TESTIMONY OF JACQUELINE M. EBANKS
EXECUTIVE DIRECTOR, COMMISSION ON GENDER EQUITY

COMMITTEES ON HEALTH and WOMEN AND GENDER EQUITY OVERSIGHT HEARING
SEXUAL AND REPRODUCTIVE RIGHTS IN NYC
WEDNESDAY, OCTOBER 28, 2020

Introduction

Good afternoon Chairs Levine and Rosenthal, and members of the Committees on Health and Women and Gender Equity.

I am Jacqueline Ebanks, Executive Director of New York City's Commission on Gender Equity (CGE). In this role I also serve as an advisor to the Mayor and First Lady on policies and issues impacting gender equity in New York City for all girls, women, transgender, and gender non-binary New Yorkers regardless of their ability, age, ethnicity/race, faith, gender expression, immigrant status, sexual orientation, and socioeconomic status.

CGE works to create a deep and lasting institutional commitment to tearing down equity barriers across New York City and carries out its activities across three areas of focus within a human rights framework and using an intersectional lens. These areas of focus are:

1. **Economic Mobility and Opportunity**. The goal is to create a City where people of all gender identities and gender expressions live economically secure lives and have access to opportunities to thrive.
2. **Health and Reproductive Justice**. The goal is to foster a City free from gender- and race-based health disparities.
3. **Safety**. The goal is to foster a New York City free from gender- and race-based violence.

During the pandemic, working across all three areas of focus, CGE connected New Yorkers to services provided by city agencies using three key strategies: (1) amplifying available services and program on all three of our social media platforms, (2) documenting reported service gaps in community, and (3) serving on interagency networks to address service gaps.

In the early months of the pandemic, community partners raised several sexual and reproductive rights issues related to access and availability of services. CGE communicated these concerns with appropriate city agency personnel and provided responses to the community partners. During these early months, CGE aimed to assure New Yorkers that the City was "up and running" even as city agencies pivoted to provide services in different ways.

Also during the early months of the pandemic, CGE amplified the availability of sexual and reproductive health programs and services through our social media accounts. Finally, CGE staff serves on the Task Force on Racial Inclusion and Equity and the LGBTQ COVID-19 Response and Planning Workgroup, established to focus on communities and populations disproportionately impacted by the pandemic. Sexual health and reproductive rights of low-income, minority, and LGBTQ communities are issues addressed in both groups.

Regarding the bills before us today, CGE will offer comments on those addressing female genital mutilation and cutting (FGM/C):

Int. 1828 would establish a committee on female genital mutilation and cutting (FGM/C) within the Mayor's Office to End Domestic and Gender Based Violence. While the Administration supports bringing government and community partners together to address FGM/C, we want to consider the existing advocate-led efforts on this issue. Additionally, we would like to have further conversations about the goals of the committee. While New York City residents are impacted by FGM/C, many incidents of FGM/C do not occur locally.

Preconsidered Int. 2020-6774 would require multiple agencies to conduct culturally competent training for all staff on recognizing the signs of FGM/C. The Administration supports the intent of this legislation, and increasing awareness of FGM/C broadly, but we would like to have further discussions about implementation and Council's goals for this bill.

As the pandemic continues, CGE remains committed to amplifying available sexual and reproductive health services and programs on all three social media platforms, documenting reported service gaps, and serving on interagency networks to address sexual and reproductive health service gaps in community, from an intersectional gender lens.

Again, thank you for inviting me to speak today. I look forward to working with the City Council to address this issue further. Now, my colleague from the New York City Department of Health and Mental Hygiene will tell you about the ways they continue to address the sexual and reproductive rights of New Yorkers during the pandemic.

Testimony

of

Demetre C. Daskalakis, M.D., M.P.H.
Deputy Commissioner, Division of Disease Control
New York City Department of Health and Mental Hygiene

before the

New York City Council

Committee on Health

and

Committee on Women and Gender Equity

on

Sexual and Reproductive Rights in New York City

and

Intro 1625, Intro 1662, Intro 1748, Intro 1828, Intro 2064, Preconsidered 6774, Resolution 919 and Resolution 920

October 28, 2020
Virtually
New York, NY

Good morning Chairs Levine and Rosenthal, and members of the committees. I am Dr. Demetre Daskalakis, Deputy Commissioner for the Division of Disease Control at the New York City Department of Health and Mental Hygiene. On behalf of Commissioner Chokshi, I want to thank you for the opportunity to testify today on the Health Department's work to protect New Yorkers' sexual and reproductive rights and for the City Council's continued partnership in this work.

Even as we work to stop the spread of COVID-19, the Health Department remains committed to ensuring that New Yorkers have access to the sexual and reproductive health services and programming they need. The Health Department has an expansive portfolio aimed at improving New Yorkers' sexual and reproductive health.

Though COVID-19 initially presented challenges to in-person engagement and service delivery for critical work such as HIV services, we quickly adapted to this new normal and have reimagined our approach to reach New Yorkers in new ways. For example, while maintaining limited in-person services at our Chelsea Clinic for urgent needs, we launched the NYC Sexual Health Clinic Hotline for STI and HIV telehealth services so that we could ensure continued services while the City was in a period of widespread community transmission. We are in the process of re-opening our clinics and, as of today, three of our eight Sexual Health Clinics are open and offering walk-in services.

COVID-19 has not stopped us from enhancing services to better serve New Yorkers. I am excited to share that we recently launched long-acting reversable contraception, or LARC, services at our Fort Greene and Jamaica Sexual Health Clinics. Another exciting development is that, as of September, all of our Sexual Health Clinics are now co-located with COVID-19 Express – COVID-19 testing sites with results within 24 hours or less – and we are also in the process of rolling out flu vaccinations at some of these sites. We are proud to have built these community health sites to have the capacity to quickly convert and expand their services during public health emergencies.

Our NYC Health Map has long been a source for New Yorkers to find sexual and reproductive health services, including services targeted at LGBTQ+ and youth. To accommodate changes to service offerings and delivery during COVID-19, the Health Department developed online directories of providers currently offering in-person and telehealth sexual and reproductive health services, as well as PlaySure Network providers currently offering HIV and STI testing, PrEP, PEP, and other services.

We also developed some home delivery health services. Launched in April 2020, our Community Home HIV Test Virtual Giveaway offers participants coupon codes from nearly 60 partner organizations to redeem online for a free HIV self-test kit delivered to their address. We promote this program via social media, dating and hook-up apps, text messaging, and email, and the majority of participants are among communities most affected by HIV, including Black and Latina women and Black and Latino men who

have sex with men. The program has distributed over 2,000 HIV self-test kits. Our PEP hotline also began distributing 28 days of PEP, rather than just a starter pack, during the first few months of the public health emergency. This was an important stop gap to provide services while people were staying home and largely refraining from in-person medical services. And in June 2020, our NYC Condom Availability Program launched Door 2 Door, a service through which New Yorkers could order free condoms and other safer sex products via home delivery. Door 2 Door distributed over 322,000 safer sex products to New York City residents, greatly exceeding expectations.

The Health Department has also adjusted engagement with New Yorkers related to reproductive health and services, moving to largely virtual formats but also working to address the unique needs presented by COVID-19 for many families. Our Newborn Home Visiting Program and Nurse Family Partnership providers have implemented telehealth services for families and children. Preliminary evaluations suggest that telehealth has increased the capacity of program nurses and community outreach staff to conduct more client engagements each day since they no longer need to travel. During the spring, the Health Department also supported families and new parents by distributing essential resources, such as diapers, baby wipes, and feminine hygiene products.

Additionally, the Health Department has continued its critical efforts to address maternal mortality through coordination of the Maternal Health Quality Improvement Network – or MHQIN – and the convening of the Maternal Mortality and Morbidity Review Committee. Spearheaded by the Health Department and in partnership with NYC Health + Hospitals, the MHQIN is a comprehensive strategy with New York City public and private maternity hospitals to address the root causes of persistent racial and ethnic disparities in maternal mortality and severe morbidity, with an emphasis on establishing an in-house quality improvement process. At the start of the pandemic, there were some challenges. For example, case reviewers were not allowed on site at hospital facilities, hospitals were unable to continue their monthly scheduled calls, and in-person trainings had to be changed to virtual meetings. But since May, we have reinstated monthly calls with most of the MHQIN hospitals and case reviewers have resumed at most sites. Both our doula capacity-building and implicit bias trainings have moved from in-person to virtual modalities. Furthermore, under MHQIN, the Birth Justice Defenders continued their engagement efforts in communities impacted by maternal health disparities and worse health outcomes.

We have worked tirelessly over the past eight months to release as much guidance as possible to help New Yorkers navigate the pandemic and stay healthy. In March and June, we released our very popular guidance on safer sex and COVID-19, which other health departments and community-based organizations have used as a model. Our guidance received widespread media coverage, even featuring on Saturday Night Live and the Late Show with Stephen Colbert. We also created COVID-19 pregnancy resources for people who are pregnant, breastfeeding or caring for newborns, or infant feeding during the pandemic; guidance

for doulas; and a community resources guide for pregnant and postpartum families. We released guidance for providers on COVID-19 and HIV, PrEP and PEP best practices during COVID-19, maintaining HIV and STI services during COVID-19, and treating STIs during COVID-19. Recognizing the importance of addressing social determinants of health, which have been deepened by the pandemic, our *New York Knows* initiative disseminates weekly digests on COVID-19-related topics, including coping with grief, food and financial assistance, telework, and tips on protesting safely, to hundreds of community partners citywide.

I will now quickly speak to the bills being heard today.

Intro 2064-2020

Intro 2064 would require the Health Department to create an advisory board for gender equity in hospitals. As we strive to create a more equitable health system, promoting gender equity is crucial to improving outcomes, particularly for underserved patients and communities. We support the creation of a gender equity advisory board and would like to discuss further with Council the proposed composition of the advisory board, which should be required to represent the racial, ethnic, socioeconomic, age, and gender diversity of New York City, with an emphasis on representing groups that disproportionately face barriers to accessing care. We also suggest the board recommend measures to address gender equity in healthcare settings, not just hospitals, and among both staff and patients.

Intro 1662-2020

Intro 1662 would require the Health Department to provide mandatory annual training to staff at locations where lactation rooms are made available, and to develop protocols for providing access to the rooms and cleaning and maintaining them. The Health Department would also be required to inspect the lactation rooms at least quarterly. Although the Health Department supports the right to a safe and clean lactation space for breastfeeding persons, we do not currently have a program for inspecting lactation spaces at other city agencies, and our inspection workforce is already stretched with COVID-19 related enforcement. Access, cleaning and maintenance of lactation rooms is currently done on a site-by-site and agency basis depending on the security and logistics of each building involved. Given this, and the current fiscal situation, the Department cannot support a new inspection program at this time.

Intro 1625-2020

Intro 1625 would require the Health Department to make long-acting reversible contraception (LARC) available at its health centers and to offer related cultural competency training to our employees. While we are supportive of increasing access to LARC, given the current fiscal situation, we have concerns about our ability to make it available at all our Sexual Health Clinics at this time. LARC is now available

at our Fort Greene and Jamaica Sexual Health Clinics, and we continue to offer information on how patients can access LARC and offer referrals at our other Sexual Health Clinics.

Intro 1748-2020

Intro 1748 would require the Health Department to implement a public information and outreach campaign regarding medically unnecessary treatments and interventions in infants born with intersex traits. Although the Health Department supports the intent of this bill, we are currently prioritizing COVID-19 communication campaigns and previously planned budgeted campaigns on other topics given the ongoing pandemic and the City's fiscal crisis. We appreciate Council's interest in this area, as the practice of assigning gender through corrective surgery and the harm it can cause is largely unknown by the public. Providing parent education about this practice would go a long way to inform parents and prevent non-consensual intersex surgeries from occurring. We would be interested in discussing this idea further with Council, as well as with the NYC Unity Project and community advocates who are leaders in this space.

Our staff have been quite literally working around the clock over the last eight months to combat the COVID-19 pandemic and continue the agency's other critical work. We remain fiercely committed to protecting the health and safety of all New Yorkers during this unprecedented time for public health. I want to thank Chairs Rosenthal and Levine for holding this hearing today. We are proud to be partners in this work, and I am happy to answer any questions.

CAROLYN B. MALONEY
12TH DISTRICT, NEW YORK

2308 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-3212
(202) 225-7944

COMMITTEES:
FINANCIAL SERVICES

GOVERNMENT REFORM

JOINT ECONOMIC COMMITTEE,
(SENIOR HOUSE DEMOCRAT)

Congress of the United States

House of Representatives

Washington, DC 20515-3212

DISTRICT OFFICES:

1651 THIRD AVENUE
SUITE 311
NEW YORK, NY 10128
(212) 860-0606

31-19 NEWTOWN AVENUE
ASTORIA, NY 11102
(718) 932-1804

619 LORIMER STREET
BROOKLYN, NY 11211
(718) 349-5972

WEBSITE: www.house.gov/maloney

November 2, 2020

Esteemed Members of the New York City Council,

As a legislator, proud former City Council Member and citizen of New York City, I write in support of Intro 1828 and Preconsidered Int. ___ (formerly LS 9293). These pieces of legislation must be ratified in order to provide crucial protection for women and girls at risk of or who have survived Female Genital Mutilation (FGM/C) in our city.

FGM/C is internationally recognized as a gross violation of human rights, a form of violence against women and girls, and a manifestation of gender inequality.

Ending violence against women and girls has always been a top priority for me, both on the New York City Council and in Congress. I have been working on the issue of FGM/C since I was elected to Congress. In that time, we have made great progress both on the local and federal level in combatting horrific human rights abuse, including passing a federal FGM ban in 1996, the Federal Prohibition of Female Genital Mutilation Act.

However, city-level legislation on FGM/C is now even more crucial than ever because the Federal Prohibition of Female Genital Mutilation Act is under attack. In 2018, a federal judge ruled the federal FGM ban unconstitutional. The Trump administration has declined to defend the law, putting thousands of women and girls at risk. Last month, the U.S. House of Representatives unanimously passed the bipartisan *Stop FGM Act of 2020* to bolster the law and to clarify its connection to interstate commerce. It has been sent to the Senate, where it waits to be passed before it can become law.

We are doing all we can in Congress to shore up protections for the most vulnerable, but local protections are crucial to ending this practice. Thirty-nine states, including New York, now have laws against FGM/C but due to the nature of FGM/C, it is extremely important that we have federal, state and local laws.

We need a comprehensive strategy at all levels of government to prevent this human rights abuse from occurring and to support survivors of FGM/C.

I urge you to ratify Intro 1828 and Preconsidered Int. ___ (formerly LS 9293). to establish this FGM/C specific committee, create culturally-competent training on how to identify FGM/C, and provide necessary resources to those at risk and survivors.

Thank you for all you do,

Carolyn B. Maloney

Carolyn B. Maloney
MEMBER OF CONGRESS

New York City Council
Testimony of Brooklyn Borough President Eric Adams
Committee on Women and Gender Equity and Committee on Health
October 28, 2020

Hello, my name is Eric Adams, and I am Brooklyn's borough president, representing more than 2.6 million residents who call Brooklyn home. I want to thank Council Member Helen Rosenthal, chair of the Committee on Women and Gender Equity, and Council Member Mark Levine, chair of the Committee on Health, for convening this oversight hearing on "Sexual and Reproductive Rights in New York City."

I am testifying in support of two bills before these committees, which were submitted at my request: Intro 1662 relating to the training and inspection of lactation rooms, and Intro 1828, relating to establishing a committee on female genital mutilation and cutting (FGM/C).

When we opened our lactation room at Brooklyn Borough Hall in 2015, we knew it was only a first step toward improving the lives of nursing mothers and their children. Intro 1662 is a necessary follow-up to the groundbreaking legislation this Council passed in 2016 requiring lactation rooms in certain public buildings throughout New York City. Intro 1662 builds upon that legislation by ensuring this improved access is clean, comfortable, and safe at locations throughout the city. Putting the lactation rooms in place was the first piece, but we must be sure that they meet the standards necessary for safety and hygiene. When we fail to inspect what we expect, it is suspect.

Intro 1828 addresses a very real problem in New York City. While many people believe that female FGM/C are practices that only occurs overseas, the World Health Organization (WHO) estimates that more than 500,000 women and girls have undergone, or are at risk of, female genital mutilation in the United States. They estimate that 13 percent of those women and girls live in the New York City metropolitan area. Those are staggering numbers, and this issue must be addressed by this Administration. One area to improve the legislation would be to include the Offices of the Borough Presidents and Public Advocate as recipients of the annual report mandated by the legislation. I thank CMs Alicka Ampry-Samuel, Rosenthal, and partners for working on this issue with my office.

