by Health Center 9, are being afforded all the supports they need. That they have sufficient resources to meet their needs. If this were true, infant mortality and low birth weights would not be as high as they are. I'm a 30-year resident of that area. We have limited support service in this part of the City. And as executive director of the Philadelphia Black Women's Health Project, I often get calls from women in

these neighborhoods seeking help with medical services, child care services, referrals for food, clothing, housing, and utility bills. These women want to know why so few services are in their neighborhoods. Lack of these necessities impact upon a woman's ability to successfully bring a healthy baby to term.

There's been a change in the demographics in this area, and I think that you look at the statistics and you go -- you look at statistics every 10 years. Ten years ago or 20 years -- let's go 20 years ago when the neighborhood was beginning to change. If you look at the statistics then, that area was primarily senior citizens. And you cannot look at statistics every 10 years and expect to make a change because neighborhoods change quicker than that. I have been there for 30 years and began to see the change at the time the young lady spoke, that Health Center 7 and 8 closed. That's the time that the change came. That's the time when there were younger families in the neighborhoods who were now having these teenagers or other younger children who are getting pregnant. Services are not there. And they're

looking at stats that were true in 1970. The neighborhood is not what it was in 1970. I look at the churches in the neighborhood, that when I moved there, were synagogues. Now they're baptist churches, because the neighborhood has changed. Those things cannot be overlooked when it comes to providing services.

There's a dire need for more community-based organizations in the Germantown, Olney and Oak Lane sections. I don't ignore the services that are provided by hospitals and the various nurses programs. These programs, unfortunately, are not reaching the most needed -- the women who most need the services. The visiting nurses program is offered by Temple, Chestnut Hill, LaSalle. Visiting nurses have limited capacity to address the needs of this largely minority, underserved population. In addition, many woman who are victimized by the lack of cultural competency are more comfortable interfacing with grass roots community-based services. These types of organizations have much to offer in the way of support, resources, education and nuturing.

Organizations like the Project and

Maternity Care Coalition have been providing services to this target group of women for many years, and yet neither organization is able to adequately meet the growing and critical needs of the women who reside in East and West Oak Lane where we see rising infant mortality rates.

It's clear that attention needs to be paid to funding and support in areas of Northwest Philadelphia and Oak Lane. With unemployment rates rising, managed care locking poor women out of sensitive, quality medical care and community-based organizations with limited capacities to provide adequate support services, childbearing women are made very vulnerable. These woman so desperately need sensitive and competent organizations that will provide supports to better insure health outcomes.

Increased education and support through community-based organizations would help women starting in the teenage years to begin to look more critically at their health and to avoid many of the things that impact upon their health. Education and training offered by community-based organizations would make teens and women more aware of nutritional needs for them and their children, would teach life

skills that, in turn, would allow teens and women to make better overall choices for themselves. This would lead to healthier lifestyles that benefit women throughout their lives. The Project believes that healthy women have healthy families.

Community-based organizations provide a variety of supports for women who may be at risk for -- healthy pregnancy. These supports better enable a woman to have a full-term healthy baby with less risk of mortality. Community-based organizations oftentimes are staffed with women from the community who are in tune to their community and its needs. They are more likely to be on the same level as the women they are working with and, therefore, have fewer barriers to overcome in working with them.

These organizations need more support so that culturally sensitive programs and services can be provided to this population of teens and women. Though there are many organizations, there is limited support. The need for them is growing and resources are diminishing. We need more investment from our elected officials and policy makers for the health and the lives of women and children so that all women and children can enjoy healthier and happy

lives.

COUNCILWOMAN TASCO: Thank you.

MS. YANOFF: Good afternoon.

COUNCILWOMAN TASCO: Good afternoon.

MS. YANOFF: I'm Shelly Yanoff from Philadelphia Citizens for Children and Youth, the regions outside of Government Child Advocacy Organization. I want to commend my colleagues on this panel and actually before -- I'm just going to give my recommendations because you've been sitting for a while, but I want to say that every recommendation that was made today was very important. And we totally agree with all of them. Except perhaps that the state gives enough to maternal and child care. Babies shouldn't be expected to stand up and pull themselves up by their own bootstraps either.

