Testimony

of

Aletha Maybank, M.D., MPH

Deputy Commissioner, Center for Health Equity

New York City Department of Health and Mental Hygiene

before the

New York City Council Committee on Health

Oversight Hearing- Department of Health and Mental Hygiene's Center for Health Equity

February 27, 2018

City Hall Committee Room

New York, NY

Good morning Chair Levine, and members of the committee. I am Dr. Aletha Maybank, Deputy Commissioner of the Center for Health Equity at the Department of Health and Mental Hygiene. On behalf of Commissioner Bassett, thank you for the opportunity to testify. I would like to also recognize Councilmembers Eugene, Barron, Ampry-Samuel, and Powers for your commitment to the health and well-being of all New Yorkers.

Much like other cities in our country, but at the same time unique in its own way, New York City is best understood when appreciating the distinctive characteristics of our respective neighborhoods. These are characteristics that we can boast of and promote, but also those that illustrate significant differences in the lives that are being lived across them.

An 11-year gap in life expectancy currently exists in our city between the Financial District in Manhattan and Brownsville in Brooklyn. Stark inequities exist across other key health outcomes like infant mortality and premature mortality, as well as health conditions such as asthma, diabetes and mental illness. We refer to these disparities in health outcomes as health inequities. They are the consequence of well-documented social inequities that exist at the neighborhood level. These include disparate concentrations of poverty, and differences related to education and incarceration. We call these drivers the social determinants of health, and they often keep our residents from living their healthiest lives.

We have known for quite some time that health inequities are not a biological phenomenon, but rather the result of long-tenured systems of racism that have segregated and assaulted communities of color. During the history of our institutions and government, unjust policies and practices have yielded inequitable health outcomes. Dismantling systems and structures that perpetuate injustice requires a commitment to equity beyond equality. Furthermore, we must recognize that people do not start their lives with equal power and privilege. Without the advancement of equity, there can be no real equality.

While the national conversation regarding inequity is often categorized by class, particularly in regards to wealth, in our city, equity is principally a matter of racism. 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 decisions made through the prism of racism.

At the beginning of Commissioner Bassett's tenure, she committed the Department to equity, justice, and inclusion. The principal demonstration of this was the formation of the Center for Health Equity. The Center prioritizes the Department's work on the elimination of health inequities, which are rooted in historical and contemporary injustices and discrimination. With that commitment came an understanding of the City's historical role in executing injustice, and our present responsibility to undo it.

The Center for Health Equity's first role is to reform our own institution. We are working to transform the Health Department into a racial justice, multi-cultural organization that actively promotes the cultures and needs of communities that have been and still are oppressed. These include communities of color and the LGBTQ community. Our second role is to expand the narrative around what creates health, and make injustices visible through the Department's data.

We seek to elevate the stories of those directly affected and the efforts to confront it. Our third role is to provide support to neighborhoods and communities that are most affected today. We are investing in neighborhoods with some of the worst and most inequitable health outcomes in the city.

As a city agency, we also recognize the influence we have to make change. Our fourth role is to engage our sister agencies and other institutions to provide guidance and support to advance equity. Our fifth role is in checking our influence and privilege as a city agency. To support health on the local level, we cannot just be the leaders and deciders, but far more often we need to be followers and supporters. Today I want to share with you some of our efforts to reform our institution and to invest in key neighborhoods.

In 2016, the Center for Health Equity launched Race to Justice, our internal reform effort. We understand that structural racism is the fundamental cause of health inequities in our nation and through this initiative, we are learning more about how racism operates within our own institution. That is why we are engaging staff in conversations about race, power, and privilege. We are also facilitating trainings to improve staff capacity to undo racism and gender bias, to recognize how implicit bias affects us all. Finally we are fostering leadership for racial and gender equity advancement. The Department is working collaboratively with experts in this field and other cities engaged in similar efforts across the country.

In order to ensure dissemination and sustainability of this effort, we organized a diverse core team of staff champions from across the Department. Their work is focused on four areas: communications and organizational identity; community engagement and partnerships; workforce equity and development; and equitable contracting and budgeting practices.

