CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HEALTH

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B E F O R E: COREY D. JOHNSON
Chairperson

COUNCIL MEMBERS: Rosie Mendez
Mathieu Eugene
Peter A. Koo
James Vacca
James G. Van Bramer
Inez D. Barron
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Rafael L. Espinal, Jr.

A P P E A R A N C E S (CONTINUED)

Dr. Deborah Kaplan, Assistant Commissioner
Bureau of Maternal, Infant and Reproductive Health
NYC Department of Health and Mental Hygiene

Dr. Jane Zucker, Assistant Commissioner
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Elizabeth Holtzman

Sang Hwang, Project Director
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[sound check, pause]

CHAIRPERSON JOHNSON: Good afternoon, everyone. I am Council Member Corey Johnson, Chair of the New York City Council's Committee on Health. I want to thank you all for joining us for today's hearing where we're going to hear three bills: Introductions Nos. 1161, 1162 and 1172. All three bills were introduced by my friend Council Member Elizabeth Crowley and would—would require reporting from the Department of Health and Mental Hygiene. The first Bill Introduction 1161 would require reporting by the city on HPV vaccination rates. HPV vaccines protecting its many strains of Human Papillomavirus, and can prevent many instances of cervical cancer, anal cancer, vulva cancer and vaginal cancer. This—this vaccine is recommended by the World Health Organization, the Center for Disease Control, and other medical experts for pre-teen and teenage girls and boys as well as some older men who have sex with men, and people with compromised immune systems. The Department of Health and Mental Hygiene collects immunization data through the Citywide Immunization Registry Citywide Immunization Registry, and I believe that this anonymized data should be

publicly available to see how we're promoting vaccination rates. Getting an HPV vaccination rate annually, as this bill would require, would be a good start.

The second bill Introduction 1162 would require reporting by the city on the use of Long-Acting Reversible Contraceptives such as intrauterine devices. Long-Acting Reversible Contraceptives, also known as LARCs, are considered by many to be a convenient form of birth control and have lower failure rates than other common methods of contraception such as oral contraceptives and condoms. The Affordable Care Act requires most private insurers to cover contraceptives including LARCs without a co-pay. Awareness of LARCs has been promoted recently by the Department of Health and Mental Hygiene as part of its Maybe The IUD campaign, which aims to increase awareness of IUDs to inform discussions between women and their doctors. This bill would require the Department of Health and Mental Hygiene to collect data on LARC usage, and to report this data to the City Council to monitor the effectiveness of this campaign and other efforts to

increase awareness on this effective method of contraception.

And finally, Introduction 1172 would require reporting by the city on maternal mortality. New York City's maternal mortality rate improved significantly between the years 2001 and 2010, the latest year analyzed. However, New York City still has vast disparities in pregnancy associated mortality. Black, non-Hispanic women are approximately 12 times more likely to die from pregnancy related causes as White non-Hispanic women. The Department of Health and Mental Hygiene already collects data on maternal mortality, and has published studies analyzing this data in the past, most recently last year. This bill would require annual reporting so the Council and others can monitor the city's progress in lowering maternal mortality rates and disparities in this area. I look forward to hearing from the department and others on these bills today. I want to say that we've been joined by Council Member Jimmy Vacca who is a member of this committee. I want to acknowledge the staff that helped make today happen. David Seitzer the Committee Counsel, Crystal Pond, the Policy Analyst

for the Committee, and Louis Cholden-Brown, my Legislative Director, and before I turn it over to Council Member Crowley for a statement, I want to thank a friend of mine, Elizabeth Holtzman is here today, and is and who is a trailblazer in many ways, elected official in this city, and just a leading advocate on progress women's causes and I—I just am really glad she's here. She's going to testify after the department testifies, and I know she's been in touch with both me as Chair of the Committee, and also Council Member Crowley on some of these efforts, and she has some bigger ideas that she's going to talk about today as well. So with that, I'm going to turn it over to my friend and colleague Council Member Elizabeth Crowley.

COUNCIL MEMBER CROWLEY: Good afternoon. Thank you, a big thank you to my colleague the Chair, Council Member Corey Johnson for hearing this package of legislation today, and for his efforts in advancing equal opportunity, and for being a strong, strong advocate for women's health. This legislation will further improve the health of girls and women throughout New York City. HPV is a cancer causing sexually transmitted disease that is so common that

according to the Center for Disease Control and Prevention, nearly all sexually active men and women will get at some point in their lives HPV. HPV often goes away on its own, but sometimes it doesn't and can linger without any symptoms and lead to many forms of cancer. This is a vaccination that is available for HPV prevention, which is common for girls and boys to receive at ages 11 and 12. The vaccination is administered in two to three doses over a period of six months, and is highly effective at preventing diseases caused by HPV. I believe that the number of HPV infections could be reduced if vaccination rates were made public, and more people were aware of these numbers. I have, therefore, introduced 1161-A to require the Department of Health to publish vaccination rates annually. Data collected pursuant to this bill can be used to determine how effectively DOHMH is reaching targeted groups and determine where early prevention resources are most needed throughout the city.

Long-Acting Reversible Contraceptive or LARCs are among the most effective means of birth control. LARCs can be in the form or intrauterine devices or implants, and depending on the type of

device can last from three to twelve years. Despite the availability of this effective means to prevent unintended pregnancies, research reports have concluded that women are often unfamiliar with LARCs. I have, therefore, introduce 1162, which would require the Department of Health to report on LARC usage rates as part of its annual community health survey. The data collected pursuant to this bill can be used to direct outreach efforts made to inform women about the availability of birth control methods so that they can make the best choices to suit their own lifestyles.

Maternal mortality here and—here at home and in other—sorry. Maternal mortality here at home is another issues we must take a hard look at. All over the world maternal mortality rates are decrease. Studies show that global—global death rates fell by more than one-third from 2000 to 2015, but the United States as a whole is one of the few countries with an increasing number, and in New York City specifically our rates are 5% higher than they national rate. We must make sure that as a place with the best healthcare institutions in the entire world that we do more to decrease maternal mortality rates. The

Mayor's Management Report does not report any data on the rates of maternal mortality. Rather, the Department of Health issues a report every five years. This leaves us with an unclear picture on exactly where we are when it comes to maternal mortality, and exactly what we need to do to tackle these problems. I believe that by having data disaggregated by race, age and other demographic indicators showing the number of pregnancy related deaths that occur on an annual basis along with the information about the leading causes of such deaths and recommendations that local governments can take to prevent these types of deaths need to be made annually. I, therefore, introduce Local 1172 to require such disclosures. I look forward to hearing from the Administration and from all other advocates who are here today to testify, and also before I turn it back to the Chair, I'd like to thank Liz Holtzman for being here today, for her leadership for women and the—the city and I look forward to hearing her testimony. Thank you, Chair.

CHAIRPERSON JOHNSON: Thank you, Council Member Crowley. We've been joined by Council Member Peter Koo who is a member of this committee from

Queens. We are going to now hear from Deborah Kaplan from the New York City Department of Health and Mental Hygiene and Jane Zucker from the department as well. Before they being their testimony, I'm going to have the committee counsel swear you in.

LEGAL COUNSEL: Please raise your right hand. Do you affirm to tell the truth, the whole truth and nothing but the truth in your testimony today, and to answer Council Member questions honestly?

I do. Thank you.

CHAIRPERSON JOHNSON: Thank you very much. Just make sure the mic is close to you, and great you may begin.

ASSISTANT COMMISSIONER KAPLAN: Good morning Chair Johnson and members of the committee. I'm Dr. Deborah Kaplan, Assistant Commissioner of the Bureau of Maternal, Infant and Reproductive Health at the New York City Department of Health and Mental Hygiene, and I'm joined by my colleague Dr. Jane Zucker, Assistant Commissioner of the Bureau of Immunization. I will note and I apologize for my voice. I have a bad cold, and surrounded by things to keep me going, and Dr. Zucker has an injury. So

her leg is raised, but here in full [laughter] ability to respond—to testify and respond to questions.

CHAIRPERSON JOHNSON: The Best public health department in the world.

ASSISTANT COMMISSIONER KAPLAN: [laughs] We're limping here, but ready to go.

ASSISTANT COMMISSIONER ZUCKER: Nothing will stop us.

ASSISTANT COMMISSIONER KAPLAN: [laughs] On behalf of Commissioner Bassett, I want to thank you for the opportunity to testify on these important issues. [coughs] I'd also like to recognize member—Council Member Crowley and the Women's Caucus for championing women's rights in this city, and to thank Speaker Melissa Mark-Viverito. I know she's not here today, but we wanted to thank her for her leadership, and for courageously using her story to reduce stigma surrounding HPD, and to encourage more New Yorkers to get vaccinated. The mission of the department is to improve the health of all New Yorkers and to eliminate health inequities, which are rooted in historical and contemporary injustices and discrimination including racism. It's through this

lens that we focus our work related to maternal, sexual and reproductive health. [coughs] Starting in 20014, the department began a five-year initiative to increase awareness of and access to a full continuum of sexual and reproductive health and related services including the full range of contraceptive methods so that all people can make informed decisions about their sexual and reproductive health, and act on those decisions. We adopted a Sexual and Reproductive Justice framework, which promotes individual choice in body autonomy within the context of our nation's history of reproductive oppression and coercion directed at women of color low-income women. Sexual and Reproductive Justice exists when all people have the power and resources to make healthy decisions about their bodies, sexuality and reproduction. Reproductive Justice is a term coined by women of color in 1994, and from which emerged a framework and a collective sister song led by and for indigenous women and women of color, and Reproductive Justice is the human right to decide if and when you will have a child, and the conditions under which you will give birth or create a family; decide if you will not have

a child and your options for preventing or ending a pregnancy; parent the child or children you want or already have with the necessary social supports and safe environments and healthy communities, and without threat of harm from individuals, organizations or institutions of the state, and bodily autonomy from any form of sexual or reproductive oppression. As part of this approach, we regularly convene a group of community leaders, activists and non-profit organizations known as the Sexual and Reproduction Justice Community Engagement Group where we jointly plan and implement activities. Last fall, we launched a citywide public awareness campaign Maybe The IUD that provided information about the IUD among the full range of birth control options. Stressing the importance of assuring that women who want birth control are supported to choose the contraceptive that best meets their needs. Additionally, we work with local hospitals on a learning collaborative to implement best clinical practices for the provision of contraceptive services postpartum, post-abortion, and in a primary care setting ensuring that reproductive decisions are made with complete information and free of coercion.

[coughs] A key issue that affects sexual and reproductive framework seeks to address the disparities in reproductive health outcomes, which includes maternal mortality. Addressing these disparities is a top priority of the department. Complementing this work are the ongoing efforts of the department to provide clinical services for all New Yorkers at eight STD clinics. Our work focuses on New Yorkers at highest risk of negative sexual health outcomes who face obstacles to accessing needed services elsewhere. In addition, the department has a multi-pronged approach toward prevention of the Human Papillomavirus infection otherwise known as HPV. The most effective way stop HPV is to vaccinate eligible people. In accordance with CD recommend—CDC recommendations, we strongly encourage vaccination for pre-teens and for teens and young adults who were not previously vaccinated. HPV vaccines are up to 99% effective in preventing cervical, vaginal, and vulva infections, which could develop into cancer if left untreated. The vaccines can also prevent anal cancer precursor lesions and likely penile and oro—oropharyngeal cancers. In regard to the bills being heard today, Intro 1161,

[coughs] the Administration supports the intent of Intro 1—1161, which would require the department to report data on New Yorkers' immunization rates for HPD. The department collects data regarding immunization rates by gender and number of doses received through the Citywide Immunization Registry, and we'd be happy to work with the Council to determine the most appropriate way for this information to be shared.

In New York City, HPV vaccine is admin— administered by a broad range of pediatric care providers including public clinics, private practitioners, school-based health centers, and the department's Immunization Clinic. Throughout the Citywide Immunization Registry—through the Citywide Immunization Registry, providers can identify patients who have not received HPV vaccines, and those needing to complete the series and generate follow-up letters or list of patients to call for follow up. To further facilitate HPV vaccinations, the department released a new text messaging recall service, which providers can use without charge.

