CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HEALTH

Jointly with

COMMITTEE ON WOMEN

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Helen K. Rosenthal
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CHAIRPERSON LEVINE: Good morning, everybody. Welcome. I am Mark Levine, Chair of the City Council's Health Committee, pleased to be co-chairing this hearing with the wonderful Helen Rosenthal, Chair of the Women's Affairs Committee, and we are going to be-- Chair of the Women, Committee on Women. I stand corrected. Already the man is off to a bad start. I'm actually getting-- I'm going to try and model enlightened male behavior by giving a short and not scripted opening statement so we can pass it off to my colleague who will delve into some of the details. So, when a mother dies in childbirth or due to complications of pregnancy, that is what some people call a "zero-acceptability event," which is to say it's never okay, and there's no level at which we can say that we are-- that we can tolerate. Every single time a mother dies in childbirth or during pregnancy, it's a failure of our health system. It's a failure of our society, and it is happening in New York City on average 30 times a year, on average 30 times a year, a number which is going up, a rate which is higher than the rest of the country, a rate which compares poorly to the rest of

the world. Another 3,000 times a year, women suffer near-death events during pregnancy and childbirth, and these are not trivial complications. They can often lead to life-long disability and health complications-- 3,000 times a year near-death events. And this scourge is not affecting all women equally in New York City. The maternal mortality rate is 12 times greater for African-American mothers in New York City than it is for white mothers. So, I'm going to pause and let that sink in. The maternal mortality rate for African-American mothers in New York City is 12 times greater than it is for white mothers in New York City. How can this be? We don't actually have satisfactory answers to that question, which is part of the reason why we're convening the hearing today, because we need to demand answers to fix this, but there is increasing evidence to support the notion that the healthcare system itself is treating black mothers differently than it's treating white mothers, that the views and feelings of black mothers are being ignored in the pregnancy and birthing process by the medical profession, a phenomena which was dramatically illustrated by non-other than Serena Williams, who has suffered from a

blood condition that she was well-aware of. This is a professional athlete who obviously is in-tune with her body as an athlete would be, knew that she was experiencing something that was wrong and was ignored by her doctors and nearly died after a C-section because she was ignored. This was a celebrity, a woman with money, a black woman who was ignored. One can imagine the obstacles that someone without the celebrity and status and resources could face as black women in the healthcare system. We need a cultural shift in healthcare in New York City, in America, that tackles implicit bias, that respects the views of black women that listens to them, that hears them when they express pain, when they report on what their own bodies are experiencing. We need to empower frontline medical providers like nurses to be heard by doctors and others higher up in the food chain when they are echoing the feelings of these mothers, and we need to tackle the broader societal impacts of racism, which are leading to disparate health outcomes, whether it's in housing or air quality or lack of health insurance that are now being magnified during pregnancy and childbirth and are leading to some of these unconscionable

statistics. I am really excited today to talk about these solutions and to talk about a package of bills that Chair Rosenthal's putting forward that are going to get us towards a solution. And on that note, I am going to pass it over to Chair Rosenthal for further introductory remarks. Thank you.

CHAIRPERSON ROSENTHAL: Thank you so much, Chair Levine, certainly, one of the men who gets it. Good morning, my name is Helen Rosenthal. I Chair the Committee on Women. The rates of maternal mortality and morbidity, especially among black women point to a health crisis both nationally and locally. Not only is the United States' maternal mortality rate the highest in the developed world, but it has increased in recent years, and the issues that New York City face are even worse than at the national level, due especially to the disproportionate death rate of black mothers. Chair Levine highlighted many of the key statistics that explain what brought us here today. Among the most startling, I think, is how the United States compares to nations that are the best at caring for pregnant people and keeping them safe. In 2016, the United States maternal mortality rate was nearly 29 deaths

per 100,000 births, shockingly high compared to other industrialized nations. Italy's rate was 3.9 percent, Finland's 3.4. Disaggregated by race, the crisis is shown to be even more stark. While white women in the United States has a mortality rate of nearly four times that of women in Finland, the rate for black women was nearly 13 times higher. Maternal health outcomes are a textbook example of the issues that our country faces at the intersection of race and gender. These issues are perpetuated by implicit and explicit bias. In the medical profession, especially, myths about different pain thresholds between the races persist, as do harmful stereotypes about the competency of women of color. Broader environmental factors, exposure to polluted or unsafe neighborhoods and homes, as well as the stressed caused by navigating a racist and misogynist power structure also contribute to the health crisis. As such, the City must approach this issue with a broader, public health lens, and not confine policy to what happens within the walls of a hospital. Most fundamentally-- I'm sorry, I'm just smiling because the doulas have arrived with the babies, and I'm just so delighted to welcome them here. Most

2 fundamentally, high rates of maternal mortality and
3 morbidity are a direct result of a society that while
4 theoretically can be responsive to the needs of a
5 fetus does not adequately consider the needs of the
6 pregnant person, a structure that subjects those
7 already in a vulnerable position to the most
8 unacceptable of experiences. Today, we will hear
9 testimony from witnesses who have experienced this
10 bias and unwillingness to listen in its most severe
11 form. We will also hear how the City has committed
12 itself to addressing this fundamental imbalance and
13 is to rectify the situation. The Department of
14 Health and Mental Hygiene will testify about their
15 impressive roster of initiatives aimed at improving
16 maternal health outcomes. This includes the Healthy
17 Start initiative in Brooklyn, which includes the
18 provision of doulas through the By My Side Program.
19 Another is the Sexual and Reproductive Justice
20 Community Engagement Group, a grassroots group of
21 community leaders, activists and nonprofit
22 organizations that meets monthly to plan and
23 implement policies and programs on issues such as
24 this. The Department has also set up a Maternal
25 Mortality and Morbidity Review Committee to ensure

2 that every single mortality incident is carefully
3 reviewed by medical experts and community leaders,
4 and that lessons are learned to prevent more deaths
5 in the future. I look forward to hearing from the
6 Department of Health about these and other
7 extraordinary programs and how they can be improved
8 upon and expanded. Now, is the time to think about
9 how to scale up existing programs and address the
10 crisis head-on to take on our new challenges. To
11 that end, I'm proud to introduce two pieces of
12 legislation which we will consider today. The first,
13 Intro. 913 would require the Department of Health and
14 Mental Hygiene to create a plan to provide access to
15 doula services to all New Yorkers. A doula is a
16 trained professional who provides continuous
17 physical, emotional, and informational support to a
18 pregnant person and their family before, during and
19 shortly after childbirth. A doula is not a medical
20 professional, but they can play a critical role in
21 supporting a pregnant person. During pregnancy this
22 can include everything from practical help scheduling
23 medical appointments to answering basic health
24 questions to providing emotional support. During
25 childbirth doulas can play a critical role in

providing physical and emotional support to a person in labor. They can also support the decisions made by the person in labor, helping communicate these decisions to the medical team, and ensure they are taken seriously. And after childbirth, services can include practical educational and emotional support. You're not going to just hear it from me. We're so excited to hear from the doulas and the doula leaders in the room today. The academic research has shown that these support services can make a difference. In 2017, the Cochran Pregnancy and Childbirth Group conducted a comprehensive review of research into programs around the world that provided doula services. It found that women allocated continuous support by people like doulas were among other benefits more likely to have a spontaneous vaginal birth and less likely to have a Caesarean birth or instrumental vaginal birth, more likely to have a healthy child as measured by the five-minute APGAR score, and less likely to report negative ratings of or feelings about their childbirth experience. Here in New York City research has revealed similar results for infant health and maternal satisfaction, although not for direct maternal health outcomes, and

that will be interesting to understand why. And I'm going to posit a guess that it has to do with our-- what happens inside the birthing room here in the United States versus other countries. Analysis by the By My Side pilot program in Brooklyn has revealed statistically significant decreases in pre-term birth and underweight babies as well as significant improvements in women's evaluation of the childbirth experience. We will also hear testimony-- we will be hearing testimony from our local doulas today about their experiences in New York City and how their services can and could more help the communities most in need. Now's the time to begin planning how to scale up the provision of doula support services and how to do so in a way that stays true to the roots of doula services here in New York City. The Governor recently announced his intention to set up a pilot for using Medicaid funding to pay for doula services. This represent an exciting opportunity, but also a challenge. Part of what has made doulas so effective in communities across the City has been their grassroots nature. We are at a crossroads for the provision of doulas. Intro. 913 comes at a perfect time to ensure that the City of New York is prepared

2 to meet the challenges and take advantage of the
3 opportunities of this movement as we consider how to
4 ensure that every person who wants one is able to
5 access a doula. The committees will also consider
6 Intro. 914 which builds on Local Law 55 of 2017 by
7 expanding the reporting requirements and codifying
8 the Department of Health's Maternal Mortality and
9 Morbidity Review Commission. I look forward to
10 working with the Department of Health and other
11 stakeholders to make sure that we get the reporting
12 requirements right, safeguarding privacy, but also
13 ensuring that meaningful analysis on the causes of
14 medical negative maternal health outcomes will
15 continue into the future. In addition to these
16 bills, today's hearing is an opportunity to discuss
17 the steps that are needed beyond the legislative
18 power of the City Council. We must start talking
19 about how to influence the culture of medical care
20 and public health. The advocacy that doulas provide
21 is only as effective as the doctors allow it to be.
22 The recommendations of the Mortality and Morbidity
23 Review Committee will only be effective if
24 implemented by the medical providers. As such, we
25 must think bigger than a single law. What is needed

2 is a coalition between the City, the State, community
3 activists, and medical providers to redesign the way
4 we care for pregnant people from the ground up.
5 Maternal mortality and morbidity is a crisis in this
6 country, but it's solvable. What it will take is
7 listening to women, listening to all pregnant people.
8 It's on us to design a system in which their voices,
9 our voices are heard. Let me conclude with a note on
10 language. Both pieces of legislation under
11 consideration today refer to pregnant people rather
12 than pregnant women. Certainly, most pregnant people
13 are women, and it doesn't make sense to divorce
14 pregnancy from the broader range of women's health
15 issues, but non-binary, Trans and gender-
16 nonconforming individuals also give birth in New York
17 City. Giving the health disparities that the LGBTQ
18 community faces more generally, it is important that
19 we are inclusive as we consider solutions to
20 pregnancy-related deaths and health complications.
21 It is hard to get that language exactly right. The
22 standard term is maternal mortality, after all, but
23 know that this City Council and this city want to
24 approach this conversation as inclusively as
25 possible. Let me thank the staff who made this

hearing possible, including the Committee on Women Counsel, Brenda McKinney [sp?], Policy Analyst Chloe Rivera, Finance Analyst Daniel Croup [sp?], Legal Fellow Ravi Akaseem [sp?], as well as my Legislative Director Sean Fitzpatrick, and our Legislative Interns Rob Bently-- Buntliesky [sp?], and Anisa Ayu [sp?] for their work in preparing for this hearing. And with that, I'd like to recognize the other members of the City Council, Brad Lander, Alicka Ampry-Samuel, Laurie Cumbo, Keith Powers, and Diana Ayala. I turn it back to you, Chair Levine.

CHAIRPERSON LEVINE: Thank you, Madam Chair. We're going to hear from our fist panel, the Administration, and I'm going to ask our Committee Counsel to please administer the affirmation.

COMMITTEE COUNSEL: Please raise your right hands. Do you affirm to tell the truth, the whole truth and nothing but the truth in your testimony before this committee and to respond honestly to Council Member questions?

ASSISTANT COMMISSIONER KAPLAN: I do.

ASSISTANT COMMISSIONER EASTERLING: Yes.

ASSISTANT COMMISSIONER KAPLAN: Good morning Chairpersons Rosenthal and Levine and members

of the Committees. I'm Doctor Deborah Kaplan, Assistant Commissioner of the Bureau of Maternal, Infant and Reproductive Health and the Department of Health and Mental Hygiene. I'm joined by Doctor Torian Easterling, Assistant Commissioner of the Brooklyn Neighborhood Health Action Center. On behalf of Commissioner Bassett, I want to thank you for the opportunity to testify on the Department's work to reduce maternal mortality in New York City and related pieces of legislation. The mission of the Department is to improve the health of New Yorkers and to eliminate health inequity which are rooted in historical and contemporary injustices and discrimination, including structural racism. It is through this lens that we focus our work related to maternal infant and reproductive health. The history of New York City includes the systematic segregation of people of color into neighborhoods that were deprived of resources for decades. To this day, these neighborhoods still carry the burden of under-investment, including limited access to healthy food, safe places to walk and exercise and other resources necessary to be healthy and thrive. The Department recognizes that improving women's health before

2 pregnancy is critical to reducing maternal and infant
3 mortality and addressing the unacceptable racial
4 disparities in birth outcomes. To inform our work, e
5 monitor and report on maternal mortality and severe
6 maternal morbidity surveillance data. To date, the
7 Department; has issued two reports on enhanced
8 surveillance of pregnancy-associated mortality which
9 are deaths during pregnancy or within one year of
10 pregnancy from any cause and pregnancy-related
11 mortality, a subset of these deaths that are causally
12 related to the pregnancy based on data from 2001 to
13 2005 and 2006 to 2010, and you have those-- you
14 should have those reports. A similar analysis for
15 2011 to 2015 is currently under way and will be
16 completed by the end of the year. The Department
17 collects this information through death certificate
18 data and additional surveillance of pregnancy-
19 associated deaths using New York State Department of
20 Health's Statewide Planning and Research Cooperative
21 System, known as SPARCS, to analyze in-patient
22 hospital discharge data. As was noted earlier, in
23 New York City, approximately 30 women die every year
24 of pregnancy-related causes, and while the pregnancy-
25 related mortality ratio decreased 48 percent in New

2 York City between 2001 and 2010, it is consistently
3 higher than the national average and the racial
4 disparities in pregnancy-related mortality are
5 unacceptable. From 2006 to 2010 black women were 12
6 times more likely to die from a pregnancy-related
7 cause than white women. Pregnancy-related mortality
8 is associated with obesity, underlying chronic
9 disease and poverty that also disproportionately
10 affect New York City's black population. The chronic
11 stress of racism and social inequity contributes to
12 pregnancy-related mortality, along with racial
13 disparities and other health outcomes, including
14 infant mortality, pre-term birth, and low birth
15 weight. In 2016, the Department released a report on
16 our citywide severe maternal mortality surveillance
17 system. We are the first municipality in the United
18 States to do so. Severe maternal morbidity is
19 defined as a life-threatening complication during
20 childbirth. Examples include heavy bleeding, kidney
21 failure, stroke, or heart attack during delivery. To
22 put this in perspective, for every woman who dies of
23 a pregnancy-related cause in New York City,
24 approximately 100 women almost die. Our surveillance
25 found that the rate of severe maternal morbidity in

2 New York City was higher than the national severe
3 maternal morbidity rate, and that it increased 28
4 percent from 2008 to 2012. Nearly 3,000 women
5 experienced life-threatening complications during
6 pregnancy in 2012, and as with maternal mortality we
7 found stark racial disparity. The severe maternal
8 morbidity rate among black women was three times that
9 of white women. This holds true regardless of other
10 socioeconomic factors such as education. In New York
11 City, a black woman with a college degree or higher
12 is more likely to have serious complications during
13 childbirth than a white woman with less than a high
14 school education. The Department has a number of
15 ground-breaking programs focused on addressing
16 systemic causes of maternal mortality and severe
17 maternal morbidity through hospital and community-
18 driven interventions. The Department currently
19 operates a Maternal Mortality and Morbidity Review
20 Committee known as M3RC to review maternal deaths and
21 make evidence-based recommendations at the community
22 health system provider, patient, and policy levels to
23 prevent future deaths and life-threatening
24 complications. Members of the M3RC include health
25 providers from local hospitals and other health