A key part of implementing Race to Justice is normalizing conversations among Department staff on race, gender and LGBTQ issues, as well as power, privilege, and equity. Since we began this effort in 2016, over 5,000 staff have received some form of training on these topics. We anticipate that all Department staff will be trained over the next three years on racism and gender equity which is in alignment with the City's Race and Gender Equity legislation, passed by the Council in 2017. We commend our City Council and the Administration for moving on this important issue.

This learning and lens is already starting to change the way we do our work. Our epidemiologists changed how we present neighborhood-level data to show more clearly the inequities that exist across them. The most recent Community Health Profiles show data by community-board, the local geography that parallels what most New Yorkers identify as their neighborhoods. This has made the data more accessible and readable for residents and advocates alike.

Our emergency preparedness staff have revisited how the city organizes and deploys staff in the event of a public health emergency or natural disaster. And they are working to ensure that qualified leadership is equitably located in all neighborhoods across New York City in times of crisis.

Our early intervention program provides services to children under 3 years who are experiencing developmental delays and disabilities. After documenting an inequitable pattern, we started to ask questions about why Black children were utilizing free, eligible services at a lower rate than Latinx, Asian, and particularly, White children. The program is now building demand by getting out the news about these free services, and educating providers in prioritized neighborhoods.

While we are not the first institution to seek to become a racial justice organization, we have started a transformative process. It is one that we are working with our sister agencies to amplify. However, we cannot wait for our institutions to transform, we must also serve the communities who need help now. That is why we are also focusing efforts in neighborhoods that have long experienced public and private disinvestment, and endured some of the worst health outcomes in the city.

Our recently established Neighborhood Health Action Centers stand on the shoulders of the District Public Health Offices, established in 2002, and draw on the history of over a century of District Health Centers in New York City. Started under Mayor LaGuardia, these were meant to serve those too poor to pay for private doctors and make additional resources available to physicians working in these neighborhoods. The District Health Center movement sought to institutionalize collaboration between government agencies and community partners, fostering collective action.

For over a decade, the District Public Health Offices in the South Bronx, East Harlem and Central Brooklyn developed and implemented programming, conducted primary research, participated in coalitions, and worked with other city agencies on local projects – all at the neighborhood level. Many strong initiatives started in these offices, and continue today, including:

The New York City Teens Connection, our teen pregnancy prevention program, which started in the South Bronx, recently expanded to Central Brooklyn and Northern Staten Island, and the program's reach and impact continues to grow. Teen pregnancy rates in New York City declined 60 percent from 2000 to 2015, and the racial disparity has narrowed considerably.

Asthma continues to be the leading cause of childhood hospitalizations, emergency room visits, and absenteeism for our children. The East Harlem Asthma Center of Excellence has served the needs of thousands of children with asthma and their families since 2008. From 2008-2014, program graduates have experienced significant reductions in emergency department visits and hospitalization due to asthma and have contributed to a significant improvement in the rate of hospitalizations in East Harlem.

In Brooklyn, our office worked with the Department of Transportation to facilitate a participatory planning effort to bring 28 miles of bike lanes to Brownsville and East New York, neighborhoods with little infrastructure in the way of supporting active transportation. This effort was critical to promoting physical activity, but also to give residents increased freedom to move about their city. Our team is now working to ensure that CitiBike expands equitably, promoting accessibility and affordability for neighborhoods that could benefit from bike share.

On the neighborhood level, we have also sought to elevate and address the major concerns of residents. For example, our Cure Violence program provides alternatives to violence and shifting community norms around violence. The program is now in 18 sites in neighborhoods that have historically been impacted by gun violence and gun related homicides. This neighborhood-based approach is part of the reason why there were only 290 murders in New York City in 2017, compared to the 335 murders the previous year.

It is because of this success, and the persistent inequities that are still plaguing our city that we committed to double down on these neighborhoods and place-based approaches. Last year, we launched the Neighborhood Health Action Centers. We have taken underutilized Department buildings and revitalized them by co-locating health services, community health centers, public hospital clinical services, community-based organizations and service providers – all under one roof. We have introduced new activities and programs in these sites. They possess convening spaces for the public to hold events, family wellness suites that offer services to support mothers, fathers and their families and plans for community kitchens. Partners are meeting, organizing, and mapping out their efforts within and outside of our walls.