In New York City as of September 30, 2016, 73% of females and 67% of males age 13 to 17

had at least one dose of HP vaccine, and 50% of females and 42% of males have received all three doses. While we're proud of the progress we've made, we are still far from achieving the national target of 80% coverage by 2020. Nationwide Latinos and lower-income groups have the highest coverage level while Whites in the higher income groups have the lowest coverage. In New York City we find similar disparities in HPV vaccination among people who attend the department's clinics that treat sexually transmitted infections. Geographically, HPV vaccine coverage is highest in the Southern Bronx and Northern Manhattan. It is lowest in Staten Island, Central and Southern Brooklyn and Greenpoint, Williamsburg. The department has undertaken a number of activities to increase coverage citywide and to target practices in low coverage neighborhoods in particular.

Intro 1162: The administration supports the intent of Intro 1162, and supports gathering and sharing information about the use of a comprehensive range of contraceptive methods. We're happy to share the available data when it is collected via the Community Health Survey in an appropriate manner and

look forward to discussing this further with the Council. The department conducts the New York City Community Health Survey annually to gather data on the health of New Yorkers including neighborhood, borough and city estimates on a broad range of chronic diseases and behavioral risk factors. The Community Health Survey is a timely surveillance instrument that is able to inform up-to-date agency priorities, and we determine the list of questions based on their ability to serve this purpose.

In 2013, 2014 and 2016, Community Health Survey collected data regarding contraceptive methods used by women 18 to 44 who had vaginal sex in the prior 12 months, and includes condoms, birth control pills, Depo-Provera, the birth control pill or—sorry, the birth control patch or ring, emergency contraception, IUDs or intrauterine devices. Contraceptive implants, a combination of methods or not method. We know from the Community Survey—Health Survey that among those women who use birth control the most popular methods were condoms in 34.6% of women, and the pill, 23.5% of women. About 8.3% of women using birth control used IUDs or contraceptive implants. Both are also known as Long-Acting

Reversible Contraception. We further note—know that in 2014 58.5% of adult female New Yorkers having vaginal sex who did not use any form of contraception did not intend to become pregnant at the time of their last intercourse. Additionally in 2013, almost 6 in 10 known pregnancies among New York City women were reported as unintended. That's 58%. These data suggest that more can be done to educate women about the range of available birth control options, and ensure that they have easy access to all options. In accordance with the Sexual and Reproductive Justice framework, we do not recommend reporting solely on one specific contraceptive methods. Our goal is not to promote one particular method over another. Rather our goal is to increase access to all birth control methods and support New Yorkers in making the contraceptive choice that's best for them.

Intro 1172: The administration supports the intent of Intro 1172 to share data regarding maternal mortality in New York City, and we look forward to working with the Council to share non-identifiable data as it becomes available. The department currently collects this information through death certificate data and addition

surveillance by pregnancy associated—of pregnancy associated deaths—associated deaths. The department has issued two reports as noted previously: Unenhanced Surveillance of Pregnancy Associated, which are the deaths during pregnancy or within one year of pregnancy from anyone (sic) and pregnancy related mortality, which is a subset of these deaths that are casually related to pregnancy based on data from 2001 to 2005 and 2006 to 2010, and we've provided the most recent report to each of you. A similar analysis of pregnancy associated mortal—mortality data from 2011 to 2015 is currently underway. Additionally, the department conducts routine surveillance on maternal deaths within 42 days of delivery. In 2014, the last date—the last year we have data, there were 23 maternal deaths, and I just brought a copy, and it's available online of our summary of vital statistics, which is usually about two years behind, and on page 39, Table No. 22, reports on the 2014 data. The data shows decreasing maternal deaths, which is consistent with the decreasing pregnancy related mortality ratio, which decreased 48% in New York City from 2001 to 2010. Both reports highlight the unacceptable racial

disparity in pregnancy related mortality in New York City. From 2006 to 2010, Black women, as Council Member Johnson mentioned, were 12 times more likely to die from a pregnancy related cause that white women. Pregnancy related mortality also disproportionately impacts Asian Pacific Islander and Latino women, although not to the same extent as for Black women. Pregnancy mortality—related mortality is associated with obesity, underlying chronic disease and poverty that also disproportionately New Yorkers' Black population. The chronic stress of racism and social inequality contributes to pregnancy related mortality along with racial disparities and other outcomes including infant mortality, pre-term birth and low birth weight outcomes. This past August, the department released a report on the first ever Citywide Severe Maternal Morbidity Surveillance System in the United States, and we also have copy of that report. Severe Maternal Morbidity is defined as a life threatening complication during child birth. Examples include heavy bleeding, kidney failure, stroke or heart attack during delivery. Our surveillance found that the rate of Severe Maternal Morbidity in New York City was higher than the

national Severe Maternal Morbidity rate, and that nearly 3,000 women experienced life threatening complications during pregnancy in 2012. Like maternal mortality we found stark disparities. The Severe Maternal Morbidity rate among Black women was three times that of White women. The department recognizes that improving women's health before pregnancy is critical to reducing maternal and infant mortality, and addressing the unexpected—unacceptable racial and ethnic disparities in birth outcomes. It is our belief that achieving this also requires a particular focus in those neighborhoods most impacted, neighborhoods with high concentrations of people of color and poverty. Furthermore, it requires an understanding of unwillingness to name and address racism and other structural factors past and present, which contribute to negative birth outcomes. Engaging community members and organizations in meaningful dialogue is essential for developing an effective strategy for improving sexual and reproductive health outcomes, and achieving health equity in our city. Thank you again for the opportunity to testify and we're happy to answer any questions.

CHAIRPERSON JOHNSON: Thank you very much. We have been joined by Council Member Robert Cornegy, a member of the committee from Brooklyn as well as Council Member Inez Barron, a member of the committee from Brooklyn. Council Member Crowley, do you have some questions?

COUNCIL MEMBER CROWLEY: Sure.

CHAIRPERSON JOHNSON: Okay. I'm going to turn it over to Council Member Crowley. We're hearing three of her bills.

COUNCIL MEMBER CROWLEY: Okay, I will start with HPV's vaccination. So I—I know that we've come a long way since the vaccination. What years did they—we start? I know when I was younger, it wasn't there most it right?

ASSISTANT COMMISSIONER ZUCKER: The vaccine was first licensed in 2006.

COUNCIL MEMBER CROWLEY: 2006. So we're doing it for 10 years?

ASSISTANT COMMISSIONER ZUCKER: Correct.

COUNCIL MEMBER CROWLEY: Okay, and—but your guess is about half of—half of the teams are not fully vaccinated?

ASSISTANT COMMISSIONER ZUCKER: Well, that's fully with three doses of vaccine.

COUNCIL MEMBER CROWLEY: And that's what you need in order for it to work?

ASSISTANT COMMISSIONER ZUCKER: Right. So the ACIP, which is the Advisory Committee on Immunization Processes, just changed the recommendation for adolescents who are between 9 and 15 years of age, and they now recommend a two-dose schedule if there's a minimum of five months between those two doses. So that's good. That's going to give us a bit more flexibility in terms of getting kids fully vaccinated. Adolescents aren't usually going to the doctor as often, and so I think it—again, it evidences that it should provide us good protection.

COUNCIL MEMBER CROWLEY: Now, I—I see that we administer the vaccination in school health clinics when we have health clinics in schools. Is there a way to recommend this as part of the vaccinations recommended before—before entering high school? It has—and is it—and—and—and what ones are?

ASSISTANT COMMISSIONER ZUCKER: Okay. So HPD vaccine is not required for a school attendance.

The other adolescent vaccines that are the meningococcal vaccines. This year there's a requirement for 7th grade and 12th grade and also the Tdap vaccine, which is Tetanus, Diphtheria and Pertussis. Those are required for school. HPV is not. That would require a change to Public Health LAW 2164.

COUNCIL MEMBER CROWLEY: State Law.

ASSISTANT COMMISSIONER ZUCKER: State Law to include—to include it as a requirement.

COUNCIL MEMBER CROWLEY: And do you think there would be opposition to such?

ASSISTANT COMMISSIONER ZUCKER: I think that would be something we'd need to—it would be worth further discussion.

COUNCIL MEMBER CROWLEY: Right, because it's—it's used, and there are a lot of teens not getting the vaccination, and if it's—there's no downside to the vaccination.

ASSISTANT COMMISSIONER ZUCKER: Right, the vaccine has proven to be very safe and all of the early data shows h ow effective it is.

COUNCIL MEMBER CROWLEY: And—and so maybe it's the messaging. Maybe it's to be called the anti-cancer vaccination?

ASSISTANT COMMISSIONER ZUCKER: Yes, that's what it is. That's what we've been promoting.

COUNCIL MEMBER CROWLEY: Right.

ASSISTANT COMMISSIONER ZUCKER: You know, you can see this in examples, you know, of our toolkit. It's all about cancer prevention. We recommend that doctors are not focused on sex. The minute that that comes up as a conversation we get a negative response from parents, especially when they're talking about their 11-year-old. Often the—the provider isn't really willing to have that discussion nor is the—is the parent. We've done focus groups of parents. We've done in-depth interviews with providers as well. So examples in the toolkit are, in fact, how do you have that conversation? You know, what we want you to do is a child is in front of you in office, and you say so and so is due for three vaccines today. We're going to give you, you know, Tdap, meningococcal and HPD, and move on, you know, and not— It's the same way they do with childhood vaccines. They don't say you

need this, and oh this one is option. We'll wait, but it is not required for school, and we know that happens. It's why we've been working very hard on the messaging with providers.

COUNCIL MEMBER CROWLEY: Are you holding providers accountable, or do you have an idea if one provider has more of the higher vaccination rate versus another?

ASSISTANT COMMISSIONER ZUCKER: So the— all providers, pediatric care providers in the city get a report from us twice a year on their adolescent coverage, and we tell them how well they're doing on HPD vaccine coverage, and we tell them how well they're doing against their peers. So their percentile ranking, and we also do what—these assessment visits in doctor's offices. We go to about a quarter of all pediatric care providers across the city, and we give doctors very specific feedback on their vaccine coverage, what they're doing well, what they're doing wrong, and give them— we give them a toolkit and we give them guidance on how to improve their workflows to increase HPV vaccine uptake in coverage.

COUNCIL MEMBER CROWLEY: And a child can get the vaccination without the parent present if they want to?

ASSISTANT COMMISSIONER ZUCKER: So the—it's in the context of sexual—getting sexual reproductive care, and—and that's been where some of the confusion happens, but fore most pediatric practices the—you know, I think it's up to the practice what they're—what they're doing and whether a child is in for a routine visit. It's a rough one.

COUNCIL MEMBER CROWLEY: [interposing] But you have all the information, right?

ASSISTANT COMMISSIONER ZUCKER: Yes.

COUNCIL MEMBER CROWLEY: Providers have to provide the information when they provide this vaccine?

ASSISTANT COMMISSIONER ZUCKER: Absolutely. We get everything reported from the register.

COUNCIL MEMBER CROWLEY: So—so then you would—so once we get the numbers we'll be able to see if there are certain zip codes and there are certain doctors within the zip codes. We had a falling shore. (sic)

ASSISTANT COMMISSIONER ZUCKER: Right, of course, and we know that. I mean I think we've—yeah, there was a question on that.

COUNCIL MEMBER CROWLEY: I didn't see that, no.

ASSISTANT COMMISSIONER ZUCKER: Yeah, so we can—these are from the community health profiles and this atlas was part of it.

COUNCIL MEMBER CROWLEY: Of higher rate sections.(sic)

ASSISTANT COMMISSIONER ZUCKER: Right, so we do know where the higher coverage neighborhood are. We know where the lower coverage neighborhoods are and, in fact that's how we've targeted our outreach efforts. Clear back in 2015, e actually did nurse-led provider visits. So that was really designed to have a sort of peer-to-peer education among the healthcare staff, working with them to educate the staff why—why HPD vaccine was so important. How to deliver effective messages, and tell them how to improve again, you know, workflows to increase coverage and, in fact, we saw a 28% increase in vaccination in those practices.