I urge you to pass both of these vital pieces of legislation to protect our citizens and continue our efforts to provide true equity to women and girls in New York City.

Thank you.

PUBLIC ADVOCATE FOR THE CITY OF NEW YORK

Jumaane D. Williams

TESTIMONY OF PUBLIC ADVOCATE JUMAANE D. WILLIAMS TO THE NEW YORK CITY COUNCIL COMMITTEE ON HEALTH AND COMMITTEE ON WOMEN AND GENDER EQUITY OCTOBER 28, 2020

Good morning,

My name is Jumaane D. Williams, and I am the Public Advocate for the City of New York. I would like to thank Chairs Rosenthal and Levine for holding this very important hearing. Sexual and reproductive rights are an important issue that is overlooked far too often at the municipal level. At the center of this lack of consideration is gender discrimination, a problem that we are continuously trying to eradicate in our society. Our efforts to address this matter is the reason for the legislation being heard today. I support the efforts of my Council colleagues and I thank them for introducing these bills.

In speaking about sexual and reproductive rights, I would be remiss not to mention the maternal mortality and morbidity problem that is disproportionately affecting Black and Brown communities. In New York City, Black women are 8 times more likely to die during childbirth. And if it is not death that poses a risk, Severe Maternal Morbidity (SMM), which refers to life-threatening complications from delivery, does. Women and pregnant persons of more color in this City, especially Black non-Hispanic women, face a Severe Maternal Morbidity rate three times that of white non-Hispanic women. We have passed legislation at the federal, State, and municipal levels to study why women and pregnant persons of more color face maternal health risks at rates higher than that of their white counterparts. In 2020, we know why this is happening; causes include pulmonary embolism, preeclampsia, and hemorrhages. It is no longer enough to study this problem; we have to be proactive about implementing solutions. Our City needs to expand free doula programs to make them more accessible to minority women and pregnant persons, especially those who are low-income. And our State needs to pass legislation that would require health insurance plans to provide free coverage of midwifery and doula services while ensuring that midwives and doulas are being reimbursed at a liveable wage. It is time we effectively tackled the maternal health issue in this City.

The bills being heard today are a good first step towards addressing the other areas of sexual and reproductive health in New York. Intro 1625, sponsored by Councilmember Rivera, would require the Department of Health and Mental Hygiene to make FDA-approved methods of non-surgical contraception and long-acting reversible contraception available at its health centers, clinics, and other facilities. Expanding access to contraception can make all the

difference when it comes to family planning. We want to ensure that women and individuals with embryos and/or uteri have as much autonomy as possible in deciding when to get pregnant, and this bill aims to do just that. I commend Councilmember Rivera for this piece of legislation.

In addition to ensuring that women have agency over their body's reproduction, it is also our responsibility as lawmakers to ensure that women are protected from horrible acts like female genital mutilation. This is a cruel, gross violation of women's rights, and although it is considered a bigger issue outside of the United States, the truth of the matter is that it poses a risk to thousands of women and girls right here in New York City. Unfortunately, it is not uncommon for adherents of FGM from certain parts of Africa, the Middle East, and South Asia to either send U.S.-born women and girls to their countries of origin to be circumcised, or to pay to bring a person from overseas to come to perform circumcision on several girls. I applaud Councilmember Ampry-Samuel for her piece of legislation, Intro 1828, which would create a committee on female genital mutilation and cutting within the Mayor's Office to End Domestic and Gender-Based Violence, and Councilmember Rosenthal for her bill, Preconsidered Intro T2020-6774, which would require inter-agency efforts to conduct culturally competent training for all staff on recognizing the signs of FGM and cutting. By working to stop this act of torture from continuing, we will save more women from physical health problems, mental health disorders, and trauma that this procedure leaves on them.

I would also like to highlight another bill from Councilmember Rosenthal, Intro 2064, which would create an advisory board for gender equity in hospitals. Community advocates have communicated to my Office the importance of this bill, which is only underscored by the pay gaps, lack of upward mobility, sexual assault, and sexual harassment that many women in the medical field face across this country. We see a clear example of this problem in the 2019 federal lawsuit filed by eight individuals alleging sex, age, and race discrimination by the Mount Sinai Health System and four of its male employees. I stand with the victims in this case and I attended a rally they held in front of Mount Sinai earlier this month. Discrimination should have no place in medicine and science, and so we need to ensure that our healthcare workers are protected.

I especially want to acknowledge Councilmembers Cornegy and Dromm for their pieces of legislation, and for being prime examples of true allies in the fight to end gender discrimination. Intro 1662, which would mandate training and inspections regarding lactation rooms, would ensure that individuals who are breastfeeding have a clean and safe place to go to while lactating. Intro 1748, which would require DOHMH to implement a public information and outreach campaign regarding medically unnecessary treatments or interventions in infants born with intersex traits, would tremendously impact the health of intersex infants by determining whether medical intervention should be delayed.

I would also like to highlight Councilmember Ayala's Resolution 919, which calls on the federal government to dismiss the change to Title X funding which would prohibit recipients from using it to perform, promote, refer for, or support abortion, and Councilmember Chin's Resolution 920, which would support a woman's right to abortion and to oppose sex-selective abortion bans that perpetuate racial stereotypes and undermine access to care. A pregnant person's right to choose is just that – their right. We should be eliminating barriers that safeguard that right, not creating additional ones.

In order to effectively tackle gender discrimination, we must address it in all forms. We need to address maternal health disparities in Black and Brown communities, secure access to contraception, protect women and girls from FGM, ensure that women in the healthcare industry can go to work everyday without having to face sexism from male coworkers, provide safe and clean lactation rooms, provide information about medical procedures with regard to intersex children, and protect the right to choose – even when the federal government is currently making decisions that put that particular right at greater risk every day. Thank you.

October 30th, 2020

To: Committee on Women and Gender Equity, The Council of the City of New York
From: Dr. Holly G. Atkinson
Re: Written testimony in support of Bill #Int. 2064

My name is Holly G. Atkinson, M.D., a physician who is Clinical Professor and Medical Student Advisor at the CUNY School of Medicine in New York City. (I am writing as an individual, and my views are my own.) I am writing to express my full support for the creation of an **advisory board for gender equity** in hospitals as introduced by Council Members Rosenthal, Public Advocate Williams, Chin, Louis, Rivera and Cumbo.

I, along with seven other colleagues, filed a federal lawsuit in 2019 alleging sex, age, and race discrimination by Mount Sinai Health System and four of its male employees, including the dean of the medical school. As our complaint details, we left Mount Sinai emotionally and psychologically scarred after being demeaned by male leadership, denied promotions, underpaid compared to male colleagues, and systematically gaslit by internal reporting structures after we filed a complaint with Mount Sinai Human Resources. I personally suffered a 40% pay cut, was demoted in my leadership position, and assigned menial tasks, such as managing a Mailchimp subscription list. I was virtually ignored and frozen out of important work streams, and as I was sidelined, I watched as mostly younger men were hired as a new layer of management was put in place above we women who had helped to create the Institute. Members of our group were referred to as "bitches" and "cunts" by our colleagues without any repercussions. Those are just a few of the forms of mistreatment we endured at Mount Sinai's Arnhold Institute for Global Health.

Our experience reflects what a recent national report has revealed. In 2018, the National Academy of Sciences, Engineering and Medicine (NASEM) published its consensus development report on sexual harassment of women in the sciences. Key findings of the report include:

- There is extensive sexual harassment in these sectors
- Gender harassment* is the most common form of sexual harassment
- Sexual harassment undermines research integrity, reduces talent pool, and harms targeted individuals and bystanders
- Legal compliance is necessary but not sufficient to reduce harassment
- Changing climate and culture can prevent and effectively address sexual harassment

*[*NASEM defines gender harassment as "verbal and nonverbal behaviors that convey hostility, objectification, exclusion, or second-class status."]*

The NASEM report found that sexual harassment is very prevalent in academic science, engineering, and medicine. Studies shows that around 50 percent of women faculty and staff in academia experience sexual harassment. The NASEM report cited a study that revealed up to 50% of female students surveyed during medical school had experienced sexual harassment by

faculty or staff. Women of color experience more harassment (sexual, racial/ethnic, or a combination of the two) than men of color, white women, or white men experience. Studies also reveal that sexual harassment not only undermines women's professional and educational attainment, but also can profoundly affect their mental and physical health. Today, seven of us eight plaintiffs have left Mount Sinai's Arnhold Institute for Global Health, most with our careers derailed, and many of us with psychological and physical health problems.

Since filing our lawsuit, we have been contacted by scores of women — physicians, nurses, technicians, medical students — from not only Mount Sinai, but also from other health care institutions across New York, as well as from around the nation. We've heard about gaps in pay, lack of promotion, stolen ideas, retaliation for challenging male colleagues, sexualization of learning materials, sexual assault — the list goes on. Most individuals who tell us their disturbing stories are too afraid to make a report to their human resources department or to speak up in any way — they fear retaliation, and rightly so.

As the Association of American Medical Colleges recently stated: "Sexual harassment is morally indefensible, unacceptable, and presents a major obstacle that is keeping women from achieving their rightful place in science."

Institutions must be held accountable for their actions — or their lack of action. Creating a Gender Equity Advisory Board for New York City would signal to our institutions that they must begin to do the work *in earnest* of changing the climate and culture of medicine in our hospitals and academic medical centers. A Gender Equity Advisory Board will help shine a light on the damaging circumstances that so many women suffer in silence. We can and must create safer work environments for women and gender minorities. Everyone will ultimately benefit, including all of the patients these institutions serve.

Sincerely yours,

Holly G. Atkinson, M.D.
Clinical Professor & Medical Student Advisor
CUNY School of Medicine
New York, New York
hatkinson@cuny.med.edu

To Whom It May Concern:

I am a registered nurse practicing at a large teaching hospital in Manhattan. I self-identify as a cis, gay man (he/him/his).

During my tenure as a nurse in NYC, I have repeatedly been witness to and recipient of sex/gender discrimination/harassment. Here is a brief recall of the most upsetting instances:

- Supervisor asking that I "tone down" my attire at work;
- My having been promised a promotion that never came to fruition;
- Supervisor saying that he feels LGBTQIA people are the result of poor parenting;
- Supervisor describing female colleague as "good" because she has children;
- Supervisor remarking that surgical colleague is a competent surgeon, "even for a woman";
- Supervisor questioning colleague's taking a day off work for a personal doctor visit, stating she was "dressed too sexy to be going to the doctor";
- Male supervisor undermining female physician clinical plan of care;
- Male surgeon commenting on female colleague's choice of makeup and dress.

Gender harassment and sex discrimination are pervasive here at my hospital and throughout the healthcare industry. Women and gender minorities are made to feel incompetent, angry, afraid and sad. Inevitably, this toxic milieu of unbridled patriarchy and gender discrimination affects patient care. Female and gender minority staff are not empowered to think and act autonomously; we tow the countless micro-aggressions committed by our male colleagues behind us into every patient encounter; we fear defending ourselves when our decisions are questioned or when our voices are too strong; we grieve the identities we might have had.

I stand in support of the creation of a Gender Equity Advisory Board as it would signal to healthcare institutions that they will be held accountable to women and gender minorities.

Deborah Ottenheimer, MD, FACOG

Director, Women's Holistic Health Initiative
Harlem United/ URAM, The Nest Community Health Center

Clinical Instructor, Weill Cornell Medical College
Faculty, Weill Cornell Center for Human Rights

Adjunct Assistant Professor, Icahn School of Medicine at Mount Sinai
Forensic evaluator, Mount Sinai Human Rights Program

October 27, 2020

Declaration in support of City Council Proposal 1828

The World Health Organization (WHO) has defined female genital mutilation/cutting (FGM/C) as "all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs, for non-medical reasons" and has classified FGM/C into four fundamental types FGM/C is practiced around the world, primarily in Africa (e.g., Somalia, Guinea, Egypt), the Middle East (e.g., Iraq and Yemen) and Southeast Asia (e.g. Indonesia). Increasingly, due to migration, women and girls affected by FGM/C have become members of societies where the practice is not normative, including the United States (US).[1]

The CDC estimates that over 500,000 women and girls in the United States are affected by or at risk for FGM/C.[2] New York City and environs is home to the largest proportion of these women and girls, numbering approximately 65,000.[3] Unfortunately, these numbers represent a "best guess" approximation of the prevalence of FGM/C based on country-specific, national prevalence statistics and immigration trends from practicing countries. There is a pressing need to collect accurate data on the prevalence of women and girls living in New York City, and in the US over all, who have already been cut, as well as the incidence of the cutting of girls from FGM/C-practicing groups living in the NYC in order to promulgate policies and evaluate practices. We need to understand the age at which FGM/C is performed on girls living in the US, as well as

[1] World Health Organization. Care of women and girls living with female genital mutilation: a clinical handbook. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO. Available at http://www.who.int/reproductivehealth/publications/health-care-girls-women-living-with-FGM/en/

[2] Goldberg H, Stupp P, Okoroh E, Besera G, Goodman D, Danel I. Female Genital Mutilation/Cutting in the United States: updated estimates of women and girls at risk, 2012. *Public Health Rep.* 2016;131(2):340-347

[3] Population Reference Bureau: available at https://www.prb.org/us-fgmc/

how often it is performed here in American versus in the family's country of origin during visits abroad ("vacation cutting"), who is doing the cutting, how it is being carried out, and the types of resulting complications. Furthermore, there is mounting evidence that during the COVID 19 crisis rates of Gender Based Violence have increased, including the incidence of FGM/C both here and abroad.

Practice guidelines, promulgated by the World Health Organization, encourage multidisciplinary holistic care for women who are affected by FGM/C. Nonetheless, despite the high prevalence of affected women and girls in the US, there are significant gaps in American practitioners' knowledge about and ability to care for this population[4] and almost no dedicated medical services are currently in existence. Currently only Arizona and Boston have such clinics. New York City is home to the largest concentration of affected women and girls in the United States. The establishment of a dedicated medical clinic, as well as the systematic education of medical professionals, in New York City is urgently needed. It is also imperative that community stake holders be involved in the development of medical services and educational tools, so that the medical needs of affected women and girls are accurately represented and satisfied.

Action at the city council and mayoral levels to develop programs ensuring the health and well being of affected and at risk women and girls is vital. Given the known association of FGM/C with other forms of gender based violence including child marriage, forced marriage and intimate partner violence, the location of the proposed committee within the Mayor's Office to End Domestic and Gender Based Violence will allow for essential programmatic and strategic coordination. Proposal 1828 is a critical step in launching New York City's efforts to protect women and girls from FGM/C through the development and implementation of strategies to eliminate the practice, educate the community, and provide comprehensive healthcare strategies addressing the complex issues around the practice of FGM/C.

I fully support this proposal and I would be honored to answer any further questions. I can be reached by phone at 917 887 0522 or by email at deb@ottenheimerhealth.com

[4] Reig-Alcaraz M, Siles-González J, Solano-Ruiz C. A Mixed-Method Synthesis of Knowledge, Experiences and Attitudes of Health Professionals to Female Genital Mutilation. *J Adv Nurs.* 2016;72(2):245–60.

Dear Councilmember,

I am a registered nurse who is fully in support of INT. 1748-2019. I, along with the intersex community, ask for your support in co-sponsoring INT. 1748-2019 which would require an educational campaign directed towards health care providers and parents of intersex newborns to discuss the importance of bodily autonomy. Approximately one to two percent of people are born with variations in bodily sex characteristics — such as genitalia, reproductive organs, hormones, and chromosomes — sometimes referred to as "intersex traits." A subset of these variations are recognized at birth, while others may go unnoticed until later in life, if ever. Although a small number of infants who are born with variations in their sex characteristics may require immediate medical attention–for example, being born without the ability to pass urine–most children with variations in sex traits are able to live rich, fulfilling lives without any modification of their genitalia or internal reproductive anatomy.

Affirming bodily autonomy and protecting infants born with variations in their physical sex characteristics from emotionally and physically damaging surgeries — which are rooted in homophobia and transphobia and have been motivated by societal biases intended to "normalize" babies who are born with natural variations in their sex traits — is a critical human rights issue. The United Nations, World Health Organization, European Parliament, Human Rights Watch and all major intersex-led groups have urged policymakers to address this issue and protect people from these clear human rights violations. As a nurse I am also urging policymakers to address this issue and help me to protect my patients from these human rights violations and give them back their bodily autonomy.