The Neighborhood Health Action Centers (or "Action Centers" for short) are located in the respective neighborhoods of Tremont, East Harlem, and Brownsville. Through co-location of services and programs from different organization and agencies, we are better able to collectively serve community members, act as an engine of improved asset linkages, and identify gaps in coverage and reduce duplication of services. A key partner in this effort has been NYC Health + Hospitals, whose health centers operate in several of our locations. And having IDNYC on site in East Harlem and Tremont has brought many New Yorkers through our doors. We have also brought on a team of community health workers and staff to support neighborhood residents to navigate what is available in the building, and to refer them to additional services in the neighborhoods. Governance bodies are being formed to provide partners and residents the opportunity to guide the work, and take ownership of the neighborhood assets.

The East Harlem Action Center has numerous co-located partners providing services to residents. These partners include the Association to Benefit Children, Concrete Safaris, Public Health Solutions, and SMART University. The Department's Harlem Health Advocacy Partners program has provided over 800 residents of NYCHA developments with one-on-one coaching, and over 1,700 residents have participated in group wellness activities such as Shape Up classes and walking groups, out of this location. Over last year, the East Neighborhood Harlem Action Center received over 16,000 visits.

The Brownsville Action Center has a particular focus on reducing racial disparities in the rates of infant mortality and severe maternal morbidity The Action Center features services provided by our co-located partners like Health and Hospitals' adult and pediatric clinical services, and Brownsville Multiservice Family Health Center's HIV care coordination, cardiology and nutritional services. One of the Action Center partners, Brooklyn Perinatal Networks' doula services, provides emotional support programming and peer education trainings to neighborhood woman and their families. Over last year, the Brownsville Action Center received nearly 14,000 visits.

At our Tremont Action Center, we are providing primary care as well as teen pregnancy and opioid overdose prevention. I'm proud to announce that last week the Action Center was officially registered with the State as an Opioid Overdose Prevention Program, and now delivers monthly overdose prevention trainings to community members. The Action Center is also a steering committee member for the #Not62 campaign. The campaign supports borough-wide efforts to improve the health of Bronx residents. In addition we are elevating the history of the neighborhood. Earlier this month we launched an exhibit titled, Undesign the Red line. The interactive exhibit explores the history of structural racism and wealth inequality, how these designs compounded each other from the 1938 Redlining maps until today, and how residents, our partners, and other stakeholders can come together to undesign these systems. Over last year, the Tremont Neighborhood Health Action Center received over 8,000 visits.

The Action Centers also operate as critical conduits for amplifying other work of the Health Department in our neighborhoods. Throughout all three Action Centers we have focused on outreach to residents to help them prevent and control diabetes. We work with the National Diabetes Prevention Program to support ten community and faith based organizations who deliver yearlong workshops for community members, reaching over 65,000 New Yorkers each year. In addition, the Action Centers serves as a hub for training community members in Mental Health First Aid, including over 1,000 faith leaders, as well as connecting visitors to mental health services.

Over the last year, the Action Centers have collectively welcomed more than 37,000 visits and provided over 500 referrals. We welcome all residents of our neighborhoods and surrounding areas to visit us soon. In the words of the Action Center's public awareness campaign, we encourage our neighbors to be heard, be powerful and be here! This is just the start for the Center for Health Equity and the Neighborhood Health Action Centers. A lot is being done, but there is so much more to do.

Thank you for the opportunity to testify. It is an honor to lead this important mission. I am happy to take any questions.

UN WOMEN
United Nations Entity for Gender Equality and the Empowerment of Women

NATIONAL COMMITTEE
UNITED STATES
Metropolitan New York Chapter

CELEBRATING 30 YEARS
1987 — 2017

Testimony: Oversight -DOHMHs Center for Health Equity
February 27. 2018

I am Mary Luke, President of the US National Committee for UN Women, Metropolitan New York Chapter. We a tax exempt, volunteer organization with the mission of women's empowerment and gender equality based on human rights principles. We educate and advocate locally on issues affecting women and girls globally. Using a gender lens, we advocate for health is a human right with a focus on violence against women, sexual and reproductive health rights, early marriage, economic and political participation.