COUNCIL MEMBER CROWLEY: Right.

ASSISTANT COMMISSIONER ZUCKER: We think those are tremendous so the self--

COUNCIL MEMBER CROWLEY: Is it—is it the parents do you think are the reason that these kids are not getting vaccinated?

ASSISTANT COMMISSIONER ZUCKER: [interposing] It's a—honestly, it's a combination. It's a combination of a—-of the parent. You know it's anecdotal. I've been in our own immunization clinic where an adolescent was telling her mom she wanted the vaccine, and the mom was, No. I mean and I—I couldn't even reason with the—with the mom to get the child vaccinated and, you know, we've also we did in-depth interviews with providers and, you know, the truth is that there are many providers who have maybe not the most up-to-date or their own misinformation about the vaccine.

COUNCIL MEMBER CROWLEY: Right.

ASSISTANT COMMISSIONER ZUCKER: We're very pleased that we got a new grant from the Center for Disease Control and, in fact, it's going to allow us to fund more nurse-led visits. We've shown that they were effective, and it's a—it's going to allow us to fund more peer-to-peer education. So it's

going to be physician to physician, education to try to counter a lot of these misconceptions that we've seen.

COUNCIL MEMBER CROWLEY: So you have—you say that the department has enough money to get the message out there to—to get better results in that area?

ASSISTANT COMMISSIONER ZUCKER: [interposing] So I—I do have money for the—you know, we did—we have done effective media campaigns. I think they're—you know that can be a follow-up conversation also in terms of what the, you know, what we can do in addition if there was additional funding.

COUNCIL MEMBER CROWLEY: Okay. So if you had additional funding you could use it?

ASSISTANT COMMISSIONER ZUCKER: Right.

COUNCIL MEMBER CROWLEY: I'm going to go into questions about the LARC. In your testimony you said 58% of I mean of pregnancies are unintended.

ASSISTANT COMMISSIONER ZUCKER: Uh-huh.

COUNCIL MEMBER CROWLEY: How do you get that type of information? I'm surprised that you know. We have such a strong handle on the data.

ASSISTANT COMMISSIONER KAPLAN: Well, it's a—the calculation around unintended pregnancy takes—takes into—it's based on survey data where women are asked whether the pregnancy that women are asked through our planned survey, which is surveillance, too, for all—it represents women who give birth in New York City and they're asked if the—if the pregnancy occurred sooner than they wanted, at the right time, later than—or did they not want to be pregnant? It's set to their side of questions to assess whether this was a planned pregnancy or not, and we--

COUNCIL MEMBER CROWLEY: [interposing] And do you know what that percentage for those pregnancies that go full term?

ASSISTANT COMMISSIONER KAPLAN: We—we actually have that data for women who give birth as well.

COUNCIL MEMBER CROWLEY: And do you know what that is?

ASSISTANT COMMISSIONER KAPLAN: I can't tell that, but we can get back to you on that.

COUNCIL MEMBER CROWLEY: So—so you know-- from the 58% do you know how many were using LARCs? I know you said you have a--

ASSISTANT COMMISSIONER KAPLAN: [interposing] No, we don't have it broken up that way, but what we did have, which I think was an interesting specific, which I'll restate. Give me one second. So, 58.5—50—about 59% of adult females who were having vaginal sex who did not use any birth control didn't—stated that they did not intend to be pregnant at that time. So they had that. There were at risk of getting pregnant because they had vaginal sex and, you know, we wanted to pull out women who were trying to get pregnant. So for women who did not intend to get pregnant, over half of those women did not use birth control.

COUNCIL MEMBER CROWLEY: Okay.

ASSISTANT COMMISSIONER KAPLAN: Which to us is a good way of trying to understand if we pull out really the women who don't--

COUNCIL MEMBER CROWLEY: [interposing] Right.

ASSISTANT COMMISSIONER ZUCKER: --want to be pregnant, what percent are actually using birth control.

COUNCIL MEMBER CROWLEY: Are you aware of Colorado's are doing it or a program that is administered, focused heavily on a campaign to install the LARC--

ASSISTANT COMMISSIONER KAPLAN: [interposing] Uh-huh.

COUNCIL MEMBER CROWLEY: --in women and that they saw their rates of unintended pregnancies drop 40% in only a few years.

ASSISTANT COMMISSIONER KAPLAN: Yes, we are familiar with that study and other studies, and as we've been looking out of New York we also know that, you know, those were—that's very important work, and we know that there have been many barriers to IUDs and implants or LARCs, and that there's been much success when it—when costs and other factors are removed. But we also know that sometimes there are people who are self-selecting themselves into studies like that, and so—and what we—we—we look at data in New York City, and in providers where we know every method is available, and that there are no barriers.

Some of our partner providers who—who operate with really good practices around access, and we're not seeing anything near 80%. We're seeing more like 30 or 40%. I think what we're very concerned and I stated this in my testimony is that we—because of the history of coercion around contraception particularly for women of color, the fact that we know that birth control has been used to—as population control. We know that there is a very tragic history even in this country of women being sterilized without their consent, including Mexican-American women in California, and we know that in Puerto Rico many women were sterilized without their consent. And even as recently as 15 or 20 years ago, welfare reform in some states was tied to women using birth control and having fewer benefits if they—if they did have another child, and—and—and we know from many conversations with partners in the community and organizations led by women of color nationally that there's been a lot of concern about the way LARC methods have been promoted, and that instead of centering women, putting women in the center and women's choices, let's put LARC in the center. And I think one thing we've—we've heard from our partners,

and actually we heard it when we did our Maybe The IUD campaign. Women in the community reached out to us, and it's what led to us forming our Sexual Reproductive Justice Community Engagement group. That—while IUDs we have to remove all barriers to IUDs and, in fact, we—our Health Department played a major role in working with the state to get IUDs available immediately following delivery, and to have a carve-out for that benefit. We feel very strongly that we need to center women, and then make all those methods available. One thing we've heard from women is that not all women and particularly women of color who were concerned about coercion and bias, don't necessarily trust the messaging from their providers. They believe that providers offer certain methods based on their race and ethnicity, and they feel—and they feel that sometimes providers say something different depending on their race and ethnicity. So we feel—and that effectiveness isn't the only criteria. Some women want a method they can control, and they can't control IUDs. And so—and there's been issues of women not being able to get them removed, and so I want to be clear. I fully support and we're working very hard to removed barriers to IUDs and

implants, but we think it's critical that when we talk about it, we talk about it in the context of all contraceptive methods, and report all methods not just IUDs because it—it privileges one method over another when for many women that's not the main part--part.

COUNCIL MEMBER CROWLEY: [interposing] Is it difficult to remove one? Can the woman go to go a Planned Parenthood or a local clinic?

ASSISTANT COMMISSIONER KAPLAN: [interposing] It's not--

COUNCIL MEMBER CROWLEY: --to get that removed?

ASSISTANT COMMISSIONER KAPLAN: -- difficult technically to remove an IUD, but I don't think that's what you meant, but in terms of access, if someone loses her insurance and frankly—-I mean I'm sure you've heard in the papers of women who are now this large—rapid increase recently in women going to Planned Parenthood for IUDs since the elections, and I think people are afraid if they lose their insurance—what if they lose their insurance, and they're not able to go and get it removed? That was a legitimate concern.

COUNCIL MEMBER CROWLEY: I was under the impression that with Planned Parenthood and other public health institutions in the city that we would offer all types of birth control to those who may not have insurance or are under-insured?

ASSISTANT COMMISSIONER KAPLAN: Right. Yes, so in New York City we're very fortunate in New York States that we have federal funding to—right now Title 10 funding.

COUNCIL MEMBER CROWLEY: Should we have people fear that—that—if—if they were to install something like this that they could not do a reversal because we don't know the future of healthcare agencies?

ASSISTANT COMMISSIONER KAPLAN: Well, I—I think it—I'm not worried in New York City. I'm telling you—I guess what I was getting at--

COUNCIL MEMBER CROWLEY: [interposing] Our focus is on New York City?

ASSISTANT COMMISSIONER KAPLAN: Yes.

COUNCIL MEMBER CROWLEY: I just want to other people on the line>

ASSISTANT COMMISSIONER KAPLAN: [interposing] In New York—No, you could—yes, in New

York City, we are—we are a beacon of reproductive rights in New York City and New York State, and we feel very confident. Our Mayor had said that very publicly that we will assure that nobody loses their benefits. I was speaking to concerns women have whether--

COUNCIL MEMBER CROWLEY: [interposing] Yeah.

ASSISTANT COMMISSIONER KAPLAN: --whether that will come to class or not.

COUNCIL MEMBER CROWLEY: Okay, and now the last known year that you have data on maternal mortality is from 2014. Is that where you said we had 23?

ASSISTANT COMMISSIONER KAPLAN: Yes, and that needs to be clear. The report that you referred to earlier. So we have reports that do what's called enhanced surveillance, and that has much more in-depth information and it goes to a year following pregnancy, following delivery--

COUNCIL MEMBER CROWLEY: [interposing] And I propose to make sure that that's an accurate number because even in our city we're collecting I don't know, compare it to construction fatalities,

but there was just an article saying that there are actually a third more than the number that the City actually has because they didn't calculate OSHA related deaths or where. (sic) It's not a question. I mean it was just a—I just want to make sure that that's that the real number.

ASSISTANT COMMISSIONER KAPLAN: Well—well, so what I want to say is the--

COUNCIL MEMBER CROWLEY: [interposing] Yeah.

ASSISTANT COMMISSIONER KAPLAN: --the number that I stated for 2014 that is routinely surveillance and it's based on a check-off box on the death certificate that says that the woman was pregnant. So we—and it is the reason we know that doesn't get at every death--

COUNCIL MEMBER CROWLEY: [interposing] Right.

ASSISTANT COMMISSIONER KAPLAN: --and—and one, someone could just forget to check off the box.

COUNCIL MEMBER CROWLEY: So as a—a professional working for the city, you—you realize this is probably not the accurate number, and—and there's probably--

ASSISTANT COMMISSIONER KAPLAN: [interposing] Well, that's why we do enhanced surveillance. So that's—the reports that I referred to and that you have a copy of, which take longer to do--

COUNCIL MEMBER CROWLEY: [interposing] Yes.

ASSISTANT COMMISSIONER KAPLAN: --is where we have an obstetrician and gynecologist who reviews every chart. We look at the Office of the Medical—Medical Examiner. We look at hospital discharge data and actually if you compare the data and vital statistics to what we get in our enhanced report, our numbers are higher, and we also don't just look at pregnancy related deaths. We look at deaths for example if a woman dies from homicide during her year after pregnancy that's something that can inform issues or concerns potentially around domestic violence. So we—we feel it's critical to go beyond what we can do from the death certificate. What's good about that is we can get data out sooner. We've now committed because of this—these findings and the major disparity, we've realigned the staffing in my bureau, and we now have a full-time person who

started two months ago. Her full job is Maternal Morbidity and Severe Maternal Morbidity Surveillance. And so we feel we're going to move forward in a way to have more rapid for that.

COUNCIL MEMBER CROWLEY: [interposing] I'll probably circle back later, but I know that the Chair and others have questions. Thank you.

CHAIRPERSON JOHNSON: Thank you, Council Member Crowley. [coughs] Before I got to Council Member Barron—before I go to Council Member Barron, I had a few questions to follow up on Council Member Crowley's questions. So you mentioned that the HPV vaccination rates are currently lowest but improving on Staten Island Central and Southern Brooklyn, and Greenpoint in Williamsburg. Why do those communities have the lowest vaccination rates?