2 facilities, as well as representatives from
3 community-based organizations, doulas, mid-wives,
4 researchers, first-responders, and others to develop
5 comprehensive recommendations that are meaningful
6 from both a clinical and social perspective. There
7 are similar committees in several other states across
8 the country, though ours is the only committee
9 focused on the city. The New York City M3RC is
10 especially valuable because roughly half of the
11 statewide maternal deaths in New York State occur in
12 the five boroughs. The Department is also focused on
13 supporting women's health before, during, and--
14 before and during pregnancy to ensure optimal
15 outcomes. In May, the Department announced the
16 Maternal Care Connection, a collaboration with SUNY
17 Downstate Medical Center to improve obstetric care
18 and chronic disease management, both of which
19 contribute to racial disparities and birth outcomes.
20 We look forward to updating you further on this work
21 soon once details are finalized. Related to this
22 work is the Sexual and Reproductive Justice Community
23 Engagement Group, or CEG, which is co-led by the
24 Department and community partners, including
25 community leaders, activists, and nonprofit

organizations to guide and inform the implementation of the Department's sexual and reproductive justice work. Through the CEG, a focus on birth justice has been adopted so that people know their rights during pregnancy, birth and immediate post-partum period in the healthcare setting. Key to the birth justice campaign are the Birth Justice Defenders and birth justice champions. The Birth Justice Defenders are a group of community residents who come together to educate others in their communities and advocate for safe and respectful maternity care for all individuals. The Birth Justice Champions are medical providers, including OBGYNs, physicians, midwives, and doulas who work to mobilize their communities around the principal that everyone giving birth deserves to be treated with respect and attention and to have their needs met. This group promotes best practices for respectful care at birth within healthcare facilities. The Birth Justice Champions are conducting a series of grand rounds presentations on birth justice and respectful maternity care at hospitals around the City, and presentations have occurred at Elmhurst Hospital, Jamaica Hospital, and Montefiore Medical Center, and more are planned for

this summer. Intro. 914: I would now like to turn to the bills being heard today. The Department supports the intent of Intro. 914 which would expand Local Law 55 of 2017 to require the Department to report additional data on maternal mortality and severe maternal morbidity and establish a Maternal Mortality Review Committee. As I mentioned, it's important to have a local Maternal Morbidity Review Committee in New York City, and we thank the Council for recognizing the important work our committee is accomplishing. The Department currently reports to the Council on maternal deaths disaggregated by borough of residence and race/ethnicity, and we understand the importance of being able to track progress in order to understand the factors associated with these complications and develop policies and programs to move the needle in the right direction. Protecting the confidentiality of the women whose cases we study is of the utmost importance to the Department, and we're happy to work with Council to determine appropriate aggregate level maternal mortality data to add to the report to provide a more comprehensive description of maternal mortality cases in New York City while protecting

2 patient confidentiality. Intro. 913: Intro. 913
3 would require the Department to assess the needs of
4 pregnant people and the availability of free and low-
5 cost doula services. We support the intent of this
6 legislation and look forward to working with Council
7 to provide meaningful data to inform this work. The
8 Department currently operates a number of programs
9 supporting doula services and growing the doula
10 workforce in New York City. Through funding from
11 Healthy Start, a federally-funded program that aims
12 to eliminate perinatal health disparities, we operate
13 the By My Side Birth Doula Support-- the By My Side
14 Birth Support Program. By My Side provides free
15 doula support to low-income women during their labor
16 and delivery. Since its creation in March 2010, By
17 My Side has served over 850 clients and their
18 families, including labor support at more than 670
19 births. The Healthy Women, Healthy Futures
20 initiative funded by the City Council offers doula
21 services to low-income women throughout New York
22 City. The initiative also trains and hires women
23 from neighborhoods served by the program to serve as
24 birth doulas. The majority of clients are referred
25 through partner--through participating CBOs which

2 include Caribbean [sic] Women’s Health Association,
3 Brooklyn Perinatal Network, and Community Health
4 Center of Richmond. The Department also collects
5 data on the needs of pregnant women. Since 2001, we
6 have collected these data through the Pregnancy Risk
7 Assessment Monitoring System, or PRAMS, a population-
8 based survey of new mothers in New York City designed
9 to monitor maternal experiences and behaviors before,
10 during and after pregnancy. Findings in PRAMS are
11 used to enhance our understanding of maternal
12 behaviors, develop and evaluate programs to improve
13 maternal and infant health, and inform policy
14 development. Doulas are an important part of the
15 compendium of services to increase infant and
16 maternal health outcomes, including midwifery and
17 hospital and community-based interventions. We share
18 the Council’s goal of increasing access to doula
19 services for pregnant individuals, and are currently
20 working with the New York State Department of Health
21 as they develop their pilot project to expand
22 Medicaid coverage to include doula services. Thank
23 you again for the opportunity to testify. We’re
24 happy to answer any questions.
25

CHAIRPERSON LEVINE: Thank you very much, Doctor Kaplan. I think we've been joined by-- nope. We-- everyone-- okay. We're not use to such prompt committee members. It through me off.

COUNCIL MEMBER LANDER: You can say our names again, though.

CHAIRPERSON LEVINE: Welcome, Council Member Barron. We have a full house. Thank you all for joining us. You did mention the disparity between black and white mothers in New York City, a 12 to one ratio, unconscionably high. You did not mention, unless I missed it, disparate treatment by medical professionals, in particular the phenomena which both Chair Rosenthal and I mentioned in our opening statements of tendency to disregard what black mothers or expectant mothers report about what they're experiencing, including pain. Would you care to comment on that, and more importantly, tell us how we're going to fix this?

ASSISTANT COMMISSIONER KAPLAN: Absolutely. Thank you for that really important question. So, in addition to structural racism and how that affects health outcomes, we need to look at, and we look at institutional racism. What happens

within the four walls of a hospital or other institution that is based on us living in a racist society and the impact it has on very institutions that are there to serve people. And so initially, one of our concerns we've heard certainly from individuals and our partnerships with community engagement group with doulas that we work with from people who have spoken to their experience of being disrespected or treated poorly and their belief that this was based on their race and their gender, both actually. And so we do not-- what we first looked at at the Health Department as we are very much data-driven and want to have data to document and quantify this to make it even more powerful-- we looked at the PRAMS surveillance that we-- I mentioned earlier, which is a representative sample of women who give birth in New York City-- and we decided to add questions on disrespect during and respectful care and how women are treated at the time they give birth. We worked with representatives from the Community Engagement Group and other experts in this field and developed questions to add to our PRAMS surveillance. No one in the country has ever done that, and we did it in time to field it this year.

2 So we are now collecting data on a representative
3 sample of women who give birth in New York City
4 specifically asking questions about their experience,
5 were they treated-- we use the word 'disrespect.' We
6 ask them how they were treated, and we will be able
7 to document that and report it out we hope early next
8 year. We will have that report earlier than usual.
9 So, that's the first step. The second step is as we
10 work with hospitals, and we mentioned the Maternal
11 Care Connection at SUNY Downstate in East Flatbush,
12 and we hope to continue to work with other hospitals.
13 There is a new protocol called the Perinatal
14 Disparities Bundle, and Bundle refers to best
15 practices. It's very new and has not-- it's just
16 being piloted at this time, but it is a-- and we-- it
17 is a steps that hospitals can take to address
18 institutional racism. It recognizes that not only
19 does it exist, but that need to be institutional, not
20 just individual trainings, but structural changes in
21 the hospital to both measure and address and give
22 patients served the opportunity to say what happened
23 and give that feedback back to the hospital. There
24 is implicit bias training to-- and interesting to
25 talk about explicit bias and implicit. What are-- so

that people who sometimes are aware and hold biased opinions, some people who don't realize that they're behaving differently based on someone's race, ethnicity, gender, and other differences, helping them to become aware of this, and then measuring how that-- as actually experienced by women when they give birth, by asking them directly about that. So not just by PRAMS, which is a first step, but that's citywide. It won't tell us information at the hospital level. So, and we-- SUNY downstate has agreed, and we're looking to encourage other hospitals to agree to implement that disparities bundle. We're bringing in a national consultant who as an OBGYN has worked around birth equity for years to help support our implementation. Because this is new, we need to evaluate and carefully-- we need to evaluate it carefully. We have a lot to learn on-- are these the right pieces? And we need to have continuous feedback to help us with that. The other thing I will add is the Birth Justice Champions, and actually a consultant who works on them is here with us today and representing doulas, which are really bringing on providers to be people who are committed to Respect for Birth and be a voice. We've held

2 initial first-time ever Grand Rounds in four
3 hospitals. There will be another one this week where
4 we for the first time brought in women, people who
5 have experienced traumatic birth experiences in one
6 way or another, to tell their stories at the Grand
7 Rounds, and so we now have 45 people from around the
8 City who are trained in story-telling, to really how
9 to tell their story in the most powerful way
10 possible, and part of our Grand-- if you've ever been
11 or heard about Grand Rounds, generally this is case
12 presentations. They're very clinical. They focus on
13 what went wrong clinically and bringing in someone
14 who is there to tell their story. We believe, and
15 we've heard from initial feedback is an incredibly
16 powerful way to drive home a message. It's not
17 theoretical anymore. There's a human being there
18 telling what happened to them and why certain
19 behaviors by providers or the institution affected
20 how they experienced their birth.
21 CHAIRPERSON LEVINE: I'm very happy to
22 hear about your move to collect data on patient
23 experience, from perspective of the mother, and glad
24 to hear about the piloting of implicit and explicit
25 bias training. I would urge you not to wait for the

2 data to come in. We know-- we know this problem is
3 out there, and we need to act immediately. And I'm
4 generally not a fan of pilots. I believe we just
5 need action, and when it comes to this training it
6 needs to be rolled out immediately. As we're doing
7 in other professions in the police force and
8 elsewhere, anywhere where implicit bias needs to be
9 addressed, I'm not-- I understand there's a lot of
10 medical providers we have to reach, but we should
11 move immediately to touch everybody because this
12 problem is real and people are dying, and we have to
13 address it now.
14 ASSISTANT COMMISSIONER KAPLAN: Just to
15 add, we could not agree with you more. This is a
16 crisis. This is unacceptable to have our city with
17 the 39 maternity facilities, 38 hospitals and one
18 birthing center. There are many hospitals in the
19 City that people can access, and yet we're seeing
20 these unacceptable disparities. We're not waiting for
21 the data, let me stress. We are moving forward, and
22 we agree there is what we're describing that we're
23 working on today, there is much, much more to do, and
24 we're looking at what more we can do right now. So,
25 the-- but the data will both create a baseline of

2 data and help us to see are we being successful. Are
3 we actually changing? Are we seeing an impact a year
4 from now and every year if we continue to measure
5 this? Without that, we will not know-- it will be--
6 well, it's one way to know are we having an impact.
7 CHAIRPERSON LEVINE: I am pleased that
8 we're joined by Doctor Easterling who I believe
9 represents-- is leading the Brownsville Health Action
10 Center, which I think it's in Council Member Alicka
11 Ampry-Samuel's district.
12 COUNCIL MEMBER AMPRY-SAMUEL: Of course
13 it is. Of course it is.
14 CHAIRPERSON LEVINE: So, I'm sure she's
15 happy to have you here as well. The work that the
16 centers are doing on the ground is directly
17 addressing the conditions which are leading to
18 disparate health outcomes for people of color,
19 particularly expectant mothers, African-American
20 mothers, and I would like for you to tell us a little
21 bit about how your work directly impacts some of the
22 challenges that we're talking about today.
23 ASSISTANT COMMISSIONER EASTERLING: Sure.
24 First, good morning to the Council, the Committee, to
25 Chair Rosenthal, as well as Chair Levine, to everyone

2 in the audience. This has been a long time coming.
3 And so, just on behalf of the hundreds of doulas in
4 this City who have been advocating for their voices
5 to be heard, to be at this table to really make sure
6 that they were being valued in their work, I just
7 really wanted to commend the committee for really
8 championing this work. And so, as you've mentioned,
9 Chair Levine, so I serve as the Assistant
10 Commissioner for the Brooklyn Neighborhood Health
11 Action Center. There are three Neighborhood Health
12 Action Centers throughout the City, one is in
13 Brownsville. The other two, one is in Harlem, East
14 Harlem, and the other one is in the South Bronx in
15 Tremont. We work to coordinate and collocate
16 services so we have both clinical and nonclinical
17 services, because we understand that individuals are
18 not leading and living single-issue struggles in
19 single-issue lives. And so therefore, we want to
20 make sure that we're coordinating clinical services
21 as well as making sure that people have cribs and
22 making sure that they have car seats and they have
23 child-birth education classes, and the exercise
24 classes that they need. But the other-- the most
25 important piece that we do out of our Action Centers

2 is coalition building as well as community-based
3 organizations, hospitals, faith-based organizations,
4 and many other stakeholders within those
5 neighborhoods. For example, in Community District
6 16, Council Member Samuel's district, what we do to
7 work with all providers as well as community-based
8 organizations is to understand what the challenges
9 and barriers are that people are facing that deals
10 with implicit bias, that also deals with explicit
11 bias, as well as how services are rendered and
12 allocated to individuals. And we know that the data
13 already shows that there are disparate health
14 outcomes in Brownsville, social outcomes that are--
15 and educational outcomes that are disparate as well.
16 And so how can we better connect services to the
17 people, but also make sure that these are culturally
18 relevant and quality services. And so as we had
19 already talked about, for instance, the Maternal Care
20 Connection, there's an opportunity to bring an
21 amplified voices as people are providing these
22 services, how services are going to be presented.
23 And so having those voices at the table will
24 certainly help to make sure that the providers are
25 presenting in the best way possible, and I think

2 that's the best way that our Action Centers can be a
3 vehicle to be an amplification of all the voices in
4 the neighborhoods to make sure that providers are
5 showing them the best way.
6 CHAIRPERSON LEVINE: Well, as you
7 mentioned, we have grand total of three of these
8 extremely important on-the-ground public health
9 centers, Neighborhood Action Centers, and some of the
10 neighborhoods with the largest population of African-
11 American communities are not currently served,
12 including Rockaway, Jamaica, Northshore of Staten
13 Island, and what's particularly incredible is in each
14 of these locations, I believe, there are formerly--
15 they're now vacant-- formerly occupied public health
16 centers that the Department used to run that we've
17 shut down. I think there were 30 in the La Guardia
18 era. So, you know, we made it a top budget priority,
19 one that unfortunately wasn't funded in the budget to
20 expand these centers, and I do think it is directly
21 relevant to our topic today, which is the kind of
22 preventative care that can avoid a crisis occurring
23 during pregnancy and childbirth. I want to pass it
24 off to my colleague. Just my last question for
25 Doctor Kaplan is, often in these hearings when the

Administration says, “We support the intent of a bill”-- translated to English, that means we don’t support the bill. So, I just-- I want to give you a chance to clarify what the Administration’s stance on these two bills are before I pass it off to my colleague.