We are pleased to be speaking before the City Council today about the importance of **gender assessment based on gender disaggregated data** in the planning, policies and services of the Department of Health and Mental Hygiene.

We begin by congratulating the DOHMHH and the Center for Health Equity for its commitment and leadership to promote health and stand against injustice in all forms. We applaud the center's guiding principles of equity, justice and social inclusion. We agree with the broad strategies to make change including: investing in neighborhoods, making injustice and disparities visible through data, advancing health equity in all policies, community power through giving it voice, and through its focus on internal reform to support the goals of racial and gender justice.

Dr. Aletha Maybank, in her testimony in April,2017, states that: Structural racism is at the root of the health gaps by race. Years of racist policies and unjust practices across our institutions have led to worse health outcomes in communities of color than in white communities. For example, discriminatory housing policies in the 1950s created racially segregated neighborhoods and concentrated poverty in communities of color. The results of these policies are visible today in the limited resources and opportunities in low-income areas, which are largely communities of color.

Race to Justice is the DOHMH's internal reform process for advancing racial equity and social justice. Through this effort, the department is learning how racism operates within the institutions and structures; how racism shapes the social, economic and health inequities within the city and how it affects the work, decisions and priorities.

The Center for Gender Equity has also launched the **Gender Justice Initiative** which was formed to focus on gender and power relations, norms and structures as a core strategy for challenging health inequity. The purpose is also on training and strategic planning to reform internal policies and structures to build staff awareness of how gender discrimination impacts the work of the Health Department, its policies and services. Initially this initiative appears to focus

on inclusion of LGBTQ employees and improving the agency's ability to serve the LGBTQ communities. An important change is the expansion of the Community Health Survey and Social Determents of Health to be more inclusive of transgender persons.

However the Center for Health Equity is yet to articulate clearly its vision for planning and implementation through a gender lens. Although we recognize the intersectionality of the issues concerning race, gender, ethnicity, religion, disability, etc. it is important to understand the unique impact that gender discrimination has on health gaps, policies and access to services, distinct from race.

The Center for Health Equity has produced a comprehensive report with annual updates on the health of NYC's population :*New York Take Care 2020.* It reports on 26 indicators citywide and by borough selected because of their importance to community and social justice. Although data may have been captured by gender, data by gender was not displayed in the main tables. Equity and targets were mainly compared to baseline by race or high poverty neighborhoods. Although the report gives an annual update on progress overall, the fact that gender disaggregated data is missing provides an incomplete picture of the health problems, and therefore limits the policy responses, type and access to services for all genders.

Indicators such obesity, physical activity, overdose deaths, and unmet mental health needs are currently viewed through a race or poverty lens, but would be enhanced if also viewed from a gender perspective. Knowing that single women with children are the majority heads of households in poverty would help in designing programs that meet their special health needs. The indicator on unmet mental health needs is linked to poverty neighborhoods, but there is no recognition of who comprises that target population in terms of gender. Mental health prevention and services for women with children would look quite different than if the target population were men. (see examples of TCNY's indicator table below)

Gender analysis is a tool that is used to analyze women's needs and concerns and integrate the results in the policies and practice of departments and government. To conduct gender analysis successfully, gender disaggregated data must be available. Gender analysis could also be used to document the differential impact of services, employment practices and budgetary allocation on women and men. Gender analysis would facilitate ways for the Health Department to address these areas of concern along with staff, customers, women's and community groups.

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) is an international Human Rights Treaty adopted by the United Nations in 1979 and is known as the international bill of rights for women. It is based on human rights principles that provides a broad framework protecting women and girls worldwide from discrimination of all forms. The US is one of seven countries which have not signed this international treaty.

RECOMMENDATIONS

The USNC-UNWomen Metro NY Chapter and the NYC4CEDAW Coalition recommends that the Department adopt a human rights approach including equity, equality and inclusion such as that laid out in CEDAW. Using such a framework would enable the DOHMH to assess gender

and racial discrimination and inequities where they overlap, rather than separately and address other intersectionalities as well.

Further, we recommend a strong implementation plan based on gender analysis that includes inputs by the communities to be served. The Commission on Gender Equity, working the DOHMH gender liaisons, should serve as the primary agency to provide the technical support to plan, conduct and analyze the gender analysis. We recommend funding of the Commission on Gender Equity to develop a pilot plan to work with the DOHMH and community to demonstrate the impact of assessing policies and programs from a gender perspective.