ASSISTANT COMMISSIONER KAPLAN: Well, I think that's a good question. I thin kit tracks racial and ethnic disparities that we see, which, in fact, are reversed disparities for this vaccine. When we [coughs] did our interviews with the providers we were very surprised that the providers were sort of cherry picking their adolescents. I didn't have practices in place to routinely vaccinate

every child. So we have, you know, in the registry part of what we offer, our physician support so that if a physician doesn't make a decision about which child needs what vaccine, if there's 11-year-old who comes in, you know, gets an HPD vaccine. But, in fact, there was a lot of cherry picking. You know, this—this girl needs it now. You know, this boy can wait [coughs] and it's not best practice, and so that's the kind of education that we provided. There could also be some underreporting. We get better vaccine reporting from lower income neighborhoods because they get the vaccines—for children's vaccines given to them for free and for accountability. They need to report better. So some of the—there may be some again difference in reporting as well. We do hear from some of the communities you mentioned. There are some additional—whether it's religious or—or cultural beliefs, we are talking about sex at that early of an age as somewhat of a taboo, and not part of the routine sort of provider patient interaction. It's part of what we hope to address with the physician to physician peer education that I—that I mentioned.

CHAIRPERSON JOHNSON: Does any of this have to do with religious objection?

ASSISTANT COMMISSIONER ZUCKER: Not religious exemption per se. I think it's in part and we sort of more--

CHAIRPERSON JOHNSON: [interposing] Not exemption, objection.

ASSISTANT COMMISSIONER ZUCKER: Objection, no—no I would--

CHAIRPERSON JOHNSON: When I saw that the—that the—one of the neighborhoods with the low—I'm not trying stereotype here--

ASSISTANT COMMISSIONER ZUCKER: Yeah, I know that.

CHAIRPERSON JOHNSON: One of the neighborhoods with the lowest vaccination rates is Borough Park, and so I'm wondering is that their rent 20% of the population there is reported as not being vaccinated. Does that have anything to do with any sort of cultural or religious differences?

ASSISTANT COMMISSIONER ZUCKER: Well, see, yes, I didn't mean object—exemption. It's more of a—it's not religious as much as philosophical as much as not talking about having those conversations

about sex with a—with a young child or having—or thinking, you know, there's more of a thought. Well, this child is adolescent. They can have sex until [coughs] until they're married, and they don't need the vaccine yet. So, you know, so they can wait. You know, one of the physicians that we're hiring for our peer-to-peer education is actually—actually from the community, and we hope we can do better sort of education that way. They can be better accepted, and we can find better culturally appropriate messages.

CHAIRPERSON JOHNSON: So you mentioned to Council Member Crowley that the state law would not be changed for the—the school based requirement on HPD vaccinations. Does the city stand in support of changing state law? Does the city have a—have a position on that?

ASSISTANT COMMISSIONER ZUCKER: Well, the city does not have an official position on that. [off mic] We'll have to deal with it.

CHAIRPERSON JOHNSON: We should have—

ASSISTANT COMMISSIONER ZUCKER: [interposing] I think we—

CHAIRPERSON JOHNSON: --we should have apposition on it.

ASSISTANT COMMISSIONER ZUCKER: We should. I mean I think we would—I think we can bring it up for—for a discussion officially.

CHAIRPERSON JOHNSON: Okay. [coughs] And has there been any progress in investigating whether the HPD vaccination is as effective and in two does as-as well as, you know, you're supposed to get three doses as well as, you know, you're supposed to get three doses. But what is the sort of success rate if you get two doses? How—how—how good is that?

ASSISTANT COMMISSIONER ZUCKER: Yeah, so the evidence for that looks good. So that recommendation was changed in October by the Advisory Committee on Immunization Processes, and so that's now the recommendation from 9 to up to the 15th birthday. Those adolescents can get two doses as long as they're five months apart, and we're actually making those changes on the Immunization Registry for the decision support, and we've sent notification to all providers after that October vote to let them know about the change. [coughing] In fact, our phone rang off the hook the next day because providers are really quite excited about that change.

CHAIRPERSON JOHNSON: We've been joined by Council Member Majority Leader Jimmy Van Bramer who is a member of the committee. So, in the—in the testimony you presented to us, Dr. Kaplan, you had said that the Community Health Survey that 34% of women and the most population method for contraception was condoms. The pill was 23.5%, and about 8% of women using birth control used IU—IUDs or contraceptive implants. So is 8.3% considered low if we look at other municipalities, other cities, other states is that a low number?

ASSISTANT COMMISSIONER KAPLAN: [off mic] I think [on mic] I think based on looking at other areas it has got increased. I'd say with full access and based on even looking at other providers where we look at when there's full access, the number is usually higher. So I would say that this likely reflects barriers—still barriers to this option.

CHAIRPERSON JOHNSON: And is there a target goal of what that number should be?

ASSISTANT COMMISSIONER KAPLAN: We don't feel comfortable setting a target for a contraceptive methods because that certainly---

CHAIRPERSON JOHNSON: [interposing] It's a personal choice.

ASSISTANT COMMISSIONER KAPLAN: Exactly, and also, you know, from a—from a government agency but from anyone setting a target can lead to a provider behavior that feels like okay we have to meet our targets as opposed to really guiding—being guided by what the woman's needs are.

CHAIRPERSON JOHNSON: It's a coercion fear--

ASSISTANT COMMISSIONER KAPLAN: Yes.

CHAIRPERSON JOHNSON: --that providers will be coercing women to--

ASSISTANT COMMISSIONER KAPLAN: [interposing] Well--

CHAIRPERSON JOHNSON: --take a certain path.

ASSISTANT COMMISSIONER KAPLAN: Or—or be—feel motivated to prioritize or, you know, privilege a particular method as opposed to saying, you know, what's starting with the woman, what is your lifestyle? What is going on? I mean we've always in New York City prided ourselves on reproductive choice, and the idea behind that is no matter how

great the method, we think medically that we—we start from what a woman's needs are, and make sure—many times women will come in with misinformation about IUDs or other methods and we want to clear that up and make—and it's why we did the Maybe The ID—IUD campaign was a playful campaign to help people go oh, what is that, and then—but then when they go to our website, they see all the methods, and we want—we want to remove this. We want to remove financial barriers, but we don't want to have a target.

CHAIRPERSON JOHNSON: How much does the City spend on—not on the campaign but on IUD access? So put the campaign—put the media campaign aside, how much do we spend on contraceptive access?

ASSISTANT COMMISSIONER KAPLAN: So I'd have to—so there are two major areas where we're doing this work, and I'm going to probably have to get back to you with the amount, but one is that we have $250,000 a year for a five-year campaign, but campaign in the broader—broader sense, not just maybe the IUD. This is what we've been used to form our sexually protective justice community engagement group, which has over 35 community-based organization working with us to develop a campaign, and it's

actually a way—a new way of working that we have never worked before certainly in my bureau. It's really guided by Dr. Bassett's message around how we engage community, but we're not going in and saying this is what we're going to do. We have shared leadership and joint decision making, and actually we launched a Sexually Protective Justice video, which is available on our website. It's a four-minute long very powerful video that we've gotten some great feedback on. So that's—the $250,000 includes consultants and training. We had community consultations, all of that are gathering information from over 250 women in 10 locations around the end man, around the city and transgender men and women around issues related to reproductive justice and contraction and other issues. So that's one piece. The other is our Quality Improvement Network for Contraceptive Access where we currently work with ten hospitals to implement the ten best practices around access to contraception postpartum, post-abortion, and primary care. And that is approximately for the—paying a consultant it's about $200,000 a year. There's also all the in—the staff time and other materials. So between the two, I'd say we're close

to half a million, and maybe there's somewhat more, but that's about what I would estimate right now with these things. (sic)

CHAIRPERSON JOHNSON: And [coughs] does State Medicaid pay for IUDs for qualifying women? Is that covered?

ASSISTANT COMMISSIONER KAPLAN: Yes, and with the Affordable Care Act, basically it's a—it's a core preventive service. There's no co-pay. If you have insurance through the Affordable Care Act there is no pay—co-pay for women's healthcare including any contraceptive method that's been approved by—by the FDA, which includes IUDs.

CHAIRPERSON JOHNSON: So the city's Department of Health and Mental Hygiene's STD clinics when a woman goes to an STD clinic to get a test or get a vaccination, can they request an IUD at that vaccine—at that STD clinic and receive one?

ASSISTANT COMMISSIONER KAPLAN: So currently at the STD clinics the only method of contraception that you can receive is emergency contraception, which is a method—an oral method that is really post-coital after someone has sex, and

within 120 hours they can use this to help prevent a pregnancy. If they had on a particular--

CHAIRPERSON JOHNSON: [interposing] How come that I—how come that IUDs?

ASSISTANT COMMISSIONER KAPLAN: That right now that is the only method available through STD clinics. I mean we—that's—that's—the focus has been on STDs, and one—the one method has been IUD. I'm sorry, emergency contraception. However, we have a wide range of family planning clinics and providers throughout the city where the STD clinics would refer women who want the other methods, and we've developed the Teams in New York City apps that makes it very easy for young people and we're working on an adult one called Doing it in New York City that will help people find where they can go for free or local options for birth control.

CHAIRPERSON JOHNSON: I understand but—but if we're going to talk about sexual health holistically, and if someone got an STD and is going to get treated, and during the course of their examination with the medical provider, they're talking about their sexual history, wouldn't it be good instead of making them go an additional step to

go to an additional provider, a referral? Wouldn't it be good to actually sort of offer the services there?

ASSISTANT COMMISSIONER KAPLAN: I think your point is very well taken. I can't—we don't have that right now. I think it's something that I—we will bring back to the department and talk with—with folks there about.

CHAIRPERSON JOHNSON: Because we want to ensure especially I would think that in some of the areas where the STD clinics exist, Upper Manhattan, Central Brooklyn and other places, where some of the community health survey data shows disparities, racial disparities to create an additional step instead of working to fight those disparities. Where they're interacting with the city, I think would make sense.

ASSISTANT COMMISSIONER KAPLAN: Uh-huh, and I think it's a very good point. I think we'll need that further discussion about, and CHAIRPERSON JOHNSON:

CHAIRPERSON JOHNSON: Okay. Lastly, and then I'm going to go to Council Member Barron. So, in a health committee hearing in November of 2013

before I was here at the Council, you, Dr. Kaplan I'm told stated that the department planned to assess the effectiveness of an outreach effort to clinicians to prevent maternal deaths due to hemorrhage. Has that assessment been completed?

ASSISTANT COMMISSIONER KAPLAN: So in—not quite in the way it was describe, but it is—we have worked on it. So just to-I remember that testimony, and we were sharing information on seeing the numbers around hemorrhage as a cause of maternal death, and knowing that often that is a cause of death that is preventable. And we developed posters. We worked with training with providers. We worked with a number of OBGYN providers at all of the maternity hospitals. Since then, we have partnered with the American Congress of Obstetricians and Gynecologists, which is the professional organization that represents all obstetricians and gynecologists in the city, and they implement something called the Safe Motherhood Initiative, SMI, and through different funding streams have developed what they call bundles, which are preventive measures to take during delivery around the most common causes of material death, and one of those is hemorrhage. And so we are

partnering with them on the Safe Motherhood Initiative. They now have 33 of the 40 New York City Maternity Hospitals, and I can provide you with a list of which ones. We were involved in implementing these bundles, which are evidenced based approaches to treating a hemorrhage to reduce the risk of a woman dying from hemorrhage. So, our follow up has really been through partnership with a cog that took this on as major part of their work.

CHAIRPERSON JOHNSON: So you mentioned it in your testimony, but I think it's worth repeating, and Dr. Bassett has talked a lot about the institutional systematic racism that exists in our healthcare system, and the importance of, you know, culturally competent healthcare that's provided to specific demographics and populations. The numbers I think are stark and appalling that the severe maternal morbidity rate among black women was three times that of white women, which is like horrifying. And that the black women were 12 times more likely to die from pregnancy related causes. I mean it's like— it's horrifying.

ASSISTANT COMMISSIONER KAPLAN: Yes.

CHAIRPERSON JOHNSON: So, has the rise in health insurance coverage due to the Affordable Care Act has this impacted maternal morbidity or mortality in any way? Do we know?