ASSISTANT COMMISSIONER KAPLAN: What that means in this case is we have a committee. So, when the Council speaks to assuring a committee, we have one and we want to, and we already report data. We are able to provide additional data, and I can give you-- in fact, I want to make sure I get this right. I need new glasses. Yeah, so we will be able to give more comprehensive information on the deaths and we don’t want to-- what-- the reason we can’t be specific in the testimony is because we’re looking at and wanting to assure that we protect confidentiality. Some of the data requests could compromise, because of the small number of deaths each year. And so while we are able to provide specific-- more data than we already are, we can’t commit to the specifics without a conversation after the hearing.

2 CHAIRPERSON LEVINE: I appreciate that,
3 and I'm going to pass it off to Chair Rosenthal for
4 further questions on that and other topics.
5 CHAIRPERSON ROSENTHAL: Thank you so
6 much, Chair Levine. I'm just going to ask a few
7 questions, because I know my colleagues are eager to
8 ask questions as well, and we have a room full of
9 doulas who are eager to testify as well, and we've
10 worked so hard together. I do just want to follow up
11 a bit on Council Member Levine's question. Would it
12 be possible for you-- and I understand the hesitancy
13 about data privacy, that's fine. I don't think you
14 answered the question that-- I'm not sure if you
15 asked, but the same question as it has to do with
16 provision of doulas to everyone who needs one, and
17 what I would ask that you put together after this
18 hearing is a strategic timeline of what you think is
19 do-able. I'm sure there are financial considerations
20 when it has to do with the doula services, but when
21 we think about, again, referring back to Council
22 Member Levine's point about, you know,-- we have to,
23 you know, be in Grand Rounds in every hospital
24 immediately. If that piece, too, you could think
25 about a strategic timeline for how we get to every

hospital in New York City to make sure that people understand here the story-telling from women who have had these experiences. It's-- you know, as we look at the data, we-- the one question comes to mind: why not send all people to better hospitals than the worst hospitals for maternal outcomes? But no, all the hospitals need to be providing service that is without bias. So, what I would ask is that I would like to see a timeline, a strategic timeline for getting it done in New York City. I get it, it's a big city and there are a lot of hospitals, but that's simply, you know, the city we live in. So that's not an excuse. What does it take and how long will it take to get this done in every hospital, specifically about the issue of story-telling? If there are other ideas that you specifically know can be helpful now, I would include that on the timeline as well.

ASSISTANT COMMISSIONER KAPLAN: Absolutely. Just to underscore what you said, which is that this is-- what we described is not sufficient. There is much more to do. This has been an intractable, unsuccessful [sic] situation for years. The fact that the disparity widened from 2001 to-- between 2001 and 2005 and 2006 and 2010, and

2 we'll soon see more recent data. The fact that the
3 severe maternal morbidity went up 28 percent, it was
4 already bad, and it's going in the absolutely wrong
5 direction. So, we agree 100 percent, and I just
6 realized I found-- I just wanted to underscore around
7 additional data that could be included, which is to
8 Council Member Levine's question, it could include
9 date [sic], aggregated information on for people who
10 died around age, education, birthplace, interactions
11 with the health system such as prenatal care, and
12 location of death. And we're merely wanting to have
13 that conversation post-hearing to make sure we're
14 very careful about that balance between having
15 comprehensive data that's publicly available and not
16 compromising confidentiality.
17 CHAIRPERSON ROSENTHAL: A hundred
18 percent. There's no question that that will be done.
19 ASSISTANT COMMISSIONER KAPLAN: Great.
20 ASSISTANT COMMISSIONER EASTERLING: Can I
21 just add? I know you brought this up regarding
22 Intro. 913, and I just wanted to be clear, that the
23 Department fully supports the expansion of doula
24 birth support services, post-partum services in the
25 City of New York, full-stop. And I think the

language around intent, the support of this legislation, is really to the point around the assessment of the needs of pregnant people as proposed by Intro. 913. The Department wants to work with the Council on how best to collect that meaningful data. As Doctor Kaplan already mentioned, we have various tools to collect that data. So, we just want to work with you to make sure that we do that properly.

CHAIRPERSON ROSENTHAL: I say this with a full heart. You know how much I appreciate the Department of Health, and the fact that you are already leading the way, compared to any other City in the work that you're doing, I fully appreciate. We have this tiny window of three and a half years to get some real work done, and I would just love to see a one-year timeline or what we can get done very, very quickly. Actually, just-- I have questions. I'd like to move on. I'd like to let my colleagues ask some questions. Majority Leader-- oh, sorry. So, Council Member Levine and I refer-- defer-- So, Majority Leader Cumbo, I know you wanted to make a statement and ask some questions. Thank you for your service.

2 COUNCIL MEMBER CUMBO: Thank you to my
3 Chairs Rosenthal and Levine. Thank you so much for
4 hosting this incredibly important hearing at this
5 particular time. I just want to first start by saying
6 I am so happy that at the City Council that babies
7 have become such a permanent picture in City Hall.
8 Every day there's another group of babies that are
9 here, and it's just phenomenal, because we are
10 certainly changing the dynamics of where it's
11 appropriate to bring a baby. And so I hope that
12 through these hearings and continued conversations we
13 begin to see a normal society is a normal society
14 anywhere that babies are. So this is really very
15 powerful, and I thank you all for being here. As a
16 new mom, I have questions. Obviously, as an African-
17 American woman, I just gave birth at the age of 42 to
18 a 10-month old. And let me tell you, normally, when
19 I get applause, I'm like, "No, stop it." But after
20 hearing these statistics, it really is unfortunately
21 something that has to be applauded because over the
22 last five years that I have been here, and I hear all
23 of the hearings that we face, you know, when we talk
24 about disparities, particularly between African-
25 American women and all other women and women of

2 color, you know, everything from the disparities
3 around pay equity to HIV and AIDS to issues around
4 domestic violence, heart disease, issues around
5 mortality and breast cancer, and now talking about
6 maternal mortality; it's really a miracle that
7 African-American women are ultimately here and still
8 thriving and beating the odds and continuing to
9 challenge these-- I would say that the reason why
10 we're in many of these situations is because of
11 racial disparities, and they're not just stereotypes.
12 There have been systematic issues in place,
13 everything from a lack of healthcare and insurance to
14 many others that we're here to address today. So, I
15 certainly thank you for being here. For me, as a new
16 mom, when I was giving birth, I didn't want to have
17 an epidural. I wanted to do it the way that, you
18 know, I wanted to be completely 100 percent natural,
19 but I had had a miscarriage five years prior, and
20 because I had a miscarriage five years prior it was
21 recommended to me that I have what's known as a
22 cerclage. So, that would be a stitching up of your
23 cervix, and they would remove the cerclage about a
24 month and a half prior to your actually pregnancy.
25 So, I had my stitches removed, and when I went to

give birth, for some reason they kept stating-- and I'm having extreme pain, but I knew that having a baby was going to be painful, but I had extreme pain that kept dropping my heartrate. And they couldn't figure it out. They didn't understand why my cervix wasn't opening. I had been at the hospital for hours only to find out that the doctors that took out my stitches from my cervix didn't take out all the stitches. So, I had to have an emergency epidural placed, and they had to remove the stitches, and then my cervix was then able to open, and I was able to then 24 hours later give birth. But these are the challenges that many women face, and it's-- it goes against every stereotype from economic to education. These are the stereotypes that every woman faces. And so I think that it's important that we continue to have these particular dialogues and conversations, because our mortality and the issues surrounding it are very real. So, just fast-forwarding to questions, when I left the hospital, and that's what I-- or even before. You know, I had spoken to my doctors about the fact that I wanted to have a midwife. I spoke. Someone had sent me a video of Ricki Lake having a baby naturally, right, in the

water. And I saw all of these things. Now, it may seem funny because I'm 43, so in many ways I thought I don't ever have to know anything about having a baby. I don't know have to know anything about that because I'm not having a baby, but then pow, I'm having a baby. So, it's like I had to learn all of these things. So, people are sending me all these videos. So, when I spoke to the doctor about it, it was basically making me seem like those ideas were ridiculous, this idea of not wanting to have the baby at the hospital, the idea of wanting to have a midwife or a doula, the idea of having a baby at home, all of these concepts that I heard of that I presented to the doctor were immediately-- and because I'm a City Council Member I don't have time to find out if what I thought was ridiculous or not ridiculous. And then coming home, no one ever stated to me, like, we have services that could come to your home. Because what happened for me is that I utilized basically the emergency room as my doula care, if you will. So, when I brought the baby home and his birth weight dropped, I brought him back to the hospital, only really to find out that babies do drop their birth weight naturally after you have a

2 baby, and then afterwards he didn't poop for one or
3 two days, and there are supposed to be, I guess, some
4 type of routine of what color the poop is supposed to
5 be and how often it's supposed to be. I didn't know
6 all of these different things. So I can image for
7 myself, and I have about a hundred of these stories
8 about why I went back to the emergency room. What
9 can be done so that women that need support during
10 and after are paired with that support? Because I
11 was never paired with that support afterwards, and I
12 only gave birth 10 months ago. And if that support
13 is still available, I'd love to have it.
14 ASSISTANT COMMISSIONER KAPLAN: Yeah,
15 I'll just start by saying that I have two grown
16 children both through midwife delivery, and even when
17 I needed a C-section I had the midwife there, and I
18 believe that midwives are critical, and there's
19 strong evidence to show that women who give birth who
20 are attended by a midwife, even if they require more
21 complex care by an obstetrician/gynecologist or a
22 maternal [sic] medicine person have better outcomes.
23 So, you know, we strongly believe that that should be
24 available to any person who wants to have a midwife
25 birth, that that should be available. There are not

2 nearly enough midwives right now in New York City to
3 provide that kind of support, and there's real
4 variation by hospital, but that it is critical. The
5 doula piece-- so, right now, you know,-- and this is
6 unex-- really where you go for care and who you see
7 has a big impact on what is made available to you,
8 what you're informed, etcetera. We are working with
9 our community engagement group on developing guidance
10 around, and it will soon be out. I wish it was out
11 today, but it will be by the end of the month,
12 guidance on standards for respectful care at birth.
13 And our hope is that through our work at the
14 community level and with providers, that all people
15 have information on. This is what you have the right
16 to, and to help people fell that they can-- if they
17 can't get that where they're going, that that's
18 something that is av-- should be available and where
19 they can go to receive it. So, that is going to--
20 you know, will that be tomorrow, everyone know about
21 it? No, but we, you know, believe that many people
22 are not informed. I mean, one thing that you didn't
23 mention that I would add is that we hear about some
24 of the publicity that came to complications for women
25 either dying or almost dying after delivery, where

2 women who went home and then came back to the
3 hospital and had comp-- serious complaints that were
4 not always addressed properly. And so it's also
5 about educating people on what are the warning signs
6 that something might be going on, and trusting your
7 body like Serena Williams did. You know, not
8 everyone can feel that level of-- okay, I have a bad
9 headache and no matter what someone says I know
10 something's wrong. We need people to feel that that
11 is-- that those symptoms are concerning, and if you
12 don't get the care you need, you need to go somewhere
13 else. And it's a lot easier said than done because
14 there are-- people may not have access or feel they
15 can get that care. So, I'd say in the short-run I
16 agree with you. Where can you go to get that care?
17 There are doulas in this room, and you know, I think
18 that is available, but I think-- right now it should
19 be available for across the City and it's not. So we
20 have a lot more work to do to assure that people have
21 the choice of a midwife and a choice of a doula if
22 they wanted, but also the education of our OBGYNs
23 around the kind of information that you deserve to
24 have that was not provided to you around your
25 symptoms, what you wanted, the fact that you asked

2 for something, and it sounds like it was dismissed.
3 That's not okay. That meant there's, in my mind, no
4 reason you couldn't have had a midwife even if you
5 needed for some reason a doctor there as well.
6 COUNCIL MEMBER CUMBO: I think that what
7 you're saying is valuable. I think that sometimes
8 when you work, when you're so familiar with something
9 you take it for granted that someone is mildly even
10 as aware of you. So, if you don't know what's out
11 there, you don't know what to ask for. So, I
12 wouldn't have known necessarily to ask for doula care
13 or a midwife. I would not have necessarily understood
14 how that would have come into play. I think other
15 questions that need to be asked of mothers when
16 they're going home are questions around who are you
17 going home to. What is your home environment? Do
18 you have a support system? Are you going home alone?
19 Are you going home to a spouse? What are the
20 circumstances within the relationship? Do you feel
21 that you perhaps need additional support? When do
22 you have to go back to work? You know, like, there
23 needs to be like a series of questions so that it can
24 be-- a profile can be given of that person to know
25 exactly what support services that they are going to

need either coming in or, you know, if you have C-section you may not be able to prepare meals for yourself because you have to rest, so someone that could come in and help you with those sorts of things. Currently, for-- and you may have expressed this in your statement. How could a woman be connected to a doula in New York City in 2018 coming from a low-income background in the City of New York? How would that happen?

ASSISTANT COMMISSIONER EASTERLING: So, typically those have been through referrals, but through hospitals, but some hospitals are already connected to certain programs. Many of the organizations that are sitting in this room today are working to make sure that they have the type of messaging, the flyers, the branding, and the connectivity to the clinical center. So, if any mother or any woman, or anyone is needing doula services, that they can be connected to a doula. And again, you know, we have a number of programs that provide doula services, and so, you know, if there's a no wrong door situation that is established in networks like our Neighborhood Health Action Centers, like other community centers, even if you're not

2 offering doula services, you can be connected to a
3 program. So, if someone comes into our Neighborhood
4 Health Action Center in Brownsville and they are
5 letting someone know that they are planning to have a
6 pregnancy, then they could say, "Okay, we can connect
7 you to Brooklyn Perinatal Network. They're upstairs,
8 and you can set up an appointment." But--
9 COUNCIL MEMBER CUMBO: [interposing] And
10 how is it paid for?
11 ASSISTANT COMMISSIONER EASTERLING: So,
12 the Healthy Woman Healthy Future initiative is funded
13 by you, by the City Council, and--
14 COUNCIL MEMBER CUMBO: [interposing] So,
15 any and every woman can receive it?
16 ASSISTANT COMMISSIONER EASTERLING: Yes,
17 any and every woman can receive it, yeah.
18 COUNCIL MEMBER CUMBO: But it's somewhat
19 hit or miss if you're in the right place at the right
20 time to know that it exists, because I would see
21 myself as in some ways I never heard of it, I mean,
22 in the sense of going through my own process. I've
23 heard about it through hearings and that sort of
24 things, but even in hearing about it through hearings
25 and that sort of thing, I still didn't have the time

to be able to go through my papers and look through the folder and pull it out and say, "I could go here," kind of thing. So, without that type of-- it seems like if you're at the right place, like if I were at Brownsville and I walked past that center on a regular basis, I'd know to go in there. But if you don't know that, how do you know it?