The health status of New Yorkers has already seen progress in certain areas. By integrating a human rights and gender based approach, we can better understand – and eliminate- the impact that gender discrimination has on health gaps, policies and access to services.

Thank you for your time and consideration.

Selected indicators in the report *New York Take Care 2020*

TCNY 2020 Indicator	**Baseline and target citiwide**	**TCNY 2020 equity priority**	**TCNY Equity priority baseline and target**	**Related prevention priority**
Obesity- percent of adults who are obese	Baseline 25%. Target: 23%	Very high poverty neighborhood	Baseline 31%. Target 25%	Prevent chronic disease
Unmet mecical need	Baseine 10% Target: 9%	Latinos	Baseline 14%. Target 10%	Prevent chronic disease; promote heathy women, children
Controlled high blood pressure	Baseline: 67%. Target: 76%	Blacks	Baseline: 62%. Target: 74%	Prevent chronic disease
Unmet mental health need	Baseline 22%. Target 20%	Very high -and high poverty neighborhoods	Baseline 30%. Target 22%	Promote mental health
Overdose deaths	Baseline 11.6/100,000. Target: 11.0/100,000	Very high poverty neighborhoods	Baseline: 15.9/100,000. Target: 14.3per 100,000.	Promote mental health and prevent substance abuse

Community Service Society | Fighting Poverty Strengthening New York

633 Third Avenue 10th Floor
New York, NY 10017
PH 212.254.8900
FAX 212.260.6218
www.cssny.org

David R. Jones
President & Chief Executive Officer

Steven L. Krause
Executive Vice President &
Chief Operating Officer

Testimony of the

Community Service Society of New York on

The New York City Department of Health and Mental Hygiene's Center for Health Equity

At a Public Hearing before the

New York City Council Committee on Health

February 27, 2018

The Community Service Society of New York (CSS) would like to thank the New York City Council Committee on Health for holding a hearing on the important work of the New York City Department of Health and Mental Hygiene's (DOHMH) Center for Health Equity. For more than 170 years, CSS has been an unwavering voice for low- and moderate-income New Yorkers. Our health programs help New Yorkers enroll into health insurance coverage, find health care if they are ineligible or cannot afford coverage, and help them use their coverage or otherwise access the health care system. We do this through a live answer helpline and through our partnerships with over 50 community-based organizations throughout New York State. Annually, CSS and its partners serve over 100,000 New Yorkers—many of whom are New Yorkers of color.

CSS would like to focus its comments on the Harlem Health Advocacy Partnership (HHAP), a first in the nation, place-based initiative serving five public housing developments in East and Central Harlem. DOHMH established this multi-stakeholder partnership with the New York City Housing Authority (NYCHA), CSS, and the New York University-City University of New York Prevention Research Center in November 2014 to reduce health disparities related to chronic disease. Since 2014, HHAP has served 896 unique residents with more than 2,600 individual needs. CSS recommends that the City expand the HHAP model to other high need neighborhoods in New York City as a part of its efforts to achieve health equity.

Who HHAP Serves

HHAP serves approximately 13,000 residents of the Taft Houses, Jonson Houses, Kings Towers, Clinton Houses, and Lehman Village NYCHA developments in East and Central Harlem. Although the demographic profile of the people living in these developments is similar to that of all

NYCHA residents, they are more likely than all other New Yorkers to identify as female and Black and/or Latino/a. The residents who live in HHAP developments are also more likely than other New Yorkers to be children under the age of 18, elders over the age of 65, and to live at or below the Federal Poverty Level. Finally, residents who live in HHAP developments report disproportionate diagnosis of hypertension, diabetes, and current asthma.

The HHAP Model

The HHAP model is guided by a health equity framework and employs a three-prong approach to address the needs of the residents living in the target NYCHA developments. The model combines the assistance of 12 Community Health Workers, three Health Advocates, and 5 Community Health Organizers to improve chronic disease management as well as long-term health and quality of life for the residents it serves.

The HHAP Community Health Workers, Health Advocates, and Community Health Organizers all have a close understanding of the East and Central Harlem neighborhoods and the people who live there. They each provide a unique set of services that work together to build individual and community capacity.