I want to just begin for a minute, Joanne mentioned 9/11 and the CDC recently -- and I think, Councilwoman Tasco, you referred to it -- did a study and it compared infant mortality rates in the 52 largest cities in the country. And it reported on infant mortality rates. And then it reported on the black infant mortality rates and

white infant mortality rates and Latino infant mortality rates. And one had to gasp at the persistent large gaps between African American babies dying and white babies dying. And in this time when we're talking about 9/11, I sort of think we should have a moment of silence for every one of those babies who died unnecessarily, and because of a community that refuses, a society that refuses, to hold every baby born up and say, look what a miracle this is and get behind it. And we ought to be about the business of doing that.

But now I want to just turn -- well, before I turn, I want to comment that I grew up and lived next door to the area we're talking about. And it is not, by a long shot, the poorest community in this City. It is a community of working-class and middle-class people. It's numbers are shocking, therefore, and have to bring us back to say, there are not a lot of community-based organizations there because most of those people have been out doing other things, working. They've not been spending a lot of time in their community. That's not a value statement. That's just the reality. So what do we do? What do you do as policy makers? What do we do

as advocates in addition to the recommendations that have been made? I think we've got to -- somehow, there's something for all of us. There's something for the federal government to do in making it an imperative that real serious research dollars be addressed to looking at that gap and to making and funding programs, making recommendations and funding them to close it. It is a disgrace. It is something that is shocking.

Secondly, we ought to insist that our state officials do, indeed, talk to -- when, not if, but when they're going to apply for a Medicaid waiver so that we can, in fact, assure women that they will be covered in those most vulnerable times. We've all talked today about the critical importance of healthy women for healthy babies and, in fact, I want to commend the Health Department for its analyses of what's going on in -- particularly in your area, Councilwoman Tasco. And what they found was a very high degree of chronic hypertension among the women. Well, we all say women should be healthy before pregnancy and take care of themselves. But what do we do to make that possible? First of all, hospitals are curtailing services. You know it.

You've heard it. The City must become an active proactive convener in the action of health care providers. In the last six years many hospitals have closed services without a public discussion or debate concerning the impact of those on the community. The infant mortality rate may well be much worse next year because we have not seen the numbers yet as a result of this year's closing or last year's closing. We still just got 2000. This is 2002. We have just named another four hospitals that have closed.

We urge the Council to hold hearings, examine the impact and take appropriate action. All of those service providers get some support from the City. You are not powerless. We are not powerless to do that. We also ask again that the state act on the insurance crisis and develop appropriate consumer patient focus responses, in addition to extending Medicaid.

The second issue we want to talk about for a minute is the danger of working in hazardous environments. Many of the women who work in that area work in small business outside of the reach of the Family Medical Leave Act, outside of all other

health and safety reaches. They're working in small businesses. We urge you to recognize that inhaling smoke is very dangerous, whether you're smoking or you're working in a smoke environment. It's bad. It's bad for your baby. Therefore, we urge you to support City Council's legislation that has been introduced before to prohibit smoking in the workplaces of the City. And, actually, I have to say that it doesn't make it -- it doesn't make it easier to make exemptions where you know women work in those areas. So there's a lot of problems with excluding some areas like restaurants because that's whose waitressing most of the time. It's most of those women.

The difficulty of securing appropriate physical and mental health treatment during the workday has got to be addressed. My colleagues mentioned the fact that the welfare reform, used in quotation marks, does require people to go to work. And as a result most of them do not have the ability to go to secure treatment, whether it's for their depression, for their hypertension or just prenatal care. They can't go during nine-to-five hours. And there's not a lot of other options for them. So we

have got to figure out ways that this City and this City Council can do something about that. I think that we could. We would urge you to pull together the Chamber of Commerce Small Business Task Force, some citizen activists, some health professionals, and work together on how, indeed, the City could develop a model program to assure that women can go and take care of their medical and their children's health needs during the workday at the same time. Of course, as we have to also urge that you keep track of insisting that any health care provider make room for an hours after work and on Saturdays so that people can go visit and get their health care needs taken care of. There are not enough health clinics, centers, prenatal care or mental health programs in many sections of the City. And that is absolutely true in the section we are talking about. The City should expand it's services to meet the needs of the people in the Northwest, to encourage its private partners to do so and, actually, there are other areas as well, but clearly in the sections of the Northwest we're talking about.