ASSISTANT COMMISSIONER EASTERLING: Yeah, no, I totally hear that, and there has to be a better system about getting that messaging out. I think the Department has worked hard to promote and again amplify the organizations that are providing these services. So, either A, they can get a referral, so word of mouth, because I think that most of the referrals come from someone that previously received doula services through Caribbean Women's Health Association or Brooklyn Perinatal Network, or Ancient Song Doula, and then they're referred to that, to another doula. And again, through hospitals, or if you're clinical center is aware of those services as well. So, we need to really work harder to create that infrastructure so we can get that messaging out.

COUNCIL MEMBER CUMBO: I just have two more questions, and I want to turn it back over. I

think what I'm hearing is that from the time a woman understands that she's having a baby, that there has to be some sort of mechanism in place for her to know what all the services that she has available to her that she can utilize right at her fingertips without having to run all over the city to kind of figure out what those particular resources are. In the Fiscal 2019 budget, the personnel services budget for maternal and child health totals 11.1 million and supports 176 fulltime positions. This represents an increase in headcount of 45 positions when compared to 2018. Can you tell us more about this 34 percent increase in budget headcount and maternal and child health? Correct.

ASSISTANT COMMISSIONER KAPLAN: I'm sorry. I forgot to put on the mic. I'd have to get back to you on some of what that covers, but two things I can tell you very specifically are we received funding, and this came actually from the previous Speaker's advocacy and others from City Council funding to expand Nurse Family Partnership, which is a home visiting program for low-income first time mothers that enrolls families right at the-- as soon as possible during pregnancy and can follow

2 families until the baby is two years old. And we now
3 serve-- with the expansion, we're going to be able to
4 serve another over 800 families, which brings our
5 ability to serve to 3,000 per year, and part of the
6 expansion was to increase to three additional-- four
7 additional teams. One of them is something in Nurse
8 Family Partnership called our targeted citywide
9 initiative which prioritizes and puts actually
10 exclusively on teens who are pregnant and having
11 children who are in foster care, women and teens in
12 shelters who are homeless, and women and teens
13 involved in the criminal justice system or at Rikers
14 Island. And we have a brand new team. We are-- so
15 that is one piece of that, as the hiring of those
16 nurses. We also hired additional teams in Brooklyn
17 and in Manhattan, and we'll be moving-- we've been
18 able to remove our zip code restrictions because we
19 know that with the gentrification in New York City,
20 while there are neighborhoods that stand out as the--
21 overall has the worst outcome, there are pockets of
22 women, of people of color throughout the city who
23 often need these services. So, a lot of the staffing
24 was hiring more public health nurses. We also
25 received funding to expand our newborn home visiting

program which is a paraprofessional nonclinical staff who go and make a home visit after the baby is born, and we focus on the neighborhoods where the Neighborhood Health Action Centers are. The expansion was to, in partnership with homeless services, offer that visit to every baby born in a shelter, and we rolled that out over the last two years. So, we hired more teams of what are called Public Health Advisors as well as social workers and nurses to support, to visit, and we've now in the last year we looked and we were able to reach 75 percent of families with babies under two months of age who are residing in shelter to provide services to them in the shelter. So, those were the main increases. There may be others that you're referring to that we can check to look at specifically what other staff were brought on, but those were the main headcount increases.

COUNCIL MEMBER CUMBO: I just want to close with this question, and because I really want to understand the scope of what we're focusing on. So, just to be as real about it as you possibly can be. So, do we have on staff in terms of trained doula care professionals and that sort of thing to

2 meet the need that is here in the City of New York?
3 Do we have the actual amount of childcare
4 professionals to address the need that we have in
5 terms of maternal mortality, around issues around
6 giving birth to a healthy child, from the time that
7 we understand a child is coming into the world to
8 once the child is here, or is it that we more so are
9 just-- we just have enough resources now to respond
10 to whoever happens to be, for whatever reason,
11 geography, location, circumstances, able to know that
12 services exist? So, there are times when you can say
13 we're not really necessarily promoting this to the
14 world, but we kind of can manage if people find out
15 about us to provide that level of service. But if we
16 all across the board said everyone that's having a
17 baby in New York City that we know is at-risk, we
18 have the services to address that. And if that is
19 the answer, what is it that we actually need in order
20 to be able to provide that?
21 ASSISTANT COMMISSIONER KAPLAN: So, I'll
22 start and I think Doctor Easterling may want to say
23 something as well. No, we do not-- there is much,
24 much more that needs to be done. We're proud that
25 we're a city that is doing more in this area. And I

2 have to say, having been at the Health Department
3 since 2001, and I think there is one tremendous
4 alignment an partnership with many of the community
5 partners who are here, some who are not today around
6 putting the "M" back in Maternal and Child Health
7 around focusing on the mother. There's many years
8 where have focused on babies, and babies are
9 critical, but we're finally really seeing the
10 importance of healthy women, healthy people who give
11 firth. We do-- there is-- we are at the-- we are
12 doing a lot and we're proud of what we are doing, but
13 much more needs to be done. No, right now we can't.
14 What you describe requires a number of things, and
15 I'll just say generally, but, you know, we look
16 forward to further discussions on this and being
17 informed by our community partners who are the ones
18 who really raised to us in the Community Engagement
19 group that's been in place for over three years, this
20 idea of respectful care at birth. Because we had
21 doulas that were part of the Community Engagement
22 group who are seeing these issues day after day, and
23 the need for letting people know about the human
24 right. Because in the United States we don't have a
25 codified civil right to many of these protections as

2 frankly there are in other countries, some other
3 countries. So we need to let people know of their
4 human rights. There's education. They're screening
5 of pregnant women around all their needs, not just
6 their medical needs. And we-- so, -- and we
7 recently-- you can say more about this. Thank you. We
8 recently launched a Here for You campaign. That was
9 last fiscal year that to help people. That was a
10 public awareness campaign to let people know about
11 the services available to pregnant people and to
12 families with than infants. But that ws one
13 campaign. We need a lot more about the-- both City
14 wide, but also at the neighborhood level. It's why I
15 think the work of the Action Centers and other
16 community-based work in neighborhoods where there
17 aren't action centers that need it, because people
18 may see a subway campaign, and that's critical, but
19 we also need to do community-level awareness. So
20 there's an awareness raising. There's more services.
21 There's education in the hospitals and neighborhood.
22 We are-- I think we know more and more what needs to
23 be done.
24 COMMISSIONER BERMUDEZ: [interposing]
25 Right.

2 ASSISTANT COMMISSIONER KAPLAN: But we
3 need to scale it up and we agree with you.
4 COUNCIL MEMBER CUMBO: What percentage
5 would you say you feel you're meeting the need?
6 ASSISTANT COMMISSIONER KAPLAN: Let me
7 get back to you. I don't know that I could quantify
8 it off the top of my head. I think there's-- I just
9 need to say generally that there is much more to do.
10 We're doing good work. I've very proud, and there's
11 much more to do.
12 COUNCIL MEMBER CUMBO: Could you say 25
13 percent we feel we're meeting, 50 percent, 75
14 percent?
15 ASSISTANT COMMISSIONER KAPLAN:
16 Remaining.
17 COUNCIL MEMBER CUMBO: Like, we feel
18 we're addressing 25 percent of the City's need in
19 terms of women in need that need these types of
20 services? Or would you say we're like at 50 percent.
21 Or-- we're like close 100 but not really.
22 ASSISTANT COMMISSIONER KAPLAN: We're not
23 close to a hundred, I can say that, and I'd like to
24 really get back to you with a more--
25

2 COUNCIL MEMBER CUMBO: [interposing] Okay,
3 that's--
4 ASSISTANT COMMISSIONER KAPLAN:
5 [interposing] With a better answer, because I don't--
6 I want to think about what we can say in terms of
7 where we are compared to what the need is.
8 COUNCIL MEMBER CUMBO: Thank you.
9 ASSISTANT COMMISSIONER KAPLAN: Thank
10 you.
11 CHAIRPERSON LEVINE: We don't officially
12 applaud in the Council Chamber, but can we do a
13 handshake for Council Member Majority Leader Cumbo,
14 an incredibly powerful, powerful statement and series
15 of questions. Thank you so much, Majority Leader.
16 It's wonderful to have you here. We're next going to
17 go to Health Committee Member Council Member Alicka
18 Ampry-Samuel.
19 COUNCIL MEMBER AMPRY-SAMUEL: Good
20 morning still, everyone. And I just want to thank
21 the Chairs for this powerful hearing, because it just
22 blends so many of my worlds together, clearly as a
23 mother. And thank you, Majority Leader, for your
24 comments and questions, and a lot of what I was going
25 to address and say, the Majority Leader addressed a

lot of it. I'm the mother of an amazing son, and I gave birth to him in a hospital here in Brooklyn, and it was a difficult time, but because I had an amazing husband and a very aggressive and knowledgeable mother in the room with me, I'm just thankful that everything worked out, because I did bleed out on the table. Everyone had to be rushed out. It was a traumatic experience for the entire family, but again, because of my loved ones being there and able to advocate for me when I wasn't able to, I don't know where I would be today. And having that experience, but then leaving the United States and working for the United States Government in developing countries across West Africa, it was interesting to see how we as a country spend so much money on maternal and child mortality, again in developing countries, and here it is in the United States and in particular in New York City such a wealthy city, we have the numbers that were stated today. It's quite alarming, and I honestly did not know that these numbers existed until just recently, and I was doing so much work in developing countries, so it's pretty interesting. But-- and I just want to say I appreciate the work that you're doing in

Brownsville, Doctor Easterling, and when you talked about just looking at families and not just a mother and a child, but overall what we can do to wrap our arms around the families as a whole, I really do thank you for the work that you're doing, because the staff at the Help Action Center will show up at shooting responses and looking to see how they can be supportive of the mothers, to those families. So, thank you so much, and we really are taking this to a level of true partnership, and I look forward to that partnership in this capacity. But I do have a question about the Office of Faith-Based Initiatives. Can you explain the work of this office and how this office was established, and in particular, is this office involved with pregnancy-related care at all?

ASSISTANT COMMISSIONER EASTERLING: So, the Office of Faith-Based Initiatives is an office that's within the Center for Health Equity at the New York City Department of Health. Their primary objectives have been to engage houses of worship, all different faiths, particularly around chronic disease management and prevention. And so they've been doing a lot to implement ACT [sic] transportation, healthy eating programs in houses of worship across the city.

2 Their primary areas in their catchment area is in
3 South Bronx, East Harlem, Central Harlem, as well as
4 Central Brooklyn. And to your specific questions,
5 you know, are they focusing on mothers? Their
6 primary program has been around breastfeeding and
7 increasing both education and awareness to leaders
8 around breastfeeding initiation and duration, because
9 we see in African-American communities that
10 initiation rates are higher than duration rates as
11 they dip off significantly after the mom is
12 discharged from the hospital. And so they've been
13 going into houses of worship and really working with
14 their leaders to really make sure that their houses
15 of worship are breastfeeding friendly, that they can
16 provide lactation spaces and pumps also for the
17 public as well. So, that has been their primary
18 focus around engaging community to be supportive and
19 advocate for mothers, but I think that there is
20 definitely more opportunity where definitely around
21 with ThriveNYC there's a connection that they can
22 make to support families around maternal depression,
23 paternal depression, and other adverse experiences
24 that we know exist in communities.
25

2 COUNCIL MEMBER AMPRY-SAMUEL: And so you
3 think they have the capacity to do that as well?
4 ASSISTANT COMMISSIONER EASTERLING: There
5 is capacity. I wouldn't commit to saying that they
6 can take it on at this moment, because I think that
7 there are a number of programs that they currently
8 have that they're rolling out, and I think we'll have
9 to do an assessment to see what are some of the
10 programs that they can continue to phase out and
11 begin to take on as well.
12 COUNCIL MEMBER AMPRY-SAMUEL: Okay.
13 Well, I look forward to working with you all on that
14 as well. Thank you.
15 CHAIRPERSON ROSENTHAL: If I could also
16 just jump in again, in response to Majority Leader
17 Cumbo's very persuasive story-telling herself. You
18 know, the Deputy Mayor just announced women.nyc,
19 which is a very exciting focus for this city on
20 welcoming women to New York City, but it has nothing
21 on it, and this is just a gentle reminder to those
22 that put women.nyc together, a gentle reminder that
23 we should probably put information about doula
24 services, about you know, search-- information that
25 should come up when women search for information

about their pregnancy, and make sure that's integrated into the new resource guide. Thank you.

CHAIRPERSON LEVINE: Thank you, Chair. And we have-- and we will now turn to Council Member Barron. Did you have questions, Council Member? Great.

COUNCIL MEMBER BARRON: Thank you to the Chairs for this committee hearing, and thank you to the panel for being here. I was so pleased to see in your testimony as I have always seen in the testimony of the Department under the leadership of Doctor Bassett the statements, the acknowledgement of institutional, systemic racism and its impact. In her book, Medical Apartheid, there are references to so many documented instances of women being used experimentally as with Doctor Simms for medical "research." I think that there are vestiges of that and that there are many in the black community who don't trust the medical profession. We also all know about the syphilis experiments that were done in Tuskegee. So, we're talking about training for the medical profession. We're talking about addressing implicit and explicit bias. What are we going to do with the other component, the other facet that talks

2 about the perception based on historical reality that
3 black people have that questions the honesty and the
4 integrity of the medical system?
5 ASSISTANT COMMISSIONER KAPLAN: Thanks
6 for that question. I just wanted to make sure I
7 understand. The question is the mistrust--
8 COUNCIL MEMBER BARRON: [interposing] Yes,
9 that prevent--
10 ASSISTANT COMMISSIONER KAPLAN:
11 [interposing] that black people have of the--
12 COUNCIL MEMBER BARRON: That has people
13 not going to seek medical attention, not trusting
14 that the care that they're getting is adequate,
15 hearing instances of lack of professionalism and
16 wondering was it just-- not just. Was it an instance
17 of someone's lack of medical training or was there
18 some intent? How are we going to address that
19 public?
20 ASSISTANT COMMISSIONER KAPLAN:
21 Absolutely. So, I think we are starting to address
22 it and it's really at the beginning stages with
23 something I mentioned in the testimony with Birth
24 Justice Defenders and Champions. So, this is really-
25 - our goal is to have people in the community who

have given birth or whose loved ones, friends, family have given birth, we have grandmothers involved, who can speak to their experience to educate the provider and to help-- you know, to sort of bring human being to human being and to hear those stories to speak to what is-- what was that experience, and for-- because it won't just be educate-- I mean, I believe in training strongly, but we know that training doesn't necessarily change behavior.

COUNCIL MEMBER BARRON: That's right.

ASSISTANT COMMISSIONER KAPLAN: And so we need-- that's a beginning step. It's not an end in itself, because there need to be-- I mean, if people have had a bad experience and word-of-mouth is that don't go there because you don't get treated well, the institution is then going to need to show and demonstrate a change that reflects that people are treated differently here, and that's going to be a culture-- a culture shift that won't happen overnight. I mean, I speak from our experience working to make the hospitals baby-friendly, and to support people who want to breastfeed, and it took three to four years for most hospitals to make that change. People get used to doing things a certain

way. They don't even realize that they're disrespecting people. I think it's going to have to be a two-way street. People are going to-- we need the voices of community members speaking to and educating. We need providers engaged and those hopefully growing numbers who are willing to call out what's not acceptable, and what's not-- and I think it' going to have to be proven time and time again for the perception to change, because we need people to be able to go and get the decent respectful care they deserve.