Community Health Workers help residents manage their existing health issues and set health goals for the future. They then work with residents to address perceived barriers to health and reach their goals by providing referrals to local health and social services, conducting educational health workshops, and organizing community wellness events.

The three Health Advocates from CSS provide health insurance enrollment and post-enrollment expertise and assistance to help residents enroll in and use their health coverage to get the care they need. Since HHAP's establishment in 2014, CSS Health Advocates have handled 2,354 cases and saved HHAP residents nearly $170,000. Health Advocates work with Community Health Workers to identify uninsured residents, help enroll eligible uninsured residents into free or low-cost health insurance coverage, and help insured residents address any issues with using their health coverage. Health Advocates also help residents who are ineligible for health coverage or who need additional services to find free or low-cost health care. Finally, Health Advocates have conducted more than 200 workshops attended by 2,785 residents to help them understand how their health insurance works and ensure that they are able to access services.

Community Health Organizers promote HHAP and raise awareness about the services available from Community Health Workers and Health Advocates. They conduct outreach to residents in the target NYCHA developments and identify additional resources. Community Health Organizers also lead Community Activation Teams and Peer Support Groups, which aim to improve the health of East and Central Harlem NYCHA residents through community organizing, community advocacy and engagement. HHAP Community Health Organizers have reached more than 1,700 residents through outreach events.

Community Service Society | Fighting Poverty Strengthening New York

Impact

The HHAP model is instrumental to the reduction of health disparities. This is especially true of the work of Health Advocates. Health Advocates are able to work one-on-one with residents who may not be aware of the health insurance options available to them. They can help residents enroll into secondary or tertiary health coverage so that they can afford the co-pays, premiums, and deductibles for their care and fill in any gaps in existing coverage. Health Advocates' specialized knowledge of health care consumer protections and the additional technical assistance provided by CSS, allows them to advocate directly on behalf of residents to appeal health care decisions, or negotiate with providers when necessary. Because HHAP brings Health Advocate services directly to the community, residents are well-positioned to take advantage of them to improve their health.

For example, an HHAP Community Health Worker referred a resident who needed help resolving billing issues from cancer therapy she was receiving. Through advocacy, the Health Advocate was able to resolve these bills, saving her over $1,500. While the Health Advocate was working with this client, her food insecurity issues became apparent. She also developed neuropathy as a result of chemotherapy treatment, causing extreme pain in her feet and greatly limiting her mobility. She needed to keep her feet elevated, but had no furniture outside of her bed where she could elevate them. Her doctor had recommended a foot massager to relieve the pain, but this was not covered by her health insurance. The Health Advocate applied for a grant through the NY Times Neediest Fund for a weekly fresh food box through GrowNYC, full of local fresh fruits and vegetables from local farms to supplement the client's SNAP benefits. She also requested funds for the foot massager the doctor had recommended, and a recliner that allowed her to keep her feet elevated throughout the day.

Recommendation

CSS recommends that the HHAP model be expanded to other high need New York City neighborhoods as a part of the City's efforts to achieve health equity. The place-based approach of HHAP has already proven valuable in serving the health care needs of NYCHA residents in a comprehensive way. Implementing this approach in a larger scale could be equally effective in reducing health disparities in other parts of the city with similar levels of chronic health and socioeconomic conditions. We hope the New York City Council Committee on Health will work with DOHMH to make this possible.

Thank you for the opportunity to submit this testimony today. Should you have any questions, please do not hesitate to contact me at: 212.614.5353 or jpinzon@cssny.org.

New York City for CEDAW

Ensuring equal rights & protection for the women and girls of NYC.

Testimony: Oversight - DOHMH's Center for Health Equity

27th march 2018

14th Floor Committee Room
250 Broadway, New York, NY

NYC4CEDAW Act

Convention on the Elimination of All forms of Discrimination Against Women
My name is Sheila Katzman. I am President of the International Association of Women in Radio and Television-USA and Chair for the steering committee of New York City for CEDAW Act (NYC4CEDAW). We are a volunteer community-based coalition advocating for a women's bill of rights in New York City based upon international standards embodied in CEDAW (Convention on the Elimination of All Forms of Discrimination Against Women).