Not unlike the survivors of so-called "conversion therapy," people born with variations in their sex traits who are living with the results of medically unnecessary attempts at 'normalizing treatment,' often deal with the harmful emotional and physical consequences for the rest of their lives. These individuals therefore require further medical care throughout their life that would not have been necessary had they not undergone medically unnecessary and harmful surgery. Consequences can include permanent hormonal imbalance that requires supplemental hormones to correct, damage to genitalia leading to loss of sensation, difficulty with urination, painful menstruation and a number of other complications. Meanwhile, parents who have expressed reluctance about surgery for their children born with variations in sex traits are provided insufficient information regarding the extensive risks involved and the alternatives, including delaying surgery. Unfortunately, this practice has been normalized in healthcare and passed along through generations of healthcare providers. Education for healthcare providers such as myself would help to allow us to support parents and provide them with accurate information. In my experience parents want to do what is best for their child and trust us to help guide them in making those decisions. We need to help educate them to support their healthy child and not convince them to put their child through unnecessary procedures.

I, along with the intersex community, ask for you to do the right thing and co-sponsor INT. 1748-2019. Additionally, we ask that you support an amendment which would require a community advisory board be appointed, comprised of people with lived intersex experience.

Warmly,

Frances Burney, BSN, RN

I am an intersex adult currently living in Sacramento, California and I highly urge you to pass INT 1748. As an intersex adult, I cannot express how impactful it would be for parents to receive comprehensive education about their intersex child and whether or not surgery is the right option for them. Many intersex people are forced to live with the consequences of decisions that we did not make. I myself have been forced into receiving treatment that I did not want nor ask for. Passing INT 1748 would allow the parents of intersex children to be as informed as possible in a way that all parents of intersex children should be. It has the ability to positively impact countless lives and allow for correct, informed consent to be given in the event of such an intimate decision as genital surgery. While I may not be in NYC, I do believe that if INT 1748 passed it could impact law and policy across the country.

Thank you for your time.

Sincerely,
Mari Wrobi

October 26, 2020

Re: Support for New York City Council Int. 1748 (Dromm)

To Whom It May Concern:

interACT: Advocates for Intersex Youth is the oldest and largest organization in the United States dedicated to advocacy on behalf of young people born with variations in their sex characteristics— sometimes known as intersex traits. As an intersex person and Executive Director, I write to urge your support for Int. 1748, which would direct the NYC Department of Health and Mental Hygiene to create educational resources to increase public awareness about intersex variations. This crucial bill will make significant progress toward achieving health equity for the intersex community by educating the public, families of intersex children, and doctors that healthy intersex variations can be celebrated rather than surgically erased. Empowering adults to safeguard the autonomy of intersex children in their care bolsters the goals of the intersex movement by spreading the word that, when it comes to non-emergent surgeries, delay is okay. With an amendment to create an advisory board composed of intersex-identified individuals and advocates to oversee the development and implementation of the educational campaign and materials, this often-marginalized community will be given a voice, and the expertise that comes from their lived experience will be honored. We respectfully ask you to join us in supporting this bill today, and in supporting intersex empowerment through such an amendment.

"Intersex" is an umbrella term that refers to individuals born with variations in physical sex characteristics—including genitals, gonads, chromosomes, and hormonal factors—that do not fit typical definitions of male or female bodies. About 1.7 percent of the population is born with intersex traits, meaning that there could be over 2000 intersex births in New York City every year. Despite being relatively common, "intersex" is still an unfamiliar term to many. This lack of awareness can cause feelings of stigma and loneliness for intersex people—and can also leave new parents feeling adrift if they happen to have an intersex baby.

In almost every case, children born with intersex variations will not have immediate health concerns related to their differences. However, they are still frequently subjected to surgical interventions to make their bodies appear more "typical" for either boys or girls, depending on the sex assigned. Most commonly occurring before the age of two, these operations include clitoral reductions, vaginoplasties, repeated penile surgeries, and even gonadectomies that can be sterilizing. Other consequences include chronic pain, urinary incontinence, sexual dysfunction, psychological trauma, and the chance that surgery will enforce a sex assignment that the child will not identify with later. Despite condemnation from numerous human rights groups and medical associations,[1] the

[1] Report of the Special Rapporteur on Torture, Juan E. Mendez, UN Doc. A/HRC/22/53 (2013), http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf; United Nations Office of the High Commissioner for Human Rights, *Intersex Awareness Day: End violence and harmful medical practices on intersex children and adults, UN and regional experts urge* (26 October 2016), https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20739&%3BLangID=E; WORLD HEALTH ORGANIZATION, *Eliminating forced, coercive or otherwise involuntary sterilization: An interagency statement* (OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF and WHO) (2014), http://apps.who.int/iris/bitstream/10665/112848/1/9789241507325_eng.pdf?ua=1; Amnesty International, *First, Do No Harm: Ensuring the Rights of Children Born* Intersex (2017), https://www.amnesty.org/en/latest/campaigns/2017/05/intersex-rights/; Human Rights Watch, *"I Want to be Like Nature Made Me": Medically Unnecessary Surgeries on Intersex Children in the US* (2017),

practice of nonconsensual surgery on intersex infants continues to this day in hospitals all over the country, including in New York City. The most in-depth report on the practice was released by Human Rights Watch in 2017 and identified New York City as a major center of non-consensual intersex surgeries. A provider in New York who has been identified in the press previously as a perpetrator of childhood sexual abuse, Dix P. Poppas, Chief of Pediatric Urology at Weill-Cornell/New York Presbyterian, has come under fire in the past not only for his performance of clitoral reduction surgeries on intersex children, but also for his follow-up "sensitivity testing" that involved applying a medical vibratory device to the surgically reduced clitorises of children as young as 6. Despite this shocking practice, he continues to operate on his own patients.

There are no proven medical benefits associated with performing these procedures before the intersex individual can participate in these weighty decisions about their own bodies and lives, but parents frequently report feeling pressure to consent to these surgeries on their child's behalf. When parents do approve these surgeries, they often do so in a state of overwhelm and with incomplete information about the risks and alternatives, and what their child's medical needs might be as they grow up. interACT has heard from parents who pushed back, asked questions, and successfully advocated for their children to have the chance to make these choices for themselves, but we have also heard from other parents who are wracked with regret over consenting to irreversible damaging procedures that could have been avoided if they had known more at the time. Even medical providers are often not adequately educated about the intersex patients who may come to them for care, with intersex individuals reporting that they frequently need to explain their diagnosis and medical needs to new doctors or that they cannot find any doctor who is qualified to help them.

Int. 1748 would begin to address these problems. Increasing awareness of intersex variations throughout the city would tell the intersex individuals living here that they are seen and that they belong. It would help ensure medical professionals are prepared to serve all of the people in their communities. And it could empower parents to make more informed decisions to preserve the autonomy of their intersex children. Including an advisory board amendment will center intersex individuals and advocates throughout the process—a crucial aspect of building intersex justice as this bill seeks to do. We respectfully ask for your support in achieving these goals.

Sincerely,

Kimberly Zieselman
Executive Director, interACT

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https://www.hrw.org/report/2017/07/25/i-want-be-nature-made-me/medically-unnecessary-surgeries-intersex-children-us; M. Joycelyn Elders, David Satcher, & Richard Carmona, *Re-Thinking Genital Surgeries on Intersex Infants*, Palm Center (June 2017), https://www.palmcenter.org/wp-content/uploads/2017/06/Re-Thinking-Genital-Surgeries-1.pdf; Oxiris Barbot & Carmelyn P. Malalis, *Scalpels Down! Let Intersex Children Choose*, OZY (June 30, 2019), https://www.ozy.com/opinion/scalpels-down-let-intersex-children-choose/95202/; American Academy of Family Physicians, *Genital Surgeries in Intersex Children* (July 2018), https://www.aafp.org/about/policies/all/genital-surgeries-intersexchildren.html; GLMA: Health Professionals Advancing LGBTQ Equality, *Medical and Surgical Intervention of Patients with Differences in Sex Development* (Oct. 3, 2016), http://glma.org/index.cfm?fuseaction=document.viewdocument&ID=CEB9FEE4B8DD8B7F4F7575376BD476C3A433379DD853BEA17913AFCCB8270299C0731320B03D2F5E1022F1C15602FBEA

Hello, my name is Krys, and I am a member of National Asian Pacific American Women's Forum (NAPAWF) NYC. I am here today speaking in support of the Anti-PRENDA Resolution 920 introduced by Councilwoman Margaret Chin.

- Resolution 920 denounces the sex-selective abortion ban currently introduced in the State Assembly and could dispel harmful stereotypes about our community.
- Unfortunately, across the country, and even here in New York, we are seeing sex-selective abortion bans. These bans open the door for politicians to further intrude in personal decision-making as they weaponize harmful stereotypes about our AAPI community and could require doctors to racially profile their patients.
- Under these bans, AAPI community members could be questioned when trying to access abortion care services as to whether they are engaging in the services due to a preference of the child's gender due to the stereotype that the AAPI community has a "male preference."
- AAPI folks could be subject to medically unnecessary questions, increased scrutiny, and could even be denied reproductive health care. Patients must be able to trust their doctors and get the abortion care they need.

As a daughter of Asian parents, with numerous Asian cousins, aunties and elders who identify as female, we are proof that our culture does not unilaterally endorse gender inequity. That view is dangerous and being projected onto us without justification. Ironically, this view and this ban would strip away our autonomy and the right to safe abortions.

This same anti-Asian racism that fuels violent attacks on our community also fuels racist laws like sex-selective abortion bans, even here in NY. This will force an undue and horrific burden on them to carry through a pregnancy they do not want or cannot continue for any reason. Pregnancy is a beautiful thing when it is consensual; it is also violent, emotionally and medically traumatic when the pregnancy is non-consensual.

New York City is home to 1.2 million AAPI New Yorkers, and our city has an opportunity to stand with our AAPI community and be a leader on abortion access. We ask you to move Resolution 920 forward out of committee to be voted on by the next full City Council meeting.

Thank you.

Proposed Int. No. 1625-A and Res. no 919

Honorable Council Members Rosenthal, Levine, Rivera, Chin, Amprey-Samuel, Adams, Rose, Moya, Louis,Barron, Lander, Koslowitz, Cumbo, Gibson, Ayala, Kallos and Cornegy

My name in Mary Luke and I am representing NYC4CEDAW, PowHer NY, UN Women USA and National Asian Pacific American Women's Forum (NAPAWF). I was the Executive Director of Planned Parenthood in San Francisco and also worked globally in reproductive health, rights and justice.

Re: Int. No. 1625-A, Res. no 919 and Res 920

I. Proposed Int. No 1625-A

I speak **in support of Local Law 1625-A** to amend the administrative code of NYC to require the Dept of Health and Mental Hygrine to make available FDA approved Let Long Acting Reversible Contraceptive Methods at health stations, health clinics and other health facilities.

Let me start by thanking Council member Rivera for her opening comments on the importance of Importance of the healthcare system to provide anti racist, culturally competence and confidential care. This is especially important in providing sensitive services such as sexual and reproductive healthcare.

Long Acting Reversible Contraceptives (LARC) are proven safe methods of contraception These include IUDs, implants and injection and are the most effective forms of birth control to prevent unplanned pregnancy. Providers must be adequately trained in counseling, insertion AND removal of devices, so women can choose when to discontinue if they are not satisfied with the method, desire another method, or stop contraception to seek pregnancy.

There are two main groups that especially stand to benefit from increased access to LARC: Adolescents and young women and low income and immigrant women.

- Only 5.8% of adolescent age 15-19 have ever used these methods because of lack of information and also high costs.
  Of the more than 9,000 teen pregnancies among NYC residents in 2015, almost 8 in 10 were unintended (mistimed or unwanted).teen pregnancy rates continue to be highest in the poorest neighborhoods.

- Access to LARC is most effective for adolescents because of limited information, lack of advanced planning for sex which often leaves them unprepared and unprotected. And they are often victims of coerced sex. ACCESS to LARC will help reduce the unplanned pregnancy rate of adolescents.

- Low-income women without health insurance, including immigrant women are also able to access care at community Health centers for free or low cost. Neighborhood Health centers also offer bilingual and culturally competent services which are important for immigrant non English speaking families seeking reproductive health care.

- As many non- citizen immigrants must wait 5 years to enroll in Medicaid or Child Health Insurance Program, having access to LARC in health centers may be the only way they can plan the number and spacing of children. Undocumented immigrants also cannot access these program and cannot buy from Affordable Health care Act. Passing the HEAL Act (Heal for Immigrant women and Families Act) would enable these groups to be able to access healthcare without waiting 5 years.

II. **Res No 919**

I speak in support of Res 919.

I want to speak about the importance of community health centers and Planned Parenthood being able to continue provide essential family planning, STIS/HIV tests and treatment, and wellness checks to low income people through Title X funds.

Title X funding is a lifeline for health care for low income and uninsured women with a high percentage of Latino or Hispanic and Black or African American clients. Title X already does not allow clinics to use their funds for abortion counseling or provide abortion care. If the new federal regulations are enacted requiring full physical and financial separation from abortion-related activities, and even mentioning abortion, these clinics would lose funding and millions would be left without essential family planning services. I support Res 919 which would call on the Federal government to dismiss the changes in Title X funding.

Reproductive choice Is a fundamental human right. We are in a pivotal moment where our hard fought reproductive rights and abortion access are threatened, now, more than ever. Quality Sexual and reproductive health services must be Inclusive safe and accessible to all New Yorkers.

By supporting Res. no 919 the City Council offers adolescents and low income immigrant women the ability to take action in delaying pregnancy and to take charge of their reproductive lives.

III. Res 920

I speak in support of the Anti-PRENDA Resolution introduced by Councilwoman Margaret Chin.

- Resolution 920 denounces the sex-selective **abortion ban** currently introduced in the State Assembly and would dispel harmful stereotypes about the AAPI community.

- Unfortunately, across the country, and even here in New York state, we are seeing sex-selective abortion bans. These bans open the door for politicians to further intrude in personal decision-making as they support harmful stereotypes about the AAPI community and might contribute to doctors racially profiling their patients.

- Sex-selective abortion laws are part of the legislative campaign of groups opposed to reproductive rights. **Restricting access to abortion** is the primary motivation for sex-selective abortion bans.

- As a reproductive health specialist, I have encountered many women and heard their personal stories about why they chose to terminate a pregnancy. Some would be risking their health, others their livelihoods, even their relationships by carrying a fetus to term. At this crucial moment in our history and quest to maintain reproductive freedom, we **cannot afford** to have any further restrictions on woman's right to choose.

- We believe that all people must have the right and ability to determine when,whether and how to become a parent – or not. **We must listen to women to honor their needs and decisions relating to their own bodies and lives.**

- Under these bans, AAPI community members would be questioned when trying to access abortion care services as to whether they were seeking services due to a preference of the fetus' sex due to the stereotype that the AAPI community has a "male preference."

- Rather than changing behavior or addressing a purported problem, sex-selective abortion bans are likely to lead to the denial of health care services to AAPI women. Laws banning sex-selective abortion have been enacted on the basis of misinformation and harmful stereotypes about Asian Americans. We do not support the practice of sex selection by any means, but rather than combating discrimination, sex-selective abortion bans perpetuate it.

The same anti-Asian racism resulting in violent attacks on our community has fueled racist laws like sex-selective abortion bans even here in NY

New York City is home to 1.2 million AAPI New Yorkers, and our city has an opportunity to stand with our AAPI community and be a leader on maintaining access to abortion, based on the woman's choice . We ask you to move Resolution 920 forward out of committee to be voted on by the next full City Council meeting.

Thank you.

Hi! My name is Phoebe De Padua, and I am a member of the NAPAWF (National Asian Pacific American Women's Forum) – New York City chapter.

It is important to me that when I step into the office of a healthcare provider that there are no assumptions made about me because of my race and heritage. I want to be seen and heard for who I am - and not stereotyped - by my healthcare provider. I want to be treated with respect and dignity and to be able to discuss the full breadth of my reproductive healthcare needs, including the option for an abortion, without judgment or discrimination. I want to be able to talk about what is best for my body, health, and wellbeing without the fear of being misunderstood - and worse yet, racially profiled.

Passing this resolution is important to me because it is already so hard for many of us to go and see a healthcare provider. It can be hard to leave our job to go to a doctor's appointment, especially for many working class and low wage workers in the Asian American Pacific Islander community - many of whom are working paycheck to paycheck. It can be hard to verbally communicate our needs and navigate a bureaucratic system, especially for those of us in the Asian American Pacific Islander community who are not English proficient or have family with varying language and disability access needs. It can also be hard for us who are non-binary, transgender, and queer when healthcare providers operate on cis and heteronormative norms and are not comfortable talking to us about our lived experiences. For many of us who are undocumented, it can be also be hard to find a healthcare provider that we feel safe to be around and does not take advantage of our situation. As many of us in the community know so well, there can be a lot of barriers and emotional labor involved with going to see a healthcare provider. But we also know that the Asian American Pacific Islander community is resilient, and we take care of each other.

