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**BEFORE THE COMMITTEE ON PUBLIC HEALTH AND HUMAN SERVICES
REGARDING RESOLUTION NO. 260051
MARCH 2, 2026 1:00 PM**

Good morning Chair and Members of Council.

My name is Dr. Diana Montoya-Williams. I am a neonatologist — a baby doctor — and an immigrant health researcher focused on the health of mothers and infants at the Children's Hospital of Philadelphia's PolicyLab and the Leonard Davis Institute of Health Economics at the University of Pennsylvania. I'm also a mother.

Thank you all, and especially Councilmember Nina Ahmad, for creating space to address the reproductive health needs of Philadelphia residents. I'd like to speak with you about Hispanic and Latine women in Philadelphia as well as immigrant women.

Recent data shows that about [one in four births](#) in Philadelphia are to Hispanic/Latina mothers. And while not all Hispanic or Latine women in our city are immigrants, many are. Many live in mixed-documentation status families. That reality has profound implications for the reproductive health of Hispanic women and thus the public health of our city.

For years, we have known that immigrant women face barriers to health care, insurance eligibility gaps, language barriers, and fear tied to immigration status.²

But we are now in a moment of heightened risk.

A large body of research shows that punitive immigration policies and aggressive enforcement create what we call a ["chilling effect" on healthcare use](#) and use of other critical health-promoting benefits.³⁻⁷ This has profound consequences for pregnant individuals and their infants in particular. When families fear deportation or separation, pregnant women may [delay prenatal care](#).⁸⁻¹⁰ Some may avoid it entirely.

In areas of the country that have experienced increased immigration enforcement or heightened anti-immigrant rhetoric, researchers have even documented higher rates of maternal anemia¹¹ and [lower birthweight among infants born to Hispanic mothers](#).¹²

This is measurable. But this is not abstract data to me.

In the past months, I have been working alongside community organizations in our city as they support families trying to navigate this moment. Families struggling to decide whether to bring their new babies to follow-up appointments. A pregnant refugee woman worried about how she will access postpartum healthcare when her Medicaid eligibility disappears later this year due to federal policy changes. Parents afraid to visit their own baby in the NICU because they fear immigration enforcement on the way to the hospital.

I want to let that last one sink in. A woman recovering from childbirth afraid to come see her hospitalized sick newborn because of fears about the safety of her entire family.

That is the level of stress we are talking about. And we know toxic stress is biologically harmful.

It increases the risk of hypertensive disorders of pregnancy, preterm birth, postpartum depression, and long-term developmental challenges for children. Right now, many immigrant women are navigating pregnancy and early motherhood under acute, destabilizing toxic stress.

As a physician, I worry about what happens when a woman with severe hypertension hesitates before going to the emergency department.

When a mother with postpartum depression stays home because she fears being targeted. Or when she can't access contraception.

When a baby misses preventive visits that could catch feeding issues or developmental delays early.

When mothers do not feel safe seeking care, it is not only a personal crisis, it is a public health issue for our entire city.

But there are solutions.

First, trusted messengers matter. In my [own community-engaged research](#), we have found that culturally and linguistically concordant community health workers, doulas, and peer navigators are essential during times like these.^{13,14} Women need accurate information from people they trust. And sometimes they need accompaniment —

someone physically or virtually present — to buffer fear with support. We must advocate for and support the existing doula and community health worker programs that exist within the Philadelphia health department and our local communities perhaps through special funds to sustain this indispensable workforce.

Second, we must strengthen and protect telemedicine infrastructure. Telehealth is not a replacement for in-person reproductive care — but it is a powerful supplement. Virtual care can provide blood pressure monitoring, lactation support, mental health services, and pediatric follow-up when families are fearful of travel. But telehealth must be accessible, language-appropriate, and supported by digital navigation,¹⁵ and this requires policy advocacy.

Third, we must stabilize and fund the community-based organizations already doing this work. They are the backbone of trust in our neighborhoods. If we want Latina and immigrant mothers to access care, we must ensure the organizations guiding them right now are resourced, protected, and sustained. They are working so hard under such challenging and often scary conditions.

The health of immigrant mothers is inseparable from the health of Philadelphia. When mothers receive timely reproductive, prenatal, and postpartum care, we reduce complications. When babies are born healthy and full term, we reduce NICU admissions. When families feel safe engaging with healthcare, our entire city benefits.

I am grateful to Councilmember Nina Ahmad and to this body for approaching these issues in a solutions-oriented way. I stand ready to partner with the City Council to ensure that every woman and mother in Philadelphia can safely seek the care they need, regardless of where they were born. Because when we protect the people who give birth, we protect our future.

Thank you.

Views expressed are my own and do not necessarily represent those of the University of Pennsylvania Health System (Penn Medicine), the University of Pennsylvania, or the Children's Hospital of Philadelphia.

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