ASSISTANT COMMISSIONER KAPLAN: We—we know and I wasn't able to—we know that many more women of reproductive age are covered by health insurance, which means they have access to both contraception and prevention of a—of an unplanned pregnancy or if they don't want to be pregnant and access to primary care. We don't—and we—we looked into that because thankfully you did share that question ahead, and we did not—we're going to continue to look at it. We were not able to find data at this point that could indicate whether that—we know that it's increased the women who we would be concerned about being enrolled and being covered. But I—I think it's important to note that in New York City we have a long history of women who are pregnant being able to be covered by Medicaid regardless of immigration status. So, you are pregnant, you are able to get Medicaid, and you continue to be covered, and it's up to 200% of poverty unlike regular Medicaid, which is not 200% of poverty. So it's a

wider net, and it's regardless of immigration status, which as we know isn't true for Medicaid when you're not pregnant. So almost all women in New York City who give birth are—have insurance and that was true before the Affordable Care Act.

CHAIRPERSON JOHNSON: And do we know what the maternal mortality rate [coughs] excuse me—do we know what the maternal mortality race disparities are when chronic conditions and insurance coverage are controlled for?

ASSISTANT COMMISSIONER KAPLAN: We don't have data in that manner. What we do is look at chronic illness and the association between having a chronic illness, and that's in our—actually included in the reports that we shared with you, and—and found that if you are obese, if you have one or more chronic condition including Diabetes and hypertension, you're at much greater risk of severe maternal morbidity or mortality, and if you're a black women, you are much more likely to have what we call these co-morbidities that put you at risk of a very serious complication or even death.

CHAIRPERSON JOHNSON: And then [coughs] you mentioned the Quality Improvement Network for

Contraceptive—Contraceptive Access QINCA. It's the [coughs] the local hospitals that participate. [coughs] Right now there are ten?

ASSISTANT COMMISSIONER KAPLAN: Yes.

CHAIRPERSON JOHNSON: Are there plans to expand that to beyond ten?

ASSISTANT COMMISSIONER KAPLAN: Yes, we have a second cohort that we call them cohorts that are starting in January. We have definitely—it's an application process because we need the CO of the hospital to approve it, but you really need leadership buy-in to make this happen, and—and we now have six. Hopefully two more will join, and we're hoping to have a least eight. We can take up to ten hospitals to work with us, and they sign onto work on ten best practices that and, which include— And I think it's important to stress given what we're talking about at that bias and—and institutional racism that part of their training is on ensuring that reproductive decisions are made free of coercion and they have to agree to that. And actually, today at Brookdale Hospital, which is one of the hospitals working with us and as you know located in Brownsville, serving a population that often has some

of the worst outcomes around birth outcomes. Dr. Lyn Roberts who is part of our community engagement group for Sexual and Reproductive Justice is doing the grand rounds on Sexual and Reproductive Justice. It's not just about contraception. So we're actually trying to make it normative that we talk about issues around the impact of bias and coercion on the care, and people comfort going to their provider and feeling like they can get good care. So we see that as part of this work.

CHAIRPERSON JOHNSON: And participating hospitals are both hospitals and the Health and Hospitals Network, our public hospital system and non-public hospitals?

ASSISTANT COMMISSIONER KAPLAN: Yes, we made it a point, and we know that they way all—all hospitals serve low-income families. We've tried to focus on hospitals that have a higher percent of families of color and low-income families. But yes, like Brookdale is a good example.

CHAIRPERSON JOHNSON: And is—is—do we have hospitals participating in all five boroughs?

ASSISTANT COMMISSIONER KAPLAN: We—in the first cohort, we do not. I don't—we haven't made

selections for the second cohort, and like our breast feed—our Baby Friendly Hospital Learning Collaborative, which is another collaborative we have both Staten Island hospitals participating. So far we do not have a Staten Island in our first cohort, and I have to get back to you on whether they applied for the second, but we reach out to all hospitals.

CHAIRPERSON JOHNSON: We should try to get them in the second cohort.

ASSISTANT COMMISSIONER KAPLAN: I agree.

CHAIRPERSON JOHNSON: Okay. I want to turn it over to Council Member Barron.

COUNCIL MEMBER BARRON: Thank you, Mr. Chair. Thank you to the panel for coming. My mic has got a little reverberation in it. So if you could clear that up, I would appreciate it. Thank you so much. I'm very concerned about the racial disparities that exist when we talk about healthcare, and I'm very concerned about the fact that African-Americans know that historically we have been used in experimentation, and we've been not—we have not given consent. We've been uninformed, and as recently as 1972, which is when the Tuskegee Syphilis experiment concluded, we were being used as guinea pigs. We

were not told. We were not even given treatment, which had been proven to be effective in addressing the issue of Syphilis, Penicillin. It's unconscionable that that happened. We can go back beyond that, and we talk about Harriet Lack, who is the origin of the HeLa cells, which has led to so much of the medical work that has been done trying to address the issue of cancer. She was not informed of the fact that her cells were going to be used. She did not give consent in that regard, and we can go back to the more than I think 30 women, who were subjected to the tortuous experiments of Dr. Marion Simms, J. Marion Sims called the father of gynecology. Women on whom he experimented without their consent. They were enslaved Africans, so they didn't give their consent, and were subjected to tortuous experiments without the benefit of anesthesia even though it was coming into vogue, and even though when he used his procedures on white women, he used anesthesia. So there's a history in my community of not trusting medical people. It's not the doctor that we knew. It's not the doctor that we have any confidence in. So that's certainly is a huge hurdle that needs to be addressed as we

talk about going forward and trying to get this vaccine approved. I have not recommended—I understanding medically, you know, I majored in physiology so I've got a little bit of a science background even though it's very ancient now. But people who come and will question how—how safe is this, and are we being used as guinea pigs, and how do we know for sure that this is not something again? How do we know that the vaccines that are coming in our community are of the same caliber or strength or meet with qualifications that exist in other communities? So it's a real issue, and I know that in report, I looked in your report and East New York is rated I think the fifth highest of pre-terms births, births that occur before 37 weeks, and there's a real concern. There's a real issue. There's a—a gap between the—the services that we get, the conditions that we endure, and any faith that exists with the community, with the—the medical community at large, and I'm glad you mentioned Brookdale. That's one of the hospitals that's in my district, and we're working with them and trying to develop a program with them that meets those kinds of needs. But how do we address this historic

documented incidents of African-American women and men being used in experiments, and not getting the adequate care that they are entitled to.

ASSISTANT COMMISSIONER KAPLAN: Well, thank you so much for your statement and questions, and I'll start and I don't know it Zucker might want to add specifically or HPD, but that's exactly why we in—in my bureau on Maternal, Infant and Reproductive Health and with Dr. Bassett's support and leadership adopted the Sexual and Reproductive Justice framework because we literally had women of color from the community as well as from national organizations like an organization called Sister Song, Women of Color Collective for Reproduction Justice coming to us and saying we can't talk about contraception for example without acknowledging the history of reproductive oppression, and the continued bias that women of color and particularly black women and Latino women face when they receive care. And so we really went on a journey that started about a year and a half ago where brought partners together to talk about what does that mean, and how do we make that part of our work, and incorporate that. Because we know there's mistrust, and understandably so since governments

have to acknowledge the role that government actually played in whether it was Tuskegee or sterilizations that happened, you know, previously without knowledge and other experimentation. So we feel we have to speak openly and honestly about that, and acknowledge it, and then work with in the diverse group of—that represents women in the community, national leaders, and that's exactly what we've been doing. We developed—one of our fist steps we decided was to develop this video call on Sexual and Reproductive Justice which is on our website. It was just launched last month, and what it does is it's women's stories in our group about what happened to them, their experiences of getting a C-section with nobody telling them anything about why it was happening. About having—being assaulted sexually, and self-medicating because—about learning, getting sick and never seeing someone who looked like them, a black woman who's a lesbian and never seeing a picture or any image of women in love. So all these stories where women don't see themselves, and that particularly women of color become invisible. So that is how we're now framing our work. We're using that framework, and I think it's—the other thing I

want to say is we're now launching our Neighborhood Health Action Centers in North and Central Brooklyn, in East and Central Harlem, and in the South Bronx, and as a part of that, we are opening women's health suites. 311 is already working and operating in East Harlem, and we're looking for those to be a place of—of hopefully sanctuary for women to go to for a space, and—but also for activities and support and linking women to services. Those are in development, and we see partnering with community partners in Brownsville and other communities where Neighborhood Health Action Centers are to move the work forward. So I—I couldn't agree more with what you just said, and it's exactly how we're moving forward in how we're doing this work now, which is a real change from previously in terms of how we're engaging this community to speak openly about these issues, and making that part of the conversation as we move forward.

ASSISTANT COMMISSIONER ZUCKER: Yeah, I'll just address the first part of your comments about vaccine safety. We get a lot of questions. I think that's general around vaccine safety. Perhaps more with the HPV vaccine. There's—there's still

some sense that it's new even though it's been around for—for ten years. More than 60 million doses have been administered. It has a long track record and we know the vaccine is safe. In the toolkit that we had distributed, there's also information for parents to learn about the vaccine that it's effective. What it does, how it works, and about vaccine safety, resources where they get additional materials. There's also a health bulletin that we developed to talk about HPV vaccine. All of those materials have been made available to all pediatric care providers as well as to the school based centers. All of the materials are available in—in English, but also in the nine additional DOE languages to make sure that people have access to it. So I think, you know, we need to really educate both the providers, and the providers have unfortunately the same questions that, you know, many of the parents have, and so we have to educate providers so they can give them very clear answers and recommendations to, you know, to their parents. You know, I—I got phone call from a provider recently, and this just exemplifies the—the kind of problems. They had a patient. The parent didn't want to give the child her HPV vaccine, and

she Googled something found from 2009, and said here's an example of why there's a problem with the vaccine, and she said, well, do I respond to this? And, of course, it—there were a lot of problems with the information. It was—it was old, it was false, and so forth. But, you know, then we just there's just a lot of misinformation out there, and we have to constantly be—be providing up-to-date materials, and help providers answer these kinds of questions and make sure they're prepared.

ASSISTANT COMMISSIONER KAPLAN: I'm sorry. I just want to add one other thing about Brookdale. I went on a site visit to Brookdale because they're one of our partners in the Quality Improvement Network. If you haven't gone yet around this specific program, around access to contraception, they—I was blown away by what an amazing job they've done. It's really a wonderful program, and they've met every of our ten steps around postpartum, post-abortion and primary care in terms of incorporating reproductive health services, and the other is a lot of the information that I was sharing if you go to the government, general

government website and put SRJ, you can find a lot of what we're working on now around this framework.

COUNCIL MEMBER BARRON. Thank you. I just wanted to say that I thought I heard in a part of your testimony that well we can just include it in—in the round of vaccines that are being given. I may have misunderstood or misinterpreted. I think it needs to be very clearly stated that this is optional. You don't have to do it, and it needs to be very clearly stated what the intention of the vaccine is so that once again we don't get into a cloud and a mis—misinterpretation and mistrust. It needs to be very clearly identified as what the vaccine is supposed to do. Not just say okay, here's what we're doing today without pointing it out, and as you talk about the—the Health Action Centers that you want to establish or that are being established, I would—I would want to echo the comments of the chair that we need people who are culturally sensitive in these establishments, and we need doctors and nurses and caregivers there who look like the people they are servicing so that they can have that level of expectation, comfort and connection. Thank you very much. Thank you to the Chair.

CHAIRPERSON JOHNSON: Thank you. [coughs] Majority Leader Van Bramer.