I am proud to be a Filipina migrant who comes from a family and community that celebrates women. I am proud to be my family's eldest daughter, and I am proud to have a younger sister. The stereotype that all of us, and only the AAPI community, has a preference for sons is simply NOT true. A sex selective abortion ban paints the the AAPI community with a broad brush as having son preference, which is a racist generalization and a falsehood.

As an Asian American Pacific Islander woman, I strongly believe in feminism, gender justice, and women's rights for our community. An old trick in the patriarchy and misogyny playbook is to take away the autonomy and decision making power of women. But we see right through the false narrative propagated by the PRENDA bill and a sex selective abortion ban. We know that we are best equipped to make decisions about our own healthcare. We know that AAPI women, non-binary, and trans people should have full access to quality healthcare.

I do not want to be racially profiled by New York's healthcare system. Instead, I want to be seen - as a woman with rights and the autonomy to take care of herself and her community. We at NAPAWF want to be seen and heard as integral members of the New York community. We are community members, activists, and voters. We are important, and we stand in solidarity with people of color and women of color who are leaders in the reproductive justice movement.

Speaker Corey Johnson and the New York City Council, join us in our fight for the full dignity and healthcare rights of Asian American Pacific Islander women, non-binary, and transgender people in New York. Pass Resolution 920, put an end to the racist and sexist PRENDA bill, and support the entire Women's Caucus package.

Testimony Against Sex-Selective Abortion Bans (Resolution #920)
October 26, 2020

Hello, my name is Ariel and I am a member of the National Asian Pacific American Women's Forum (NAPAWF) NYC. I am writing in support of the Anti-PRENDA Resolution 920 introduced by Councilwoman Margaret Chin.

In 1998, my mother sought an abortion after already having two children. At the time, she was working full-time and taking care of two small children. My parents did not plan to have a third child, and they wanted to ensure that they were prepared and financially stable enough to raise another child. My parents ultimately chose to have my younger brother, but it was not because the child's sex happened to be male.

People have a right to choose when and how to have a family. That is a reproductive right that should be granted to everyone. Their OB/GYN and abortion nurse respected their decisions, regardless of what they were, and provided the care my mother needed while she was pregnant.

As an Asian woman, immigrant, and non-native English speaker, my mother may have been endangered under sex-selective abortion bans like the PRENDA Act because of the racist stereotypes and narratives surrounding East Asian women that they prefer having sons over daughters.

If the PRENDA Act were to be passed, my mother's OB/GYN and abortion nurse would be required by law to racially profile my mother and other Asian & Pacific Islander people, interrogate the "real reason" why she was seeking an abortion, and, if there was any doubt, call the police on her for seeking health care. She would be subjected to medically unnecessary questions, increased scrutiny, and could even be denied reproductive health care. As with any other medical setting or circumstance, patients must be able to trust their doctors and get the abortion care they need.

This bill is important to me, as a daughter of a woman who once sought out an abortion to ensure that she could raise and parent her children the way she wanted. My mother and I are proof that it is untrue that Asian pregnant people seek to end pregnancies because they prefer having sons over daughters. If they did, I would not have been born.

Our community needs Resolution 920 now more than ever. The PRENDA Act follows the same anti-immigrant and anti-Asian sentiments as Trump's visa restrictions on pregnant people, family separation in ICE detention centers, and anti-Asian violence due to COVID-19. And, with the confirmation of Amy Coney Barrett as a Supreme Court Justice today, Asian pregnant people may be in even more real danger. In 2018, Barrett supported Indiana's sex-selective abortion ban and has made clear that she plans to overturn Roe vs. Wade.

New York City is home to 1.2 million Asian (American) & Pacific Islander New Yorkers, and our city has an opportunity to stand with our community and be a leader on abortion access. We ask you to move Resolution 920 forward out of committee to be voted on by the next full City Council meeting.

Thank you,

Ariel Hsu
(she/her)
NAPAWF*NYC

Hello, my name is Katherine Maningas and I am a member of National Asian Pacific American Women's Forum (NAPAWF) NYC. I am here today speaking in support of the Anti-PRENDA Resolution 920 introduced by Councilwoman Margaret Chin.

- Resolution 920 denounces the sex-selective abortion ban currently introduced in the State Assembly and would dispel harmful stereotypes about our community.
- Unfortunately, across the country, and even here in New York, we are seeing sex-selective abortion bans. These bans open the door for politicians to further intrude in personal decision-making as they weaponize harmful stereotypes about our AAPI community and would require doctors to racially profile their patients.
- Under these bans, AAPI community members would be questioned when trying to access abortion care services as to whether they are engaging in the services due to a preference of the child's gender due to the stereotype that the AAPI community has a "male preference."
- AAPI folks would be subjected to medically unnecessary questions, increased scrutiny, and could even be denied reproductive health care. Patients must be able to trust their doctors and get the abortion care they need.

This bill is important to me because this would eliminate one less potential barrier that I have when it comes to healthcare. As a Filipino woman who would like to be the victim of these discriminatory procedures, and as someone with an extensive history of poor healthcare access, I do not have the wherewithal to endure one more obstacle. This act, that claims that "women...possess the same fundamental human and civil rights as men," is actively working to control our right to our bodies.

The same anti-Asian racism resulting in violent attacks on our community has fueled racist laws like sex-selective abortion bans even here in NY.

New York City is home to 1.2 million AAPI New Yorkers, and our city has an opportunity to stand with our AAPI community and be a leader on abortion access. We ask you to move Resolution 920 forward out of committee to be voted on by the next full City Council meeting.

Thank you.

Katherine Maningas

Legislative Affairs
One Whitehall Street
New York, NY 10004
212-607-3300
www.nyclu.org

Testimony of the New York Civil Liberties Union
Before the New York City Council Committees on
Women and Gender Equity and Health

Regarding

Oversight: Sexual and Reproductive Rights in New York City

October 28, 2020

The New York Civil Liberties Union (NYCLU) is grateful for the opportunity to submit the following testimony. The NYCLU, the New York State affiliate of the American Civil Liberties Union, is a not-for-profit, nonpartisan organization with eight offices across the state and over 180,000 members and supporters. The NYCLU defends and promotes the fundamental principles and values embodied in the Bill of Rights, the U.S. Constitution, and the New York Constitution through an integrated program of litigation, legislative advocacy, public education, and community organizing. The NYCLU supports legislation under consideration by these Committees that improves access to non-discriminatory health care and provides these comments on the following bills and resolutions.

The NYCLU strongly supports improving access to the full spectrum of quality reproductive and pregnancy-related health care that empower people to make decisions about their lives, bodies, and families. **Int. 1625** advances this objective by requiring DOHMH facilities to make all non-surgical FDA-approved methods of contraception available, including Emergency Contraception (EC) and types of long-acting reversible contraception (LARC). Importantly, and in recognition of the historical patterns related to reproductive coercion and forced sterilization within Black and Brown communities, the bill also requires access to LARC removal. Ultimately, providing patients with quality care and counseling that support their ability to select the contraceptive method that meets their health and lifestyle needs is in line with both reducing rates of unintended pregnancy and ensuring equal participation in settings that have historically shut out women and those with the capacity to become pregnant, namely workplaces, schools, and other public fora.

The NYCLU also strongly supports **Int. 1662**. In furtherance of public health policy and principles of gender equality, nursing parents must be allowed to effectuate their choice to breast/chestfeed and return to work after childbirth. The benefits of breast/chestfeeding are well established. Numerous studies demonstrate that the use of human milk for infant feeding has health, nutritional, developmental benefits for infants, including improved cognitive development and a decreased rate of digestive problems, allergies, and respiratory ailments.[1] Psychological, social, economic, and environmental benefits, not only for infants, but also for parents and the population at large, complement these demonstrated benefits for infant health.[2] For these reasons, every relevant leading medical organization (including the American Association of Pediatrics, the American Medical Association, and the American Public Health Association) promotes breast/chestfeeding as a practice that should be encouraged.[3]

In recognition of these public health benefits, government entities and agencies at the state and federal level, including the U.S. Surgeon General, the Department of Health and Human Services, the Centers for Disease Control and Prevention, the New York State Department of Health, and the New York City Department of Health and Mental Hygiene (DOHMH), strongly recommend and promote breast/chestfeeding.[4]

Toward this end, New York State has enacted legislation and regulations protecting people's right to breast/chestfeed in public, promoting breast/chestfeeding in the hospital postpartum, and giving employees the right to express milk at work.[5]

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[1] *See, e.g.,* Stanley Ip et al. 2007. *Breastfeeding, Maternal & Infant Health Outcomes*. Agency for Healthcare Research and Quality, Rockville, MD. (May 2009), http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hserta&part=B106732; Michael S. Kramer et al. 2008. *Breastfeeding and Child Cognitive Development*. Arch Gen Psychiatry. (2008) *http://archpsyc.ama-assn.org/cgi/content/short/65/5/578*.

[2] *See* United States Breastfeeding Committee, Economic Benefits of Breastfeeding [issue paper], Raleigh, NC: United States Breastfeeding Committee (2002); Jon Weimer, U.S. Department of Agriculture, The Economic Benefits of Breastfeeding: A Review and Analysis (Mar. 2001).

[3] *See, e.g.,* American Academy of Pediatrics, Policy Statement: Breastfeeding and the Use of Human Milk, 115 (2) Pediatrics 496, 496-502 (Feb. 2005); Am. Med. Ass'n, Policy Position H-245.982 AMA Support for Breastfeeding; Am. Pub. Health Ass'n, Policy Statement: Breastfeeding (1982).

[4] Dep't of Health and Human Servs. Office on Women's Health, *HHS Blueprint for Action on Breastfeeding* 3-4 (2000); U.S. Dep't of Health and Human Servs., Ctrs. for Disease Control and Prevention, K.R. Shealy et al., *CDC Guide to Breastfeeding Interventions* i-ii; N.Y.S. Dep't of Health, *Breastfeeding Promotion Program*, http://www.health.state.ny.us/community/pregnancy/breastfeeding/index.htm; N.Y.C. Dep't of Health, *Breastfeeding Your Baby*, https://www1.nyc.gov/site/doh/health/health-topics/breastfeeding.page#:~:text=Health%20experts%20recommend%20that%20you,long%20as%20you%20are%20comfortable.

[5] *See* N.Y Pub. Health Law § 2505-a (including the "Breastfeeding Mothers' Bill of Rights"); NY Civ. Rights Law § 79-e ("Notwithstanding any other provision of law, a mother may breast feed her baby in

However, despite the stated national and local policy goals of promoting and increasing the rate of breast/chestfeeding as well as the legal protections to do so, there continue to be many barriers for people who seek to continue breast/chestfeeding while returning to or maintaining employment – particularly for low-wage workers.[6] Int. 1662 builds on existing protections to provide for training programs for staff working at locations that are required to make a lactation room available and requires the inspection of such rooms including an assessment of their cleanliness, safety, and accessibility. This measure is critical to ensuring that people's right to express milk at work is protected and honored. And there is certainly more that the City can do to support breast/chestfeeding, such as clarifying that lactation rooms are required for students in school settings and public buildings; the exclusion of these rights from these and other public settings raises serious gender discrimination statutory and constitutional concerns.

In addition, the NYCLU supports **Int. 1748**, which would establish a public education campaign around medically unnecessary surgeries for intersex[7] children, but the bill requires an amendment to ensure that a community board of directly impacted individuals, rather than DOHMH, creates the materials for the public education campaign. Directly impacted individuals are the most likely to know what information they wished they had access to, and they are the most likely to communicate that information in a respectful and culturally appropriate way.

This bill responds to an issue at the intersection of bodily autonomy – the ability to make decisions for oneself about one's own body – and combatting gender stereotypes. Surgeries on infants with intersex traits are often about trying to make a baby conform both to a gender binary and to societal expectations about what "typical" male and female bodies should look like. Nonconsensual, medically unnecessary surgeries on intersex children also implicate constitutional rights; the Constitution protects the rights of all people – including children – to be free from unnecessary medical interventions,[8] including those that are based not in science but in social biases.

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any location, public or private, where the mother is otherwise authorized to be, irrespective of whether or not the nipple of the mother's breast is covered during or incidental to the breast feeding."); 10 N.Y.C.R.R. § 405.21 (establishing minimum standards for hospitals including provisions promoting women's right to breastfeed newborns and refuse supplemental formula feedings); N.Y. Labor Law § 206-c.

[6] *See, e.g.*, Ruowei Li, et al., *Breastfeeding Rates in the United States by Characteristics of the Child, Mother, or Family: The 2002 National Immunization Survey,* 115 Pediatrics e31 (2005).

[7] *See generally Intersex 101: Everything you want to know!*, INTERACT, Mar. 2017, https://interactadvocates.org/wp-content/uploads/2017/03/INTERSEX101.pdf.

[8] *See Parham v. J. R.*, 442 U.S. 584, 600 (1979) ("It is not disputed that a child, in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment.").

Intersex children should have an opportunity to make decisions about their bodies once they are able to determine what is best for themselves.

Done right, the public education campaign Int. 1748 requires will give parents, as well as intersex youth themselves, the tools they need to better understand and contextualize the medical interventions offered to them. Intersex people are too often invisible in society and too often have been pathologized and treated as abnormal. The public education campaign will also challenge that view and help New Yorkers to recognize the breadth of human sexuality and gender expression that people in fact experience.

The NYCLU also supports the animating force behind **Int. 2064**, which creates an advisory board for gender equity in hospitals. We are in the midst of an unprecedented reckoning and demand for accountability and prevention of workplace harassment, particularly sexual harassment. Despite the longstanding prohibitions against harassment based on sex – as well as harassment based on race, color, religion, national origin, age, and disability – these reprehensible behaviors continue to infect our workplaces and deny working people, especially working women, equal employment opportunities, safety, and dignity. Unfortunately, New York City and the City's hospitals are no exception to this trend, and workplace discriminatory harassment remains just as pervasive here as it is in the rest of the country. Against this backdrop, Int. 2064's focus on gender equity in hospitals – and in particular on addressing the discrimination, harassment, and assault hospital staff, students, and faculty face – is especially timely.

Still, workplace discriminatory harassment is but one gender equity issue impacting New York City's hospitals. The City Council should also pursue opportunities to investigate the racial and gender biases that pervade our health care systems and feed New York's maternal mortality crisis; the racially discriminatory practice of targeting pregnant people in hospital settings for drug testing, which leads to separation of newborns from nursing parents and deters pregnant people from seeking health care; nonconsensual, medically unnecessary surgeries to make babies with intersex traits conform both to a gender binary and to societal expectations about what "typical" male and female bodies should look like; and coercive medical care on pregnant individuals that leads to negative health outcomes.

The NYCLU strongly supports **Reso. 0919** which calls on the Federal Government to rescind discriminatory and manipulative changes to Title X funding. Created in 1970, and first signed in to law by Richard Nixon, the Title X program is meant to provide comprehensive preventative health services to individuals who would otherwise not be

able to afford it. The Trump-Pence administration, and many before it, have used Title X to play abortion politics, and by doing so has devastated communities who rely on Title X clinics for their health care. The restrictions on the program have never been as severe as they are now. Indeed, just five months after the rule went in to effect, over 800,000 fewer individuals throughout the country received care than the year before.[9] And over 1,000 sites in 34 states withdrew from the program; these sites provided Title X funded services to over 1.5 million people.[10] Reso. 0919 opposes these changes to the program and their outcome. It is critical that New York City continue to raise its voice to urge Congress to lift this domestic gag rule, increase funding, and restore integrity to the program. Our communities need and deserve this.

Last, and critical to this agenda today, the NYCLU supports **Reso. 0920** urging Congress and the New York Legislature to support a person's right to abortion and oppose any bans on sex-selective abortions, which perpetuate racial stereotypes and undermine access to care. While sex-selective abortion bans claim to address gender and racial inequality, in reality they play on stereotypes of Asian American and Pacific Islander (AAPI) women and women of color in an attempt to limit access to care and stigmatize people's decision making. Enough is enough – since Roe became the law of the land, anti-abortion advocates have used every attempt to malign abortion care and the people who access it. We applaud Council Members for seeing through yet another ruse and call on this body to swiftly pass these pieces of legislation. The people of New York City deserve nothing less.

The NYCLU thanks the Committees for the opportunity to provide testimony today and for their consideration of these critically important issues.

[9] Key Facts About Title X. (n.d.). Retrieved October 27, 2020, from https://www.nationalfamilyplanning.org/title-x_title-x-key-facts.

[10] *Id*.

October 27, 2020

Re: Support for Int. 1748 (Dromm)

Dear Councilmembers,

My name is Bria Brown-King and I am the Director of Engagement at interACT: Advocates for Intersex Youth, the nation's oldest and largest policy organization dedicated to advancing the rights of intersex people. I am here to urge you to vote in support of Int. 1748, which would be a crucial step forward in protecting the rights of many others like me.