COUNCIL MEMBER BARRON: Thank you. and just to comment, I'm so pleased that Brookdale Hospital is reaching out to make sure that we spread the message about the advantages of breastfeeding, and my sons are 35 and 45, and but that was back during the 70's, and you know, the Revolutionary movement, and so I just felt, well, this is the natural thing to do so I'm going to breastfeed my sons. I'm so glad that I did. And I do want to also acknowledge that yesterday the Brownsville Action Center had a fantastic event. It was their second one. It was well-attended. It was better than the first one, and the first one was grand and great, and

2 so much information was available. I stopped and I
3 thanked every one of the tables and picked up lots of
4 brochures. So, I will be sending your office
5 requests for large quantities of some of the
6 information that I got, and compliments for that
7 grand event. It was wonderful.
8 ASSISTANT COMMISSIONER EASTERLING: Thank
9 you.
10 CHAIRPERSON LEVINE: Thank you, Council
11 Member--
12 COUNCIL MEMBER BARRON: [interposing]
13 Thank you.
14 CHAIRPERSON LEVINE: Barron. And thank
15 you to the Administration. We are now going to move
16 to our next panel, which is going to be outstanding,
17 because it's a mix of doulas and a few people who are
18 not doulas but who have babies that they have to
19 leave to take care of. So, that's going to be a
20 great mix of voices, and I'm going to start by asking
21 Renat Dre [sp?], Michael Bast, Deborah Lasane, Tanya
22 Hardy [sp?], and Chanel Porchia-Albert to please come
23 to the next panel. We have many people who want to
24 testify, so we are going to have a three-minute clock
25 on testimony, but I promise you that we will be very

2 flexible and generous. We want to hear all of your
3 voices in this important discussion. Is there one of
4 you that needed to leave due to childcare needs?
5 Okay. Please, kick us off.
6 CHANEL PORCHIA-ALBERT: Good afternoon,
7 everyone. First, I'd like to say welcome to the
8 doulas and the mothers and the advocates in the room,
9 and thank you, City Council, for hearing our
10 testimony, Ancient Song's testimony. So, good
11 afternoon to all and give thanks for joining to
12 support a movement towards justice in maternal
13 health. Just to give you a little bit of background-
14 - okay. Ancient Song Doula Services is a Brooklyn-
15 based organization and has actively worked towards
16 bridging racial disparities in maternal health
17 through addressing racial and implicit bias since
18 2008. We have trained over 300+ doulas, both locally
19 and nationally and served over 200 individuals
20 citywide alone last year. Community-based and
21 culturally relevant organizations are crucial in
22 spearheading the fight against the disparities in
23 black maternal mortality and morbidity in New York
24 City where African-American women are often 12 times
25 more likely to die of a childbirth-related

complication or suffer a near-miss. Ancient Song stands in favor of the bills proposed today. We would, however, like to stress a couple of crucial areas that can assure an effective implementation of such reform. First, if these bills are to achieve the lasting change they seek, the inclusion of community-based maternal health experts and addressing implicit bias and racism within maternal health outcomes is imperative. While often regarded as a luxury item, doulas of color, particularly community-based doulas, address systemic racism, intergenerational trauma, implicit bias in the birth room both during and before it happens. As we have seen in recent accounts published by Propublica's Lost Mothers series, is Serena Williams who recounts: while recovering in the hospital Serena suddenly felt short of breath. Because of her history of blood clots and because she was off of her daily anticoagulant regime due to the recent surgery, she immediately assumed she was having another pulmonary embolism. Serena lived in fear of blood clots. She walked out of the hospital room so her mother wouldn't worry and told the nearest nurse between gasps that she needed a CT scan with contrast of IV

2 Heparin, a blood thinner, right away. The nurse
3 thought her pain medicine might be making her
4 confused, but Serena insisted, and soon enough her
5 doctor was preforming an ultrasound on her legs. She
6 insisted I need-- "I was like, I need a Doppler
7 [sic]. I told you I need a CT scan. I need a
8 Heparin drip." she remembers telling them. The
9 ultrasound received nothing, so they sent her for a
10 CT, and sure enough several blood clots had settled
11 in her lungs. Minutes later she was on a drip, and I
12 was like, "Listen to Doctor Williams." We have
13 another account of Erica Gardner [sp?], a mother of
14 an eight-year-old daughter and a four-month-old son
15 who was thrust into an activist role against police
16 brutality following the death of her father, Eric
17 Gardner while in police custody, and who died four
18 months post-partum, and countless other mothers here
19 in the United States whose stories are never told.
20 Time and time again the voices of black women have
21 been ignored within healthcare and continue to be
22 dismissed as an afterthought, forced coercion into
23 complying with medical procedures by threatening to
24 call Child Protective Services, the continued lack of
25 access to equitable culturally-relevant care, and to

2 compound it by stress of racism and implicit bias
3 continue to kill us on a daily basis, and it's
4 showing up in the birth room and during the post-
5 partum period. Over times, organizations such as
6 Ancient Song Doula Services have been providing
7 community-based doula care to marginalized
8 communities, both on a local and national level to
9 address these continued injustices. According to
10 Choices in Childbirth, community-based doulas offer
11 ample culturally appropriate support from trained
12 community health workers and primarily serve under-
13 resourced communities with care on a sliding scale as
14 a tailor to specific needs of the community.
15 Community health workers such as doulas are equipped
16 to address discrimination and disparities through
17 bridging barriers and language and the gaps in
18 culture. Given that payment for these community-
19 based services are usually out-of-pocket, the absence
20 of any reimbursement makes doula care highly
21 inaccessible, especially for families with limited
22 means. In addressing maternal mortality head-on, we
23 first must consider all of the factors that limit
24 access to effective maternal healthcare and can
25 result in such drastic disparities and outcomes. We

have to think about food and housing insecurities, the access to cultural humility within that healthcare system, and given that systematic oppression is a social determinant of black high infant maternal mortality rate within New York City. Assisting [sic] task and responsibilities down the hierarchy of the healthcare system is both necessary and ideal for marginalized communities. For these reasons, the most crucial aspect is free, low-cost doula services. Prioritizing the reimbursement of community-based, culturally relevant doula services through Medicaid is key, as its beneficiaries are often those who are affected the most and looking at such disparities within maternal healthcare system. We ultimately stress that the implementation of Medicaid reimbursement be equitable, community-based, and provide access to a scope of services needed to be adequate to the needs of the consumers. Reimbursement should be nothing less than a rate that is of a living wage. We urge that you use your voice to advocate for community-based doula programs being included in Andrew Governor Cuomo's proposed doula pilot program which seeks to address racial disparities in maternal health. Without

2 comprehensive inclusion, more-after-- moreover,
3 community-based stakeholders who are doing the work
4 within maternal healthcare are doomed to fail before
5 it even gets started. We also have the following
6 recommendations: We call for institutional reform
7 from administration to staffing that provides
8 education on all implicit bias, racial
9 discrimination, and a human rights in childbirth--
10 and human rights framework in childbirth that address
11 bodily autonomy, informed consent, and shared
12 decision-making within reproductive health choices.
13 We call for accountability measures to be implemented
14 that tracks and monitors intuitions and staffing, and
15 that allows for consumers and staffing to report
16 implicit bias and discrimination during prenatal,
17 childbirth, and the post-partum period. We call for
18 community members to be seen and incorporated within
19 the review of all proposed healthcare models and
20 those accountability measures. We call for an
21 evidence-based review of all systems of reproductive
22 healthcare within New York City, and in particular
23 all public and private hospital facilities within
24 areas that exhibit high maternal mortality rates or
25 near misses. And we also call for midwifery care to

be incorporated as a viable system in addressing racial disparities and implicit bias, and Medicaid reimbursement for those services be at a living wage regardless of where the patient decides to birth. In addition, certified professional midwives been seen as an additional resource in adjusting the shortages of midwives within New York City. So, I leave you all with the words of Audrey Lorde [sp?], that when we speak we are afraid our words will not be heard or welcomed, but when we are silent we are still afraid. So, it's better to speak, and we will continue to do so until racial disparities within healthcare and implicit bias are addressed within New York City. Thank you.

CHAIRPERSON LEVINE: Thank you, Chanel, and we appreciate that very powerful-- yes, powerful. We do remind folks that our custom here to express support is to wave, just a little bit of decorum. Technically, we need to ask you to state your name for the record. So,--

CHANEL PORCHIA-ALBERT: My name is Chanel Porchia-Albert. I'm the Founder and Executive Director of Ancient Song Doula Services, and we are located in Brooklyn, New York.

2 CHAIRPERSON LEVINE: Excellent. And we
3 have been joined by our colleague on the Health
4 Committee, Council Member Doctor Mathieu Eugene. And
5 I do want to ask folks to bear in mind we have a lot
6 of people who are testifying, and so if I jump in to
7 ask you to summarize if you're over time, please
8 understand it's just that we want to hear from
9 everybody, and then I'll ask you to please take it
10 away.
11 MICHAEL BAST: Much better now. Good
12 morning. I'm Michael Bast. I'm a Medical Malpractice
13 Lawyer. I have an office on Court Street in Brooklyn,
14 and I've been practicing law for about 40 years. I
15 have never seen a case like the one I'm about to tell
16 you now, the case of Renat Dre [sp?]. Councilwoman
17 Rosenthal mentioned the need to listen to women,
18 listen to them tell their stories. Ms. Barron also
19 mentioned that people are not aware of what's going
20 on and not listening to their patients. Many times
21 in the past, perspective clients would come into my
22 office seeking representation, and they would tell me
23 a story that goes like this: "I was nine months
24 pregnant. I went into the hospital to deliver my
25 baby, and the doctor gave me a C-section even though

2 I didn't want it." I would say, well, if that's
3 something that's a bad thing, fine, bring in the
4 medical records and we'll take a look and see if
5 that's enough to make a case or not. And a few
6 months later the woman would bring in the hospital
7 records, and we'd look at it, and there would always,
8 always be an entry reading: "After much discussion
9 with the patient and her husband, patient agreed to a
10 Cesarean Section." And there in the record the
11 woman's signature appears on the consent form, and
12 the prospective clients would say, "And they badgered
13 me, and they threatened me, and they made me sign
14 that consent form, but I really didn't want it." And
15 I would have to explain, I'm sorry this is not a
16 winnable case, because a jury is going to hear you
17 consented. You're going to lose. Thanks for coming
18 in. And the woman would say, "But what about this
19 gruesome scar I have. I almost died. What about
20 this infection? What about my lacerated bladder?"
21 And I would say, "I'm sorry, but those are considered
22 a risk of the procedure." A risk of the procedure,
23 meaning women who have C-sections, they get injured.
24 You consented. The women who come into my office are
25 telling the truth about what they wanted and about

2 what happened to them, but I wouldn't take their
3 cases, and neither would anybody else. Then, in
4 January of 2014, Renat Dre walked into my office with
5 a statute of limitations about to expire and the
6 medical records in her hand. She had a similar
7 story, but this time it was in writing. In July of
8 2011 she had been forced to have a C-section against
9 her will at Staten Island University Hospital. The
10 medical record said in the Doctor's own handwriting,
11 "The woman had decisional capacity. I have decided
12 to override her refusal to have a C-section, and her
13 attending doctor and the hospital attorney are in
14 agreement." And that's what they did. They wheeled
15 her into the operating room over her objection.
16 What? How is this possible? How could this be? Not
17 only did a doctor admit to performing a surgery
18 without consent, but the hospital general counsel
19 agreed to it. Isn't this America? Can someone be
20 forced to have major abdominal surgery without at
21 least a court order?
22 CHAIRPERSON LEVINE: And Mr. Bast, we
23 very much value hearing this story. If I can ask you
24 to wrap it up or perhaps I don't know if Ms. Dre is
25

speaking herself, just because we're over time. We have so many people who want to speak.

MICHAEL BAST: Very well. The case is still litigation, and we don't know how it's going to come out, but I did bring with me Renat Dre who is going to tell her own story what happened to her.

CHAIRPERSON LEVINE: Thank you. Ms. Dre?

CHAIRPERSON ROSENTHAL: Just turn on the mic. See the red dot? And state your name for the record.

RENAT DRE: My name is Renat Dre, my date of birth is December [sic] 10, 1979. The time of the event I was 32 years old, and I lived with my husband.

CHAIRPERSON LEVINE: And if you can just speak directly into the mic. We're having a hard time hearing.

CHAIRPERSON ROSENTHAL: But also you should know we--

MICHAEL BAST: [interposing] They're going to [inaudible] time. You're just going to tell the story about when you first became pregnant.

CHAIRPERSON ROSENTHAL: Hang on one second, sir. Hang on one second. Ma'am, I want to

welcome you to the chambers. I can't tell you how much I appreciate your being here. You're sharing your story. It's powerful, really powerful for us to hear it. So, feel comfortable. We're all on your side. This is not any-- this does not have to do with your lawsuit or any litigation. This is simply the public wanting to know what happened to you, what your experience was, and how you felt about it. Don't-- no one's-- you know, you can feel really comf-- you're in a safe space, and you don't even have to read anything. Just tell us from your heart what happened.

RENAT DRE: Just having very bad experience with my first two pregnancies with doctors pushing me to do a C-section, which I wasn't happy with that. Later on I had a very hard recoveries. So, my third pregnancy I had-- I was looking for hospital and a doctor which will allow me to do VBAC after I did two previous experience I had which was very bad. And then I researched the topic, compared risk of C-section, repeat the section compared to a VBAC, and I checked it out, and I read that it's not-- I mean, I decided it's much better choice for me to try for a VBAC. I went to one hospital in the

2 beginning of my third pregnancy. I was going to the
3 hospital, which I found out that they didn't allow to
4 try after two Cesareans to try for VBAC. So, when I
5 found out that they don't allow it, I left that
6 hospital and I looked for a different hospital and a
7 doctor which will allow me to try to have a vaginal
8 birth. So, I found a hospital, [inaudible]
9 University, allow a trial of VBAC after two previous
10 Cesarean, and the doctor which allow to try to. His
11 name was Doctor Dory [sic]. He was instructing me
12 what should I do to get-- I mean, to get the best
13 chances to have a vaginal birth after previous
14 Cesareans, and I mean, I did everything he said. I--
15 following the certain diet he said, and July 25,
16 2011, about a week after my estimated due date I felt
17 contractions. We called the ambulance which took me
18 to Staten Island University Hospital, was examined
19 and found to be only two centimeters dilated. I
20 decided to return home and to labor at home. The
21 next morning on July 26th I had more contractions and
22 I suspected my water had broken. I called my doula.
23 I hired the doula in order to help me and support
24 that I would get to have a natural birth. My
25 contraction became more intense and together. With

2 my mother we went to the hospital in the ambulance.
3 We arrived to emergency room around eight o'clock.
4 My regular OBGYN, Doctor Dory, was not there.
5 Another physician from his practice, Doctor Gorelik
6 [sic] examined me. The triage nurse told me that I
7 was three centimeters dilated, 90 percent effaced,
8 and the baby's head was in minus two or minus three
9 station. She said the contraction was strong coming
10 three minutes apart. The baby's heartbeat was doing
11 well. I also learned that my water had not yet
12 broken. Doctor Gorelik immediately told me to have a
13 Cesarean section. He didn't give much explanation.
14 He just said, "You had two previous Cesarean, so you
15 should have another one." I responded by telling him
16 that I researched the VBAC, and I knew that having
17 Cesarean having risk too. I considered returning
18 home again with my doula to continue my labor there.
19 When Doctor Gorelik heard this he became upset and
20 said, "Okay, go home and rupture your uterus at
21 home." He gave me an ultimatum. He said, "Either
22 you have a Cesarean now, or you go home AMA, against
23 medical advice." He told me, "If you leave, you
24 shouldn't come back." I didn't like the way Doctor
25

2 Gorelik was treating me, making threats and giving me
3 ultimatums. I did not want to stay at the hospital.
4 CHAIRPERSON LEVINE: [speaking another
5 language]
6 RENAT DRE: Thank you.
7 CHAIRPERSON LEVINE: [speaking another
8 language] Just was just briefly saying how amazing
9 Renat is and how much we support her and how much her
10 bravery has come through in her testimony and in your
11 long fight. [speaking another language].
12 RENAT DRE: Thank you.
13 CHAIRPERSON LEVINE: And we support you
14 in that.
15 RENAT DRE: Thank you.
16 CHAIRPERSON ROSENTHAL: You know, if I
17 could just ask, I think for the purposes of this
18 hearing, it's very clear that, as you said, women
19 need to be listened to, and that women's choices are
20 imperative with-- if it's okay, and so if not to pain
21 you. We have your written testimony. We understand
22 what you're talking about. You know, the next
23 speaker is also talking about the issue of listening
24 to women's choices. Would it-- with deepest respect
25 and heartfelt appreciation of you, are we okay to--

is there one final statement you'd like to make, or may we turn it over to the next speaker who also is going to be speaking about the importance of listening to women and choices?