COUNCIL MEMBER VAN BRAMER: Thank you very much, Mr. Chair and my colleague for important legislation. I just wanted to—to say because I went through this entire pamphlet of the community health profiles, every single page, and—and I'm sure each and every one of us feels the same way. You're just—you're not shocked, but—but it's still incredibly sobering to see page after page where the health outcomes, life expectancy and infant mortality—it's—it's the Bronx. It's Northern Manhattan. It's parts of Southeast Queens, parts of—of Brooklyn, and we know the intersectionality of racism and—and poverty, and other factor lead to those outcomes. But they're unacceptable from a—from a—from a human perspective, right, from—from a city that—that people of color, poor people have—have those outcomes, and are experiencing those outcomes. I know that you're committed to—to addressing that. So are a lot of the folks in the audience, right? None of us want this. I question is because this would get really sad when you see it time and time, right? Are you seeing improvements, right? I mean I understand, you know,

if you look at the—your life expectancy for example from the worst or lowest life expectancy to the highest, a ten year difference between what neighborhood you're living in. But are you seeing because I'm assuming that there is targeted resources, targeted programs. You know, some of the things that Council Member Barron was talking about. Are we doing any better in—in making sure that—that how you live or how you live isn't defined by what neighborhood you—you live in and what zip code you have. And I realize that's a big question but—but I just couldn't look through this—and—and—I know you folks prepared these, and it's important information, but it's—it's—it's—I kept looking at this thing. You know we should all be really angry, right. We should al be really angry at—at what this says.

ASSISTANT COMMISSIONER KAPLAN: Well, I'll start. Yeah, thank you for saying that. I think we are in agreement. I think, you know, our commissioner has really made I think her legacy and her leadership about health equity undoing injustice, speaking out about structural racism. In a way I've, you know, been under about three commissioners, and I mean this has been really very strong and her

expectation that we work in a different way that really works with other city agencies because the Health Department alone isn't going to be able to address structural factors, social determinants of health. But we know that inequities are driven by many factors including racism, residential segregation, housing quality, education, poverty, and we see it all the time. My staff are going on home visits in communities, and seeing what people, their lives are like, and they leave trying to help around breast feeding and environmental, and leave and see they're leaving like, you know. And they—they're not going to be able to fix everything because they made a home visit obviously. But they are giving someone a sense that they matter, and if we always talk about how important that is that they're going in and they're saying, you—we know you're here and you matter, and we're going to try to connect you. But the big—the problem is not going to be solved on an individual level. It's important the individual services. I think that is the commitment of our commissioner. It's why she created the Center for Health Equity. It's why we reframed our Take Care New York document around equity goals in a—in a way

that's different from our previous version, and we're holding ourselves to doing things to change to do those efforts. We've been partnering in some of our work in my bureau with the Department of Social Services, now the Homeless Services as well as ACS, and some of the other government agencies to— Well, HRA is the other one I meant to say, and others to really look at what is the role across government agencies, because that's where we touch many people in different ways that can get at some of the structural issues. But I will say to date while the infant mortality rate for example, which is believed to be one of the most sensitive measures of the health of the community. In 2014, we were at an all-time low of 4.2 deaths per thousand. That's much better than the CDC Healthy People 2020, or the U.S. rate. That's remarkable, but we have not see one—any change in the racial disparity. It has hoverer around 2-1/2 to 3 times greater risk of a black baby dying than whites for more than 10 years. We have not seen a reduction pre-term birth, and we believe that is because we know that babies are living longer, and technology still keeps more babies alive. But we have not been able—we—it will—it is a multi-

year all across the board struggle and effort, and I think that's what I heard from Commissioner, and it has to happen both at the level of policy, at the agency level and across many agencies, and I know it's a commitment of our Mayor who ran his campaign on Tale of Two Cities, and it also has to happen at the community level from the ground up. And the ideal of the Neighborhood Health Action Centers, which are really just getting off the ground has been to change—re—re-imagine and change how the District Public Health Officers are working for the same neighborhoods. But now we're co-locating primary care services, homeless services, kitchens to do cooking and greenhouse activities all in one building that's builds on something that happened 100 years ago. We're going back to something that worked then that allows a partnership across different efforts to hopefully move the needle, but it's going to take a multi-year effort, and focus. So I—I agree with you. I think that's the—where our commissioner and where many other commissioners are going. We're not going to see results quickly, but we need to keep chipping away at it.

COUNCIL MEMBER VAN BRAMER: Yeah. No, I mean it's obviously not specific to your administration--

ASSISTANT COMMISSIONER KAPLAN: [interposing] No, I know.

COUNCIL MEMBER VAN BRAMER: --and, you know, and—and no doubts the Mayor's commitment to addressing these very important disparities and—and everyone is committed to it. I know the Chair is—is—cares a great deal about these things. We all care a great deal about these things. It's just—it's frustrating and—and no more so for than you, the professionals who are in change, right, that—that if you're saying that, you know, we're not seeing some of these things being chipped away as quickly as we would like them. I mean look at the obesity rates, you know, and then the—the life expectancy rates, and obviously there's a—there's a correlation in some of those—those numbers. You know, I—I just—it's—it's frustrating, right? This is something that is so important and, you know, we should never see maps that are color coded like that, that are obviously reflecting who's living where and—and—and how they're living.

ASSISTANT COMMISSIONER KAPLAN: I totally agree, and just I mean the op—on the optimism side I feel like we're doing some of the things we need to do to move the needle. I know I do think if it's entrenched and longstanding the inequities and—but I do—we have to be—keep reminded by the maps, but I also feel that some of what the city is doing, and I can just speak specifically for my agency. But some of the partnerships we have with fellow agencies like ACS around safe sleep and housing quality we're moving forward on a campaign, yeah are different in the way in my experience over the 16 years I've been at the Health Department, and before where we're truly trying to address some of the structural issues with other agents, with our sister agencies. So I feel hopeful even in the midst of seeing that things haven't moved as much as we'd like them to.

COUNCIL MEMBER VAN BRAMER: Thank you.

CHAIRPERSON JOHNSON: Thank you, Majority Leader Van Bramer. Thank you very much for testifying. We're going to call up the our panel—next panel Elizabeth Holtzman, Sang Hwang from Choices in Childbirth, and Elizabeth Adams from Planned Parenthood New York City. [pause] And then

after this panel we have Diana Christian from Community Healthcare Network in the following panel and Danielle Castaldi-Micca from the National Institute for Reproductive Health. Good to see you, Danielle. If there is anyone else that wishes to testify, they can sign up with the sergeant. [pause] Okay, do you want to start us off, Liz? Pleas make sure the mic—here we go. Yep.

ELIZABETH HOLTZMAN: Thank you very much, Mr. Chairman and members of the Committee on Health. I want to thank you very much for the opportunity to testify you—before you on Intro 1162. You can ask me questions on the other intros, but I—I just want to specify my focus on this. I want to begin by congratulating Corey Johnson, the Chair of this Committee for his leadership in scheduling this hearing on this important subject. Let me also congratulate Council Member Elizabeth Crowley for her extraordinary leadership in introducing Intro No. 1162 as well as the other bills, and the 11 other Council Members who co-sponsored it. 1162 seems to be a modest bill. What it calls for is requiring the New York City Department of Health to collect data and publicly report annually on the utilization rates

of long-acting reversible contraceptives. But what is really at stake here is not modest at all. The bill actually is trying to make New York, the City Health Department deal effectively with the rates of teen-age pregnancy in our city, and if progress can be made on that front through this bill, then this bill packs a huge whollup. As we all know, rates of ten pregnancy are way too high in the United States, and New York City is no exception. In fact, U.S. rate is substantially higher than that in other industrialized countries around the world. The consequences of teen pregnancy are extremely harmful. According to the Department of Health, the U.S. Department of Health's Office of Adolescent Health children of teen mothers suffer "poor educational behavior and health problems throughout their lives compared with children born to older parents." According to the Center for Disease Control, the cost of teen pregnancy to the taxpayers has been estimated at about $9 billion, and affects the teen mothers negatively as well as their children. The problem has been difficult to correct, but we now know a solution. Recently the State of Colorado began a pilot program funded by a foundation to provide long-

acting reversible contraceptives such as IUDs to the state's teenage population. The results, although predictable, are still astonishing. Colorado saw a reduction of about 45% in the rate of teen pregnancy. The Colorado program is one recognition across the United States, and there are relatively few instances to respond to the concerns of Council Member Van Bramer in which we have such dramatic results from a single program, and is remarkable and proven results. Despite these results, New York City has been sitting on the sidelines on providing teen-agers with reversible long-lasting contraceptives. The State of New York has also been sitting on the sidelines. This is inexcusable. The State and the City should be leaders in the country on reducing the rate of teenage pregnancy. Sorry. Any political figure concerned about inequality or poverty should be leaping on the bandwagon of replicating the Colorado program here, but that hasn't happened. This bill force the City to track and publicize what is happening on the provision of long-term reversible contraception and thereby will allow the press and the public, not to mention the City Council, to monitor whether the city has embraced the Colorado

exampled or continues to ignore. Whether it has seriously tried to give young women the tools to take control of their lives or not. Whether it really cares about alleviating poverty and inequality that is the direct consequences of teen pregnancy or is indifferent to these problems. Again, I thank Council Member Johnson and Council Member Crowley for their leadership, and I hope this legislation and this hearing will push New York both city and state into the forefront of remedying the problem of teenage pregnancy. Given the Colorado example, the city and state have tremendous opportunity to put a real dent in this problem, and I certainly hope they take up the challenge to do this. Thank you very much, Mr. Chair.

CHAIRPERSON JOHNSON: Thank you very much. [pause]

SANG HWANG: Good afternoon, Chairman Johnson and City Council Members. My name is Sang Hwang, and I am the Project Director of Choices in Childbirth, a non-profit organization working to ensure that all families can access childbirth related care that is healthy, safe, equitable and empowering. Our mission is to promote evidence-based

family centered childbirth options through public education, advocacy and policy reform. Previous to this role, I served as Project Director of the Health Department's first surveillance of severe maternal morbidity. So I'm very pleased to submit this testimony in support of the City Council's proposed local law to amend the Administrative Code of the City of New York in relation to requiring the Department of Health and Mental Hygiene to issue an annual report on maternal mortality. Despite significant global progress in reducing maternal mortality in recent years, the United States is one of the few countries in the world where the maternal mortality ratio is on the rise. With an MMR of 14 deaths for every 100,000 live births, the United States is currently ranked 46 out of 184 countries worldwide. From 2000 to 2014, the estimated— estimated MMR in the U.S. increased by 27% for four to eight states and the District of Columbia. With approximately 120,000 births each year within 42 states nationwide, New York City is in a unique position to convene their own maternal mortality surveillance. We would like to recognize the leadership that New York City Department of Health

and Mental Hygiene has shown by becoming one of the only cities in the United States to conduct an ongoing maternal mortality surveillance process. In 2015, as you've all heard, the New York City Department of Health and Mental Hygiene found that pregnancy related mortality was higher in New York City than in the United States for every year from 2001 to 2010. However, while pregnancy related mortality decreased from 33.9 deaths per 100,000 live births in 2001, to 17.6 deaths per 100,000 live births in 2010, significant disparities by race and ethnicity were present (sic) within the data. Black non-Hispanic women in New York City were 12 times more likely than white non-Hispanic women to die from pregnancy related causes between 2006 and 2010. Whereas the mortality risk was seven times greater from 2001 to 2005. Other women of color also face greater risks. Asian Pacific Islander women were more than four times as likely, and Hispanic women were more than three times as likely as white non-Hispanic women to die from pregnancy related causes. The causes of maternal mortality are complex, but a number of factors contribute tot these poor outcomes, which include that in New York City 59% of pregnancy

related deaths between 2006 and 2010 occurred in women with a pre-existing chronic condition with obesity being the most common condition. Delayed childbearing can also lead to more complications during pregnancy and child birth. The pregnancy related mortality rate was highest among women age 40 and older in New York City. Older women are at greater risk of entering pregnancy with pre-existing chronic conditions that add to the risk of complications or death during pregnancy and birth. Diabetes, hypertension, hearth conditions, and obesity are among the factors contributing to worsening maternal health. Medical interventions that are beneficial in particular circumstances are being used routinely in situations where the risk may outweigh their benefits, and no risk, low tech solutions are being underutilized. While cesarean births can be lifesaving, the increase in primary cesarean birth rates has not resulted in the reduction of either maternal or infant mortality. Cesarean rates are now widely recognized as well beyond what is needed or appropriate. Lastly, as we've all discussed, place matters can cause significant disparities by place of residence exists