First, we wish to express our gratitude to the NYC Council for inviting us to participate in these proceedings on matters of importance to our city.

We also want to emphasize how happy we at NYC4CEDAW were when the First Lady of NYC, Chirlane McCray, launched the Mental Health Initiative and the training of personnel to work with people who may have some mental health problems and we appreciate the robust action taken to address the issue. We see these actions as creating a healthy and safe City. Which brings us to the Safe City Agreement the City signed with UN Women. By including Mental Health in the safe city paradigm, we are creating a safer city.

Allow me to highlight three specific articles of the 17 articles enshrined in CEDAW that have particular resonance to women's health and mental health:

Article 12. Health Care and Family Planning:

Countries must guarantee equal access to health care and ensure women and girls are not discriminated against in health care and have access to services for family planning and reproductive health.

Article 13. Economic and Social Life:

Countries must eliminate discrimination against women and girls in economic and social life

Article 16. Marriage and Family Life:

Countries must eliminate discrimination against women in marriage and family relations.

Could the results of discriminations over time lead to mental health problems? Preventing women from reaching their potential and tying girls into early marriage could result in depression and other mental health problems. Having said all that, with a gender assessment, NYC4CEDAW Act would require the DOHMH to pay close attention to trends and make sure problems are properly identified.

Too often, the media is inundated with news on mental health. However, we are concerned that these reports usually refer to men and to men who are privileged, like the Las Vegas Shooter or the most recent shooter in Florida. Mental health becomes a major topic. When we speak of homelessness and mental health, the gender is male. We are concerned that women will be overlooked, or worse, assume their needs without asking them. Race and gender clarifies who can be identified as having mental health problems – or being merely a violent criminal, depending on race and gender.

Too often, women are the discriminated majority. Historically, mental health has been used to take away women's voices with egregious practices of drugs and even institutionalization. Thankfully, we are no longer at that place, but we wish to ensure that this could never again be.

Our major ask is that each city agency and department assess their work through a gender lens. The city is a major employer; the city is a major implementor of programs; the city is a major funder of projects. In each of these areas, we want to ensure that gender discrimination is a thing of the past. A key component to any gender assessment is access to disaggregated data.

There are many areas that may be inadvertently overlooked, and a gender assessment will ensure that nothing is missed. A gender assessment will help the city, and the public, to identify these problems and allow the City to take action. Gender assessments need access to data that is disaggregated by gender and is accessible to the public.

We commend the Department of Health in its collection of data broken up by gender and wish for its continuance and for public access to the raw data. We would like to ensure that this data collection is incorporated in law and not just policy, so that future administrations may not easily change this forward-looking policy.

We know that other forms of discrimination aggravate problems of gender, so we recognize that intersectionality also requires disaggregation of data by race and other traits that have been historically discriminated against.

End.

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: MARY WILKE

Address: 230 Park Place, Apt 6E Brooklyn

I represent: UN Women-Metro NY, NYC4 CEDAW

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: 27 Feb 2018

(PLEASE PRINT)

Name: Sheila Katzman

Address: 19 Berkeley Pl., 3L Brooklyn NY 11217

I represent: NYC4CEDAW Act

Address: 19 Berkeley Place - 11217

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Jay Cassiopea Toner

Address: Assistant Commissioner

I represent: DOHMH

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Javvs Lopez

Address: Assistant Commissioner

I represent: DOHMH

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Dr. Nal Manyindo

Address: Asst. Commissioner

I represent: DOHMH

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

2.27.18

Date: _____

(PLEASE PRINT)

Name: Dr. Jane Bachelet

Address: Assistant Commissioner

I represent: DOHMH

Address: DOHMH

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Dr. Torian Hollerling

Address: Asst. Commissioner

I represent: DOHMH

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 2.27.18

(PLEASE PRINT)

Name: Dr. Aletha Maybank

Address: Deputy Commissioner

I represent: DOHMH

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 2/27/2018

(PLEASE PRINT)

Name: Juan Finzon

Address: 633 third Avenue

I represent: Community Service Society of NY

Address: 633 third Avenue, 10th Floor NY

Please complete this card and return to the Sergeant-at-Arms