RENAT DRE: I just want to say that I was treated really, really bad, and I was forced into something that I didn't want to, and there was no real reason to behave this way. It's just-- and the reason he told me is just-- he said it doesn't have-- that he doesn't have the whole day for me. Also was trying to scare me that the state was going to take my child, using all kinds of scary tactics and forcing me to C-section without the consent, which was really, really bad. Okay, thank you.

CHAIRPERSON ROSENTHAL: Thank you. I'm sorry for what happened to you, and I appreciate your coming here today.

RENAT DRE: Thank you.

CHAIRPERSON ROSENTHAL: Thank you.

RENAT DRE: Thank you.

CHAIRPERSON ROSENTHAL: Please.

DEBRA LASANE: Good morning, I just would like to say to you that your story is known throughout all of New York City. We know about what

2 happened to you, and we appreciate that you are
3 highlighting this issue for all to know, and we all
4 support you. You have support of many women in New
5 York City.
6 CHAIRPERSON ROSENTHAL: If you could just
7 state your name for the record.
8 DEBRA LASANE: Good morning. My name is
9 Debra Lasane, and I am the Director of Programs at
10 the Caribbean Women's Health Association, also known
11 as CWHA. I am also a member of the New York City
12 Maternal Mortality and Morbidity Review Committee,
13 which was recently established by the New York City
14 Department of Health and Mental Hygiene. I'm here
15 today toe express my support for both bills. I'm
16 going to cut short my testimony to allow others to
17 speak. CWHA is located in the Flatbush Community of
18 Brooklyn, and we've been providing support to
19 pregnant and parenting women for more than 30 years.
20 It's ironic that CWHA was established 30 years ago
21 specifically to meet the needs of pregnant women from
22 the Caribbean who did not have access to adequate
23 prenatal care and who were experiencing high rates of
24 poor birth outcomes, including miscarriages,
25 premature birth, and infant deaths. Over the years

our services have expanded to include additional services such as HIV education and immigrant legal assistance. We still have a particular focus on the Central Brooklyn communities of Bedford-Stuyvesant, Brownsville, and East New York. During the last two years, CWHA provided breastfeeding education and additional support services to more than 250 pregnant women and their families. In addition, CWHA coordinates doula support services to the residents of Manhattan and the Bronx as part of the Healthy Women, Healthy Futures initiative which is funded by the New York City Council. Thank you, New York City Council. We are a citywide initiative providing free doula support before, during and after birth in the most high-need areas of New York City. Healthy Women, Healthy Futures also provides free doula training to low-income women from the five boroughs. This is the fourth year that Healthy Women, Healthy Futures has been funded and operational. Each year, a new cohort of community-based women, predominantly women of color, receive birth doula training, post-partum doula training or both. To date, the Healthy Women, Healthy Futures initiative has been responsible for training more than 200 New York City

2 resident doulas. The citywide Healthy Futures
3 initiative is coordinated by CWHA, the Brooklyn
4 Perinatal Network and the Community Health Center of
5 Richmond. I'm going to skip a few things. I just
6 want to state that I would also like to see more
7 focus on severe maternal morbidity. It was mentioned
8 earlier. The community districts in New York City
9 with the highest severe maternal morbidity rates are
10 in Brooklyn, all in Brooklyn, Brownsville, East
11 Flatbush, and East New York. Newly arrived women
12 from the Caribbean, Central America, and Africa have
13 higher severe maternal morbidity than immigrant women
14 who have been living in the US for more than a year.
15 My recommendations to address many of the issues
16 stated today is that the New York City Council and
17 the New York City Department of Health should
18 increase the overall number of trained doulas in New
19 York City with a particular focus on training doulas
20 who can appropriately support the Caribbean, Central
21 American, and African immigrant communities. In
22 addition, the New York City Council and the New York
23 City Department of Health should also provide for
24 birth education to all women in New York City,
25 childbirth education. This is to address the issue

2 that was brought up by Council Member Cumbo. Women
3 simply don't know what their options and choices are.
4 Women don't know what a doula is. We need to make
5 more effort and provide more resources to providing
6 this information to women so that they can know what
7 resources are available. I'd also like to recommend
8 better coordination between community-based services
9 and hospital clinicians so that the women in the
10 hospital receiving care in the hospital and the
11 clinicians in the hospital know what resources are
12 available to women in the community and can provide
13 direction to women who are receiving care. Thank you
14 for this opportunity to testify today.
15 CHAIRPERSON ROSENTHAL: If I can just jump
16 in. I really appreciate your testimony in support of
17 more doulas and for everyone for coming today taking
18 the time. Thank you.
19 CHAIRPERSON LEVINE: Thank you to this
20 great panel. We truly appreciate your perspective,
21 and we have our next panel, which I think is also
22 going to be very powerful. We have Doctor Lisa
23 Nathan. We have Patricia James, Helena Grant, and I
24 apologize if I'm mispronouncing, I can't read the
25 handwriting, but Anne Gibeon [sic] from Jacobi

Medical Center. Doctor Nathan, did you want to kick us off? Please.

LISA NATHAN: Sure. Can you-- is this on?

CHAIRPERSON LEVINE: Yes.

LISA NATHAN: Okay. Good afternoon. My name is Lisa Nathan. I am an Assistant Professor in MFM [sic] Specialist High-Risk Obstetrician at NYU Langone Health in Brooklyn. I also serve as a consultant doing maternal death case abstractions for the New York City Department of Health. So, thank you all for having me and allowing me to discuss this important issue that I feel incredibly passionate about. I'm going to skip straight to the question of why, since we've heard a lot about the actual problem. Addressing why there is such stark racial disparities in maternal outcomes in this wealthy country of ours is a big question, and it's difficult to answer, of course. I agree with others that the disparities come to exist are due to a complex interplay of three main factors: patient, provider and, system-level factors. And due to the complexity of the problem and the interplay between all of these factors, I don't think there's ever going to be an

easy solution, nor will there ever be a single solution that in isolation is going to solve the problem we have to address all of these issues simultaneously to actually see the change that we're hoping to achieve. It's clear, of course, that we have to start with increasing access to quality health insurance, a big problem that we all face, in order to provide a strong foundation for increasing access, but we know that access to care does not always translate into utilization of care, because utilization of care is a complicated issue in and of itself. There are social determinants, other patient-level factors that come into play. In addition, culturally competent, compassionate, unbiased, and patient-centered care is a provider factor that we also know is severely lacking, and also does play a role in the patient continuing care with that provider, and adhering to any plan that's been laid out. Disturbingly, as we've all been talking about, we know that there's more and more evidence of the overt and subconscious racism that's playing a factor in patient care and adherence to plans as well as outcomes. And that implicit bias exists amongst healthcare professionals I think is

2 inescapable, but to think that it might compromise
3 care being provided to the most vulnerable patients
4 is just truly unacceptable, and I think implicit bias
5 awareness in training is an essential component of
6 what we need to address. In my years of work in this
7 city I can also attest to the fact that it's critical
8 to improve the quality of the actual medical care
9 that's being provided to these women from the pre-
10 conception period through the post-partum period.
11 Physicians also need regular structured training
12 sessions in the major obstetric emergencies so that
13 when an emergency happens it's recognized quickly and
14 it's managed efficiently. Research has shown that
15 nearly half of all cases of severe maternal morbidity
16 and maternal deaths are actually preventable,
17 exemplifying the fact that quality of care provided
18 is a critical piece that needs to be addressed as
19 well. Where I work in Brooklyn we work with an
20 incredibly diverse linguistically, culturally,
21 racially-- the patient population there is very
22 challenging in many ways. We deliver over 4,500
23 women a year, and we are regularly providing
24 simulation-based training to all of our staff as well
25 as requiring that implicit bias training is completed

2 by all staff members as well. Thank you for the
3 opportunity to talk. I'd love to address any
4 questions you might have.
5 CHAIRPERSON ROSENTHAL: Thank you so
6 much. If I could just ask the Sergeant at Arms to
7 close the door in the back. Thank you. Go ahead.
8 ANNE GIBEAU: Hi, good morning. My name
9 is Anne Gibeau. I'm currently the Practice Director
10 for the Midwifery Practice at Jacobi Medical Center
11 where I've been for over 25 years. I'm also the
12 local representative for the Downstate Region for the
13 New York State Association of Licensed Midwives, and
14 I'm pleased to be speaking today in favor of bill
15 number 194, which is amending the Administrative Code
16 of the City of New York in relation to reporting on
17 maternal mortality. So, I would just like to lend my
18 support and consistent [sic] until my arms are aching
19 agreement with the testimony brought forth. So, as
20 Doctor Nathan said, I'm going to jump right to it.
21 In considering amending the Maternal Mortality Review
22 Board, we have a couple different thoughts.
23 Certainly, we need to have coordination between
24 what's going on in the state level to the city level.
25 So we would ask, for example, that there be

2 consideration as congruence of time period. So,
3 currently what is recommended in this bill is that
4 pregnancy-related mortality and morbidity be at 42
5 days, and on the state level it's actually defined as
6 up to a year. And also, we also think that it's
7 important that actually there be also direct and
8 consistent communication between what's going on at
9 the state level with what's going on at the city
10 level, because that communication will lead to
11 transparency, and also just helping to understand
12 fully the issue across the State of New York which
13 will inform what goes on here at the City. You can
14 read this later. You can read this later. I think we
15 also think that there's several different issues that
16 need to be addressed. Number one, the inclusion of
17 community members in this process is critical in
18 order to include different views, approaches, and
19 questions to better understand the roots of this
20 reality. You know, the people who are a part of the
21 community understand the sensibility [sic] of the
22 community related to healthcare, and certainly
23 healthcare in New York City-- is true in most of the
24 United States-- is dominated by the medical model of
25 care. And what has been lacking in the formulation

and implementation of healthcare policy and programs is indeed the input of the women, the families, the pregnant individuals for which those specific policies and programs are meant to serve. Many women in New York City do not perceive that they have control over how their healthcare is provided, and after that, the identified concerns regarding perceptions of disrespectful and discourteous care. So, this deleterious approach to healthcare delivery has a strong and negative effect as we've heard. And so we ask that the report as it is conceptualized include, also for example, an understanding of the kind of care that women have received in relation to the fact that it is evidence-based and where it sits in terms of the continuum of best practices, that we also understand that there are communities in New York who are very mobile, and that not only should the borough of residents be elucidated but also the place of birth. So, for example, I care for women, many women who are in the shelter system, and they're with me because they were placed in a shelter in the Bronx, and next thing I know they're coming from Coney Island to see me. So, and they want to birth in the Bronx. We think that that's also important.

Additionally, HIPPA requirements are stated in the amendment to protect the privacy of the women, but considering New York City's litigious environment, it's essential that there be complete unbiased and effective reviews on the part of members of the committee, and we need to understand what the protections are for the committee members. And lastly, emerging issues in terms of review of maternal morbidity and mortality are emerging across the country. For example, including assessment of maternal mental health, suicide, and substance use disorder, and we ask that this committee attend to and report on these emerging issues as well as things that come up through review of the population. So, I thank you, and I welcome any questions.

CHAIRPERSON ROSENTHAL: Thank you.

HELENA GRANT: Good afternoon now. I'm Helena Grant. I'm the Director of Midwifery at the NYU School of Medicine Woodhull Affiliate Division, and I am also a member of the New York State License Association of Midwives, and I'm also a professor at Concordia College for a class called Spiritual and Cultural Concepts in Nursing, and I am one of the three midwives that sits on the New York City DOH's

Maternal Mortality and Morbidity Review Committee. I sit here today in support of both bills for trained qualified doula care for all women in this great City of New York. As a midwife that has served various communities in New York City for 21 years, I want to say that midwives and other obstetric providers and specialties are all needed as a hands-on approach along with doula care in a synergistic way. Midwives and doulas actually do have very similar philosophies and have long worked together as members of the same team. As mentioned so many times today and as need to be mentioned because of the evidence that conclusively demonstrates that women of color, especially black women, have a risk of 12 times of their white counterparts. We do need this all-hands-on-deck approach to ensure that maternity care experiences become one where women are given the opportunity to access information and resources in the form of this helping hearts and helping hands approach outside of the hospital, the clinic, the private office walls that the women themselves can bring inside with them as well to be received with respect and a willingness to listen and shift the trajectory of these statistics. Doula care,

especially when the doulas represent the communities being served, become not only continuing care support specialists, but an invaluable resource and insight to things that are nonclinical that the client may be experience that effect and affect her pregnancy and birth experience. Important part here on the assessment of need. Although doulas, as we said, are not medically trained and do not replace the clinical expertise of midwives or physicians, they are absolutely invaluable. Evidence shows that they decreased C-section rates by 50 percent, the length of labor, use of oxytocin and epidurals. There was a question earlier about statistics. A 2014 study surveyed that nationwide only six percent of women reported the use of doula care and even midwifery care only stands nationwide after about 10 percent. Many of the women are not aware of the benefits of either, and with this in mind as has been brought up before, I would ask that the Council not actually evaluate the demand as a prelude to need. I instead ask that the work be done to remove barriers to women being made aware of these evidence-based resources and statistics so that they can be empowered to speak to their need and that government agencies become

2 information and care conduits for families that seek
3 parenthood for all women. One of the primary goals,
4 as mentioned, is for doulas to enhance the women's
5 emotional health and her positive experience in
6 birth, and this is achieved through home visits
7 during pregnancy, post-partum phone visits, on-care
8 presence, reassurance during labor, and this is a
9 care bundle that whether we practice in the hospital
10 or the private sector, practicing midwives in
11 obstetrics have to admit we're not offering this to
12 women and especially those women who are perceived to
13 garner the most benefit. On the issue of
14 availability about free and low-cost doulas, I would
15 also submit to the Council that the words 'free and
16 low-cost' be actually removed, because during my 21
17 years as a practicing midwife many times I had
18 witnessed one doula hired by a woman come back and
19 forth over the course of a three-day medical
20 induction and stay non-stop for 18 hours once the
21 labor became established. And so in the public
22 health service, especially women need the same
23 equitous [sic] doula care that their counterparts who
24 can afford it have. And so I went through some
25 statistics about rates in here that can be read, and

I just want to say very much like midwifery, women that have access to doula care rate their experience positively, and women need to know that doulas, midwives, obstetrics, obstetricians that provide them with respective information and individualized care are available to them, and thank you.