Next, many pregnant women do not know

that they and their infants are eligible for health insurance and the importance of prenatal care. It still exists, that non-information. The City, in collaboration with the private sector and the state, should develop a major public education program about the importance of seeking prenatal care. And actually, as well, the important of breast-feeding.

Lastly, many women are not prepared for the difficult, important task of parenthood. Confusion leads to complications. When Councilwoman Tasco and I were first pregnant we were supposed -- we thought you were supposed to put your babies down on their belly. Then we found 15 years later that that wasn't true. Well, luckily our babies were okay, but --

COUNCILWOMAN TASCO: I should have put him on his back.

MS. YANOFF: Well, it's true. They were just very different things. This City can be safer. The City and state should develop programs that assures all babies have home visits, not just the few that -- those that meet the David Olds model, which is a wonderful program. And we should have it all over and not have it be like a lot of programs.

If you're outside of the boundaries, you don't get it. One of the reasons I would posit that West Oak Lane and Cedarbrook and Ogontz have such bad figures right now is that they were never bad enough. They were triaged out right away. And so we turn around and we look and we have to pay for the consequences. But we're not paying. Babies are and families are. We should be doing much better than that.

So I think we can reduce SIDS by home visiting, and really building that kind of relationship up with home visiting. And make the state and the City come together and say, we're going to visit every baby, every newborn, and we're going to follow up where necessary.

Second, we can deal much better with how healthy women are during their pregnancy if they, in fact, are reached out to, if they are informed, and if there's a place they can go to get the care and it's open when they need it. And they've got to be able to do that not just when they're pregnant. They've also got to be able to do that -- if we're going to have healthy babies, the moms have to be healthy. What research says is before they get pregnant. That doesn't mean we have to plan that

I'm going to get pregnant in two years and, therefore, I'll be healthy. It means they've got to be healthy anyway. And I think that, in that, we've got to deal with the states, Medicaid extension and we've got to really deal with there being adequate clinics. There's no health care clinic really that's set up to deal with the population in the area you're talking about. We can do better than that if we open our eyes to it.

And I want to also say that I think we need to have hearings on this every year. We are not constantly alert to issues in public health that can save babies, that can save children. And only when you have a public calling together do people say, oh, wow, yeah, it didn't do so well. We can do better than that. And at least 224 babies this year should tell us that we ought to. Thank you.

COUNCILWOMAN TASCO: Thank you very much. We really appreciate your comments and your recommendations. I do agree with Karen and you too, Shelly, because what we fail to do, what government fails to do, is to look at the change in the trends. Well, you know, 1990 census said, this is what the neighborhood looked like. And if you go up and you

drive through the neighborhood, you see it doesn't look like the neighborhood in 1970 or '75 or '80.

Or even though you have -- you talk about white flight. You talk about middle-class black flight. Because when we moved to that area, it was predominantly upper, middle-class working people. A lot of them did have health care because they worked for the schools. They were doctors. And I can name some very important people who lived right around my neighborhood who have now gone on. And that's okay because people's income increase and they move. And, of course, people followed in their footsteps. They may not have the same level of income that they had. And so instead of the bureaucrats saying, well, we have to follow the federal guidelines, we have to deal with the census information that exists today. And, you know, the demographics of the neighborhood has changed. And so, I was like a voice in the wilderness because, as you said, we weren't that bad. We didn't meet the numbers, but we knew that the problems existed.

And we don't have a lot of community-based organizations in that community because they just have not evolved. You have to

know that neighborhood. But there are organizations that we might be able to encourage to come into the community if we find a facility for them to operate out of. So there are a lot of things that I've -- thoughts in my head that sort of -- that have come to me about what we can do to provide outreach up there in that community. Not re-inventing the wheel, but hopefully using the existing resources that are available just to expand in that area and to work to get those resources for them to operate in that community.

