



**Testimony**

of

**Deborah Kaplan, DrPH, MPH, R-PA  
Assistant Commissioner, Bureau of Maternal, Infant and Reproductive Health  
Division of Family and Child Health  
New York City Department of Health and Mental Hygiene**

before the

**New York City Council Committee on Health**

on

**Intros 1161, 1162, 1172**

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New York City**

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Good morning Chair Johnson and members of the Committee. I am Dr. Deborah Kaplan, Assistant Commissioner of the Bureau of Maternal, Infant and Reproductive Health at the New York City Department of Health and Mental Hygiene. I am joined by my colleague Dr. Jane Zucker, Assistant Commissioner of the Bureau of Immunization. On behalf of Commissioner Bassett, I want to thank you for the opportunity to testify on these important issues. I would like to also recognize Council Member Crowley and the Women's Caucus for championing women's rights in this City, and thank Speaker Melissa Mark-Viverito for her leadership and for courageously using her story to reduce the stigma surrounding HPV and encourage more New Yorkers get vaccinated.

The mission of the Department is to improve the health of all New Yorkers and to eliminate health inequities, which are rooted in historical and contemporary injustices and discrimination, including racism. It is through this lens that we focus our work related to maternal, sexual and reproductive health.

Starting in 2014, the Department began a five-year initiative to increase awareness of and access to a full continuum of sexual and reproductive health and related services, including the full range of contraceptive methods, so that all people can make informed decisions about their sexual and reproductive health, and act on those decisions. We adopted a sexual and reproductive justice framework, which promotes individual choice and body autonomy within the context of our nation's history of reproductive oppression and coercion directed at women of color and low-income women. Sexual and reproductive justice exists when all people have the power and resources to make healthy decisions about their bodies, sexuality and reproduction.

Reproductive Justice is a term developed by women of color, from which emerged a framework and a collective, SisterSong, led by and for indigenous women and women of color. Reproductive Justice is the human right to:

- Decide if and when you will have a child and the conditions under which you will give birth or create a family.
- Decide if you will *not* have a child and your options for preventing or ending a pregnancy.
- Parent the child(ren) you want or already have with the necessary social supports in safe environments and healthy communities, and without threat of harm from individuals, organizations or institutions of the state.
- Bodily autonomy from any form of sexual or reproductive oppression.

As part of this approach, we regularly convene a group of community leaders, activists and nonprofit organizations known as the Sexual and Reproductive Justice Community Engagement Group, where we jointly plan and implement activities. Last fall, we launched a citywide public awareness campaign – “Maybe the IUD” – that provided information about the IUD among a full range of birth control options, stressing the importance of assuring that women who want birth control are supported to choose the contraceptive method that best meets their needs. Additionally, we work with local hospitals on a learning collaborative to implement best clinical practices for the provision of contraceptive services postpartum, post-abortion and in primary care settings, ensuring that reproductive decisions are made with complete information and free of coercion. A key issue that a sexual and reproductive justice framework seeks to address is the disparities in

reproductive health outcomes, which includes maternal mortality. Addressing these disparities is a top priority of the Department.

Complementing this work are the ongoing efforts of the Department to provide clinical services for all New Yorkers at eight STD clinics. Our work focuses on New Yorkers at highest risk for negative sexual health outcomes who may face obstacles to accessing needed services elsewhere. In addition, the Department has a multi-pronged approach toward prevention of the human papillomavirus virus infection, otherwise known as HPV. The most effective way to stop HPV is to vaccinate eligible people. In accordance with CDC recommendations, we strongly encourage vaccination for pre-teens, and for teens and young adults who were not previously vaccinated. HPV vaccines are up to 99 percent effective in preventing cervical, vaginal and vulvar infections, which could develop into cancer if left untreated. The vaccines can also prevent anal cancer precursor lesions and likely penile and oropharyngeal cancers.

With regard to the bills being heard today:

### **Intro. 1161**

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

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

In New York City, as of September 30, 2016, 73 percent of females and 67 percent for males aged 13 to 17 had at least one dose of HPV vaccine; and 50 percent of females and 42 percent of males have received all three doses. While we are proud of the progress we have made, we are still far from achieving the national target of 80 percent coverage by 2020. Nation-wide, Latinos and lower-income groups have the highest coverage levels, while Whites and higher-income groups have the lowest coverage. In New York City, we find similar disparities in HPV vaccination among people who attend the Department's clinics that treat sexually transmitted infections. Geographically, HPV vaccine coverage is highest in the southern Bronx and northern Manhattan. It is lowest in Staten Island, Central/Southern Brooklyn and Greenpoint/Williamsburg. The Department has undertaken a number of activities to increase coverage citywide and to target practices in low coverage neighborhoods in particular.