PATRICIA JAMES: Good afternoon. My name is Patricia James. I am a registered nurse working at Health + Hospitals for over 30 years, and I am also on the NYSNA Executive Committee, representing over 9,000 nurses. Thank you for allowing me to address you here today. Thank you to the Chairs of these committees, Mark Levine and Helen Rosenthal, for highlighting this very important issue. I want you to know that the 9,000 nurses of Health + Hospitals stand ready to work with you to do what we can to support the expansion of midwife services and reporting on the maternal mortality in our hospital and facilities. That's why we support Intro. 914. Our goal is to help develop and implement strategies to reduce maternal mortality and maternal health disparities in New York City. Despite the recent trend of a global decline in maternal deaths, the US maternal mortality ratio has increased, and I'm not

2 going to go over this because we've heard of the
3 maternal mortality rate over and over again during
4 this session. Significant racial disparities in
5 maternal death persist both in New York City and New
6 York State according to the Center for Disease
7 Control and Prevention. Maternal death ratios among
8 black women are three to four times higher than among
9 white women. Race is not the cause of health
10 inequities. When you see inequities in health, think
11 about systems, because systems create inequities.
12 Access to safe affordable housing, a living wage,
13 education, and healthy foods are social determinants
14 that can lead to chronic stress. Stress affects
15 physical and emotional health and can foster
16 unhealthy behaviors that produce health consequences.
17 To improve maternal health and the health of women of
18 color it requires institutional transformation. The
19 public hospital system leaders, families, and
20 providers have the power to operationalize the equity
21 and decrease preventable maternal death and improve
22 the quality of healthcare. Illinois representative
23 Robin Kelly [sp?] announced the bill earlier this
24 year that aims to save more women from dying during
25 early pregnancy or childbirth. The bill titled The

Mothers and Offspring Maternal and Morbidity Awareness, MOMMA, Act addressing racism in the health. Many midwives focus not only on maternity care, but also on the full range of health needs throughout life. Certified nurse midwives provide care from your first period until after menopause, plus all the important health events in between. Before a woman can start a pregnancy that's healthy, she must be healthy herself. Providers have to open a dialogue about health, about healthy lifestyles, about family planning, about pre-existing conditions, about concerns. For example, poor mobility is the presence of one or more additional disease or disorders who are current with [inaudible] disorder. The additional disorder may be a behavior or a mental disorder. Mental health conditions increase accidental deaths, suicide and homicide when untreated. These deaths may or may not become include in current data for maternal mortality. Pregnancy-related deaths can be caused by hemorrhage, cardiovascular and coronary conditions, Cardiomyopathy or infections. Many pregnancy-related deaths are preventable. Opioid use has been identified das having an impact on maternal

mortality. Mothers in jail do not have access to adequate healthcare, those who are in there for the opioid use. Factors that contribute to the death include a lack of patient knowledge on warning signs, provided misdiagnosis and lack of coordination between providers. In 2018, it is time to train healthcare providers to properly listen and assess patient's complaints in order to effectively diagnose and treat properly. I believe access to Medicaid for a year following giving birth would help mothers to remain healthy. Midwives work with other members of the healthcare team such as physicians and nurses, which reduces fragmentation in care. They work in a variety of settings such as hospitals, medical services, clinical birth centers, and homes. They provide general healthcare services, gynecology care, and family planning as well as maternity care before, during, and after childbirth. Health + Hospitals has an outstanding midwifery program at North Central Bronx Hospital. We urge you to learn more about that program. Significant strides in addressing maternal mortality in New York have been made recently. However, significant deficits and inequities remain. We must improve and standardize that collection by

2 incorporating data on race and geography, conducting
3 better analysis on the stress responses toward
4 racism, accepting Medicaid in all hospitals, training
5 and educating providers, and conducting research on
6 pre-disease pathways and on connections between
7 maternal and infant death. I thank you again.
8 CHAIRPERSON ROSENTHAL: Thank you very
9 much, and I will say on behalf of my family, it was
10 nurses who rescued my children when they were born.
11 So, thank you.
12 PATRICIA JAMES: Thank you.
13 CHAIRPERSON ROSENTHAL: I just want to
14 ask really quickly because we have two more panels to
15 get to, and I want to give everyone a fair shot at
16 talking, so just very, very short answers. In your
17 experience, have any written materials or explanation
18 been given to mothers about doula services or about
19 the availability of midwives? Does that happen in
20 the place that you were?
21 HELENA GRANT: So, at Woodhull Hospital,
22 we are a facility that is all midwives and certified
23 M.D.s as well, and because we have a midwifery
24 service we are very integrated into the community,
25 and we often do referrals to places like Ancient Song

and Doula By My Side, because the midwifery community and the doula community is so well integrated. The patient population who comes to Woodhull and who comes to Jacobi and who comes to North Central Bronx, they know that midwives are there. A lot of them have researched midwives. A lot of them use midwives or bateras [sic] in their countries, and so they come and they seek the service. And the hallmark in these places is that there's no woman that does not get a midwife if she wants one. There's a misnomer that midwives only take care of low-risk women. Midwives take care of all women, and really the model needs to be moved to patients and women and people accessing these other high-risk care services as they need it. So, in other words, they don't' risk out of midwifery care. The risk into the other things that they need. And that way, we create a synergy between the team, between the midwife, between the physician, between the nurses, and between the doulas. We're bringing the inside out and the outside in and really creating a team collaboration to give women that best that every specialty has to offer.

CHAIRPERSON ROSENTHAL: I appreciate that. I'm afraid we have to move on to other panels. Thank you all so much for your time.

CHAIRPERSON LEVINE: Next up we have Alice Bufkin from Citizen's Committee for Children. Nonkululeko Tyehemba from the Harlem Birth Action Committee, Savannah Brown [sp?] from Black Women's Blueprint. Okay, thank you. Please.

SAVANNAH BROWN: Good afternoon. Thank you Chairpersons for this meeting and for this hearing and for community who has shown up to this space. My name is Savannah Brown, and I represent Black Women's Blueprint. I am a survivor of child sexual abuse. Child sexual abuse impacts over 67 percent of black women and girls. Before the age of 18, some form of sexual trauma is experienced, and that is from our research that we conducted in 2013, and for those 67 percent of black women and girls who are survivors of sexual trauma, they go on to become mothers, to become pregnant people like myself. And the day that I learned I was pregnant I was actually at Ancient Song Doula Services. So, I was in tribe. I was with a village of doulas and midwives, and I knew from that very moment that I was not going to go

2 to a public hospital in New York City. I was not
3 even going to go to the birthing center. I knew that
4 I was going to birth at home with a midwife, with a
5 doula for fear of obstetric violence, fear of
6 nonconsensual medical intervention, fear of birth
7 trauma or use of force on behalf of medical staff and
8 physicians, of triggers, of Post-Traumatic Stress
9 disorder, and that should never happen. A women in
10 New York City, a New York City resident, should never
11 decide that they will not go or walk into a public
12 hospital, because they are a survivor of trauma and
13 fear of re-traumatization and re-victimization. And
14 so it is my call to action and my charge that doulas
15 and midwives and medical practitioners all come
16 together and be trained in the lens of survivor-led
17 and trauma-informed care, maternal care. So not just
18 respectful care, but trauma-informed care, so that
19 women and laboring people do not leave the hospital
20 feeling re-traumatized or re-victimized as a result.
21 And so it’s really the intersection of sexual
22 violence and reproductive health and maternal health.
23 That needs to be amplified in our efforts to train
24 around this movement, birth just movement, that
25 considers the rights of all women and laboring people

2 and looks at reproductive justice holistically.
3 Doulas decrease stress, nutritional instability, lack
4 of childbirth education, and shift the culture of
5 care within birthing facilities every day and night
6 in New York City where birth trauma impacts of the
7 lives of women and pregnant people. And those trauma
8 echoes, those triggers and those memories are
9 experiences that come up for pregnant survivors that
10 are related to their sexual assault and their
11 experiences with ongoing violence. And many women in
12 their prenatal-- during their prenatal time are also
13 experiencing sexual violence and intimate partner
14 violence, and that impacts birth outcomes and
15 maternal mortality, and it is with access to doulas
16 and more midwives that this impact of trauma on the
17 body and the health of birthing persons can be
18 mang3ed and addressed to benefit the supporting
19 pregnant people and their communities. So, it is
20 with gratitude that I'm here to testify and share my
21 own story of a healthy birth outcome that I had at
22 home with a home-birth midwife. And I understand
23 that that is not the privilege of every woman in New
24 York City but that we can move towards that culture
25 of care, and with highest esteem to Nonkululeko who

2 I'm sharing this space with, and I cannot wait to
3 hear her remarks as well. Thank you so much.
4 ALICE BUFKIN: Good afternoon
5 CHAIRPERSON LEVINE: My goodness, that
6 was very powerful testimony. Thank you.
7 ALICE BUFKIN: Good afternoon. My name
8 is Alice Bufkin. I'm the Director of Policy for
9 Child and Adolescent Health with Citizen's Committee
10 for Children of New York. Thank you very much for
11 holding this really important hearing today. We also
12 appreciate DOHMH's ongoing commitment to addressing
13 birth equity and reducing racial disparities in
14 infant/maternal health outcomes. As DOHMH and the
15 City Council consider strategies for addressing
16 maternal mortality, we do urge increased attention to
17 the impact that federal immigration policies will
18 have on maternal health. We've already heard
19 anecdotal evidence of immigrants due to public charge
20 changes that are potentially coming down the pipeline
21 or other issues forgoing really essential health
22 benefits because-- out of fear. So we really do urge
23 the City Council, the Administration, and DOHMH to
24 invest in additional outreach and direct services to
25 immigrant populations. Again, we very much thank the

2 Committee for holding today's oversight hearing. I
3 wanted to address both of the bills today which we
4 very strongly support. We strongly support the goals
5 of Intro. 914 and feel the establishment of a
6 Maternal Mortality Review Board was a critical step
7 towards addressing the City's high maternal mortality
8 rates. We hope it'll be provided with adequate
9 resources to really intensify and strengthen its
10 efforts. We do want to echo the issue that was
11 raised by DOHMH earlier today just to make sure that,
12 you know, as additional data is be examined it does
13 protect the confidentiality of the individuals who
14 are part of that study. CCC also strongly supports
15 Intro. 913. We have heard extensively just now in
16 this panel repeatedly about the value of doulas and
17 the enormous impact they can have on women in the
18 City. So, you know, despite their benefits, we know
19 that access to doulas remains out of reach for many
20 of the most vulnerable women in the City, including
21 low-income women and women of color. We're very
22 pleased that the Governor is looking at expanding
23 Medicaid for doula services. We don't yet know how
24 that will roll out in practice, and we also want to
25 make sure that we are really supporting community-

2 based doulas as we're looking at how Medicaid
3 reimbursement will work. So, in our support for this
4 bill, we do have a couple of recommendations. One,
5 to echo what others have said, we urge continued and
6 committed collaboration with community stakeholders
7 to help inform City Council's recommendations. This
8 includes the voices of community-based doulas who are
9 actively working in within high-risk communities and
10 have close ties with the clients and communities that
11 they serve. And one of the challenges that we do
12 hear form doulas is that there can be some sort of
13 lack of collaboration sometimes with nurses, with
14 providers, who may not know enough about doulas, and
15 so we would ask consideration of including as part of
16 the doula study really looking at hospital practices
17 and what the attitudes are towards doulas, and
18 knowing about that might help foster better
19 collaboration between doulas, nurses, physicians, and
20 other medical providers. So, again, thank you very
21 much for this hearing today.
22 NONKULULEKO TYEHEMBA: Thank you. Thank
23 you. My name is Nonkululeko Tyehemba, and I'm
24 celebrating my 52nd anniversary as a registered nurse
25 and my 33rd anniversary as a midwife, a certified

midwife. I live in a community where hospitals are failing black women. I spent my entire life, working life, passionately involved with women, and as you know that women, black women, are dying three times the rate of white women, that's not important. What's important is that women are dying. Women are dying. Babies are dying, and then I'm beginning to wonder in a sense, and I'm sort of talking off my nots, and I'll get back to them, but I've become more passionate as I've been here. I'm really, really concerned that we don't lose sight of the importance of the family, and I think there should be-- I support both bills, but I also support the importance of teaching the family members like we used to do, like Aunt Mary and Ms. Betsy, whoever their family members were in terms of this, the doula. We need midwives as well. We need doulas, but we also need-- we need more midwives. I don't think New York or this country itself is as friendly as it should be in terms of midwives. It's been proven that midwives have been key to maintaining successful healthy births. As we speak-- as we speak right now, women across the country are being threatened, they're being coerced, they're being manipulated into making

2 decisions that put them at a high risk of dying of
3 pregnancy-related childbirth. And we need a
4 revolution, not with guns, but with minds and with
5 attitudes, and a new way of thinking about how
6 babies, mothers, women should be treated in this
7 country. As the director of the Harlem Birth Action
8 Committee we've spent many, many years educating
9 women in our community, working with mothers and
10 families to instill a culture that celebrates birth
11 as a natural process. One of the-- I'll end with
12 this statement. One of the major things that I see
13 taking place in the maternal mortality is the fact
14 that another cause for pregnancy-related mortality is
15 institutionalized racism. You know, it's more than
16 just what we-- it's fashionable now to say, okay,
17 it's okay now. High mortality in Texas. And I've
18 been to different-- I go, I volunteer in different
19 countries, and where I go-- I was in Texas last
20 month, and I was told that Texas has the highest
21 mortality rate. Then I go to California, the highest
22 rate there. So, it's almost like we're in a race to
23 have the highest rate of all for maternal mortality,
24 maternal morbidity, and we're going to have to-- this
25 is 2018. This is not 1814 [sic]. So, I'm just

hoping that what I said has made some sense and that we-- that we sort of work towards doing more than just, "Okay, now it's okay to report." After the reporting, after the woman is murdered, then what do we do after that? Is it we just report that Mary Jones died on April 5th? She died of hemorrhage or whatever the case might be. Is that where we'll end there? Will there be a court? Will there be anything after that? I just sort of wonder. Thank you.

CHAIRPERSON ROSENTHAL: Thank you all for your testimony, each one more powerful, each one very, very powerful, and I think that everything you're calling for is common sense. The way people are treated in the hospital, and I just really want to-- I'm a little bit speechless. I'm sorry. There's nothing to say. Thank you for coming to testify. Really, we are hearing everything that you are talking about.

UNIDENTIFIED: Thank you.