I was born with Congenital Adrenal Hyperplasia, CAH for short. This means that my body naturally produces higher levels of testosterone, which produces what we typically refer to as "secondary male characteristics," but I also have XX chromosomes, ovaries, and a uterus.

When intersex children like me are born, parents and doctors often make decisions about their bodies, including choosing unnecessary surgeries to change the appearance or size of the intersex child's genitals. These decisions are often made based on their fear that intersex bodies aren't healthy instead of being based on what is truly medically necessary. When fear is the decision-maker, the standards for what makes someone's body "healthy" can become deeply flawed. Oftentimes we are compared to people who are cisgender, white, able-bodied, and thin. The truth is, intersex children are already healthy. It's the ideas surrounding our bodies that need to be changed, not our bodies themselves.

Take the idea that clitorises are supposed to come in one size. Not only is this problematic and another form of patriarchal policing of women's bodies, but it's also responsible for so many surgeries on intersex children like me -- surgeries that remove clitoral tissue permanently just to fit this arbitrary ideal. (Penises come in different shapes and sizes, too, but no one's rushing to perform surgery because a penis is "too big.") These high-risk and irreversible surgeries are performed to conform our bodies to gender expectations, often with patients having little or no say in this personal decision to determine what, if any, treatment or surgery is appropriate for us. They may be well-intentioned, but these surgeries are oftentimes carried out with the assumption that this is what children would want as adults. Good intentions aren't enough. Parents need to be properly educated and made aware of the risks associated with these surgeries, and doctors should be accountable for the information and treatment options that they

offer. Doctors and parents should know that delaying these surgeries so the intersex person can make their own decision is the safe and ethical choice.

Intersex bodies are not the problem. Being forced to undergo these harmful and life altering surgeries is the problem. Doctors may tell parents that surgery is the cure for all of our problems, but we are not problems. We are perfect as we are. They don't want to talk about cases like mine and so many others where surgery doesn't go as planned or what happens years later when their daughters realize that they can't experience full sexual pleasure because that right was stolen from them without their knowledge or consent. They don't want to talk about the fact that these procedures have been deemed a form of torture by the United Nations.

Intersex people are always being prepared to have sex with our "future husbands," with the assumption that we will all grow up to be female and heterosexual, instead of being told that we also deserve to experience sexual pleasure. If the doctors who see intersex patients had access to better educational resources themselves, then this might not be the case. We need more of our doctors and our parents to know that our bodies developed the way that they were supposed to. There are many intersex people living healthy and fulfilling lives without surgery. This is what we need to highlight, and this is a message that a campaign like the one that will be created by Int. 1748 could spread all across this city. With this educational campaign, doctors could be offering intersex-affirming resources to intersex patients and their families about how to get connected to the intersex community for support, not rushing them into surgery.

This is why the bill is so important. It empowers adults to safeguard the autonomy of intersex children and will enable the New York City Department of Health to spread the word to people everywhere that, when it comes to non-emergent surgeries, delay is okay. Children born in New York City deserve to be protected against this injustice, and it's high time we center care on the needs of intersex people themselves. I ask for your support in passing Int. 1748.

Sincerely,

Bria Brown-King

Written testimony that was also read during the NYC Council's Committee on Health and the Committee on Women and Gender Equity on 10/28/2020.

Thank you Chair Rosenthal and Chair Levine, and the rest of the council members for holding this hearing.

My name is Phoebe Suva, and I am a policy associate representing the National Asian Pacific American Women's Forum (NAPAWF). We are the only progressive, multi-issue, community organizing and policy advocacy organization for Asian American and Pacific Islander (AAPI) women and girls in the country. I am here today to express strong support for Resolution No. 920, urging Congress and the New York State legislature to support a women's right to abortion and to oppose bans on sex-selective abortions that perpetuate racial stereotypes and undermine access to care.

Sex-selective abortion bans are based on deeply false stereotypes that Asian American women prefer sons. In reality, for Asian Americans, the ratio of males to females at birth is standard when compared to the ratio of all births in the U.S, and foreign-born Chinese, Indian, and Korean Americans actually have more girls overall than white Americans.[1]

Despite this, sex-selective abortion bans have gained sweeping popularity among anti-abortion legislatures in recent years. In 2013, sex-selective abortion bans were the second most-proposed abortion restriction across the U.S. and continued to gain momentum. Currently, there are 14 states that have passed sex-selective abortion bans, with the law effective and enforceable in ten of these states.[2] Just this year alone, 10 states have introduced sex-selective abortion bans.[3]

These racist and xenophobic steyotypes have been used to limit abortion access across the country, for many years. These are also the states with the fastest growing AAPI populations: 12 of the 15 states with the largest AAPI populations and 10 of the 15 states with the highest AAPI growth rates have proposed this ban.[4,5] The large overlap illustrates how anti-immigrant sentitment and fear -- not the intent of

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[1] Brian Citro et. al., *Replacing Myths with Facts*: *Sex Selective Abortion Laws in the United States*, (June 2014), https://chicagounbound.uchicago.edu/cgi/viewcontent.cgi?article=1004&context=ihrc

[2]https://www.guttmacher.org/state-policy/explore/abortion-bans-cases-sex-or-race-selection-or-genetic-anomaly

[3] https://www.guttmacher.org/state-policy

[4] California (AB 2336 (2014)), New York (A07610 (2011-2012), S05033 (2011-2012), A02553 (2013-2014), S02286 (2013-2014)), Texas (HB 309 (2012-2013)), New Jersey (AB 3951 (2009), AB 2157 (2012-2013)), Illinois (Illinois Abortion Law of 1975. 720 ILCS 510/6(8)), Florida (HB 1327 (2012), SB 1702 (2012), HB 845 (2013), SB 1072 (2013)), Virginia (HB 1316 (2013), HB98 (2014)), Pennsylvania (Pennsylvania Abortion Control Act. 18 Pa.C.S.A. § 3204 (1982)), Massachusetts (H 484 (2011-2012), HB 1567 (2013-2014)), Georgia (SB 529 (2010), HB 1155 (2010)), North Carolina (H716 (2013)), Michigan (HB 5125 (2009), SB 799 (2009), HB 5731 (2012)); US Census Bureau, American Community Survey 5-year estimates, https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml.

[5] California (AB 2336 (2014)), New York (A07610 (2011-2012), S05033 (2011-2012), A02553 (2013-2014), S02286 (2013-2014)), Texas (HB 309 (2012-2013)), New Jersey (AB 3951 (2009), AB 2157 (2012-2013)), Illinois (Illinois Abortion Law of 1975. 720 ILCS 510/6(8)), Florida (HB 1327 (2012), SB 1702 (2012), HB 845 (2013), SB 1072 (2013)), Virginia (HB 1316 (2013), HB98 (2014)), Pennsylvania (Pennsylvania Abortion Control Act. 18 Pa.C.S.A. § 3204 (1982)), Massachusetts (H 484 (2011-2012), HB 1567 (2013-2014)), Georgia (SB 529 (2010), HB 1155 (2010)), North Carolina (H716 (2013)), Michigan (HB 5125 (2009), SB 799 (2009), HB 5731 (2012)); US Census Bureau, American Community Survey 5-year estimates, https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml.

“saving” Asian girls-- are the driving forces behind these bans. Proponents of the bill know this: In 2011, a state senator from Arizona said, “We know that [female infantcide] is pervasive in some areas [like China and India]. We know that people from those countries and from those cultures are moving and immigrating in some reasonable numbers to the United States and to Arizona.” The 2010 Census showed Asians were the fastest growing population in Arizona, nearly doubling in ten years.

Sex-selective abortion bans claim to address gender inequality when in reality, they inadvertently discourage AAPI women from seeking appropriate reproductive health care, which is already out of reach for many AAPI people and women of color while exploiting our communities and stripping us of our agency.

As NYC has the second-largest AAPI population in the country, passing this resolution would be a huge step to ensuring everyone has access to abortion care without fear of discrimination. We urge the committees and the full city council to pass this resolution so that Congress and the NY State legislature does not introduce these bans that are so harmful to our communities.

Thank you.

Phoebe Suva
Policy Associate, National Asian Pacific American Women’s Forum (NAPAWF)
psuva@napawf.org
Washington, DC

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Care. No matter what.
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26 Bleecker Street
New York, NY 10012
t: 212.274.7200
ppgreaterny.org

Testimony of Planned Parenthood of Greater New York Before the New York City Council Committees on Women and Gender Equity and Health on Sexual and Reproductive Rights in New York City

October 28th, 2020

Good Morning. My name is Carmina Bernardo and I am the Senior Director of Public Policy at Planned Parenthood of Greater New York (PPGNY). I would like to thank Committee chairs Rosenthal and Levine for holding this important hearing to explore how we can strengthen sexual and reproductive healthcare access in New York City. I would also like to thank the chairs of the Women's Caucus, Council Members Gibson and Louis and all the caucus members for championing this important package of legislation that brings us closer to achieving reproductive freedom and making this city more justice for all.

PPGNY has proudly provided the full range of sexual and reproductive healthcare services and quality education programs to all New Yorkers for over 100 years. Last year, our New York City health centers conducted over 104,000 patient visits, providing care regardless of patients' immigration status, identity or ability to pay for services. Our education programs also engaged over 19,000 people—including 1,800 youth. Project Street Beat, through their offices and mobile health center, conducted over 20,000 encounters with marginalized community members. And, in 2019, we enrolled over 6,300 people in health insurance programs. In response to the COVID-19 pandemic, we have continued to provide this vital healthcare through in person visits and telehealth appointments, as well as educational programming. We transformed our care delivery model to ensure individuals could safely access our services while adhering to government guidelines to decrease the spread of the virus.

The pandemic has highlighted the devastating impact inequities in our healthcare system have on marginalized people in this country with over 220,000 individuals losing their lives. Since the first confirmed case of COVID-19 in New York City, there have been over 200,000 confirmed cases and over 25,000 COVID-19 related deaths in New York City alone.[1] Black and Brown people and low income communities were hardest hit by the virus and represented a large

[1] The New York Times. (2020, May 09). New York City Covid Map and Case Count. Retrieved October 22, 2020, from https://www.nytimes.com/interactive/2020/nyregion/new-york-city-coronavirus-cases.html

number of deaths.[2] As the pandemic continues, the federal government has dismissed this reality and has even taken steps to dismantle this country's public health system and limit healthcare access to those most in need. We have also seen renewed attacks on sexual and reproductive freedom. In the last year, Title X, the nation's only federally funded grant program dedicated to providing sexual and reproductive health care to low-income and uninsured individuals, was fundamentally altered with the implementation of a domestic "gag-rule". The changes to Title X forced PPGNY and other health care providers to withdraw from the program and opened the door for anti-abortion organizations that also do not provide the full range of medically-approved contraceptive methods to benefit from the program. More recently, we witnessed the federal and conservative state governments use the pandemic as tool to restrict abortion access around the country. It was recently revealed that immigrants in ICE detention centers experienced forced sterilizations[3], adding to this country's long history of this unjust practice on marginalized people. Additionally, the federal administration's efforts to stack the Supreme Court with anti-reproductive rights judges presents a threat to Roe v Wade and reproductive freedom.

New York City must stand up and push back against these attacks from the federal government and work to ensure that all New Yorkers can obtain quality, affordable, and culturally competent healthcare. The city has made much progress in safeguarding reproductive health access in recent years including publically funding abortion care, creating standards for respectful births, and prohibiting discrimination and harrasment by employers towards employees attempting to access reproductive healthcare. However, there is more work to be done. The legislation that is a part of today's hearing moves us closer to our goal.

Resolution No. 919: Opposing changes to Title X

Created in 1970, the Title X program provides comprehensive, culturally relevant preventative health services, cancer screenings, and community education programs. The program aims to serve low income individuals and families and those who are uninsured or underinsured who would otherwise not have access to care. Before the implementation of the gag rule, over four million Americans relied on Title X funded services each year.[4] Planned Parenthood health centers provided services to over 41% of individuals who depended on Title X.[5] In New York City, over 150,000 individuals received care from Title X funded organizations. There were also 22 Title X funded providers that operated over 50 health centers throughout the city.[6] The gag rule has had a devastating impact on communities in need. Just five months after going into

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[2] Mansoor, S. (2020, April 05). Data Suggests Coronavirus Hits NYC's Low-Income Areas Hard. Retrieved October 22, 2020, from https://time.com/5815820/data-new-york-low-income-neighborhoods-coronavirus/

[3] ACLU News & Commentary. (2020). Retrieved October 22, 2020, from https://www.aclu.org/news/immigrants-rights/immigration-detention-and-coerced-sterilization-history-tragically-repeats-itself/

[4] Parenthood, P. (n.d.). Title X: Affordable Birth Control and Reproductive Health Care. Retrieved October 27, 2020, from https://www.plannedparenthoodaction.org/issues/health-care-equity/title-x

[5] What is Title X? An Explainer. (n.d.). Retrieved October 27, 2020, from https://prh.org/what-is-title-x-an-explainer/

[6] Title X Funding in NYC: A Critical Resource That Must Be Protected. (n.d.). Retrieved October 27, 2020, from https://comptroller.nyc.gov/reports/title-x-funding-in-nyc-a-critical-resource-that-must-be-protected/

effect in 2019, 835,000 fewer individuals throughout the country received care than the year before.[7] And over 1000 sites in 34 states withdrew from the program; these sites provided Title X funded services to over 1.5 million people.[8]

The Trump-Pence Administration's domestic gag rule forced many of these providersm, including PPGNY, to withdraw from the program.

PPGNY supports this resolution that documents New York City's opposition to these changes. However, some time has passed since the reconfiguration of Title X. The participation of many healthcare providers in the program depends on a new administration undoing these harmful changes and strengthening the qualifications of the program. Leaving such an important program's fate in the hands of changing administrations is not sustainable and leads to much confusion for providers and leaves many individuals without vital resources. We ask that the Council instead urge Congress to pass an appropriations bill that removes the domestic gag rule, increases funding, and restores integrity to the program. We look forward to working with the Council to update this resolution.

Intro No. 1625: Requiring DOHMH to make all non-surgical FDA approved methods of contraception available at their facilities

With women's rights under threat in the Trump administration and in state legislatures across the country, it has never been more important for the City to ensure that New Yorkers can easily access contraceptive care in their community. Requiring DOHMH facilities to provide all non-surgical contraceptive methods including emergency contraception (EC) and long-acting reversible contraception (LARC) will continue to help reduce the rate of unintended pregnancy and ensure that people who can get pregnant are able to fully participate in society. Improving access to reproductive health care is fundamental to gender equality and women's health.

Resolution No. 920: Opposing sex-selective abortion bans

Sex-selective abortion bans claim to address gender and racial inequality but in reality they will limit abortion care for many Asian American and Pacific Islander (AAPI) women and women of color while exploiting AAPI communities in an attempt to undermine reproductive rights. These bans condone the racial profiling of AAPI women seeking abortion care, reducing their agency and undermining their dignity. Referencing the sex selection occurring in India and China, authors of these bans across the U.S. make race-based assumptions about Asian Americans and claim that they need such abortion bans in the U.S. to eliminate preferences for male children. However, there is no factual evidence showing that sex-selective abortions are prevalent in the U.S. In fact, a demographic study completed in 2014 by the University of Chicago found that Asian Americans in the U.S. are actually having more girls on average than their white Americans counterparts.[9] We support this resolution that helps protect the AAPI community against these thinly veiled and racially motivated threats to healthcare access.

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[7] Key Facts About Title X. (n.d.). Retrieved October 27, 2020, from https://www.nationalfamilyplanning.org/title-x_title-x-key-facts

[8] Ibid.

[9] Brian Citro et al., "Replacing Myths with Facts: Sex-Selective Abortion Laws in the United States," Cornell Faculty Law Publications (2014), https://www.napawf.org/uploads/1/1/4/9/114909119 /replacing-myths-with-facts-final.pdf.

Intro No. 1662: Clean and Safe Lactation Rooms for Nursing Parents

PPGNY also fully supports Intro No. 1662 and believes that all individuals who are nursing should be able to do so in a space that is safe and clean. The bill would mandate the Department of Health to provide training to staff at locations where lactation rooms are available. Additionally, the DOH would be required to inspect the lactation rooms for cleanliness, safety, and accessibility quarterly. Breastfeeding has been linked to numerous positive health outcomes for both the parent and the baby. Studies show that the use of human milk for infant feeding has health, nutritional, developmental benefits for infants, including improved cognitive development, and a decreased rate of digestive problems, allergies and respiratory ailments.[10] All parents deserve the resources they need to take care of their family in a way that is right for them. For nursing parents, this includes the ability to breastfeed or pump comfortably. Protecting accommodations for breastfeeding is important for parents who may not always feel comfortable or safe nursing or pumping in public. This bill would ensure that this important resource continues to be accessible and protocols are in place to ensure safety and cleanliness compliance.