in maternal health. Residents of low-income communities and communities of color face disproportionate rates of poor maternal and infant health outcomes. Dr. Elizabeth Howell recently published findings showing that black mothers are more likely to deliver at poor performing hospitals than white mothers, and this discrepancy contributes to the disparities. Poverty and it's attended factors along with racism, chronic stress and disparities in access to and utilization of care also play a role in who suffers serious complications with pregnancy and childbirth. Routine systematic surveillance of maternal mortality is a core public health function and a first step in identifying the causes and potential strategies for reducing maternal mortality. The City Council's proposed Local Law to require the Department of Health and Mental Hygiene to issue annual findings on maternal mortality will ensure the proper--the regular collection, analysis and distribution of this information on a routine basis so that it can be used to improve maternal health, eliminate health disparities and reduce deaths for the people of New York City. The inclusion of Section 112.1 before the provision

requiring the issuance of recommendations regarding strategies to improve maternal health and reduce disparities provides some critical opportunity to ensure that the data are used to inform system changes that can in turn improve health outcomes. The requirement to issue recommendations also creates an opportunity for the Health Department to not only provide guidance on how to reduce maternal mortality, but to convene stakeholders that can help operationalize the recommendations into actionable steps and implement them to effect change. Thus, Choices in Childbirth supports the City's Council— Council's proposed Local Law to require the Health Department to issue regularly timed reports on maternal mortality, and develop recommendations to improve maternal health, eliminate health disparities and reduce maternal death. Choices in Childbirth is committed to working with the Health Department and the larger maternal health community to move data to action to effect meaningful change in New York City. We thank the Health Department for its commitment to ongoing surveillance of maternal mortality and morbidity, and to improving maternal health. We also thank the City Council for shining a light on this

critical by often overlooked issue. Any maternal death is one too many, but this law will ensure that lessons are learned, and then allow future losses to be prevented. Thank you.

CHAIRPERSON JOHNSON: Thanks. [pause]

ELIZABETH ADAMS: Good afternoon. My name is Elizabeth Adams. I'm the Director of Government Relations at Planned Parenthood of New York City. I'm pleased to be here to testify on Intros 1161, 1162 and 1172 today. Thank you to Council Member Elizabeth Crowley, Council Member Corey Johnson, and the entire Health Committee here today. PPNYC serves more than 64,000 patients annually and provides the full range of contraception, STD treatment, prep, GYN care, abortion, as well as PAP screenings, HIV vaccine, and colposcopies to help prevent and diagnose HPV related cancers. We support Intro 1161, which would require DOHMH to report on the current HPV vaccination rates for New York City. HPV is the most common sexually transmitted infection in the U.S. and can lead to serious health problems including cervical cancer and genital warts. Yet, HPV related cancers are largely preventable with the CDC estimating that regular

screening and vaccination rates could prevent up 93% of cervical cancers nationwide. However, vaccination rates are shockingly low, and many patients are not receiving the full dose of series. Public reports on dosage, and also broken down by gender would help to provide insight into barriers and opportunities for improvements. We respectfully recommend to the Council that the required data also be broken down by age to assess specific access barriers that young people may face. Until recently, minors could not consent on their own, which will likely contribute to low vaccination rates. We hope this policy change will raise public awareness of the benefits of the vaccine and enable more young people to obtain care on their own. A PPNYC, we are committed to a patient-centered approach and offer the full range of contraceptive methods so their patients may choose the one that is best for them based on benefits side effects and considerations of each method. We support Intro 1162, and data collection on LARC usage. LARCs are highly effective reverse—reversible contraceptive methods that prevent pregnancy and last for several years. While we support this bill, it is imperative that Citywide LARC metrics do not leave

providers and public health officials to promote one method over another. To this end, we respectfully recommend the Council extend the reporting requirements to all forms of contraception so that we have a more accurate picture of contraception usage. We also recommend adding a breakdown by both borough and age. A patient-centered approach necessitates that an individual's own reproductive health needs, goals and priorities are valued, and that public health interests do not supersede a patient's interests. PPNYC acknowledges that a long history of reproductive coercion and oppression of marginalized communities cannot be separated out from current— current public health practices. And that practices such as forced sterilization of women of color must be—must inform our current provision of care. It is incumbent on us as providers to support our patients' reproductive decisions without judgment or bias, but with trust and information. Lastly, we are proud to support Intro 1172, which would require annual reports on maternal mortality. While overall rates are decreasing citywide, as we know, the racial disparity has dramatically increased indicating an urgent need to address the social determinants of

heath. The city needs informed and innovative approaches to combat the current rates of pregnancy related deaths particular among women of color, and we support this step in identifying gaps in recommendations. In addition to reporting, however, New York City must directly engage community experts and patient centered models of care in efforts to reduce rates of maternal mortality. Citywide programs often serve women once they become pregnant, but few specifically address a woman's health needs before and between pregnancies, and engage community members most directly in policy solutions. We urge the Council to pass the legislation proposed today to better meet the health needs of our communities. Thank you.

CHAIRPERSON JOHNSON: Thank you all very much. Thank God for Planned Parenthood in this dark time that we're in. Congratulations on your anniversary, and thanks for all the work you guys have done. I want to ask Liz Holtzman a question about you—you were here for the Department of Health and Mental Hygiene's testimony on their access to contraceptives long-acting contraceptives. I know that you have focused, of course, the success in

Colorado in driving unwanted pregnancies down to I think it was zero in the—in the data. Could you talk a little bit about what you think the Health Department should be focused on in this area?

LIZ HOLTZMAN: I'm not a public health expert despite the implications in the Chair's question, but I do want to say that we ought to be-this--I think collecting data is one thing, but I think the real and—and I think you and Council Member Crowley and Mr. Van Bramer have reached this point. What are we going to do about these problems? It's one thing to have the information, and you can't do something unless you have the information, but what's the plan of action? What's the remedy? What are we going to do, and are we goals of—I mean I—I think the concerns about the past with regard to coercion are very serious, but that can't stymie us from appropriate action now. We've got to figure out how to-- So I think the Chair's suggestion for example about providing information that the existing health—city health facilities is an excellent one. There may be other similar areas. How do you—how do you being to educate a young—how do you begin to educate people about long-term and contraception, and—and

their availability? Why is it that there's such a small percentage of people using it. It's not just in—in New York City. It's not just an issue of cost, although that obviously is a factor because in Colorado, they gave it to girls for free. That made a big difference. They used it. So I think cost is an issue, but I think education is really important. What are they doing about this? I mean I didn't hear anybody talking about something called community health workers. Community health workers are people who come from a community and they can communicate with people in the community. I mean that's what they're doing. That's what they did in Colombia to deal with the Zika problem. What are we doing to use people like that here? So it seems to me that people—the City of New York Department of Health and the State ought to be thinking about not just what the problem, but what the solutions are. And some of them may be radical and dramatic like Colorado, but some of them may be small in agreement, but not just to sit there and say isn't terrible. It is terrible. It's been terrible for a long time. It's shocking and—and women's health, I mean we're talking about it. Half the population of this city is comprised of

women, and we're just ignoring this problem. I wouldn't say ignoring, but we're not devoting the same attention to it. I mean the Mayor sat there every day talking about traffic deaths. I know that's really important, but this is really important, too, and who's out there everyday giving that message? I mean I—I-so I think that strategies—PR strategies, education strategies. I think the question you raised about should the public—should the city have a position on whether the—the vaccine is required? I mean what have they been doing all these years sitting around? They don't have a position it. It's not—that's what I'm saying. People have to be moved off the dime, and develop strategies. I'm sure that you could work with them about it, but that's—that's not just saying that they're not willing and they're not well intentioned, but maybe they're not an action agency, and they need to be one.

CHAIRPERSON JOHNSON: Thank you. Council Member Crowley.

COUNCIL MEMBER CROWLEY: An interesting comparison. Last year in Fiscal Year 2016, which ended in June, there were 236 traffic fatalities. So

there is lot. The—the number is almost 50% of what it used to be because of what the City has done, and I think the number we heard was over 30 for each year a women—a woman is dying because of complications to- to pregnancy. So, in comparison we haven't broke that number down really, and from the testimony I heard we as a country are doing—faring much worse than other countries if there's—we're—we're coming in as number 46 when—when we should be coming at the top because we do have the best healthcare, and so we need to be focusing more attention, more resources. Because here's a question for you. Do you think and—and there are some folks here.(sic) Do you think if—if these problems pertain more to men? You know, we heard that 120 odd thousand births a year, and I'm not sure how many of those are unplanned, but if almost 60% of pregnancies are unplanned, and that was a situation that happened to a man, do you think that we would be focusing more on prevention and planning, and I mean ability?

ELIZABETH HOLTZMAN: Yeah, well if men—if men got pregnant, I don't think Planned Parenthood would have the problem [laughs] as to the safety first (sic). So, yeah, I—I—I think your answer—your

questions answers itself, but I think that—that you're right, the—the numbers are—are staggering here, and we talk abut the numbers with regard to unplanned pregnancies, and New Start (sic) are heading that, and—and maternal mortality rates and then these other rates. I mean obviously it's a big problem, and it's been pushed under the rug. It's been a—a footnote in the public health world. I mean not the public health people. I'm sure they care a lot about it, but to the people who can make changes and that's where you come in, and I—I applaud my—my colleagues on this panel for the important work they've done. But I think that we need strategies for change.

COUNCIL MEMBER CROWLEY: Well, first my last question is I—I didn't hear any statistics today, but I saw a report in the New York Times about the different types of birth control, and they said for women who are on birth control whether they're using contraception that is oral, or the IUD or traditional condoms, I—I think they meant there is also a hormone—a hormonal type, but—but they said that the—the form that works the best is the LARC. But it doesn't seem like that education is getting

out there, and it seems as if the providers that could—that do provide it and even the Department of Health it's a—it's a complicated situation in terms of pushing one form versus another, but at least to be making sure that people are educated about the effectiveness of each form. It seems to be very—it should be more apparent other than—other the—the ad that maybe this could work for you but do you know which works most effectively I think would be a good--

ELIZABETH HOLTZMAN: Well, just to add to your point, which I think is a really important point. We talking about coercion, but you think about teenage girls, what kind of choice sometimes do they have? And sometimes they are—the man or the teenage boy does not want to wear a condom, and then what? So, in some cases this does give girls particularly some more control. So I think that it's really important not to shy away. I mean the answer we got from the Health Department was oh, my goodness, women are concerned about using IUDs because maybe they won't be able to get them out, but then it turns out, of course, in New York City that's not an issues. So I—I hope that the—that the reasons

that are—that are really affecting the distribution of information and of the—of the reproductive methods themselves, I mean the—the contraceptives themselves are—are accurate.

ELIZABETH ADAMS: Just to quickly add to that, and I think when it's important to also recognize that LARCs do not protect against STDs and for young people being important to always using a condom. But in terms of the—the education piece I do think it's important to—to your earlier point, too, in terms of how this breaks down by gender. These—these recent numbers show that in New York City under the—the Youth Risk Behavior Survey, that high school students in New York City have a—a much higher rates than nationally of not using more effective methods. We have a higher rate of using condoms, but—but—but we use—but New York City students use the pill, the patch, you know, an implant kind of the different more effective methods at a much lower rate. Which I think really gets to the importance of education, of comprehensive sex education and that we're teaching our young people about what services are available, and where they can go to get them, and that services are confidential, and that places like Planned

Parenthood will provide you with care. I also just to Council Member to your point about from the provider's side is I—I think the approach that—that we've really taken, and just to underscore Dr. Kaplan's point of really seeing this as—as part of, you know, the full range of the methods that we provide. But, we do also really see the importance of access as—as—as foremost kind of one of the most important things. So with that, we have, you know, in this this past year through the Speaker's Office secured a new mission of two funds long after the reversible contraceptives that we provide to our patients regardless of immigration status, regardless of income. So that if someone comes in and doesn't have insurance, which, you know, our family planning dollars cover folks who do have insurance. But for folks that don't have insurance or may not want to use that because of confidentiality reasons or a whole host of reasons, that we are able to provide LARCs as a method, as a—as an affordable method, and that it doesn't—it's not cost prohibitive, and with that also, that initiative amount funding covers removal. So that people—we—we know that about 20% of people choose to remove an IUD before the time that

it necessarily needs to be, and so how critical that funding to make sure that if someone wants that removed that it's—it's not prohibitive as well. So I think for us from Planned Parenthood we really work to make sure that access to all methods and LARCs is one of them. And information about how—the effectiveness of LARCs and that it is—is front and center and that it's—that there are restrictions in terms of kind of your insurance status or how much you make. I think that's our approach.