## **Intro. 1162**

The Administration supports the intent of Intro 1162, and supports gathering and sharing information about the use of a comprehensive range of contraceptive methods. We are happy to share the available data when it is collected via the Community Health Survey in an appropriate manner, and look forward to discussing this further with the Council.

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

The 2013, 2014 and 2016 Community Health Survey collected data regarding contraceptive methods used by women 18-44 who had vaginal sex in the prior 12 months, and includes condoms, birth control pills, Depo-Provera, the birth control patch or ring, emergency contraception, IUDs, contraceptive implants, a combination of methods or no method. We know from the Community Health Survey that among those women who used birth control, the most popular methods were condoms (34.6%) and the pill (23.5%). About 8.3% of women using birth control used IUDs or contraceptive implants. We further know that in 2014, 58.5% of adult female New Yorkers having vaginal sex who did not use any form of contraception did not intend to become pregnant at the time of their last intercourse. Additionally, in 2013, almost 6 in 10 known pregnancies among NYC women are unintended (58%). These data suggest that more can be done to educate women about the range of available birth control options and ensure that they have easy access to all options. In accordance with the sexual and reproductive justice framework, we do not recommend reporting solely on one specific contraceptive method. Our goal is not to promote one particular method over another. Rather, our goal is to increase access to all birth control methods and support New Yorkers in making the contraceptive choice that's best for them.

## **Intro. 1172**

The Administration supports the intent of Intro 1172 to share data regarding maternal mortality in New York City, and we look forward to working with the Council to share non-identifiable data as it becomes available.

The Department currently collects this information through death certificate data and additional surveillance of pregnancy-associated deaths. The Department has issued two reports on enhanced surveillance of pregnancy-associated (deaths during pregnancy or within one year of pregnancy from any cause) and pregnancy-related mortality (a sub-set of these deaths that are causally related to the pregnancy) based on data from 2001-2005 and 2006-2010. A similar analysis of pregnancy-associated mortality data from 2011-2015 is currently underway. Additionally, the Department conducts routine surveillance on maternal deaths within 42 days of delivery; in 2014, the last year we have data, there were 23 maternal deaths. The data shows decreasing maternal deaths; this is consistent with the decreasing pregnancy-related mortality ratio, which decreased 48% in NYC from 2001 to 2010.

Both reports highlight the unacceptable racial disparity in pregnancy-related mortality in New York City. From 2006-2010, Black women were twelve times more likely to die from a pregnancy-related cause than White women. Pregnancy-related mortality also disproportionately impacts Asian/Pacific Islander and Latina women, although not to the same extent as for Black women. Pregnancy-related mortality is associated with obesity, underlying chronic disease, and poverty that also disproportionately affect New York City's Black population. The chronic stress of racism and social inequality contributes to pregnancy-related mortality, along with racial disparities in other health outcomes, including infant mortality, preterm birth and low birth weight outcomes.

This past August, the Department released a report on the first ever citywide severe maternal morbidity surveillance system in the United States. Severe maternal morbidity is defined as a life-threatening complication during childbirth. Examples include heavy bleeding, kidney failure, stroke or heart attack during delivery. Our surveillance found that the rate of severe maternal morbidity in New York City was higher than the national severe maternal morbidity rate, and that nearly 3,000 women experienced life threatening complications during pregnancy in 2012. Like maternal mortality, we found stark disparities. The severe maternal morbidity rate among Black women was three times that of White women.

The Department recognizes that improving women's health before pregnancy is critical to reducing maternal and infant mortality and addressing the unacceptable racial and ethnic disparities in birth outcomes. It is our belief that achieving this also requires a particular focus on those neighborhoods most impacted – neighborhoods with high concentrations of people of color and poverty. Furthermore, it requires an understanding of and willingness to name and address racism and other structural factors, past and present, which contribute to negative birth outcomes. Engaging community members and organizations in meaningful dialogue is essential for developing an effective strategy for improving sexual and reproductive health outcomes and achieving health equity in our city.

Thank you again for the opportunity to testify. We are happy to answer any questions.