Given our current political climate, it is important that New York City ensure that all people have access to the best health care for themselves and their families. In a moment when our communities face unprecedented attacks on reproductive freedom, we are thankful to the Council for holding this hearing and standing with our communities by prioritizing the fight for sexual and reproductive health and rights. We look forward to working alongside the Council to make New York City a fairer place for us all.

Thank you.

[10] Ip, S. (2007). Breastfeeding and Maternal and Infant Health Outcomes in Developed Countries. Retrieved October 27, 2020, from https://www.ncbi.nlm.nih.gov/books/NBK38337/

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Planned Parenthood of Greater New York (PPGNY) is a leading provider, educator, and advocate of sexual and reproductive health care in New York State. PPGNY offers a wide range of services at its 30 locations across 65% of NYS - including gynecological care; birth control; cancer screenings; pregnancy testing; STI testing and treatment; HIV prevention, testing, and counseling; transgender hormone therapy; and vasectomy. PPGNY is also proud to provide abortion services to anyone who needs compassionate, non-judgmental care. PPGNY is a trusted source of medically-accurate, evidence-based information that allows people to make informed decisions about their health and future. As a voice for reproductive freedom, PPGNY supports legislation and policies that ensure all New Yorkers have access to the full range of reproductive health services and education.

October 2020

Testimony of Shruti Rana in support of Resolution 920 (Written Submission)

Members of the Committees,

My name is Shruti Rana. I'm a mother, a lawyer, and a Professor at Indiana University, and co-chair of the Indiana chapter of the National Asian Pacific American Women's Forum. I'm the oldest of three daughters proudly raised by feminist parents who came to the U.S. from India in 1968 and 1970. My two sisters and I now ourselves have four daughters among us (and coincidentally no sons), between the ages of 1 and 7. In these respects, our family actually fits the norm—data shows that Asian American families in the US have a higher ratio of daughters to sons than other population groups, contrary to the false stereotypes that pro-PRENDA groups are trying to promote.

I'm speaking here today in support of the Anti-PRENDA Resolution 920. Specifically, I'm here to share more about Indiana's history with similar abortion bans and urge you to act before it is too late, so that you can avoid repeating Indiana's failures.

First, I urge you not to be fooled by groups who attempt to co-opt the language of civil rights to promote abortion bans. These groups travel the nation claiming that they are fighting eugenics or discrimination but they are doing exactly the opposite, making discrimination and eugenics more likely. Why is that? *Roe* and related cases protect reproductive liberty and decision-making autonomy. That means they protect both the right to choose, but also the right not to be forced to have an abortion or endure forced sterilization.

Taking away a person's right to make these personal and individual decisions will do nothing to protect anyone from discrimination, nor will it do anything to ensure that that individuals who are discriminated against will be treated with dignity and equality. In fact, bills like the PRENDA bills would allow the government or politicians, not women, to decide when and who is allowed to have a child. That is a textbook example of eugenics.

Lawmakers who actually want to support equality and civil rights would not be trafficking in ugly, discredited stereotypes or attempting to divide Americans. But that is exactly what happened in Indiana. Indiana passed a PRENDA bill in 2016 which was rejected by both the US Court of Appeals for the 7th Circuit, and also just last year, was rejected by a conservative majority in the US Supreme Court.

The Indiana Bill was the culmination of years of discrimination against Asian American women in Indiana. The only two pregnant women who have been prosecuted to date under Indiana's feticide laws are two Asian American women, Purvi Patel and Bei Bei Shuai. The state of Indiana recently prosecuted these women for feticide and murder in cases that were marked by ugly racist stereotyping and a rejection of actual evidence and data. These charges were later overturned on appeal or dismissed, but only after contributing to rising levels of xenophobia, hate & discrimination against Asian Americans in Indiana.

The PRENDA bills in Indiana are just the latest in a long history of using women's bodies to promote discrimination; in fact, Indiana was the first state in the nation to pass a forced sterilization law, in 1907. That law targeted poor white women--but if bills like the PRENDA bill pass, any group of women could be targeted next. This is one of the powerful arguments for why *we must protect* the fundamental rights of individual liberty guaranteed to individuals by the US Constitution.

Resolution 920 will protect us from those who would usurp the right to choose when and/or if to have a child from individuals and place that decision in the hands of the state.

Indiana's experience shows that the history of using xenophobia and eugenics arguments to take away women's liberty and autonomy has a long and ugly history. I urge you not to repeat this story of hate and discrimination in New York. Thank you.

Shruti Rana
Co-chair, National Asian Pacific American Women's Forum-Indiana Chapter
Professor of International Law Practice
Hamilton Lugar School of Global and International Studies
Indiana University Bloomington
(Academic titles provided for identification purposes only)

Dear Councilmember,

I, along with the intersex community, ask for your support in co-sponsoring INT. 1748-2019 which would require an educational campaign directed towards health care providers and parents of intersex newborns to discuss the importance of bodily autonomy. Approximately 1-2% of people are born with variations in bodily sex characteristics — such as genitalia, reproductive organs, hormones, and chromosomes — sometimes referred to as “intersex traits.” Some of these variations are recognized at birth, while others may go unnoticed until later in life, or never identified. Although a small number of infants who are born with variations in their sex characteristics may require immediate medical attention – for example, being born without the ability to pass urine – most children with variations in sex traits are able to live healthy, fulfilling lives without any modification of their genitalia or internal reproductive anatomy.

Affirming bodily autonomy and protecting infants born with variations in their physical sex characteristics from emotionally and physically damaging surgeries — which are rooted in homophobia and transphobia and have been motivated by societal biases intended to “normalize” babies who are born with natural variations in their sex traits — is a critical human rights issue. The United Nations, World Health Organization, European Parliament, Human Rights Watch and all major intersex-led groups have urged policymakers to address this issue and protect people from these clear human rights violations.

Not unlike the survivors of so-called “conversion therapy,” people born with variations in their sex traits who are living with the results of medically unnecessary attempts at ‘normalizing treatment,’ often deal with the harmful emotional and physical consequences for the rest of their lives. Meanwhile, parents who have expressed reluctance about surgery for their children born with variations in sex traits are provided insufficient information regarding the extensive risks involved and the alternatives, including delaying surgery.

I, along with the intersex community, ask for you to do the right thing and co-sponsor INT. 1748-2019. Additionally, we ask that you support an amendment which would require a community advisory board be appointed, comprised of people with lived intersex experience.

Warmly,
Jill Rosok

Ossé 21
District 36

10.27.2021
Re: FGM+C: Intro 1828 and Intro 6774

Good Day Chair & Councilmembers,

The genital altering or injury of our women and girls is not a global issue happening on foreign soil. **Female Genital Mutilation & Cutting (**FGM + C) is a problem affecting neighbors in our city and state. We must be committed to protecting our communities.

Some will argue this protection is savior-ism or distorted observations based on modernist biases. Some will claim the acts are protected because they are based on age-old cultural practices and/or religions. FGM+C is about power and control over women and girls. It is removing the sovereignty of young girls before they understand the definition.

Like most challenges in New York City, there are nuances: Many women are unwilling to discuss FGM+C; falsified truths are used to justify; communities are chained to archaic social norms; and, young women are hurt physically and emotionally.

It is our job to overcome the challenges to shield and defend the children. This defense is not found in criminalizing communities or solely arresting individuals. Education, cultural awareness and City-level agency support are important steps to interrupting the damage Female Genital Mutilation & Cutting can cause. Growth and change are difficult to achieve and require a well-rounded approach that is not clasped to criminal justice. This would be arbitrary and fuels animus. We want positive change and protection.

Central Brooklyn—a home to amazing African, Middle Eastern and Asian communities —stands in solidarity with and support of the New York City Council bill Intro 1828 and its companion, Intro 6774.

I stand in complete support of the bills and I look forward to them helping to protect our women and young ladies.

Thank you for the time.

Chi Osse
Candidate for 36th City Counsel District.

The below is a copy of my oral testimony from 10/28/2020

Thank you for this opportunity to speak.

I am here today to speak on my own behalf in strong support of the creation of a Gender Equity Advisory Board.

My name is Joe Truglio, and I am a physician in the departments of Internal Medicine, Pediatrics and Medical Education at the Icahn School of Medicine at Mount Sinai.

I completed my residency, served as Chief Resident, and completed my Masters in Public Health at Mount Sinai.

Over the last 10 years I have served as a course director at the medical school, worked with residents throughout our health system and now serve as the Program Director for our Combined Internal Medicine and Pediatrics Residency.

I have also been a mentor and a resource to students and trainees at numerous institutions in New York and around the country. Many of my colleagues, trainees and students cannot testify today due to fear of retribution. As a cisgender white man I feel this risk is less for myself.

Today I speak in strong support for the creation of the Gender Equity Advisory Board. Over the last decade I have seen the devastating impact of gender discrimination on the lives and experiences of students, trainees, clinicians and other health professionals – and patients – throughout the city.

I show up to work every day with the intent of promoting gender equity for my students, trainees and patients. However in health care we know that intent simply isn't good enough, and I fail in my efforts far too often. All too often I let my own implicit biases impact my professional decisions, I overlook sexist and discriminatory comments made by patients or clinicians towards teammates and I remain silent and complicit in the face of broader systems of gender-based oppression.

Even when I recognize the issues at hand, I often find the mechanisms available to address them woefully inadequate. I have seen students survive sexual assault only to have to choose between near-daily encounters with their assailant and delaying their medical training. I have seen friends, colleagues and mentors leave our profession rather than continue to face daily gender-based discrimination. Consider the investment made by society in the decade-long training of a physician, only to fail these same clinicians in ensuring equitable training, clinical and work environments. Consider the patients these physicians will not treat and the students they will not teach.

Intent is not enough. And our current practices are not enough. We need systems and support structures in place that continually strive towards true gender equity in health care.

I will now share reflections and experiences from those unable to present today on their own behalf:

- *I was advised by a supervisor to "watch my tone" so as to not seem too "bossy."*
- *A supervisor told me he was "glad I didn't have kids" because I wouldn't be able to take on as much at work.*
- *I have been told we "go out of our way to recruit men" because primary care is a "female dominated field."*

- *I have witnessed awful treatment directed towards Black women, both on behalf of colleagues and administration.*
- *Any action to address equity needs to encompass gender and race.*
- *There are no true systems of accountability as these systems are often run by perpetrators.*
- *The cost of speaking out it too high, especially if you do not have family or other connections within the institution. Intimidation and retaliation are common tactics to force silence.*

These are only a few examples. Many were too painful for individuals to share.

I thank you for your time and the opportunity to testify on my own behalf, and on the behalf of those our profession has attempted to silence.

Testimony from Natasha Anushri Anandaraja MD, MPH
anu.anandaraja@gmail.com
www.equitynowatmountsinai.com
917 3189834

October 28, 2020

I am testifying in support of Intro 2064-2020 to create an NYC Gender Equity Advisory Board.
I am Dr. Natasha Anushri Anandaraja , I use she/her pronouns – I am a Pediatrician and Public Health physician.
I worked at Mount Sinai for the past 18 years, beginning with my residency in pediatrics from 2002 to 2005. From 2005, I worked within the Icahn School of Medicine at Mount Sinai to build Mount Sinai's global health programs that reached into underserved communities around the globe. Since September 2018 I have worked as the Director of Wellbeing and Resilience for the Mount Sinai Health System. I resigned from Mount Sinai last week, in large part because I could no longer be part of an institution that gave only lip service to racial and gender equity.

Myself and 8 other current and former employees of Mount Sinai are currently engaged in a federal lawsuit against Mount Sinai for sex, age, and race discrimination. The case is on public record and we are permitted to speak about it. I go into detail now to provide an example of what happens to female healthcare across our city every day.

In 2015, a new Director was brought in to lead our Global Health Institute – he was young, inexperienced, and did not meet any of the criteria for the position – he was the pick of Dennis Charney, Dean of the Medical School, and so he was guaranteed a position regardless of his inexperience and lack of qualifications.
After he came into power, even though I had 10 years more of experience and had indeed built the global health program, I was quickly demoted and a layer of inexperienced men were placed in layers of leadership above me. My work was criticized, dismissed, denigrated, and I was removed from important work-streams to which I had been key. I was isolated from my peers, instructed not to meet with leadership that I had worked with for years, and was gaslit about work projects. Other women in our case were screamed at by male co workers, called bitches and other offensive names, their work was stolen and they were retaliated against when they spoke out.
By the time we asked for an internal investigation into what was happening, more than ten women had resigned from the institute.

Our experience with Mount Sinai HR and legal teams during the internal investigation were humiliating and devastating, and ended with us being told that we were mistaken about what we had experienced, that this young man would be protected because he had "potential" and that we could expect nothing from them – no recourse, no support. At one point the head legal counsel of Mount Sinai, Marina

Lowy, even told us that she was reading a book about "why women think they are being discriminated against when they are not".

The federal case against Mount Sinai was our last resort - we are among the lucky few women experiencing workplace discrimination who are able to find good affordable legal representation. After our case became public, letters of support demanding accountability and action against the bullying and hostile environment at Mount Sinai were sent to the Mount Sinai Board of Trustees by students, alum and employees of Sinai – there were over 1000 signatures. To date, the Board of Trustees has failed to respond to their request, or to meet with the organizers.

Since we filed our case in April 2019 we, the plaintiffs, have been approached by scores of women from the Mount Sinai Health System, from healthcare institutions around New York City and across the country reporting the experiences mirroring our own. We realized that our case is just one example of a pervasive problem. We formed our group, Equity Now, to support the women who were reaching out to us, to raise awareness about sex discrimination in healthcare, and to advocate for change.

The prevalence and impact of gender discrimination and sexual harassment in healthcare and academic medicine are well studied. We know that the field of academic medicine is second only to the military in its rates of gender harassment. We know that up to 50% of female medical students will experience sexual harassment by faculty and staff during medical school. We know that up 70% of female doctors will experience sexual harassment or gender discrimination during their career. We know that a very small proportion of women experiencing discrimination or harassment will ever report it or seek justice – reflecting the lack of hope that anything will be done, and the fear of and real risk of retaliation when women do speak up. Please see the National Academies of Science, Engineering and Medicine Report from 2018 for more information.

80% of the healthcare workforce is women, but they are leaving medicine broken and with the careers derailed - like I did, and like my co-plaintiffs did. We are losing essential women from the healthcare workforce pipeline, and the ones who remain are not reaching their full potential. With 80% of the workforce being female and in a time of unprecedented medical crisis, we cannot afford this – we need to be valuing, supporting, promoting, our women.

There are concrete steps that can be taken to protect women in the healthcare workforce and provide an equitable work and educational environment. Institutions must be pressured to take action, and to be held accountable for the outcomes. These actions should include the following:

- Establish independent and safe reporting systems for women, gender minorities, and anyone experiencing mistreatment
- Conduct comprehensive annual data collection on discrimination and harassment and publicly report this data.

- Create systems that support survivors, rather than demonizing, re-traumatizing and gas-lighting them. Human Resources department and Title IX offices are not that resource.
- Create independent and fair adjudication systems for discrimination cases (e.g. truly independent Faculty and Peer Councils in the academic setting) – ones that do not include potential perpetrators as decision makers in the process.
- Establish institutional gender equity programs that are lead by people who actually have experience and expertise in the field, who have adequate resources to carry out their job, and who do not answer to the same institutional power structures that diminish women.
- Diversify leadership, with a focus on women and BIPOC in leadership positions. Mount Sinai's website's leadership page shows 23 leaders – 17 men, six women; 22 whites, one black (unsurprisingly in charge of diversity and equity), and no other BIPOC.

We are fortunate to receive the support of Helen Rosenthal's office as we seek legislative approaches to ensuring institutional accountability for implementation of actions such as those listed above. We applaud her introduction of this bill to create a Gender Equity Advisory Board. We have learned that we cannot rely on our institutions to protect us – they will not. Independent bodies, such as the Gender Equity Advisory Board, are absolutely needed to ensure robust investigation into what is happening to women and gender minorities in healthcare, and to hold institutions accountable for change.