So, we are going to be very active in trying to bring those resources to that area. And, of course, I do agree with Dr. Robinson, education is extremely important. And there is hope now. Today what we will do with this, the results of this hearing, we will develop a report and then we'll develop an action plan. And certainly we'll be back to you about that action plan because it will probably involve you in whatever we do. And we have some preconceived notions about what we want to do, but we haven't come to a conclusion on that yet. It will evolve as a result of the testimonies today. And I think we got some very, very good information.

I think now we have enough statistics. We have enough documentation. What we need to do is figure out what is the action plan and how we get it moving.

And so, I'm encouraged by the Health Commissioner. I'm encouraged that he's brought on staff to work in this problematic area. We will be meeting with them very soon.

And, again, I don't want anyone to feel that I begrudge any community for having received funds or are working with the City on programs in their neighborhood. My role is to advocate and secure something for my district. And so what we have to do is look at how we restructure the way we fund programs and how do we just find a better way of doing business. And so we appreciate everyone who has come.

Councilwoman, do you have any comments or you have questions?

COUNCILWOMAN BROWN: No, I don't.

COUNCILWOMAN TASCO: Is there anyone else here to testify on this resolution? We will not adjourn. We will recess to the call of the Chair because it leaves the record open. And we

will call our Health Commissioner back definitely this time next year, but you never what happens between now and then in terms of what action or information we may need to call this committee back and we can do that with adequate notice. Joanne.

MS. FISCHER: I know a number of us will be upset if we don't get on the record the connection with oral health and pregnancy.

COUNCILWOMAN TASCO: Oh, yes.

MS. FISCHER: And that there are very important new research findings there. And also, looking at the oral health status, particularly of adolescent girls, is another area that we really have to look at in addressing this issue.

COUNCILWOMAN TASCO: Yes?

MS. YANOFF: I wanted one more, if I may?

COUNCILWOMAN TASCO: Sure.

MS. YANOFF: That is that there are a lot of rumors right now because the City is facing perhaps a financial crunch of critical programs being lessened. This City government -- and I've been advocating, as you know, for a long time -- has never seriously, never, ever, ever seriously

invested in maternal and child health. And the idea that there are rumors now that we may be facing a pulling back of the few home visiting programs that do exist, we ask you to exercise a lot of guardianship over those programs because we don't want to wake up one day when it's too late, we could have done some -- made some noise had we known. Thank you.

COUNCILWOMAN TASCO: I'd just like to say that my child is much older than 22, but I remember when I first went to -- and I didn't know anything about having a baby -- but I went to the University of Penn clinic. And they had a mother's club. And the mother's club we went once -- every time we went for a visit, we went to the mother's club. And we made clothes for our babies. And at the mother's club they talked to us about what it meant to have a baby, what was going to happen to you. So you got a lot of information. And certainly you see on television, everybody says, well, my water's going to break right away. And mine leaked, but I wouldn't have known it had I not gone to the mother's club. So that kind of information is very important. Then after my son

was born I had a visiting nurse. She came to help me. And it was just a nice experience because having a child is just very traumatic anyway. It's an experience unto itself. But having those supportive services are very important. And someone said earlier all of those social services, all those programs, are no longer in existence. That would make it exciting for a young girl to want to go and have her baby, if she had access to a mother's club or that kind of thing, which was fun. You met other women and you had dialogue.

But we still have a lot to do, a long ways to go and it's not over yet. And hopefully we can create some noise that we can make a difference.

Again, I want to thank all of you for contending. Those people who came who did not testify, but listened, we appreciate your presence. Thank you very much.

I'd like to thank Ross Associates, Bill Miller, and Janet Parrish who provided the technical -- and Heidi Gold -- I'm sorry, Heidi -- for providing the technical assistance to this committee on this whole issue. And they will be working with us to prepare the report and whatever future

activity we are involved in. We will work with them.

Thank you very much.

(Council recessed at 2:40 p.m.)

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

I HEREBY CERTIFY that the foregoing proceedings of the Council of the City of Philadelphia of Public Health and Human Services, were reported fully and accurately by me, and that this is a correct transcript of the same.

RE: COMMITTEE ON PUBLIC HEALTH AND HUMAN SERVICES

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Lisa C. Bradley, RPR
and Notary Public