COUNCIL MEMBER CROWLEY: [off mic] Thank you.

CHAIRPERSON JOHNSON: Thank you and—and I don't mean to—I'm going to get beaten up by Ms. Holtzman for saying this because she's going to think that I'm trying to embarrass her, but for the folks that are here today, especially the women I guess who—who may not know about her really trailblazing career, you know, she was the youngest woman elected to congress at the age of 31. She beat a 50-year incumbent, the longest serving member of the House at the time, and held that record for 42 years. The first woman elected Controller in New York City. The first woman elected DA in Kings County in Brooklyn,

and, you know, I—she is a role model not just for women but for men for having a long sustained career during elective office and after elective office of continuing to press on important issues. And so for her to take time out of her schedule, and be here with us today, and talk to Council Member Crowley and myself is really, really—I'm full of gratitude for your friendship and for your support, and I'm glad you're still hard at work here in New York City trying to make our city better. So thank you very much.

ELIZABETH HOLTZMAN: Thank you very much. Thank you.

CHAIRPERSON JOHNSON: I want to call up the final panel. Diana Christian from Community Healthcare Network and Danielle from NARAL. Thank you. [background comments, pause] Okay, you may begin. Whatever order you'd like.

DIANA CHRISTIAN: Hello. Thank you Chairman Johnson and members of the Committee for the opportunity to speak this afternoon, and particularly thank you to Councilwoman Crowley for introducing these very important bills. My name is Diana Christian, and I am the Senior Policy Associate of

the Community Healthcare Network. CHN is a network of 11 federally qualified health centers plus to mobile medical vans, and a school-based health center. We provide affordable primary care, dental, behavioral health and social services for 85,000 New Yorkers annually in four boroughs especially in the Bronx, the Northern end of Manhattan, Queens and Brooklyn, both across the bridge and in East New York. On behalf of CHN, we fully support the New York City Council in passing the bills before you. We are encouraged by the strides that the city is making to improve the reporting and monitoring of sexual and reproductive health issues, and urge the Council to recognize how critical it is for organizations like ours, which Ms. Holtzman so kindly mentioned, to have access to reliable, consistent and reported data. With this, we can address pockets of need with culturally competent care that is specific to our communities. As a provider of comprehensive healthcare services in underserved communities for over three decades, CHN has extensive experience in identifying gaps in service and healthcare needs within communities, and then develop implementing— developing and implementing systems and programs to

address those needs. We are continuously evaluating patient needs through patient surveys, focus groups, and most notably through community surveillance of local data. It is considered best practices to utilize evidence simply in programs. Public health priorities cannot be determined without appropriate information about where to focus and on what. We currently have a robust sexual and reproductive health program in which we provide clinical and educational services, comprehensive education about how to prevent sexually transmitted infections, testing for STIs and HIV, treatment and counseling, and many different types of birth control including implants, injections and intrauterine—intrauterine devices at low or no cost. So far in 2016, our providers have provided 820 HPV vaccinations, inserted 1,043 long-acting reversible contraceptives, and given prenatal care to 1,724 women. We often use city reported data to inform decisions on how to prioritize our efforts. For example, we recently implemented new maternal health programs at two—our two health centers in Jamaica, Queens. After looking at citywide and neighborhood specific data, we found that despite a decrease in infant mortality across

the city, Jamaica and Hollis have the highest infant mortality rate in the city at 9 per 1,000 live births, and nearly double the average rates for Queens and for all of NYC. The neighborhood also had higher rates of pre-term births, teen births, individuals lacking health insurance, and of late or no prenatal care. In response to the identified population health need, CHN applied for and received funding to implement a new program model, which targets mothers and their infants on safe sleep, breast feeding, women's health, family planning and toxic stress and trauma. Families are reached via two levels: Individually through personalized telephone calls, and in-person visits and in group settings. Both levels require conducting group education sessions and targeted support groups. In addition to the new programs, we use surveillance data to create a baseline for our own services. Recently, we have used city data to evaluate colonoscopy numbers, STD testing and treatment and HIV viral load suppression and other methods of HIV quality. As an example, with the new data, we would be able to see the average percentage of individuals in the city who are receiving HPV vaccinations, and

evaluate if our patients are receiving less HPV vaccinations than that. If so, CHN can direct more resource—resources to ensure that we meet or exceed these numbers. Without this, we will be less able to plan programs and monitor our levels of care. In closing, I strongly encourage the New York City Council to pass these three bills, which will enforce the reporting and monitoring of HPV vaccination rates, LARC utilization, and maternal mortality rates. Thereby enabling New Yorkers to lead sexually healthy and responsible lives. Thank you again for holding this hearing today.

CHAIRPERSON JOHNSON: Thank you.

DANIELLE CASTALDI-MICCA: Good afternoon. Thank you, Chair Johnson, Council Member Crowley, the members of the committee. It is very cold up here.

CHAIRPERSON JOHNSON: You're freezing in there.

DANIELLE CASTALDI-MICCA: It's colder up here than it is in that corner, Chair. It's very cold up here. [coughs] My name is Danielle Castaldi-Micca. I'm the Director of Political and Government Affairs at the National Institute for Reproductive Health formally known as NARAL Pro-

Choice New York. We work in New York State and across the country to ensure that every woman has the right and ability to make the reproductive health decisions that are best for her life and her family. That includes preventing unintended pregnancy, bearing healthy children and choosing safe and legal abortion. Each of the bills before you address important public health matters, and our written testimony indicates our support for all three. However, in the interest of time today, I'm only going to address Intro 1162, which directs the DOH to collect data on usage for LARCs including IUDs and implants. Although LARCs are the most effective form of contracept—some of the most effective forms of contraception, uptake in the U.S. is relatively low compared to other western countries. This is due to several factors including lack of awareness as a method, persistent myths about their dangers among school patients and providers, and that's I think the one that I hear the most is people asking if IUDs are safe, insufficient training on insertion and removal; the high cost of the device, which right now is less of an issue, but a year into this new administration it may become more of an issue depending on what

happens at the ACA, and operational challenges just associated with the offering. The National Institute has collaborated with the Department of Health here on a lot of LARC related projects including developing maybe the IUD campaign, the Reproductive Justice could mandated to improve, and the New York City LARC Access Taskforce. And we really appreciate the DOH and the City Council's recognition of LARCs as an important form of contraception for women across the city. We also, however, join with some of our colleagues in cautioning against the inadvertent Promotion of LARCs as the best form of contraception for all women. It's important to note that there have been movement to deny access to contraception as well as a long history of government and other institutions using contraception as a means of oppressing women in particular women of color. Contraception is a deeply personal decision, and data collection prescribed by this bill shouldn't be misconstrued or misunderstood as encouraging medical providers to increase LARC use by their patients. More data can be helpful to advocates for sure, and government agencies as we work with diverse populations around the city on matter of

contraceptive access, but there should be no implication of a hierarchy amongst contraceptive types. The ultimate goal of all of our work on contraceptive access is, and only should be, to ensure that all people have an understanding of the full range of methods available to them, and are able to determine and access the method that is the best fit for them. With that, I want to thank the Council and the Committee for casting light on these three important issues, and the National Institute of Reproductive Health supports all three bills, and urges the Council to pass them.

CHAIRPERSON JOHNSON: Council Member Crowley.

COUNCIL MEMBER CROWLEY: The first question is for Danielle. Do you find that people have come to you, and some have providers could be discouraging of LARCs?

DANIELLE CASTALDI-MICCA: Yes, but less in recent years, and I have found that it's primarily—and this is so anecdotal. This is just amongst like my own conversations. I've found—I've heard more discouraging comments from people hearing them from their providers if they are older. So the

young people that I've spoken to rarely say that. It's usually women in their like mid to late 20s, and the doctor is saying do you really want something that last for five to ten years, and I think that is more about implications of when women are expected to have children and less to do with the method of contraception, but again, purely anecdotal.

COUNCIL MEMBER CROWLEY: And then is the— the Health Department and the City giving you enough resources? Are they doing enough? Is there more we could do as a city to reduce the percentages of unplanned pregnancies and reduce the spread of HTD— STDs?

DANIELLE CASTALDI-MICCA: [laughs] All of them. Reduce the spread of everything. I—I think certainly the DOH does a very good job, and we work really closely with them, and consider them really trusted partners. In doing this work I would be remiss if I didn't echo my friends from Planned Parenthood and say that one of the ways the city could do a lot better in reducing STIs and unintended pregnancies is through comprehensive sex ed in New York City schools, which does not currently exist,

and I think that would be a tremendous step although one slightly less out of DOH's hands.

COUNCIL MEMBER CROWLEY: But if we—we have the schools not providing the service, what other means of communication can we use to get the word out to educate?

DANIELLE CASTALDI-MICCA: If the schools aren't doing it?

COUNCIL MEMBER CROWLEY: That's right.

DANIELLE CASTALDI-MICCA: You know, I think that there is a host of pretty innovative things that have been presented here today that are happening. Communication around public health in New York City is always a challenge. We have here from Humes (sic) you know how many languages are spoken here even in terms of language access is often a challenge, but I think that a lot of the provider education that's been happening and is continuing to happen through DOH, is a really key component to that. [background comments]

COUNCIL MEMBER CROWLEY: Are we doing enough as a city or what ways could we utilize communication to—to educate the public about different forms of birth control or the importance of

the immunization, and—and the general overall health to reduce the risk of maternal mortality? What we could do more as a city? Well, certainly we could try to find more in the city budget.

DANIELLE CASTALDI-MICCA: Right. I was going to say we all—everybody needs more money.

COUNCIL MEMBER CROWLEY: Yes.

DANIELLE CASTALDI-MICCA: I think DOH needs more money. I think all of the agencies want more money, but that is sort of the endless booth (sic) of need more money. But I also think that we need to continue and expand programs like the Community Engagement Group that we're doing around Reproductive Justice with the DOH. It's a really innovative approach and really important in a city as diverse as ours that an agency is making such a concerted effort to ensure that the voices of people who represent communities that have the least access are front and center at the table. And I think increased and continuing and increasing programs like that not just for public health, but also for things like education can really go a long way.

DIANA CHRISTIAN: So I would just say from the FQHC perspective I think in trying to

generate new patients and new things like that, there is a big disconnect between our availability and other places like schools, et cetera pushing people who are in need of healthcare providers towards existing facilities. And we work with a lot of our partnering organizations in trying to get our materials out there and things, but broadly people don't really know what Federally Qualified Health Centers are, and they don't know that they exist, and they don't know that they provide these services. And we're—the majority of our patients are Millennials like the—a large majority are Millennials, and we have been—we went into school-based health center. We're expanding into another school-based health center to try to get the information directly to them, but perhaps some sort of, you know, always like an awareness campaign or something like that in terms of generating a linkage between the—the need for care and where you can actually access care, which I don't think is very—is really happening right now.

COUNCIL MEMBER CROWLEY: [off mic] Thank you, thank you. [coughs]

CHAIRPERSON JOHNSON: Thank you both very much. Thank you all for this hearing today. Thank you to Council Member Crowley for introducing these bills, and thanks again to the committee staff. With that that, this hearing is adjourned. [gavel]

C E R T I F I C A T E

World Wide Dictation certifies that the foregoing transcript is a true and accurate record of the proceedings. We further certify that there is no relation to any of the parties to this action by blood or marriage, and that there is interest in the outcome of this matter.

Date December 29, 2016