We offer the following recommendations to ensure that the Gender Equity Advisory Board will represent the experience and interests of healthcare workers and trainees, and will not be biased towards protecting institutional interests:

- Recruit from across the diverse healthcare disciplines – include not only doctors and nurses, but also research scientists, Physicians Assistants and Nurse Practitioners, Respiratory Therapists, Social Workers, Healthcare Admin staff etc
- Recruit from across levels of training, including medical students, PhD and post-grad students, Residents and Fellows, Junior Faculty and Senior Attendings.
- Recruit with intersectionality in mind – ensure representation across race, gender orientation, ability, age, ethnicity etc
- Recruit based not only on high-level institutional recommendations, but on the recommendation of peers and colleagues.
- Look for candidates who demonstrate a commitment to activism and advocacy, rather than those with only institutional accolades.
- Include representation from labor organizations such as New York State Nurses Association, Council of Interns and Residents, and Doctors Council.

Thank you for this opportunity to provide testimony, and thank you for standing with women and gender minorities in healthcare.

Gender Equity in Healthcare Facts:

There is gender parity and even a predominance of women at the instructor level. However the share of women faculty declines at each subsequent rank, such that the share of women professors is 53% lower than the share of women assistant professors.[1]

Less than 20% of all deans and department chairs are women.[1]

This decline in women representation is even more pronounced among racial and ethnic minorities. Only 12% of women chairs are from an underrepresented minority group.[1]

Women are encouraged to seek promotions two to four years later than men and do not receive similar sponsorship for senior roles and positions.[1]

Women make up nearly 80 percent of the health care workforce, but only 20 percent of the decision makers — including hospital leadership, executives, and association presidents — are women.[2]

Female specialists earn 76cents to the dollar compared to their male colleagues. Female primary care physicians earn 80cents to the dollar.[7]

Academia has the second-highest rate of sexual harassment behind the military.[3]

Women have made up about 50% of medical student graduates since 1998 but make up only 35% of the physician workforce.[3]

As many as 50% of female medical students report experiencing sexual harassment.[3]

More than 30% of postdoctoral students in academic medicine had personally experienced harassment, with women of color experiencing even higher rates.[3]

Research shows that almost 40% of women physicians go part-time or leave medicine altogether within six years of completing their residencies.[1]

Women account for 16% of medical school deans, 18% of department chairs, and 25% of full professors.[1]

Across five of the most prominent surgical journals, nearly 80% of first authors were male. [4]

Among 10 separate medical societies there are no female presidents[5]. This despite a survey of more than 1,200 female physicians that found half reported being interested in future election.[6]

Four factors increase the likelihood that women in academic sciences, engineering, and medicine will be targeted with sexual harassment:
- male-dominated work settings;
- hierarchies that concentrate power in individuals and make students, junior faculty, and others dependent on them for funding, research direction, mentorship, and career advancement;
- symbolic legal compliance policies and procedures that are ineffective at preventing harassment; and

- uninformed leadership at all levels lacking the tools, intention, and/or focus needed to undertake the key actions necessary to reduce and prevent sexual harassment.[8]

Of 9,282 U.S. COVID-19 cases reported among HCP in April 2020, median age was 42 years, and 73% were female, reflecting these distributions among the HCP workforce. [9]

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5 Silver JK, Ghalib R, Poorman JA, *et al.* Analysis of Gender Equity in Leadership of Physician-Focused Medical Specialty Societies, 2008-2017. *JAMA Intern Med* 2019; **179**: 433.

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7 Medscape Physician Compensation report 2020 https://www.medscape.com/slideshow/2020-compensation-overview-6012684

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Personal Testimony for NYC INT 1748-2019 Hearing, October 28, 10AM EST

My name is Hida Viloria and I'm an intersex adult and author who was born and raised in NYC without receiving any medical interventions on my visible intersex traits. In over two decades of working with my intersex community, I've been in contact with numerous intersex individuals—lawyers, artists, teachers, therapists, doctors, parents, and others—living happily, as I do, with genital variance and other intact intersex traits. Like me, they feel blessed to have been allowed to grow up as they are because we lack the physical and psychological issues that so many intersex people subjected to medically unnecessary cosmetic surgical procedures in their infancy or childhood have experienced.

The difficulty we *do* face is how hard it is to live openly as intersex in a culture which not only doesn't acknowledge and incorporate our existence, but actively sends the message that being intersex is so negative that it needs to be surgically erased. This lack of awareness about and stigma around our existence also makes it very challenging for parents of intersex newborns to embrace their children's differences and to feel it is safe to allow them to grow up as who they are. I urge you to pass INT 1748 because in order to support intesex people and our families, the general public needs to be aware that being intersex is as natural as being typically male or female, and that intersex people have not only lived but *thrived,* without medical intervention, since the dawn of humanity, and continue to do so.

Thank you for you time and consideration of this important issue.

Good morning and thank you for this opportunity. I am Dr. Betty Kolod and I use she/her pronouns. I am a primary care physician, board certified in internal medicine, and I am currently completing additional training in public health and preventive medicine. I am here to tell you about my personal experiences with gender discrimination during my medical training and the discrimination that I will face as I to transition to a faculty position eight months from now.

In medical school I was used to sexist mnemonics* and frequent questions about my plans to have children, but I did not take these slights personally until my first undeniable experience with gender discrimination. In my final year of medical school, during my most important hospital rotation, my sub internship in which I was expected to audition and prove I was prepared to graduate to residency, I worked with a resident who treated me differently. I had rotated at Kings County Hospital many times previously and I was familiar with the autonomy and independence that trainees are afforded when caring for marginalized patients in safety net hospitals. This was my moment to shine and I was ready to take on many patients and work hard to show all I had learned in medical school. However this resident made me stand on the sidelines and watch, and would not allow me to take on my own patients. On rounds I was embarrassed to have nothing to contribute because he would not allow me to admit patients, even when our team was quite busy. One night we were on call together and he revealed the reason for his strange behavior. He asked me point blank: “Are you sure you want to go into medicine? It’s so hard for a woman.” I went to my Dean and reported this discrimination. The next month he worked with two female sub-interns and both confirmed this same experience. I was shocked to find out that not only was he never disciplined but he was promoted to the prestigious position of chief resident the following year.

I believed that my experience with gender discrimination in medical school was an isolated incident. But during residency interviews I was proven wrong. During one of my interviews a male program director invited me into his office and closed the door. He then rotated his computer screen to show me the photo I had included in my application. He turned to me and said, “Now this this is a good photo. But I like you even better in person. I’m a smile man.”

Discrimination and sexual harassment are common experiences among my colleagues and the doctors who came before us. When I bring it up with my female mentors they advise me to keep my head down and my mouth shut. They don’t want me to jeopardize my career because they know that the predominantly male leadership may retaliate.

I am now applying and interviewing for faculty positions in academic medicine and my colleagues have informed me of what to expect. Two of my colleagues from residency applied for the same position at the same institution in New York City. The man was offered a salary nearly $20,000 higher than the woman, and she has a Masters degree that he does not. Further, my female colleagues warned me that any time I contribute to teaching will be unpaid for the first several years. To me this explains why, according to the Association of American Medical Colleges, in 2018 women made up 58% of first-year academic medical faculty but only 37% of tenured associate professors. While hiring of women to faculty positions is increasing, so is departure of women from academic medicine. Can you blame women from leaving this environment of under-recognition, discrimination, and uncompensated work training the next generation of physicians? No, but this phenomenon is unacceptable. No trainee should lose her mentor. Worse, women make up the majority of physicians in primary care fields and more

than 20% of women will leave medicine altogether within six years of finishing their training. Patients suffer from the departure of women for medicine.

For these reasons, I am here to support the creation of an advisory board for gender equity in healthcare. We must create a safe and welcoming environment for women and members of gender minority groups in medicine. If our workplaces are sick, how can we hope to heal our patients?

*Examples of mnemonic devices recently distributed by a NYC medical school professor:

Cranial Nerves Mnemonics

Read the columns from top to bottom, to match with their cranial nerves
In the 3rd column, S=sensory, M=motor , B=both.
Don't say you didn't learn anything in Anatomy today.

I

Nerve	Mnemonic	Sensory, Motor, or Both?
I, Olfactory	Oh	Some
II, Optic	Oh	Say
Iii, Oculomotor	Oh	Marry
IV, Trochlear	To	Money
V, Trigeminal	Touch	But
VI, Abducens	And	My
VII, Facial	Feel	Brother
Viii, Vestibulocochlear	Virgin	Says
IX, Glossopharyngeal	Girls'	Big
X, Vagus	Vaginas	Boobs
XI, Accessory	Ah	Mean
Xii, Hypoglossal	Heaven	More

October 27, 2020

Re: Support for New York City Council Int. 1748 (Dromm)

Dear Councilmember,

When I was almost 5 months pregnant with my first child in November of 2018, my husband and I went for a routine ultrasound at a well-known New York City hospital. We were excited to find out everything we could about what to expect. We were fortunate, everything had been normal up until then, or as normal as being pregnant can be.

During the utlrasound, when we got to the genital area, the tech looked at the scan and asked if my husband and I knew the sex. We told her that the blood tests said it was a boy. She told us that couldn't be right and pointed to the screen. My husband was a little confused but turned to me and said "oh! It's a girl, that's great!" But the tech stopped and said she would have to step out for a moment and get the doctor. The tone of the room immediately shifted from excitement to fear--no one wants to hear that.

The doctor came into the room and repeated the scan. He turned to my husband and I and said, "this could be a very serious disorder." I was stunned--terrified--so was my husband. As I tried to catch my breath, the ultrasound tech, who was looking at my chart, asked if we had done genetic testing. When I told her no we hadn't, I could see she was disappointed, exasperated maybe? The doctor told us we had to see a genetic counselor immediately and that was the start of the most terrifying two weeks of our lives.

We scheduled a phone call with the genetic counselor for the next day while waiting for our OB-GYN, who we saw right after that ultrasound appointment. When our OB-GYN entered the room, the first words out of her mouth were "I'm so sorry." She said "I had a case like this exactly like yours, three years ago, and I'm going to put you in touch with this person...you're not too late, you can terminate." And so the message was that whatever was happening, it was so awful that the option was an abortion, without us even talking about it.

That was the message. And what you have to understand is our child is perfectly healthy. She has a mild intersex variation called Androgen Insensitivity Syndrome, which means her body does not respond to androgens. So while her chromosomes are XY, her body looks like a typical girl. Instead of saying this common intersex difference could be the cause, and it's perfectly fine, everyone approached this situation as if it were horrible, as if we were horrible, as if she was horrible. I wish I could go back in time and tell myself that we were going to have a perfectly healthy baby, but instead we cried every night, desperately researching whether there was actually any risk for serious health problems.

We went for a second and third opinion and eventually found another OB-GYN who told us about androgen insensitivity. He described what it was and he was very normal about it--he was

the first doctor who was more educated about intersex, who didn't treat our family like there was something wrong.

Our child is 1 and doing great now. She's awesome. I knew deep down somewhere that what they were telling me wasn't right, I had that maternal instinct, but it's hard when people present things as facts that aren't true--that being intersex is actually a sickness. But now, we know she's not different from any other child. And that's what they should have told us. Education is desperately needed.

I don't think our story is unique. That's why we wanted to share it all with you, to raise awareness and urge you to support interACT's legislation, Proposed Bill 1748, which would require the city to provide informational resources for the medical community and the public, showing that these differences aren't something to be afraid of. Doctors in New York shouldn't be stuck back in a time when intersex was something to discriminate against. Our families deserve support. We learned that eventually, but it was at an enormous personal cost. When we look at our precious beautiful baby daughter we cannot believe what we've been through (an ordeal we will never forget) and that such negligent opinions were given from professionals we trusted. Opinions, that if were acted on, would've without a doubt ruined our lives.

We urge you to support Int. 1748 (Dromm).

To the Committees on Women and Gender Equity and Health:

Please accept this written statement as my testimony in support of Int. 1748-2019. This bill would go a long way toward preventing the needless suffering of people born with genitals that do not conform to standards established by persons and systems that are not concerned with health and wellbeing--whether individually determined or not.

As an adult, still contending with the consequences--physical, emotional, psychological, financial--of surgical operations I underwent at the ages of 1, 2 and 3, I know firsthand the needless suffering at stake. Doctors diagnosed me with a relatively common congenital defect of my urethra at birth. Surgical intervention was recommended. And my parents, being good parents, followed doctors' orders.

But complications ensued, and I returned to the surgery table twice more for further repairs. I can still remember, post-surgery at age 3, wearing diapers--though I was toilet-trained--because to acknowledge going to the bathroom meant to acknowledge the inevitable searing pain that accompanied urination while I healed.

None of the procedures were necessary. Perversely, none of the procedures had the purported intended effect: to "normalize" my genitals. Now, in adulthood, I have been forced to make difficult decisions about whether to undergo additional medical procedures to correct true medical problems with true medical consequences that, had I not been the subject of surgery so young, I would not have faced in adulthood. Those difficult decisions have been complicated and risky due to complications and risks born of the needless surgeries. Had I wished to achieve "normality"--or something else--my choices are now drastically limited.

The effects extend beyond the physical, and they are profound. In a society that cultivates worship of particular traits, one does not need a powerful imagination to consider the fallout of botched genital surgery.

The surgeries I faced are not the generators of this worship, they are its result. Pediatric surgery may be big business. Certainly in my case doctors reaped a windfall. And in my adulthood, I'm still paying off the true cost of those needless procedures.

Among the universal truths is the injunction that God shall not be mocked. We will reap what we sow when we make false idols of our egos. Unfortunately, "we" includes the innocent who suffer the collective karma that endures as our society relentlessly seeks to honor the gods of our own making, and not the God of love that would have us correct this mistake through a renewed perception.

Please vote to ensure that Int. 1748-2019 has a chance to become law. In considering this bill, I urge you to take an expansive view of "medically unnecessary" to ensure that so-called defects like hypospadias are covered in the information and campaign that this bill would require. The vast majority of the medical profession may not even consider conditions like hypospadias to be

an “intersex” trait, but we should be critical of this categorization and its patriarchal roots in misogyny. While members of the medical profession are capable of miracles, many are subject, knowingly or not, to undue influences that infect their judgment. We should be suspicious of the so-called “necessity” of surgeries that, even if routinized, at their root are manifestations of the serious social and spiritual illnesses of our world. Thank you for taking steps to address these illnesses in this important way.

Nick Connell, Brooklyn Resident

CAROLYN B. MALONEY
12TH DISTRICT, NEW YORK

2308 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–3212
(202) 225–7944

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(718) 932–1804

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(718) 349–5972

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November 2, 2020

Esteemed Members of the New York City Council,

As a legislator, proud former City Council Member and citizen of New York City, I write in support of Intro 1828 and Intro 6774. These pieces of legislation must be ratified in order to provide crucial protection for women and girls at risk of or who have survived Female Genital Mutilation (FGM/C) in our city.

FGM/C is internationally recognized as a gross violation of human rights, a form of violence against women and girls, and a manifestation of gender inequality.

Ending violence against women and girls has always been a top priority for me, both on the New York City Council and in Congress. I have been working on the issue of FGM/C since I was elected to Congress. In that time, we have made great progress both on the local and federal level in combatting horrific human rights abuse, including passing a federal FGM ban in 1996, the Federal Prohibition of Female Genital Mutilation Act.

However, city-level legislation on FGM/C is now even more crucial than ever because the Federal Prohibition of Female Genital Mutilation Act is under attack. In 2018, a federal judge ruled the federal FGM ban unconstitutional. The Trump administration has declined to defend the law, putting thousands of women and girls at risk. Last month, the U.S. House of Representatives unanimously passed the bipartisan *Stop FGM Act of 2020* to bolster the law and to clarify its connection to interstate commerce. It has been sent to the Senate, where it waits to be passed before it can become law.

We are doing all we can in Congress to shore up protections for the most vulnerable, but local protections are crucial to ending this practice. Thirty-nine states, including New York, now have laws against FGM/C but due to the nature of FGM/C, it is extremely important that we have federal, state and local laws.

We need a comprehensive strategy at all levels of government to prevent this human rights abuse from occurring and to support survivors of FGM/C.

I urge you to ratify Intro 1828 and Intro 6774 to establish this FGM/C specific committee, create culturally-competent training on how to identify FGM/C, and provide necessary resources to those at risk and survivors.

Thank you for all you do,

Carolyn B. Maloney

Carolyn B. Maloney
MEMBER OF CONGRESS

Hello, my name is Elizabeth Estrada I am the field and advocacy manger at the Latina Institute-NY, and I am here supporting the National Asian Pacific American Women's Forum (NAPAWF) NYC. I am here today speaking in support of the Anti-PRENDA Resolution 920 introduced by Councilwoman Margaret Chin.

I stand in solidarity with the Asian American Pacific Islander community in opposition to sex selective abortion bans in NYC and across the country during a time where access to abortion is under attack. Every person deserves the human right to decide for themselves if, when, and how to create the family they want.