CHAIRPERSON LEVINE: Thank you so much. I second those remarks, and we're going to move onto our final panel, and that will consist of Doctor Sharon Griffith from Community Healthcare Network,

2 Lindsey Dubois [sp?] also from CHN, Kylynn Grier from
3 Girls for Gender Equity, and Brittany Brathwaite also
4 from Girls for Gender Equity. And to those of you
5 who have remained with us throughout this incredibly
6 powerful and important hearing, even though the
7 chamber is no longer full, everything that you're
8 testifying to today will be recorded. It's being
9 live-streamed. It'll be available on video. It'll
10 be transcribed, and it's an important part of the
11 record today, and one which will undoubtedly help us
12 make the case for this legislation and for tackling
13 this problem. So we're grateful to all of you for
14 your remarks today, and I'll ask you to take it away.
15 Thank you.
16 SHARON GRIFFITH: Good afternoon,
17 Chairperson Rosenthal, Levine, members of the Council
18 and the audience. I thank you for the opportunity to
19 be able to speak with you today. My name is Doctor
20 Sharon Griffith. I'm an obstetrician/gynecologist
21 and the Director of Women's Health at Community
22 Healthcare Network, also known as CHN. CHN is a
23 nonprofit network that is a federal qualified health
24 centers, two school-based health centers and a fleet
25 of mobile vans. We provide comprehensive services

2 including primary care, prenatal care, behavioral
3 health, and social services to over 85,000 New
4 Yorkers. Thirty years ago CHN was established as a
5 family planning clinic. Approximately seven years
6 ago we added to our network two centers that were
7 originally maternal, infant, and child centers in
8 Jamaica, Queens and Tremont in the Bronx.
9 Comprehensive sexual and reproductive health and
10 prenatal care has always been the core of our
11 mission. Today, we provide prenatal care to
12 approximately 2,000 patients. The majority of our
13 patients that are prenatal are of Hispanic or
14 African-American race or ethnicity. Over 75 percent
15 of our patients have Medicaid-based insurance. One-
16 quarter of our patients have a primary language other
17 than English. Our patients give birth at Cardinal
18 Hospitals throughout the City, and they're encouraged
19 to return to us for prenatal care and well-baby
20 visits. At CHN centers we care for patients of
21 obstetrical risk as well as collaborate with partner
22 hospitals' maternal fetal units to refer patients for
23 clinically recognized high-obstetrical risk. As
24 previously stated, maternal mortality in New York
25 City represents approximately four percent of

2 maternal deaths, and we already know the statistics
3 that black women are disproportionately more affected
4 and likely to die. Because we care for a population
5 of New Yorkers that is disproportionately represented
6 in these statistics, we are here to demonstrate our
7 support for the proposed bill to require DOHMH to
8 report to the City Council on cases maternal
9 mortality and the proposal to codify the Maternal
10 Mortality and Morbidity Review Committee created last
11 year. The City and State of New York are taking
12 steps to investigate cases of maternal mortality and
13 desire interventions that can improve health outcomes
14 and reduce health disparities, and we support these
15 efforts. It is important that the committee is
16 comprised of various types of maternal health
17 experts. Doctors, nurses, midwives are essential, but
18 the committee should also represent, as stated
19 previously, social workers, health educators, doulas,
20 patient navigators, and others with a nuanced
21 understanding of social determinants of health. The
22 committee must ensure transparency in all activities.
23 This is necessary to guarantee proper use of funds
24 and the efficiency of the review process. We would
25 like to advocate for the greater availability of

2 disaggregated data. The fragmentation of EMR systems
3 across the City make it difficult to track patients
4 seen at different institutions and ensure continuity
5 of care. The committee should consider sharing
6 patient-level data with providers to help facilitate
7 ongoing linkage to care in a way that protects
8 patient confidentiality. Finally, the review
9 committee should ensure proper dissemination of key
10 findings to all relevant stakeholders and publish
11 results for the general public. The review committee
12 should also coordinate with members of the state-
13 appointed Morbidity Mortality Review Committee to
14 better understand development and trends in maternal
15 health at the population level. In conclusion, we
16 applaud the City's efforts in dedicating vital
17 resources to investigate the devastating rate of
18 maternal mortality. We are committed to any efforts
19 to collaborate with the City and Administration to
20 further these goals, and thank you for the
21 opportunity to speak today.
22 CHAIRPERSON LEVINE: Thank you very much.
23 LINDSAY DUBOIS: Hi, good afternoon. My
24 name is Lindsay DuBois, and I'm Associate Director
25 for Women's Health at Community Healthcare Network.

I also work as a doula, as a private practice doula and a community-based-- and also for community-based doula programs. Over the last few years I've supported over 75 families through their birth experience, and I can tell you that doulas make an incredible difference. We're here to show our support for this bill and the City's efforts to expand access to doula care. A doula's role providing physical, emotional, and informational support throughout pregnancy and birth is essential to improving birth outcomes for all New Yorkers. People who receive continuous support in birth are more likely to have spontaneous vaginal birth and less likely to have pain medication, epidurals, negative feelings about childbirth, vacuums or forceps assisted deliveries, and Cesareans. Despite these benefits, doulas only attend five percent of births in New York City. So we have an important opportunity to expand access and create lasting population impacts. The plan developed by the Department of Health must respond to the alarming health disparities as we've heard today that we see in New York City, and black women in New York City are 12 times more likely to die from pregnancy-

related causes than white women. So with greater resources, community-based doula programs can help mitigate this devastating health crisis. At the same time, public health researchers are deepening their understanding of the driving factors associated with maternal mortality and other health disparities. The Weathering [sic] Theory suggests that toxic racism sustained over a lifetime can cause premature deterioration of the body which can have a negative impact on birth. Doula have an important role to play in understanding this process and the differential treatment experienced by certain groups. Expanded access to doula support will require training and certification for a large cohort of new doulas. It's essential that training include cultural competency and greater understanding of implicit bias. The plan must also dedicate adequate resources to ensure program sustainability and guarantee that doulas are compensated with a living wage. In my work as a doula I've had the opportunity to support many women who have endured conditions of toxic stress. My clients have included people who are undocumented and people who do not speak English. I've supported women living in domestic violence

shelters without any social support at the time they gave birth. In the face of these challenges, my experience has shown me that doulas help reduce fear, build confidence, improve communication, and simply humanize birth. As one client stated, "Having the help of a doula can be a blessing. It was for me. My doula listened to me and my body. She handled me with great care and concern. For me, labor wasn't like the horror stories I've heard. My doula made sure I was relaxed, safe, and comfortable. She wasn't just another trained professional in the room. She felt like family. This is why we need our doulas." Thank you.

CHAIRPERSON LEVINE: Thank you. And I want to acknowledge we've been joined by stall work advocate for health equity, Council Member Andy Cohen, and we're going to add one more person to this panel. If I could ask Catherine McFadden, you could maybe just grab a chair on the side and we will hear from you as well. Thank you for testifying. Please continue.

KYLYNN GRIER: Hi, my name is Kylynn Grier. I'm actually here on behalf of a young person. I work in policy at Girls for Gender Equity, and I'm

testifying on behalf of Megon [sp?] who can't be here today. "Good afternoon. My name is Megon Jun Lee [sp?], and I'm a junior at Macaulay Honor's College at Brooklyn College studying biomedical ethics and cross-cultural psychology. I would also like to thank the Committee on Health and Committee on Women for having this hearing on access to doula services and maternal mortality. I am a member of Girls for Gender Equity's Young Ones Advisory Council. GGE is an intergenerational organization committed to the physical, psychological, social, and economic development of girls and women. Through education, organizing, and physical fitness, GGE encourages communities to remove barriers and create opportunities for girls and women to live self-determined lives. Doulas are committed to lowering the infant mortality and maternal morbidity rate. Their collective action and offering resources to families so that they can make informed decisions about their care. Their purpose is to ensure a safe and empowering birthing experience. A recent Cochran review found that continuous support during labor may improve outcomes for women and infants, including shorter duration of labor, decrease use of

2 anesthesia, and decreased negative feelings about
3 childbirth experiences. Doulas can become vital in
4 the birthing process for pregnant people within New
5 York City. If we put resources behind assessing and
6 demand of these workers, we can reduce the maternal
7 mortality rate. Signing Intro. 0913, access to doula
8 services, would be the first step in achieving this
9 goal. Additionally, as a young person, I
10 respectfully ask that Intro. 0914 include reporting
11 on the number of maternal mortality disaggregated by
12 race or ethnicity, borough of residence, and age. In
13 Intro. 0913 it is also imperative that the access to
14 doulas include people across the age spectrum. In
15 particular, I want to amplify the importance of young
16 parent’s timely and meaningful access to doulas as
17 the Department of Health and Hygiene expands this
18 program, and to point to the expertise of Ancient
19 Song Doula Services as the program is expanded.
20 Together, we can work to reduce maternal mortality
21 rate by ensuring that we have data that provides the
22 full context to the issue. New York City’s maternal
23 mortality rate is slightly above average for the US,
24 with 30 of the 700 to 900 deaths related to pregnancy
25 and childbirth nationwide each year. New York City

accounts for around 30. Intro. 0913 would protect the maternal mortality-- sorry. The collaboration of New York City and New York State in the pursuit of reducing maternal mortality will establish a precedent for other large states to follow. The maternal mortality rate in the United States is simply unacceptable. In the United States black women die of pregnancy-related causes four times as often as white women. I hope that with the data found in this report, in the reporting, that we can continue to reduce the structural inequalities seen in New York City, whether it be access to healthy food, clean drinking water, good schools, and safe neighborhoods. I ask that you support Intro. 0913 and 0914. Thank you for your time."

CHAIRPERSON LEVINE: Thank you for your testimony. Truly appreciate it.

KYLYNN GRIER: I'll let Megon know.

CHAIRPERSON LEVINE: Thank you.

BRITTANY BRATHWAITE: Hello, good afternoon, Chairperson Rosenthal, Chairperson Levine, and other committee members. My name is Brittany Brathwaite, and I'm the Organizing and Innovation Manager at Girls for Gender Equity. Thank you for

calling attention to the pertinent issue of maternal mortality and inequitable reproductive health outcomes, especially amongst communities of color. GGE envisions a city where people of all ages and genders and their partners, if applicable, are empowered during pregnancy, labor, post-partum to make healthy decisions for themselves, their children, their families, and their communities. With regard to Intro. 0913, which we support, studies have shown that access to doula care improves maternal health outcomes by providing people-centered care and reducing likelihood of surgical intervention such as Cesarean deliveries. We recommend that the City Council require the DHMH to include community-based and culturally-relevant organizations such as Ancient Song Doula Services as an organization that has been actively spearheading the fight against disparities in maternal mortality and morbidity, particularly for black women over the last decade. Black women and transgender non-conforming people face discrimination in medical systems at different intersections of their identity. For example, black women in the US are vulnerable to anti-black racism and gender oppression, and in April 2018 the New York

Times' expose showed that even when we control the factors that may lead to lower quality healthcare such as income or health insurance, black women still have disproportionately negative outcomes when it comes to childbirth and post-partum care. We recommend-- to that end, we must ensure that health providers receive training on implicit bias class and gender bias, anti-racism, and human rights in the practice of healthcare. We also recommend that you support full-spectrum doula work which supports people during all phases of pregnancy including abortion, miscarriage, birth, and adoption, as well as the discussion on issues like race, class, immigration, gender, age, and sexuality impact and affect doula care. As you know, GGE's work focuses on young people, and to that end, all people should receive safe, respectful, affordable, quality healthcare where they live throughout the course of their lives, especially young people. Access to full-spectrum doula care should be accessible to pregnant and parenting students. As GGE has previously articulated in the School Girls Deserve [sic] Report, pregnant and parenting young people experience particular obstacles and impact to

2 complete their education. In addition to young
3 people receiving access to full-spectrum doula care,
4 we recommend that each DOE school assign the role of
5 a pregnant and parenting student's liaison to school
6 staff who embodies and upholds social justice, social
7 work practice, and human rights approach in
8 advocating for the needs of pregnant and parenting
9 students at school. We applaud and support the
10 advancement of Intro. 0914. We're particularly glad
11 to see the bill requires disaggregated data by race,
12 gender, geography, and other demographic factors that
13 can help paint a better picture for the needs of New
14 York City. Any data collection should include both
15 quantitative and qualitative methods including
16 community-based participatory data in order to
17 understand the impact of race, gender, and
18 socioeconomic inequality on black TGNC young people.
19 Finally, the City should cross-reference the National
20 Violent Death Reporting System. The NVDRS data
21 maintained by the CDC with all maternal mortality and
22 morbidity data. The NVDRS which contains information
23 on violent deaths is important too for black women in
24 particular because violence is a significant health
25 risk for many black women. In some states, homicide

is one of the leading causes of death among pregnant women. As one of the 32 states participating in this data model, we have access to data that will help us identify maternal deaths that may be missed in other identification methods. We applaud the City on the bills advanced today, and we urge the City to take also responsibility for directly confronting racial inequities in maternal health. That's it. Thank you for your work to advance the bills being heard today.

CATHERINE MCFADDEN: [off mic] Hi, my name is Catherine McFadden. I just-- I wanted to offer like a public comment, and I don't want to detract from everyone who came so well prepared.

CHAIRPERSON LEVINE: You're not detracting at all. We're very happy to have you.

CATHERINE MCFADDEN: I graduated last year with my Masters in Midwifery from SUNY Downstate and I've also been a NICU nurse at SUNY Downstate for the past five years. I've been attending things on maternal mortality frequently in the past several years, a personal and professional passion of mine. But something I continually see is that govern-- like, it's government official predominantly who are-- like, the DOH has programs and a lot of government-

funded programs to combat the discrepancies we see, but that-- at the government-funded hospitals there's no similar programming or initiative to address those issues. There's chronic understaffing. There's acute understaffing. By that I mean, we don't have specialists at the hospital that should be working in the hospital, and we don't have specialists for the NICU that should be there, and that we don't-- we often don't have enough nurses to provide sufficient care to the patients that we care for, and so it's just-- I'd love to see an integrated approach. The OBGYNs and like the people who are responsible for the patient care environment where a lot of these bad outcomes are happening get their-- are government employees and I wish there was an integrated approach. And I also hope going forward that hospitals will not be able to guard their confidentiality on negative outcomes. I think that's something that the public has a right to know, and especially government-funded hospitals, because even if we only looked at places like King's County and SUNY Downstate we would find a lot of the causes for health outcome discrepancies, and thank you.

CHAIRPERSON ROSENTHAL: Really appreciate your jumping in on that. It definitely makes sense. Just so everyone knows, the Department of Health-- thank you, Brenda-- has these reports that they've put out. You can find them online. I have a copy. I have an extra copy here, but everyone can see the data that they're currently collecting and see what their findings are. Thank you so much.

CHAIRPERSON LEVINE: Thank you to everyone who participated in this hearing today. It was incredibly, incredibly powerful, powerful discussion that is going to force this city to deal with the unacceptable racial inequalities in maternal mortality and a problem that needs to be addressed systematically from top to bottom in our health system. What you said today, all of you, is going to be entered into the public record. This was streamed online live and it's going to be available for download by tomorrow with transcripts available in the coming days. SO, this is going to be an important record on this critical issue. Thank you very much. This concludes our hearing.

[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 July 28, 2018