As a Mexican immigrant whose primary language is not English, I grew up going to doctors and clinics where my parents and I were received with judgement and lack of cultural competency because we didn't speak English.

Now as an adult who has had two abortions, I have experienced the scrutiny doctors have put me under because they made a judgment about me based on stereotypes about Latinas. That judgement and stigma has been deeply harmful to the relationship I have with my healthcare providers and echoes the experiences many AAPI immigrants face when accessing healthcare. Sex selective abortion bans stigmatize AAPI people to advance an anti-choice agenda. Restricting access to abortion, NOT preventing gender-based discrimination, is the primary motive for sex-selective abortion bans.

As a community organizer living and organizing in The Bronx I work and speak to people all over the borough and across New York City who tell me they can't trust their doctors to get the healthcare they need because of discrimination and judgement based on gender, ethnicity, and immigration status. Immigrants and the AAPI community already face many barriers to accessing healthcare, including immigration status, lack of health insurance, limited English proficiency and financial restraints. They do not need another obstacle.

NY City has the opportunity to stand with the AAPI community and be a leader on abortion access. I ask you to move Resolution 920 forward out of committee to be voted on by the next city council meeting.

Thank you.

Proposed Int. No. 2064

Honorable Council Members Rosenthal, the public advocate, Mr. Williams, Chin, Louis, Rivera and Cumbo.

Chairs Rosenthal and Levine,

My name in Mary Luke and I am representing NYC4CEDAW Act, PowHer NY, UN Women USA and the National Asian Pacific Women's Forum (NAPAFW).

Let me thank Chair Rosenthal for her strong leadership of the Women and Gender Equity Committee and the two chairs for holding this important hearing on sexual and reproductive health and rights at this important moment.

I speak in **favor of Res 2064** amending Chapter 1 of title 17 of the administrative code of the city of New York to add a new section 17-199.14 to establish a **Gender Advisory Board** to focus on gender equity issues in the provision of healthcare services in hospitals.

The COVID-19 pandemic has laid bare many inequities in our healthcare systems, with Black women and Latinx and other women of color- staff and clients- who have suffered disproportionately from systems that are biased and discriminatory. The COVID- 19 crisis has revealed the stark realities of systemic racial discrimination. According to the COVID Tracking Project of *The Atlantic*, Black or Africa American deaths were 26% (14% of population); Hispanic or Latinx 27% (19% of population) compared to whites 33% (56% population).

I thank Executive Director Jacqueline Ebanks for her remarks on the importance of an intersectional, anti-racist approach to ensure health equity for staff and patients in our healthcare system. This approach is consistent with the vision of PowHer NY and its coalition of 100+ agencies, and NYC4CEDAW Act as described in "A Roadmap to Create Inclusive Gender Justice in New York: Building an Equitable Recovery in the Wake of COVID-19." .http://www.powherny.org/2020/09/16/roadmap/. In this document, we define inclusive gender justice as anti-racist – equality for people of all gender identities, gender expressions and sexual orientations. Systems and policies must change to achieve the paradigm shift necessary to achieve inclusive gender justice for health workers and patients.

We believe that a Gender Advisory Board must take an **intersectional approach,** looking at the linkages between gender and racial justice, especially. Looking at gender alone is not sufficient to identify and understand the full scope of the problem- we must look for solutions **from a gender justice and anti-racist lens.**

I appreciated hearing the earlier testimonies of the female doctors who had been harassed and discriminated against by their institutions and hospitals. Unfortunately the male-dominated, patriarchal culture of training medical students, doctors and residents has remain unchanged, even though women have entered the profession in equal numbers to men and have demonstrated their competence in every aspect of the profession. Prejudice, discrimination and harassment against female medical

students, residents, and doctors, especially those who are women of color, is part of the hospital culture- where POWER lies in the hands of supervisors who are predominately white heterosexual men. Nurses and assistants hold even less power, and LGBTQI and gender diverse people may face even more prejudice and discrimination.

What can be done to change this system of discrimination and institutionalized racism? Health systems are training providers in Implicit bias and understanding of how their attitudes affect patients. New anti-harassment laws are in place for providers and staff to report incidents and follow-up. Data is vitally important to document the extent of problems. Victims must be supported legally and emotionally to speak up, tell their stories and create a momentum for broad-based systemic change.

What is the impact of bias and discrimination on the quality of care and patient outcomes. It is well documented that Maternal Mortality among Black women in the US is higher than other developed countries. And in NYC Black women die 8 times higher than other women. In an article by the Commonwealth Fund, authors state that "Black women are 22% more likely to die from heart disease,, 71% more likely to perish from cervical cancer, and 243% more likely to die from pregnancy or childbirth-related cases than white women".
https://www.commonwealthfund.org/publications/newsletter-article/2018/sep/focus-reducing-racial-disparities-health-care-confronting?gclid=CjwKCAjw8-78BRA0EiwAFUw8LMYHeS6FwM3WePx0u98fJXl6bNnJOdCpFHl_j7c5Elvnffx36-phPxoCrBAQAvD_BwE.
Their recommendations include:

- Prioritizing the measurement of health disparities within institutions and among providers. Minnesota, which requires health care providers to track racial and ethnic disparities in treatment for a wide range of conditions, has encouraged this by publicly reporting performance on these metrics.
- Building partnerships to enable patients to play a meaningful role in developing solutions. Many health care organizations partner with community advisory boards or collect patient-reported experiences and outcome measures to identify potential problems.
- Making racial equity a strategic priority. Efforts to reduce racial disparities must go beyond cultural competency or workforce diversity initiatives. At HealthPartners, "key equity measures are built into our scorecards, our health equity sponsor group meets regularly, and equity is a standing topic at every board of directors' quality committee meeting.

Recommendation on healthcare personnel :

- Human resource data on hiring, pay equity, promotions, access to benefits, tenure and resignations must be compiled, analyzed for all levels, from hospital administrators to doctors, healthcare personnel and care workers to understand inequities and create plans to address.
- Data on all levels of personnel, especially those providing direct services, should be analyzed by **gender and race,** and compared to the demographics of the patient population served. This data should be included in the reporting of the Gender Advisory Board for recommendations to change.

- There should be external review process of discrimination and harassment complaints by medical students, residents, healthcare workers, etc. with reports available to the GAB, without divulging confidentiality.
- Training plans must be designed and carried out with a gender justice and cultural lens to uncover implicit bias and help providers examine their attitudes regarding gender and race.

Recommendations on quality of care:

- Put in place a system to **systematically track data** of patient outcomes which is analyzed by gender, race, disability, gender identity and sexual orientation to understand systemic racism, misogyny, and sexism in the provision of health care.
- Special attention must be given to long standing, systemic problems, such as Maternal Mortality among Black women. There should be coordination with other committees that have been established (such as the MHQIN) to review action plans and improve quality of care to this vulnerable group.
- In coordination with other quality improvement systems, data on service outcomes should be analyzed from a gender and racial perspective to understand trends and make improvements,
- Client advocates should be authorized to support patients and help them communicate patient needs to providers and managers.
- Client surveys (and client exit interviews, as appropriate) should be conducted periodically and confidentially to determine satisfaction with services, identify problems and help develop corrective action plans.

Recommendations on the role and composition of the Gender Advisory Board:

- The board must consist of at least two public members who have direct experience with the healthcare system, both as patients and **direct service providers** (not only as managers).
- In addition to the member with gender expertise, there should be technical expert on race and health systems issues.
- Overall membership should be diverse from a gender and racial perspective, reflecting the population served in NYC hospitals and healthcare system.
- The board should be clear in its goals and priorities and set objectives accordingly. Is the focus mainly on addressing provider equity issues or on improving patient care?
- The board should hold public hearings to get stories directly from patients and providers. (A Recent webinar by NYC4CEDAW Act on Maternal Mortality had powerful testimonies from several families whose wives/ daughters had died from giving birth or in the post-natal period due to inadequate care).

The Gender Advisory Board can play a strategic role by shining a light on the systemic issues and biases affecting provider performance and quality of care . It can help to change a system to be more equitable and just so that providers and patients alike are treated with dignity and respect and ensure Health Equity for all.

The Commission on Women and Gender Equity should have the financial resources to oversee studies, analysis of data and technical expertise to provide guidance to the Gender Advisory Board.

Thank you for this opportunity to make recommendations for the Gender Advisory Board.

October 31, 2020

To Council Member Helen Rosenthal,

I am writing in support of the creation of a Gender Equity Advisory Board. I have worked as a physician in many settings for over 20 years and have witnessed the dire need for accountability to women.

The only time I directly experienced sexual harassment was as a medical student. The male physician who was employed by the medical school and worked in student heath, had clearly inappropriately touched me during a required physical. When I reported it, the significance was minimized and it was never addressed. I believe the reason this was the only time I was directly adversely affected on the basis of my gender, is because I stayed part time for a long time and was never driven to rise in the ranks. Indirectly, I have definitely worked for men who were not great at their job. I often wondered how they got there. Meanwhile, I watched as a brilliant, overcommitted woman was reprimanded for coming in late and leaving slightly early at times in order to get her small kids to and from school. She was so insulted by the circumstances, she left. These seemingly small and insignificant inappropriate actions are pervasive and the reason women are being left behind.

Discrimination against women in medicine is loud if you look. One has to ask, why are there so few Department Chairs of Hospitals and Medical Schools women? According to 2018 AAMC data, 16% of all medical school deans are women and 18% are department chairs, yet there are now more female medical students overall. I am proud to say I currently work in an academic job with the above mentioned 16 and 18 percent. I hope the development of a Gender Equity Advisory Board will allow women to succeed and for these percentages to grow and reflect the very large untapped pool of talent.

Sincerely,

Anjali Gupta MD, MPH

I am a medical student at a prominent NYC medical school. I do not feel comfortable sharing any other identifying information because I do not feel safe at my institution. I worked extremely hard to get into medical school and now persist in this toxic environment because I want to care for patients. The pervasive tolerance for sexual harassment, assault, and discrimination I have witnessed at my institution makes it feel all the more urgent that I become and doctor so I can protect my patients and coworkers from sexual predators and bullies. This is not what I ever imagined when I envisioned becoming a doctor.

The institution's tolerance for sexually inappropriate behavior is made clear early on. Our class materials are often sexualized by our professors, and our complaints about them go unanswered – unsurprisingly because those complaints go to the same individuals who are perpetrating such behavior. I myself was touched by a professor in a way that made me very uncomfortable, but he has access to student mistreatment reports, and so I did not report the incident. I know far too many classmates who have been sexually assaulted by male students. The ones who have made reports were then dragged through the mud by administration, while their perpetrators carried on with life as usual. Left with little recourse, I study in fear, I work in fear, and I move through the hospital in fear.

We need change. We need accountability. We need safety.

I stand in support of the creation of a Gender Equity Advisory Board as it will shine a spotlight on damaging circumstances that so many women suffer in silence and so that we can create safer work environments for women and gender minorities.

Oct 28, 2020
Testimony in Support of Gender Equity Advisory Board

I am a female medical student who was previously employed at the Icahn School of Medicine at Mount Sinai. I am submitting my testimony anonymously for fear of retaliation.

After working in an entry level position for a year, I approached my superiors to discuss a promotion. I was told that the department leadership had approved my promotion but that these things take time. It is worth noting that I was constantly praised for the quality of my work by my supervisors and co-workers, and for my willingness to go above and beyond to help out fellow team members. Subsequently, I received the highest score of "Role Model" on my annual performance appraisal, which also recommended promotion. Despite the verbal promises and written recommendation, I waited 7 months without any movement, even though I repeatedly reminded the relevant management staff. Ultimately, the pandemic hit and everything halted. Prior to this, my team gained a male member hired to position higher than mine, who I was tasked with training. I then continued to have more responsibilities than he did, despite my lower position and lower salary. While I was happy to do the work to ensure the success of the team, I felt I deserved a title and salary to match my responsibilities and my skills. Unfortunately, this was never realized and I left my job feeling utterly defeated and disillusioned.

There is no doubt that systemic discrimination has gripped healthcare institutions from ground level and has served to demoralize and break the spirit of women from the very start of their careers. Therefore, I am in full support of the creation of a Gender Equity Advisory Board. I believe this board will help reveal just how pervasive discrimination is in healthcare institutions. It is only through confronting this discrimination that we will be able to move forward and build a better future. I hope we can strive for a workplace where women and gender minorities are recognized for the incredible work that they do, including through promotion and fair compensation.

Joint Hearing: Committee on Women and Gender Equity, Committee on Health

RE: Oversight Sexual and Reproductive Rights in New York City

Oral Testimony of: Natasha R. Johnson, JD/RYT

Executive Director/Founder, Globalizing Gender

Chair, NY Coalition Against FGM/C, Partnerships and Liaison Committee

Founder, The V March: Voices, Victories and Vitality/ Anti-FGM/C March

October 28, 2020

Testimony in Support of Pre-considered Int. no.1828 and Pre-considered Int. no. 6774.

Thank you for the opportunity to present my views to both of these Committees.

Female Genital Mutilation/Cutting involves the cutting or complete removal of the clitoris or the sewing of the labias. There are no medical nor religious reasons for this practice, yet more than 125 million women live with the scars of Female Genital Mutilation/Cutting (FGM/C) internationally. Nearly 500,000 women/girls in the US have either undergone or are at risk of FGM/C and every state has reported cases of FGM/C (except Hawaii). California, Minnesota, and New York incur the highest incidences, with nearly 65,000 women/girls at threat throughout the NYC metropolitan area.

The United Nations has declared FGM/C a crime against humanity while a 2018 Detroit case ruled that FGM/C was not unconstitutional. While FGM/C and Vacation Cutting – the act of returning minor girls to their families' country of origin to get cut during school breaks- are both illegal in NY. While NY Penal Law §130.85 (2015) exists, there are no citywide coordinated responses in place to work with families experiencing these issues. Criminality alone, and criminality of primarily black and brown bodies, creates a vulnerability to communities experiencing FGM/C, exposing families to the risk of separation, foster care, incarceration and/or deportation. Moreover, the current status leaves women and young girls without any agency and body autonomy. As a children's rights, women's rights, human rights, immigrant rights, maternal health, public health, and mental health issue- a more nuanced and sophisticated approach akin to structures that currently exist for survivors of domestic violence (DV) and human trafficking (trafficking) is required.

In an era where honoring COVID-19 shelter-in-place guidelines has been a catalyst in the surge of all forms of gender-based violence, including FGM/C and the future of women's rights lay in peril

by our federal judiciary, the status of New York City as a sanctuary city is ever more relevant today. Therefore, I urge the council to support the passage of Pre-considered Int. no. 1828 and Pre-considered Int. no. 6774 to create a committee on FGM/C and FGM/C culturally-aware mandated training. Establishment of said legislation would enable:

1. The collection of accurate and prevalent data in New York City on women and girls who have undergone FGM/C and on girls who may be at risk of cutting. This data should be arrogated by borough and reflect ethnic and community practices;

2. The education of medical, mental health, youth-based educators, and other direct service family-based providers on the identification and proper care of women and girls who have undergone FGM/C. The FGM/C committee would be charged with developing a cohort of better practices the aforementioned professionals can employ for enhanced service delivery. The passage of Pre-considered Int. no. 6774 would provide the roadmap to bring this need into fruition.;

3. The establishment of a holistic specialty clinic focused exclusively on the care of women and girls who have undergone FGM/C, and which can serve as a model. This clinic will provide on-going gynecological, reproductive restoration and mental health support. While the pre-existing work of Gouverneur Hospital is noted, they are only one clinic with one medical doctor with FGM/C expertise. They do not have the capacity to work with the underestimated 65,000 women and girls in the NYC metropolitan area. Moreover, they have little to no outreach about their services within the communities most greatly impacted by FGM/C. Finally, as a safety measure, their location can often put women and girls seeking medical attention at risk of detection if their efforts are not supported by significant others and/or family members.

4. This policy and advocacy based citywide committee should be composed of leading members from a multitude of disciplines including, but not limited to, community-based, local government, health, education, medical, mental health, and law enforcement. The committee should meet regularly to develop industry-wide practices, resources, and initiatives based on guidance from its' governing body. This integrated engagement is what is desired from the advocacy-based actors of administration. The coordinated participation of city administration would further bolster the pre-existing infrastructure, validate this issue and fortify their political will.

Passage of Pre-considered Int. no. 1828 and Pre-considered Int. no. 6774, will establish an exclusive committee dedicated to the physical, mental, and social well-being of some of New York's' most vulnerable women and girls impacted by FGM/C and provide a body of culturally-aware service providers to offer support. Establishment of an FGM/C committee and culturally-aware mandates will be the first of its' kind in the country.

I sincerely urge the council to move both of these matters out of committee and for consideration of the entire voting body.

I thank the Committee members for your time and attention.